MO HEALTHNET OVERSIGHT COMMITTEE
Follow-Up Information to
February 3, 2009 Meeting

As a result of requests made during the February 3, 2009 meeting, the following information was provided to Committee members and is included in this packet.

1. Description of the comprehensive diabetes care HEDIS measure.

2. Changes made to the MO HealthNet managed care contract effective October 1, 2009.

COMPREHENSIVE DIABETES CARE

Cholesterol control for people with diabetes can improve cardiovascular conditions by up to 50 percent.

Diabetes is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or use the hormone insulin. It is one of the leading causes of death and disability in the U.S.[1] More than 20 million Americans live with diabetes today.[2] One-third of people with diabetes are not diagnosed.[1] Much of the burden of illness and cost of diabetes treatment is attributed to potentially preventable long-term complications including heart disease, blindness, kidney disease and stroke.[3] Timely screening and treatment can significantly reduce the disease burden.

About Diabetes

- People with diabetes are 2 to 4 times more likely than others to die as a result of heart disease.[3]
- Diabetes accounts for almost 45 percent of new cases of kidney failure.[4]
- 60 to 70 percent of people with diabetes have mild to severe forms of nervous system damage, including impaired sensation in the feet and hands and carpal tunnel syndrome.[5]
- Diabetic retinopathy, the damage of blood vessels in the retina, is the most common diabetic eye disease and a leading cause of blindness, causing 12,000 to 24,000 new cases of blindness annually.[1]
- Every 10 millimeters of mercury reduction in systolic blood pressure in diabetics results in a 12 percent reduction in diabetic complications.[1]

Measure Definition

These measures assess several features of effective management of diabetes and its potential complications. The measures estimate the percentage of health plan members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (> 9.0 percent)*
- A retinal eye exam
- LDL-C screening
- LDL-C control (less than 100 mg/dL)
- Medical attention for kidney disease (nephropathy)
- Blood pressure control (< 130/80 mm Hg)
- Blood pressure control (< 140/90)mm Hg)

** Lower rates are better for this measure.*

Note: In the *State of Health Care Quality 2007*, the Comprehensive Diabetes Care measure included a first-year indicator of HbA1c control to less than 7 percent. Since the report's publication last fall, two widely publicized studies, ACCORD and ADVANCE, raised potential patient safety issues related to aggressive HbA1c management.

Although the level of HbA1c control studied in ACCORD and ADVANCE was substantially lower than NCQA's target of 7.0 percent, NCQA opted to remove this measure from public reporting in 2008. NCQA has, in consultation with its Committee on Performance Measurement and a panel of diabetes experts, closely examined the underlying data and monitored developments; this measure will be modified for HEDIS 2009.

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO HEDIS 2009

- Added *amylin analogs* category to Table CDC-A.
- Deleted CPT code 99499 from Table CDC-C.
- For the eye exam indicator, removed the requirement that HCPCS S0625 (Table CDC-G) be billed by an optometrist or ophthalmologist.
- Added CPT codes 67041-67043, 67113 to Table CDC-G.
- Clarified the use of CPT Category II code 3072F in Table CDC-G.
- Deleted CPT codes 83715, 83716 from Table CDC-H.
- Deleted DRGs from Tables CDC-B, CDC-K.
- Added UB Type of Bill code 72x to Table CDC-K.
- Added POS code 65 to Table CDC-K.

Note: *Because of the anticipated publication of several new relevant studies, NCQA will review the HbA1c good control (<7.0%) indicator during summer 2008. Modifications to the indicator will be announced in the Volume 2* Technical Update.

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following.

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c good control (<7.0%)
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- Blood pressure control (<130/80 mm Hg)
- Blood pressure control (<140/90 mm Hg)

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one 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 Medical.

Event/diagnosis Two methods identify members with diabetes: pharmacy data and claim/encounter data. The organization must use both to identify the eligible population, but a member only needs to be identified in one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A).

Table CDC-A: Prescriptions to Identify Members with Diabetes

Description	Prescription		
Alpha-glucosidase inhibitors	• acarbose	• miglitol	
Amylin analogs	• pramlinitide		
Antidiabetic combinations	• glimepiride-pioglitazone • glimepiride-rosiglitazone • glipizide-metformin • glyburide-metformin	• metformin-pioglitazone • metformin-rosiglitazone • metformin-sitagliptin	
Insulin	• insulin aspart • insulin aspart-insulin aspart protamine • insulin detemir • insulin glargine • insulin glulisine • insulin inhalation • insulin isophane beef-pork • insulin isophane human • insulin isophane pork • insulin isophane-insulin regular	• insulin lispro • insulin lispro-insulin lispro protamine • insulin regular beef-pork • insulin regular human • insulin regular pork • insulin zinc beef-pork • insulin zinc extended human • insulin zinc human • insulin zinc pork	
Meglitinides	• nateglinide	• repaglinide	
Miscellaneous antidiabetic agents	• exenatide	• pramlintide	• sitagliptin
Sulfonylureas	• acetohexamide • chlorpropamide • glimepiride	• glipizide • glyburide	• tolazamide • tolbutamide
Thiazolidinediones	• pioglitazone	• rosiglitazone	

Note: *Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis coding only. NCQA will provide a complete list of medications and NDC codes on its Web site (www.ncqa.org) by November 14, 2008.*

Claim/encounter data. Members who had *two* face-to-face encounters with a diagnosis of diabetes (Table CDC-B) on different dates of service in an outpatient setting or nonacute inpatient setting, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table CDC-C for codes to identify visit type.

Table CDC-B: Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Table CDC-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c testing An HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in Table CDC-D.

Table CDC-D: Codes to Identify HbA1c Tests

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F, 3047F	4548-4, 4549-2, 17856-6

HbA1c poor control >9% Use automated laboratory data to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is >9.0% or is missing a result or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the automated result for the most recent HbA1c test during the measurement year is ≤9.0%.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-E and use the most recent code during the measurement year to evaluate whether the member is numerator compliant (3046F indicates the member is numerator compliant; 3044F, 3045F, 3047F indicate the member is not numerator compliant).

Note: *For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).*

Table CDC-E: Codes to Identify HbA1c Levels >9%

Description	CPT Category II
Numerator compliant (HbA1c >9.0%)	3046F
Not numerator compliant (HbA1c ≤9.0%)	3044F, 3045F, 3047F

HbA1c good control <7% Use automated laboratory data to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is <7.0%. The member is not numerator compliant if the automated result for the most recent HbA1c test is ≥ 7.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-F and use the most recent code during the measurement year to evaluate whether the member is numerator compliant (3044F indicates the member is numerator compliant; 3045F, 3046F, 3047F indicate the member is not numerator compliant).

Table CDC-F: Codes to Identify HbA1c Levels <7%

Description	CPT Category II
Numerator compliant (HbA1c <7.0%)	3044F
Not numerator compliant (HbA1c ≥7.0%)	3045F, 3046F, 3047F*

* CPT Category II code 3047F indicates HbA1c ≤9% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization may elect to use other sources (laboratory data, hybrid reporting method) to determine if the HbA1c result was less than 7%.

Eye exam An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following.

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, ***or***
- A *negative* retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Refer to Table CDC-G for codes to identify eye exams. For exams performed in the year prior to the measurement year, a result must be available.

Table CDC-G: Codes to Identify Eye Exams*

CPT	CPT Category II**	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F***	S0620, S0621, S0625**, S3000	V72.0	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16

* Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.

** The organization does not need to limit CPT Category II codes or HCPCS S0625 to an optometrist or an ophthalmologist. These codes indicate an eye exam was performed by an eye care professional.

*** CPT Category II code 3072F can only be used if the claim/encounter was during the measurement year because it indicates the member had "no evidence of retinopathy in the prior year." Additionally, because the code definition itself indicates results were negative, an automated result is not required.

LDL-C screening An LDL-C test performed during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in table CDC-H.

Organizations may use a calculated LDL for LDL-C screening and control indicators.

Table CDC-H: Codes to Identify LDL-C Screening

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 24331-1, 39469-2, 49132-4

LDL-C control <100 mg/dL Use automated laboratory data to identify the *most recent* LDL-C test during the measurement year. The member is numerator compliant if the most recent automated LDL-C level is <100 mg/dL. If the automated result for the most recent LDL-C test during the measurement year is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the member is not numerator compliant.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-I and use the most recent code during the measurement year to evaluate whether the member is numerator compliant. Use Table CDC-I to determine compliance (3048F indicates the member is numerator compliant; 3049F, 3050F indicate the member is not numerator compliant).

Table CDC-I: Codes to Identify LDL-C Levels

Description	CPT Category II
Numerator compliant (LDL-C <100 mg/dL)	3048F
Not numerator compliant (LDL-C ≥100 mg/dL)	3049F, 3050F

Medical attention for nephropathy A nephropathy screening test ***or*** evidence of nephropathy, as documented through administrative data.

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

Nephropathy screening test A nephropathy screening test during the measurement year (Table CDC-J).

Table CDC-J: Codes to Identify Nephropathy Screening Tests

Description	CPT	CPT Category II	LOINC
Nephropathy screening test	82042, 82043, 82044, 84156	3060F, 3061F	1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13801-6, 14956-7, 14957-5, 14958-3, 14959-1, 13705-9, 14585-4, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 34535-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1

Evidence of nephropathy

Any of the following meet criteria for evidence of nephropathy.

- A claim/encounter with a code to indicate evidence of treatment for nephropathy (Table CDC-K) during the measurement year.
- A nephrologist visit during the measurement year, as identified by the organization's specialty provider codes (no restriction on the Diagnosis or Procedural code submitted).
- A *positive* urine macroalbumin test in the measurement year, as documented by claim/encounter or automated laboratory data. Refer to Table CDC-K for codes to identify urine macroalbumin tests. "Trace" urine macroalbumin test results are not considered numerator-compliant.
- Evidence of ACE inhibitor/ARB therapy during the measurement year. Members who had a claim indicating therapy (Table CDC-K) or received an ambulatory prescription or were dispensed an ambulatory prescription for ACE inhibitors or ARBs during the measurement year are compliant. Table CDC-L lists the ACE inhibitors/ARBs included in this measure.

Table CDC-K: Codes to Identify Evidence of Nephropathy

Description	CPT	CPT Category II*	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS	LOINC
Urine macroalbumin test*	81000-81003, 81005	3062F							5804-0, 20454-5, 24356-8, 24357-6
Evidence of treatment for nephropathy	36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512	3066F	G0257, G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6	0367, 080x, 082x-085x, 088x	72x	65	
ACE inhibitor/ ARB therapy		4009F							

*A CPT Category II code indicates a positive result for urine macroalbumin; the organization must use automated laboratory data to confirm a positive result for tests identified by CPT or LOINC codes.

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription
Angiotensin converting enzyme inhibitors	• benazepril • captopril • enalapril • fosinopril • lisinopril • moexipril • perindopril • quinapril • ramipril • trandolaprilt
Angiotensin II inhibitors	• candesartan • eprosartan • irbesartan • losartan • olmesartan • telmisartan • valsartan
Antihypertensive combinations	• amlodipine-benazepril • benazepril-hydrochlorothiazide • candesartan-hydrochlorothiazide • captopril-hydrochlorothiazide • enalapril-hydrochlorothiazide • eprosartan-hydrochlorothiazide • fosinopril-hydrochlorothiazide • hydrochlorothiazide-irbesartan • hydrochlorothiazide-lisinopril • hydrochlorothiazide-losartan • hydrochlorothiazide-moexipril • hydrochlorothiazide-olmesartan • hydrochlorothiazide-quinapril • hydrochlorothiazide-telmisartan • hydrochlorothiazide-valsartan • trandolapril-verapamil

Note: *NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 14, 2008.*

Blood pressure control <130/80 mm Hg

Use automated data to identify the most recent BP reading during the measurement year.

The member is numerator compliant if the BP is <130/80 mm Hg. The member is not compliant if the BP is ≥130/80 mm Hg or if there is no automated BP reading during the measurement year. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-M and use the most recent codes during the measurement year to evaluate whether the member is numerator compliant for both systolic and diastolic levels.

Table CDC-M: Codes to Identify Systolic and Diastolic BP Levels <130/80

Description	CPT Category II	
	Systolic	Diastolic
Numerator compliant (BP <130/80 mm Hg)	3074F	3078F
Not numerator compliant (BP ≥130/80 mm Hg)	3075F, 3077F	3079F, 3080F

Blood pressure control <140/90 mm Hg

Use automated data to identify the most recent BP reading during the measurement year. Refer to Table CDC-N and use the most recent code to evaluate whether the member is numerator compliant.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg or if there is no automated BP reading during the measurement year. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-N and use the most recent codes during the measurement year to evaluate whether the member is numerator compliant for both systolic and diastolic levels.

Table CDC-N: Codes to Identify Systolic and Diastolic BP Levels <140/90

Description	CPT Category II	
	Systolic	Diastolic
Numerator compliant (BP <140/90 mm Hg)	3074F, 3075F, 3076F	3078F, 3079F
Not numerator compliant (BP ≥140/90 mm Hg)	3077F	3080F

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line. The organization may reduce the same size using the current year's administrative rate or the prior year's audited, product-line specific results. The organization should first take the inverse of the HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate), and then reduce using the lowest rate among all the reported CDC indicators. For information on reducing sample size, refer to the *Guidelines for Calculations and Sampling*.

Numerators

HbA1c testing

An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

Administrative

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result. The organization may count notation of the following in the medical record.

- A1c
- Hemoglobin A1c
- HgbA1c
- HbA1c
- Glycohemoglobin A1c

HbA1c poor control >9%

The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing or was not done during the measurement year, as documented through automated laboratory data or medical record review.

Note: *For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).*

Administrative

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result.

HbA1c good control <7%

The *most recent* HbA1c level (performed during the measurement year) is <7.0% as identified by automated laboratory data or medical record review.

Administrative

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in medical record must include a note indicating the date on which the HbA1c test was performed and the result.

Eye exam

An eye screening for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following.

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, ***or***
- A *negative* retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Administrative

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include one of the following.

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date on which the procedure was performed and the results, ***or***
- A chart or photograph of retinal abnormalities indicating the date on which the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

LDL-C screening

An LDL-C test performed during the measurement year as identified by claim/ encounter or automated laboratory data or medical record review.

Administrative

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. The organization may use a calculated LDL for LDL-C screening and control indicators.

LDL-C control <100 mg/dL

The *most recent* LDL-C level performed during the measurement year is <100 mg/dL, as documented through automated laboratory data or medical record review.

Administrative

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record

Documentation in medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result.

The organization may calculate LDL-C levels from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5)

If lipoprotein (a) is measured, use the following calculation.

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5) – 0.3 [lipoprotein (a)]

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL.

Medical attention for nephropathy

A nephropathy screening test during the measurement year ***or*** evidence of nephropathy during the measurement year as documented through either administrative data or medical record review.

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

Administrative

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record

Nephropathy screening test. At a minimum, documentation must include a note indicating the date on which a urine microalbumin test was performed, and the result. Any of the following meet criteria for a urine microalbumin test.

- 24-hour urine for microalbumin
- Timed urine for microalbumin
- Spot urine for microalbumin
- Urine for microalbumin/creatinine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio

Evidence of nephropathy. Any of the following meet criteria for evidence of nephropathy.

- Documentation of a visit to a nephrologist
- Documentation of medical attention for any of the following (no restriction on provider type)
  - Diabetic nephropathy
  - End-stage renal disease (ESRD)
  - Chronic renal failure (CRF)
  - Chronic kidney disease (CKD)
  - Renal insufficiency
  - Proteinuria
  - Albuminuria
  - Renal dysfunction
  - Acute renal failure (ARF)
  - Dialysis, hemodialysis or peritoneal dialysis
- A positive urine macroalbumin test. At a minimum, documentation in medical record must include a note indicating the date on which the test was performed, and a positive result. Any of the following meet criteria for a positive urine macroalbumin test.
  - Positive urinalysis (random, spot or timed) for protein
  - Positive urine (random, spot or timed) for protein
  - Positive urine dipstick for protein
  - Positive tablet reagent for urine protein
  - Positive result for albuminuria
  - Positive result for macroalbuminuria
  - Positive result for proteinuria
  - Positive result for gross proteinuria

  Note: *"Trace" urine macroalbumin test results are not considered numerator compliant.*
- Evidence of ACE inhibitor/ARB therapy. Documentation in medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs within the measurement year.

Blood pressure control <130/80 mm Hg The *most recent* BP level (taken during the measurement year) is <130/80 mm Hg, as documented through administrative data or medical record review.

Blood pressure control <140/90 mm Hg The *most recent* BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.

Administrative Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical record To determine if BP is adequately controlled, the organization must identify the representative BP following the steps below.

Identifying the medical record The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from which the member receives care.

Step 1 Identify the most recent BP reading notated during the measurement year. Do not include BP readings that meet the following criteria.

- BPs taken during an acute inpatient stay or an ED visit
- BPs taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)
- BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)
- BP readings taken by the member

Step 2 Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

Exclusions *(optional)*

- Members with a diagnosis of polycystic ovaries (Table CDC-O) who did not have any face-to-face encounters with a diagnosis of diabetes (CDC-B), in any setting, during the measurement year or the year prior to the measurement year. Diagnosis can occur at any time in the member's history, but must have occurred by December 31 of the measurement year.
- Members with gestational or steroid-induced diabetes (CDC-O) who did not have any face-to-face encounters with a diagnosis of diabetes (CDC-B), in any setting, during the measurement year or the year prior to the measurement year. Diagnosis can occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year.

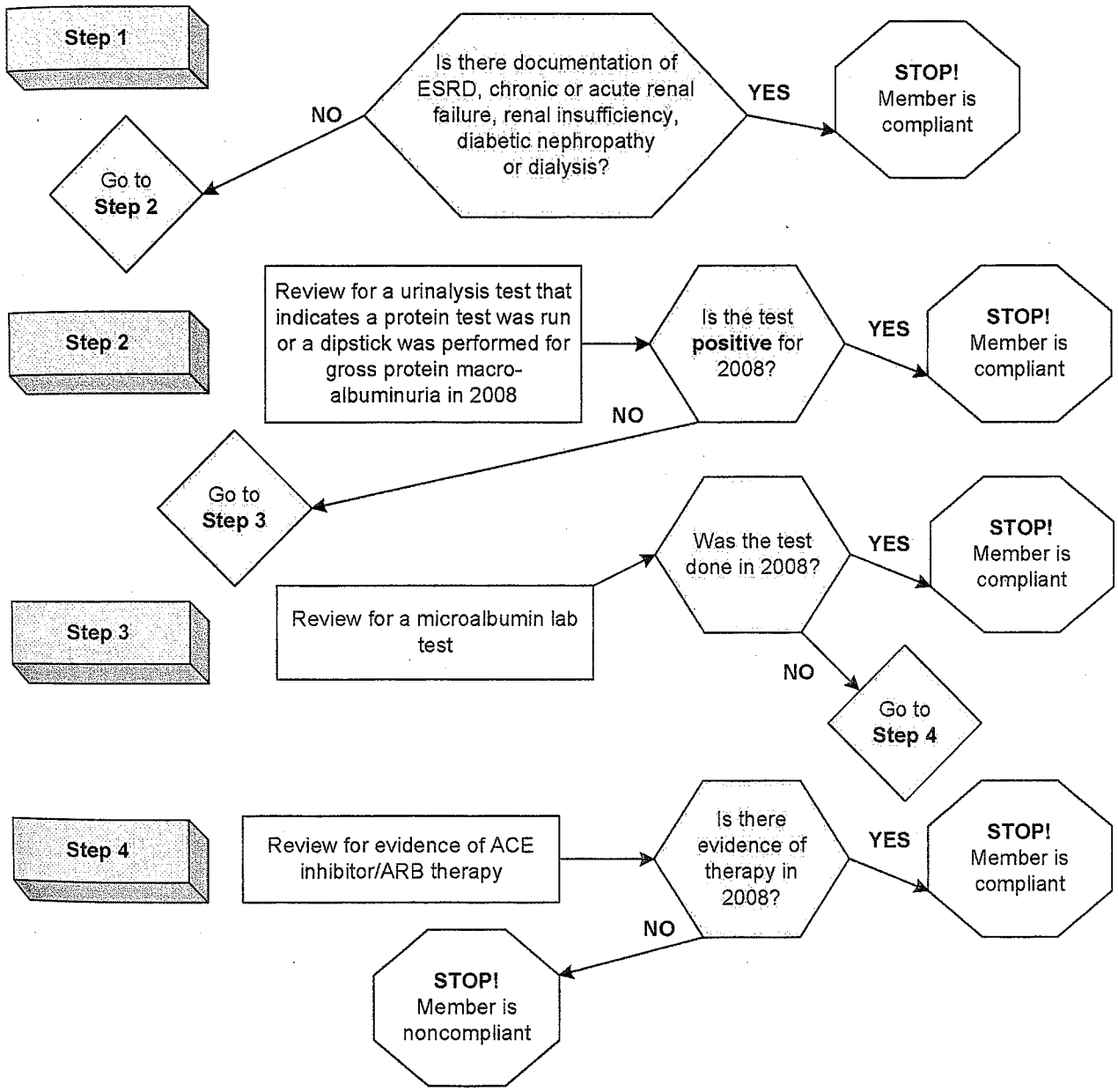
Table CDC-O: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic ovaries	256.4
Steroid induced	251.8, 962.0
Gestational diabetes	648.8

Note

- *The organization may select data collection method (Administrative vs. Hybrid) at the indicator level, but the method for screening and control rates must be consistent, as must the methodology for BP control indicators.*
- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*

Monitoring for Diabetic Nephropathy



Data Elements for Reporting

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

Table CDC-1/2/3: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	*Each of the 9 rates*	*Each of the 9 rates*
Data collection methodology (Administrative or Hybrid)	*Each of the 9 rates*	*Each of the 9 rates*
Eligible population	*Each of the 9 rates*	*Each of the 9 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 9 rates*
Current year's administrative rate (before exclusions)		*Each of the 9 rates*
Minimum required sample size (MRSS) or other sample size		*Each of the 9 rates*
Oversampling rate		*Each of the 9 rates*
Final sample size (FSS)		*Each of the 9 rates*
Number of numerator events by administrative data in FSS		*Each of the 9 rates*
Administrative rate on FSS		*Each of the 9 rates*
Number of original sample records excluded because of valid data errors		*Each of the 9 rates*
Number of administrative data records excluded		*Each of the 9 rates*
Number of medical records excluded		*Each of the 9 rates*
Number of employee/dependent medical records excluded		*Each of the 9 rates*
Records added from the oversample list		*Each of the 9 rates*
Denominator		*Each of the 9 rates*
Numerator events by administrative data	*Each of the 9 rates*	*Each of the 9 rates*
Numerator events by medical records		*Each of the 9 rates*
Reported rate	*Each of the 9 rates*	*Each of the 9 rates*
Lower 95% confidence interval	*Each of the 9 rates*	*Each of the 9 rates*
Upper 95% confidence interval	*Each of the 9 rates*	*Each of the 9 rates*

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Section	Change	Reason
General	**Pharmacy Carve-Out.** Provisions related to pharmacy have been deleted	Pharmacy has been carved out of the contract.
2.1.6	Added provision regarding **waiver of requirement to serve all regions**: "The health plan may request a waiver of the requirement to serve in all areas in the region provided there is a bonafide legal reason that prohibits the health pan from doing business in one (1) or more of the areas in the region. The health plan shall notify the state agency and provide justification articulating the legal reason for requesting the waiver at the time of the proposal submission. The state agency has the sole authority to approve or disprove the request."	Created an exception for proposers who can not serve an entire region if legal justification is submitted to the state for review and approval.
2.3	**Added new cultural competency language**: "The health plans shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. Health plans shall exhibit congruent behaviors, attitudes and policies that come together in a system that enables effective work in cross-cultural situation."	Strengthens linguistic and cultural competency language.
2.4.1	**Provider Networks** - Modified general requirements for networks, clarified that providers listed were the minimum required and added language that health plans shall regularly monitor provider networks to ensure that accessibility standards are being met, that provider listings of panel status (open and closed) are accurate, that members have and use their primary care providers and that emergency rooms are not being used unnecessarily. Added a requirement that the health plan monitoring their provider networks and report to the state agency when the provider reaches 80% capacity.	Moved language as part of the reorganization of the contract and enhanced health plan responsibilities for developing and monitoring network adequacy.

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Section	Change	Reason
2.4.12	Added several requirements for health plan responsibilities for **notifying the state about network changes**: a. "… At a minimum, this means the health plan shall notify the state agency when there is: 1) A decrease in the total number of primary care providers by more than five percent (5%); 2) A loss of providers that will result in the health plan failing to meet the access standards defined herein and in 20 CSR 400-7.095; 3) A loss of any hospital regardless of whether the loss will result in the health plan failing to meet the access standards defined herein and in 20 CSR 400-7.095; and 4) Other adverse changes to the composition of the provider network which impair or deny the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached 85% of capacity.	a. Network adequacy is fundamental in providing services to members. This language was added to ensure that the MO Health Net Division will be notified when there are significant changes to the network that might impair access.
2.5.1.	Clarified and added requirements for 24-hour coverage and type of call centers. Clarified that 24/7 coverage is required for: (1) treatment of an emergency medical condition; (2) nurse hotline which must be staffed at all times; (3) mental health crisis line to be staffed at all times by qualified mental health professionals and substance abuse counselors; (4) prior authorization line for providers which must be staffed at all times. Health plan is also required to provide an accommodation, if needed, to ensure all members equal access to 24 hour per day health care coverage and to comply with call center standards outlined elsewhere in the contract.	Language added and modified to clarify what is meant by 24/7 access with articulated standards for how coverage must be provided (e.g. in compliance with call center standards and staffed by appropriate individuals) to ensure members receive appropriate and needed services and assistance.

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Section	Change	Reason
2.5.1 b.	**Exclusive Contracts** - Added the following language: "A MO Health Net managed health care plan shall not have a contract arrangement with any provider in which the provider represents or agrees that it will not contract with another provider. A MO Health Net health plan shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider."	Added to prohibit exclusive arrangements with providers to ensure adequate access.
2.5.2	**Travel Distance Standards** - Added more specificity to travel distance requirements: "… For those providers not addressed under 20 CSR 400-7.095, the health plan shall ensure members have access to those providers within thirty (30) miles unless the health plan can demonstrate to the state agency that there is no licensed provider in that area, in which case the health plan shall ensure members have access to those providers within sixty (60) miles. .." Also added as an attachment the CSR travel and distance standards.	Additional language clarifies the standards to which health plan must comply. Adding the attachment ensures they are aware of the standards and setting an outside limit on providers not included in the CSR establishes a more clearly articulated standard for those providers.
2.5.3.d	**Appointment Standards** - Added language regarding policies and procedures for appointment standards and notification of members: "The health plan shall ensure that waiting times (defined as time spend both in the lobby and in the examination room prior to being seen by a provider) for primary care appointments doe not exceed one hour from scheduled appointment time. The health plan shall have policies and procedures for these appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The health plan shall disseminate these appointment standard policies and procedures to its in-network providers and to its members."	Removed "average" from "waiting time" language to address that an average waiting time of one hour was too lenient. Requiring that both members and providers be educated about appointment standards will help ensure they are being met.
2.5.4.a	Amended existing language to clarify that the health plan is prohibited from requiring prior authorization for emergency medical/mental health services.	Strengthened language to ensure there are no PAs for emergency services.

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Section	Change	Reason
2.5.7	**Direct Access and Standing Referral** - Amended language to clarify that the health plan shall have direct access and standing referral policies and procedures that address how a member, including but not limited to those with special health care needs, may request and obtain referrals to out-of-network providers, specialists, and specialty care centers.	Addresses access to specialists for special health care needs members.
2.6	**Payments to Providers** - Amended language on payment to providers and circumstances in which providers can bill members.	Clarification on when cost sharing is appropriate and when it is not should help minimize member issues in this area.
2.6.8	**Fee Schedule** - Added language regarding Fee Schedule for Office Visit Services and Dental Services and definitions of such services: "The Missouri 94th General Assembly approved a statutory change for the MO HealthNet Division to develop a four-year plan to achieve parity with Medicare reimbursement rates for physicians and approved a fee increase for the MO HealthNet dental and optical services. The statutory change affects MO HealthNet Managed Care health plans' reimbursement rates. Since the Missouri General Assembly appropriated funds expressly for the services required herein, the health plan shall pass fee increases to its providers commensurate with the Missouri General Assembly's intent. The health plan shall maintain the fee schedule for dental, optical and physician services at no lower than the MO HealthNet Fee-For-Service fee schedule in effect at the time of service for the codes that had a fee effective date of July 1, 2007 or later in the programs described below. The MO HealthNet Online Fee-For-Service Fee Schedule is available electronically at the MO HealthNet Division's website: http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm." Also edited existing language to amend tense to past as the actions occurred in the past.	Ensures payment provisions which were legislatively enacted are maintained.

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Section	Change	Reason
2.7.1.e.3	In HCY/EPSDT section added definition of ameliorate and clarified that all medically necessary diagnosis and treatment services must be provided as long as they are permitted under the Medicaid statute, whether or not they are covered under the state's Medicaid plan, and without any regard to any restrictions the state may impose on services for adults.	Added language to clarify definitions of and requirements for coverage of follow-up diagnostic and treatment services to meet HCY/EPSDT requirements.
2.7.1.n.1	Edited language to highlight the mental health and substance abuse services for which the health plans are responsible as opposed to those for which they are not responsible (greater detail on this appears in the section on services provided by other entities).	Minor editing to clarify responsibilities of the health plan.
2.7.1.n.5	Added to the requirement about protocols for coordinating the diagnosis, treatment, and care between primary care providers and mental health and substance abuse providers the requirement that coordination also include assigned case managers.	Due to enhanced case management requirement inclusion of case managers to coordination activities is essential.
2.7.5	Changed medical necessity language to read: The health plan shall be responsible for providing services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. A service shall be considered medially necessary if it (1) prevents, diagnoses or treats a physical or mental illness or injury; (2) is necessary for the member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.	Provide greater clarity on medical necessity language. Enhancing statewide approach to medical necessity.
2.10.6	**Pharmacy Service** – Language added that requires the health plan to coordinate with the state agency as necessary to ensure that members receive pharmacy services without interruption. In addition, the health plan shall provide information to members about appropriate prescription drug usage and monitor and manage providers' prescribing patterns through activities such as educating providers regarding practice patterns and intervening with providers whose practice patterns appear to be operating outside industry or peer norms.	Pharmacy has been carved out of the contract but coordination between MO Health Net and the health plan will be necessary to provide quality services as it relates to the pharmacy benefit.

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Section	Change	Reason
2.11	**Case Management/Disease Management** - Completely re-wrote sections for Case Management and Disease Management to more clearly articulate requirements and focus on performance and outcomes. Requiring the health plans to have disease management programs for major depression, asthma and one of the following: obesity, diabetes, hypertension or Attention Deficit Hyperactivity Disorder (ADHD).	Added clarifying language on health plan requirements and populations covered. Incorporated sections of the state's policies on case management. Identified triggers for individuals who should receive case management. Clearly defined additional conditions for disease management.
2.12.4	Revised **auto-assignment algorithm** to focus more on quality and less on proposal scoring. By region, 40% of all auto-assignments will be assigned randomly; the remaining 60% will be based on quality. In year 1 the scores will be based on 3 HEDIS scores, evaluation score and the number of FQHCs, RHCs and CMHCs (beyond the minimum of 1). Each year the state agency will change the performance measures included, recalculate the performance score and the performance auto assignment for each health plan. At a minimum, in the second year, there will be two (2) additional HEDIS measures (for a total of five (5) HEDIS measures) and the total evaluation score will be replaced by a measure based upon encounter data and the extent to which it matches with health plan financial data submissions. In the third year, there will be one (1) additional HEDIS measure (for a total of six (6) HEDIS measures) and the total evaluation score will be replaced by a measure based upon encounter data and the extent to which it matches with health plan financial data submissions. The state agency will conduct meetings with stakeholders and the health plans to solicit input on appropriate measures to be used during the second and third years. The state agency will inform the health plans of the measures to be used at least six (6) months prior to the implementation of the changed performance auto	Significant work has been done on the auto-assignment algorithm clauses to promote quality, access to services, and continuing improvement in the delivery of health care services and to de-emphasize the evaluation scores.

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Section	Change	Reason
	assignment algorithm.	
2.12.5 b	**Member Relocation** - Added new section that members relocating to another region will automatically be enrolled with the same health plan if the health plan is operational in that region.	New requirement based on health plan suggestions.
2.12.17	New provider directory section added that requires the health plan to make available on its website an up-to-date searchable provider directory that is updated at least monthly. For physician this listing shall also include board certification status and language(s) spoken. The health plan shall have printed hard copies available of the directory which shall be mailed 48 hours of a member request for a hard copy version of the provider directory."	Wanted to separate out provider directory listing. Also hope to potentially decrease expenses related to providing directory if members are able and willing to access on-line. Protections were placed to ensure if the member wants a hard copy he or she can get one.
2.14.5	Added new section for member website that requires that the health plan "have a member portal on its website that is available to all members which contains accurate, up-to-date information about the health plan, services provided, the provider network, FAQs and contact phone numbers and e-mail addresses.	Increase access for members to information to promote member involvement and accountability.
2.15.2.e.	**Distribution of Provider Grievance System** - Inserted requirement that the health plan shall distribute information on the grievance system to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim whichever is earlier. This information may be distributed to providers via the member flyer, one designed for providers or the policies and procedures.	Language added to ensure that providers—both in and out-of-network are aware of the member grievance system.
2.16.4	Added requirement that the health plan have a **provider portal on its website** that includes all pertinent information including, but not limited to, the provider manual, update newsletters and information, information on obtaining prior authorizations, and information about how to contact the health plan. The health plan shall have policies and procedures in place to ensure the website is updated regularly and contains accurate information.	Increased access to providers about the health plan and processes and updates will help educate providers and make communication and interaction with them more effective and efficient.

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Section	Change	Reason
2.18.1	Added new language about the state's quality assessment and improvement program. (italicized language is new): "*The state agency's quality assessment and improvement program consists of internal monitoring by the health plan, oversight by federal and state governments, and evaluations by an independent, external review organization.* The state agency regulates the quality assessment and improvement functions of the health plan. *The quality assessment and improvement program will be annually evaluated for effectiveness. This process includes obtaining input from stakeholders, the State Quality Assessment & Improvement Advisory Group, Consumer Advisory Committee, and approval from CMS prior to implementation. In the instance there is significant change in outcome or indicator status that is not self-limiting and impacts on more than one area of the populations' health status, modifications will be made to the reporting process. These modifications may include changes to the monthly, quarterly and annual MO HealthNet Managed Care health plan reports, on-site review topics, and MO HealthNet Managed Care performance measures.*"	State quality strategy which had been an appendix was deleted and appropriate language brought into the contract to promote clarity and accountability in the quality area. This language had appeared in Appendix 6 – the Quality Strategy of the old contract.
2.18.3	**Quality Improvement Strategy** - Added the following language: "The health plan shall meet program standards for monitoring and evaluation of systems to meet Federal and State regulations. The health plan shall implement a Quality Improvement strategy that includes components to monitor, evaluate, and implement the contract standards and processes to improve: a. Quality management; b. Utilization management; c. Records management; d. Information management; e. Care management; f. Member services; g. Provider services; h. Organizational structure; i. Credentialing; j. Network performance;	State quality strategy which had been an appendix was deleted and appropriate language brought into the contract to promote clarity and accountability in the quality area. This language had appeared in Appendix 6 – the Quality Strategy of the old contract.

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Section	Change	Reason
	k. Fraud and abuse detection and prevention; l. Access and availability; and m. Data collection, analysis and reporting"	
2.18.8.d	Created new section on Performance Improvement Projects. Added new language requiring that the health plan include adolescent well-care for ages eight (8) through eighteen (18) as a topic for a performance improvement project.	New section highlights the importance of performance improvement projects. Specific requirement for adolescent well-care targets a specific State concern.
2.18.9	**NCQA Accreditation** - Incorporated requirement that the health plan obtain NCQA health plan accreditation for the MO HealthNet product within eighteen (18) to twenty-four (24) months of the first day of the contract period. The health plan shall maintain it thereafter and throughout the duration of the contract. The state agency will require that all health plans submitting proposals in response to future RFPS for the MO HealthNet managed care program have NCQA accreditation. Also establishes benchmarks for progress, to include status updates at 6 and 12 months. Not meeting this requirement to provide status updates may result in the health plan being considered to be in breach of the terms of the contract and may be subject to remedies for violation, breach or non-compliance of contract requirements. Failure to obtain accreditation in the prescribed time period and failure to maintain accreditation thereafter shall be considered a breach of the contract and shall result in termination of this contract. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of Final Report from and may result in termination of the Agreement.	Emphasis on quality improvement and on-going commitment to quality health care was an important goal of the reorganization and re-writing of the contract. The state also wanted to put all health plans on notice that their proposal would not even be considered in future procurements unless they obtain this accreditation.
2.21.6	Added new report: "Financial Transparency and Analysis: Upon request from the state agency the health plan shall submit provider (of all types, e.g. physicians, clinics, hospitals, etc.) specific payment data in the format and time-period requested by the state agency."	State requested to better monitor provider payment information.

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Section	Change	Reason
2.22.3.b	**Provider Network Updates** - Added language requiring that the health plan update the provider network file at the time of any change and as required in the Health Plan Record Layout Manual available at http://manuals.momed.com/manuals/edb.jsp.	Added specificity on network report and when the health plan should file the report in order to better monitor provider networks.
2.26.3	**Electronic Claims Management** - Created new section on electronic claims management functionality that includes on-line and phone-based capabilities to obtain status information and ability for electronic funds transfer.	Provision will expedite claims processing and payment for providers.
2.26.4	**National Standards for Claims Processing** - Inserted requirement that the health plan shall adhere to national standards related to claims processing, including but not limited to HIPAA-based standards and other federal and state requirements.	Ensures claims processing integrity.
2.26.5	**Encounter Data Submission** - Enhanced the encounter data requirements to use HIPAA-compliant 837D, 837I, and 837P formats for encounter submissions.	State indicated a desire to increase encounter data collection to enhance rate development activities.
2.26.6	Created new section on other electronic data exchange in the areas of benefit enrollment-change transactions, provider demographic files, PCP assignment files and HBM baseline health data files.	Ensures health plan management in this area.
2.33.4	Added the following language: "The health plan shall understand and agree that the MO HealthNet managed care program is subject to modification by the Missouri General Assembly, the State of Missouri and the United States Department of Health and Human Services. Any changes to the program shall be made via notification to the health plan. The state agency will ensure that any program changes resulting in changes to rate will be done in an actuarially sound manner."	State requested language to put the health plans on notice that the MO HealthNet Program is impacted by acts and appropriations of the Missouri General Assembly.