6

Compliance with Specific Contract Requirements — HUSKY B, HUSKY Plus, and HUSKY B Co-Payment

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO has a written process to determine eligibility for HUSKY Plus programs HUSKY Plus is available for CSHCNs who are enrolled in HUSKY B and fall within income bands 1 and 2. HUSKY B Members who fall into income band 3 are excluded from the HUSKY Plus program. Clinical eligibility for HUSKY Plus services is determined by the HUSKY Plus program. The MCO shall have final decision-making authority for those services for which they are at financial risk. The HUSKY Plus program shall have final decision-making authority for those supplemental services for which they are at financial risk. The HUSKY Plus programs shall be the documented payor of last resort.	BCFP has policies that outline the eligibility and referral processes for members to the HUSKY Plus program. By policy, the HUSKY Plus case manager participates in CM conferences on a monthly basis with HUSKY Plus personnel. BCFP has written customer service policies regarding HUSKY Plus Program inquiries. Two hundred and thirty-seven (237) members have been referred to HUSKY Plus during calendar year 2005, of which two hundred and seven (207) are still actively enrolled.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
HUSKY B member referrals to HUSKY Plus: include P&Ps and tracking information Referral The MCO shall refer Members who may have intensive BH needs to HUSKY Plus Behavioral and Members who may have intensive physical health needs to HUSKY Plus Physical. Referral shall consist of completion of the HUSKY Plus Referral Form and submission of the form to the appropriate HUSKY Plus program a. The MCO shall refer and facilitate the referral process for all Members who have been identified by the MCO as potentially benefiting from HUSKY Plus. b. The MCO shall refer all Members for whom a referral has been requested to HUSKY Plus by a parent, Member, applicant, or provider. The MCO shall contact the HUSKY Plus program to which it has a referral a Member within one month of the referral in order to confirm the Member's access to HUSKY Plus services. The MCO shall contact the DEPARTMENT if confirmation of HUSKY Plus eligibility has not been received.	BCFP has policies that outline the process of referral of members to HUSKY Plus program. An Excel spreadsheet is used to track all members referred to the HUSKY Plus Program. Policies indicated that referrals may be identified by a nurse, customer service representative, provider, or self-referral by a member. BCFP staff review the eligibility status, complete the referral form, and enter the member into the tracking system. The case manager nurses follow the members while they are enrolled in HUSKY Plus to ensure coordination of services. BCFP reported that typically, they do not need to contact the Department as HUSKY Plus eligibility information has been forthcoming timely.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO tracks member referral, enrollment, and disenrollment for the HUSKY Plus program and coordinates services with HUSKY Plus.	Documentation of HUSKY Plus referrals and coordination of services was evident during the review. An Excel spreadsheet is used by BCFP to track referral, enrollment, and disenrollment for the HUSKY Plus program. CM documentation is placed into the information system to track coordination of services for the HUSKY Plus members **Strengths:** Processes for referral and coordination of members to HUSKY Plus were well-documented in policies, flowcharts, and in tracking materials.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO has documentation defining QM processes, results, and tracking for HUSKY B members.	HUSKY B members are included in all activities encompassed by the QI Program as outlined in the BCFP 2005 Annual Evaluation including, but not limited to utilization and performance measure monitoring and performance improvement projects. The measures are calculated so that Medicaid members' results can be determined separate from other insurance products.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The global plan of care shall integrate HUSKY B services as set forth in Appendix A and HUSKY Plus services as set forth in Appendix B and C. The MCO shall be responsible for managing the utilization of HUSKY B services contained in the global plan of care.	BCFP has accepted responsibility for coordinating the global plan of care for HUSKY B and HUSKY Plus members for service referral, utilization, and care coordination.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO has P&Ps for billing and collecting HUSKY B co-payments.	BCFP had multiple policies encompassing the procedures for billing and collecting HUSKY B co-payments. The policies followed contractual requirements. They have established mechanisms for tracking maximum co-payment requirements to ensure that no payments were made that should be excluded or to return payments, when appropriate. The BCFP membership card identifies co-payment responsibilities.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
P&Ps tracking of HUSKY B annual aggregate cost sharing limit and repayment processes. Families of American Indian/Alaskan Native children who are Members of a Federally recognized tribe and who are in Income Band 1 or 2 are exempted from paying HUSKY B premiums or co-payments. The MCO shall ensure that the family is not charged any premiums or co-payments for qualified American Indian/Alaskan Native children as of the date DSS makes that determination. The MCO shall notify its providers and subcontractors for the American Indian/Alaskan Native exemption from premiums and co-payments. Member handbooks and information handouts developed by the MCO shall include information about the American Indian/Alaskan Native exclusion from premiums and co-payments. The MCO shall refer any Members who believe they qualify for the American Indian/Alaskan Native exemption to DSS for a determination of their qualification. The MCO shall provide all qualified American Indian/Alaskan Native children in Income Bands 1 and 2 with Membership identification cards stating “no co-payments,” and the MCO shall inform their HUSKY B providers and subcontractors that children with Membership cards so noted shall not be charged co-payments.	Families of American Indian/Alaskan Native children who are members of a Federally recognized tribe and who are in Income Band 1 or 2 are exempted from paying HUSKY B premiums or co-payments. Providers receive notification of this exemption when presented with the member ID card that identifies no co-payment. The revised *Member Handbook* for 2006 being printed in the Fall does have a notation that the Alaskan Native and American Indian member does not have any co-pay responsibilities. Policies do indicate that any co-payments erroneously paid are reimbursed within three months of payment.	Met

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
If the family has paid premiums and/or co-payments for qualified American Indian/Alaskan Native children, it is the responsibility of the MCO to repay the premiums and/or co-payments to the family within three (3) months of the MCO's determination that they were paid. It is the responsibility of the MCO to review the Member accounts quarterly to determine which families have paid premiums and/or co-payments for qualified American Indian/Alaskan Native children. The quarterly review must be completed no later than 15 days after the end of each quarter. The MCO shall make the review available to DSS upon request		
Recommendations: None		

7

Validation of Performance Improvement Projects

Objective 1
To assess the methodology applied by BCFP for conducting a PIP.

Objective 2
To evaluate the overall validity and reliability of study results.

Objective 3
To assess compliance with State required specifications.

PIPs are an essential component of an MCO's Quality Program and are used to identify, assess, and monitor improvement in processes or outcomes of care. DSS selected all PIPs for inclusion in this review. Some of the selected projects were designed to apply DSS-developed specifications, some used HEDIS 2005 specifications, and others used designs developed by the MCOs.

Four PIPs were reviewed for BCFP. The PIPs and the specifications to be applied included:

1. Appropriate Use of Asthma Medications;
2. Improving Adolescent Access to Preventative Services;
3. Breast Cancer Screening; and
4. Cervical Cancer Screening

Review Methodology

The PIP review process included application of the CMS protocol entitled ”Validating PIPs” and assessing for the compliance to the identified specifications applicable to each project. Mercer requested BCFP to submit information for a desk review. The desk review was completed by Mercer prior to the on-site visit. The purpose of the desk review was to identify issues for follow-up, clarity, and to minimize time requirements of the BCFP staff during the on-site process.

As required by the CMS validation protocol, Mercer made a determination of the overall validity and reliability of reported results, as well as a determination of confidence in the success and sustainability of improvement efforts. The following table illustrates the possible scores for each of these determinations.

Confidence in Reported Results				Confidence in Success and Sustainability of Improvement Efforts			
High	Moderate	Low	Results not Credible	High	Moderate	Low	Results not Credible
Fully compliant with standard protocol	Substantially validated and only minor deviations from standard protocol	Deviated from protocol such that the reported results are questionable	Deviated from protocol such that reported results are not validated	Success evident and sustained or lack of success addressed; actions linked to results	Success evident and/or sustained or lack of success addressed; actions not linked to results and/or repeat of prior year	Success not evident and/or sustained or lack of success addressed; actions not linked to results and/or repeat of prior year	Unable to validate results

The following table presents a summary of BCFP PIP results. Additional details of the findings and conclusions of each study follow the results chart.

Overall Results

	2001	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Asthma—Use of Appropriate Medications									
5 – 9 year olds				Baseline 66%	88%	76.6%	High	High	DSS measurement specifications were implemented by the Plan in 2005. Therefore, comparison of data is compromised; but, nevertheless, the study results appear to show improvement.
Goal				**65%**	**90%**				

	2001	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
10 – 17 year olds				Baseline 62%	86.0%	73.6%	High	High	DSS measurement specifications were implemented by the Plan in 2005. Therefore, comparison of data is compromised; but, nevertheless, the study results appear to show improvement.
Goal				**65%**	**88%**				
18 – 56 year olds				Baseline 55%	81.50%	75.1%	High	High	DSS measurement specifications were implemented by the Plan in 2005. Therefore, comparison of data is compromised; but, nevertheless, the study results appear to show improvement.
Goal				**65%**	**85%**				

	2001	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
5 – 56 year olds				Baseline 61%	85.32%	74.1%	High	High	DSS measurement specifications were implemented by the Plan in 2005. Therefore, comparison of data is compromised; but, nevertheless, the study results appear to show improvement.
Goal				**65%**	**87%**				
Improving Adolescent Preventive Care									
Members Aged 12 – 21 Who Had a Preventive Health Care Visit			Baseline 46.6%	50.2%	46.6%	53.9%	High	High	Compliant with DSS measurement specifications.
Goal				**50%**	**50%**				

	2001	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Breast Cancer Screening Rate									
Percentage of Women Compliant with a Breast Cancer Screening	Baseline 29.7%	32.5%	30.6%	34.2%	37.0%	N/A	High	High	DSS measurement specifications were implemented by the Plan, changing numerator inclusion criteria in 2005. Therefore, comparison of data is compromised; nevertheless, the study results appear to show improvement.
Goal	**31%**	**34%**	**34%**	**34%**	**36%**				

	2001	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Cervical Cancer Screenings									
Percent of Women with a Cervical Cancer Screening Ages 18 – 64	Baseline 36.2%	40.6%	41.8%	42.3%	40.4%	N/A	High	Moderate	DSS measurement specifications were implemented by the Plan in 2005. Therefore, comparison of data is compromised; but, nevertheless, the study results appear to show improvement.
Goal	**42%**	**42%**	**42%**	**42%**	**44%**				
Percent of Women with a Cervical Cancer Screening Ages 18 – 20	NA	NA	NA	43.5%	41.9%	44%	High	Moderate	DSS measurement specifications were implemented by the Plan in 2005. Therefore, comparison of data is compromised; but, nevertheless, the study results appear to show improvement.
Goal				**44%**	**44%**				

	2001	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Percent of Women with a Cervical Cancer Screening Ages 21 – 64	NA	NA	NA	42.2%	40.2%	44%	High	Moderate	DSS measurement specifications were implemented by the Plan in 2005. Therefore, comparison of data is compromised; but, nevertheless, the study results appear to show improvement.
Goal				**44%**	**44%**				

Name of Performance Improvement Project: Appropriate Use of Asthma Medications						
Dates in Study Period: 01/01/2004 to 12/31/2005						
I. ASSESSMENT OF STUDY METHODOLOGY						
Step 1. REVIEW OF SELECTED STUDY TOPIC(S)						
Component/Standard		**M**	**PM**	**NM**	**N/A**	**Comments**
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				The topic was selected based on data reflecting the prevalence of Asthma in the Plan population as well as addressing State of Connecticut PIP requirements. Prevalence in the State was cited to support rationale.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				The PIP, initiated in 2004, addressed member education and interventions as well as physician communication and education. The "opt-out" Asthma Disease Management program addresses the needs of members diagnosed with asthma (identified from claims and RX data) with three progressively intensive categories of program interventions. Interventions are based on assessment of member current level of knowledge and functional status.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations; i.e., did not exclude certain members, such as those with SCHNs?	X				The PIP included BCFP members age 5 – 56, consistent with DSS age specification for study inclusion. The study did not exclude members with SCHNs.
Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?	X				The Study question ("Do the Plan's member, physician, and community interventions improve the appropriate use of asthma medication for BCFP members with persistent asthma?") was clearly stated and identified in supporting documents.

Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				Quantifiable measures defined eligible members, persistent asthma and appropriate asthma medications. All indicators were measurable and consistent with reporting parameters set forth by HEDIS and DSS.
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				Indicators were not specific to changes in health status, functional status or enrollee satisfaction, but served as proxies of change in health and functional status.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?	X				Benchmarks were identified from HEDIS 2004 Medicaid - 90th percentile. Realistic goals were set for the baseline year and updated for 2006 based on 2005 analysis. Rationale was cited for increasing the goal based on 2004 and 2005 results.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO/PIHP clearly define all Medicaid members to whom the study question and indicators are relevant?	X				The Study description clearly defined the members to be included in the Study. The age range was specified as 5 – 56 and broken into age categories as suggested in the previous year's audit. Members included in the study met the reporting criteria set forth by HEDIS and DSS.
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all members to whom the study question applied?	X				The Study description clearly defined the members to be included in the Study. Members included in the study met the reporting criteria set forth by HEDIS and DSS.
Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	Sampling was not used for this Study.

5.2	Did the MCO/PIHP employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*				X	
5.3	Did the sample contain a sufficient number of members?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				Study design clearly identified the data to be collected from claims encounter and Rx data.
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data in the PIP documentation.
6.3	Did the study design specify a systemic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				Supporting documentation regarding data collection methodology showed that HEDIS and DSS criteria were used for collecting data for all members in the study.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Data specifications detailed in documentation provide consistent and accurate data collection, although changes in DSS data requirements for the 2005 reporting period resulted in analysis limitations that were clearly identified in the analysis documentation.
6.5	Did the study design prospectively specify a data analysis plan?	X				Study methodology was specified originally for the 2004 baseline measurement period. Changes in methodology reflect DSS reporting requirements resulting in study limitations that were adequately addressed in the report of analysis.
6.6	Were qualified staff and personnel used to collect the data?	X				Staff was identified with credentials and experience for each team member working on Project. Team included RNs, MD, and MPH.

Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	X				Interventions were identified along with a thorough documentation of analysis and robust discussion of barriers contributing to the identified problem. Barrier analysis included literature review, discussion and survey and fishbone diagram. Survey tool was used to assist in prioritizing most significant contributing barriers requiring interventions. Interventions in 2005 were a continuation of interventions initiated in 2004 with the Asthma Disease Management program structure and processes as the primary intervention strategy.
Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?	X				Data analysis was completed consistently over the two years of the Study with the exception of DSS specification requirement changes. Specific plans for data analysis at the beginning of each measurement period were not documented.
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	X				Findings were reported in the PIP Documentation, providing easy reference to results for each measurement period and progress with improvement between the baseline reporting period and first re-measurement period.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	X				The analysis showed baseline measurement for 2004 and first re-measurement periods for 2005. Statistical significance was addressed in the analysis. Threats to reliability and validity were addressed as limitations and methodological changes between 2004 and 2005 and alternative analysis provided to evaluate improvement efforts.

8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?	X				The analysis was thorough and addressed contributing methodological factors and threats affecting results and study limitations. Benchmarks were identified as supporting basis for performance targets and reassessed in the 2005 re-measurement period analysis. The barrier analysis included a literature review, discussion and survey and fishbone diagram. Interventions were identified to address each prioritized barrier.
Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				Methodology from baseline to re-measurement period 2 was changed to meet DSS specifications. Change to specifications was clearly documented, as were threats to reliability of reported results.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?	X				Quantitative improvement was documented for each age category and indicator, except for the 10 – 17 age range. All other measures showed statistically significant improvement.
9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned QI intervention?	X				Quantitative improvement appears to be the result of the broad range of interventions implemented through the Asthma DM program. Both the study methodology and the program of intervention are well designed and executed.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	X				Statistical tests were applied and show significance ($p<0.05$) in change from baseline results to Re-measurement Period 1 results when using the new 2005 measurement criteria and when using the same measurement criteria for 2004 and 2005 results.

Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?				X	Results for only one re-measurement period were reported.
II. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?				X	Results for only one re-measurement period were reported.

Summary of Results

Results of the study indicated an increase in results over baseline for re-measurement period one. Baseline results were calculated using HEDIS 2004 specifications while 2005 re-measurement results were calculated as required by DSS and compliant with DSS specifications. While the specifications for the study changed for the re-measurement period, the impact to results appears to be minimal.

The barrier analysis included an updated literature review, discussion, and fishbone diagram identifying provider and member barriers. A survey was designed to assist in prioritizing significant barriers to be addressed.

The improvement in appropriate use of asthma medication associated with measures appears to reflect progressive improvement over the baseline period. Improvement and contributions of interventions to improvement while not sustained over measurement periods as yet, appear to be credible based on the integrity of the study design and asthma disease management program design.

The scope of intervention was broad but analysis and current plans include only one new intervention for 2006. Further analysis that may identify which interventions are working or contributing more to improvement and which interventions are not contributing, might be beneficial to enhancing the study.

PIP Recommendations

There are no recommendations.

Name of Performance Improvement Project: Improving Adolescent Access to Preventative Care						
Dates in Study Period: 01/01/2003 to 12/31/2005						
I. ASSESSMENT OF STUDY METHODOLOGY						
Step 1. REVIEW OF SELECTED STUDY TOPIC(S)						
Component/Standard		**M**	**PM**	**NM**	**N/A**	**Comments**
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				The topic was selected based on information reflecting the importance of annual monitoring for health risk behaviors in adolescents to facilitate early intervention. The study also addressed State of Connecticut DSS PIP requirements.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				The PIP interventions initiated in 2003 and 2004 addressed member outreach and education as well as provider monitoring, communication and education. The "Teen QIA" program addresses the needs of adolescent members. Interventions were based on best practices as identified from current literature review and analysis of operations from a clinical and member services perspective.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations; i.e., did not exclude certain members, such as those with SHCNs?	X				The PIP included BCFP members age 12 – 21, consistent with DSS age specification for study inclusion. The study did not exclude members with SHCNs.
Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?	X				The Study question ("Does BCFP's targeted adolescent member outreach initiatives, targeted PCP reporting and PCP and OB/GYN provider education efforts improve the percentage of adolescents receiving at least one Well Child Visit in the measurement year?") was clearly stated and identified in supporting documents.

Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				Quantifiable measures defined eligible members. All indicators were measurable and consistent with reporting parameters set forth by DSS.
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				Indicators were not specific to changes in health status, functional status, or enrollee satisfaction but served as proxies of change in health and functional status.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?	X				Benchmarks were identified annually from HEDIS Medicaid Percentiles and Ratios at 90th percentile. Realistic goals were set for the baseline year and updated for 2005 based on 2004 analysis. Rationale was cited for increasing the goal based on 2003 results and maintaining the goal for 2006 based on 2005 results.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO/PIHP clearly define all Medicaid members to whom the study question and indicators are relevant?	X				The Study description clearly defined the members to be included in the Study. The age range was specified as 12 – 21. Members included in the study met the reporting criteria set forth by DSS.
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all members to whom the study question applied?	X				The Study description clearly defined the members to be included in the Study. Members included in the study met the reporting criteria set forth by DSS.
Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	Sampling was not used for this Study.

5.2	Did the MCO/PIHP employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*				X	
5.3	Did the sample contain a sufficient number of members?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				Study design clearly identified the data to be collected from claims encounter data.
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data in the PIP Form.
6.3	Did the study design specify a systemic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				Supporting documentation regarding data collection methodology showed that HEDIS and DSS criteria were used for collecting data for all members in the study.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Data specifications detailed in documentation provide evidence of consistent and accurate data collection.
6.5	Did the study design prospectively specify a data analysis plan?	X				Study methodology was specified originally for the 2003 baseline measurement period. DSS specifications were used for baseline and re-measurement years 1 and 2.
6.6	Were qualified staff and personnel used to collect the data?	X				Staff was identified with credentials and experience for each team member working on Project. Team included RNs and MD.

Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	X				Interventions were identified along with documentation of analysis and robust discussion of barriers contributing to the identified problem. Barrier analysis included literature review, discussion, and survey as well as fishbone diagram. Survey tool was used to assist in prioritizing most significant contributing barriers requiring interventions. New barriers were identified during the 2005 analysis and interventions identified.
Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?	X				Data analysis was completed consistently over the three years of the Study.
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	X				Findings were reported in the PIP Documentation, providing easy reference to results for each measurement period.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	X				The analysis showed repeated measurements for two re-measurement periods: 2004 and 2005. Statistical significance was addressed in the analysis. Threats to reliability and validity were addressed.
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?	X				The analysis included a thorough investigation that addressed contributing methodological and procedural factors and threats affecting results. Benchmarks were identified as supporting basis for performance targets and re-assessed in the 2005 re-measurement period analysis. The barrier analysis included a literature review, discussion, survey, and fishbone diagram. Interventions were identified to address each prioritized barrier.

Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				DSS preventative care report specifications were used for both baseline and re-measurement years 1 and 2. The baseline 2003 data was run using the revised specifications so that 2004 data and subsequent year 2005 would conform to HEDIS measures.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?			X		Quantitative improvement was not documented. Results for Re-measurement Period 2 did not show any statistical improvement baseline and showed decreased performance from the previous measurement period.
9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned QI intervention?			X		Quantitative improvement from baseline to Re-measurement Period 1 was not sustained upon re-measurement for period 2 (2005), therefore improvement does not appear at this time to be valid. Analysis addresses procedural barriers that may have contributed to the lack of improvement.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?			X		Quantitative improvement from baseline to Re-measurement Period 1 was not sustained upon re-measurement for period 2 (2005), therefore improvement does not appear at this time to be valid. Analysis addresses procedural barriers that may have contributed to the lack of improvement.
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?			X		Quantitative improvement from baseline to Re-measurement Period 1 was not sustained upon re-measurement for period 2 (2005); therefore, improvement does not appear at this time to be valid. Analysis addresses procedural barriers that may have contributed to the lack of improvement.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						

2.1	Were the initial study findings verified upon repeat measurement?			X		Quantitative improvement from baseline to Re-measurement Period 1 was not sustained upon re-measurement for period 2 (2005), therefore, improvement does not appear at this time to be valid. Analysis addresses procedural barriers that may have contributed to the lack of improvement.

Summary of Results

Results of the study did not indicate an improvement over baseline for Re-measurement Period 2 and showed a decrease in performance from the previous re-measurement period. DSS preventive care report specifications were used for both baseline and re-measurement years 1 and 2.

The barrier analysis included an updated literature review, discussion, and fishbone diagram identifying provider and member barriers. A survey was designed to assist in prioritizing significant barriers to be addressed.

The improvement noted in the previous re-measurement period was not sustained but interventions appear to be credible and address barriers identified through literature review, survey, and discussion.

The scope of intervention was broad and further analysis that may identify which interventions are working or contributing more to improvement and which interventions are not contributing, might be beneficial to enhancing the study.

PIP Recommendations

There are no recommendations.

Name of Performance Improvement Project: Breast Cancer Screening

Dates in Study Period: 01/01/2001 to 12/31/2005

I. ASSESSMENT OF STUDY METHODOLOGY

Step 1. REVIEW OF SELECTED STUDY TOPIC(S)

Component/Standard		M	PM	NM	N/A	Comments
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				The topic was selected based on the importance of screening to prevent invasive breast cancer. Prevalence was cited for US, and the State to support rationale; PIP also addressed the State's DSS PIP requirements.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				The PIP assessment and interventions initiated in 2001 addressed member education and targeted activities as well as provider communication and education. The program addresses the needs of females age 40 and over. Specifications for quantitative analysis included women ages 41 – 69 as specified by DSS. Interventions are based identification of barriers and include member and provider focused activities.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations; i.e., did not exclude certain members, such as those with SHCNs?	X				The PIP included BCFP female members age 41 – 69, consistent with DSS age specification for study inclusion. The study did not exclude members with SHCNs.
Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?	X				The Study question ("Do the Plan's member and physician interventions improve the mammography screening rate?") was clearly stated and identified in supporting documents.
Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				Quantifiable measures were defined. All indicators were measurable and consistent with reporting parameters set forth by DSS.

3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				Indicators were not specific to changes in health status, functional status or enrollee satisfaction but served as proxies of change in health status.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?		X			Benchmarks were not identified, citing data measurement differences precluding considering benchmark as comparable. Goals were set based on historical performance. Rationale was cited for increasing the goal based on 2004 and 2005 results. Benchmarks should be considered (i.e., HEDIS) even though precise measurement might not be the same. Benchmarks can serve as discussion points in analysis of limitations surrounding the measurement issues addressed.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO/PIHP clearly define all Medicaid members to whom the study question and indicators are relevant?	X				The Study description clearly defined the members to be included in the Study. The age range was specified as 41 – 69. Members included in the study met the reporting criteria set forth by DSS.
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all members to whom the study question applied?	X				The Study description clearly defined the members to be included in the Study. Members included in the study met the reporting criteria set forth by DSS.
Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	Sampling was not used for this Study.
5.2	Did the MCO/PIHP employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*				X	

5.3	Did the sample contain a sufficient number of members?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				Study design identified the data to be collected from claims encounter data.
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data.
6.3	Did the study design specify a systemic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				Supporting documentation regarding data collection methodology showed that DSS specifications were used for collecting data for all members in the study.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Data specifications detailed in documentation reveal changes in measurement criteria between re-measurement periods. The change in the 2005 (cycle 4) numerator criteria was directed by DSS. Although changes in DSS data requirements for 2005 reporting period resulted in analysis limitations, they were clearly identified in the analysis documentation.
6.5	Did the study design prospectively specify a data analysis plan?	X				Study methodology was specified originally for the 2001 baseline measurement period. Changes in methodology reflect plan data review and improvement as well as DSS reporting requirements resulting in study limitations that were adequately addressed in the report of analysis.
6.6	Were qualified staff and personnel used to collect the data?	X				Staff was identified with credentials and experience for each team member working on Project. Team included RNs, MD, and MPH.

Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	X				Interventions were identified along with a thorough documentation of analysis and discussion of barriers contributing to the identified problem. Barrier analysis included literature review, discussion, survey, and fishbone diagram. A survey tool was used to assist in prioritizing most significant contributing barriers requiring interventions.
Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?	X				Data analysis was completed and reviewed annually over the five years of the Study. Specific plans for data analysis at the beginning of each measurement period were not documented.
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	X				Findings were reported in the PIP Documentation, providing easy reference to results for each measurement period.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	X				The analysis showed repeated measurements for five measurement periods: 2001 through 2005. Statistical significance was addressed in the analysis of each re-measurement period. Threats to reliability and validity were addressed as limitations and methodological changes.
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?		X			The analysis addressed contributing methodological factors and threats affecting results and study limitations. Performance targets were identified based on previous experience, but benchmarks were not used in determining targets. The barrier analysis included a literature review, discussion, provider and member survey, and fishbone diagram. Interventions were identified to address each prioritized barrier. 2005 (cycle 4) results did show improvement that was statistically significant.

Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				Methodology from baseline to Re-measurement Cycle 4 was changed to meet DSS specifications. Change to specifications was clearly documented, as were threats to reliability of reported results.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?	X				Quantitative improvement was documented from baseline to Re-measurement Cycle 4; and from Re-measurement Cycle 3 to Re-measurement Cycle 4 that was statistically significant.
9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned QI intervention?	X				Quantitative improvement appears to be the result of the broad range of interventions implemented through the Breast Screening program. Both the study methodology, as well as the program of intervention appears well designed and executed.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	X				Statistical test were applied and show significance ($p<0.05$) in change from baseline results as well as previous re-measurement cycle results to Re-measurement Cycle 4 results.
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?	X				Results demonstrating improvement were sustained for the first 4 years of the study. Goal for next re-measurement cycle was increased, addressing continuous improvement and opportunity for further improvement.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?	X				Results demonstrating improvement was sustained for the first 4 years of the study. Goal for next re-measurement cycle was increased, addressing continuous improvement and opportunity for further improvement.

Summary of Results

Results of the study indicated an increase in results over baseline for Cycle 4 re-measurement period as well as an increase over the previous re-measurement period. While the specifications for the study changed for the Cycle 4 re-measurement period, the impact to results appears to be minimal. 2005 Cycle 4 re-measurement results were calculated as required by DSS and compliant.

Benchmarks were not identified, citing data measurement differences precluding considering benchmark as comparable. Goals were set based on historical performance. Rationale was cited for increasing the goal based on 2004 and 2005 results.

The barrier analysis included an updated literature review, discussion, and fishbone diagram identifying provider and member barriers. A survey was designed to assist in prioritizing significant barriers to be addressed.

The improvement in breast cancer screenings appears to reflect progressive improvement over the baseline period. Improvement and contributions of interventions to improvement, sustained over measurement periods, appear to be credible based on the integrity of the study design and breast cancer screening and awareness program implemented by the Health Plan.

The scope of interventions was broad but analysis and current plans do not appear to address plans for any new interventions for 2006 other than interventions previously initiated and continuing for 2006. Further analysis that may identify which interventions are working or contributing more to improvement and which interventions are not contributing, might be beneficial to enhancing the study.

PIP Recommendations

- Include review of benchmarks to help guide and reinforce choice of goal; citing limitations if measurement criteria is different.

Name of Performance Improvement Project: Cervical Cancer Screening

Dates in Study Period: 01/01/2001 to 12/31/2005

I. ASSESSMENT OF STUDY METHODOLOGY

Step 1. REVIEW OF SELECTED STUDY TOPIC(S)

Component/Standard		M	PM	NM	N/A	Comments
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				The topic was selected based on the importance of screening to prevent invasive cervical cancer. Prevalence was cited for US, and CT to support rationale. PIP addressed State of Connecticut DSS PIP requirements.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				The PIP assessment and interventions initiated in 2001 addressed member education and targeted activities as well as provider communication and education. The program addresses the needs of members (women age 18 – 64). Interventions are based on identification of barriers and include member and provider focused activities.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations; i.e., did not exclude certain members, such as those with SHCNs?	X				The PIP included BCFP female members age 18 – 64, consistent with DSS age specification for study inclusion. The study did not exclude members with SHCNs.
Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?	X				The Study question ("Do the Plan's member and physician interventions improve the BCFP cervical cancer screening rate?") was clearly stated and written in supporting documents.
Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				Quantifiable measures were defined. All indicators were measurable and consistent with reporting parameters set forth by DSS.

3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				Indicators were not specific to changes in health status, functional status or enrollee satisfaction, but served as proxies of change in health status.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?		X			Benchmarks were not identified, citing data measurement differences precluding considering benchmark as comparable. Goals were set based on historical performance. Rationale was cited for increasing the goal based on 2004 and 2005 results. Benchmarks should be considered even though precise measurement might not be the same. Benchmarks can serve as discussion points in analysis and limitations surrounding the measurement issues addressed.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO/PIHP clearly define all Medicaid members to whom the study question and indicators are relevant?	X				The Study description clearly defined the members to be included in the Study. The age range was specified as 16 – 64 and broken into age categories. Members included in the study met the reporting criteria set forth by DSS.
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all members to whom the study question applied?	X				The Study description clearly defined the members to be included in the Study. Members included in the study met the reporting criteria set forth by DSS.
Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	Sampling was not used for this Study.
5.2	Did the MCO/PIHP employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*				X	

5.3	Did the sample contain a sufficient number of members?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				Study design clearly identified the data to be collected from claims encounter data.
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data.
6.3	Did the study design specify a systemic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				Supporting documentation regarding data collection methodology showed that DSS specifications were used for collecting data for all members in the study.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Data specifications detailed in documentation reveal changes in measurement criteria between re-measurement periods. The change in the 2005 numerator criteria was directed by DSS. Although changes in DSS data requirements for 2005 reporting period resulted in analysis limitations, they were clearly identified in the analysis documentation.
6.5	Did the study design prospectively specify a data analysis plan?	X				Study methodology was specified originally for the 2001 baseline measurement period. Changes in methodology reflect plan data review and improvement as well as DSS reporting requirements resulting in study limitations that were adequately addressed in the report of analysis.
6.6	Were qualified staff and personnel used to collect the data?	X				Staff was identified with credentials and experience for each team member working on Project. Team included RNs, MD, RD and MPH.

Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	X				Interventions were identified along with a thorough documentation of analysis and discussion of barriers contributing to the identified problem. Barrier analysis included literature review, discussion and survey and fishbone diagram. Survey tool was used to assist in prioritizing most significant contributing barriers requiring interventions.
Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?	X				Data analysis was completed and reviewed annually over the five years of the Study. Specific plans for data analysis at the beginning of each measurement period were not documented.
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	X				Findings were reported in the PIP Documentation, providing easy reference to results for each measurement period.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	X				The analysis showed repeated measurements for five measurement periods: 2001 through 2005. Statistical significance was addressed in the analysis of each re-measurement period. Threats to reliability and validity were addressed as limitations and methodological changes.

8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?		X			The analysis addressed contributing methodological factors and threats affecting results and study limitations. Performance targets were identified based on previous experience, but benchmarks were not used in determining targets. The barrier analysis included a literature review, discussion, survey, and fishbone diagram. Interventions were identified to address each prioritized barrier. 2005 results did not show improvement. The need for further analysis to determine possible causes for the decrease in performance was documented, but the analysis was not completed and only one new intervention for 2006 was listed in the "Interventions Table."
Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				Methodology from baseline to re-measurement period 5 was changed to meet DSS specifications. Change to specifications was clearly documented as were threats to reliability of reported results.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?			X		Quantitative improvement was not documented. Performance decreased for re-measurement year 5 from year 4, although still increased from baseline.
9.3	Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned QI intervention?			X		Quantitative improvement was not documented. Performance decreased for re-measurement year 5 from year 4, although still increased from baseline.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?			X		Quantitative improvement was not documented. Performance decreased for re-measurement year 5 from year 4, although still increased from baseline.

Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?		X			Results demonstrating improvement was sustained for the first 4 years of the study but not for the 2005 re-measurement period.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?		X			Results demonstrating improvement was sustained for the first 4 years of the study but not for the 2005 re-measurement period.

Summary of Results

Results of the study indicated a decrease in results for the 2005 re-measurement period one from the previous re-measurement period (2004). 2005 re-measurement results were calculated as required by DSS and compliant.

Benchmarks were not identified, citing data measurement differences precluding considering benchmark as comparable. Goals were set based on historical performance. Rationale was cited for increasing the goal based on 2004 and 2005 results.

The barrier analysis included an updated literature review, discussion, and fishbone diagram identifying provider and member barriers. A survey was designed to assist in prioritizing significant barriers to be addressed.

Improvement in cervical screening rates did not occur in 2005, although improvement was sustained over baseline. While not sustained from the previous measurement period, the study appears to be credible based on the integrity of the study documentation and interventions to date.

While analysis of 2005 results addressed the need for further analysis to determine possible causes for the decreased performance in 2005, this analysis was not documented. Only one new intervention for 2006 is identified and documented on the Intervention Table. Further analysis that may identify the non-compliant population and which interventions are working or contributing more to improvement, and which interventions are not contributing, might be beneficial to enhancing the study.

PIP Recommendations

- Include review of benchmarks to help guide and reinforce choice of goal; citing limitations if measurement criteria is different.
  - Address possible causes for the decreased performance in 2005. Identify characteristics of the non-compliant population and identify additional interventions targeted for this population that are plan

8

Validation of Performance Measures

Objective 1
Validate the accuracy of Medicaid PMs reported by BCFP.

Objective 2
To determine the extent to which Medicaid-specific PMs calculated by an MCO followed specifications established by DSS for the calculation of PMs.

Objective

The purpose of this review is to assess the validity of the following PMs undertaken by BCFP for the time period CY 2005:

Measure 1 — Asthma Medications;
Measure 2 — EPSDT;
Measure 3 — Cervical Cancer Screening; and
Measure 4 — Adequacy of Prenatal Care.

Assessment of Strengths and Weaknesses

An information request was developed to gather information from BCFP regarding the PMs and a review of the documentation was performed. The following steps were completed, and key questions answered (as applicable), in validating each measure:

- Assess documentation of processes used to calculate and report PMs.
- Do appropriate and complete measurement plans and programming specifications exist that include data tables used and programming logic?
- Review processes used to produce denominators.
- Are data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) complete and accurate?
- Is continuous enrollment criteria correctly applied?
- Are age and gender specifications adhered to?
- Are member months or member years calculated correctly?
- Review processes used to produce numerators.
- Are 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 MCO network) complete and accurate?
- Are clinical codes (e.g., ICD-9, CPT4, DSM-IV) used appropriately?
- Are correct time parameters (e.g., admission and discharge dates or treatment start and stop dates) used?
- Are medical record review documentation and tools adequate?
- If hybrid method was used, is the integration of administrative and medical record data adequate?
- If hybrid method or solely medical record review was used, do the results of the medical record review validation substantiate the reported numerator?
- Assess the sampling processes.
- Is sample unbiased?
- Does sample treat all measures independently?
- Are sample size and replacement methodology specifications met?
- Assess submission of required PM reports to DSS.
- Are DSS specifications for reporting PMs followed?

After all audit elements were assessed, a validation finding for each measure was determined based on the magnitude of errors detected in the review, according to the following scale.

Validation Findings

Fully Compliant	Substantially Compliant	Not Valid	Not Appli
Measure was fully compliant with DSS specifications.	Measure was substantially compliant with DSS specifications and had only minor deviations that did not significantly bias the reported rate.	Measure deviated from the DSS specifications 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.	Measure w MCO/PIHP members t denominat

A summary of the results are presented in the following table. A detailed presentation of the findings and conclusions of each measure follows:

PM	2005 Validation Findings
Asthma Medications	Fully Compliant
EPSDT	Fully Compliant
Cervical Cancer Screening	Fully Compliant
Adequacy of Prenatal Care	Not Valid

Conclusions Drawn

The validation findings assigned to each measure are based on the documentation provided. Specific issues with each PM follow:

PM	2003 Validation Findings	2004 Validation Findings	2005 Validation Findings	Issues
Asthma Medications	N/A	Fully Compliant	Fully Compliant	▪ The following inconsistency was noted in the SA Mercer would like BCFP to verify this notation ar where necessary. ▪ The HEDIS 2006 specifications state the followin dispensing events for prescriptions longer than 3 supply by 30 and **round down** to convert." The S "**Ceil**" function, which rounds up, not down. – Suggested update: – The "Floor" function should be utilized to rou reflect the HEDIS specifications.

PM	2003 Validation Findings	2004 Validation Findings	2005 Validation Findings	Issues
EPSDT	Substantially Compliant	Fully Compliant	Fully Compliant	▪ The following inconsistency was noted in the SA Mercer would like BCFP to verify this notation ar where necessary. ▪ The HUSKY A final report reflects N/A for line ite Referred for Corrective Treatment" across all ag believed to be a calculation error. ▪ On page 8 of the SAS programming code in the purpose of the code is to remove duplicate claim specified does not seem to remove the duplicate ▪ On page 10 of the SAS programming code, ther currently reads: line9 + 1 **Suggested update:** line9 = 1
Cervical Cancer Screening	Substantially Compliant	Fully Compliant	Fully Compliant	The following inconsistency was noted in the SAS pr would like BCFP to verify this notation and update th necessary. ▪ Diagnosis code 91.46 is not included in the SAS should be. ▪ Code 58285 is unnecessarily repeated in the pro should only be referenced once. ▪ The age limit defined in the SAS programming c defined in the DSS specifications. The correct ag the coding should be limited to a maximum of 64
Adequacy of Prenatal Care	Substantially Compliant	Fully Compliant	Not Valid	▪ The exact specifications utilized to calculate the disclosed in the documentation provided. ▪ The SAS programming code provided relates to not Adequacy of Prenatal Care. The coding shou identified performance measure for validation in year. ▪ Time parameters including measurement year a clearly defined according to DSS specifications i For example, the measurement end date should not December 30, 2005. ▪ It is unclear from the documentation provided if t substantiate the reported numerator.

The 2005 Adequacy of Prenatal Care measure is the only measure found to be deficient in the 2005 measurement year. This measure failed to provide adequate documentation supporting the calculation and adherence to the DSS specifications. The Asthma Medications, EPSDT, and Cervical Cancer Screening measures maintained their fully compliant status although areas of concern were identified for each.

Recommendations

- Fully disclose the specifications utilized to calculate the Adequacy of Prenatal Care performance measure including codes utilized to identify and verify a live birth. In

addition, the DSS specifications identifying reporting requirements should be included in the documentation of this measure.

- Document programming logic provided for the Adequacy of Prenatal Care measure to correspond to the identified measure and clearly reflect the requirements and specific clinical codes identified in the DSS specifications.
- Document accurately and consistently the time parameters of the Adequacy of Prenatal Care measure.
- Provide clear and full disclosure of the MRR process and the integration of results with the administrative data for the Adequacy of Prenatal Care measure.
- Document accurately the Asthma Medications, EPSDT, and Cervical Cancer Screening measures incorporating the identified comments listed in tabular form in the report.

9

Calculation of Performance Measures

Objective 1
To calculate Medicaid PMs for BCFP, in accordance with specifications prescribed by DSS.

Objective 2
To provide information to DSS on the extent to which BCFP's information systems provided accurate and complete information necessary toward the calculation of PMs.

The purpose of this component of the EQR was to use BCFP's encounter data (submitted monthly by BCFP to Mercer) to calculate the following six measures:

- Measure 1 –NICU Admits/100 Births;
- Measure 2 – ED Usage/1,000 Member Months;
- Measure 3 – Readmission Rates;
- Measure 4 – Diabetic Retinal Exams;
- Measure 5 – Breast Cancer Screening/Mammography; and
- Measure 6 – ED Usage by Asthmatics.

Baseline rates for 4 of the measures were established 2 years ago. In calculating these measures again, we were able to assess if BCFP had improved performance in these areas. Specifications for the ED visits per 1,000 member months changed this year; however, all 3 years were recalculated using the new methodology. The change was made so that the specifications match a report that the State receives currently from the health plans. The last measure related to ED usage by asthmatics, replaced the previous year's Provider Network Adequacy measure. Last year's calculation represents the baseline measurement.

Assessments and Measurements

The reporting period for the measurements was CY 2005, which includes January 1, 2005 through December 31, 2005.

Measure 1 – NICU Admits/100 Births

Description: Percentage of live newborns during the reporting period who were admitted to the NICU.

The denominator was the number of live births that occurred during the reporting period. Births were determined using the ICD-9 codes 640–669 where the fifth digit was a "1" or "2" (this indicates a delivery occurred), 650 (with or without fourth and fifth digits), and V27.0, V27.2, V27.3, V27.5 and V27.6. The numerator was the number of admissions to the NICU determined by revenue codes 0172, 0173, and 0174 or CPT4 codes 99295, 99296, 99298, and 99299.

Measure	Value		
	2003	2004	2005
Number of NICU Admissions	270	324	415
Number of Births	3,120	3,858	4,164
NICU Admits/100 Births	**8.7%**	**8.3%**	**10.0%**

National rates vary from 8 to 12 percent for this measure. The overall rate for the 4 State health plans in 2005 was 11.7 percent. BCFP's 2005 rate is within the benchmark norms for 2005, and the rate is less than the State's overall rate.

Measure 2 – ED Usage/1,000 Member Months
Description: Number of ED visits during the reporting period per 1,000 member months

The denominator was the number of member months for CY 2005. The numerator was the number of ED visits between January 1, 2005 and December 31, 2005, where ED visits were defined by revenue codes 0450, 0451, 0452, and 0459. Any visits that resulted in a hospital admission were included in the numerator as this is how BCFP reports to the State.

Measure	Value		
	2003	2004	2005
Number ED Visits	79,899	80,571	92,435
Member Months	1,467,226	1,541,009	1,555,314
ED Usage/1,000 Member Months	**54.5**	**52.3**	**59.4**

Methodology for this measure changed this year to match State reports more closely. The rate for the State overall for 2003 was 58.0, 2004 was 55.5, and for 2005 was 61.1. Benchmarks are highly variable as a variety of measurement types are used in the literature. Consensus is that rates are going up, but there is no agreement of how to measure this. Another factor to keep in mind is that according to HEDIS, the Medicaid rates are triple those of commercial plans and so we would expect a higher rate of usage. BCFP's 2005 rate is higher than last year, but is lower than the State's overall rate.

Measure 3 – Readmission Rates
Description: Rate of hospital readmissions for same or similar diagnosis within seven days of discharge.

The denominator was the number of hospital discharges between January 1, 2005 and December 31, 2005. The numerator was the number of hospital readmissions within seven days of a hospital discharge for a same or similar diagnosis. Only primary diagnosis codes were used to calculate this measure. Only the first three digits of the diagnosis code were used for this analysis. Prior to counting readmissions, it is important to apply continuing stay criteria so that the readmission rate is not artificially inflated. This entails combining stays for a member who had a date of admission on the same date as a discharge or within one day of discharge. This removed the impact of any interim billing that might exist.

Measure	Value		
	2003	2004	2005
Number of Readmits	94	120	139
Number of Discharges	12,000	14,642	15,149
Readmission Rates	**0.8%**	**0.8%**	**0.9%**

No national benchmarks are available for this measure. It is being tracked annually to determine if there are any significant changes. The State plan average for 2005 was 1.2 percent an increase from the average rate in 2004 of 0.8 percent. BCFP's 2005 rate is lower than the State's overall rate.

Measure 4 – Diabetic Retinal Exam
Description: Percent of members 18 – 75 years of age with diabetes (Type 1 and 2) who were continuously enrolled during the study period who had a retinal eye exam performed during the study period.

The denominator was the number of members between 18 and 75 years of age as of December 31, 2005, who were enrolled during the study period with no more than a one-month gap in enrollment. These members had an administrative record of diabetes during the study period or in the year prior to the study period. Diabetes was determined by either of two methodologies. The first was an administrative record of a diabetic prescription using the list of drugs provided by NCQA. The second way of determining a diabetic was a diagnosis code of 250, 357.2, 362.0, 366.41, 648.0, or a DRG code of 294 or 205 with either 2 outpatient or physician administrative records on different dates of service or 1 inpatient or ED record. The numerator was the number of members who received a retinal eye exam defined by the CPT codes 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 99204, 99205, 99214, 99215, 99242, 99243, 99244, 99245, ICD-9 procedure codes 14.1, 14.2, 14.3, 14.4, 14.5, 14.9, 95.02, 95.03, 95.04, 95.11, 95.12, 95.16 or an ICD-9 diagnosis code of V72.0 between the dates of January 1, 2005 and December 31, 2005. These codes are specified by NCQA in the HEDIS 2006 manual, volume 2.

Measure	Value		
	2003	2004	2005
Number of members receiving eye exam	179	246	1,996
Continuously enrolled eligibles	1,338	1,579	2,261
Diabetic Retinal Exam	**13.4%**	**15.6%**	**88.3%**

HEDIS benchmarks for Medicaid plans for this measure were 54.0 percent in 2002, 51.6 percent in 2003, 45.0 percent for 2004 and 44.1 percent in 2005. The State's overall rate

is 87.8 percent for 2005. BCFP is well above the national benchmark and is above the overall State rate. The 2005 measures increased substantially when compared to the previous years as a change was made to the HEDIS specifications. The diagnosis code of V72.0 (general eye exam) was added to the codes used to identify the numerator. There is no way to identify that a dilated eye exam was performed using administrative data and therefore V72.0 was added as a proxy.

Measure 5 – Breast Cancer Screening/Mammography
Description: Percent of women ages 41 – 69 as of December 31, 2005, who were continuously enrolled during the reporting period, did not have bilateral mastectomies and who had a mammogram during the reporting period.

The denominator was the number of women 41 – 69 years of age as of December 31, 2005, who were enrolled with no more than a one-month gap during the enrollment period, who did not have a bilateral mastectomy on or before December 31, 2005. Bilateral mastectomy was determined with ICD-9 procedure codes 85.42, 85.44, 85.46, or 85.48 or CPT codes 19180, 19200, 19220, or 19240. The numerator was the number of women who received a mammogram between January 1, 2005 and December 31, 2005. Mammograms were defined by CPT codes 76090, 76091 or 76092 or ICD-9 codes V76.11 or V76.12, or revenue codes 0401 or 0403.

Measure	Value		
	2003	2004	2005
Number of women with mammograms	1,219	1,490	1,551
Number of women continuously enrolled	3,958	4,427	4,323
Breast Cancer Screening/Mammography	**30.8%**	**33.7%**	**35.9%**

No benchmarks are available for this measure as the specifications vary widely. The State plan average in 2003 was 31.4 percent, 2004 was 31.9 percent and in 2005 was 34.8 percent. BCFP's 2005 rate is higher than the State's overall rate for 2005 and has increased each year.

Measure 6 – ED Usage by Asthmatics
Description: Percent of asthma patients greater than age two as of December 31, 2005 who were continuously enrolled during the reporting period and for the six months preceding the reporting period, who received a service with a primary diagnosis of asthma in the six months preceding the reporting period, who had one or more ED visits during the reporting period and who did not have a non-primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or Emphysema on the same encounter as a primary asthma diagnosis during the reporting period or preceding six month period.

The denominator was the number of members greater than two years of age, who were enrolled with no more than a one-month gap during the enrollment period and the previous six months and who had a diagnosis of asthma during the six months prior to the reporting period. The numerator was the number of members greater than two years of age on December 31, 2005 who had an asthma diagnosis during the six months preceding

the reporting period, who had a visit to an ED during the reporting period and who did not have COPD or Emphysema. Asthma diagnoses were identified by the ICD-9 code of 493, regardless of the fourth or fifth digits. COPD and Emphysema were identified using ICD-9 codes 491.20, 491.21, 943.2, 943.20, 493.21, 493.22, 496.xx, 506.4, 518.1, 518.2, 492.xx or 506.xx. ED visits were identified using revenue codes 0450, 0451, 0452, 0459, 0981 or CPT codes 99281, 99282, 99283, 99284, 99285, or 99288. Inpatient and outpatient records were compared and for those claims with equal dates of service only one was used. Any ED visits resulting in a hospital admission were excluded.

Measure	Value		
	2003	2004	2005
Number of asthmatics who were seen in the ED	N/A	518	605
Total of asthmatic members	N/A	3,558	3,886
ED Usage by Asthmatics	**N/A**	**14.6%**	**15.6%**

Benchmarks for this measure are not available. Mercer will track these rates annually. The State's overall rate for this measure in 2005 is 15.4 percent. BCFP's rate is greater than the State's overall rate, and has increased over the previous year.

Recommendations

- Evaluate the increase in the NICU rate this year and determine if there are areas of concern that can be addressed.
- Re-evaluate data collection/claims efforts for breast cancer screening.
- Conduct root cause analysis of non-compliant members to increase the rates of mammography.

Conduct an analysis of ED utilization to determine if any trends exist that could be addressed.