



Final Report

External Quality Review:
Blue Cross of Idaho Final
Report of Findings
2017

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**External Quality Review Organization:
Blue Cross Idaho
Annual Review and Summary
2017**

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External Quality Review Summary

In accordance with the United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) rule, Telligen, Inc. conducts onsite evaluations of Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) under contract with the Idaho Department of Health and Welfare (IDHW). The purpose of the evaluation is to assure that each contracted MCO/PIHP is providing quality services for its Medicaid members in accordance with the CMS Protocols. The CMS (42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rule specifies the requirements for evaluation of Medicaid managed care programs.

In July 2014, Idaho began providing Medicaid benefits to eligible enrollees statewide through the Blue Cross of Idaho Medicare-Medicaid Coordinated Plan (MMCP). Called the True Blue Special Needs Plan or the True Blue Special Needs HMO SNP, it combines Medicare Advantage benefits (Parts C and D) with most Medicaid- administered waiver benefits and is available to participants who are enrolled in both Medicare and Medicaid programs. This technical report involves Blue Cross of Idaho's (BCI) performance as evaluated during desk reviews of BCI's policies and procedures and an onsite review conducted on January 9, 2018 at their Meridian, ID location. Completing an External Quality Review (EQR) requires a great deal of effort from numerous people. To obtain a meaningful finished product, honest communication, careful study, patience, follow-up, and a spirit of collaboration are required. The staff at Blue Cross exemplified these traits, and without their efforts, honesty, patience, and accommodating nature it would have not been possible to deliver a finished product of this caliber and do so within the time allotted. Of particular assistance was Nancy Gallivan, Compliance Specialist, who tirelessly and efficiently saw the process to its fruition.

During the time of this review (Calendar Year 2017) BCI reported serving 2,615 Medicaid lives in Idaho; this is an increase over the 2,480 lives reportedly served in 2016, the 1,688 lives served in 2015, and the 684 served in 2014.

BCI was the only MCO under contract in 2017 in the State of Idaho to provide Medicaid physical-health services. Therefore, this report will not include comparative analysis with any other plan's performance.

The Telligen External Quality Review (EQR) Evaluation Team (the Team) includes Telligen staff with extensive managed care experience and the Security Administrator. Team members are experienced in managed care peer-to-peer review, quality improvement principles, and outcomes measurement. The Team is supported by an independent writer with many years of experience in EQR analysis and validation. This writer analyzed the findings and wrote an independent summary of those findings.

BCI participants in the on-site review included:

Blue Cross of Idaho

Peter Sorensen, VP Individual and Government Markets
Kathy Whaley, VP Service Operations
Dean Reichert, Manager IT Support & Services
Tom Wilmot, Acting Director and Manager IT Infrastructure
Kate Belvoir, Manager IT Claims Systems
Sophie Loya, Supervisor, Care Coordination
Sheri Core, Manager Customer Service
Monique Barber, Dual-Eligible Outreach Specialist
Jill Alessi, Director Care & Quality Management (RN)
Nancy Gallivan, Compliance Specialist
Genii Hamilton, Supervisor MA Appeals and Grievances
Jennifer Rogalla, Interim Director Grievances and Appeals

The External Quality Review Team included:

Telligen, Inc.

Scott Tiffany, Program Director
Jennifer Bly, RN
Joe Fontenot, Security Administrator
Amy McCurry Schwartz, EQRO Consultant

This EQR technical report analyzes and aggregates data from three mandatory EQR activities as described below:

CMS regulations require an annual review of PIPs and PMs, and a tri-annual (every three year) review of Compliance. The regulations also require an annual follow-up review of any identified Quality Standards that did not meet expectations during the prior evaluation period. This is a full compliance review year. The IDHW also requires an annual Information Systems Capabilities Assessment (ISCA).

1) Validating Compliance with Managed Care Regulations.¹

The Team conducted an evaluation of compliance with Quality Standards addressing access to care, structure and operations, and quality management and improvement per 42 CFR §438.

2) Validating Performance Improvement Projects²

BCI conducted Performance Improvements Projects (PIPs) during the 12 months preceding the audit, as required in 42 CFR 438.20 (b)(1). Two PIPs were then validated by the Team:

- Promote Effective Management of Chronic Disease: Promotion of Effective Management of Osteoporosis

¹ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol I: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, D.C.: Author.

² Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September, 2012. Washington, D.C.: Author.

- Reducing the voluntary disenrollment rate in the True Blue Special Needs HMO SNP dual eligible Medicaid Population

3) Validating Performance Measures³

Two Performance Measures (PMs) that were underway the preceding 12 months were validated by the Team as required by 42 CFR 438.20(b)(2). These PMs were:

- Idaho Home Choice Money Follows the Person
- Call Center Performance Measures

and

4) Information Systems Capabilities Assessment (ISCA)⁴

The ISCA is the evaluation of the MCO's information systems by the Team. This evaluation is intended to assess the strength of those systems and their capability to accurately and reliably produce performance measure data and reports, as well as manage the care of enrollees.

The Team used review procedures for the ISCA that were based on the CMS protocol for this activity. For each ISCA review area, reviewers used the information collected from BCI in the ISCA data collection tool, responses to interview questions, and results of walkthroughs during the on-site visit to rate the MCO's performance in five review areas.

To clearly report findings, technical methods of data collection, description of the data, conclusions, and recommendations for improvement will be discussed separately for the requirements pertaining to Quality Standards as well as PIPs, PMs, and the ISCA.

³ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, D.C.: Author.

⁴ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Appendix V: Information Systems Capabilities Assessment – Activity Required for Multiple Protocols, Version 2.0, September, 2012. Washington, D.C.: Author.

Compliance

Review of Quality Standards

Technical Methods of Data Collection and Analysis:

BCI was subject to a full compliance audit during this review year. The content of this 2017 audit will include review of all the components of the Quality Standards: Enrollee Rights and Protections; Access and Availability; Structure and Operations; and Measurement and Improvement Standards, as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Review of Grievance and Appeals files
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol EQR Protocol I: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR) (Compliance Protocol). See Attachment I. Utilizing this tool, BCI was evaluated on the timeliness, access, and quality of care provided. This report incorporates a discussion of Plan strengths and areas for improvement with recommendations to enhance overall performance and compliance with standards.

The Telligen rating scale is as follows:

P = Proficient

Documentation supports that all components were implemented, reviewed, revised, and/or further developed and MCO staff provided responses to reviewers that are consistent with the standard and with the documentation.

D = Developing

All documentation listed under a component was present, however MCO staff are unable to consistently articulate evidence of compliance, or MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.

N = No Documentation

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation.

A summary of compliance with all evaluated Quality Standards is included in Table I.

Table I. Compliance Ratings

Measure	2016 Rate	2017 Rate
<i>Enrollee Rights and Protections</i>	Developing	Proficient
<i>Access and Availability</i>	Proficient	Proficient
<i>Coordination and Continuity of Care</i>	Proficient	Proficient
<i>Coverage and Authorization of Services</i>	Proficient	Proficient
<i>Provider Selection</i>	Proficient	Proficient
<i>Grievance System</i>	Developing	Developing
<i>Sub-Contractual Relationships and Delegations</i>	Proficient	Proficient
<i>Enrollment and Disenrollment</i>	n/a	n/a
<i>Practice Guidelines</i>	Proficient	Proficient
<i>Quality Assessment and Performance Improvement Program</i>	Developing	Developing
<i>Health Information Systems</i>	Proficient	Proficient
Overall Rating	Developing	Developing

Description of the Data:

The review of Quality Standards was completed using Attachment I, BBA Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations. All areas rated as proficient for the 2016 review were not examined in detail during the 2017 review as the 2017 review was a follow-up to the full compliance review conducted during the 2016 review.

The areas of Access and Availability, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Sub-Contractual Relations and Delegations, Practice Guidelines and Health Information Systems were found to meet all required standards.

Enrollee Rights and Protections

The category of Enrollee Rights and Protections addresses 46 individual standards. For the 2016 review, BCI received a rating of developing, as it was rated as proficient in 44 areas; rated as developing in one area; and rated as no documentation in one area. For the 2017 review, BCI is rated as proficient in all 46 standards.

For the 2016 review, the information regarding the requirements and timeframes for filing a grievance or appeal (CFR 438.10(g)(1)(iii)) was rated as developing. This was due to the lack of specific information on how to file a grievance or appeal in the member handbook as required by BCI's contract with IDHW. For the 2017 review, this has been corrected and specific information is found in BCI's member handbook regarding the timeframes for filing a grievance or complaint.

Additionally, during the 2016 review, the availability of assistance in the filing of grievances or appeals (CFR 438.10(g)(1)(iv)) was rated as no documentation. Although the member handbook and EOC provided information that would allow a member to contact BCI when filing an appeal or complaint; it was never specifically stated that BCI would assist a member to file a grievance or appeal. For the 2017 review, the Team observed that BCI's member handbook had been modified to direct members to contact BCI for assistance with filing a grievance or appeal.

Grievance System

The category of Grievance System addresses 55 standards. BCI was rated proficient in 38 standards, developing in sixteen standards and no documentation in one standard. This is an improvement over the 2016 review when BCI was rated as proficient in 36 standards, developing in seventeen standards and no documentation in two standards.

All sixteen developing ratings and one no documentation rating were received because of Telligen's on-site review of BCI grievance and appeals files. Telligen found files that were missing Notice of Action letters and letters that were missing an explanation of the reason for an action (CFR 438.404 (b)(1 and 2)). Telligen also found letters that did not include information regarding the enrollee's right to examine the case file (CFR 438.406(b)(3)). Telligen found two files that did not meet the timeliness requirements (CFR 438.404(c)(1 and 2), CFR 438.404(c)(3) and CFR 438.404(c)(4)(ii)). The final area rated as developing pertains to the requirement that BCI "give enrollees any reasonable assistance in completing forms and taking other procedural steps"; although the BCI member handbook has been improved in this area over the 2016 review, the documentation in the files reviewed on-site did not show staff's willingness to help complete forms, staff only instructed enrollees on how to complete the forms themselves (CFR 438.406(a)(1)).

Quality Assessment and Performance Improvement Program

The category of Quality Assessment and Performance Improvement Program addresses 10 standards. BCI was rated as proficient in 8 standards and developing in two standards.

The two standards that received the rating of developing pertained to BCI's Performance Improvement Projects. Data collection and analysis issues (CFR 438.240(b)(1)) were present in both PIPs and the effectiveness of interventions was not adequately analyzed in the non-clinical PIP (CFR 438.240(d)(1)(iii)). More details regarding the specifics of BCI's performance on these standards can be found in the Performance Improvement Projects section of this report.

Enrollment and Disenrollment

The five standards under Enrollment and Disenrollment are rated as "not applicable". This function has been retained by IDHW, however the Team did discuss enrollment and disenrollment issues with BCI and per that conversation, some recommendations for improvement are detailed later in this section.

Overall Evaluation and Recommendations for Improvement

This plan is committed to providing a high level of care to its members. BCI has a commitment to timeliness, access and quality of care.

Timeliness

BCI provides quarterly newsletters to members and providers on seasonal topics, as well as an Annual Newsletter to all members. Members are also able to access BCI's website to obtain additional information in real time.

Access To Care

Neither the Team nor BCI have not identified any areas of concern regarding access in their network, but BCI continues to monitor the network for access issues.

The Team identified areas of concern regarding BCI's grievance and appeals practices. During the on-site

review, BCI was open to the Team's concerns and communicated that new management had been hired for those areas. An Interim Director was named and at the time of the on-site review BCI had extended an offer of employment to a permanent Director.

Quality of Care

The quality of care provided by BCI contracted providers is assured by BCI's compliance with the standards of review set forth in the areas of Quality Assessment. All BCI providers are credentialed and monitored according to required policies and procedures. Additionally, a Member Advisory Committee meets quarterly.

All levels of evaluation during this review show that BCI is committed to their members as the users of its services.

Recommendations for Improvement:

1. The EQRO recommends that BCI make every effort to ensure all grievances and appeals are processed according to standards.
2. The EQRO recommends that BCI ensure all documentation regarding grievances and appeals are maintained in the grievance and appeals files.
3. The EQRO recommends additional training and emphasis be placed on the grievance and appeals processing so that all standards are met for each occurrence.

Performance Improvement Projects

BCI, under the direction of IDHW, has compiled two Performance Improvement Projects (PIPs) which will be discussed during this review. They are:

- Effective Management of Chronic Disease: Promotion of Effective Management of Osteoporosis
- Reducing the voluntary disenrollment rate in the True Blue Special Needs HMO SNP dual eligible Medicaid Population

Technical Methods of Data Collection:

The technical methods of data collection and analysis incorporated by BCI are developed internally. These methods incorporate information from existing Plan reporting programs and databases. Utilizing the Performance Improvement Project Validation Worksheet (Attachment 2), analysis of internal processes utilized to document and interpret data results was completed by the Team. Finally, an interpretation of the interventions and ensuing improvements was incorporated as a measure of the effectiveness of the improvement process.

The reviewers incorporated document review, interview, and observation techniques to fully evaluate the components of each Performance Improvement Project. All evaluation was calculated utilizing the CMS Final Protocol, Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review.

The rating scale reflecting compliance with standards is as follows:

P = Proficient

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

D = Developing

Documentation supports some but not all components were present.

N = No Documentation

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation.

A summary of compliance with all evaluated Performance Improvement Projects is included in Table 2

Table 2 - Performance Improvement Project Ratings

Step	Promote Effective Management of Chronic Disease: Management of Osteoporosis	Reducing the voluntary disenrollment rate in the True Blue Special Needs HMO SNP dual eligible Medicaid Population
Step 1: Selected Study Topics	Proficient	Proficient
Step 2: Study Questions	Proficient	Proficient
Step 3: Study Indicators	Proficient	Developing
Step 4: Study Populations	Developing	Developing
Step 5: Sampling Methods	n/a	n/a
Step 6: Data Collection Procedures	Developing	Developing
Step 7: Improvement Strategies	Proficient	Developing
Step 8: Analysis and Interpretation of Study Results	Developing	Developing
Step 9: Validity of Improvement	n/a	n/a
Step 10: Sustained Improvement	n/a	n/a
Overall Rating	Developing	Developing

Promote Effective Management of Chronic Disease: Promotion of Effective Management of Osteoporosis

Description of the Data:

BCI utilized many methods of data collection for this PIP. These data collection methods include:

- Administrative data derived from claims/encounters (inpatient and outpatient)
- Pharmacy data
- Medicare Health Outcomes Survey (HOS)

BCI utilized claims/encounter data files to determine eligible members age 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. These members were continuously enrolled for 12 months before the Index Episode State Date (IESD) through 180 days after the IESD. No more than one gap in enrollment of up to 45 days was allowed. These guidelines were set by the Healthcare Effectiveness Data and Information Set (HEDIS) measure Osteoporosis Management in Women Who Had a Fracture (OMW). HEDIS is a tool used by health plans to measure performance on important dimensions of care and services.

The baseline measurement period for this PIP was July 1, 2013 through June 30, 2014 (HEDIS 2015) for OMW and Calendar Year 2014 for the HOS. The first re-measurement period was July 1, 2014 through June 30, 2015 (HEDIS 2016) for OMW and Calendar Year 2016 for the HOS. The second re-measurement period was July 1, 2015 through June 30, 2016 (HEDIS 2017) for OMW and Calendar Year 2017 for the HOS.

BCI selected two measurements/indicators for this study.

Study Measurement #1: The first study measurement was “the percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture”. The goal for this study measurement was to improve from their baseline of 17.9%. A specific target goal was not set.

Study Measurement #2: The second study measurement was “the change in health status over time for monitoring physical activity and reducing the risk of falling”. The goal for this study measurement was to improve measures related to monitoring physical activity and reducing the risk of falling. No specific target percentage was set, although BCI did equate their baseline rating of 51% on the “Monitoring Physical Activity” measure as receiving a three-star rating from Medicare and the “Reducing Risk of Falling” baseline rating of 59% as receiving a two-star rating from Medicare.

The Team’s evaluation processes incorporated a review of study documentation regarding decision-making processes, identification of interventions, and anticipated change or hypothesis. Results were evaluated for statistical significance and compared to the defined goals for the study year.

Conclusions:

The rationale that BCI details in the PIP narrative for selecting this PIP pertains to: 1) increasing awareness of the importance of bone health and 2) promoting member self-management of prevention and knowledge of fall risk.

There are two study questions:

Study Question #1: Will member and provider engagement promote effective management of osteoporosis?

Study Question #2: Will member and provider engagement reduce healthcare disparities?

Table 3 – HEDIS 2015 – HEDIS 2017 Results

Measure	Numerator/Denominator			Rate			Goal		
	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2015	HEDIS 2016	HEDIS 2017
#1 Osteoporosis Management	22/128	39/171	33/141	17.19%	22.81%	23.40%	Above 52%	Above 52%	Above 52%
	CY 2014	CY 2016	CY 2017	CY 2014	CY 2016	CY 2017	CY 2014	CY 2016	CY 2017
#2a Monitoring Physical Activity	420/827	405/831	366/747	50.79%	49%	49%	Above 51%	Above 51%	Above 53%
#2b Reducing the Risk of Falling	207/352	209/381	165/296	58.81%	55%	55.74%	Above 59%	Above 59%	Above 66%

Analysis of the study showed that BCI demonstrated statistically significant improvement in the OMW measure from HEDIS 2015 to HEDIS 2016 and from HEDIS 2016 to HEDIS 2017. The HOS survey results did not improve and although no statistically significant decrease was observed in these measures, both rates did show a decrease from the 2014 baseline.

The OMW HEDIS measure was further analyzed for improvement. Analysis was conducted by what intervention was effective for the compliant members and then further drilled down to the MMCP members. MMCP members improved from zero percent compliance for nine members in 2016 to 50% compliance for eight members in 2017. Three intervention categories were undertaken in 2017, these included: provider education; enrollee education; and care coordination. Inpatient clinicians followed members with fragility fractures that were admitted to the facility. Members (if hospitalized) were called by the BCI Transitions of Care Team.

The 2017 results for the HOS Reducing the Risk of Falling and Monitoring Physical Activity did not improve significantly. Additionally, the rate has declined since the start of the PIP. However, two articles about bone health and fall prevention were mailed to all members. Reports are run at a minimum every other month.

Strengths:

- 1) BCI's rationale for choosing this PIP is clearly documented. The literature review contained a study that was well explained and BCI utilized this as support for "tackling" this project.
- 2) BCI's study goals were easily understood.
- 3) During the first year of this PIP, BCI identified a barrier to outcomes for this study as the lack of education to providers. BCI provided additional interventions to target provider education in response to the EQRO's recommendations.

Areas for Improvement:

- 1) Although reports are run at least every other month, BCI reported annual data compilation, review and analysis. The EQRO recommends a minimum data analysis cycle of quarterly going forward. This would allow BCI to identify any trends and make corrections as needed in a timely manner.

Reducing the Voluntary Disenrollment Rate in the True Blue Special Needs HMO SNP dual eligible Medicaid Population

Description of the Data:

BCI utilized administrative data derived from enrollment files for this PIP.

The baseline measurement period for this PIP was August 2014 through October 2015. The first re-measurement period was February 2016 through December 2016. The second re-measurement period was January 2017 through September 2017.

BCI has selected two measurements/indicators for this study.

Study Measurement #1: New Enrollment

Study Measurement #2: Voluntary Disenrollment

The Team's evaluation processes incorporated a review of study documentation regarding decision-making processes, identification of interventions, and anticipated change or hypothesis. Results were evaluated for statistical significance and compared to defined goals for the study year.

Conclusions:

The rationale that BCI details in the PIP narrative for selecting this activity pertains to having many "enrollee-reported reasons for disenrollment that suggest the enrollees do not understand how BCI works." BCI hypothesized that enrollees had many misconceptions about BCI. BCI also hypothesized that their interpretation that the Medicare Marketing Guidelines only allowed BCI to contact enrollees following their effective date contributed to the enrollees' misconceptions.

Study Question: Will the voluntary disenrollment rate be reduced if the health plan contacts the enrollee to review how the True Blue plan works within 10 days of enrollment instead of within 10 days of the effective date of coverage?

Table 4 – New Enrollment and Disenrollment data (2015 - 2017)

	2015 Average	2016 Average	2017 Average
# Total Enrollment	1353	2385	2329
# New Enrollment (NE)	92	74	53
# Voluntary Disenrollment (DE)	7	2	9
# DE <90 days		2	2
# DE Enrolled via Outreach Spec.	0	1	2
Percentage DE to NE	8%	2%	17%
Percentage DE <90 days to NE		2%	4%
Percentage DE<90 days to DE		89%	25%
Percentage DE to total enrollment	0.52%	0.07%	0.40%

Analysis of the study showed that BCI reduced the percentage of voluntary disenrollments from 10% to 2% from baseline to re-measurement period I (2016). In 2017, this rose to 27%. BCI attributes this increase to significantly lower new enrollment than in previous years due to a decrease in the number of outreach seminars and marketing initiatives undertaken.

Evaluation of the Study and Recommendations for Improvement:

BCI determined that not contacting enrollees until after their effective date was hampering those enrollees' ability to understand the MMCP. While BCI had been conducting enrollment events and had a BCI representative at those events to present BCI and answer questions, they were not able to reach all new enrollees through this method. BCI had data that showed that those who enrolled after an in-person enrollment event were significantly less likely to voluntarily dis-enroll than those who enrolled through other means.

Originally, there were two interventions in this PIP. One was that of the BCI representative conducting enrollment events throughout the state of Idaho. Additional to this intervention, in 2016 BCI Care Coordinators were given the "green light" to contact all new enrollees within 10 days of their enrollment, which is often prior to the member's effective date. Therefore, in 2017 care coordinators outreached to members within 10 days of enrollment processing and a second intervention was implemented if the care coordinators were unable to contact the member and this intervention was a standardized verification call at the time of enrollment processing. The impact of these interventions is measured in the PIP analysis, as these forms of contact were available to new enrollees.

BCI contacted all new enrollees within the 10-day window of enrollment, however, BCI did not provide analysis of how quickly those who chose to dis-enroll were contacted. Analysis of this factor may show a trend. For example, did those contacted within 5 days have no requests for disenrollment? However, this analysis was not performed. BCI may wish to add this to the PIP should they continue this PIP going forward.

Although recommended by the EQRO, BCI did not report the reasons for the disenrollment of the few new enrollees who requested to dis-enroll after receiving the interventions. BCI does have this information in their Facets system. This information may be interesting to further the study. Without additions such as this, the PIP should be retired and BCI should begin work on a new project.

Strengths:

- 1) BCI's commitment to improving enrollment rates.

Areas for Improvement:

- 1) BCI provides a study question that focuses on the effect of contacting members within 10 days of enrollment, but does not stratify how quickly enrollees were indeed contacted. This could impact the number who request to disenroll.
- 2) BCI's study question only emphasizes the intervention of contacting enrollees within 10 days of enrollment, as stated it does not measure the effect of those who participated in in-person enrollment events and received the call within 10 days versus those who did not participate in in-person and received a call within 10 days.
- 3) Due to staffing issues, BCI was unable to conduct as many in-person enrollment events during 2017, this had a significant impact on their new enrollment and presumably on their rates.

Overall Evaluation and Recommendations for Improvement

Timeliness

BCI was clearly focused on the timeliness of services delivered to the population in both PIPs. The clinical PIP: Promote Effective Management of Chronic Disease: Promotion of Effective Management of Osteoporosis focused on providing timely services to older women who suffered a fracture. The non-clinical PIP, Reducing the voluntary disenrollment rate in the True Blue Special Needs HMO SNP dual eligible Medicaid Population, focused on providing timely contact to new enrollees to maintain their enrollment.

Access To Care and Quality of Care

The interventions selected by BCI in the non-clinical PIP were client-focused and were targeted to improve access to care. However, the planned interventions could not be fully implemented as in years past due to staffing issues. The additional interventions for the clinical PIP were also client-focused and the MMCP populations responded more to the interventions than in past review years. BCI should prospectively design intervention strategies, ~~so as~~ ~~to~~ define what happens next after each project year is complete. A prospective plan design will afford the greatest potential for improvement in the future.

Recommendations:

- 1) Continue to utilize the CMS Protocol, Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), to understand the need to explore new interventions and to improve BCI's understanding of all project requirements.
- 2) Request technical assistance, as needed, when developing PIPs or implementing new interventions.
- 3) Focus PIPs on member outcomes, PIPs should have the end goal of improving the health of members.
- 4) Consider expanding PIPs beyond the obvious. Look at "what if's".
- 5) Consider digging a bit deeper, analysis of some reasons for members' non-compliance may further a PIP's usefulness.
- 6) Both PIPs have reached their potential and should be retired for two new PIPs. BCI is encouraged to contact the Team for technical assistance in designing and implementing the new PIPs.

BCI is an organization with a commitment to excellence for their members; this is a significant strength. It is the opinion of this Team that these PIPs warrant a rating of Developing.

Information Systems Capabilities Assessment (ISCA)

Objectives

Telligen examined BCI's information systems and data processing and reporting procedures to determine the extent to which those systems and procedures support the production of valid and reliable State performance measures and the capacity to manage care of MCO enrollees.

Methodology

The ISCA procedures are based on the CMS protocol Appendix V⁵, as adapted for BCI. For each ISCA review area, reviewers used the information collected in the ISCA data collection tool, responses to interview questions, and results of the security walkthroughs to rate the MCO's performance for seven review areas. Scores are based on the following: fully meeting, partially meeting or not meeting standards.

The ISCA review process consists of four activities:

Activity 1: Standard information about the MCO's information systems is collected. The MCO completed the ISCA data collection tool before the onsite review.

Activity 2: The completed ISCA data collection tools and accompanying documents are reviewed. Submitted ISCA tools are thoroughly reviewed. Follow-up is conducted as needed.

Activity 3: Onsite visits and walkthroughs with the MCO are conducted. Data center security walkthroughs are conducted. In-depth interviews with knowledgeable MCO staff are conducted. Additional documents are requested if needed, based upon interviews and walkthroughs completed at the MCO.

Activity 4: Analysis of the findings from the MCO's information systems onsite review. In this phase, the material and findings from the first three phases are reviewed. The MCO-specific ISCA evaluation report is then finalized.

The following sections discuss the specific criteria for assessing compliance in each of the five ISCA review areas.

Section A: Information Systems

Section B: Hardware Systems

Section C: Information Security

Section D: Data Acquisition Capabilities

Section E: Provider Data

⁵ Ibid.

Scoring

All evaluation was calculated against the CMS Final Protocol, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR). The rating scale reflecting compliance with standards was as follows:

M = Met

BCI's measurement and reporting was fully compliant with State specifications.

PM= Partially Met

Substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

NM = Not Met

BCI's measurement and reporting process was not compliant with State specifications.

NV = Not Valid

Measure deviated from State 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.

n/a = Not Applicable

Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Table 6. ISCA scoring

ISCA Section	Description	Score
A. Information Systems	This section assesses the MCO's information systems for collecting, storing, analyzing and reporting medical, member, provider and vendor data.	Partially Met
B. Hardware Systems	This section assesses the MCO's hardware systems and network infrastructure.	Met
C. Information Security	This section assesses the security of the MCO's information systems.	Partially Met
D. Data Acquisition Capabilities	This section assesses the MCO's ability to capture and report accurate medical services data and the MCO's ability to capture and report accurate Medicaid enrollment data.	Met
E. Provider Data	This section assesses the MCO's ability to capture and report accurate provider information.	Met

Summary of ISCA Review

Telligen examined BCI's information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable State performance measures and the capacity to manage care of MCO enrollees.

The determination of Medicaid eligibility, initial assessment and enrollment is handled by IDHW.

Information Systems

This section assesses the MCO's information systems for collecting, storing, analyzing and reporting medical data by member, provider and vendor. Information systems that facilitate valid and reliable performance measurement have the following characteristics:

- flexible data structures
- no degradation of processing with increased data volume
- adequate programming staff
- reasonable processing and coding time
- ease of interoperability with other database systems
- data security via user authentication and permission levels
- data locking capability
- proactive response to changes in encounter and enrollment criteria
- adherence to the Federally required format for electronic submission of claims/encounter data.

Strengths, areas for improvement, and recommendations are based on the BCI ISCA submission, 2017 findings validation, onsite interviews, and facility review.

Strengths:

1. All Blue Cross internal users access VDI desktops through secure gateway which limits the ability of data leak or breach. Controls are in place to block transferring of data from secure VDI desktops to the physical laptop or to other devices. Also, transferring data from the physical laptop to the VDI is blocked.
2. Both SQL Server and Sybase databases are encrypted at rest.

Areas for Improvement:

1. Sybase database current version 15.7 SPI22 - May 2014 outdated and vulnerable. This version is used due to a compatibility issue with the Facets software. Blue cross plans to update to the latest version of Sybase or migrate to SQL Server when Facets is updated to a newer version. No specific timeframe was provided by Blue Cross on this upgrade.
2. One legacy SQL Server database which runs Crystal Reports is SQL Server 2005 which is end of life as of April 12, 2016. This system is in the DMZ and Blue Cross plans to decommission this server in the next 6 months.

Recommendations:

- I. Create a plan and timeline for upgrading the Facets application and upgrade to the latest version of Sybase or SQL Server.

Hardware Systems

This section assesses the MCO's hardware systems and network infrastructure. Appropriate protocol for sustaining quality hardware systems include:

- Infrastructural support that includes maintenance and timely replacement of computer equipment and software, disaster recovery procedures, adequate training of support staff and a secure computing environment.
- Redundancy or duplication of critical components of a hardware system with the intention of increasing reliability of the system, usually in the case of a backup or fail-safe.

Strengths, areas for improvement, and recommendations are based on the BCI ISCA submission, 2017 findings validation, onsite interviews, and facility review.

Strengths

- I. Hardware refresh plan exceeds customer requirements in terms of frequency.

Areas for Improvement

- I. Setup redundant SQL server in a SQL cluster to increase availability; and redundancy with database servers.

Recommendations

None Identified.

Information Security

This section assesses the security of the MCO's information systems. Appropriate practices for securing data include:

- Maintaining a well-run security management program that includes IT governance, risk assessment, policy development, policy dissemination and monitoring.
- Protecting computer systems and terminals from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates.
- Securing paper-based claims and encounters in locked storage facilities when not in use. Data transferred between systems/locations should be encrypted.

- Utilizing a comprehensive backup plan that includes scheduling, rotation, verification, retention and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.
- Verifying integrity of backups periodically by performing a “restore” and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite, climate-controlled facility.
- Ensuring databases and database updates include transaction management, commits and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
- Employing formal controls in the form of batch control sheets or assignment of a batch control number to ensure a full accounting of all claims received.

Strengths, areas for improvement, and recommendations are based on the BCI ISCA submission, 2017 findings validation, onsite interviews, and facility review.

Strengths:

1. SQL server and Sybase databases are encrypted at rest.
2. Quarterly Privacy training is required for all employees.
3. Verbose internal and external Information Security and Privacy Assessments program:
 - a. External
 - i. AICPA Service Organization Control (SOC) I formerly SAS 70
 - ii. AICPA Service Organization Control (SOC) 2
 - iii. Annual Penetration Testing – performed by third party vendor
 - b. Internal self-assessments
 - i. HITRUST – Targeting late 2018 or early 2019 to certify with HITRUST
 - ii. HIPAA – Annual assessments
 - iii. Nessus Vulnerability Scans – Run at least weekly. These scans are both internal and external. They also run credentialed and non-credentials scans.
4. 24 x 7 Security Monitoring of Information Systems and Applications.

Areas for Improvement:

1. Visitor control – verify identity of all visitors with a government issued photo identification card.
2. Backup data transferred to backup datacenter should be encrypted in transit.

Recommendations:

1. Identification card photos – develop a formal documented process for an ID badge refresh – employees stated photos were refreshed in the last year.
 - a. Consider adding an expiration on the user profile or identification badge of either 3 or 5 years.

Data Acquisition Capabilities

This section assesses the MCO's ability to capture and report accurate medical services and Medicaid enrollment data. To ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, it is important to have documented standards, a formal quality assurance of input data sources and transactional systems, and readily available historical data. Timely and accurate eligibility data are paramount in providing high-quality care and for monitoring services reported in utilization reports.

Strengths, areas for improvement, and recommendations are based on the BCI ISCA submission, 2016 findings validation, onsite interviews, and facility review.

Strengths:

1. BCI accepts encounter data in electronic format either through Electronic Data Interchange (EDI) or by each agency manually entering encounter data directly into a dedicated dataset through a secure connection.
2. Claims are submitted electronically via 837-transaction formats, or through a web-based direct claims entry system. Claims without required fields completed are rejected, sent back to the provider and are not accepted into the claims processing system.
3. The claims adjudication system has built-in edits to validate required components on a claim record (i.e., procedure and diagnosis codes are loaded with an effective and termination date).
4. HEDIS performance measure data is calculated through NCQA certified software and HEDIS-like queries are run as needed.

Areas for Improvement:

1. The current database server is outdated and potentially vulnerable.
 - a. The Sybase database current version at the time of the on-site review is 15.7 SP122.
2. The legacy database server is at end of life with support.
 - a. SQL Server 2005.
 - b. Plans to decommission this server in the next 6 months.
 - c. This server contains legacy data all other SQL servers are SQL Server 2008 R2 or later.
 - d. The legacy server is in the DMZ.

Recommendations:

None Identified.

Provider Data

This section assesses the MCO's ability to capture and report accurate provider information. MCOs need to ensure accuracy in capturing rendering provider type as well as provider service location. MCOs also need to be able to uniquely identify each provider. MCOs must also present accurate provider information within the MCO provider directory.

Strengths:

1. Medicaid fee schedules are reviewed and compared with the Medicaid fee schedules published on the Idaho Medicaid website, in conjunction with fee schedule change notices published in monthly electronic newsletters. Updating authority is via BCI's Provider Network Management and Pricing Analysts departments.
2. Provider directories are updated nightly against the Facets provider information, with the Provider Information Management staff being those with change authority. BCI maintains provider profiles in its information system.
3. Providers are uniquely identified by provider ID's for each provider.

Areas for Improvement:

None observed.

Performance Measures

As a part of the EQR evaluation, BCI reported the results of two Performance Measures (PMs) for this evaluation period. The PMs were:

Idaho Home Choice Money Follows the Person

and

Call Center Stats MMCP

Technical Methods of Data Collection:

The PMs are administrative indicators utilized by BCI to evaluate performance. The technical methods of data collection and analysis incorporated by BCI are internally defined utilizing available State and Plan data. Utilizing the PM Validation Worksheet (Attachment 3), a subsequent analysis of internal processes utilized to document and interpret data results was completed by the Team. The Team incorporated document review, interview, and observation techniques to fully evaluate the identified components of the PMs.

A list of performance measure specifications was provided to Telligen. Several of these measures were data elements submitted by BCI to IDHW for use in further analysis or calculations by the IDHW (e.g., the Home Choice enrollee data elements); other measures were calculated by the MCO. The measures were derived from several sources, including claims/encounter systems, an enrollment/eligibility system, and BCI's automated call distribution (ACD) system.

All evaluation was calculated against the CMS Final Protocol, Validation of Performance Measures ~~Reported~~ by the MCO: A Mandatory Protocol for External Quality Review (EQR). The rating scale reflecting compliance with standards was as follows:

M = Met

BCI's measurement and reporting was fully compliant with State specifications.

PM = Partially Met

Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

NM = Not Met

BCI's measurement and reporting process was not compliant with State specifications.

NV = Not Valid

Measure deviated from State 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.

n/a = Not Applicable

Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

A summary of compliance for the evaluated PMs is included in Table 7.

Table 7: Performance Measure Compliance Rating Summary Table

Step	Idaho Home Choice Money Follows the Person Demonstration Measures	Call Center Performance Measures
Documentation	Met	Met
Denominator: Data Source	Met	Met
Denominator: Calculation	Met	Met
Numerator: Data Source	Met	Met
Numerator: Calculation	Met	Met
Numerator: Integration	Met	Met
Numerator: Validation	Met	Met
Sampling: Unbiased	n/a	n/a
Sampling: Methodologies	n/a	n/a
Reporting	Met	Met
<u>Overall Compliance Rating*</u>	FC	FC

*The overall rating is one of the following:

FC = Fully Compliant (Measure was fully compliant with State Specifications.)

SC = Substantially Compliant (Measure was substantially compliant with State Specifications.)

NV = Not Valid (Measure deviated from State 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.)

Idaho Home Choice Money Follows the Person

Description of Data:

BCI utilized data from several sources to produce this performance measure. The information used by BCI to produce this performance measure came from several sources including: BCI's Facets system; utilization data from JIVA; data from IDHW's SharePoint; and a medical record review. The study examined many elements of member enrollment in the Idaho Home Choice Money Follows the Person (IHCMFP) Demonstration project.

Those elements included:

1. The total number of enrollees enrolled into IHCMFP.
2. Each enrollee's current place of residence, including physical address and type of qualified residence.
3. The date of the last care-coordination visit to each enrollee.
4. Any inpatient facility stays during the quarter.
5. The total number of enrollees disenrolled from IHCMFP during the quarter.
6. Medicaid Statistical Information System Data (MSIS) that includes expenditures for all 1915c waivers, home health services, personal care if provided as a State Plan optional service, and HCBS spending on IHCMFP participants and spending under HCBS capitated rates programs; including expenditures for Transition Management T2022 and Transition Services T2038.
7. Total number of enrollees for Self-Directed and Consumer Services.
8. Number of enrollees transitioned from a nursing facility or ICFIID.
9. Of enrollees who transitioned from a nursing facility: the number and percentage of enrollees who transitioned to (a) community-based residential alternative facility, (b) a residential setting where the enrollee will be living independently, and (c) a residential setting where the enrollee will be living with a relative or other caregiver.
10. Of enrollees who transitioned from a nursing facility: (a) the number and percentage of enrollees who are still in the community, (b) returned to a nursing facility within 90 calendar days after transition, (c) returned to a nursing facility more than 90-calendar days after transition, and (d) the number of enrollees identified as potential candidates for transition from a nursing facility.
11. Of enrollees identified as potential candidates for transition: the number and percent of enrollees who were identified by referral, via the Minimum Data Set, via care coordination and by another source. The report includes the total number of enrollees transitioning from a Nursing Facility to the community.

The data was gathered using administrative data collection and manual processes. A report was generated quarterly and supplied to IDHW for review.

Conclusions:

This performance measure was missing many of the traditional elements of a performance measure. Although IDHW has stated that BCI should have in place mechanisms to identify potential enrollees who may benefit from participation in the Idaho Home Choice (IHC) program, they have set the goal at 100% “of those who may benefit”. This is not a well-defined goal and is not prescriptive enough to ensure that all who may benefit are enrolled. There is no interpretation of results expected by BCI. BCI is not requested to analyze or compare prior year enrollments or trend enrollment numbers. This performance measure was designed to allow IDHW to track the number of enrollees in the IHCMHP demonstration, but no expectations for participation or evaluation were set.

Based on Telligen’s ISCA review and the documentation supplied by BCI, it is determined that the process to collect, integrate, and report this measure met the standards set by IDHW.

Evaluation of the Study and Recommendations for Improvement:

BCI put forth extensive effort in complying with the many elements of this PM. Although the Team believes that this measure does not fully meet the definition of a performance measure, it is evident that BCI has complied with all the requirements placed on it by the State. Although a lack of direction or goals for achievement exists in this PM, this measure was given a rating of “Fully Compliant” as it is compliant with all state contractual requirements.

The following discussion will clarify target areas for improvement.

Strengths:

1. Each quarterly report incorporated historical information, thus reducing the potential for errors.

Areas for Improvement:

1. Much of the data required for the report is manually obtained, however, the numbers were low per quarter (n=10), thereby mitigating some issues with data vulnerability.

Recommendations:

1. Reference the CMS Protocol, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR) to produce higher quality studies.
2. Request technical assistance from CMS and/or the EQRO to enhance understanding of PM requirements and steps.
3. Target should be set by IDHW for this performance measure, this would allow for analysis of the progress of this program.
4. IDHW and BCI should examine opportunities where there may be duplication in reporting and take actions to minimize or eliminate these areas of duplication.

Call Center Stats MMCP

Description of Data:

BCI utilized data regarding inbound calls offered for MMCP providers and members. The study provided a measure of timeliness of answered calls and number of calls abandoned. The study denominator included all calls received for MMCP providers and members. The time-period studied was 2015, 2016 and 2017.

Three measures were evaluated:

1. Percentage of calls answered within 30 seconds;
2. Average wait time for assistance; and
3. Call abandonment rate.

These three measures were reported for this performance measure.

Conclusions:

BCI's goals were:

1. 80% or more of the MMCP inbound calls be answered within 30 seconds.
2. Average wait time for assistance < 30 seconds.
3. Call abandonment rate < 5%.

Table 8. Service Competency Scores 2015

Service Competency Scores	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015	4th Quarter 2015
Total Calls on Designated MMCP Lines Member & Waiver	3583	2594	2548	2901
Percent of calls answered in 30 seconds or less	75%	87%	87%	83%
Abandoned Call Rate	4%	3%	2%	3.3%
Average speed of answer	Not measured	18	17	19

Table 9. Service Competency Scores 2016

Service Competency Scores	1st Quarter 2016	2nd Quarter 2016	3rd Quarter 2016	4th Quarter 2016
Total Calls on Designated MMCP Lines Member & Waiver	3752	3256	2940	3079
Percent of calls answered in 30 seconds or less	82%	87%	90%	87%
Abandoned Call Rate	4%	4.7%	4%	2%
Average speed of answer	22	19	16	16

Table 10. Service Competency Scores 2017

Service Competency Scores	1st Quarter 2017	2nd Quarter 2017	3rd Quarter 2017	4th Quarter 2017
Total Calls on Designated MMCP Lines Member & Waiver	2736	2736	1910	2262
Percent of calls answered in 30 seconds or less	86%	86%	84%	80%
Abandoned Call Rate	3%	4%	4%	5%
Average speed of answer	18	15	26	30

Evaluation of the Study and Recommendations for Improvement:

BCI has made tremendous progress on these measures and has met the goals in all but one quarter since 2015. BCI does note that the 1st quarter of each year is lower than the other years for the percentage of calls answered in 30 seconds or less. This is attributable to the fact that the 1st quarter of each year has the greatest number of calls due to new enrollment. Even with some staffing difficulties due to storms, BCI met all their targets for CY2017.

This Performance Measure was a measure of the quickness of call response by BCI to all calls made in to the member and provider call center. This measure did not measure the effectiveness of those calls on the members, nor did it measure if more than one call was required to resolve an issue.

Based on documentation supplied by BCI and on the Team's ISCA review, the process used to collect, integrate and report this measure meets all standards. During the on-site review, the Team and BCI discussed the possibility of new Performance Measures to be reviewed in the coming year. This performance measure has become part of BCI's day to day operation and has produced successful results, it would be beneficial to identify and target new issues to be improved.

The following discussion of evaluation and recommendations will clarify target areas for improvement.

Strengths:

1. BCI clearly defined the measurement period adding consistency in data measurement.
2. BCI identified performance measures that impact their day to day operations.
3. BCI has set its goal to achieve the State of Idaho's requirements.

Areas for Improvement:

1. When comparing data from year to year, be sure that the data being compared is the same.
2. The narrative supplied to the Team for review did not contain a description of the data source or calculation of the Denominator.

Recommendations:

1. Reference the CMS Protocol, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR) to produce higher quality studies.
2. Continue to request technical assistance from CMS and/or the EQRO to enhance understanding of PM requirements and steps.
3. Work with IDHW to propose new Performance Measures for the coming year.
4. Provide a narrative explanation of the Performance Measure that can be read prior to the on-site review.

Overall Evaluation and Recommendations for Improvement

BCI demonstrated a commitment to improvement by participating in and requesting Technical Assistance. There was evidence of understanding of the PMs as data measurement studies or projects.

Timeliness

BCI's choice to focus on the Call Center was an effort to impact the timing of care received by its enrollees. This was to be accomplished by ensuring members received quick answers to all calls.

Access to Care

BCI placed a great deal of emphasis on their enrollees' access to care. Both the Idaho Home Choice Money Follows the Person and Call Center PMs were clearly focused on enrollee access to appropriate care. BCI should begin to shape outreach projects and additional enrollee interventions that will further improve the rates for these two PMs and may lead to the development of PIPs.

Quality of Care

BCI was fully committed to their members' quality of care. Each of these PMs contained a quality of care element. BCI recognized that the care members receive should occur in the most appropriate setting. BCI was committed to ensuring quality care was received by their members and they have used the data available to them to make informed policy and practice decisions that will further impact members' quality of care in the future.

It is the opinion of the Team that, the studies presented for review during this measurement year be considered: Fully Compliant.

ATTACHMENTS

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Attachment 1

BBA Compliance Audit Tool 2017 Compliance Review

Idaho EQR Plan Tool – BCI Health Plan (January 2018 onsite for timeframe CY 2017)

- * – State and Plan responsibility Numbering sequenced on master tool; individual State and Plan tools will not be sequential.
 (MCO, PHIP, PAHP, PCCM) has been changed to Plan ****Individual Component Scoring:** (scoring present on each line of the administrative tool)
- P = Proficient** - Documentation supports that component was implemented, reviewed, revised, and/or further developed.
D = Developing - Documentation supports some but not full compliance was present.
N = No Documentation - No documentation was found to substantiate component compliance.
n/a = Not Applicable - Component is not applicable to the focus of the evaluation.

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights.

Tool	CFR		Score*
A-1	438.100	§438.100(a) General rule. The State must ensure that- (1) each Plan has written policies regarding the enrollee rights specified in this section; and (2) each Plan complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees. (b) Specific rights – (1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in this section. (2) An enrollee of a Plan has the following rights: The right to— (i) receive information in accordance with §438.10: §438.10 Information requirements. (b) Basic rules. (1) Each Plan must	
*A-2	438.10(b)(1)	Provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. (<i>“easily understood” not specifically defined by State</i>)	P
A-4	438.10(b)(3)	Each Plan must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of BCI.	P
A-6	438.10(c)(2)	Make available written information in each prevalent non-English language. (<i>prevalent not defined by State</i>)	P
*A-8	438.10(c)(4)	Make oral interpretation services available and require each Plan to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent. (<i>prevalent not defined by State</i>)	P
*A-9	438.10(c)(5)(i-ii)	Notify enrollees and potential enrollees, and require each Plan to notify its enrollees—(i) That oral interpretation is available for any language and written information is available in prevalent languages; and (ii) How to access those services. (<i>prevalent not defined by State</i>)	P
A-10	438.10(d)(1)(i)	Format. (1) Written material must – (i) Use easily understood language and format (<i>“easily understood” not specifically defined by State</i>)	P
A-11	438.10(d)(1)(ii)	Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	P
*A-12	438.10(d)(2)	All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.	P
		438.10(e) <i>Information for potential enrollees.</i> (1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:	
		438.10(f) <i>General information for all enrollees of Plans.</i> Information must be furnished to Plan enrollees as follows:	
*A-26	438.10(f)(3)	The State, its contracted representative, or BCI must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after BCI receives, from the State or its contracted representative, notice of the recipient’s enrollment.	P
*A-27	438.10(f)(4)	The State, its contracted representative, or BCI must give each enrollee written notice of any change (that the State defines as “significant”) in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change. (<i>“significant” not defined by State</i>)	P
A-28	438.10(f)(5)	BCI must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		438.10(f)(6) The State, its contracted representative, or BCI must provide the following information to all enrollees:	
A-29	438.10(f)(6)(i)	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For Plans this includes, at a minimum, information on primary care physicians, specialists, and hospitals. <i>(related to 438.10(e)(2)(ii)(D) for State above)</i>	P
A-30	438.10(f)(6)(ii)	Any restrictions on the enrollee's freedom of choice among network providers.	P
A-31	438.10(f)(6)(iii)	Enrollee rights and protections, as specified in § 438.100. (following pages)	P
A-32	438.10(f)(6)(iv)	Information on grievance and fair hearing procedures, and for Plan enrollees, the information specified in § 438.10(g)(1), <i>and for PAHP enrollees, the information specified in § 438.10(h)(1).</i>	P
A-33	438.10(f)(6)(v)	The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	P
A-34	438.10(f)(6)(vi)	Procedures for obtaining benefits, including authorization requirements.	P
A-35	438.10(f)(6)(vii)	The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.	P
A-36	438.10(f)(6)(viii)	The extent to which, and how, after-hours and emergency coverage are provided, including: (A) What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in § 438.114(a). <i>(attached for reference)</i>	P
A-37	438.10(f)(6)(viii) (B)	The fact that prior authorization is not required for emergency services.	P
A-38	438.10(f)(6)(viii) (C)	The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	P
A-39	438.10(f)(6)(viii) (D)	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.	P
A-40	438.10(f)(6)(viii) (E)	The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.	P
A-41	438.10(f)(6)(ix)	The post-stabilization care services rules set forth at § 422.113(c) of this chapter.	P
A-42	438.10(f)(6)(x)	Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	P
A-43	438.10(f)(6)(xi)	Cost sharing, if any.	P
A-44	438.10(f)(6)(xii)	How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that BCI does not cover because of moral or religious objections, BCI need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		438.10(g) <i>Specific information requirements for enrollees of Plans.</i> In addition to the requirements in § 438.10(f), the State, its contracted representative, or BCI must provide the following information to their enrollees: 438.10(g)(1)(i)(A) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§ 438.400 through 438.424, in a State-developed or State-approved description, that must include the following:	
A-45	438.10(g)(1)(i)(A)	For State fair hearing— (A) The right to hearing;	P
A-46	438.10(g)(1)(i)(B)	The method for obtaining a hearing;	P
A-47	438.10(g)(1)(i)(C)	The rules that govern representation at the hearing.	P
A-48	438.10(g)(1)(ii)	The right to file grievances and appeals.	P
A-49	438.10(g)(1)(iii)	The requirements and timeframes for filing a grievance or appeal.	D
A-50	438.10(g)(1)(iv)	The availability of assistance in the filing process.	D
A-51	438.10(g)(1)(v)	The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.	P
		438.10(g)(1)(vi) The fact that, when requested by the enrollee—	
A-52	438.10(g)(1)(vi)(A)	Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and	P
A-53	438.10(g)(1)(vi)(B)	The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.	P
A-54	438.10(g)(1)(vii)	Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.	P
A-55	438.10(g)(2)	Advance directives, as set forth in § 438.6(i)(2). (<i>adults only</i>)	P
		438.10(g)(3) Additional information that is available upon request, including the following:	
A-56	438.10(g)(3)(i)	Information on the structure and operation of BCI.	P
A-57	438.10(g)(3)(ii)	Physician incentive plans as set forth in § 438.6(h) of this chapter.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)			
Tool	CFR		Score*
		438.10(h) <i>Specific information for PAHPs.</i> The State, its contracted representative, or the PAHP must provide the following information to their enrollees: 438.10(h)(1) The right to a State fair hearing, including the following:	
A-58	438.10(h)(1)(i)	The right to a hearing.	n/a
A-59	438.10(h)(1)(ii)	The method for obtaining a hearing.	n/a
A-60	438.10(h)(1)(iii)	The rules that govern representation.	n/a
A-61	438.10(h)(2)	Advance directives, as set forth in § 438.6(i)(2), to the extent that the PAHP includes any of the providers listed in § 489.102(a) of this chapter. <i>438.6(i)(2): All PAHP contracts must provide for compliance with the requirements of § 422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in § 489.102(a) of this chapter.</i>	n/a
A-62	438.10(h)(3)	Upon request, physician incentive plans as set forth in § 438.6(h).	n/a
		438.10(i) <i>Special rules: States with mandatory enrollment under State plan authority—(1) Basic rule.</i> If the State plan provides for mandatory enrollment under § 438.50, the State or its contracted representative must provide information on Plans (as specified in paragraph (i)(3) of this section), either directly or through BCI. (2) <i>When and how the information must be furnished.</i> The information must be furnished as follows:	
*A-64	438.10(i)(2)(ii)	For enrollees, annually and upon request.	n/a
		438.10(i)(3) <i>Required information.</i> Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting Plan in the potential enrollees and enrollee’s service area:	
*A-66	438.10(i)(3)(iv)	To the extent available, quality and performance indicators, including enrollee satisfaction.	n/a
A-67	438.100(b)(2)(ii)	Be treated with respect and with due consideration for his or her dignity and privacy.	P
A-68	438.100(b)(2)(iii)	Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand. [The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in § 438.10(f)(6)(xii).] Include requirements of §438.102 (next page)	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		<p>438.102 Provider-enrollee communications.</p> <p>(a) <i>General rules.</i></p> <p>(1) A Plan may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:</p> <p>(i) The enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.</p> <p>(ii) Any information the enrollee needs in order to decide among all relevant treatment options.</p> <p>(iii) The risks, benefits, and consequences of treatment or non-treatment.</p> <p>(iv) The enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.</p> <p>(2) Subject to the information requirements of paragraph (b) of this section, a Plan that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section is not required to do so if BCI objects to the service on moral or religious grounds.</p> <p>(b) <i>Information requirements: Plan responsibility.</i></p> <p>(1) A Plan that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows:</p> <p>(i) To the State—</p> <p>(A) With its application for a Medicaid contract; and</p> <p>(B) Whenever it adopts the policy during the term of the contract.</p> <p>(ii) Consistent with the provisions of § 438.10—</p> <p>(A) To potential enrollees, before and during enrollment; and</p> <p>(B) To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle BCI to the option provided in paragraph (a)(2) of this section, the overriding rule in § 438.10(f)(4) requires the State, its contracted representative, or Plan to furnish the information at least 30 days before the effective date of the policy.)</p> <p>(2) As specified in § 438.10, paragraphs (e) and (f), the information that Plans must furnish to enrollees and potential enrollees does not include how and where to obtain the service excluded under paragraph (a)(2) of this section.</p> <p>(c) <i>Information requirements: State responsibility.</i> For each service excluded by a Plan under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in § 438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).</p> <p>(d) <i>Sanction.</i> A Plan that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.</p>	
A-69	438.100(b)(2)(iv)	Participate in decisions regarding his or her health care, including the right to refuse treatment.	P
A-70	438.100(b)(2)(v)	Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.	P
A-71	438.100(b)(2)(vi)	If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.	P
A-72	438.100(b)(3)	An enrollee of a Plan (consistent with the scope of the PAHP’s contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.	P
Findings:			

B. Subpart C Regulations: Access Standards - §438.206 Availability of services.			Score*
Tool	CFR		
	§438.206(a) <i>Basic rule.</i> Each State must ensure that all services covered under the State plan are available and accessible to enrollees of Plans. (b) <i>Delivery network.</i> The State must ensure, through its contracts, that each Plan consistent with the scope of BCI's contracted services, meets the following requirements:		
*B-1	438.206(1)	Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each Plan must consider the following:	P
B-2	438.206(1)(i)	The anticipated Medicaid enrollment.	P
B-3	438.206(1)(ii)	The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular Plan.	P
B-4	438.206(1)(iii)	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.	P
B-5	438.206(1)(iv)	The numbers of network providers who are not accepting new Medicaid patients.	P
B-6	438.206(1)(v)	The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.	P
B-7	438.206(2)	Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	P
B-8	438.206(3)	Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	P
B-9	438.206(4)	If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, BCI must adequately and timely cover these services out of network for the enrollee, for as long as BCI is unable to provide them.	P
B-10	438.206(5)	Requires out-of-network providers to coordinate with BCI with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.	P
B-11	438.206(6)	Demonstrates that its providers are credentialed as required by § 438.214.	P
	438.206(c)(1) <i>Timely access.</i> Each Plan must do the following:		
B-13	438.206(c)(1)(i)	Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.	P
B-14	438.206(c)(1)(ii)	Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.	P
B-15	438.206(c)(1)(iii)	Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	P
B-16	438.206(c)(1)(iv)	Establish mechanisms to ensure compliance by providers.	P
B-17	438.206(c)(1)(v)	Monitor providers regularly to determine compliance.	P
B-18	438.206(c)(1)(vi)	Take corrective action if there is a failure to comply.	P
B-19	438.206(c)(2)	<i>Cultural considerations.</i> Each Plan participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	P
Findings:			

C. Subpart C Regulations: Access Standards- §438.208 Coordination and continuity of care.			Score*
Tool	CFR		
	§438.208(a)	<i>Basic requirement</i> —(1) <i>General rule.</i> Except as specified in paragraphs (a)(2) and (a)(3) of this section, the State must ensure through its contracts, that each Plan complies with the requirements of this section. 438.208(a)(2) <i>PIHP and PAHP exception.</i> For PIHPs and PAHPs, the State determines, based on the scope of the entity’s services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to— <i>PIHP and PAHP exception.</i> For PIHPs and PAHPs, the State determines, based on the scope of the entity’s services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to—	
C-1	438.208(a)(2)(i)	Meet the primary care requirement of paragraph (b)(1) of this section; and	P
C-2	438.208(a)(2)(ii)	Implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.	P
C-3	438.208(a)(3)(i)	<i>Exception for Plans that serve dually eligible enrollees.</i> (i) For each Plan that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the State determines to what extent BCI must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals	P
C-4	438.208(a)(3)(ii)	The State bases its determination on the services it requires BCI to furnish to dually eligible enrollees.	P
		438.208(b) <i>Primary care and coordination of health care services for all Plan enrollees.</i> Each Plan must implement procedures to deliver primary care to and coordinate health care service for all Plan enrollees. These procedures must meet State requirements and must do the following:	
C-5	438.208(b)(1)	Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.	P
C-6	438.208(b)(2)	Coordinate the services BCI furnishes to the enrollee with the services the enrollee receives from any other Plan.	P
C-7	438.208(b)(3)	Share with other Plans serving the enrollee with special health care needs the results of its identification and assessment of that enrollee’s needs to prevent duplication of those activities.	P
C-8	438.208(b)(4)	Ensure that in the process of coordinating care, each enrollee’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	P
		438.208(c)(1) <i>Additional services for enrollees with special health care needs</i> —(1) <i>Identification.</i> The State must implement mechanisms to identify persons with special health care needs to Plans, as those persons are defined by the State. These identification mechanisms—	
C-11	438.208(c)(3)(i)	<i>Treatment plans.</i> If the State requires Plans to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be— (i) Developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; <i>(not required by State)</i>	P
C-12	438.208(c)(3)(ii)	Approved by BCI in a timely manner, if this approval is required by BCI; and	P
C-13	438.208(c)(3)(iii)	In accord with any applicable State quality assurance and utilization review standards.	P
C-14	438.208(c)(4)	<i>Direct access to specialists.</i> For enrollees with special health care needs determined through an assessment by appropriate health care professionals [consistent with §438.208(c)(2)] to need a course of treatment or regular care monitoring, each Plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee’s condition and identified needs.	P
Findings:			

D. Subpart C Regulations: Access Standards- §438.210 Coverage and authorization of services.			Score*
Tool	CFR		
D-1	438.210(b)	<i>Authorization of services.</i> For the processing of requests for initial and continuing authorizations of services, each contract must require— (including 438.114 emergency and post-stabilization services) (1) That BCI and its subcontractors have in place, and follow, written policies and procedures. 438.210(b)(2) That BCI—	
D-2	438.210(b)(2)(i)	Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and	P
D-3	438.210(b)(2)(ii)	Consult with the requesting provider when appropriate.	P
D-4	438.210(b)(3)	That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.	P
*D-5	438.210(c)	<i>Notice of adverse action.</i> Each contract must provide for BCI to notify the requesting provider, and give the enrollee written notice of any decision by BCI to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For Plans, the notice must meet the requirements of § 438.404, except that the notice to the provider need not be in writing. 438.210(d) <i>Timeframe for decisions.</i> Each Plan contract must provide for the following decisions and notices:	P
*D-6	438.210(d)(1)	<i>Standard authorization decisions.</i> For standard authorization decisions, provide notice as expeditiously as the enrollee’s health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—	P
D-7	438.210(d)(1)(i)	The enrollee, or the provider, requests extension; or	P
D-8	438.210(d)(1)(ii)	BCI justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee’s interest.	P
D-9	438.210(d)(2)(i)	(2) <i>Expedited authorization decisions.</i> (i) For cases in which a provider indicates, or BCI determines, that following the standard timeframe could seriously jeopardize the enrollee’s life or health or ability to attain, maintain, or regain maximum function, BCI must make an expedited authorization decision and provide notice as expeditiously as the enrollee’s health condition requires and no later than 3 working days after receipt of the request for service.	P
D-10	438.210(d)(2)(ii)	(ii) BCI may extend the 3 working day time period by up to 14 calendar days if the enrollee requests an extension, or if BCI justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee’s interest.	P
Findings: D-6: NCQA requirement is 15 days – EQRO must ensure 14-day timeframe is followed.			

E. Subpart C Regulations: Structure and Operation Standards- §438.214 Provider selection.			Score*
Tool	CFR		
E-2	438.214(b)(2)	Each Plan must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with BCI.	P
E-3	438.214(c)	<i>Nondiscrimination.</i> Plan provider selection policies and procedures, consistent with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P
E-4	438.214(d)	<i>Excluded providers.</i> Plans may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	P
E-5	438.214(e)	<i>State requirements.</i> Each Plan must comply with any additional requirements established by the State. (n/a)	n/a
Findings:			

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems.			Score*
Tool	CFR		
	<p>Subpart F: Grievance System. § 438.400(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.</p> <p>(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.</p> <p>(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of BCI.</p> <p>(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.</p> <p>(b) <i>Definitions.</i> As used in this subpart, the following terms have the indicated meanings:</p> <p><i>Action</i> means— In the case of a Plan—</p> <p>(1) The denial or limited authorization of a requested service, including the type or level of service;</p> <p>(2) The reduction, suspension, or termination of a previously authorized service;</p> <p>(3) The denial, in whole or in part, of payment for a service;</p> <p>(4) The failure to provide services in a timely manner, as defined by the State;</p> <p>(5) The failure of a Plan to act within the timeframes provided in § 438.408(b); or</p> <p>(6) For a resident of a rural area with only one Plan, the denial of a Medicaid enrollee’s request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.</p> <p><i>Appeal</i> means a request for review of an action, as “action” is defined in this section.</p> <p><i>Grievance</i> means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at BCI level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.)</p>		
G-2	438.402	§ 438.402 General requirements. (a) <i>The grievance system.</i> Each Plan must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State’s fair hearing system.	P
G-3	438.402(b)(1)(i)	<i>Filing requirements—</i> (1) <i>Authority to file.</i> (i) An enrollee may file a grievance and a Plan level appeal, and may request a State fair hearing.	P
G-4	438.402(b)(1)(ii)	A provider, acting on behalf of the enrollee and with the enrollee’s written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee’s authorized representative in doing so.	P
*G-5	438.402(b)(2)(i)	<i>Timing.</i> The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on BCI’s notice of action. Within that timeframe— The enrollee or the provider may file an appeal; and	P
G-6	438.402(b)(2)(ii)	In a State that does not require exhaustion of Plan level appeals, the enrollee may request a State fair hearing.	P
*G-7	438.402(b)(3)(i)	<i>Procedures.</i> (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with BCI.	P
G-8	438.402(b)(3)(ii)	The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.	P
G-9	438.404(a)	§ 438.404 Notice of action. (a) <i>Language and format requirements.</i> The notice must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding.	D
G-10	438.404(b)(1)	<i>Content of notice.</i> The notice must explain the following: (1) The action BCI or its contractor has taken or intends to take.	D
G-11	438.404(b)(2)	The reasons for the action.	D
G-12	438.404(b)(3)	The enrollee’s or the provider’s right to file a Plan appeal.	D
*G-13	438.404(b)(4)	If the State does not require the enrollee to exhaust BCI level appeal procedures, the enrollee’s right to request a State fair hearing. <i>(required)</i>	D
G-14	438.404(b)(5)	The procedures for exercising the rights specified in this paragraph.	D
G-15	438.404(b)(6)	The circumstances under which expedited resolution is available and how to request it.	D

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			Score*
Tool	CFR		
G-16	438.404(b)(7)	The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.	D
G-17	438.404(c)(1)	<i>Timing of notice.</i> BCI must mail the notice within the following timeframes: (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter. (10 days before action)	D
G-18	438.404(c)(2)	For denial of payment, at the time of any action affecting the claim.	D
G-19	438.404(c)(3)	For standard service authorization decisions that deny or limit services, within the timeframe specified in § 438.210(d)(1). (within 14 days)	D
G-20	438.404(c)(4)(i)	If BCI extends the timeframe in accordance with § 438.210(d)(1), it must— (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and	D
G-21	438.404(c)(4)(ii)	Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	D
G-22	438.404(c)(5)	For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.	D
G-23	438.404(c)(6)	For expedited service authorization decisions, within the timeframes specified in § 438.210(d). (3 days)	D
		§ 438.406 Handling of grievances and appeals. (a) <i>General requirements.</i> In handling grievances and appeals, Plans must meet the following requirements:	
G-24	438.406(a)(1)	Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	P
G-25	438.406(a)(2)	Acknowledge receipt of each grievance and appeal.	D
G-26	438.406(a)(3)(i)	Ensure that the individuals who make decisions on grievances and appeals are individuals—(i) Who were not involved in any previous level of review or decision-making; and	P
G-27	438.406(a)(3)(ii)	(Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves clinical issues.	P
G-28	438.406(b)(1)	<i>Special requirements for appeals.</i> The process for appeals must: (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.	P
G-29	438.406(b)(2)	Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (BCI must inform the enrollee of the limited time available for this in the case of expedited resolution.)	P
G-30	438.406(b)(3)	Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.	P
G-31	438.406(b)(4)(i)	Include, as parties to the appeal— The enrollee and his or her representative; (ii) or the legal representative of a deceased enrollee's estate.	P

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			Score*
Tool	CFR		
		§ 438.408 Resolution and notification: Grievances and appeals. (a) <i>Basic rule.</i> BCI must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.	
G-32	438.408(b)(1)	<i>Specific timeframes—(1) Standard disposition of grievances.</i> For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day BCI receives the grievance.	N
G-33	438.408(b)(2)	<i>Standard resolution of appeals.</i> For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day BCI receives the appeal. This timeframe may be extended under paragraph (c) of this section.	P
G-34	438.408(b)(3)	<i>Expedited resolution of appeals.</i> For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after BCI receives the appeal. This timeframe may be extended under paragraph (c) of this section.	P
G-35	438.408(c)(1)(i)	<i>Extension of timeframes—(1)</i> BCI may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—(i) The enrollee requests the extension; Or	P
G-36	438.408(c)(1)(ii)	BCI shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.	P
G-37	438.408(c)(2)	<i>Requirements following extension.</i> If BCI extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.	P
G-39	438.408(d)(2)(i)	<i>Appeals.</i> (i) For all appeals, BCI must provide written notice of disposition.	P
G-40	438.408(d)(2)(ii)	For notice of an expedited resolution, BCI must also make reasonable efforts to provide oral notice.	P
G-41	438.408(e)(1)	<i>Content of notice of appeal resolution.</i> The written notice of the resolution must include the following: (1) The results of the resolution process and the date it was completed.	P
G-42	438.408(e)(2)(i)	For appeals not resolved wholly in favor of the enrollees—(i) The right to request a State fair hearing, and how to do so;	P
G-43	438.408(e)(2)(ii)	The right to request to receive benefits while the hearing is pending, and how to make the request; and	P
G-44	438.408(e)(2)(iii)	That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds BCI's action.	P
G-46	438.408(f)(1)(ii)	If the State <u>does not require exhaustion</u> of BCI level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on BCI's notice of action. (<i>required</i>)	P
G-48	438.410	§ 438.410 Expedited resolution of appeals. (a) <i>General rule.</i> Each Plan must establish and maintain an expedited review process for appeals, when BCI determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.	P
G-49	438.410(b)	<i>Punitive action.</i> BCI must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	P
G-50	438.410(c)(1)	<i>Action following denial of a request for expedited resolution.</i> If BCI denies a request for expedited resolution of an appeal, it must—(1) Transfer the appeal to the timeframe for standard resolution in accordance with § 438.408(b)(2);	P
G-51	438.410(c)(2)	Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.	P

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			Score*
Tool	CFR		
G-52	438.414	§ 438.414 Information about the grievance system to providers and subcontractors. BCI must provide the information specified at § 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.	P
G-53	438.416	§ 438.416 Recordkeeping and reporting requirements. The State must require Plans to maintain records of grievances and appeals and must review the information as part of the State quality strategy.	P
G-54	438.420	§ 438.420 Continuation of benefits while BCI appeal and the State fair hearing are pending. (a) <i>Terminology.</i> As used in this section, “timely” filing means filing on or before the later of the following: (1) Within ten days of BCI mailing the notice of action. (2) The intended effective date of BCI’s proposed action.	P
G-55	438.420(b)	<i>Continuation of benefits.</i> BCI must continue the enrollee’s benefits if— (1) The enrollee or the provider files the appeal timely; (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) The services were ordered by an authorized provider; (4) The original period covered by the original authorization has not expired; and (5) The enrollee requests extension of benefits.	P
G-56	438.420(c)	<i>Duration of continued or reinstated benefits.</i> If, at the enrollee’s request, BCI continues or reinstates the enrollee’s benefits while the appeal is pending, the benefits must be continued until one of following occurs: (1) The enrollee withdraws the appeal. (2) Ten days pass after BCI mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10- day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. (3) A State fair hearing Office issues a hearing decision adverse to the enrollee. (4) The time period or service limits of a previously authorized service has been met.	P
G-57	438.420(d)	<i>Enrollee responsibility for services furnished while the appeal is pending.</i> If the final resolution of the appeal is adverse to the enrollee, that is, upholds BCI’s action, BCI may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b) of this chapter.	P
G-58	438.424	§ 438.424 Effectuation of reversed appeal resolutions. (a) <i>Services not furnished while the appeal is pending.</i> If BCI or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, BCI must authorize or provide the disputed services promptly, and as expeditiously as the enrollee’s health condition requires.	P
G-59	438.424(b)	<i>Services furnished while the appeal is pending.</i> If BCI, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, BCI or the State must pay for those services, in accordance with State policy and regulations.	P

Findings:

EQRO reviewed 10 Appeals and 5 Grievance files; two files did not contain Notice of Action letters, therefore G9-G23 all received a developing rating.
 G-11 The reason for the action was missing from NOA letters that were present in files.
 G-25 Receipt of grievance or appeal was not acknowledged in two files reviewed.
 G-30 Information regarding the enrollee’s right to examine the file was not present in all files reviewed.
 G-32 Two files did not meet the timely requirements.

H. Subpart C: Structure and Operation Standards - §438.230 Sub contractual relationships and delegation.			
Tool	CFR		Score
H-2	438.230(b)(1)	<i>Specific conditions.</i> (1) Before any delegation, each Plan evaluates the prospective subcontractor's ability to perform the activities to be delegated.	P
H-3	438.230(b)(2)(i)	There is a written agreement that—(i) Specifies the activities and report responsibilities delegated to the subcontractor; and	P
H-4	438.230(b)(2)(i)	Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	P
H-5	438.230(b)(3)	BCI monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.	P
H-6	438.230(b)(4)	If any Plan identifies deficiencies or areas for improvement, BCI and the subcontractor take corrective action.	P
Findings:			

I. Subpart C: Measurement and Improvement Standards - §438.236 Practice guidelines			
Tool	CFR		Score
		438.236(a) <i>Basic rule: The state must ensure through its contracts that each Plan meets the requirements of this section. Each Plan adopts practice guidelines that meet the following requirements:</i>	
I-1	438.236(b)(1)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	P
I-2	438.236(b)(2)	Consider the needs of BCI's enrollees.	P
I-3	438.236(b)(3)	Are adopted in consultation with contracting health care professionals.	P
I-4	438.236(b)(4)	Are reviewed and updated periodically, as appropriate.	P
I-5	438.236(c)	BCI disseminates the guidelines to all affected providers, and upon request, to enrollees and potential enrollees.	P
I-8	438.236(d)	Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	P
<p>Findings: I-4: NCQA prescribes updating the guidelines at least every two years. I-8: EQRO must determine whether enrollee education is consistent with the guidelines.</p>			

J. Subpart C: Measurement and Improvement Standards - §438.240 Quality assessment and performance improvement program.			Score
Tool	CFR		
		438.240(b) <i>Basic elements of Plan quality assessment and performance improvement programs.</i> At a minimum, the State must require that each Plan comply with the following requirements:	
J-3	438.240(b)(1)	Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.	D
J-4	438.240(b)(2)	Submit performance measurement data as described in paragraph (c) of this section.	P
J-5	438.240(b)(3)	Have in effect mechanisms to detect both underutilization and overutilization of services.	P
J-6	438.240(b)(4)	Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	P
*J-7	438.240(c)(1)	<i>Performance measurement.</i> Annually each Plan must—(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of § 438.204(c) and § 438.240(a)(2); (2) Submit to the State, data specified by the State, that enables the State to measure BCI's performance; or (3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.	P
J-8	438.240(d)(1)(i)	<i>Performance improvement projects.</i> (1) Plans must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: (i) Measurement of performance using objective quality indicators.	P
J-9	438.240(d)(1)(ii)	Implementation of system interventions to achieve improvement in quality.	P
J-10	438.240(d)(1)(iii)	Evaluation of the effectiveness of the interventions.	D
J-11	438.240(d)(1)(iv)	Planning and initiation of activities for increasing or sustaining improvement.	P
J-12	438.240(d)(2)	Each Plan must report the status and results of each project to the State as requested, including those that incorporate the requirements of § 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.	P
J-15	438.240(e)(2)	The State may require that a Plan have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. (n/a with EQR)	n/a
<p>Findings: J-3 Both PIPs submitted by BCI require modifications in data collection and analysis. J-10 BCI's non-clinical PIP did not adequately define the interventions.</p>			

K. Subpart C: Measurement and Improvement Standards - §438.242 Health information systems.			
Tool	CFR		Score
K-1	438.242(a)	<i>General rule.</i> The State must ensure, through its contracts, that each Plan maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. (b) <i>Basic elements of a health information system.</i> The State must require, at a minimum, that each Plan comply with the following:	
K-2	438.242(b)(1)	(1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.	P
K-3	438.242(b)(2)(i)	Ensure that data received from providers is accurate and complete by—(i) Verifying the accuracy and timeliness of reported data;	P
K-4	438.242(b)(2)(ii)	Screening the data for completeness, logic, and consistency; and	P
K-5	438.242(b)(2)(iii)	Collecting service information in standardized formats to the extent feasible and appropriate.	P
K-6	438.242(b)(3)	Make all collected data available to the State and upon request to CMS, as required in this subpart.	P
Findings:			

***Individual Component Scoring:** (scoring present on each line of the administrative tool)

P = Proficient - Documentation supports that component was implemented, reviewed, revised, and/or further developed.

D = Developing - Documentation supports some but not full compliance was present.

N = No Documentation - No documentation was found to substantiate component compliance.

n/a = Not Applicable - Component is not applicable to the focus of the evaluation.

Attachment 2

PIP Audit Tools

- **Promote Effective Management of Chronic Disease: Promotion of Effective Management of Osteoporosis**
- **Reducing the Voluntary Disenrollment rate in the True Blue Special Needs HMO SNP Dual Eligible Medicaid Population**

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

Demographic Information

Plan Name or ID: BCI Health Plan

Name of PIP: Promote Effective Management of Chronic Disease: Promotion of Effective Management of Osteoporosis

Dates in Study Period: 01/01/2014 to 12/31/2017

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	P	
1.2. Did BCI's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	P	
1.3. Did BCI's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	P	

Step 2: REVIEW THE STUDY QUESTION(S)

2.1 Was/were the study question(s) stated clearly in writing?	P	
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Step 3: REVIEW SELECTED STUDY INDICATOR(S)

3.1 Did the study use objective, clearly defined, measurable indicators?	P	HEDIS 2016 technical specifications used for the Osteoporosis Management in Women Who Had a Fracture (OMW) and Medicare Health Outcomes Survey used for "members' perception".
3.2 Did the indicators measure changes in health status, functional status or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	P	

Component/Standard	Score	Comments
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did BCI clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	P	Although the OMW cannot be separated in the HEDIS reporting, BCI separated the MMCP population in order to perform further analysis.
4.2 If BCI studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	D	The HOS is conducted on a randomized sample that includes all HMO True Blue members and the MMCP members cannot be separated.
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (overestimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	n/a	
5.2 Did BCI employ valid sampling techniques that protected against bias? Specify the type of sampling or census used:	n/a	
5.3 Did the sample contain a sufficient number of enrollees?	n/a	
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	P	
6.2 Did the study design clearly specify the sources of data?	P	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	P	
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	P	NCQA certified auditor and vendor were used.
6.5 Did the study design prospectively specify a data analysis plan?	D	Data is analyzed annually according to the HEDIS specifications and specifications of the HOS. During the on-site review, the EQRO discussed with BCI the need to analyze data on a minimum of quarterly basis.

Component/Standard	Score	Comments
Component/Standard	Score	Comments
Step 6: REVIEW DATA COLLECTION PROCEDURES (continued)		
6.6 Were qualified staff and personnel used to collect the data?	P	
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	P	
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	D	It was, but only on a yearly basis.
8.2 Did BCI present numerical PIP results and findings accurately and clearly?	P	
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?	P	
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	P	<p>Year One Outcomes: 2016 HEDIS, True Blue HMO, including dual eligible, 39/171= 29.85% 2016 HOS: Monitoring Physical Activity, True Blue HMO including dual eligible, 405/831, 49% Reducing the Risk of Falling, True Blue HMO including dual eligible, 209/381, 55%</p> <p>The OMW HEDIS measure was further analyzed for improvement. The MMCP membership in the measure accounted for 4/8 or 50% compliance. Analysis is conducted by what intervention was effective for the compliant members and then further drilled down to the MMCP members. This was an improvement over 2016 when of the nine MMCP members none were compliant.</p>

Step 9: ASSESS WHETHER IMPROVEMENT IS “REAL” IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	P	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	P	
9.3 Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of BCI quality improvement intervention?	P	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	D	The OMW improvement seems like true improvement, however there has been no improvement in the HOS numbers.
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	D	Measurement only occurs annually and improvement has only been observed in the last year of the OMW measure, repeated measurement wasn't performed.
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
	Score	Comments
1. Were the initial study findings verified upon repeat measurement?	P	
ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.		
<p>Where possible, BCI was asked to separate the findings for MMCP members only. BCI was also advised of the benefits of analyzing data on a more frequent basis, this would allow for implementation of interventions at a mid-year basis, if needed.</p> <p>The EQRO recommends that this PIP be retired and that BCI present a new PIP for review in the coming year.</p> <p>Check one: <input type="checkbox"/> High confidence in reported Plan PIP results <input checked="" type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible</p>		

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

Demographic Information

Plan Name or ID: BCI Health Plan

Name of PIP: Reducing the voluntary disenrollment rate in the True Blue Special Needs HMO SNP dual eligible Medicaid Population

Dates in Study Period: 2/1/2016 through 12/31/2017

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Score	Comments
a. Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	P	
b. Did BCI's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	P	
c. Did BCI's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	P	

Step 2: REVIEW THE STUDY QUESTION(S)

2.1 Was/were the study question(s) stated clearly in writing?	P	
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Step 3: REVIEW SELECTED STUDY INDICATOR(S)

3.1 Did the study use objective, clearly defined, measurable indicators?	P	
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	P	BCI added a measurement that analyzes whether the enrollees are satisfied with BCI following an initial period.

Attachment 2

Component/Standard	Score	Comments
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did BCI clearly define all Medicaid enrollees to whom the study questions and indicators are relevant?	P	
4.2 If BCI studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	P	
Step 5: REVIEW 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?	n/a	
5.2 Did BCI employ valid sampling techniques that protected against bias? Specify the type of sampling or census used:	n/a	
5.3 Did the sample contain a sufficient number of enrollees?	n/a	
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	P	
6.2 Did the study design clearly specify the sources of data?	P	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	P	
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	P	
6.5 Did the study design prospectively specify a data analysis plan?	D	BCI tells how and what data they will collect, and what they expect the data to show; they do not tell us what they will do if the data does show what they expect nor what they will do if it does not show what they expect.

Attachment 2

Component/Standard	Score	Comments
Step 6: REVIEW DATA COLLECTION PROCEDURES (continued)		
6.6 Were qualified staff and personnel used to collect the data?	P	
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	D	No barrier analysis was performed. No new interventions were started in 2017.
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	P	
8.2 Did BCI present numerical PIP results and findings accurately and clearly?	P	
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?	D	Statistical analysis was not performed. Factors that influence comparability were not discussed, nor factors that threaten validity.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	D	No follow up activities were discussed.
*Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	P	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	D	Improvement was not seen in 2017.
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of BCI quality improvement intervention?	D	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	N	No statistical analysis performed.

Attachment 2

Component/Standard	Score	Comments
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	D	Repeated measurement was done, but no improvement.
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Score		
Comments		
I. Were the initial study findings verified upon repeat measurement?	P	
ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.		
<p>Although some documentation was missing and BCI was unable to staff their intervention as in past years, this PIP was somewhat successful. Additional analysis should be performed to determine what other factors may influence results and to determine if there are other ways to improve the rate of disenrollment. BCI should retire this PIP and design a new PIP to improve another issue for members.</p> <p>Check one: <input type="checkbox"/> High confidence in reported Plan PIP results <input checked="" type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible</p>		

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Attachment 3

PM Audit Tool

Idaho Home Choice Money Follows the Person Demonstration Measures

Call Center Performance Measures

Performance Measure Validation Worksheet

Performance Measure to be Validated: Idaho Home Choice Money Follows the Person

Methodology for Calculating Measure: Administrative Medical Record Review Hybrid

- Scoring: MET: BCI's measurement and reporting process was fully compliant with State specifications.
 NOT MET: BCI's measurement and reporting process was not compliant with State specifications. (This designation should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include explanation of the deviation in the comments section.)
 n/a: The audit element was not applicable to BCI's measurement and reporting process.

Audit Element	Specifications	Score	Comments
DENOMINATOR			
1. Population	<ul style="list-style-type: none"> Medicaid population appropriately segregated from commercial/Medicare. 	Met	IHCMFP is a demonstration project, all those enrolled in the program meet grant criteria.
	<ul style="list-style-type: none"> Population defined as effective Medicaid enrollment as of 	Met	
	<ul style="list-style-type: none"> Dual Medicaid and Medicare beneficiaries are included. 	Met	
2. Geographic Area	<ul style="list-style-type: none"> Includes only those Medicaid enrollees served in BCIs reporting area. 	Met	All members in all counties with the condition were included in this measure.
3. Age & Sex	<ul style="list-style-type: none"> All project eligibles 	Met	
4. Enrollment Calculation	<ul style="list-style-type: none"> Were members of Plan on 	Met	
	<ul style="list-style-type: none"> Were continuously enrolled 	Met	
	<ul style="list-style-type: none"> Switches between populations (Medicare, Medicaid, and commercial) were not counted as breaks. 	n/a	

Audit Element	Specifications	Score	Comments
DENOMINATOR (continued)			
5. Data Quality	<ul style="list-style-type: none"> Based on the IS assessment findings, are any of the data sources for this denominator inaccurate? 	Met	
6. Proper Exclusion Methodology in Administrative Data (If no exclusions were taken, score as n/a)	<ul style="list-style-type: none"> Only members with contraindications or data errors were excluded. 	n/a	
	<ul style="list-style-type: none"> Contraindication exclusions were performed according to current State specifications. 	n/a	
	<ul style="list-style-type: none"> Only the codes listed in specifications as defined by State were counted as contraindications. 	n/a	
NUMERATOR			
7. Administrative Data: Counting Clinical Events	<ul style="list-style-type: none"> Standard codes listed in State specifications or properly mapped internally developed codes were used. (Intended to reference appropriate specifications as defined by State.) 	Met	
	<ul style="list-style-type: none"> Members were counted only once. 	Met	
8. Medical Record Review Documentation Standards	<ul style="list-style-type: none"> Record abstraction tool required notation of the date that the element was performed. 	Met	Medical record abstraction required for one submeasure.
	<ul style="list-style-type: none"> Record abstraction tool required notation of the element result or finding. 	Met	
9. Time Period	<ul style="list-style-type: none"> Element performed on or between <u>7/1/13</u> & <u>6/30/14</u> (baseline) <u>7/1/14</u> & <u>6/30/15</u> (year 1). 	Met	

Audit Element	Specifications	Score	Comments
NUMERATOR (continued)			
10. Data Quality	<ul style="list-style-type: none"> Properly identified enrollees. 	Met	
	<ul style="list-style-type: none"> Based on the IS assessment findings, were any of the data sources used for this numerator inaccurate? 	Met	
SAMPLING (If administrative method was used, score as "n/a" for audit elements 11, 12, and 13)			
11. Unbiased Sample	<ul style="list-style-type: none"> As specified in State specifications, systematic sampling method was utilized. 	n/a	
12. Sample Size	<ul style="list-style-type: none"> After exclusions, sample size is equal to <ol style="list-style-type: none"> _____ the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or the total population. 	n/a	
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, score as n/a)	<ul style="list-style-type: none"> Only excluded members for whom medical record review revealed <ol style="list-style-type: none"> contraindications that correspond to the codes listed in appropriate specifications as defined by State, or data errors. 	n/a	
	<ul style="list-style-type: none"> Substitutions were made for properly excluded records and the percentage of substituted records was documented. 	n/a	

Audit Element	Specifications	Score	Comments
ADDITIONAL QUESTIONS			
Were members excluded for contraindications found in the administrative data?		n/a	
Were members excluded for contraindications found during the medical record review?		n/a	
Were internally developed codes used?		No	
VALIDATION FINDING			
<p>Although this Performance Measure is rated as Fully Compliant with State specifications, the State specifications do not include many of the traditional elements of a performance measure. No goals were set for BCI by IDHW and no interpretation of results was expected by BCI. This performance measure was designed to allow IDHW to track the number of enrollees in the IHCMHP demonstration, but no expectations for participation or evaluation were set.</p>			
FC = Fully Compliant	Measure was fully compliant with State specifications.		
SC = Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.		
NV = Not Valid	Measure deviated from State 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.		
n/a = Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.		

Performance Measure Designation:

FC

Performance Measure Validation Worksheet

Performance Measure to be Validated: Call Center Statistics MMCP

Methodology for Calculating Measure: Administrative Medical Record Review Hybrid

Scoring: MET: BCI's measurement and reporting process was fully compliant with State specifications.
 NOT MET: BCI's measurement and reporting process was not compliant with State specifications. (This designation should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include explanation of the deviation in the comments section.)
 n/a: The audit element was not applicable to BCI's measurement and reporting process.

Audit Element	Specifications	Score	Comments
DENOMINATOR			
1. Population	• Medicaid population appropriately segregated from commercial/Medicare.	Met	
	• Population defined as effective Medicaid enrollment as of ____	n/a	
	• Dual Medicaid and Medicare beneficiaries are included.	Met	
2. Geographic Area	• Includes only those Medicaid enrollees served in BCIs reporting area.	Met	Specific phone numbers are available to these members and providers.
3. Age & Sex	• No specifications, all included	Met	
4. Enrollment Calculation	• Were members of Plan on ____	n/a	This is a measure of call center compliance.
	• Were continuously enrolled from ____ to ____ with one break per year of up to 45 days allowed.	n/a	This is a measure of call center compliance.

Audit Element	Specifications	Score	Comments
DENOMINATOR (continued)			
4. Enrollment Calculation (continued)	<ul style="list-style-type: none"> Switches between populations (Medicare, Medicaid, and commercial) were not counted as breaks. 	n/a	
5. Data Quality	<ul style="list-style-type: none"> Based on the IS assessment findings, are any of the data sources for this denominator inaccurate? 	Met	
6. Proper Exclusion Methodology in Administrative Data (If no exclusions were taken, score as n/a)	<ul style="list-style-type: none"> Only members with contraindications or data errors were excluded. 	n/a	
	<ul style="list-style-type: none"> Contraindication exclusions were performed according to current State specifications. 	n/a	
	<ul style="list-style-type: none"> Only the codes listed in specifications as defined by State were counted as contraindications. 	n/a	
NUMERATOR			
7. Administrative Data: Number of calls to dedicated MMCP phone lines	<ul style="list-style-type: none"> Standard codes listed in State specifications or properly mapped internally developed codes were used. (Intended to reference appropriate specifications as defined by State.) 	n/a	
	<ul style="list-style-type: none"> Members were counted only once. 	Met	Calls were only counted once.
8. Medical Record Review Documentation Standards	<ul style="list-style-type: none"> Record abstraction tool required notation of the date that the element was performed. 	n/a	
	<ul style="list-style-type: none"> Record abstraction tool required notation of the element result or finding. 	n/a	

Audit Element	Specifications	Score	Comments
NUMERATOR (continued)			
9. Time Period	<ul style="list-style-type: none"> Element performed on or between __ & __. 	Met	Daily, during call center operating hours.
10. Data Quality	<ul style="list-style-type: none"> Properly identified enrollees. 	Met	
	<ul style="list-style-type: none"> Based on the IS assessment findings, were any of the data sources used for this numerator inaccurate? 	Met	
SAMPLING (If administrative method was used, score as "n/a" for audit elements 11, 12, and 13)			
11. Unbiased Sample	<ul style="list-style-type: none"> As specified in State specifications, systematic sampling method was utilized. 	n/a	
12. Sample Size	<ul style="list-style-type: none"> After exclusions, sample size is equal to <ol style="list-style-type: none"> n/a the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or the total population. 	n/a	

Audit Element	Specifications	Score	Comments
SAMPLING (If administrative method was used, score as "n/a" for audit elements 11, 12, and 13) (continued)			
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, score as n/a)	<ul style="list-style-type: none"> Only excluded members for whom medical record review revealed <ol style="list-style-type: none"> contraindications that correspond to the codes listed in appropriate specifications as defined by State, or data errors. 	n/a	
	<ul style="list-style-type: none"> Substitutions were made for properly excluded records and the percentage of substituted records was documented. 	n/a	
ADDITIONAL QUESTIONS			
Were members excluded for contraindications found in the administrative data?			n/a
Were members excluded for contraindications found during the medical record review?			n/a
Were internally developed codes used?			n/a

VALIDATION FINDING

The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be “NOT MET.” Consequently, it is possible that an error for a single audit element may result in a designation of “NV” because the impact of the error biased the reported performance measure by more than “x” percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and, thus the measure could be given a designation of “SC.” The following is a list of the validation findings and their corresponding definitions:

FC = Fully Compliant	Measure was fully compliant with State specifications.
SC = Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
NV = Not Valid	Measure deviated from State 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.
n/a = Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Performance Measure Designation:

FC

This Performance Measure was a measure of the quickness of call response by BCI to any and all calls made in to the member and provider call center. This measure did not measure the effectiveness of those calls on the members, nor did it measure if more than one call was required to resolve an issue.