The URAC Guide to Medicaid Managed Care External Quality Review

URAC Accreditation: A Resource in Medicaid Managed Care Oversight

© URAC 2009

SUMMARY

THE URAC GUIDE TO MEDICAID MANAGED CARE EXTERNAL QUALITY REVIEW illustrates how URAC Accreditation can serve to demonstrate compliance with federally mandated external quality review (EQR) activities in Medicaid Managed Care Oversight. The Guide incorporates references to relevant Centers for Medicare and Medicaid Services (CMS) protocols and highlights where URAC standards are comparable to federal Medicaid managed care requirements:

- For Access to Care (42 CFR §§ 438.206, 438.207, 438.208 and 438.210)
- For Structure and Operations (42 CFR §§ 438.214, 438. 218, 438.224, 438.226, 438.228 and 438.230); and
- For Quality Measurement and Improvement (42 CFR §§ 438.236, 438.240 and 438.242)

Note: The URAC Guide to Medicaid Managed Care External Quality Review has been reviewed by CMS and is available through links at www.cms.gov and www.urac.org.

For questions concerning this Guide and additional URAC resources, including workshops, webinars and teleconferences for regulators, please contact URAC Government Relations staff:

- URAC Government Relations Director Mara Osman (202/962-8838, mosman@urac.org)
- URAC Government Relations Specialist Justin Peters (202/962-8832, jpeters@urac.org)

General information about URAC is available at:

www.urac.org · (202) 216-9010

Table of Contents

Summary Page 2

Introduction Page 4

Background: Medicaid Managed Care Oversight Page 4

Overview of URAC Page 6

"Duplication Potential": Comparability of URAC Standards
And Medicaid EQR Requirements Page 9

The Crosswalk: EQR and URAC Standards Page 14

Appendix A: Summary Table: Comparability of URAC Standards
and Medicaid EQR Requirements

Appendix B: CMS Protocol Bibliography and Key

Appendix C: Federal Medicaid Managed Care Regulations
Crosswalk to URAC Health Plan Standards (Version 5.1, 2007)

Appendix D: Sample Documentation and Onsite Survey Questions

Appendix E: URAC Health Plan Standards (Version 5.1)

Appendix F: URAC Health Utilization Management Standards (Version 5.1)

INTRODUCTION

In response to requests from state Medicaid agencies and managed care organizations (MCOs), URAC developed the *URAC Guide to Medicaid Managed Care External Quality Review* in order to illustrate how URAC Accreditation may be used to show compliance with federally mandated external quality review (EQR) activities. As a national accreditation entity recognized by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 CFR 422.158, URAC can offer its accredited organizations some "deeming" under the Medicaid Managed Care Regulations (i.e., 42 CFR 438.200 et seq.) and can serve as a supplemental resource to state Medicaid agencies seeking to contain administrative costs.

The Guide contains a crosswalk that maps URAC Accreditation standards to the federal Medicaid Managed Care Regulations (i.e., 42 CFR 438.200 et seq.) and references relevant CMS protocols. In particular, the crosswalk highlights where there is duplication between URAC standards and CMS regulations addressing Access to Care (i.e., 42 CFR §§ 438.206, 438.207, 438.208 and 438.210), Structure and Operations (i.e., 42 CFR §§ 438.214, 438. 218, 438.224, 438.226, 438.228 and 438.2300), and Quality Measurement and Improvement (i.e., 42 CFR §§ 438.236, 438.240 and 438.242). An "operational review" for compliance with these regulations constitutes one of the mandatory EQR activities required by 42 CFR 438.358, promulgated pursuant to Balanced Budget Act of 1997. Where duplication exists with the regulations subject to operational review, states may use the information from a URAC accreditation review to show EQR compliance.

URAC Accreditation Standards are comparable to 81% of the regulatory standards subject to operational review under the mandatory External Quality Review activities.

CMS requires state Medicaid quality strategies to identify the regulatory standards for which the EQR will use information from private accreditation reviews (i.e., 42 CFR 438.360). URAC encourages state Medicaid agencies to review the materials in this Guide and evaluate how URAC Accreditation can help states meet their quality goals.

BACKGROUND: MEDICAID MANAGED CARE OVERSIGHT

States generally rely on MCOs and Prepaid Inpatient Health Plans (PIHPs) in order to deliver health care services to Medicaid managed care beneficiaries. The Balanced Budget Act of 1997

(BBA) mandated that states ensure the delivery of quality health care by all their Medicaid managed care contractors by participating in an EQR process. The BBA specified three mandatory EQR activities:

(1) Validation of performance improvement projects undertaken by an MCO/PIHP;

(2) Validation of performance measures produced by an MCO or PIHP; and

(3) An "operational review", conducted within the past three years, to determine MCO/PIHP compliance with federal Medicaid managed care regulations.

42 CFR 438.358
(a) General rule. The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.

(b) Mandatory activities. For each MCO and PIHP, the EQR must use information from the following activities:

(3) A review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards (except with respect to standards under Sec. 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of Sec. 438.204(g).

42 CFR 438.204
At a minimum, State strategies must include the following:
(g) Standards, at least as stringent as those in the following sections of this subpart [Subpart D], for access to care, structure and operations, and quality measurement and improvement.

These mandatory EQR activities (42 CFR 438.358) must be consistent with CMS published protocols (http://www.cms.hhs.gov/MedicaidManagCare/), and may be completed by one or more entities. A single external quality review organization (EQRO) must prepare the annual report for submission through the State Medicaid Agency to CMS, which requires an EQRO Annual Report for each state contracted Medicaid MCO and Medicaid PIHP.

In recognition of the similarities between government requirements and private accreditation standards, the CMS "non-duplication" regulation (42 C.F.R. 438.360) provides authority for states to use information obtained from a private accreditation review to demonstrate compliance with the third EQR activity listed above -- an operational review for compliance with federal Medicaid managed care regulations addressing:

- Access to Care (42 CFR §§ 438.206, 438.207, 438.208 and 438.210);
- Structure and Operations (42 CFR §§ 438.214, 438. 218, 438.224, 438.226, 438.228 and 438.2300); and
- Quality Measurement and Improvement (42 CFR §§ 438.236, 438.240 and 438.242).

42 CFR 438.360
(a) General rule. To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specified in Sec. 438.358 if the conditions of paragraph (b) or paragraph (c) of this section are met.

(b) MCOs or PIHPs reviewed by Medicare or private accrediting organizations. For information about an MCO's or PIHP's compliance with one or more standards required under Sec. 438.204(g), (except with respect to standards under Sec. 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) the following conditions must be met:

(1) The MCO or PIHP is in compliance with standards established by CMS for Medicare+Choice or a national accrediting organization. The CMS or national accreditation standards are comparable to standards established by the State to comply with Sec. 438.204(g) and the EQR-related activity under Sec. 438.358(b)(3).

(2) Compliance with the standards is determined either by--

(i) CMS or its contractor for Medicare; or

(ii) A private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in Sec. 422.158.

(3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare or private accreditation review applicable to the standards provided for in Sec. 438.204(g); and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the standards for which the EQR will use information from Medicare or private accreditation reviews, and explains its rationale for why the standards are duplicative.

As a private national accrediting organization recognized by CMS pursuant to 42 CFR 422.158 (Fed. Reg. Vol.71, No. 102, p. 30422-23; Friday, May 26, 2006), with accreditation standards comparable to the federal Medicaid managed care regulatory standards, URAC meets the conditions of the “non-duplication” regulation. This Guide maps URAC standards to the federal regulations and provides states with a tool to use information from URAC accreditation reviews in their EQR activities.

OVERVIEW OF URAC

Incorporated in 1990, URAC is an independent, nonprofit organization whose mission is to promote continuous improvement in the quality and efficiency of healthcare management through the processes of accreditation and education. To support this goal, our Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers’ compensation carriers and regulators.

URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer more than 25 accreditation and certification programs across the health care spectrum:

- Case Management
- Claims Processing
- Consumer Education and Support
- Core Organizational Quality
- Credentialing Support
- Credential Verification Organization
- Disease Management
- Drug Therapy Management
- Health Call Center
- Health Content Provider
- Health Network
- Health Plan
- Health Provider Credentialing
- Health Utilization Management
- Health Web Site
- HIPAA Privacy
- HIPAA Security
- Independent Review Organization
- Mail Service Pharmacy
- Medicare Advantage Deeming
- Pharmacy Benefit Management
- Specialty Pharmacy
- Vendor Certification
- Wellness
- Workers' Compensation Pharmacy Benefit Management
- Workers' Compensation Utilization Management

Many states have found URAC's accreditation standards helpful in meeting regulatory requirements for managed care plans and other health care organizations and functions. Thirty-eight states and the District of Columbia currently recognize one or more of URAC's accreditation programs to satisfy state requirements, making URAC the most recognized national accreditation body at the state level. In the Medicaid sector, several states recognize URAC accreditation standards (e.g., Health Plan, Health Network, Health Utilization Management and Disease Management Accreditation Standards) through references in statutes, regulations, requests for proposals and contract language. (For further details, see the documents posted at http://www.urac.org/policyMakers/resources/governmentRecognition.aspx.)

At the federal level, four federal agencies recognize URAC accreditation. CMS recognizes URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC Health Network Accreditation, Disease Management Accreditation, Health Utilization Management Accreditation and Case Management Accreditation; and the Department of Veterans' Affairs recognizes URAC's Health Call Center Accreditation.

URAC Standards Development

URAC accreditation serves as a symbol of excellence in the health care industry, promoting prevailing industry standards and consumer protections. In the rapidly evolving field of health care, URAC standards are developed through a dynamic process that identifies best practices and promotes high quality performance measurement. All stakeholders in the health care arena actively participate with URAC in developing these quality benchmarks through an inclusive process that incorporates an opportunity for public comment.

URAC's standards development process begins with a period of careful research, debate and discussion among stakeholders. An initial set of standards is then proposed and made available for a public comment and review. URAC's Standards Committee reviews the submitted comments, makes appropriate changes, and the draft standards are then beta tested with a discrete group of companies in order to ensure that they work in practice. After beta testing, the standards may be modified again, and then they are forwarded to URAC's Board of Directors for consideration and approval. URAC revises its standards at least every two years.

URAC Accreditation Review Process

The URAC accreditation review process begins with applicants for accreditation submitting material through AccreditNet, URAC's secure online application system. When an application arrives, a reviewer is assigned to conduct an assessment of the submitted documentation for compliance with URAC standards. Any standard that appears non-compliant is noted and communicated to the client with a recommended course of action to meet the standard. Then an onsite review is conducted for each applicant.

URAC staff reviewers are clinical experts who provide application support through the entire accreditation process, including a sharing of best practices during the onsite review. The objective of the onsite review is to verify operational compliance with URAC standards. URAC reviewers, for example, interview the applicant's staff and review a statistically valid sampling of relevant documentation, including specific quality information. With respect to quality data, URAC accepts nationally recognized measures, such as HEDIS measures to evaluate plan performance and CAHPS data to evaluate consumer satisfaction. URAC may also consider other credible, CMS-recognized quality measures such as the Wisconsin MEDDIC-MS and MEDDIC-MS SSI Performance Measures.

The findings from an applicant's onsite review are anonymously presented to the URAC committees that make the accreditation determinations through an Executive Summary report. Committee members include industry peers and experts such as physician providers, plan physicians, quality management professionals, information technology experts, pharmacists and security/privacy officials. Levels of accreditation are awarded in accordance with corporate policy and URAC's accreditation scoring methodology. Applicants receive an official notification letter with their accreditation status and a certificate of accreditation.

DUPLICATION POTENTIAL: COMPARABILITY OF URAC STANDARDS AND MEDICAID EQR REQUIREMENTS

The following charts illustrate the comparability between URAC accreditation standards and federal Medicaid managed care requirements. These requirements are highlighted in the attached crosswalk as having "duplication potential" pursuant to 42 CFR 438.360. The methodology for calculating the duplication potential is also presented below.

Summary: Comparability of URAC Standards and Medicaid EQR Regulations

Access to Care (42 CFR 438.206, 207, 208, 210)	**83%** of the federal requirements are comparable to URAC standards
Structure and Operations (42 CFR 438.214, 218, 224, 226, 228, 230)	**89%** of the federal requirements are comparable to URAC standards
Measurement and Improvement (42 CFR 438.236, 240, 242)	**70%** of the federal requirements are comparable to URAC standards
All Deemable Regulations (see above)	**81%** of the federal requirements are comparable to URAC standards

Methodology:
The charts presented provide a graphic representation of the extent to which URAC standards duplicate the deemable Medicaid managed care regulations in three areas: Access to Care, Structure and Operations, and Measurement and Improvement. The duplication potential is reported at the top of each chart as the percentage of federal regulations having a parallel URAC accreditation standard that partially or fully meets the intent of the regulation.

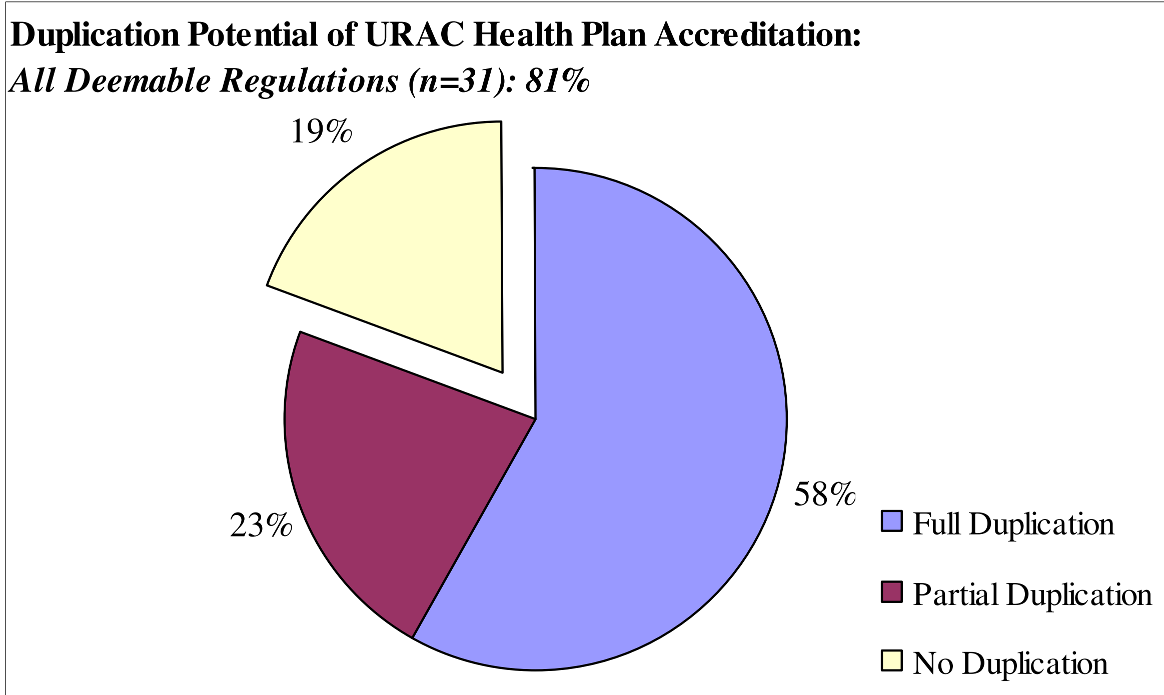
URAC quantified the applicable deemable regulations by section (e.g., 42 CFR 438.210b). URAC then examined the number of elements within each section duplicated by URAC Health Plan accreditation standards. For example, 42 CFR 438.210(b) contains two elements:

> 438.210(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must include:
>
> **(1)** That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.
> **(2)** That the MCO, PIHP, or PAHP
> (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
> (ii) Consult with the requesting provider when appropriate.

URAC Standard Core 3 and Core 17(b) meet element (1), while URAC Standard Core 8, 9, 11, and 12 and URAC Standard HUM 10, 13, and 15 together meet element (2); resulting in full duplication for 42 CFR 438.210(b). If URAC standards duplicated some but not all elements in a section, URAC considered this partial duplication.

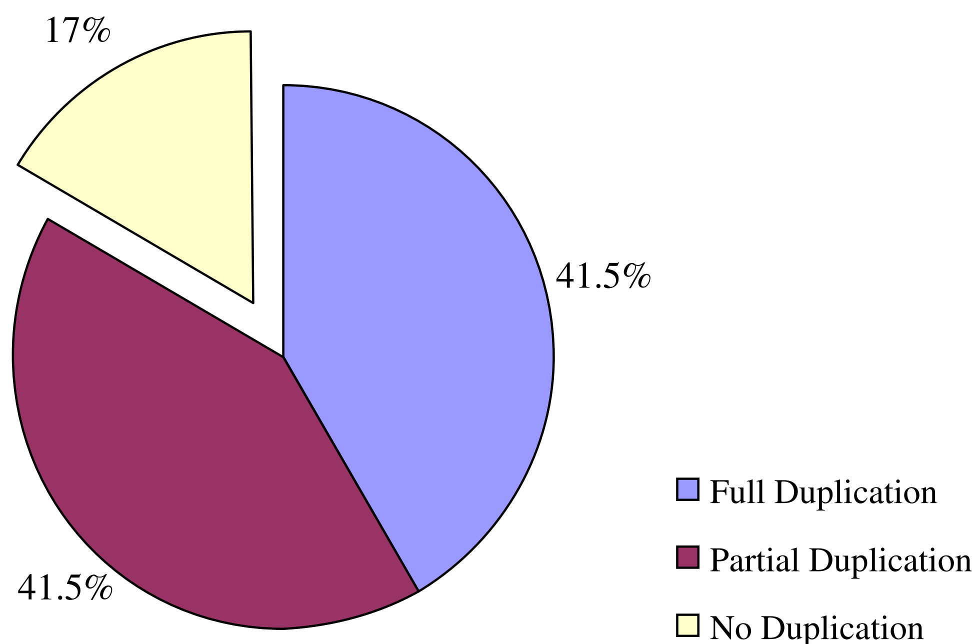
Within each deemable area, some regulatory requirements are marked “not applicable” in the duplication column of the attached crosswalk. These federal requirements apply to the state Medicaid agency rather than the MCO and are thus excluded from the duplication potential calculations. (URAC standards apply to the managed care entity.)

COMPARABILITY OF URAC STANDARDS AND MEDICAID EQR REGULATIONS



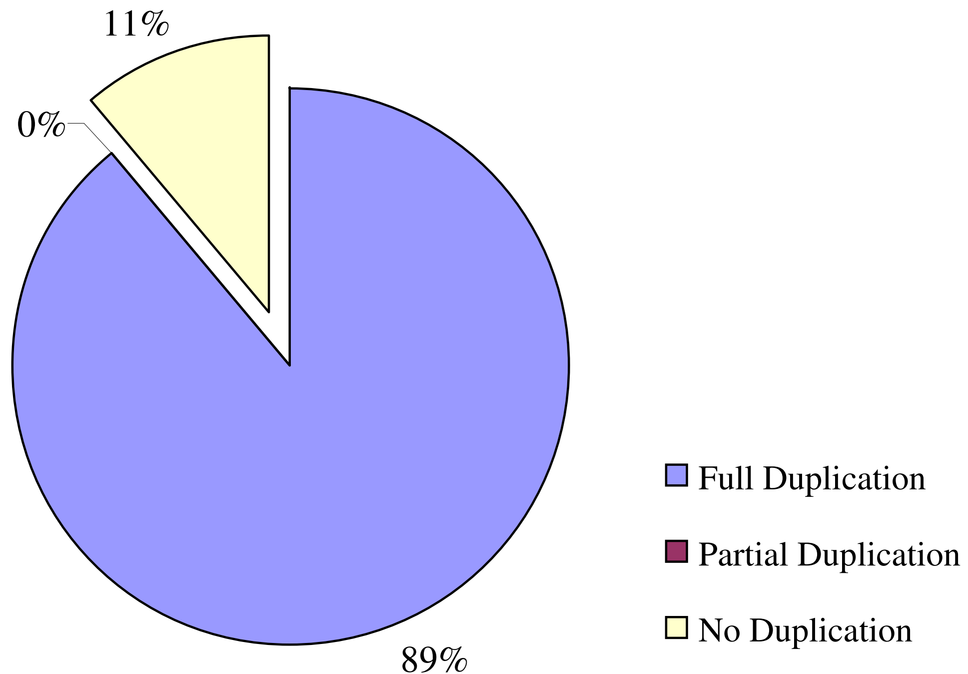
URAC Accreditation Standards are comparable to 81% of the regulatory standards subject to operational review under the mandatory External Quality Review activities. URAC standards are comparable to 7 of the 31 deemable regulations, and fully duplicative of 18 regulations. The six regulatory sections for which URAC does not currently have a specific standard most often refer to state reporting requirements covered implicitly by URAC Core 19: Regulatory Compliance. (This standard requires accredited managed care organizations to maintain a regulatory compliance program that tracks applicable laws and regulations in the jurisdictions where the organization conducts business and monitors the organization's compliance.)

COMPARABILITY OF URAC STANDARDS AND MEDICAID EQR REGULATIONS



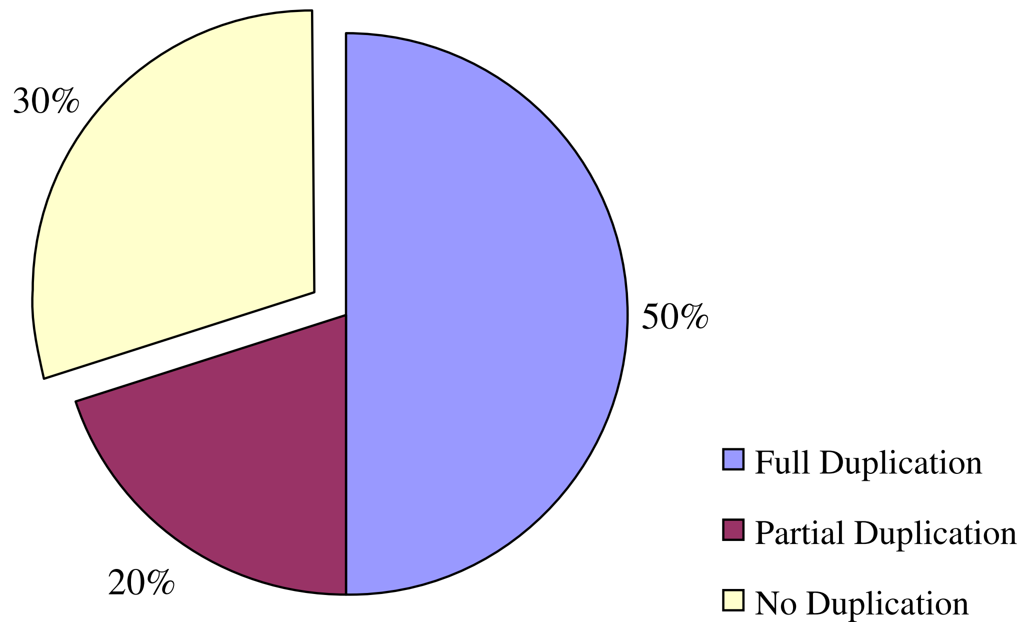
URAC Accreditation Standards are comparable to 83% of the Access to Care standards subject to operational review under the mandatory External Quality Review activities. URAC standards are comparable to five of the 12 deemable Access to Care regulations, and fully duplicative of five regulations. URAC's Core, Network Management, and Provider Credentialing standards mirror the access regulations, addressing emergency and out of network services, provider contracts and credentialing, and enrollee communication practices. URAC's Health Utilization Management standards also meet the enrollee protections in this area. (42 CFR 438.206(a), 438.207(d), 438.207(e), and 438.208(a) are not applicable.)

COMPARABILITY OF URAC STANDARDS AND MEDICAID EQR REGULATIONS



URAC Health Plan Accreditation is fully duplicative of 89 percent of the Structure and Operations regulations. The high potential for duplication in this area reflects the strength of URAC's Core Standards, the foundation for all URAC accreditation programs. The Core standards touch all levels of the managed care organization to ensure effective management, adherence to industry best practices, and oversight of providers and delegated functions. (42 CFR 438.218, 438.226, and 438.228(b) are not applicable.)

COMPARABILITY OF URAC STANDARDS AND MEDICAID EQR REGULATIONS



URAC Accreditation Standards are comparable to 70% of the Measurement and Improvement standards subject to operational review under the mandatory External Quality Review activities. URAC standards are comparable to two of the 10 deemable Measurement and Improvement regulations, and fully duplicative of five regulations. URAC's Quality Improvement Project (QIP) Standards (Core 29-35 and P-QM 1 and 2) are particularly pertinent. All URAC accredited health plans are required to complete three QIPs. Two QIPs must focus on clinical quality, and the final QIP must relate to consumer protection/safety. QIPs must address quantifiable outcomes measured at the baseline and periodically to determine performance. (42 CFR 438.236(a) is not applicable.)

THE CROSSWALK:
EXTERNAL QUALITY REVIEW AND URAC STANDARDS

URAC designed the *Federal Medicaid Managed Care Regulations (42 CFR 438.200 et seq.) Crosswalk to URAC Health Plan Standards (Version 5.1)* to illustrate the comparability between the regulations and URAC standards. This tool provides state Medicaid agencies with the information necessary to incorporate URAC Accreditation into their state quality strategies, pursuant to the CMS "non-duplication" regulation (42 CFR 438.360).

The Crosswalk maps the federal Medicaid Managed Care regulations (Column I) to URAC standards (Column II). Specific matches, where duplication exists, are highlighted in Column IV as "Duplication Potential." The Crosswalk also features "Sample Documentation and Onsite Survey Questions" (Column III) used by URAC reviewers when evaluating accreditation applicants for compliance with URAC standards. (Appendix D contains "Sample Documentation and Onsite Survey Questions" for all the URAC standards which are duplicative of specific regulatory requirements.) In addition, Column III includes references to relevant CMS protocols.

EXCERPT: MEDICAID MANAGED CARE REGULATIONS CROSSWALK TO URAC HEALTH PLAN STANDARDS

Federal Medicaid Managed Care Regulations	Related URAC Health Plans Standards (Version 5.1) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.206 Availability of services.**	**ACCESS TO CARE STANDARDS: DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 112-122)	
438.206(b) Delivery network. The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements: (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP, and PAHP must consider the following: (i) The anticipated Medicaid enrollment.	**Core 19 – Regulatory Compliance** **Core 25 – Access to and Monitoring of Services** **P-NM 1 – Scope of Services** **P-NM 2 – Provider Network Access and Availability** **P-NM 3 – Provider Selection Criteria -- See P-NM (c)** **P-NM 7 – Participating Provider Written Agreements** **P-NM 9 – Written Agreement Inclusions** **P-MR 2 – Consumer Information Disclosure -- See P-MR 2(a)**	**RESOURCE:** **CMS Protocol 7B** (pages 115-118) **Core 25** **Documents:** • Policies addressing consumer and client access to program services • Sample meeting minutes where data related to access to program services is shared with the relevant QM or departmental committee. **Interview Questions** 1. Management interviews to discuss consumer and client access to program services with management.	Core 25, P-NM 1, P-NM 2, P-NM 3 and P-NM 7 meet 438.206(b)(1)

Crosswalk Key:

Deemable Regulation

Specific Duplication Potential

Deeming authority for Mandatory EQR Activities

Appendix A

SUMMARY TABLE:
COMPARABILITY OF URAC STANDARDS AND MEDICAID EQR REQUIREMENTS

Regulation	Elements Duplicated	Duplication Potential
Access to Care Regulations		
438.206(a)	N/A	N/A
438.206(b)	3/6	Partial
438.206(c)	1/2	Partial
438.207(a)	1/1	Full
438.207(b)	2/2	Full
438.207(d)	N/A	N/A
438.207(e)	N/A	N/A
438.207(c)	0/2	No
438.208(a)	N/A	N/A
438.208(b)	1/4	Partial
438.208(c)	0/4	No
438.210(a)	.33/3	Partial
438.210(b)	3/3	Full
438.210(d)	1/2	Partial
438.210(e)	1/1	Full
438.210(c)	1/1	Full
Structure and Operations Regulations		
438.218	N/A	N/A
438.224	1/1	Full
438.226	N/A	N/A
438.214 (c)	1/1	Full
438.214(a)	1/1	Full
438.214(b)	2/2	Full
438.214(d)	0/1	No
438.214(e)	1/1	Full
438.228(a)	1/1	Full
438.228(b)	N/A	N/A
438.230(a)	1/1	Full
438.230(b)	4/4	Full
Measurement and Improvement Regulations		
438.236(a)	N/A	N/A
438.236(b)	3/4	Partial
438.236(d)	0/1	No
438.236(c)	1/1	Full
438.240(a)	2/2	Full
438.240(d)	2/2	Full
438.240(e)	1/1	Full
438.240(c)	0/3	No
438.242(a)	1/1	Full
438.242(b)	0/3	No
438.240(b)	2/4	Partial

Appendix B

CMS PROTOCOL BIBLIOGRAPHY AND KEY

CMS Protocol	Code
Conducting Focused Studies of Health Care Quality: A Protocol for Use in Conducting Medicaid External Quality Review Activities/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocol: *Conducting Focused Studies of Health Care Quality*	**1**
Information Systems Capabilities Assessment for Managed Cared Organizations and Prepaid Health Plans: An Appendix to the External Quality Review Activity Protocols/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocol: *Information Systems Capabilities Assessment*	**2**
Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocol: *Conducting Performance Improvement Projects*	**3**
Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocol: *Validating Performance Improvement Projects*	**4**
Calculating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocol: *Calculating Performance Measures*	**5**
Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human	**6**

Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocol: *Validating Performance Measures*	
Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al./ Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (February 11, 2003) CMS Protocol: *Monitoring MCOs and PIHPs*	**7**
"Monitoring - Attachment A: Summary of Compliance Determination Activities of Public and Private Quality Oversight Organizations;" *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al./ Version 1.0*; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (February 11, 2003) CMS Protocol/Monitoring Attachment A: *Summary of Compliance Determination Activities*	**7A**
"Monitoring - Attachment B: Compliance Determination Activities for Individual Regulatory Provisions;" *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al./ Version 1.0*; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (February 11, 2003) CMS Protocol/Monitoring Attachment B: *Compliance Determination Activities*	**7B**
"Monitoring - Attachment C: Sample Documentation and Reporting Tool for Recording MCO/PIHP Compliance with Medicaid Managed Care Regulatory Provisions;" *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al./ Version 1.0*; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (February 11, 2003)	**7C**

CMS Protocol/Monitoring Attachment C: *Sample Documentation and Reporting Tool*	
Administering or Validating Surveys: Two Protocols for Use in Conducting Medicaid External Quality Review Activities/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocols: *Administering or Validating Surveys*	**8**
Validating Encounter Data: A Protocol for Use in Conducting Medicaid External Quality Review Activities/Version 1.0; Centers for Medicare and Medicaid Services, Department of Health & Human Services; OMB Approval No. 0938-0786 (May 1, 2002) CMS Protocol: *Validating Encounter Data*	**9**
State External Quality Review Tool Kit for State Medicaid Agencies; Division of Quality, Evaluation and Health Outcomes, Centers for Medicaid and State Operations, Centers for Medicare and Medicaid Services, Department of Health & Human Services (October 2006) CMS 2006 State External Quality Review Tool Kit	**10**
Return on Investment Forecasting Calculator; Center for Health Care Strategies CHCS ROI Forecasting Calculator	**11**