



Expert Auditing and Monitoring Practices to Measure Quality and Performance Improvement Strategies in Medicaid Managed Care

Jennifer Tryder | Program Director
Lori Dillard | Program Director
Mike Walsh | Senior Auditor

About IntegrityM



Headquartered in Alexandria, Virginia, Integrity Management Services, Inc. (IntegrityM) is a certified women-owned small business, CMMI Level 3 appraised, ISO 9001:2015, and FISMA compliant organization. IntegrityM was created to support the program integrity efforts of Federal and State government programs, as well as private sector organizations. IntegrityM provides experience and expertise to government programs and private businesses supporting government programs. Results are achieved through analysis and support services, such as statistical and data analysis, compliance audits, investigations, medical review, outreach and education, and software solutions.

IntegrityM provides services to the Centers for Medicare & Medicaid Services (CMS) in determining whether Medicare service costs and statistics claimed on the Medicare Managed Care Organizations (MCO's) cost report are accurate and allowable to ensure fair apportionment and proper reimbursement from Medicare.



Agenda



1. Major Change Provisions Within the 2016 Medicaid Rule



2. CMS Strategic Goals and Meaningful Measures Framework for Quality Of Care

- Determining an Effective Strategy for Audit Planning
- State Agency & MCO Contractual Considerations



3. Applying and Reporting Quality of Care Performance Measurements in Medicaid Managed Care & CHIP

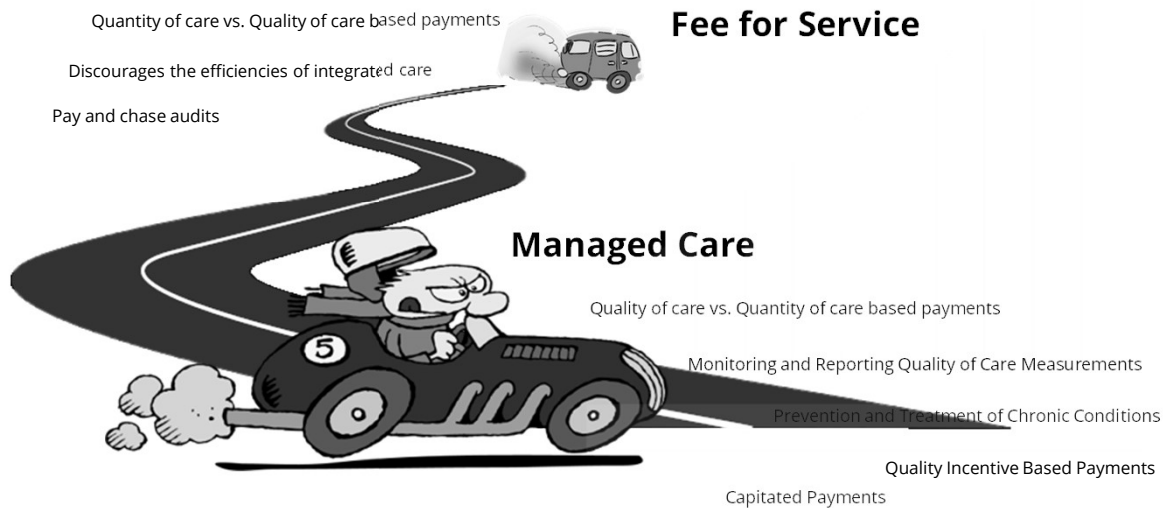
- Understanding HEDIS Clinical and Administrative Measures
- HEDIS Measurement Examples (Child and Adult Core Set Measures)
 - Well Child Visits (W34)
 - Childhood Immunization Status (CIS)
 - Cervical Cancer Screening (CCS)
 - Controlling High Blood Pressure (CBP)



4. Best Practices for Sampling, Auditing and Monitoring Data Quality Measurements

- The Importance of Expert Data Validation & Sampling
- Establishing Internal and External Controls and Reporting for Quality Assessment & Performance Improvement

Where Have We Traveled From & What Is Our Destination?



On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued final regulations revising and significantly strengthen existing Medicaid managed care rules

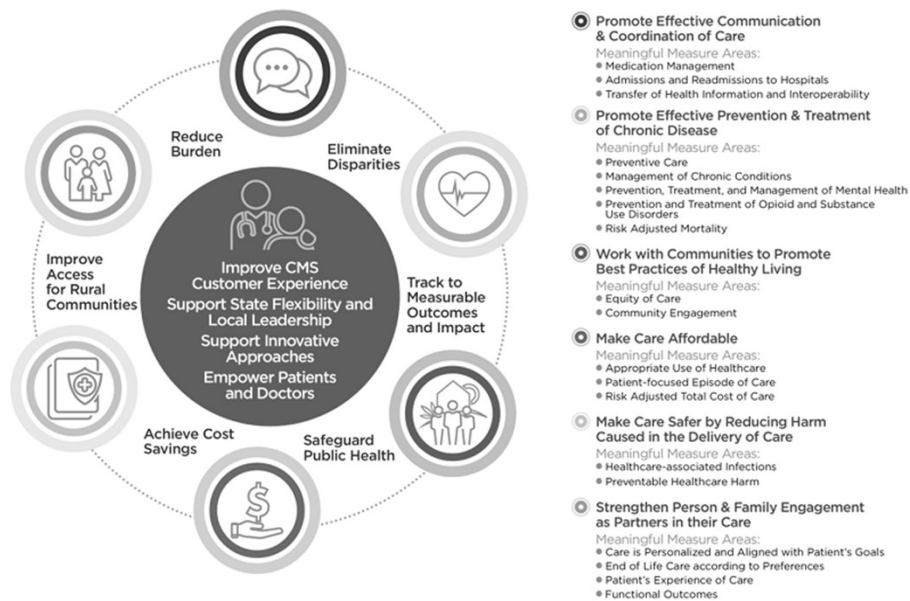
- Rule increased Federal expectations of fundamental aspects of State Medicaid Managed Care Programs

Significant changes include:

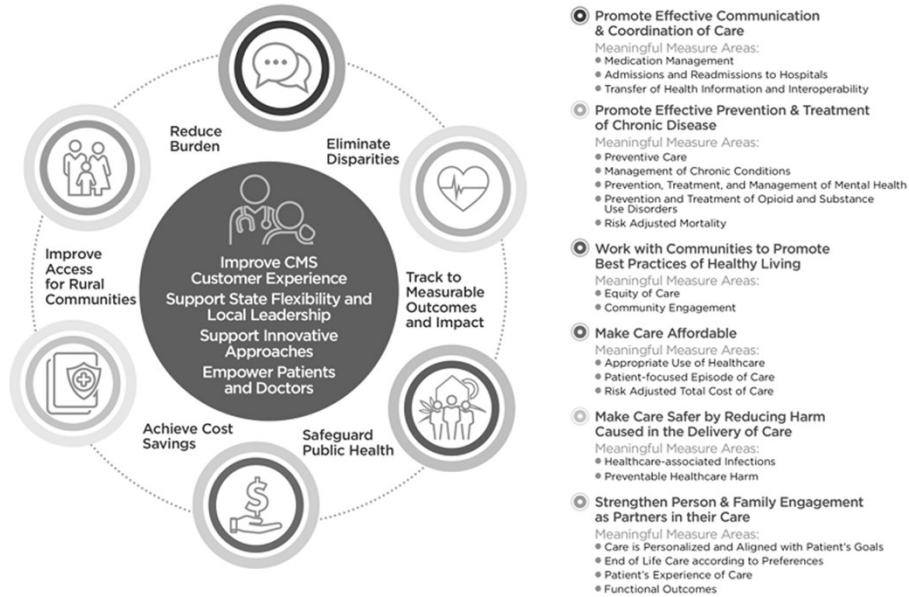
- Promote quality of care and enhance the beneficiary experience of care and strengthen beneficiary protections
- Strengthen payment provisions through the assurance of complete, accurate and timely encounter data
- Improve standards for network adequacy and patient access to care
- Further disbursement of program integrity responsibilities across CMS, States, and MCOs
- Align Medicaid and CHIP managed care requirements with other major health coverage programs (MA, Marketplaces)

<https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicare-managed-care-a-summary-of-major-provisions/>

CMS Meaningful Measures Framework



CMS Strategic Goals and Quality of Care Related Measures



Determining an Effective Strategy for Audit Planning

• Each audit should proceed logically and systematically to use audit resources efficiently and effectively. Audit work should be broken down into 7 phases, each of which has a bearing on how and to what extent the audit is conducted. The phases are defined as follows:

- **Phase 1 - Selection of Auditee and Scope of Review**
- **Phase 2 - State Agency Background Information**
- **Phase 3 - Initial Risk Evaluation**
- **Phase 4 - MCO Documentation (contracts)**
- **Phase 5 - Risk Re-evaluation**
- **Phase 6 - Detailed Audit Procedures & Data Verification based on protocols**
- **Phase 7 - Reporting**

State Strategy for Monitoring MCO Contracts

- Ensure specific data and reporting requirements are included in MCO contracts in order for states to conduct efficient monitoring and proper controls
- Collect, validate, and analyze MCO reports and data to verify compliance with quality measures
- Evaluate program enrollees on a monthly basis to identify gaps and loss of eligibility for covered services
- Develop state specific audit and monitoring policies, including exceptions
- Review contracts annually and anytime there is a significant change that would affect the adequacy and capacity of services (i.e. new population enrollment, changes to benefits/service area)

Although CMS does not require inclusion of these elements in contracts (i.e., states can also include these in other documentation outside of the contract), states generally require contractors to consider these elements, and thus should consider including them in their risk-based contracts.

State Agency MCO Contractual Considerations

- **Properly Define the Following:**
 - Service & encounter types specific to each program
 - Internal control assessments
 - External Audits
 - Defining a sample unit and allowable error rates
 - Defining attributes and errors of accuracy, timeliness and completeness
 - Identify how to treat missing records and data (error vs.no finding)
 - Reporting requirements
 - Impact assessment on State Agency and MCO

**Allowable error rates
and expected error rates**

**Encounters make good
sample units for MCOs**

Applying Quality of Care Performance Measurements in Medicaid Managed Care

Lori Dillard · Program Director · CMS Managed Care Contract



2020 Quality of Care Performance Measurement

- Quality measures seek to measure the degree to which evidence-based treatment guidelines are followed, where indicated, and assess the results of care. The use of quality measurement helps strengthen accountability and support performance improvement initiatives at numerous levels. These measures can be used to demonstrate a variety of activities and health care outcomes for particular populations such as Medicaid & Children's Health Insurance Program (CHIP) enrollees.
- **HEDIS Performance Measurement Areas of Focus:**
 - Adult and Child Health Care Quality Measures
 - Initial Core Set of Children's Health Care Quality Measures
 - Initial Core Set of Adult Health Care Quality Measures
 - CHIPRA Quality of Care and Performance Measurement
 - Adult Medicaid Quality Grants
 - Nationwide Adult Medicaid CAHPS



<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/index.html>

Reporting HEDIS for Medicaid & CHIP

- Separate Medicaid HEDIS reports must be produced for each state with which an organization has a Medicaid contract.
- If an organization contracts with a local entity (i.e., with a county, rather than with a state) and with each locality where it provides service, the state and the organization may consider providing a comprehensive Medicaid HEDIS report that encompasses all geographic areas in the state that are served by the organization.
- If the state has identified CHIP members to a contracting organization and the contracting organization also collects and reports Medicaid audited HEDIS results, the organization follows the state's direction and:
 - Reports required HEDIS measures separately for CHIP members, or
 - Includes CHIP members in its Medicaid product-line reports.
- **Incentivize state & provider payments for quality of data received**



Understanding HEDIS Clinical & Administrative Measures

- **Administrative Specification:**
 - **Data selection** from an eligible population using a numerator that defines qualified criteria for measurement.
- **Hybrid Specification:**
 - A **systematic sample** drawn from the eligible population that can be used to perform medical record and coding reviews.
- **Measurement Recommendations:**
 - Identify data elements from billing/coding systems and electronic medical records
 - Set data and reporting criteria to run on a scheduled or ad-hoc basis
 - Incorporate on-going measurement audits into standard audit protocols
 - Ensure timely reviews of each study to identify weaknesses in data or internal controls
 - Address all risks quickly, ensuring complete documentation of findings and corrective actions/education
 - Determine and respond to repayment errors and proper reimbursement
 - Work measurement requirements and reporting into managed care contracts for accountability

Efforts to Standardize Audit Protocols & Data Collection

- **Eliminate poor planning and “audit scramble” by performing on-going standardized and proactive data and documentation collection:**

- Include audit and reporting requirements for quality measurements in provider contracts
- Standardize and perform MCO data collection throughout the year, not just during HEDIS Audit
- Reduce MCO and provider burden by establishing standardized and repetitive audit protocols and systematic data collection throughout the year
- Report and document findings and implement corrective action measures
- Work closely with providers and deliver education to support their understanding and involvement
- Identify data points and sample selection methods, as well as standardized reporting across provider network

HEDIS Measurement Examples Child and Adult Core Set Measures



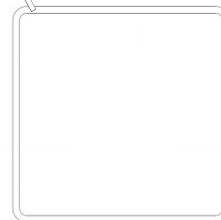
Well Child Visits



Cervical CA Screen



Childhood Immunization Status



Control High Blood Pressure

Child Core Set

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

- **Description:** The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.
- **Allowable Gap:** No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.

Administrative Specification	
Denominator	Numerator
The eligible population	At least one well-child visit (<u>Well-Care Value Set</u>) with a PCP during the measurement year. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

Hybrid Specification		
Denominator	Numerator	Medical Record
A systematic sample drawn from the eligible population for the Medicaid product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate.	At least one well-child visit with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.	Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of <i>all</i> of the following: <ul style="list-style-type: none"> • A health history. • A physical developmental history. • A mental developmental history. • A physical exam. • Health education/anticipatory guidance.

Childhood Immunization Status

- **Description:** The percentage of children 2 years of age who had the following:

Childhood Immunization Vaccines for Measurement	
4 diphtheria Tetanus and acellular pertussis (DTaP);	1 chicken pox (VZV);
3 polio (IPV); one measles, mumps and rubella (MMR);	4 pneumococcal conjugate (PCV);
3 haemophilus influenza type B (HiB);	1 hepatitis A (HepA);
3 hepatitis B (HepB),	2 or three rotavirus (RV);
2 influenza (flu) vaccines	

The measure calculates a rate for each vaccine and nine separate combination rates

- **Allowable Gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.

Childhood Immunization Status

Administrative Specification	
Denominator	Numerator
The eligible population	<p>For MMR, hepatitis B, VZV and hepatitis A, count any of the following: Evidence of the antigen or combination vaccine, <i>or</i> Documented history of the illness, <i>or</i> A seropositive test result for each antigen.</p> <p>For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count only: Evidence of the antigen or combination vaccine.</p> <p>For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.</p>

Childhood Immunization Status

Hybrid Specification		
Denominator	Numerator	Medical Record
<p>A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year's administrative rate for the lowest rate or the prior year's audited, product line-specific results for the lowest rate.</p>	<p>For MMR, hepatitis B, VZV and hepatitis A, count any of the following: Evidence of the antigen or combination vaccine. Documented history of the illness. A seropositive test result.</p> <p>For DTaP, HiB, IPV, pneumococcal conjugate, rotavirus and influenza, count <i>only</i>: Evidence of the antigen or combination vaccine. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens</p>	<p>For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following: A note indicating the name of the specific antigen and the date of the immunization. A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.</p>

Adult Core Set

Cervical Cancer Screening (CCS)

- **Description:** The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
 - Women 21–64 years of age who had cervical cytology performed every 3 years.
 - Women 30–64 years of age who had cervical cytology/human papillomavirus co-testing performed every 5 years.
- **Allowable Gap:** No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.

Administrative Specification	
Denominator	Numerator
The eligible population.	The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.

Cervical Cancer Screening (CCS)

Hybrid Specification		
Denominator	Numerator	Medical Record
A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.	The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review.	<p>Step 1: Identify the number of women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:</p> <ul style="list-style-type: none"> • A note indicating the date when the cervical cytology was performed. • The result or finding <p>Step 2: From the women who did not meet step 1 criteria, identify the number of women 30–64 years of age as of December 31 of the measurement year who had cervical cytology and an HPV test on the same date of service during the measurement year or the four years prior to the measurement year and who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:</p> <ul style="list-style-type: none"> • A note indicating the date when the cervical cytology and the HPV test were performed. • The results or findings. <p>Step 3: Sum the events from steps 1–2 to obtain the rate</p>

Controlling High Blood Pressure (CBP)

- **Description:** The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:
 - Members 18–59 years of age whose BP was <140/90 mm Hg.
 - Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
 - Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.
- **Allowable Gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- **Note:** Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups

Controlling High Blood Pressure (CBP)

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population. The organization may reduce the sample size using the prior year's audited, product line-specific rate. To confirm the diagnosis of hypertension, the organization must find notation of one of the following in the medical record anytime during the member's history on or before June 30 of the measurement year:

Hypertension.
HTN.
High BP (HBP).
Elevated BP (↑BP).
Borderline HTN.
Intermittent HTN.

History of HTN.
Hypertensive vascular disease (HVD).
Hyperpiesia.
Hyperpiesis.
A diagnosis code for hypertension documented in the medical record.

Controlling High Blood Pressure (CBP)

Hybrid Specification

Denominator Continued;

It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list
- Office note.
- Subjective, Objective, Assessment, Plan (SOAP) note.
- Encounter form.
- Diagnostic report.
- Hospital discharge summary.

Note: If the diagnosis of hypertension cannot be confirmed, the member is excluded and replaced by the next member from the oversample.

Controlling High Blood Pressure (CBP)

Hybrid Specification

Numerator

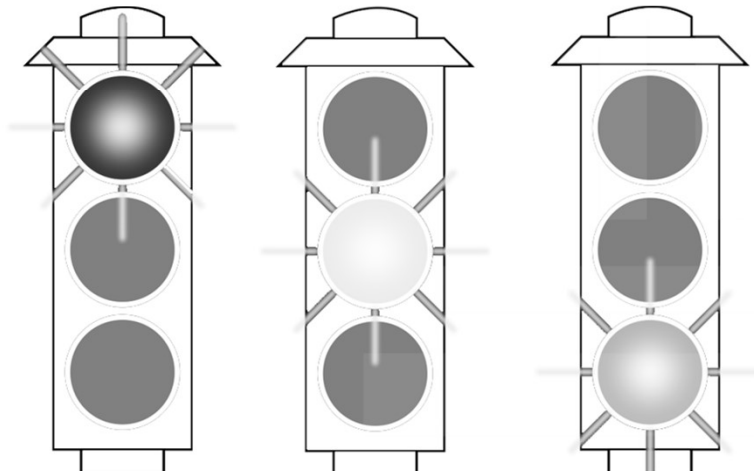
The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.

To determine if the member's BP is adequately controlled, the representative BP must be identified.

Best Practices for Sampling, Auditing & Monitoring Data Quality Measurements

Mike Walsh · Sr. Auditor and Master Statistician



The Importance of Expert Data Validation & Sampling

• When determining the need for internal or external consulting resources to support agency efforts with program evaluation, it is critical that each Managed Care Program within both the State Agency and MCO Entity, take the following into consideration for data evaluation:

- **Analyzing data output**
- **Standardized audit and investigation protocols**
- **Statistical and quality data analysis (i.e., sampling)**
- **Definition and generation of performance metrics based on the above**
- **Well defined audit objectives**
- **Compare against prior audit results**
- **Specific program experience is beneficial**

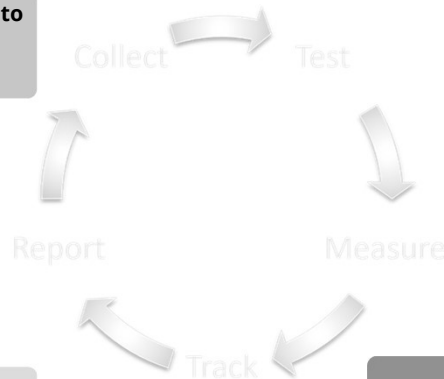


Establishing Internal and External Controls and Reporting for Quality Assessment & Performance Improvement

Are your processes periodically tested to make sure they are functioning as intended?

Do you match quality measures and provider contracts to specific compliance requirements (HEDIS, State Quality Measure Reporting?)

Have you ever spot checked enrollees to verify enrollment gaps?



The MCO should have a system of verification to ensure that the elements are in place.

Have you verified that all regulatory requirements are included? E.g. quality measures, audits, reporting review and resolution?

Innovative solutions change over time. Are they tracked and reported?



Thank You!

Thank you for attending today's presentation. We'll be happy to answer any questions!

For more information, or to contact us, please contact info@integritym or (703) 683-9600.



twitter.com/integritym_inc



linkedin.com/company/integritym-inc