

2012 EXTERNAL QUALITY REVIEW (EQR) PROTOCOLS

APPENDIX III: EQR GLOSSARY OF TERMS

Acceptable Error Rate: The maximum percentage of missing, surplus, or erroneous records that the State accepts.

Algorithm: A specific set of instructions for carrying out a procedure or solving a problem.

Bias: A systematic distortion in data collection, analysis, or reporting of research findings.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA): Reauthorizes the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIPRA ensures that States may continue their existing CHIP programs and provides funding to cover additional low-income children, including children eligible for CHIP or Medicaid but not currently enrolled. It also establishes authority for CMS to support States in improving quality of care for children in Medicaid and CHIP by establishing an initial core set and then enhanced voluntary quality measures.

Claims Data: See "Encounter Data"

Confidence Level: The likelihood, expressed as a percentage that a sample finding is true for the population from which the sample was taken. A 95 percent confidence interval indicates a 5 percent chance that the sample result is due to chance and is not true for the population.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): A public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

Compliance Review: A process to determine the extent to which Medicaid and CHIP MCOs are complying with regulatory requirements at 42 C.F.R. Part 438, subparts D and E.

Correlation Coefficient: A statistical measure of the interdependence of two random variables, the value of which indicates how much a change in one variable is related to a change in the other variable. Correlation coefficients range in value from -1 to +1. A perfect positive correlation is +1 and a perfect negative correlation is -1. Zero indicates the absence of a relationship between the variables.

CPT codes: A coding system, defined in the American Medical Association publication Current Procedural Terminology, for medical procedures that is used for billing and quality measures.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0786. The time required to complete this information collection is estimated to average 1,591 hours per response for all activities, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

Data: Factual information, especially information organized for analysis or used to reason or make decisions.

Database Management System (DBMS): A set of computer programs that controls the creation, maintenance, and use of a database.

Denominator: Provides the general specifications of any clinical component that is the basis for inclusions and exclusions in the population to be considered in a measure; the number below the numerator as in a fraction.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): A comprehensive and preventive child health program for Medicaid enrollees under age 21 that includes periodic screening, vision, dental, and hearing services.

Edit Checks: A program instruction or subroutine that tests the validity of input in a data entry program.

Encounter Data: The electronic record of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid) when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provide the same type of information that is found on claim forms (e.g., UB-04 or CMS 1500), but not necessarily in the same format.

Erroneous Encounters: Encounters that occurred and are represented by an encounter record that contains incorrect data elements.

External Quality Review (EQR): The analysis and evaluation of aggregated information on quality, timeliness, and access to health services provided to Medicaid/CHIP enrollees by MCOs or their contractors.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth at 42 C.F.R. §438.354, for an organization to perform an EQR and/or other EQR-related activities as set forth in 42 C.F.R. §438.358.

Fee for Service: Payment method where physicians and other health care providers receive a fee for each service, such as an office visit, test, procedure, or other health care interaction.

Generalizability: The extension of findings and conclusions from a study sample to the population from which the sample was drawn.

Healthcare Effectiveness Data and Information Set (HEDIS®): A collection of standardized performance measures and their definitions designed to ensure that purchasers and consumers can reliably compare the performance of managed health care plans. The performance measures are related to public health issues such as cancer, heart disease, and asthma and also include well-child visits. HEDIS® is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA).

Indicator: Easily identified features of a society which can be measured, which vary over time, and are taken as revealing some underlying aspect of social reality.

Information System Capabilities Assessment (ISCA): Assessment of the desired capabilities of the MCO's information system which poses standard questions used to assess the strength of the system; this provides information to the EQRO about the extent to which the information system is capable of producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its beneficiaries.

Managed Care Organization (MCO): Includes all managed care organizations, including PIHPs under a Medicaid and/ or CHIP program. While multiple legal definitions of MCO appear in various regulatory and legislative requirements, the term MCO in these EQR protocols refers only to those managed care organizations that are subject to external quality review.

Margin of Error: A statistic expressing the amount of random sampling error in a survey's results. The larger the margin of error, the less faith one should have that the sample result is the true population value.

Measure: A standard used for valuing, ascertain the extent or quantity of something.

Missing Encounters: Encounters that occurred but are not represented by an encounter record.

Non-probability sampling: Selecting the sample based on the decisions of those administering the study, and not on random chance

Numerator: In reference to the larger population of patients, the number of patients in a study meeting the specifications of a clinical component in a measure.

Pay for Performance: An emerging movement in healthcare, in which providers and sometimes MCOs are rewarded for quality of healthcare services.

Performance Improvement Projects (PIPs): A process/project to assess and improve processes, thereby improving outcomes of healthcare.

Performance Measure: The specific representation of a process or outcome that is relevant to the assessment of performance; it is quantifiable and can be documented.

Probability sampling: A sampling method that allows for specifying for each case in the population the probability of its inclusion in the sample; to select a sample that is representative as possible of the population.

Quality: The degree to which the MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six

domains of quality, as specified by the Institute of Medicine (IOM) – efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

Quality Assurance Plan: Plan that includes processes to monitor, evaluate and review all aspects of the survey administration procedure. The purpose of a quality assurance plan is to document a strategy of reviews and audits to assure that the appropriate processes are being followed correctly; a document to ensure the final products are of the upmost quality; the quality.

“Real” Improvement: A measurable, statistically significant change in performance related to an intervention.

Reliability: 1) The internal consistency of a study instrument, and 2) The reproducibility of study results when the survey or intervention is administered under different conditions (e.g., by different people, or at different times).

Sample: A subset selected from a population.

Sample Frame: The population from which the sample will be drawn; a list of all members of the study population eligible for the study which is used to select the sample.

Sampling Plan: How an unbiased subset of the population (a sample) will be identified and how data from that sample will be collected, striving to have the sample be as representative of the overall population as possible.

State Regulation: A rule or order promulgated by a State prescribing what can and cannot be done. They are the enactment of policy determinations.

State Requirement: That which is obligatory and must be performed; generally considered important and necessary.

Standard: A reference point, generally the ideal, against which other things can be evaluated; the model of authority or excellence.

Study Population: A group of individuals taken from the general population to be included in the study.

Surplus Encounters: Encounters for which an encounter did not occur or which duplicated other records.

Study Question: Identifies the focus of the study and sets the framework for data collection, analysis, and interpretation.

Sustained Improvement: Changes in the fundamental processes of health care delivery demonstrated through repeated measurements over comparable time periods.

Unit of Analysis: The entity that is being studied during data analysis; it is the “what” or “whom” that is being studied.

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Validity: The degree to which a tool measures what it is intended to measure.

Variable: A characteristic or condition that changes or has different values for different individuals.