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External Quality Review
State of Connecticut

Summary Report

MERCER
Government Human Services Consulting

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Executive Summary

An External Quality Review (EQR) of the four managed care organizations (MCOs) that provide health care services to the Medicaid population for the State of Connecticut was conducted by Mercer Government Human Services Consulting (Mercer) at the request of the State's Department of Social Services (DSS). The MCO compliance reviews were completed in August and September 2005, at the MCO sites in the State of Connecticut (State). Areas included in the review were:

- compliance with the recommendations made in the 2004 EQR reports;
- compliance with Federal Medicaid Managed Care regulations and DSS standards relating to timeliness and access to services;
- performance improvement projects (PIPs);
- performance measure (PM) validation; and
- PM calculation.

DSS requested that Mercer also review MCO compliance with the financial standards for the HUSKY B membership, as well as the process for referral of HUSKY B members to HUSKY Plus.

The purpose of these independent reviews was to identify whether the MCOs and their programs are achieving quality outcomes and timeliness of, and access to, the services covered under their contracts with DSS. Recommendations made to the MCOs to improve their operations may be found in Appendix A. The review also sought to identify areas of strength. The strengths identified follow.

Strengths

Anthem Blue Care Family Plan

One example of an area in which Anthem Blue Care Family Plan (BCFP) performs well is member outreach. The Health Reach Department, which is organized to focus on providing an array of member-centered services, also maintains ongoing interfaces with other departments to ensure availability of information and supporting coordination and access to care.

Community Health Network of Connecticut, Inc.

A particular strength of Community Health Network of Connecticut, Inc.'s (CHNCT) is the development and implementation of interventions to improve its performance. The interventions are well researched and thought out. They are creative and specifically targeted towards the study population. For instance, focus groups with teen-aged participants were held to provide input to the development of interventions to improve the number of adolescents receiving well-child care. The analysis of the effectiveness of the interventions and the modifications made based on the results of the study are well reasoned and appropriate.

FirstChoice Health Plan

While not uncommon in the industry, FirstChoice Health Plan (FCHP) successfully instituted two member workgroups, the Service Quality Improvement (QI) Workgroup and the Member Advisory Workgroup, and incorporated feedback from the workgroups in FCHP's quality strategy.

The Member Advisory Workgroup provides input to FCHP about its identification of needed QIs through first-hand interaction with MCO services, about barriers to improvement in processes, as well as participating in decision making. Topics addressed by the Member Advisory Workgroup include:

- timeliness of transportation services;
- issues with ID Cards, including timely distribution; and
- prescription refill process issues.

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Introduction

As the result of a request by the Department of Social Services (DSS), Mercer Government Human Services Consulting (Mercer) performed independent External Quality Reviews (EQR) of the four Managed Care Organizations (MCOs) who provide health care services to the State of Connecticut (State) Medicaid population for DSS: Anthem Blue Care Family Plan (BCFP), Community Health Network of Connecticut, Inc. (CHNCT), FirstChoice Health Plan (FCHP), and Health Net of Connecticut, Inc. (HN). The purpose of these reviews was to assess the organizations' Quality Assessment and Performance Improvement (QAPI) strategy as it related to their performance improvement projects (PIPs) and performance measures (PMs), as well as their compliance with the recommendations from the previous year's EQR, with Federal Medicaid Managed Care regulations and DSS standards covering timeliness of, and access to, services and to DSS standards related to the HUSKY B program. HN does not participate in the HUSKY B program and; therefore, was not included in this part of the review.

Interviews of MCO staff were conducted by Mercer at each MCO office in the State, in August and September 2005. Prior to the EQR, Mercer requested, received, and reviewed specific documentation from the MCOs. The documentation reviews and on-site interviews were conducted to gain a more complete and accurate understanding of the MCOs' operations and how they contribute to compliance with the Balanced Budget Act of 1999 (BBA) regulations in the provision of health care services to their members.

The information obtained through the on-site interviews and through the separate documentation reviews was not independently verified or audited by Mercer, except to the extent detailed in this report. This report represents a summary of the information gathered and received during the EQR, as well as strengths and opportunities noted through analysis of the information obtained.

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Methodology

As a consulting firm with more than 100 individuals specializing in Medicaid and other publicly funded programs, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, the Mercer team included experienced physicians, nurses, pharmacists and allied health professionals, reporting and monitoring experts, senior data analysts, and statisticians.

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

Desk Review

Mercer reviewed all documents submitted by the MCOs 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 and 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 second-year reviews. The focus of the desk reviews was to: assess the extent to which the MCOs had implemented their corrective actions related to recommendations from the previous year's EQR regarding the Husky A and Husky B programs; identify general compliance with both the BBA (Husky A program) and DSS contractual rules and regulations for timeliness of, and access to, covered services; and to identify compliance with Husky B specific DSS contractual requirements. The information gleaned from this task assisted Mercer in focusing on-site observations and interviews in areas where additional information was still needed. A listing of all material reviewed for the Compliance sections can be found in Appendix A of each individual MCO report.

On-Site Review

The compliance and performance improvement on-site review took place in August and September 2005. The on-site reviews began with a combined introductory session with all appropriate MCO staff, after which the reviewers conducted more focused interviews with staff and completed file reviews. The interview sessions again followed the major areas of required review — implementation of corrective actions, timeliness of, and access to, covered services as required by DSS contract; and compliance with specific requirements for the HUSKY B population. A complete list of the interview groupings and sequencing is provided in Appendix B of each individual MCO report.

In following this sequence, Mercer complied with CMS regulations to conduct the EQRs in a logical fashion that assisted in assessing the MCOs' overall performance and their compliance with Federal and DSS 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 their Medicaid members.

At the end of the review phases, comprehensive analysis of the information gleaned from all activities was conducted. This report is comprised of the results of this analysis, as are the individual MCO reports and is written in a format consistent with federal protocols to easily identify compliance with BBA standards, as written in the *Federal Register*, June 14, 2002.

In summary, in all areas of review, Mercer followed CMS' protocol for monitoring Medicaid MCOs and effectively 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.

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Compliance with Federal Medicaid Managed Care Regulations — Review of 2004 Corrective Action Plan

As a result of the 2004 EQR, each MCO was given a set of recommendations to bring them into compliance with Federal and State requirements. The MCOs were required to submit a corrective action plan (CAP) that covered all of the recommendations received. During the 2005 EQR, the MCOs' progress in implementing their CAP was measured. In those areas where the implementation was incomplete, recommendations were given. The MCOs will be required to include actions in their CAP for 2006 to complete the implementation which will bring them into compliance.

There were four areas in which the MCOs had received recommendations in the 2004 EQR:

1. the intent of **Enrollee Rights and Protections** is to assure enrollees are provided with comprehensive information such that they are adequately aware of their rights and privileges and can then make fully informed health care decisions;
2. **Quality Assessment and Performance Improvement (QAPI)** standards, which encompass most of the MCO operations. The EQR concentrated primarily on clinical operations. A few of the areas reviewed include availability, continuity and coordination of services, provider selection, enrollment and disenrollment, and clinical practice guidelines;
3. **Grievance and Appeals**, along with State Administrative Hearing processes, which cover MCO responsibilities when members exercise their right to express dissatisfaction and to request that the MCO review its decision to take an action such as one that denies or reduces requested services or payment for services; and

4. **Information Systems** (IS) which must be capable of producing valid administrative and other data necessary to support QAPI, as well as to manage the delivery of health care services to its enrollees.

In the area of Enrollee Rights and Protections, the 2004 recommendations primarily addressed the MCOs' communication and explanation of rights to enrollees and providers. Community Health Network of Connecticut, First Choice Health Plan and Health Net did not meet the requirements for Advanced Directives. There was no theme in the CAPs in the other areas of review. The table below presents the numbers of recommendations in each area from 2004, the number of actions that had been fully implemented to bring the MCOs into compliance for the 2005 EQR, and the recommendations made as a result of the 2005 EQR.

Full Implementation of Corrective Actions From the 2004 EQR

	Number of 2004 EQR Recommendations	Number in Compliance in 2005 EQR	2005 Recommendations
Enrollee Rights and Protections			
BCFP	2	0	1. The intent of Enrollee Rights and Protections is to ensure that enrollee, providers, vendors, and staff are fully informed regarding Enrollee Rights. BCFP should follow through with the development and distribution of a member bulletin updating Enrollee Rights information. 2. BCFP should include the definition of post-stabilization services in the *Member Handbook*, as specified in the work plan, and include the definition in the member bulletin created and distributed to members informing them of additional rights. This bulletin was intended to provide information to members while awaiting review of the updated *Member Handbook*, which is in the approval process.
CHNCT	5	3	1. CHNCT should describe in the Advance Directive policy 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. 2. CHNCT should 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.
FCHP	13	12	1. FCHP's process of notifying enrollees within 15 days after finding out their specialist terminates should be defined by including it in a policy and in the provider manual.
HN	7	1	1. HN should develop and implement a policy which describes the requirements for updating the provider directory. 2. Incorrect information in the alphabetical index in the provider directory should be identified and corrected.

Full Implementation of Corrective Actions From the 2004 EQR

	Number of 2004 EQR Recommendations	Number in Compliance in 2005 EQR	2005 Recommendations
HN (cont)	7	1	3. A process to monitor and assure HN and vendor provider compliance with Enrollee Rights should be implemented. 4. HN should disseminate Enrollee Rights to sub-contracted providers, along with the providers' responsibilities to honor the Enrollee Rights. 5. HN should modify its Advanced Directive P&Ps to include information about Advanced Directives training for the community and how the community will be informed that this information is available. 6. HN should reconsider the established time line by which providers must discuss Advanced Directives with members. For members who are seen infrequently by their Primary Care Provider (PCP), the current requirement that the discussion must take place after three visits, could result in an inordinate delay in the member receiving the information. 7. Information regarding Advanced Directives in the *Member Handbook* should be expanded to include instructions about exercising Advanced Directives or where this information is available to the public. The language describing Advanced Directives should be revised to accommodate low literacy readers. 8. HN should ensure all pertinent information in the description of a member's right to a second opinion is included in the Member Handbook. 9. HN should continue the process of monitoring, tracking, and trending CM documentation so as to be able to give feedback to Case Managers about the quality of their case file documentation. 10. Initial health risk assessments (HRAs) should be conducted so that results are available within 30 days rather than the current 45-day goal for completion. 11. 3,781 members, who did not complete an HRA survey by phone, were mailed an HRA survey during a four-month period. Two months after the completion of the four-month period, only 293 had been returned. The HRA survey process should be assessed and revised to improve the response rate. 12. HN should re-evaluate current HRA reporting to ensure it better reflects results. 13. A process for the identification and assessment of groups for SHCNs should be implemented.
Quality of Assessment and Performance Improvement			
BCFP	1	1	None
CHNCT	6	4	1. The completeness of the documentation in the CM files is inconsistent. The quality of the documentation in

Full Implementation of Corrective Actions From the 2004 EQR

	Number of 2004 EQR Recommendations	Number in Compliance in 2005 EQR	2005 Recommendations
			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. 2. Because the extent of follow up by different Case Managers was inconsistent, their performance should be monitored either through peer or manager review, with feedback given to each Case Manager. 3. Action should be taken to increase the consistency with which appropriate CM is provided to CHNCT Members. 4. Member education materials should be reviewed 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.
FCHP	6	6	None
HN	0	0	None
Grievances and Appeals			
BCFP	0	0	None
CHNCT	2	2	None
FCHP	2	1	1. Notice of Action (NOA) decision rationale in appeal files was found to be written at a clinical level rather than for the layperson. FCHP should revise NOA so that the explanation for the action is written for the layperson.
HN	1	1	None
Information Systems			
BCFP	0	0	None
CHNCT	4	4	None
FCHP	0	0	None
HN	1	1	None

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Compliance with Standards for Timeliness and Access to Services

This section of the 2005 EQR covered the service delivery systems of the MCOs. It includes compliance with Federal and State requirements covering the depth and breadth of the provider network, the timeliness of services and entry to care, and the coordination and delivery of early, periodic screening, diagnosis, and treatment (EPSDT) services to those less than 21 years of age.

The MCOs are required to design their networks taking into consideration a number of factors, including, among other things, anticipated enrollment, expected utilization given the characteristics and needs of the Medicaid population, and the geographic location of their enrollees and the providers.

Mercer analyzed the information provided by the MCOs for the desk review, as well as the results of the interviews conducted during the on-site visit to measure the adequacy of each of the provider networks to deliver all goods and services for which DSS contracted; for geographic access of PCPs, Obstetricians/Gynecologists (OB/GYN), Dentists, and Behavior Health (BH) Providers; the capacity of specialists, and the provisions for out-of-network (OON) referrals when services were not available from the contracted network. Timeliness of services was also analyzed by looking at the appointment availability for PCPs, BH Providers, and Dentists, along with the MCOs ability to assure utilization of well care by enrollees and that EPSDT services were delivered in compliance with the DSS periodicity schedule.

For the most part, Mercer found that the MCOs had P&Ps which met the standards for EPSDT services. All MCOs had processes in place, to allow use of OON providers when their networks were unable to provide reasonable access. Only two of the MCOs were not able to provide sufficient information regarding geographic access to Dental and BH Providers.

The MCOs face challenges in obtaining the agreement of specialists to participate in their networks, particularly for orthopedics and dermatology. They have been successful in providing specialty care to their enrollees through their contracted networks and the referral to OON providers when necessary.

All of the MCOs have a process in place to monitor the entry to care of new enrollees and the appropriate utilization of well care by their enrollees. Three of the four MCOs have P&Ps in place to perform outreach to those not accessing this care in a timely manner.

The following table displays the percentage of standards with which each MCO is compliant. For areas not fully compliant, recommendations to reach full compliance (100%) are provided. Each recommendation also provides summary information on the area of deficiency; comprehensive information is provided in the individual MCO reports.

2005 EQR Timeliness and Access to Services

	Percent of Compliant Standards	2005 Recommendations
Adequacy of Provider Network		
BCFP	100%	None
CHNCT	50%	1. When developing the provider network, all components required by the contract should be incorporated into the process; for example the number of providers accepting new members and the expected utilization of services by its members.
FCHP	100%	None
HN	0%	1. A network development plan should be developed and implemented that includes all elements required by the contract and takes into consideration results of member satisfaction surveys.
Geographic Access		
BCFP	75%	1. BCFP should continue the following activities for dental: develop and implement recruitment plans related to increasing dental staff in the network; work in partnership with DSS and Wellpoint, their dental vendor to identify opportunities to improve access; continue performance improvement initiatives in place to improve screening rates and examine options to expand interventions; review goals by age group to ensure ongoing improvement is identified; and continue the expedited unit to assist members who have difficulty to access a dental provider.
CHNCT	75%	1. The results of monitoring efforts should be utilized to identify areas of the network that are out of compliance; interventions to improve availability should then be implemented.

2005 EQR Timeliness and Access to Services

	Percent of Compliant Standards	2005 Recommendations
FCHP	75%	1. The 2005 QI Program description was labeled "Preferred One-Medicare Choice." The access and availability standards in the document were not Medicaid standards. FCHP should review and update this document to accurately reflect the requirements of the Medicaid contract.
HN	25%	1. HN should modify GeoAccess reports of provider access, in order to assess adequacy of the provider network, including specialists. 2. HN QI and provider relations staff should be familiarized with the specifications of provider reports to allow for better analysis of results. 3. HN should analyze results of member satisfaction surveys and incorporate the analysis, conclusions, and interventions in the network development plan. 4. HN should complete and implement the proposed vendor audit tool. 5. Doral Dental should be required to monitor their provider network appointment availability and to report the results to HN. 6. A process should be instituted to ensure members are able to schedule an appointment for a routine dental visit within six weeks. 7. Include dental screening and cleaning utilization in the assessment of the adequacy of the dental network.
Capacity of Specialty Network and Out-of-Network Referrals		
BCFP	100%	None
CHNCT	100%	None
FCHP	100%	None
HN	100%	None
Appointment Availability		
BCFP	25%	1. A plan to track and monitor overall PCP compliance with access requirements should be developed. In order to assure that enrollees have timely access to PCP services, a plan to track and monitor overall PCP compliance should be developed. This plan would allow the MCO to track the overall compliance rate to access requirements and to identify and implement appropriate interventions to improve compliance.

2005 EQR Timeliness and Access to Services

	Percent of Compliant Standards	2005 Recommendations
BCFP (cont)	25%	2. BCFP should continue the following activities for dental: develop and implement recruitment plans related to increasing dental staff in the network; work in partnership with DSS and Wellpoint, their dental vendor to identify opportunities to improve access; continue performance improvement initiatives in place to improve screening rates and examine options to expand interventions; review goals by age group to ensure ongoing improvement is identified; and continue the expedited unit to assist members who have difficulty to access a dental provider.
CHNCT	50%	1. The results of monitoring efforts should be utilized to identify areas of the network that are out of compliance; interventions to improve availability should then be implemented.
FCHP	50%	1. FCHP should continue to assess and address network access and availability through independent survey. In addition to addressing availability issues with specific providers, FCHP should assess the need to expand the network beyond the maximum enrollment parameters established by DSS to improve appointment availability.
HN	50%	1. A primary verification process to assure timely and correct reporting of provider appointment availability should be implemented. 2. HN should ensure all provider appointment availability standards are included in the provider manual.
Well Care Utilization		
BCFP	100%	None
CHNCT	100%	None
FCHP	100%	None
HN	50%	1. HN should formalize the process by which provider network issues are identified and forwarded to the Network Subcommittee for review and action. 2 HN should develop and implement actions to assure members are seen by their primary care physician (PCP) within six months of enrollment with HN.
EPSDT		
BCFP	100%	None
CHNCT	100%	None
FCHP	100%	None

2005 EQR Timeliness and Access to Services

	Percent of Compliant Standards	2005 Recommendations
HN	50%	1. Information about the EPSDT program and requirements should be communicated to the provider network. 2. A process to identify children with SHCNs in a timely fashion should be developed and implemented.

6

Compliance with Specific Contract Requirements — HUSKY B, HUSKY Plus, and HUSKY B Copayment

HUSKY B is the Title XXI program for uninsured children (under age 19 in Connecticut. HUSKY Plus is available for children within certain income bands and with special health care needs (SHCNs) enrolled in HUSKY B. Three of the four MCOs were included in the review of this program during the EQR. HN does not participate in the HUSKY B program.

The areas included in this part of the EQR included: appropriate referral of HUSKY B members to the HUSKY Plus program; the coordination between the MCO and HUSKY Plus administrations, CM of children enrolled in HUSKY B and HUSKY Plus; the processes for Quality Management (QM) and Improvement of care and service to HUSKY B enrollees; reporting to DSS; and compliance with cost sharing requirements. As shown in the table below, the MCOs were, for the most part, compliant with the standards reviewed.

HUSKY B and HUSKY Plus

	Percent of Compliant Standards	2005 Recommendations
Referral to HUSKY Plus		
BCFP	100%	None
CHNCT	100%	None
FCHP	100%	None
Coordination Between MCO and HUSKY Plus		
BCFP	100%	None
CHNCT	100%	None
FCHP	100%	None
Case Management		
BCFP	100%	None
CHNCT	100%	None
FCHP	100%	None
Quality Management and Improvement		
BCFP	100%	None
CHNCT	100%	None
FCHP	50%	1. The 2005 QI Program description was labeled “Preferred One-Medicare Choice.” The access and availability standards in the document were not Medicaid standards. FCHP should review and update this document to accurately reflect the requirements of the Medicaid contract.
Cost Sharing		
BCFP	100%	None
CHNCT	100%	None

HUSKY B and HUSKY Plus		
	Percent of Compliant Standards	2005 Recommendations
FCHP	50%	1. FCHP should proceed with planned system enhancements to further automate the process for tracking HUSKY B copayments, aggregate cost sharing limits, and repayment.
Reporting to State		
BCFP	100%	None
CHNCT	100%	None
FCHP	100%	None

7

Validation of Performance Improvement Projects

The State and the Federal government require MCOs with Title XIX and XXI enrollees to incorporate QI processes into their operations. Each of the four MCOs was required to develop and implement at least four PIPs. The purpose of a PIP is to improve health care outcomes through ongoing assessment and improved processes. The initial step in the process is the analysis of enrollee needs, care, and services to ensure the PIP is targeted to the needs of the population. A baseline measurement is then completed, interventions for improvement are determined and implemented, and, following the identified time period, results are re-measured and analyzed. The process is repeated until goals are met and results are maintained.

DSS selected all PIPs for inclusion in this review. Some of the selected projects were to apply DSS-developed specifications, some PIPs were to use Health Plan Employer Data and Information Set (HEDIS) 2005 specifications, and other projects were designed by the MCO.

The EQR assessed the methodology used by the MCO, evaluated the overall validity and reliability of the study results, and assessed compliance with the specifications required by DSS. The reviewers used the CMS protocol entitled “Validating Performance Improvement Projects,” as a guide for the validation.

The results of each step of the review were then considered as part of an evaluation of two levels for each PIP; first, confidence in the overall validity and reliability of reported study results, and second, confidence in the success and sustainability of improvement efforts. each PIP was assigned a summary rating for each of these tow levels using the following scales:

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

The PIPs for BCFP, CHNCT, and FCHP were reviewed. The results of HN's PIPs were not available at the time of the review, and therefore, are not included in this report.

The following tables present summaries of the MCO PIP results, followed by the recommendations given to each of the MCOs.

BCFP Overall Results

	2001	2002	2003	2004	Benchmark Most Recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with specifications
Improving the Breast Cancer Screening Rate	29.7% Baseline	32.5%	30.6%	34.2%	N/A	Moderate	High	Partially Compliant with Specifications
Goal	31%	31%	34%	34%				
Increase use of appropriate medications for Asthma				61.21% Baseline	71%	Moderate	N/A Baseline Year	Partially Compliant with Specifications
Goal				65%				
Adolescent Access to Preventive Care			46.6% Baseline	50.2%	52.3%	High	High	Fully Compliant with Specifications
Goal				50%				
Improving Cervical Cancer Screening Rates	36.2% Baseline	40.6%	41.8%	42.3%	N/A	Moderate	High	Partially Compliant with Specifications
Goal				42%				

BCFP Recommendations:

1. For PIPs, any variation in specifications, process, or IS limitations, regardless of their prevalence or size of the impact, should be identified in the study.

FCHP Overall Results

	2001	2002	2003	2004	Bench-mark Most Recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Increase use of appropriate medications for Asthma				Baseline		High	N/A (Baseline)	Fully Compliant with Specifications
5 – 9 year old				72.79%	86.05%			
10 – 17 year old				66.33%	75.16%			
18 – 56 year old				56.83%	87.32%			
5 – 56 year old				66.11%	83.72%			
Decrease use of Emergency Department (ED) for Members with Asthma			Baseline 31%	21.52%	24%	High	High	Fully Compliant with Specifications
Decrease use of Inpatient for Members with Asthma			Baseline 4.9%	5.06%	5.4%	High	High	Fully Compliant with Specifications
Improving Frequency of Prenatal Care		50%	1/1 – 6/30: 59% 7/1 – 12/31: 66%	1/1 – 6/30: 59% 7/1 –2/31: 69%	83.71%	High	High	Fully Compliant with Specifications

	2001	2002	2003	2004	Bench-mark Most Recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Improving Frequency of Post-Partum Care		49%	1/1 – 6/30: 50% 7/1 – 12/31: 39%	1/1 – 6/30: 47% 7/1–12/31: 49%	83.33%	High	High	Fully Compliant with Specifications
Improving Adolescent Access to Preventive Care			Baseline 43%	53.4%	60.93%	High	High	Fully Compliant with Specifications

FCHP Recommendations:

1. When the hybrid methodology is used for PIP data collection, clearly define the data collection instrument for medical record abstraction, instructions for data collection, plan for data analysis, and assessment of completeness of data.

CHNCT Overall Results

	2001	2002	2003	2004	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
1. ED Utilization for Managed Members				To be measured when 2005 data is available		N/A	N/A	N/A
2. ED Utilization for All Members with Asthma				Baseline 29.7%		High	N/A	Fully Compliant with Specifications
3. Increase in Members Identified with Depression				Baseline 6	6	High	N/A	Fully Compliant with Specifications
4. Inpatient Utilization for Managed Members				To be measured when 2005 data available		N/A	N/A	N/A
5. Inpatient Utilization for All Members with Asthma				Baseline 21%		High	N/A	Fully Compliant with Specifications

	2001	2002	2003	2004	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
6. Increase Use of Appropriate Medications for Asthma				Baseline				
5 – 9 year old				69.47%		High	N/A	Fully Compliant with Specifications
10 – 17 year old				62.77%		High	N/A	Fully Compliant with Specifications
18 – 56 year old				61.40%		High	N/A	Fully Compliant with Specifications
5 – 56 year old				64.35%		High	N/A	Fully Compliant with Specifications
Overall Rate				64.4%		High	N/A	Fully Compliant with Specifications
Goal 3% improvement for Measures 1, 2, 4, 5, and 6								
Breast Cancer Screening		Baseline 33.1%	32.2%	32.5%	70%	High	Low	Fully Compliant with Specifications
Goal			35.5%	35.5%				
Neonatal Intensive Care Unit (NICU) Days of Stay as a Percentage of Total Newborn Days			Baseline 49.2%	50.7%	49.2%	High	High	Fully Compliant with Specifications
Goal				45%				

	2001	2002	2003	2004	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
NICU Admissions as a Percentage of Live Births			Baseline 12.3%	12.3%	12.3%	High	High	Fully Compliant with Specifications
Goal				9%				
Infants Born Weighing ≤ 2500 Grams			9.3%	5.3%	9.3%	High	High	Fully Compliant with Specifications
Goal				<5%				
Percent of Women with ≥ 80% of Recommended Prenatal Visits			Baseline 86.4%	76.1%	86.4%	Low	High	Fully Compliant with Specifications
Goal				90%				
Percent of Women with Post-Partum Visits Between 21 – 56 Days After Delivery			Baseline 52.9%	47.1%	52.9%	Low	High	Fully Compliant with Specifications
Goal				70%				

CHNCT Recommendations:

1. CHNCT should report the results of the assessment of the completeness of the administrative data used in its breast cancer screening PIP.
2. Based on its analysis of PIP utilization and barriers to increase the utilization of mammograms by the eligible population, CHNCT should implement and maintain interventions to improve the number of eligible women who receive mammograms.
3. In the Healthy Beginnings PIP, CHNCT should make the study question more clear and simple by splitting it into two questions.
4. In the Health Beginnings PIP, CHNCT should 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 CHNCT.

5. CHNCT should consider whether all five measures are necessary to assess whether interventions are successful in the Healthy Beginnings PIP. 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, which would simplify the data collection process.

HN Overall Results

N/A

HN Recommendations:

1. PIPs for 2005 should be prepared and finalized prior to the State's designated deadline.
2. HN should consider reviewing the "CMS Protocols for EQR of MCOs," in order to gain a better understanding of expectations in an EQR.

8

Validation of Performance Measures

Performance measures (PMs) are tools used by organizations to provide objective results by which to measure the improvement in the quality of their operations as a result of interventions. A baseline measurement is usually done prior to the implementation of the intervention(s).

The MCOs provided DSS with a list of their annual performance measures. DSS selected four measures from each of the lists to be validated by Mercer during the EQR. The CMS protocol for validating PMs was used by Mercer for this part of the EQR. The MCO conformance with DSS specifications and the completeness and accuracy of documentation, programming logic and data used to calculate the PMs are some of the areas reviewed to validate the PMs. The PMs of BCFP, CHNCT, and FCHP were validated. HN results were not available at the time of the review.

After all of the elements are assessed, a validation finding for each PM was determined, based on the magnitude of errors detected, 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 the DSS specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator

A summary of the conclusions drawn from the findings of the review of each MCO's results are presented in the following tables. Recommendations made to each MCO follow each table.

BCFP Conclusions Drawn

PM	2003 Validation Findings	2004 Validation Findings	Issues
Asthma Medications	N/A	Fully Compliant	▪ Information was sufficient and complete.
EPSDT	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.
Access to Prenatal Care	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.
Adequacy of Prenatal Care	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.

The 2004 Asthma Medications measure is the only measure which was not included in the 2003 reported validation PMs and cannot be compared against previous findings. The validated PMs for 2004 indicate improvement and accurate implementation of recommendations from the prior year's reporting.

BCFP Recommendations:
None

CHNCT Conclusions Drawn

PM	2003 Validation Findings	2004 Validation Findings	Issues
Asthma Medications	N/A	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 programming logic.
Practitioner Access	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.
Children's Access to Preventive Care	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.
Inpatient Utilization	Fully Compliant	Substantially Compliant	▪ Age is limited to 15 – 44 and should not be limited at all according to State specifications and HEDIS requirements. ▪ Time parameters specified in programming logic and final report should be consistent.

Due to deficiencies in the documentation regarding consistency of time parameters, the Inpatient Utilization measure declined from a fully compliant measure in 2003 to a substantially compliant measure in 2004. The 2004 Asthma Medications measure was not included in the 2003 reported validation PMs and cannot be compared against previous findings.

The Practitioner Access and Children's Access to Preventive Care validated PMs for 2004 indicate improvement and accurate implementation of recommendations from the prior year's reporting.

CHNCT Recommendations:

1. The time parameters referenced in PMs should be consistent throughout all aspects of the measure, including programming logic and final reporting.
2. PM age calculations should follow State specifications for individual measures.

FCHP Conclusions Drawn

PM	2003 Validation Findings	2004 Validation Findings	Issues
Asthma Medications	N/A	Fully Compliant	▪ Information was sufficient and complete.
EPSDT	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.
NICU Days	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.
Prenatal/Post-Partum Care	Substantially Compliant	Fully Compliant	▪ Information was sufficient and complete.

The Asthma medications measure was not included in the 2003 reported validation measures and cannot be compared against previous findings. The validated PMs for 2004 indicate notable improvement and accurate implementation of all recommendations from the prior year's reporting.

FCHP Recommendations:
None.

HN Conclusions Drawn

N/A.

HN Recommendations:

1. Validated PMs for 2005 should be prepared and finalized prior to the State's designated deadline for each individual measure.
2. A comprehensive review of the EQR information request and the "CMS Protocol for Validating PMs," will identify all necessary information to be included in the 2005 validated PM submission.
3. Documentation supporting the validated PMs should include, but is not limited to, the following key components: identification of individual measure, definition of measure, data source and system identification, programming logic, clinical coding, time parameters, and final report.
4. PM documentation should be self-contained and not cross-referenced with PIP documentation.
5. HN's ED usage is low compared to the State's overall rate and should be investigated. It should be determined whether this is due to incomplete data, improper reporting, or true lower than average usage.
6. Last year, Mercer recommended that HN re-evaluate their data collection/claims efforts to determine if they were capturing a complete accounting of all diabetic retinal exams. An additional recommendation was that patients be tracked by their PCPs and a report be issued quarterly, listing the diabetic members who have not received their eye exams. As HN's rate has dropped even further and is well below national standards, Mercer again strongly recommends that HN address their diabetic population's needs.
7. Last year, Mercer provided several recommendations for improving HN's breast cancer screening rates. These included, evaluation of data collection, root cause analysis, and research into geographic or demographic differences that could be addressed. It is strongly recommended that HN increase their activity in this area.

9

Calculation of Performance Measures

DSS selected six PMs to be calculated by Mercer using encounter data submitted by the MCOs. For every service for which the MCO is financially responsible, that is delivered to an MCO enrollee, the MCO must submit an “encounter” to Mercer. An encounter contains much the same information as a claim, such as the enrollee’s identifying information, the provider who delivered the service, the diagnosis(es) associated with the service, the service delivered and the cost of the service. However, unlike a claim, an encounter does not trigger payment. In addition to calculating the PMs in accordance with DSS specifications and as described in the CMS protocol, Mercer assessed the accuracy and completeness of the administrative data submitted by the MCOs.

The six PMs calculated by Mercer were:

1. NICU Admissions/100 Births;
2. ED Visits/1,000 Members;
3. Inpatient Readmission Rates;
4. Diabetic Retinal Exams;
5. Breast Cancer Screenings/Mammograms; and
6. ED Visits by Asthmatics.

Baseline rates for the first five measures were established last year. With one exception, the re-calculating of these measures allows for an assessment of an MCO's improved performance from year to year. The measure related to ED usage by asthmatics will represent baseline, since this measure replaced the previous year’s Provider Network Adequacy measure.

Performance Measure Calculations

Measures	BCFP 2003	BCFP 2004	CHNT 2003	CHNT 2004	FCHP 2003	FCHP 2004	HN 2003	HN 2004	Overall 2004 Rate of the 4 MCOs
NICU Admits/100 Births	8.7%	8.3%	13.9%	12.9%	9.9%	12.3%	11.1%	10.3%	10.3%
ED/Usage/1,000 Members	648	428	700	560	731	375	484	373	429
Readmission Rates	0.8%	0.8%	0.9%	1.2%	1.0%	0.6%	0.7%	0.6%	0.8%
Diabetic Retinal Exam	13.4%	15.6%	12.7%	11.5%	16.8%	12.2%	16.9%	14.4%	14.1%
Breast Cancer Screening/Mammography	30.8%	33.7%	32.3%	31.7%	22.6%	23.2%	32.7%	31.4%	31.87%
ED Usage by Asthmatics	N/A	10.4%	N/A	13.1%	N/A	11.1%	N/A	9.1%	10.5%

2005 Recommendations

BCFP

1. Last year, Mercer recommended that BCFP re-evaluate their data collection/claims efforts to determine if they are achieving a complete accounting of diabetic retinal exams. Additional recommendations were that BCFP diabetic patients should be tracked by their PCP. Quarterly reports should be issued to PCPs listing diabetics who had not received their diabetic retinal exam. Although BCFP has increased their rate, they are still substantially lower than national standards, including the HEDIS Medicaid benchmark of 45.0% for 2004. Mercer recommends that BCFP continue to work to improve in this area.
2. Re-evaluation of data collection/claims efforts was recommended for breast cancer screening for BCFP last year. In addition, root cause analysis and activities designed to increase the rates of mammography were suggested. BCFP has increased their breast cancer screening rates, but it is recommended that they continue their efforts in this area.

CHNCT

1. The results for the NICU admits per 100 births PM have decreased since last year, but remain higher than national benchmarks. CHNCT should continue to focus on prenatal care standards, particularly on high-risk pregnancies.
2. ED usage has decreased since last year, but remains higher than the State's overall rate. Last year Mercer suggested that CHNCT research the diagnoses contributing to high ED usage and implement strategies to better manage these members. Mercer reiterates these recommendations this year.
3. CHNCT'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.

Performance Measure Calculations

4. 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 exam. Medical records review is also again recommended.
5. CHNCT's breast cancer screening rate has decreased since last year. Mercer re-emphasizes the need for CHNCT to evaluate data collection/claims efforts to determine if they are receiving all claims concerning mammograms. If the numbers are correct, activities should be implemented to increase the number of screening mammograms. PCPs should be sent quarterly report cards listing eligible women who have not received a mammogram within the last year.

FCHP

1. NICU usage has increased to slightly more than the national average. FCHP should evaluate the prenatal care standards and perhaps implement more rigorous standards for high-risk pregnancies.
2. ED usage has decreased substantially and is lower than national standards. This may be due to reporting practices, but FCHP should research to ensure that this decrease is not due to some other underlying problem with ED usage.

HN

1. HN's ED usage is low compared to the State's overall rate and should be investigated. It should be determined whether this is due to incomplete data, improper reporting, or true under usage.
2. Last year, Mercer recommended that HN re-evaluate their data collection/claims efforts to determine if they were capturing a complete accounting of all diabetic retinal exams. An additional recommendation was that patients be tracked by their PCPs and a report be issued quarterly, listing the diabetic members who have not received their eye exams. As HN's rate has dropped even further and is well below national standards, Mercer again strongly recommends that HN address their diabetic population's needs.
3. Last year, Mercer provided several recommendations for improving HN's breast cancer screening rates. These included, evaluation of data collection, root cause analysis, and research into geographic or demographic differences that could be addressed. It is strongly recommended that HN increase their activity in this area.

Appendix A

2005 EQR Recommendations

Anthem Blue Care Family Plan (BCFP)

1. The intent of Enrollee Rights and Protections is to ensure that enrollee, providers, vendors, and staff are fully informed regarding Enrollee Rights. BCFP should follow through with the development and distribution of a member bulletin updating Enrollee Rights information.
2. BCFP should include the definition of post-stabilization services in the *Member Handbook*, as specified in the work plan, and include the definition in the member bulletin created and distributed to members informing them of additional rights. This bulletin was intended to provide information to members while awaiting review of the updated *Member Handbook*.
3. A plan to track and monitor overall PCP compliance with access requirements should be developed.
4. BCFP should continue the following activities for dental: develop and implement recruitment plans related to increasing dental staff in the network; work in partnership with DSS and Wellpoint, their dental vendor to identify opportunities to improve access, continue performance improvement initiatives in place to improve screening rates, and examine options to expand interventions, review goals by age group to ensure ongoing improvement is identified, and continue the expedited unit to assist members who have difficulty to access a dental provider.
5. For PIPs, any variation in specifications, process, or IS limitations, regardless of their prevalence or size of the impact, should be identified in the study.
6. Last year, Mercer recommended that BCFP re-evaluate their data collection/claims efforts to determine if they are achieving a complete accounting of diabetic retinal exams. Additional recommendations were that BCFP diabetic patients should be tracked by their PCP. Quarterly reports should be issued to PCPs listing diabetics who had not received their diabetic retinal exam.

Although BCFP has increased their rate, they are still substantially lower than national standards. Mercer recommends that BCFP continue to work to improve in this area.

7. Re-evaluation of data collection/claims efforts was recommended for breast cancer screening for BCFP last year. In addition, root cause analysis and activities designed to increase the rates of mammography were suggested. BCFP has increased their breast cancer screening rates, but it is recommended that they continue their efforts in this area.

Community Health Network of Connecticut, Inc. (CHNCT)

1. CHNCT should amend their Advance Directive policy to cover community education and documentation of an executed Advance Directive in a member's medical record.
2. The Case Managers' performance should be monitored, with feedback given to each to improve the consistency of the delivery of case management services and the quality of the documentation.
3. Member education materials should be reviewed 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.
4. All required components should be incorporated into the provider network development process; monitoring for compliance should then be used to identify the need for additional interventions to improve appointment availability.
5. CHNCT should be consistent in the time parameters referenced in performance measures (PM) and should follow State specifications for age calculations.
6. CHNCT should evaluate its data collection and claims, and its interventions for those PMs, whose results decreased in the past measurement year or those whose results are below the benchmark, to improve the quality of its performance. These areas include NICU admits per 100 births, ED usage, readmission rate, diabetic retinal exams and the breast cancer screening rate.
7. CHNCT should include the assessment results regarding the completeness of its administrative data for its breast cancer screening performance improvement process (PIP), as well as implement and maintain interventions to improve the results.
8. CHNCT should make the Healthy Beginnings PIP more clear and simple by breaking the study question into two and by considering whether all five measures are necessary to assess the success of its interventions

FirstChoice Health Plan (FCHP)

1. FCHP's process of notifying enrollees within 15 days after finding out their specialist terminates should be defined by including it in a policy and in the provider manual.

2. NOA decision rationale in appeal files was found to be written at a clinical level rather than for the layperson. FCHP should revise NOAs so that the explanation for the action is written for the layperson.
3. The 2005 QI Program description was labeled "Preferred One-Medicare Choice." The access and availability standards in the document were not Medicaid standards. FCHP should review and update this document to accurately reflect the requirements of the Medicaid contract.
4. FCHP should continue to assess and address network access and availability through independent survey. In addition to addressing availability issues with specific providers, FCHP should assess the need to expand the network beyond the maximum enrollment parameters established by DSS to improve appointment availability.
5. FCHP should proceed with planned system enhancements to further automate the process for tracking HUSKY B copayments aggregate cost sharing limits, and repayment.
6. When the hybrid methodology is used for PIP data collection, clearly define the data collection instrument for medical record abstraction, instructions for data collection, plan for data analysis, and assessment of completeness of data.
7. NICU usage has increased to slightly more that the national average. FCHP should evaluate the prenatal care standards and perhaps implement more rigorous standards for high-risk pregnancies.
8. ED usage has decreased substantially and is lower than national standards. This may be due to reporting practices, but FCHP should research to ensure that this decrease is not due to some other underlying problem with ED usage.

Health Net of Connecticut (HN)

1. HN should develop a provider directory policy which includes the schedule for updates and should correct errors in the directory's index.
2. Health Net should disseminate Enrollee Rights and providers' responsibilities to honor these rights to sub-contracted providers; then monitor provider compliance (including that of providers of Health Net vendors) with these responsibilities
3. Health Net should modify its Advance Directive policies and procedures to include information about community training and should consider revising the deadline by which providers must discuss Advance Directives with their members.
4. Information regarding Advance Directives in the Member Handbook should be expanded to include instructions about exercising Advanced Directives or where this information is available to the public. The language describing Advanced Directives should be revised to accommodate low literacy readers.
5. HN should ensure all pertinent information in the description of a member's right to a second opinion is included in the *Member Handbook*.
6. HN should continue the process of monitoring, tracking, and trending CM documentation so as to be able to give feedback to Case Managers about the quality of their case file documentation.

7. The HRA survey process should be assessed and revised to improve response rates, and so that reports accurately reflect the results and are available within 30 days
8. A process for the timely identification and assessment of groups with SHNCs should be implemented.
9. Information about the EPSDT program and requirements should be communicated to the provider network.
10. Health Net QI and provider relations staff should be familiarized with provider network reports so that they can give input into the design of the reports and to allow for better analysis of results and design of interventions to improve the network.
11. The network development plan should incorporate all elements required by contract and should include the results of an analysis and the conclusions drawn from Health Net's analysis of the member satisfaction survey.
12. Health Net should include all provider availability standards in the provider manual and implement a primary verification process to monitor provider compliance with the standards.
13. HN should complete and implement the proposed vendor audit tool.
14. Doral Dental should monitor the dental network appointment availability and should ensure that members are able to schedule dental appointments with in the contract availability standards. The results of the monitoring should be reported to Health Net.
15. Include dental screening and cleaning utilization in the assessment of the adequacy of the dental network.
16. HN should formalize the process by which provider network issues are identified and forwarded to the Network Subcommittee for review and action.
17. HN should develop and implement actions to assure members are seen by their PCP within six months of enrollment with HN.
18. Health Net should comprehensively review the "CMS Protocols for EQR of Medicaid MCOs" and the EQR information request prior to compiling PIP reports which should describe the measurement year 2005.
19. Validated PMs for 2005 should be prepared and finalized prior to the State's designated deadline for each individual measure.
20. Health Net should comprehensively review the "CMS Protocols for EQR of Medicaid MCOs" and the EQR information request to gain a better understanding of what information is required for validation of performance measures (PM) which includes, but is not limited to, the following key components: identification of individual measure, definition of measure, data source and system identification, programming logic, clinical coding, time parameters, and the final report. The PM documentation should be self-contained and not cross-referenced with PIP documentation.
21. HealthNet should review its data collection process for completeness and assess the effectiveness for the interventions instituted to improve its results for the following PMs: ED usage, diabetic retinal exams and breast cancer screening.

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