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State of Connecticut 2010 External Quality Review

Government Human Services Consulting

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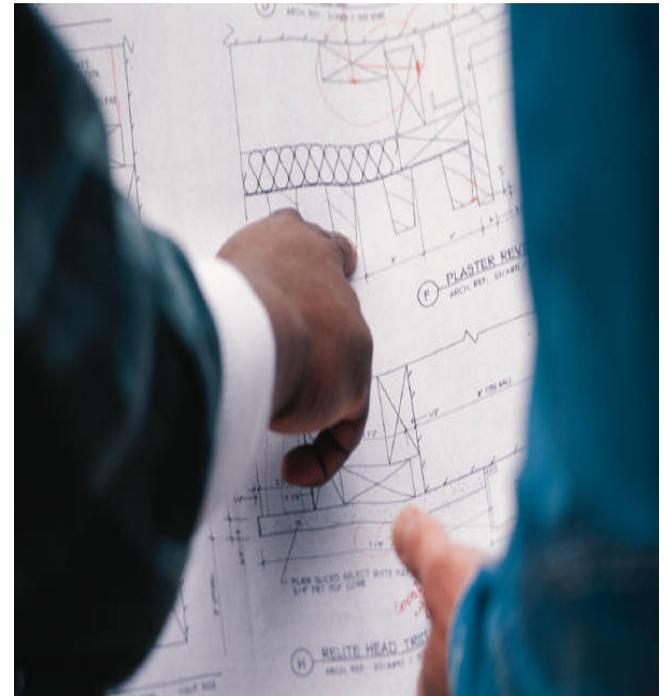
Introduction

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- The Balance Budget Act of 1997 (sections 4705(a) and 4705(b)) requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs)
- Federal regulations 42 CFR Part 438 Subpart E – External Quality Review, specifies that the following activities be performed annually:
 - Validation of Performance Measures required by the State and reported by MCOs in the preceding 12 months
 - Validation of Performance Improvement Projects required by the State and underway in the preceding 12 months
 - A review conducted in the previous 3-year period, to determine compliance with Federal and State Managed Care Quality Standards for access to care, structure and operations, and quality measurement and improvement
- More recently, key provisions of Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) emphasize child health quality and require that Children’s Health Insurance Program(s) (CHIP) adhere to Medicaid managed care standards, such as enrollee protections and quality assurance standards

External Quality Review Cycle (Current Husky Medicaid three year cycle)

- The scope of EQRO activities follows a three year cycle; one year of comprehensive review, followed by two years of targeted review or follow-up
- **2009** Comprehensive review of 2008 information
- **2010**
 - Review of Corrective Action Plans (CAPs)
 - Performance Improvement Projects (PIPs)
 - Performance Measures (PMs)
 - File reviews
 - Credentialing
 - Notices of action and appeals
 - Case management
- **2011**
 - Final review of Corrective Action Plans (CAPs)
 - Performance Improvement Projects (PIPs)
 - Performance Measures (PMs)
 - File reviews



Compliance with contractual and regulatory standards

- CMS has identified ***Access to care***, ***Timeliness of care*** and ***Quality*** as principle dimensions of the EQR that are evaluated by determining compliance with the following standards:
- **Access**
- **Structure and Operations**
- **Measurement and Improvement**



CMS specifies that “Quality, as it pertains to external review, means the degree to which the health plan increases the likelihood of desired health outcomes through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge”¹

¹Department of Health and Human Services Centers for Medicare & Medicaid Services. Federal Register, Code of Federal Regulations, Title 42, Vol. 3, October 1, 2005.

Compliance with contractual and regulatory standards: Access to care



Availability of Services 42 CFR 438.206	<i>Review of:</i> <ul style="list-style-type: none">▪ Provider directory and contracts▪ MCO provider reports▪ Policies and procedures (e.g. monitoring and compliance with timely access standards; coordination and continuity of care, authorization processes, etc.)▪ Provider and member survey results regarding accessibility and availability▪ Member materials and member handbook▪ Provisions to address cultural, ethnic, racial and linguistics needs▪ Grievance and appeal data
Assurances of adequate capacity and services 42 CFR 438.207	
Coordination and continuity of care 42 CFR 438.208	
Coverage and authorization of services 42 CFR 438.210	

Compliance with contractual and regulatory standards: Structural and Operational Standards

Provider selection 42 CFR 438.214	<p><i>Review of:</i></p> <ul style="list-style-type: none"> ▪ Provider selection criteria, credentialing and re-credentialing process and procedures including file review ▪ Policies and procedures (e.g. network, confidentiality, etc.) ▪ Provider and member survey results ▪ Member information on enrollment and disenrollment ▪ Member handbook ▪ Grievance and appeal procedures including file review ▪ Subcontractor contracts and results of delegated activities
Enrollee information 42 CFR 438.218	
Confidentiality 42 CFR 438.224	
Enrollment and disenrollment 42 CFR 438.226	
Grievance systems 42 CFR 438.228	
Sub-contractual relationships and delegation 42 CFR 438.230	

Compliance with contractual and regulatory standards: Measurement and Improvement



Practice guidelines 42 CFR 438.236	<i>Review of:</i> <ul style="list-style-type: none">▪ Practice guidelines▪ Provider manuals and information on practice guidelines through newsletters, bulletins and other forms of communication▪ MCO quality plan and policies▪ Quality committee minutes▪ Performance measures reports▪ Performance improvement project documentation▪ MCO encounter and claims procedures and reports
Quality assessment and improvement program 42 CFR 438.240	
Health information system 42 CFR 438.242	



2010 Key Findings Compliance with Regulations

Key Findings

● Met all requirements

◐ Met majority of requirements

○ Did not meet majority of requirements

Gray cells with ● indicate compliance in year 1 of 3 yr cycle (2009), and thus, not evaluated in 2010

	Aetna	AmeriChoice	CHNCT
Enrollee rights contract requirements	◐	○	●
Enrollee information requirements	◐	◐	◐
Enrollee rights and protections – Emergency and post stabilization services	●	◐	◐
Access standards – Availability of services	◐	◐	●
Access standards – Coordination and continuity of care	◐	◐	●
HUSKY Plus Physical Program coordination	◐	●	◐
Access standards – Coverage and authorization of services	●	●	◐

Key Findings (continued)

● Met all requirements

◐ Met majority of requirements

○ Did not meet majority of requirements

Gray cells with ● indicate compliance in year 1 of 3 yr cycle (2009), and thus, not evaluated in 2010

	Aetna	AmeriChoice	CHNCT
Structure & operation standards – provider selection	●	●	●
Structure & operation standards – sub-contractual relationships and delegation	●	●	●
Measurement & improvement standards – practice guidelines	●	●	●
Measurement & improvement standards – quality of care by network	◐	○	●
Grievance system – general requirements	●	●	◐
Grievance system – information about the grievance systems to providers and sub-contractors	●	●	●
Husky B provisions	◐	◐	●

Key Findings (continued)

● Met all requirements

◐ Met majority of requirements

○ Did not meet majority of requirements

Gray cells with ● indicate compliance in year 1 of 3 yr cycle (2009), and thus, not evaluated in 2010

	Aetna	AmeriChoice	CHNCT
Systems maintenance, backup & recovery	◐	◐	●
Information systems and claims personnel	○	◐	○
Electronic data interchange	●	◐	●
Encounter data	○	◐	◐
Enrollment & eligibility processing	◐	◐	●



Validation of Performance Measures

Validation of Performance Measures

<p>PM Validation Activities this Past Year</p>	<ul style="list-style-type: none">▪Cervical Cancer Screening (all MCOs)▪Chlamydia Screening in Women (all MCOs)▪Developmental Screening (all MCOs)▪Breast Cancer Screening (Aetna)▪Well-Child Visits in 3rd, 4th, 5th & 6th Years of Life (AmeriChoice)▪Use of Appropriate medications for people with Asthma (CHNCT)
<p>Overall Findings</p>	<p>All MCOs utilized a NCQA-certified HEDIS software tool to calculate PM results (except for Developmental Screening), therefore the EQRO did not have access to proprietary software code required to award a fully compliant (●) score</p>
<p>Recommendations</p>	<p>Move from non-HEDIS to HEDIS performance specifications when possible</p> <p>Require MCOs to have a plan for implementation of CPT Category II Codes (a set of supplemental tracking codes that can be used for performance measurement)</p>

Validation of Performance Measures

- Met all requirements
- ◐ Met majority of requirements
- Did not meet majority of requirements
- N/A = Not Applicable

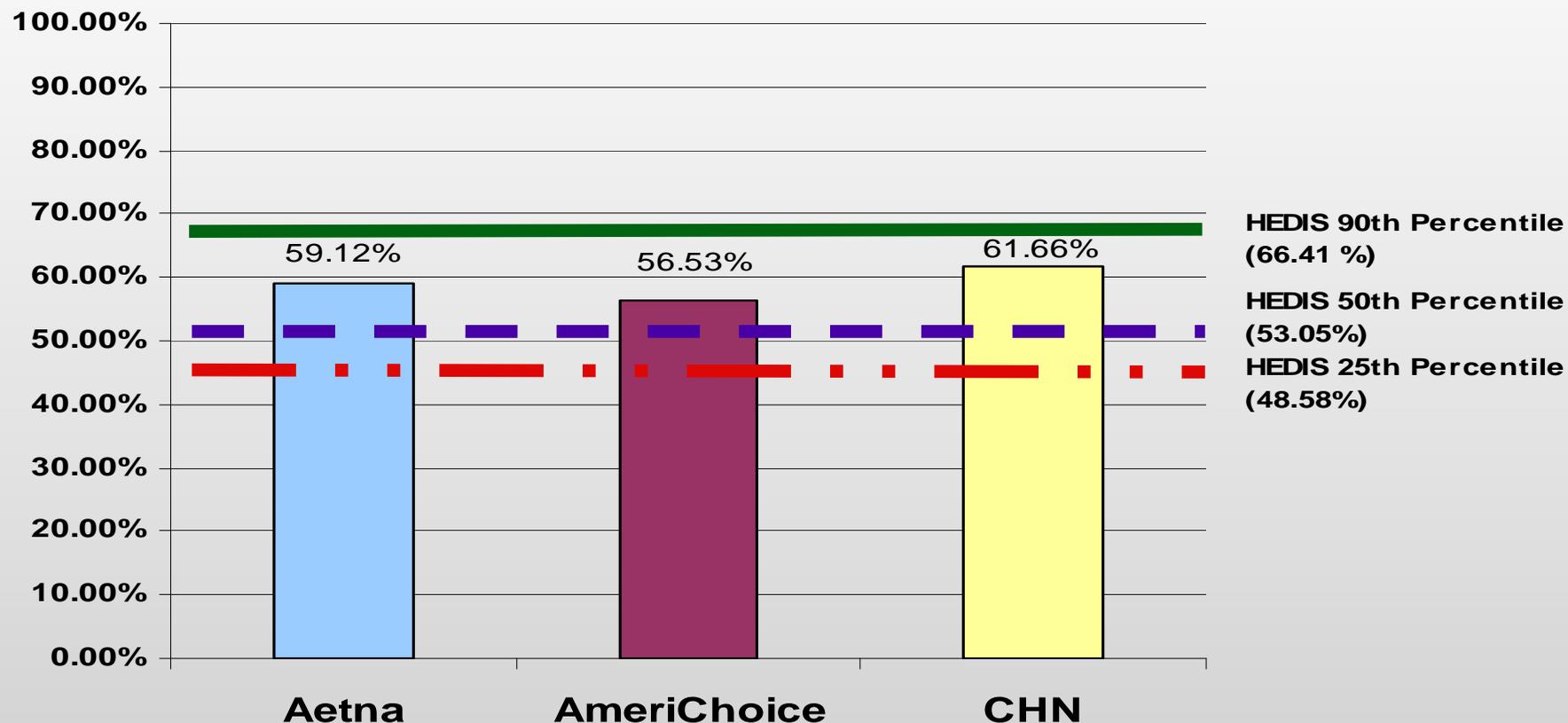
<i>Validated Measure</i>	Specification Source	Aetna	AmeriChoice	CHNCT
Cervical Cancer Screening	HEDIS 2010	◐	◐	◐
Chlamydia Screening	HEDIS 2010	◐	◐	◐
Developmental Screening	DSS defined	●	●	●
Breast Cancer Screening	HEDIS-like (DSS defined)	◐	N/A	N/A
Well-Child Visits in 3rd, 4th, 5th & 6th years of life	HEDIS 2010	N/A	◐	N/A
Use of appropriate medications for people with Asthma	HEDIS 2010	N/A	N/A	◐



Performance Measures

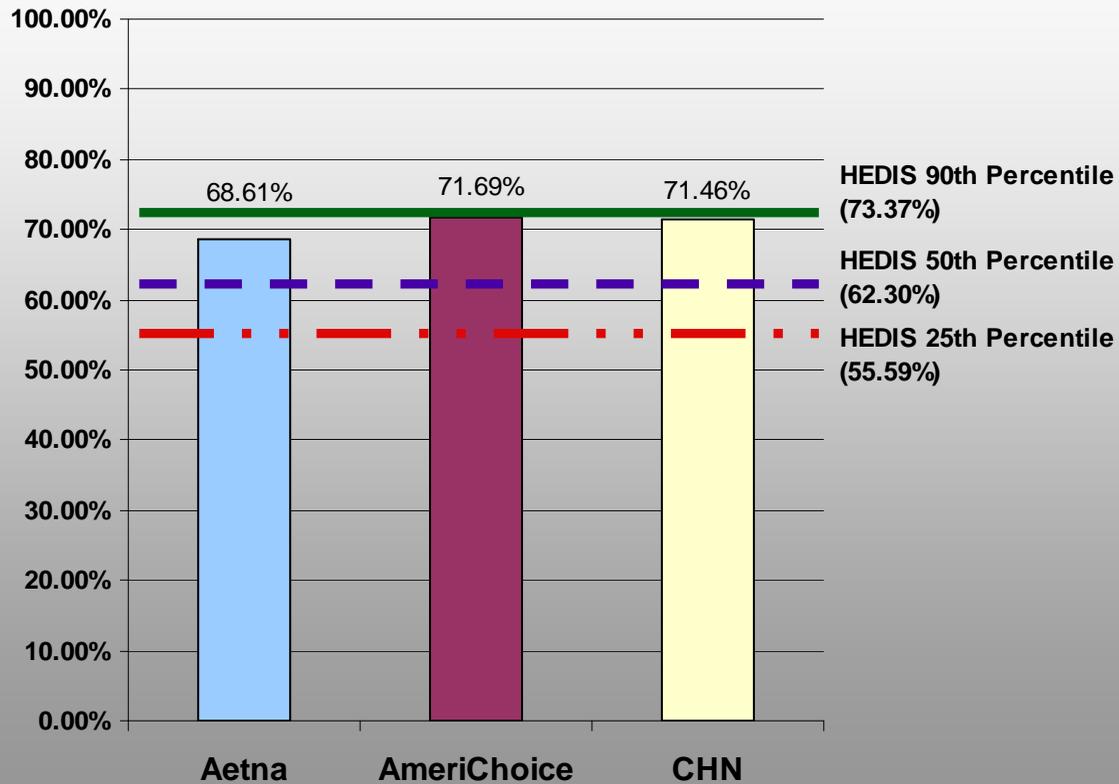
Validated Performance Measure: Chlamydia Screening

Chlamydia Screening in Women (16 – 20 years of age)



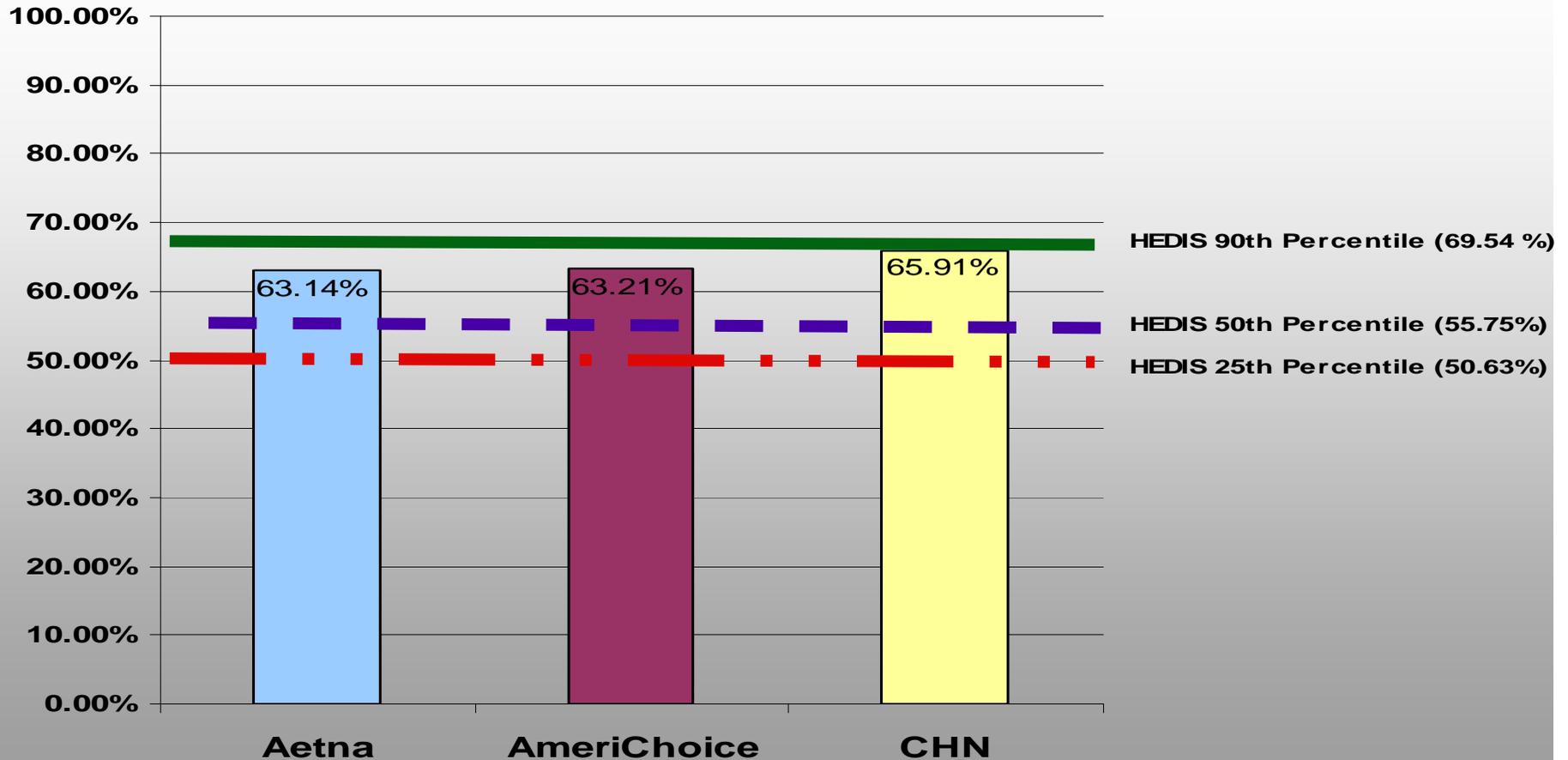
Validated Performance Measure: Chlamydia Screening (continued)

Chlamydia Screening in Women (21- 24 years of age)



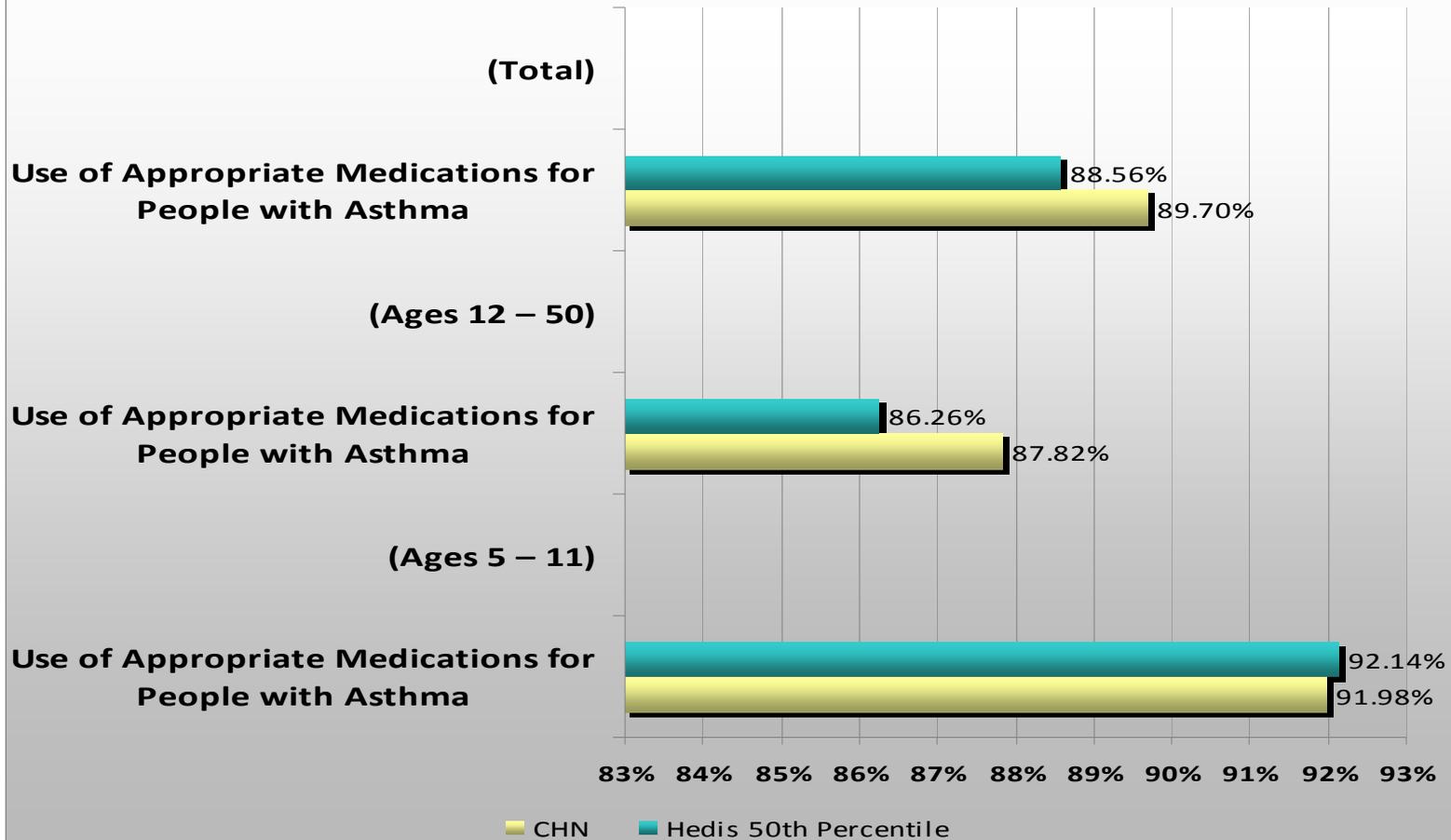
Validated Performance Measure: Chlamydia Screening (continued)

Chlamydia Screening Total



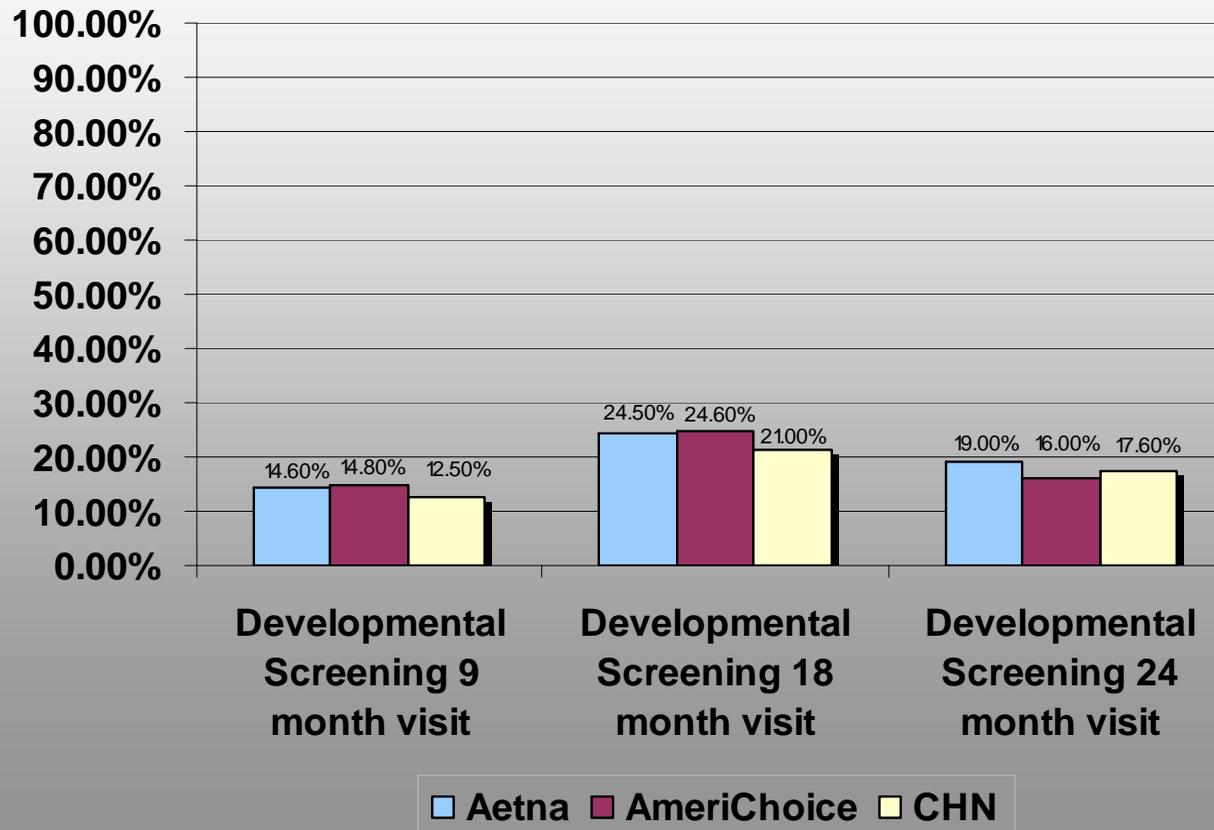
Validated Performance Measure: Use of Appropriate Medications for People with Asthma

Use of Appropriate Medications for People with Asthma

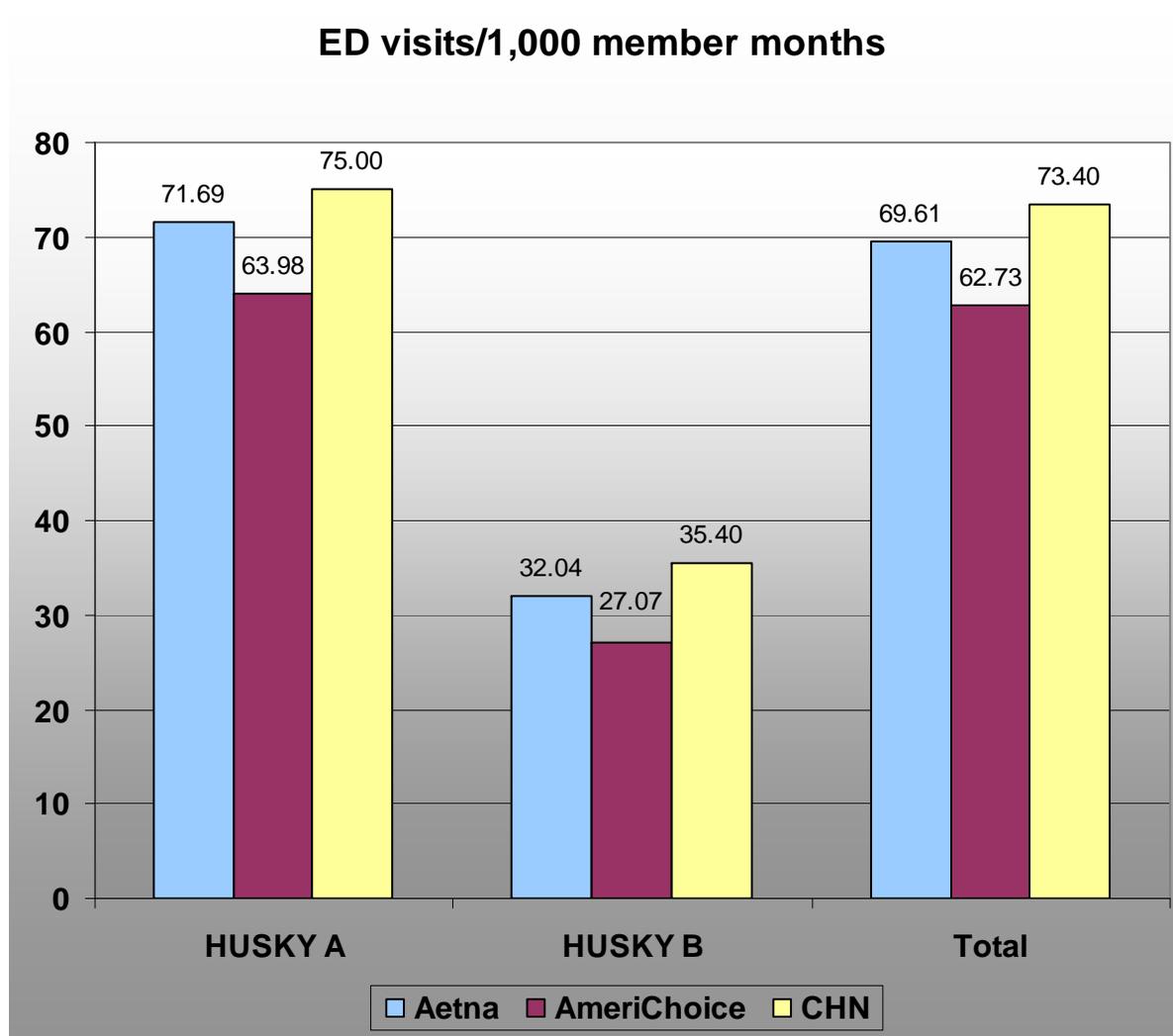


Validated Performance Measure: Developmental Screening

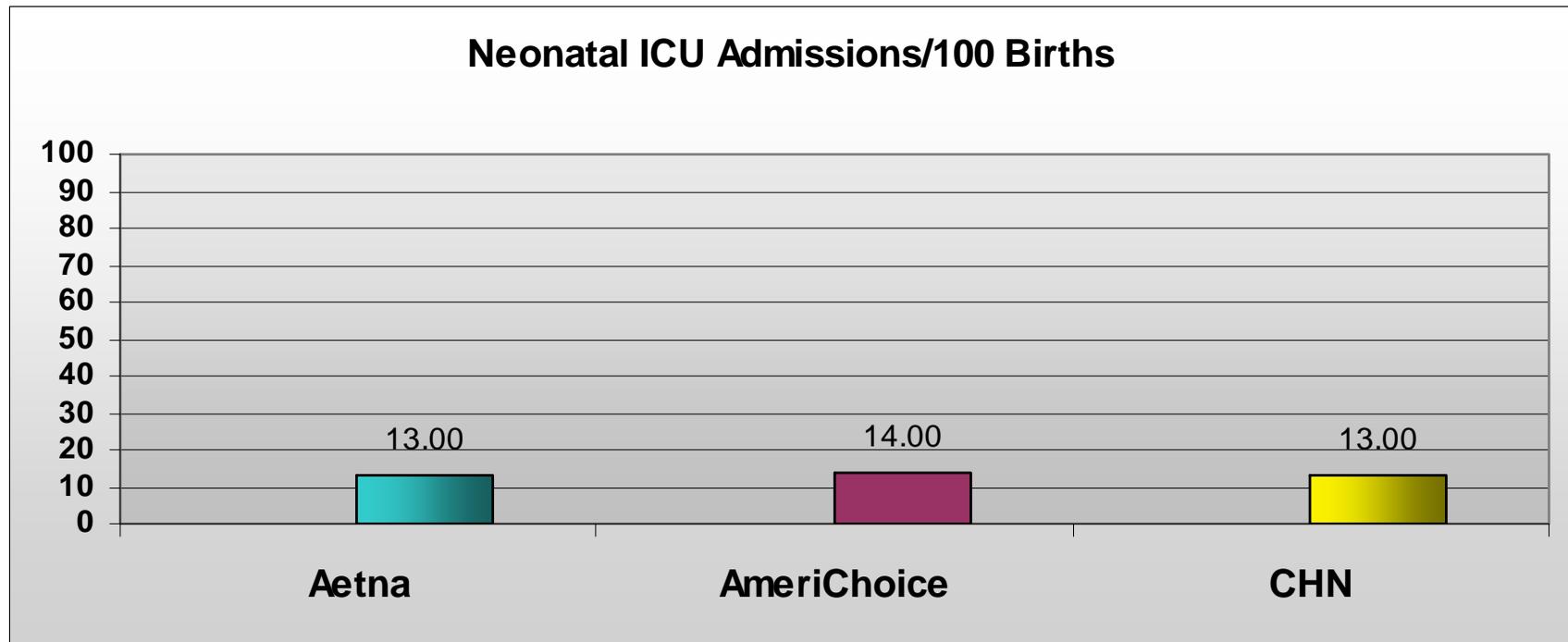
Developmental Screening (Not a HEDIS measure)



Calculated Performance Measure: Emergency Department Visits Per 1000 Member Months

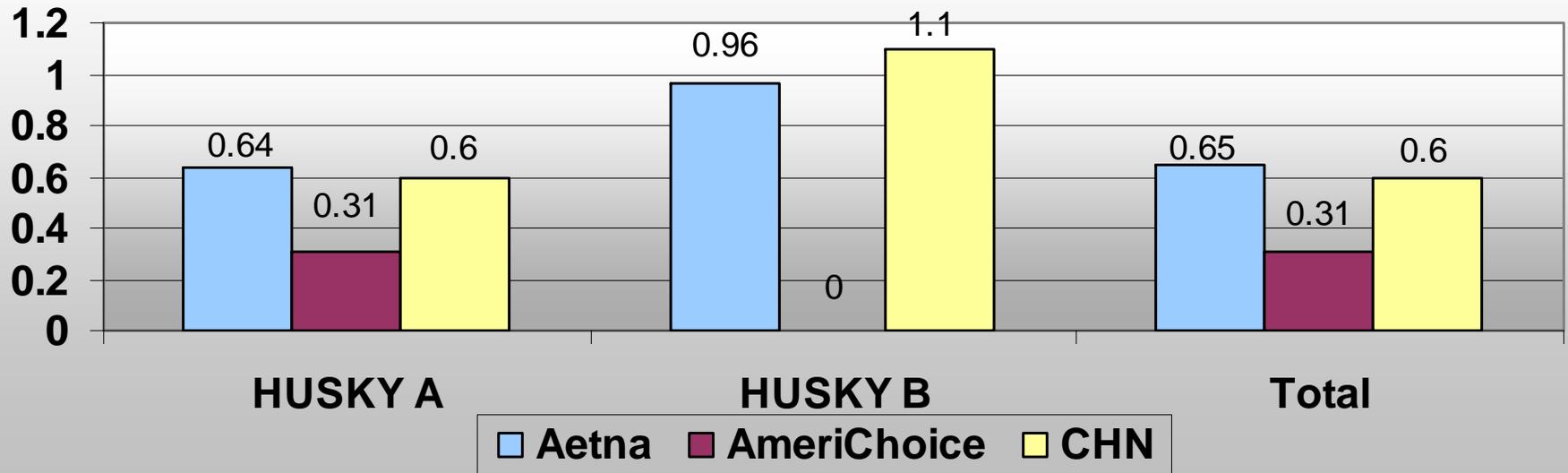


Calculated Performance Measure: Neonatal Intensive Care Unit (ICU) Admissions Per 100 Births



Calculated Performance Measure: Seven Day Readmission Rates

Seven day readmission rates (readmission/discharges)





Performance Improvement Projects (PIPs)

Performance Improvement Projects

PIP Validation Activities this Past Year	<ul style="list-style-type: none">▪Breast Cancer Screening▪Well Child Visit 15 months▪Well Child Visits in the 3rd, 4th, 5th & 6th years of life▪Adolescent Well Care▪Prenatal and Postnatal Care▪Comprehensive Diabetes Care
Overall PIP Findings	<p>All MCOs implemented PIPs but with varying specificity of documentation of the improvement process, including barrier analysis, and evaluation of interventions to address barriers and achieve goals. While all MCOs were substantially compliant with specifications for calculating results, confidence in success and sustainability of improvement efforts could not be determined since all MCOs implemented new baselines for performance improvement projects</p>
Recommendations	<p>In addition to annual PIP documentation, require MCOs to submit minutes of quality committee meetings and PIP status updates on a quarterly basis, reflecting discussion, analysis and direction by qualified committee members for each PIP</p>

Performance Improvement Projects (continued)

- Met all requirements
- ◐ Met majority of requirements
- Did not meet majority of requirements



	Aetna	AmeriChoice	CHNCT
Topic Selection	●	◐	●
Question Statement	●	○	●
Indicator Selection	●	◐	◐
Population Identification	●	●	●
Data Collection Procedures	●	◐	◐
Improvement Strategies	●	○	●
Data Analysis & Interpretation of Results	●	◐	◐
Confidence in Reported Results	●	●	●
Compliance with Specifications	●	●	●



EQR Recommendations

General themes

- General themes that Mercer noted as a result of EQR activities included the following key areas:
 - Access
 - Coordination of care
 - Case management
 - Quality improvement processes
 - Encounter data submission

Access

- Each MCO should develop processes (approved by DSS) to assess practice capacity to accommodate Husky A and Husky B members with quarterly reporting to DSS as well as the following:
 - Continue to ensure the network meets the needs of the population from both a primary care and a specialist perspective. Standardize reports with control limits detailing out-of-network versus in-network services with corrective action plans to adjust network when control limits exceeded
 - Run access reports with only providers that are accepting new patients to identify geo areas for more aggressive recruitment
 - Implement ongoing provider monitoring processes to assure network PCPs adhere to timely scheduling of appointments through DSS defined methodology for random appointment call/audit
 - Work with PCP practices to offer expanded hours (i.e. evenings, weekends)
 - Evaluate the utilization and effectiveness of 24/7 nurseline services or 24 hour physician lines
 - Consider the addition of HEDIS Use of Services measures for monitoring under and over utilization

Coordination of care

- Consider a collaborative quality improvement project to include MCOs, Behavioral Health and/or Dental Partnerships to evaluate current coordination of care processes and develop new processes to improve coordination of care as evidenced by measurement goals
- Review National Quality Forum² recommendation for care coordination for possible addition for quality strategy goals and MCO requirements based on dimensions of care coordination including:
 - Enhancements to discharge planning
 - Proactive plan of care and follow-up
 - Strategy for communication
 - Medication information and reconciliation
 - Availability of information systems to support care
 - Process for transitions or "hand-offs" (across providers and settings)

2 National Quality Forum (NQF), Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report, Washington, DC: NQF; 2010. © 2010. National Quality Forum

Case management

- Review processes that MCOs have in place for identification of members for case management programs and consider contract requirements for DSS approval of case management and chronic care management identification processes, enrollment processes and intervention strategies
- MCOs may want to consider adding an all-cause readmissions measure as required reporting
- Evaluate emergency room utilization/costs and implement appropriate follow-up processes for members with multiple ER admissions
- Review and enhance care management programs for high-risk members with multiple chronic conditions/co-occurring medical/behavioral health needs with methodology for evaluating impact of program on costs and quality metrics



Quality Improvement Process

- Update Quality Strategy to align with DSS Program goals and include Husky B program quality evaluation activities
- MCOs should be required to report on a set of HEDIS measures to the EQRO to assist in comparing performance and providing data on MCOs for public reporting (including year to year progress on measures). This set of measures would include core set of reportable measures, measures that the EQRO would validate and/or calculate and measures for which MCOs are conducting performance improvement projects. The set of measures should include more children's measures to adequately evaluate quality performance for the Husky A and Husky B population
- Consider including requirements for action plans when MCOs are below the 25th percentile of national average for Medicaid on any measure in the Reporting Set as described above
- In addition to annual PIP documentation, require MCOs to submit minutes of quality committee meetings on a quarterly basis, reflecting discussion, analysis and direction by committee members for each PIP

Encounter data submission

- Consider project to evaluate accuracy of encounter data and devise action plan for improving reporting and assuring ongoing-consistency of reliability and timely encounter reporting by MCOs



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