Title Page

RFP Subject/Number

External Quality Review Organization: MED12009

Vendor's Name/Address

Qsource

Business Address
3340 Players Club Parkway, Ste. 300
Memphis, TN 38125

Telephone: 901-682-0381
Fax: 901-273-2695

Contact
Dawn M. FitzGerald, MS, MBA
Chief Executive Officer
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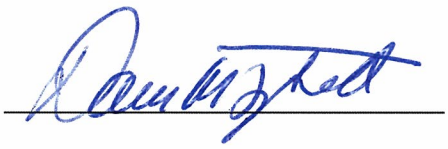
Signature: 

Date: **03/01/2012**

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2.3 Qualifications and Experience

Qsource's qualifications and experience relevant to the scope of this RFP are highlighted in **Attachment A: Vendor Response Sheet** below. Information includes experience with similar projects; references; copies of staff certifications and degrees applicable to this project; a proposed staffing plan; descriptions of past projects completed replete with locations of projects, project managers' names and contact information, types of projects, and projects' goals and objectives and how they were met.

Attachment A: Vendor Response Sheet

Qsource®[1] was founded in 1973 and has been in business continuously for nearly 39 years. Qsource has a total of 106 current employees. Qsource's client base includes the Centers for Medicare & Medicaid Services (CMS), the Office of the National Coordinator, the states of Arkansas and Tennessee, and multiple private and nonprofit entities. Headquartered in Memphis, Qsource maintains two additional offices in Nashville and Knoxville. Qsource also operates a subsidiary company, Qsource of Arkansas, with an office in Little Rock.

Qsource—Memphis Office

3340 Players Club Pkwy, Ste. 300

Memphis, TN 38125

Number of Employees: 57

Qsource—Nashville Office

49 Music Square West, Ste. 402

Nashville, TN 37203

Number of Employees: 23

Qsource—Knoxville Office

9111 Cross Park Drive, Ste. 275

Knoxville, TN 37923

Number of Employees: 7

Qsource Subsidiary—Qsource of Arkansas

124 West Capitol Avenue, Ste. 900

Little Rock, AR 72201

Number of Employees: 19

1 **Qsource®** is a registered trademark.

General Qualifications and Experience

Since 2005, Qsource has served as the primary External Quality Review Organization (EQRO) for the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare). Qsource's regional roots and unique knowledge of and experience with external quality review (EQR) requirements provide a significant level of experience in performing EQRO services. Qsource is also the CMS-designated Tennessee Quality Improvement Organization (QIO), a contract held continuously since 1973. **Table 1** highlights Qsource's EQRO and QIO work, additional contracts with relevant services and the years performed.

Table 1. Relevant EQRO Experience

Contract	Term	Relevance
TennCare External Quality Review (EQR)	10/1/10–present 10/1/05–9/30/10	Qsource currently serves as the EQRO for the State of Tennessee, Bureau of TennCare and has provided all of the services defined in this RFP, and additional quality improvement (QI) services, at the request of TennCare. HEDIS®/CAHPS®[2] annual comparative analysis and quarterly provider data validations.
TennCare EQR	10/1/00–9/30/05	Qsource served as the Nashville-based subcontractor to conduct quality assurance review of managed care organizations (MCOs) through annual compliance audits, network adequacy review, EPSDT review,
Tennessee CoverKids EQR	1/1/10–present	Qsource currently provides the State of Tennessee Department of Finance and Administration, Division of Insurance Administration with an independent, external review of the quality of services available to State Children's Health Insurance Program members encompassing most of the services defined in this RFP.
TennCare HCBS EQR	2/1/08–9/30/08 1/1/07–12/31/07	Qsource conducted annual reviews through field and office audits using data collection tools collaboratively developed by Qsource and the State. Qsource provided annual quality reports to the TennCare Department of Long Term Care, assessing the quality of healthcare and services provided to waiver enrollees in the Elderly and Disabled programs. Reports provided an evaluation of contract compliance and a comparison of quality of healthcare and services provided among programs. Further, Qsource identified areas for improvement and monitored progress toward meeting compliance standards over time.
Centers for Medicare & Medicaid Services	1973–July 2014	Qsource assists providers such as nursing homes, home health agencies, hospitals and physician practice sites in the following areas: measuring and reporting quality, producing and using clinical information, redesigning care processes, and transforming organizational cultures to accelerate the rate of quality improvement.

2 **HEDIS®** is a registered trademark of the National Committee for Quality Assurance (NCQA)
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Projects of a Similar Scope

Qsource is uniquely qualified to be West Virginia's EQRO. Qsource has developed a proven approach to providing state contract services based on our effective service history with TennCare and continuous federal service for nearly four decades as the CMS-designated QIO for the State of Tennessee. Under the QIO contract, Qsource has excelled at providing service to Medicare by addressing quality of care for over 1.2 million Medicare enrollees and over 5,000 healthcare providers statewide. Through nine Scopes of Work (SoW), Qsource has become a recognized leader in quality improvement (QI) and the methodologies necessary to affect sustainable improvements in health status.

From 2000 until 2005, Qsource provided subcontracting services for the TennCare EQRO. As Qsource's role has grown, our team has ensured stability of operations for Tennessee EQRO activities and in the retention of qualifications and experience necessary to assist TennCare and its Managed Care Contractors (MCCs), building upon the accomplishments of the previous 10 years.

Highly qualified Qsource EQRO staff members include master's-level health analysts, database administrators, technical writers and a National Committee for Quality Assurance (NCQA) Certified Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Auditor (CHCA), as well as clinical QI specialists with Bachelor of Science degrees in Nursing (BSNs) and current Tennessee licensure as registered nurses (RNs). The staff also has extensive experience affording an in-depth knowledge and understanding of managed care organizations (MCOs) and their service delivery systems; QI methods; research design, methodology and statistical analyses; NCQA Accreditation; HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and related historical and current legislation.

Qsource has been consistent in expertise and customer service, and has readily adapted to TennCare program changes, including the streamlining of health plans; the return to a full-risk, capitated model; and the integration of medical, behavioral and long-term care services under the TennCare MCOs. As a result of demonstrated excellence serving TennCare, Qsource was selected in 2010 as the EQRO for CoverKids, Tennessee's Children's Health Insurance Program (CHIP). Qsource used our expertise to guide CoverKids' staff through EQR oversight implementation. Early assistance included contract review for the program's medical benefits

manager (MBM) and dental benefits manager (DBM), and the selection of appropriate compliance oversight and evaluation activities. Most recently, Qsource served as one of six key witnesses for the State in a federal trial and was instrumental in testimony that ultimately led to a favorable ruling for the State and the lifting of a 14-year-long consent decree from the TennCare program.

Qsource has held a number of other state contracts, which included a variety of external evaluation activities on behalf of the State of Tennessee, the State of Arkansas and CMS to provide quality oversight and assessment services. The following paragraphs are examples of various additional contracts with relevant services, and the years of work:

In 2007 and 2008, Qsource conducted a comprehensive annual QA/QI review of the ***STATEWIDE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) HOME- AND COMMUNITY-BASED SERVICES (HCBS) ELDERLY AND DISABLED (E&D) WAIVER PROGRAMS*** for the State of Tennessee. The annual reviews were conducted through field and office audits using data collection tools collaboratively developed by Qsource and the State. Qsource's goal in performing annual quality reviews (AQRs) for the HCBS programs was to provide useful, meaningful reports to the TennCare Department of Long Term Care to assist in assessing the quality of healthcare and services provided to E&D HCBS enrollees, to compare the healthcare service quality provided among programs, to identify areas for improvement and to monitor improvements over time.

From April 2008 to June 2009, the Tennessee Department of Health contracted with Qsource to assist in the evaluation of grant programs as part of its ***HEART DISEASE AND STROKE PREVENTION*** (HDSP) initiative. Much of this work involved the identification of successful outcomes and the applicability of a similar methodology elsewhere in the state. Qsource has worked with the State to review and clarify grantee contracts, defined tools to support the collection of measureable results among program grantees, and created an overall framework for program planning, including the use of a logic model for project planning and implementation. As a result of these efforts, Qsource has been called upon by other agencies in the Department of Health to provide in-kind assistance for program evaluation.

From June 2008 to May 2009, the Tennessee Hospital Association contracted with Qsource to conduct a process and outcome evaluation of the ***DELTA STATES STROKE NETWORK TELESTROKE PILOT PROJECT***. As the external evaluation lead, Qsource assisted in provider and vendor selection, reviewed training program effectiveness and assessed outcomes such as sustainability, reproducibility and barriers to successful implementation. Program effectiveness measures included the number of patients treated via Telestroke, door-to-tPA (tissue plasminogen activator) time for patients treated via Telestroke, and improved patient outcomes (morbidity/mortality) as a result of the program.

From April 2008 to March 2009, Tennessee's ***COMMUNITY HEALTH NETWORK*** contracted with Qsource to assist in the development of baseline data for five performance reporting items from the U.S. Health Resources and Services Administration (HRSA). Qsource also provided input regarding elements of program evaluation. The baseline data established under HRSA

included disease management for diabetes, disease management for cardiovascular disease and antibiotic timing for pneumonia patients and pneumonia/flu immunizations, and smoking cessation information provided.

As a component of our State of Arkansas ***MANAGEMENT OF MEDICAID QUALITY INITIATIVES*** contract, Qsource conducts management and evaluation of a maternity high-risk pilot program that provides health management to pregnant women and to infants up to one year of age. Qsource coordinates all activities among Specialty Disease Management Services, Inc., the BirthWait®[3] program provider and Arkansas Department of Human Services to ensure health management services are available to the high-risk pregnant women and infants who are eligible for Arkansas Medicaid in four pilot counties. Qsource has held this contract since December 2008.

From February 2008 to April 2011, Qsource was contracted by the ***HEALTHY MEMPHIS COMMON TABLE*** (HMCT) to provide data aggregation services in developing a community physician performance measurement and public reporting system based on pooling administrative data across health plans. Primary services included data analyses and report generation and distribution, as well as data warehousing, security and backup. Qsource also provided health plan leadership and staff tools and onsite education/training on the basics of data abstraction and performance reporting strategies (e.g., HEDIS report abstraction and reporting experience, SAS©[4] programming, Excel®/Access® assistance). Qsource supported all technical aspects of the project, convening and facilitating collaborative sharing opportunities (processes, lessons learned, best practices, tools, etc.) among group participants.

From August 1999 to July 2008, Qsource held the role as CMS's nationally designated ***UNDERSERVED QIO SUPPORT CENTER (UQIOSC)***. The UQIOSC supported CMS in identifying areas of healthcare disparities, researched effective intervention strategies via literature review and developed tools for evaluating the overall QIO program's effectiveness in reducing healthcare disparities among the underserved.

Qsource is currently contracted with CMS to perform our 10th QIO Scope of Work (8/1/2011 to 7/31/2014), which includes a focus on making patient care safer; promoting effective coordination of care; assuring care is person and family centered; promoting prevention and treatment of the leading causes of mortality; helping communities support better health; and making care more affordable for individuals, families, employers and the government by reducing costs through continual improvement. Qsource provides technical expertise in QI, program evaluation, EQR, communications and data analyses to a number of state and local agencies. In addition to our demonstrated federal contract expertise, Qsource is well known as a leader in Tennessee healthcare QI. Since 2005, Qsource has served as the prime EQRO for TennCare. First awarded the contract in October 2005, Qsource was granted both optional one-year extensions, with a contract renewal in 2010.

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3 **BirthWait®** is a care management program designed by U.S. Care Management

4 **SAS©**, a copyright of the SAS Institute Inc., is an integrated system of software products known as Statistical Analysis System

Contract Tables

Qsource's contract history and associated reference information are provided here to demonstrate our organization's credentials in terms of similar projects successfully completed with details of responsibilities, experience and relevance to this contract.

External Quality Review Organization (EQRO) TennCare Contract	
Contracting Organization	Bureau of TennCare, State of Tennessee Department of Finance and Administration
Business Address	310 Great Circle Road Nashville, TN 37243
Contracting Officer Name, Title	Judy Womack, Director, Quality Oversight Bureau of TennCare
Telephone Number	615-507-6716
Email Address	**Judy.M.Womack@tn.gov**
Contract Number	FA-1133154
Contract Type	Fixed Price
Contract Total Value	$6,004,764
Period of Performance	10/1/2010–9/30/2013 (option: 2 extension years)
Staff Months	280 (current)

Description of Activities

Qsource provides the State of Tennessee Department of Finance and Administration with an independent, external review of the quality of services available to TennCare enrollees via the following activities:

- **Validates Performance Measures:** Performance measure validation (PMV) evaluates the accuracy of TennCare performance measures reported by the managed care organizations (MCOs). As part of this task, Qsource reviews the data management processes of the MCOs, evaluates the algorithmic compliance and verifies that state-specified performance measures are based on accurate source information. The results of the PMV process are included in individual reports by plan and region, and in the EQR Technical Report.
- **Validates Performance Improvement Project (PIP):** PIP validation is performed for each of the MCOs using the current CMS protocols, culminating with the production of a written report of findings and recommendations. Qsource evaluates the soundness and results of the PIPs implemented by the MCOs. The PIP validation results are included in individual reports by plan and region, and in the EQR Technical Report.
- **Conducts Annual Quality Survey (AQS):** An AQS is conducted of each Managed Care Contractor (MCC) for contractual compliance and includes pre-assessment, onsite review and post-onsite analysis. In accordance with CMS protocols, review criteria include contract compliance to meet current industry, federal and state requirements for managed care. Qsource provides regional MCC-specific reports with recommendations for each health plan. Results are also part of the annual technical report.
- **Conducts Annual Evaluation of Provider Network Adequacy (ANA):** The onsite evaluation helps ensure that the MCCs have the capacity to provide covered services and that those services are accessible to TennCare enrollees. The report includes objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data.
- **Performs Quality Survey for EPSDT Compliance:** As part of the onsite AQS, compliance with the State's *John B. Consent Decree* is monitored, including a review of each MCC's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) information tracking system for explicit monitoring of compliance with federal EPSDT standards. The health plans are required to achieve and maintain the capability of tracking each child for the purposes of monitoring the child's receipt of the required screening, diagnosis and treatment. An annual report of EPSDT findings and recommendations is produced.

External Quality Review Organization (EQRO) TennCare Contract	
Contracting Organization	Bureau of TennCare, State of Tennessee Department of Finance and Administration
Business Address	310 Great Circle Road Nashville, TN 37243

- **Prepares Detailed Technical Report:** This report describes the manner in which the data from all oversight activities were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness and access to the care furnished by TennCare-contracted MCCs. The report includes objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data. Other aspects of the Technical Report include an assessment of each MCC's strengths and weaknesses with respect to the quality, timeliness and access to healthcare services furnished to Medicaid recipients; recommendations for improving the quality of healthcare services furnished to each enrollee; an assessment of the degree to which each MCC has addressed effectively the recommendations for QI made by the EQRO during the previous year's review processes; and quality assurance to protect patient privacy data.
- **Provides Special Ad Hoc Reports:** Reports designed to improve the financial stability of the TennCare program and the quality of care rendered to the TennCare population are produced, including an aggregation of all HEDIS data across contributing health plans in Tennessee.
- **Analyzes HEDIS and CAHPS® Data:** An annual comprehensive analysis of HEDIS and CAHPS® data results is prepared to identify opportunities for improvement and best practices among MCOs.
- **Analyzes Other TennCare Data:** Other analyses are conducted at the request of TennCare. Past activities have included vital statistics data in the production of an assessment of the impact of TennCare on Women's Health in Tennessee and a study on emergency department utilization.

Relevance to This Contract

- Qsource conducts annual quality and network adequacy surveys that assess MCC contractor compliance with state and federal regulations, including evaluation of EPSDT programs as well as medical record reviews for appeals and utilization management denials. Qsource develops the performance criteria based on TennCare's contracts with the managed care organizations.
- Qsource works to improve the quality and effectiveness of medical care received by Tennessee Medicaid enrollees by identifying best practices and areas of noncompliance and by sharing these with MCCs and the State.
- Qsource uses HEDIS protocols to verify measures' specifications and creation of Medicaid-specific measures.
- Qsource regularly updates and maintains communication with TennCare regarding activities and enrollee, provider and policy-related concerns.
- Qsource assists the State in reviewing MCC corrective action plans (CAPs) and determining progress toward meeting CAPs.

EQRO CoverKids Contract	
Contracting Organization	Tennessee Department of Finance and Administration, Division of Insurance Administration
Business Address	312 Eighth Ave. N. 26th Floor WRS Tennessee Tower Nashville, TN 37243-0295
Contracting Officer Name, Title	Stephanie Dickerson, Assistant Director, CoverKids
Telephone Number	615-253-8572
Email Address	**Stephanie.K.Dickerson@tn.gov**
Contract Number	FA-1030464
Contract Type	Fixed Price
Contract Total Value	$1,109,000 (3 years)
Period of Performance	1/1/2010–12/31/2012
Staff Months	90

EQRO CoverKids Contract	
Contracting Organization	Tennessee Department of Finance and Administration, Division of Insurance Administration
Business Address	312 Eighth Ave. N. 26th Floor WRS Tennessee Tower Nashville, TN 37243-0295

Description of Activities

Qsource provides the State of Tennessee Department of Finance and Administration, Division of Insurance Administration with an independent, external review of the quality of services available to CoverKids enrollees. Qsource:

- **Conducts Onsite Annual Quality Survey (AQS):** An AQS is conducted of each MCC for contractual compliance and includes pre-assessment, onsite review and post-onsite analysis. In accordance with CMS protocols, review criteria include contract compliance to meet current industry, federal and state requirements for managed care. Qsource provides MCC-specific reports with recommendations for each health plan. Results are also part of the annual technical report.
- **Conducts Annual Onsite Evaluation of Provider Network Adequacy (ANA):** The evaluation helps ensure that the MCCs have the capacity to provide covered services and that those services are accessible to CoverKids enrollees. The report includes objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data.
- **Prepares Detailed Technical Report:** This report describes the manner in which the data from all oversight activities, in accordance with 42 CFR § 438.358, are aggregated and analyzed, and conclusions drawn as to the quality, timeliness and access to the care furnished by contracted MCCs to Medicaid recipients. The report includes objectives, technical methods of data collection and analyses, descriptions of data obtained and conclusions drawn. Other aspects of the report include an assessment of each MCC's strengths and weaknesses with respect to the quality, timeliness and access to healthcare services; recommendations for improving the quality of services furnished to each enrollee; an assessment of the degree to which each MCC has effectively addressed the recommendations for QI made by the EQRO during the previous year's review processes; and quality assurance to protect patient privacy data.
- Provides Special Ad Hoc Reports: As requested by the State.
- **Analyzes Other CoverKids Data:** Other analyses conducted at the request of the Division of Insurance Administration.

Relevance to This Contract

- Qsource conducts annual quality and network adequacy surveys that assess MCC contractor compliance with state and federal regulations, including retrospective file reviews for the appropriateness of credentialing and recredentialing of providers as well as medical record reviews for appeals and utilization management denials. Qsource develops the performance criteria based on TennCare's contracts with the Managed Care Organizations.
- Qsource provides detailed reports on CoverKids MCCs' compliance performance to members.
- Qsource works to improve the quality and effectiveness of medical care received by CoverKids members.
- Qsource regularly updates and maintains communication with Department of Insurance Administration regarding activities and beneficiary, provider, and policy-related concerns.

Quality Improvement Organization (QIO 10th Scope of Work) Contract	
Contracting Organization	Centers for Medicare & Medicaid Services
Business Address	7500 Security Blvd. Baltimore, MD 21244-1850
Contracting Officer Name, Title	Patty Rawlings, Contracting Officer's Representative
Telephone Number	214-767-4423
Email Address	**Patty.Rawlings@cms.hhs.gov**
Contract Number	HHSM-500-2011-TN10C

Quality Improvement Organization (QIO 10th Scope of Work) Contract	
Contracting Organization	Centers for Medicare & Medicaid Services
Business Address	7500 Security Blvd. Baltimore, MD 21244-1850
Contract Type	Cost plus Fixed Fee and Cost plus Award Fee
Contract Total Value	$13,872,643
Period of Performance	8/1/2011–8/1/2014 (current contract term), Qsource has continuously held the CMS QIO contract since 1973.
Staff Months	1,476 (current contract term)

Description of Activities

Qsource works with the Tennessee healthcare community to improve health and healthcare by assisting providers in measuring and reporting quality, producing and using electronic clinical information, redesigning care processes, and transforming organizational culture to accelerate **quality improvement** and broaden its impact. To supplement individual technical assistance, we convene providers, practitioners and patients to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvements in patient care. Activities include the following:

- Conducting patient safety initiatives focusing on reducing central line bloodstream infections by implementing the Comprehensive Unit-Based Safety Program (CUSP), then expanding to encompass catheter-associated urinary tract infections, Clostridium difficile and surgical site infections.
- Providing technical assistance for reporting inpatient and outpatient quality data to CMS.
- Working with nursing homes to decrease pressure ulcers and physical restraints and to address other healthcare-acquired conditions, such as falls and catheter-associated urinary tract infections.
- Bringing clinical pharmacists, physicians and facilities together in local Patient Safety Clinical Pharmacy Services Collaboratives (PSPC), to decrease adverse drug events. assisting physician practices to use their electronic health record system to coordinate preventive services and report related quality measures to CMS.
- Conducting physician practice learning networks focused on reducing patient risk factors for cardiac disease and partnering with Tennessee Regional Extension Center (tnREC) to promote health IT integration into clinical practice.
- Working with hospitals, nursing homes, patient advocacy organizations and other stakeholders in community coalitions to build capacity for improving care transitions and to support the coalition's success in obtaining grant funding through Section 3026 of the *Affordable Care Act*.
- Protecting the rights of Medicare beneficiaries by reviewing complaints about quality and appeals about the denial or discontinuation of healthcare services.

Relevance to This Contract

- Qsource has demonstrated experience in improving the quality of care in many provider settings.
- Qsource has demonstrated experience in developing and imparting educational programs aimed at spreading quality guidelines and innovative methods of care delivery.
- Qsource staff performed onsite visits to conduct thorough analysis of processes, identify opportunities for improvement and implement appropriate corrective actions.
- Qsource utilized highly qualified health analysts with experience in extracting data for quality metrics and developing public reports.
- Qsource developed and presented learning sessions on the fundamentals of appropriate care management and QI to improve patient care.
- Qsource demonstrated project management skills by adhering to CMS's deliverables schedule (100% timely), budgetary controls (100% reimbursement) and exceeding expectations (full pass on 9SoW).

Peer Review Organization/Quality Improvement Organization (PRO/QIO) Contract	
Contracting Organization	Centers for Medicare & Medicaid Services
Business Address	7500 Security Blvd. Baltimore, MD 21244-1850
Contracting Officer Name, Title	Patty Rawlings, Project Officer
Telephone Number	214-767-4423
Email Address	**Patty.Rawlings@cms.hhs.gov**
Contract Number	HHSM-500-2008-TN9THC
Contract Type	Cost plus Fixed Fee and Cost plus Award Fee
Contract Total Value	$11,600,632 (most recent previous contract)
Period of Performance	Qsource has continuously held the CMS PRO/QIO contract since 1973.
Staff Months	1,140 (most recent previous contract)

Description of Activities

Qsource assisted providers (nursing homes, home health agencies, hospitals and physician practice sites) in measuring and reporting quality, producing and using electronic clinical information, redesigning care processes and transforming organizational cultures so as to accelerate the rate of QI and broaden its impact. Qsource focused on two domains of activity: assisting providers in developing the capacity for and achieving excellence in care. Activities included the following:

- Conduct utilization and quality of care review of beneficiaries.
- Work with Tennessee providers to achieve system-level changes improving clinical performance measure results; increasing clinical performance measurement and reporting; process improvement; and systems improvement and organizational culture change. Focused clinical topics include reducing rates of healthcare-associated methicillin-resistant Staphylococcus aureus (MRSA) infections; reducing rates of pressure ulcers in nursing homes; reducing rates of use of physical restraints in nursing homes; improving inpatient surgical safety and heart failure treatment in hospitals; improving drug safety; and providing QI technical assistance to nursing homes in need.
- Improve the quality and frequency of preventive healthcare services in three areas: Core Prevention, Diabetes Disparities and Chronic Kidney Disease (CKD). In conducting Core Prevention activity, Qsource focuses on improving mammography and colorectal cancer screening, influenza vaccination and pneumococcal vaccination rates. Qsource assists collaborating practices to implement care management processes, using their certified EHRs.
- Improve safety in the delivery of prescription drugs through implementation of QI projects focusing on improved prescribing, using evidence-based guidelines, and development and implementation of new methods to gather and disseminate better evidence for engaging physicians.

Relevance to This Contract

- Qsource has demonstrated experience in improving the quality of care in many provider settings.
- Qsource has demonstrated experience in developing and imparting educational programs aimed at spreading quality guidelines and innovative methods of care delivery.
- Qsource staff performed onsite visits to conduct thorough analysis of processes, identify opportunities for improvement and implement appropriate corrective actions.
- Qsource utilized highly qualified health analysts with experience in extracting data for quality metrics and developing public reports.
- Qsource developed and presented learning sessions on the fundamentals of appropriate care management and QI to improve patient care.
- Qsource demonstrated project management skills by adhering to CMS' deliverables schedule (100% timely), budgetary controls (100% reimbursement) and exceeding expectations (full pass on 9SoW).

Tennessee's Regional Extension Center (tnREC) Grant	
Contracting Organization	Office of the National Coordinator for Health Information Technology (HHS/ONC)
Business Address	30 C Street, Ste. 1100 Washington, DC 20201
Contracting Officer Name, Title	Larry Jessup
Telephone Number	202-720-2861
Email Address	**Larry.Jessup@hhs.gov**
Contract Number	90RC0026/01
Contract Type	Fixed Price
Contract Total Value	$8,304,438
Period of Performance	02/08/2010–02/07/2014
Staff Months	829

Description of Activities

Qsource assists physicians and hospitals select and successfully implement certified electronic health records (EHRs) in order to achieve meaningful use status and qualify for Medicare and Medicaid grant funds through providing the following services:

- Progress toward the meaningful use of EHRs
- Privacy and security training
- Office workflow redesign
- Onsite technical assistance
- Workforce development training
- Health Information Exchange (HIE) interoperability
- Qsource has assisted over 1,400 physicians in the first two years of this program.

Relevance to This Contract

- Onsite technical assistance
- Training
- Process evaluation

Arkansas Medicaid Therapy Retrospective Review and Personal Care Prior Authorization	
Contracting Organization	State of Arkansas, DHS – DMS
Business Address	P.O. Box 1437, Slot S-401 Little Rock, AR 72203-1437
Contracting Officer Name, Title	Rosemary Edgin, Chief Program Administrator, Utilization Review
Telephone Number	501-682-8464
Email Address	**Rosemary.Edgin@arkansas.gov**
Contract Number	4600019487
Contract Type	Unit Price
Contract Total Value	$1,674,515 annually, approx. $6,698,060 to SFY
Period of Performance	7/1/2008–6/30/2012 (option: 3 extension years)
Staff Months	76 (current contract)

Description of Activities

Services provided under the Arkansas therapy review contract include the following:

- Retrospective review of medical records to determine if occupational, physical and speech therapy services delivered to Medicaid beneficiaries under age 21 and reimbursed by Medicaid meet medical necessity requirements and if services comply with the utilization review criteria set forth in Arkansas Medicaid's Therapy Provider Manual.

Arkansas Medicaid Therapy Retrospective Review and Personal Care Prior Authorization	
Contracting Organization	State of Arkansas, DHS – DMS
Business Address	P.O. Box 1437, Slot S-401 Little Rock, AR 72203-1437

- Prior authorization (PA) review for personal care services for Medicaid beneficiaries under age 21. Primary to this role is performing PAs for initial and extension of benefits for the Personal Care U/21 program.
- Participation in appeals and hearings resulting from adverse actions related to therapy review outcome determinations.

Relevance to This Contract

- Qsource staff includes experienced nurse reviewers for clinical onsite audits.
- Qsource's nurse and physician reviewers have thorough chart abstraction and data abstraction expertise.
- Qsource is experienced and knowledgeable about medical necessity criteria, screening guidelines and the overall review process.
- Qsource prepares weekly, monthly, quarterly and annual reports for Arkansas Medicaid.

Arkansas Management for Medicaid Quality Initiatives and Technical Support	
Contracting Organization	State of Arkansas, DHS – DMS
Business Address	P.O. Box 1437, Slot S-401 Little Rock, AR 72203-1437
Contracting Officer Name, Title	Rosemary Edgin, Chief Program Administrator, Utilization Review
Telephone Number	501-682-8464
Email Address	**Rosemary.Edgin@arkansas.gov**
Contract Number	4600019486
Contract Type	Fixed Price
Contract Total Value	$1,522,200
Period of Performance	12/1/2008–6/30/2012 (option: 3 extension years)
Staff Months	36 (current contract)

Description of Activities

Contract management and evaluation of the High Risk Pilot Program to provide health management to high-risk pregnant women and infants up to one year of age, including coordination of all activities between Specialty Disease Management Services, Inc., BirthWait program and Arkansas DHS, to ensure health management services for high-risk Arkansas Medicaid-eligible pregnant women and infants in three pilot counties. In our collaborative relationship with program staff, Qsource works to:

- Identify, document and report detailed processes and activities, including successes, barriers and lessons learned.
- Assist with troubleshooting problems, problematic providers and/or resource identification/ utilization by gathering issues and acting as a liaison through issue resolution.
- Conduct participant satisfaction and health perception surveys.
- Evaluate provider satisfaction and performance measures.
  Perform interviews and data analysis.

Project management of the Regional Quality Initiative, including the following:

- Facilitation of stakeholder meetings.

Arkansas Management for Medicaid Quality Initiatives and Technical Support	
Contracting Organization	State of Arkansas, DHS – DMS
Business Address	P.O. Box 1437, Slot S-401 Little Rock, AR 72203-1437

- Collection and analysis of performance measures.
- Standardization and aggregation of healthcare data across multiple payers to calculate measures.
- Development/Production of reports on diabetes, cervical cancer, well-child care, and additional chronic and preventative health quality metrics.
- Technical support for policy development is provided through data analysis and clinical literature search related to local and national health policy initiatives.

Relevance to This Contract

- Qsource reviews state policy and current, relevant clinical and non-clinical literature to recommend policy, process and/or screening criteria updates.
- Qsource performs extensive data validation, measures implementation, database and data file linkage and quality improvement for the program.
- Qsource prepares weekly, monthly, quarterly and annual reports for Arkansas Medicaid.
- Qsource provides support to the Arkansas Medicaid Medical Director, Health Policy's research initiatives.
- Qsource prepares provider communiqués: Web messaging, assistive "how to" materials, eNewsletters, presentations, exhibits and direct mail.

Arkansas Medicaid ePrescribing Initiative	
Contracting Organization	HP Enterprise Services
Business Address	500 President Clinton Ave., Ste. 400 Little Rock, AR 72201
Contracting Officer Name, Title	Melissa St. Clair, Operations Manager
Telephone Number	501-374-6609, ext. 215
Email Address	**Melissa.St-Clair@hp.com**
Contract Number	103568
Contract Type	Cost Reimbursed
Contract Total Value	$1,100,000
Period of Performance	7/1/2008–6/30/2012
Staff Months	48 (current contract)

Description of Activities

Provides expertise in the technical aspects of the adoption and use of electronic clinical information, specifically ePrescribing. Facilitation and coordination of intra/inter physician office and hospital outpatient workflow design to maximize health information exchange among providers regarding continuity of treatment, QI and patient safety as it relates to ePrescribing.

Relevance to This Contract

- Qsource is capable of implementing web-based technologies to enhance health information management and patient care.
- Qsource works to improve the quality and effectiveness of medical care received by Arkansas Medicaid beneficiaries by establishing and maintaining positive relationships with Medicaid providers and assisting providers to adopt the latest technology.
- Qsource prepares weekly, monthly, quarterly and annual reports for Arkansas Medicaid.
- Qsource prepares provider communiqués: Web messaging, assistive "how to" materials,

Arkansas Medicaid ePrescribing Initiative	
Contracting Organization	HP Enterprise Services
Business Address	500 President Clinton Ave., Ste. 400 Little Rock, AR 72201

presentations, exhibits and direct mail.

Arkansas Data Mining and Program Evaluation (DMPE)	
Contracting Organization	Health Services Advisory Group, Inc. (HSAG)
Business Address	3133 East Camelback Road, Ste. 300 Phoenix, AZ 85016
Contracting Officer Name, Title	Thomas Miller, Executive Director, Research and Analysis Team
Telephone Number	602-801-6960
Email Address	**TMiller@hsag.com**
Contract Number	N/A
Contract Type	Cost Reimbursed
Contract Total Value	$240,582
Period of Performance	7/1/2010 – Current
Staff Months	16 (current contract)

Description of Activities

Qsource provides expertise in the technical aspects of medical record procurement and communications tasks as a subcontractor to HSAG for Arkansas Medicaid. Qsource staff travels the state, communicating and visiting Arkansas Medicaid primary care physicians, acquiring medical records related to selected HEDIS measure specifications and beneficiary eligibility.

Relevance to This Contract

- Qsource works to improve the quality and effectiveness of medical care received by Arkansas Medicaid beneficiaries by procuring medical records related to select HEDIS measures for the prime contractor (HSAG) to measure performance.
- Qsource maintains positive relationships with Medicaid providers by interacting at least biannually to ascertain medical record documentation status and processes.
- Qsource prepares monthly and annual provider communiqués: data performance reports for Arkansas Medicaid primary care physicians via direct mail.

Tennessee Hospital Association: Get with the Guidelines	
Contracting Organization	Tennessee Hospital Association (THA)
Business Address	500 Interstate Blvd. South Nashville, TN 37210
Contracting Officer Name, Title	Craig Becker, President
Telephone Number	615-256-8240
Email Address	**CBecker@tha.com**
Contract Number	N/A
Contract Type	Fixed Price
Contract Total Value	Term 1: $10,000; Term 2: $10,000
Period of Performance	01/01/2010–12/31/2010; 2/15/2011–12/31/2011
Staff Months	3

Tennessee Hospital Association: Get with the Guidelines	
Contracting Organization	Tennessee Hospital Association (THA)
Business Address	500 Interstate Blvd. South Nashville, TN 37210

Description of Activities

Qsource assisted THA with evaluation of the heart disease and stroke systems of care initiatives by assessing participating hospitals' compliance with the evidence-based guidelines and the resulting improvement in standards of care in the following clinical areas:

- Stroke care evidence-based guidelines
- Heart failure care evidence-based guidelines

Relevance to This Contract

Demonstrates knowledge in evaluation of effectiveness of quality improvement programs. Perform data audit and provider support/education for common fatal conditions.

Healthy Memphis Common Table (HMCT) Data Aggregator	
Contracting Organization	Healthy Memphis Common Table
Business Address	6027 Walnut Grove Plaza., Ste. 215 Memphis, TN 38120
Contracting Officer Name, Title	Renee Frazier, Executive Director
Telephone Number	901-684-6011
Email Address	**Renee.Frazier@healthymemphis.org**
Contract Number	N/A
Contract Type	Fixed Price
Contract Total Value	$277,500
Period of Performance	2/1/2008–4/30/2011
Staff Months	19

Description of Activities

Qsource provided data aggregation services to develop a community-based physician performance measurement and public reporting system based on pooling administrative data across health plans. Data aggregation services include the following:

- Provided the structure for pooling data from multiple sources and providing onsite education/training/tools for plan leadership and/or staff on the basics of data abstraction and performance reporting strategies (e.g., HEDIS report abstraction and reporting experience, SAS assistance and programming, Excel/Access assistance and programming, etc.) on all technical aspects of the project.
- Convened and facilitated collaborative sharing opportunities (processes, lessons learned, best practices, tools, etc. among group participants) and provide ongoing technical support.
- Provided data analysis, report generation and distribution as well as data warehousing, data security and backup.
- Developed community-level reports and public reporting format for web-based public reporting roll-out.

Relevance to This Contract

- Qsource created healthcare-related performance reports acceptable to HMCT using aggregated physician administrative data.
- Qsource developed criteria for physician review of practice-level data and submission of medical information to make corrections.
- Qsource provided a Physician Feedback Report on performance measures to Shelby County, Tennessee practices to assist with public reporting.

Home and Community-Based Services (HCBS) Contract	
Contracting Organization	Bureau of TennCare, State of Tennessee Department of Finance and Administration
Business Address	310 Great Circle Road Nashville, TN 37243
Contracting Officer Name, Title	Carolyn Fulghum, Director, Long Term Care Division, Quality and Administration, Elderly and Disabled Services, Bureau of TennCare
Telephone Number	615-507-6671
Email Address	**Carolyn.d.fulghum@tn.gov**
Contract Number	FA-06-16559-01; 082221600
Contract Type	Fixed Price
Contract Total Value	Term 1: $179,820; Term 2: $277,485
Period of Performance	1/1/2007–12/31/2007; 2/1/2008–9/30/2008
Staff Months	36; 32

Description of Activities

Qsource provided a comprehensive QA/QI oversight program for elderly and disabled HCBS statewide and PACE programs in Tennessee:

- Conducted an Annual Onsite Quality Survey of each of the nine HCBS agencies, the Commission on Aging and Disability and PACE provider to assess contract compliance and other elements associated with current industry, federal and state requirements for Medicaid 1915(c) waiver.
- Provided agency-specific reports, developed and evaluated plans of correction, and provided aggregate reports with recommendations for each agency.
- Collected survey data through document and medical record reviews; interviewed HCBS provider personnel, enrollees and/or caretakers; and assessed the adequacy of staffing and resources.
- Provided support and technical assistance to the State and HCBS waiver providers to integrate a QI model approach with existing QA activities.
- Validated appropriate service utilization and medical necessity of home care services via validation of billed services against those of the ordering physician.
- Verified individual enrollee plan of care and ensured that physician orders were updated according to state regulatory requirements.

Relevance to This Contract

- Conducted medical record review to assess adequacy and documentation of care plans, eligibility and required standards for enrollee service.
- Developed criteria and tools for survey.
- Coordinated and conducted agency site visits and enrollee home visits statewide to assess compliance, including staff credentials, provider oversight, and enrollee service provision and utilization.
- Developed and submitted comprehensive reports, including opportunities for improvement and plan of correction requests.
- Evaluated agency corrective action plans.

UQIOSC Amendment to the QIO Contract	
Contracting Organization	Centers for Medicare & Medicaid Services
Business Address	7500 Security Blvd. Baltimore, MD 21244-1850
Contracting Officer Name, Title	Patty Rawlings, Project Officer
Telephone Number	214-767-4423
Email Address	**Patty.Rawlings@cms.hhs.gov**
Contract Number	HHSM-500-2005-TN001C-01
Contract Type	Amendment to base QIO contract
Contract Total Value	$2,403,896
Period of Performance	8/1/1999– 7/31/2008
Staff Months	180

Description of Activities

- As CMS' only designated Underserved QIO Support Contractor (UQIOSC), Qsource assisted CMS in its efforts to improve performance measure results among underserved populations in three clinical areas: breast cancer, adult immunizations and diabetes.
- Qsource focused on providing cultural competency education and technical assistance to QIOs as the work with physician offices to implement the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) Standards, measuring Medicare healthcare disparities nationally and evaluating the effectiveness of QIO efforts to reduce healthcare disparities within each state.

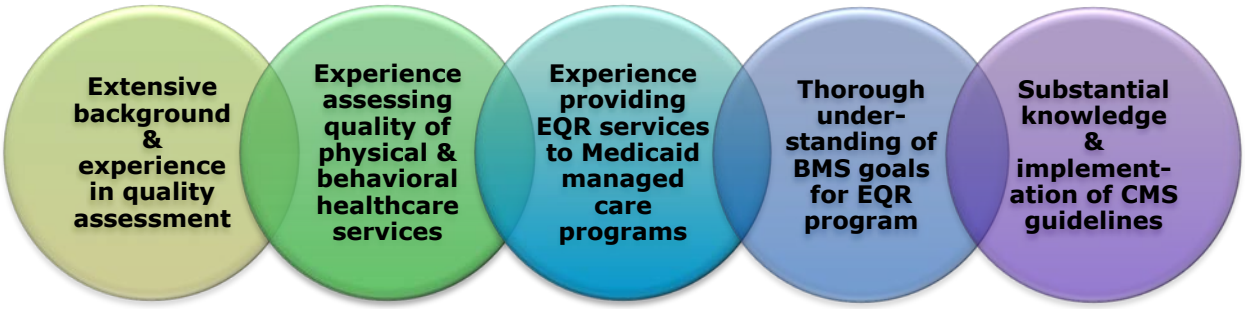
Relevance to This Contract

- Qsource conducted training and education on culturally competent healthcare and conducted QIO tool evaluations to ensure that they were culturally competent.
- Qsource developed communication strategies to improve clinical performance for underserved populations.

EQRO Expertise

Every state with a managed care Medicaid program is required by federal legislation to have an EQRO assess the quality, timeliness and accessibility of the care and services delivered to members. The *Balanced Budget Act of 1997* (BBA) requires that Qsource assess each health plan's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients."

Qsource is eager to work with the West Virginia Bureau of Medical Services (BMS), its Mountain Health Trust (MHT) Medicaid managed care program, and the three managed care organizations (MCOs) that serve MHT enrollees. We look forward to providing for BMS quality oversight services that strive to improve the timeliness, quality and access to care currently furnished by Carelink, The Health Plan of the Upper Ohio Valley, and Unicare. In addition, our well-qualified staff is prepared to exceed the expectations of this RFP through our expertise in successfully completing the mandatory EQR activities, as demonstrated by the following Qsource characteristics diagram, as well as additional activities not mandated by the BBA.



Qsource's corporate mission of continuous QI supports the EQRO activities we will conduct for BMS. In our EQRO role, Qsource has provided quality assurance (QA) review of TennCare's MCCs through survey and review, including annual compliance audits; network adequacy and benefits delivery review (ANA); performance improvement project (PIP) validations; validation of performance measures (PMVs); Early Periodic Screening, Diagnosis and Treatment (EPSDT) review; HEDIS and CAHPS® annual comparative analyses; and quarterly provider data validations (PDVs).

Program/Quality Management System (QMS)

Qsource executes continuous monitoring of contract performance via our International Organization for Standards (ISO) program and internal quality control (IQC) dashboard. Qsource first achieved certification to ISO 9001 in July 2005 and is currently certified to ISO 9001:2008. The ISO 9001 standards are integrated in Qsource's quality management system (QMS) to ensure the organization's ability to fulfill

- customer requirements;
- applicable regulatory requirements; and
- continual improvement of our performance in pursuit of contract objectives.

Qsource has all the necessary resources to successfully provide the services and deliverables as specified in the West Virginia BMS RFP #MED12009: External Quality Review Organization. Qsource is committed to bringing all of our knowledge gleaned from previous work to provide BMS with efficient and effective quality review. **Table 2** demonstrates the Qsource team's core qualifications based on successfully completed projects of like size and/or scope.

Table 2. Qsource Corporate Qualifications										
Corporate Qualifications by Successfully Completed Contract	**Project Management/Evaluation**	**Contract Management**	**Medicaid Programs**	**Data/Statistical Analyses**	**Form Development and/or Record Management**	**Onsite Compliance Visits**	**Performance Measure Criteria Development**	**Database Development/Management**	**Data Collection/Validation**	**Quality Reports**
QIO Contract	●	●		●	●		●	●	●	●
TennCare EQRO Contract	●	●	●	●	●	●	●	●	●	●
Tennessee CoverKids EQRO Contract	●	●	●	●	●	●	●	●	●	●
QA/QI Review of Statewide/PACE HCBS E&D Waiver Programs	●	●	●	●	●	●	●	●	●	●
Tennessee Heart Disease & Stroke Prevention	●	●		●					●	●
Delta States Stroke Network Telestroke Pilot Project	●	●		●	●		●		●	●
Community Health Network	●	●					●			
Arkansas MMQI & Technical Support	●	●	●	●	●	●	●	●	●	●
Arkansas Therapy Review and Prior Auth	●	●	●		●		●			
HMCT Data Aggregator	●	●		●	●		●	●	●	●
tnREC Grant	●	●	●	●	●	●		●	●	●

References

Table 3 provides three references who can attest to Qsource's qualifications and experience relevant to serving as West Virginia's EQRO. Reference information also appears in Section 2.4.14, as required by this RFP, and in individual letters of reference included in Appendix I.

Table 3. Reference Contact Information				
Organization	**Contact**	**Phone**	**Address**	**Email Address**
Bureau of TennCare, Tennessee Department of Finance and Administration	Judy Womack, Director of Quality Improvement	615-507-6716	310 Great Circle Road, Nashville, TN 37243	**Judy.M.Womack@tn.gov**
Cover Tennessee Programs, Tennessee Department of Finance and Administration, Division of Health Care Finance and Administration	Stephanie Dickerson, Director, CoverKids	615-253-8572	Snodgrass TN Tower, 26th floor 312 Rosa L. Parks Avenue, Nashville, TN 37243	**Stephanie.K.Dickerson@tn.gov**

Table 3. Reference Contact Information				
Organization	**Contact**	**Phone**	**Address**	**Email Address**
Division of Medical Services, Arkansas Department of Human Services	Marilyn Strickland, Interim Director	501-682-8330	P.O. Box 1437, Slot S-401,l Little Rock, AR 72203-1437	**Marilyn.Strickland@arkansas.gov**

Proposed Project Team

Qsource has assembled a team of key personnel with the talents critical to effectively manage and execute the activities of the EQRO contract. Combined, our team has over 20 years of experience performing the activities required by this RFP. In addition, key personnel of our proposed team hold advanced degrees in their fields; support staff members, likewise, retain advanced degrees and/or specialized certifications in their fields. Detailed resumes for all proposed staff are located in **Appendix II**.

Our team offers expertise in EQR, Medicaid managed care, NCQA, HEDIS and CAHPS®, federal and state court orders, QI studies, statistics, epidemiology, claims data analyses and the life cycle of performance measurement and QI. This includes design, implementation, testing, and reporting to ensure overall success in attaining the RFP-specific deliverables and performance indicators. Team members responsible for managing and implementing the tasks set forth in this opportunity have been involved in similar work for a decade or longer and bring a unique set of knowledge and qualifications to this work.

Qsource's expertise is matched by longevity, as demonstrated by high retention rates and staff members' years of service. Six of our associates have been with Qsource for more than 20 years, five between 15 and 20 years, nine between 10 and 15 years, and 41 between one and five years. Qsource will request prior approval from BMS for changes to/deletions from the proposed staffing and will notify BMS immediately upon any unexpected changes to program staff. Qsource will ensure current licensure is maintained and non-exclusion status verified for all licensed professionals throughout the contract.

Qsource Corporate Management

Table 4 delineates the corporate management structure that will support the EQRO contract. Qsource's corporate leadership is actively involved in the organization's quality management processes, including the IQC and ISO processes that will support all contract activities. These are described in detail in **Section 2.4.13**.

Table 4. Corporate Management Structure to Support Contract Activities
Board of Directors (BoD)
Chief Executive Officer (CEO) Reports to the BoD
Chief Financial Officer (CFO) Reports to the CEO
Vice President of Corporate Compliance and Development Reports to the CEO
EQRO Director Reports to the CEO

Qsource operates under the direction of a Chief Executive Officer (CEO) who reports to a Board of Directors (BoD). Its members are a diverse subset of individuals who exceed requirements for organizational integrity and board

composition established by the American Health Quality Association (AHQA) and recommended by CMS. The Chief Financial Officer (CFO) regulates and monitors Financial and Human Resource activities, while the Vice President of Corporate Compliance and Development (VPCCD) regulates and monitors organizational compliance. The CFO and VPCCD report directly to the CEO.

Qsource **CEO Dawn M. FitzGerald**, MS, MBA, oversees all federal, state and local contracts, including the QIO for Medicare in Tennessee, the EQRO for the Tennessee Medicaid managed care organization (TennCare), the Tennessee Regional Extension Center (tnREC), and numerous other commercial and state contracts that provide HIT, program evaluation, QI, consultation and implementation support to providers in Tennessee and Arkansas, the latter via our subsidiary, Qsource of Arkansas.

FitzGerald has 20 years' experience in healthcare quality measurement, assurance and improvement. She has co-authored several articles on QI, healthcare disparities and analyses of Medicare data, and has made numerous presentations to CMS, QIOs and healthcare provider communities. FitzGerald currently sits on the NQF's Healthcare Disparities and Cultural Competency Steering Committee and recently served on the Institute of Medicine's (IOM) Committee on Future Directions for the National Healthcare Quality and Disparities Reports. FitzGerald is a former member of the NQF's Ambulatory Measures of Health Care Disparities Workgroup and the NQF panel on Performance Measures for Minority Populations and Implementation and Improvement Workgroup. FitzGerald is also a member of a number of local and statewide boards and community coalitions.

FitzGerald received her Master of Science (MS) degree in Developmental Psychology and Gerontology from the University of Florida, and a Master of Business Administration (MBA) from the University of Memphis. In 2005, she received the Outstanding Leader in Operations Management Award, a prestigious national honor from the James Q. Cannon Endowment for Healthcare Quality Improvement.

Program Leadership

Two individuals will be directly responsible for managing the EQRO contract and ensuring all deliverables are met on time, on strategy and on budget. Qualifications and responsibilities of these key personnel are provided in **Table 5**.

Table 5. Profiles of Direct Oversight Personnel

Key Personnel	Qualifications	Responsibilities
John Couzins, MPH, CHCA EQRO Director, Qsource	♦ Licensed CHCA with a Master of Public Health ♦ Over a decade of management experience in EQROs and clinical healthcare ♦ Expertise in EQRO processes for Medicaid managed programs ♦ Advanced knowledge of NCQA accreditation, health plan	**Reports to Qsource CEO.** Responsible for all direction provided to Program Manager related to contract activities for the BMS EQRO contract. Serves as Primary Point of Contact to State of West Virginia for the BMS EQRO contract.

Table 5. Profiles of Direct Oversight Personnel		
Key Personnel	**Qualifications**	**Responsibilities**
	compliance audit processes and ISO 9001 certification ♦ Advanced knowledge of health data analyses and clinical tasks/epidemiology	Provides significant administrative oversight.
Michelle North, BSN, RN, CPHQ EQRO Program Manager, Qsource	♦ Current, unrestricted Tennessee RN license ♦ Over 16 years clinical experience, including streamlining healthcare and administrative processes and facilitating provider corrective action plans ♦ Over seven years experience in healthcare QI ♦ Extensive knowledge of managed care systems, including QI and utilization management ♦ Knowledgeable of clinical data/statistical analyses	**Reports to Qsource EQRO Director.** Responsible for all direction provided to program staff associated with QI and administrative activities for the BMS EQRO contract. Responsible for oversight and coordination of day-to-day program activities and development of task-specific timelines, tools and communications. Leads BMS EQRO contract staff in achievement of required activities, including onsite reviews of health plans and generating reports detailing review results.
Deborah Crouse, MHA/INF, BSN, CPHQ, CCM Project Coordinator, Qsource	♦ More than 28 years' experience in healthcare and 14 years of experience combined in quality improvement, utilization management and case management ♦ Nearly a decade of service for CMS contract with Qsource ♦ Emphasized experience in supervising training, coordinating continuing education opportunities and large-scale collaboration ♦ Experienced in data abstraction, methodology and protocol development as well as utilization assessment	**Reports to Qsource EQRO Program Manager.** Responsible for working across groups, aligning internal team members and external stakeholders. Responsible for coordinating project phases and schedules, arranging support services, ordering supplies and tracking progress. Serves as liaison to ancillary support.

John Couzins, MPH, CHCA, the **EQRO Director/Epidemiologist**, who reports to the CEO, will be directly responsible for managing the EQRO contract and ensuring all deliverables are met on time, on strategy and on budget. As the EQRO Director, Couzins will be responsible for overall contract performance and deliverables; directing, monitoring and facilitating all EQRO-related activities; managing and overseeing the EQRO staff; and monitoring and evaluating subcontractor performance. Couzins has more than 12 years' experience in healthcare assessment, data collection and analyses, and more than seven years in management. He

conducts contract compliance, ANA and NCQA HEDIS Compliance Audits™[5]. Couzins' previous experience includes being a health analyst and epidemiologist for the National Health and Nutrition Examination Survey (NHANES) and National Health Interview Survey (NHIS) national databases, for the Institute for Healthcare Improvement (IHI) collaboratives, and for the Centers for Disease Control and Prevention (CDC). He has also led healthcare improvement projects and epidemiological initiatives. Recently, Couzins served as one of six key witnesses for the State in a federal trial and was instrumental in testimony that ultimately led to a favorable ruling for the State and the lifting of a 14-year-long consent decree from the TennCare program.

As EQRO Director, Couzins will provide technical assistance to BMS's MCOs regarding HEDIS and contract compliance. Couzins serves as Qsource's epidemiologist and oversees all data analytics and research-related activities under the current EQRO and CoverKids contracts for TennCare. Couzins has conducted several presentations on healthcare testing, variables, database and project management, web-based programs and educational materials. He has published an article on group-randomized evaluation in the *Journal of Clinical Epidemiology*. Couzins holds a Master of Public Health (MPH) in Epidemiology from Emory University and a Bachelor of Science (BS) in Microbiology from The Ohio State University.

As the **EQRO Program Manager/Clinical QI Specialist**, **Michelle North**, BSN, RN, CPHQ, will report to the EQRO Director and be responsible for coordination of all contract deliverables, collaboration with state and other contract stakeholders, conducting PIP validation, organizing taskforce meetings, assessing EPSDT compliance, and assisting in clinical QI tasks of participation in AQSs and performance of all required medical record reviews.

She has more than 16 years of clinical experience, five of which have been in healthcare delivery settings, with more than eight in healthcare QI. North has extensive managed care experience, including demonstrated QI and UM expertise with an NCQA-accredited company. She holds specialized experience in labor, delivery and postpartum mother/baby care; well-child visits; medical record review; assessing and streamlining healthcare and administrative processes; and facilitating provider corrective action plans (CAPs). North earned her Bachelor of Science in Nursing (BSN) at The University of Memphis in Tennessee. She is currently a licensed registered nurse (RN) and has earned her designation as a Certified Professional in Healthcare Quality (CPHQ).

In her role as **EQRO Project Coordinator**, **Deborah Crouse**, MHA/INF, BSN, CPHQ, CCM, will be responsible for working across groups, aligning internal team members and external stakeholders. She also will coordinate project phases and schedules, arrange support services, order supplies and track progress as well as serve as liaison to ancillary support. Crouse has more than 28 years' experience in healthcare and 14 years of experience combined in quality improvement, utilization management and case management, with nearly a decade of service under the CMS contract with Qsource as the Tennessee QIO. She also has emphasized

[5] **NCQA HEDIS Compliance Audit™** is a trademark of the National Committee for Quality Assurance (NCQA).

experience in supervising, training, coordinating continuing education (CEU/CME) opportunities and large-scale collaboration, as well as data abstraction, methodology and protocol development, and utilization assessment with high-risk, high-cost populations, including cancer and transplant patients, and diabetics. In addition, Crouse's experience extends to data abstraction, methodology and protocol development as well as utilization assessment. Crouse is a licensed registered nurse and holds certifications as a Certified Case Manager (CCM), CPHQ and Certified Professional in Utilization Review (CPUR).

Swapna Mehendale, MHA, BPharm, in her role as **Health Analyst**, will edit, clean and score large datasets. She will conduct accurate and verified descriptive and statistical analyses of health outcomes data, and create analysis reports and results for dissemination, reporting and presentations. She also will apply skills in GIS, SAS and SQL for analyses and report production. Mehendale is professionally experienced in importing, editing, and exporting SAS datasets and in creating summary tables, graphs and reports. She has managed projects for a 490-bed hospital and conducted assessments. She is also experienced in research studies and presenting outcomes. Mehendale is trained in Six-Sigma and technically proficient in SAS, MS Office, Project2003, SPSS, Web design and SQL. She is a SAS Certified Advanced Programmer.

In her role as **Technical Writer**, **Kelly Agee**, MS, BA, will assist in the annual production of reports for External Quality Review (EQR) activities pertaining to contractor quality improvement (QI)/assurance, national healthcare measure benchmarking, and national/state policy and best practices. She will write, edit, proofread, research, compile, format and organize data for reporting while collaborating with EQR team members and state agencies to help ensure compliance. She will assist in organizing team deliverable processes, including creation of work plans and process documentation guides. Agee has 17 years' experience in writing, editing and proofreading multiple documentation types in varied electronic and print formats, as well as 10 years' experience in academic and educational settings. Her experience includes managing multiple projects in a deadline-driven, team-oriented environment. Her expertise extends to media and dissemination, including overseeing research and development of publications; standard American English; and most familiar writing styles, most notably APA, AP, MLA, Chicago, Turabian and IEEE. Agee is a competent professional presenter for a variety of topics and is technically proficient in Microsoft Office, QuarkXPress, Blackboard, QuestionMark and Mathematica.

Lingling Gong, **Senior Programmer/Database Administrator**, MS, OCA, MCP, will be responsible for loading, manipulating, editing, verifying, validating and merging data sets and generating queries from MS Oracle (PL SQL), SQL Server (T-SQL) and MS Access database. She will develop, implement and maintain content management of Intranet (Visual Studio 2005/VB.Net/ASP.Net/SQL Server 2005). Gong will perform data management functions to ensure data integrity and write custom programs and database applications. She also will maintain and administrate the Windows 2003 Oracle and SQL database servers. Gong has more than five years' experience as lead-level programmer and database/server administrator. She is an expert in the development, improvement and refinement of database systems, custom programs and reporting applications. Gong is well versed in numerous platforms including

SQL Server, Oracle and Access, with the ability to synchronize and optimize across multiple databases and locations while maintaining data integrity. She has additional expertise in process improvement and in web design/content management using multimedia applications and software tools. Her fields include federal government, finance and higher education. Gong is an Oracle Certified Associate (OCA) and Microsoft Certified Professional (MCP).

As **Network Specialist**, **Ashley Mudd** will maintain computer hardware and software as well as the operating system on devices connected to the Corporate Network (LAN). She will assist in the management of operating systems including system security, adding users, maintaining menus and operating systems and operating systems support. She will serve as backup to the Network Administrator for mission-critical applications and environments and serve as second-level support for the server backups and data restore procedures as necessary. Mudd will provide technical support for the phone and voicemail systems as necessary and perform problem diagnostics and regular maintenance on all hardware. She will assist in the maintenance of hardware/software databases, periodically performing assistance in physical inventory to reconcile and provide daily technical assistance support to all EQRO users as needed. She also will assist in supporting video conference equipment and in maintaining data communications lines (T1) and equipment such as routers and switches. Mudd brings six years' network experience to the team, including serving as an IT analyst with various support duties. Her experience includes training new associates and providing innovative suggestions for process improvement. She has extensive computer skills and software experience, including Linux/Unix, AutoCAD, NAMeS, Rockwell software, WonderWare, Eagle, Hertzler, QAD/MLS, I/Gear, change control processes, ABB software, PCdims (CMM software), database maintenance backup plans, Symantec Endpoint Protection, Avaya phone systems, Microsoft Server 2003, Microsoft Office Standard/Professional 2003/2007 and Microsoft Windows NT/95/98/ME/2000/XP/Vista/7.

Resumes of Key Staff

Resumes of key staff for this EQRO contract are provided in **Appendix II**.

Staff Certifications/Degrees

Staff certifications and degrees applicable to this EQRO project are provided in **Appendix III**.

Communications and Support Staff

Steeped in practical marketing tactics and social marketing techniques, Qsource's Marketing and Communications Department (MarCom) prides itself on a proven ability to create messages that fit its audiences' needs and capabilities using the correct vehicle to spur action. This includes an expertise at creating variable literacy material that simplifies the complexity of healthcare without compromising the clinical nature of the subject. Qsource's communications professionals understand that *easy-to-read* is comprised of more than the use of low-literacy language; at its foundation is the inclusion of design elements and factors that determine the success of a message and the practical function and use of materials by end users. This understanding is spread across all print and electronic materials developed. Whether the communications piece is a website offering educational resources and information or a full

campaign with direct mail and point-of-contact messaging, consistency in messaging and design for best comprehension is of the utmost importance.

Qsource has successfully used email marketing tactics (short messages via eBlasts and newsletter-type content via eBriefs) for branding messages, tracking the delivery and outcome of those messages and determining how to better communicate with the various audiences we serve. The technology employed (Constant Contact® online service) provides the necessary tools for personalizing each message and for reporting features on all email activity to allow detailed access to a message's level of success and outreach. One of the most important features of Qsource's eMarketing strategy is the ability to provide embedded hyperlinks to new and additional content on websites. Through examining reporting data, Qsource has determined that eMarketing within the QIO community has been particularly effective at guiding providers and media outlets to partner/stakeholder sites for additional and/or updated content. Collectively, the MarCom staff has received numerous honors including Aster Awards, APEX Awards, National Mature Media Awards, the Public Relations Society of America (PRSA) Vox Award, and healthcare marketing and public relations societies' awards.

Additional Resources

Qsource administrative staff maintains the same level of efficiency and effectiveness that has been critical to our success. Associates in this department have an extensive history of maintaining a robust system for medical records management, including the receipt, scanning and storing of over 1,000 records per quarter. Administration is also capable of producing print media using a robust print and assembly center:

- **Online printing:** Printing and shipping any document anytime, anywhere
- **High-volume digital printing and copying:** Completing any size job with the print capacity of an extensive corporate network
- **Color and black and white digital printing:** Producing professional prints from digital files
- **Color and black and white copying:** Assuring clear, crisp copies from document originals
- **Finishing and binding:** Making documents easy to use, long lasting and professional

Qsource will deploy additional corporate resources as an effective way to regulate costs and successfully run the organization, including the additional allocation of EQR staffing during peak audit and report production, effective utilization of corporate staff as needed and the use of expert consultants, resources, tools and technologies to assist with its contract management, program evaluation and review activities. When available, Qsource will work to integrate science-based, proven and effective interventions into process/assistance models. Many of the tasks will provide opportunities to cross-share information, resources and tools, which will maximize resources to better manage costs and ensure that information is filtered to the appropriate people.

2.4 Project and Goals

Section 2.4.1

Qsource employs CMS protocols to guide mandatory EQRO activities as identified by the *Balanced Budget Act of 1997* (BBA) and delivers services in accordance with federal and state laws, regulations and policies pertaining to Medicaid, the State Medicaid plan, and applicable BMS provisions. Qsource has extensive experience in conducting the required and optional activities listed in this RFP and has demonstrated the capacity to fulfill ad hoc requests that are of importance to the State. To successfully conduct all activities, we have developed a number of tools and processes that maximize the efficiency of our program, resulting in cost-effective service delivery.

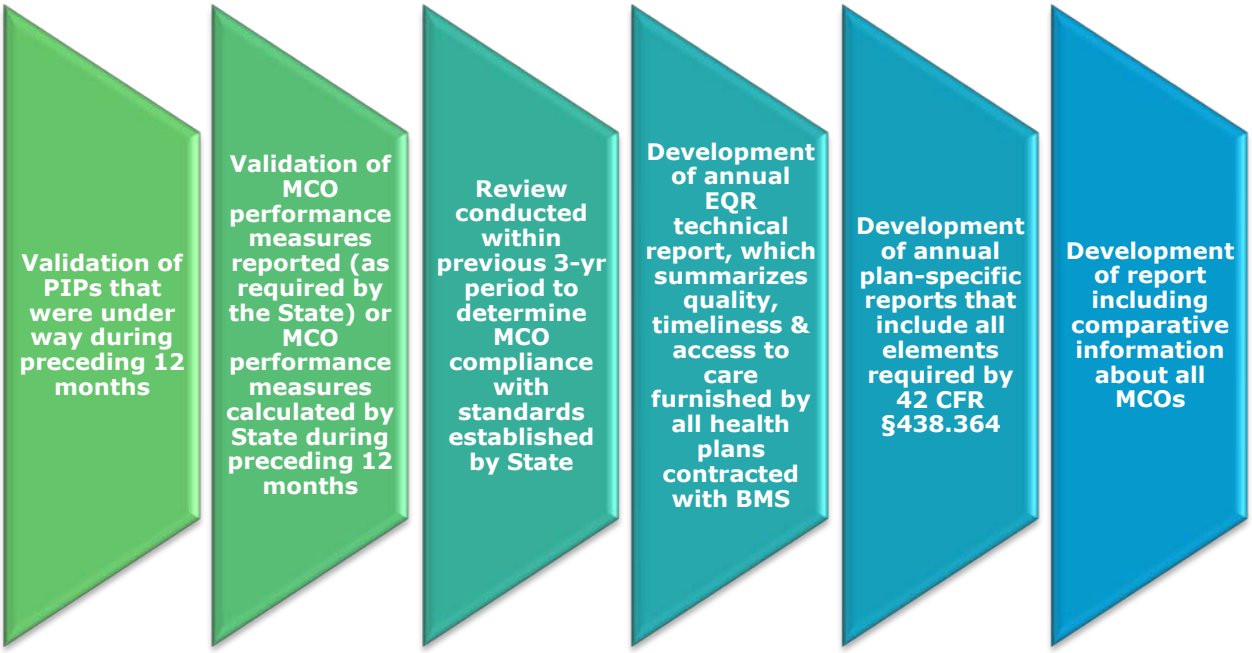
Qsource's comprehensive approach to oversight links QI, data aggregation and analyses, regulatory expertise and performance report production. By orchestrating these components and applying the following specialized strengths, we are in a unique position to provide BMS with an unparalleled level of EQR oversight and client service:

- Nearly 39 years of state healthcare quality leadership as a PRO/QIO, including the evaluation of QI program performance measures and disease management programs in a variety of healthcare settings
- Almost 12 years of experience as a state EQRO with extensive understanding of EQR federal regulations
- Integration of QI into annual review activities
- Expertise in analyzing healthcare quality and utilization to identify clinical focus areas and potential areas of reduced variation
- Extensive experience in the measurement and identification of evidence-based interventions that reduce or eliminate disparities
- Identifying and utilizing benchmarks appropriate for comparing and evaluating MCO effectiveness for HEDIS, CAHPS® and other nationally endorsed clinical performance measures
- Well-developed IT infrastructure that includes customized databases designed to capture all contractual requirements
- Making available to both the State and BMS MCOs an eLibrary of all EQRO reports via a secure VPN site in addition to providing hard-copy versions of the reports
- Our reputation for supporting and improving healthcare as a core component of our overall organizational mission
- Maintaining an up-to-date library of legislative, regulatory and policy literature relevant to the BMS program

Qsource understands and will deliver all of the required elements specified in this RFP upon contract award. These services and deliverables represent a high level of importance to the State and are critical to the integrity of the BMS program. Qsource's overall understanding of the steps necessary to successfully address the program elements is demonstrated in this section. Time estimates for each significant segment of work are presented also; however, Qsource will work with BMS to establish a timetable for deliverables that best suits BMS's needs and will submit initial work and operations plans for BMS's approval.

Prior to beginning EQRO activities for BMS, Qsource will conduct onsite visits with BMS to discuss implementation goals and processes. In addition, Qsource will conduct annual onsite pre-audit orientation meetings with the MCOs and BMS to prepare them for all review activities that will take place during the year.

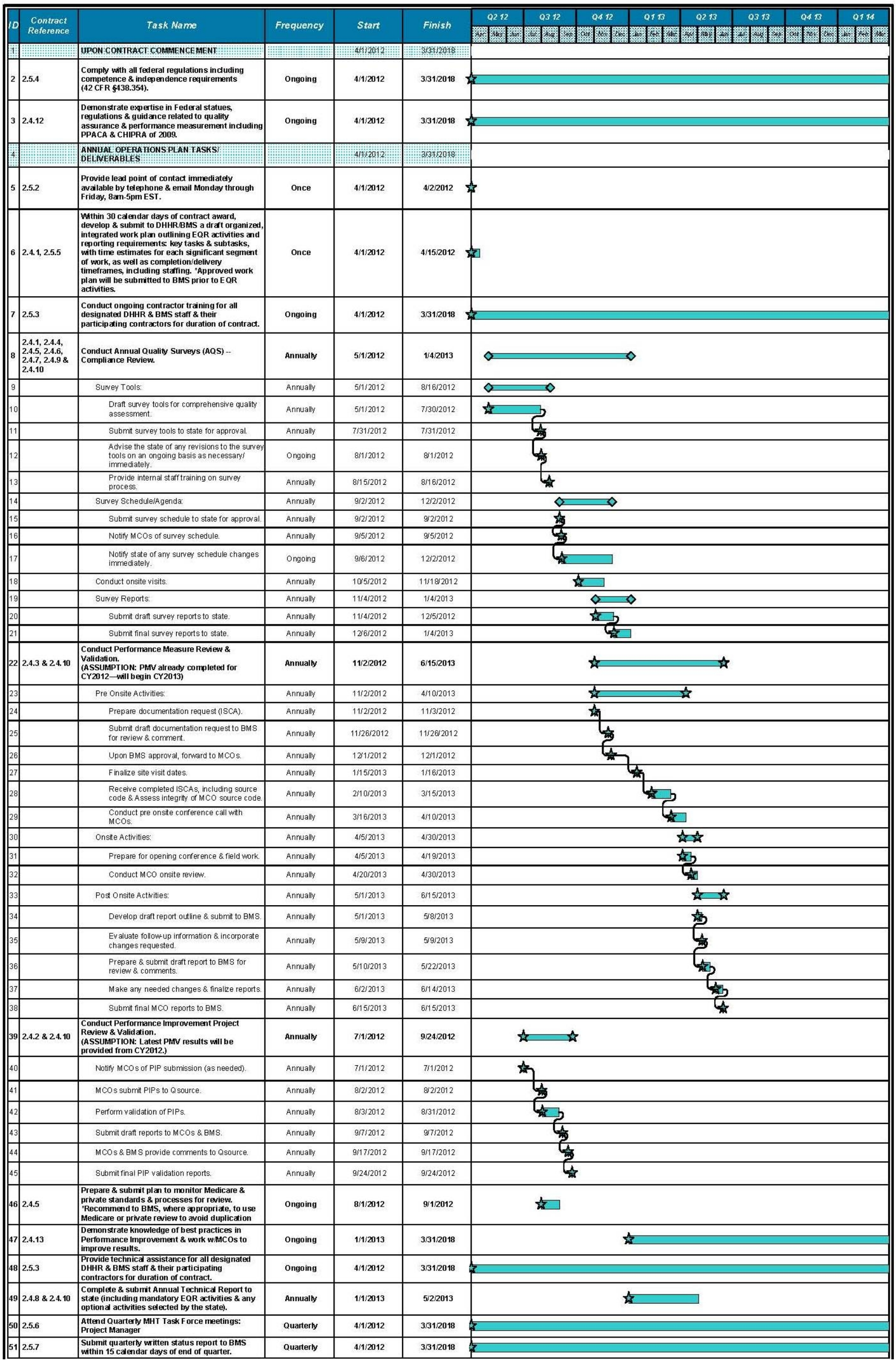
In accordance with the BBA, 42 CFR § 438.358, as the EQRO for the State of West Virginia, Qsource will perform the following required and BMS-requested EQR activities to evaluate the quality of MCOs participating in the West Virginia MHT program:



With years of experience as an EQRO, Qsource will employ our proven successful methodology for conducting all EQR activities and reporting requirements in the most efficient manner for both State and MCO staffs. In an effort to minimize disruption to the MCOs' staffs and to maintain a well-organized plan for completing EQR activities, Qsource will limit our reviews to two annual onsite visits, one for the Annual Quality Survey (AQS) and the other for PMV. Other activities will be conducted through documentation submission to Qsource via our secure VPN. Qsource is flexible in development of the actual EQRO Work Plan for tasks associated with this RFP and will tailor activities to best accommodate BMS and MCO needs upon BMS's input. For BMS's consideration, Qsource is including the following sample EQRO Work Plan.

Sample EQRO Work Plan

ID	Contract Reference	Task Name	Frequency	Start	Finish
1		**UPON CONTRACT COMMENCEMENT**		4/1/2012	3/31/2018
2	2.5.4	**Comply with all federal regulations including competence & independence requirements (42 CFR §438.354).**	**Ongoing**	**4/1/2012**	**3/31/2018**
3	2.4.12	**Demonstrate expertise in Federal statues, regulations & guidance related to quality assurance & performance measurement including PPACA & CHIPRA of 2009.**	**Ongoing**	**4/1/2012**	**3/31/2018**
4		**ANNUAL OPERATIONS PLAN TASKS/ DELIVERABLES**		4/1/2012	3/31/2018
5	2.5.2	**Provide lead point of contact immediately available by telephone & email Monday through Friday, 8am-5pm EST.**	**Once**	**4/1/2012**	**4/2/2012**
6	2.4.1, 2.5.5	**Within 30 calendar days of contract award, develop & submit to DHHR/BMS a draft organized, integrated work plan outlining EQR activities and reporting requirements: key tasks & subtasks, with time estimates for each significant segment of work, as well as completion/delivery timeframes, including staffing. *Approved work plan will be submitted to BMS prior to EQR activities.**	**Once**	**4/1/2012**	**4/15/2012**
7	2.5.3	**Conduct ongoing contractor training for all designated DHHR & BMS staff & their participating contractors for duration of contract.**	**Ongoing**	**4/1/2012**	**3/31/2018**
8	2.4.1, 2.4.4, 2.4.5, 2.4.6, 2.4.7, 2.4.9 & 2.4.10	**Conduct Annual Quality Surveys (AQS) -- Compliance Review.**	**Annually**	**5/1/2012**	**1/4/2013**
9		Survey Tools:	Annually	5/1/2012	8/16/2012
10		Draft survey tools for comprehensive quality assessment.	Annually	5/1/2012	7/30/2012
11		Submit survey tools to state for approval.	Annually	7/31/2012	7/31/2012
12		Advise the state of any revisions to the survey tools on an ongoing basis as necessary/ immediately.	Ongoing	8/1/2012	8/1/2012
13		Provide internal staff training on survey process.	Annually	8/15/2012	8/16/2012
14		Survey Schedule/Agenda:	Annually	9/2/2012	12/2/2012
15		Submit survey schedule to state for approval.	Annually	9/2/2012	9/2/2012
16		Notify MCOs of survey schedule.	Annually	9/5/2012	9/5/2012
17		Notify state of any survey schedule changes immediately.	Ongoing	9/6/2012	12/2/2012
18		Conduct onsite visits.	Annually	10/5/2012	11/18/2012
19		Survey Reports:	Annually	11/4/2012	1/4/2013
20		Submit draft survey reports to state.	Annually	11/4/2012	12/5/2012
21		Submit final survey reports to state.	Annually	12/6/2012	1/4/2013
22	2.4.3 & 2.4.10	**Conduct Performance Measure Review & Validation. (ASSUMPTION: PMV already completed for CY2012—will begin CY2013)**	**Annually**	**11/2/2012**	**6/15/2013**
23		Pre Onsite Activities:	Annually	11/2/2012	4/10/2013
24		Prepare documentation request (ISCA).	Annually	11/2/2012	11/3/2012
25		Submit draft documentation request to BMS for review & comment.	Annually	11/26/2012	11/26/2012
26		Upon BMS approval, forward to MCOs.	Annually	12/1/2012	12/1/2012
27		Finalize site visit dates.	Annually	1/15/2013	1/16/2013
28		Receive completed ISCAs, including source code & Assess integrity of MCO source code.	Annually	2/10/2013	3/15/2013
29		Conduct pre onsite conference call with MCOs.	Annually	3/16/2013	4/10/2013
30		Onsite Activities:	Annually	4/5/2013	4/30/2013
31		Prepare for opening conference & field work.	Annually	4/5/2013	4/19/2013
32		Conduct MCO onsite review.	Annually	4/20/2013	4/30/2013
33		Post Onsite Activities:	Annually	5/1/2013	6/15/2013
34		Develop draft report outline & submit to BMS.	Annually	5/1/2013	5/8/2013
35		Evaluate follow-up information & incorporate changes requested.	Annually	5/9/2013	5/9/2013
36		Prepare & submit draft report to BMS for review & comments.	Annually	5/10/2013	5/22/2013
37		Make any needed changes & finalize reports.	Annually	6/2/2013	6/14/2013
38		Submit final MCO reports to BMS.	Annually	6/15/2013	6/15/2013
39	2.4.2 & 2.4.10	**Conduct Performance Improvement Project Review & Validation. (ASSUMPTION: Latest PMV results will be provided from CY2012.)**	**Annually**	**7/1/2012**	**9/24/2012**
40		Notify MCOs of PIP submission (as needed).	Annually	7/1/2012	7/1/2012
41		MCOs submit PIPs to Qsource.	Annually	8/2/2012	8/2/2012
42		Perform validation of PIPs.	Annually	8/3/2012	8/31/2012
43		Submit draft reports to MCOs & BMS.	Annually	9/7/2012	9/7/2012
44		MCOs & BMS provide comments to Qsource.	Annually	9/17/2012	9/17/2012
45		Submit final PIP validation reports.	Annually	9/24/2012	9/24/2012
46	2.4.5	**Prepare & submit plan to monitor Medicare & private standards & processes for review. *Recommend to BMS, where appropriate, to use Medicare or private review to avoid duplication**	**Ongoing**	**8/1/2012**	**9/1/2012**
47	2.4.13	**Demonstrate knowledge of best practices in Performance Improvement & work w/MCOs to improve results.**	**Ongoing**	**1/1/2013**	**3/31/2018**
48	2.5.3	**Provide technical assistance for all designated DHHR & BMS staff & their participating contractors for duration of contract.**	**Ongoing**	**4/1/2012**	**3/31/2018**
49	2.4.8 & 2.4.10	**Complete & submit Annual Technical Report to state (including mandatory EQR activities & any optional activities selected by the state).**	**Annually**	**1/1/2013**	**5/2/2013**
50	2.5.6	**Attend Quarterly MHT Task Force meetings: Project Manager**	**Quarterly**	**4/1/2012**	**3/31/2018**
51	2.5.7	**Submit quarterly written status report to BMS within 15 calendar days of end of quarter.**	**Quarterly**	**4/1/2012**	**3/31/2018**



EQR Activities

PIP Validation

In accordance with 42 CFR § 438.358(b)(1), Qsource will conduct PIP validations for each of BMS's three MCOs. Qsource's quality assessment background and experienced staff, as well as expertise in CMS guidelines and familiarity with BMS goals for its EQR program, will provide BMS with a well-organized process for evaluating MCO PIPs on an annual basis.

Having based our process on CMS protocols, Qsource already has established PIP validation tools ready for use in evaluating BMS's MCOs, following any BMS-desired modifications. Always striving to improve processes and in keeping with Qsource's corporate culture and ISO: 9001 standing, we will monitor plan progress with PIPs and provide MCOs technical assistance, as approved by BMS. These provisions, along with frequent follow-up with the health plans, will ensure PIPs are validated reliably and consistently from year to year.

With a BMS-approved PIP validation tool in place, Qsource will begin the validation process by requesting supporting documentation from all MCOs. Along with this data and form-completion request, Qsource will provide each MCO with a process timeline to ensure timely project completion. To perform the validation, Qsource will use a multidisciplinary team of experts, including an analyst, biostatisticians and clinical staff. This highly trained staff will use the 10 CMS review activities to evaluate MCO compliance for conducting PIPs.

Following validation completion, Qsource will report overall validity and reliability findings to BMS. Qsource also monitors performance indicators after completion of the PIP to ensure sustained improvements. For future PIP submissions, an MCO found deficient in any area of the evaluated PIP must submit a revised PIP Summary Form. A sample PIP Technical Papers report is included in **Appendix IV**.

PMV Validation

Qsource also will conduct a validation of MCO performance measures reported (as required by the State) or MCO performance measures calculated by the State during the preceding 12-month period. This EQR requirement is established in 42 CFR § 438.240(b)(2).

With our expertise in MCO performance measure requirements and reporting processes, Qsource can offer BMS timely and efficient PMV completion. Using performance measures supplied by BMS, Qsource will develop a timeline and project plan to complete this validation, working closely with BMS. Qsource bases our approach to validating MCO performance measures largely on CMS protocol and divides the process into three main activities: Pre-Onsite, Onsite and Post-Onsite. However, Qsource will collaborate with BMS to tailor the validation process and results reporting to best suit BMS's needs.

Qsource will communicate with BMS to ensure understanding of performance measures to be validated. Qsource will also introduce our PMV team and clearly define its roles and responsibilities through teleconference calls with each MCO. To facilitate a well-organized

validation process, Qsource will confirm critical dates for each milestone of the audit with appropriate staff and ensure that needed staff members are available for the onsite phase of the audit.

The Pre-Onsite stage of validation will include Qsource's assessment of MCO information systems (IS) as well as MCO procedures for data collection and integration. During the Onsite stage, Qsource will examine the MCO's IS integration and control, performance measures calculated and reported documentation, numerator and denominator production, sampling/ medical chart abstraction procedures and performance measure reporting procedures.

Following the onsite evaluation, Qsource will determine the validation results for each measure by aggregating the findings for each of the audit elements. Qsource will analyze the results of the audit and quantify the extent to which the findings have impacted each performance measure's result. Preliminary findings will identify any areas of concern for each measure as well as suggestions for improvement. Qsource is prepared to work with BMS to determine the most appropriate option of the two that CMS permits to assess the validity of each MCO's performance measure; however, Qsource recommends our use of a clearly defined set of uniform decision rules for determining the validity of each measure and submission of all working papers and summary of findings. Specific findings for each validation activity as well as those discovered by the validation team will be included in Qsource's PMV reports, including areas of strength and weaknesses.

AQS Review

In accordance with 42 CFR § 438.358(b)(3), Qsource will perform a review, conducted within the previous three-year period to determine each MCO's compliance with standards established by the State to comply with the requirements of 42 CFR § 438.204(g). Qsource's Annual Quality Survey (AQS) process will include a pre-assessment documentation review, an onsite visit and post-onsite analyses for each MCO. Qsource will use the federal protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al, as well as state MCO contracts with BMS and federal consent decrees for guidance in developing the AQS tool. Prior to onsite AQS reviews of each MCO, Qsource will work collaboratively with BMS and make recommendations for AQS tool development considering all applicable accreditation achievements, contract changes and managed care Medicaid requirements specific to the West Virginia MHT program.

Prior to beginning pre-onsite AQS activities, Qsource, along with BMS personnel, if they choose to participate, will offer MCOs AQS orientation and training. As the onsite visit nears, Qsource will send each MCO the BMS-approved AQS assessment tool to allow gathering of required data and to facilitate the onsite assessment. Qsource also will send a request letter for specific pre-assessment documentation. In addition, each MCO will receive instructions on organizing and preparing documents for AQS reviewers prior to the onsite review. The Qsource survey team will remain available to provide technical assistance until the onsite visit. To facilitate efficient AQS onsite reviews, surveyors will complete pre-assessment activities and document

preliminary findings prior to site visits. During pre-assessment, surveyors also will note areas lacking documentation and requiring follow-up during the health plan visits.

Qsource will prepare onsite agendas and discuss time frames and needs with each MCO prior to the scheduled visit to maximize results while minimizing operational disruption. During the onsite review, MCO staff will be available for interview and assistance in locating documentation or data sources. At the end of the visit, Qsource surveyors will meet with MCO representatives to summarize initial findings/recommendations, including identified specific strengths, areas of noncompliance and suggestions.

Following the onsite AQS review, the Qsource team will calculate and report compliance, using tested protocols and scoring methods; compile and analyze all data, calculating compliance; and prepare a report of findings and recommendations for each health plan. Qsource proposes to review MCO activities that are unique to the MHT program, such as Early Periodic Screening, Diagnosis and Treatment (EPSDT) outreach, during our AQS reviews, providing a more efficient process and less disruption to MCOs' staff members. The AQS is inclusive of CAPs and Qsource's ongoing technical assistance.

The proposed reporting format is attached as a blinded sample MCO AQS report in **Appendix V**.

Technical Report

Qsource will, in accordance with 42 CFR § 438.358 and § 438.364 and toward constant QI, develop the Annual EQR Technical Report for BMS each year. The report will summarize the quality, timeliness and access to care furnished by all three MCOs contracted with BMS. Qsource proposes collaborating with BMS to achieve the highest quality annual technical report while adhering to CMS protocols defined in 42 CFR § 438.364.

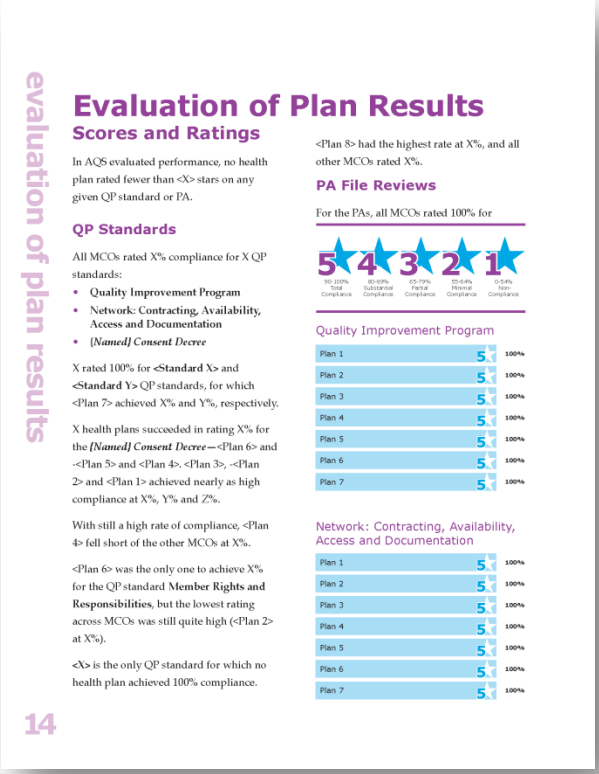
Results included in the report will be determined via the aggregation and analysis of data obtained through the PIP, PMV and AQS assessments. Report sections and content will be determined by CMS-recommended scope of work components for EQR technical reporting defined in the *CMS State External Quality Review Tool Kit for State Medicaid Agencies*, *October 2006*.

The report will close with conclusions and recommendations for MCOs, categorized by PMVs, PIPs and monitoring compliance with standards (AQS). This section also will offer Qsource's recommendations to the State derived from the EQR activities performed and organized by the three dimensions of Medicaid managed care activity that are federally required and outlined in the CMS guidelines in the technical report. Finally, detailed data for health plan findings and sample assessment tools will be provided as appendices to the technical report. The proposed reporting format is attached as a sample EQR Technical Report in **Appendix VI**.

Annual Plan-Specific Reports

As requested by BMS and adhering to requirements established in CFR 42 §438.364, Qsource will provide health-plan-specific technical reports, including the PIP, PMV and AQS reports. An assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness and access to healthcare services furnished to Medicaid recipients will be included as well as

recommendations for improving the quality of healthcare services furnished by each MCO based on the evaluation of the EQR activities. An assessment of the degree to which each MCO has addressed effectively Qsource's recommendations for quality improvement during the previous year's EQR also will be included in these MCO-specific reports, in addition to an assessment of the extent to which corrective actions recommended by Qsource have been implemented and the results of these corrective actions.


evaluation of plan results

Evaluation of Plan Results

Scores and Ratings

In AQS evaluated performance, no health plan rated fewer than <X> stars on any given QP standard or PA.

QP Standards

All MCOs rated X% compliance for X QP standards:

- **Quality Improvement Program**
- **Network: Contracting, Availability, Access and Documentation**
- ***[Named] Consent Decree***

X rated 100% for **<Standard X>** and **<Standard Y>** QP standards, for which <Plan 7> achieved X% and Y%, respectively.

X health plans succeeded in rating X% for the ***[Named] Consent Decree***—<Plan 6> and -<Plan 5> and <Plan 4>, <Plan 3>, -<Plan 2> and <Plan 1> achieved nearly as high compliance at X%, Y% and Z%.

With still a high rate of compliance, <Plan 4> fell short of the other MCOs at X%.

<Plan 6> was the only one to achieve X% for the QP standard **Member Rights and Responsibilities**, but the lowest rating across MCOs was still quite high (<Plan 2> at X%).

<X> is the only QP standard for which no health plan achieved 100% compliance.

<Plan 8> had the highest rate at X%, and all other MCOs rated X%.

PA File Reviews

For the PAs, all MCOs rated 100% for

5 4 3 2 1

90-100% Total Compliance | 80-89% Substantial Compliance | 70-79% Partial Compliance | 55-64% Minimal Compliance | 0-54% Non-Compliance

Quality Improvement Program

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	100%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

Network: Contracting, Availability, Access and Documentation

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	100%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

14

Qsource will use the PIP and AQS technical papers, as well as annual PMV reports, to inform BMS of individual MCO strengths and weaknesses in the areas of quality, timeliness and access to healthcare services. Following analysis of PIP, AQS and PMV results, Qsource will offer each MCO recommendations for improvement. While overall MCO and state-level recommendations will be found in the Annual EQR Technical Report, each MCO's PIP, AQS and PMV reports provide health-plan-specific QI targets.

For example, the PIP Technical Papers, following an overview of PIP topics and indicators as well as validation status, will offer an analysis of results that includes suggestions for improvement for the MCO based upon areas of noncompliance (AONs) identified during Qsource validation of the MCO's PIPs. AONs are identified where a plan achieves less than 100% compliance on any given quality process (QP) standard element or performance activity (PA). They reflect what a plan should do and may be accompanied by Qsource recommended policy, procedure or process changes.

Similarly, the AQS Technical Papers will provide suggestions for improvement based upon AONs. The AQS process will require that an MCO submit a CAP for each deficient performance area. In addition, Qsource will monitor each MCO's progress toward completing its action plan for each area of deficiency.

More specific information about the PIP, PMV and AQS processes is aforementioned in this section. A sample PIP Technical Papers report is provided in **Appendix IV**, and **Appendix V** contains a sample AQS Technical Papers report. Similar reports can be created for PMV, depending on BMS's needs.

Comparative Report

To provide BMS comparative information across all three MCOs, with BMS's approval, Qsource will offer comprehensive summary reports, which merge results from individual review activities. While individual MCO reports are limited to the detailed results of a particular health plan, the summary reports will compare overall results of each health plan using graphic elements to provide, at a glance, a clear overview of how the health plans have performed on key criteria in a given activity or contractual mandate. Provided as an example summary report in **Appendix VII** is a redacted AQS Summary Report prepared by Qsource for BMS's consideration.

Sections 2.4.2 through **2.4.14** provide additional information about how Qsource proposes to successfully complete EQR activities for all three West Virginia MHT MCOs in a timely, efficient manner.

Section 2.4.2

As one of three mandatory EQR activities, the BBA, 42 CFR § 438.358(b)(1) requires EQROs to conduct a validation of performance improvement projects (PIPs) mandated by the State to comply with the requirements set forth in 42 CFR §438.240(b)(1) that were under way during the preceding 12 months. Managed Medicaid MCOs are required to conduct PIPs that are 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. PIPs should be ongoing, focus on clinical and nonclinical areas, and include the following:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

Qsource has extensive experience in validating PIPs and is uniquely positioned to be highly efficient in assisting the State of West Virginia BMS with meeting and exceeding its objectives for ensuring that plan PIPs effectively assess and improve processes and outcomes of care.

PIP Validation

Qsource's process largely follows the validation protocols issued by CMS—*Validating Performance Improvement Projects, A protocol for use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol Version 1.0, May 1, 2002*. Qsource's approach offers BMS the following benefits:

- An established evaluation tool, based on national standards, proven to be effective for evaluating plan performance on conducting PIPs, and easily modified to meet BMS needs
- Continuous monitoring of plan progress with PIPs for early identification of issues

- Proactive provision of technical assistance approved by BMS to assist with bringing the plans that are not performing well up to the same level as plans that are performing well
- Frequent follow-up with the plans to ensure PIPs stay on track

The purpose of conducting PIPs is to assess and improve processes and ultimately outcomes of care. CMS protocol defines "outcomes" as measures of patient health, functional status or satisfaction following the receipt of care and services. In order for PIPs to achieve demonstrable improvement, they must be designed, conducted and reported in a methodologically sound manner. The following outlines Qsource's current tools and process for validating PIPs, and Qsource is prepared to work with BMS, if necessary, to modify our existing validation technique to meet the needs of each MCO while complying with established guidelines.

PIP Validation Tool

Qsource will use a comprehensive PIP evaluation tool that has proven effective for assessing PIPs. This tool was also developed using standards and guidelines outlined in the CMS protocol. The tool and scoring methodology have undergone rigorous testing and have been successfully used to evaluate both physical and behavioral health in several other states. Qsource has identified both critical and non-critical elements for our validation tool. Critical elements are those where compliance must be 100 percent for the PIP to be considered accurate and reliable enough to pass the validation.

To be consistent with requirements outlined in the MCO contracts, the tool will be modified by EQRO staff at least annually and in conjunction with reassessing the criteria and scoring methodology, and updating tool components based on effectiveness, changes in federal and/or BMS policies, and/or changes to national and regional guidelines and protocols. Qsource will submit the recommended criteria and scoring methodology for BMS approval and make revisions accordingly.

Once the tool has been finalized, Qsource will prepare an informational document request, including a cover letter outlining the PIP validation process, a PIP form that will be completed by the MCOs, instructions for completion of the form, a sample completed PIP form, a timetable for all PIP review activities and information on where to direct any future inquiries. The PIP form is developed in conjunction with the PIP tool and is populated by the MCOs with the information needed to complete the validation process. This data request process will be efficient and effective, providing the plans with sufficient information to successfully complete the PIP form in the most straightforward manner.

PIP Validation Process

Qsource will use a multidisciplinary team of experts, including an analyst, biostatisticians and clinical staff, to perform the validation. The validation process used by Qsource to evaluate PIPs consists of 10 major activities, summarized in **Table 6**.

Table 6. 2011 PIP Review Activities		
Review Activities	**Evaluation Elements Met/Applicable**	**Critical Elements Met/Applicable**
Choose the Study Topic(s)	X/6	X/1
Define the Study Question(s)	X/2	X/2
Select the Study Indicator(s)	X/7	X/3
Use a Representative and Generalizable Study Population	X/3	X/2
Use Sound Sampling Methods	X/6	X/0
Use Valid and Reliable Data Collection Procedures	X/11	X/1
Include Improvement Strategies	X/4	X/1
Review Data Analysis and Interpretation of Study Results	X/9	X/2
Assess for Real Improvement	X/4	X/0
Assess for Sustained Improvement	X/1	X/0
Total	**X/53**	**X/12**

The following paragraphs provide more detail about each activity listed above:

Review the selected study topic(s) to assess whether data collection and analysis of plan member needs, care and services support the necessity to conduct the PIP; the PIP targets improvement in relevant clinical care and non-clinical services; the PIP is representative of the plan's Medicaid population; there are sufficient sources for data collection; and the plan can impact change in the area under study. Project topics may also be indicated by evaluating patterns of inappropriate utilization. The project must demonstrate a clear focus on the indicators and correction of deficiencies in care or services. The goal of the project or study should be to improve processes and outcomes of care.

Review the study question(s) to verify if it is clearly defined in writing and is answerable. The study questions will help maintain the focus of the PIP and set the framework for data collection, analysis and interpretation.

Review selected study indicator(s) to determine if it is measurable, clearly defined and pertinent to the study question; has adequate data sources; addresses limitations on collecting data; has clearly defined criteria for data collection; measures process and outcomes of care; and has realistically set performance goals and benchmarks. Each project should have one or more quality indicators to track performance and improvement over time as well as the rationale and documentation for the selection of those indicators.

Review the identified study population to determine how the study population was defined, if all individuals relevant to the study question and indicators are included or if a sample of these individuals is included, if there are any defined continuous enrollment criteria, and if the data collection plan ensures the capture of all individuals in the study population. Once the population is identified, the plan

must identify whether to review data for the entire population or select a sample of that population.

V **Review sampling methodology (if sampling was used)** to determine if the study sample is derived in accordance with generally accepted principles of research design and statistical analysis sufficient to make meaningful conclusions, and whether it will provide valid and reliable results.

VI **Review data collection procedures** to determine if data collection techniques comply with industry standards; data collection is performed in a manner that preserves internal and external validity; the method for calculating indicators is appropriate; the algorithm for extracting automated information systems (IS) data is sound/accurate; the manual data collection tool complies with indicator specifications and ensures accurate data collection; that clearly written, specific instructions on how to complete each section of the manual data collection tool are provided, and guidelines on how to handle situations not covered by the instructions are provided; manual data collection staff resources are adequate and qualified; and the data validation process is effective in verifying the accuracy of the data collected.

VII **Assess improvement strategies** to determine if the barrier analysis was adequate to identify barriers to improvement, appropriate improvement strategies were developed, and the timeline for implementation of interventions is reasonable. The protocol defines an "improvement strategy" as an intervention designed to change behavior at an institutional, practitioner or beneficiary level. The effectiveness of the intervention activity or activities is determined by measuring the plan's change in performance.

VIII **Review data analysis and interpretation of study results** to determine if data analysis techniques comply with industry standards, appropriate statistical tests are used and accurate/reliable information is obtained, interpretation and analysis are based on continuous improvement philosophies and causes are appropriately attributed to findings, and study results are communicated to appropriate internal committees and external entities. Interpreting data should involve development of a hypothesis about the causes of poor performance and collecting data to support the hypothesis.

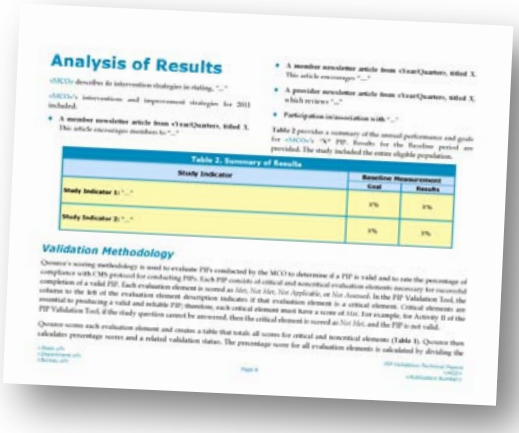

Analysis of Results

Table 2. Summary of Results

Validation Methodology

IX **Assess the likelihood that reported improvement is "real" improvement** to verify significant improvement has been achieved and reported improvement in process or outcomes of care is actual improvement. Qsource will assess the extent to which any changes in performance reported by the plan can be found to be statistically

significant. BMS may choose to establish its own numerical thresholds for reported improvements to be "significant."

Assess whether the documented improvement has been sustained to determine if the process can reasonably ensure continued improvement over time. Real change results from changes in healthcare delivery that can be documented by the plan.

Evaluating Overall Validity and Reliability of Study Results

For each completed PIP, Qsource will assess the implications of all study findings on the likely validity and reliability of findings and inform BMS regarding the confidence level of the reported findings. Qsource will assess threats to the validity and reliability of PIP findings and determine when an accumulation of threats reaches a point at which the findings are no longer credible. Following this assessment, Qsource will report overall validity and reliability findings:

- High confidence in the reported study findings
- Confidence in the reported study findings
- Low confidence in the reported study findings
- Lack of credibility in the reported study findings

Qsource also monitors performance indicators after completion of the PIP to ensure sustained improvements. For future PIP submissions, an MCO found deficient in any area of the evaluated PIP must submit a revised PIP Summary Form that includes additional information to address any suggestions and any critical and noncritical areas scored as *Not Met*. The proposed reporting format is attached as a blinded sample MCO PIP report in **Appendix IV**.

Section 2.4.3

EQROs are also required to conduct a validation of MCO performance measures that are reported (as required by the State) or MCO performance measures that are calculated by the State during the preceding 12 months. This validation complies with the requirements set forth in 42 CFR § 438.240(b)(2), as one of the three mandatory EQR activities required by the BBA, 42 CFR § 438.358(b).

Understanding of State Requirements

Qsource has a comprehensive understanding of and a wealth of experience with the MCO performance measure requirements and reporting processes. Qsource understands that BMS determines performance measures and provides the EQRO (Qsource) with complete information concerning the performance measures to be calculated by the MCOs, the specifications to be followed in calculating these measures, and the manner for and mechanisms for reporting these measures to BMS. Annually, Qsource will develop a timeline and project plan, working closely with BMS to receive the necessary information for successful validation of MCO performance measures.

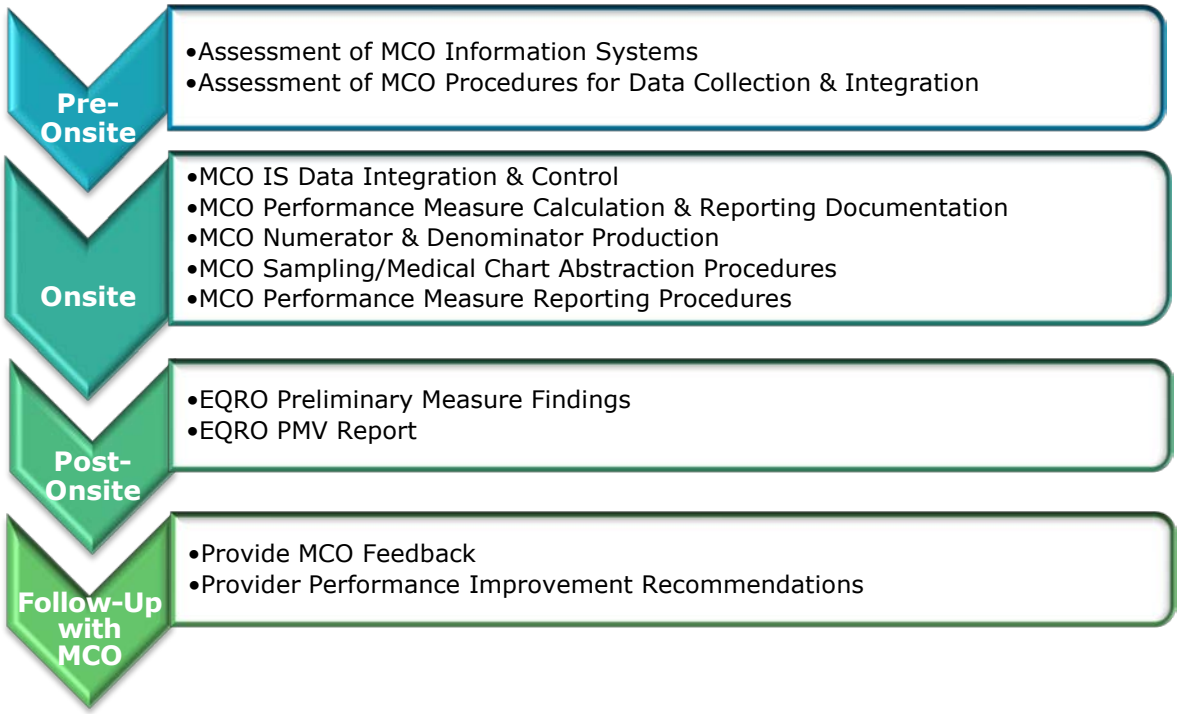
Validation of MCO Performance Measures

There are two acceptable processes an EQRO may use to validate MCO performance measures:

1. CMS protocol–*Validating Performance Measures: A protocol for use in Conducting Medicaid External Quality Review Activities. Department of Health and Human Services Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002*, or
2. An NCQA HEDIS Compliance Audit™ performed by a Certified HEDIS Compliance Auditor (CHCA) under the auspices of an NCQA Licensed Organization.

The purpose of the CMS protocol is to evaluate the accuracy of Medicaid performance measures reported by or on behalf of an MCO, and to determine the extent to which Medicaid-specific performance measures calculated by an MCO (or by an entity acting on behalf of an MCO) followed specifications established by the state Medicaid agency (the State) for the calculation of the performance measure(s). Qsource's approach to validating MCO performance measures is largely based on the CMS protocol and divides the process into four main activities: **Pre-Onsite**, **Onsite**, **Post-Onsite** and **Follow-Up with MCOs**. For each of these activities, Qsource follows the methods outlined by the protocol and incorporates the recommended procedures and forms into our process. However, Qsource will collaborate with BMS to tailor the validation process and results reporting to best suit BMS's needs.

The following description outlines Qsource's current process for each phase of the performance measure validation (PMV).



Pre-Onsite

Qsource will communicate with BMS to ensure it understands the performance measures to be validated, including any prescribed reporting methodologies, such as sampling guidance and

technical specifications, comprising each measure's numerator and denominator. Qsource will also conduct teleconference calls with each MCO, in order to introduce the Qsource PMV team and clearly define its roles and responsibilities, including those of the BMS and MCO program staff. Qsource will confirm critical dates for each milestone of the audit with appropriate staff and ensure that said staff is available for the onsite phase of the audit. Finally, Qsource will communicate our policies and procedures for safeguarding confidential information.

Assessment of MCO Information Systems

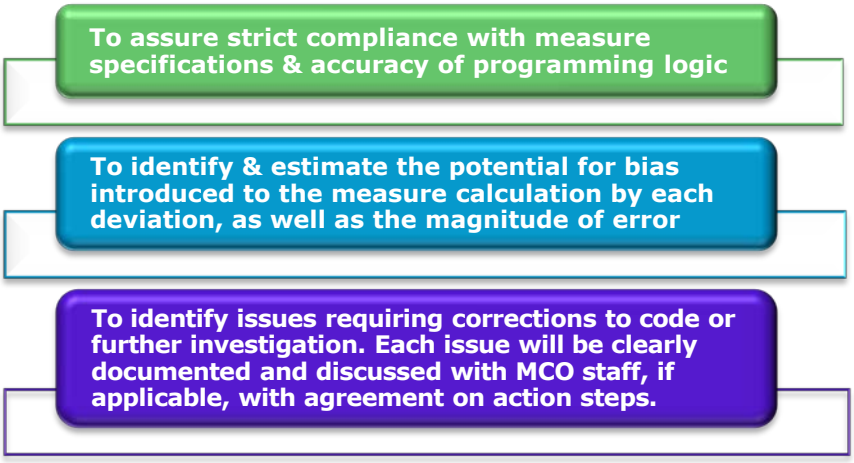
Qsource will request a completed CMS Information Systems Capabilities Assessment (ISCA) Tool from each MCO. This tool is consistent with the PMV objectives identified by CMS and consists of questions and requests documentation that will provide Qsource with necessary background information on each MCO, its policies, processes and data needed for the onsite validation activities. Prior to evaluating individual performance measures, Qsource will use the ISCA to assess the integrity of each MCO's information system (IS) and the completeness and accuracy of the data produced by all relevant systems contributing to each performance measure. While CMS does not permit an EQRO to accept audited results from other entities to satisfy the PMV requirement, if an MCO reports HEDIS data and completes NCQA's HEDIS Roadmap, Qsource can accept the completed Roadmap to satisfy certain components of the ISCA and thereby reduce the administrative burden on the MCO.

Qsource will evaluate responses against IS capabilities deemed necessary to accurately and completely calculate and report performance measures and will identify any problem areas or items in need of clarification prior to or during the onsite visit. This process will further focus the onsite validation on areas most likely to be an issue in the validation process, and it provides a basis for effective interviews with key personnel. If an MCO has recently undergone an independent IS assessment, then, in an effort to reduce duplicative activities, Qsource will evaluate the extent to which the previous assessment could be used as a valid data source to satisfy EQR PMV requirements.

Assessment of MCO Procedures for Data Collection and Integration

As part of the ISCA, Qsource will receive detailed information regarding all data systems that feed into collection and reporting of performance measures, including (but not limited to) membership/enrollment data, provider data, claims and encounter data, medical record data and vendor data, such as laboratory and pharmacy information. The audit team will review the documents submitted to identify particular system or procedural weaknesses that may have an impact on the accurate calculation of performance measures. Qsource will assess each data system to isolate the minimum data elements necessary for each performance measure. The MCOs will also include flowcharts and detailed descriptions of data integration processes that provide detailed information on how each data source contributes to each performance measure. Further, specifications and detailed source code for each measure's denominator and numerator, as well as accompanying information, are also provided. Qsource programmers, assigned based on familiarity and expertise with the programming language, conduct a detailed review of each line of code.

Qsource teams reviewing source code have three major objectives:



Any deviations from specifications are noted and described in detail via feedback in writing; verbal consultation is provided as well. Qsource auditors review the ISCA documentation and programming logic or source code to identify all issues requiring action before the onsite visit, enabling onsite discussions of specific strategies or verification of corrective actions. After all code corrections are verified by the validation team, Qsource will provide a final, written summary of the programming review process, findings and implications for measure designations to each MCO.

Onsite

The pre-onsite activities provide the background information on the MCO's ability to collect and integrate valid source data, which is necessary for calculating performance measures. The onsite activities focus on responding to IS findings identified in the pre-onsite IS assessment as being potentially problematic or in need of further review or clarification, as well as validating the production and reporting of performance measures through observation of documentation or procedures.

MCO IS Data Integration and Control

The onsite phase will allow Qsource direct examination of IS policies and procedures in conjunction with interviews with key personnel who can potentially provide helpful information related to performance measure production. Qsource will directly analyze the MCO's ability to link data from multiple sources and the data integrity controls the MCO has in place to ensure the accuracy of the performance measures. Qsource will examine each data source for accuracy and completeness, and review and assess the MCO's procedures for collecting and integrating internal and external data sources.

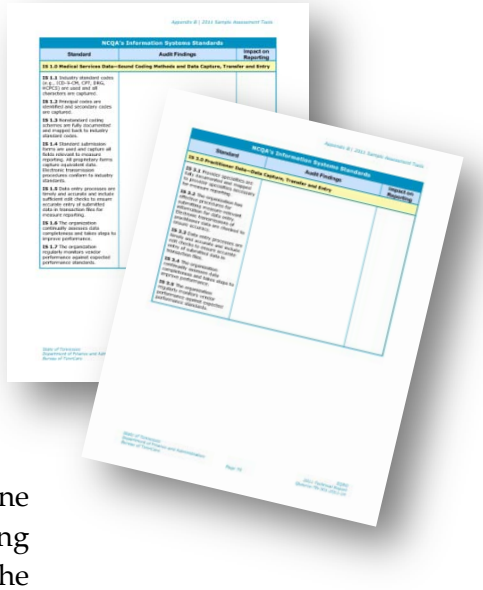
Qsource will use primary source verification and examine samples of data for each measure to ensure MCO data consolidation procedures are implemented effectively and accurately. Actual results from file consolidations will be compared to original data sources to ensure the integrity

of the merged data and that repository structures appropriately enable performance measure reporting.

A critical component to performance measure production is the development and implementation of sound procedures regarding routine maintenance, establishment of security levels and backup procedures. Qsource will examine the MCO's policies and procedures related to all three processes and determine the extent to which the MCO documentation supports appropriate processes.

MCO Performance Measure Calculation and Reporting Documentation

It is critical that each MCO retain documentation of all steps used in the production of the required performance measures, including the collection of data from various sources; steps taken to integrate the required data; and the procedures used to generate denominators, generate samples, determine numerators and apply the correct algorithms for measure production. Qsource will review performance measure plans to ensure that all data fields are appropriately identified, and when applicable, non-standard medical codes will be mapped to industry standard codes. Results of statistical testing and any necessary corrections that were identified will then be evaluated. Qsource will expect to see all documentation supporting measure production, including (but not limited to) detailed medical record review processes, data warehouse repositories and original data sources.



MCO Numerator and Denominator Production

Qsource will use the State's prescribed methodologies to determine the extent to which the MCOs used appropriate data, including linking data from separate data sets, to accurately identify the entire eligible population, specifically for each measure. Qsource will determine each measure's accuracy by analyzing initially identified populations, resulting numerators and denominators, and the programming logic and source code used to produce each population. Eligibility and enrollment files will be examined to further support the accuracy of measure denominators. Qsource will determine the extent to which numerators accurately reflect qualifying medical events through the use of primary source verification, live system demonstrations and interviews with source code programmers and system administrators.

MCO Sampling/Medical Chart Abstraction Procedures

For performance measures that supplement administrative data with medical record data, Qsource examines the MCO's sampling procedures to ensure accordance with generally accepted statistical practices. The MCO should not exclude any population subgroups relevant to a performance measure and should be able to reproduce non-biased, statistically valid samples. Qsource will examine medical record review tools to ensure that they reliably support

each performance measure and to ensure that the MCO has developed comprehensive medical record review instructions specific to each measure for medical chart abstractors. In addition to ensuring that the MCO has well-established policies and procedures, to measure inter-rater reliability between medical chart abstractors, Qsource will randomly review a sample of medical charts in order to further determine compliance by the MCO. Only clinically qualified staff with prior experience in chart abstraction and performance measure reporting are used in this process. Interviews with key quality staff will help Qsource identify established accuracy standards, pinpoint results during the measure production timeline and determine what corrective actions are taken when performance falls below established standards.

MCO Performance Measure Reporting Procedures

Qsource will work with BMS and the MCOs to ensure MCO performance measure reporting occurs in an acceptable format and within specified time requirements. Qsource has experience in developing templates for either an MCO self-reporting process or a process by which Qsource submits results on behalf of the MCO.

Post-Onsite

EQRO Preliminary Measure Findings

Qsource determines the validation results for each measure by aggregating the findings for each of the audit elements. Particular audit elements can contain deficiencies that do not significantly bias a reported result. Conversely, a single error could impact a measure to the extent that results are invalidated. Qsource will analyze the results of the audit and quantify the extent to which the findings have impacted each performance measure's result. Preliminary findings will identify any areas of concern for each measure as well as suggestions for improvement. Qsource will work with BMS to determine if the MCOs will be permitted to submit additional documentation to support the correction of factual errors and omissions, or if the MCO will be allowed to recalculate performance measures based on Qsource's findings, in which case, Qsource will revalidate the revised measures.

EQRO PMV Report

CMS permits two options for determining the validity of each MCO's performance measure:

1. BMS would make the final decision based on Qsource's submitted working papers and summary of findings.

2. Qsource uses a clearly defined set of uniform decision rules for determining the validity of each measure and submits (in entirety) all the working papers and summary of findings.

Qsource is prepared to work with BMS to determine the most appropriate option; however, Qsource recommends the second option. This option further exemplifies the external nature of Qsource's activities. Qsource's PMV reports will include findings specific for each validation activity as well as those discovered by the validation team, including areas of strength and

weaknesses. In accordance with CMS protocols, Qsource suggests the designations in **Table 7** to summarize the validation findings for each measure.

Table 7. PMV Designations Per Measure

Abbreviation	Designation	Explanation
FC	Fully Compliant	Measure was fully compliant with technical specifications.
SC	Substantially Compliant	Measure was substantially compliant with technical specifications and had only minor deviations that did not specifically bias the reported rate.
NV	Not Valid	Measure deviated from technical specifications such that the reported rate was significantly biased. Qsource will make recommendations and work with BMS to determine the thresholds for determining significant bias. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
NA	Not Applicable	Measure was not reported because the MCO did not have any Medicaid enrollees that qualified for the denominator.

Follow-Up with MCOs

During the course of required corrective action or following final results, Qsource is prepared to work with each MCO and provide technical assistance and follow-up with respect to any areas of improvement identified.

According to the data collection processes used by each MCO or at the direction of BMS, Qsource can modify some of the above steps, or modify or include additional steps in the process. Qsource's experience in conducting audits of MCOs and other state Medicaid agencies allows for quick adjustments to different requirements, modifying the review process as necessary.

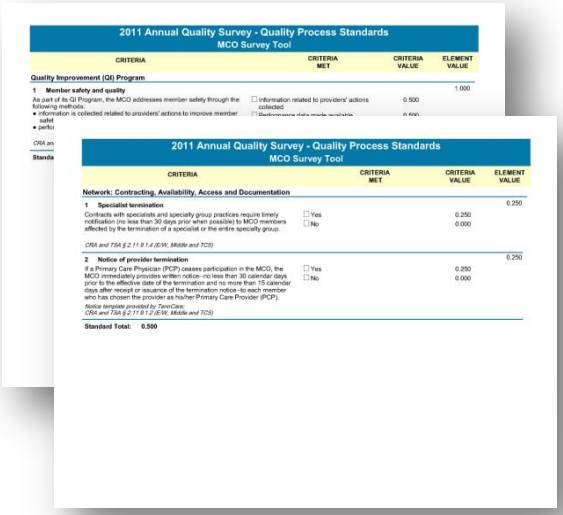
Section 2.4.4

In addition to the PIP and PMV reviews, the BBA, 42 CFR § 438.358(b)(3) requires EQROs to perform a review, conducted within the previous three-year period, to determine the MCO's compliance with standards (except with respect to standards under §438.240(b)(1) and (2), for the conduct of PIPs and calculation of performance measures respectively) established by the State to comply with the requirements of 42 CFR § 438.204(g).

An essential component for assessing MCO compliance with state, federal and contractual requirements is the Annual Quality Survey (AQS), which also includes **pre-onsite activities**, an **onsite visit** and **post-onsite analyses** for each MCO. Specifically, Qsource will use the federal protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al, titled *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, coupled with state MCO contracts with BMS and federal consent decrees as guidance in developing the AQS tool.

Tool Development

Comprehensive review processes and a sound survey methodology are essential for assessing MCO performance. Qsource has extensive experience in conducting various compliance surveys and developing the necessary methodologies and survey tools. Qsource will work collaboratively with BMS and make recommendations for AQS tool development considering all applicable accreditation achievements, contract changes and managed care Medicaid requirements specific to the MHT program. The following steps will be completed to develop and finalize the AQS tools:



- Review the most recent MCO contracts.
- Review current legal actions as they apply to MCOs.
- Review current managed care industry standards.
- Identify any accreditation achievements and potential implications on the AQS in an effort to prevent duplication of activities.
- Review internal and external evaluations from the most recent previous survey to determine processes that can be improved.
- Revise survey processes as warranted.
- Incorporate revisions from review of MCO contract amendments, legal actions and industry standards into the current survey tool.
- Submit to BMS the revised draft survey tools and any processes that warrant revision.
- Collaborate with BMS regarding the revised tool and processes, and incorporate further revisions recommended by BMS.

For the 2011 review of 2010 MCO performance, the general scope of Qsource's MCO AQS assessment tools was defined by QP standards and PAs. QP standards focus on documented processes, evidenced implementation and follow-through of criteria to evaluate compliance with contractual obligations. PAs involve a method of review used by Qsource to ensure that MCO policies and procedures are effectively implemented. For example, Qsource has reviewed utilization management denials and grievance and appeal files to ensure that MCOs adhere to time standards established in their policies and procedures. Collectively QP standards and PAs have contributed to successful comprehensive quality reviews of MCO practices.

The QP standard and PA data collection tools will be developed in Microsoft Access and designed specifically for MCO AQSs. The functionality of the automated tools will help to ensure a thorough assessment of each MCO's quality program and ensure valid scoring. The tool will include all applicable review standards and capture details pertaining to level of

compliance in meeting the element as well as the score achieved. Surveyor comments documenting MCO compliance efforts for each evaluation element, including strengths or areas of noncompliance (AONs), will also be captured.

Pre-Onsite Activities

Prior to the surveyors' onsite visits, the approved surveyor tools will be sent to each MCO to allow gathering of required data and to facilitate the onsite assessment. Qsource also will send a request letter for specific pre-assessment documentation, such as Member Handbooks and Provider Manuals. The survey team will include instructions on organizing and preparing documents for AQS reviewers and will remain available to provide technical assistance until the onsite visit.

Qsource surveyors will examine information obtained from pre-assessment materials and document preliminary findings in the survey tools before the onsite visits for insight into MCO structure and operations, to enable initial compiling of data and to help ensure an expedient and thorough visit. For the PAs, pre-assessment requests will include files from which Qsource will abstract a random sample and oversample. During pre-assessment, surveyors also will note areas lacking documentation and requiring follow-up during the health plan visits.

Onsite Review Activities

Qsource will prepare onsite agendas and discuss time frames and needs with each MCO prior to the scheduled visit to maximize results while minimizing operational disruption. MCO staff will be available for interview and assistance in locating documentation or data sources. These data could include policies/procedures, committee meeting minutes, quality studies, reports, medical record/file review and other related health plan documentation. Surveyors will interact with MCO staff to determine the degree of compliance with contractual requirements, to explore any issues not fully addressed in the documents reviewed and to increase overall understanding of the health plans' performance. At the end of the visits, Qsource surveyors will meet with MCO representatives to summarize initial findings/recommendations, including identified specific strengths, areas of noncompliance and suggestions.

Post-Onsite Activities

Following the onsite visits, the Qsource team will calculate and report compliance, compiling and analyzing all data, calculating compliance, and preparing a report of findings and recommendations for each health plan.

Compliance Scoring

Qsource will use tested protocols and scoring methods to assess MCO compliance. Using specific criteria, each QP standard score will be calculated by adding individual evaluation element scores. Each of the PAs will be assigned a 20-point value. Any tool component considered not applicable (NA) will be excluded from scoring. A rating of one to five stars, as shown in **Table 8**, will be assigned for every QP standard and PA based on the percentage of total points earned for each.

Table 8. AQS Rating Scale Key		
Plan Performance	**Compliance Rating**	**Star Rating**
90-100%	Total Compliance	☆☆☆☆☆
80-89%	Substantial Compliance	☆☆☆☆
65-79%	Partial Compliance	☆☆☆
55-64%	Minimal Compliance	☆☆
0-54%	Noncompliance	☆

Annual Quality Survey Reporting Format

The AQS reports, titled *Technical Papers*, will follow a standardized format, which will include the following sections:

- Overview
- AQS Activities
- Results
- PA File Review Tool Instructions
- Acronyms and Initialisms

In compliance with CMS protocol, these report sections will include:

- a detailed assessment of MCO strengths regarding the quality, timeliness and accessibility of their healthcare services;
- identified specific AONs to help the health plan improve performance; and
- Qsource's assessment to ensure the health plan's continued improvement on standards with less than 100 percent compliance.

Additionally, completed QP standard and PA data collection tools will be presented as appendices in the reports. Improvements in MCO performance from the previous years will be identified with strengths and AONs. BMS and the MCOs will have the opportunity to respond to their draft AQS report. Any MCO comments received, as well as Qsource's response to those comments, will also be included in an appendix of the MCO's final report.

Qsource will produce both hard-copy reports and electronic versions, which will be delivered via Qsource's secure VPN. Qsource will maintain both historical and current AQS reports for immediate access by the State. The proposed reporting format is attached as a blinded sample MCO AQS report in **Appendix V**.

Section 2.4.5

It is critical for state agencies and managed Medicaid plans to operate as efficiently as possible, delivering high-quality care timely, while at the same time ensuring compliance with all

regulations. As defined in 42 CFR § 438.360, to avoid duplication, the State may use, in place of a Medicaid review by an EQRO, information about the MCO obtained from Medicare- or CMS-approved private accreditation reviews to provide information otherwise obtained from the EQR mandatory activities.

Qsource has extensive experience in identifying EQR functions that are duplicative with MCOs that have achieved acceptable Medicare or private accreditations. Qsource will work with BMS to ensure its Quality Strategy identifies the standards for which the EQR will use information from Medicare or private accreditation reviews, and explains the rationale for why the standards are duplicative, maximizing both BMS's and the MCO's resources. Annually, Qsource will perform a careful examination of each MCO's Medicare or private accreditation results to ensure the standards meet at the minimum or exceed those established by BMS's Quality Strategy. Qsource is also prepared to assist BMS with the collection of each MCO's accreditation results and findings.

Historically, Qsource has most frequently identified duplicative activities as a result of MCOs that have achieved accreditation from private organizations such as NCQA. Qsource has worked extensively with state agencies to create cross walks that detail those standards that meet or exceed state requirements. Qsource continues to monitor those standards that fall below state-required thresholds as well as those standards that may be outside of the accreditation surveys. This has proved to be an efficient methodology, allowing Qsource to maximize time for MCO reviews and reduce any unnecessary burden to qualifying MCOs.

Section 2.4.6

Qsource is well versed as the EQRO providing review of state Medicaid program requirements. As such, we are prepared to review MCO activities that are unique to the MHT program, including review of grievance and appeals processes, timelines, and notifications regarding State fair hearing processes and Medicaid's EPSDT outreach and notices. Highly qualified Qsource staff will evaluate all MCO requirements relative to MHT programs. For example, the AQS review provides just such an opportunity.

Part of the AQS is an evaluation of performance activities (PA) standards. The PA file reviews consist of reviewing medical records and/or internal MCO documentation of processes, such as appeal and denial handling, to evaluate MCOs' compliance in several areas, including UM denials, EPSDT tracking information system, appeals, and complaints time frame compliance. In addition, Qsource's experience preparing an annual EPSDT report in our role as the State of Tennessee's EQRO speaks to our expertise in reviewing and reporting results of unique MCO activities.

Preliminary Review Findings and CAPs

Qsource will notify MCOs and BMS of preliminary review findings through AQS results on the final day of onsite AQS visits, when Qsource surveyors will meet with MCO representatives to summarize initial findings/recommendations, including identified specific strengths, AONs and

suggestions. Following the onsite visits, the Qsource team will calculate and report compliance, compiling and analyzing all data, and preparing a report of findings and recommendations for each health plan. Each MCO will be able to provide feedback on AQS findings before they are published in a final report.

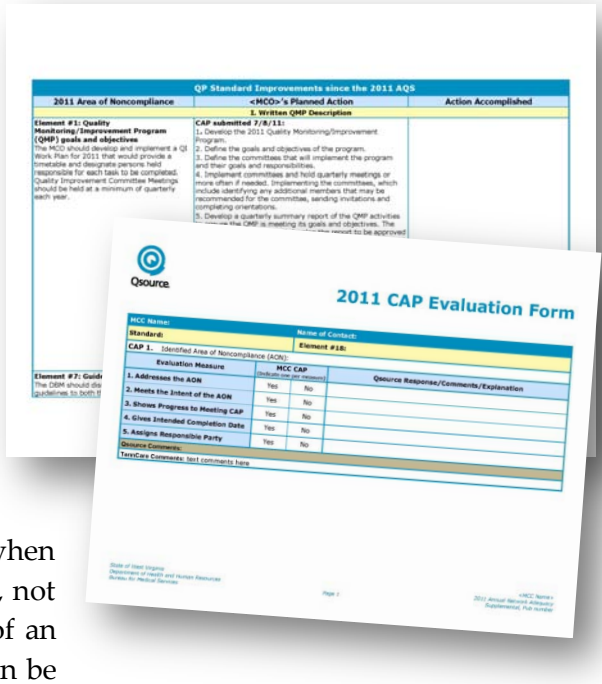
Any area in which an MCO is noncompliant will require the submission of a CAP to Qsource. For each element that garnered an AON during the AQS, the MCO will describe a plan to improve its performance in that area and achieve full compliance. Once Qsource receives a CAP, we will evaluate if the performance deficiency is appropriately being addressed. Qsource will use a progress monitoring tool to track the status of each CAP on an ongoing basis. Additional detail about the CAP process is provided in **Section 2.4.7**.

Section 2.4.7

Qsource will provide BMS information that accurately and reliably summarizes the performance of each MCO in each quality management area and identifies areas for corrective action and performance improvement. Part of Qsource's strategy for providing this information involves reviewing MCO performance for all mandatory EQR activities and detailing results of the reviews in activity- and health-plan-specific reports that will make comparisons among MCOs and offer trending data where possible. Qsource's multidisciplinary team of highly qualified experts, including clinicians, analysts and technical writers all holding advanced degrees and/or certifications in their fields, is involved in conducting quality reviews and in generating results reports.

Identifying/Submitting CAPs

States are required to establish a method to ensure that MCOs respond to performance deficiencies in an appropriate and timely manner. CAPs have traditionally been used to document an MCO's intent to modify its activities to comply with contractor expectations and to outline the timeframe for completion of these improvement activities in each quality management area.



Qsource will work with BMS to identify those EQR activities that would require a CAP when performance thresholds are not met. For example, not achieving 100 percent on an individual element of an AQS would require a CAP. CAP requirements can be implemented for all three EQR review activities, including the PMV, PIP and AQS.

Qsource will work with BMS to establish a timeframe for CAP submission and to identify the appropriate MCO contact persons to receive the CAPs. The CAP forms identify AONs by standards and elements and identify what the MCO should include in its CAP to fully address the AON and achieve ultimate compliance. These forms will be electronically forwarded to those MCOs requiring CAPs to ease/guide submission.

CAP Evaluation/Assistance

Upon receipt of an MCO's CAP, Qsource will complete a thorough evaluation to determine the appropriateness of the CAP in addressing the performance deficiency. Documented in an electronic CAP Evaluation Form, the evaluation addresses the following elements:

- Does the MCO's CAP address the identified recommendation?
- Does the MCO's CAP meet the intent of the identified standard?
- Does the MCO describe proposed actions to show progress toward meeting the CAP?
- Is a realistic completion date identified?
- Does the MCO identify a person responsible, by title, for actions described in the CAP?

Qsource will track the status of each CAP on an ongoing basis using a progress monitoring tool, which shows improvements since the last MCO onsite review, to ensure submission deadlines are met. For each AON, an MCO must submit its action plan to address the AON. If a CAP does not fully address the performance deficiency or does not sufficiently outline steps the MCO will take to correct deficiencies, Qsource will work with BMS to identify the best possible next step.

If deemed appropriate and at BMS's direction, Qsource will contact the MCO to provide technical assistance so that a revised CAP can be implemented. Such assistance may be telephonic, in writing or onsite, depending upon the degree of the deficiency and the MCO's need for direction and guidance. Qsource uses the CAP progress monitoring tool to track MCO improvements in deficient areas from year to year. During subsequent onsite surveys, Qsource surveyors would specifically assess the MCO's implementation of its CAP, determine if the steps taken fulfill the MCO's contractual requirements and report on the findings.

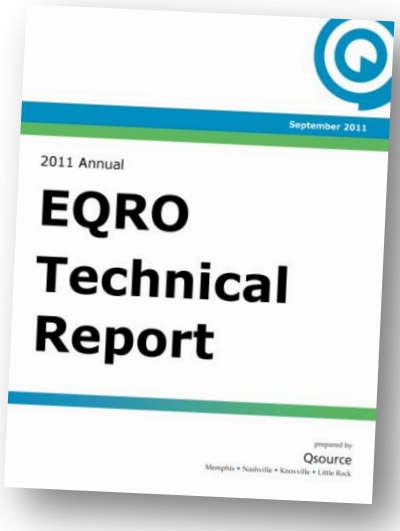
Section 2.4.8

In accordance with 42 CFR § 438.358 and § 438.364 and toward constant QI, each year experienced Qsource staff will develop the Annual EQR Technical Report, which will summarize the quality, timeliness and access to care furnished by all health plans contracted with BMS. Qsource proposes collaborating with BMS to achieve the highest quality annual technical report while adhering to CMS protocols for EQR technical reporting. CMS protocols defined in 42 CFR § 438.364 and the *CMS State External Quality Review Tool Kit for State Medicaid Agencies*, *October 2006*, are outlined in **Table 9**.

Table 9. Recommended Scope of Work Components for EQR Technical Reporting		
EQRO Technical Report Component	**Content Addressed**	**Comments**
Executive Summary	Summarize: ♦ EQR Process ♦ Major findings/conclusions for timeliness/access/quality of care ♦ Recommendations for State and MCOs	
Background	♦ History of the State's Medicaid Related Managed Care Program(s) ♦ Summary of the State's Quality Strategy Objectives, Performance Measures and PIP requirements and targets, and Operational System Standards.	This information is useful to external audiences in understanding the background of managed care in the State and may provide a better context for the results that are reported.
Description of EQRO Activities	♦ Summarize "entities" utilized in completing the reviews required for the three mandatory activities, and the EQRO contracted for final technical reporting. ♦ Summarize if optional activities are included in the report. ♦ Summarize how the annual EQR Technical Reporting process is used for assessing the State's progress in meeting overall State Quality goals and objectives.	States can vary in the number of activities included in annual EQR review and the number of EQROs or other entities utilized in conducting mandatory and optional EQR activities. This will clarify for external audiences the State's process for EQR.
State Quality Initiatives	♦ Highlight quality initiatives implemented by the State to support MCO efforts to improve the quality of care and services for Medicaid managed care enrollees.	Example: implementation of a State immunization registry or participation in a regional health information organization collaborative for data sharing.
MCO Best and Emerging Practices for Improving Quality of Care and Service	♦ Highlight MCO activities that are unique, effective in demonstrating improvements in care or service, or generate high satisfaction survey results.	♦ Are any plans recognized by a national entity (e.g., NCQA, CHCS, NAHP, etc.)? ♦ Are there any performance measures, operational standards or performance improvement project findings that really stand out?
Organizational Assessment and Structure Performance	♦ Provide background on assessment process. ♦ Reference assessment tool in appendices. ♦ Summarize comparative results for entities reviewed. ♦ Highlight best practices identified for this mandatory activity–strengths for the State as well as individual plans. ♦ Document major opportunities identified – particularly areas	♦ Document entity performing the mandatory review (if not the reporting EQRO). ♦ Document if CMS protocol or a comparative assessment protocol was utilized. ♦ Include timeframe covered to review all entities. ♦ Highlight any changes in standards previously reviewed/required by the State.

Table 9. Recommended Scope of Work Components for EQR Technical Reporting		
EQRO Technical Report Component	**Content Addressed**	**Comments**
	requiring follow-up for more than one reporting period. ♦ Reference individual plan findings in appendices.	
Performance Measurement Performance	♦ Provide background on assessment process. ♦ Reference assessment tool in appendices. ♦ Summarize comparative results for participating entities. ♦ Highlight best practices identified for this mandatory activity—strengths for the State and individual plans. ♦ Document major opportunities identified – particularly areas requiring follow-up for more than one reporting period. ♦ Reference individual plan findings in appendices.	♦ Document entity performing the mandatory review (if not the reporting EQRO). ♦ Document if CMS protocol or a comparative assessment protocol was utilized. ♦ Include timeframe covered to review all entities. ♦ Highlight any changes in standards previously reviewed/required by the State.
Performance Improvement Project Performance	♦ Provide background on assessment process. ♦ Reference assessment tool in appendices. ♦ Summarize comparative results for participating entities. ♦ Highlight best practices identified for this mandatory activity—strengths for the State and individual plans. ♦ Document major opportunities identified – particularly areas requiring follow-up for more than one reporting period. ♦ Reference individual plan findings in appendices.	♦ Document entity performing the mandatory review (if not the reporting EQRO). ♦ Document if CMS protocol or a comparative assessment protocol was utilized. ♦ Include timeframe covered to review all entities. ♦ Highlight any changes in standards previously reviewed/required by the State.
Conclusions and Recommendations for the State	♦ Summary conclusions on data collected for all mandatory activities with regards to the quality, timeliness and access to care across all participating managed care entities should be documented.	Required by 42 CFR § 438.364 (A)(1)
Conclusions and Recommendations for MCOs	♦ Specific conclusions and recommendations for each mandatory activity should be documented and referred to in the next reporting period.	Required by 42 CFR § 438.364(a)(3) and CFR § 438.364(a)(5)

Results included in the report will be determined via the aggregation and analysis of data obtained through the following three federally mandated EQR activities, which Qsource performs:



- Validation of Performance Measures (PMVs)
- Validation of Performance Improvement Projects (PIPs)
- Monitoring compliance with federal and state standards, measured through the Annual Quality Survey (AQS)

Qsource's annual technical report will provide an executive summary, which will present major findings for access, timeliness and quality of care as well as systemwide conclusions and recommendations for MCOs and the State. A background section will give a brief history of the State's managed care Medicaid program; current state quality strategy goals and objectives; technical report guidelines and a description of EQR activities the report will summarize, including requirements and objectives. A reporting of EQR mandatory and optional activities and Qsource contractual activities, and suggestions for the State's use of the technical report will be provided in the description of EQRO activities. The technical report also will offer updates for state quality initiatives, such as Pay-for-Performance incentives and statewide MCO collaboratives. MCO best and emerging practices will be divided into general quality practices and EQR-related practices, which will be identified by each EQR activity.

In addition, for each review activity Qsource conducts during the year, the following information will be provided:

- Assessment background, including technical methods of data collection and a description of the data obtained
- Comparative findings
- MCO strengths, best practices and opportunities
- State strengths and best practices

The report will close with conclusions and recommendations for MCOs, categorized by PMVs, PIPs and monitoring compliance with standards (AQS). This section also will offer Qsource's recommendations to the State derived from the EQR activities performed and organized by the three dimensions of Medicaid managed care activity that are federally required and outlined in the CMS guidelines in the technical report. Finally, detailed data for health plan findings and sample assessment tools will be provided as appendices to the technical report. In no section of the report will the identity of any individual patient be disclosed.

Qsource will submit an electronic draft of the Annual EQR Technical Report for BMS's review via our secure VPN site. After BMS reviews the draft and EQRO staff implements any necessary changes to the report, the final draft will be submitted electronically and in hard-copy format

for BMS. The proposed reporting format is attached as a sample EQR Technical Report in **Appendix VI**.

Section 2.4.9

In addition to producing an Annual EQR Technical Report as well as other state-level pieces for the evaluation of quality and appropriateness of care, Qsource will provide health-plan-specific technical reports, including the PIP, PMV and AQS reports. Qsource will adhere to requirements established in 42 CFR § 438.364 by offering a reporting of the following elements:

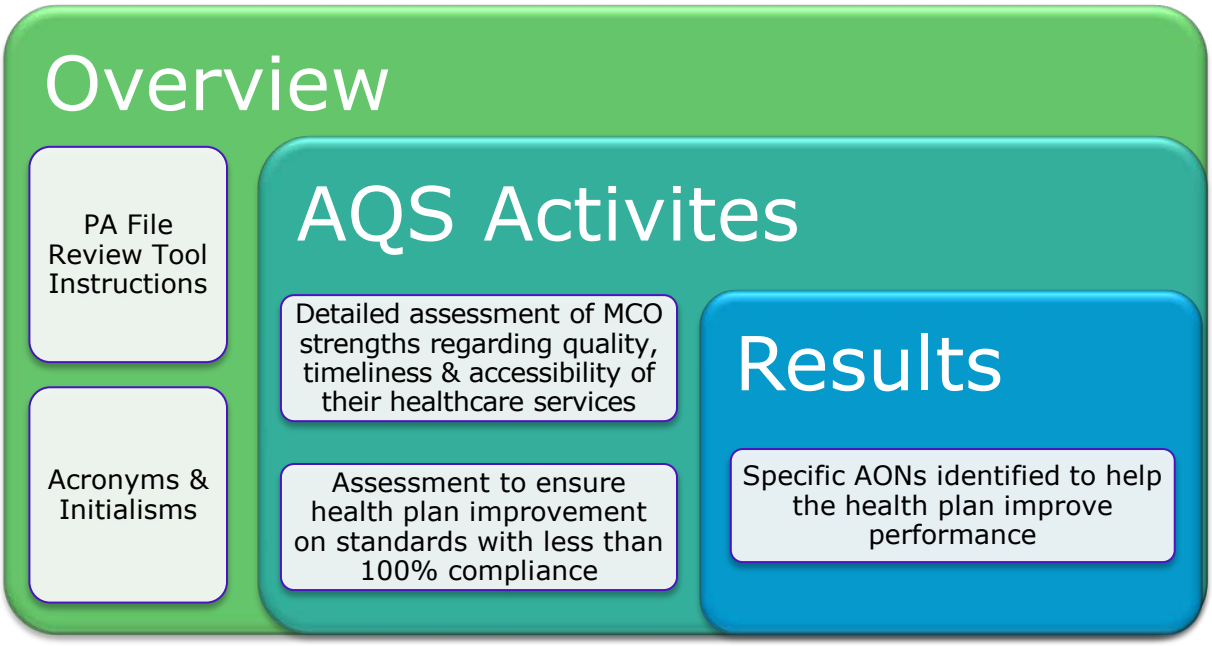
- An assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness and access to healthcare services furnished to Medicaid recipients
- Recommendations for improving the quality of healthcare services furnished by each MCO based on the evaluation of the EQR activities
- An assessment of the degree to which each MCO has addressed effectively Qsource's recommendations for quality improvement during the previous year's EQR
- Assessment of the extent to which corrective actions recommended by Qsource have been implemented and the results of these corrective actions

Assessing Strengths and Weaknesses

Qsource will use the PIP and AQS technical papers as well as annual PMV reports to inform BMS of individual MCO strengths and weaknesses in the areas of quality, timeliness and access to healthcare services. The purpose of conducting PIPs is to assess and improve processes and ultimately outcomes of care. Qsource has extensive experience in validating PIPs and is uniquely positioned to be highly efficient in assisting BMS with meeting and exceeding its objectives for ensuring that plan PIPs effectively assess and improve processes and outcomes of care. Following validation of each MCO's PIPs, Qsource will assess the implications of all study findings on the likely validity and reliability of findings and inform BMS regarding the confidence level of the reported findings. Qsource will assess threats to the validity and reliability of PIP findings and determine when an accumulation of threats reaches a point at which the findings are no longer credible. Following this assessment, Qsource will report overall validity and reliability findings according to four levels of confidence:

Qsource also monitors performance indicators after completion of the PIP to ensure sustained improvements. For future PIP submissions, an MCO found deficient in any area of the evaluated PIP must submit a revised PIP Summary Form that includes additional information to address any suggestions and any critical and noncritical areas scored as *Not Met*.

AQSs include a pre-assessment documentation review, an onsite visit and post-onsite analyses for each MCO. Following the onsite visits, the Qsource team will calculate and report compliance, compiling and analyzing all data, calculating compliance, and preparing a report of findings and recommendations for each health plan. The AQS reports will follow a standardized format, which will include the following sections:



In compliance with CMS protocol, these report sections will include:

- a detailed assessment of MCO strengths regarding the quality, timeliness and accessibility of their healthcare services;
- identified specific AONs to help the health plan improve performance; and
- Qsource's assessment to ensure the health plan's continued improvement on standards with less than 100 percent compliance.

Additionally, completed QP standard and PA data collection tools will be presented as appendices in the reports. Improvements in MCO performance from the previous years will be identified with strengths and AONs. BMS and the MCOs will have the opportunity to respond to their draft AQS report. Any MCO comments received, as well as Qsource's response to those comments, will also be included in an appendix of the MCO's final report.

PMV reports will also provide BMS and each MCO with health-plan-specific performance. The purpose of the PMV process is to evaluate the accuracy of Medicaid performance measures reported by or on behalf of an MCO, and to determine the extent to which Medicaid-specific

performance measures calculated by an MCO (or by an entity acting on behalf of an MCO) followed specifications established by the state Medicaid agency for the calculation of the performance measure(s). CMS permits two options for determining the validity of each MCO's performance measure:

1. BMS would make the final decision based on Qsource's submitted working papers and summary of findings.

2. Qsource uses a clearly defined set of uniform decision rules for determining the validity of each measure and submits in their entirety all the working papers and summary of findings.

Qsource is prepared to work with BMS to determine the most appropriate option; however, Qsource recommends following the second option. This option further exemplifies the external nature of Qsource's activities. Qsource's PMV reports will include findings specific for each validation activity as well as those discovered by the validation team, including areas of strength and weaknesses.

Recommendations for Improvement

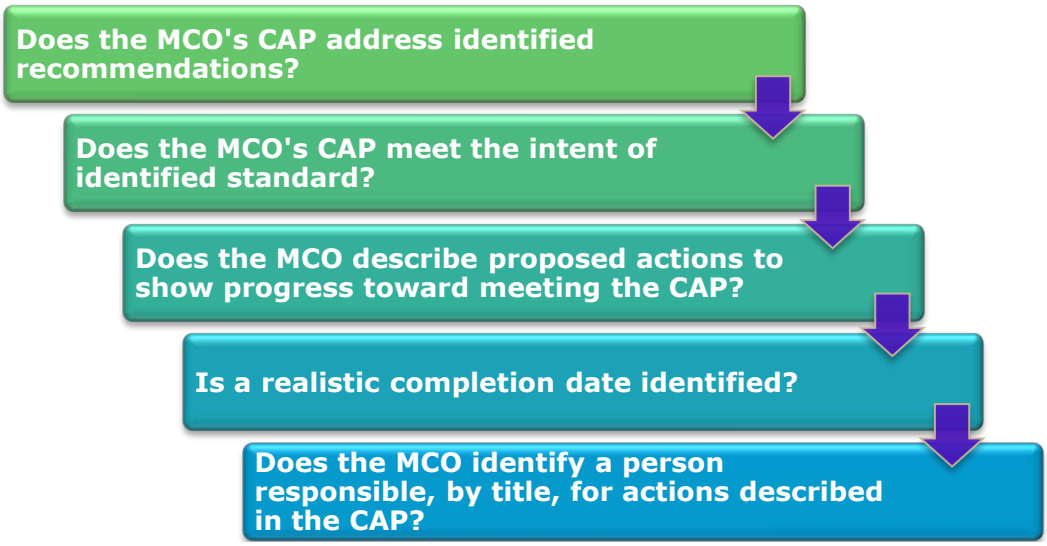
Following analysis of PIP, AQS and PMV results, Qsource will offer each MCO recommendations for improvement. While overall MCO and state-level recommendations will be found in the Annual EQR Technical Report, each MCO's PIP, AQS and PMV reports provide health-plan-specific QI targets.

The PIP Technical Papers, following an overview of PIP topics and indicators as well as validation status, will offer an analysis of results that includes suggestions for improvement for the MCO based upon AONs identified during Qsource validation of the MCO's PIPs. Similarly, the AQS Technical Papers will provide suggestions for improvement based upon AONs. The AQS process will require that an MCO submit a CAP for each deficient performance area.

Monitoring Quality Improvement Actions

Following up with recommendations made for improvement, Qsource will monitor each MCO's progress toward completing its action plan for each area of deficiency. MCOs will resubmit PIPs that fail to meet validation standards. In addition, Qsource will provide ongoing evaluation of each MCO's CAPs submitted in response to AONs found by Qsource surveyors during AQS onsite visits.

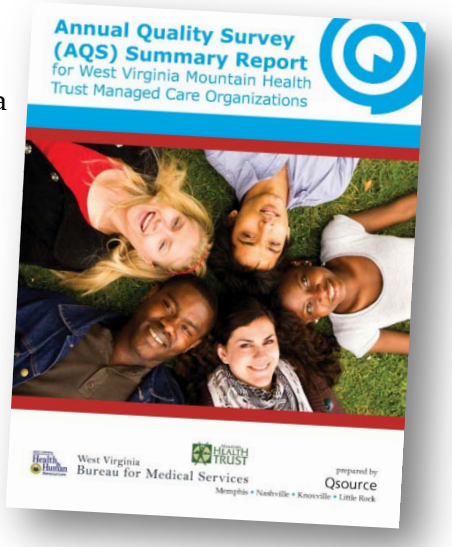
Upon receipt of an MCO's CAP, Qsource will complete a thorough evaluation to determine the appropriateness of the CAP in addressing the performance deficiency. Documented in an electronic CAP Evaluation Form, the evaluation addresses the following elements:



Qsource will track the status of each CAP on an ongoing basis using a progress monitoring tool, which shows improvements since the last MCO onsite review, to ensure submission deadlines are met. For each AON, an MCO must submit its action plan to address the AON. If a CAP does not fully address the performance deficiency or does not sufficiently outline steps the MCO will take to correct deficiencies, Qsource will work with BMS to identify the best possible next step.

If deemed appropriate and at BMS's direction, Qsource will contact the MCO to provide technical assistance so that a revised CAP can be implemented. Such assistance may be telephonic, in writing or onsite, depending upon the degree of the deficiency and the MCO's need for direction and guidance. Qsource uses the CAP progress monitoring tool to track MCO improvements in deficient areas from year to year. During subsequent onsite surveys, Qsource surveyors would specifically assess the MCO's implementation of its CAP, determine if the steps taken fulfill the MCO's contractual requirements and report on the findings.

Section 2.4.10



For the AQS and PIP activities, Qsource has developed a comprehensive summary report format that merges results from individual reviews of MCOs already presented in detailed reports, and presents those results in a more visually appealing and brief manner. While individual MCO reports are limited to the detailed results of a particular health plan, the summary reports compare overall results of each health plan using graphic elements to provide, at a glance, a clear overview of how the health plans have performed on key criteria in a given activity or contractual mandate.

The brief summary reports are prepared using software that equally allows for electronic 508-compliant PDFs or full-color hard-copy outputs. Because these

summary comparative reports should be only 10 to 14 pages, they may be shared easily and relatively cost efficiently as BMS deems necessary. Qsource will prepare summary reports for all EQR review activities if BMS so desires. Included in **Appendix VII** is a sample PDF of a redacted AQS Summary Report prepared by Qsource for BMS's consideration.

Section 2.4.11

Per the MED12009 Addendum #1, 2.4.11 is being deleted.

Section 2.4.12

Qsource is well versed in state and federal legislation, regulations and policies that affect both Medicaid programs and the managed care delivery system, including the Patient Protection and Affordable Care Act (ACA) and the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Using multiple web sources, news feeds, publications, professional meeting/forum information and social media, we will continually monitor state and federal activities for their potential short- and long-term effect on BMS, its MCOs and stakeholders, and federal EQR requirements. Our experience providing an annual Impact Analysis Report to the State of Tennessee—requiring staying abreast of current legislation, regulations and policies and researching pertinent topics deemed attention worthy by TennCare and Qsource—demonstrates our capabilities in this area. Our role as the EQRO for Tennessee's CHIPRA program (CoverKids) also attests to our expertise in state and federal regulations. The monthly Healthcare Policy Report prepared as part of our EQRO work with CoverKids also necessitates our diligence in researching and reporting current trends.

Qsource will make observations, suggestions and recommendations for BMS on an ongoing basis. We also will examine public response to laws and regulations to demonstrate how they will impact various stakeholder groups and to make recommendations or raise thoughtful questions. Additionally, we will not be satisfied with static information. While the websites, publications and other resources we will use are invaluable, we will make direct contact with federal, state and private organizations as needed to clarify, supplement or update information found through traditional sources. Each year, for example, we will contact CMS to ensure that no new protocols have been issued for EQR assessment or reporting. We will also reach out to CMS for clarification on decision memos and to state-specific programs whose programs could offer insight to BMS.

As a current state EQRO, Qsource has developed an extensive knowledge base that reflects a unique understanding of not only what to investigate but how to do it most efficiently. Qsource will monitor federal regulations via three primary sources, as shown in **Table 10**: 1) the CMS website, 2) the *Federal Register* and 3) a stable of government, private, and not-for-profit websites and free subscription services.

Table 10. Qsource Web Research Resources	
Source	**Link**
CMS–*Quarterly Provider Update (QPU)*	**www.cms.gov/home/regsguidance.asp** **www.cms.gov/QuarterlyProviderUpdates/**
Federal Register	**www.gpoaccess.gov/fr/**
GPO & Thomas sites	**www.gpoaccess.gov** **www.thomas.gov**
West Virginia General Assembly's	**www.legis.state.wv.us**
West Virginia Department of State	**www.sos.wv.gov/Pages/default.aspx**
Bureau of Medical Services	**www.dhhr.wv.gov/bms/Pages/default.aspx**
Healthcare Innovations Exchange for Disparities Reduction	**www.innovations.ahrq.gov**
CMS–*CHI Promising Practices*	**www.cms.gov/MedicaidCHIPQualPrac**

The CMS website **www.cms.gov/home/regsguidance.asp** details regulations promulgated for both the Medicaid and Medicare programs. These include notices of proposed rulemaking and interim final rules—both of which provide opportunities for comment—and final rules. The Quarterly Provider Update (QPU), part of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) requirements for rapid public reporting of MMA provisions, lists all of the regulations that CMS has or will issue for each quarter. Qsource will review these regulations and, when possible, make BMS aware of pending Medicaid regulations before they are announced in the *Federal Register*. Early notifications will alert BMS personnel to opportunities to comment on federal regulations while they are in process. The QPU is online at **www.cms.gov/QuarterlyProviderUpdates**.

Via the CMS website, Qsource also will subscribe to alerts for newly issued State Medicaid Director and State Health Official Letters, which provide interim guidance after legislation has been enacted but often before final regulations are in place. The CMS site also links to the *Federal Register*, the official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as executive orders and other presidential documents. CMS generally issues its regulations on the fourth Friday of each month. Qsource will monitor the *Federal Register*, online at **www.gpoaccess.gov/fr**, not only for CMS rules/notices but for those issued by other federal agencies such as the Department of Health and Humans Services, the Office of the Inspector General, and the Food and Drug Administration.

Using **www.gpoaccess.gov** and **www.thomas.gov**, Qsource also will monitor healthcare and Medicaid-specific bills and laws. Using the Thomas site, Qsource can monitor legislative activity on a daily basis via RSS feeds, daily digests and bill-specific tracker alerts. Congressional committee activity can also be followed.

Qsource understands that monitoring federal developments is not limited to legislation and regulations. Some of our past successful report topics as a state EQRO include potential changes to the CMS-416 form (the primary vehicle through which EPSDT screening rates are captured) and new/updated recommendations from the United States Preventive Services Task Force

(USPSTF) regarding child obesity screening. While their impact is longer term, USPSTF findings are based on the most up-to-date clinical information available on health topics that may be of critical importance to BMS.

Webinars are another source of current policy information from experts in the field. Sharing notices of online education opportunities with staff members corporate wide is a seminal part of Qsource's quality culture. The following are just a few of the presentations and webinars Qsource EQRO staff members have attended in 2011:

- USAID National Institutes of Health (NIH) Global Health Address
- MCO Quality Reporting
- Differences in Healthcare Utilization Among the Chronically Ill in TennCare
- Using Race, Ethnicity and Language Data to Address Disparities
- Coordinated School Health in Action: Tennessee's Unique Treasure
- Focus Group Fundamentals
- Electronic Health Record (EHR) Implementation
- EHR Provider Incentive Program
- Improving Member Outreach Materials
- HEDIS 2010 Relative Resource Utilization (RRU) Results
- NCQA HEDIS Update and Best Practices Conference

Qsource will create a reference document of sources used to stay abreast of federal and state requirements. To be updated regularly and available for use by all staff members, these will include government-based sites such as the National Association of State Medicaid Directors and the National Academy for State Health Policy; private/not-for-profit organizations like the Kaiser Family Foundation and The Commonwealth Fund; managed care discussion groups on professional networking sites such as LinkedIn.com; and topic-specific websites that offer additional insight on policy issues that are important to BMS. Other subject-focused sources Qsource would want to explore would follow the priorities defined by BMS as well as Qsource's own knowledge of state and federal MCO contract requirements.

To stay current with state legislative and policy developments at large, Qsource would first focus on West Virginia. The West Virginia General Assembly's website, **www.legis.state.wv.us**, will be a primary source and offers a bill status and tracking resource. As necessary, we will use the most current *West Virginia Code Annotated* via Michie's Legal Resources.

We also will use **www.sos.wv.gov/Pages/default.aspx**, the West Virginia Department of State website, to access new acts and resolutions and to track state rules and regulations. Within two to five business days of filing, proposed rules, rulemaking hearing rules/notices and emergency rules must be posted to the site, which also offers RSS feed and text alert services for targeted, timely monitoring. We also will access BMS's official website, **www.dhhr.wv.gov/bms/Pages/default.aspx**, on a regular basis for the most current BMS news and any additional information that may have an impact on EQR activities.

To our research, Qsource would add an exploration of the successful interventions implemented by other state Medicaid programs. Interventions can provide answers to the challenges posed by state and federal requirements, connecting what must be done with how it can be accomplished. Resources include the Healthcare Innovations Exchange for disparities reduction at **www.innovations.ahrq.gov** and CMS's Medicaid and CHI Promising Practices page at **www.cms.gov/MedicaidCHIPQualPrac**. Best practices presented at the national conferences of such organizations as the NCQA and AHRQ are another resource.

Through these and other regularly reviewed resources, Qsource will develop a strategic approach to staying current and well informed on government laws, regulations and policies. Our analysis will be refined and internally vetted so as to generate the most germane alternatives and recommendations for changes and enhancements to support state and federal requirements.

Section 2.4.13

Over Qsource's years of experience, a key to successful QI has been collaboration through sharing best practices from high-performing MCOs and encouraging MCOs to focus on QI projects. Our rapid dissemination of review results in the form of reports, coupled with our attendance at quarterly MHT Task Force meetings, will enable Qsource to supply MCOs with necessary data and other information to effect quality improvement. Qsource's ability to work with MCOs to improve results is supported by our corporate culture of continuous quality improvement.

Continuous Quality Improvement Framework

The IQC is the cornerstone of Qsource's performance-driven culture, which is fully supported by our corporate mission, strategic plan and management structure. Our mission is to create and enhance programs, services and collaborative relationships that improve healthcare quality. Qsource's strategic plan fully integrates CQI and ISO principles into project management activities. Qsource is one of only a few healthcare companies registered as an ISO 9001:2008 certified company. ISO is an international quality management standard and framework for business-to-business operations and, in a healthcare capacity, guides Qsource in the design, development and delivery of consulting and education programs to healthcare providers.

Proven Performance Improvement Experience

Qsource's 38-plus-year QIO contract experience with CMS, coupled with over 11 years of Medicaid EQRO experience, has provided us the opportunity to locally impart hands-on knowledge of nationally developed guidelines in quality of care and models of healthcare QI. Qsource staff is a unique mix of experienced clinicians, quality specialists, healthcare analysts, IS professionals, communication specialists and diverse field staff. Our thorough commitment to understanding statewide challenges in delivery of healthcare operations uniquely positions us to analyze data and identify opportunities for improvement. Qsource staff receives the most up-to-date training in nationally recognized evidence-based guidelines, systems and process improvement techniques in healthcare delivery, improving organizational culture and facilitating change management. Consequently, MCOs have sustained decades of improved performance.

Sharing Best Practices

Qsource has successfully engaged MCOs in QI activities and has supported system-wide change where opportunities have been identified by reviewing HEDIS data, offering technical assistance and sharing information on proven improvement strategies. As EQRO for the BMS program, Qsource will work to improve the quality and effectiveness of medical care received by West Virginia Medicaid members by identifying best practices and AONs through onsite annual reviews and by sharing these with MCOs and the State. Qsource will identify best practices and facilitate their timely distribution to MCOs. Qsource also could deploy a quarterly email with information and links that could be used to better educate and improve care for MHT patients. We will provide tools and resources each quarter that will be gathered from our evolving outreach efforts in collaboration with BMS.

Section 2.4.14

Table 11 provides three references from similar projects of work Qsource has performed within the past five years. Detailed descriptions of the work follow.

Table 11. Qsource References

Organization Name, Address, Current Telephone Number	Contact Name, Phone Number, Email Address of Project Administrator	Staff Members Who Worked on Project	Time Period of Project	Scheduled Completion Date	Actual Completion Date
Bureau of TennCare, State of Tennessee Department of Finance and Administration 310 Great Circle Road, Nashville, TN 37243 800-342-3145	Judy Womack 615-507-6716 **Judy.M.Womack@tn.gov**	John Couzins Michelle North Deborah Crouse Swapna Mehendale Kelly Agee Lingling Gong	10/1/10–present 10/1/05–9/30/10	9/30/13 (with option of 2 extension years) 9/30/10	NA 9/30/10
CoverKids, State of Tennessee Department of Finance and Administration Snodgrass TN Tower 26th Floor, 312 Rosa L. Parks Ave., Nashville, TN 37243 866-CoverTN	Stephanie Dickerson 615-253-8556 **Stephanie.K.Dickerson@tn.gov**	John Couzins Michelle North Kelly Agee Lingling Gong	1/1/12–12/31/12 1/1/10–12/31/11	12/31/12 12/31/11	NA 12/31/11
Arkansas Department of Human Services, Division of Medical Services P.O. Box 1437, Slot S-401, Little Rock, AR 72203-1437 501-682-8292	Marilyn Strickland 501-682-8292 **Marilyn.Strickland@arkansas.gov**	Swapna Mehendale Lingling Gong	7/1/08–6/30/12	6/30/12 (with option of 3 extension years)	NA

Descriptions of Prior Similar Work

Qsource's experience completing EQRO work of a similar nature as that described in this RFP is exemplified through the following work descriptions corresponding to references listed in **Table 11**.

Bureau of TennCare: EQRO TennCare Contract

Qsource provides the State of Tennessee Department of Finance and Administration with an independent, external review of the quality of services available to TennCare enrollees via the following activities:

- **Validates Performance Measures:** Performance measure validation (PMV) evaluates the accuracy of TennCare performance measures reported by the Managed Care Organizations (MCOs). As part of this task, Qsource reviews the data management processes of the MCOs, evaluates the algorithmic compliance and verifies that state-specified performance measures are based on accurate source information. The results of the PMV process are included in individual reports by plan and region, and in the EQR Technical Report.
- **Validates Performance Improvement Project (PIP):** PIP validation is performed for each of the MCOs using the current CMS protocols, culminating with the production of a written report of findings and recommendations. Qsource evaluates the soundness and results of the PIPs implemented by the MCOs. The PIP validation results are included in individual reports by plan and region, and in the EQR Technical Report.
- **Conducts Annual Quality Survey (AQS):** An AQS is conducted of each MCC for contractual compliance and includes pre-assessment, onsite review and post-onsite analysis. In accordance with CMS protocols, review criteria include contract compliance to meet current industry, federal and state requirements for managed care. Qsource provides regional MCC-specific reports with recommendations for each health plan. Results are also part of the annual technical report.
- **Conducts Annual Evaluation of Provider Network Adequacy (ANA):** The onsite evaluation helps ensure that the MCCs have the capacity to provide covered services and that those services are accessible to TennCare enrollees. The report includes objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data.
- **Performs Quality Survey for EPSDT Compliance:** As part of the onsite AQS, compliance with the State's John B. Consent Decree is monitored, including a review of each MCC's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) information tracking system for explicit monitoring of compliance with federal EPSDT standards. The health plans are required to achieve and maintain the capability of tracking each child for the purposes of monitoring the child's receipt of the required screening, diagnosis and treatment. An annual report of EPSDT findings and recommendations is produced.
- **Prepares Detailed Technical Report:** This report describes the manner in which the data from all oversight activities, in accordance with 42 CFR § 438.358, were aggregated and

analyzed, and how conclusions were drawn as to the quality, timeliness and access to the care furnished by TennCare-contracted MCCs. The report includes objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data. Other aspects of the Technical Report include an assessment of each MCC's strengths and weaknesses with respect to the quality, timeliness and access to healthcare services furnished to Medicaid recipients; recommendations for improving the quality of healthcare services furnished to each enrollee; an assessment of the degree to which each MCC has addressed effectively the recommendations for QI made by the EQRO during the previous year's review processes; and quality assurance to protect patient privacy data.

- **Provides Special Ad Hoc Reports:** Reports to improve the financial stability of the TennCare program and the quality of care rendered to the TennCare population, including an aggregation of all HEDIS data across contributing health plans in Tennessee.
- **Analyzes HEDIS® and CAHPS® Data:** An annual comprehensive analysis of HEDIS and CAHPS® data results is prepared to identify opportunities for improvement and best practices among MCOs.
- **Analyzes Other TennCare Data:** Other analyses conducted at the request of TennCare. Past activities have included vital statistics data in the production of an assessment of the impact of TennCare on Women's Health in Tennessee and a study on emergency department utilization.

CoverKids: EQRO CoverKids Contract

Qsource provides the State of Tennessee Department of Finance and Administration, Division of Insurance Administration with an independent, external review of the quality of services available to CoverKids enrollees. Qsource:

- **Conducts Onsite Annual Quality Survey (AQS):** An AQS is conducted of each MCC for contractual compliance and includes pre-assessment, onsite review and post-onsite analysis. In accordance with CMS protocols, review criteria include contract compliance to meet current industry, federal and state requirements for managed care. Qsource provides MCC-specific reports with recommendations for each health plan. Results are also part of the annual technical report.
- **Conducts Annual Onsite Evaluation of Provider Network Adequacy (ANA):** The evaluation helps ensure that the MCCs have the capacity to provide covered services and that those services are accessible to CoverKids enrollees. The report includes objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data.
- **Prepares Detailed Technical Report:** This report describes the manner in which the data from all oversight activities, in accordance with 42 CFR § 438.358, are aggregated and analyzed, and conclusions drawn as to the quality, timeliness and access to the care furnished by contracted MCCs to Medicaid recipients. The report includes objectives, technical methods of data collection and analyses, descriptions of data obtained and conclusions drawn. Other aspects of the report include an assessment of each MCC's

strengths and weaknesses with respect to the quality, timeliness and access to healthcare services; recommendations for improving the quality of services furnished to each enrollee; an assessment of the degree to which each MCC has effectively addressed the recommendations for QI made by the EQRO during the previous year's review processes; and quality assurance to protect patient privacy data.

- **Provides Special Ad Hoc Reports:** As requested by state.
- **Analyzes Other CoverKids Data:** Other analyses conducted at the request of Division of Insurance Administration.

Arkansas Department of Human Services: Arkansas Medicaid Therapy Retrospective Review and Personal Care Authorization

Services provided under the Arkansas therapy review contract include the following:

- Retrospective review of medical records to determine if occupational, physical and speech therapy services delivered to Medicaid beneficiaries under 21 and reimbursed by Medicaid meet medical necessity requirements and if services comply with the utilization review criteria set forth in Arkansas Medicaid's Therapy Provider Manual.
- Prior authorization (PA) review for personal care services for Medicaid beneficiaries under 21. Primary to this role is performing PAs for initial and extension of benefits for the Personal Care U/21 program.
- Participation in appeals and hearings resulting from adverse actions related to therapy review outcome determinations.

2.5 Mandatory Requirements

Attachment B: Mandatory Specification Checklist

Our proposal meets or exeeds all the mandatory specifications of this RFP. Qsource agrees to provide any additional documentation deemed necessary by the Bureau to demonstrate compliance with the mandatory specification. A **signed certification document** is included at the end of this section.

2.5.1

Qsource will comply with the requirements listed in Attachment D. Our proposal does not include proprietary language within the technical proposal; therefore, an electronic copy omitting any proprietary language for publishing to the Department of Health and Human Resources (DHHR) website need not be submitted. Qsource agrees that BMS retains ownership of all data, procedures, programs, workpapers and all materials gathered or developed under the contract with West Virginia. Qsource's signed certification is included as **Attachment D** at the end of this section.

2.5.2

Qsource will provide a lead point of contact who will be immediately available by telephone and email at a minimum, during business hours of Monday through Friday, 8 a.m. until 5 p.m. Eastern Standard Time (EST):

Dawn M. FitzGerald, MS, MBA
Chief Executive Officer
DFitzGerald@qsource.org
3340 Players Club Parkway, Ste. 300
Memphis, Tennessee 38125
Telephone 901.273.2650
Facsimile 901.273.2695

John Couzins, MPH, CHCA
EQRO Director
JCouzins@qsource.org
49 Music Square West, Ste. 402
Nashville, Tennessee 37203
Telephone 615.244.2007
Facsimile 615.244.2018

2.5.3

Qsource will provide necessary training and technical assistance to all designated DHHR and BMS staff and their contractors participating in this project during the duration of this contract.

2.5.4

Qsource will comply with all federal regulations. Qsource meets the competence and independence requirements as specified in 42 CFR § 438.354.

2.5.5

Qsource will prepare and submit a draft work plan for review and approval by DHHR/BMS within 30 calendar days from the date of contract award. The approved work plan will be submitted to BMS prior to beginning EQR activities.

2.5.6

Qsource's project manager or a designated representative will attend all quarterly meetings of the BMS Task Force.

2.5.7

Qsource will provide quarterly written status reports to BMS within 15 calendar days of end of quarter.

2.5.8

Qsource will provide additional services to comply with externally driven changes to BMS programs and requirements, including any state or federal laws, rules and regulations. Additional services are being bid as an all-inclusive hourly rate, to include all general and administrative staffing, travel, supplies and other resource costs necessary to perform all services within the scope of this procurement. Qsource will obtain BMS approval of a Statement of Work (SoW) and submit a related Cost Estimate.

I certify that the proposal submitted meets or exceeds all the mandatory specifications of this RFP. Additionally, I agree to provide any additional documentation deemed necessary by the Bureau to demonstrate compliance with said mandatory specifications.

Qsource
(Company)

(Representative Name, Title)

Phone: 901-682-0381/Fax: 901-273-2695
(Contact Phone/Fax Number)

03/01/2012
(Date)

Attachment D: Special Terms and Conditions

If a Vendor's proposal includes proprietary language within the technical proposal, an electronic copy omitting any proprietary language for publishing to the DHHR web-site shall be submitted.

Agree that BMS retains ownership of all data, procedures, programs, workpapers and all materials gathered or developed under the contract with West Virginia.

I certify that I have acknowledged the additional contract provisions contained in Attachment D and that the proposal meets or exceeds all additional requirements as listed.

Qsource
(Company)

(Representative Name, Title)
Phone: 901-682-0381/Fax: 901-273-2695
(Contact Phone/Fax Number)
03/01/2012
(Date)

Appendix I: Reference Letters

TennCare External Review Organization (EQRO)	
Primary Contact	Alternate Contact
Judy Womack, Director of Quality	Pauline McIntyre, Assistant Director, QO
615-507-6716	615-507-6915
Judy.M.Womack@tn.gov	Pauline.McIntyre@tn.gov
Bureau of TennCare, State of Tennessee Department of Finance and Administration (TennCare)	Bureau of TennCare, State of Tennessee Department of Finance and Administration (TennCare)
310 Great Circle Road Nashville, TN 37243	310 Great Circle Road Nashville, TN 37243

Sign: Pauline S McIntyre Date: 10-13-11

Business Office Operations for Services

TennCare is the State of Tennessee's Medicaid program that provides healthcare for 1.2 million Tennessee residents and operates with an annual budget of approximately 8 billion dollars. The TennCare program operates under a Section 1115 waiver from the Centers for Medicare & Medicaid Services (CMS). Begun in 1994, TennCare is the only program in the nation to enroll the entire state Medicaid population in managed care. TennCare services are offered through managed care entities, including managed care organizations, a pharmacy benefits manager and a dental benefits manager across the three Grand Regions of the state: East, Middle and West. TennCare offers a federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, TENNderCare, whose objective is to promote good health in children from birth until age 21.

Date(s) and Detailed Experience

Contract duration: 10/01/2005 – Current

Qsource provides the State of Tennessee Department of Finance and Administration with an independent, external review of the quality of services available to TennCare members via the following activities:

- Validates Performance Measures: Performance measure validation (PMV) evaluates the accuracy of TennCare performance measures reported by the Managed Care Organizations (MCOs). As part of this task, Qsource reviews the data management processes of the MCOs, evaluates the algorithmic compliance, and verifies that State-specified performance measures are based on accurate source information. The results of the PMV process are included in individual reports by plan and region, and in the EQR Technical Report.

- Validates Performance Improvement Project (PIP): PIP validation is performed for each MCO using the current Centers for Medicare & Medicaid Services (CMS) protocols, culminating with the production of a written report of findings/recommendations. Qsource evaluates the soundness and results of the PIPs implemented by the MCOs. The PIP validation results are included in individual reports by plan and region, and in the EQR Technical Report.
- Conducts Annual Quality Survey (AQS): An AQS is conducted of each Managed Care Contractor (MCC) for contractual compliance and includes pre-onsite assessment, onsite review and post-onsite analysis. In accordance with CMS protocols, review criteria include contract compliance to meet current industry, federal, and State requirements for managed care. Onsite, Qsource performs policy and procedure review as well as complaints and utilization management denials/appeals file review for compliance with contractual obligations. Qsource provides MCC-specific reports with health plan recommendations. Results are also part of the annual technical report.
- Performs Quality Survey for EPSDT Compliance: As part of the onsite AQS, MCC compliance with the State's *John B. Consent Decree* is monitored, including a review of each Managed Care Organization's (MCO) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) information system tracking for explicit monitoring of compliance with federal EPSDT standards. MCOs are required to achieve and maintain the capability of tracking each child for the purposes of monitoring the child's receipt of the required screening, diagnosis and treatment. An annual report of EPSDT findings and recommendations is produced.
- Conducts Annual Evaluation of Provider Network Adequacy (ANA): The onsite evaluation helps ensure that the MCCs have the capacity to provide covered services and that those services are accessible to TennCare members. The report includes objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.
- Prepares Detailed Technical Report: This report describes the manner in which the data from all oversight activities, in accordance with 42 CFR 438.358, were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by TennCare-contracted MCCs. The report includes objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. Other aspects of the Technical Report encompass an assessment of each MCC's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid recipients; recommendations for improving the quality of healthcare services furnished to each member; an assessment of the degree to which each MCC has addressed effectively the recommendations for QI made by the EQRO during the previous year's review processes; and quality assurance to protect patient privacy data.
- Analyzes HEDIS and CAHPS Data: An annual comprehensive analysis of HEDIS and CAHPS data results is prepared to identify opportunities for improvement and best practices among MCOs. Additionally, Qsource has providespecial ad hoc reports designed to improve the quality of care rendered to the TennCare population, including an aggregation of all HEDIS data across contributing health plans in Tennessee.

Description of How the Respondent's Past Applies

As TennCare's EQRO since 2005, Qsource knows the importance of quality oversight for Medicaid and Medicare programs. Qsource has a decade of continuous experience since 2000 in assessing federal, state and contractual compliance for multiple managed care health plans, including the health plans' compliance for TennCare's EPSDT program. Qsource has provided consistent expertise and customer

service in the face of significant TennCare program changes, such as the streamlining of health plans and the integration of medical, behavioral and long-term-care services under managed care companies (MCCs). Qsource produces nearly 50 quality reports summarizing EQR findings each year. Those reports include the Annual Quality Survey (AQS) and EPSDT Evaluation Summary Report. For the AQS, Qsource customized evaluation tools to assess compliance with all EPSDT mandate elements. Additionally, a component of Qsource's evaluation focuses on compliance with the tracking of services delivered to TENNderCare members. At TennCare's request, Qsource also has facilitated and participated in multiple strategic planning efforts and aided program leadership in CMS compliance activities.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
COVER TENNESSEE PROGRAMS
Snodgrass TN Tower 26th Floor
312 Rosa L. Parks Avenue
NASHVILLE, TENNESSEE 37243

December 5, 2011

Dawn M. FitzGerald
Qsource
3340 Players Club Pkwy., Suite 300
Memphis, TN 38125

Subject: Letter of Recommendation

Ms. FitzGerald:

I am pleased to provide this letter of recommendation for Qsource. As a result of demonstrated excellence as the External Quality Review Organization (EQRO) for CoverKids, Qsource was selected in 2010 as the EQRO for Tennessee's Children's Health Insurance Program (CHIP), CoverKids.

Performing oversight for a state's CHIP is a federal requirement on which Qsource provides expert guidance to CoverKids staff. Early assistance included contract review for the program's medical and dental plan administrators and the selection of appropriate compliance oversight and evaluation activities. For CoverKids, Qsource conducts annual plan administrator reviews of quality assurance, provider network adequacy and compliance with federal and state mandates for the care of enrollees. In addition, Qsource researches Medicaid and CHIP policy, regulations and best practices. Qsource also produces annual quality reports for CoverKids, including the Annual Quality Survey and Annual Network Adequacy reports, the EQR Technical Report, as well as quarterly Provider Data Validation reports and the monthly Healthcare Policy Report.

Qsource has carried out all contracted functions in accordance with federal and state requirements and fulfilled deliverables in a timely and professional manner. In October of 2011, the state extended its CoverKids EQRO contract with Qsource for an additional year.

We look forward to continuing a positive working relationship with Qsource. Please contact me if we can provide additional information or be of assistance.

Sincerely,

Stephanie Dickerson
Director, CoverKids

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
P.O. Box 1437, Slot S-401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197 · TDD: 501-682-6789

December 10, 2011

Dawn M. FitzGerald
Qsource
3340 Players Club Pkwy., Suite 300
Memphis, TN 38125

Subject: Reference letter

Ms. FitzGerald,

Arkansas Department of Human Services Division of Medical Services provides this letter of recommendation for your organization. Qsource of Arkansas has been and continues to be a Medicaid contractor in Arkansas.

The Qsource – Medicaid contractual relationship began in 2008, when Medicaid contracted with Qsource on its Arkansas Therapy Review and Personal Care Prior Authorization under 21 contract. This contract has been renewed each year since. During this contract, core competencies have been demonstrated, such as: Qsource of Arkansas is experienced and knowledgeable about clinical standards of care, Medicaid medical necessity criteria, screening guidelines and the overall medical record data review process. Qsource regularly updates and maintains communication with DMS regarding activities and provider/beneficiary/stakeholder lessons learned and/or barriers. Qsource accesses the type of professionals required that provide medical care and services received by Arkansas Medicaid beneficiaries and maintains positive relationships with the provider community. Qsource prepares weekly, monthly, quarterly, and annual reports for Arkansas Medicaid.

Medicaid also contracts with Qsource to provide Management for Medicaid Quality Initiatives and Technical Support. Through this contract Qsource responsibilities include review of Medicaid policy and current, relevant literature to recommend policy, process, and/or screening criteria updates. Qsource oversees data validation, performance measure development and implementation as well as database creation for this program. Qsource prepares topic-specific reports for Arkansas Medicaid; in addition to providing support to the Arkansas Medicaid Medical Director's research initiatives. Qsource prepares provider communiqués: Web messaging, assistive "how to" materials, eNewsletters, presentations, exhibits and direct mail.

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As a subcontractor, Qsource provides expertise in the technical aspects of the adoption and use of electronic clinical information, specifically ePrescribing. The facilitation and coordination of intra/inter physician office and hospital outpatient workflow design to maximize health information exchange for continuity of treatment, QI and patient safety as it relates to ePrescribing has been visible through the growing number of Arkansas providers prescribing electronically.

The Qsource team consists of highly qualified professionals with strong program evaluation, clinical and project management expertise and experience. Qsource is known as a trusted local source of quality improvement/performance improvement expertise. Please don't hesitate to contact me if I can provide any additional information.

Sincerely,

Marilyn Strickland

Marilyn Strickland
Interim Director
Division of Medical Services

Attachment

Appendix II: Key Staff Resumes

John Couzins, MPH, CHCA

Current Qsource associate and American citizen with more than 12 years experience in epidemiology/clinical tasks and health data analyses, more than nine of which has been within the QI community, more than seven years in management. CHCA with advanced knowledge of the NCQA accreditation, health plan compliance audit processes and ISO 9001 certification. Expertise in EQRO processes for Medicaid managed programs. Heightened analytical, research and communication skills. Advanced coursework work in epidemiology and public health.

PROFESSIONAL EXPERIENCE

Qsource — **Nashville, TN**

EQRO Director/Epidemiologist — **Mar 2007 to Present**

Is responsible for the day-to-day management of the EQRO contract with TennCare, including technical assistance to the State regarding state and federal regulations affecting the managed Medicaid program, and the coordination of oversight activities with TennCare MCCs. Performs NCQA HEDIS®[6] Compliance Audits for MCOs throughout the country.

Epidemiologist/Senior Health Analyst — **May 2003 to Mar 2007**

Conducted and completed NCQA HEDIS Compliance Audits™. Provided technical assistance to TennCare MCOs regarding HEDIS and TennCare contract compliance as part of the TennCare's EQRO. Conducted contract compliance and network adequacy audits for TennCare. Prepared written reports regarding contract compliance of TennCare MCOs. Served as an internal resource for analytic support.

Georgia Medical Care Foundation — **Atlanta, GA**

Epidemiologist/Health Data Analyst — **Jan 2000 to May 2003**

Served as the project leader and measurement advisor for an Institute for Health Care Improvement collaborative involving 11 rural hospitals in Southeast Georgia. Analyzed national/statewide data on healthcare outcomes and utilization for the Peer Review Organization/QI Organization in Georgia. Performed advanced analyses of Medicare claims/enrollment data using various statistical techniques (e.g., survival analysis, regression analysis, hierarchical data analysis, etc.). Developed and implemented an Access-based surveillance system for a statewide diabetes QI initiative. Assisted in the analytic design and project planning for a statewide breast cancer project.

DeKalb County Board of Health — **Decatur, GA**

County Epidemiologist — **Feb 1999 to Jan 2000**

Analyzed and interpreted public health surveillance data (including case-control and cohort studies). Used ArcView/geographic information system (IS) to map public health data and perform spatial analyses. Developed and implemented countywide surveillance system for tuberculosis. Provided training, technical assistance, and consultative services regarding

6 **HEDIS®** refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA)

epidemiology and control of diseases. Served as Co-chair of Safe Communities Data Committee which was charged with the design of a public safety data collection tool aimed at gathering comprehensive information regarding motor vehicle crashes.

CDC National Institute of Occupational Safety and Health — **Atlanta, GA**
ASPH/CDC Intern — **Jun 1998 to Sep 1998**

For the Association of Schools of Public Health (ASPH) through the CDC, analyzed data for case control study of occupational exposures and neurodegenerative disorders. Prepared written summary of methods and the results for publication. Performed descriptive epidemiologic analysis of NHANES and NHIS national databases in preparation for a study of occupational exposures and mental health attributes. Completed SAS©[7] categorical data analysis training course.

CDC Mycotic Diseases Branch — **Atlanta, GA**
Data Analyst — **Jan 1998 to Feb 1999**

Analyzed data collected for a two-year cohort study regarding the risk of oral thrush among male HIV patients at the Atlanta VA Medical Center. Prepared written report of results. Performed polymerase chain reaction analysis and classification of mycotic cultures obtained from cohort of male patients for a molecular epidemiological study.

EPA of New South Wales Australia — **Sydney, AU**
Administrative Officer — **Feb 1997 to Apr 1997**

Worked with the Global Ozone Department, Environmental Protection Authority (EPA), coordinating efforts to establish policies prohibiting the use of CFCs within the State of New South Wales, Australia. Created and developed databases regarding the sales and usage of CFCs. Organized meeting to address concerns of both the public and private industries relating to the newly developed policy.

Riverside Methodist Hospital Pharmacy — **Columbus, OH**
Pharmacy Technician — **Aug 1993 to Dec 1996**

Filled in-patient and outpatient prescriptions and catalogued drugs. Assisted in the compounding of prescriptions. Packaged/delivered medications to hospital departments.

EDUCATION

Master of Public Health, Epidemiology (MPH) — **May 1999**
Emory University, Rollins School of Public Health — Atlanta, GA

Bachelor of Science, Microbiology — **Dec 1995**
The Ohio State University — Columbus, OH

Certifications/Licensures

Certified HEDIS Compliance Auditor (CHCA) — Oct 2003

Continuing Education/Seminars

Navigating NCQA Accreditation — May 2005

7 **SAS©**, a copyright of the SAS Institute Inc., is an integrated system of software products known as Statistical Analysis System

HEDIS: The Basis for Performance Measurement	Oct 2003, May 2005
ISO 9001:2000 Implementation Documentation Course	Jan 2005
ISO 9001:2000 Internal Auditing Course	Jan 2005
HEDIS Auditors Update Conference	Nov 2004
HEDIS Updates and Best Practices	Oct 2003, Oct 2004
SAS Programming II: Manipulating Data with the DATA Step, SAS Institute	2002-03
SQL Processing with the SAS System, SAS Institute	2002-03
SAS Macro Language, SAS Institute	2002-03
SAS Color Graphics, SAS Institute	2002-03
Basic and Advanced Output Delivery System Topics with SAS, SAS Institute	2002-03

SELECT PUBLICATIONS

McClellan W, Millman L, Presley R, **Couzins J**, Flanders D. Improved diabetes care by primary care physicians: results of a group-randomized evaluation of the Medicare Health Care Quality Improvement Program (HCQIP). *Journal of Clinical Epidemiology* 2003;56:1210-1217.

SELECTED PRESENTATIONS

Couzins J. Do quarterly Glycosylated Hemoglobin tests predict survival? [oral]. Presented at: The American Health Quality Association (AHQA) Technical Conference; February 1, 2002; Dallas, TX.

Couzins J. An investigation into the demographic, ecological and clinical variables associated with the care of patients with diabetes [oral]. Presented at: The Tri-Regional Conference; June 15, 2001; St. Petersburg, FL.

Couzins J. A comprehensive database and project management tool for the outpatient initiatives [oral]. Presented at: The Tri-Regional Conference; June 15, 2001; St. Petersburg, FL.

Couzins J. Mailing practice-specific quality of care profiles linked to educational materials improved the care of diabetes mellitus: A randomized trial. Poster presented at: The AHQA Technical Conference; February 10, 2001; Los Angeles, CA.

Couzins J. Web-based immunization program. Poster presented at: SDPS/HCFA User's Group Meeting; September 29, 2000; Des Moines, IA.

SELECT OUTREACH/SERVICE

Volunteer, The Leukemia and Lymphoma Society — May 1999-present

- Tennessee Chapter Board of Trustees Member
- Coach Team-in-Training participants to complete marathons and triathlons while raising money to support Leukemia and Lymphoma research
- Independently raised over $20,000 to benefit local leukemia patients and their families
- Trained to successfully complete 25 marathons and ten Ironman triathlon competitions

Member, Human Resources Committee, QSource, Memphis, Tennessee — 2006-09

Resume of Michelle North, BSN, RN, CPHQ

Michelle North, BSN, RN, CPHQ

Current Qsource associate with American citizenship and more than 16 years clinical experience, eight of which have been in healthcare review/assessment and over seven in healthcare quality improvement (QI). Extensive managed care experience, including QI and utilization management (UM) with an NCQA accredited company. Ability to understand and verbalize clinical information. Instrumental in increasing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) charting and compliance among west Tennessee providers. Specialized experience in labor and delivery and postpartum mother/baby care, well-child visits, medical record review, assessing and streamlining healthcare care and administrative processes, and facilitating provider corrective action plans. Experience providing support for organizational continuous QI (CQI) by using ISO9001 as a tool for measuring intervention effectiveness, measuring customer satisfaction and improving relationships and by adhering to requirements of Qsource's Quality Management System (QMS) and HEDIS as well as NCQA standards.

PROFESSIONAL EXPERIENCE

Qsource — **Nashville, TN**

EQRO Program Manager — **Sep 2010 to Present**

Continue to perform responsibilities identified for Clinical QI Specialist position. Assisted in development of Performance Improvement Project (PIP) database and tool for PIP validation. Acted as clinical lead in 2011 PIP Validation. Serve as one of the primary points of contact for TennCare Quality Oversight Department. Assisted in collection and transfer of EPSDT related data and activities for TennCare. Meet routinely with TennCare Quality Oversight staff to discuss EQRO activities related to EPSDT, disease management, etc. Conduct annual surveyor training of EQRO staff as it relates to Annual Quality Surveys (AQSs). Training topics include evaluation of element criteria and file reviews (e.g., EPSDT Tracking Systems and Utilization Management Denials for Members Under 21 Years of Age).

Clinical QI Specialist — **Sep 2007 to Sep 2010**

Conducts managed care company AQSs for the Tennessee EQRO, including, but not limited to, survey tool development, scheduling, pre-assessment documentation review and report preparation. Assists in evaluations of health plan PIPs. Coordinates quarterly meetings for TennCare Quality Oversight Department and health plan representatives with TennCare staff by developing an agenda, and contacting/arranging for presenters. Participates in HEDIS/PMV projects as needed. Conducted compliance surveys for State HCBS programs as needed. Participates in State level meetings as directed.

Mercy Care Plan — **Phoenix, AZ**

QM Coordinator — **Feb 2007 to Aug 2007**

Reviewed member, provider and facility files for quality of care concerns. Researched member complaints regarding services or level of care provided by Mercy Care Plan Medicaid and Medicare network providers. Interfaced with Medical Directors to assign appropriate level or degree of quality concerns. Wrote reports based on findings of medical record reviews. Answered questions that were posed by various State agencies related to member care. Reviewed provider records in their office setting for appropriate documentation based on established guidelines.

John C Lincoln Hospital North Mountain — **Phoenix, AZ**

RN, Birthing Center — **May 2006 to Feb 2007**

Managed laboring patients; triaged incoming patients for labor status. Cared for postpartum mother/baby couplets. Circulated operating room for cesarean sections.

CSN of West TN — **Memphis, TN**

QM Manager — **Jan 2006 to May 2006**

Assisted the Medical Director in analysis of Community Services Network (CSN) member prescription data and related activities. Monitored case management services for timeliness of notification related to hospitalizations, identified risk factors, or changes to plans of care. Reviewed/revised QM Program description. Revised provider site survey tools. Analyzed provider satisfaction surveys.

Unison Health Plan — **Memphis, TN**

QI Coordinator — **Apr 2002 to Jan 2006**

Was responsible for educating network providers in West Tennessee on health plan and/or TennCare regulations and EPSDT (well-child checkups). Acted as liaison between providers and TennCare representatives to resolve conflicts regarding EPSDT requirements. Served as representative at TennCare meetings. Assisted with organization of internal documents for NCQA surveys. Conducted medical record reviews and chart audits. Assisted with coordination of HEDIS projects, including medical record abstraction, analyzing data, and managing provider issues related to the HEDIS process. Played an active role in HEDIS process for Pennsylvania lines of business, Three Rivers Administrative Services, which was named one of the top twenty-five Medicaid health plans by US News and World Report.

UM Coordinator — **Jul 2001 to Apr 2002**

Served as point of contact for hospital case managers and physician office personnel to obtain authorization and approval for hospital admissions. Also provided authorization and approval for home health agencies, durable medical equipment companies and other outpatient services.

CIGNA HealthCare — **Memphis, TN**

Nurse Reviewer — **Nov 2000 to Jul 2001**

Developed process for streamlining appeals, which resulted in a significant reduction in backlog of old appeals and medical reviews. Reviewed predetermination requests for medical procedures or services to determine medical necessity. Approved and submitted appeals of denied procedures. Coordinated workflow within medical review team to maintain accurate records. Responsible for resolving escalated issues involving high profile accounts. Communicated with claims adjuster and customer service associates regarding approvals, denials and payments to resolve problems, answer questions and expedite determination process.

Methodist Healthcare — **Germantown, TN**

RN, Labor and Delivery Floor — **Mar 1997 to Nov 2000**

RN, Medical/Surgical Floor — **Mar 1996 to Mar 1997**

Ridgelake Ambulatory Center — **Memphis, TN**

Medical Records Assistant — **Mar 1993 to Mar 1996**

Resume of Michelle North, BSN, RN, CPHQ

EDUCATION

Bachelor of Science, Nursing (BSN) **Dec 1995**
University of Memphis Memphis, TN

Certifications/Licensures

Licensed RN, TN Current

Continuing Education/Seminars

HEDIS: The Basis for Performance Measurement Oct 2005

SELECT OUTREACH/SERVICE

Presentation to TN TennCare Quality Oversight and health plan representatives on AQS Plan of Corrections process; Nashville, TN. Jun 3, 2008

Presentation to TN TennCare Quality Oversight and health plan representatives on AQS updates; Nashville, TN. Jan 15, 2008

Deborah P. Crouse, MHA/INF, BSN, CPHQ, CCM

Current Qsource associate and British citizen with US Green Card/Permanent residency and 28 years experience in healthcare, 14 years combined in quality improvement (QI), utilization management (UM), and case management (CM). Nearly a decade of service under the Centers for Medicare & Medicaid Services (CMS) contract with Qsource as the Tennessee Quality Improvement Organization (QIO). Specialized expertise working with underserved populations. Emphasized experience in supervising, training, coordinating continuing education (CEU/CME) opportunities and large-scale collaboration, as well as data abstraction, methodology and protocol development, and utilization assessment with high-risk, high-cost populations, including cancer and transplant patients, and diabetics.

PROFESSIONAL EXPERIENCE

Qsource **Nashville, TN**

tnREC Liaison, tnREC Team **Jun 2010 to Present**

Works as a single point of contact for the tnREC contract with the Marketing and Communications department to facilitate timely work order production of communication activities: website updates, monthly enews, press releases, marketing material production, eblast and product branding. Identifies and develops content as appropriate. Collaborates with the Controller and Contractor Administrator to ensure all billing information is accurate and timely. This includes performing monthly reconciliation activities. Responsible for the collection, finalization and data entry of all contract information, educates all tnREC to ensure all contract elements submitted are 100% compliant to meet audit specifications and emails all tnREC clients copies of executed contract agreements. Works closely with the Vice President of Contract Compliance and Development to facilitate appropriate tnREC contract administration and aids in the development of new policies and letters pertaining to tnREC activities. Additional duties include; workflow process development, the identification of new tool and resources for clients, vendors and staff.

QI Specialist, CKD Team **Aug 2008 to May 2010**

Recruits physician office practices, for participation in QI efforts with a focus on Chronic Kidney Disease (CKD) prevention among diabetic Medicare beneficiaries. Provides support to all assigned physician practice groups regarding clinical interpretations, continuous QI efforts, and effective use of data through onsite visits, regional meetings, scheduled conference calls and ad hoc requests for additional involvement. Develops and presents education materials for beneficiaries and providers to improve treatment processes and predefined clinical measures related to appropriate medication and screening. Acts as a primary contact to facilitate collaboration with community partners to enhance project goals and improve patient outcomes. Participates in the development and feedback of measurement data, and researches and reviews clinical literature and other materials to support project definition, development and revision. Performs External Quality Review Organization (EQRO) and Home-and Community-Based Services (HCBS) review/audit activities for the Bureau of TennCare (TennCare) managed care contracts as needed.

Project Task Manager, UQIOSC **Nov 2004 to Jul 2008**

Performed leadership/support functions associated with the CMS Underserved QIO Support Center (UQIOSC) contract. Worked directly with the Special Studies Program Manager and

analytic team to identify disadvantaged populations. Helped to establish target groups/define methods to extract population data from a variety of sources, and provided technical support to QIOs in the US. Collaborated with other QIOSCs and supported QIOs in their performance of Task 1e projects for the QIO 8th Scope/Statement of Work (8SoW). Coordinated CEUs/CMEs for more than 350 attendees at Qsource's 2004 Internal Annual Quality Conference and the multi-site 2005 QIO Cultural Competency Regional Training. Performed EQRO and HCBS review/audit activities for the TennCare contracts.

QI Specialist, Hospital Team **Aug 2002 to Oct 2004**

During the 7SoW, worked with 118 acute-care hospitals in Tennessee with a focus on four national topics: Pneumonia, Heart Failure, Acute Myocardial Infarction and Surgical Infection Prevention. Developed and presented educational sessions using a modified collaborative breakthrough series methodology adapted from the Institute for Healthcare Improvement (IHI) to improve processes of care in predefined measures for the four national topics. Served as primary contact with 100 plus quality liaisons and QI contacts, which required database development, management and tracking. Coordinated CEUs for more than 350 attendees at Qsource's Internal Annual Quality Conference. Performed EQR activities for the TennCare contract.

Project Manager, Payment Error Prevention Program (PEPP) **Nov 1999 to Jul 2002**

Oversaw Tennessee QIO program design/implementation of 112 Prospective Payment System (PPS) acute care hospitals, including 1,200 direct contacts. Worked with team to help hospitals implement a comprehensive education/QI program. Conducted educational sessions and worked with multifunctional hospital teams to reduce errors in at-risk billing. Worked within a $4.5M PEPP operating budget for the QIO 6SoW. Developed a successful statewide education/process improvement program, enabling all Tennessee hospitals to monitor and reduce Medicare inpatient billing errors. Assisted with the design of educational tools, including admission screening criteria, compact disc, video and DRG validation tools. Assisted and directed the planning of five regional, biannual meetings with more than 250 attendees. Ensured all deliverables were completed in a timely manner.

Baptist and Physicians IDS **Memphis, TN**

Case Manager (CM) **Nov 1997 to Oct 1999**

Oversaw CM activities via Integrated Delivery System functioning as a managed care organization for Baptist Memorial Health Care Corporation employees and other risk products. Was responsible for approximately 50,000 covered lives. Performed on-site CM activities at four facilities for all risk products and managed length-of-stay, cost and quality. Used McKesson's Interqual Criteria as a screening tool to assist with assessing appropriate utilization for inpatient admissions. Coordinated care for large CM activities for high-risk, high-cost cases such as cancer and transplants. Developed algorithms, questionnaires and protocols for use in a diabetic population.

Center For Healthcare Quality **Memphis, TN**

Manager, Project Data Collection and Sanctions Coordinator **Nov 1993 to Jun 1997**

Hired, trained and supervised project staff. Coordinated/organized data collection for all local projects, which saw an increase of 400 percent. Was the first non-physician presenter of QI data to a multidisciplinary team. Served on the QI Committee that reviewed all hospital QI plans for the

State of Tennessee. Coordinated all sanction activities from chart review to committee meetings. Managed utilization review activities using McKesson's Interqual Criteria on Medicare Beneficiary charts to determine appropriateness of admission and quality of care issues.

Baptist Hospital of Memphis — **Memphis, TN**
Registered Nurse — **Nov 1992 to Mar 1994**

Served on Orthopedic/Neurology 32-bed unit treating elective and trauma cases. Administered patient assessments, IV medications, application and care of traction. Supervised Patient Care Technicians.

Cordova Rehabilitation and Nursing Center — **Cordova, TN**
Registered Nurse — **Nov 1992 to Oct 1993**

Served as weekend nurse/facility supervisor. Was responsible for patient assessments, medications, and the supervision and education of nursing staff.

Other Employment — **Various**
Registered Nurse (RN) — **Sep 1979 to Oct 1992**

Engaged in a wide range of QI, UM, CM and clinical nursing in acute care in Orthopedics/Neurology and Medical-Surgical/Telemetry (M-S/T) units. Employed by St. Mary's Hospital–Maryland (one year, M-S/T); Dr. R. Berger–Maryland (one year, Dermatology); Queen of the Valley Hospital–California (six months, M-S/T); King Khalid National Guard Hospital–Saudi Arabia (three years, Orthopedics/ER); and Alnawa Emergency Hospital–Saudi Arabia (two years, ER).

EDUCATION

Master of Healthcare Administration/Informatics (MHA/INF) — **Oct 2009**
University of Phoenix — Web-based

Bachelor of Science in Nursing (BSN) — **Dec 2007**
Union University — Germantown, TN

Certifications/Licensures

Licensed registered nurse (RN), Tennessee	Current
Certified Case Manager (CCM)	Current (Jun 1999)
Certified Professional in Healthcare Quality (CPHQ)	Current (Nov 1995)
Certified Professional in Utilization Review (CPUR)	Expired 2011 (Feb 1994)
Licensed RN, Sat Boards, Sacramento, California	1990
Licensed RN, Northampton General Hospital, Northampton, England	Sep 1979

Continuing Education/Seminars

HEDIS: The Basis for Performance Measurement	Oct 2005
ISO Internal Audit Training	Jun 2007
Doctor's Office Quality-Information Technology (DOQ-IT) Training, Session 1	Feb 2005
QI Collaboration Training in IHI Methodology	Feb 2005
Statistical Process Control Course, Wheeler Institute	Apr 1997
Advanced Quality Tools, Juran Institute	Apr 1996

HONORS/AWARDS

Sigma Theta Tau (Honor Society of Nursing) Nov 2007-08

SELECT OUTREACH/SERVICE

Member, National Association for Healthcare Quality (NAHQ) Corporate Membership 2005-08

Member, Tennessee Association for HealthCare Quality (TAHQ)-Memphis (West) 2004-08

Member, Tennessee Hospital Association (THA) 2004-08

Resume of Swapna Mehendale, MHA, BPharm

Swapna Mehendale, MHA, BPharm

Certified Advanced Programmer for SAS 9

Current Qsource associate and citizen of India with an H-1 Visa. Professionally experienced in importing, editing, and exporting SAS[8] datasets and in creating summary tables, graphs and reports. Managed projects for a 490-bed hospital and conducted assessments. Experienced in research studies and presenting outcomes. Trained in Six-Sigma and technically proficient in SAS, MS Office, Project2003, SPSS, Web design, and SQL.

PROFESSIONAL EXPERIENCE

Qsource — **Nashville, TN**

Health Analyst — **Oct 2008 to Present**

Edits, cleans and scores large datasets. Conducts accurate and verified descriptive and statistical analyses of health outcomes data. Creates analysis reports and results for dissemination, reporting and presentations. Applies skills in GIS, SAS and SQL for analyses and report production.

Element Technologies — **Piscataway, NJ**

SAS Consultant — **Oct 2007 to Oct 2008**

Trained in SAS version 9.1 using SAS/Base, SAS/STAT, SAS/GRAPH, SAS/Access, SAS/Connect, Macros, and SQL. Imported data from various databases and created, edited and exported SAS datasets. Analyzed data using SAS procedures, e.g., PROC REPORT, PROC SQL, PROC FREQ, PROC MEANS, PROC TABULATE, PROC TRANSPOSE and PROC PRINT. Computed statistical analysis using PROC ANOVA, PROC GLM, and PROC REG. Created reports using PROC REPORT and graphs using SAS/GRAPH. Wrote SQL queries.

The Medical Center — **Bowling Green, KY**

Intern — **Jan 2007 to Apr 2007**

Conducted three individual projects in the 490-bed hospital: 1) Assessed Physician protocol compliance by evaluating medical records for all the patients admitted during a specific period and subsequently creating a database to analyze the adherence to protocol by the doctors for antibiotic prescriptions across the hospital; 2) Developed educational awareness by planning/developing a workshop for employees of the Adult Day Care on patients' behavior, suffering from Alzheimer's disease and other dementia disorders; 3) Improved vaccination outreach through Six-Sigma by evaluating data, preparing charts for a Six-Sigma project – Influenza and Pneumococcal Vaccination, and developed an entire Computer Based Learning (CBL) module for nurses' continuous mandatory educational and testing program. Also, worked on Chest Pain Accreditation Process for the Director of Education, which involved creating a database for STEMI and NSTEMI patients. Carried out rotations in various departments, including Department of Pharmacy, Infection Control, Education, and Adult Day Care.

8 **SAS**©, a copyright of the SAS Institute Inc., is an integrated system of software products known as Statistical Analysis System

Western Kentucky University — **Bowling Green, KY**

Graduate Associate & Team Lead — **Aug 2006 to Dec 2006**

Created a business plan to set up the Neonatal Intensive Care Unit (NICU) in The Medical Center.

Graduate Assistant, Department of Public Health — **Aug 2005 to Dec 2006**

Assisted the Healthcare Administration department head with alumni relations research project in various universities to create a resourceful alumni database.

Leadership Assessor, Center for Leadership Excellence — **Feb 2006 to Sep 2006**

Completed two student assessment workshops and then assessed students' leadership qualities.

Bombay Drug House — **Mumbai, India**

Intern — **May 2003 to Jun 2003**

Received hands-on practical training in analysis of raw material and finished products using chemical, instrumentation and biological methods.

EDUCATION

Masters in Healthcare Administration (MHA) — **May 2007**
Western Kentucky University (WKU) — Bowling Green, KY

Bachelor of Science, Pharmacy (BPharm) — **June 2004**
MET's Institute of Pharmacy, Mumbai University — Mumbai, India

Certifications

SAS Certified Advanced Programmer — Aug 2009

SELECTED PRESENTATIONS

Wyant D, **Jamode S**. The public health component in health care administration programs not based in colleges of public health. Presented at: The Association of University Programs in Health Administration (AUPHA) Annual Meeting; May 31-June 3, 2007; Orlando, Fla.

Wyant D, **Jamode S**. Approaches to including required epidemiology in health management curriculum. Poster presented at: AUPHA Annual Meeting; June 22-25, 2006; Seattle, Wash.

HONORS/AWARDS

Nominated Outstanding Graduate Student, College of Health and Human Services, WKU — 2007

Outstanding Graduate Student Assistant, Department of Public Health, WKU — 2006

Resume of Kelly Agee, MS, BA

Kelly Agee, MS, BA

Current Qsource associate with American citizenship and 17 years' experience in writing, editing and proofreading multiple documentation types in varied electronic and print formats, as well as 10 years' experience in academic and educational settings. Experience managing multiple projects in a deadline-driven, team-oriented environment. Expertise in media and dissemination, including overseeing research and development of publications; standard American English; and most familiar writing styles, most notably APA, AP, MLA, Chicago, Turabian and IEEE. Competent professional presenter for variety of topics. Technically proficient in Microsoft Office Suite, QuarkXPress, Blackboard, QuestionMark and Mathematica.

PROFESSIONAL EXPERIENCE

Qsource — **Nashville, TN**

Technical Writer — **Jul 2011 to Present**

Assists in the annual production of nearly 30 reports for the External Quality Review (EQR) activities for the state's managed care Medicaid program (TennCare) and Children's Health Insurance Program or CHIP (CoverKids) pertaining to contractor quality improvement (QI)/ assurance, national healthcare measure benchmarking, and national/state policy and best practices. Writes, edits, proofreads, researches, compiles, formats and organizes data for reporting while collaborating with EQR team members and state agencies to help ensure compliance. Assists in organizing team deliverable processes, including creation of work plans and process documentation guides. Serves on corporate Human Resources Committee.

Mississippi State University, College of Education — **Starkville, MS**

Freelance Editor — **Jul 2007 to Present**

Reviews dissertations, providing editing and formatting services for doctoral degree candidates, to ensure compliance with Mississippi State University Libraries guidelines as well as the Publication Manual of the American Psychological Association.

Freelance Editing and Writing — **TN, MS, FL, ME**

Independent Editor and Writer — **1995 to Present**

Pursues independent contracts to edit/write for various publications in multiple media formats. Individual projects include authoring articles and columns for newspaper and online outlets as well as grant proposals, and editing entire conference proceedings for the 2006 International Workshop on Future Intelligent Earth Observing Satellites, research proposals and other academic papers. Edited textbook Across the Aisle: The Seven-Year Journey of the Historic Montgomery GI Bill, published in 2010.

Maine Department of Education — **Augusta, ME**

Data and Technology Consultant/Education Specialist III — **Oct 2010 to Jun 2011**

Collected and assessed educational data at state, regional and local levels. Prepared data reports for submission to U.S. Department of Education, as federally mandated. Provided data analysis reports to school directors and held strategic planning meetings with key school personnel and other stakeholders to determine improvement plans. With other team members, conducted Comprehensive School Reviews for secondary schools, analyzing documentation to show compliance with federal and state mandates, interviewing school personnel and students, and authoring and editing state reports. Conducted Methods of Administration Civil Rights Reviews

for secondary schools and community colleges. Oversaw accountability for Perkins online grants for all 27 Maine career and technical education centers as part of Perkins grant administration duties. Served on the Maine Department of Education (MDOE) Data Management Team and the MDOE Science, Technology, Engineering and Mathematics (STEM) Team and regularly collaborated with data personnel at the Maine Department of Labor. Participated in nationwide collaboratives, such as the Data Quality Campaign, and served as liaison to secondary schools in two regions of the state. Initiated development of process documentation guides for primary tasks associated with data and technology consultant position, including data collection, analysis and reporting. Worked on team to revise Maine's career cluster and pathway framework.

Mississippi State University, Research and Curriculum Unit **Starkville, MS**

Project Manager for Publications and Dissemination/
Research Associate III **Jan 2010 to Sep 2010**
Editor/Technical Writer/Research Associate II **Jun 2007 to Dec 2009**

As project manager, served educators across the state, working with project coordinators and other Research and Curriculum Unit (RCU) staff, as well as the Mississippi Department of Education, the State Board for Community and Junior Colleges, and other external clients, to develop and produce an array of publications media. Routinely wrote and edited content for publications in addition to overseeing their development, including newsletters, briefs, brochures, presentations, letters, memos and the RCU website. Managed a team of six, including an editor, two multimedia specialists, a graphic designer, a graduate assistant and a student worker. Also was responsible for the RCU Media Center, from collaboration with Mississippi State University Libraries staff to development of materials, including overseeing an annual budget of $30K. Served as adviser for the university's Bulldog Toastmasters Club and Recycling Club.

Mississippi State University, Bagley College of Engineering **Starkville, MS**

Instructor, Shackouls Technical Communication Program **Aug 2006 to Jun 2007**

Taught three sections of Technical Writing for Engineers for junior- and senior-level Bagley College of Engineering students. As a full-time 75/25 instructor for the college, was responsible for conducting scholarly research as well as publishing and presenting articles based upon research. Participated in collaborative effort to design the course each semester, making decisions about written and oral course assignments. Routinely edited and proofread journal articles for Bagley College of Engineering professors, and provided editing and counseling services for students as they prepared scholarly articles and job-search materials. Delivered professional presentations at conferences and upon request for classes in other colleges and departments. Served as adviser for the university's Bulldog Toastmasters Club.

Mississippi State University **Starkville, MS**

Lecturer **Aug 2005 to Jul 2006**

Taught two sections of Technical Writing for Engineers for the Bagley College of Engineering and two sections (on an alternating schedule) of Basic Composition, Composition I, Composition II and Introduction to Literature for the Department of English.

State Gazette — **Dyersburg, TN**
Interim Managing Editor — **Jul 2004 to Jul 2005**

Made all layout, content and artwork decisions for daily news publication. Paginated newspaper using QuarkXPress and Adobe Photoshop. Oversaw staff of six, including journalists, copyeditor, print shop personnel and support staff; held weekly staff meetings; and conducted annual performance evaluations. Was responsible for reporters' assignments. Authored articles and editorial content regularly and provided copyediting support. Served on numerous committees for community civic organizations, including Rotary and Kiwanis International clubs.

Tennessee Department of Education — **Nashville, TN**
Facilitator, Highly Qualified Teacher Academy — **Jun to Jul 2004**

Led one-week training sessions for two groups of secondary educators, one in Dyersburg and one in Jackson, for credentialing to become highly qualified teachers according to federal guidelines enacted by the No Child Left Behind Act.

Dyersburg Middle School — **Dyersburg, TN**
Language Arts Teacher — **Jun 2002 to Jun 2004**

Taught language arts for eighth-grade students. Served as adviser for Dyersburg Middle School Student Council. Created and served as adviser for Young Writers Club.

Ripley High School — **Ripley, TN**
English Teacher/Honors English Teacher — **Jan 2001 to May 2002**

Taught English for freshman, sophomore and junior students. Taught honors freshman English. Served as Ripley High School Student Council adviser, as ninth-grade spirit adviser and as Prom Committee Chair.

Dyersburg News and Dyer County Tennessean — **Dyersburg, TN**
News and Features Writer/Copyeditor/Weekly Columnist — **Jan 1998 to Dec 2000**

Authored articles and weekly editorial column for news publication. Provided copyediting, layout and formatting services.

Kearney Publishing Corporation — **Orlando, FL**
Associate Editor — **1996 to 1998**

Assisted with production of four weekly and monthly publications. Edited all materials before dissemination. Researched Lake Mary area for viability of additional publication and initiated publication. Oversaw freelance writers and their assignments. Assisted with layout and design of publications.

EDUCATION

Master of Science, English Education — **Aug 2005**
Concentration in Secondary English
University of Tennessee — Martin, TN

Bachelor of Arts, English — **May 1994**
Concentration in Technical Writing
University of Tennessee — Knoxville, TN

Certifications

Teacher Consultant, National Writing Project	2003-present
Tennessee Teaching License, English, Grades 7–12	2001-2011

Continuing Education/Seminars

Course Work at Mississippi State University, toward MS, Industrial and Systems Engineering,Probability (ST 6523)	Fall 2009
Linear Algebra (MA 3113) and Calculus IV (MA 2743)	Spring 2009
Calculus III (MA 2733)	Fall 2008
Calculus II (MA 1723)	Summer 2008
Statistics (ST 2113) and Calculus I (MA 1713)	Spring 2008
SuccessFactors Training	Jan 12, 2012
Designing E-Learning: Art, Science or Witchcraft? [Webinar]	Aug 5, 2011
Data Quality Institute, Perkins Collaborative Resource Network	Jun 7-8, 2011
Maximizing the Power of Education Data While Protecting the Privacy, Security and Confidentiality of Student Information, Data Quality Campaign	Apr 28, 2011
Access 2003 Queries and Reports, VTEC Education Center	Nov 8, 2010
A Teacher in Your Pocket: Easily Build a 24/7 Classroom That Drives Student Engagement and Achievement [Webinar]	Mar 24, 2010
Unlocking the Potential of Google Docs	Mar 2, 2010
Blended Learning: Making It Work for Your District [Webinar]	Feb 18, 2010
Secondary Online CTE Courses [Webinar]	Jan 20, 2010
Annual American Society for Engineering Education (ASEE) Conference	Jun 13-17, 2009
Annual ASEE K-12 Workshop on Engineering Education: Engineering Change In K-12 STEM Education	Jun 14, 2009
How to Create a House Style Guide [Audioconference]	Feb 19, 2009
Mathematica 6 in Education and Research	Oct 15, 2008
Social Influences on Girls' Interest in Math and Science [Webinar]	Oct 9, 2008
First-Year Experience Programs at MSU, Center for Teaching and Learning	Sep 17, 2008
QuarkXPress I and QuarkXPress II, EEI Communications	Apr 7-10, 2008
Grammar Bugbears 4: Capitalization and Trademarks [Audioconference]	Mar 25, 2008
Building Learning Communities, Center for Teaching and Learning	Mar 19, 2008
SNAP Survey Software Training	Mar 18, 2008
EndNote 101: Managing Your Citations and More	Feb 29, 2008
Printing and Communicating Equipment Workshop	Jan 15, 2008
Microsoft Office 2007: Word, PowerPoint and Excel	Dec 5, 2007
Cyber Safety Training	Nov 26, 2007
Between Two Dogs: Johnny Cash, Sin and Redemption [Invited guest lecture]	Nov 2, 2007
Styles and Formatting in Word 2007 [Webinar]	Oct 18, 2007
Annual Frontiers in Education Conference, ASEE	Oct 12-14, 2007
Introduction to SPSS 15.0 for Windows	Sep 20, 2007
Digital Toolbox for Trainers, Windows Media Encoder and Wink	Sep 4, 2007
Grammar Bugbears 3: Nouns, Pronouns and Antecedents—And Verbs Again [Audioconference]	Aug 21, 2007

Advanced Writing and Editing Workshop for Corporate Communicators	Aug 13-14, 2007
Digital Toolbox for Trainers, Podcasting and RSS Feeds	Aug 6, 2007
Boot Camp: Get an Edge on Teaching [Invitational technology institute]	May 8-10, 2007
Effective Teaching in Science, Engineering and Mathematics	Jan 4-5, 2007
Designing Courses to Address the ABET Accreditation Criteria	Jan 5, 2007
Implementing a New Process for Student Evaluations of Teaching at MSU, Center for Teaching and Learning	Nov 17, 2006
Fall National Academy of Engineering Lecture, Bagley College of Engineering	Oct 26, 2006
Maintaining Academic Honesty in the Classroom, Center for Teaching and Learning	Oct 20, 2006
Beyond Scrapbooking: Writing Family Stories, Tennessee Writers Alliance	Mar 5, 2005
Annual National Council of Teachers of English Conference	Nov 20-23, 2003
Annual National Writing Project Conference	Nov 20-23, 2003
Summer of the Skunks: Family Stories Across the Curriculum, West Tennessee Writing Project	Aug 2, 2003
Teaching Strategies	Jul 28-29, 2003
West Tennessee Writing Project Invitational Reading and Writing Summer Institute, National Writing Project	Jun 9-Jul 3, 2003
Brain Matters	Jul 29-30, 2002
Middle School Strategies	Jul 31, 2002
Helping Your Struggling Students to Be More Successful Readers and Writers, Bureau of Education and Research	Apr 24, 2001

SELECT PUBLICATIONS

Kehrer D, McGrevey M. *Across the Aisle: The Seven-Year Journey of the Historic Montgomery GI Bill*. **Agee K**, Murdock A, eds. Jackson, MS: University Press of Mississippi, 2010.

Agee K, Murdock A. Pathway implementation. *MDE Brief*. Spring 2009;3(1).

Irvin L, Abraham P, Bock S, **Agee K**. Murdock A. *The Mississippi Workforce University Initiative* [White paper]. Mississippi State, MS: Research and Curriculum Unit, 2008.

Mississippi Department of Transportation. *Career Awareness: Roadway to Success (CARS)*. **Agee K**, Murdock A, eds. Mississippi State, MS: Research and Curriculum Unit, 2008.

Agee K. Supplemental STEM training for teachers slated for summer. *Connections*. Spring 2008;7(1):9.

Agee K, Murdock A. New ICT I teacher enjoys updated curriculum. *MDE Brief*. Spring 2008;3(1):5.

Agee K. Using charades to prepare engineering students for professional presentations. *Proceedings of the Annual Conference of Frontiers in Education*. Milwaukee, WI: Frontiers in Education, 2007.

Agee K. Pascagoula instructor wins a $25,000 classroom makeover. *Connections*. Fall 2007;6(1):29-30.

Kehrer D. *Toward building an associate, bachelor's, or master's degree concentration in veterans' programs administration* [Exploratory paper]. **Agee K**, Murdock A, eds. Mississippi State, MS: Research and Curriculum Unit, 2007.

Agee K. CARS program helps pave pathway for student success. *Research and Curriculum Unit Annual Report*. 2007;9-10.

Agee K. Technical writing for engineering students: Using tenets of the National Writing Project for effective writing instruction. *Paper presented at the 2007 Southeastern Section Meeting of*

the American Society for Engineering Education, Louisville, KY, April 1-3, 2007.

Stevenson T, Powe A, **Agee K**. Engineering and golf: A professional development partnership between Mississippi State University's Center for Engineering Student Excellence and Professional Golf Management program. *Paper presented at the 2007 Southeastern Section Meeting of the American Society for Engineering Education, Louisville, KY, April 1-3, 2007*.

Agee K. A teaching story: From below the mire of mediocrity. *Field Notes*. Fall 2003;12(1):6-7.

Agee K. I see the world in titles. National Writing Project website: **www.writingproject.org**

SELECT PRESENTATIONS

Agee K. CTE data and Infinite Campus. Presented at: Maine Department of Education; June 9-10, 2011; Nashville, TN.

Agee K. Coaching your students for speech competition. Presented at: Annual Meeting of the Mississippi Association for Career and Technical Education; July 21-25, 2008; Raymond, MS.

Agee K. Public speaking: What to say and what not to say (and how to say it). Presented at: SkillsUSA Fall Leadership Conference; November 30, 2007; Pearl, MS.

Agee K. Using charades to prepare engineering students for professional presentations. Presented at: Annual Meeting of Frontiers in Education; October 10-13, 2007; Milwaukee, WI.

Agee K. Technical writing for engineering students: Using tenets of the National Writing Project for effective writing instruction. Presented at: Annual Meeting of the American Society for Engineering Education, Southeast Section; April 1-3, 2007; Louisville, KY.

Stevenson T, Powe A, **Agee K**. Engineering and golf: A professional development partnership between Mississippi State University's Center for Engineering Student Excellence and Professional Golf Management program. Presented at: Annual Meeting of the American Society for Engineering Education, Southeast Section; April 1-3, 2007; Louisville, KY.

Brocato J, **Agee K**, Powe A. Presenting as a professional: Audience, purpose and you. Presented at: ESCAPE Conference; March 2-4, 2007; Starkville, MS.

Powe A, **Agee K**. Correspondence: An overview. Presented at: TKB 2413-01, Administrative Office Procedures, Mississippi State University; February 15, 2007; Starkville, MS.

Brocato J, **Agee K**, Powe A. Technical writing. Presented at: Center for Advanced Vehicular Systems, Mississippi State University; May 12, 2006; Starkville, MS.

Agee K. I can't make up things about people I don't know: A picture writes a thousand words. Presented at: St. Mary's Catholic School; August 16, 2005; Jackson, TN.

Agee K. Kuwait and the Middle East. Presented at: Great Decisions, Dyersburg State Community College; April 19, 2005; Dyersburg, TN.

Agee K. T is for teacher: Good teaching is still good teaching. Presented at: West Tennessee Writing Project, University of Tennessee; August 28, 2004; Martin, TN.

Agee K. The reading-writing workshop: Joining together reading, writing, spelling and grammatical conventions. Presented at: Dyersburg Middle School; September 5, 2003; Dyersburg, TN.

Agee K. Story sandwich: Juxtaposition writing. Presented at: West Tennessee Writing Project, University of Tennessee; June 9, 2003; Martin, TN.

SELECT RESEARCH/GRANT SUPPORT

Trauma Quality Improvement Organization, State of Arkansas: Assisted in editing/formatting/production of proposal for Qsource-Arkansas — 2011

Annual Proposal for Continuation of Services, State of Mississippi: Assisted in writing/editing/formatting/production of proposal for Research and Curriculum Unit, Mississippi State University — 2008-2010

HONORS/AWARDS

Recipient, Tennessee Council of Teachers of English Adrian McClaren Memorial Scholarship	2003
Recipient, Mabel Miller Morelock Academic Scholarship, University of Tennessee	1990
Recipient, Fred M. Roddy Merit Scholarship, University of Tennessee	1990

OUTREACH/SERVICE

Member, Corporate Committee, Qsource, Memphis, TN Human Resources Committee	2011-present
Participant, State Collaborative on Assessment and Student Standards, Council of Chief State School Officers	2011
Member, Maine Department of Labor Workforce Development Report Card Workgroup	2010-2011
Member, Perkins Collaborative Resource Network Next Steps Workgroup	2010-2011
Member, Association for Career and Technical Education	2007-2011
Presenter, Best Practices for Career and Technical Educators, Mississippi State University	2007-2010
Member, American Society for Engineering Education	2005-2010
Faculty Adviser, MSU Recycling Club	2009-2010
Team Leader/Faculty Volunteer, MSU Service DAWGS	2009-2010
Reviewer, American Society for Engineering Education and Frontiers in Education Annual Conferences	2006-2010
Member, Society for Technical Communication (STC)	2008-2010
Graduate Student Member, Bagley College of Engineering Transportation Working Group	2008-2009
Facilitator, Mississippi Association for Career and Technical Education	2008-2009
Faculty Volunteer, MVNU2MSU	2007-2009
Faculty Adviser, MSU Bulldog Toastmasters Club	2006-2009
Member, West Tennessee Writing Project Focal Team	2004-2005
Member, Rotary International	2004-2005
Member, Alpha Delta Kappa	2002-2004
Member, Dyersburg Cotillion Club	1999-2003
Member, Kiwanis International	1998-2000, 2004-2005
Member, American Business Women's Association	1998-2000

Lingling Gong, MS, OCA, MCP

Current Qsource associate and citizen of China with a Permanent Resident Card, and five years experience as lead-level programmer and database/server administrator. Expert in the development, improvement and refinement of database systems, custom programs and reporting applications. Well-versed in numerous platforms including SQL Server, Oracle and Access with the ability to synchronize and optimize across multiple databases and locations while maintaining data integrity. Additional expertise in process improvement and in web design/content management using multimedia applications and software tools. Fields include federal government, finance and higher education. An Oracle Certified Associate (OCA) and Microsoft Certified Professional (MCP).

PROFESSIONAL EXPERIENCE

Qsource — **Memphis, TN**

Senior Programmer/DBA — **Jul 2006 to Present**

Is responsible for loading, manipulating, editing, verifying, validating and merging data sets and generating queries from MS Oracle (PL SQL), SQL Server (T-SQL) and MS Access database. Develops, implements and maintains content management of Intranet (Visual Studio 2005/VB.Net/ASP.Net/SQL Server 2005). Performs data management functions to ensure data integrity in the SDPS applications such as PRS (Program Resource System). Writes custom programs and database applications. Maintains and administrates the Windows 2003 Oracle and SQL database servers.

Eurofins Scientific Inc. — **Memphis, TN**

Applications Developer — **Aug 2001 to Jul 2006**

Designed Enterprise applications for multi-functional in-house Laboratory Information Management System (Object-Oriented Programming). Administered/Maintained SQL Server 2000/7.0 and Oracle8i/9i (OCA) databases for multiple locations. Built application to automate data synchronization between SQL Server and remote Oracle database. Developed web-based data inquiry system and report generation system (Visual Studio 2003/VB.Net/ASP.Net/Crystal Report 9). Developed application for distributed client/server system in Java/SQL Server/OLE DB/Crystal Report. Developed software under quality control/assurance environment (FDA Regulation Part 11 compliance, ISO, GMP and GLP).

Interface Age, Inc./P.L. McMickle, CPA — **Memphis, TN**

System Developer — **May 2001 to Aug 2001**

Developed accounting application software based on the concept of three-tiered topology, designed in VB6.0, SQL Server7.0 and ADO2.5.

The University of Memphis — **Memphis, TN**

Graduate Assistant — **Aug 1999 to May 2001**

Developed a Java-based webpage with Flash and multimedia animations. Designed a decision support system to help make the award decision for Human Resources Dept. (DSS software Cdplus30). Built a relational database system for rental apartments in Oracle and a business career service information system designed for Fogelman College. Provided computer technical support.

Guangdong Telecommunications **China**

System/Database Administrator **Nov 1996 to Feb 1999**

Developed and maintained relational database (VB/SQL Server). Involved in physical database design, system debugging/testing and optimizing. Analyzed statistical data and developed new data models for increased user demands. Coordinated two cross-functional productivity improvement teams, and developed models to study efficiencies in operation flow in optimizing operations.

EDUCATION

Master of Science, Business Administration - MIS **May 2001**
The University of Memphis Memphis, TN

Bachelor of Science, Chemistry **Jul 1996**
East China University of Science and Technology Shanghai, P.R. China

Certifications/Licensures

Oracle Certified Assistant (OCA) Jun 2004
Microsoft Certified Professional (MCP) Jan 2003

Continuing Education/Seminars

ISO 9001: Internal Auditing Course Jun 2007

SELECT OUTREACH/SERVICE

Co-Chair, Quality Council, Qsource 2007-09

Ashley Mudd, AS

Current Qsource associate with American citizenship and six years' network experience, including serving as an IT analyst with various support duties. Experience in training new associates and providing innovative suggestions for process improvement. Extensive computer skills and software experience, including Linux/Unix, AutoCAD, NAMeS, Rockwell software, WonderWare, Eagle, Hertzler, QAD/MLS, I/Gear, change control processes, ABB software, PCdims (CMM software), database maintenance backup plans, Symantec Endpoint Protection, Avaya phone systems, Microsoft Server 2003, Microsoft (MS) Office Standard/Professional 2003/2007 and MS Windows NT/95/98/ME/2000/XP/Vista/7.

PROFESSIONAL EXPERIENCE

Qsource — **Nashville, TN**

Network Specialist — **Jan 2012 to Present**

Maintains computer hardware/software/operating system on devices connected to Corporate Network or the SDPS Network. Assists in managing operating systems for Corporate Local and Wide Area Network (LAN/WAN) and SDPS MS Area Networks including system security, adding users, maintaining menus and operating systems and operating systems support. Serves as backup to the Corporate and SDPS Network Administrators for mission critical applications and environments. Serves as second-level support for server backups and data restore procedures as necessary. Provides technical support for the phone and voicemail systems as necessary. Performs problem diagnostics and regular maintenance on all hardware. Assists in the maintenance of a hardware/software (Remedy) database, periodically performing assistance in physical inventory to reconcile. Provides daily technical assistance to all SDPS/Corporate LAN/WAN users as needed. Assists in supporting Video Conference Equipment. Assists in maintaining data communications lines (T1) and equipment such as routers and switches.

Tower Automotive — **Chicago, IL**

IT Analyst — **May 2010 to Sep 2011**

Fulfilled same responsibilities as in IT Analyst position in Bardstown, Kentucky, as well as additional projects. Took over support for all shop floor software in North America sites. Was responsible for leading a project to ensure that all robot programs were backed up and stored properly. Was proactive in training and supporting new hires within the department and supplied several improvements to the current company LAN standards.

Tower Automotive — **Bardstown, KY**

IT Analyst — **Jul 2008 to May 2010**

Production — **May 2006 to Jul 2008**

Supported local network for locations in Kentucky and Tennessee and provided desktop and telephone support for colleagues in both states as well. Worked toward standardization to lower IT costs. Provided CMM and barcode printer support as well as backup support for Eagle for all North American locations. Supported two Mississippi locations for three months in addition to regular responsibilities while company worked to backfill position.

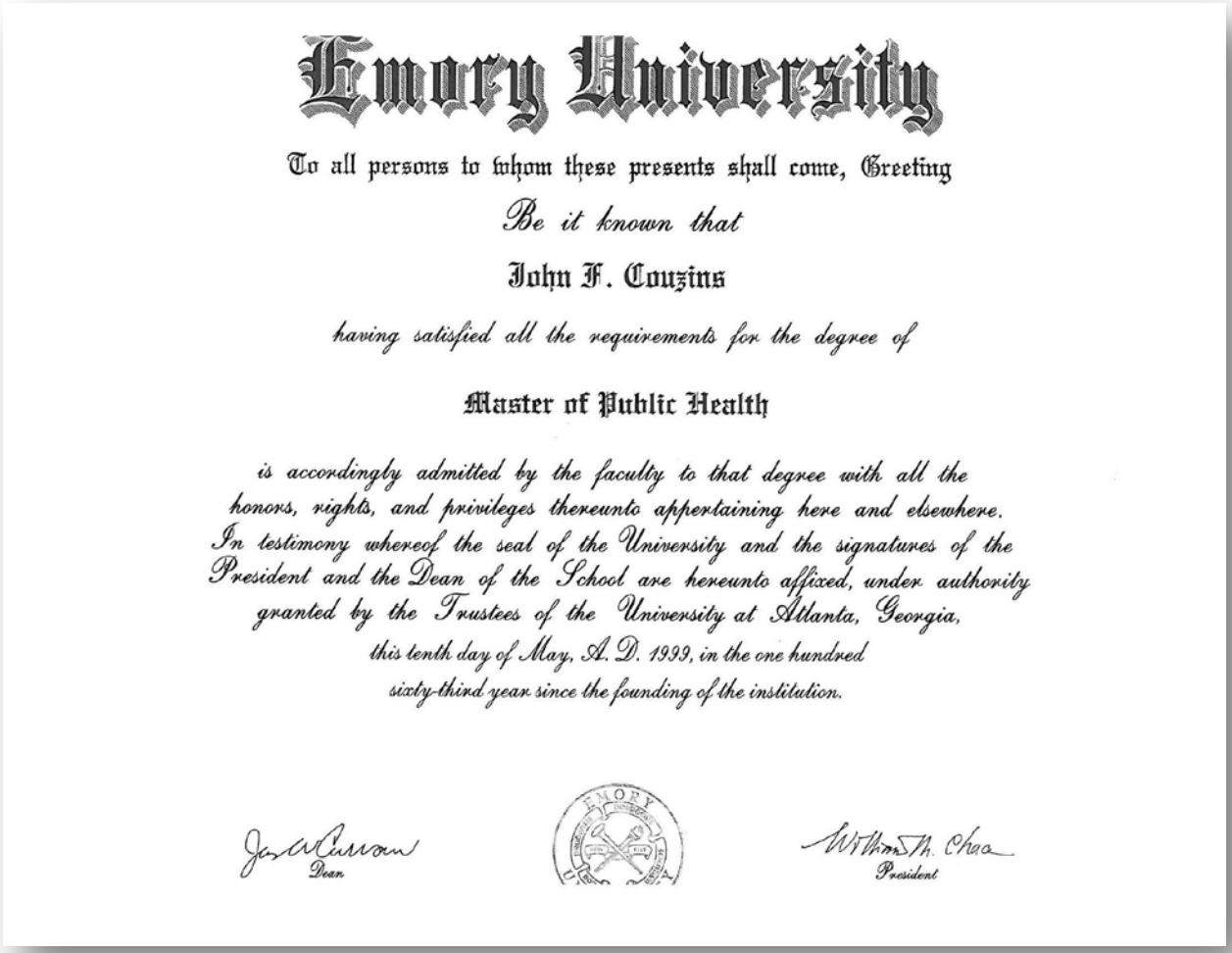
EDUCATION

Associate's Degree, Computer Network Systems — **Dec 2009**

ITT Technical Institute — Louisville, KY

Appendix III: Key Staff Certifications/Degrees

John Couzins, MPH



Emory University

To all persons to whom these presents shall come, Greeting

Be it known that

John F. Couzins

having satisfied all the requirements for the degree of

Master of Public Health

is accordingly admitted by the faculty to that degree with all the honors, rights, and privileges thereunto appertaining here and elsewhere. In testimony whereof the seal of the University and the signatures of the President and the Dean of the School are hereunto affixed, under authority granted by the Trustees of the University at Atlanta, Georgia, this tenth day of May, A. D. 1999, in the one hundred sixty-third year since the founding of the institution.

Dean

President

John Couzins, CHCA

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

is pleased to announce

John Couzins

passed the HEDIS® Auditor Examination,
fulfilled all the necessary requirements to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

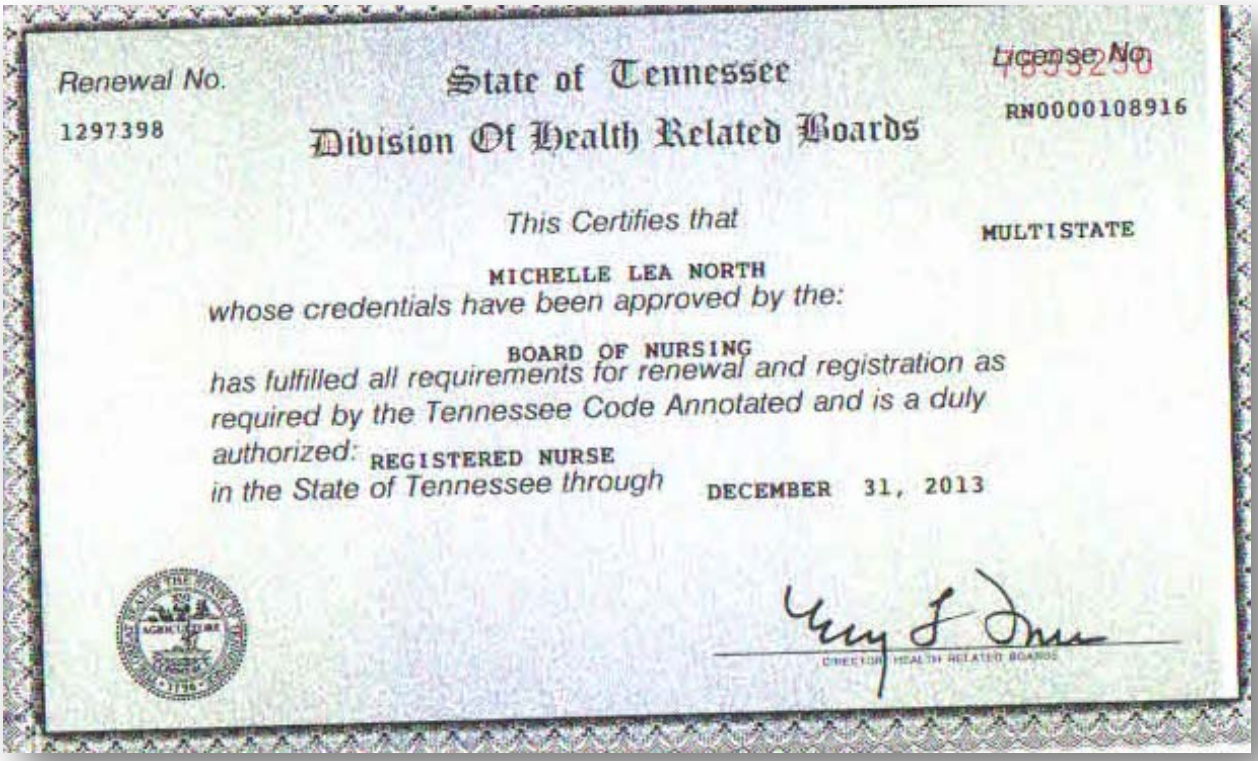
NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2011
DATE CERTIFIED

10/31/2013
EXPIRATION DATE

Michelle North, RN



Renewal No. 1297398

State of Tennessee
Division Of Health Related Boards

License No. 4893298
RN0000108916

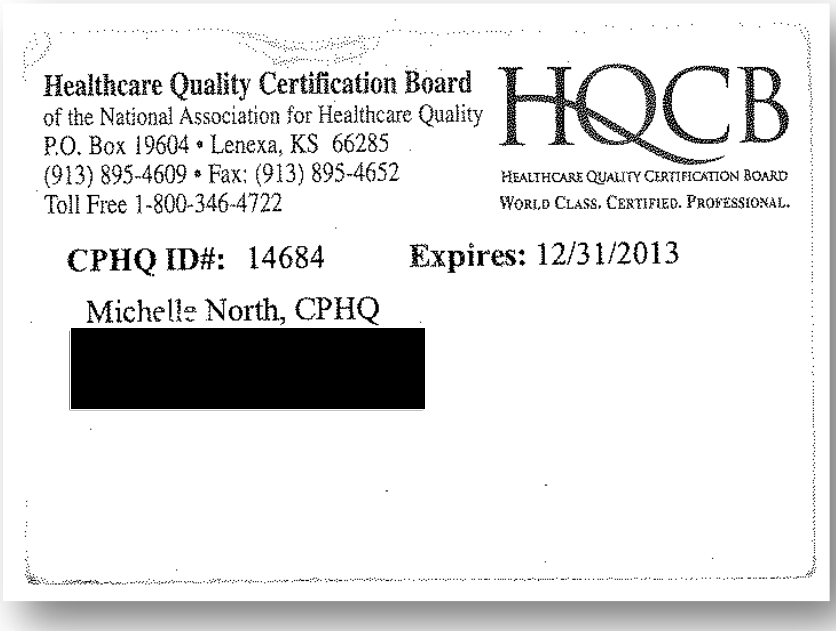
This Certifies that

MULTISTATE

MICHELLE LEA NORTH
whose credentials have been approved by the:

BOARD OF NURSING
has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: REGISTERED NURSE
in the State of Tennessee through DECEMBER 31, 2013

Michelle North, CPHQ



Healthcare Quality Certification Board
of the National Association for Healthcare Quality
P.O. Box 19604 • Lenexa, KS 66285
(913) 895-4609 • Fax: (913) 895-4652
Toll Free 1-800-346-4722

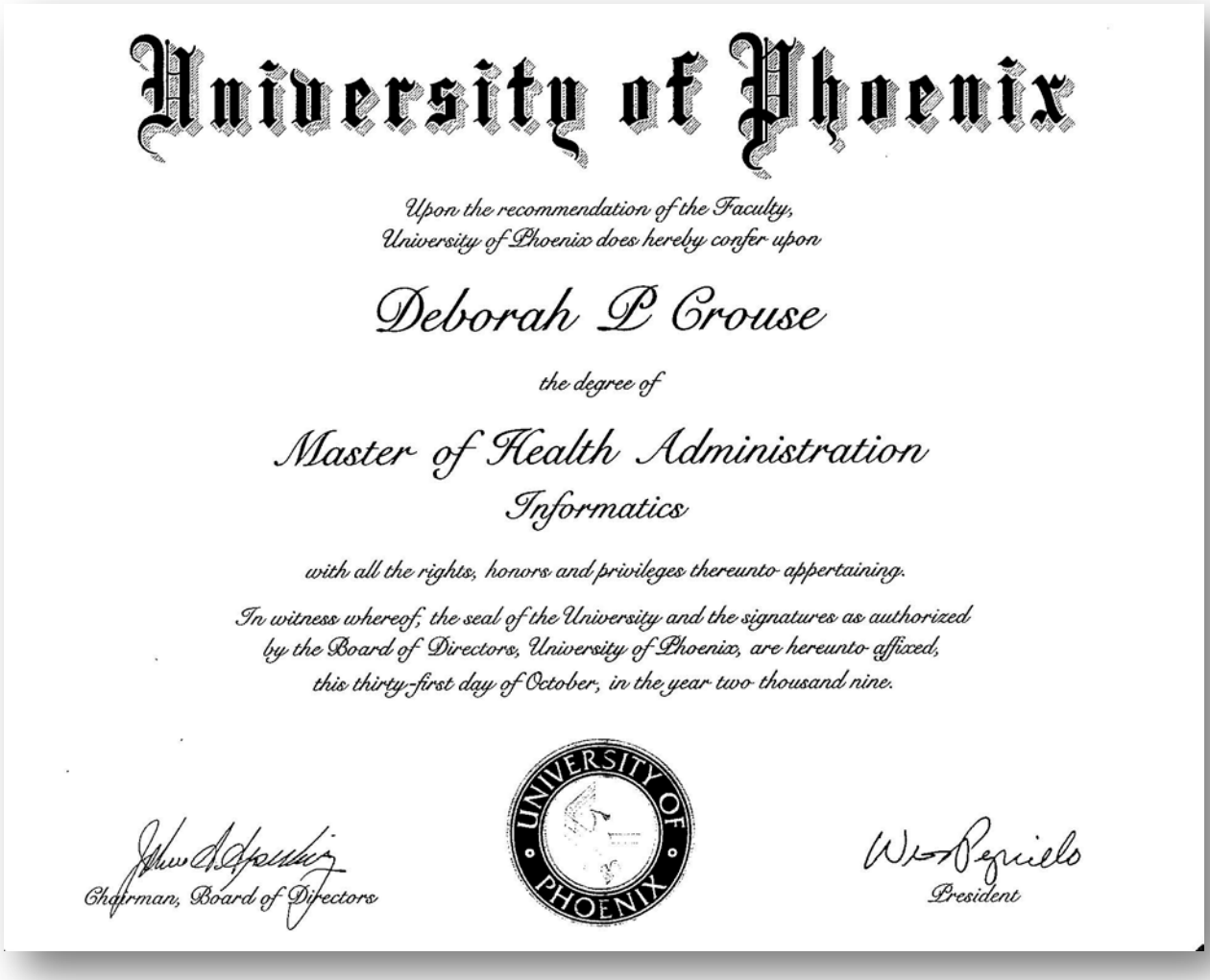
HQCB
HEALTHCARE QUALITY CERTIFICATION BOARD
WORLD CLASS. CERTIFIED. PROFESSIONAL.

CPHQ ID#: 14684 **Expires:** 12/31/2013

Michelle North, CPHQ

[redacted]

Deborah Crouse, MHA / INF



University of Phoenix

Upon the recommendation of the Faculty,
University of Phoenix does hereby confer upon

Deborah P Crouse

the degree of

Master of Health Administration

Informatics

with all the rights, honors and privileges thereunto appertaining.

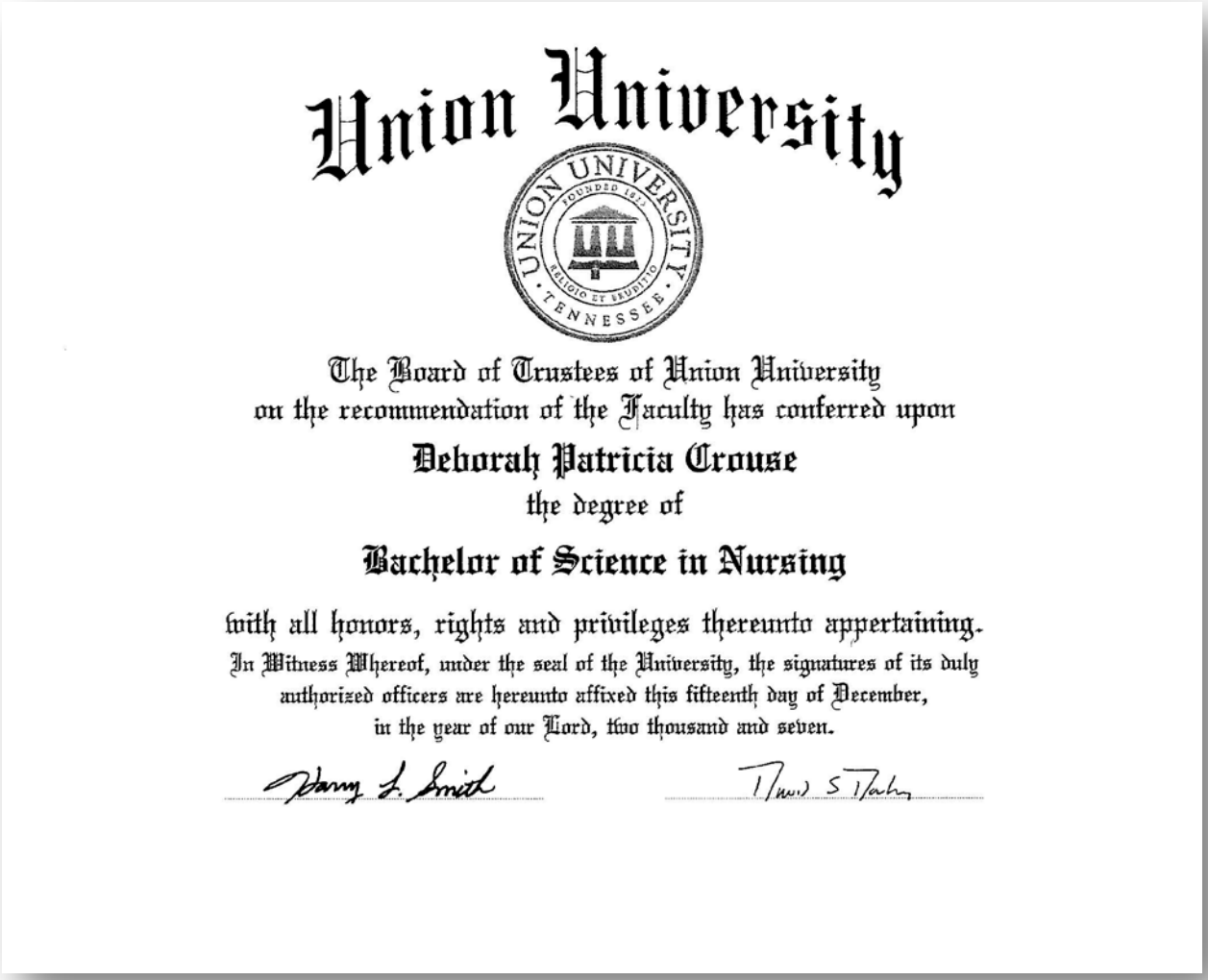
In witness whereof, the seal of the University and the signatures as authorized
by the Board of Directors, University of Phoenix, are hereunto affixed,
this thirty-first day of October, in the year two thousand nine.

UNIVERSITY OF PHOENIX

Chairman, Board of Directors

President

Deborah Crouse, BSN



Union University

The Board of Trustees of Union University
on the recommendation of the Faculty has conferred upon

Deborah Patricia Crouse

the degree of

Bachelor of Science in Nursing

with all honors, rights and privileges thereunto appertaining.

In Witness Whereof, under the seal of the University, the signatures of its duly authorized officers are hereunto affixed this fifteenth day of December, in the year of our Lord, two thousand and seven.

Deborah Crouse, RN

Renewal No. 1225448

State of Tennessee
Division Of Health Related Boards

License No. 7121543
RN0000093277

This Certifies that

MULTISTATE

DEBORAH P CROUSE
whose credentials have been approved by the:

BOARD OF NURSING
has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: REGISTERED NURSE
in the State of Tennessee through JUNE 30, 2012

DIRECTOR HEALTH RELATED BOARDS

Deborah Crouse, CPHQ

HQCC
HEALTHCARE QUALITY CERTIFICATION COMMISSION

4700 W. Lake Avenue
Glenview, IL 60025-1485

February 28, 2012

RE: Deborah Crouse, CPHQ

To Whom It May Concern:

Please accept this official letter as verification of Deborah Crouse, CPHQ, as a Certified Professional in Healthcare Quality through 12/31/2013 CPHQ # 6009.

Please do not hesitate to contact us should you need any additional information.

Sincerely,

Healthcare Quality Certification Commission

Deborah Crouse, CCM

The COMMISSION *for*
CASE MANAGER CERTIFICATION

hereby certifies that

Deborah P. Crouse

has met the renewal requirements of approved continuing education as administered under the authority of the Commission for Case Manager Certification and is therefore qualified for continued practice in the field of case management as a

CERTIFIED CASE MANAGER (CCM)

CHAIR

SECRETARY

THE NATIONALLY ACCREDITED CCMC CASE MANAGER CREDENTIAL

00039220
CERTIFICATE NUMBER

5/31/2014
VALID THROUGH

Swapna Mehendale, MPH

Western Kentucky University

Bowling Green, Kentucky

The Board of Regents of Western Kentucky University upon Recommendation of the Faculty, have conferred on

Swapna S. Jamode

Who has completed the studies and fulfilled all requirements thereof, the degree of

Master of Health Administration

and is entitled to all the rights and privileges pertaining to that degree.

This diploma granted in the month of May, two thousand seven.

R. Earl Fischer
Chair of the Board of Regents

Gary A. Ransdell
President

Barbara B. Burch
Provost and Vice President for Academic Affairs

Kelly Agee, BA

The Trustees
of
The University of Tennessee

on the recommendation of the Faculty have conferred on

Kelly Renae Agee

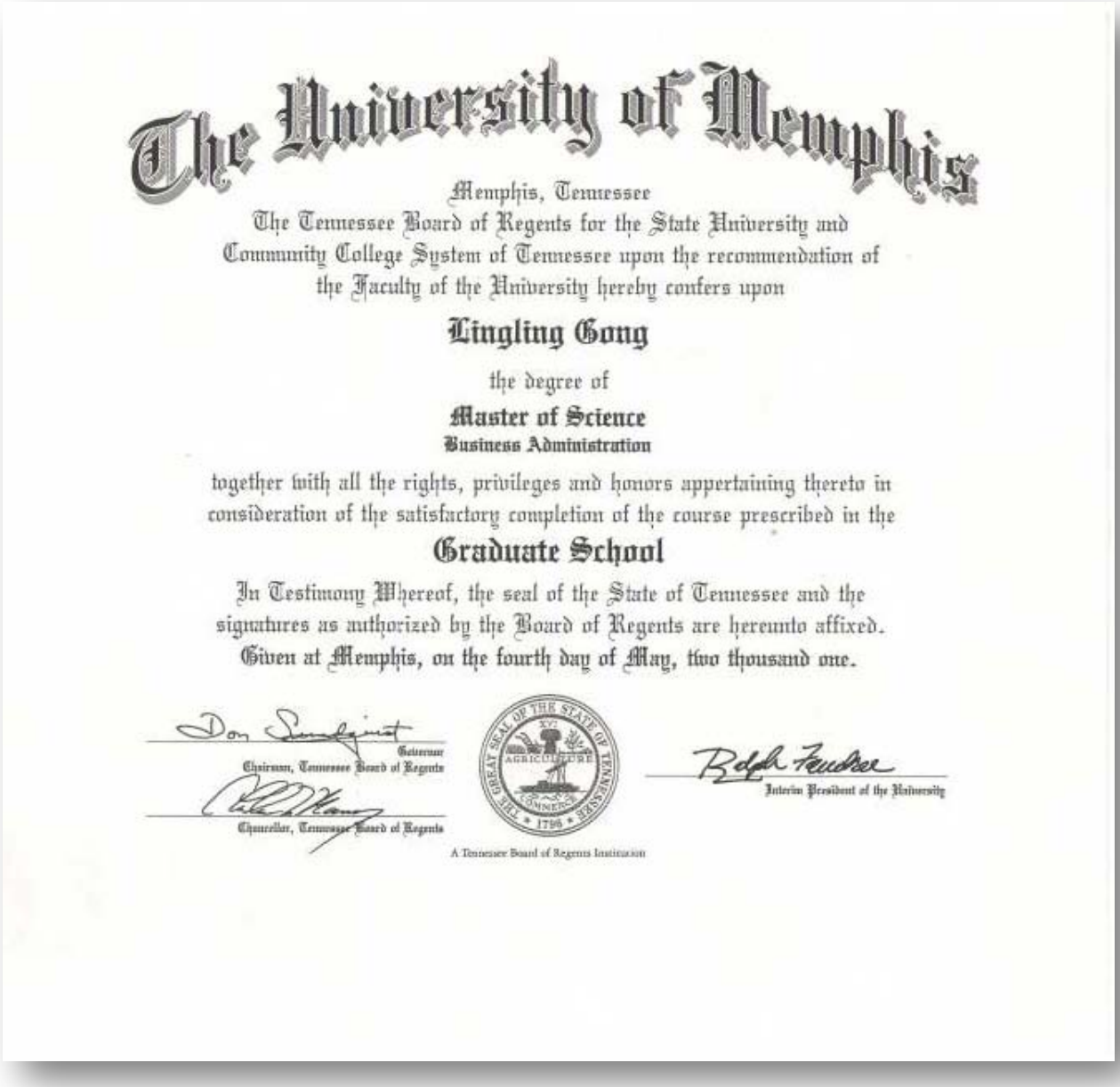
the degree of

Bachelor of Arts

with all the Rights Privileges and Honors thereunto appertaining
In witness whereof this diploma is granted and the Seal of the
University and the signatures of the President of the University and the
Secretary of the Board of Trustees are hereunto affixed

Given at Knoxville in the State of Tennessee this thirteenth day of May
in the year of our Lord nineteen hundred and ninety-four
and of the University the two hundredth

Lingling Gong, MS



The University of Memphis

Memphis, Tennessee

The Tennessee Board of Regents for the State University and Community College System of Tennessee upon the recommendation of the Faculty of the University hereby confers upon

Lingling Gong

the degree of

Master of Science

Business Administration

together with all the rights, privileges and honors appertaining thereto in consideration of the satisfactory completion of the course prescribed in the

Graduate School

In Testimony Whereof, the seal of the State of Tennessee and the signatures as authorized by the Board of Regents are hereunto affixed.

Given at Memphis, on the fourth day of May, two thousand one.

Governor
Chairman, Tennessee Board of Regents

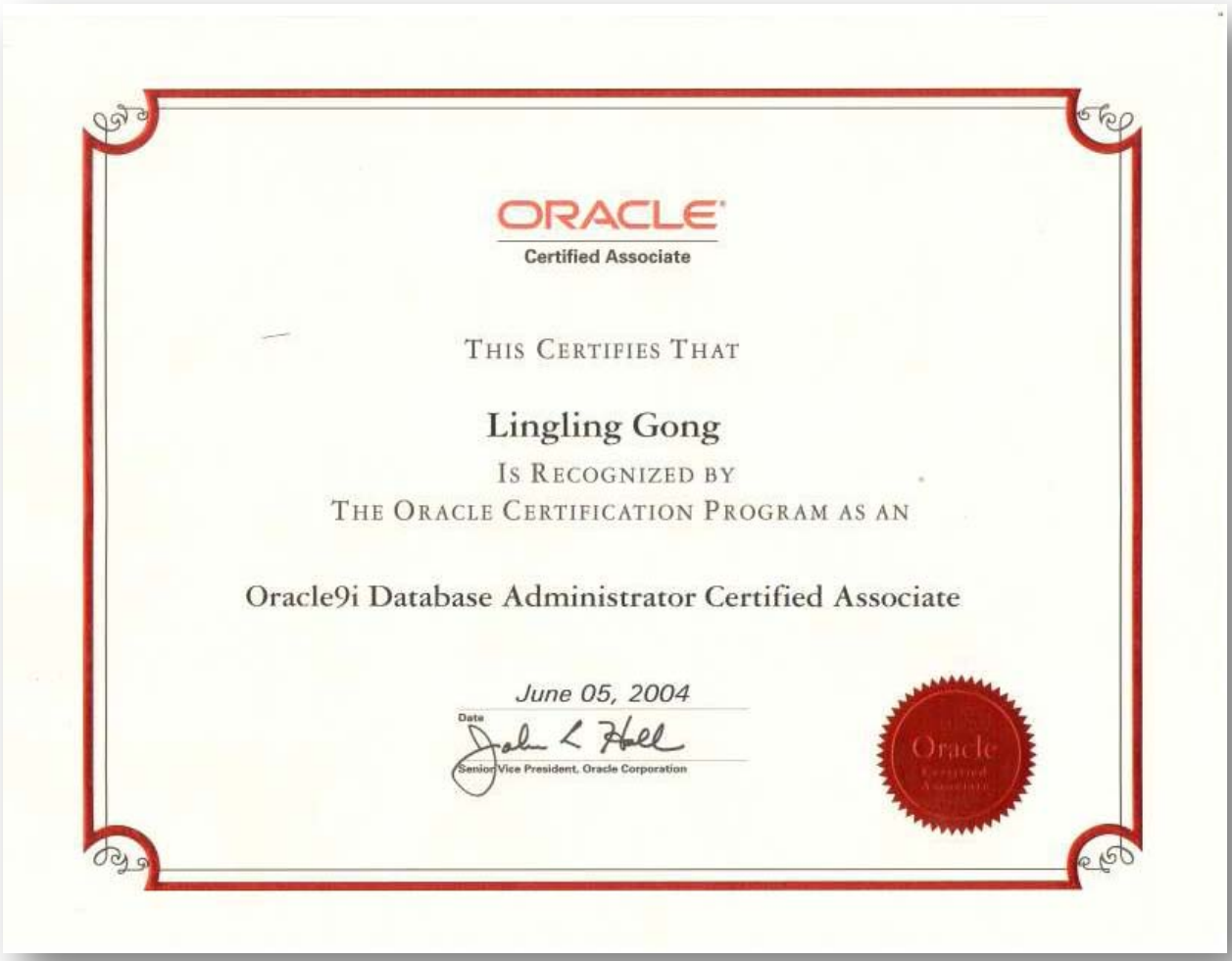
Chancellor, Tennessee Board of Regents

Interim President of the University

A Tennessee Board of Regents Institution

Lingling Gong, MCP

Lingling Gong, OCA



ORACLE
Certified Associate

THIS CERTIFIES THAT

Lingling Gong

IS RECOGNIZED BY
THE ORACLE CERTIFICATION PROGRAM AS AN

Oracle9i Database Administrator Certified Associate

June 05, 2004
Date

Senior Vice President, Oracle Corporation

Oracle

Appendix IV: Sample PIP Technical Papers Report

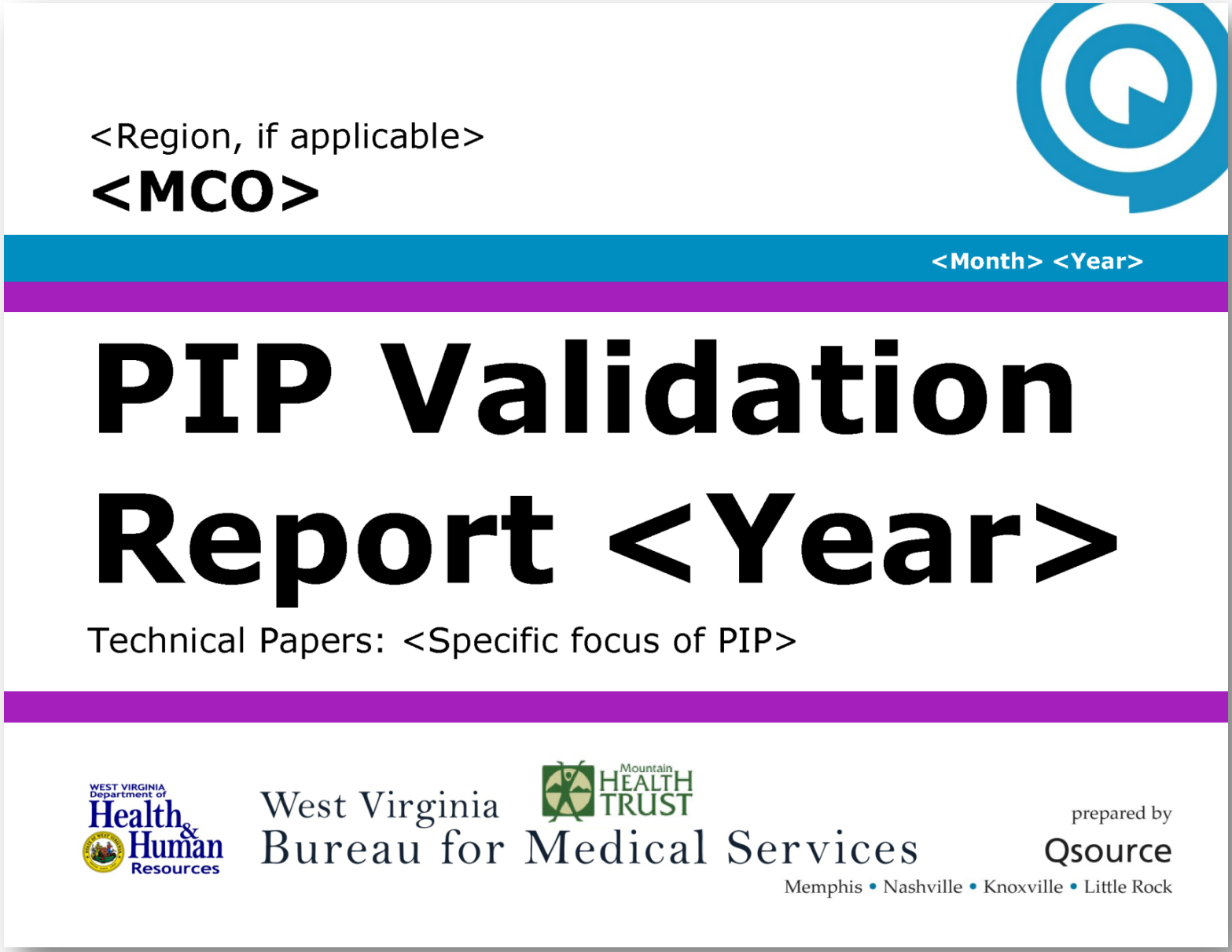

<Region, if applicable>
<MCO>
<Month> <Year>
PIP Validation Report <Year>
Technical Papers: <Specific focus of PIP>
WEST VIRGINIA Department of Health & Human Resources
West Virginia Bureau for Medical Services
Mountain HEALTH TRUST
prepared by
Qsource
Memphis • Nashville • Knoxville • Little Rock

Table of Contents

List of Tables

Acronyms/Initialisms and Acknowledgements/Copyrights

ADHD..... Attention Deficit Hyperactivity Disorder
CFR.....*Code of Federal Regulations*
CMS..... Centers for Medicare & Medicaid Services
EQR..... External Quality Review
HEDIS®..... Healthcare Effectiveness Data and Information Set registered trademark of NCQA
IPSD..... Index Prescription Start Date
MCO..... Managed Care Organization
NCQA.....National Committee for Quality Assurance
PIP.....Performance Improvement Project
Q.....Quarter
Qsource®.....is a registered trademark

Overview

One activity included in Qsource's external quality review (EQR) contract with **<state contractor>** is the validation of one Performance Improvement Project (PIP) completed by each of the Managed Care Organizations (MCOs) participating in the **<state contractor>** program. Qsource worked closely with **<state contractor>** and <MCO> throughout the PIP to ensure a supportive and coordinated approach. Qsource has prepared these technical papers to provide findings from the **<year>** PIP.

PIP validation involves 10 required activities; each activity consists of elements necessary for the successful completion of a valid PIP. Some of the elements are critical elements and must be *Met* to produce an accurate and reliable PIP. Given the importance of critical elements, any critical element receiving a *Not Met* score will result in a *Not Met* validation status.

The primary objective of the PIP validation is to determine each PIP's compliance with the requirements set forth in **<contract reference>**, including:

- Performance measurement using objective quality indicators.
- System intervention implementation for quality improvement.
- Evaluation of intervention effectiveness.
- Planning and initiation of activities to increase or sustain improvement.

PIP Topic and Indicators

<MCO> submitted a new PIP for **<year range>**, **<PIP title>**, and its study question was presented as follows:

<Study Question>

The PIP had two study indicators:

- The **Initiation Phase indicator** was *"…"*
- The **Continuation and Maintenance Phase indicator** was *"…"*

Validation Status/Conclusion

For <MCO>'s **<year range>** validation cycle, Qsource validated Activities <X> through <X>, with the exception of Activity <X>, as<X> was not involved. Activities <X> and <X> were not included in the validation as the study had not yet progressed to this point. **Table 1** displays the MCO's performance across PIP activities. The second column represents the total number of evaluation elements *Met* by the MCO compared to the total number applicable for each activity reviewed, including critical elements. The third column represents the total number of critical elements *Met* by the MCO for each activity reviewed compared to the total number applicable.

Table 1. Performance Across <year range> PIP Activities

Review Activities	Evaluation Elements Met/Applicable	Critical Elements Met/Applicable
I. Choose the Study Topic(s)		
II. Define the Study Question(s)		
III. Select the Study Indicator(s)		
IV. Use a Representative and Generalizable Study Population		
V. Use Sound Sampling Methods		
VI. Use Valid and Reliable Data Collection Procedures		
VII. Include Improvement Strategies		
VIII. Data Analysis and Interpretation of Study Results		
IX. Assess for Real Improvement		
X. Assess for Sustained Improvement		
Overall Percentage and Validation		
Percentage of Evaluation Elements Met	**X%**	
Percentage of Critical Elements Met	**X%**	
Validation Status	**<Met/Not Met>**	

Findings for the PIP demonstrated an overall score of X percent, a critical element score of X percent, and a **<Met/Not Met>** Validation Status. Based on the validation of this PIP, Qsource's assessment determined **<high/low>** confidence in the results.

Analysis of Results

<MCO> describes its intervention strategies in stating, "…"

<MCO>'s interventions and improvement strategies for 2011 included:

- **A member newsletter article from <Year/Quarter>, titled *X*.** This article encourages members to "…"
- **A member newsletter article from <Year/Quarter>, titled *X*.** This article encourages "…."
- **A provider newsletter article from <Year/Quarter>, titled *X*,** which reviews "…"
- **Participation in/association with** "…"

Table 2 provides a summary of the annual performance and goals for <MCO>'s "X" PIP. Results for the Baseline period are provided. The study included the entire eligible population.

Table 2. Summary of Results

Study Indicator	Baseline Measurement	
	Goal	Results
Study Indicator 1: "…"	X%	X%
Study Indicator 2: "…"	X%	X%

Validation Methodology

Qsource's scoring methodology is used to evaluate PIPs conducted by the MCO to determine if a PIP is valid and to rate the percentage of compliance with CMS protocol for conducting PIPs. Each PIP consists of critical and noncritical evaluation elements necessary for successful completion of a valid PIP. Each evaluation element is scored as *Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. In the PIP Validation Tool, the column to the left of the evaluation element description indicates if that evaluation element is a critical element. Critical elements are essential to producing a valid and reliable PIP; therefore, each critical element must have a score of *Met*. For example, for Activity II of the PIP Validation Tool, if the study question cannot be answered, then the critical element is scored as *Not Met*, and the PIP is not valid.

Qsource scores each evaluation element and creates a table that totals all scores for critical and noncritical elements (**Table 1**). Qsource then calculates percentage scores and a related validation status. The percentage score for all evaluation elements is calculated by dividing the

number of elements (including critical elements) *Met* by the sum of evaluation elements that were *Met* and *Not Met*. The percentage score for critical elements *Met* is calculated by dividing the critical elements *Met* by the sum of critical elements that were *Met* and *Not Met*. The validation status score is based on the percentage score and whether critical elements were *Met* or *Not Met* **(Table 3).** Qsource uses the *Not Assessed* scoring designation when the PIP has not progressed to the remaining activities in the CMS protocol. *Suggestions* are used when documentation for an evaluation element includes the basic components to meet requirements for the evaluation element (as described in the PIP narrative), but enhanced documentation would demonstrate a stronger understanding of CMS protocols.

Due to the importance of critical elements, any critical element scored as *Not Met* will invalidate the PIP. Noncritical elements scored as *Not Met* will not invalidate the PIP; however, they will affect the overall percentage score (which indicates the percentage of the PIP's compliance with the CMS protocol for conducting PIPs). Qsource will provide technical assistance to help the MCO understand the CMS protocol and make necessary revisions to the PIP for future submissions. For subsequent validation years, the MCO will submit a revised PIP Summary Form that includes additional information to address any *Suggestions* and any critical and noncritical areas scored as *Not Met*.

The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all applicable/assessed evaluation elements (*Met* and *Not Met*). The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met* and *Not Met*. *Met* equals high confidence/confidence that the PIP was valid. *Partially Met* equals low confidence that the PIP was valid. *Not Met* equals reported PIP results that were not credible. *Met* and *Not Met* scores are aggregated to reflect an **overall** score based on the following criteria:

Table 3. PIP <year> Evaluation Criteria

Overall Evaluation	Criteria
Met	All critical elements are *Met* **AND** 80 to 100 percent of all elements are *Met* across all activities.
Partially Met	All critical elements are *Met* **AND** 60 to 79 percent of all elements are *Met* across all activities.
Not Met	All critical elements are *Met* **AND** less than 60 percent of all elements are *Met* across all activities **OR** One or more critical elements are *Not Met*.
Not Applicable (NA)	*Not Applicable* elements (including critical elements) are removed from all scoring.
Not Assessed	*Not Assessed* elements (including critical elements) are removed from all scoring.
Suggestion	Used when documentation for an evaluation element includes the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP); however, enhanced documentation would demonstrate a stronger understanding of CMS protocols.

The scoring methodology is designed to ensure that critical elements are a must-pass activity. If at least one critical element is *Not Met*, the overall validation status is *Not Met*. In addition, the methodology addresses the potential situation in which all critical elements are *Met*; however, suboptimal performance is observed for noncritical elements. The final outcome is based on the overall percentage score.

Strengths/PIP Progression

Strengths are noted when a health plan demonstrates particular proficiency on a given activity and are identified independent of a *Met* or *Not Met* validation status. <MCO> demonstrated strength in its results for:

Activity X: X
The MCO provided X.

Areas of Noncompliance (AONs)

Qsource determines AONs based on those evaluation elements that receive a *Not Met* score, indicating that those elements are not in full compliance with Centers for Medicare & Medicaid Services (CMS) protocols. As the PIP study progresses, <MCO> must address all of the following recommendations for improving on activities with a *Not Met* validation status:

Activity I: Study Topic
The PIP should "…"

Activity III: Study Indicators
The study indicators were "…" The MCO should "…"

Activity VI: Data Collection Procedures
The MCO should "…"

Activity VII: Improvement Strategies
The MCO should "…"

Activity VIII: Data Analysis and Interpretation of Study Results
The PIP did not include "…"

Suggestions

Qsource also offered suggestions for the MCO to consider in the interest of continually improving performance in those areas deemed compliant:

Activity II: Study Question
The MCO could "…"

Activity VI: Data Collection Procedures
The MCO "…"

Activity VIII: Data Analysis and Interpretation of Study Results
The MCO could "…"

Appendices | PIP Validation Tool and MCO Summary Form

The Appendices contain the PIP Validation Tool completed by Qsource followed by the PIP Summary Form that <MCO> submitted to Qsource for review. Qsource has not altered the content or made grammatical corrections. This appendix does not include any attachments provided with the PIP submission.

Appendix V: Sample AQS Technical Papers Report

<Region, if applicable>

<MCO>

<Month> <Year>

Annual Quality Survey <Year>

Technical Papers

West Virginia Department of Health & Human Resources

West Virginia Bureau for Medical Services

Mountain HEALTH TRUST

prepared by Qsource

Memphis • Nashville • Knoxville • Little Rock

Table of Contents

Overview

Qsource has prepared these technical papers to provide findings from the 2011 Annual Quality Survey (AQS). They include the following:

- AQS Steps
- Pre-Assessment Documentation List
- AQS Participants
- Onsite Documents Reviewed
- Quality Process (QP) Standard Elements
- AQS Compliance Summary
- Strengths, Areas of Noncompliance and Suggestions
- Improvements since the Previous AQS
- Completed QP Standard Survey Tool
- Completed Performance Activity (PA) Tools
- PA Tool Instructions

AQS Activities

Qsource worked closely with **<state contractor>** and <MCO> throughout the AQS to ensure a supportive and coordinated approach. The survey team contacted the Managed Care Contractor (MCC) to exchange information, to set dates for the Qsource health plan visit, and to discuss other requirements for an accurate and successful evaluation.

AQS Steps

From start to finish, the AQS includes four major activities: (1) Tool Development, (2) Document Review, (3) Health Plan Visit and (4) Calculating Compliance. The AQS Steps table summarizes the details of these activities.

AQS Steps
Step 1: Establish survey schedule.
♦ Before the onsite visit, Qsource submitted the survey schedule to **<state contractor>** for approval.
Step 2: Prepare data collection survey tools and submit them to <state contractor> for review/approval.
♦ Qsource developed evidence-based oversight/monitoring tools in consultation with **<state contractor>** representatives to ensure criteria specific to Contractor Risk Agreements (CRAs) were met and that all data sought were collected. ♦ The approved tools for the **<Year>** AQS are in the **Scored Survey Tools** section.
Step 3: Submit survey tools to the MCC.
♦ Qsource forwarded the survey tools to the health plan, giving it the opportunity to gather the required data and facilitate process streamlining for the onsite visit.
Step 4: Prepare/Submit the Pre-Assessment Documentation List to the MCC.
♦ Qsource sent a letter to **<state contractor>** MCCs requesting that specific desk review documents be submitted to Qsource. The **Pre-Assessment Documentation List** was accompanied by instructions on how to organize and prepare the documents for surveyors.

AQS Steps
Step 5: Respond to MCC questions/information requests prior to onsite review.
♦ Qsource remained in contact via telephone and email to respond to questions and to provide additional information as needed to key health plan personnel and **<state contractor>** representatives, particularly concerning clarification of the Pre-Assessment Documentation List and the onsite assessment process.
Step 6: Receive pre-assessment documentation and gather information before the onsite visit.
♦ Qsource used the survey tools to examine and document all information received before the onsite visit to offer surveyors insight into the health plan's structure, member population, providers, services, operations, resources and delegated functions to enable initial compiling of data. ♦ From the PA data submitted by the health plan, Qsource abstracted a random sample of files, including an oversample, for desk review. ♦ During the desk review process, the surveyors: (1) took notes to assist in the completion of the survey tools and guide determination about compliance with the regulatory provisions; (2) identified those areas and issues requiring further clarification or follow-up during the onsite interviews; and (3) clarified which requested information was not found in the pre-assessment documentation.
Step 7: Develop an onsite agenda.
♦ Qsource surveyors developed a general agenda to assist the health plan staff in participation planning, documentation gathering and addressing logistical issues (such as arranging locations for surveyors to conduct document reviews and interviews).
Step 8: Conduct the onsite visit.
♦ During the onsite document assessment, health plan staff was available to answer questions or assist the Qsource review team in locating specific documents or information sources. ♦ Qsource coordinated discussions with staff to maximize results while minimizing disruption to plan operations. Document review, along with interaction and interviews with plan staff, all contribute significantly to compliance determinations. ♦ The review team interacted with staff to determine the degree of compliance with contractual requirements, to explore any issues not fully addressed in the documents reviewed and to increase overall understanding of the health plan's performance.
Step 9: Review information and documentation using the survey tools.
♦ Throughout the documentation review and onsite assessment processes, Qsource reviewers used the survey tools to obtain information and to document findings regarding the health plan's compliance with set standards through a review of policies/procedures, committee minutes, quality studies, reports, medical record/file review and other related health plan documentation. ♦ Surveyors took notes during staff interviews and document review to obtain the required data. These notations are included in the **completed survey tools** and serve as a comprehensive record of the assessment activity.
Step 10: Summarize findings at the completion of the survey.
♦ As a final step for completing the onsite survey, Qsource met with health plan staff to summarize initial findings and recommendations.

AQS Steps
Step 11: Calculate the individual ratings for the MCC's performance.
♦ For comparing performance and determining the health plan's compliance with QP standards and program requirements, Qsource incorporated nationally recognized guidelines from three sources: (1) *Standards and Guidelines for the Accreditation of Health Plans* from the National Committee for Quality Assurance (NCQA) (2) Centers for Medicare & Medicaid Services (CMS) protocols (3) state and federal regulations ♦ Qsource analyzed every element in the survey tools using weighted point values to determine the MCC's performance on each standard.
Step 12: Prepare a report of findings and recommendations.
♦ After completing data analyses, Qsource prepared this report of the review findings and recommendations. A draft of the AQS Technical Papers was due 30 days after the survey was completed, with the final version due 60 days after completion of the survey. Both reports were forwarded to TennCare for approval within these deadlines.
Step 13: Provide post-survey support to the MCC.
♦ Qsource provided the health plan with technical assistance as needed to foster performance improvement.

Document Review

Pre-Assessment Documentation List

Pre-assessment document review allows Qsource to record initial findings before the health plan visit takes place. Qsource sent <MCO> a written request for such documents that included but was not limited to:

1. Member Handbooks in English and Spanish
2. Provider Manual
3. **<Year>** Quality Improvement (QI) Program Description
4. QI Program Evaluation of **<Year>** activities
5. All provider and member newsletters
6. **<Year>** quarterly and annual EPSDT reports
7. **<Year>** Utilization Management (UM) Program Description
8. UM Program Evaluation of **<Year>** activities
9. Disease Management (DM) Program Descriptions
10. **<Year>** DM satisfaction surveys
11. Case Management (CM) Program Descriptions
12. All provider and member satisfaction surveys
13. Information and documentation related to **<Year>** AQS Corrective Action Plan (CAP) activities and interventions
14. Policies that define the MCC's time standards for handling all UM denials and appeals
15. Completed table of time standards used for the resolution of UM denials and appeals

AQS Participants

During the AQS, <MCO> personnel were available to answer questions and help Qsource find the information necessary to assess all requirements. Qsource also met with health plan staff at the end of the survey to summarize initial findings and recommendations. The AQS Participants table lists all participants involved in the onsite visit.

AQS Participants		
Name	Credentials	Title
Qsource Onsite Surveyors		
<MCO> Participants		

AQS Participants		
Name	Credentials	Title
<MCO> Participants		

Onsite Documents Reviewed

While at the health plan, Qsource surveyors examined the following additional documents that were not included in the pre-assessment review:

Onsite Documentation for <MCO> <Year> AQS

Calculating Compliance-QP Standard Elements

Qsource calculates QP standard compliance by dividing the points the health plan earned by the total points possible. The value of each QP standard is based on a sum of the elements listed in the QP Standard Elements table. These elements help identify the health plan's ability to improve safety, provide quality care, communicate with members, and adhere to state and federal laws and guidelines. *The element titles in these tables do not necessarily reflect the entirety of the content reviewed for each QP standard identified.*

QP Standard Elements
Quality Improvement (QI) Program
1) Member safety and quality
Network: Contracting, Availability, Access and Documentation
1) Specialist termination
2) Notice of provider termination
QI Activities
1) Coordination between physical and behavioral health
2) Mental health services following inpatient/residential treatment
3) Monitoring of behavioral health provider training
4) Enrollment of CHOICES members in DM programs
5) DM treatment plans
6) Stratification of CHOICES members in DM programs
7) DM and CHOICES care coordination
8) Keeping care coordinator informed
9) Care coordinator review
10) Integration of DM program into CHOICES members' plan of care
11) Care coordinator responsibilities for CHOICES members
12) CM services for members
13) Identification of members for CM services
14) Identification of increase in member needs during transition
15) Transition of CHOICES Group 2 members in community-based residential alternative (CBRA) settings
16) Implementation of services for members enrolled under Immediate Eligibility
17) Transition of CHOICES members from nursing facilities
18) Telephonic screening for CHOICES referrals
19) CHOICES level of care assessment

QP Standard Elements
Clinical Criteria for Utilization Management (UM) Decisions
1) Availability of criteria
2) Transition to other care
Member Rights and Responsibilities
1) Member Handbook development and distribution
2) Complaint procedures
3) Communication of rights and responsibilities in Member Handbook
4) Member Handbook inclusions
5) Notice of right to file a complaint
6) Notification of changes to written materials
7) Translation services
8) Translated vital documents
***John B. Consent Decree* (EPSDT)**
1) New member calls
2) Outreach contacts
3) Documenting outreach
4) Declined services
5) Re-notification if no services used
6) Undeliverable mail
7) Accurate provider lists
8) Targeted activities
9) Outreach to illiterate, blind, deaf and LEP
10) Community contacts approved
11) Prenatal appointment assistance
12) Referrals from one level of screening to another

QP Standard Elements
***John B. Consent Decree* (EPSDT) continued...**
13) Notify Managed Care Organization (MCO) if unable to make referral
14) Medically necessary services
15) Rehabilitation and maintenance services
16) Medical necessity
17) Limitations/Capitations/Delays
18) Qualified UM personnel
19) Services without prior authorization
20) Specialist list
21) MCO CM
22) Medically necessary CM services
23) CM central function
24) Family involvement and accessible services
25) Follow-up after inpatient or residential treatment
26) Screening components including follow-up
27) Interperiodic screen
28) Prior authorization prohibited
29) Screening standards met
30) Transportation
31) Program coordination
32) Individualized Education Programs (IEPs)
33) Tracking system
34) EPSDT language in contracts
35) EPSDT contract review

QP Standard Elements
Grier Revised Consent Decree
1) Appeals unit
2) *Grier*/Appeals procedures
Non-Discrimination Compliance
1) Non-Discrimination Compliance Plan
2) Assurance of Non-Discrimination
3) Display of non-discrimination posters
4) Non-discrimination written materials
5) Written policy and procedure
6) Complaint resolution and reporting
7) Member Handbook notification and Complaint Form
8) Quarterly newsletter notification
9) Subcontractor compliance education

The element titles in these tables do not necessarily reflect the entirety of the content reviewed for each QP standard identified.

Results

This section contains results for the **<Year>** <MCO> AQS, including the scored QP Standard Survey Tool, PA tools and noted **improvements since the previous survey**. These items represent Qsource's collective findings. The health plan has the opportunity to respond to these findings following submission of the draft AQS report.

Scores and Ratings

<MCO> achieved 100% compliance on "..." The MCO also received "..."

<MCO> also achieved "…"

A score of 100% indicates that all requirements for a QP or PA standard were fully met. Where compliance was less than 100%, <MCO>'s performance ranged from X% to X%.

<Year> <MCO> Compliance Summary		
QP Standard	**% Compliant**	**Star Rating**
PA	**% Compliant**	**Star Rating**

Strengths and Areas of Noncompliance

The AQS aids Qsource and the **<State>** Department of Finance and Administration, Bureau of X, in the identification of strengths and areas of noncompliance to benefit <MCO>. **Strengths** indicate that the health plan demonstrated particular proficiency on a given QP standard element or PA, and can be identified independent of 100% compliance. The lack of an identified strength should not be interpreted as a shortcoming on the part of <MCO>. **Areas of noncompliance** were identified where <MCO> achieved less than 100% compliance. They reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from Qsource. A score of 100% on a standard indicates that <MCO> fully met the criteria and, therefore, is in full compliance. <MCO>'s strengths and areas of noncompliance for the **<Year>** AQS are detailed below. Noncompliance items repeated from prior survey(s) are noted in bold.

<Year> <MCO> QP Standard Strengths and Areas of Noncompliance	
Strengths	**Areas of Noncompliance**
<QP Standard>	
<QP Standard>	
<QP Standard>	
<QP Standard>	
<QP Standard>	
<QP Standard>	
<QP Standard>	
<QP Standard>	

<Year> <MCO> PA Strengths and Areas of Noncompliance	
Strengths	**Areas of Noncompliance**
<PA Standard>	
<PA Standard>	
<PA Standard>	
<PA Standard>	
<PA Standard>	

Suggestions

Corrective Action Plan (CAP) Process

CAPs are designed to improve performance in areas of noncompliance. **<State contractor>** requires that the MCO submit a CAP for any QP standard element or PA that has been identified as an area of noncompliance (i.e., less than 100% compliance), regardless of overall performance on the corresponding QP standard or PA. The AQS represents an opportunity for health plans to receive technical assistance—from **<state contractor>** or Qsource—while developing a CAP for areas that require improvement. CAPs are considered On Request Reports (ORRs), meaning that **<state contractor>** may request them at its discretion and not solely based on the MCO's Performance outcomes.

Within 14 days of the posting notification of its final AQS report, <MCO> must electronically submit all required CAPS to each of the following recipients:

- **<State contractor>** Quality Oversight
- **<State contractor>** Office of Contract Compliance and Performance
- Qsource

CAPs will not be considered submitted if they are not received by all three parties within the required time frame. Following CAP evaluation, <State contractor> will send the health plan either a letter of approval or a denial with a request for additional clarifying information.

Scored Survey Tools

Improvements since the Previous AQS

As part of the AQS, Qsource documents the quality improvements made by the health plan since the previous year's survey. The following table summarizes the areas of noncompliance identified during the **<Year>** <MCO> AQS, the MCC's planned action as described in its CAPs, and whether those actions satisfied the element associated with the area of noncompliance by the health plan's **<Year>** AQS. More detailed results on <MCO>'s previous areas of noncompliance include the following.

QP Standard Improvements since the <Year> AQS		
<Year> Area of Noncompliance	**<MCO>'s Planned Action**	**Action Accomplished**
<QP Standard>		
<QP Standard>		

Scored QP Standard Survey Tool

This section contains the completed QP Standard Survey Tool for <MCO>'s 2011 AQS. Each evaluation element is referenced with relevant paragraphs/sections of the CRA and/or other applicable state or federal rules or laws.

Scored PA File Review Tools

During the <Year> <MCO> AQS, Qsource conducted member file reviews for the following PAs "..." This section contains the scored tools for these reviews. **Instructions** for completing each PA tool follow.

PA File Review Tool Instructions

This section contains the specific guidelines Qsource used to conduct PA file reviews for the **<Year>** <MCO> AQS.

MCC Utilization Management (UM) Denials – File Review Instructions

Authority: *Contractor Risk Agreement (CRA) between TennCare and East, West and Middle Managed Care Organizations (MCOs) § 2.14.7 and TennCare*Select *Agreement (TSA) § 2.14.7; CRA between TennCare and DBM § A.30 and .89; and 42 Code of Federal Regulations (CFR) § 438.210 and .404 and § 431.211 and .213.*

Tool Components

Record the **name** of the MCC and the **date** of the review in the spaces provided.

Time Standard

Review the MCC's policy and procedure regarding UM denials and note the maximum **hours/days** allowable for a decision to be made **and** for the member and provider to be notified of the decision to deny/reduce the requested service. Then, compare the

MCC's standards to the CFR time frames listed below. **The time standard used for this review is the shorter of the two (MCC and CFR).**

The time frames the federal government has listed in the CFR are as follows:

- *Expedited authorization decisions* must be provided "as expeditiously as the member's health condition requires and **no later than 3 working days** after receipt of the request for service." The MCC "may extend the 3 working days time period by **up to 14 calendar days** if the member requests an extension, or if the MCC justifies a need for additional information and how the extension is in the member's interest."
- *Standard authorization decisions* "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 certain conditions apply.

Review the previously selected UM denial files for members age 20 and younger, completing **columns 2–12** on the *MCC UM Denials – File Review Tool*. If a file is not applicable (i.e., anything other than a denial, or the member is 21 years or older), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 denials.

- **Column 1 – File #**: This column is pre-populated (1–10) to identify which of the files is being reviewed.
- **Column 2 – Case ID**: Record the case identification number assigned to the file.
- **Column 3 – Date Request Received**: Enter the month, day and year (MM/DD/YY) on which the request for the service or procedure was received by the MCC.
- **Column 4 –Review Criteria Used Appropriately**: Mark the "Y" cell in each row if review criteria were used appropriately to make the decision to deny or reduce the amount, duration or scope of the requested service; otherwise, mark the "N" cell. If the MCC did not receive the required medical/dental records with the request **and** did not follow up with the provider's office to request such records, mark the "N" cell.
- **Column 5 – Requesting Provider Consulted**: Mark the "Y" cell if the requesting provider was consulted prior to making the denial decision. Mark the "N" cell if she/he was not consulted, but there is evidence she/he should have been; otherwise, mark the "NA" cell.
- **Column 6 – Final Denial Decision by Qualified Professional**: A licensed physician or Doctor of Dental Surgery must make all final denial and reduction of service decisions regarding inpatient hospital services. All other decisions to deny or reduce a service should "be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease." Mark the "Y" cell if an appropriate professional made the decision; otherwise, mark the "N" cell.

- **Column 7 – Decision Based on Medical Necessity of Member's Condition**: MCCs may not deny or reduce the amount, duration or scope of a requested service solely because of the type of illness, diagnosis or condition of the member. The member's individual medical needs must be considered. Mark the "Y" cell if the decision was based on the member's individual needs; otherwise, mark the "N" cell. If the MCC did not receive the required medical/dental records necessary to make a determination based on the member's individual needs **and** did not follow up with the provider's office to request such records, mark the "N" cell.
- **Column 8 – E/S**: Indicate the type of file under review by recording an "E" (expedited) or an "S" (standard).
- **Column 9 – Date Notified**: Enter the month, day and year (MM/DD/YY) on which the MCC notified the member and provider of the decision to deny.
- **Column 10 – Number of Days for Notification:** Enter the number of days it took the MCC to make the notification. Calculate by subtracting **column 3 from column 9**.
- **Column 11 – Notification Time Standard**: Enter the number of days the MCC used as its time standard to notify members and providers about a denial/reduction in service decision.
- **Column 12 – Notification Time Standard Met**: If **column 10 is ≤ column 11,** mark the "Y" cell; otherwise, mark the "N" cell.

Scoring Directions

- **Applicable Answers**: In **column 5,** enter the applicable number of cells (i.e., all of those with "Ys" and "Ns"). All other columns are pre-populated with the number of files reviewed.
- **Compliant Answers**: In **columns 4–7 and 12,** enter the total number of compliant answers for each column (i.e., the number of "Y" cells marked in each).
- **Total Compliant**: Enter the sum of the **Compliant Answers**.
- **Total Applicable**: Enter the sum of the **Applicable Answers**.
- **Percent Compliant**: Divide the **Total Compliant by the Total Applicable,** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25%).

MCC Appeals (*Grier*) – File Review Instructions

Authority: Grier v. Wadley Revised Consent Decree (Grier Revised CD), *§ C.7 and C.16.b; Contractor Risk Agreement (CRA) between TennCare and East, West and Middle Managed Care Organizations (MCOs) § 2.19 and TennCare*Select *Agreement (TSA) § 2.19; CRA between TennCare and DBM § A.97-.111; and 42 Code of Federal Regulations (CFR) § 438.406 and .408*

Tool Components

Record the **name** of the MCC and the **date** of the review in the spaces provided.

Review the previously selected appeal files, completing **columns 2–12** on the *MCC Appeals* (Grier) – *File Review Tool*. If a file is not applicable (i.e., anything other than an appeal), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 appeals.

- **Column 1 – File #**: This column is pre-populated (1–10) to identify which of the files is being reviewed.
- **Column 2 – Case ID:** Record the case identification number assigned to the file.
- **Column 3 – Date Appeal Received:** Enter the month, day and year (MM/DD/YY) on which the appeal request was received by the MCC.
- **Column 4 – Requesting Provider Identified**: If this is true, mark the "Y" cell; otherwise, mark the "N" cell. If no practitioner/provider was involved in the case, mark the "NA" cell.
- **Column 5 – Reviewed by Same Practitioner Type as Requester**: The file should have been reviewed by a qualified professional (i.e., a practitioner with clinical expertise in the condition for which the request was made). Mark the "Y" cell if a qualified professional reviewed the file; otherwise, mark the "N" cell.
- **Column 6 – Appeal Investigation Documented:** Mark the "Y" cell if the substance of the appeal was investigated and documented; otherwise, mark the "N" cell.
- **Column 7 – E/S:** Indicate the type of file under review by recording an "E" (expedited) or an "S" (standard).
- **Column 8 – Date Member Notified of Decision**: Enter the month, day and year (MM/DD/YY) on which the MCC notified the member of the appeal decision.
- **Column 9 – Number of Days for Resolution:** Enter the number of days it took the MCC to make the decision and contact the member.

- **Column 10 – Resolution Time Standard**: Enter the number of hours/days allowable for the file type (i.e., expedited or standard). The most stringent standard (based on the *Grier Revised CD,* MCC policy or the CFR) should be used.
- **Column 11 – Resolution Time Standard Met**: If **column 9 is ≤ column 10,** mark the "Y" cell; otherwise, mark the "N" cell.
- **Column 12 – State-Mandated Letter Used**: Mark the "Y" cell if the MCC used and completed the template from TennCare to notify member of the appeal decision; otherwise, mark the "N" cell.

Scoring Directions

- **Applicable Answers**: In **column 4,** enter the applicable number of cells in the column (i.e., all of those with "Ys" or "Ns"). All other columns are pre-populated with the number of files reviewed.
- **Compliant Answers**: **In columns 4–6, 11 and 12,** enter the total number of compliant answers for each column (i.e., the number of "Y" cells marked in each).
- **Total Compliant**: Enter the sum of the compliant answers.
- **Total Applicable**: Enter the sum of the applicable answers.
- **Percent Compliant**: Divide the **Total Compliant by the Total Applicable,** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25%).

EPSDT Information System Tracking – File Review Tool Instructions

Authority: John B. Consent Decree *(EPSDT) ¶ 94; Contractor Risk Agreement (CRA) between TennCare and East, West and Middle Managed Care Organizations (MCOs) § 2.7.6.1.8.and TennCare*Select *Agreement (TSA) § 2.7.6.1.8.*

Tool Components

Record the name of the MCO and the date of the review in the spaces provided.

Review the previously selected EPSDT files to complete **columns 2–9** on the *EPSDT Information System Tracking – File Review Tool* until there is a denominator of 10 files, all of which are EPSDT. If a file is not applicable (i.e., anything other than an EPSDT file), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 EPSDT files.

- **Column 1 – File #**: This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2 – Case ID**: The Case ID represents the order of the file taken from the file review list (comprised of those files randomly abstracted from the MCO's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, Qsource and the MCO are able to determine which file was reviewed should that be needed at a later date.
- **Column 3 – Medical Record (MR) and Information System (IS)**: There are two rows per file for **columns 3–7**. The **MR** row is used to document information found in the member's medical record; the **IS** row is used to document information found in the health plan's IS tracking program.
- **Column 4 – Receipt of Screening**: Mark the "Y" cell in the **MR** row if the member's receipt is documented in the medical record; otherwise, mark the "N" cell. Mark the "Y" cell in the **IS** row if the member's receipt is documented in the health plan's IS tracking program; otherwise, mark the "N" cell.
- **Column 5 – Diagnosis Documented**: Mark the "Y" cell in the appropriate row if the diagnosis for this encounter is documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.
- **Column 6 – Treatment, Immunization, Lab Work Documented**: Mark the "Y" cell in the appropriate row if any treatment, immunization or laboratory work was *done, given to* or *prescribed* for the member. Mark the "N" cell if none was *done, given to* or *prescribed* but there is evidence that treatment, immunization or laboratory work was indicated; otherwise, mark the "NA" cell. Complete this process in the **MR** and **IS** rows for each file.
- **Column 7 – Ability to Determine Screening Status**: Mark the "Y" cell in the appropriate row if the member's current screening status was documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.
- **Column 8 – Actions Taken to Improve Member's Screenings by Contacting Provider**: Mark the "Y" cell if the primary care provider (PCP) was contacted regarding the need to set appointments for the member as a direct result of the information in the MCO's tracking system; otherwise, mark the "N" cell. Mark the "NA" cell if contacting the PCP was not indicated because the medical record and tracking system showed evidence that the member was up to date.

- **Column 9 – Actions Taken to Improve Member's Screenings by Contacting Parent/Guardian/ Member**: Mark the "Y" cell if the parent/guardian/member was contacted regarding the need to make an appointment and receive EPSDT services as a direct result of the information in the MCO's tracking system; otherwise, mark the "N" cell. Mark the "NA" cell if contacting the parent/guardian/member was not indicated because the medical record and tracking system showed evidence that the member was up to date.

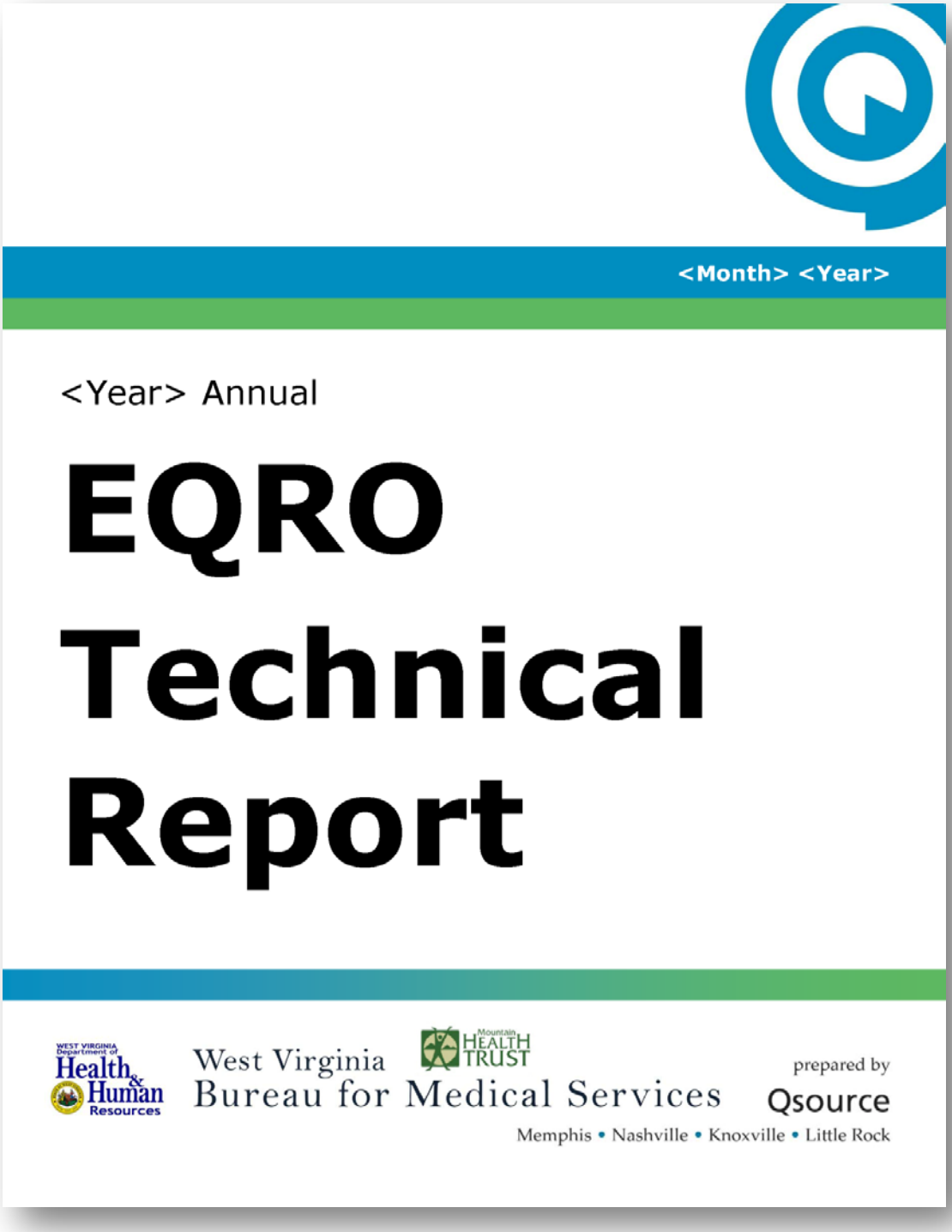
Scoring Directions

- **Applicable Answers, columns 6, 8 and 9**: Enter the applicable number of cells for each column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed
- **Compliant Answers, columns 4–9**: For **columns 4–7** enter the total number of rows where the "Ys" or "Ns" are the same for each member. For **columns 8 and 9**, enter the total number of rows that are marked "Y."
- **Total Compliant**: Enter the sum of the numbers from **Compliant Answers, columns 4–9**.
- **Total Applicable**: Enter the sum of the numbers from **Applicable Answers**, **columns 4–9**.
- **Percent Compliant**: Divide the **Total Compliant** by the **Total Applicable** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25%).

Acronyms and Initialisms

AAP .....American Academy of Pediatrics
ABA ..... Applied Behavioral Analyst
AQS ..... Annual Quality Survey
ASH .....Abortion, Sterilization and Hysterectomy
B/C..... Business Days/Calendar Days (CHOICES file review)
BH .....Behavioral Health
CAP .....Corrective Action Plan
CCC .....CHOICES Care Coordinator
CCMS ..... Care Communication Management System
CD..... Consent Decree, Compact Disc
CEO .....Chief Executive Officer
CFR ..... Code of Federal Regulations
CM..... Case Management
CMS..... Centers for Medicare & Medicaid Services
COE .....Center of Excellence
CRA .....Contractor Risk Agreement
CSR ..... Customer Service Representative
DBM..... Dental Benefits Manager
DM ..... Disease Management
DMPD.....Disease Management Program Description
DMS.....Disease Management Specialist
ED ..... Emergency Department
E/S .....Expedited or Standard (*Grier* file review)
EPSDT ..... Early and Periodic Screening, Diagnosis, and Treatment (federal standard) also the *John B. Consent Decree* (state mandate)
EQRO ..... External Quality Review Organization
Grier.....*Grier Revised Consent Decree* (state mandate)
..... also used in reference to member appeals
IEP.....Individual Education Plan
IRR .....Inter-Rater Reliability
IS ..... Information System
LEP .....Limited English Proficiency
MCC ..... Managed Care Contractor
MCO ..... Managed Care Organization
MR .....Medical Record
NA .....Not Applicable
OCCP..... Office of Contract Compliance and Performance
P&P .....Policy and Procedure
PA.....Performance Activity
PAM..... Provider Administration Manual
PCP ..... Primary Care Physician/Provider
PE..... Presumptive Eligible
PMPY ..... Per Member Per Year
POC.....Plan of Care
QI .....Quality Improvement
QM .....Quality Management

Appendix VI: Sample EQRO Technical Report Excerpt



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List of Tables and Charts

Health Plan Updates

Calendar year (CY) 2011 brought about several health plan changes in the state. For the *2012 Annual EQR Technical Report*, the following updates are recognized:

- <MCO full title> (<MCO>), formerly recognized as <MCO>, serves <State>'s Region X.
- <MCO full title> provides member services to all three Regions under the name of <MCO>, -<MCO>, and <MCO>, respectively, whereas in CY2010 the Managed Care Organization (MCO) operated as <MCO>, <MCO> and <MCO> in all three respective regions.
- <DBM full title> (<DBM>) became the new Dental Benefits Manager (DBM) effective <Date>, at which time <DBM full title> (<DBM>) ended its contract as the state's DBM.

Acknowledgements/Copyrights

Acronyms & Initialisms

(MCOs and state-specific mandates/titles have been removed)

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ANA	Annual Provider Network Adequacy and Benefit Delivery Review also known as Annual Network Adequacy
AQS	Annual Quality Survey
BHO	Behavioral Health Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COE	Centers of Excellence
CPC	Clinical Practice Consultant
CRA	Contractor Risk Agreement
CY	Calendar Year
d.b.a.	Doing Business As
DBM	Dental Benefits Manager
DM	Disease Management
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (federal standard)
EQR/EQRO	External Quality Review/External Quality Review Organization
HEDIS	Healthcare Effectiveness Data and Information Set
IS	Information Systems
LEP	Limited English Proficiency
MCC	Managed Care Contractor
MCO	Managed Care Organization
NA	Not Applicable
NCQA	National Committee for Quality Assurance
NR	Non-Reportable Rate
OB/GYN	Obstetrician/Gynecologist
PA	Performance Activity
PCP	Primary Care Physician/Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measure Validation
QI	Quality Improvement
QMP	Quality Management Program
QP	Quality Process
Quality Strategy	Quality Assessment and Performance Improvement Strategy
R	Reportable Rate

Roadmap ..... Record of Administrative Data Management and Processes
SCP ..... Specialty Care Provider
UM ..... Utilization Management

Executive Summary

This report summarizes the quality, timeliness and access to care furnished by the health plans contracted with the <State bureau> for the members of the state's managed care Medicaid program. Results were determined via the aggregation and analysis of data obtained through the following three federally mandated External Quality Review (EQR) activities, which Qsource, the External Quality Review Organization (EQRO) for <State bureau>, performed:

- Validation of Performance Measures (PMVs)
- Validation of Performance Improvement Projects (PIPs)
- Monitoring compliance with federal and state standards, measured through the Annual Provider Network Adequacy and Benefit Delivery Review (ANA) and the Annual Quality Survey (AQS)

Qsource produced and delivered this *2012 Annual EQR Technical Report* to summarize findings and conclusions from these activities. Results are based on a review of <State bureau> Managed Care Contractors (MCCs), which include six Managed Care Organizations (MCOs) in the X, X and X Grand Regions; one statewide MCO; and a statewide Dental Benefits Manager (DBM). The DBM's assessment activities for this report are limited to its contractual dates of operation: <date range>.

Major Findings

Results from Qsource's 2012 EQR activities show that, overall, <State bureau>'s MCCs are exhibiting a strong commitment to their members by delivering timely, accessible, high-quality care. Specific findings for each activity are summarized in this section.

Quality Care: Validation of Performance Measures

As part of National Committee for Quality Assurance (NCQA) accreditation, all <State bureau> health plans are required to report a full set of measures from the Healthcare Effectiveness Data and Information Set (HEDIS). Select measures from this set are then validated for accurate results and to assess MCO compliance with reporting standards.

Results from 2012 demonstrate that all MCOs passed the performance measure validation audit, were determined to be in full compliance with all standards, and received a *Report* designation for the two audited measures: <*Measure 1 Title*> and <*Measure 2 Title*>.

The HEDIS 2012 weighted state rate for the *Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase (ADD)* measure exceeded the HEDIS 2011 National Medicaid Average, as shown in **Table 1**, demonstrating a continued <increase/decrease> of nearly X percent from the HEDIS 2011 weighted state rate.

While the HEDIS 2012 weighted state rate for the *Breast Cancer Screening (BCS)* measure <increased/decreased from> the HEDIS 2012 National Medicaid Average, as shown in **Table 1**,

state rates have <improved/decreased> from HEDIS 2012, with an X percent increase. Individual MCO results and available trending are presented in the Performance Measure Validation section and in Appendix A: PMV Results. The DBM is not required to report performance measures and, as such, does not undergo PMV.

Table 1. 2011 PMV Results for MCOs (HEDIS 2012)

Measure	<state> Weighted Rate	HEDIS 2011 Medicaid National Average	<state> Performance
Breast Cancer Screening (BCS)	X%	X%	⬇⬆
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase (ADD)	X%	X%	⬆⬇

Quality Care: Validation of PIPs

Performance Improvement Projects (PIPs) are designed to measure performance using objective quality indicators, implement interventions for quality improvement and evaluate their effectiveness, and plan/initiate activities for increasing or sustaining improvement. For the year under review, MCOs are contractually required to conduct PIPs, and <State bureau> chooses one PIP from each health plan to be evaluated by the EQRO. Health plans are not informed of which of their PIPs will be chosen for validation by <State bureau> prior to submission. Generally, PIPs selected for validation are those that align with the strategy, goals and objectives set forth by <State bureau> in the Quality Assessment and Performance Improvement Strategy for CMS. For 2010–2011, <State bureau> selected one new PIP to be validated for each MCO. Those chosen for validation were at different stages of progress; three were at remeasurement two, three were at remeasurement one and one was in its baseline year. The following three PIP topics were validated for compliance:

- Follow-Up Care for Children Prescribed ADHD (Attention Deficit Hyperactivity Disorder) Medication (<MCO>)
- Behavioral Health Postpartum Depression Screening (<MCOs>)
- Improving Compliance with Continuing Treatment for Major Depressive Disorders (<MCOs>)

Table 2 summarizes the PIP validation status across MCOs. <MCOs> achieved a *Met* validation status. <MCO>, however, as well as <MCOs>, achieved a *Not Met* validation status. The DBM is not required to submit PIPs for validation.

Table 2. 2010–2011 PIP Validation Status

Status	Number of MCOs
Met	3
Partially Met	0
Not Met	4

Access, Timeliness and Quality: Monitoring Compliance with Standards

Annual Network Adequacy

Table 3 shows each MCC's 2011 ANA evaluation scores, all of which equate to *Total Compliance*. *Network Adequacy* includes the number and type of providers in each MCC's provider network, and the proximity of members to these providers. *Benefit Delivery* evaluates the MCC's delivery of covered benefits (handbooks, contracts and policies) to its members and providers.

Table 3. 2011 ANA Ratings

MCC	Network Adequacy	Benefit Delivery
	X%	X%
	X%	X%
	X%	X%
	X%	X%
	X%	X%
	X%	X%
	X%	X%
	X%	X%

Overall *Network Adequacy* ratings ranged from X to X percent, the latter of which was achieved only by the DBM, <DBM>. Three of the MCOs earned a *Network Adequacy* rating of X percent: <MCO> and<MCO> and <MCO>. For *Benefit Delivery*, X of the X MCOs achieved X percent, with <MCO> earning an X percent rating. The DBM's *Benefit Delivery* rating was X percent.

Annual Quality Survey

As part of the AQS, MCCs were assessed for compliance with quality process (QP) standards and performance activities (PAs) based on contractual, regulatory, legislative and judicial requirements. All <State bureau> MCOs are accredited by NCQA and were therefore assessed on the same QP standards and PAs. With some exceptions, the DBM, which is not subject to NCQA accreditation, was evaluated on a distinct set of criteria established from its contract with <State bureau>.

X MCOs are achieving *Substantial* to *Total Compliance*, demonstrating X percent compliance on the majority of QP standards and PAs during the 2011 AQS. Where there were exceptions to X percent compliance, scores ranged from X to X percent across both categories, as shown in **Table 4**.

Table 4. Overall 2011 AQS Results

MCCs	Individual QP Standards Range	Individual PA Range
MCOs	X%–X%	X%–X%
DBM	X%–X%	X%–X%

The DBM ranged in compliance ratings from X to X percent for the QP standards and from X to X percent for the three PAs. Compliance of X percent was achieved for X of the QP standards (<*Standards*>), while X percent compliance was earned for three other QP standards (<*Standards*>).

Conclusions & Recommendations

Managed Care Contractors

Health-plan-specific recommendations can be found in each MCC's report for the three federally mandated EQR activities. The following recommendations were noted as system-wide areas in need of performance improvement:

- **Performance Measure Validation** – To enhance HEDIS results, Qsource recommends that all MCOs continue efforts to increase electronic data submission, with most health plans at nearly an X percent electronic submission rate for medical claims data files. In addition, MCOs should consider using supplemental data, from external sources where feasible. In doing so, the health plans should ensure adherence to NCQA HEDIS protocols for all data sources. Measure-specific rates should be examined, and opportunities for improvement should be identified.
- **Performance Improvement Projects** – PIP activities should be accurate and complete. This includes clearly defined study indicators, baseline goals and timelines for all measurement periods. When submitted, the PIPs should include the necessary documentation for data collection, data analysis plans and an interpretation of all results. In conjunction with improvement strategies based upon valid and reliable data analysis and interpretation, these actions work toward creating and sustaining improvements in member health and satisfaction.
- **Annual Network Adequacy** – To address network deficiencies, MCCs should review Member Handbooks and Provider Manuals at least annually to ensure that they contain all required information, supplementing materials with policy updates and amendments. The MCOs also should verify that appropriate education and training have been conducted for those service providers not required to be licensed or certified. The health plans should continue to improve monitoring of credentialing and recredentialing activities as well as provide more oversight of provider files processed by delegated vendors. Finally, all MCOs must be dedicated to improving the quality of and access to member services by ensuring that MCO Contractor Risk Agreement (CRA) standards are met for all *Network Adequacy* activities.
- **Annual Quality Survey** – Qsource recommends that the health plans monitor Corrective Action Plan (CAP) activities throughout the year to ensure the intended actions for correcting deficiencies are fully completed within documented timelines. To foster improvement, MCOs should focus renewed energy on member communications in particular, striving to keep members up-to-date and informed with notifications regarding alterations to materials and changes to provider contacts, procedures and policies. All health plans should continue to identify and implement the necessary processes to ensure that contractual obligations are met across all standards, including John B. Consent Decree *(EPSDT)*, *QI Activities* and *Member Rights and Responsibilities*.

Bureau of <State bureau>

The following recommendations for <State bureau> were derived from EQR activity findings and Qsource's involvement in/knowledge of various <State bureau> quality initiatives:

- Continue the Pay-for-Performance quality incentive program to encourage MCOs to demonstrate significant improvement from previous reporting years for specified HEDIS measures.

- Continue to link performance measure outcomes and improvements with the *Quality Assessment and Performance Improvement Strategy* and EQR oversight activities.
- Consider expanding the MCC statewide collaboratives beyond adolescent outreach and diabetes and maternity wellness.
- Evaluate the current statewide collaboratives to assess outcomes and opportunities for improvement.
- Continue encouraging MCOs to provide DM education to promote member self-awareness of DM techniques.
- Continue quality initiatives and activities that target specific populations, including disabled members.
- Continue the quality initiatives that promote the successful coordination of medical–behavioral services.
- Continue to support provider electronic health record (EHR) incentives and other new federal legislative and regulatory provisions.

Background

This section provides a brief history of the managed care Medicaid program in <State> (known as <State bureau>), its current Quality Strategy, the guidelines for this *2012 Annual EQR Technical Report* and a description of the External Quality Review (EQR) activities it summarizes.

History of <State>'s Managed Care Programs

In establishing the <State> Department of Finance and Administration, <State bureau> on <date>, <State> became the X state in the nation to implement a comprehensive managed care model for Medicaid. The program was granted an X-year waiver by the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services (CMS). The waiver has been continuously extended and has remained in effect since the original approval.

The new model was an attempt to control the escalating costs of Medicaid while continuing to provide quality care for its members. <State bureau> also allowed for expanded coverage to include uninsured/uninsurable individuals who were not previously eligible for Medicaid. To achieve these goals, Managed Care Contractors (MCCs) were selected to provide healthcare services to <State bureau> members.

In 1996, Behavioral Health Organizations (BHOs) were brought into the managed care system to deliver mental health and substance abuse treatment services. Similarly, children under the age of 21 began receiving dental services through a Dental Benefits Manager (DBM) in 2002. Drug benefits for members who are eligible for both <State bureau> and Medicare were separated in 2000 and for all remaining members in 2003, when a Pharmacy Benefits Manager was contracted to manage the drug program.

Under the direction of the <State> Department of Finance and Administration, <State bureau> continues to provide services to traditional Medicaid members, pregnant women, children and as many medically needy <State> citizens as possible. While program changes to control costs have resulted in the disenrollment of some uninsured and uninsurable members, the governor appointed a group to develop and implement safety net services for many of these individuals.

In concert with these changes, the pharmacy benefit structure was significantly adjusted due to rapidly expanding prescription costs. Additionally, the entire <State bureau>program shifted from a full-risk to an Administrative Services Only model during a period of financial instability for some of its Managed Care Organizations (MCOs). Under this model, the health plans received an administrative fee for managing programs, while <State bureau> was responsible for the medical costs associated with each member.

Since enacting reform measures, the <State bureau>program has stabilized, allowing for a return to the full-risk model, under which MCOs are paid a per-member-per-month capitation rate for delivering care. In <date>, two nationally recognized MCOs with experience in Medicaid managed care were awarded bids under this model, which was also marked by a

reintegration of medical and behavioral health services and an enhanced focus on disease management (DM). These MCOs began serving members in the X Region on <date>. Region X MCOs returned to the full-risk, integrated model effective <date>. Region Y MCOs also returned to this model on <date>, marking integration by all health plans and eliminating the need for BHOs to continue serving <State bureau> members.

As of <date>, all MCOs now manage long-term-care service delivery for their members as part of the X program. The *X Act*, passed by the <State> legislature in <month/year>, paved the way for this integration while shifting the focus from institutional to home- and community-based services.

State Quality Strategy Goals & Objectives

The goals of <State bureau>'s *2012 Quality Assessment and Performance Improvement Strategy* (Quality Strategy) are designed to ensure that members have access to continually improving, quality healthcare and that they are satisfied with the services they receive.

Measures from the Healthcare Effectiveness and Data Information Set (HEDIS) and MCO Performance Improvement Projects (PIPs) are the primary mechanisms for assessing these goals, which apply to the integrated medical–behavioral services delivered by <State bureau>'s health plans. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is used to measure member satisfaction. For select measures, incentives are offered where MCOs demonstrate significant improvement from the previous reporting period as determined by established National Committee for Quality Assurance (NCQA) methodology.

Additional Quality Strategy objectives have been established based on the X program implemented in 2011. As the name suggests, X is designed to provide adults who are elderly or have physical disabilities with viable alternatives to institutional care. Quality assurance for these services focuses on the following:

- Levels of care
- Service plans
- Qualified providers
- Health and welfare
- Administrative authority
- Participant rights

The integration of long-term care with medical–behavioral care and required health plan accreditation forms a strong foundation upon which future Quality Strategy objectives and success will be built. <State bureau>'s continued focus on Health Information Technology supports these efforts, providing an ever-evolving digital infrastructure for quality improvement.

Technical Report Guidelines

To assist both External Quality Review Organizations (EQROs) and state Medicaid agencies, CMS supplemented the requirements of 42 *Code of Federal Regulations* (CFR) § 438.364 and

provided guidelines for the format and content of this *2012 Annual EQR Technical Report*, which—in addition to the Executive Summary and this Background—includes the following:

- Description of EQRO Activities
- State Quality Initiatives
- MCC Best & Emerging Practices
- Performance Measure Validation (PMV)
- Performance Improvement Projects (PIPs)
- Organizational Assessment & Structure Performance (includes Annual Network Adequacy [ANA] and Annual Quality Survey [AQS])
- MCC Conclusions & Recommendations
- State-Level Conclusions & Recommendations

EQR Activity Summary

As mandated by <*State*> *Code Annotated* <contract reference> and at the direction of the <State> Department of Commerce and Insurance and <State bureau>, Qsource performs annual EQR activities to determine each health plan's compliance with federally mandated activities. Acting as Qsource's subcontractor, <Subcontractor Name> assists in the completion of these activities, which are summarized in this *2012 Annual EQR Technical Report* and include the following:

- A brief description of the data collection, aggregation and analyses for each of the three EQR compliance activities
- A summary of findings from each activity's reviews (PMV, PIP, ANA and AQS)
- A summary of strengths and opportunities demonstrated by each health plan in providing healthcare services to <State bureau> members
- Recommendations for improving the quality of these services

During 2012, the seven MCOs under review were <MCOs 1-7>. The statewide DBM was <DBM full title> (<DBM>), whose contract start date was <date>. Due to the time of operation—only three months of the 12-month review period—assessment for the DBM was limited.

Table 5. 2012 Survey & Review Periods for EQR Activities

Activity	Audit Period	Period under Review
PMV	<date range>	January 1–December 31, 2011
PIP	<date range>	January 1–December 31, 2011
ANA	<date range>	January 1–December 31, 2011*
AQS	<date range>	January 1–December 31, 2011*

**The period under review for <DBM> was October 1–December 31, 2010.*

The mandated EQR activity audit and survey periods for these health plans are summarized in **Table 5**. The three-year survey history that appeared in previous technical reports is no longer listed due to limited trending capabilities. Reasons include contract differences related to NCQA accreditation and medical–behavioral services integration rollout, as well as changes to validated performance measures and PIPs.

The following MCO-specific reports were generated for each of the reviews conducted:

- 2012 Report of Performance Measure Validation
- 2012 Performance Improvement Project Validation Report
- 2012 Annual Provider Network Adequacy and Benefit Delivery Review Report
- 2012 Annual Quality Survey

Both the *2011 Annual Provider Network Adequacy and Benefit Delivery Review Report* and the *2012 Annual Quality Survey* were conducted for the DBM. The detailed findings upon which this *2012 Annual EQR Technical Report* is based can be examined in these reports. Specific EQR activity requirements and objectives are listed in the following sections.

Performance Measure Validation (PMV)

Requirements and Objectives

To evaluate performance levels, <State bureau> selected a process for an objective, comparative review of quality-of-care outcomes and performance measures. Its primary objectives were to evaluate the accuracy of MCO-reported measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs and to meet the requirements set forth in 42 CFR § 438.240(b)(2), <State bureau> identified for validation the following two HEDIS measures, defined by the NCQA and validated by conducting an NCQA HEDIS Compliance Audit:

- Breast Cancer Screening (BCS)
- Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase (ADD)

Performance Improvement Projects (PIPs)

Requirements and Objectives

The primary objective of the EQRO's PIP validation was to determine the compliance of each MCO with the requirements set forth in 42 CFR § 438.240(b)(1). As part of their Quality Assessment and Performance Improvement programs, the health plans were required to achieve significant, sustained improvement in clinical and nonclinical care areas via ongoing measurement and intervention. This structured method of assessing and improving processes was expected to have a favorable effect on health outcomes and member satisfaction. PIPs are further defined in 42 CFR § 438.240(d)(1) to include all of the following:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

The PIP topics, one from each MCO, selected for validation for calendar year (CY) 2011–2012 were (a) <PIP Topic 1>; (b) <PIP Topic 2>; and (c) <PIP Topic 3>.

Per federal regulations, the PIP validation was only applied to those PIPs under way during the 12 months preceding review. The validation process included a review of the study design and

approach, as well as compliance with the analysis plan and the effectiveness of health plan interventions.

Monitoring Compliance with Standards: Annual Provider Network Adequacy and Benefit Delivery Review (ANA)

Requirements and Objectives

The *Balanced Budget Act of 1997* requires EQROs to assess "strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid recipients." Per 42 CFR § 438.204(g) and 438.206 and their respective contracts, <State bureau> MCCs must ensure that

- all covered benefits are available and provided to members;
- an adequate number of qualified, skilled providers and healthcare facilities (as defined by the MCO or DBM contract) are employed or contracted; and
- these providers/facilities have sufficient resources and the availability to guarantee members access to quality medical care for all covered benefits.

ANA reviews are designed to evaluate both the adequacy of each health plan's provider network and the completeness of its member and provider communication regarding <State bureau>-covered services during the review year. The multiple measures used to assess each are listed in the Organizational Assessment & Structure Performance section of this report.

Monitoring Compliance with Standards: Annual Quality Survey (AQS)

Requirements and Objectives

The AQS is bound by the same mandates as ANA reviews. AQS requirements are further defined by (1) 42 CFR § 434 and 438; (2) each health plan's Contractor Risk Agreement (CRA); (3) the court-ordered provisions of the *John B. Consent Decree* and *Grier Revised Consent Decree*; and (4) additional quality standards established by the state. The objective of the AQS is to assess <State bureau> MCC compliance with the abovementioned requirements during a pre-assessment review, an onsite review and a post-onsite assessment.

Qsource evaluated health plan compliance using customized quality process (QP) standard and performance activity (PA) tools. These tools provide required data and meaningful information that <State bureau> and the health plans can use to

- compare the quality of service and healthcare that MCCs provide to their members, including medical–behavioral integration, where applicable;
- identify, implement and monitor system interventions to improve quality;
- evaluate performance processes; and
- plan/initiate activities to sustain and enhance current performance processes.

Required data were also obtained through NCQA accreditation, which had been earned by all <State bureau> MCCs by the end of CY2009. Accreditation does not apply to the DBM.

Appendix VII: Sample AQS Summary Report

contents

Contents

Report Preparation

This report was prepared by Qsource, the External Quality Review Organization (EQRO) for <State>, under a contract with the state Department of Health and Human Resources, <Bureau of X>

Individual health plan *Annual Quality Survey 2012-Technical Papers* provide more detailed findings, including

- AQS Steps
- Pre-Assessment Documentation List
- AQS Participants
- Onsite Documents Reviewed
- Quality Process (QP) Standard Elements
- AQS Compliance Summary
- Strengths, Areas of Noncompliance and Suggestions
- Improvements since the Previous AQS
- Completed QP Standard Survey Tool
- Completed Performance Activity (PA) Tools
- PA Tool Instructions

For a copy of individual health plan technical papers, send a written request to:

Bureau for Children and Families
ATTN: Responsible Party/Department
Street Address
City, WV ZIP Code

Monitoring Compliance
2012 AQS
Executive Summary

Each state with a managed care Medicaid program is required by federal legislation to have an External Quality Review Organization (EQRO) assess the quality, timeliness and accessibility of the care and services delivered to members.

As the state-designated EQRO for <State> since <year>, Qsource conducts the Annual Quality Survey (AQS) and a number of other required and optional EQRO activities. The AQS is an evaluation of the compliance of the state of <X>, Bureau of <X> Managed Care Organizations (MCOs or health plans) with federal and state mandates, including legislation, judicial decrees and contractual requirements.

The AQS involves four main evaluation stages:

- Tool Development
- Document Review
- Health Plan Visit
- Calculating Compliance

The *2012 AQS Summary Report* compiles findings for <state>'s MCOs that provide Medicaid health services. Individual findings for each MCO are accessible in the 2012 AQS *Technical Papers* obtainable from <X>.

The AQS includes a pre-assessment documentation review, an onsite visit and post-onsite analyses for each MCO. Qsource develops assessment tools to document results of these reviews.

Tools, timelines and templates are developed in collaboration with <state bureau> using established quality review protocols to best meet the state's Medicaid program EQRO needs and are updated as changes in federal and state mandates occur.

The AQS tools are built from quality process (QP) standards and performance activities (PAs) derived from evaluating these criteria and mandates. QP standards focus on documented processes, evidenced implementation and follow-through of criteria, while PAs involve review of documentation in member files demonstrating compliance.

To assist in understanding calculated compliance,

West Virginia Department of Health & Human Resources

West Virginia
Bureau for Medical Services

Mountain Health Trust

prepared by
Qsource
Memphis • Nashville • Knoxville • Little Rock

2011 AQS Executive Summary

Qsource assigns a star rating corresponding with compliance percentage earned for each QP standard and PA. In addition to compliance scores and star ratings, Qsource identifies strengths, areas of noncompliance and suggestions to benefit the health plans, <state bureau> and all members through improving the quality of healthcare and service delivery.

In 2012 AQS evaluated performance, no health plan rated fewer than <X> stars on any given QP standard or PA.

90-100% Total Compliance

Noted strengths in overall MCO performance were primarily for the <X> QP standard, with <X> strengths combined for all <X> health plans. <X> were identified for the Non-Discrimination Compliance standard, <X> for the PAs.

80-89% Substantial Compliance

Areas of noncompliance were noted for <X> QP standards. The most were identified for QI Activities at <X>, and the <X> *standard* at <X>. <X> PAs also had areas of noncompliance—(A, B and C). A corrective action plan (CAP) was required for any QP standard element or PA where a health plan rated as an area of noncompliance, i.e., less than 100% compliance.

For the 2012 AQS, <X> MCOs submitted their CAPs in a timely fashion. Qsource is currently continuing review of submitted CAPs for appropriateness, and is making recommendations to <state bureau> on next steps. CAPs will be reviewed during the 2012 AQS to discern quality improvements successfully implemented.

During the 2012 AQS, surveyors noticed several areas where the health plans improved from the previous year. The MCOs demonstrated a strong commitment to providing services for long-term-care members through the <X> program and continue to work with the state to enhance provision of these services.

Also, each MCO fully participated in statewide collaborative work groups with <X> and other health plans, improving how the MCOs educate and conduct outreach to members and providers by presenting a unified message on topics such as smoking cessation for pregnant members.

MCO Recommendations

1. Health plans should monitor CAP activities throughout the year to ensure the intended actions for correcting deficiencies are fully completed within submitted timelines.
2. To foster improvement, MCOs should focus renewed energy on member communications in particular, striving to keep members up-to-date and informed with notifications regarding alterations to materials and changes to provider contacts, procedures and policies.

Introduction

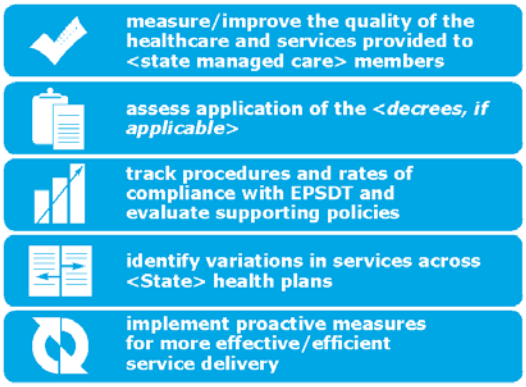
Each state with a managed care Medicaid program must contract with an External Quality Review Organization (EQRO) to assess the quality, timeliness and accessibility of the care and services delivered to members. As the state-designated EQRO for <State>, Qsource conducts quality review activities to evaluate the performance of the State of <X>, Bureau of <X>'s Managed Care Organizations (MCOs or health plans).

External Quality Review (EQR) requires specified mandated activities, optional activities and other state-assigned EQRO responsibilities, such as the provision of ongoing technical assistance.

As set forth in <contract reference>, one of the three mandatory EQR activities that must be performed is monitoring compliance with federal and state standards, measured through an Annual Quality Survey (AQS).

AQS goals are illustrated at right and defined by

1. <contract reference>;
2. each health plan's Contractor Risk Agreement (CRA) with <state>;
3. the court-ordered provisions of the *<decrees, if applicable>*; and
4. additional quality standards established by the state.



Qsource provides technical assistance to <State bureau> and its MCOs in maintaining ongoing, collaborative communication with the state and supporting the MCOs with their EQR activities through sharing our expertise in Medicaid legislation, MCO accreditation standards and guidelines, and continuous quality improvement.

This *2012 AQS Summary Report* compiles findings of the year for <State bureau>'s MCOs that provide physical, mental and long-term health services to Medicaid members across the state or by designated Grand Region <regions, if applicable>.

As there is one dental benefits manager and requirements differ for provision of dental health services, its findings and detail, reported in the 2012 <*dental plan*> *Annual Quality Survey–Technical Papers*, will not be included.

Evolving State AQS Mandates for Health Plans

<State> was the <x> state in the nation to mandate that its MCOs become accredited by the National Committee for Quality Assurance (NCQA). Currently the primary accrediting body for health plans in the United States, NCQA is an independent, 501(c)(3) nonprofit that assesses and scores health plan performance in quality improvement, utilization management, provider credentialing, and member rights and responsibilities.

This requirement has been one of several implemented to improve quality while optimizing operations and promoting fiscal integrity of the <State bureau> program.

As the EQRO, Qsource helps ensure compliance and reporting with those standards not included in NCQA accreditation, and provides technical assistance to health plans to improve in areas of noncompliance. This combined effort ensures MCOs provide the highest quality of care and service to members.

<State bureau> requires the MCOs to emphasize the prevention of exacerbation and complications in disease management (DM) programs designed to help members with disease self-management.

In <year> <State bureau> increased the number of DM programs that the health plans in the <X> Region were required to offer, including maternity management, congestive heart failure, asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease, bipolar disorder, major depression, schizophrenia and obesity.

These requirements have been extended to the other Grand Regions as well.

Federal and State Mandates

Balanced Budget Act of 1997 (BBA) — Directed the federal Department of Health and Human Services to develop regulations for state Medicaid agencies to fulfill a statutory required "external independent review" of managed care. In response, the Centers for Medicare & Medicaid Services (CMS) issued mandates in the *Code of Federal Regulations* (CFR).

<Applicable state mandates will appear here>

<State bureau> began integrating behavioral and medical healthcare delivery in <year>, accompanied by a return to the full-risk managed care model.

By the end of <year>, all of <State bureau>'s health plans were fully accredited by NCQA and were operating as full-risk contractors offering integrated services.

Following the state's passage of the <*specific act*> in <Month, year>, <State bureau> was approved by the CMS for an amendment to its <waiver X> in <Month, year>, resulting in the <X> program.

Designed to provide adults who are elderly or have physical disabilities with viable alternatives to institutional care, <X> has also been integrated into health plan operations and was included in AQS evaluations for the first time in 2012.

Qsource worked collaboratively with <State bureau> to develop tools to determine the health plans' compliance with designated time frames for each of the <X> groups:

- **<Group X>**consists of members residing in nursing facilities at the time of the <X> program implementation or enrollment with the MCO.
- **<Group Y>** members are those residing in the community and receiving services in those settings.

Each group consists of several sub-groups and, for the 2012 AQS, Qsource worked with <State bureau> to establish ways to measure the MCOs' compliance with completing activities and assessments that were required as members were enrolled.

<MCO> only covers members under <Group X>; therefore, files were not reviewed for <Group Y> for that MCO.

As these changes have occurred, Qsource has assisted <State bureau> by integrating them in EQRO methodology, assessment tools and activities; thereby giving health plans the opportunity to provide truly comprehensive care that is well coordinated and patient centered.

Methodology

As described, the AQS is based on managed care Medicaid requirements additional to those included in NCQA accreditation and specific to the <State bureau> program.

Qsource collaborates with <State bureau> throughout the survey to develop timelines, assessment tools, and templates using CMS and other established quality review protocols to best meet the EQR needs of the state's Medicaid program.

These protocols govern the four major AQS activities:

- Tool Development
- Document Review
- Health Plan Visit
- Calculating Compliance

Qsource assembled a team of experienced health plan surveyors and operational support service personnel to collect and analyze data; complete a review of contractual, clinical and administrative outcomes; and prepare individual reports for <State bureau> and the health plans.

The AQS includes a pre-assessment documentation review, an onsite visit and post-onsite analyses for each MCO.

Open communication among the Qsource survey team, <State bureau> and each MCO helps ensure a supportive and coordinated approach to and the success of AQS oversight activities.

Qsource EQRO Qualifications

Qsource meets all qualifications and standards of independence for EQROs set forth in 42 CFR § 438.354, including demonstrated expertise with Medicaid program assessment as well as managed care policies, processes and data systems.

Qsource is a 501(c)(3) nonprofit whose survey staff includes registered nurses and master's-level analysts, technical writers and database administrators.

Qsource's strategic plan fully integrates continuous quality improvement and International Organization for Standardization (ISO) principles. Our Quality Management System is certified to ISO 9001:2008 standards.

Qsource is also certified by the State of <X> as a utilization review agent.

Tool Development

Qsource developed and annually updates evidence-based oversight/monitoring tools in consultation with <State bureau> representatives to ensure CRA-specific criteria are met, related judicial and federal developments are incorporated and all data sought are collected.

The AQS tools are built from quality process (QP) standards and performance activities (PAs) derived from evaluating these criteria and mandates.

QP standards focus on documented processes and evidenced implementation and follow-through of criteria, while PAs involve review of documentation in member files demonstrating compliance.

The tools help Qsource assess health plan progress toward annual quality goals and are the basis for all strengths, areas of noncompliance and suggestions identified by surveyors during the AQS.

Tool formats allow for displaying these surveyor notations in completed tools with the criteria and the reference from which the criteria were identified.

This enables <State bureau> and the MCOs to clearly see in which areas the health plans are excelling, which require additional effort and the type necessitated.

Quality Process (QP) Standards

Quality Improvement (QI) Program
Examines the structure, organization and execution of the health plan's QI system.

Network: Contracting, Availability, Access and Documentation
Assesses the network of providers contracted to deliver care to <State bureau> members.

QI Activities
Monitors health plan services, including disease management, case management, integrated care and long-term care (LTC).

Clinical Criteria for Utilization Managment (UM) Decisions
Confirms the use of medical necessity standards, clinical practice guidelines and care transition procedures for UM decision-making.

Member Rights and Responsibilities
Ensures members receive critical information regarding benefits, services and obligations.

Consent Decrees Included
Describes any consent decrees in place that need review.

Performance Activities (PA)

UM Denials
Verifies that decisions to deny/reduce services meet <State bureau> Guidelines. Applies to children age 20 and younger.

EPSDT Tracking Information System
Tracks the documentation of diagnoses/screenings/treatments for children age 20 and younger in member medical records and the health plan's information system.

Appeals
Ensures that MCOs answer member appeals using <State bureau> guidelines and the *Grier Revised Consent Decree*.

Long-Term Care (LTC) Compliance
Determines if MCOs manage LTC transitions according to <State bureau> guidelines.

Document Review

Surveyors noted each MCO's contract term and reporting period under review (operational time for the previous calendar year). Survey tools approved by TennCare were forwarded to each MCO to allow gathering of required data and to facilitate the onsite visit.

Qsource followed tool sharing with a letter to the MCO requesting submission of specific pre-assessment documentation, such as Member Handbooks and Provider Manuals. The survey team included instructions on organizing and preparing documents for AQS reviewers, and remained in contact with the MCOs and <State bureau> via telephone and email to provide technical assistance.

Qsource surveyors examined information obtained from pre-assessment materials and documented preliminary findings in the survey tools before the onsite visits for insight into MCO structure/operations, to enable initial compiling of data and to help ensure an expedient and thorough visit.

For the PAs, pre-assessment requests included files from which Qsource abstracted a random sample and oversample.

During pre-assessment, surveyors also noted areas lacking documentation and requiring follow-up during the health plan visits.

Health Plan Visit

Qsource prepared onsite agendas and discussed time frames and needs with the health plans prior to the scheduled visit to maximize results while minimizing operational disruption.

Health plan staff was available for interview and assistance in locating documentation or data sources. These data could include policies/procedures, committee meeting minutes, quality studies, reports, medical record/file review and other related health plan documentation.

Surveyors interacted with MCO staff to determine the degree of compliance with contractual requirements, to explore any issues not fully addressed in the documents reviewed and to increase overall understanding of the health plans' performance.

At the end of the visits, Qsource surveyors met with MCO representatives to summarize initial findings/recommendations, including identified specific strengths, areas of noncompliance and suggestions.

Calculating and Reporting Compliance

Qsource uses tested protocols and scoring methods to calculate MCO compliance. The value of each QP standard is the sum of the values assigned to each element, which represent the criteria assessed.

Qsource analyzed each element in the survey tools using weighted point values to determine MCO performance. Each PA is assigned the same possible overall value.

The QP standard and PA scores are determined by dividing the total points earned (numerator) by the total possible points (denominator).

To assist in understanding calculated compliance, Qsource assigns a star rating corresponding with compliance percentage earned for each QP standard and PA.

Though for <State bureau> any score less than 100% is considered a noncompliance, protocols predicate a rating system designed to relay degree of variance from five stars for 90 to 100% to one star for 0 to 54%.

After compiling and analyzing all data and calculating compliance, Qsource prepared a report of findings and recommendations for each health plan.

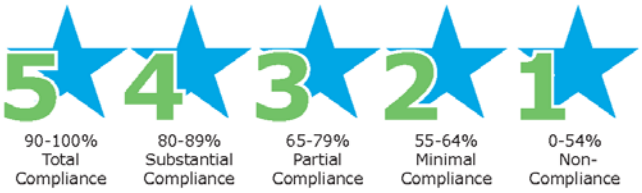
Titled *Technical Papers*, these reports were submitted as drafts within 30 days of each MCO's survey completion, finalized following <State bureau> and health plan responses, and printed/submitted to <State bureau> within 60 days of survey completion.

Scoring Methodology

$$\frac{\text{Points Earned}}{\text{Points Possible}} = \text{Percent Compliant} \rightarrow 5\text{★}$$

Qsource completed all technical papers within set deadlines, often earlier than required, and provided {State Bureau} and the MCOs with technical assistance as needed to foster performance improvement.

Health plan participants in the survey process and onsite documentation reviewed were noted in the technical papers. Surveyor notes were contained in completed survey tools, which were included in the appendices of the individual health plan technical papers submitted to <State bureau> and the health plans upon completion to serve as a comprehensive record of assessment activity.



Evaluation of Plan Process

The AQS reviews were conducted by Qsource, pursuant to the following nationally recognized guidelines (sources indicated in parentheses):

- 2009 *Standards and Guidelines for the Accreditation of MCOs* (NCQA)
- *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, Final Protocol Version 1.0, February 11, 2003 (CMS)
- Additional state/federal regulations

All tools were approved by <State bureau> prior to conducting the survey. This year's AQS onsite visits took place from March to May 2012 and, with the pre-assessment documents reviewed, evaluated performance of MCO services provided during the previous calendar year (January–December 2011).

The survey review team consisted of clinicians with expertise in quality improvement and a health analyst with expertise in data analyses and validation.

For the onsite visits, pre-assessment documentation was required to be available with all curricula vitae/resumes for UM staff involved in medical necessity decision-making. Also required were predetermined oversamples of files for PA file reviews:

- 15 UM denial files (EPSDT-eligible members only)
- 15 EPSDT files
- 15 Long-Term Care files

The QP standard tool was used to measure compliance with federal and state requirements, while the PA file reviews were conducted to assess handling of member utilization management (UM) denials, appeals, tracking and long-term care/services requests.

PA file reviews consist of reviewing medical records and/or internal MCO documentation of processes such as appeal and denial handling. Qsource obtains the sample of records to review from files, submitted to <State bureau> by the MCOs, that reflect the measurement year's activities (i.e., denials, appeals or ambulatory visits). Qsource assigns case numbers to the files that correspond to their sample order to maintain confidentiality yet retain the ability to internally identify the file at a later date if needed.

The UM Denial file review was restricted to members age 20 and younger to assess health plan compliance with the EPSDT program.

Preassessment Documentation

Documentation requested from each health plan before the onsite for desk review included:

1. Member Handbooks in English and Spanish
2. Provider Manual
3. 2011 Quality Improvement (QI) Program Description
4. QI Program Evaluation of 2010 activities
5. <State> Program Description
6. All provider and member newsletters
7. 2011 quarterly and annual Early Periodic Screening, Diagnosis, and Treatment (EPSDT) reports
8. 2011 Utilization Management (UM) Program Description
9. UM Program Evaluation of 2010 activities
10. All provider and member satisfaction surveys
11. Information and documentation related to 2011 AQS Corrective Action Plan (CAP) activities and interventions
12. Policies that define the MCO's time standards for handling all denials and appeals
13. Completed table of time standards used for the resolution of UM denials and appeals

{Necessary} files were reviewed for compliance with the *Named Consent Decrees*.

EPSDT Information System Tracking file review assessed compliance with the state's *John B. Consent Decree.*

The Long-Term Care file reviews evaluated compliance with the required time frames of the program's two groups.

As needed, required data were also obtained through the health plans' NCQA accreditations.

Contractual requirements regarding Credentialing and Recredentialing and Benefit Delivery Review were not included in AQS review because they are evaluated via the health plans' Annual Network Adequacy and Benefit Delivery Reviews (ANAs), a separate EQRO activity that was completed <Month, year>.

Completed tools, AQS technical papers and this summary report provide required data and meaningful information that <State Bureau> and the health plans can use to

- compare the quality of service and healthcare that MCOs provide to their members;
- identify, implement and monitor system interventions to improve quality;
- evaluate performance processes; and
- plan/initiate activities to sustain and enhance current performance processes.

Evaluation of Plan Results

Scores and Ratings

In AQS evaluated performance, no health plan rated fewer than <X> stars on any given QP standard or PA.

QP Standards

All MCOs rated X% compliance for X QP standards:

- **Quality Improvement Program**
- **Network: Contracting, Availability, Access and Documentation**
- ***{Named} Consent Decree***

X rated 100% for **<Standard X>** and **<Standard Y>** QP standards, for which <Plan 7> achieved X% and Y%, respectively.

X health plans succeeded in rating X% for the ***{Named} Consent Decree***—<Plan 6> and -<Plan 5> and <Plan 4>. <Plan 3>, -<Plan 2> and <Plan 1> achieved nearly as high compliance at X%, Y% and Z%.

With still a high rate of compliance, <Plan 4> fell short of the other MCOs at X%.

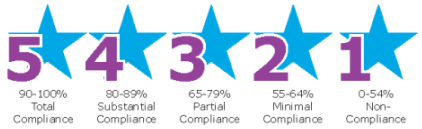
<Plan 6> was the only one to achieve X% for the QP standard **Member Rights and Responsibilities**, but the lowest rating across MCOs was still quite high (<Plan 2> at X%).

<X> is the only QP standard for which no health plan achieved 100% compliance.

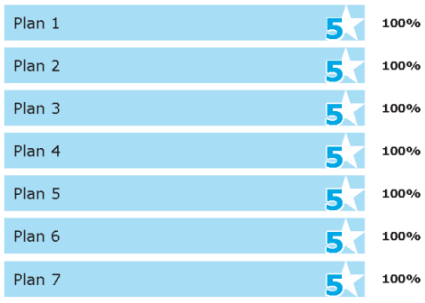
<Plan 8> had the highest rate at X%, and all other MCOs rated X%.

PA File Reviews

For the PAs, all MCOs rated 100% for



Quality Improvement Program



Network: Contracting, Availability, Access and Documentation

Quality Process Standards *(continued)*

QI Activities

Plan 1	5	91.9%
Plan 2	5	91.9%
Plan 3	5	91.9%
Plan 4	5	95.3%
Plan 5	5	91.9%
Plan 6	5	91.9%
Plan 7	5	91.9%

Clinical Criteria for UM Decisions

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	4	80.0%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

Member Rights and Responsibilities

Plan 1	5	95.3%
Plan 2	5	100%
Plan 3	5	95.3%
Plan 4	5	94.4%
Plan 5	5	98.1%
Plan 6	5	98.1%
Plan 7	5	98.1%

John B. Consent Decree (EPSDT)

Plan 1	5	98.8%
Plan 2	5	97.7%
Plan 3	5	97.7%
Plan 4	4	89.5%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

Grier Revised Consent Decree

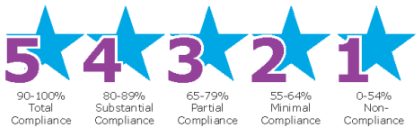
Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	100%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

Non-Discrimination Compliance

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	94.7%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

Information System Tracking and **Appeals**, both of which are tied to court mandates (*Named Consent Decrees*). Besides <Plan 5> (X%)and <Plan 1> (Y%), the MCOs earned Z% compliance for **UM Denials**.

At X%, <Plan 9> was the only health plan to not achieve X% compliance for **Long-Term Care**.



UM Denials
(age 20 and younger only)

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	100%
Plan 5	5	95.8%
Plan 6	5	100%
Plan 7	5	93.8%

Information System Tracking
John B. Consent Decree (EPSDT)

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	100%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

Appeals
Grier Revised Consent Decree

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	100%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

CHOICES 1
Time Frame Compliance

Plan 1	4	85.7%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	5	100%
Plan 5	5	100%
Plan 6	5	100%
Plan 7	5	100%

CHOICES 2
Time Frame Compliance

Plan 1	5	100%
Plan 2	5	100%
Plan 3	5	100%
Plan 4	4	85.7%
Plan 5	5	100%
Plan 6	5	90.5%
Plan 7		NOT APPLICABLE

** Room for any table notes*

Strengths and Noncompliances

In addition to compliance scores and star ratings, Qsource identified strengths, areas of noncompliance and suggestions to benefit the health plans, <State bureau> and all members through improving the quality of healthcare and service delivery.

Strengths indicate an MCO demonstrated particular proficiency on a given QP standard element or PA and are identified independent of 100% (i.e., full) compliance. The lack of an identified strength should not be interpreted as a shortcoming on the part of a health plan. **Suggestions** are sometimes noted, even where 100% compliance is achieved, to help the MCO maximize its quality efforts. **Areas of noncompliance** (AONs) are identified where a plan achieved less than 100% compliance on any given QP standard element or PA. They reflect what a plan should do and may be accompanied by Qsource recommended policy, procedure or process changes.

During the 2012 AQS, noted QP standard strengths in overall MCO performance were focused primarily on the ***John B. Consent Decree*** **(EPSDT)** standard, with X total strengths across all seven health plans. X strengths were identified for the **Non-Discrimination Compliance** QP standard also. X strengths were identified for PAs.

AONs were noted for X QP standards, including <Standard A>(X), **<Standard B>** (X), and **<Standard C>** (X). The largest number of AONs for a QP standard were for **<Standard D>** (X) and <Standard E> (X). AONs were identified in three PAs—**<Standard 1>** (X), **<Standard 2>** (X) and **<Standard 3>** (X).

Additional details and suggestions can be obtained from individual health plan 2012 AQS technical papers through <State bureau>.

Corrective Action Plans

CAPs are designed to improve performance and give the health plan the opportunity to receive technical assistance from <State bureau> or Qsource. The MCO must submit a CAP for any QP standard element or PA with less than 100% compliance, regardless of overall performance on the standard or activity. Qsource provides assistance and templates to the health plans in completing CAPs, then evaluates CAPs and makes recommendations to <State bureau> for follow-up. <State bureau> may also request CAPs at its discretion.

Summary and Recommendations

During the 2012 AQS, surveyors noticed several areas where the health plans improved from the previous year. One area was each MCO's commitment to participating in the statewide collaborative work groups with <State bureau> and other health plans. These collaborations have improved how the MCOs educate and conduct outreach to their members and providers by presenting a unified message on topics such as smoking cessation for pregnant members.

Despite some identified AONs, the health plans demonstrated a strong commitment to providing services for the long-term-care population through the CHOICES program. The MCOs continue to work with the state to enhance their processes related to the provision of long-term-care services.

CAPs Required

A CAP was required to be submitted for any QP standard element or PA where a health plan rated less than 100% compliance. For the 2012 AQS, all MCOs submitted their CAPs in a timely fashion.

<MCO> was required to complete <X> CAPs to adequately improve processes, policies and procedures. <Plan 1>, <Plan 2> and <Plan 3> had X CAPs to submit. <Plan 4> submitted four CAPs, and UnitedHealthcare-Middle submitted three. CAPs will be reviewed during 2012 AQS to discern quality improvements successfully implemented. Qsource is currently continuing review of CAPs for appropriateness and compliance and making recommendations to <State bureau> regarding next steps.

Quality Improvements

<State bureau>'s MCOs showed improvement on most of the opportunities identified during the 2011 AQS. <Plans 1, 2 and 3> all resolved AONs from the previous survey year. However, several plans had multiple AONs that had continued.

Health plans should monitor CAP activities throughout the year to ensure the intended actions for correcting deficiencies are fully completed within documented timelines. To foster improvement, MCOs should focus renewed energy on member communications in particular, striving to keep members up-to-date and informed with notifications regarding alterations to materials and changes to provider contacts, procedures and policies.

Acronyms and Initialisms

ANA	Annual Network Adequacy and Benefit Delivery Reviews
AON	Area of Noncompliance
AQS	Annual Quality Survey
BBA	*Balanced Budget Act of 1997*
CAP	Corrective Action Plan
CFR	*Code of Federal Regulation*
CMS	Centers for Medicare & Medicaid Services
CRA	Contractor Risk Agreement
DM	Disease Management
EQRO	External Quality Review Organization
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
LTC	Long-Term Care
MCO	Managed Care Organization
NCQA	National Committee for Quality Assurance
PA	Performance Activity
QI	Quality Improvement
QP	Quality Process
UM	Utilization Management