December 20, 2006

External Quality Review
State of Connecticut

Community Health Network of Connecticut, Inc.

MERCER
Government Human Services Consulting

MMC Marsh & McLennan Companies

Contents

1. Executive Summary 1

2. Introduction 4

3. Methodology 6

4. Compliance with Federal Medicaid Managed Care Regulations — Review of 2005 Corrective Action Plan 9

5. Compliance with Standards for Timeliness and Access to Services 34

6. Compliance with Specific Contract Requirements — HUSKY B, HUSKY Plus, and HUSKY B Co-Payment 48

7. Validation of Performance Improvement Projects 55

8. Validation of Performance Measures 84

9. Calculation of Performance Measures 89

Appendices

Appendix A – Documentation Submitted for Review 96

Appendix B – Agenda for On-Site Review Session 106

Appendix C – MCO Corrective Action Plans 109

1

Executive Summary

The State of Connecticut (State), Department of Social Services (DSS), has contracted with Mercer Government Human Services Consulting (Mercer) to be the State's External Quality Review Organization (EQRO). As required in 42CFR Part 438, Subpart E, Mercer completed an External Quality Review (EQR) of the managed care organization, Community Health Network of Connecticut (CHN), on July 18, 2006 at CHN's offices in Wallingford, Connecticut. Annual EQRs are done in a three-year cycle; 2006 is the third year in the current cycle. During the first year, a comprehensive EQR was done; MCO compliance with all regulations related to the Balanced Budget Act of 1997 (BBA) was assessed. In 2007, the first year of a new three-year cycle, the EQR will once again be comprehensive.

The content of this EQR included:

- implementation by CHN of its corrective action plan (CAP) related to recommendations from the EQR of 2005;
- compliance of CHN with Federal Medicaid Managed Care regulations and State standards relating to quality, timeliness and access to services;
- performance improvement projects (PIPs) validation;
- performance measure (PM) validation;
- PM calculation; and
- at the request of DSS, CHN's compliance with Healthcare For Uninsured Kids and Youth (HUSKY) B contractual requirements.

The following include the strengths of CHN identified during the EQR, as well as recommendation for improvement in areas of weakness. Detailed information about each area can be found in the body of this report.

Strengths

A particular strength of CHN's is the quality of the communication that exists within the organization. Processes are in place, which help to eliminate the "silo" phenomenon between units.

Recommendations

1. Incorporate into policy the requirement to document in a prominent part of the medical record whether or not a member has executed an advance directive and include more specifics in the provider education materials.
2. Devote personnel and resources to research readmission rates and to develop and implement interventions to improve the results.
3. Assess the delivery of Early Periodic Screening Diagnosis and Treatment (EPSDT) services to children to identify interventions to improve the number of children receiving these services. Implement interventions to improve the completeness and accuracy of claims data, as well.
4. Develop and implement specific interventions to improve appointment availability for primary care providers (PCPs) and dentists. Implement a process for primary verification of provider appointment availability.
5. Institute processes to monitor and encourage new members to obtain appropriate well-care.
6. Focus case management (CM) file audits on assessment, goals, progress and barriers to meeting goals, referral and coordination and education and interventions. Continue to audit an increased sample of files until there is 90 percent compliance. Provide a prototype sample chart as a desk reference for the Case Managers.
7. Provide a more detailed description in the notice of action of the reason an action was taken using layperson language at the seventh grade reading level, rather than clinical language.
8. Provide support to the PIP subject selection by including a discussion about its pertinence to the CHN HUSKY population.
9. Document the rationale for the PIP performance goals and how it is related to the benchmark.
10. Address in the PIP documentation, changes in measurement methods between the baseline reporting period and subsequent re-measurement periods.
11. Add analysis language to PIP documentation that describes techniques used for barrier analysis and specify what interventions address each barrier.
12. Identify staff and their qualifications, who are involved in the PIP development and execution.
13. Assure all PIP documentation content is consistent from document to document.
14. Submit 2006 results with complete documentation by the deadline for submission of desk review information.

15. Evaluate the completeness of the data collected for the Breast Cancer Screening PIP.
16. Complete all PIPs as agreed with DSS.
17. Disclose data sources, systems, and protocols used to calculate the validated PMs.
18. Provide consistent documentation across all measurement years for the validated PMs.
19. Follow all DSS specifications for validated PMs.

2

Introduction

Federal regulations require each state, that contracts with managed care organizations to deliver care to its Medicaid enrollees, have an independent External Quality Review Organization (EQRO) validate performance improvement projects (PIPs) and performance measures (PM) done by the MCOs. An External Quality Review (EQR) is also required. The State of Connecticut (State), Department of Social Services (DSS) requested that Mercer Government Human Services Consulting (Mercer) complete an EQR of the MCOs who deliver services to Enrollees of the State's Medicaid Healthcare For Uninsured Kids and Youth (HUSKY) A program. Compliance with the HUSKY B contractual requirements was also included in the EQR.

Mercer requested certain documentation from each of the MCOs, which was reviewed prior to an on-site component of the Review. A list of the specific documents can be found in Appendix A of this report. The EQRO team interviewed CHN staff in the organization's Wallingford offices on July 18, 2006. Mercer used this process to better understand CHN's operations and how they contribute to compliance with federal regulations.

The information obtained from the documentation and interviews was not independently verified or audited by Mercer, other than as is described in this report.

CHN is a not-for-profit 501(c)(4) MCO. It is sponsored by seven Federally Qualified Health Centers (FQHCs) located throughout Connecticut. It has 134 employees. Its membership as of July 2006 was 52,982 HUSKY A members and 2,497 HUSKY B members. CHN also has contracted with DSS to deliver care to those enrolled in the State Administered General Assistance Medical Program (SAGA) program for the uninsured. There are 34,000 SAGA members assigned to CHN.

CHN subcontracts administrative responsibilities with four entities. These include an administrative services only (ASO) agreement with Block Vision for vision services; an ASO agreement with Caremark for pharmacy services; an ASO agreement with BeneCare for dental services, and an agreement with DST Health Solutions to provide medical information system (MIS) services.

3

Methodology

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties and talents that could meet the requirements of the EQR process.

The methodology used by Mercer during this review process was organized into five critical phases presented in the following diagram.

Request for Information
Mercer used the MCO Request for Information (RFI), designed by Mercer and modified to meet the needs of DSS to acquire information specific for all areas of the review. The specified information, such as policies and procedures (P&Ps), enrollee documents, and copies of program descriptions/evaluations were sent to Mercer prior to the on-site review. From the information received, Mercer identified records to be pulled for the on-site review relating to compliance; a files request was sent to CHN relating to case management (CM) and disease management (DM) documentation files, provider credentialing files, and enrollee denials/appeals files.

Desk Review

Mercer reviewed all documents submitted by CHN over a series of weeks. For the compliance area, Mercer developed a comprehensive EQR Compliance Review tool, which was adapted from the Centers for Medicare & Medicaid Services (CMS) protocols. The tool was tailored to meet the specific reporting requirements and to address the key issues and priorities of DSS. The tool assisted the reviewers in grouping documents along the lines of processes related to the main areas of the third year review. The focus of the desk review was to assess the extent to which CHN had implemented its corrective actions related to recommendations from the previous year's EQR; identify general compliance with both the Balanced Budget Act of 1997 (BBA) and State-contractual rules and regulations for timeliness of, and access to, covered services; State contractual requirements for the HUSKY B and the HUSKY Plus populations, CM procedures and documentation and the specialty provider network. The information gleaned from this task assisted Mercer in focusing on-site observations and interviews in areas where additional information was needed. A listing of all material reviewed for the compliance section can be found in Appendix A.

On-Site Review

The compliance and performance improvement on-site review took place on July 18, 2006 (see agenda in Appendix B for a complete listing of the interview groupings and sequencing.). The on-site review began with a combined introductory session with all appropriate CHN staff. CHN executives provided an overview of the organization, its strategic plan and challenges faced by CHN. During the sessions that followed, the reviewers conducted more focused interviews with staff and completed file reviews. The interviews again followed the major areas of required review — implementation of corrective actions, the quality and timeliness of, and access to, covered services as required by the State contract; and compliance with requirements for the HUSKY B and HUSKY Plus populations.

In following this sequence, Mercer complied with CMS regulations to conduct the EQR in a logical fashion that assisted in assessing CHN's overall performance and its compliance with Federal and State rules and regulations. Many of the interview groups were multidisciplinary and reflected the flow of processes conducted by various departments in delivering information, education, and health care services to its Medicaid enrollees.

At the end of the review phases, a comprehensive analysis was conducted of the information obtained from all activities. The results of this analysis make up this report and are written in a format consistent with federal protocols to easily identify compliance with BBA standards, as written in the *Federal Register*, June 14, 2002.

To summarize all the areas of review, Mercer followed CMS' protocol for monitoring Medicaid MCOs and used the required seven activities:

1. planning for compliance monitoring activities;
2. obtaining background information from the State Medicaid Agency;
3. documenting the review;
4. conducting interviews;
5. collecting any other accessory information;
6. analyzing and compiling findings; and
7. producing a report which contains the final analysis and findings of the review.

4

Compliance with Federal Medicaid Managed Care Regulations — Review of 2005 Corrective Action Plan

Enrollee Rights and Protection

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Enrollee Rights and Protections. Provide educational information to staff and the community about Advance Directives	CHN developed a policy, which described processes to educate its members, providers, and staff. There was no reference to the community. Recommendations: Describe in the Advance Directives Policy the process by which the community will be in-formed about the availability of Advance Directive education and the process by which that education will be delivered.	The policy will be updated to describe the process by which the community will be informed about the availability of Advance Directive education and the process by which that education will be delivered. A Member Education Workgroup has been established which will create educational material for posting on CHN's website and for distribution to FQHCs and clinics on flyers.	Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Comments: Members requesting more information about Advance Directives are directed to their provider or lawyer. Most enrollees do not have access to legal representation and many providers are not experts about executing advance directives. The State's Attorney General's office is a good resource for information about Advance Directives and of the forms necessary to execute them. CHN may want to consider providing the website and/or telephone number for the Attorney General's office when inquiries are made by its members or members of the public.			
Recommendations: None			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Enrollee Rights and Protections. Advance Directive P&P's do not address whether an individual has executed an Advance Directive or not must be documented in a prominent part of the individual's current medical record	The medical record audit form used during credentialing visits included "Evidence of discussion of Advance Directives with a copy of signed form, if one is executed." The requirement that information about a member's Advance Directive should be in their chart was included in the provider newsletter at the end of 2004. CHN auditor re-ported that providers were using a sticker to indicate whether a member had executed an Advance Directive. Recommendations: Incorporate into policy the requirement that whether or not a member has executed an Advance Directive should be documented in a prominent part of the current medical record by the provider.	The 2006 provider newsletter will advise providers that whether or not a member has executed an Advance Directive should be documented in a prominent part of the current medical record. CHN will include this as an element in the credentialing site visit audit.	Not Met

Comments:

The Advance Directive P&P MSO28 does not cover inclusion of Advance Directive information in the medical record.

The provider newsletter states “Members have the right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that this information is in the patient’s record.” The federal requirement is quite specific–the information about whether or not an enrollee has executed an Advance Directive, must be documented in a prominent part of the medical record. A copy of the federal regulation was given to CHN staff.

Recommendations:

Incorporate into policy the requirement that whether or not a member has executed an advance directive should be documented in a prominent part of the current medical record by the provider. This recommendation was made after the 2005 EQR.

Include more specifics about the advance directive requirements in provider education materials and when monitoring compliance with those requirements.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Coordination and Continuity of care (438.208) The documentation of CM/DM activities needs attention. The following are recommended: a standardized clinical health assessment documentation format should be developed. All education materials sent to members should be recorded. Coordination with primary care providers (PCPs) and specialists and documentation of these events are encouraged. More thorough periodic evaluation of care plan goals status should be done.	A review of the case files revealed inconsistency in the completeness of the documentation and of the extent of CM follow up. Some files showed that goals and planned actions were developed, as new needs were identified. Other files contained an initial assessment and goals but no ongoing assessments. New problems were ignored; goals were not updated nor were there new goals or actions developed. The use of home health nurses was common in the cases reviewed. The documentation of the actions of he home health nurse and their follow up with provide was deficient. Recommendations: The quality of the documentation in the CM files should be monitored on a regular basis with feedback to the Case Managers and the development of CAPs for those needing to improve their performance. The Case managers' performance should be monitored either through peer or manager review with feedback given to each case manager. Action should be taken to increase the consistency with	In addition to inter-rater reliability reviews, CHN proposes to audit CM cases pulled from the DSS CM report submitted to the state quarterly. This audit will include a sampling from each case manager and DM nurse. Managers in each area will be responsible for monthly reviews and development of CAPs with individual staff members. Documentation of these audits will be kept in binders in the respective departments. Audits will focus on all elements of CM and DM including assessments, history, goals, barriers - social and otherwise, interventions, educational materials, outside resource agencies utilized, outcomes, and will also include documentation of any discussions regarding patient's progress that are received from any home care agency that is involved in these cases. Further, there will be quarterly peer review meetings and the results of these meetings will also be documented in binders in the respective departments. CHN currently utilizes CaseStepp, a	Partially Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
	which appropriate CM is provided to CHN members.	CM component of our data system for authorizations and claims. The current CM system allows for free text but does not outline for the nurses a structured assessment and treatment plan. After review of programming hours and costs to enhance our current system, CHN has determined that we have a homegrown CM program with all the necessary elements that was built some years ago. This system resides on our desktop via "CHNPAL." Our timeline is as follows: Week of November 7th – Review of CHNPAL Case Management Program by original programmer to allow for review of how to use and for recommendations as to any necessary modifications to current program. November 11th – November 30th – Case Managers and DM nurses will enter all their current cases into CHNPAL Case Management Program.	

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
		January 3, 2006 – All new cases will be entered into CHNPAL Case Management System. January 15, 2006 – Audits will commence. There will be a manager audit and a manager plus peer audit done on a regularly scheduled basis and documented in the respective departments – one for DM cases and one for CM cases. January 2006 – Reports component of system to be reviewed and tested.	

Comments:

CHN has purchased a new automated CM documentation tool, CHNPAL. It is in the testing phase. A new position of manager has been added to the CM unit and filled. The manager assists with the increased auditing of documentation that is being done. While the CHN CAP appears to address the findings from the 2005 review, the effect of the corrective actions was not observed in the 2005 and early 2006 documentation reflected in the audited files.

Recommendations:

Complete implementation of CM documentation tool.

Increase audit sample to 50 percent for next 3 months to review cases with activity post implementation of CHNPAL.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Enrollee Rights and Protections. In 2004, Mercer recommended that clinical practice guidelines be translated into lay level and actively shared with members for whom they are pertinent. CHN is encouraged to mention the availability of the guidelines in the *Member Handbook*.	CHN has not translated its Clinical Practice Guidelines for its members. The staff did not believe that the guidelines can be written in a lay language and still be meaningful. The staff believed the content of the guidelines was included in its member educational materials. Information about obtaining these materials was included in the member handbook. The dissemination of the guidelines in a requirement of CFR 438.236 (C). Recommendations: Review member education materials to assure all relevant information from the Clinical Practice Guidelines is included in an easily accessible fashion. This would include the information being gathered in one place and clearly labeled for ease in identification.	Clinical practice guidelines are currently available on our website. Additionally, a Member Education Workgroup has been established to provide educational information to members on specific diseases and Advance Directives. Communications regarding this information will be provided to the members, FQHCs and clinics for ease of accessibility to members.	Met
Comments: If a member requests a copy of a practice guideline, it is sent to them along with other pertinent educational materials.			
Recommendations: None			

Timeliness and Access to Services

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Standards for Timeliness and Access to Services. The MCO shall maintain a provider network capable of delivering/arranging for the delivery of all covered health goods and services to all members.	CHN did not consider anticipated enrollment, the number and types of providers needed to furnish the Medicaid services, and the geographic location of providers and members when designing its provider network. It also used feedback from providers and members when identifying additional needs of the network. Expected utilization of services, consideration of the characteristics/health care needs of its specific Medicaid population and the number of providers accepting new members were not incorporated into the network planning process. Satisfaction surveys showed a low level of satisfaction when compared to other MCOs' results with a member's ability to get needed care. Providers exhibited a low level of satisfaction with the network composition. Recommendations: Incorporate all required components when developing the provider network.	Monitor and report network development activities as follows:• Required reporting to DSS as per contract• Quarterly access and availability studies and reports to CHN Management and QI Committee• Monthly reporting to CHN Sr. Management	Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Comments: CHN's Network Management Contracting Strategy 2005–2006 lists all of the required components for consideration in the design and development of its network.			
Recommendations: None			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Standards for Timeliness and Access to Services. The MCO shall contract with a sufficient number of dentists throughout the state to assure access to oral health care.	A 2004 secret shopper survey reported that 88 percent of the dentists could accommodate a member for a routine appt within 6 weeks. 100 percent of the CHN membership had access to a dentist within 20 miles of their home according to the GeoAccess Report run by the MCO. CHN has provided capital funds to FQHC's to update their equipment or to add operatories to their dental clinics. CHN makes the language line available to its providers. There are instructions in the provider manual about how to arrange for face-to-face interpretive services. Recommendations: Utilize the results of monitoring efforts to identify areas of the network out of compliance and implement interventions to improve availability.	Intervention 1. Reach out to non-compliant providers and inform them of the deficiency. 2. Restate their contractual obligation. 3. Monitor compliance. Review Measurement Process 1. Review sampling methodology and size requirements. 2. Provide a description of the impact of small sample sizes and therefore, sampling variation on the validity of reported results. 3. Provide a description as to how results should be interpreted. Investigate the feasibility (cost/resource) of increasing sample size. The dental provider fee structure has been increased. As such it's anticipated that availability will improve.	Met

Comments:

BeneCare, the CHN dental vendor, was contacted about those dentists that were identified as not meeting standards. BeneCare, in turn, contacted the non-compliant dentists and counseled them about their performance. Additionally, the fee schedule was adjusted upward in an attempt to increase both the number of dentists in the provider network and the number of enrollees seen by participating dentists.

Recommendations:

None

Performance Improvement Projects

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Validation of Performance Improvement Project. Breast Cancer Screening	Results received a LOW score in confidence in Success & Sustainability of Improvement Efforts. Recommendation: The study design and methodology should include an estimation of the degree of completeness of the automated data used for the study indicators.	CHN will modify its methodology. CHN will evaluate data collection and claims to determine if all claims concerning mammograms are received and correct. Mammogram report cards will be sent quarterly which will list patients who have not had a mammogram within the last calendar year.	Not Met
Comments: CHN did not include a discussion about the validity or reliability of the data collection method.			
Recommendations: Include in the discussion of the study design, a description of data collection that includes the degree of completeness, as well as the validity and reliability of the data.			

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Mammogram Screening Rate – Step 1 – Review the Selected Study Topic 1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	There was a brief discussion about the relevance of breast cancer in the general population and the importance of screening to identify the disease in its early stages however there was no analysis that discussed the relevance of this measure to CHN's own population. This PIP was mandated by DSS.	CHN will analyze relative to its own population. CHN currently sends postcard notification to members who haven't had a mammogram in the twelve months prior to their birth month. The postcards are mailed to the member during their birth month. Also, biannual report cards are mailed to providers identifying members who haven't had a mammogram in the previous twelve months.	Partially Met

Comments:

The PIP submitted for 2005 did not address the rate of breast cancer in its own population.. There was a brief discussion of the relative frequency of mammograms in its population versus national rates.

Recommendations:

A discussion of the importance of screening for breast cancer specific to the State's CHN Medicaid population should be included in the discussion of topic selection.

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Mammogram Screening Rate – Step 7 – Access Improvement Strategies 7.1 Were reasonable interventions undertaken to address the causes/barriers identified through data analysis and QI processes undertaken?	It appears that no new interventions were implemented from the year 2000 until December 2004. For the 2005 re-measurement year two new interventions were implemented in December 2004. CHCT will provide more educational materials to this population and telephone calls from the outreach staff will be made to women for whom a mammogram claim has not been received in the past year.	A significant portion of CHN's membership is below the age of 40. However, CHN is committed to screening for identification of breast cancer in its early stages. Effective December 2004, CHN implemented a member education plan, which includes identification of members, contact via postcards as noted above. Also noted above is that a Member Education Workgroup has been implemented and this group is charged with preparing appropriate member educational material for breast cancer and disseminating this information to members via the CHN website and flyers to FQHCs and clinics. An audit of the 2005 calendar year will be reflective of improvements based on a full year's implementation of this effort. These implementations were not in effect during the subject audit period.	Met

Comments:

As reported last year, two new interventions were implemented in December of 2004. The process of a postcard mailed to those who have not received a mammogram has not been shown to be effective in increasing the numbers of women who then schedule and receive the screening. This is true both in the experience of CHN and in general. Phone calls to women, who have not had their mammogram, may prove to be more effective as it offers the health plan the opportunity to provide information targeted to a woman's specific issues and concerns.

Recommendations:

None

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Validation of Performance Improvement Project.	Results received a LOW score in confidence in Reported Results.	The specifications utilized are those required by the State. CHN will evaluate and validate the data collection method.	N/A
Comments: The findings quoted by CHN in their CAP are incorrect. There was a finding of “high confidence” in this area.			
Recommendations: None			

Healthy Beginnings

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Validation of Performance Improvement Project – Percent of Women with Post Partum Visits Between 21–56 Days After Delivery	Results received a LOW score in confidence in Reported Results.	CHN will evaluate and validate the data collection method.	Met
Comments: CHN evaluated and changed its method of data collection.			
Recommendations: None			

Healthy Beginnings

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Healthy Beginnings PIP – Step 2 – Review of Study Question – 2.1 Was the study question stated clearly written?	Recommendations: Make the study question more clear and simple by splitting it into two questions. Consider changing the eligibility requirements for Measures 4 and 5 to account for changes in enrollment and HUSKY A & B eligibility. Health Plan Employer Data and Information Set (HEDIS) has measures, which are similar to those of CHN. Consider whether all 5 of the measures are necessary to assess whether interventions are successful. The prenatal and post partum maternal visits are used for proxies for birth outcomes it may not be necessary to also include outcome measures which are duplicative this would simplify the data collection process.	The study question has been split into two: Does an educational mailing program for all pregnant members positively impact pregnancy outcomes in terms of adequate prenatal care, NICU utilization, low birth weight and premature neonates, and percentage of women who have postpartum physician visits? Will the addition of a telephonic education program for members experiencing certain high-risk pregnancies positively impact this subset of members for the same outcomes?	Met
Comments: None			
Recommendations: None			

Healthy Beginnings

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Healthy Beginnings PIP – Step 3 – Review of Selected Study Indicator – 3.1 \ Did the study use objective, clearly defined, measurable indicators?	Recommendations: 1. Make the study question more clear by splitting it into two questions. 2. Consider changing the eligibility requirements for Measures 4 and 5 to account for changes in enrollment and HUSKY A and B eligibility; HEDIS has measures which are similar to those of CHN. 3. Consider whether all five of the measures are necessary to assess whether interventions are successful. The prenatal and post partum maternal visits are used as proxies for birth outcomes, it may not be necessary to also include outcome measures which are duplicative; this would simplify the data collection process.	The eligibility requirements for the study population are identical to those required by the State for its reports. The gap in eligibility is addressed by identifying day one of the current eligibility period after a thirty (30) day gap. As to quantitative improvement, a number of processes have been established to address this issue. They are: stratification of low, medium and high risk pregnancies, outreach to all pregnancies based on risk factors which also enables earlier identification of new onset of risk factors, standardized PCRF form throughout health plans for consistency.	Met

Comments:

These recommendations were made based on the identification, by CHN, of problems with capturing data to identify eligible women for the PIP. CHN also discussed the problems it had in resourcing collection of data. Changes were made to the data collection process to improve accuracy of data.

Recommendations:

None

Validation of Performance Measures

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Validation of Performance Measures Measure Substantially Compliant Asthma Medications	Age cohorts should be calculated as of December 31 of the measurement year rather than by the discharge date. Allowable gap in coverage should be limited to 30 days for the Medicaid population instead of the 45 days included in the programming logic. Time parameters to identify the eligible population should be clearly documented in the programming logic.	The programming logic will be modified to calculate age cohorts as of December 31 of the measurement year rather than by discharge date. The allowable gap in coverage will be limited to 30 days.	Not Met

Comments:

Age computations were based on varying dates depending on the event criteria specified. The allowable gap allowed in enrollment remained at 45 days, rather than the 30 days in the required specifications.

Recommendations:

Calculate the age of enrollees as of December 31 of the measurement year as required in the specifications.

Allow only one gap of 30 days in enrollment as specified by HEDIS 2006.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Validation of Performance Measures Measure Substantially Compliant Inpatient Utilization	Age is limited to 15–44 and should not be limited at all according to the state specifications and HEDIS requirements. Time parameters specified in programming logic and final report should be consistent. Recommendations: Time parameters referenced should be consistent throughout all aspects of the measure, including programming logic and final reporting. Age calculations should follow DSS specifications for individual measures.	The programming logic will be modified to calculate age cohorts as of December 31 of the measurement year rather than by discharge date. The allowable gap in coverage will be limited to 30 days. The breakout was based on state specifications. The total was also reported which was inclusive of the 15-44 age range.	Partially Met
Comments: The age specifications were followed. The time parameters continue to be inconsistent between the coding and the reporting.			
Recommendations: Modify the time parameters so that they are consistent throughout the measure.			

Calculation of Performance Measures

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Calculation of Performance Measures Newborn Intensive Care Unit (NICU) Admits	NICU admits/100 births have decreased since last year but remain higher than national benchmarks. CHN should continue to focus on prenatal care standards particularly on high risk pregnancies.	Please see response to perinatal efforts.	Met
Comments: CHN did modify its Healthy Beginnings program in an attempt to improve the results. The effectiveness of these interventions is discussed in the Healthy Beginnings PIP review in Section 7 and in the NICU PM calculation in Section 9.			
Recommendations: None			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Calculation of Performance Measures Emergency Department (ED) Usage	ED usage has decreased since last year but remains higher than the State's overall rate. Last year Mercer suggested that CHN research the diagnoses contributing to high ED usage and implement strategies to better manage these members. Mercer reiterates these recommendations this year.	CHN recently implemented an outreach program, which identifies member with three ED visits during the year. Calls are made to the members to identify factors involved. Additionally those members with 3 asthma related ED visits are referred to the Asthma nurse for inclusion in the newly established Asthma DM program, as this is a criterion for inclusion in the Asthma DM program. As such, an evaluation of ED utilization is undertaken for this purpose in addition to general ED utilization In addition to the asthma diagnosis, CHN will develop member education materials relative to avoiding accidental injury. This will be available on the CHN website. Further, CHN will initiate informational mailings on cardiovascular disease. Attached please find ER Utilization diagnoses for calendar years 2001 through 2004 inclusive.	Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Comments: The effectiveness of the interventions instituted by CHN is discussed in Section 9.			
Recommendations: None			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Calculation of Performance Measures Readmission Rates	CHN's readmission rate has risen since the last measurement. An evaluation of which members/diagnoses were involved was suggested last year. Mercer emphasizes that these evaluations should be put into place.	CHN currently runs a daily report of members admitted the previous day. A QI nurse is assigned to review this report and identify readmissions as well as any pertinent quality issue. Such issues include but are not limited to: trends, infections, delays in service and readmissions within three days of discharge. These matters are brought to the Chief Medical Officer for discussion and intervention as appropriate. Interventions include notification of an issue to the Quality Department the relevant hospital, presentation to the CHN Quality Improvement Committee and direct contact with a provider. CHN will work to create a report, which identifies readmissions based on specific diagnoses.	Not Met

Comments:

There is no evidence of action taken to improve the readmission rates.

Recommendations:

Devote personnel and resources to research this measure and to develop and implement interventions to improve the results. CHN's poor results may reflect significant quality of care issues as well as considerable expense.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Calculation of Performance Measures Diabetic Retinal Exams	Diabetic retinal exams have decreased since last year and continue to be well below national norms. Mercer repeats our advice to re-evaluate data collection/claims efforts to determine if complete accounting of eye exams is occurring. Diabetic patients should be tracked by their PCP and postcards should be sent quarterly to those patients who have not had their eye exam. Medical records review is also recommended again.	CHN will run quarterly reports of members who have not had diabetic retinal exams. This report will be forwarded to our Vision vendor for notification of our members, with CHN oversight. CHN will evaluate and validate the data collection method.	Not Met
Comments: There is no evidence of actions taken to assure submitted data is complete and accurate. There has been a change in the calculation methodology for 2006., which is discussed in Section 9, 'Calculation of Performance Measures.", page 92.			
Recommendations: Implement proposed corrective actions to improve results.			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations From 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Calculation of Performance Measures Breast Cancer Screening	CHN's breast cancer screening rate has decreased since last year. Mercer re-emphasizes the need for CHN to evaluate data collection/claims efforts to determine if they are receiving all claims concerning mammograms. If the members are correct activities should be implemented to increase the number of screening mammogram. PCP's should be sent quarterly report cards listing eligible women who have not received a mammogram within the year.	Report Cards are already in place. However, because many of our members receive free mammograms, claims are not submitted. As such evaluation of claims data is not a measure of whether eligible members are receiving their mammograms. CHN currently runs a monthly report of members who are age eligible for a mammogram. CHN will develop process to call these members to remind them to obtain a mammogram and/or ascertain whether they had a free mammogram during the previous twelve months.	Met
Comments: The CHN breast cancer screening rate did improve.			
Recommendations: None			

5

Compliance with Standards for Timeliness and Access to Services

Standards for Timeliness and Access to Services	Analysis	2006 Findings
Coordination and provision of Early Periodic Screening Diagnosis and Treatment EPSDT screening services in accordance with the schedules for immunizations and periodicity of well-child services as established by the DEPARTMENT and federal regulations. Provide necessary coordination and CM services for children with special health care needs (CSHCNs).	The overall rate of children under the age of 21 years who received at least one EPSDT screening improved from 2004 to 2005. However, the rate still remains far lower than the DSS standard of 80 percent. Older children, over the age of 10 years have the lowest rates–with results falling as the population ages to 19 years. CHN feels there is a problem in data collection; providers do not correctly code their claims to include an EPSDT screening. The MCO is converting their capitated providers to FFS in an effort to improve the capture of accurate data. The MCO does have a process in place to identify those CSHCNs. See discussion of CM at the end of this section for analysis of the MCO's CM.	Not Met

Recommendations:

Assess the delivery of EPSDT services to children to identify interventions to improve the number of children receiving services.

Implement interventions to improve the completeness and accuracy of claims data.

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall provide all emergency services 24 hours each day, 7 days a week or arrange for the provision of said services 24 hours each day, 7 days a week through its provider network. The MCO shall cover and pay for emergency services without regard to prior authorization and regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO shall not limit the number of emergency visits.	The MCO does not require prior authorization for emergency services. The MCO does not limit the number of visits to the emergency department nor are does it restrict access to qualified emergency providers for members with an emergent condition. This information is included in the Member Handbook and the provider manual.	Met
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall serve Members statewide. The MCO shall ensure that its provider network includes access for each Member to PCPs, OB/GYN providers, and mental health providers at a distance of no more that 15 miles for PCPs and OB/GYNs, and no more than 20 miles for general dentists and mental health providers as measured by the Public Utility Commission. The MCO shall ensure that its provider network has the capacity to deliver or arrange for all goods and services reimbursable under the Medicaid FFS program.	The CHN network has at least 1 PCP within 15 miles of each HUSKY A and HUSKY B member. The network has at least 1 pediatrician within 15 miles of each HUSKY A and HUSKY B member aged 19 years and under. The network has at least 1 obstetrician/gynecologist within 20 miles of each HUSKY A and HUSKY B female member 10 years or older. All but 9 members have access to dentists within 20 miles of their residences.	Met
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall maintain a provider network capable of delivering or arranging for the delivery of all covered health goods and services to all Members. In addition, the MCO's provider network shall have the capacity to deliver or arrange for the deliver y or all the goods and services reimbursable under this contract regardless of whether all of the goods and services are provided through direct provider contracts. The MCO shall submit a file of their most current provider network listing to the DEPARTMENT or its agent. The file shall be submitted at a minimum, once a month in the format specified by the DEPARTMENT. In establishing and maintaining its provider network, the MCO shall consider the following: 1. Anticipated enrollment; 2. Expected utilization of services, 3. Taking into consideration the characteristics and health care needs of the specific Medicaid populations in the MCO; 4. The number and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services; the numbers of network providers who are not accepting new Medicaid patients; and 5. The geographic location of providers and Medicaid Members, considering distance, travel time, the means of transportation ordinarily used by Medicaid Members, and whether the location provides physical access for Members with disabilities.	The CHN 2005-2006 Provider Network Development Plan reflected consideration of all required components for designing the network.	Met
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
In the event that the number of Members in a given county equals or exceeds 90 percent of the capacity determined in accordance with section a noted above, the DEPARTMENT shall evaluate the adequacy of the MCO's network on a monthly basis.	CHN has never exceeded the 90 percent capacity standard. Its highest capacity is in New Haven where it is 79 percent.	Met
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall ensure that the PCPs in its network adhere to the following PCP scheduling practices: 1. Emergency cases shall be seen immediately or referred to an emergency facility; 2. Urgent cases shall be seen within 48 hours of PCP notification; 3. Routine cases shall be seen within 10 days of PCP notification; 4. Well-care visits shall be scheduled within six weeks of PCP notification; 5. EPSDT/Health Track comprehensive health screens and immunizations shall be scheduled in accordance with the Department's Health Track periodicity and immunization schedules; 6. New Members shall receive an initial PCP appointment in a timely manner; (for those Members who do not access goods and services within the first six months of enrollment, the MCO shall identify and remedy any access problems; and 7. Waiting times at PCPs are kept to a minimum.	The results of the 2005 CAHPS Member Survey were essentially unchanged from the previous year regarding CHN enrollee's satisfaction with their ability to get needed care, getting care quickly and how they rated their health care. All CHN scores were in the 25th percentile for scores reported by Medicaid MCO nationally. The results of a telephone survey of 20 PCP offices by CHN showed that 90 percent of PCPs could provide an emergency office visit the same day as the call. Eighty percent of the offices could see a member with an urgent problem within 48 hours, as well as routine cases within 10 days. Eighty percent of the PCP offices could see enrollees for a well-care visit within six weeks of the request for an appointment. Seventy-five percent of the offices reported they could see new members within 6 weeks. Almost all offices reported that members waited a minimal length of time in the office before being called for their appointment.	Not Met

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
	It is of interest to note that there were offices that either did not know the availability of various appointments or refused to cooperate with the surveyors. MCO staff report there are attempts to improve the availability of access to PCP appointments by increasing the number of participating providers. There are no other procedures to monitor appointment availability other than the telephone survey.	
Recommendations: Implement a process for primary verification of appointment availability to assure accuracy. Develop and implement specific interventions to improve appointment availability for network PCPs.		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall contract with a sufficient number and mix of specialists so that the Member population's anticipated specialty care needs can be substantially met within the MCO's network of providers. The MCO will also be required to have a system to refer Members to out of network (OON) specialists if appropriate participating specialists are not available. The MCO shall make specialist referrals available to its Members when it is medically necessary and medically appropriate and shall assume all financial responsibility for any such referrals whether they be in-network or OON. The MCO shall ensure that the Member does not incur any costs for such referrals whether the referral is to an in-network or an OON provider. The MCO must have policies and written procedures for the coordination of care and the arrangement, tracking, and documentation of all referrals to specialty providers.	CHN is in the process of recruiting additional physicians in the specialties of gastroenterology, cardiology, neurology, dermatology, urology and ear, nose and throat. The staff is trying to expand the number of physicians who participate via groups with whom they already have contracts, such as Yale and Hill-Health; contacting physicians who are co-located with contracted physicians, agreeing to limit the volume of referrals to contracted specialists and in some cases review reimbursement. In cases where appropriate in-network appointment availability is not available, CHN allows referrals to OON providers. The fact that authorized referrals to in-network and OON specialists are covered services is included in the Member Handbook.	Met
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall contract with a sufficient number of dentists throughout the state to assure access to oral health care. The MCO shall: 1. Maintain an adequate dental provider network throughout the state's eight counties including access to orthodontic services. 2. Implement a plan that includes a systematic approach for enhancing access to dental care through monitoring appointment availability, provision of training to providers around issues of cultural diversity and any other specialized programs. 3. To ensure that access standards are met with respect to dental screens and appointment availability, the MCO shall ensure that the scheduling of a routine dental visit is within 6 weeks. 4. Provide for sufficient access to dental services for different age groups.	The BeneCare GeoAccess reports show that all but a very few of the members have access to a dentist within 20 miles of their residence. For those who do not have such access the distance ranged from 22 to 26 miles. A telephone survey by CHN of dental offices showed that 70 percent of the office could schedule routine appointments within six weeks. 85 percent of the offices could schedule a routine appointment in 45 days. BeneCare contacted and counseled those dental offices, which were out of compliance with the appointment availability standard.	Partially Met
Recommendations: Institute a primary verification process to assure accurate results when monitoring appointment availability. Implement interventions to improve compliance with the appointment availability standard.		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall have systems in place to ensure access to medically necessary and medically appropriate well-care by its Members. The MCO shall develop procedures to identify access problems and shall take corrective action as problems are identified. These systems and initiatives shall include, but not be limited to: monitoring new Members to ensure that a well-care appointment is scheduled within 6 months of enrollment for those whose last well-care visit does not fall within the recommended age appropriate schedules.	The CHN member handbook contains information about choosing a PCP and the importance of doing so. Welcome calls are made to new members to identify those with on-going services and those with complex medical conditions for transitioning to CHN. Neither contains specific information about the importance of scheduling an initial well-care appointment with their PCP. CHCNT does not have a system to monitor whether or not new members receive a well-care visit within six months. When a CHN staff member becomes aware of a network gap or an issue of access to a provider, those issues are forwarded to provider services for follow up.	Partially Met

Recommendations:

Implement processes to monitor and encourage new members to obtain appropriate well-care. Consider expanding member handbook information to stress the importance of accessing a well-care visit with a PCP.

Case Management/Disease Management Records Review

Nine medical records were reviewed to evaluate CM activities reflecting compliance with coordination and continuity of care. Most documentation represented activity and services in 2005 and therefore did not reflect improvements, which would be expected from implementation of the CHNPAL Case Management Documentation System in Jan 2006.

Documentation in cases showed utilization review of requested services with extensive use of home health services for cases with special needs.

Assessment and Care Plan: While all but one case included an initial assessment, the assessment was brief and often lacked important data such as allergies, immunization status, psychosocial history, and functional assessment. Medications such as Lexapro were noted but there was no mention of depression in the assessment or care plan. Both parents of one patient were injured in caretaker activities but there was no goal or interventions in care plan to address family health and injury prevention. Care plans in 2005 cases contained vague goals such as “will receive appropriate home care services.”

Treatment Progress: The narrative documentation system in 2005 did not provide a mechanism to update progress toward goals and to update goals and interventions.

Coordination of Resources: Two cases out of the nine contained referrals to community resources. All cases reflected referral to medical resources, primarily home health and physicians through documentation of authorization for services.

Education: Documentation did not include evidence of distribution of education materials about the CM program or disease specific educational material aimed at prevention or improved self-management of the disease process.

Recommendations

While the MCO CAP appears to address the findings from the 2005 review, the effect of the corrective actions was not observed in 2005 and early 2006 documentation reflected in the audited files.

- focus case file audit on:
  - essential assessment elements,
  - behaviorally specific goals,
  - progress and barriers toward meeting goals,
  - referral and coordination events including communication of plan with PCP, and
  - education contacts and interventions – specific telephone contacts and mailings (date and content);
- continue increased audit sample until compliance at 90 percent; and
- develop a prototype sample chart that shows evidence of 100 percent compliance with documentation standards and can provide a visual desk reference for Case Managers.

Credentialing Files Review

Credentialing files of general and specialty providers (physicians, Advanced Registered Nurse Practitioners, Physician Assistants, and chiropractors) who were terminated either by the plan or who had terminated their contract with the plan during 2005 were reviewed to determine:

- timeliness of credentialing and re-credentialing activities;
- completeness of credentialing and re-credentialing activities, and
- any evidence to suggest discrimination of the provider by the health plan.

From the files review, it appears that there has been a marked improvement in the timeliness and completeness of the credentialing and re-credentialing processes over the past 18 months. Two records with re-credentialing dates in 2001 and 2002 demonstrated late re-credentialing. However, all records with re-credentialing dates from the second quarter 2005 and later were timely. All providers had current licenses, board certification inquiry noted when applicable, valid and active DEA numbers when applicable, checks for eligibility for federal programs, documentation of attestation of correctness and completeness of the application by the provider, and initial on-site visit conducted by health plan with medical record review (MRR) when applicable. No on-site or MRRs scored low enough to require a CAP. All files had documentation of primary source verification of education, of disciplinary actions against their license checked, of NPDB inquiry, except for one that was credentialed prior to 2005. No evidence of any discrimination by the health plan was identified.

Recommendations

None

Grievance System File Review

A review of 20 grievance system appeals files was done. The files associated with member appeals of CHN actions were well organized and complete. Time lines for decisions and member notification were met. The forms required by DSS were used in communicating with members. The number of initial authorization decisions overturned upon review by CHN after a member appeal was reasonable. However few of the notices of action described the reason for the action in language understandable to a layperson or for a person with limited reading proficiency. Most did not contain language customized to the member's situation so that they could understand the reason for the action as it related to the request for service authorization.

Recommendations

- Provide details particular to each request for service authorization in the explanation of the reason for an action taken by CHN when preparing notices of action. Use layperson language at the seventh grade level, rather than clinical language in the notices of action.

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 children with SHCNs 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.	The CHN policy and procedure describing eligibility and referral processes for the HUSKY Plus program are complete and correct.	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.	CHN case managers contact the HUSKY Plus administration to confirm a referred member's access to the program, if no feedback has been received within a month of referral. They are instructed to contact DSS if they are unable to get the confirmation.	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.		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.	CHN does not differentiate between HUSKY A and HUSKY B members in its QM processes and tracking.	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.		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.	CHN does have a P&P that describes the correct processes regarding co-payments.	Met
Recommendations: None		

7

Validation of Performance Improvement Projects

Objective 1
To assess the methodology applied by CHN 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 Health Plan Employer Data and Information Set (HEDIS) 2005 specifications, and others used designs developed by the MCOs.

Three PIPs were reviewed for CHN. The PIPs and the specifications to be applied included:

1. Asthma Medications;
2. Healthy Beginnings (high risk pregnancy); and
3. Breast Cancer Screening Rate.

CHN was to do a total of four PIPs in 2005; however, the Adolescent Access to Preventive Care PIP was not continued.

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 that CHN 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 CHN 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

Overall Results

	2003 Baseline	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							
Use of Appropriate Medications in People With Asthma	66.9%*	66.5%*	64.4%*	78.0%	Low	Low	Partially Met
Goal		**Decrease 3%**					
Healthy Beginnings Maternity Program							
Measure # 1							
NICU days of stay as a percentage of total newborn days	49.2%	50.7%	51.4%	49.2%	High	Low	Partial
Goal			**45%**				
Measure # 2							
NICU admissions as a percentage of live births	12.3%	12.3%	13.3%	12.3%	High	Low	Partial
Goal			**9%**				
Measure # 3							
Infants born weighing ≤ 2500 grams as a percentage of live births	9.3%	9.3%	10.9%	9.3%	High	Low	Partial
Goal			**<5%**				

	2003 Baseline	2004	2005	Benchmark Most Recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with specifications
Measure # 4							
Percent of women with ≥ 80 % of recommended prenatal visits as a percentage of all deliveries	86.4%	76.1%	68.3%	86.4%	High	Low	Partial
Goal			**90%**				
Measure # 5							
Percent of women with postpartum visits between 21 and 56 days after delivery as a percentage of all deliveries	52.9%	47.1%	36.7%	52.9%	High	Low	Partial
Goal			**70%**				
Breast Cancer Screening							
Female Members Aged 40-69 Who Received a Mammogram During the Measurement Year	32.2%	32.5%	36.3%	70%	Low	Moderate	Not Met
Goal			**40%**				

Overall PIP Recommendation

- CHN should complete all PIPs as agreed with DSS.

Name of Performance Improvement Project: Appropriate Use of Asthma Medications

Dates in Study Period: 1/01/2003 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 data reflecting the prevalence of Asthma in the CHN HUSKY population as well as addressing State of Connecticut 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 2003 addressed physician communication and education mailed to members with asthma but did not address contributing concerns regarding members' use and understanding of the written educational materials provided and development of asthma management plans. The DM program implemented in February 2005 and continuing into 2006 has addressed aspects of service that includes members' current level of knowledge and the application of an individualized treatment plan, with potential for improving medication management for members with asthma through facilitating self-management.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees, such as those with special health care needs (SHCNs)?	X				The PIP included CHN HUSKY members age 5 – 56, consistent with HEDIS age specification for study inclusion. The study did not exclude members with SHCNs; although it should be noted that technical specifications were not provided in the PIP documentation but were found in other documentation provided by the Plan.

Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?		X			The Study questions: ("Will asthma education increase pharmacy claims for long acting beta agonists in CHN's asthma population by three percent?" and "Will an asthma intervention targeting physicians caring for asthmatic members have an impact on CHN's HEDIS measure?") are awkward and limit study scope and direction. Clearer wording that could be considered would be: "Will plan interventions to providers and members increase use of appropriate asthma medications for eligible members identified with persistent asthma?" Quantifiable measures should operationally define: eligible members, persistent asthma and appropriate asthma medications

Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?			X		Study Indicators in the CHN "Appropriate Use of Asthma Medications" 2005 Report described Study Indicators as: "Number of members who exceeded the threshold for the use of inhaled beta2 agonists and the percent of change" "Number of inhaled beta2 agonists used and the percent of change " and "Average number of inhaled beta2 agonists per member and the percent of change" The study indicators appear to be different than the measurement descriptions in the QI/Preventive Health Activity Summary Report "The percentage of enrolled members aged 5 – 56 during the measurement year who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year." The Numerator definition referred to "those who had at least one dispensed prescription of inhaled corticosteroids…" whereas the Study Question refers to long acting beta2 agonists. The eligible population is not clearly defined. HEDIS 2006 specifications cite that "While long-acting beta agonist are a preferred adjunct therapy for long-term control of moderate to severe asthma, their recommended use is in addition to inhaled corticosteroids. If prescribed alone without inhaled corticosteroids they do not count toward this measure"

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 although a clear definition of appropriate medication could serve to indicate improved process of care.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?			X		There is no documentation of the rationale for choosing the performance target. The benchmark, 78 percent is the HEDIS 2005 – 2006 90 percentile.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?		X			The Study description was not clear in defining the enrollees to be included in the Study. The age range was specified as 5 - 56. The Word document describing the 2005 CHN "Appropriate Use of Asthma Medications" PIP states that the "program will be open to the HUSKY group of CHN's membership." The QI/Preventive Health Activity Summary Report defines the denominator for the study as "the eligible population" without further specific reference to defining the enrollees and participation requirements.
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X				The data collection approach was not specified in the "QI Activity Summary" but was found in other documentation provided by the Plan.

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 enrollees?				X	

Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?		X			The Study methodology was not clearly defined. Study Indicators in the CHN "Appropriate Use of Asthma Medications" 2005 Report described Study Indicators as: "Number of members who exceeded the threshold for the use of inhaled beta2 agonists and the percent of change" "Number of inhaled beta2 agonists used and the percent of change " and "Average number of inhaled beta2 agonists per member and the percent of change" The study indicator in the QI/Preventive Health Activity Summary Report is "The percentage of enrolled members aged 5 – 56 during the measurement year who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year." The Numerator definition referred to "those who had at least on dispensed prescription of inhaled corticosteroids…" whereas the Study Question refers to long acting beta2 agonists. The term for "persistent asthma" was not defined.

6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data in the QI/Preventive Health Activity Summary. Reference in the 2005 CHN Appropriate Use of Asthma Medications Report was made to Pharmacy data "Caremark (CHN's) pharmacy benefits manager drug utilization reports will be used to identify those members who would be included in the numerator".
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 details regarding data collection methodology was not submitted for review with QIP documentation although specifications that were most probably used by the Plan were submitted in other documentation binders.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?		X			Supporting documentation details regarding data collection methodology was not submitted for review with QIP documentation although specifications that were most probably used by the Plan were submitted in other documentation binders.
6.5	Did the study design prospectively specify a data analysis plan?		X			Supporting documentation details regarding data collection methodology was not submitted for review with QIP documentation although specifications that were most probably used by the Plan were submitted in other documentation binders.
6.6	Were qualified staff and personnel used to collect the data?		X			Reference in the 2005 CHN "Appropriate Use of Asthma Medications" Report described the personnel attending "asthma program" meetings throughout the year. Credentials of participating members were not identified.

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 although documentation of analysis was not a robust discussion of barriers contributing to the identified problem where quality improvement analytical techniques are traditionally utilized. Interventions in 2005 also were a continuation of interventions initiated in 2003 and 2004 with a shift in 2005 toward using the Asthma DM 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			A specific data analysis plan was not found. Data analysis was completed for three years of the Study. Changes in data collection and analysis between the three measurement periods, which might have been introduced due to DSS specification requirement changes were not addressed. 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 on page 6 of the QIA Documentation Form, but reference "ER utilization for managed members" as opposed to the applicable "Use of appropriate medications in people with Asthma" measure. It is difficult to tie this years report to last years. The baseline year for ER Utilization for managed members was to be 2005. The results in last year's report for "Increase Use of Appropriate Medications for Asthma" were labeled 2004 and baseline. This year's report had baseline results reported for 2003. The 2004 results changed from 64.4 percent to 66.5 percent and the 2005 results of 64.4 percent were the same as reported last year for 2004.
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 measurements for three measurement periods: 2003, 2004 and 2005 although it is unclear if the results are for the ER utilization measure or the Asthma medication management measure. Statistical significance was addressed in the analysis. Analysis addressing contributing factors to results, internal and external validity factors and study limitations was not documented.
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 limited discussion of results. An analysis addressing contributing factors to results, internal and external validity threats and study limitations was not documented. All interventions were tied to one barrier.

Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?		X			It is unclear if methodology from baseline to Re-measurement Period 1 and Re-measurement Period 2 was changed to meet DSS specifications. Change to specifications was not clearly documented.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?			X		Quantitative improvement was not documented.
9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?				X	Quantitative improvement was not documented.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?				X	Quantitative improvement was not documented.
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?				X	Quantitative improvement was not documented.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?				X	Quantitative improvement was not documented for Re-measurement Period 1 or Re-measurement Period 2.

Summary of Results

Results of the study did not indicate a significant improvement in use of appropriate medications for people with asthma. Study questions and data collection methodology were not clear.

Documentation submitted does not include the techniques used to complete root cause analysis and identify barriers and causes that can be addressed by specific interventions of the DM program.

PIP Recommendations

The Study methodology should be re-considered to improve confidence in reported results and ongoing improvement. Recommendations include:

- Describe asthma prevalence and costs for CHN HUSKY population compared to CHN's population and the State's population in order to provide support for Study selection.
- Document how benchmark supports performance target (goal).
- Clarify study question that reflects consistent measures in all documents and include any operational definitions that will assist in defining measurable indicators.
- Provide data collection plan that includes data collection methods and specifications including eligibility and coding logic.
- Address any changes in measurement methods between the baseline reporting year and subsequent re-measurement periods.
- Add analysis documentation that describes techniques used for barrier analysis and specify what interventions in the DM program are planned and implemented to address each barrier. Interventions were identified but analysis was not a robust discussion of barriers contributing to improvement using traditional quality improvement analytical techniques. Interventions in 2005 were a continuation of interventions initiated in 2003 and 2004 with a shift in 2006 toward using the DM program structure and processes as the primary intervention strategy. Documentation currently does not allow the reader to know what barrier the intervention or DM program activity will address.
- Identify qualifications of staff completing analysis and directing study. Credentials of participating committee members were not identified. Documentation did not provide evidence that medical professionals with respiratory healthcare experience or education were included in planning, data collection, analysis, and directing or supporting interventions for improvement.

Name of Performance Improvement Project: Healthy Beginnings Maternity Program

Dates in Study Period: 1/01/2003 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 data reflecting the importance of pre-natal care in preventing infant mortality and decreasing low birth rate infants as well as addressing State of Connecticut 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 addressed member education, redesign of the Healthy Beginnings program including increased telephonic contact and incentives. The maternity DM program and high risk CM program continuing into 2005 and 2006 have addressed aspects of service that includes member current level of knowledge and application of treatment plan addressing medical and psychosocial risk factors.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees, such as those with SHCNs?	X				The PIP included CHN HUSKY A and B members enrolled with CHN and was consistent with HEDIS eligibility requirements 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 an educational mailing program for all pregnant members, and a telephone education program for members experiencing certain high-risk pregnancies positively impact pregnancy outcomes in terms of adequate prenatal care, NICU utilization, low birth weight and percentage of women who have timely postpartum physician visits?") is clearly stated. Another wording that would broaden the application beyond "members experiencing high-risk pregnancies" would be: "Will plan interventions to CHN HUSKY pregnant members improve maternal and infant health as evidenced by deceasing NICU utilization and low birth weight births and increasing percentage of pregnant women receiving adequate prenatal care and postpartum physician visits?"

Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				Study Indicators in the CHN "Healthy Beginnings Maternity Program QI Activity Summary" included: 1. NICU days of stay as a percentage of total newborn days. 2. NICU admissions as a percentage of live births. 3. Infants born weighing ≤2500 grams as a percentage of live births. 4. Percent of women with ≥80 percent of recommended prenatal visits as a percentage of all deliveries. 5. Percent of women with postpartum visits between 21 and 56 days after delivery as a percentage of all deliveries. Indicators were clearly stated and compliant with State DSS requirements
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 address changes in health status and health care and are associated with improved infant mortality and health outcomes.

3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?		X			There is evidence of benchmarking in the narrative description with reference to Healthy People 2010 goals. The documentation of benchmarks on pages 6 and 7 of the "QI/PH Activity Summary" appear to reflect baseline activity rather than current benchmarks. Te current goals appear to represent the long-term goal based on the benchmarking analysis. Benchmarking is the process of establishing a standard of excellence and comparing activity with that standard to improve quality. While there are four kinds of benchmarking (internal, competitive, functional and generic), an internal benchmark would not reflect baseline activity.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?		X			The Study description was not clear in defining the enrollees to be included in the Study. The narrative stated that the program was open to all HUSKY A & B members enrolled and pregnant. The Study question as phrased in the "QI/PH Activity Summary" implies the study population was "members experiencing high-risk pregnancies".
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X				The data collection approach was described in the narrative, although specifications were found in other documentation provided by the Plan. As stated above, the study question seems to imply a narrower study population than the indicator definitions.
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 enrollees?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				The study design and data collection plan was described in the Healthy Beginnings Performance Improvement Project 2005 narrative.
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data as well as medical records in the QI/PH Activity Summary.
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 details data collection methodology as well as factors affecting validity of data and results. Barriers and limitations to data were identified and changes to the data collection process outlined to address identified problems.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Supporting documentation details data collection methodology as well as factors affecting validity of data and results. Barriers and limitations to data were identified and changes to the data collection process outlined to address identified problems.
6.5	Did the study design prospectively specify a data analysis plan?	X				Supporting documentation included a data analysis plan as well as changes planned in 2006 to address identified data collection problems and changed in processes.
6.6	Were qualified staff and personnel used to collect the data?	X				The narrative provided in the "Healthy Beginnings Performance Improvement Project 2005" Summary detailed the qualification of staff involved in providing oversight of the study

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 addressing barriers contributing to the identified problem. Interventions in 2005 were a continuation of interventions initiated in 2003 and 2004.
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			The data analysis plan was documented in the "Healthy Beginnings Performance Improvement Project 2005" Summary. There is a brief discussion of the data used in the analysis, but no information is included about the technique used in the analysis.
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?			X		The data analysis plan was documented in the "Healthy Beginnings Performance Improvement Project 2005" Summary, but the results and analysis for 2005 (re-measurement 2) were not available, initially. They were made available at the time of the on-site review.
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 data analysis plan was documented in the "Healthy Beginnings Performance Improvement Project 2005" Summary. The analysis did not include the factors that influence comparability of initial and repeat measurements.
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 data analysis plan was documented in the "Healthy Beginnings Performance Improvement Project 2005" Summary. There was no discussion about the lack of progress made, but new follow-up activities for 2006 were described.

Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				The documentation shows there was no change to the methodology used for the baseline in the next two measurement periods.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?			X		Quantitative improvement was not documented.
9.3	Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?				X	Quantitative improvement was not documented.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?				X	Quantitative improvement was not documented.
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?				X	Quantitative improvement was not documented.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?				X	Quantitative improvement was not documented for Re-measurement Period 1 or Re-measurement Period 2.

Summary of Results

Results of the study indicated there was no improvement in maternal and infant health. For those measures where there were statistically significant changes in the rates from 2004 to 2005, results indicated a decline in performance. Data collection methodology has been improved. Results were not available by the deadline for submission.

PIP Recommendations

Recommendations include:

- Document how benchmark supports performance target (goal).
- Clarify study question that reflects consistent study population in all documents..
- Submit 2006 results with desk review documentation by deadline.
- Assess barriers and interventions for appropriateness given there has been little to no improvement since the baseline measurement period.

Health Plan						
Name of Performance Improvement Project: Breast Cancer Screening						
Dates in Study Period: 1/1/2005 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 HP did not address the rate of Breast Cancer in its own population.
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 did address a key aspect of women's preventive health care.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees, such as those with SHCNs?	X				All women who met the age and enrollment period criteria were included in the study.
Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?		X			The study questions incorporate interventions within the questions. Additional interventions have been implemented, making the questions incomplete. Study questions could be improved by changing the specific language to more general language, such as "Will plan interventions to providers and members increase the rate of annual mammography screenings for women aged 40–69?"
Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				The documentation states that the HEDIS Breast Cancer Screening Measure as modified by DSS was used.
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				The indicator measured changes in a process of care. Early detection of breast cancer has been shown to improve outcomes.

Health Plan						
3.3	Was there documentation of chosen Performance Targets, including benchmarks used, or rationale/justification for the chosen performance target?		X			The benchmark used, 70 percent, is the Healthy People 2010 standard for mammograms. This standard covers a 2 year measurement period, while the indicator used by CHN has a 1 year measurement period. There is no description of the rationale for the goal figure of 40 percent.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	X				
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?			X		Specifications were not included in the documentation.
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	A sampling methodology was not used.
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 enrollees?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?			X		Specifications were not included with the documentation.
6.2	Did the study design clearly specify the sources of data?	X				The CHN Claims data warehouse was the source of the data.

Health Plan						
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		There was no discussion of the validity or reliability of the data collection method. The study did not include an evaluation of the completeness of the data.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?			X		Pertinent information was not included in the documentation.
6.5	Did the study design prospectively specify a data analysis plan?		X			There was a brief discussion of the plan, including analysis semi-annually of pertinent claims data and of process measures covering interventions.
6.6	Were qualified staff and personnel used to collect the data?			X		There was no description of the staff or their qualifications.
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			The barriers all assume a knowledge deficit on the part of the population. Research has shown there are additional barriers leading to reluctance on the part of women to obtain a mammogram. Additionally, in the description of the PIP, it stated that CHN would begin sending PCPs a semi-annual report listing women, in the appropriate age group, for whom no claim for a mammogram had been received during the previous 12 months. This was not included in the Summary document under the analysis and identification of opportunities for improvement section of the documentation.
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			No analysis of the findings was provided other than the fact that results were statistically significant. The results of the semi annual analysis of claims data were not mentioned.

Health Plan						
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	X				
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			There is no identification of threats to the validity of the data. Statistical significance was given, as well as the test used to calculate the significance.
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		There was no further discussion of barriers preventing CHN from meeting their goal or benchmark.
Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?			X		The general description of the methodology appears to be similar, but because details were sparse, a judgment cannot be made.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?	X				The percent of eligible women who received a mammogram increased by 11.7 percent. However, the 36.3 percent was below the current goal of 40 percent and far below the benchmark of 70 percent.
9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	X				
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	X				

Health Plan						
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?			X		
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?	X				This is the first measurement period in which significant improvement was shown.

Summary of Results

The results indicate there was a significant improvement in the number of women who received a mammogram.

Specifications for the PM were not submitted with the documentation.

PIP Recommendations

Recommendations include:

- Submit complete 2007 documentation by the deadline for desk review documents.
- Assess barriers for appropriateness and to assure that all barriers are considered.
- Add analysis documentation that describes techniques used for barrier analysis.
- Evaluate the completeness of the data and include a description of the process and findings in the documentation.
- Include a description of staff and their qualifications in the documentation.

8

Validation of Performance Measures

Objective 1
To evaluate the accuracy of Medicaid PMs reported by CHN.

Objective 2
To determine the extent to which selected PMs calculated by CHN followed the specifications established by DSS.

Objective

The purpose of this review was to assess the validity of the following PMs undertaken by CHN for the time period calendar year 2005:

- Measure 1 — Asthma Medications;
- Measure 2 — Practitioner Access;
- Measure 3 — Children's Access to Preventive Care; and
- Measure 4 — Inpatient Utilization.

Assessment of Strengths and Weaknesses

An information request was developed to gather information from CHN 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 clinical codes (e.g., ICD-9, CPT-4, DSM-IV) used appropriately?
- 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 correct time parameters (e.g., admission and discharge dates or treatment start and stop dates) used?
- Are MRR documentation and tools adequate?
- If hybrid method was used, is the integration of administrative and medical record data adequate?
- If hybrid method or solely MRR was used, do the results of the MRR 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 Applicable
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 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 was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator

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	Substantially Compliant
Practitioner Access	Fully Compliant
Children's Access to Preventive Care	Substantially Compliant
Inpatient Utilization	Fully Compliant

Conclusions Drawn

The validation findings assigned to each measure were 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	Substantially Compliant	Substantially Compliant	▪ Age cohorts should be calculated as of December 31 of the measurement year rather than the discharge date. ▪ Allowable gap in coverage should be limited to 30 days for the Medicaid population instead of the 45 days included in the programming logic. ▪ Time parameters to identify the eligible population should be clearly documented in the PM programming logic.
Practitioner Access	Substantially Compliant	Fully Compliant	Fully Compliant	▪ All of the GeoAccess reports should be run in the measurement year. For validation purposes, practitioner access is considered for the measurement year under review, not at the time materials are submitted to the EQRO. ▪ Disclosure of data sources and a comprehensive description of the CHN protocol for utilizing the GeoAccess system to customize results to CHN's specifications are desired for a more comprehensive review of processes and procedures.
Children's Access to Preventive Care	Substantially Compliant	Fully Compliant	Substantially Compliant	▪ References to measurement year should be consistent throughout the coding logic. ▪ Allowable gap should be limited to 1 month (30 days); not 2 months (60 days) as indicated in the programming logic for both the 3–6 and 12–21 age groupings. ▪ The 12–21 age grouping includes the following codes not included in the DSS specifications: (160, 160A, 160B, 160E, 960).
Inpatient Utilization	Fully Compliant	Substantially Compliant	Fully Compliant	▪ Time parameters should be explicitly displayed in the initial PseudoCode print screens and consistent in the final reports for both HUSKY A and B. ▪ Final reports with results for the entire measurement year should be included in the documentation for both the HUSKY A and B populations.

The Asthma Medications measure is substantially compliant, similar to the prior year in that the issues identified previously have not been resolved. These issues must be addressed in the following year to increase the measure to a fully compliant status. Due to deficiencies in the coding logic regarding the unsubstantiated addition of several clinical codes for the 12-21 age grouping and the time parameters specified for allowable gap, the Children's Access to Preventive Care measure has declined from a fully compliant measure in 2004 to a substantially compliant measure in 2005. The Practitioner Access measure maintained it's fully compliant status from the prior year, and the Inpatient Utilization Measure improved from substantially compliant to fully compliant for the 2005 measurement year.

Recommendations

- All measures would benefit from the explicit disclosure of data sources, systems, and protocols utilized to calculate measures (in particular those measures utilizing internal specifications).
- Consistent measurement year documentation throughout the specifications, programming logic, and resulting reports would support the overall validity of each measure.

9

Calculation of Performance Measures

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

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

The purpose of this component of the EQR was to use CHN's encounter data (submitted monthly by CHN 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 CHN 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 currently receives 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 calendar year 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	232	267	296
Number of Births	1,674	2,067	2,145
NICU Admits/100 Births	**13.9%**	**12.9%**	**13.8%**

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. CHN's 2005 rate is higher than both the national and State overall rates.

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 calendar year 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 the way CHN reports to the State.

Measure	Value		
	2003	2004	2005
Number ED Visits	42,089	41,160	46,264
Member Months	644,891	658,391	688,237
ED Usage/1,000 Member Months	**65.3**	**62.5**	**67.2**

Methodology for this measure changed 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. CHN's 2005 rate is higher than last year and is substantially higher 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 a 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	55	82	197
Number of Discharges	6,233	7,106	7,765
Readmission Rates	**0.9%**	**1.2%**	**2.5%**

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 2004 average of 0.8 percent. CHN's 2005 rate is much higher than the State's overall rate this year and has increased substantially over last year. If CHN's data is removed, the State's overall rate is 0.84 percent for the year.

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 National Committee on Quality Assurance (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 two outpatient or physician administrative records on different dates of service or one 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	98	101	998
Continuously enrolled eligibles	771	881	1,202
Diabetic Retinal Exam	**12.7%**	**11.5%**	**83.0%**

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. CHN's 2005 rate is above the national average but lower than the State's overall 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	579	613	703
Number of women continuously enrolled	1,795	1,933	1,945
Breast Cancer Screening/Mammography	**32.3%**	**31.7%**	**36.1%**

Benchmarks are not 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. CHN's 2005 rate is higher than the State's overall rate for 2005 and increased over last 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. Emergency department 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	281	276
Total of asthmatic members	N/A	1,730	1,660
ED Usage by Asthmatics	**N/A**	**16.2%**	**16.6%**

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. CHN's rate is higher than the State's overall rate and has increased slightly over the previous year.

Recommendations

- NICU admits per 100 births remains higher than national benchmarks. Mercer strongly recommends that CHN should continue to focus on prenatal care standards, particularly on high-risk pregnancies.
- ED usage has increased since last year, and remains substantially higher than the State's overall rate. Last year Mercer suggested that CHN research the diagnoses contributing to high ED usage and implement strategies to better manage these members. Mercer reiterates these recommendations this year.
- CHN's readmission rate has risen substantially since the last measurement. In the past two years, Mercer recommended that CHN evaluate the members and diagnoses involved in readmissions. We continue to emphasize the need for this type of evaluation. In addition, CHN should analyze the accuracy of its encounter data that is submitted and would be affect these results.
- CHN's breast cancer screening rate has increased since last year. CHN should continue their efforts in this area.

Appendix A

Appendix A – Documentation Submitted for Review

Community Health Network of Connecticut
2006 MERCER EQR
Binder #1
General Information

Table of Contents

1. Mission Statement

2. Company Overview

3. Strategic Plan

Community Health Network of Connecticut
2006 MERCER EQR
Binder #2
Record Review

Table of Contents

1. List of terminated providers, including letters for providers who were not accepted into CHNCT's provider network

2. Case Management Report for 10/01/2005-12/31/2005

3. Appeal Tracking Log
   *Please note Grievance Tracking reports are submitted in the Grievance System Binder

Healthy Beginnings Performance Improvement Project

Table of Contents

Tab 1

PIP description document
- Selection of Study Topic
- Root Cause Analysis, Member and Provider Mailings
- Definition of Measures

Other documents used in the program (Registration forms)
Committee Minutes

Tab 2

Policies & Procedures
Scripts

Tab 3

Quality Improvement Activity Report
- Includes areas of deficiency from prior review processes

HEDIS Data Results
State Reports *(due to the State Report schedule, reports for 2005 are not yet available; however, the first half of 2005 will be available at the time of the onsite review.)*
Postpartum Depression outcomes reports

Table of Contents
Validation of Performance Measures Binder

I.	Use of Appropriate Medications for People With Asthma Includes: MedMeasures Pseudo Code Report, Technical Specifications, and HEDIS Report	Tab 1
II.	Inpatient Utilization Report Includes: Program Development Documentation, DSS Specifications, Report Template, Calculated Reports	Tab 2
III.	Children's Access to Care Includes: Program Development Documentation, Report Specifications, Report Template, and Calculated Reports	Tab 3
IV.	Practitioner Access Reports	Tab 4

Community Health Network of Connecticut

2006 MERCER EQR

Binder #5

Quality Assessment and Performance Improvement (QAPI)

Table of Contents

1. **Member Handbook** **Tab 1**
2. **Enrollee Rights & Responsibilities** **Tab 2**
   Member Rights and Responsibilities Policy
   Enrollee Rights listed on the Website
   Enrollee Right section lifted from Mercer Handbook
3. **Credentialing Committee Minutes from CY 2005** **Tab 3**
   Credentialing Statistics
4. **Member Satisfaction Survey Results** **Tab 4**
5. **QM Minutes Discussing Issues** **Tab 5**
6. **Utilization Management Program Description** **Tab 6**
7. **Quality Improvement Program Description** **Tab 7**
8. **Quality Improvement Program Evaluation** **Tab 8**
9. **Quality Improvement Work Plan** **Tab 9**
10. **Husky B Member Referrals TO Husky Plus** **Tab 10**
11. Husky B Policy and Procedures **Tab 11**
    Husky B B and 2&3 Billing Cycle, Cash Application & Adjustment Policy
    Husky B B and 2&3 Premium Invoice Production Process
    Delinquent Accounts Policy
    Husky B B and 2&3 Individual Premium Refund Policy
    Husky B Co-Pay Reporting & Management of members
    Reaching Co-Pay ceiling
12. **Call Center Statistics** **Tab 12**
13. **Annual Utilization Management Statistical Report** **Tab 13**
14. **Provider Selection Criteria** **Tab 14**
15. **Provider Profiling Report** **Tab 15**
16. **Provider Newsletters and Communications** **Tab 16**
17. **Member Needs Assessments related to QAPI/Network Adequacy-Refer to member satisfaction survey submitted in tab 4**
18. **Process to Determine Eligibility for Husky Plus-Refer to policy submitted in Tab 20**
19. **P&P's tracking demonstrating coordination of referral process for Husky Plus members- Refer to policy submitted in Tab 20**
20. **Documentation defining quality measurement processes, results and tracking for Husky B members** **Tab 20**
21. **Staff Educational Topics/Programs List** **Tab 21**
22. **Coordination of Care Policies** **Tab 22**

Co Management for members with medical and behavioral health needs
Case Management Services: Intra-Departmental Collaboration
Continuity of Care Policy for New Members Transitioning into CHNCT

23. Medical Record Audit Tool
Refer to Tab in Corrective Action Binder

24. Access/Availability Studies
Refer to Tab in Corrective Action Binder

Community Health Network of Connecticut
2006 MERCER EQR
Binder #6
Grievance Systems
Table of Contents

1. Appeal System
    Notice of Action Policy
    Husky B Denial Letter Policy
    Member Appeal Administrative
    Hearing Process for HUSKY A Members Policy
    Member Appeals for Husky B Members Policy

2. Committee Minutes Discussing Grievances and Appeals

4. Grievance Tracking System

Community Health Network of Connecticut
2006 MERCER EQR
Binder #7
Corrective Plan Implementation
Table of Contents

1. **Case Management Disease Management System** **Tab 23**
2. **CHCT On-Site Training** **Tab 24**
3. **Medical Record Audit Form and Advance Directive Policy** **Tab 25**
4. **Provider Newsletter** **Tab 26**
5. **Healthy Beginnings PIP Study Question** **Tab 27**
6. **Member Education Materials** **Tab 28**
7. **Network Development** **Tab 29**

Community Health Network of Connecticut, Inc

Managed Care Accessibility Analysis for the Members of Community Health Network Of Connecticut

May 15, 2006

Table of Contents

1. Husky A Primary Care Providers

Primary Care Provider Network for all Members

Primary Care Pediatrician Network for Members 0 – 19

2. Husky A Specialty Providers

Cardiology Provider Network

Dermatology Provider Network

Ears, Nose, and Throat Provider Network

Gastroenterology Provider Network

Neurology Provider Network

OBGYN Provider Network Female Members over the age of 10

Orthopedic Provider Network

Urology Provider Network

3. Husky B Primary Care Providers

Primary Care Provider Network for all Members

Primary Care Pediatrician Network for Members 0 – 19

4. Husky B Specialty Providers

Cardiology Provider Network

Dermatology Provider Network

Ears, Nose, and Throat Provider Network

Gastroenterology Provider Network

Neurology Provider Network

OBGYN Provider Network Female Members over the age of 10

Orthopedic Provider Network

Urology Provider Network

5. SAGA Primary Care Providers

Primary Care Provider Network for all Members

6. SAGA Specialty Providers

Cardiology Provider Network

Dermatology Provider Network

Ears, Nose, and Throat Provider Network

Gastroenterology Provider Network

Neurology Provider Network

OBGYN Provider Network Female Members over the age of 10

Orthopedic Provider Network

Urology Provider Network

Appendix B

Appendix B – Agenda for On-Site Review Session

MERCER
Government Human Services Consulting

COMMUNITY HEALTH NETWORK OF CONNECTICUT **DRAFT**
EXTERNAL QUALITY REVIEW AGENDA
BREAK-OUT DISCUSSIONS
Date: July 18, 2006

Mercer
Nan Jeannero, RN, BSN, MBA
Nancy Abbott, RN, MSN, SpCLN
Jennie Echols, RN, DSN

DSS
Theresa Rugens

Note: Meeting times may vary based upon the results of the desk review.

8:30 a.m. to 8:45 a.m.	***Introductions and Overview of EQR***
Location: TBD	**Attendees:**
8:45 a.m. to 10:00 a.m.	***Corrective Action Plan***
	Attendees:
	Quality, Medical Management, and Network Managers and staff or others who can address corrective action plan issues and results.
11:00 a.m. to 1:00 p.m.	***Chart Reviews and Working Lunch***
1:00 a.m. to 2:30 p.m.	***Compliance to Access and Timeliness Requirements***
	Attendees:
	Quality, Medical Management, and Provider Services Managers and staff and others who can address comprehensive processes related to access and timeliness of services.
2:30 p.m. to 3:00 p.m.	***HUSKY B***
	• ***HUSKY Plus***
	• ***HUSKY B Aggregate Cost Sharing***
	Attendees:
	Participants should include those who can address issues related to HUSKY Plus and HUSKY B processes.
3:00 p.m. to 3:15 p.m.	***Break***

3:15 p.m. to 4:15 p.m.	***Performance Improvement Projects and Performance Measures*** **Attendees:** Quality, Medical Management, and IS Managers and staff and others who can address questions related to PIPs and PMs.
4:15 p.m. to 5:00 p.m.	***Closing Summary*** **Attendees:**

g:\work\conmed\project\eqr\2006\agendas and chart requests\chn on-site agenda.doc

Appendix C

Appendix C – MCO Corrective Action Plans

Community Health Network of CT Response/Correction Action Plan for 2005 Compliance Review

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Enrollee Rights and Protections- Page 10, Section 3. Provide educational information to staff and the community about Advance Directives	CHN developed a policy, which described processes to educate its members, providers, and staff. There was no reference to the community. **Recommendations: Describe in the Advance Directives Policy the process by which the community will be in-formed about the availability of Advance Directive education and the process by which that education will be delivered.**	The policy will be updated to describe the process by which the community will be informed about the availability of Advance Directive education and the process by which that education will be delivered. A Member Education Workgroup has been established which will create educational material for posting on CHN's website and for distribution to FQHCs and clinics on flyers.	Roberta Geller, Health Services, Steve Mackinnon, Operations Support.	March 1, 2006
Enrollee Rights and Protections - Page 11, Section 4. Advance Directive P&P's do not address whether an individual has executed an Advance Directive or not must be documented in a prominent part of the individual's current medical record	The medical record audit form used during credentialing visits included "Evidence of discussion of Advance Directives with a copy of signed form, if one is executed." The requirement that information about a member's advance directive should be in their chart was included in the provider newsletter at the end of 2004. CHN auditor re-ported that providers were using a sticker to indicate whether a member had executed an advance directive. **Recommendations: incorporate into policy the requirement that whether or not a member has executed an advance directive should be documented in a prominent part of the current medical record by the provider.**	The 2006 provider newsletter will advise providers that whether or not a member has executed an advance directive should be documented in a prominent part of the current medical record. CHN will include this as an element in the credentialing site visit audit.	Jim Sumler, Provider Relations Roberta Geller, Quality Improvement.	July 30, 2006 January 30, 2006

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Enrollee Rights and Protections: Page 15, Section 10. The documentation of CM/DM activities needs attention. The following are recommended: a standardized clinical health assessment documentation format should be developed. All education materials sent to members should be recorded. Coordination with PCP's and specialists and documentation of these events are encouraged. More thorough periodic evaluation of care plan goals status should be done**.**	A review of the case files revealed inconsistency in the completeness of the documentation and of the extent of CM follow up. Some files showed that goals and planned actions were developed, as new needs were identified. Other files contained an initial assessment and goals but no ongoing assessments. New problems were ignored; goals were not updated nor were there new goals or actions developed. The use of home health nurses was common in the cases reviewed. The documentation of the actions of he home health nurse and their follow up with provide was deficient. **Recommendations: The quality of the documentation in the CM files should be monitored on a regular basis with feedback to the Case Managers and the development of CAPs for those needing to improve their performance. The Case managers' performance should be monitored either through peer or manager review with feedback given to each case manager. Action should be taken to increase the consistency with which appropriate CM is provided to CHN members.**	In addition to inter-rater reliability reviews, CHN proposes to audit CM cases pulled from the DSS CM report submitted to the state quarterly. This audit will include a sampling from each case manager and DM nurse. Managers in each area will be responsible for monthly reviews and development of CAPs with individual staff members. Documentation of these audits will be kept in binders in the respective departments. Audits will focus on all elements of CM and DM including assessments, history, goals, barriers - social and otherwise, interventions, educational materials, outside resource agencies utilized, outcomes, and will also include documentation of any discussions regarding patient's progress that are received from any home care agency that is involved in these cases. Further, there will be quarterly peer review meetings and the results of these meetings will also be documented in binders in the respective departments. Community Health Network of CT (CHN) currently utilizes CaseStepp, a CM component of our data system for authorizations and claims. The current CM system allows for free text but does not outline for the nurses a structured assessment and treatment plan. After review of programming hours and costs to enhance our current system, CHN has determined that we have a homegrown CM program with all the necessary elements that was built some years ago. This system resides on our desktop via “CHNPAL”.	Lynn Childs, Health Services	Completed by January 1, 2006. System utilization commences January 3, 2006 Monthly audits commence February 6, 2006.

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
		This Case Management System includes the following components: 1. Member Information Screen which includes all member information and demographics. 2. The second tab/screen is for the Case Management Clinical/Assessment Report which includes: - Current Medications - Behavioral Health Care Needs - Social / Environmental Factors - Other Resources: State/Community - Comments - Problem/Condition/Disease (with drop down boxes for history, other medical problems, risk level stratification, etc.) 3. The third tab/screen is the Case Management Treatment Plan/Interventions which include: - Problem/Goal/Outcome (fields for whether outcomes were met or not as well as outcome variance and completion date) - Interventions (including intervention date and target date as well as evaluation and follow up dates) 4. The fourth tab/screen is for all Case Management Call Activities and includes: - Call History - Type of call – initial assessment, reassessment, follow-up		

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
		- Dates and Time - Case Manager Name or DM Nurse Name Our timeline is as follows: Week of November 7th – Review of CHNPAL Case Management Program by original programmer to allow for review of how to use and for recommendations as to any necessary modifications to current program. November 11th – November 30th – Case Managers and Disease Management nurses will enter all their current cases into CHNPAL Case Management Program. January 3, 2006 – All new cases will be entered into CHNPAL Case Management System. January 15, 2006 – Audits will commence. There will be a manager audit and a manager plus peer audit done on a regularly scheduled basis and documented in the respective departments – one for Disease Management cases and one for CM cases. January 2006 – Reports component of system to be reviewed and tested.		
Enrollee Rights and Protections: Page 16, Section 11. Mercer recommends that clinical practice guidelines be translated into lay level and actively shared with members for whom they	CHN has not translated its Clinical Practice Guidelines for its members. The staff did not believe that the guidelines can be written in a lay language and still be meaningful. The staff believed the content of the guidelines was included in its member educational materials. Information about obtaining these materials was included	Clinical practice guidelines are currently available on our website. Additionally, a Member Education Workgroup has been established to provide educational information to members on specific diseases and Advance Directives. Communications regarding this information will be provided to the members, FQHCs and clinics for ease of accessibility to members.	Roberta Geller, Health Services	July 1, 2006

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
are pertinent. CHN is encouraged to mention the availability of the guidelines in the Member Handbook.	in the member handbook. The dissemination of the guidelines in a requirement of CFR 438.236 (C) **Recommendations: Review member education materials to assure all relevant information from the Clinical Practice Guidelines is included in an easily accessible fashion. This would include the information being gathered in one place and clearly labeled for ease in identification.**			
Compliance with Standards for Timeliness and Access to Services: Page 23, Section 3. The MCO shall maintain a provider network capable of delivering/arranging for the delivery of all covered health goods and services to all members	CHN did not consider anticipated enrollment, the number and types of providers needed to furnish the Medicaid services, and the geographic location of providers and members when designing its provider network. It also used feedback from providers and members when identifying additional needs of the network. Expected utilization of services, consideration of the characteristics/health care needs of it's specific Medicaid population and the	Monitor and report network development activities as follows:· Required reporting to DSS as per contract· Quarterly access and availability studies and reports to CHN Management and QI Committee· Monthly reporting to CHN Sr. Management	Jim Sumler, Health Services	Quarterly, beginning 3/30/06

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
	number of providers accepting new members were not incorporated into the network planning process. Satisfaction surveys showed a low level of satisfaction when compared to other MCOs' results with a member's ability to get needed care. Providers exhibited a low level of satisfaction with the network composition. **Recommendations: Incorporate all required components when developing the provider network.**			
Compliance with Standards for Timeliness and Access to Services - Page 26 , Section 6. The MCO shall contract with a sufficient number of dentists throughout the state to assure access to oral health care. The MCO shall: • Maintain an adequate dental provider network throughout the State's eight counties including access to orthodontic services;	A 2004 secret shopper survey reported that 88 percent of the dentists could accommodate a member for a routine appt within 6 weeks. 100 percent of the CHN membership had access to a dentist within 20 miles of their home according to the GeoAccess Report run by the MCO. CHN has provided capital funds to FQHC's to update their equipment or to add operatories to their dental clinics. CHN makes the language line available to its providers. There are instructions in the provider manual about how to arrange for face-to-face interpretive services. **Recommendations: Utilize the results of monitoring efforts to identify areas of the network out of compliance and**	Intervention 1. Reach out to non-compliant providers and inform them of the deficiency 2. Restate their contractual obligation 3. Monitor compliance Review Measurement Process 1. Review sampling methodology and size requirements 2. Provide a description of the impact of small sample sizes and therefore, sampling variation on the validity of reported results. 3. Provide a description as to how results should be interpreted. Investigate the feasibility (cost/resource) of increasing sample size The dental provider fee structure has been increased. As such it's anticipated that availability will improve.	Jim Sumler, Lou A'auria, Health Services	July 30, 2006

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
• Implement a plan that includes a systematic approach for enhancing access to dental care through monitoring appointment availability, provision of training to providers around issues of cultural diversity, and any other specialized programs. • Ensure that access standards are met with respect to dental screens and appointment availability; the MCO shall ensure that scheduling of a routine dental visit is 6 weeks. • Provide for sufficient access to dental services for different age groups.	**implement interventions to improve availability.**			
Validation of Performance Improvement Project -	Results received a LOW score in confidence in Success & Sustainability of Improvement Efforts	CHN will modify its methodology. CHN will evaluate data collection and claims to determine if all claims concerning mammograms	Roberta Geller, Health Services; Stuart Macdonald, Information Services.	

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Page 33 Breast Cancer Screening	**Recommendation: The study design and methodology should include an estimation of the degree of completeness of the automated data used for the study indicators.**	are received and correct. Mammogram report cards will be sent quarterly which will list patients who have not had a mammogram within the last calendar year.		July 30, 2006
Validation of Performance Improvement Project - Page 33 Percent of Women with > or equal to 80 percent	Results received a LOW score in confidence in Reported Results	The specifications utilized are those required by the State. CHN will evaluate and validate the data collection method.	Roberta Geller, Health Services; Stuart Macdonald, Information Services.	July 30, 2006
Validation of Performance Improvement Project - Page 33 Percent of Women with Post Partum Visits Between 21-56 Days After Delivery	Results received a LOW score in confidence in Reported Results	CHN will evaluate and validate the data collection method.	Roberta Geller, Health Services; Stuart Macdonald, Information Services.	July 30, 2006
Mammogram Screening Rate - Step 1 - Review the Selected Study Topic 1.1 - Page 42 Was the topic selected through Data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	There was a brief discussion about the relevance of breast cancer in the general population and the importance of screening to identify the disease in it's early stages however there was no analysis that discussed the relevance of this measure to CHN's own population. This PIP was mandated by DSS.	CHN will analyze relative to it's own population. CHC currently sends postcard notification to members who haven't had a mammogram in the twelve months prior to their birth month. The postcards are mailed to the member during their birth month. Also, biannual report cards are mailed to providers identifying members who haven't had a mammogram in the previous twelve months.	Roberta Geller, Health Services	July 30, 2006 Postcards and report cards are ongoing.

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Mammogram Screening Rate - Step 7 - Access Improvement Strategies 7.1 - Page 44 Were reasonable interventions undertaken to address the causes/barriers identified through data analysis and QI processes undertaken?	It appears that no new interventions were implemented from the year 2000 until December 2004. For the 2005 re-measurement year two new interventions were implemented in December 2004. CHCT will provide more educational materials to this population and telephone calls from the outreach staff will be made to women for whom a mammogram claim has not been received n the past year.	A significant portion of CHN's membership is below the age of 40. However, CHN is committed to screening for identification of breast cancer in its early stages. Effective December 2004, CHN implemented a member education plan, which includes identification of members, contact via postcards as noted above. Also noted above is that a Member Education Workgroup has been implemented and this group is charged with preparing appropriate member educational material for breast cancer and disseminating this information to members via the CHN website and flyers to FQHCs and clinics. An audit of the 2005 calendar year will be reflective of improvements based on a full year's implementation of this effort. These implementations were not in effect during the subject audit period.	Roberta Geller, Health Services	Currently in progress and ongoing.
Mammogram Screening Rate - Step 9 - Assess Whether Improvement is Real Improvement - 9.1 - Page 46 Was there any documented quantitative improvement in processes or outcomes of care?	There has been no statistically significant improvement since 2002	Please see above.	Roberta Geller, Health Services	Ongoing
Mammogram Screening Rate - Step 10 - Assess Sustained Improvement - 10.1 - Page 46 Was sustained improvement demonstrated through	None reported	Please see above.	Roberta Geller, Health Services	

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
repeated measurements over comparable time periods				Ongoing
Healthy Beginnings PIP - Step 2 - Review of Study Question - 2.1 - Page 48 Was the study question stated clearly in writing?	**Recommendations: Make the study question more clear and simple by splitting it into two questions. Consider changing the eligibility requirements for Measures 4 and 5 to account for changes in enrollment and HUSKY A & B eligibility; HEDIS has measures, which are similar to those of CHN. Consider whether all 5 of the measures are necessary to assess whether interventions are successful. The prenatal and post partum maternal visits are used for proxies for birth outcomes it may not be necessary to also include outcome measures which are duplicative this would simplify the data collection process.**	The study question has been split into two: Does an educational mailing program for all pregnant members positively impact pregnancy outcomes in terms of adequate prenatal care, NICU utilization, low birth weight and premature neonates, and percentage of women who have postpartum physician visits? Will the addition of a telephonic education program for members experiencing certain high-risk pregnancies positively impact this subset of members for the same outcomes?	Roberta Geller, Health Services.	Completed.

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Healthy Beginnings PIP - Step 3 - Review of Selected Study Indicator - 3.1 Page 49 Did the study use objective, clearly defined, measurable indicators?	Recommendations: **1. Make the study question more clear by splitting it into two questions.** **2. Consider changing the eligibility requirements for Measures 4 and 5 to account for changes in enrollment and HUSKY A and B eligibility; HEDIS has measures which are similar to those of CHN.** **3. Consider whether all five of the measures are necessary to assess whether interventions are successful. The prenatal and post partum maternal visits are used as proxies for birth outcomes, it may not be necessary to also include outcome measures which are duplicative; this would simplify the data collection process.**	The eligibility requirements for the study population are identical to those required by the State for it's reports. The gap in eligibility is addressed by identifying day one of the current eligibility period after a thirty (30) day gap. As to quantitative improvement, a number of processes have been established to address this issue. They are: stratification of low, medium and high risk pregnancies, outreach to all pregnancies based on risk factors which also enables earlier identification of new onset of risk factors, standardized PCRF form throughout health plans for consistency.	Roberta Geller, Health Services	Ongoing
Healthy Beginnings PIP - Step 6 - Review of Data Collection Procedures - 6.4 - Page 50 Did the instruments for data collection provide for consistent accurate data collection over the time periods studied?		Please see above. See also Attachment: Tool for Medical Record Review.	Roberta Geller, Health Services	Ongoing

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Healthy Beginnings PIP - Step 9 - Assessment of Improvement - Step 9 - 9.2 Page 52 Was there any documented quantitative improvement in processes or outcomes of care?		Please see above.	Roberta Geller, Health Services	Ongoing
Validation of Performance Measures				
Validation of Performance Measures - Page 64 Measure Substantially Compliant Asthma Medications	Age cohorts should be calculated as of December 31 of the measurement year rather than by the discharge date. Allowable gap in coverage should be limited to 30 days for the Medicaid population instead of the 45 days included in the programming logic. Time parameters to identify the eligible population should be clearly documented in the programming logic.	The programming logic will be modified to calculate age cohorts as of December 31 of the measurement year rather than by discharge date. The allowable gap in coverage will be limited to 30 days	Roberta Geller, Health Services; Stuart Macdonald, Information Services.	April 1, 2006

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Validation of Performance Measures Page 64 Measure Substantially Compliant Inpatient Utilization	Age is limited to 15-44 and should not be limited at all according to the state specifications and HEDIS requirements. Time parameters specified in programming logic and final report should be consistent. **Recommendations: Time parameters referenced should be consistent throughout all aspects of the measure, including programming logic and final reporting. Age calculations should follow DSS specifications for individual measures.**	The programming logic will be modified to calculate age cohorts as of December 31 of the measurement year rather than by discharge date. The allowable gap in coverage will be limited to 30 days. The breakout was based on state specifications. The total was also reported which was inclusive of the 15-44 age range.	Roberta Geller, Health Services; Stuart Macdonald, Information Services.	April 1, 2006
Calculation of Performance Measures				
Calculation of Performance Measures- Page 72 NICU Admits	NICU admits/100 births have decreased since last year but remains higher than national benchmarks. CHN should continue to focus on prenatal care standards particularly on high risk pregnancies	Please see response to perinatal efforts.	Roberta Geller, Health Services; Stuart Macdonald, Information Services.	Ongoing
Calculation of Performance Measures - Page 72 ED Usage	ED usage has decreased since last year but remains higher than the State's overall rate. Last year Mercer suggested that CHN research the diagnoses contributing to high ED usage and implement strategies to better manage these members. Mercer reiterates these recommendations this year.	CHN recently implemented an outreach program, which identifies member with three ED visits during the year. Calls are made to the members to identify factors involved. Additionally those members with 3 asthma related ED visits are referred to the Asthma nurse for inclusion in the newly established Asthma DM program, as this is a criterion for inclusion in the Asthma DM program. As such, an evaluation of ED utilization is undertaken for this purpose in addition to general ED utilization	Roberta Geller, Health Services.	Ongoing

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
		In addition to the asthma diagnosis, CHN will develop member education materials relative to avoiding accidental injury. This will be available on the CHN website. Further, CHN will initiate informational mailings on cardiovascular disease. Attached please find ER Utilization diagnoses for calendar years 2001 through 2004 inclusive.		
Calculation of Performance Measures - Page 72 Readmission Rates	CHN's readmission rate has risen since the last measurement. An evaluation of which members/diagnoses were involved was suggested last year. Mercer emphasizes that these evaluations should be put into place.	CHN currently runs a daily report of members admitted the previous day. A QI nurse is assigned to review this report and identify readmissions as well as any pertinent quality issue. Such issues include but are not limited to: trends, infections, delays in service and readmissions within three days of discharge. These matters are brought to the Chief Medical Officer for discussion and intervention as appropriate. Interventions include notification of an issue to the Quality Department the relevant hospital, presentation to the CHN Quality Improvement Committee and direct contact with a provider. CHN will work to create a report, which identifies readmissions based on specific diagnoses.	Health Services	Ongoing July 30, 2006

Regulation Found Partially or Non-complaint During 2004 Review	Analysis	MCO Corrective Action	Responsible Person for Corrective Action Item	Target Completion Date of Corrective Action
Calculation of Performance Measures - Page 72 Diabetic Retinal Exams	Diabetic retinal exams have decreased since last year and continue to be well below national norms. Mercer repeats our advice to re-evaluate data collection/claims efforts to determine if complete accounting of eye exams is occurring. Diabetic patients should be tracked by their PCP and postcards should be sent quarterly to those patients who have not had their eye exam. Medical records review is also recommended again.	CHN will run quarterly reports of members who have not had diabetic retinal exams. This report will be forwarded to our Vision vendor for notification of our members, with CHN oversight. CHN will evaluate and validate the data collection method.	Roberta Geller, Health Services.	April 1, 2006
Calculation of Performance Measures - Page 72 Breast Cancer Screening	CHN's breast cancer screening rate has decreased since last year. Mercer re-emphasizes the need for CHN to evaluate data collection/claims efforts to determine if they are receiving all claims concerning mammograms. If the members are correct activities should be implemented to increase the number of screening mammogram. PCP's should be sent quarterly report cards listing eligible women who have not received a mammogram within the year.	Report Cards are already in place. However, because many of our members receive free mammograms, claims are not submitted. As such evaluation of claims data is not a measure of whether eligible members are receiving their mammograms. CHN currently runs a monthly report of members who are age eligible for a mammogram. CHN will develop process to call these members to remind them to obtain a mammogram and/or ascertain whether they had a free mammogram during the previous twelve months.	Roberta Geller, Health Services.	July 30, 2006

MERCER

Government Human Services Consulting

Mercer Government Human Services Consulting
3131 E. Camelback Road, Suite 300
Phoenix, AZ 85016-4536
602 522 6500

MMC Marsh & McLennan Companies