2008

MO HealthNet Managed Care Program

External Quality Review

Report of Findings

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Contract Number: C301154801, Amendment 007

Review Period: January 1, 2008 to December 31, 2008

Draft Submitted on: October 1, 2009

Final Copy Submitted on: December 1, 2009

Submitted by: Behavioral Health Concepts, Inc.

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LIST OF ACRONYMS

BA+	Blue-Advantage Plus of Kansas City
BHO	Behavioral Health Management Organization
CAHPS	Consumer Assessment of Health Plans Survey
CDC	Centers for Disease Control and Prevention
Chi-square	A statistical test that is used to examine the probability of a change or difference in rates is due to chance.
CI	Confidence Interval
CMFHP	Children's Mercy Family Health Partners
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
CPT	Current Procedural Terminology
CY	Calendar Year
DHHS	U.S. Department of Health and Human Services
DHSS	Missouri Department of Health and Senior Services
DSS	Missouri Department of Social Services
EPSDT	Early, Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	MO HealthNet Fee-for-Service
HARMONY	Harmony Health Plan
HCUSA	Healthcare USA
HCY	MO HealthNet Healthy Children and Youth, the Missouri Medicaid EPSDT program
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act

HIS	Health Information Systems
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, Ninth Revision, Clinical Modification, World Health Organization
ICN	Internal Control Number
ISCA	Information Systems Capability Assessment
LPHA	Local Public Health Agency
MBE	Minority-owned Business Enterprise
MC+	The name of the Missouri Medicaid Program for families, children, and pregnant women, prior to July 2007.
MC+ MCOs	Missouri Medicaid Program Managed Care Organizations (prior to July 2007)
MCHP	Managed Care Health Plan
MCO	Managed Care Organization
MCP	Mercy CarePlus
MDIFP	Missouri Department of Insurance, Financial Institutions and Professional Registration
MMIS	Medicaid Management Information System
MO HEALTHNET	The name of the Missouri Medicaid Program for families, children, and pregnant women.
MO HealthNet MCHPs	Missouri Medicaid Program Managed Care Health Plans
MOHSAIC	Missouri Public Health Integrated Information System
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee for Quality Assurance
N.S.	Not significant, indicating that a statistical test does not result in the ability to conclude that a real effect exists.
NSF/CMS 1500	National Standard Format/ Center for Medicare and Medicaid Services Form 1500

PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PRO	Peer Review Organization
QA & I	MO HealthNet Managed Care Quality Assessment and Improvement Advisory Group
QI/UM Coordinator	Quality Improvement/Utilization Management Coordinator
SMA	State Medicaid Agency, the Missouri Department of Social Services, MO HealthNet Division
SPHA	State Public Health Agency, the Missouri Department of Health and Senior Services
UB-92	Universal Billing Form 92

GLOSSARY AND OPERATIONAL DEFINITIONS

Administrative Method	The Administrative Method of calculating HEDIS Performance Measures requires the MCHP to identify the denominator and numerator using transaction data or other administrative databases. The Administrative Method outlines the collection and calculation of a measure using only administrative data, including a description of the denominator (i.e., the entire eligible population), the numerator requirements (i.e., the indicated treatment or procedure) and any exclusion(s) allowed for the measure.
Accuracy (Match) Rate	The ratio of identical or correct information in the medical record and the SMA relative to the number of encounters that took place.
Accuracy of a data field	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alpha numeric) in the proper format (e.g., mm/dd/yyyy for date field).
Accuracy of the State encounter claims database	The extent to which encounters are being submitted for 100 percent of the services that are provided. [1]
Commission (or surplus encounter claim)	An encounter that is represented in the SMA encounter claims database but not the medical record; or a duplicate encounter.
Completeness of a data field	The extent to which an encounter claim field contains data (either present or absent).
Confidence interval or level	The range of accuracy of a population estimate obtained from a sample.

[1] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition

Encounter data	"Encounter data are records of health care services that have been provided to patients." [2]
Error	An error in coding or recording an encounter claim.
Fault (Error) Rate	The ratio of missing and erroneous records relative to the total number of encounters that took place[3]. The rate at which the SMA encounter claims data does not match the medical record or the MCHP paid encounter claims data (the converse of match rate).
Hybrid Method	Hybrid Method requires the MCHP to identify the numerator through both administrative and medical record data. The MCHP reports a rate based on members in the sample who are found through either administrative or medical record data to have received the service identified in the numerator.
Interrater reliability (IRR)	A method of addressing the internal validity of a study by ensuring that data are collected in a consistent manner across data collectors.
Omission (or missing encounter claim)	An encounter that occurred but is not represented in the State encounter claims database.
Paid claim	An encounter claim that has been paid by the MCHP.

[2] Medstat (1999).: A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data. Medstat: Santa Barbara. Second Edition

[3] Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in conducting Medicaid External Quality Review activities, Final Protocol, Version 1.0, U.S. Department of Health and Human Services.

Probability sample	A sample in which every element in the sampling frame has a known, non-zero probability of being included in a sample. This produces unbiased estimates of population parameters that are linear functions of the observations from the sample data[4].
Random sample	Selection of sampling units from a sampling frame where each unit has an equal probability of selection.
Reasonableness of a data field	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date); also referred to as validity of the data.
Reliability	The consistency of findings across time, situations, or raters.
Sampling frame	The population of potential sampling units that meet the criteria for selection (e.g., Medical encounter claim types from January 1, 2004 through March 31, 2004).
Sampling unit	Each unit in the sampling frame (e.g., an encounter).
Simple sample	Selection of sampling units from one sampling frame.
Unpaid claim	All unpaid and denied claims from the MCHP; All claims not paid by the MCHP either through capitation or through other payment methodology.

[4] Levy, P.S., Lemeshow, S. (1999). Sampling of Populations: Methods and Applications, Third Edition. John Wiley and Sons: New York.

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1.0 EXECUTIVE SUMMARY

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I.1 Introduction

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by MO HealthNet Managed Care health plans (MCHPs) and their contractors to recipients of MO HealthNet Managed Care services. The Centers for Medicare and Medicaid Services (42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rule specifies the requirements for evaluation of Medicaid managed care programs. The present report summarizes the findings of the third year of implementation of the mandatory activities for External Quality Review of the MO HealthNet Managed Care Program in Missouri as conducted by Behavioral Health Concepts, Inc., a PRO-Like Entity certified by CMS to conduct External Quality Review (EQR) in all U.S. states and territories.

The State of Missouri contracts with the following MO HealthNet Managed Care health plans represented in this report:

- Molina Health Plan of Missouri (Molina)
  (Referred to as Mercy CarePlus (MCP) for all data prior to October 2008)
- HealthCare USA (HCUSA)
- Harmony Health Plan of Missouri (Harmony)
- Missouri Care (MOCare)
- Children's Mercy Family Health Partners (CMFHP)
- Blue-Advantage Plus of Kansas City (BA+)

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as described below:

1) Validating Performance Improvement Projects[5]

Each MO HealthNet Managed Care health plan (MCHP) conducted performance improvement projects (PIPs) during the 12 months preceding the audit; two of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division (MHD).

2) Validating Performance Measures[6]

The three performance measures validated were HEDIS 2008 measures of Adolescent Well Care Visits (AWC), Use of Appropriate Medications for People with Asthma (ASM), and Annual Dental Visit (ADV).

3) Validating Encounter Data[7] (optional activity)

Validation of Encounter Data examined the completeness, accuracy, and reliability of specific fields in the SMA database; and the extent to which paid claims in the SMA were represented in the medical records of MC+ Managed Care Members; and

4) MO HealthNet Managed Care health plan Compliance with Managed Care Regulations.[8]

The EQRO conducted all protocol activities, with the exception of the MCHP Compliance with Managed Care Regulations Protocol. The SMA conducted these activities and requested the EQRO to review them (Compliance Review Analysis).

[5] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[6] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Measures: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[7] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[8] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2003). 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 §400, 430, et al., Final Protocol, Version 1.0, February 11, 2003. Washington, D.C.: Author.

1.2 Preparation for the 2008 External Quality Review

Preparation with the State Medicaid Agency

Effective July 1, 2006 the State of Missouri contract for the External Quality Review of the MO HealthNet Managed Care Program (State of Missouri Contract No: C306122001, Amendment No.: 003) was revised to comply with federal requirements for states to contract with an external, independent entity to implement the mandatory protocols for External Quality Review. The first monthly meeting for planning the scope of work, technical methods and objectives, and analyses was held by the SMA in October 2008. Meetings were held with the SMA and the EQRO in January 2009, March 2009, April 2009, May 2009 and August 2009. Additional meetings and teleconference calls were conducted as needed between SMA and EQRO personnel.

At the first meeting in October 2008, the previous years' report was discussed and the plan for the 2008 audit was discussed. During the month of October, the EQRO clarified the SMA's objectives for each of the protocols, developed data requests, prepared detailed proposals for the implementation and analysis of data for each protocol, and prepared materials for SMA review. Written proposals for each protocol were submitted in November 2008 by the EQRO for review, discussion, revision, and approval. By December 2008, the EQRO had negotiated with the SMA the data request for State encounter data to be validated.

Preparation of MO HealthNet Managed Care Health Plans

During October 2008, preparation of MO HealthNet Managed Care health plans for the implementation of the 2008 EQR was conducted by the EQRO Project Director and personnel. To begin, the EQRO Project Director presented a timeline for project implementation and answered MCHP questions at the October 2008 MO HealthNet Managed Care QA&I Advisory Group meeting and MO HealthNet Managed Care All-Plan Meetings. The EQRO Project Director and personnel conducted orientation to the protocols and the EQR processes with each MO HealthNet Managed Care health plan on December 1 and 2, 2009.

The EQRO Assistant Project Director arranged the dates of the teleconference calls with health plan QI/UM Coordinators or Plan Administrators. A detailed presentation, tentative list of data requests, and the proposals approved by the SMA were sent to health plans prior to the

teleconference orientation sessions. MO HealthNet Managed Care health plans were requested to have all personnel involved in fulfilling the requests or in implementing activities related to the protocols (e.g., performance improvement projects to be validated, performance measures to be validated, encounter data requested) present at the teleconference calls. [The orientation presentation is contained in Appendix 1.] An SMA representative attended all conference calls and received minutes of the meetings taken by the EQRO upon completion of all the calls. To avoid confusion and the inundation of multiple requests at once, the requests for information from MO HealthNet Managed Care health plans were implemented in a staged approach from January 2009 through April 2009. All communications (letters, general and specific instructions) were submitted for review, revision, and approval by the SMA prior to sending them to the health plans.

Development of Worksheets, Tools, and Rating Criteria

The EQRO Project Director, Research Associate, Assistant Project Director, and a healthcare provider were responsible for modifying the worksheets and tools used by the EQRO during the 2007 and 2008 audit. The EQRO Assistant Project Director revised the worksheet (Attachment B) of the Validating Performance Improvement Project Protocol to add detail for several items that were specific to the MO HealthNet Managed Care Program.

For the Validating Encounter Data Protocol, the EQRO Project Director revised both the data analytic plan in collaboration with the SMA as well as methods and procedures based on the content, quality and format of data provided by the SMA and health plans. The SMA selected the fields to validate for completeness, accuracy, and reliability of paid claims submitted by MO HealthNet Managed Care health plans. The EQRO developed definitions of all field parameters for review, revision, and approval by the SMA. Encounter data critical field parameters were approved by the SMA via email in December 2008.

The Validating Performance Measures Protocol worksheets were revised and updated by the EQRO Project Director and Research Associate to reflect the Performance Measures selected for review for HEDIS 2008. The worksheets had been developed by Behavioral Health Concepts, Inc. staff during the previous year's audit.

The SMA continued to conduct the activities of the MO HealthNet Managed Care Compliance with Managed Care Regulations Protocol through the state contract compliance monitoring process and

the work of the EQRO involved the review and evaluation of this information (see Medicaid Program; External Quality Review of Medicaid Managed Care Organizations of 2003, CFR §438.58). The state contract for EQRO requires the review of SMA's activities with regard to the Protocol, however, additional policies and documents were requested prior to and during the on-site visits with health plans when information was incomplete or unclear. To facilitate the review of compliance with federal regulations, the EQRO Assistant Project Director revised a previously developed cross-walk between the SMA contract requirements for Medicaid managed care and the federal Medicaid Managed Care Regulations.

The MO HealthNet Managed Care Program consultant, who has participated in the EQRO for the past seven years, reviewed and refined the tool. Feedback on inconsistencies between the MO HealthNet Managed Care contract and federal requirements was provided immediately to the SMA. The EQRO utilized the rating system developed during the 2004 audit to provide ratings for each health plans' compliance. The SMA provided state compliance review information to the EQRO for all health plans from February 2009 through July 2009. The EQRO staff and the consultant reviewed all available materials and met with SMA staff to clarify SMA comments and compliance ratings; and identify issues for follow-up at site visits. Updates on MO HealthNet Managed Care health plan compliance were provided through July 2009 to ensure that the EQRO had up-to-date information prior to the beginning of the on-site reviews. Recommended ratings were provided to SMA which were approved for utilization in this report.

The following sections summarize the aggregate findings and conclusions for each of the mandatory protocols. The full report is organized according to each protocol and contains detailed descriptions of the technical methods, objectives, findings, and conclusions (strengths, areas for improvement, and recommendations). In addition, it provides health plan to health plan comparisons and individual MO HealthNet Managed Care health plan summaries for each protocol.

1.3 Validation of Performance Improvement Projects

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs for each MO HealthNet Managed Care health plan that were underway during 2008. A total of 12 PIPs were validated. Eligible PIPs for validation were identified by the health plans, SMA, and the EQRO. The final selection of the PIPs for the 2008 validation process was made by the SMA in December 2008. Below are the PIPs identified for validation at each Health Plan:

Molina HealthCare of Missouri	Members at High Risk of Cesarean Wound Infection Improving Adolescent Well Care
HealthCare USA	Readmission Performance Improvement Improving Adolescent Well Care
Missouri Care	Partnership to Improve WIC Participation & Increase Well Child Visit Rates Improving Adolescent Well Care
Children' Mercy Family Health Partners	Improving Dental Utilization Rates Improving Adolescent Well Care
Blue Advantage Plus	Ambulatory Follow-Up After Hospitalization for Mental Health Disorders Improving Adolescent Well Care
Harmony Health Plan	Lead Screening Improving Adolescent Well Care

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes, and/or the healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. Under the State contract for MO HealthNet Managed Care, Health Plans are required to have two active PIPs, one of which is clinical in nature and one non-clinical. Specific feedback and technical assistance was provided to each Health Plan by the EQRO during the site visits for improving study methods, data collection, and analysis.

ACCESS TO CARE

Access to care was a prominent theme throughout all of the PIP submissions reviewed.

- One specific PIP worked to impact needed improvement in access to dental care (Children's Mercy Family Health Partners);
- Two Health Plans focused on the availability of appropriate aftercare when there is a surgery or hospitalization (Molina HealthCare of Missouri, and HealthCare USA);
- Five of the Statewide PIP submissions focused on improving the access to adolescent well-care.
- All the projects reviewed utilized the format of the PIP to recognize improvements in access to care for members.
- One of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for mental health related issues (BA+).
- One PIP focused on improving preventive services through a community partnership that also enhanced member access to ancillary services (Missouri Care).
- One PIP focused on a key aspect of prevention (Harmony Health Plan).
- The on-site discussions with Health Plan staff indicate that they realize that improving access to care is an ongoing aspect of all projects that are developed.

The Statewide PIP was expanded to enable each Health Plan to address individual approaches to improving Adolescent Well Care. Five of these PIPs utilized interventions that informed or educated members about the availability of these services, and encouraged increased utilization of the health care services available.

QUALITY OF CARE

The Performance Improvement Projects reviewed exemplified the importance of providing quality health care to members. This was evident in the identification of the topics chosen for the clinical PIPs.

- Molina HealthCare of Missouri: The Health Plan recognized that reducing the number of members returning to the hospital with a wound infection after a Cesarean birth was of primary importance to them and their families. Members' risks were identified and interventions developed to reduce these risks;

- HealthCare USA: The Health Plan identified the need to reducing the number of hospital readmissions after surgery to decrease the negative impact on members and their families. Research surrounding this issue was cited and the Health Plan's response included interventions to clearly improve the quality of care for members at risk.
- Missouri Care: The Health Plan chose a project, in partnership with another community agency – the WIC program, to increase members' utilization of this resource, while improving the number of children obtaining Well Child Visits. The interventions improved the quality of care for members in preventive health care and resource availability.
- Children's Mercy Family Health Partners: This Health Plan attacked one of the most difficult problems for the population they serve, which is the availability of dental services. The PIP improved the availability of providers, and members' knowledge and utilization of services, which is significant in increasing their quality of care.
- Blue Advantage Plus: Improving access to aftercare services when a member has been hospitalized for a mental health disorder. The Health Plan employed diligent interventions to improve the availability of aftercare services to members to ensure that they receive appropriate outpatient treatment, including in-home services.
- Harmony Health Plan: The Health Plan attacked one of the primary prevention services, lead screening, in an effort to improve both physicians attention to this need, and members' education regarding the importance and availability of these screenings.

Each of these topics clearly focused on improving the quality of health care, as well as the quality of life, for members. The interventions utilized focused on internal and external processes to improve the quality and availability of health care and preventive services. These PIPs addressed barriers to quality care and health outcomes, and were designed to positively impact the members served. These interventions addressed key aspects of member care and services, such as medication and treatment management; risk identification and stratification for various levels of care; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

TIMELINESS OF CARE

Timeliness of care was not ignored as a crucial factor in the PIPs reviewed.

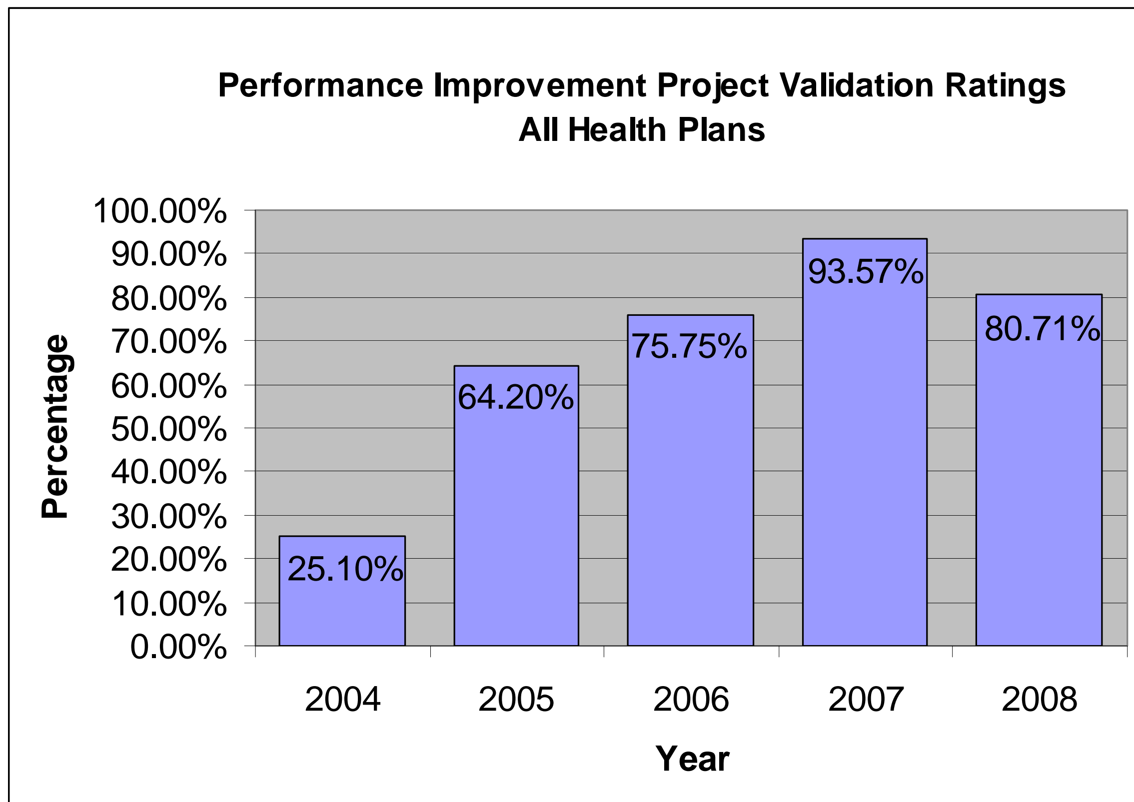
1. Three projects directly identified the need for timely aftercare for members who required inpatient hospitalization (Blue Advantage Plus, HealthCare USA, and Molina HealthCare of Missouri).
2. The remaining three projects focused on subjects such as timely utilization of preventive care (Missouri Care, and Harmony Health Plan), and improved access to dental services (Children's Mercy Family Health Partners). All of these projects identified the need for timely access to preventive and primary health care services as principal components for success.
3. The Health Plans related their awareness of the need to provide not only quality, but timely services to members as motivators for these projects. The Health Plans reflected this awareness in the way they addressed internal processes and direct service improvement.
4. Interventions included initiation of follow-up services prior to members leaving the hospital setting, authorization of in-home services, specific educational activities to improve self-care, and awareness of the advantages of utilizing preventive services.

Five of the PIPs, related to improving Adolescent Well Care, stress the importance of obtaining timely screenings in their interventions. The Health Plans recognize that this is an essential component of effective preventive care.

CONCLUSION

The Health Plans have made significant improvements in utilizing the PIP process since the current measurement process began in 2004. Figure 1 indicates the improvements the Health Plans have made in providing valid and reliable data for evaluation. An essential element in validating these projects is analyzing the projects ability to create sustained improvement. In 2004 this measure of the PIPs submitted was rated at 20% compliant. In 2008 this measure was rated at 100% for the projects mature enough to complete this evaluation. The Health Plans also exhibit the commitment to incorporating their successful Performance Improvement Projects into daily operations when the study process is complete. Examples of this can be found in the "Best Practice" section of this Executive Summary.

Figure 1 – Performance Improvement Project Validation Ratings, All Health Plans



1.4 Validation of Performance Measures

The Validating Performance Measures Protocol requires the validation or calculation of three performance measures at each MO HealthNet Managed Care health plan by the EQRO. The measures selected for validation by the SMA are required to be submitted by each health plan on an annual basis. The measures were also submitted by the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for all Managed Care Organizations (MCOs) operating in the State of Missouri. They were: (1) HEDIS 2008 Adolescent Well-Care Visit (AWC); and (2) HEDIS 2008 Use of Appropriate Medications for People with Asthma (ASM) (3) HEDIS 2008 Annual Dental Visit (ADV). Detailed specifications for the calculation of these measures were developed by the National Committee for Quality Assurance (NCQA), a national accrediting organization for managed care organizations. The EQRO examined the information systems, detailed algorithms, health plan extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol. The data reported to the SPHA was based on MO HealthNet Managed Care health plan performance during 2007.

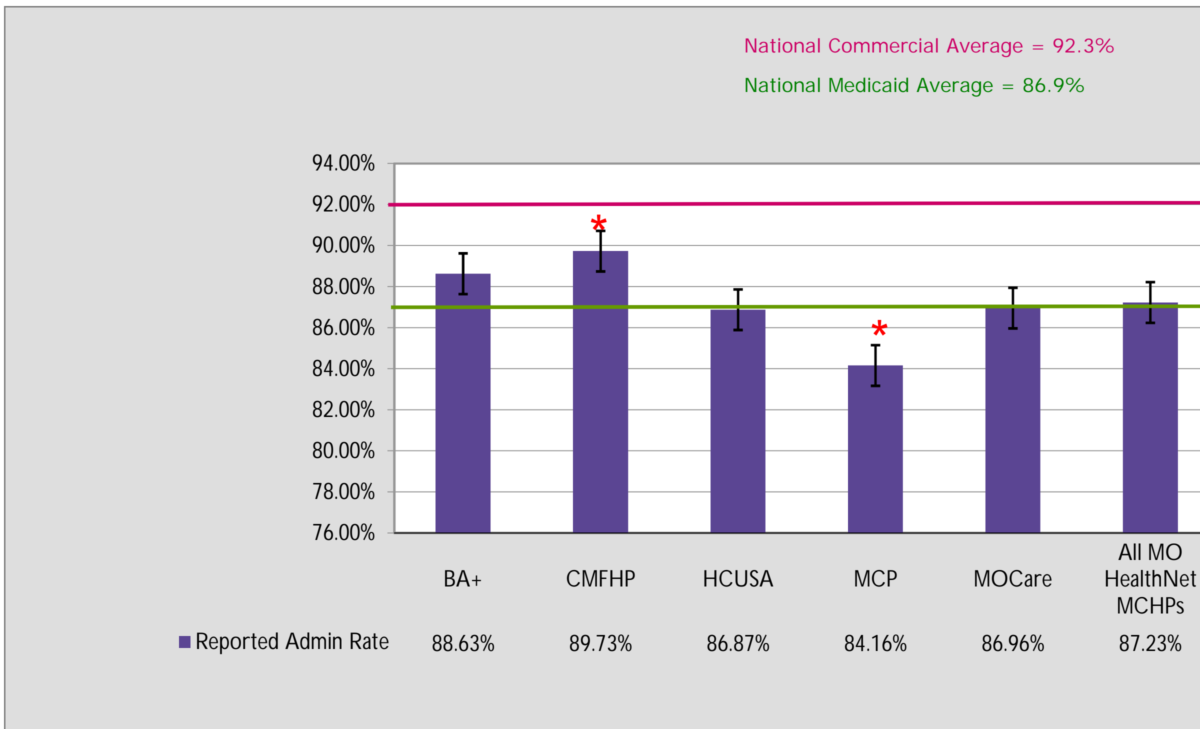
QUALITY OF CARE

The HEDIS 2008 Use of Appropriate Medications for People with Asthma measure is categorized as an Effectiveness of Care measure and is aimed at measuring the effectiveness/quality of care received by health plan members. Members must receive the appropriate medications on an ongoing basis to qualify for calculation in this measure.

Three MO HealthNet Managed Care health plans (Healthcare USA, Mercy CarePlus and Missouri Care) were substantially complaint with the specifications for calculation of this measure. Harmony Health Plan is not included in this evaluation as they did not have enough eligible members identified to meet the requirements for reporting this measure. The remaining two health plans (Blue-Advantage Plus of Kansas City and Children's Mercy Family Health Partners) did not report some of the necessary information for the EQRO to recalculate the measure and were therefore rated as not valid for the Asthma measure.

Four of the five MO HealthNet Managed Care health plan rates reported for the Use of Appropriate Medications for People with Asthma measure were close to or above the National Medicaid Average of 86.9% (BAPlus-88.63%, CMFHP-89.73%, HCUSA-86.87%, MOCare-86.96%). See Figure 1. The overall MO HealthNet Managed Care health plan average (87.23%) was also higher than the National Medicaid rate. None of the rates reported were higher than the National Commercial Rate of 92.3%.

Figure 2 – MO HealthNet Managed Care Program HEDIS 2008 Use of Appropriate Medications for People With Asthma

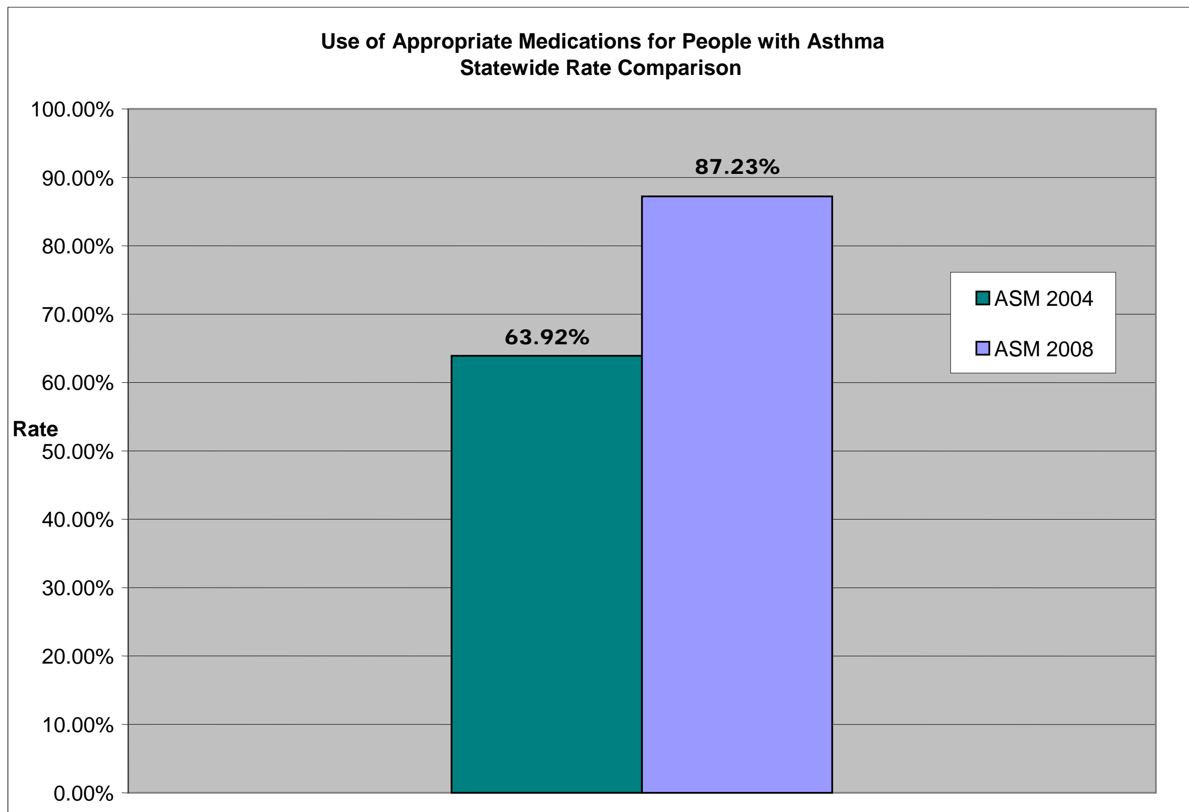


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2008 DST; National Committee for Quality Assurance (NCQA).

The EQRO last audited the Use of Appropriate Medications for People with Asthma measure in 2004; the health plans have shown a marked increase in the overall average rate over the past 4 years. This rate has increased from 63.92% in 2004 to 87.23% in 2008, an improvement of 23.31%. (See Figure 2.)

This shows significant improvement in the quality of care for asthma patients received by MO HealthNet Managed Care members in Missouri for the HEDIS 2008 measurement year.

Figure 3 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Use of Appropriate Medications for People With Asthma

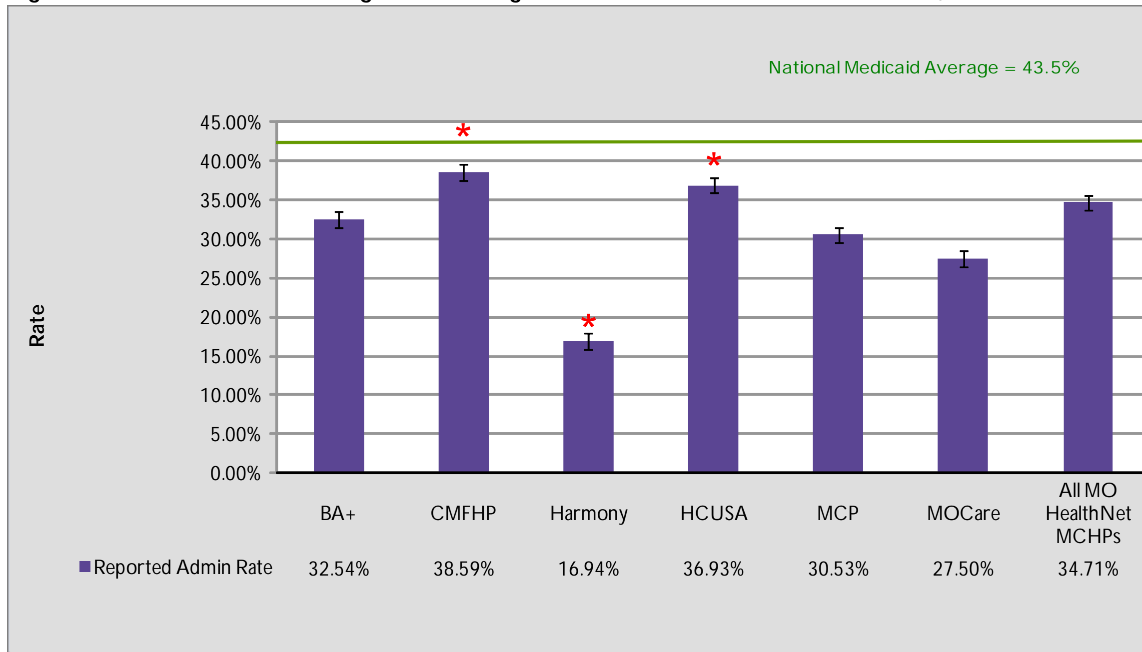


ACCESS TO CARE

The HEDIS 2008 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

For the Annual Dental Visit measure, four of the six MC HealthNet Managed Care health plans (Children's Mercy Family Health Partners, Harmony Health Plan, Healthcare USA and Mercy CarePlus) reviewed were substantially compliant with the calculation of this measure. (See Figure 4) One health plan's calculations were fully compliant (Missouri Care), and one plan's calculations were rated as not valid (Blue-Advantage Plus of Kansas City) due to their failure to provide the requested denominator information.

Figure 4 – MO HealthNet Managed Care Program HEDIS 2008 Annual Dental Visit, Administrative Rates

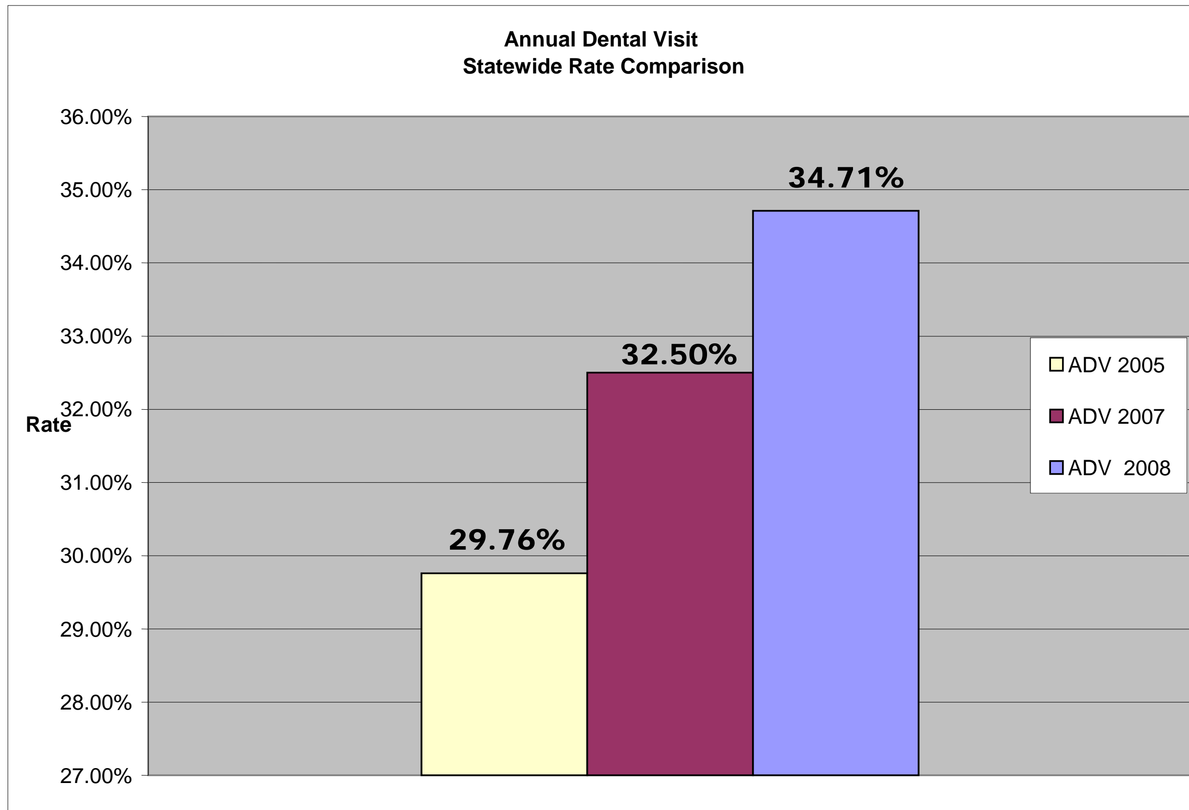


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

The Annual Dental Visits measure has been audited in the 2005, 2007, and 2008 external quality reviews. Over the course of these review periods, the rates for all MO HealthNet Managed Care health plans have improved a total of 4.95%; the rates reported were 29.76% in 2005, 32.50% in 2007 and 34.71% in 2008 (see Figure 5). However, although the rates have increased for the Annual Dental Visit measure, none of the health plans reported a rate in 2008 higher than the National Medicaid Average of 43.5%.

This trend shows an increased level of dental care received in Missouri by MO HealthNet members, illustrating an increased access to care for these services for the HEDIS 2008 measurement year.

Figure 5 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit



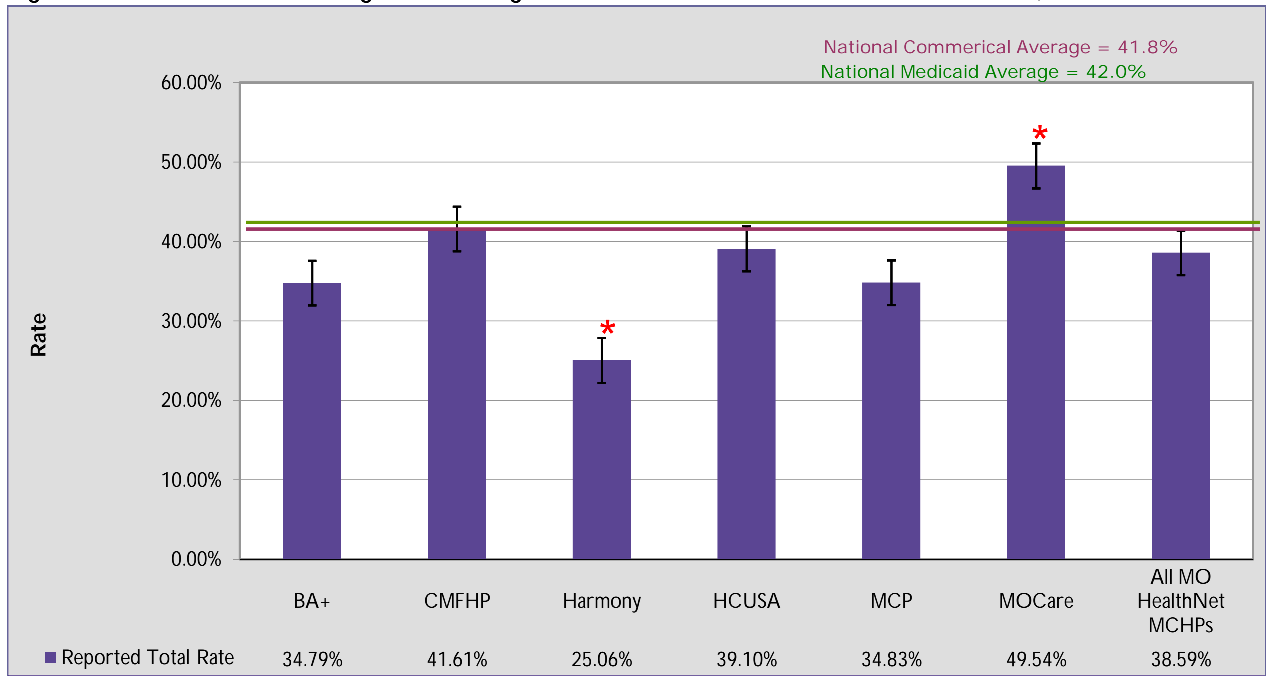
TIMELINESS OF CARE

The HEDIS 2008 Adolescent Well Care Visits is categorized as a Use of Services measure and aims to measure the timeliness of the care received. To increase the rates for this measure, age specific services must be delivered to members on a yearly basis.

For the Adolescent Well Care Visits measure, one health plan (Children's Mercy Family Health Partners) was fully compliant with the specifications for calculation of this measure; one (Blue-Advantage Plus of Kansas City) was found to be not valid, and the remaining four (Harmony Health Plan, Healthcare USA, Mercy CarePlus and Missouri Care) were substantially compliant with the measure's calculation.

For the Adolescent Well Care Visits measure, Missouri Care reported a rate (49.54%) higher than both the National Medicaid Rate (42.0%) and the National Commercial Average (41.8%). Children's Mercy Family Health Partners also reported a rate very close to these Averages at 41.61%. (See Figure 6.)

Figure 6 – MO HealthNet Managed Care Program HEDIS 2008 Adolescent Well-Care Visits, Rates

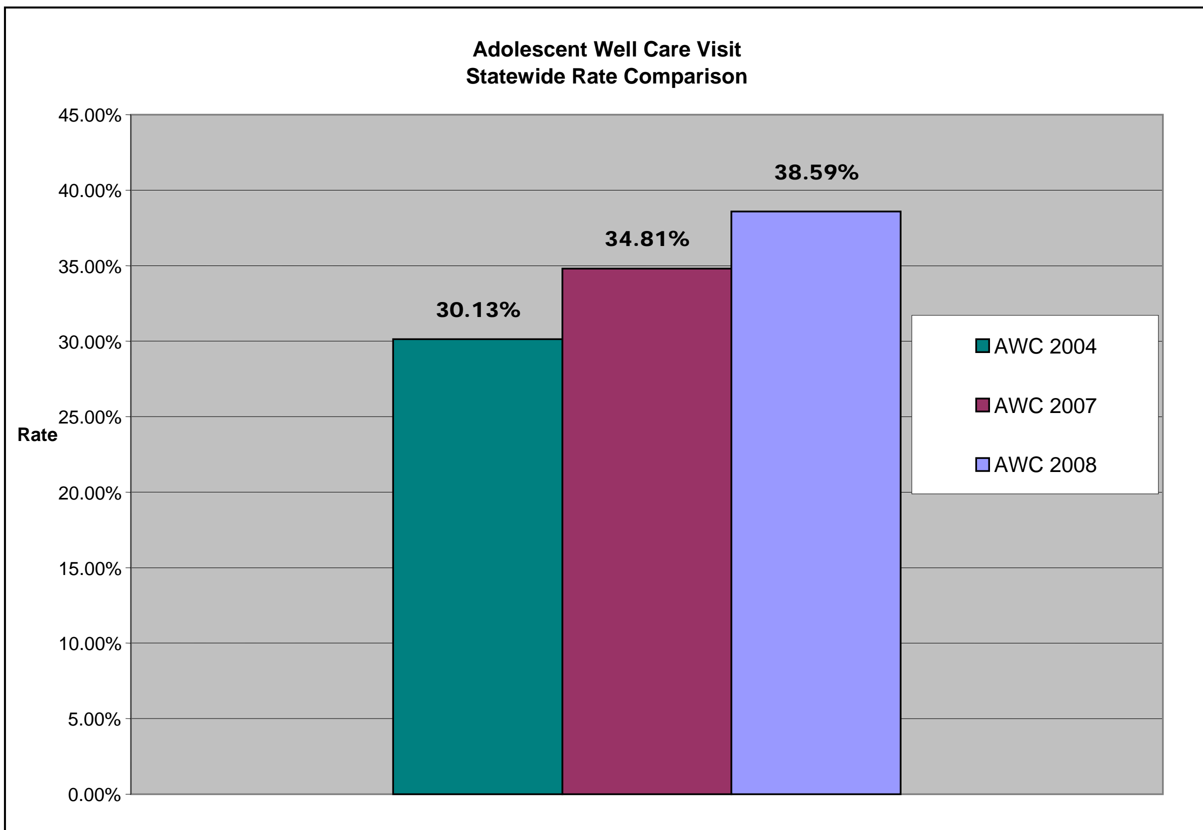


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Although the remaining health plans reported rates lower than these national averages, the overall rate for all MO HealthNet Managed Care health plans has improved by 8.46% over the past three periods this measure has been validated (30.13% in 2004, 34.81% in 2007, and 38.59% in 2008; see Figure 7).

This illustrates an improvement of timeliness of care for well care visits delivered to adolescents in Missouri during the HEDIS 2008 measurement year.

Figure 7 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Adolescent Well Care Visit



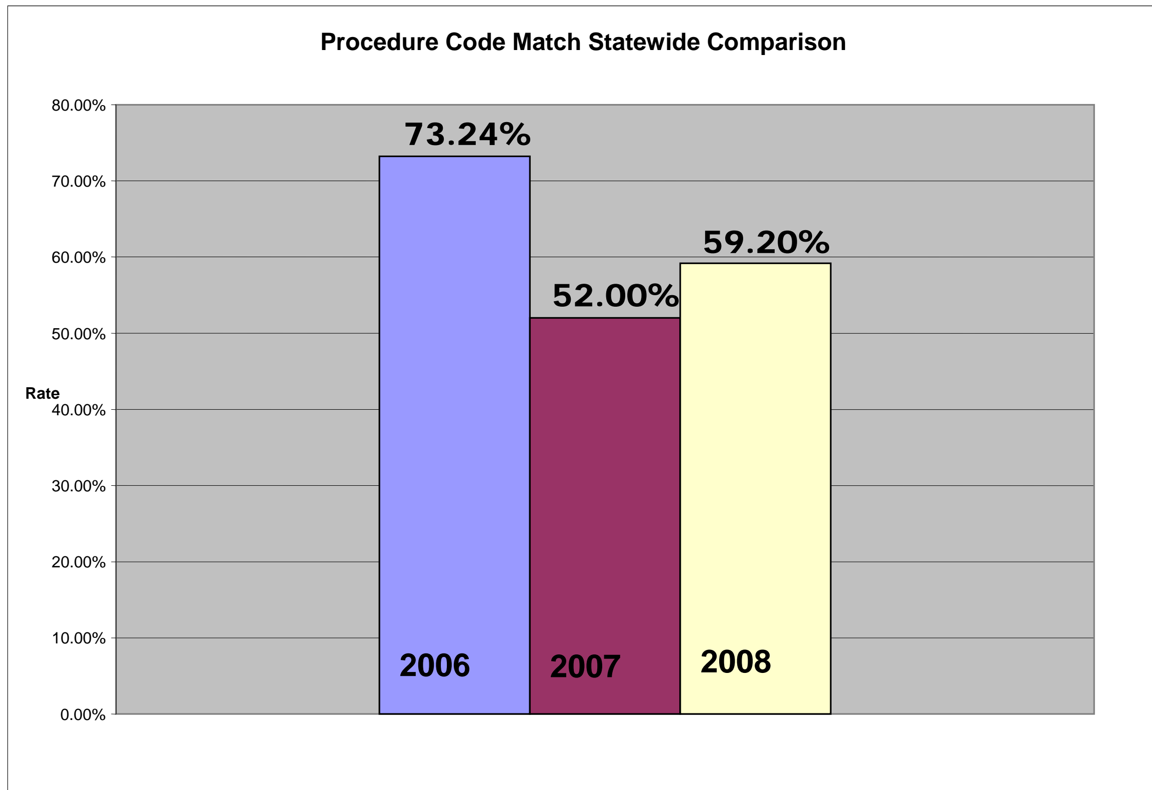
1.5 Encounter Data Validation

Encounter claims data are used by SMAs to conduct rate setting and quality improvement evaluation. Before SMA encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields (e.g., diagnosis and procedure codes, units and dates of service, member and provider identifiers) are complete (each field contains information), accurate (the information contained in each field is of the right size and type), and valid (the information represents actual dates or procedure and diagnosis codes). Several critical fields for each of six claim types (Medical, Dental, Home Health, Inpatient, Outpatient Hospital, and Pharmacy) were identified by the SMA and examined by the EQRO for completeness, accuracy, and validity using an extract file from SMA paid encounter claims. To examine the extent to which the SMA encounter claims database was complete (the extent to which SMA encounter claims database represents all claims paid by MO HealthNet Managed Care health plans); the level and consistency of services was evaluated by examining the rate of each of six claim types. Additionally, the representativeness (or completeness) of the SMA encounter claims database was examined by comparing data in the SMA encounter claims database to the medical records of members.

A random sample of medical records was used to compare the: 1) diagnosis codes and descriptions and 2) the procedure codes and descriptions in the SMA encounter claims database with documentation in MO HealthNet member medical records. The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type procedures were 59.20%, although an increase over 2007 (52.0%), a significant decrease from the 2006 match rate of 73.24% (see Figure 7). Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

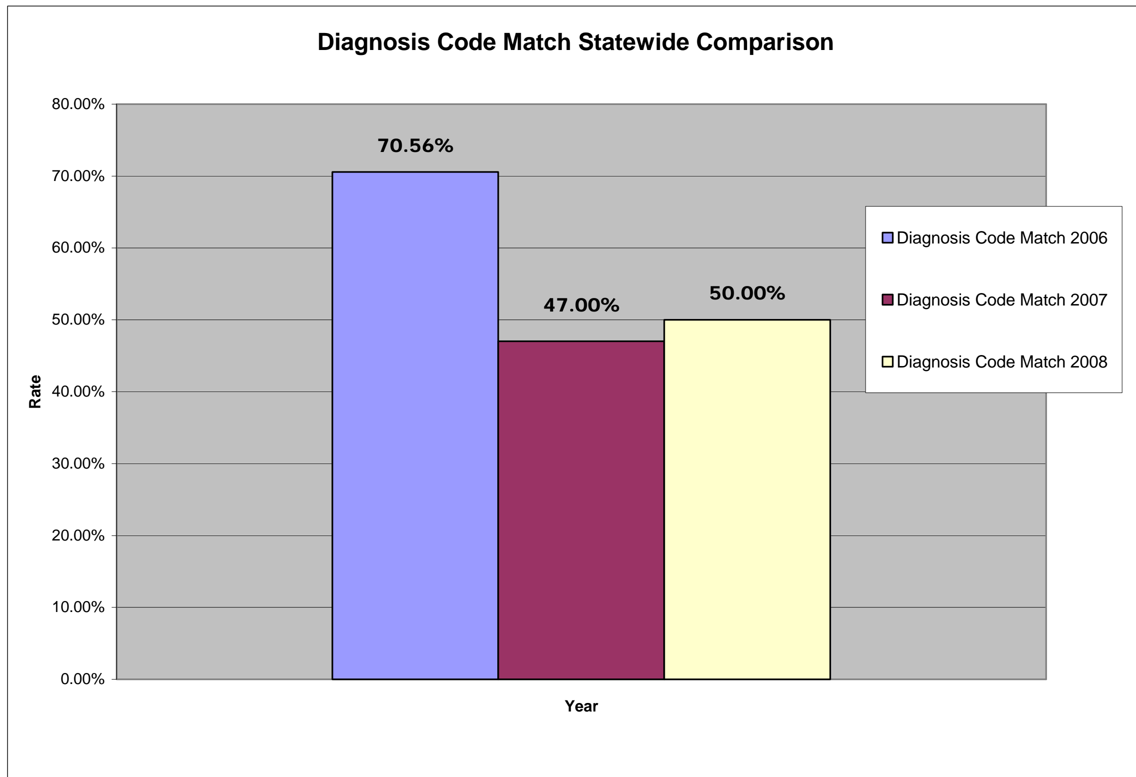
The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type diagnoses were 50.0%, although an increase over 2007 (47.0%), this is significantly lower than the 2006 match rate of 70.56%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

Figure 8 – MO HealthNet Managed Care Program Statewide Rate Comparison for Procedures



The findings of these comparisons were used to determine the completeness of the SMA encounter claims database in regards to the medical records of members. The completeness of the SMA paid encounter claims was then compared with MO HealthNet Managed Care health plan records of paid and unpaid claims. All six MO HealthNet Managed Care health plans provided data in the format necessary to make the comparisons. The results obtained are detailed in the results of the Aggregate Encounter Data Validation section of this report.

Figure 9 – MO HealthNet Managed Care Program Statewide Rate Comparison for Diagnoses



Strengths

- All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet Managed Care health plans. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.

- All MO HealthNet Managed Care health plans submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.

- The examination of the level, volume, and consistency of services found significant variability between MO HealthNet Managed Care health plans in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), however, no patterns of variation were noted by Region or type of MO HealthNet Managed Care health plan.

- There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all Managed Care health plans.

- Unpaid claims represented less than .0001% of all claims submitted to the SMA during the period July1, 2008 through September 30, 2008.

Areas for Improvement

1. The Procedure Code field in the Outpatient Home Health, Outpatient Hospital and Outpatient Medical claim types included some invalid information. Most of this was due to blank fields or fields containing ".00".
2. The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.

1.6 MO HealthNet MCHP Compliance with Managed Care Regulations

The purpose of the protocol to monitor Health Plan Compliance with Managed Care Regulations is to provide an independent review of MO HealthNet Managed Care Health Plan activities and assess the outcomes of timeliness and access to the services provided. The protocol requires the utilization of two main sources of information to determine compliance with federal regulations. These sources of information are document review and interviews with Health Plan personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MO HealthNet Managed Care Health Plan.

The policy and practice in the operation of each Health Plan was evaluated against the seventy (70) regulations related to operating a Medicaid managed care program. The regulations were grouped into three main categories: Enrollee Rights and Protections, Quality Assessment and Improvement, and Grievance Systems. The category of Quality Assessment and Improvement was subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, the SMA reviewed each MO HealthNet Managed Care Health Plan's policy to determine compliance with the requirements of the MO HealthNet Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO.

After discussions with the SMA, it was decided that the 2008 Compliance Review would include in-depth interviews with Member Services and Case Management Staff, as well as the Health Plan Administrative Staff. The goal of these interviews was to validate that practices at the Health Plans, particularly affecting members' access to quality and timely health care, were in compliance with the approved policies and procedures.

The initial document review, provided evidence that the MO HealthNet Managed Care Health Plans continued to make progress in developing appropriate and compliant written policies and procedures. Subsequently, interview questions were developed using the guidelines available in the Compliance Protocol, focusing on areas of concern based on each Health Plan's Annual Evaluation and the SMA Quality Strategy.

During the 2006 and 2007 EQR reviews, interviews were conducted with administrative and management level Health Plan staff, although member services and case management staffs were included. The information obtained enabled reviewers to obtain a clearer picture of the degree of compliance achieved through policy implementation. Corrective action taken by each Health Plan was determined from previous years' reviews. This process revealed a wealth of information about the approach each Health Plan took to become compliant with federal regulations.

The current process of a document review, supported by interviews with front line and administrative staff, was developed to provide evidence of systems that delivered quality and timely services to members, and the degree to which appropriate access was available. The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. This approach continued follow-up from previous EQRO evaluations. Site visit questionnaires for Member Services and Case Management staff, and separately for Administrators, were developed specific to each Health Plan. The questions were developed to seek concrete examples of activities and responses that would validate that Health Plan activities are compliant with contractual requirements and federal regulations.

QUALITY OF CARE

There are thirteen regulations pertaining to Enrollee Rights and Protections. Nine were found to be100% compliant by all Health Plans, and include:

- Communicating MO HealthNet Managed Care Members' rights to respect, privacy, and treatment options were primary and compliant.
- Communicating, orally and in writing, in the member's native language or with the provision of interpretive services is an area of strength for all Health Plans.
- The MO HealthNet Managed Care Health Plans recognized that these requirements are essential to create an atmosphere of delivering quality healthcare to members.
- The Health Plans maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare.
- The Health Plans responded to physical, emotional and cultural barriers experienced by members with diligence and creativity.
- The Health Plans demonstrated an awareness of Enrollee Rights and Protections by have standards and practices in place that were compliant and evident in discussions with the staff who interact directly with members. The attention to ensuring quality care was apparent throughout each of the Health Plans.

There are 10 regulations for Structure and Operations Standards that lead to the provision of quality healthcare. The Health Plans were 100% compliant with seven of these regulations.

- These regulations included provider selection, and network maintenance, subcontractual relationships, and delegation.
- The Health Plans had active mechanisms for oversight of all subcontractors.
- The Health Plans improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their MO HealthNet Managed Care Members.

ACCESS TO CARE

There are seventeen (17) regulations pertaining to Access Standards. Nine of these regulations were found to be 100% compliant by all of the Health Plans. Four of the MO HealthNet Managed Care Health Plans (HealthCare USA, Missouri Care, Children's Mercy Family Health Partners, and Blue Advantage Plus) were fully compliant with the 17 federal regulations concerning Access Standards. These nine regulations found to be fully compliant included:

- Second Opinions;
- Utilization of out-of-network services, including cost sharing and adequate and timely coverage;
- Timely access to care;
- Cultural Competency in Provider Services;
- Timeliness for decisions and expedited authorizations;
- Compensation of utilization management activities; and
- Timeliness of decisions regarding care and emergency and post-stabilization services.

All six MO HealthNet Managed Care Health Plans monitored high risk MO HealthNet Managed Care Members and had active case management services in place.

- The Case Management staff at each Health Plan described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs.
- Examples of case management programs that exceeded the strict requirements in the MO HealthNet Managed Care contract were described during interviews.
- All six Health Plans could describe efforts to participate in community events and forums that provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that are required.
- The Health Plans were acutely aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members.

One area of concern is care coordination. Four of six Health Plans had all required policy in place. The Health Plans do admit that practice in this area can be strengthened.

TIMELINESS OF CARE

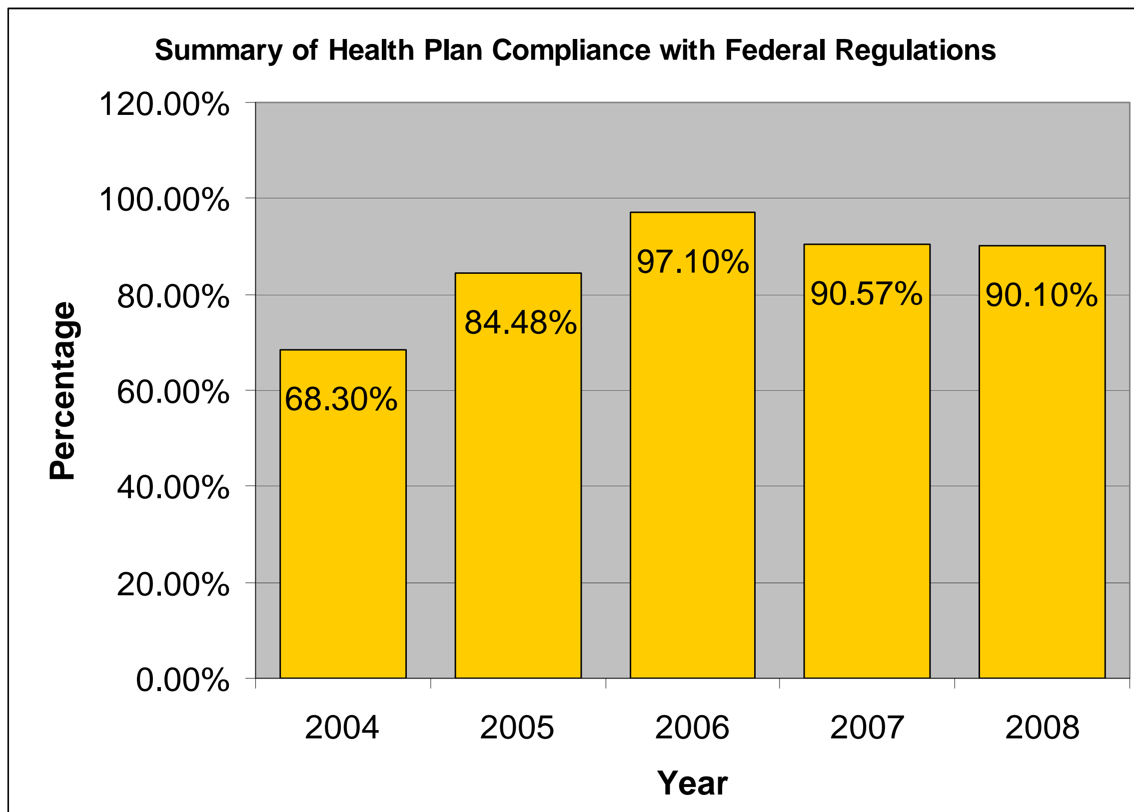
There are twelve (12) regulations for Measurement and Improvement that address the need for timeliness of care. Four of these were found to be 100% compliant by all of the Health Plans. Five of the six MO HealthNet Managed Care Health Plans (Molina, HealthCare USA, Missouri Care, Children's Mercy Family Health Partners, and Blue Advantage Plus) met all of these regulatory requirements.

- All six Health Plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members.
- The Health Plans used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.
- The Health Plans continue to exhibit improvement in the utilization of data and demographics in their systems to track and trend information on members to assist in determinations of risk and prevention initiatives.
- Several Health Plans began using member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery.
- The Member Services and Case Management departments had integral working relationships with the Provider Services and Relations Departments of the Health Plans.
- All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of Health Plan members.
- The Health Plans all provided examples of how these relationships served to ensure that members received timely and effective healthcare. An example is that at each Health Plan staff contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

CONCLUSION

The MO HealthNet Managed Care Health Plans have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially in 2004 the Health Plans did not have complete and approved written policy and procedures. Health Plan processes did not exhibit compliance with contractual and regulatory requirements. In subsequent measurements the Health Plans made concerted efforts to complete policy and procedural requirements. In 2007 and 2008 the review examined not only the written policy, but also conducted interviews to identify if the activities of front line and administrative staff were in compliance. With the exception of one Health Plan (Harmony Health Plan), which has not yet completed required policy, and is continuing to develop compliant organizational processes, continued improvement was observed. The Health Plans have used previous External Quality Reviews to ensure that compliant policies are in place, and continue their efforts to ensure compliant and member focused procedures.

Figure 10 – Summary of Health Plan Compliance with Federal Regulations



1.7 MO HealthNet Managed Care Health Plan Best Practices

For this year's review, it was requested of the EQRO to obtain a best practice from each health plan to be included in the Annual Report. Below are summaries of these best practices by health plan.

Blue-Advantage Plus of Kansas City	**Immunization Initiative** – This initiative provides education to members regarding the need for regular check-ups and the importance of obtaining required immunizations.
Children's Mercy Family Health Partners	**Wellness and Prevention** – This project synchronized the distribution of information to members in coordination with local and national recognition months for health screenings and disease management awareness.
Harmony Health Plan	**Pay for Quality Program** – This project focused on improving access to care and the delivery of quality services to members by rewarding providers when their individual statistics reflected their efforts to assist in improving member education and other preventive services.
HealthCare USA	**Cultural Competency Program** – This program strives to ensure that members receive appropriate care in a culturally-sensitive environment, and further ensures that Health Plan staff focus on cultural competency at all levels.
Missouri Care Health Plan	**"I CAN…Help My Child Stay Healthy" Project** – The Health Plan partnered with the Central Missouri Community Action Center ensure that all eligible children in the region were enrolled in Head Start, and that all children in Head Start obtain all preventive health care available. The goals of the partnership include decreased Emergency Room visits and improved parent health literacy.
Molina Health Care of Missouri	**Case Management for Pregnant Women** – **B**eginning **A**nother **B**eautiful **Y**ou through **C**oordination of care, **A**ssessment, **R**eferral and **E**ducation (B.A.B.Y. C.A.R.E.) has been implemented to improve obstetrical outcomes, reduce obstetrical-related hospital admissions and decrease the incidence of pre-term deliveries by identifying, educating and managing members with risk factors throughout their pregnancy.

Blue-Advantage Plus of Kansas City
Immunization Initiative

Blue-Advantage Plus of Kansas City, Inc. (BA+) understands the importance of immunizations. They have a goal to provide as much education to members about going to the doctor and obtaining all required immunizations. In 2008 BA+ initiated an immunization initiative. The details are as follows:

Members indicating a need for information on vaccines on their Health Risk Assessment Form received a letter and educational materials on vaccinations. Educational materials included:

- Vaccination Initiative Letter -- Information on the importance of receiving all required immunizations
- Shots for Tots brochure – A brochure that provides information on immunizations and the diseases immunizations protect against
- Elliot's Book about Shots (activity book) – Information about immunizations with fun activities for children
- Protect Your Preteen or Teen with Shots: They're not just for Babies! – Information about immunizations that preteens and teenagers may need, and where they can go to obtain them
- Older Adults Need Shots brochure – Information for older adults on the importance of flu shots
- Moms and Dads! Elliot Says, don't Forget Your Child's Shots! – Information about the importance of immunizations and the periodicity schedule
- Shots For Your Child's Health – General information about immunizations

Other materials included are:

- Don't Lose Your Healthcare Coverage – Flyer encouraging members to take an active step in preventing loss of healthcare coverage, including information on the Family Support Division Offices
- Urgent Care List – Information for urgent care centers and on the most common non-emergency conditions that can be treated there

Through 2008 BA+ reached out to sixty-three (63) members with this initiative. In addition, the Health Information Coordinators create a case in the Health Plan's FACETS system, assign the case to a case manager, and save the information as a potential initial referral to Case Management for any member indicating that they need assistance in obtaining immunizations.

Children's Mercy Family Health Partners
Wellness and Prevention

CMFHP has implemented a number of initiatives to increase member awareness in the areas of Prevention and Wellness. They have synchronized the distribution of information to members in order to coordinate with local and national recognition months for health screenings and disease management awareness. An example is the month of February, which is Children's Dental Month. CMFHP provides information on dental screenings through member postcards, the member newsletter, on-hold recordings, and the post customer call Hot Topic, as well as information posted on the Health Plan website.

CMFHP has also focused on well-care exams, lead screening and immunizations through a birthday card program. All members ages 1 – 11 receive a birthday card from CMFHP which contains the periodicity schedule appropriate for their age. The Health Plan sends a congratulatory card for all newborns with a periodicity schedule for the first year of life.

In order to provide a targeted information campaign focused on Teens, CMFHP has developed a Teen Newsletter, "Your Space," printed semi-annually. The Health Plan also has a dedicated page on their website that highlights issues relevant to teens. They develop these topics in conjunction with their Teen Advisory Board from Children's Mercy Hospital to ensure that the message reaches their target audience.

The Health Plan strives to assist members to make the most of their health care benefits. One of the methods of communication regarding the myriad resources that are available through the Health Plan and community is their Quick Resource Guide. CMFHP developed a one-page guide for members who may need assistance in obtaining services, equipment or assistance in managing a chronic disease. The recently implemented Quick Resource Guide is being placed in the New Member Packet, on the website, and in the member newsletter. In the future this publication will be part of the Member Handbook.

Currently CMFHP provides a key fob and magnet for members with a periodicity schedule for distribution with all new enrollment packets. They key fobs contain key phone numbers, such as that of the transportation provider, Customer Services number, and a place to enter PCP information, or other important numbers.

The following postcards are used throughout the year by CMFHP to keep members informed regarding needed and available services:

- Annual Dental Visits – Combined Rate/annually
- Birthday Card – Well Man/annually
- Birthday Cards – WCV/ annually
- Anniversary Cards & Teen Magazines – Adolescents WCV/annually
- Cervical Cancer Screening/2 times each year
- Chlamydia Screening/annually
- Diabetes/annually
- Follow-up after Hospitalization for Mental Illness/annually
- Lead/2 times each year
- Mammogram/2 times per year
- No PCP visit in last year/2 times each year
- Postpartum Care/annually
- Timeliness of Prenatal Care/annually
- Well Woman/annually

Harmony Health Plan
Pay for Quality Program (2008 PFQ)

As part of Harmony Health Plan's commitment to improving access to care and delivery of quality services to members, the Health Plan has implemented a Pay for Quality Program. The Health Plan identified barriers to achieving quality service provision. These included lack of member education, lack of provider education, and lack of member and provider incentives. Harmony Health Plan has implemented several interventions to address these barriers. The provider focused incentive is a new program, based on improved HEDIS measures, beginning with reports based on the 2008 data. The program description includes:

Goals of the program:

- Pay for financial incentives to physicians and groups to provide needed preventive and other disease-specific services to Harmony Members.
- Improve the accuracy and completeness of encounter and claims data submission from providers.
- With additional PFQ dollars, enable physicians and groups to implement their own member outreach programs.
- Encourage a friendly competition among providers toward improving quality by sharing best PFQ results and practices.

Brief Description of the Program:

- All PCPs with 50 or more members qualify for the program.
- Ten (10) HEDIS measures, including Adolescent Well Care (AWC) are included.
- Based on Quality Compass Medicaid rates, three specific targets are set at 50th, 75th, and 90th percentiles.
- On achieving the target the plan is to pay approximately $40 to $80 per measure.
- Harmony Health Plan staff periodically share the PFQ data and the non-compliant member lists with the physicians and groups throughout the year as part of one-on-one meetings.

Results and Future Plans:

- Since 2008 CY is the first year this program is implemented in Missouri, Harmony Health Plan is currently analyzing the HEDIS 2009 and CY 2008 PFQ data.
- By September 2009 the final results will be available and the incentive checks will be distributed.
- Based on the results and feedback from providers, Harmony Health Plan will modify the program to increase its effectiveness and efficacy.
- Harmony Health Plan is considering implementing a "Star System" to recognize high performing physicians and groups.

HealthCare USA
Cultural Competency Program

HealthCare USA strives to ensure that members receive appropriate care in a culturally-sensitive manner. They do so by maintaining a focus on cultural competency at all levels. They provide education to staff and providers, address language access issues, and include cultural competency in their outcome-based measures. The Health Plan uses the Offices of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) as models for improving policy and practice related to cultural competence. During the past year HCUSA began a program to develop and implement interventions that serve as a foundation for responding to the needs of minority members and eliminating health disparities in historically underserved populations. This program focused on members, providers, and employees and the organization. The over-arching goal is to reduce racial and ethnic health care disparities to improve health status of all members. To achieve this goal the Health Plan implemented the following interventions:

For members in all three MO HealthNet Managed Care Regions:

- Utilize member education materials in other languages
- Print the Member Handbook in Braille and make audio versions available upon request
- Make verbal interpretation or written translation available in preferred language to members upon request

- Make a new Language Service Brochure for LEP members available
- Participate in various ethnic-sponsored events and organizations

For providers and other stakeholders the following interventions occurred:

- Completed a survey of PCPs and other providers in all regions through the credentialing process to determine the languages spoken in each office. This information is made available in HCUSA provider directories and on the on-line provider search.
- Create new provider handouts "Find Your Language," which is a tool that allows for identification of over 20 languages with instructions on accessing language services.
- Participated in the St. Louis Health Care Call to Action Initiative. This symposium focused on establishing meaningful community dialogue on the best methods to achieve 100% access to health care and zero disparities in the St. Louis' health care system.

For members of the HCUSA organization the following interventions occurred:

- Completed organization-wide and individual cultural competency surveys during 2008
- Implemented a multi-disciplinary, intra-departmental team to establish and implement an organization-wide cultural competency program consistent with the CLAS standards in 2008
- Providing three organization-wide all-staff cultural competency trainings presented by Language Access Metro Project (LAMP) to be completed in 2009 that focus on the specific ethnic populations across the state of Missouri
- Continued partnership with BJC Health System's Center for Cultural Diversity in the on-going deployment of HCUSA's cultural competency program
- Participation by 35 management and staff employees in the Poverty Simulation exercise. The exercise was conducted by the Community Action Agency of St. Louis County (CAASTLC). Additional sessions will be held in the Central and Western Regions throughout 2009
- Produced educational materials in the member's preferred language or provided translation services upon request
- Provided all new employees diversity training through a program entitled "Footprints," an online program, which provides education about respecting the differences of others in the workplace. The focus is challenging and enhancing employees' understanding of the importance of valuing and respecting co-workers' differences
- Hired bilingual member services and member outreach staff
- Conducted behavioral health educational seminars at the International Institute regarding mental health issues facing immigrants and refugees. This will occur in all three regions
- Investigated the "undetermined" language category on the State data file. They sent surveys to 144 member households who selected "other" on their State-provided file. The returned surveys reported that 41% reported Bosnian as their primary language. The Health Plan continues to track various languages in the member population using LAMP, BJC Center for Diversity and Cultural Competency, and other translation services used in all three MO HealthNet Managed Care regions. This process will be repeated annually

The Health Plan has experienced remarkable outcomes as the result of this initiative. The have built a significant network of community partnerships in order to reach out to members. Through partnerships with local hospitals, physicians, health centers, community agencies, and community organizations they have been able to consistently improve well-child visits as reported through HEDIS, and through the results of the CAHPS survey. HCUSA has recruited a culturally-diverse workforce that reflects the diversity of their membership. The staff reflects of the diversity experienced in all three MO HealthNet Managed Care Regions. The Health Plan has developed a culturally diverse provider network in all three Regions as well. The Provider Survey reflects that over 200 PCPs and over 500 specialists speak 69 languages other than English. And finally, in serving non-English speaking members, the Health Plan has learned that over 69% were aware of translation services and interpreter services. From 2006 through 2008 the number of members that use language services, in the Eastern Region alone, has increased by 142%.

Missouri Care Health Plan
"I CAN…Help My Child Stay Healthy" Project

Missouri Care, an Aetna Health Plan, is partnering with the Central Missouri Community Action (CMCA) center in support of the "I CAN Help My Child Stay Healthy" project. "I CAN" is a collaboration between CMCA and the UCLA/Johnson & Johnson Health Care Institute in providing Head Start and Early Head Start program training tools to deliver health literacy training to Head Start families across America.

Studies show that 90 million Americans lack the necessary health literacy skills to effectively utilize the healthcare system. The inappropriate use of emergency rooms has been identified as a major contributor to increased health care costs. The UCLA/Johnson & Johnson project trains Head Start families, who are predominately uninsured or on Medicaid, how to treat minor childhood illnesses. Tracking 9240 Head Start families enrolled in the health literacy program – and impacting nearly 20,000 children in 35 states – researchers found that visits to a hospital ER or clinic dropped by 58 percent and 42 percent, respectively, as parents opted to treat their children's fevers, colds, and earaches at home. This added up to a potential annual savings to Medicaid of $554 per family in direct costs associated with such visits or about $1.5 million annually.[9]

[9] Empowering Parents, Benefiting Children: A Study of the Impact of Health Literacy Training on Head Start Parents and the Healthcare System. UCLA/Johnson & Johnson Health Care Institute for Head Start.

In early 2008 Missouri Care initiated a partnership with the CMCA center in providing "I CAN" training for Head Start parents in Central Missouri. Training includes use of "I CAN's" easy-to-read medical reference guide, group classes, and follow-up home sessions. The goals of the partnership are to decrease ER visits and improve parent health literacy. Class participants who are Missouri Care members are asked to participate in a follow-up evaluation of subsequent ER utilization and well-child visits, using claims data. Only aggregate outcomes will be reported.

Missouri Care has been a co-sponsor with CMCA on two class training events in Columbia and Sedalia, drawing 250 and 80 families, respectively. Most recently, Missouri Care was a co-sponsor with CMCA and the UCLA/Johnson & Johnson Health Care Institute in a 'night on the town' for parents of Head Start children. Parents were provided with gift bags with the medical reference guide, literature and a digital thermometer with Missouri Care's logo. The parents were able to take their temperature using the digital thermometer as well as review the medical reference book. Dinner and door prizes were provided.

Missouri Care will conduct follow-up claims data analysis for participating families in the future.

Molina HealthCare of Missouri
Case Management for Pregnant Women

Beginning **A**nother **B**eautiful **Y**ou through **C**oordination of care, **A**ssessment, **R**eferral and **E**ducation (B.A.B.Y. C.A.R.E.) has been implemented to improve obstetrical outcomes, reduce obstetrical-related hospital admissions and decrease the incidence of pre-term deliveries by identifying, educating and managing members with risk factors throughout their pregnancy. This program provides early identification of pregnancies and intervention for all members. Based on the Pregnancy Risk Screening assessment, Molina HealthCare of Missouri's Obstetrical Case Managers formulate an individualized plan of management to accomplish and meet the B.A.B.Y.C.A.R.E. Program's objectives. Case management services include identifying, tracking and monitoring all pregnant members through prenatal and postpartum care.

Molina HealthCare of Missouri identified low birth weight (LBW), very low birth weight (VLBW), and extremely low birth weight (ELBW) infants as a problem for the health plan and its members. The cost of care of these infants was problematic. More of an issue was the quality of life for the infants and their families when future physical, mental, emotional, and socio-economic problems

occurred as the result of issues associated with their premature birth. As a result the Health Plan hypothesized that early identification of risk factors in pregnant women, and implementation of an OB Case Management program for all pregnant Health Plan members, would positively impact these individuals create an atmosphere for healthier and more successful birth outcomes.

The project started as a Performance Improvement Project (PIP) in January 2005 and continued through November 2008. The interventions included risk assessment screenings for all pregnant Health Plan members. All members would receive some case management services which increased with the level of risk assessed. The risk levels are defined as:

- Level 1: No Risk – The member entered into prenatal care in the first 12 – 14 weeks of pregnancy; had longer than 18 months between pregnancies; and reported no previous pregnancy complications.
- Level 2: Low Risk – The member had a pre-pregnancy weight of less than 100 pounds, or greater than 200 pounds; has or had a sexually transmitted disease; had a previous "C" section; entered prenatal care after 12 weeks gestation; is non-compliant with prenatal care; interconceptual spacing of less than 18 months; has a history of medical conditions; has severe social stressors; is a teenager at the time of conception; is a smoker; has a history of previous fetal or infant death; or has had seven or more pregnancies.
- Level 3: High Risk – The member has a chronic or exacerbated medical condition; is currently a drug or alcohol abuser; advanced maternal age of greater than 35 years; has intrauterine growth retardation or fetal anomalies; is 16 years or less at time of conception; is identified with lead toxicity; has chronic or recent mental illness; reports multiple gestations; has current or history of preterm labor; has a history of low or very-low birth weight infants; has gestational diabetes; has pregnancy induced hypertension; or hyperemesis.

The amount of case management services increases with the level of risk assessed as follows:

Level 1 – Information packets are sent to all pregnant women. An ante-partum home visit is made and the member is found stable. A letter is sent each trimester and the case managers tracks the women to ensure that birth notification is received. The member receives a post partum home visit, which may include additional visits as needed or ordered by the member's obstetrician. The case is closed after six weeks.

Level 2 – Information packets are sent to all pregnant women. The member receives a home visit, and through the assessment process is determined to need additional interventions. Closer tracking occurs, with trimester letters delivered, and additional home visit scheduled as needed. The case manager is notified of the birth and arranges a post partum visit. Additional assessment occurs and the case manager remains involved as necessary.

Level 3 – Information packets are sent to all pregnant women. The member receives a home visit and further assessment occurs. Letters are sent each trimester. The case manager maintains at least monthly telephone contact with the member. Additional services are arranged, as needed, by the mother. After the notification of delivery, the case manager makes a post-partum visit. They authorize additional visits or services as needed, or as authorized by the physician.

The conclusion at the completion of this PIP is that increased rates of Obstetrical Case Management correspond to decreased rates of low birth weight, very low birth weight, and extremely low birth weight babies born during the periods 2005 through 2008. These outcomes are based on yearly reports.

The process of providing some level of case management to all pregnant women has been incorporated into Molina HealthCare of Missouri's normal plan operations as the result of the PIP and its findings. While all cases of prematurity are not avoidable, managing the at-risk members with intensive case management appears to lead to a significant decrease in the rates of VLBW and ELBW babies. The Obstetrical Case Managers report that member satisfaction, as well as the positive supporting data, has greatly improved birth outcomes. The positive effect on member health is creating well being in both the long and short term. This is now a part of the routine for OB Case Management at Molina HealthCare of Missouri.

2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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2.1 Definition

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care…that is designed, conducted and reported in a methodologically sound manner." The Validating Performance Improvement Projects Protocol specifies that the EQRO conduct three activities in the validation of two PIPs at each Health Plan that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. The State Medicaid Agency (SMA: the Department of Social Services, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2008. This selection included evaluating the Statewide Project entitled Increasing Adolescent Well-Care Visits. The aggregate report was evaluated, and each individual Health Plans response and interventions were examined. Criteria for identification of a PIP as outlined in the CMS protocols include the following:

- PIPs need to have a pre-test, intervention, and post-test
- PIPs need to control for extraneous factors
- PIPs need to include an entire population
- Pilot projects do not constitute a PIP
- Satisfaction studies alone do not constitute a PIP
- Focused studies are not PIPs: A focused study is designed to assess processes and outcomes on one-time basis, while the goal of a PIP is to improve processes and outcomes of care over time.

The State of Missouri contract for Medicaid Managed Care (C30611801-07) describes the following requirements for Health Plans in conducting PIPs:

> Performance Improvement Projects: The health plan must conduct performance improvement projects 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 member satisfaction. The Health Plan must report the status and results of each project to the state agency as requested. The performance improvement projects must involve 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.

- Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- Performance measures and topics for performance improvement projects specified by CMS in consultation with the state agency and other stakeholders.

2.2 Purpose and Objectives

The purpose and objectives of the present review were to evaluate the soundness and results of PIPs implemented by Health Plans during the calendar year 2008. The MO HealthNet Managed Care health plans were to have two active PIPs in place, one clinical and one non-clinical. The validation process examines the stability and variability in change over multiple years. The evaluation in 2008 included the initial and ongoing methods utilized in the Statewide PIP, which was the non-clinical PIP evaluated for each Health Plan. An aggregate report of the planning, objectives, and outcomes of the Statewide PIP was reviewed. Each Health Plan also implemented individualized interventions to create improved outcomes for their members. These PIPs were evaluated as the nonclinical PIP for each Health Plan.

2.3 Technical Methods

There are three evaluation activities specified in the protocol for Validating Performance Improvement Projects. "Activity One: Assessing the MCOs/PIHPs Methodology for Conducting the PIP" consists of ten steps:

Activity One: Assessing the MCOs /PIHPs Methodology for Conducting the PIP

1. Step One: Review the selected study topic(s)
2. Step Two: Review the study question(s)
3. Step Three: Review selected study indicator(s)
4. Step Four: Review the identified study population
5. Step Five: Review sampling methods (if sampling was used)
6. Step Six: Review the MCOs/PIHPs data collection procedures
7. Step Seven: Assess the MCOs/PIHPs improvement strategies
8. Step Eight: Review data analysis and interpretation of study results
9. Step Nine: Assess the likelihood that reported improvement is "real" improvement
10. Step Ten: Assess whether the MCO/PIHP has sustained its documented improvement

"Activity Two: Verifying PIP Study Findings" is optional, and involves auditing PIP data. "Activity Three: Evaluate Overall Reliability and Validity of Study Findings" involves the accessing whether the results and conclusions drawn from the PIP are valid and reliable. Activities One and Three were conducted by the EQRO.

Time Frame and Selection

Two projects that were underway during the preceding 12 months at each MO HealthNet Managed Care Health Plan were selected for validation. The projects to be validated were reviewed with SMA and EQRO staff, in February 2008. The intent was to identify projects which were mature enough for validation (i.e., planned and in the initial stages of implementation), underway or completed during calendar year 2008. The SMA made the final decision regarding the actual PIPs to be validated from the descriptions submitted by the MO HealthNet Managed Care Health Plans.

Preparation of MO HealthNet Health Plans

All Health Plans were contacted during November 2008 to prepare them for the 2008 External Quality Review. All Health Plans quality management staff or plan administrators were contacted to discuss the onset of the External Quality Review Organization (EQRO) activities and to schedule training teleconferences in November and December. The Health Plans were

explicitly requested to have all staff or subcontractors available who would be responsible for obtaining and submitting the data required to complete all validation processes. During these teleconferences, all aspects of the EQR, including the requirements of submissions for the Performance Improvement Projects, were discussed.

The training teleconference agenda, methods and objectives, and schedule were sent to all Health Plans, following approval from the State Medicaid Agency (SMA), in early November 2008. SMA staff agreed to participate in these conference calls, allowing time for presentation of information, clarification, and questions. Submission of data was scheduled for February through March 2009. This allowed for completion of all 2008 activities and compilation of initial data for projects underway in the previous year. Historically Health Plans were allowed to update data at the time of the on-site reviews. Several Health Plans submitted initial data with the caveat that completed data would be available at the time of the 2009 on-site visits.

REVIEWERS

Three reviewers conducted the Validating Performance Improvement Project Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director is a licensed attorney with a graduate degree in Health Care Administration, and seven years of experience in public health and managed care in two states. This was her fourth review. She conducted interviews and provided oversight to the PIP Protocol team. The Assistant Project Director was conducting her fifth review. She has experience with the MO HealthNet Managed Care Program implementation and operations, interviewing, program analysis, and Medicaid managed care programs in other states, and thirteen years experience in program evaluation and research. The third reviewer participated in eight previous MO HealthNet Managed Care Program reviews and on-site visits. This reviewer was knowledgeable about the MO HealthNet Managed Care Program through her experience as a former SMA employee responsible for quality assessment and improvements, as an RN, and a consultant. All reviewers were familiar with the program improvement project requirements and validation process, as well as research methods, and the requirements of the MO HealthNet Managed Care Program.

2.4 Procedures for Data Collection

The evaluation involved review of all materials submitted by the MO HealthNet Health Plans including, but not limited to, the materials listed below. During the training teleconferences MO HealthNet Health Plans were encouraged to review Attachment B of the Validating Performance Improvement Projects Protocol and ensure that they include supporting documents, tools, and other information necessary to evaluate the projects submitted, based on this tool.

- Narrative descriptions
- Problem identification
- Hypotheses
- Study questions
- Description of interventions(s)
- Methods of sampling
- Planned analysis
- Sample tools, measures, survey, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Overall analysis of the validity and reliability of each study
- Evaluation of the results of the PIPs

The EQRO Project Director, Assistant Project Director, and Review Consultant met with the MO HealthNet Health Plan staff responsible for planning, conducting, and interpreting the findings of the PIPs during the on-site reviews occurring between July and August 2009. The review focused on the findings of projects conducted during 2008. MO HealthNet Health Plans were instructed that additional information and data not available at the time of the original submission could be provided at the time of the on-site review or shortly thereafter. The time scheduled during the on-site review was utilized to conduct follow-up questions, to review data obtained, and to provide technical assistance to Health Plans regarding the planning, implementation and credibility of findings from PIPs. In addition, individual clarifying questions were used to gather more information regarding the PIPs during the on-site interviews. The following questions were formulated and answered in the original documentation, or were posed to the Health plans during the on-site review:

- Who was the project leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What were the interventions(s)?
- What was the time period of the study?
- Was the intervention effective?
- What did the MO HealthNet Managed Care Health Plan want to learn from the study?

All PIPs were evaluated by the Review Consultant and the Assistant Project Director. In addition, the projects were reviewed with follow-up suggestions posed by the Project Director, who approved final ratings based on all information available to the team.

Analysis

All PIPs submitted by MO HealthNet Health Plans prior to the site visits were reviewed using an expanded version of the checklist for conducting Activity One, Steps 1 through 10, and Activity Three (Judgment of the Validity and Reliability of the PIPs) of the Validating Performance Improvement Projects Protocol, Attachment B (see Appendix 2). Because certain criteria may not have been applicable for projects that were underway at the time of the review, some specific items were considered as "Not Applicable." Criteria were rated as "Met" if the item was applicable to the PIP, if there was documentation addressing the item, and if the item could be deemed Met based on the study design. The proportion of items rated as "Met" was compared to the total number of items that were applicable for the particular PIP. Given that some PIPS were underway in the first year of implementation, it was not possible to judge or interpret: results; validity of improvement; or sustained improvements (Steps 8-10). The final evaluation of the validity and reliability of studies was based on the potential for the studies to produce credible findings. Detailed recommendations and suggestions for improvement were made for each item where appropriate, and are presented in the individual MO HealthNet Health Plan summaries. Some items are rated as "Met" but continue to include suggestions and recommendations as a method of improving the information presented. The following are the general definitions of the ratings developed for evaluating the PIPs.

Met:	Credible, reliable, and valid methods for the item were documented.
Partially Met :	Credible, reliable, or valid methods were implied or able to be established for part of the item.
Not Met:	The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed; errors in logic were noted; or contradictory information was presented or interpreted erroneously.
Not Applicable:	Only to be used in Step 5, when there is clear indication that the entire population was included in the study and no sampling was conducted; or in Steps 8 through 10 when the study period was underway for the first year.

BHC, 2008 EQR criteria

2.5 Findings

Below are the PIPs identified for validation at each Health Plan:

Molina HealthCare of Missouri	Members at High Risk of Cesarean Wound Infection
	Improving Adolescent Well Care
HealthCare USA	Readmission Performance Improvement
	Improving Adolescent Well Care
Missouri Care	Partnership to Improve WIC Participation & Increase Well Child Visit Rates
	Improving Adolescent Well Care
Children' Mercy Family Health Partners	Improving Dental Utilization Rates
	Improving Adolescent Well Care
Blue Advantage Plus	Ambulatory Follow-Up After Hospitalization for Mental Health Disorders
	Improving Adolescent Well Care
Harmony Health Plan	Lead Screening
	Improving Adolescent Well Care

STEP 1: SELECTED STUDY TOPICS

Study topics were selected through data collection and the analysis of comprehensive aspects of member needs, care, and services; and to address a broad spectrum of key aspects of member care and services. In all cases they included all enrolled populations pertinent to the study topic without excluding certain members. One of the PIPs addressed follow-up care after discharge from hospitalization from mental illness; one addressed members at risk of cesarean wound infection and one addressed hospital readmission; one addressed lead screening; one addressed dental utilization; one improving well-child visit rates through a community partnership; six addressed improving adolescent well care through Health Plan specific interventions, as extensions of the Statewide PIP.

TABLE 2STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. They should be specific enough to suggest the study methods and the outcome measures. The MO HealthNet Managed Care Health Plans made a concerted effort to ensure that statements were provided in the form of a question, and in most cases the questions were directly related to the hypotheses and topic selected. Eleven (91.6%) of the PIPs included clearly stated study questions (Step 2.1). The study purposes identified were consistent with the remainder of the PIP (the target population, interventions, measures, or methods) in most instances.

Table 2 shows the ratings for each item and PIP by MO HealthNet Health Plan. All 12 PIPs provided some rationale demonstrating the extent of the need for the PIP and provided adequate information to support selection of the study topic. Most discussed literature or research supporting the activities to be undertaken, and provided some benchmark comparison data. This entire section met all the criteria required 100% of the time. All the MO HealthNet Managed Care Health Plans addressed a broad spectrum of key aspects of member care and services (100%). Each Health Plan submitted one clinical and one non-clinical intervention for review. An array of aspects of enrollee care and services that were related to the identified problem was described. Utilization or cost issues may be examined through a PIP, but were not to be the sole focus of any study. There were some descriptions of the member populations targeted for intervention in the PIPs. Because the Health Plans vary widely in the member populations they serve (e.g., other state Medicaid managed care members, commercial members, or Medicare members), it was previously not entirely possible to determine the extent to which the PIP identified, addressed, and measured the needs of the MO HealthNet Managed Care Program population in all cases. During 2008 the PIPs submitted did reflect projects that were focused on this population. In addition, PIPs should specifically indicate whether all enrolled populations within the MO HealthNet Managed Care Program were included in the interventions. Finally, age and demographic characteristics should be described. All ten of the PIPs (100%) "Met" these criteria (Step 1.3).

Table 1 – Performance Improvement Project Validation Findings by Health Plan

Step	Item	MO HealthNet Managed Care Health Plans											
		Molina		HCUSA		Harmony		MOCare		CMFHP		BA+	
		Members at High Risk of Cesarean Wound Infection	Improving Adolescent Well Care	Readmission Performance Improvement	Adolescent Well Care	Lead Screening	Adolescent Well Care	Partnership to Improve WIC Participation & Increase Well Child Visit Rates	Adolescent Well Care	Improving Dental Utilization Rates	Adolescent Well Care	Ambulatory Follow-Up After Mental Health Hospitalization	Adolescent Well Care
	1.1	2	2	2	2	2	2	2	2	2	2	2	2
	1.2	2	2	2	2	2	2	2	2	2	2	2	2
Step 1: Selected Study Topics	1.3	2	2	2	2	2	2	2	2	2	2	2	2
Step 2: Study Questions	2.1	2	2	2	2	2	2	2	2	2	2	1	2
	3.1	2	2	2	2	2	2	2	2	2	2	2	2
Step 3: Study Indicators	3.2	2	1	2	2	2	1	2	2	2	2	2	2
	4.1	2	2	2	2	2	2	2	2	2	2	2	2
Step 4: Study Populations	4.2	2	2	2	2	2	1	1	2	2	1	2	2
	5.1	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	5.2	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 5: Sampling Methods	5.3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	6.1	2	2	2	2	1	2	2	2	2	2	2	2
	6.2	2	2	2	2	1	1	2	2	2	2	2	2
	6.3	1	1	2	2	1	1	2	2	2	2	2	2
	6.4	1	0	2	2	2	1	2	2	2	2	2	2
	6.5	2	0	2	1	1	0	2	2	2	2	2	2
Step 6: Data Collection Procedures	6.6	2	1	2	2	2	2	1	1	2	2	2	2
Step 7: Improvement Strategies	7.1	2	1	2	1	2	1	2	2	1	2	2	2
	8.1	NA	1	1	1	1	1	2	2	2	1	2	2
	8.2	NA	1	2	2	2	1	2	2	2	1	2	2
	8.3	NA	0	2	2	2	1	2	2	2	1	2	2
Step 8: Analysis and Interpretation of Study Results	8.4	NA	1	2	1	0	0	2	2	2	1	2	2
	9.1	NA	1	NA	2	NA	1	2	2	2	NA	2	2
	9.2	NA	1	NA	2	NA	1	2	2	2	NA	2	2
	9.3	NA	1	NA	NA	NA	NA	2	2	2	NA	2	2
Step 9: Validity of Improvement	9.4	NA	0	NA	NA	NA	NA	2	2	2	NA	2	2
Step 10: Sustained Improvement	10	NO	NA	NA	NA	NA	NA	2	2	NA	NA	NA	NA
Number Met		13	9	18	17	13	8	23	23	22	14	22	23
Number Partially Met		2	10	1	4	5	11	1	1	1	5	1	0
Number Not Met		0	4	0	0	1	2	0	0	0	0	0	0
Number Applicable		15	23	19	21	19	21	24	24	23	19	23	23
Rate Met		86.7%	39.1%	94.7%	81.0%	68.4%	38.1%	95.8%	95.8%	95.7%	73.7%	95.7%	100.0%

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. They should be specific enough to suggest the study methods and the outcome measures. The MO HealthNet Managed Care Health Plans made a concerted effort to ensure that statements were provided in the form of a question, and in most cases the questions were directly related to the hypotheses and topic selected. Eleven (91.6%) of the PIPs included clearly stated study questions (Step 2.1). The study purposes identified were consistent with the remainder of the PIP (the target population, interventions, measures, or methods) in most instances.

Table 2 - Summary of Performance Improvement Project Validation Ratings by Item, All Health Plans

Step	All MO HealthNet					
	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	12	0	0	12	100.00%
	1.2	12	0	0	12	100.00%
	1.3	12	0	0	12	100.00%
Step 2: Study Questions	2.1	11	1	0	12	91.67%
Step 3: Study Indicators	3.1	12	0	0	12	100.00%
	3.2	10	2	0	12	83.33%
Step 4: Study Populations	4.1	12	0	0	12	100.00%
	4.2	9	3	0	12	75.00%
Step 5: Sampling Methods	5.1	0	0	0	0	n/a
	5.2	0	0	0	0	n/a
	5.3	0	0	0	0	n/a
Step 6: Data Collection Procedures	6.1	11	1	0	12	91.67%
	6.2	10	2	0	12	83.33%
	6.3	8	4	0	12	66.67%
	6.4	9	2	1	12	75.00%
	6.5	8	2	2	12	66.67%
	6.6	9	3	0	12	75.00%
Step 7: Improvement Strategies	7.1	8	4	0	12	66.67%
Step 8: Analysis and Interpretation of Study Results	8.1	5	6	0	11	45.45%
	8.2	8	3	0	11	72.73%
	8.3	8	2	1	11	72.73%
	8.4	6	3	2	11	54.55%
Step 9: Validity of Improvement	9.1	6	2	0	8	75.00%
	9.2	6	2	0	8	75.00%
	9.3	5	1	0	6	83.33%
	9.4	5	0	1	6	83.33%
Step 10: Sustained Improvement	10.1	2	0	0	2	100.00%
Number Met		205	43	7	254	80.71%

Note: Percent Met = Number Met/Number Applicable; Item refers to the Protocol specifications.
Source: BHC, Inc., 2006 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

Most of the PIPs "Met" the criteria for defining and describing the calculation of study indicators. Twelve (100%) of the PIPs Met the criteria for using objective, clearly defined, measurable indicators (Step 3.1). The calculation of measures was described and explained. Even when well-known measures were used (e.g., Health Employer Data Information Set; HEDIS; Consumer Assessment of Health Plans Survey; CAHPS), there was a detailed description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Again, because MO HealthNet Managed Care Health Plans vary in their method of calculation, details regarding the measures and methods of calculating those measures should be included in PIPs. All but two of the 12 PIPs identified and detailed at least one study indicator that was related to health or functional status; or to processes of care strongly associated with outcomes. Ten of the 12 (83.33%) were rated as "Met" (Step 3.2); and two were Partially Met. The link between the intervention and the outcomes measured by the PIP should be explicit in the narrative.

STEP 4: STUDY POPULATIONS

The MO HealthNet Managed Care Health Plans all made an attempt to meet the criteria for adequately defining the study population. The evaluation examines if all the MO HealthNet Managed Care Program Members to whom the study question(s) and indicator(s) were relevant are included. All twelve (100%) did include adequate information to make this determination (Step 4.1). All PIPS, including those considered non-clinical, made an attempt to define the applicable study population considered. The selection criteria should clearly describe the MO HealthNet Managed Care Member populations included in the PIP and their demographic characteristics. Nine of the 12 PIPs (75.0%) described data collection approaches indicating that data for all members to whom the study question applied were collected (Step 4.2). In most cases there was a description that at least allowed inference of how data were collected and how participants were identified.

STEP 5: SAMPLING METHODS

None of these PIPs employed true sampling techniques. The type of sample (e.g., convenience, random) or sampling methods (e.g., simple, cluster, stratified) should be described if utilized. It should be noted that for the six (6) PIPs concerning Adolescent Well Care results were based on the HEDIS technical specifications, which are an actual sample. However, this was accepted by all Health Plans and an assessment of this sampling technique was audited in the Performance Measure section of this report.

STEP 6: DATA COLLECTION PROCEDURES

Eleven of the 12 PIPs (91.6%) described the data to be collected with adequate detail and description of the units of measurement used (Step 6.1). Ten of the 12 (83.33%) PIPs clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). Two MO HealthNet Managed Care Health Plans used the National Committee for Quality Assurance (NCQA) Quality Improvement Activity (QIA) Form to write up their PIP narrative. This form provides a structure for reporting measures and data sources. However, when there is more than one source of data, it is important that the Health Plan specifically states the sources of data for each measure. The Health Plans were reminded that the strict use of this format limits the narrative and explanation that must accompany the PIP in order for the EQRO to validate each element. Eight of the 12 PIPs (66.67%) clearly described systematic and reliable methods of data collection (Step 6.3). There was some description of the data collection procedures in all cases. It is not possible to judge the reliability or credibility of any PIP without sufficient detail regarding data collection processes, procedures, or frequency. Nine of the PIPs used a data collection instrument that was described in detail. Two provided information on the methods or instruments to be used to collect data, but the information was not presented in a method which allowed that consistent and accurate data would be collected over time (Step 6.4). In one case the Health Plan did not provide adequate information to determine if accurate data would be collected over time. However, Nine (75%) Met this element, two Partially Met this element, and one did not meet the requirements of this element.

When using surveys, medical records, or telephone protocols for data collection, it is important to provide the tool for review, discuss the piloting of the tool, and discuss training and interrater reliability for the recording of information on the tool. Standard provider and consumer surveys provide manuals describing the characteristics of instruments that should be incorporated into the narrative of the PIP. This level of detail was not provided in the narrative for all PIPs, but in most cases the calculation of the measure did include sufficient information to make a judgment for this validation element.

Eight of the PIPs (66.67%) included a complete data analysis plan, while two additional PIPs were rated Partially Met for specifying a plan (Step 6.5). Two PIPs submitted did not include any information that prospectively specified a data analysis plan. This plan should be developed prior to the implementation of the PIP, be based on the study questions, explain the expected relation between the intervention(s) and outcome(s) being measured (i.e. independent and dependent

variables), and include the method(s) of data collection, and the nature of the data (e.g., nominal, ordinal, scale).

Nine of the 12 (75%) PIPs identified the project leader and qualifications of that individual in the narrative submitted. They also identified who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). Health Plan staff interviewed on-site also included team members who were involved and knowledgeable about the PIPs and methods. Additional information about all the PIP team members and their qualifications and roles were rarely described in detail. This information would have provided additional clarification and validity to the process and the measures. When submitting subsequent information after the on-site review, most Health Plans did provide additional information about PIP team members. Three Health Plans did not provide adequate information to provide confidence that the staff involved in implementing and managing the PIP were qualified.

STEP 7: IMPROVEMENT STRATEGIES

Eight of the 12 (66.67%) PIPs identified reasonable interventions to address the barriers identified through data analysis and quality improvement processes undertaken. Four of the PIPs were Partially Met in this requirement. The nature of identification of the barriers, a description of barriers, and a plan for addressing barriers should be described.

STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Eleven of the 12 PIPs were mature enough to have data to analyze. These MO HealthNet Managed Care Health Plans conducted the analyses according to the data analysis plan (Step 8.1). However, only 5 of the 11 (45.45%) had a complete and thorough analysis of the data presented. Of the eleven (11) PIPs that presented baseline or re-measurement data, eight (72.73%) presented numerical findings accurately and clearly (Step 8.2). In some instances, data were presented in formats different from those described in the calculation of measures (e.g., presenting percentages in graphic format while the description of the calculation of measures indicated rates per 1,000). Three PIPs Partially Met this criteria. Axis labels and units of measurement should be reported in Tables and in Figure legends and this information should be made clearly identifiable to the reader. In one case the baseline data was in table form and the re-measurement was in a graphic form. This creates difficulty in evaluation of the data presented.

Of the eleven PIPs that presented at least one re-measurement period, eight (72.73%) indicated the re-measurement period for all of the measures identified in the study (Step 8.3). Of the eleven PIPs describing the findings, six (54.55%) described the extent to which the intervention was effective (Step 8.4).

STEP 9: VALIDITY OF IMPROVEMENT

Six of the eight PIPs (75.0%) with re-measurement points used the same method at re-measurement as the baseline measurement (Step 9.1). Whenever possible the baseline measure should be recalculated consistent with the re-measurement method to ensure validity of reported improvement and comparability of measurement over time. The same source of measures should also be used at re-measurement points. Six of the eight PIPs (75%) that were mature enough to include data analysis employed statistical significance testing to document quantitative improvements in care (Step 9.2). They were able to show significant improvement over multiple re-measurement points, however, this improvement was not always statistically significant. Five of the six (83.33%) PIPs reporting improvements had face validity, meaning that the reported improvement was judged to have been related to the intervention applied (Step 9.3). These PIPs provided some discussion or interpretation of findings by Health Plans. Additional narrative in this area would ensure proper evaluation of all data and information provided. After reporting findings, there should be some interpretation as to whether the intervention or other factors may have accounted for improvement, decline, or lack of change. Five of the six PIPs (83.33%) that had reached a level of maturity to include this data did provide statistical evidence that the observed improvement was true improvement (Step 9.4). Then, barriers should be identified and addressed for the next cycle of the PIP, or reasons for discontinuing the PIP should be described.

STEP 10: SUSTAINED IMPROVEMENT

Of the two PIPs examining multiple measurement points over time, both (100.0%) PIPs used statistical significance testing to demonstrate improvement. The low numbers in this area are a function of the lack of maturity that many of the PIPs exhibited.

ANALYSIS OF THE STATEWIDE PIP

HISTORY

During 2008 the SMA and the MO HealthNet Managed Care Health Plans engaged in their first collaborative effort to produce a Statewide PIP. The MO Health Net Managed Care Health Plans submitted a collaborative non-clinical Performance Improvement Project, the Health Pans focused on a collaborative effort to improve Adolescent Well Care. In was hypothesized that taking a statewide approach to improving well care visits among adolescents would improve outcomes as well as foster wellness, prevention and personal responsibility for the members ages 12 through 21.

FINDINGS

Topic selection was well documented and included a thorough literature and research review. The justification concluded that adolescents are viewed as a challenging section of the Health Plan population. Adolescents are normally healthy and tend to be non-compliant with recommended preventive health interventions. The PIP identified that the provision of adolescent preventive services is well below the optimal level for all of the Health Plans. In Missouri the MO HealthNet Managed Care Health Plans 2005 HEDIS "statewide average" for adolescent well care was 33%, which was well below the 2005 national Medicaid mean of 39.4% Each Health Plan reported that they had implemented some activities in an attempt to impact or improve this measure, but had little success.

The Health Plans identified this issue as one that could be defined as a common focus. The study topic documentation related that in addition to improving the outcomes of care for adolescents, improving the rate of well care screenings will improve the rate of adolescent preventive services available to the members, which is also an outcome desired by the SMA.

The study question for this PIP is, "Will a coordinated statewide improvement effort, with health plan specific interventions, improve the HEDIS rate of adolescent well care?" This question is clear, concise, outcome focused, and measurable. The primary indicator defined in the PIP is the HEDIS measure for Adolescent Well Care. A HEDIS measure was chosen as all Health Plans are required to report this measure. In addition, all data collection and reporting is consistent across Health Plans. The HEDIS technical specifications define adolescent well care as the rate of eligible members age 12 through 21 years of age who had at least one comprehensive well care visit with a primary

care provider (PCP) or an Obstetrician/Gynecologist (OB?GYN). The statewide HEDIS average across all Health Plans will serve as the baseline rate. This rate will be the well care rate from HEDIS 2007 (2006 data). The first measurement period will be HEDIS 2008 (2007 data).
The study provider population included all PCPs and OB/GYNs who serve adolescents. The member population is all eligible adolescents between the ages of 12 -20.
The study design did identify the data to be collected, including identifying the appropriate CPT and ICD-9 codes to be extracted from appropriate claims data. The study explained that each Health Plan will use their own software system to analyze claims data and determine their rate of compliance. The study recognized that all Health Plans did not utilize HEDIS certified software. However, all are required to be audited by a NCQA HEDIS certified auditor. The information provided maintained the assumption that these rates, calculated in this manner would be valid and reliable. Success of the project will be evaluated by demonstrating an increase in the statewide AWC HEDIS average for the Health Plans, as defined in the HEDIS technical specifications. The 2007 HEDIS rate serves as the baseline. Comparisons will be made yearly to identify statistically significant increases.

The original interventions were consistent across all Health Plans beginning in 2007. All proposed interventions were described in detail. Two interventions or initiatives were implemented with prospective outcomes described in the narrative. An educational flyer was developed for providers to disseminate to the members they served. It provided education on the importance of well care and immunization, as well as ensuring members that transportation was available. Posters were developed with similar content, and distributed to providers to educate and to increase awareness for office staff and members.

It was decided to initiate a new methodology for the 2008 continuation of the PIP process. Each Health Plan will develop individualized interventions. The Health Plans reflected that they were aware of the needs of their members, the regional differences existed, and that they were uniquely qualified to develop interventions that best suited their members. The PIP Team was to continue to meet quarterly to share interventions, outcomes and lessons learned. Each individual Health Plan was responsible for conducting a root cause /barrier analysis of the 2007 intervention, and the incorporation of this information into future individual interventions.

The project will be evaluated using statewide AWC HEDIS rates. The Health Plans were to report their rate by June 15th of each year. Comparisons are to be made yearly to identify any statistically significant increase in the statewide rate. This will define the success of the combined and individual interventions. The goal of the project is to reach or exceed the national Medicaid mean on this HEDIS measure. Updates will be developed to reflect outcomes each year after the HEDIS calculations are complete.

CONCLUSION

The basis for this PIP is well-developed and founded on a health care issue common to all MO HealthNet Managed Care Health Plans. The Health Plans utilized the study as a foundation to implement their own interventions. This project was not only an attempt to impact their HEDIS rates, but also to improve the provision of preventive health services to their members. The Health Plans remain committed to this collaborative project. This effort has informed the Health Plans and the SMA about their ability to recognize common health care issues, implement coordinated initiatives, and utilize individual interventions to improve services to all MO HealthNet Managed Care members. The results of the individual interventions are reflected in each Health Plan's individual PIP section of this report.

2.6 Conclusions

Across all MO HealthNet Managed Care Health Plans, the range in proportion of criteria that were "Met" for each PIP validated was 38.1% through 100%. Across all PIPs validated statewide, 80.71% of criteria were met. All sources of available data were used to develop the ratings for the PIP items. The EQRO comments were developed based on the written documentation and presentation of findings. In all cases, there was enough information provided to validate the PIPs. On-site interviews and subsequent information provided revealed in-depth knowledge of the PIPs and detailed outcomes.

All of the PIPs presented included thoughtful and complex information. In some of the PIPs, enhanced information obtained at the on-site review, made it clear that the Health Plans intended to use this process to improve organizational functions and the quality of services available or delivered to members. In several cases the performance improvement project had already been incorporated into Health Plan daily operations. PIPs are to be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the Health Plan regarding the need to address barriers to implementation. Health Plan personnel involved in PIPs had extensive experience in clinical service delivery, quality improvement, and monitoring activities. It was clear that they had made a significant improvement and investment in designing valid evaluation studies using sound data collection and analysis methods. This requires technical expertise in health services research and/or program evaluation design.

Based on the PIP validation process, at least four Health Plans (Children's Mercy Family Health Partners, Blue-Advantage Plus, HealthCare USA, and Missouri Care) had active and ongoing PIPs as part of their quality improvement programs. One Health Plan (Molina Healthcare of Missouri) significantly improved their utilization of the PIP process as a tool to develop their performance and improve services to members, particularly in the area of clinical care. One Health Plan (Harmony Health Plan) submitted PIPs for review for the first time. They have a commitment to develop quality programming although their projects reflect areas that need improvement. An improved commitment to the quality improvement process was observed during the on-site review at all Health Plans.

Table 3 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Members at High Risk for Cesarean Wound Infection	NA
Improving Adolescent Well Care (Molina)	Low Confidence
Readmission Performance Improvement	NA
Improving Adolescent Well Care (HCUSA)	NA
Lead Screening	Moderate Confidence
Improving Adolescent Well Care (Harmony)	Low Confidence
Partnership to Improve WIC Participation & Increase Well-Child Visit Rates	High Confidence
Improving Adolescent Well Care	Moderate Confidence
Improving Dental Utilization Rates	High Confidence
Improving Adolescent Well Care	NA
Ambulatory Follow-Up After Mental Health Hospitalization	Moderate Confidence
Improving Adolescent Well Care	High Confidence

Note: Not Credible = There is little evidence that the study will or did produce results that could be attributed to the intervention(s); Low Confidence = Few aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); Moderate Confidence = Many aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); High Confidence = The PIP study was conducted or planned in a methodologically sound manner, with internal and external validity, standard measurement, and data collection practices, and appropriate analyses to calculate that there is a high level of confidence that improvements were a result of the intervention. A 95% to 99% level of confidence in the findings was or may be able to be demonstrated. NA = Not Applicable due to maturity.
Source: BHC, Inc., 2006 External Quality Review Performance Improvement Project Validation.

The following summarizes the quality, access, and timeliness of care assessed during this review, and recommendations based on the findings of the Validation of Performance Improvement Projects activity.

ACCESS TO CARE

Access to care was a prominent theme throughout all of the PIP submissions reviewed.

- One specific PIP worked to impact needed improvement in access to dental care (Children's Mercy Family Health Partners);
- Two Health Plans focused on the availability of appropriate aftercare when there is a surgery or hospitalization (Molina HealthCare of Missouri, and HealthCare USA);
- Five of the Statewide PIP submissions focused on improving the access to adolescent well-care.
- All the projects reviewed utilized the format of the PIP to recognize improvements in access to care for members.
- One of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for mental health related issues (BA+).
- One PIP focused on improving preventive services through a community partnership that also enhanced member access to ancillary services (Missouri Care).
- One PIP focused on a key aspect of prevention (Harmony Health Plan).
- The on-site discussions with Health Plan staff indicate that they realize that improving access to care is an ongoing aspect of all projects that are developed.

The Statewide PIP was expanded to enable each Health Plan to address individual approaches to improving Adolescent Well Care. Five of these PIPs utilized interventions that informed or educated members about the availability of these services, and encouraged increased utilization of the health care services available.

QUALITY OF CARE

The Performance Improvement Projects reviewed exemplified the importance of providing quality health care to members. This was evident in the identification of the topics chosen for the clinical PIPs.

- Molina HealthCare of Missouri: The Health Plan recognized that reducing the number of members returning to the hospital with a wound infection after a Cesarean birth was of primary importance to them and their families. Members' risks were identified and interventions developed to reduce these risks;

- HealthCare USA: The Health Plan identified the need to reducing the number of hospital readmissions after surgery to decrease the negative impact on members and their families. Research surrounding this issue was cited and the Health Plan's response included interventions to clearly improve the quality of care for members at risk.
- Missouri Care: The Health Plan chose a project, in partnership with another community agency – the WIC program, to increase members' utilization of this resource, while improving the number of children obtaining Well Child Visits. The interventions improved the quality of care for members in preventive health care and resource availability.
- Children's Mercy Family Health Partners: This Health Plan attacked one of the most difficult problems for the population they serve, which is the availability of dental services. The PIP improved the availability of providers, and members' knowledge and utilization of services, which is significant in increasing their quality of care.
- Blue Advantage Plus: Improving access to aftercare services when a member has been hospitalized for a mental health disorder. The Health Plan employed diligent interventions to improve the availability of aftercare services to members to ensure that they receive appropriate outpatient treatment, including in-home services.
- Harmony Health Plan: The Health Plan attacked one of the primary prevention services, lead screening, in an effort to improve both physicians attention to this need, and members' education regarding the importance and availability of these screenings.

Each of these topics clearly focused on improving the quality of health care, as well as the quality of life, for members. The interventions utilized focused on internal and external processes to improve the quality and availability of health care and preventive services. These PIPs addressed barriers to quality care and health outcomes, and were designed to positively impact the members served. These interventions addressed key aspects of member care and services, such as medication and treatment management; risk identification and stratification for various levels of care; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

TIMELINESS OF CARE

Timeliness of care was not ignored as a crucial factor in the PIPs reviewed.

1. Three projects directly identified the need for timely aftercare for members who required inpatient hospitalization (Blue Advantage Plus, HealthCare USA, and Molina HealthCare of Missouri).
2. The remaining three projects focused on subjects such as timely utilization of preventive care (Missouri Care, and Harmony Health Plan), and improved access to dental services (Children's Mercy Family Health Partners). All of these projects identified the need for timely access to preventive and primary health care services as principal components for success.
3. The Health Plans related their awareness of the need to provide not only quality, but timely services to members as motivators for these projects. The Health Plans reflected this awareness in the way they addressed internal processes and direct service improvement.
4. Interventions included initiation of follow-up services prior to members leaving the hospital setting, authorization of in-home services, specific educational activities to improve self-care, and awareness of the advantages of utilizing preventive services.

Five of the PIPs, related to improving Adolescent Well Care, stress the importance of obtaining timely screenings in their interventions. The Health Plans recognize that this is an essential component of effective preventive care.

RECOMMENDATIONS

1. It is recommended that Health Plans continue to refine their skills in the development and implementation of the Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available. One Health Plan (Children's Mercy Family Health Partners) continues to utilize the services of a statistician from a local university to ensure valid and reliable findings.
2. In the design of PIPs, Health Plans need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, "Conducting Performance Improvement Projects" were recommended by the EQRO at each Health Plan as a guideline to frame the development, reporting and analysis of the PIP.

3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions.
4. PIPs that are not yet complete should include narrative reflecting next steps and the plan for how the PIP will be maintained and enhanced for future years.
5. Efforts to continue to improve outcomes related to the Statewide PIP should be continued. Several Health Plans provided results indicating some improvement in their HEDIS measure has occurred. A number of innovative approaches were used to impact this issue. The Health Plans should continue with their individualized interventions, while continuing to collaborate on this project as a statewide effort.
6. It appears that many Health Plans conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs as tools to improve the organizations ability to serve members will be beneficial.

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3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Definition

The EQRO is required by the Validating Performance Measures Protocol to evaluate three performance measures reported by each MO HealthNet MCHP. These measures are selected by the State Medicaid Agency each year (SMA; the Missouri Department of Social Services, MO HealthNet Division; MHD). For the HEDIS 2008 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Adolescent Well-Care Visits (AWC), and Use of Appropriate Medications for People with Asthma (ASM). Two of these measures, Annual Dental Visits and Adolescent Well-Care Visits, were also reviewed for the HEDIS 2007 evaluation period. Protocol activities performed by the EQRO for this audit included: 1) Review of the processes used by the MO HealthNet health plans to analyze data; 2) Evaluation of algorithmic compliance with performance measure specifications: and 3) Recalculation of either the entire set of performance measure data (administrative rates) or a subset of the data (hybrid rates) to verify and confirm the rates reported by the health plans are based upon accurate calculations.

3.2 Purpose and Objectives

The objectives for validating performance measures were to: 1) evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, MO HealthNet Managed Care health plans; and 2) determine the extent to which MO HealthNet Managed Care health plan-specific performance measures calculated by the health plans (or by entities acting on behalf of the health plans) followed specifications established by the SMA and the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for the calculation of the performance measure(s).

REVIEWERS

Interviews, document review, and data analysis activities for the Validating Performance Measure Protocol were performed by two reviewers from the External Quality Review Organization (EQRO). The Project Director conducted interviews and document review; she is a licensed attorney with a graduate degree in Health Care Administration, as well as eight years experience in public health and managed care in two states. This is her fourth External Quality Review. Data analysis and interviews were conducted by the EQRO Research Analyst, who is an Information Technology specialist with a Bachelors Degree in Computer Science and a Masters Degree in Business Administration. She has worked for over five years managing data in large and small databases.

3.3 Technical Methods

Reliable and valid calculation of performance measures is a critical component to the EQRO audit. These calculations are necessary to calculate statewide rates, compare the performance of MO HealthNet Managed Care health plans with other MO HealthNet Managed Care health plans, and to compare State and health plan performance with national benchmarked data for Medicaid Managed Care and/or Commercial Managed Care Organization members. These types of comparisons allow for better evaluation of program effectiveness and access to care. The EQRO reviewed the selected data to assess adherence to State of Missouri requirements for MO HealthNet Managed Care health plan performance measurement and reporting. The Missouri Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) contains provisions requiring all Health Maintenance Organizations (HMOs) operating in the State of Missouri to submit to the SPHA member satisfaction survey findings and quality indicator data in formats conforming to the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) Data Submission Tool (DST) and all other HEDIS Technical Specifications[10] for performance measure descriptions and calculations. The State of Missouri contract for MO HealthNet Managed Care (C30611801-07, Revised Attachment 6, Quality Improvement Strategy) further stipulates that MO HealthNet health plans will follow the instructions of the SPHA for submission of HEDIS measures. The three measures selected by the SMA for validation were required to be calculated and reported by MO HealthNet Managed Care health plans to both the SMA and the SPHA for MO HealthNet Managed Care Members. A review was conducted for each of the three measures selected based upon the HEDIS 2008 Technical Specifications. These specifications are provided in the following tables:

[10] National Committee for Quality Assurance. HEDIS 2008, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

HEDIS 2008 Adolescent Well-Care Visits (AWC)

The following is the definition of the Adolescent Well-Care Visits measure, a Use of Services measure[11], and the specific parameters as defined by the NCQA.

> *The percentage of enrolled members who were 12–21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.*

Table 4 - HEDIS 2008 Technical Specifications for Adolescent Well-Care Visits (AWC)

I. Eligible Population	
Product lines	Commercial, Medicaid (report each product line separately).
Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
II. Administrative Specification	
Denominator	The eligible population.
Numerators	At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member. Adolescents who had a claim or encounter with a primary care practitioner or OB/GYN practitioner with one of the codes listed below are considered to have received a comprehensive well-care visit: 99383-99385, 99393-99395, V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

[11] This measure has the same structure as measures in the Effectiveness of Care domain. The MCO should follow *Specific Guidelines for Effectiveness of Care Measures* when calculating this measure.

III. Hybrid Specification	
Denominator	A systematic sample drawn from the MCO's eligible population. The MCO may reduce its sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. ***Note:*** *For information on reducing sample size, refer to the* Guidelines for Calculations and Sampling.
Numerators	At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The primary care practitioner does not have to be assigned to the member.
Administrative	Refer to the *Administrative Specification* listed above to identify positive numerator hits from the administrative data.
Medical record	Documentation in the medical record must include, a note indicating a visit to a primary care practitioner or OB/GYN practitioner, the date on which the well-care visit occurred and, evidence of all of the following. • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 5 - Data Elements for Adolescent Well-Care Visits

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

HEDIS 2008 Use of Appropriate Medications for People With Asthma (ASM)

The following is the definition of the Use of Appropriate Medications for People With Asthma measure, an Effectiveness of Care measure, and the specific parameters as defined by the NCQA.

The percentage of members 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Table 6 - HEDIS 2008 Technical Specifications for Use of Appropriate Medications for People with Asthma (ASM)

Definitions	
Dispensing Event	*A **dispensing event** is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). In addition, two different prescriptions dispensed on the same day are counted as two different dispensing events.*
Inhaler Dispensing Event	*Inhalers count as one dispensing event; for example, an inhaler with a 90-day supply is considered one dispensing event. In addition, multiple inhalers of the same medication filled on the same date of service should be counted as one dispensing event; for example a member may obtain two inhalers on the same day (one for home and one for work), but intend to use both during the same 30-day period.*
I. Eligible Population	
Product lines	*Commercial, Medicaid, Medicare (report each product line separately).*
Ages	*5–56 years by December 31 of the measurement year. Report three age stratifications and a total rate.* • *5–9 years* • *10–17 years* • *18–56 years* • *Total* *The total is the sum of the three numerators divided by the sum of the three denominators.*
Continuous enrollment	*The measurement year and the year prior to the measurement year.*
Allowable gap	*No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment year.*
Anchor date	*December 31 of the measurement year.*
Benefits	*Medical. Pharmacy during the measurement year.*
Event/diagnosis	*Follow the steps below to identify the eligible population for the measure:*

Step 1 *Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.*

- *At least one ED visit (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A)*
- *At least one acute inpatient discharge (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A)*
- *At least four outpatient asthma visits (Table ASM-B), with asthma as one of the listed diagnoses (Table ASM-A) and at least two asthma medication dispensing events (Table ASM-C)*
- *At least four asthma medication dispensing events (Table ASM-C)*

Table ASM-A: Codes to Identify Asthma

Description	ICD-9-CM Diagnosis
Asthma	493

Table ASM-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987
ED	99281-99285	045x, 0981

Table ASM-C: Asthma Medications

Description	Prescriptions		
Antiasthmatic combinations	• dyphylline-guaifenesin	• guaifenesin-theophylline	• potassium iodide-theophylline
Inhaled steroid combinations	• budesonide-formoterol	• fluticasone-salmeterol	
Inhaled corticosteroids	• beclomethasone • budesonide	• flunisolide • fluticasone CFC free	• mometasone • triamcinolone
Leukotriene modifiers	• montelukast	• zafirlukast	• zileuton
Long-acting, inhaled beta-2 agonists	• aformoterol	• formoterol	• salmeterol
Mast cell stabilizers	• cromolyn	• nedocromil	
Methylxanthines	• aminophylline • dyphylline	• oxtriphylline • theophylline	
Short-acting, inhaled beta-2 agonists	• albuterol • bitolterol	• levalbuterol • pirbuterol	

Note: *NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 15, 2007.*

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Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also meet one of the following criteria.

- Meet any of the other three criteria in step 1 in the same year as the leukotriene modifier, ***or***
- Have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

II. Administrative Specification

Denominator The eligible population.

Numerators Dispensed at least one prescription for a preferred therapy during the measurement year (Table ASM-D).

Table ASM-D: Preferred Asthma Therapy Medications

Description	Prescriptions		
Antiasthmatic combinations	• dyphylline-guaifenesin	• guaifenesin-theophylline	• potassium iodide-theophylline
Inhaled steroid combinations	• budesonide-formoterol	• fluticasone-salmeterol	
Inhaled corticosteroids	• beclomethasone • budesonide	• flunisolide • fluticasone CFC free	• mometasone • triamcinolone
Leukotriene modifiers	• montelukast	• zafirlukast	• zileuton
Mast cell stabilizers	• cromolyn	• nedocromil	
Methylxanthines	• aminophylline • dyphylline	• oxtriphylline • theophylline	

Exclusion *(optional)*

Exclude from the eligible population all members diagnosed with emphysema or COPD (Table ASM-E) any time on or prior to December 31 of the measurement year.

Table ASM-E: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Emphysema	492, 506.4, 518.1, 518.2
COPD	491.2, 493.2, 496, 506.4

Note

- *The definition used for "persistent" asthma is an approximation based on the previous two years' service and medication use rather than a clinical measure of severity. This definitional approach was chosen for logistical and feasibility reasons so that an efficient, reasonably standardized and sufficiently large population that allows unbiased organization-to-organization comparison could be identified through administrative sources.*
- *The first four classes of medication in Table ASM-C count in the numerator because they are considered acceptable as primary therapy for long-term control of asthma. The last class (inhaled beta-2 agonists) does not count in the numerator because it is recommended as add-on rather than primary therapy for persistent asthma.*
- *The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.*

III. Hybrid Specification

None.

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 7 – Data Elements for Use of Appropriate Medications for People With Asthma (ASM)

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

HEDIS 2008 Annual Dental Visit (ADV)

The following is the definition of the Annual Dental Visit measure, an Effectiveness of Care measure, and the specific parameters as defined by the NCQA.

The percentage of enrolled members 2–21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.

Table 8 - HEDIS 2008 Technical Specifications for Annual Dental Visit (ADV)

I. Eligible Population	
Product line	Medicaid.
Ages	2–21 years as of December 31 of the measurement year. The measure is reported for each of the following age stratifications and as a combined rate. • 2–3-years • 11–14-years • 19–21-years • 4–6-years • 15–18-years • Total • 7–10-years
Continuous enrollment	The measurement year.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Dental.
Event/diagnosis	None.
II. Administrative Specification	
Denominator	The eligible population for each age group and the combined total.
Numerator	One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any of the codes in Table ADV-A.
III. Hybrid Specification	
	None.

Table ADV-A: Codes to Identify Annual Dental Visits

CPT	HCPCS/CDT-3	ICD-9-CM Procedure
70300, 70310, 70320, 70350, 70355	D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97

Note: *Current Dental Terminology (CDT) is the equivalent dental version of the CPT physician procedural coding system.*

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 9 - Data Elements for Annual Dental Visits

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Methods of Calculating Performance Measures

The HEDIS technical specifications allow for two methods of calculating performance measures: 1) the Administrative Method and 2) the Hybrid Method. Of the measures selected for this review, only the Adolescent Well-Care Visits measure permits the use of either the Administrative or Hybrid methods; Annual Dental Visit and Use of Appropriate Medications for People with Asthma are each required to be calculated using the Administrative Method only.

The Administrative Method involves examining claims and other databases (administrative data) to calculate the number of members in the entire eligible population who received a particular service (e.g., well-child visits, dental visits or asthma medication events). The eligible population is defined by the HEDIS technical specifications. Those cases in which administrative data show that the member received the service(s) examined are considered "hits" or "administrative hits." The HEDIS technical specifications provide acceptable administrative codes for identifying an administrative hit.

For the Hybrid Method, administrative data are examined to select members eligible for the measure. From these eligible members, a random sample is taken from the appropriate measurement year. Members in the sample are identified who received the service(s) as evidenced by a claim submission or through external sources of administrative data (e.g., State Public Health Agency Vital Statistics or Immunization Registry databases). Those cases in which an administrative hit cannot be determined are identified for further medical record review. Documentation of all or some of the services in the medical record alone or in combination with administrative data is considered a "hybrid hit."

Administrative hits and hybrid hits are then summed to form the numerator of the rate of members receiving the service of interest (e.g., appropriate doctor's visit). The denominator of the rate is represented by the eligible population (administrative method) or those sampled from the eligible population (hybrid method). A simple formula of dividing the numerator by the denominator produces the percentage (also called a "rate") reported to the SMA and the SPHA.
Additional guidance is provided in the HEDIS 2008 Technical Specifications: Volume 2[12] for appropriate handling of situations involving oversampling, replacement, and treatment of contraindications for services.

[12] National Committee for Quality Assurance. HEDIS 2008, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

TIME FRAME

The proper time frame for selection of the eligible population for each measure is provided in the HEDIS technical specifications. For the measures selected, the "measurement year" referred to calendar year (CY) 2007. All events of interest (e.g. follow-up visits) must also have occurred during CY2007. One exception applies to this general rule in the Use of Appropriate Medications for People with Asthma (ASM) measure; the HEDIS specifications state that certain events must have occurred in the measurement year (CY 2007) OR in the year prior to the measurement year (CY 2006).

PROCEDURES FOR DATA COLLECTION

The HEDIS 2008 technical specifications for each measure validated were reviewed by the EQRO Project Director and the EQRO Research Analyst. Extensive training in data management and programming for Healthcare quality indices, clinical training, research methods, and statistical analysis expertise were well represented among the personnel involved in adapting and implementing the Validating of Performance Measures Protocol to conform to the HEDIS, SMA, and SPHA requirements while maintaining consistency with the Validating Performance Measures Protocol. The following sections describe the procedures for each activity in the Validating Performance Measures Protocol as they were implemented for the three HEDIS 2008 measures validated.

Pre-On-Site Activity One: Reviewer Worksheets

Reviewer Worksheets were developed for the purpose of conducting activities and recording observations and comments for follow-up at the site visits. These worksheets were reviewed and revised to update each specific item with the HEDIS 2008 technical specifications. Project personnel met throughout November and December 2008 to review available source documents and develop the Reviewer Worksheets for conducting pre-on-site, on-site, and post-on-site activities as described below. These reviews formed the basis for completing the CMS Protocol Attachments (V, VII, X, XII, XIII, and XV) of the Validating Performance Measures Protocol for each measure and MO HealthNet Managed Care health plan. Source documents used to develop the methods for review and complete the Attachments included the following:

- HEDIS 2008 Data Submission Tool (DST)
- HEDIS 2008 Baseline Assessment Tool (BAT)
- HEDIS 2008 Audit Report
- HEDIS 2008 SPHA Reports

Pre-On-Site Activity Two: Preparation of MO HealthNet MCOs

Orientation teleconferences with each MO HealthNet MCHP were conducted December 1, 2008 and December 2, 2008 by the EQRO. The purpose of this orientation conference was to provide education about the Validating Performance Measures protocol and the EQRO's submission requirements. All written materials, letters and instructions used in the orientation were reviewed and approved by the SMA in advance. Prior to the teleconference calls, the MO HealthNet Managed Care health plans were provided information on the technical objectives, methods, procedures, data sources, and contact information for EQRO personnel. The health plans were requested to have in attendance the person(s) responsible for the calculation of the HEDIS 2008 performance measures validated. Teleconference meetings were led by the EQRO Project Director, with key project personnel and a representative from the SMA in attendance. Provided via the teleconferences was technical assistance focused on describing the Validating Performance Measures Protocol; identification of the three measures selected for validation; the purpose, activities and objectives of the EQRO; and definitions of the information and data needed for the EQRO to validate the performance measures. All MO HealthNet Managed Care health plan questions about the process were answered at this time and identified for further follow-up by the EQRO if necessary. In addition to these teleconference calls, presentations and individual communications with personnel at MO HealthNet Managed Care health plans responsible for HEDIS 2008 performance measure calculation were conducted between December 2008 and June 2009, with follow-up telephone calls and written communications continuing as necessary through August 2009.

On December 5, 2008, formal written requests for data and information for the validation of performance measures were submitted to the MO HealthNet Managed Care health plans by the EQRO. This information was to be returned to the EQRO by January 20, 2009 (see Appendix 3). A separate written request was sent to the health plans on February 10, 2009 requesting medical records be submitted to the EQRO for a sample of cases. These records were to be submitted by the providers to the EQRO by March 19, 2009. Detailed letters and instructions were mailed to

QI/UM Coordinators and MO HealthNet Managed Care health plan Administrators explaining the type of information, purpose, and format of submissions. EQRO personnel were available and responded to electronic mail and telephone inquiries and any requested clarifications throughout the evaluation process.

The following are the data and documents requested from MO HealthNet Managed Care health plans for the Validating Performance Measures Protocol:

- HEDIS 2008 Data Submission Tool for all three measures for the MO HealthNet Managed Care Population only.
- 2008 HEDIS Audit Report.
- Baseline Assessment Tool for HEDIS 2008.
- List of cases for denominator with all HEDIS 2008 data elements specified in the measures.
- List of cases for numerators with all HEDIS 2008 data elements specified in the measures, including fields for claims data and all other administrative data used.
- All worksheets, memos, minutes, documentation, policies and communications within the health plan and with HEDIS auditors regarding the calculation of the selected measures.
- List of cases for which medical records were reviewed, with all HEDIS 2008 data elements specified in the measures.
- Sample medical record tools used for hybrid methods for the three HEDIS 2008 measures for the MO HealthNet Managed Care population; and instructions for reviewers.
- Policies, procedures, data and information used to produce numerators and denominators.
- Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of:
    - Statistical testing of results and any corrections or adjustments made after processing.
    - Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.
    - Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance.
- Policies and procedures for mapping non-standard codes, where applicable.
- Record and file formats and descriptions for entry, intermediate, and repository files.

- Electronic transmission procedures documentation. (This will apply if the health plan sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry)
- Descriptive documentation for data entry, transfer, and manipulation programs and processes.
- Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.
- Documentation of proper run controls and of staff review of report runs.
- Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such changes.
- Documentation of sources of any supporting external data or prior years' data used in reporting.
- Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.
- Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.
- Procedures used to link member months to member age.
- Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the health plan's process to re-draw a sample or obtain necessary replacements.
- Procedures to capture data that may reside outside the health plan's data sets (e.g. MOHSAIC).
- Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)
- Appendix Z – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

Pre-On-Site Activity Three: Assess the Integrity of the MCHP's Information System

The objective of this activity was to assess the integrity of the MO HealthNet Managed Care health plans' ability to link data from multiple sources. All relevant documentation submitted by the MO HealthNet Managed Care health plans was reviewed by EQRO personnel. The review protocols

indicate than an Information Systems Capability Assessment (ISCA) be administered every other year. The 2007 review year did not contain a full ISCA analysis; therefore, a new ISCA analysis was conducted for each MCHP for the 2008 review. These reviews revealed no evident issues or significant problems with any of the MCHP's information systems. EQRO personnel also reviewed HEDIS 2008 Baseline Assessment Tool (BAT) submitted by each health plan. Detailed notes and follow-up questions were formulated for the site visit reviews.

On-Site Activity One: Assess Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources and determine whether these processes ensure the accurate calculation of the measures. A series of interviews and in-depth reviews were conducted by the EQRO with MO HealthNet Managed Care health plan personnel (including both management and technical staff and 3rd party vendors when applicable). These site visit activities examined the development and production procedures of the HEDIS 2008 performance measures and the reporting processes, databases, software, and vendors used to generate these rates. This included reviewing data processing issues for generating the rates and determining the numerator and denominator counts. Other activities involved reviewing database processing systems, software, organizational reporting structures, and sampling methods. The following are the activities conducted at each health plan:

- Review results of run queries (on-site observation, screen-shots, test output)
- Examination of data fields for numerator & denominator calculation (examine field definitions and file content)
- Review of applications, data formats, flowcharts, edit checks and file layouts
- Review of source code, software certification reports
- Review HEDIS repository procedures, software manuals
- Test for code capture within system for measures (confirm principal & secondary codes, presence/absence of non-standard codes)
- Review of operating reports
- Review information system policies (data control, disaster recovery)
- Review vendor associations & contracts

The following are the interview questions developed for the site visits:

- What are the processes of data integration and control within information systems?
- What documentation processes are present for collection of data, steps taken and procedures to calculate the HEDIS measures?
- What processes are used to produce denominators?
- What processes are used to produce numerators?
- How is sampling done for calculation of rates produced by the hybrid method?
- How does the MCHP submit the requirement performance reports to the State?

From the site visit activities, interviews, and document reviews, Attachment V (Data Integration and Control Findings) of the CMS Protocol was completed for each MO HealthNet Managed Care health plan and performance measure validated.

On-Site Activity Two: Assess Documentation of Data and Processes Used to Calculate and Report Performance Measures

The objectives of this activity were to assess the documentation of data collection, assess the process of integrating data into a performance measure set, and examine procedures used to query the data set to identify numerators, denominators, generate a sample, and apply proper algorithms.

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment VII (Data and Processes Used to Calculate and Report Performance) of the CMS Protocol was completed for each MO HealthNet Managed Care health plan and measure validated. One limitation of this step was the inability of the health plans to provide documentation of processes used to calculate and report the performance measures due to the use of proprietary software or off-site vendor software and claims systems. However, all MO HealthNet Managed Care health plans were able to provide documentation and flow-charts of these systems to illustrate the general methods employed by the software packages to calculate these measures.

On-Site Activity Three: Assess Processes Used to Produce the Denominators

The objectives of this activity were to: 1) determine the extent to which all eligible members were included; 2) evaluate programming logic and source codes relevant to each measure; and 3) evaluate eligibility, enrollment, age, codes, and specifications related to each performance measure.

The content and quality of the data files submitted were reviewed to facilitate the evaluation of compliance with the HEDIS 2008 technical specifications. The MO HealthNet Managed Care health plans consistently submitted the requested level of data (e.g., all elements required by the measures or information on hybrid or administrative data). In order to produce meaningful results, the EQRO required that all the health plans submit data in the format requested. Although corrected data had to be requested, all MO HealthNet Managed Care health plans did submit the data requested in the proper format prior to completion of the validation process.

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment X (Denominator Validation Findings) of the CMS Protocol was completed for each MO HealthNet Managed Care health plan and performance measure validated.

On-Site Activity Four: Assess Processes Used to Produce the Numerators

The objectives of this activity were to: 1) evaluate the MO HealthNet Managed Care health plans' ability to accurately identify medical events (e.g., appropriate doctor's visits); 2) evaluate the health plans' ability to identify events from other sources (e.g., medical records, State Public Immunization Registry); 3) assess the use of codes for medical events; 4) evaluate procedures for non-duplication of event counting; 5) examine time parameters; 6) review the use of non-standard codes and maps; 7) identify medical record review procedures (Hybrid Method); and 8) review the process of integrating administrative and medical record data.

Validation of the numerator data for all three measures was conducted using the parameters specified in the HEDIS 2008 Technical Specifications; these parameters applied to dates of service(s), diagnosis codes, and procedure codes appropriate to the measure in question. The Annual Dental Visit measure, for example, requires that all dates of service occurred between January 1, 2007 and December 31, 2007. Visits outside this valid date range were not considered. Similar validation was conducted for all three measures reviewed. This numerator validation was conducted on either all numerator cases (Administrative Method) or on a sample of cases (Hybrid Method).

Additional validation for measures calculated using the Hybrid Method was also conducted. The Protocol requires the EQRO to sample up to 30 records from the medical records reported by the MO HealthNet Managed Care health plan as meeting the numerator criteria (hybrid hits). In the event that the health plan reported fewer than 30 numerator events from medical records, the EQRO requested all medical records that were reported by the health plan as meeting the numerator criteria. This approach did not apply to the Use of Appropriate Medications for People with Asthma or Annual Dental Visit measures, as the Administrative Method of calculation is required for these measures by HEDIS technical specifications.

Initial requests for documents and data were made on December 5, 2008, with submissions due to the EQRO by January 20, 2009. The EQRO required the MO HealthNet Managed Care health plans to request medical records from the providers. On February 10, 2009, the MO HealthNet Managed Care health plans were given a list of medical records to request, a letter from the State explaining the purpose of the request, and the information necessary for the providers to send the medical records directly to the EQRO. The submission deadline for medical records was March 19, 2009. The record receipt rate was excellent; of the 96 records contained in the sample, all 96 were received by the EQRO for review.

The review of medical records was administered by Reliable Healthcare Services, Inc. (RHS), a temporary Healthcare services provider located in Kansas City, Missouri and a Business Associate of Behavioral Health Concepts, Inc., (the EQRO). RHS is a State of Missouri certified Minority-Owned Business Enterprise (MBE) operated by two registered nurses. RHS possesses expertise in recruiting nursing and professional health care staff for clinical, administrative, and HEDIS medical record review services. The review of medical records was conducted by RNs with over 20 years of clinical experience and who were currently licensed and practicing in the State of Missouri. Two RNs participated in the training and medical record review process and both had at least ten years of experience conducting medical record reviews for HEDIS measures.

A medical record abstraction tool for the Adolescent Well-Care Visits measure was developed by the EQRO Project Director and revised in consultation with a nurse consultant, the EQRO Research Analyst, and with the input from the nurse reviewers. The 2008 HEDIS technical specifications and the Validating Performance Measures Protocol criteria were used to develop the medical record review tools and data analysis plan. A medical record review manual and documentation of ongoing reviewer questions and resolutions were developed for the review. A

half day of training was conducted by the EQRO Project Director and staff on March 20, 2009 using sample medical record tools and reviewing all responses with feedback and discussion. The reviewer training and training manual covered content areas such as Health Insurance Portability and Accountability Act (HIPAA), confidentiality, conflict of interest, review tools, and project background. Teleconference meetings between the nurses, coders, and EQRO Project Director were conducted as needed to resolve questions and coding discrepancies throughout the duration of the medical record review process.

A data entry format with validation parameters was developed for accurate medical record review data entry. A data entry manual and training were provided to the data entry person at RHS, Inc. Data was reviewed weekly for accuracy and completeness, with feedback and corrections made to the data entry person. The final databases were reviewed for validity, verified, and corrected prior to performing analyses. All data analyses were reviewed and analyzed by the EQRO Research Analyst and reviewed, approved and finalized by the EQRO Project Director. CMS Protocol Attachments XII (Impact of Medical Record Findings) and XIII (Numerator Validation Findings) were completed based on the medical record review of documents and site visit interviews.

On-Site Activity Five: Assess Sampling Process (Hybrid Method)

The objective of this activity was to assess the representativeness of the sample of care provided.

- Review HEDIS Baseline Assessment Tool (BAT)
- Review Data Submission Tool (DST)
- Review numerator and denominator files
- Conduct medical record review for measures calculated using hybrid methodology
- Determine the extent to which the record extract files are consistent with the data found in the medical records
- Review of medical record abstraction tools and instructions
- Conduct on-site interviews, activities, and review of additional documentation

For those health plans that calculated the Adolescent Well-Care Visits measure via hybrid methodology, a sample of medical records (up to 30) was conducted to validate the presence of an appropriate well-child visit that contributed to the numerator.

From the review of documents and site visits, CMS Protocol Attachment XV (Sampling Validation Findings) was completed for those MO HealthNet Managed Care health plans that elected the Hybrid Method for the HEDIS 2008 Adolescent Well-Care Visits measure.

On-Site Activity Six: Assess Submission of Required Performance Measures to State

The objective of this activity was to assure proper submission of findings to the SMA and SPHA. The DST was obtained from the SPHA to determine the submission of the performance measures validated. Conversations with the SPHA representative responsible for compiling the measures for all MO HealthNet Managed Care health plans in the State occurred with the EQRO Project Director to clarify questions, obtain data, and follow-up on health plan submission status.

Post- On-Site Activity One: Determine Preliminary Validation Findings for each Measure

Calculation of Bias

The CMS Validating Performance Measures Protocol specifies the method for calculating bias based on medical record review for the Hybrid Method. In addition to examining bias based on the medical record review and the Hybrid Method, the EQRO calculated bias related to the inappropriate inclusion of cases with administrative data that fell outside the parameters described in the HEDIS 2008 Technical Specifications. For measures calculated using the Administrative Method, the EQRO examined the numerators and denominators for correct date ranges for dates of birth and dates of service as well as correct enrollment periods and codes used to identify the medical events. This was conducted as described above under on-site activities three and four. The estimated bias in the calculation of the HEDIS 2008 measures for the Hybrid Method was calculated using the following procedures, methods and formulas, consistent with the Validating Performance Measures Protocol. Specific analytic procedures are described in the following section.

Analysis

Once the medical record review was complete, all administrative data provided by the MO HealthNet Managed Care health plans in their data file submissions for the HEDIS 2008 Adolescent Well-Care Visits measure were combined with the medical record review data collected by the EQRO. This allowed for calculation of the final rate. In order for each event of a well-care visit to be met, there had to be documented evidence of an appropriate well-care visit code as defined in the HEDIS 2008 Technical Specifications; sick visits or emergency room codes were not included. Only one well-care visit in the measurement year was required for a member to be considered a positive "hit". Multiple well-care visits for one member within the measurement year were excluded; each member was only counted once.

For the calculation of bias based on medical record review for the MO HealthNet Managed Care health plans using the Hybrid Method for the HEDIS 2008 Adolescent Well-Care Visits measure, several steps were taken. First, the number of hits based on the medical record review was reported (Medical Records Validated by EQRO). Second, the Accuracy (number of Medical Records able to be validated by EQRO/total number of Medical Records requested by the EQRO for audit) and Error Rates (100% - Accuracy Rate) were determined. Third, a weight for each Medical Record was calculated (100%/denominator reported by the health plan) as specified by the Protocol. The number of False Positive Records was calculated (Error Rate * numerator hits from Medical Records reported by the health plan). This represents the number of records that were not able to be validated by the EQRO. The Estimated Bias from Medical Records was calculated (False Positive Rate * Weight of Each Medical Record).

To calculate the Total Estimated Bias in the calculation of the performance measures, the Administrative Hits Validated by the EQRO (through the previously described file validation process) and the Medical Record Hits Validated by the EQRO (as described above) were summed and divided by the total Denominator reported by the MCHP on the DST to determine the Rate Validated by the EQRO. The difference between the Rate Validated by the EQRO and the Rate Reported by the MO HealthNet Managed Care health plan to the SMA and SPHA was the Total Estimated Bias. A positive number reflects an overestimation of the rate by the health plan, while a negative number reflects an underestimation.

Once the EQRO concluded its on-site activities, the validation activity findings for each performance measure were aggregated. This involved the review and analysis of findings and Attachments produced for each performance measure selected for validation and for the health plan's Information System as a result of pre-on-site and on-site activities. The EQRO Project Director reviewed and finalized all ratings and completed the Final Performance Measure Validation Worksheets for all measures validated for each of the MO HealthNet Managed Care health plans. Ratings for each of the Worksheet items (0 = Not Met; 1 = Partially Met; 2 = Met) were summed for each worksheet and divided by the number of applicable items to form a rate for comparison to other MO HealthNet Managed Care health plans. The worksheets for each measure were examined by the EQRO Project Director to complete the Final Audit Rating.

Below is a summary of the final audit rating definitions specified in the Protocol. Any measures not reported were considered "Not Valid." A Total Estimated Bias outside the 95% upper or lower confidence limits of the measures as reported by the MO HealthNet Managed Care health plan on the DST was considered "Not Valid".

Fully Compliant:	Measure was fully compliant with State (SMA and SPHA) specifications.
Substantially Compliant:	Measure was substantially compliant with State (SMA and SPHA) specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid:	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which the data provided to the EQRO could not be independently validated. 'Significantly Biased' was defined by the EQRO as being outside the 95% confidence interval of the rate reported by the MO HealthNet Managed Care health plan on the HEDIS 2007 Data Submission Tool.

3.4 Findings

MO HealthNet Managed Care health plans conduct the calculation of performance measures in collaboration with a variety of vendors and use a number of different management information systems to extract data for the calculation of measures. They are also required to undergo annual audits by NCQA-certified auditing firms that provide MO HealthNet Managed Care health plans with recommendations for reporting or not reporting findings of specific measures to the NCQA. Regardless of the NCQA audit rating or rotation, the health plans are required to report the performance measures validated to the SMA and SPHA. Table 10 summarizes the names of HEDIS-certified software used, medical record vendors, and HEDIS auditors for each of the MO HealthNet Managed Care health plans.

It is important to note that Mercy CarePlus became Molina Healthcare in October 2008. The data in this section, as well as the individual section of this report, are from CY2007.

Table 10 - Software, Vendors, and Auditors for the HEDIS 2008 Measures

MO HealthNet MCHP	Name of Software	Name of Medical Record Vendor	Name of HEDIS 2008 Auditor
Blue-Advantage Plus of Kansas City	Software from ViPs, Inc. MedMeasures*	QMark/HEDISHelp	Ernst & Young, LLP
Children's Mercy Family Health Partners	Software from ViPs, Inc. MedMeasures*	Children's Mercy Family Health Partners	Healthcare Data.com, LLC
Harmony Health Plan	CareEnhance Resource Management Software (CRMS)*	UNIVAL	Healthcare Data.com, LLC
Healthcare USA	Quality Spectrum* HEDIS repository by Catalyst Technologies	Not Applicable. Did not use Hybrid Method.	Healthcare Data.com, LLC
Mercy CarePlus (now Molina Healthcare)	Amisys (Novasys)	QMark/HEDISHelp	Healthcare Research Associates
Missouri Care	Quality Spectrum* HEDIS repository by Catalyst Technologies	Missouri Care	Thomson MedStat

Note: * NCQA-certified

Table 11 shows the method of calculation used by each MO HealthNet Managed Care health plan. This information was taken from the MO HealthNet Managed Care health plans' self-report to the EQRO.

Table 11 - Summary of Method of Calculation Reported and Validated by MO HealthNet Health Plans

MO HealthNet MCHP	Adolescent Well-Care Visits	Annual Dental Visit	Use of Appropriate Medications for People with Asthma
Blue-Advantage Plus of Kansas City	Administrative	Administrative	Administrative
Children's Mercy Family Health Partners	Hybrid	Administrative	Administrative
Harmony Health Plan	Hybrid	Administrative	Administrative
Healthcare USA	Administrative	Administrative	Administrative
Mercy CarePlus (now Molina HC)	Hybrid	Administrative	Administrative
Missouri Care	Hybrid	Administrative	Administrative

The validation of each of the performance measures is discussed in the following sections with the findings from each validation activity described. Subsequent sections summarize the status of submission of the measures validated to the SMA and SPHA, the Final Audit Ratings, and conclusions.

It is important to note that the performance measure data provided to the EQRO by Blue-Advantage Plus of Kansas City could not be validated. The health plan provided the appropriate numerator files but did not submit denominator data; therefore, enrollment eligibility requirements in the HEDIS specifications for each measure could not be validated. Although Blue-Advantage Plus received a rating of Not Met for each of the measures, the EQRO has presented the rates here as they would have appeared provided the eligibility requirements were met.

HEDIS 2008 Annual Dental Visit

Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2008 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. Table 12 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were met was calculated across MO HealthNet Managed Care health plans and from the number of applicable items for each health plan. Of all the MO HealthNet Managed Care health plans that calculated the measure, 100% Met all criteria for every audit element As such, each health plan Met 100% of the criteria for data integration and control.

Table 12 - Data Integration and Control Findings, HEDIS 2008 Annual Dental Visit Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	6	0	0	6	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	6	0	0	6	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	6	0	0	6	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	6	0	0	6	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	6	0	0	6	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	6	0	0	6	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling numerators and denominators; and the ability to apply proper algorithms. The findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol are summarized in Table 13. Items 7.2, 7.3, 7.5, 7.7, 7.9, and 7.10 did not apply to this measure. All MO HealthNet Managed Care health plans (100.0%) Met the criteria for applying appropriate data and processes for the calculation of the HEDIS 2008 Annual Dental Visit measure.

Table 13 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2008 Annual Dental Visit

		MO HealthNet MCHP						All MO HealthNet MCHPs				
Item	Audit Elements	BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	2	6	0	0	6	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	2	2	2	2	2	2	6	0	0	6	100.0%
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	2	6	0	0	6	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	5	5	5	5	5	5	30	0	0	30	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for calculating each measure. Table 14 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (Identification of gender of the member), 10.6 (Calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. Five of the six MO HealthNet Managed Care health plans reviewed Met 100% the criteria for producing denominators according to specifications. Blue-Advantage Plus of Kansas City did not provide the correct denominator files for the EQRO to validate the reported denominator calculations. Therefore, items 10.1, 10.3, and 10.9 were Not Met, resulting in an overall rate of 57.1% for the criteria for producing denominators according to specifications. The overall rate for all MO HealthNet MCHPs for the processes used to produce denominators was 92.9%.

Table 14 - Denominator Validation Findings, HEDIS 2008 Annual Dental Visit

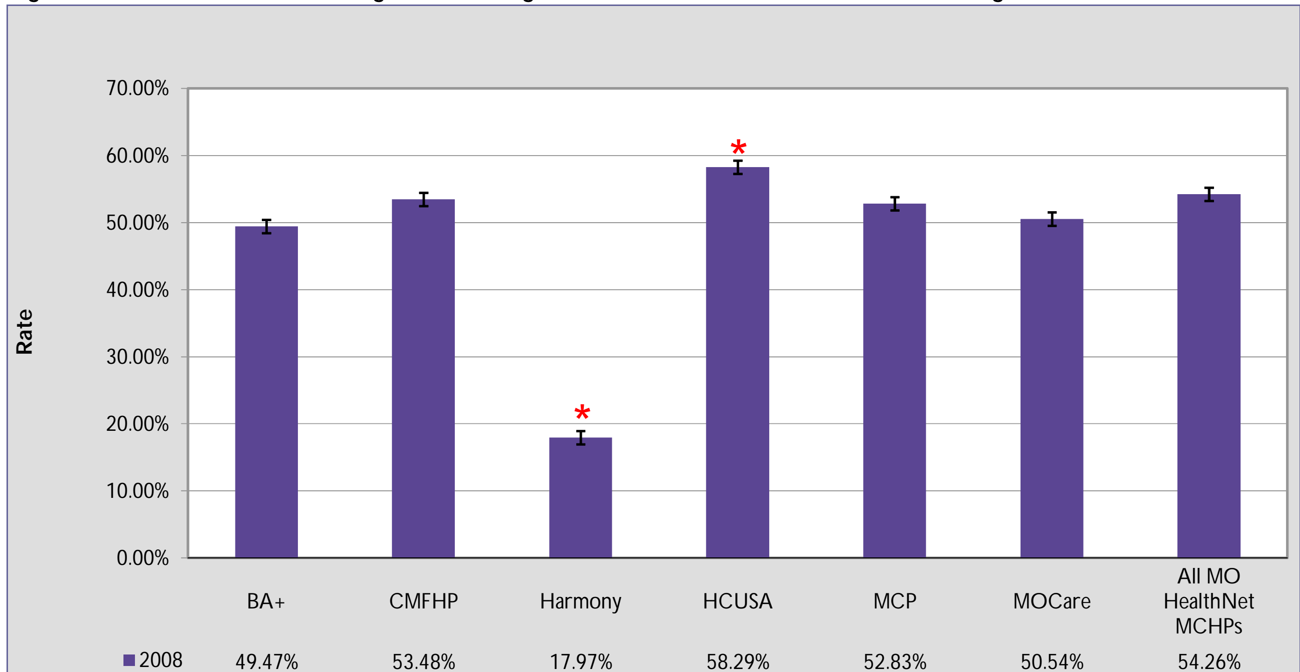
Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	0	2	2	2	2	2	5	0	1	6	83.3%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	2	6	0	0	6	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	0	2	2	2	2	2	5	0	1	6	83.3%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	6	0	0	6	100.0%
10.5	The MCHP/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	2	2	2	2	6	0	0	6	100.0%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	2	6	0	0	6	100.0%
10.9	members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	0	2	2	2	2	2	5	0	1	6	83.3%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	4	7	7	7	7	7	39	0	3	42	92.9%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	3	0	0	0	0	0					
	Number Applicable	7	7	7	7	7	7					
	Rate Met	57.1%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 =Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

When determining the denominator, it was expected that all MO HealthNet Managed Care health plans would identify similar percentages of their total population as eligible for this measure. The identification of eligible members for the HEDIS 2008 Annual Dental Visit measure is dependent on the quality of the enrollment and eligibility files. The rate of eligible members (eligible population identified / total MO HealthNet enrollment) was calculated for all health plans and is illustrated in Figure 11. Two-tailed z-tests of each health plan were conducted comparing the health plans to the rate of eligible members for all MO HealthNet Managed Care health plans at the 95% level of confidence. The percentage of eligible members identified by Harmony Health Plan (17.97%) showed a statistically significant difference (e.g. statistically lower rate) when compared to the group average. Healthcare USA showed a statistically higher rate (58.29%) than the MCHP average. These differences in rates may be due to the demographic characteristics of the member population, the completeness of claims data, or the processes of identifying eligible members.

Figure 11 – MO HealthNet Managed Care Program HEDIS 2008 Annual Dental Visit, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2007 (the measurement year) was used to calculate the rate.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 28, 2007.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. The Technical Specifications for the HEDIS 2008 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply.

Table 15 shows the numerators, denominators, rates, and confidence intervals submitted by the MO HealthNet Managed Care health plans to the SPHA on the DST for the HEDIS 2008 Annual Dental Visit measure. The rate for all health plans was calculated by the EQRO; therefore, no confidence interval is reported for the statewide rate. Healthcare USA and Mercy CarePlus (now Molina Healthcare of Missouri) both reported rates for each of the three regions (Eastern, Central, and Western) separately to the SPHA; as it is the task of the EQRO to compare MCO to MCO; these numbers have been combined to show an overall MCO rate. Therefore, there are no confidence intervals to report for these two MCHPs, because the MCOs reported confidence intervals for each region and not as a plan on the DST.

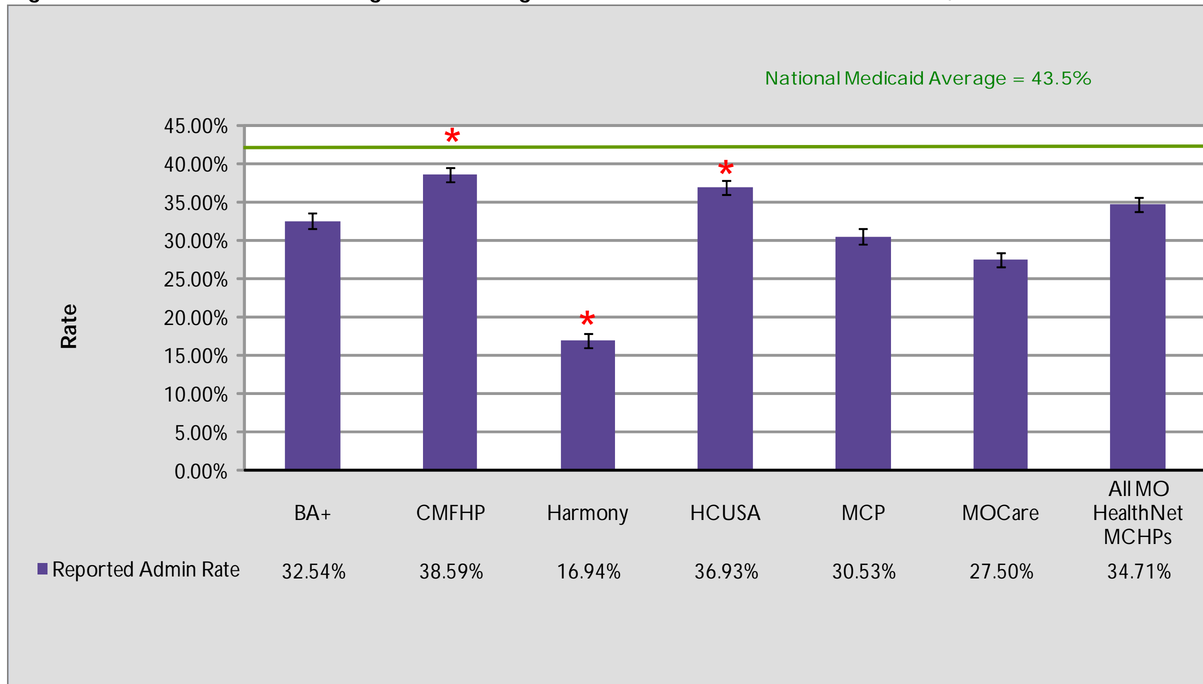
The Annual Dental Visit measure has been reviewed in audit years 2005, 2007, and this current 2008 review. In all three of those audits, the MO HealthNet Managed Care health plans reported individual rates lower than the National Medicaid Average. The combined rates for all plans were also lower than this average. However, the National Medicaid Average has increased over time, as has the combined rate for all health plans. The rate for all MO HealthNet Managed Care health plans was 29.76%, 32.50%, and 34.71% in 2005, 2007, and 2008 respectively. This indicates an increase in access to dental visits within the MO HealthNet Managed Care population. The 2008 health plan rates ranged from 16.94% (Harmony Health Plan) to 38.59% (Children's Mercy Family Health Partners) (see Table 15 and Figure 12). Harmony Health Plan reported a significantly lower rate than the average combined rate for all MO HealthNet Managed Care health plans; the rates reported by Children's Mercy Family Health Partners and Healthcare USA were significantly higher than the average.

Table 15 - Data Submission and Final Validation for HEDIS 2008 Annual Dental Visit (combined rate)

MO HealthNet Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	LCL - UCL (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	12,872	4,188	32.54%	31.72-33.35%	4,188	32.54%	0.00%
Childrens Mercy Family Health Partners	23,456	9,052	38.59%	37.97-39.22%	9,029	38.49%	0.10%
Harmony Health Plan	1,582	268	16.94%	15.06-18.82%	270	17.07%	-0.13%
HealthCare USA	98,716	36,451	36.93%		33,709	34.15%	2.78%
Mercy CarePlus (now Molina Healthcare)	36,231	11,063	30.53%		11,055	30.51%	0.02%
Missouri Care	14,103	3,879	27.50%	26.76-28.25%	3,879	27.50%	0.00%
All MO HealthNet MCHPs	186,960	64,901	34.71%		62,130	33.23%	1.48%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MO HealthNet Managed Care Health Plans' HEDIS 2008 Data Submission Tools (DST).

Figure 12 - MO HealthNet Managed Care Program HEDIS 2008 Annual Dental Visit, Administrative Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Table 16 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 was not applicable to this measure, as the services reported could not easily be obtained outside the health plan. Item 13.6 also did not apply, as none of the MO HealthNet Managed Care health plans used non-standard codes to determine the numerators. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable for the Annual Dental Visit measure. Across all MO HealthNet Managed Care health plans, 100% of the criteria for calculating the numerator were met.

Table 16 - Numerator Validation Findings, HEDIS 2008 Annual Dental Visit Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	6	0	0	6	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	2	6	0	0	6	100.0%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	2	6	0	0	6	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.9	Record review staff have been properly trained and supervised for the task.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	5	5	5	5	5	5	30	0	0	30	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

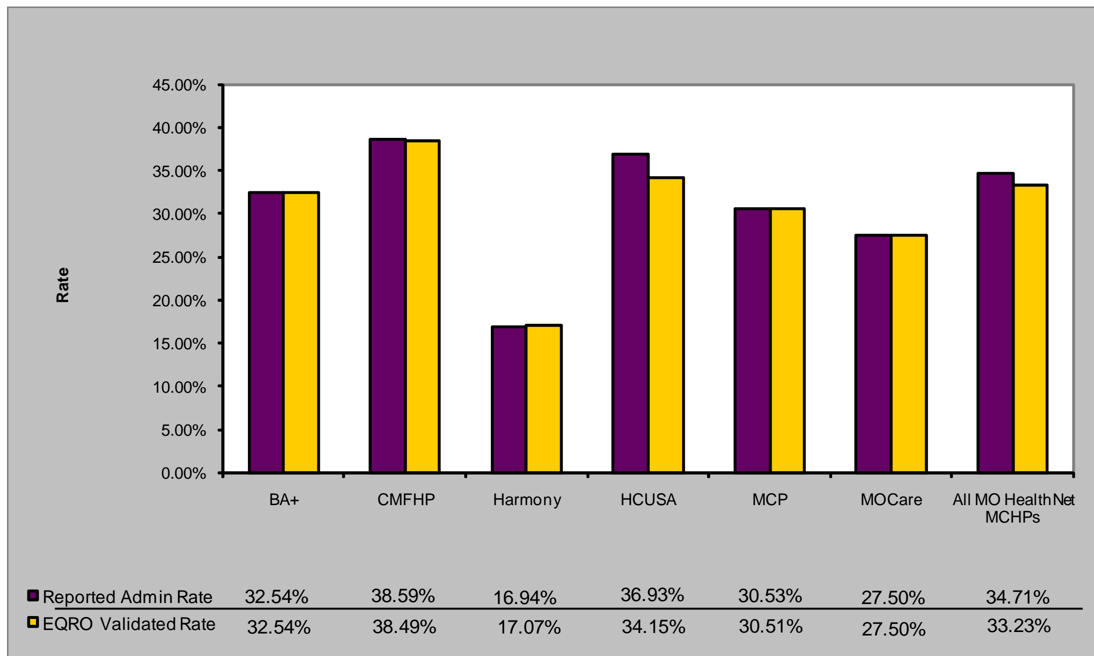
Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2008 Annual Dental Visit measure. All six MO HealthNet Managed Care health plans calculated and submitted the measure to the SPHA and SMA. All health plans in the State of Missouri are required to calculate and report the measure to the SPHA, and MO HealthNet Managed Care health plans are required to report the measure to the SMA.

Final Validation Findings

Table 15 shows the final data validation findings and the total estimated bias calculation based on the validation and review of the MO HealthNet Managed Care health plans' extract files for calculating the HEDIS 2008 Annual Dental Visit measure. Figure 13 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO for Annual Dental Visit calculations. The EQRO validated rate was 33.23%, while the rate reported by MO HealthNet Managed Care health plans was 34.71%, a 1.48% overestimate.

Figure 13 - Rates Reported by MO HealthNet MCHPs and Validated by EQRO, HEDIS 2008 Annual Dental Visit Measure



	BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	All MO HealthNet MCHPs
Reported Admin Rate	32.54%	38.59%	16.94%	36.93%	30.53%	27.50%	34.71%
EQRO Validated Rate	32.54%	38.49%	17.07%	34.15%	30.51%	27.50%	33.23%

Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); BHC, Inc. 2008 External Quality Review Performance Measure Validation.

HEDIS 2008 Adolescent Well-Care Visits

Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources for the calculation of the HEDIS 2008 Adolescent Well-Care Visits measure. It is related to the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2008 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 17 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were Met was calculated across MO HealthNet Managed Care health plans and from the number of applicable items for each health plan.

No data integration and control issues were discovered by the EQRO. All MO HealthNet Managed Care health plans (100.0%) met the criteria for all areas of data integration and control.

Table 17 - Data Integration and Control Findings, HEDIS 2008 Adolescent Well-Care Visits

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	6	0	0	6	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	6	0	0	6	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	6	0	0	6	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	6	0	0	6	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	6	0	0	6	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	6	0	0	6	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms for the calculation of HEDIS 2008 Adolescent Well-Care Visits measure. Table 18 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply to any MO HealthNet Managed Care health plans for this measure, as none of the MCOs used non-standard codes. Items 7.3 (statistical testing of results and corrections made after processing), 7.4 (inclusion of external data sources), and 7.9 (consistent data from measure to measure) did not apply to this measure. Items 7.5, 7.7, and 7.10 are only applicable for the Hybrid method of calculation, and therefore did not apply to Blue-Advantage Plus of Kansas City or Healthcare USA. Each MO HealthNet Managed Care health plan calculating the measure Met 100.0% of the criteria for processes used to calculate and report the HEDIS 2008 Adolescent Well-Care Visits measure.

Table 18 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2008 Adolescent Well-Care Visits Measure

		MO HealthNet MCHP						All MO HealthNet MCHPs				
Item	Audit Elements	BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	2	6	0	0	6	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	2	2	NA	2	2	4	0	0	4	100.0%
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	2	2	NA	2	2	4	0	0	4	100.0%
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	2	6	0	0	6	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	2	2	NA	2	2	4	0	0	4	100.0%
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	4	7	7	4	7	7	36	0	0	36	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	4	7	7	4	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2008 Adolescent Well-Care Visits measure, the sources of data include enrollment, eligibility, and claim files. Table 19 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (identification of gender of the member), 10.6 (calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to the HEDIS 2008 Adolescent Well-Care Visits measure. Blue-Advantage Plus of Kansas City did not provide the correct denominator files for the EQRO to validate the reported denominator calculations. Therefore, items 10.1, 10.3, and 10.9 were Not Met, resulting in an overall rate of 57.1% for the criteria for producing denominators according to specifications. Overall, 92.9% of the criteria were Met for the processes used to produce denominators.

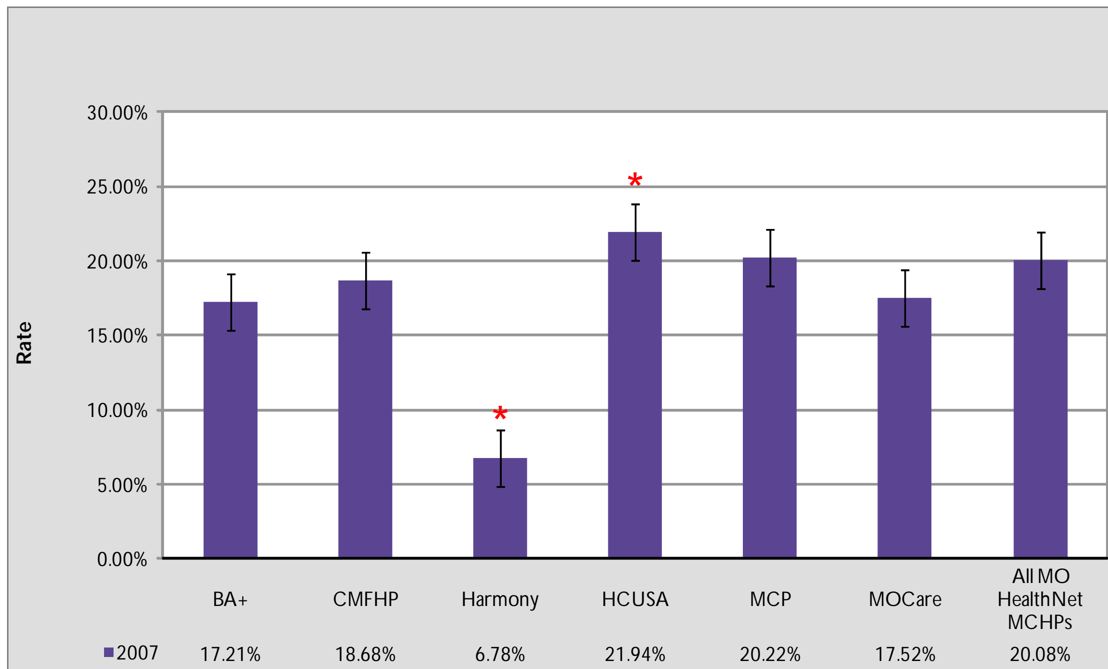
Table 19 - Denominator Validation Findings, HEDIS 2008 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	0	2	2	2	2	2	5	0	1	6	83.3%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	2	6	0	0	6	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	0	2	2	2	2	2	5	0	1	6	83.3%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	6	0	0	6	100.0%
10.5	The MCHP/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	2	2	2	2	6	0	0	6	100.0%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	2	6	0	0	6	100.0%
10.9	members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	0	2	2	2	2	2	5	0	1	6	83.3%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	4	7	7	7	7	7	39	0	3	42	92.9%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	3	0	0	0	0	0					
	Number Applicable	7	7	7	7	7	7					
	Rate Met	57.1%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 =Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Figure 14 illustrates the rate of eligible members identified by each MO HealthNet Managed Care health plan, based on the enrollment of all MO HealthNet Managed Care members as of December 28, 2007 (the end of the CY2007 measurement year). It was expected that MO HealthNet Managed Care health plans would identify similar proportions of eligible members for the HEDIS 2008 Adolescent Well-Care Visits measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MO HealthNet Managed Care health plans and two-tailed z-tests of each health plan compared to the state rate of eligible members were conducted at the 95% level of confidence. Harmony Health Plan (6.78%) identified a rate that was significantly lower than the MO HealthNet Managed Care health plan average (20.08%). The percentage of eligible members identified by Healthcare USA (21.94%) was significantly higher than the MO HealthNet Managed Care average.

Figure 14 - MO HealthNet Managed Care Program HEDIS 2008 Adolescent Well-Care Visits, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2007 (the measurement year) was used to calculate the rate.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 28, 2007.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2008 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 20 shows the numerators, denominators, rates, and confidence intervals submitted by the MO HealthNet Managed Care health plans to the SPHA on the DST. The "combined" rates for Healthcare USA and Mercy CarePlus (now Molina Healthcare) were calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western); thus, there are no confidence intervals to report. The EQRO also calculated the rate for all MO HealthNet Managed Care health plans; this statewide rate also does not have a confidence interval reported. The rate for all MO HealthNet Managed Care health plans was 38.59%, with health plan rates ranging from 25.06% (Harmony Health Plan) to 49.54 % (Missouri Care).

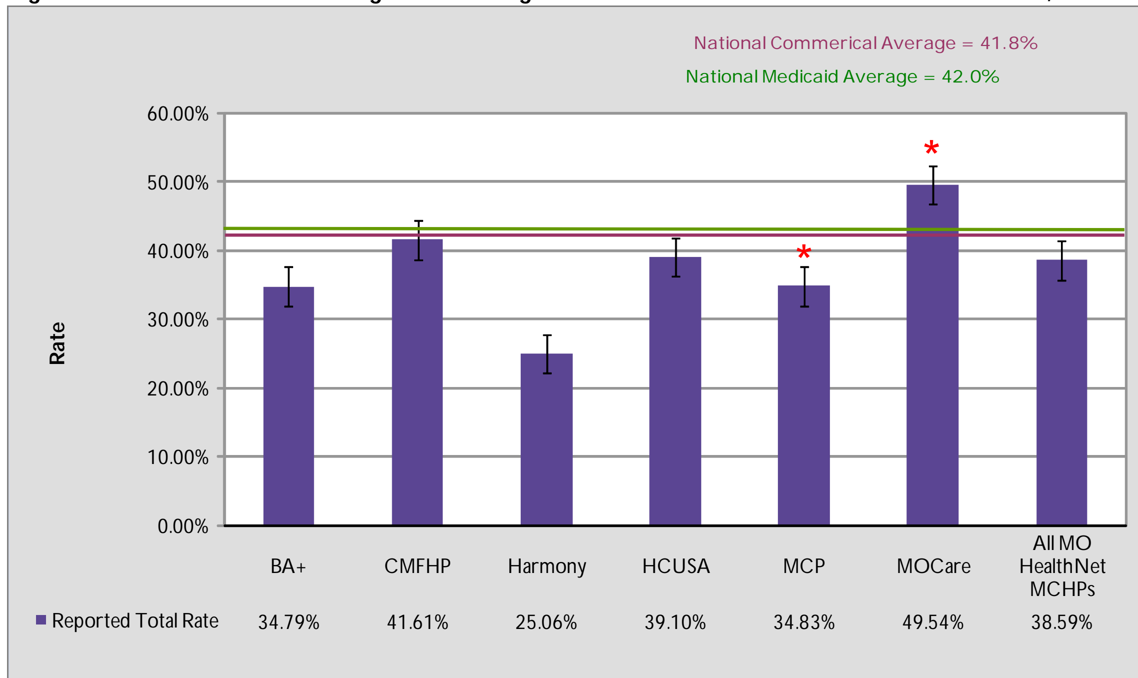
Table 20 - Data Submission for HEDIS 2008 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCHP (DST)	Hybrid Hits Reported by MCHP (DST)	Total Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	LCL - UCL (DST)
Blue Advantage Plus	Administrative	4,478	1,558	NA	1,558	34.79%	33.39% - 36.20%
Childrens Mercy Family Health Partners	Hybrid	411	141	30	171	41.61%	40.53% - 42.68%
Harmony Health Plan	Hybrid	411	92	11	103	25.06%	20.75% - 29.37%
HealthCare USA	Administrative	37,166	14,532	NA	14,532	39.10%	
Mercy CarePlus (now Molina HC)	Hybrid	603	178	32	210	34.83%	
Missouri Care	Hybrid	432	189	25	214	49.54%	44.71% - 54.37%
All MO HealthNet MCHPs		**43,501**	**16,690**	**98**	**16,788**	**38.59%**	

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. The statewide rate for all MO HealthNet MCHPs was calculated by the EQRO using the sum of numerators divided by sum of denominators. There was no statewide rate or confidence limits reported to the SMA or SPHA.
Source: MO HealthNet Managed Care Organization HEDIS 2008 Data Submission Tools (DST)

Figure 15, Figure 16, and Figure 17 illustrate the rates reported by the MO HealthNet Managed Care health plans and the rates of administrative and hybrid hits for each MO HealthNet Managed Care health plan. The rate reported by each health plan was compared with the rate for all MO HealthNet Managed Care health plans. Two-tailed z-tests of each MO HealthNet Managed Care health plan comparing MO HealthNet Managed Care health plans to the rate for all MO HealthNet Managed Care health plans were calculated at the 95% confidence interval. The rate for all MOHealth Net health plans (38.59%) was lower than both the National Medicaid rate (42.0%) and the Commercial Rate (41.8%). This was also true in the 2004 and 2007 EQRs, in which this measure was audited. However, the rate has continued to trend upward from each audit period, from 30.13% in 2004 to 34.81% in 2007 and 38.59% in 2008. This indicates an increased level of Adolescent Well-Care Visits continuing to be delivered throughout regions. The rate for Missouri Care (49.54%) was significantly higher than the average. This rate was also higher than both the National Commercial Rate and the National Medicaid Rate. Harmony Health Plan reported a rate of 25.06%, which was significantly lower than the statewide rate for all MO HealthNet Managed Care health plans.

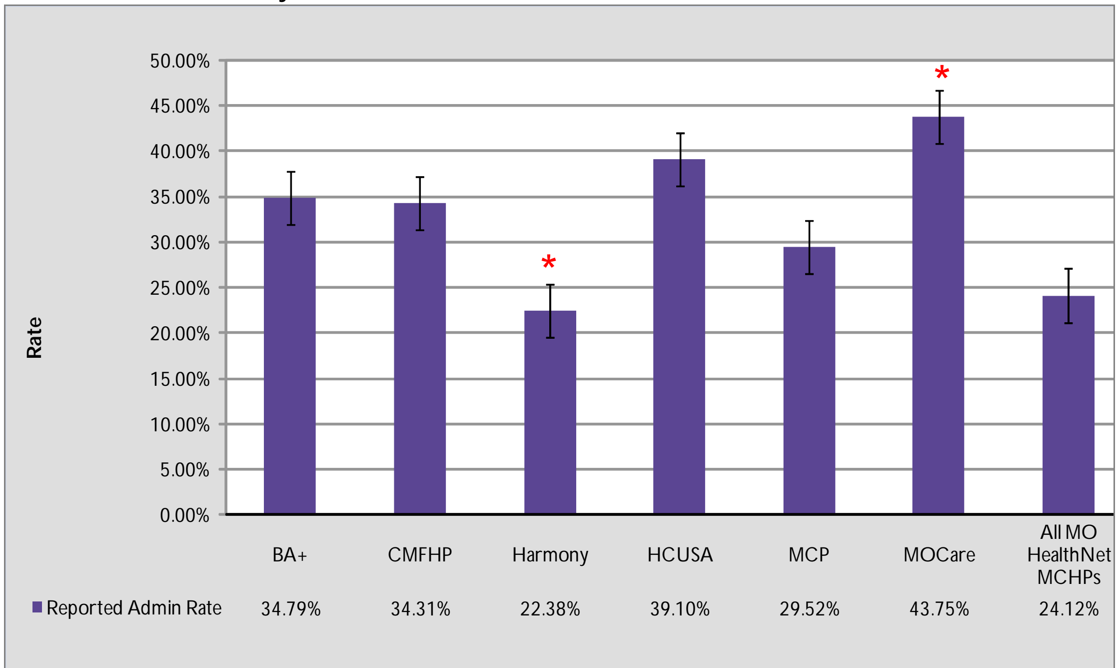
Figure 15 - MO HealthNet Managed Care Program HEDIS 2008 Adolescent Well-Care Visits, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

When the rate of administrative and hybrid hits was examined separately, there did not appear to be a great deal of variability among MO HealthNet Managed Care health plans from the administrative rate for all MO HealthNet Managed Care health plans (24.12%). Rates ranged from 22.38% (Harmony) to 43.75% (Missouri Care). Statistically, the rate reported by Harmony Health Plan was significantly lower than the statewide rate for all health plans, while the rate for Missouri Care was significantly higher than the average rate.

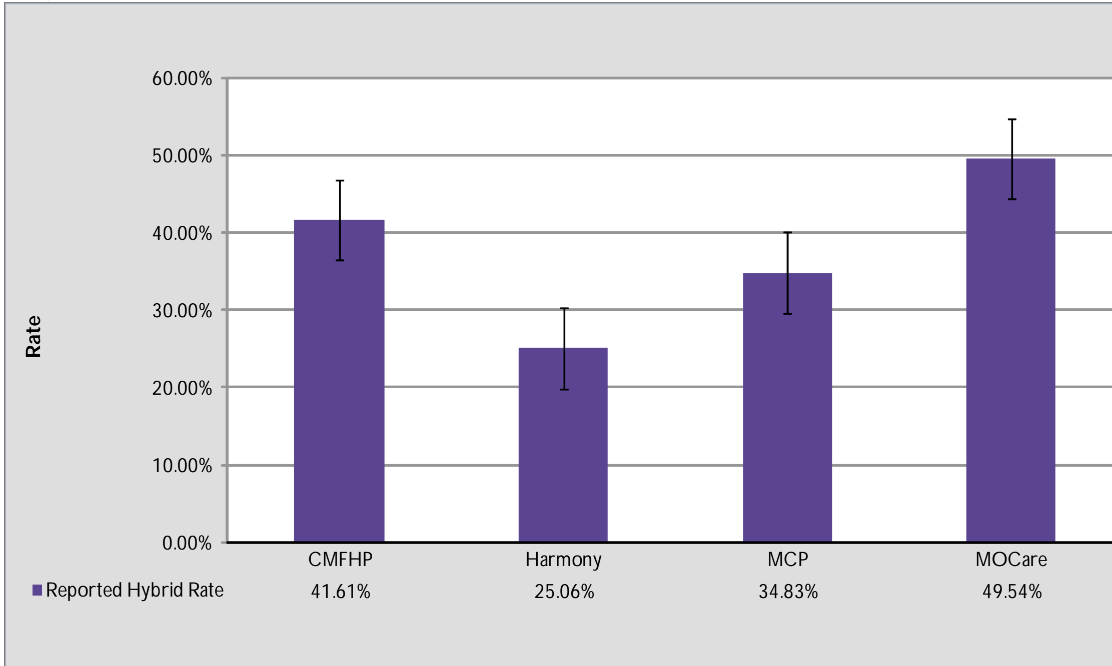
Figure 16 - MO HealthNet Managed Care Program HEDIS 2008 Adolescent Well-Care Visits, Administrative Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Four of the six MO HealthNet Managed Care health plans calculated the Adolescent Well-Care Visits measure hybridly. There were no statistically significant differences found in these rates.

Figure 17 - MO HealthNet Managed Care Program HEDIS 2008 Adolescent Well-Care Visits, Hybrid Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA)

Table 21 and Table 22 summarize the findings of the EQRO medical record review validation and Attachment XII (Impact of Medical Record Findings) of the CMS Protocol. Four of the MO HealthNet Managed Care health plans used the Hybrid Method of calculation: Children's Mercy Family Health Partners, Harmony Health Plan, Mercy CarePlus (now Molina Healthcare) and Missouri Care. Children's Mercy Family Health Partners and Harmony Health Plan each selected a sample of 411 eligible members, consistent with HEDIS technical specifications. Missouri Care selected a sample of 432 eligible members, as determined by the number of eligible members and in accordance with HEDIS technical specifications. Mercy CarePlus, which operates in three regions, selected a sample of 411 eligible members in one region and the entire eligible population (each less than 411) in the other two regions. This is consistent with HEDIS technical specifications. A total of 96 of the 98 reported medical record hybrid hits by MO HealthNet Managed Care health plans were sampled for validation by the EQRO. Of the records requested, all 96 were received for review. The EQRO was able to validate 92 of the 96 records received, an Error Rate of 4.2% across all MO HealthNet Managed Care health plans. The number of False Positive Records (the total amount that could not be validated) was 4 of the 98 reported hits. The estimated bias for individual MO HealthNet Managed Care health plans based on the medical record validation ranged from a 0.0% to 0.7% overestimate in the rate, with an average overestimate of 0.2% for all health plans. Table 22 shows the impact of the medical record review findings.

Table 21 - Medical Record Validation for HEDIS 2008 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Denominator (Sample Size)	Numerator Hits by Medical Records (DST)	Number Medical Records Sampled for Audit by EQRO	Number Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of Records Received	Accuracy Rate	Error Rate
Childrens Mercy Family Health Partners	411	30	30	30	30	100.0%	100.0%	0.0%
Harmony Health Plan	411	11	11	11	11	100.0%	100.0%	0.0%
Mercy CarePlus (now Molina HC)	608	32	30	30	26	86.7%	86.7%	13.3%
Missouri Care	432	25	25	25	25	100.0%	100.0%	0.0%
All MO HealthNet MCHPs	**1,862**	**98**	**96**	**96**	**92**	**95.8%**	**95.8%**	**4.2%**

Note: DST = Data Submission Tool; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Accuracy Rate = Number of Medical Records Validated by the EQRO/Number of Records Selected for Audit by EQRO; Error Rate = 100% - Accuracy Rate; Weight of Each Medical Record = 100% / Denominator (Sample Size); False Positive Records = Error Rate * Numerator Hits Reported by MCHP (DST); Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record. Source: MO HealthNet MCHP Data Submission Tools (DST); BHC, Inc. 2008 External Quality Review Performance Measures Validation.

Table 22 - Impact of Medical Record Findings, HEDIS 2008 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP					
		BA+	CMFHP	Harmony	HCUSA	MCP	Molina
12.1	Final Data Collection Method Used (e.g., MRR, hybrid,)	Administrative	Hybrid	Hybrid	Administrative	Hybrid	Hybrid
12.2	Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	NA	0.00%	0.00%	NA	13.30%	16.70%
12.3	Is error rate < 10%? (Yes or No)	NA	Yes	Yes	NA	No	Yes
	If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	NA	Passes	Passes	NA	NA	Passes
	If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	NA	NA	NA	See Below	NA
12.4	Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	4778	411	411	37166	608	432
12.5	Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	NA	NA	NA	NA	0.002	NA
12.6	Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA	NA	NA	32	NA
12.7	Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA	NA	NA	4	NA
12.8	Estimated Bias in Final Rate (The amount of bias caused by medical record review)	NA	NA	NA	NA	0.70%	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the Health Plan; Administrative Method was used by the Health Plan and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Table 23 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.6 did not apply to any of the MO HealthNet Managed Care health plans, as none of the health plans used non-standard codes. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable to Blue-Advantage Plus of Kansas City or Healthcare USA. Across MO HealthNet Managed Care health plans, 98.3% of the criteria for calculating numerators were met. All six (100%) of the health plans Met the criteria for using the appropriate data to identify the at-risk population, using complete medical event codes, correctly classifying members for inclusion in the numerator, eliminating or avoiding double-counting members, and following applicable time parameters. Four of the six health plans calculated this measure using the Hybrid Method (Children's Mercy Family Health Partners, Harmony Health Plan, Mercy CarePlus and Missouri Care). Three of the four Met all criteria (100.0%) relating to medical record reviews and data. One MCHP, Mercy CarePlus, Met 91.7% of the critieria; item 13.12 was Partially Met, as the EQRO was unable to verify 4 of the 30 medical record hits sampled. The MO HealthNet Managed Care health plans Met 98.3% of criteria for calculating the numerator for the HEDIS 2008 Adolescent Well-Care measure.

Table 23 - Numerator Validation Findings, HEDIS 2008 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	6	0	0	6	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	2	2	2	2	2	2	6	0	0	6	100.0%
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	2	6	0	0	6	100.0%
13.4	The MCHP/PIHP correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	2	6	0	0	6	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	2	2	NA	2	2	4	0	0	4	100.0%
13.9	Record review staff have been properly trained and supervised for the task.	NA	2	2	NA	2	2	4	0	0	4	100.0%
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	2	2	NA	2	2	4	0	0	4	100.0%
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	2	2	NA	2	2	4	0	0	4	100.0%
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools)	NA	2	2	NA	1	2	3	1	0	4	75.0%
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	2	2	NA	2	2	4	0	0	4	100.0%
	Number Met	6	12	12	6	11	12	59	1	0	60	98.3%
	Number Partially Met	0	0	0	0	1	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	6	12	12	6	12	12					
	Rate Met	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Table 24 summarizes the findings of Attachment XV (Sampling Validation Findings) of the CMS Protocol. Items 15.3 (each provider had an equal chance of being sampled) and 15.9 (documenting if the requested sample size exceeded the eligible population size) did not apply to any of the MO HealthNet Managed Care health plans for this measure; and none of the items were applicable to Blue-Advantage Plus of Kansas City or Healthcare USA. Across all MO HealthNet Managed Care health plans, the criteria for sampling were Met 100.0% of the time. The health plans using the Hybrid Method of calculating the HEDIS 2008 Adolescent Well-Care Visits measure Met 100.0% of the criteria for proper sampling.

Table 24 - Sampling Validation Findings, HEDIS 2008 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
15.1	Each relevant member or provider had an equal chance of being selected; no one was systematically excluded from the sampling.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.2	The MCHP / PIHP followed the specifications set forth in the performance measure regarding the treatment of sample exclusions and replacements, and if any activity took place involving replacements of or exclusions from the sample, the MCHP/PIHP kept adequate documentation of that activity.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.3	Each provider serving a given number of enrollees had the same probability of being selected as any other provider serving the same number of enrollees.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
15.4	any bias was detected, the MCHP/PIHP is able to provide documentation that describes any efforts taken to correct it.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.5	The sampling methodology employed treated all measures independently, and there is no correlation between drawn samples.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.6	Relevant members or providers who were not included in the sample for the baseline measurement had the same chance of being selected for the follow-up measurement as providers who were included in the baseline.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.7	The MCHP/PIHP has policies and procedures to maintain files from which the samples are drawn in order to keep the population intact in the event that a sample must be re-drawn, or replacements made, and documentation that the original population is intact.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.8	Sample sizes meet the requirements of the performance measure specifications.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.9	The MCHP/PIHP has appropriately handled the documentation and reporting of the measure if the requested sample size exceeds the population size.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
15.10	The MCHP/PIHP properly oversampled in order to accommodate potential exclusions	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.11	Substitution applied only to those members who met the exclusion criteria specified in the performance measure definitions or requirements.	NA	2	2	NA	2	2	4	0	0	4	100.0%
15.12	and the percentage of substituted records was documented.	NA	2	2	NA	2	2	4	0	0	4	100.0%
	Number Met	0	10	10	0	10	10	40	0	0	40	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	0	10	10	0	10	10					
	Rate Met	NA	100.0%	100.0%	NA	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2008 Adolescent Well-Care Visits measure. All MO HealthNet Managed Care health plans reported the measure to the SPHA and SMA.

Final Validation Findings

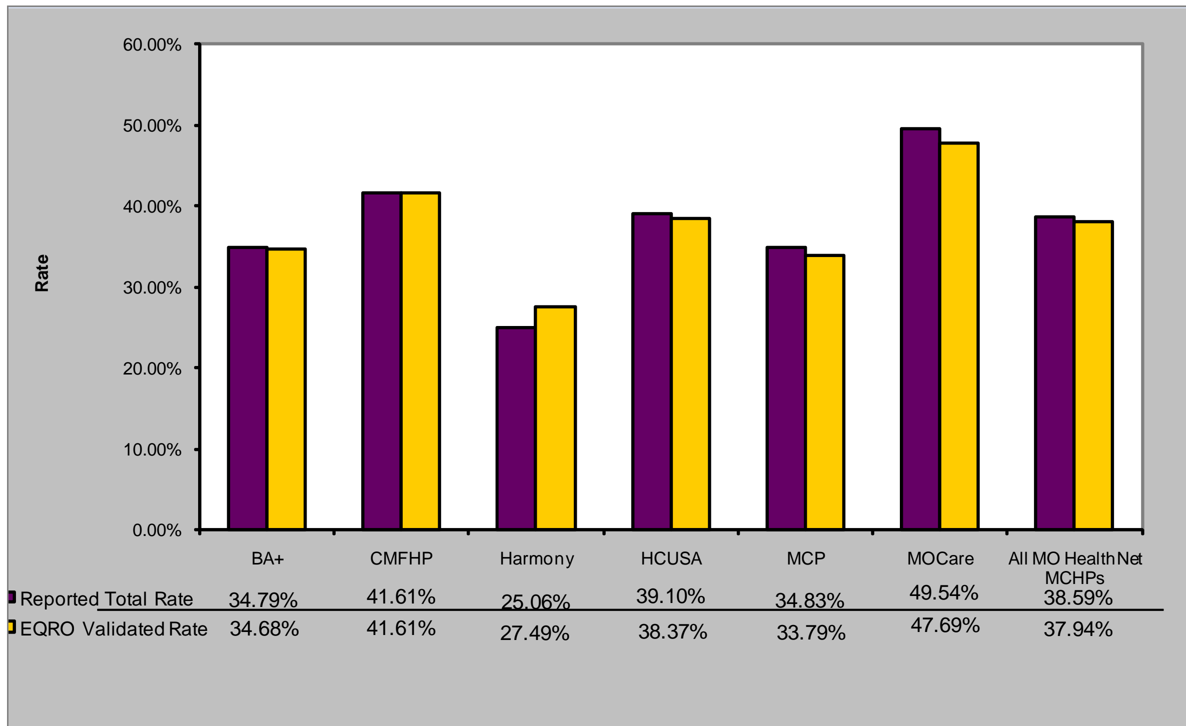
Table 25 shows the final data validation findings for the calculation of the HEDIS 2008 Adolescent Well-Care Visits measure and the total estimated bias in calculation based on the validation of medical record data and review of the MO HealthNet Managed Care health plan extract files. Figure 18 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MO HealthNet Managed Care health plans calculated based on data validated by the EQRO was 37.94%, while the rate reported by all health plans was 38.59%, a 0.65% overestimate.

Table 25 - Final Data Validation for HEDIS 2008 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Administrative Hits Validated by EQRO	Percentage of Medical Record Hits Validated by EQRO*	Total Hits Validated by EQRO	Rate Reported by MCHP (DST)	Rate Validated by EQRO	Total Estimated Bias
Blue Advantage Plus	1553	NA	1553	34.79%	34.68%	0.11%
Childrens Mercy Family Health Partners	141	100.00%	171	41.61%	41.61%	0.00%
Harmony Health Plan	102	100.00%	113	25.06%	27.49%	-2.43%
HealthCare USA	14260	NA	14260	39.10%	38.37%	0.73%
Mercy CarePlus	176	83.30%	203	34.83%	33.79%	1.04%
Missouri Care	181	100.00%	206	49.54%	47.69%	1.85%
All MO HealthNet MCHPs	**16413**	**95.83%**	**16506**	**38.59%**	**37.94%**	**0.65%**

Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); DST = Data Submission Tool; Administrative/Medical Record Hits Validated by EQRO = Hits the EQRO was able to reproduce from the data provided by the MCHP; Total Hits Validated by EQRO = Administrative Hits Validated by EQRO + Medical Record Hits Validated by EQRO; False Positive Records = Error Rate * Rate Reported by MCHP; Rate Validated by EQRO = Total Hits Validated by EQRO / Denominator (DST); Total Estimated Bias = Rate Reported by MO HealthNet MCHP - Rate Validated by EQRO. Positive numbers represent an overestimate by the MCHP.

Figure 18 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2008 Adolescent Well-Care Visits Measure



Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); BHC, Inc. 2008 External Quality Review Performance Measure Validation.

HEDIS 2008 Use of Appropriate Medications for People With Asthma

It should be noted that Harmony Health Plan did not have the necessary number of eligible members to require reporting of the Use of Appropriate Medications for People With Asthma measure.

Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure, the sources of data included enrollment, eligibility, and claim files. Table 26 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were Met was calculated across MO HealthNet Managed Care health plans and from the number of applicable items for each MO HealthNet Managed Care health plan.

Across all MO HealthNet Managed Care health plans, 100.0% of the criteria were Met. Each MO HealthNet Managed Care health plan calculating the measure Met 100.0% of the criteria for data integration and control.

Table 26 - Data Integration and Control Findings, HEDIS 2008 Use of Appropriate Medications for People With Asthma

		MO HealthNet MCHP					All MO HealthNet MCHPs				
Item	Audit Elements	BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	5	0	0	5	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	5	0	0	5	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	5	0	0	5	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	5	0	0	5	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	5	0	0	5	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	5	0	0	5	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	5	0	0	5	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	5	0	0	5	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	5	0	0	5	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	5	0	0	5	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	5	0	0	5	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	5	0	0	5	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	13	13	13	13	13	65	0	0	65	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms. Table 27 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply as none of the MO HealthNet Managed Care health plans used non-standard codes. Item 7.4 is also not applicable as a member would not receive services for this measure outside of the health plan's system. Items 7.3 (statistical testing of results and corrections made after processing), 7.5 (detailed medical record review methods and practices), 7.7 (sampling techniques), 7.9 (data consistency from measure to measure), and 7.10 (appropriate statistical functions for confidence intervals) did not apply to the measure, as the measure must be calculated using only the Administrative method. All MO HealthNet Managed Care health plans Met 100.0% of the criteria for calculating and reporting performance measures.

Table 27 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2008 Use of Appropriate Medications for People With Asthma

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	5	0	0	5	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	5	0	0	5	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	5	0	0	5	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	4	4	4	4	4	20	0	0	20	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	4	4	4	4	4					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure, the sources of data include enrollment, eligibility, and claim files. Table 28 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (identification of gender of the member), 10.6 (calculation of member months or years), and 10.10 (systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. Across all MO HealthNet Managed Care health plans, 91.4% of criteria for calculating and reporting performance measures were Met. Blue-Advantage Plus of Kansas City did not provide the correct denominator files for the EQRO to validate the reported denominator calculations. Therefore, items 10.1, 10.3, and 10.9 were Not Met, resulting in an overall rate of 57.1% for the criteria for producing denominators according to specifications. The MO HealthNet Managed Care health plans Met 91.4% of the criteria for the process used to produce denominators.

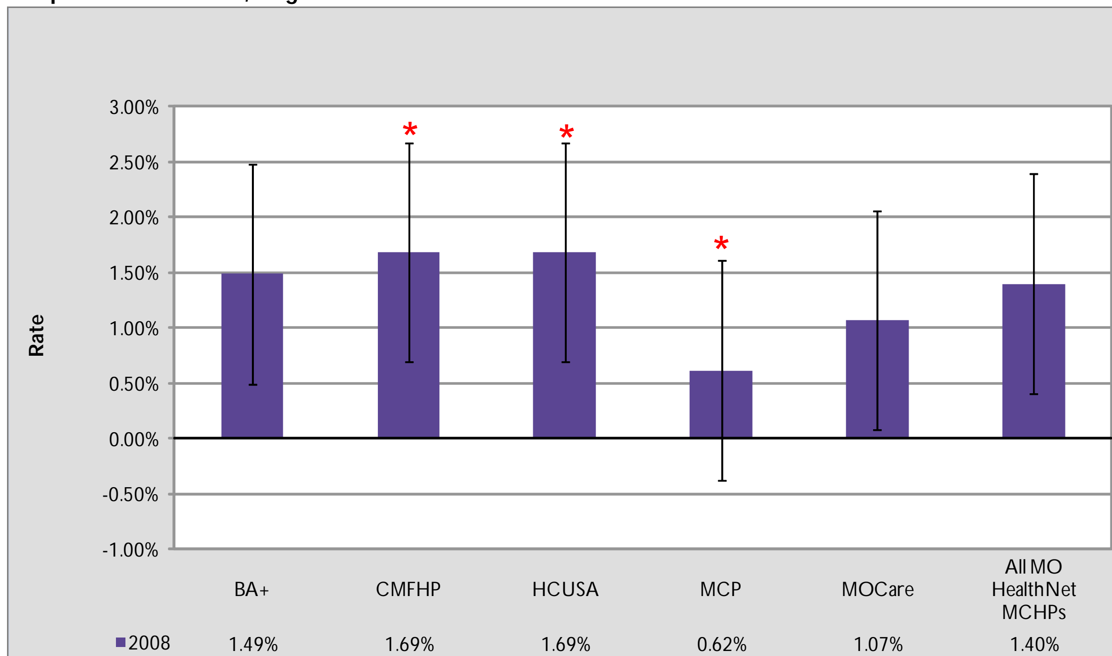
Table 28 - Denominator Validation Findings, HEDIS 2008 Use of Appropriate Medications for People With Asthma

		MO HealthNet MCHP					All MO HealthNet MCHPs				
Item	Audit Elements	BA+	CMFHP	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	0	2	2	2	2	4	0	1	5	80.0%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	0	2	2	2	2	4	0	1	5	80.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	5	0	0	5	100.0%
10.5	The MCHP/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	5	0	0	5	100.0%
10.9	members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	0	2	2	2	2	4	0	1	5	80.0%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	4	7	7	7	7	32	0	3	35	91.4%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	3	0	0	0	0					
	Number Applicable	7	7	7	7	7					
	Rate Met	57.1%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 =Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Figure 19 illustrates the rate of eligible members per MO HealthNet Managed Care health plan based on the enrollment of all MO HealthNet Managed Care Waiver Members as of December 28, 2007 (the end of the CY2007 measurement year). It was expected that MO HealthNet Managed Care health plans would identify similar proportions of eligible members for the measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MO HealthNet Managed Care health plans. Two-tailed z-tests of each MO HealthNet Managed Care health plan comparing each MO HealthNet Managed Care health plan to the state rate of eligible members for all MO HealthNet Managed Care health plans were calculated at the 95% level of confidence. Healthcare USA (1.69%) and Children's Mercy Family Health Partners (1.69%) identified significantly higher rates that the statewide rate (1.40%) for all MO HealthNet Managed Care health plans. Mercy CarePlus (0.62%) identified a significantly lower rate than the average. This variability could be due to differences in the composition of these particular health plans' populations.

Figure 19 - MO HealthNet Managed Care Program HEDIS 2008 Use of Appropriate Medications for People With Asthma, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2006 (the measurement year) was used to calculate the rate.
Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 28, 2007.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS Use of Appropriate Medications for People With Asthma measure, the procedures for the Hybrid Method did not apply, as HEDIS 2008 technical specifications allow only for the use of the Administrative Method of calculating the measure.

Table 29 shows the numerators, denominators, rates, and confidence intervals submitted by the MO HealthNet Managed Care health plans to the SPHA on the DST for the Use of Appropriate Medications for People With Asthma measure. Healthcare USA and Mercy CarePlus reported regional rates (Eastern, Central, and Western); the EQRO combined these rates to calculate a combined rate, and thus there are no confidence intervals to report. Similarly, the rate for all MO HealthNet Managed Care health plans was calculated by the EQRO, and no confidence interval is included for the statewide rate. The 2008 rate validated for all MO HealthNet Managed Care health plans was 85.1%, which was below both the National Medicaid Rate of 86.9% and the National Commercial Rate of 92.3%. However, the reported rate of 87.3% was higher than the National Medicaid Rate (see Table 29).

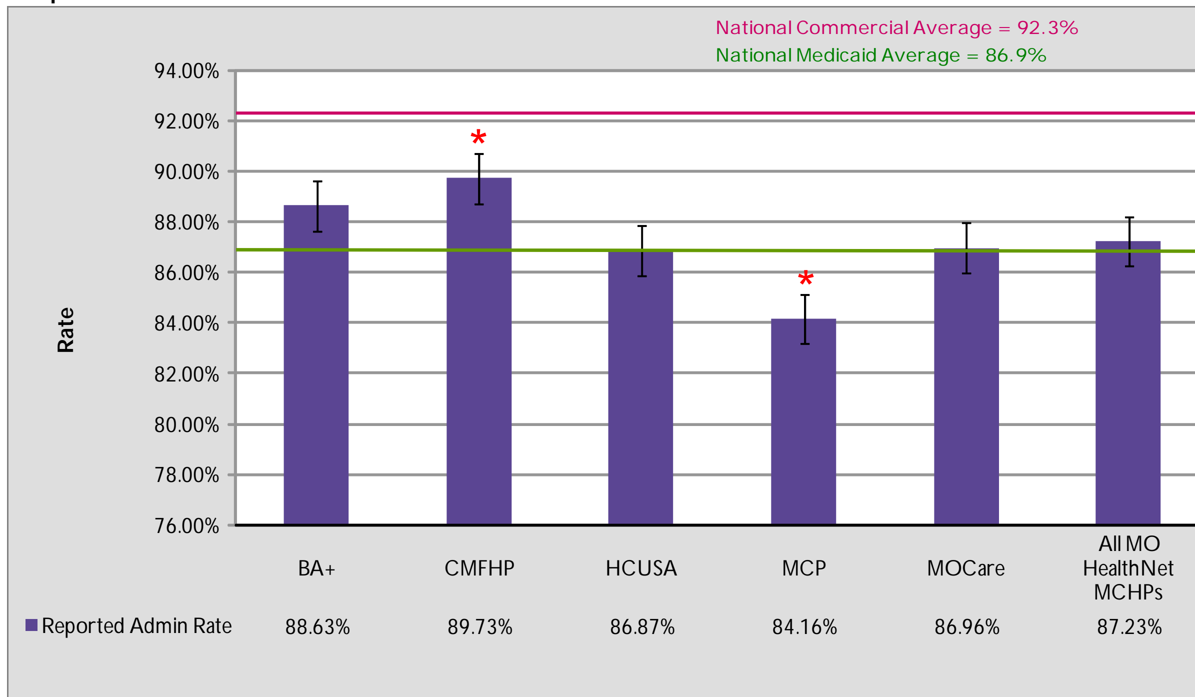
Table 29 - Data Submission and Final Data Validation for HEDIS 2008 Use of Appropriate Medications for People With Asthma

MO HealthNet MCHP	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	LCL - UCL (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	387	343	88.63%	85.34-91.92%	341	88.11%	0.52%
Childrens Mercy Family Health Partners	740	664	89.73%	87.47-91.98%	588	79.46%	10.27%
HealthCare USA	2,857	2,482	86.87%		2,474	86.59%	0.28%
Mercy CarePlus	423	356	84.16%		343	81.09%	3.07%
Missouri Care	299	260	86.96%	82.97-90.94%	259	86.62%	0.33%
All MO HealthNet MCHPs	**4,706**	**4,105**	**87.23%**		**4,005**	**85.10%**	**2.12%**

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MO HealthNet Managed Care Organization HEDIS 2008 Data Submission Tools (DST).

Figure 20 illustrates the total rate reported by the MO HealthNet Managed Care health plans. The rate reported by each MO HealthNet Managed Care health plan was compared with the rate for all MO HealthNet Managed Care health plans, with two-tailed z-tests conducted at the 95% confidence interval to compare each MO HealthNet Managed Care health plan with the rate for all MO HealthNet Managed Care health plans. Children's Mercy Family Health Partners reported a rate (89.73%) significantly higher than the statewide rate for all MO HealthNet Managed Care health plans. The rate reported by Mercy CarePlus (84.16%) was significantly lower than the average. Although none of the health plans reported rates higher than the National Commercial Average (92.3%), Blue-Advantage Plus of Kansas City, Children's Mercy Family Health Partners, and Missouri Care all reported rates higher than the National Medicaid Rate (86.9%). The overall MO HealthNet Managed Care plan rate of 87.23% was also higher than the National Medicaid Rate.

Figure 20 - MO HealthNet Managed Care Program HEDIS 2008 Use of Appropriate Medications for People With Asthma



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2008 DST; National Committee for Quality Assurance (NCQA).

Table 30 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 was not applicable to the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure. Item 13.6 did not apply, as none of the MO HealthNet Managed Care health plans used non-standard codes. Items 13.8 through 13.13 relate to the Hybrid Method of calculation and were not applicable to the measure. Across all MO HealthNet Managed Care health plans, 92.0% of the criteria for calculating numerators were met. Children's Mercy Family Health Partners Met 60% of the criteria for calculating numerators. Item 13.4 was Partially Met as the health plan provided numerator data containing invalid codes. Item 13.7 was Not Met as no service dates were provided in the numerator file. Overall, the MO HealthNet Managed Care health plans Met 92.0% of criteria for the calculation of the numerator.

Table 30 - Numerator Validation Findings, HEDIS 2008 Use of Appropriate Medications for People With Asthma Measure

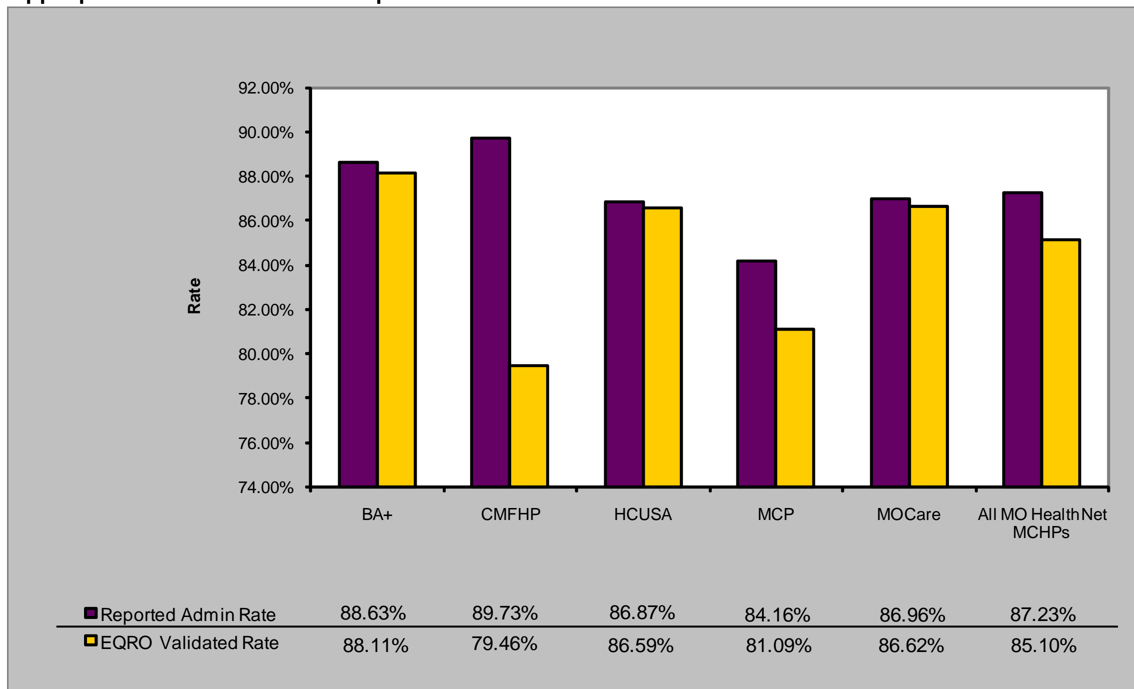
Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	5	0	0	5	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	5	0	0	5	100.0%
13.4	The MCHP/PIHP correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	2	1	2	2	2	4	1	0	5	80.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	5	0	0	5	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	0	2	2	2	4	0	1	5	80.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.9	Record review staff have been properly trained and supervised for the task.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	NA	NA	NA	NA	0	0	0	0	NA
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	NA	NA	NA	NA	0	0	0	0	NA
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	5	3	5	5	5	23	1	1	25	92.0%
	Number Partially Met	0	1	0	0	0					
	Number Not Met	0	1	0	0	0					
	Number Applicable	5	5	5	5	5					
	Rate Met	100.0%	60.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2008 Use of Appropriate Medications for People With Asthma Measure. Five of the six MO HealthNet Managed Care health plans calculated and submitted the measure to the SPHA and SMA; Harmony Health Plan did not have a large enough eligible population for this measure and therefore was not required to report this measure. The rates reported by MO HealthNet Managed Care health plans ranged from 84.16% (Mercy CarePlus) to 89.73% (Children's Mercy Family Health Partners). The rate of all MO HealthNet Managed Care health plans calculated based on data validated by the EQRO was 85.10%. The MO HealthNet Managed Care health plans reported an overall rate of 87.23%, a 2.13% overestimate (see Figure 21).

Figure 21 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2008 Use of Appropriate Medications for People With Asthma Measure



	BA+	CMFHP	HCUSA	MCP	MOCare	All MO HealthNet MCHPs
Reported Admin Rate	88.63%	89.73%	86.87%	84.16%	86.96%	87.23%
EQRO Validated Rate	88.11%	79.46%	86.59%	81.09%	86.62%	85.10%

Sources: MO HealthNet MCHP HEDIS 2008 Data Submission Tool (DST); BHC, Inc. 2008 External Quality Review Performance Measure Validation.

Final Validation Findings

Table 31, Table 32, and Table 33 provide summaries of ratings across all Protocol Attachments for each MO HealthNet Managed Care health plan and measure validated. The rate of compliance with the calculation of each of the three performance measures across all MCOs was 98.33%, 98.82%, and 96.55% for ADV, AWC, and ASM respectively.

Table 31 - Summary of Attachment Ratings, HEDIS 2008 Annual Dental Visit Measure

	All MO HealthNet MCOs						
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	All MO HealthNet MCOs
Number Met	27	30	30	30	30	30	***177***
Number Partially Met	0	0	0	0	0	0	***0***
Number Not Met	3	0	0	0	0	0	***3***
Number Applicable	30	30	30	30	30	30	***180***
Rate Met	90%	100%	100%	100%	100%	100%	***98.33%***

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2008 EQR Performance Measure Validation

Table 32 - Summary of Attachment Ratings, HEDIS 2008 Adolescent Well-Care Measure

	All MO HealthNet MCOs						
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MCP	MOCare	All MO HealthNet MCOs
Number Met	27	49	49	30	48	49	***252***
Number Partially Met	0	0	0	0	1	0	***1***
Number Not Met	3	0	0	0	0	0	***3***
Number Applicable	30	49	49	30	49	49	***255***
Rate Met	90%	100%	100%	100%	97.96%	100%	***98.82%***

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2008 EQR Performance Measure Validation

Table 33 - Summary of Attachment Ratings, HEDIS 2008 Use of Appropriate Medications for People With Asthma Measure

	All MO HealthNet MCOs					
All Audit Elements	BA+	CMFHP	HCUSA	MCP	MOCare	All MO HealthNet MCOs
Number Met	26	27	29	29	29	***140***
Number Partially Met	0	1	0	0	0	***0***
Number Not Met	3	1	0	0	0	***0***
Number Applicable	29	29	29	29	29	***145***
Rate Met	89.66%	93.10%	100%	100%	100%	***96.55%***

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2008 EQR Performance Measure Validation

Table 34 summarizes the final audit ratings for each of the performance measures and MO HealthNet Managed Care health plans. The final audit findings for each of the measures was based on the evaluation of processes for calculating and reporting the measures, medical record review validation findings, and MO HealthNet Managed Care health plan extract files from repositories. The ratings were based on the impact of medical record review findings and the degree of overestimation of the rate as validated by the EQRO. The calculation of measures was considered invalid if the specifications were not properly followed, if the rate could not be properly validated by the EQRO due to missing or improper data, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MO HealthNet Managed Care health plans on the DST.

Table 34 - Summary of EQRO Final Audit Ratings, HEDIS 2008 Performance Measures

MO HealthNet Managed Care health plan	Annual Dental Visit	Adolescent Well-Care Visit	Use of Appropriate Medications for People with Asthma
Blue-Advantage Plus of Kansas City	Not Valid	Not Valid	Not Valid
Children's Mercy Family Health Partners	Substantially Compliant	Fully Compliant	Not Valid
Harmony Health Plan	Substantially Compliant	Substantially Compliant	- NA -
Healthcare USA	Substantially Compliant	Substantially Compliant	Substantially Compliant
Mercy CarePlus	Substantially Compliant	Substantially Compliant	Substantially Compliant
Missouri Care	Fully Compliant	Substantially Compliant	Substantially Compliant

Missouri Care reported a rate for the HEDIS 2008 Annual Dental Visit measure that was able to be fully validated by the EQRO, garnering a rating of Fully Compliant. Likewise, the HEDIS 2008 Adolescent Well-Care Visit rate for Children's Mercy Family Health Partners was Fully Compliant. All three measures for Blue-Advantage Plus of Kansas City were found to be Not Valid, as denominator data was not provided to the EQRO for validation. However, assuming the denominator had been able to be validated, the Annual Dental Visit rate for this health plan would have garnered a rating of Fully Compliant. The Use of Appropriate Medications for People with Asthma rate reported by Children's Mercy Family Health Partners was also found to be Not Valid as no service dates were provided in the numerator data. Although all other ratings were not fully validated, each of them fell within the expected confidence intervals and therefore were all determined to be Substantially Compliant.

3.5 Conclusions

In calculating the measures, MO HealthNet Managed Care health plans have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2008 measures validated.

Among MO HealthNet Managed Care health plans there was good documentation of the HEDIS 2008 rate production process. Blue-Advantage Plus of Kansas City provided numerator data for each of the three performance measures audited but did not supply the EQRO with the correct denominator data. All three of the measures for this health plan were rated as Not Valid as the denominator calculations could not be validated; however, the rates for the numerator files were still calculated (assuming the denominator was correct) for purposes of providing comparison data.

The rates of medical record submission for the one measure allowing the use of the Hybrid Methodology was superb, with all MO HealthNet Managed Care health plans submitting 100% of the records requested.

Quality of Care

The HEDIS 2008 Use of Appropriate Medications for People with Asthma measure is categorized as an Effectiveness of Care measure and is aimed at measuring the effectiveness/quality of care received by health plan members. Members must receive the appropriate medications on an ongoing basis to qualify for calculation in this measure.

Three MO HealthNet Managed Care health plans were substantially complaint with the specifications for calculation of this measure. Harmony Health Plan is not included in this evaluation as they did not have enough eligible members identified to meet the requirements of reporting this measure. The remaining two health plans' calculations were determined to be not valid for the Asthma measure.

Four of the five MO HealthNet Managed Care health plan rates reported for the Use of Appropriate Medications for People with Asthma measure were close to or above the National Medicaid Average of 86.9% (BAPlus-88.63%, CMFHP-89.73%, HCUSA-86.87%, MOCare-86.96%). The overall MO HealthNet Managed Care health plan average (87.23%) was also higher than the National Medicaid rate. None of the rates reported were higher than the National Commercial Rate of 92.3%.

The EQRO last audited the Use of Appropriate Medications for People with Asthma measure in 2004; the health plans have shown a marked increase in the overall average rate over the past 4 years. This rate has increased from 63.92% in 2004 to 87.23% in 2008, an improvement of 23.31%.

This shows significant improvement in the quality of care for asthma patients received by MO HealthNet Managed Care members in Missouri for the HEDIS 2008 measurement year.

ACCESS TO CARE

The HEDIS 2008 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

For the Annual Dental Visit measure, four of the six MC HealthNet Managed Care health plans reviewed were substantially compliant with the calculation of this measure. One health plan's calculations were fully compliant, and one plan's calculations were rated as not valid.

The Annual Dental Visits measure has been audited in the 2005, 2007, and 2008 external quality reviews. Over the course of these review periods, the rates for all MO HealthNet Managed Care health plans have improved a total of 4.95%; the rates reported were 29.76% in 2005, 32.50% in 2007 and 34.71% in 2008. However, although the rates have increased for the Annual Dental Visit measure, none of the health plans reported a rate in 2008 higher than the National Medicaid Average of 43.5%.

This trend shows an increased level of dental care received in Missouri by MO HealthNet members, illustrating an increased access to care for these services for the HEDIS 2008 measurement year.

Timeliness of Care

The HEDIS 2008 Adolescent Well Care Visits is categorized as a Use of Services measure and aims to measure the timeliness of the care received. To increase the rates for this measure, age specific services must be delivered to members on a yearly basis.

For the Adolescent Well Care Visits measure, one health plan was fully compliant with the specifications for calculation of this measure; one was found to be not valid, and the remaining four were substantially compliant with the measure's calculation.

For the Adolescent Well Care Visits measure, Missouri Care reported a rate (49.54%) higher than both the National Medicaid Rate (42.0%) and the National Commercial Average (41.8%). Children's Mercy Family Health Partners also reported a rate very close to these Averages at 41.61%.

Although the remaining health plans reported rates lower than these national averages, the overall rate for all MO HealthNet Managed Care health plans has improved by 8.46% over the past three periods this measure has been validated (30.13% in 2004, 34.81% in 2007, and 38.59% in 2008).

This illustrates an improvement of timeliness of care for well care visits delivered to adolescents in Missouri during the HEDIS 2008 measurement year.

Recommendations

1. The SMA should consider requiring the Hybrid Method of calculation for some HEDIS measures. The two health plans who reported rates closest to both the National benchmarks for the Adolescent Well-Visits Measure calculated the measure hybridly, and had rates substantially higher than the two health plans using only the Administrative Method.
2. MO HealthNet Managed Care health plans with significantly lower rates of eligible members (Annual Dental Visit (Harmony), Adolescent Well Care Visits (Harmony) and Use of Appropriate Medications for People with Asthma (Mercy CarePlus)) and significantly lower administrative hits (Annual Dental Visit (Harmony), Adolescent Well Care Visits (Harmony) and Use of Appropriate Medications for People with Asthma (Mercy CarePlus)) should closely examine the potential reasons for fewer members and/or services identified. This may be due to member characteristics, but is more likely due to administration procedures

and system characteristics such as the proportion of members receiving services from capitated providers. Identifying methods of improving administrative hits will improve the accuracy in calculating the measures.

3. The SMA should continue to have the EQRO validate the calculation of at least one measure from year to year, for comparison and analysis of trend data.
4. MO HealthNet Managed Care health plans should run query reports early enough in the HEDIS season so that they may effectuate change in rates where interventions could easily be employed.
5. All MO HealthNet Managed Care health plans should carefully review both the EQRO data request formats and the health plan data files extracted prior to submission deadlines to ensure that data provided to the EQRO for validation is complete, accurate, and submitted in the correct format.

4.0 VALIDATION OF ENCOUNTER DATA

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4.1 Definition

> *"For the purposes of this protocol, an encounter refers to the electronic record of a service provided to an MCO enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under Fee-for-Service (FFS) reimbursement systems."*[13]

An encounter is the unit of service provided to a Member by the health plan. Encounter data provides the same type of information found on a claim form. It does not substitute for medical record documentation, but should be consistent with and supported by medical record documentation (e.g. date of procedure, type of procedure). The MO HealthNet Managed Care health plans' contract with the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division; MHD) details the requirements for an acceptable submission of an encounter. The SMA's requirements for encounter data submitted by the MO HealthNet Managed Care health plans include the type of encounter data and required data fields.

4.2 Purpose and Objectives

> *"Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates. However, in order for encounter data to effectively serve these purposes, it must be valid; i.e., complete and accurate…This protocol specifies processes for assessing the completeness and accuracy of encounter data submitted by MCOs and PIHPs to the State. It also can assist in the improvement of the processes associated with the collection and submission of encounter data to State Medicaid agencies."*[14]

Three objectives for the encounter validation were identified. They included: assessing the quality of data for required fields for each claim type; evaluating the representativeness (or completeness) of the SMA encounter claims database for MO HealthNet Managed Care health plan paid and unpaid claims; and validating medical records against the SMA encounter claims database. The following were the objectives and associated evaluation questions.

[13] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[14] Ibid.

1. The first objective was to obtain a quality baseline of the SMA encounter claim database (completeness, accuracy, and reasonableness). The alternative hypothesis was that all data fields in the SMA encounter claims database consist of valid (complete, accurate, and reasonable) encounter claim data. Appendix 6 shows the recommended minimum criteria established for completeness and accuracy of specific data fields. Several evaluation questions were addressed:
    - What is the baseline level of completeness, accuracy, and reasonableness of the critical fields?
    - What is the level of volume and consistency of services?
    - What are the data quality issues associated with the processing of encounter data?
    - What problems are there with how files are compiled and submitted by the health plan?
    - What types of encounter claim data are missing and why?

2. The second objective was to examine the match between MO HealthNet Managed Care health plan claims (paid and unpaid) and the SMA encounter paid claims database. This would facilitate identification of the level of completeness of the SMA encounter claims database as represented by MO HealthNet Managed Care health plans paid claims. The alternative hypotheses were that 100% of MO HealthNet Managed Care health plans paid claims are represented in the SMA encounter claims database, and 0.00% of MO HealthNet Managed Care health plans unpaid claims are represented in the SMA encounter claims database. Several evaluation questions were posed:
    - What types of paid encounter data are missing and why?
    - What is the fault/match rate of paid and unpaid encounter claims in the SMA encounter claim database and the MO HealthNet Managed Care health plans claims database?
    - What services are being provided that are not being paid?
    - How many services are being provided that are not being paid?

3. The third objective was to validate the SMA encounter claims (paid) database against medical record documentation and obtain a baseline fault (error) rate for the level of accuracy of the SMA encounter claims database relative to the services delivered by MO HealthNet Managed Care health plan providers. The alternative hypothesis was that there is a 100% match between the encounter claim data in the medical record and the data in the SMA encounter claims database. Accuracy or match rates of 70% or greater are anticipated for new Medicaid managed care organizations[15]. Several evaluation questions were addressed:
    - To what extent do the claims in the SMA encounter claims database reflect the information documented in the medical record?
    - What is the fault/match rate between SMA encounter claims and medical records?
    - What types of errors are noted?

[15] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition.

4.3 Technical Methods

TIME FRAME

The dates of service from July 1, 2008 through September 30, 2008 were selected by the SMA for the three encounter data validation objectives.

PROCEDURES FOR DATA COLLECTION

For the first objective, the SMA encounter claims extract file was used to examine the completeness, accuracy, and reasonableness of the critical fields and to calculate the rate of each claim type per 1,000 members by MO HealthNet Managed Care health plans. There are six claim types described in the SMA Health Plan Layout Manual: I = Inpatient claim type; M = Medical claim type; O = Outpatient Hospital claim type; D = Dental claim type; H = Home Health claim type; and P = Pharmacy claim type. Inpatient, Outpatient and Home Health claim types are submitted using a Universal Billing (UB-92) file layout, Medical and Dental claim types are submitted using a National Standard Format/Centers for Medicare and Medicaid Services 1500 (NSF/CMS 1500) file layout, and the Pharmacy claims are submitted using the National Council for Prescription Drug Programs, version 3 file layout (NCPDP v.3.0). All claims are sent from the MO HealthNet Managed Care health plans to the SMA through the SMA claims vendor, InfoCrossing, and claim types are assigned by the Medicaid Management Information System (MMIS).

After review and approval of the technical methods and objectives by the SMA, the EQRO reviewed, discussed with the SMA, and submitted a data request (see Appendix 7) for the SMA encounter claims extract file to be validated for each claim type and each MO HealthNet Managed Care health plan. The file request was made to the SMA on January 8, 2009 and received on February 3, 2009 by the EQRO. The SMA reviewed and approved the data request and parameters for the designated fields to be validated by the EQRO.

For the second objective of comparing the SMA encounter claims with MO HealthNet Managed Care health plans' paid and unpaid claims, the SMA encounter claims extract file was parsed by type of file layout (NSF/CMS 1500, UB-92, or NCPDP v.3.0) in preparation for matching against MO HealthNet Managed Care health plan paid and unpaid claims. A cross-walk for matching MMIS field names with those of the three national standards file layouts was developed and submitted to the

SMA for review (February 8, 2005) and approval (March 29, 2005). MO HealthNet Managed Care health plans were requested to provide paid and unpaid claims for the designated period on the sample of members selected by the EQRO. Five of the six MO HealthNet Managed Care health plans supplied the requested information.

The number of Medical encounter claims in the SMA encounter claims extract file was used for sample size estimation for the third objective and analysis of the evaluation questions. To examine the degree of match between the SMA encounter claims database and medical record procedures and diagnoses, 100 encounters from each MO HealthNet Managed Care health plan were randomly selected from Medical claim types for the period of July 1, 2008 through September 30, 2008 for medical record review. Appendix 8, Appendix 9, and Appendix 10 contain letters of request to providers for medical records, the Table of Contents for the Medical Record Review Training Manual, and copies of medical record review tools. Several challenges in requesting the data were addressed.

ANALYSES

To assess the accuracy and completeness of the SMA encounter claims database, the SMA encounter claims extract file for all MO HealthNet Managed Care health plan paid encounter claims representing services rendered from July 1, 2008 through September 30, 2008 was analyzed for completeness, accuracy, and reasonableness (validity) of the data in each "critical", or required field examined. The Inpatient, Medical, Dental, Home Health, Outpatient Hospital, Pharmacy, and critical fields were chosen by the SMA for analysis, with an established threshold of 100% for completion, accuracy, and validity:

Medical (NSF/CMS 1500) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Place of Service
Units of Service
Procedure Code
Inpatient Diagnosis (five diagnosis fields)

Dental (NSF/CMS 1500) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Units of Service
Procedure Code

Home Health (UB-92) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Units of Service
Procedure Code
Revenue Code
Inpatient Diagnosis (five diagnosis fields)

Inpatient (UB-92) Claim Type
Inpatient Claim Type
Recipient ID
Admission Type
Admission Date
Discharge Date
Bill Type
Patient Discharge Status
Inpatient Diagnosis (five diagnosis fields)
First Date of Billing
Last Date of Billing
Revenue Code
Units of Service

Outpatient Hospital (UB-92) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Place of Service
Units of Service
Procedure Code
Inpatient Diagnosis (five diagnosis fields)

Pharmacy (NCPDP v.3.0)
Recipient ID
Dispensing Date
Pharmacy Prescription Number
Drug Quantity Dispensed
Number of Days Supply
National Drug Code

Each field was examined for the presence or absence of data (completeness), the correct type and size of information (accuracy), and the presence of valid values (reasonableness) or validity using the criteria listed below.

Completeness:	The extent to which an encounter claim field contains data (either present or absent).
Accuracy:	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alphanumeric) in the proper format (e.g., mm/dd/yyyy for date field).
Reasonableness (Validity):	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date)

For the validation of the SMA encounter claims extract file with MO HealthNet Managed Care health plan medical records, the goal was to validate the procedure code and diagnosis code fields for the Outpatient claim types in the SMA encounter claims database against the information provided in the medical record. The minimum number of records required for the evaluation of two variables (procedure and diagnosis code) with an estimated error rate of 30% (based on

Medstat estimates[16]), reliability of 1.96 (95% statistical significance), and a meaningful difference of 55% were calculated using the number of Medical encounters in the SMA encounter claims file for each MO HealthNet Managed Care health plan (see Figure 22). There were no differences in the number of required records for MO HealthNet Managed Care health plans, with the minimum required sample size of 88. A total of 100 encounters for each MO HealthNet Managed Care health plan were randomly selected for medical record review using a probability sample.

Figure 22 - Formula for Calculating Minimum Required Sample Size

$$n = \frac{z^2 N P_y (1 - P_y)}{(N - 1)\, \varepsilon^2 P_y 2 + z^2 P_y (1 - P_y)}$$

Where Py, = Estimated True Error Rate; meaningful difference between true and estimated value ; z = level of reliability; ε= 1(Py - meaningful difference)/meaningful difference; N = number of Medicaid Claim Types for the period January 1, 2004-March 31, 2004; n = Minimum required sample size17

4.4 Findings

One limitation of the present analysis is that the encounter claim completeness and accuracy analysis was based on paid encounter claims and does not account for all claims that are submitted and rejected through system edits. Also, because the SMA encounter claims extract file was for service dates from July 1, 2008 through September 30, 2008, some service dates might extend beyond this period. For example, if the first date of service was later in the period (e.g., September 30, 2008), the last date of service may extend beyond the period specified by SMA parameters for the validation process (e.g., a Discharge Date of October 1, 2008). When last dates of service appeared to be within a reasonable period, dates outside the valid range were considered valid. In addition, the second through fifth diagnosis code fields are required when the information is available. Not all encounters had five diagnoses. Therefore, 100.00% completion of these fields would not be expected. Conclusions regarding the extent to which the encounter claims database reflects the accuracy and completeness of rejected claims cannot be drawn. Thereby, the information contained

[16] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition.
[17] Levy, P.S. & Lemeshow, S. L. (1999). Sampling of Populations: Methods and Applications, Third Edition, John Wiley and Sons: New York; see box 3.5 for Exact and approximate sample sizes required under simple random sampling for proportions.

in this aggregate section is available at the MO HealthNet Managed Care health plan level in the individual MO HealthNet Managed Care health plan summaries. The findings of the encounter data validation are presented in response to each evaluation question, by claim type and critical field for all MO HealthNet Managed Care health plans.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical fields?

For the Medical claim type, there were a total of 1,175,670 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate, and valid.
6. The Outpatient Procedure Code field was 92.96% complete, accurate, and valid. The remaining fields were blank.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first, Diagnosis Code fields were 93.05% complete, accurate and valid. The remaining fields were blank.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they all fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code filed was 79.99% complete, accurate and valid. The remaining fields (n = 235269 were blank). The third Diagnosis Code field was 61.77% complete, accurate and valid. The remaining fields (n= 449,466) were blank (incomplete, inaccurate, and invalid). The fourth diagnosis code field was 16.06% complete, accurate and valid. The remaining fields (n = 986,833) were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.00% complete and accurate.

For the Dental claim type, there were 135,523 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All critical fields examined were 100.00% complete, accurate and valid for all MO HealthNet Managed Care health plans.

For the Home Health claim type, there were a total of 107 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete, accurate and valid.
4. The Last Date of Service field was 100.00% complete, accurate and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Procedure Code field was 61.68% complete, accurate and valid. The remaining fields (n = 41) were blank (incomplete, inaccurate, and invalid).
7. The first, Diagnosis Code field was 97.20% complete, accurate and valid. The remaining fields (n = 3) were blank (incomplete, inaccurate, and invalid).
8. The second Diagnosis Code filed was 93.46% complete, accurate and valid. The remaining fields (n= 7) were blank (incomplete, inaccurate, and invalid).
9. The third Diagnosis Code field was 51.40% complete, accurate and valid. The remaining fields (n=52) were blank (incomplete, inaccurate, and invalid).
10. The fourth Diagnosis Code field was 23.36% complete, accurate and valid. The remaining fields (n =82) were blank (incomplete, inaccurate, and invalid).
11. The fifth Diagnosis Code field was 11.21% complete, accurate and valid. The remaining fields (n = 95) were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were a total of 118,010 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate, and valid.
4. The Admission Date field was 100.00% complete, accurate, and valid.
5. The Discharge Date field was 100.00% complete accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 94.00% complete, accurate and valid. The remaining fields (n = 7084) were blank (incomplete, inaccurate, and invalid).
9. The second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (91.22%, 75.52%, 73.50%, and 55.22%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Billing field was 100.00% complete, accurate and valid.
11. The Last Date of Billing field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 100% complete, accurate, and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were a total of 538,872 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 92.20% complete and accurate. The remaining fields were blank (incomplete, inaccurate, and invalid). The fields were 62.30% valid. There were 161,138 fields containing invalid codes.
7. The Outpatient Revenue Code field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 96.25% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they all fell well below the 100% threshold established by the SMA for this validation. . The Diagnosis Code fields were 81.46%, 56.92%, 43.03% and 13.58% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (n= 99,909; 232,151; 307,018; 465,714 respectively) (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 476,348 claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields examined were 100.00% complete, accurate and valid (Recipient ID, First Date of Service, Prescription Number, Quantity Dispensed, Days Supply, and National Drug Code).

What is the Level of Volume and Consistency of Services?

One method of examining the level, consistency, and volume of services is to assess the extent to which each MO HealthNet Managed Care health plan is consistent with the remaining MO HealthNet Managed Care health plans and the average of all MO HealthNet Managed Care health plans services represented in the SMA encounter claims database. The level, consistency, and volume of services represented in the SMA encounter claims database is a function of the acceptance of encounter claim submissions. It is also a function of the process of manipulation of data from national standard layouts for Medical (NSF/CMS 1500); Dental (NSF/CMS 1500); Inpatient, Outpatient Hospital, Home Health (UB-92); and Pharmacy claims (NCPDP 3.0) into the State MMIS system edits. Additionally, the entry and transmission of data by MO HealthNet Managed Care health plans, vendors, and providers, the accessibility of services, member utilization patterns, and provider practice patterns influence the data. With the large number of members enrolled in each

MO HealthNet Managed Care health plan, it was expected that factors such as physician practice patterns and member utilization patterns would not have a statistically significant impact on the findings, resulting in all MO HealthNet Managed Care health plans having similar rates of encounters per 1,000 members as the rate for all MO HealthNet Managed Care health plans. Statistically significant findings are more likely a function of the data quality and completeness resulting from the processing of data by providers, vendors, MO HealthNet Managed Care health plans, and the MMIS rather than the accessibility or quality of services.

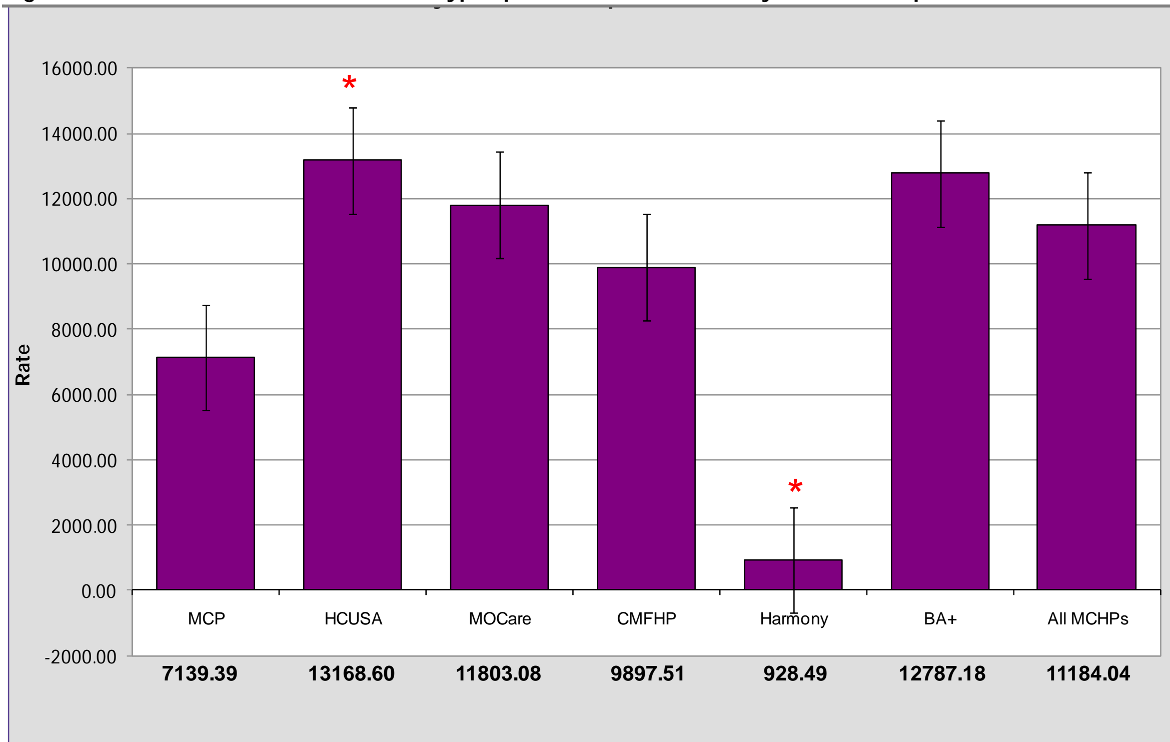
Another method of examining the level, consistency, and volume of services is to compare the baseline per 1,000 member encounter data collected during the 2007 EQRO audit to the data obtained during this audit. By comparing service levels received during the July 1, 2007 – September 30, 2007 with the service levels reported during the time July 1, 2008 – September 30, 2008, a comparison of accessibility to services and member utilization patterns can be made.

Using the SMA encounter claims extract files from July 1, 2007 through September 30, 2007, and July 1, 2008 through September 30, 2008 the volume of services for each claim type and MO HealthNet Managed Care health plan was examined. The rate of each claim type, regardless of the accuracy, consistency, and validity of the data was examined. The rate of claims per 1,000 members based on one quarter of data was calculated by dividing the number of members enrolled as of the last week of September for each year, by 4, then calculating the rate of claims per 1,000 members. The following figures illustrate the rates of claim types and the results of two-tailed z-tests comparing each MO HealthNet Managed Care health plan with the statewide rate of claims. Statistically significant differences between an MO HealthNet Managed Care health plan and the rate for all MO HealthNet Managed Care health plans at the 95% level of statistical significance are indicated by an asterisk. The 95% upper and lower confidence limits are represented by the black bars on the y-axis. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported. When there was no statistical significance, the significance level is reported as "not significant" (n.s.).

Medical encounter claim types consist of claims submitted by providers, vendors, and MO HealthNet Managed Care health plans.

The results for the 2007 EQR audit were similar to those reported in 2008, however, there was a higher rate of Medical encounter claims in 2008 than in 2007. For 2007, as shown in Figure 23, there was some variability across MO HealthNet Managed Care health plans in the statewide rate per 1,000 members of Medical encounter claim types compared to the rate for all MO HealthNet Managed Care health plans (11,184.04 Medical encounter claims per 1,000 members). One MO HealthNet Managed Care health plan (Healthcare USA, 13168.60, $\underline{z} = 0.833$; 95% CI: 9717.69, 16619.51; $\underline{p} < .01$) showed a significantly higher rate, while one MO HealthNet Managed Care health plan (Harmony 928.49, $\underline{z} = -1.79$; 95% CI: -2522.42, 4379.40; $\underline{p} < .01$) had a significantly lower rate of Medical Encounter claims than the rate for all MO HealthNet Managed Care health plans.

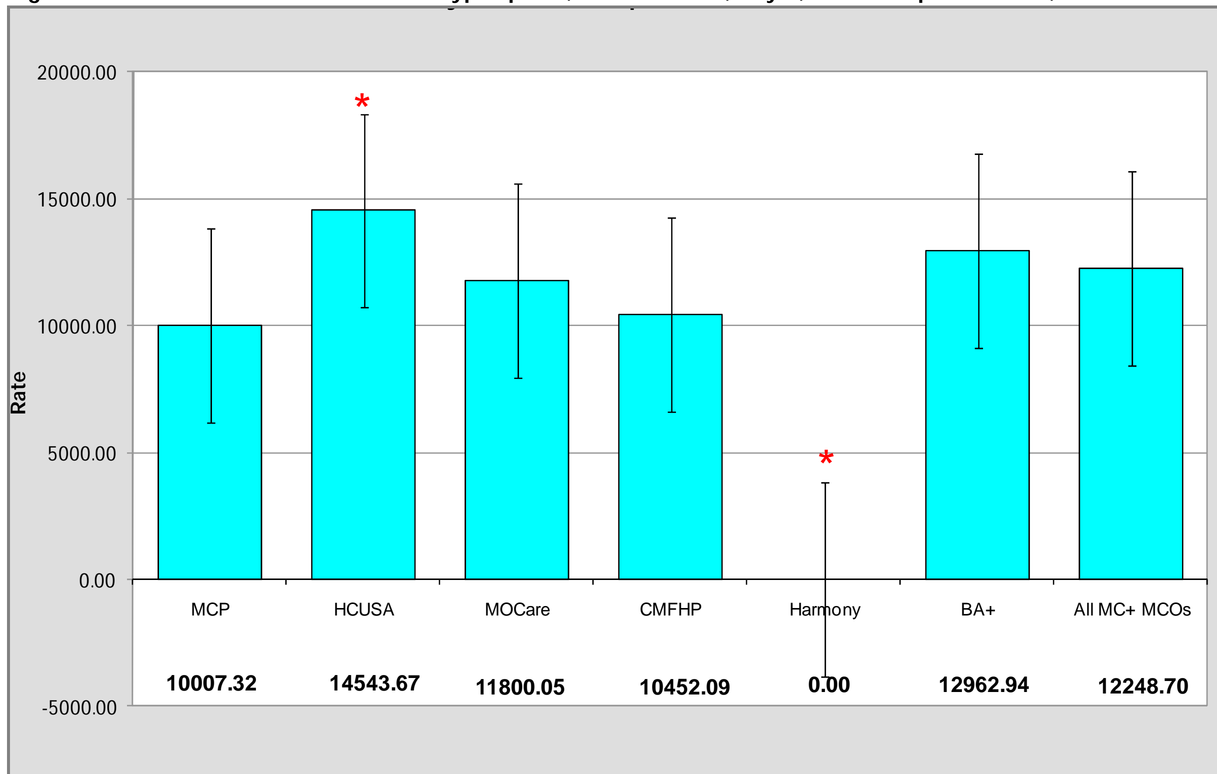
Figure 23 - Medical Encounters Claim Types per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

For 2008, as shown in Figure 24, there was variability across MO HealthNet Managed Care health plans in the statewide rate per 1,000 members of Medical encounter claim types compared to the rate for all MO HealthNet Managed Care health plans (12,248.70 Medical encounter claims per 1,000 members). One MO HealthNet Managed Care health plan showed a significantly higher rate, (Healthcare USA, 14543.67, z = 0.8993; 95% CI: 10724.95, 18362.39; $p < .01$) while one MO HealthNet Managed Care health plan (Harmony 0, z = -1.93; 95% CI: -3818.72, 3818.72; $p < .01$) had a significantly lower rate of Medical Encounter claims than the rate for all MO HealthNet Managed Care health plans.

Figure 24 - Medical Encounters Claim Types per 1,000 Members, July 1, 2008 – September 30, 2008

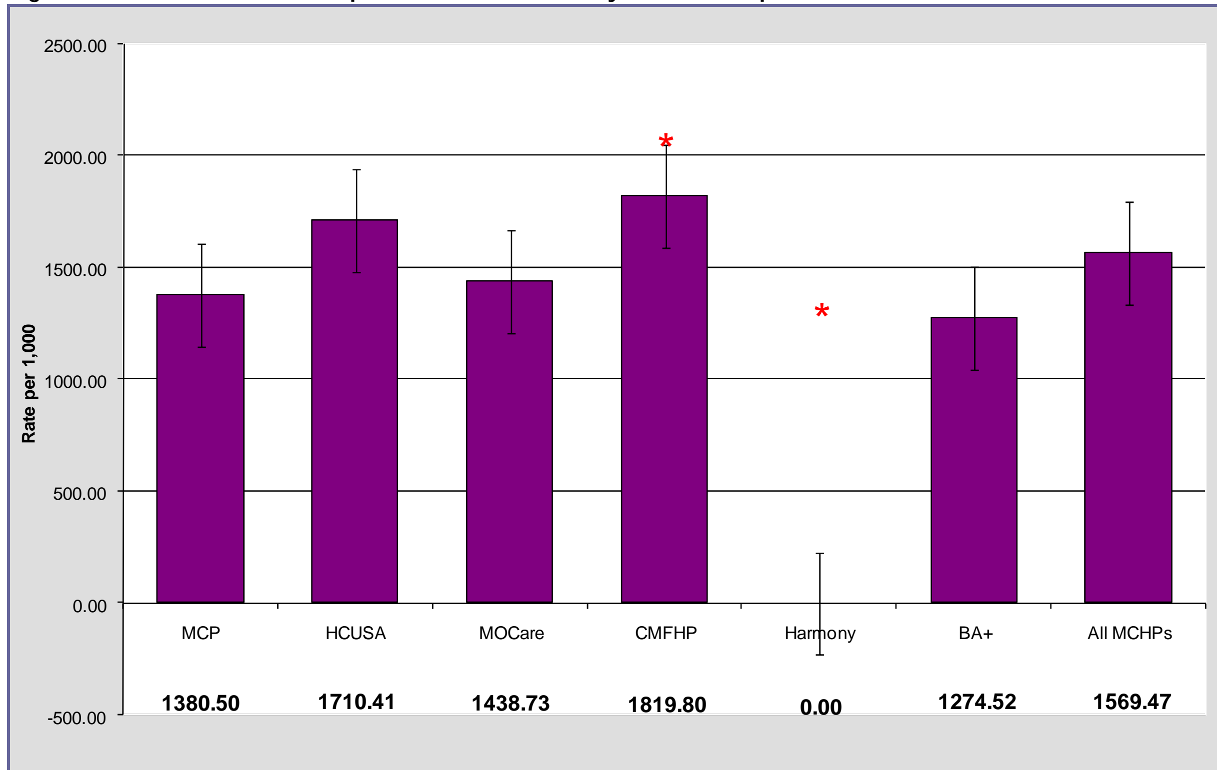


Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Dental encounter claims consist of claims submitted by providers, vendors, and MO HealthNet Managed Care health plans.

In 2007, there was a higher rate for all MO HealthNet Managed Care health plans of Dental encounter claims (1569.47 Dental encounter claims per 1,000 members) than in 2008 (see Figure 26). One MO HealthNet Managed Care health plan (Children's Mercy Family Health Partners, 1819.80, z = .84; 95% CI: 1334.04, 2305.56538.40; $p < .05$) had a significantly higher rate. While one MO HealthNet Managed Care health plan (Harmony Health Plan, 000.00, z = -1.94; 95% CI: -485.76, 485.76; $p < .05$) had a significantly lower rate of Dental encounter claims per 1,000 members than the rate for all MO HealthNet Managed Care health plans.

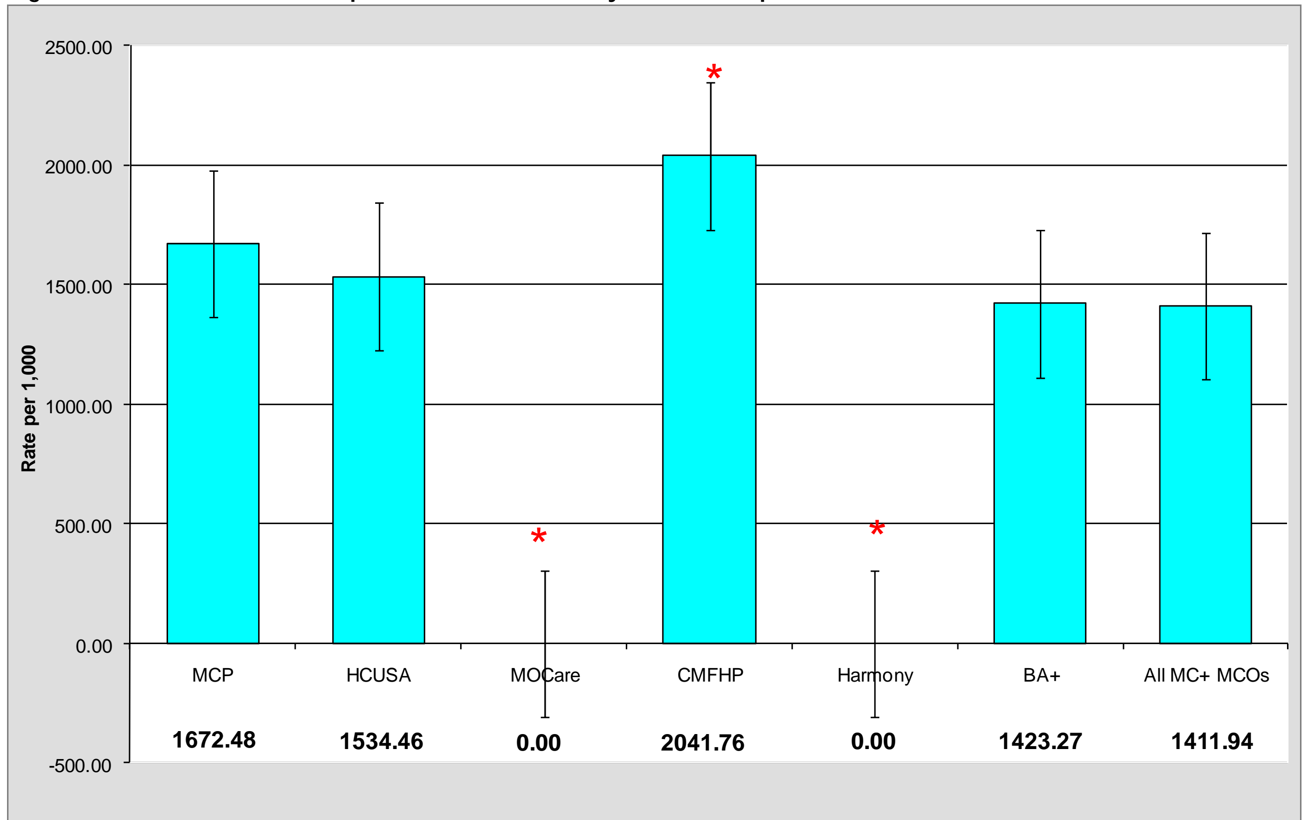
Figure 25 - Dental Encounters per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

The 2008 all MO HealthNet Managed Care health plan rate (1411.94 Dental encounter claims per 1,000 members) had one MO HealthNet Managed Care health plan (Children's Mercy Family Health Partners, 2041.76, z = .01; 95% CI: 1385.23, 2698.29; p < .05) that had a significantly higher rate. Two MO HealthNet Managed Care health plans (Harmony Health Plan, Missouri Care; 000.00, z = -1.25; 95% CI: -656.53, 656.53 p < .05) had a significantly lower rate of Dental encounter claims per 1,000 members than the rate for all MO HealthNet Managed Care health plans.

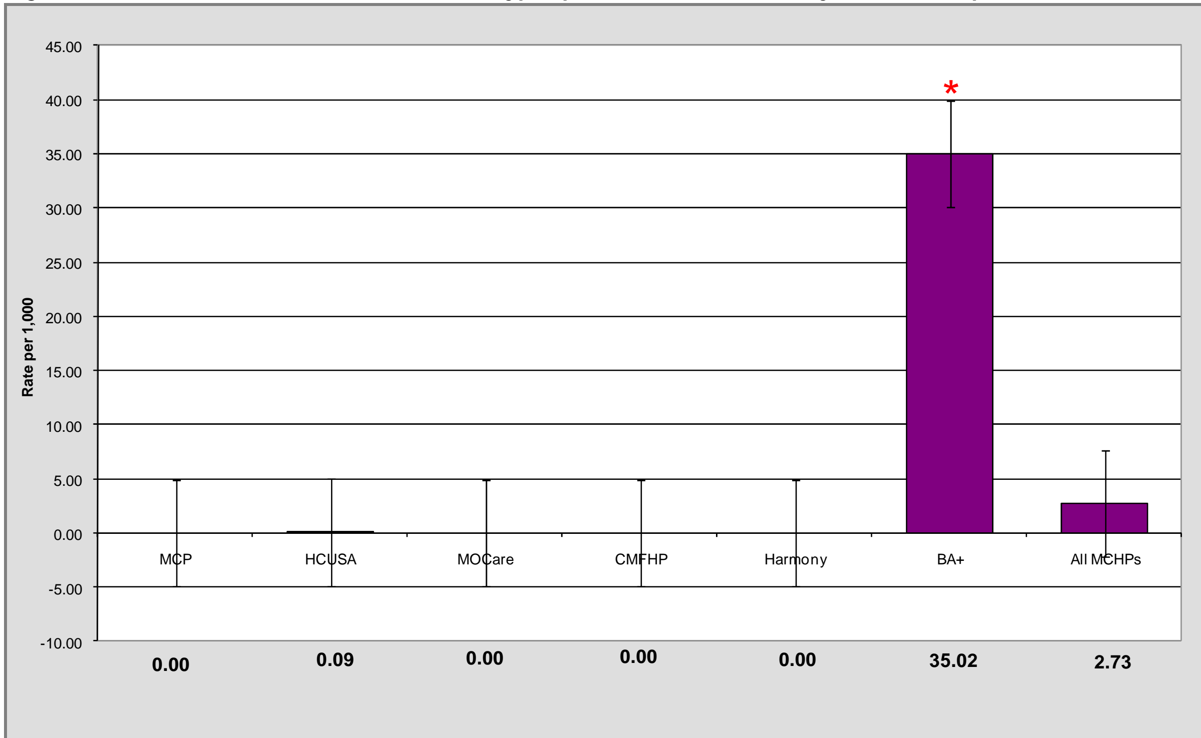
Figure 26 - Dental Encounters per 1,000 Members, July 1, 2008 – September 30, 2008



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

In 2007, only two of the six health plans submitted Home Health encounters, see Figure 27. However, only one of these health plans (BA+, 35.02, z = 2.04; 95% CI: 24.43, 45.61; p = 0.00) submitted a significantly higher rate of Home Health encounter claims than the rate for all MO HealthNet Managed Care health plans (2.73 Home Health encounter claims per 1,000 members).

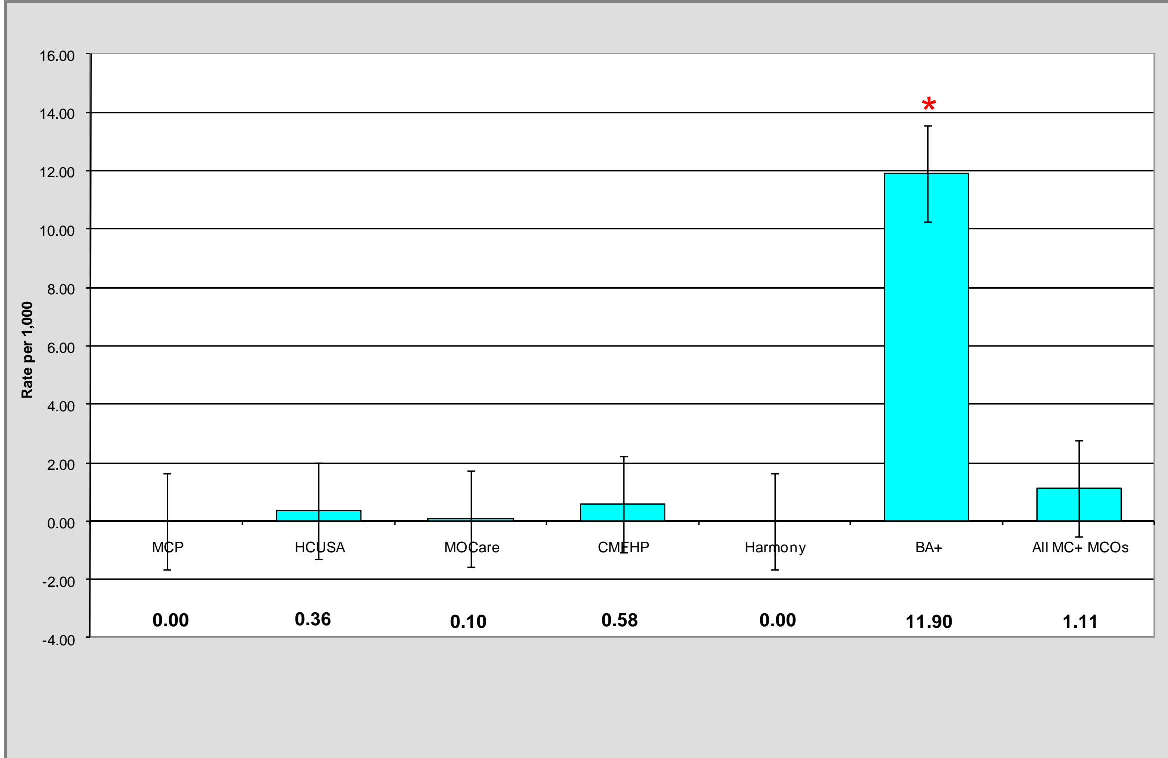
Figure 27 - Home Health Encounter Claim Types per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

In 2008, four health plans submitted Home Health encounters (Figure 28). However, only one submitted a significantly higher rate than the rate for all MO HealthNet Managed Care health plans (BA+, 11.90m z= 2.04; 95% CI: 8.36, 15.44; p = 0.00). The all plan rate was 1.11 Home Health encounter claims per 1,000 members.

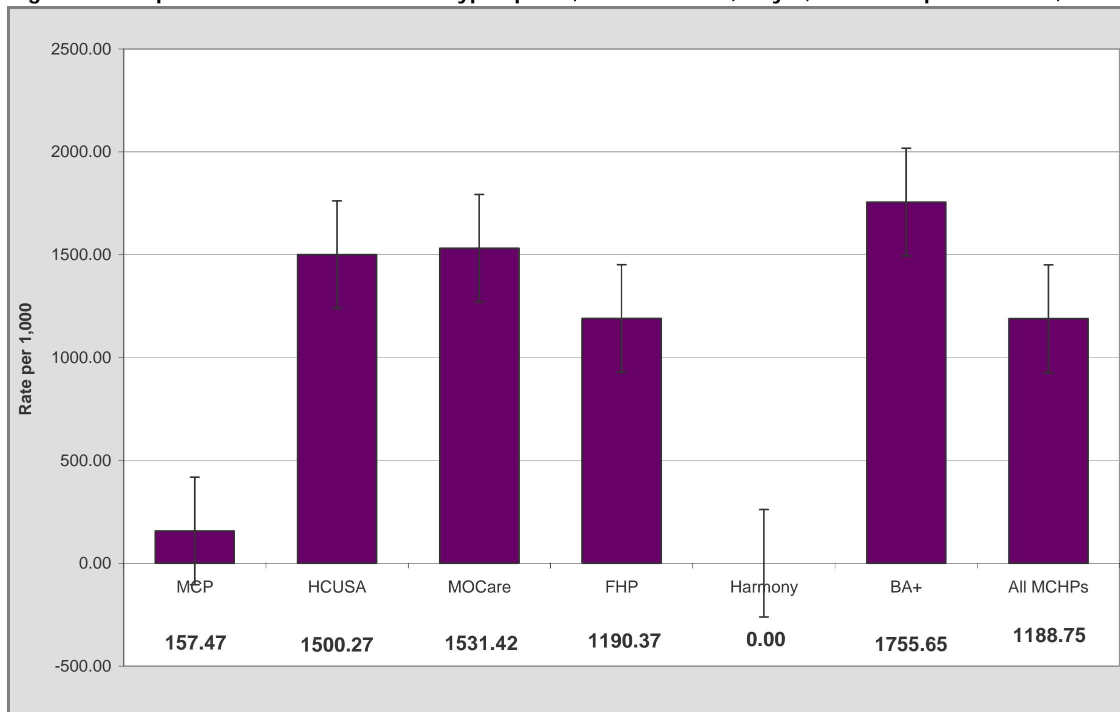
Figure 28 - Home Health Encounter Claim Types per 1,000 Members, July 1, 2008 – September 30, 2008



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers

The results for the 2007 review of Inpatient Encounter claims are strongly comparable to the 2008 results (see Figure 29). In 2007, the EQRO found that two MO HealthNet Managed Care health plans had significantly lower rates of Inpatient encounter claims (Harmony, 0.00, z = -1.36; 95% CI: -558.98, 558.98; p < .01; MercyCare Plus, 157.47, z = -1.15; 95% CI: -401.51, 716.45; p < .01). One health plan had a significantly higher rate of Inpatient encounter claims (BlueAdvantage Plus of Kansas City, 1755.65, z = 0.97; 95% CI: 1196.67, 2314.63; p < .05) compared to the rate for all MO HealthNet Managed Care health plans.

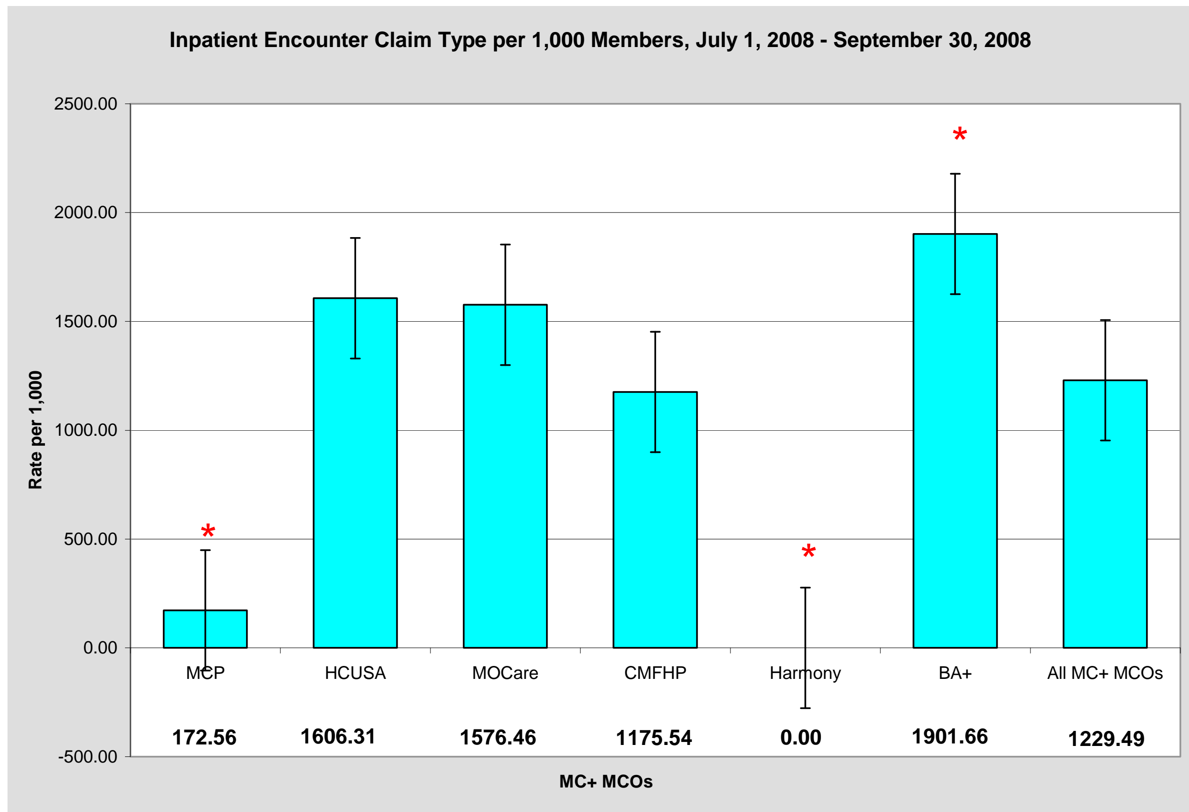
Figure 29 - Inpatient Encounter Claim Types per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Again, in 2008 the EQRO found that two MO HealthNet Managed Care health plans had significantly lower rates of Inpatient encounter claims (Harmony, 0.00, z = -1.34; 95% CI: -592.39, 592.39; p < .01; MercyCare Plus, 172.56, z = -1.12; 95% CI: -419.38, 764.95; p < .01). One health plan had a significantly higher rate of Inpatient encounter claims (BlueAdvantage Plus of Kansas City, 1901.66, z = 1.04; 95% CI: 1309.27, 2494.05; p < .01) compared to the rate for all MO HealthNet Managed Care health plans (see Figure 30).

Figure 30 - Inpatient Encounter Claim Types per 1,000 Members, July 1, 2008- September 30, 2008



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Outpatient Hospital encounter claim types consist of claims submitted by outpatient hospital facilities and MO HealthNet Managed Care health plans. In 2007 (see Figure 31), the EQRO found that the rate of Outpatient Hospital encounter claims per 1,000 members for all MO HealthNet Managed Care health plans was 5,547.72. In 2008 this rate was comparable at 5614.23 (see Figure 32).

In 2007, the EQRO found that one MO HealthNet Managed Care health plan had a significantly higher rate of Outpatient Hospital encounter claims (Missouri Care, 8785.34, $\underline{z}$ = 1.21; 95% CI: 6530.31, 11040.37; $\underline{p}$ < .01). While one MO HealthNet Managed Care health plan had a significantly lower rate of Outpatient Hospital encounter claims per 1,000 members (Harmony Health Plan, 3.43, $\underline{z}$ = -1.67; 95% CI: -2251.60, 2258.46; $\underline{p}$ < .01) than the rate for all MO HealthNet Managed Care health plans.

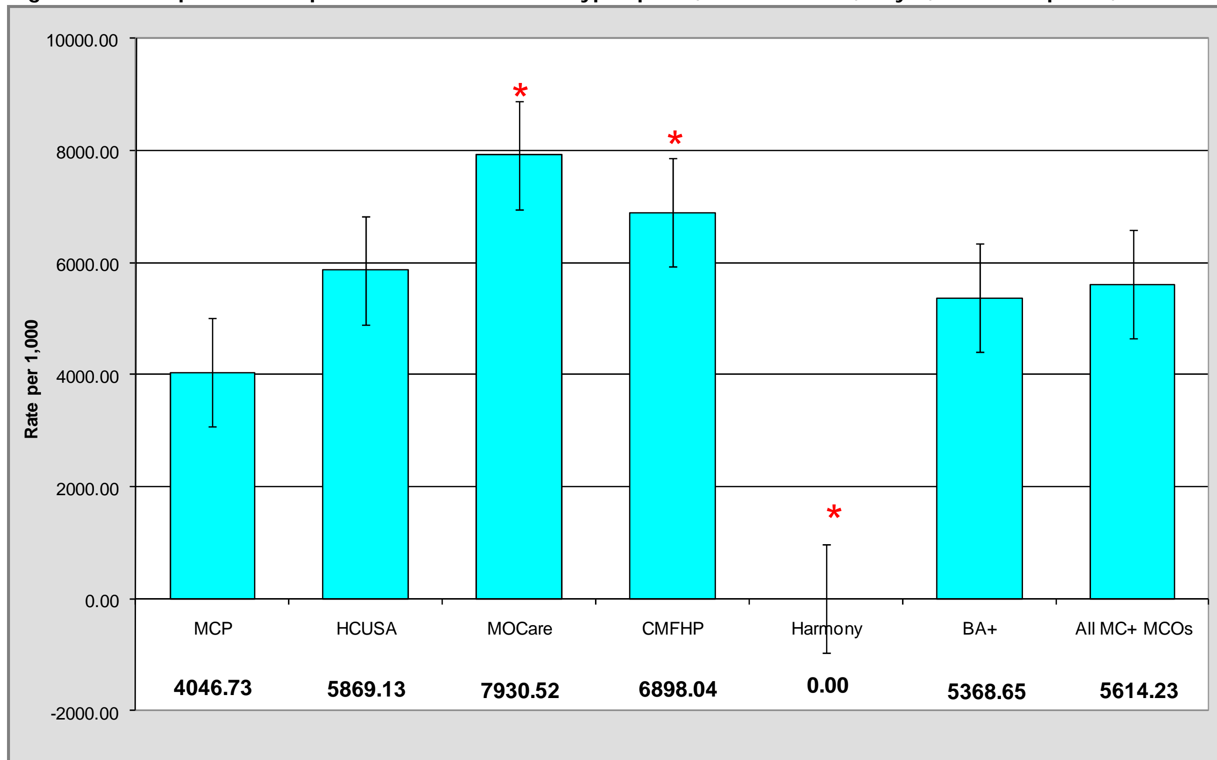
Figure 31 - Outpatient Hospital Encounter Claim Types per 1,000 Members, July 1, 2007 – Sept. 30, 2007

Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

In 2008, again the EQRO found that one MO HealthNet Managed Care health plan had a significantly higher rate of Outpatient Hospital encounter claims (Missouri Care, 7930.52, $\underline{z}$ = 1.04; 95% CI:

5861.86, 9999.18; p < .01). While one MO HealthNet Managed Care health plan had a significantly lower rate of Outpatient Hospital encounter claims per 1,000 members (Harmony Health Plan, 0.00, z = -1.80; 95% CI: -2068.68, 2068.68; p < .01) than the rate for all MO HealthNet Managed Care health plans.

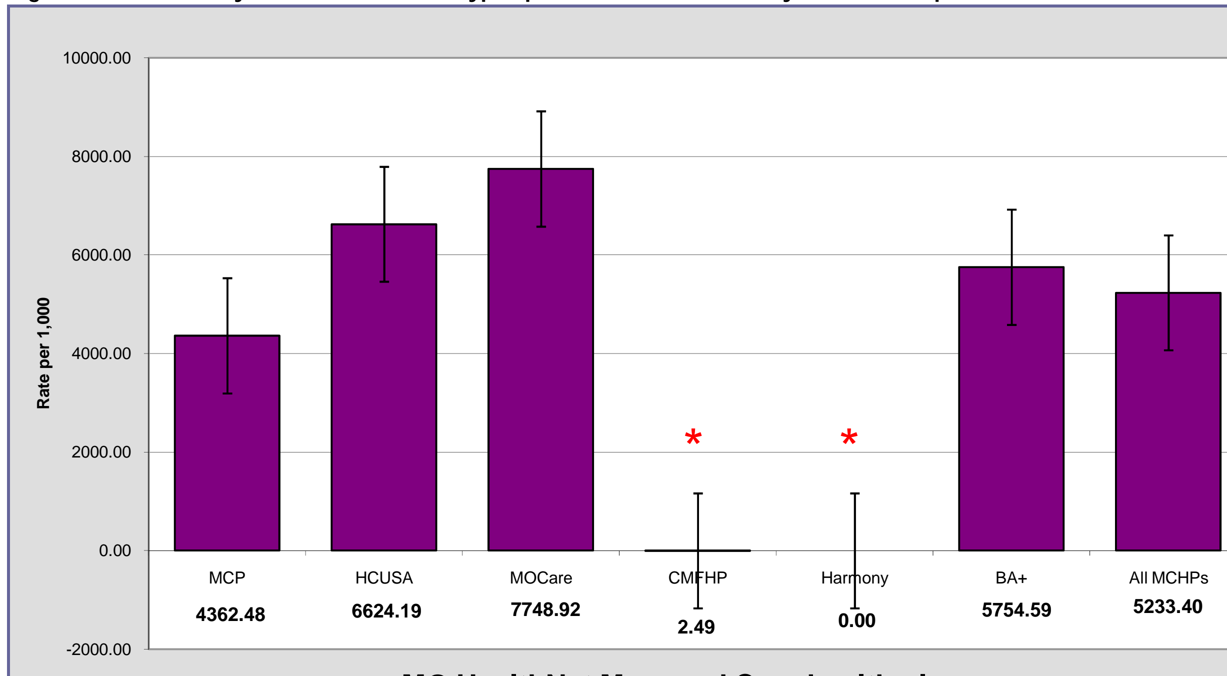
Figure 32 - Outpatient Hospital Encounter Claim Types per 1,000 Members, July 1, 2008 – Sept. 30, 2008



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MO Dept of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Pharmacy encounter claim types consist of claims submitted by pharmacy providers and MO HealthNet Managed Care health plans. In 2007, as shown in Figure 33, there was wide variability across MO HealthNet Managed Care health plans in the rate per 1,000 members of Pharmacy encounter claims compared to the rate for all health plans. Missouri Care (7748.92, z = 1.09, 95% CI: 5267.69, 10230.15; $p < .01$) had a significantly higher rate of Pharmacy encounter claims, see Figure 31. While two MO HealthNet Managed Care health plans (Children's Mercy Family Health Partners, 2.49, z = -1.22; 95% CI: -2478.74, 2481.23; $p < .01$; and Harmony Health Plan, 0.00, z = -1.22; 95% CI: -2481.23, 2481.23; $p < .01$) had a significantly lower rate of Pharmacy encounter claims per 1,000 members than the rate for all MO HealthNet Managed Care health plans.

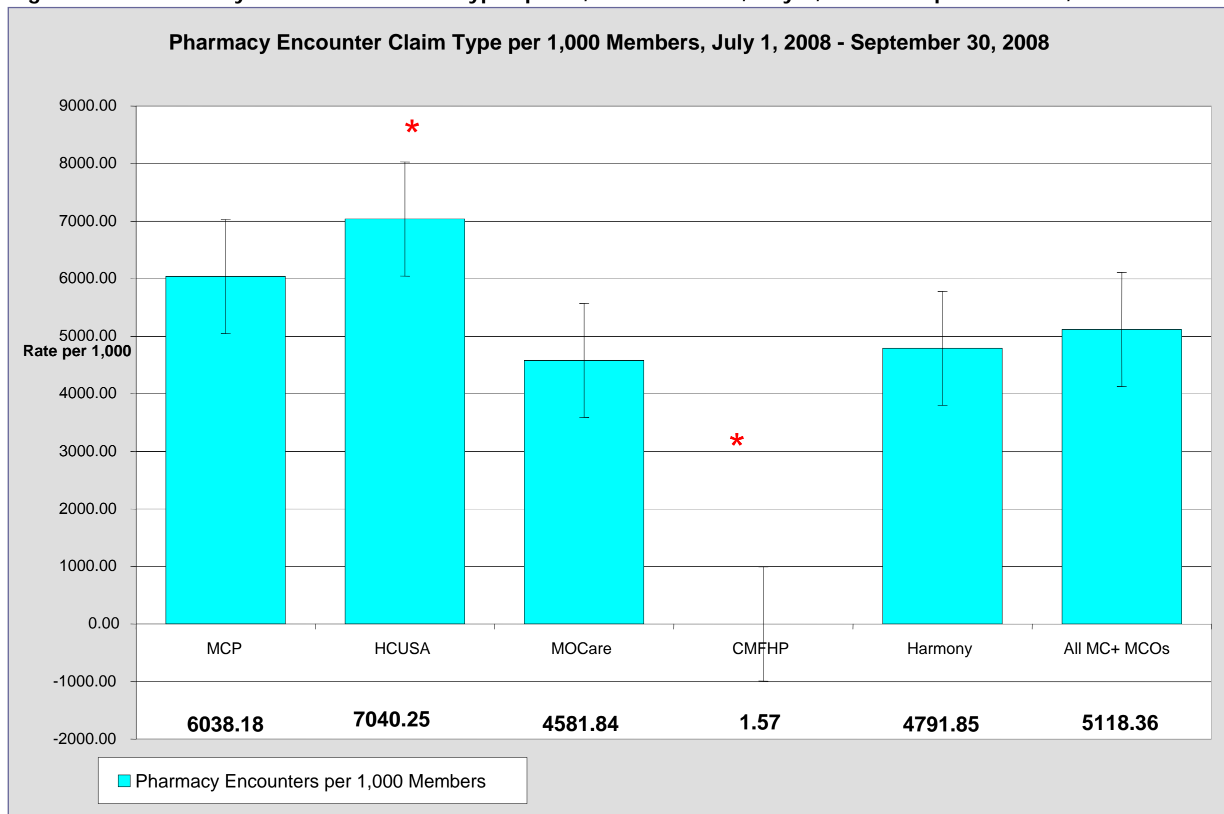
Figure 33 - Pharmacy Encounter Claim Types per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

In 2008, as shown in Figure 34, there was again wide variability across MO HealthNet Managed Care health plans in the rate per 1,000 members of Pharmacy encounter claims compared to the rate for all health plans. Healthcare USA (7040.25, $\underline{z}$ = .94, 95% CI: 4674.16, 9406.34; $\underline{p}$ < .01) had a significantly higher rate of Pharmacy encounter claims, see Figure 31. While one MO HealthNet Managed Care health plans (Children's Mercy Family Health Partners, 1.57, $\underline{z}$ = -1.66; 95% CI: -2364.52, 2367.66; $\underline{p}$ < .01) had a significantly lower rate of Pharmacy encounter claims per 1,000 members than the rate for all MO HealthNet Managed Care health plans.

Figure 34 - Pharmacy Encounter Claim Types per 1,000 Members, July 1, 2008 – September 30, 2008



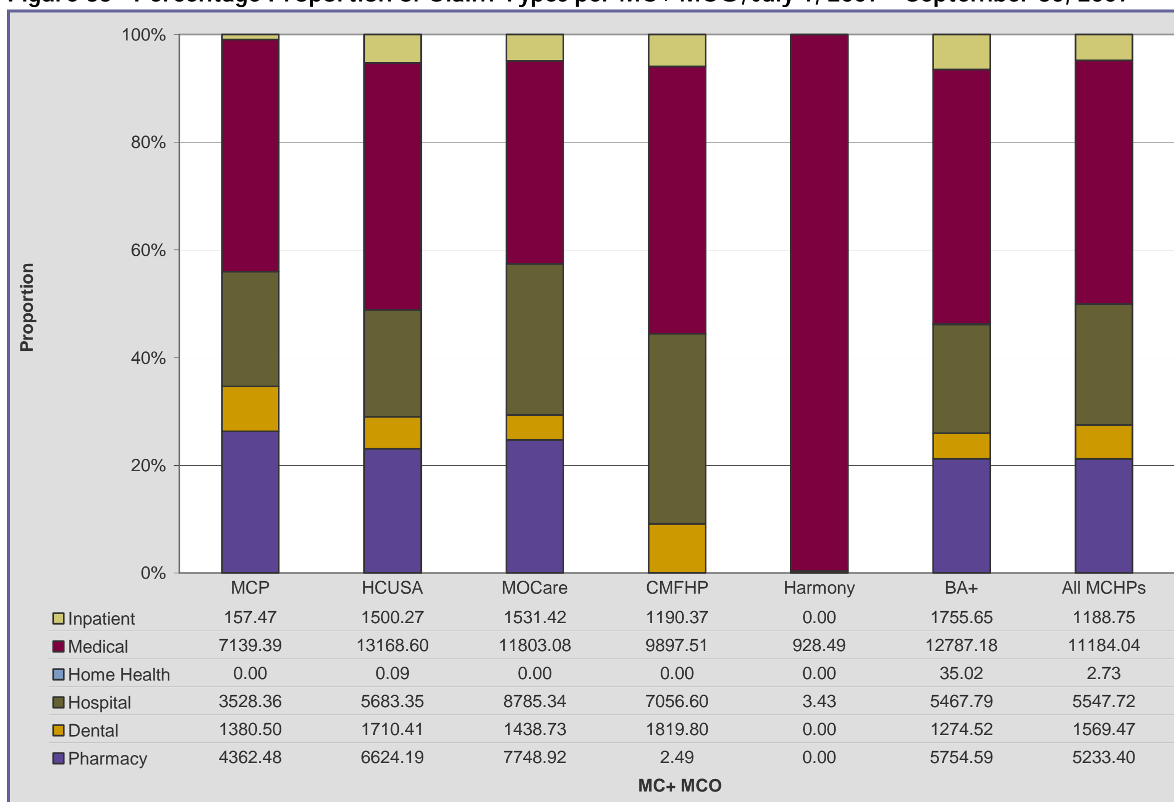
Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MO Dept of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Table 35 and Figure 35 show the proportion of claim types for each MO HealthNet MCHP based on the SMA encounter claims extract file. Healthcare USA had the highest proportion of Medical and Pharmacy claims relative to all other MO HealthNet MCHPs; Children's Mercy Family Health Partners had the highest proportion of the Dental claim types; Blue-Advantage Plus of Kansas City had the highest proportion of Home Health and Inpatient claim types; and Missouri Care had the highest proportion of Hospital claims. There were no patterns observed across MO HealthNet Plans, suggesting that the variations are not related to member or provider practice characteristics.

Table 35 - Numerical Proportion of Claim Types per MC+ MCO, July 1, 2007 –September 30, 2007

MCHP	Medical	Dental	Inpatient	Home Health	Hospital	Pharmacy
MCP	7139.39	1380.50	157.47	0.00	3528.36	4362.48
HCUSA	13168.60	1710.41	1500.27	0.09	5683.35	6624.19
MOCare	11803.08	1438.73	1531.42	0.00	8785.34	7748.92
CMFHP	9897.51	1819.80	1190.37	0.00	7056.60	2.49
Harmony	928.49	0.00	0.00	0.00	3.43	0.00
BA+	12787.18	1274.52	1755.65	35.02	5467.79	5754.59
All MCHPs	**11184.04**	**1569.47**	**1188.75**	**2.73**	**5547.72**	**5233.40**

Figure 35 - Percentage Proportion of Claim Types per MC+ MCO, July 1, 2007 – September 30, 2007



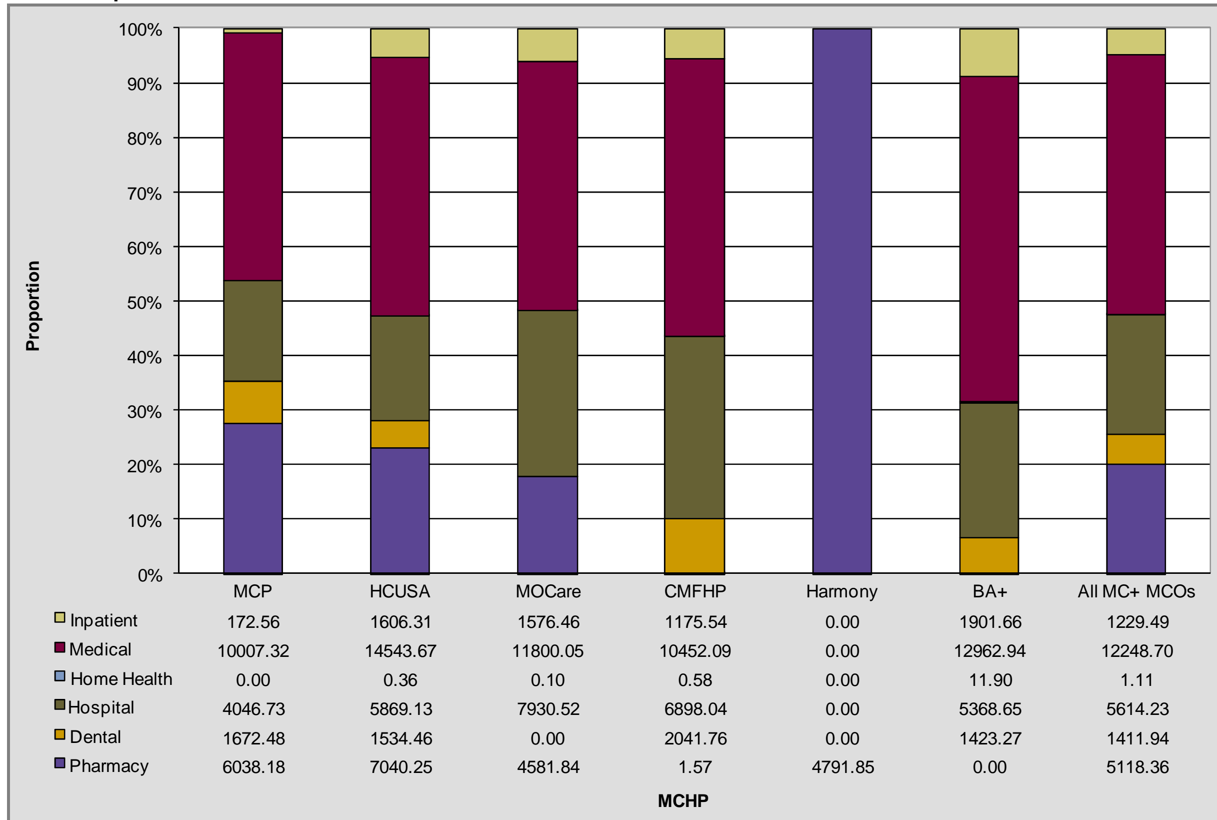
Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, February15, 2008.

In 2007, Missouri Care had the highest proportion of Pharmacy and Hospital; Healthcare USA had the highest proportion of Medical claims; Blue-Advantage Plus of Kansas City again had the highest proportion of Home Health and Inpatient claims; and Children's Mercy Family Health Partners again had the highest proportion of Dental claims relative to all other MO HealthNet Managed Care health plans (see Table 36 and Figure 36).

Table 36 - Numerical Proportion of Claim Types per MO HealthNet Managed Care health plan, July 1, 2008 – September 30, 2008

MCHP	Medical	Dental	Inpatient	Home Health	Hospital	Pharmacy
MCP	10007.32	1672.48	172.56	0.00	4046.73	6038.18
HCUSA	14543.67	1534.46	1606.31	0.36	5869.13	7040.25
MOCare	11800.05	0.00	1576.46	0.10	7930.52	4581.84
CMFHP	10452.09	2041.76	1175.54	0.58	6898.04	1.57
FG	0.00	0.00	0.00	0.00	0.00	4791.85
BA+	12962.94	1423.27	1901.66	11.90	5368.65	0.00
All MCHPs	**12248.70**	**1411.94**	**1229.49**	**1.11**	**5614.23**	**5118.36**

Figure 36 - Percentage Proportion of Claim Types per MO HealthNet Managed Care health plan, July 1, 2008 – September 30, 2008



	MCP	HCUSA	MOCare	CMFHP	Harmony	BA+	All MC+ MCOs
Inpatient	172.56	1606.31	1576.46	1175.54	0.00	1901.66	1229.49
Medical	10007.32	14543.67	11800.05	10452.09	0.00	12962.94	12248.70
Home Health	0.00	0.36	0.10	0.58	0.00	11.90	1.11
Hospital	4046.73	5869.13	7930.52	6898.04	0.00	5368.65	5614.23
Dental	1672.48	1534.46	0.00	2041.76	0.00	1423.27	1411.94
Pharmacy	6038.18	7040.25	4581.84	1.57	4791.85	0.00	5118.36

Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, February13, 2009.

Table 37 - MO HealthNet MCHPs, Rate per 1,000 Members all Encounter Claims (2007)

Claim Type	Number of Claims	Total Members	Claims Per 1000 Members
Home Health	235	343,998	2.73
Dental	134,974	343,998	1,569.47
Medical	961,822	343,998	11,184.84
Outpatient	477,101	343,998	5,547.72
Drug	450,070	343,998	5,233.40
Inpatient	102,232	343,998	1,188.75

Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2007 – September 30, 2007 / (Number members) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file.

Table 38 - MO HealthNet MCHPs, Rate per 1,000 Members all Encounter Claims (2008)

Claim Type	Number of Claims	Total Members	Claims Per 1000 Members
Home Health	107	383,933	1.11
Dental	135,523	383,933	1,411.94
Medical	1,175,670	383,933	12,248.70
Outpatient	538,872	383,933	5,614.23
Drug	491,277	383,933	5,118.36
Inpatient	118,010	383,933	1,229.49

Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2008 – September 30, 2008 / (Number members) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file.

To What Extent do the MO HealthNet MCHP claims (paid and unpaid) match the State Encounter Claims Paid Claims Data Base?

All six MO HealthNet Managed Care health plans submitted the requested internal control numbers (ICNs) generated by the SMA data system for the "paid" vs. "unpaid" analysis. Health Care USA, Missouri Care, Children's Mercy Family Health Partners and Blue-Advantage Plus of Kansas City submitted encounter claims that were "paid" or "denied" status. Blue-Advantage Plus of Kansas City and Healthcare USA also submitted claims with a status of "unpaid".

The ICNs were used to match the encounters of each claim type (Inpatient, Outpatient, and Pharmacy) between the MO HealthNet Managed Care health plan and the SMA extract files. A "match" was considered if the MO HealthNet Managed Care health plan sample encounter was identified in the SMA database.

What types of paid encounter data are missing and why?

There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all MO HealthNet Managed Care health plans.

For all MO HealthNet Managed Care health plans, all unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA. There were no unmatched encounters within the Pharmacy Claim type. For the Outpatient data, 100.00% of the 1564 unmatched claims were missing ICN numbers. Of the 1564 unmatched claims, 1421 of those were of "denied" status and would not be expected to be present in the SMA file. The remaining 143 were "unpaid" and were also not found in the SMA file. For Inpatient Claims, all 363 unmatched claims were missing ICNs. Therefore, all were legitimately missing from the SMA file.

What is the fault/match rate of paid and unpaid encounter claims in the SMA encounter claim database and the MO HealthNet MCHP claims database?

For all Outpatient Claim Types (Medical, Dental, Home Health, & Hospital; n = 1,850,172), 1421 "denied" claims were submitted by all MO HealthNet Managed Care health plans. All of these claims were unmatched with the SMA encounter data. There was a "hit" rate of 99.99% between Outpatient encounter claims and the SMA encounter data. For the Inpatient Claim Type, data submitted to the EQRO (n = 118,110), 338 "denied" claims were submitted. These claims were not found in the SMA encounter data. There were a total of 1927 unmatched records (168 "unpaid" claims were submitted) between all MO HealthNet MCHPs and the SMA, yielding a 99.99% "hit" rate.

What services are being provided that are not being paid and how many services are being provided that are not being paid?

Unpaid encounter claims were submitted for only Outpatient and Inpatient categories. 168 unpaid claims were submitted for all MO HealthNet MCHPs for all Outpatient claims and Inpatient services. These unpaid claims represent 0 .0001% of all claims submitted to the SMA.

To What Extent Do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

Table 39 shows the population (number of encounters), minimum required sample size, the number of encounters sampled, and the number and rate of records submitted for review. Of the 1,850,172 Medical encounter claim types in the SMA encounter claims extract file for July 1, 2008 through September 30, 2008, 500 encounters (100 per MO HealthNet Managed Care health plan) were randomly selected. This was an oversample, as the minimum required sample size was 88 per MO HealthNet Managed Care health plan. Providers were requested to submit medical records for review.

For the 500 selected encounters, there were 450 medical records (90.00%) submitted for review. Although this is an increase over the 86.71% submitted for review during the 2005 audit, it was a decrease from the 97.40% and 93.50% submitted for the 2006 and 2007 audits, respectively. For 2007, MO HealthNet Managed Care health plan submission rates ranged from 88.0% (Children's Mercy Family Health Partners) to 98.0% (Missouri Care). For 2008, the submission rates ranged from 76.0% (Missouri Care) to 100.0% (Blue-Advantage Plus and Healthcare USA). Encounters for which no documentation was submitted were unable to be validated.

Table 39 - Encounter Data Validation Samples and Medical Record Submission Rate

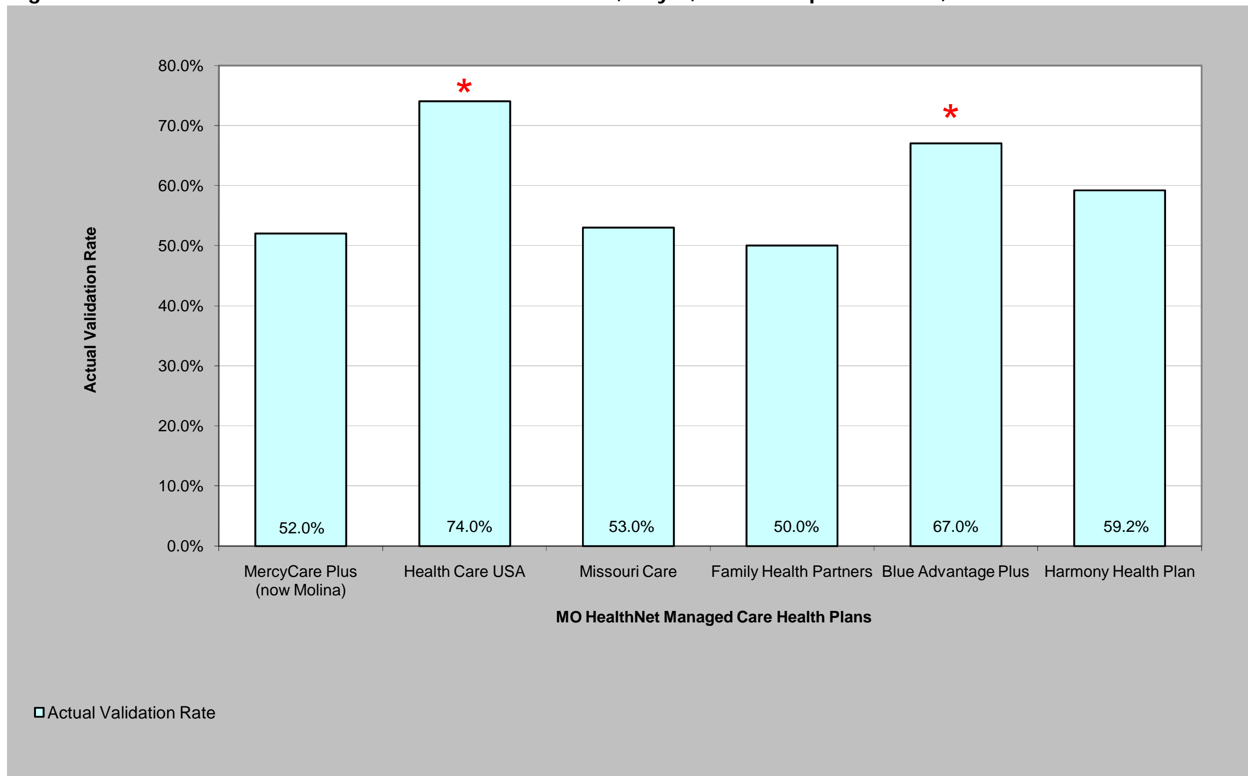
MO HealthNet MCHP	Number Encounters	Minimum Sample Size	Number Encounters Sampled	Number Medical Records Received	Submission Rate
MercyCare Plus	304,210	88	100	83	83.00%
Health Care USA	981,223	88	100	100	100.00%
Missouri Care	192,818	88	100	76	76.00%
Family Health Partners	234,038	88	100	91	91.00%
Blue Advantage Plus	137,883	88	100	100	100.00%
All MCHPs	**1,850,172**	**440**	**500**	**450**	**90.00%**

Note: The number of encounters represents the number of unique OutpatientMedical claim types found in the SMA encounter claims extract file for the period July 1, 2008 through September 30, 2008. The minimum sample size is based on the validation of medical records for two dependent variables, the procedure code and the diagnosis code. Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation. Number Medical Records Received = Number medical records submitted by MO HealthNet Managed Care health plan providers; Number Claim Forms Received = Number claim forms submitted by MO HealthNet MCHP providers; Submission Rate = Proportion of medical records submitted of the number of encounters sampled.
Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, January 2009. BHC, Inc. 2008 External Quality Review Validation of Encounter Data.

Table 40 and Figure 37 show the results of the match for procedures. Across all MO HealthNet MCOs, 59.20% of the medical records contained matching procedure codes or descriptors; this is an increase of 7.20% from the 2007 audit which found 52.00%, but a decrease of 14.04% from the 2006 audit which found 73.24%.

MO HealthNet Managed Care health plan match rates ranged from 50.0% (Children's Mercy Family Health Partners) to 74.0% (Healthcare USA). Two MO HealthNet Managed Care health plans (BA+, 67.00%; z = 0.73, 95% CI: 57.65, 736.35; and HCUSA, 74.00%; z= 1.39, 95% CI: 64.65, 83.35) had match rates significantly higher than the rate for all MO HealthNet Managed Care health plans. The remaining MO HealthNet Managed Care health plans had match rates consistent with the rate for all MO HealthNet MCOs. The CMS Protocols suggest a 99% match rate as a validity criterion. When considering only the documentation submitted for review, the match rate for all MO HealthNet Managed Care health plans for procedures was 59.20%

Figure 37 - Encounter Data Procedure Validation Rate, July 1, 2008 – September 30, 2008



Note: * Indicates values are significant at the 95% level of significance, two-tailed z-test. See corresponding tables for 95% confidence intervals.
Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, January 15, 2008. BHC, Inc. 2008 External Quality Review Validation of Encounter Data.

Table 40 - Procedure Validation Rate

MO HealthNet MCHPs	Number Encounters Sampled	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	z	p	LCL	UCL
MercyCare Plus (now Molina)	100	83	52	62.65%	52.00%	48.00%	0.3236046	0.527	42.65%	61.35%
Health Care USA	100	100	74	74.00%	74.00%	26.00%	1.3879745	0.081	64.65%	83.35%
Missouri Care	100	76	53	69.74%	53.00%	47.00%	0.9881668	0.393	43.65%	62.35%
Family Health Partners	100	91	50	54.95%	50.00%	50.00%	-0.3990375	0.025	40.65%	59.35%
Blue Advantage Plus	100	100	67	67.00%	67.00%	33.00%	0.7315001	0.780	57.65%	76.35%
All MCHPs	500	**450**	**296**	**65.78%**	**59.20%**	**40.80%**	0.6168775	0.981	49.85%	68.55%

Note: Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by MO HealthNet Managed Care health plan providers for validation; Number Validated = Number of encounters for which there was a similar or matching procedure code or description on the claim form, or adequate documentation in the medical record to support the procedure code as judged by a professional medical coder. Rate Validated of Medical Records Received = Number Validated/Number Medical Records Received; Actual Rate Validated = Number Validated/Number Encounters Sampled; LCL = Lower Confidence Limit at the 95% confidence level; UCL = Upper Confidence Limit at the 95% confidence level.

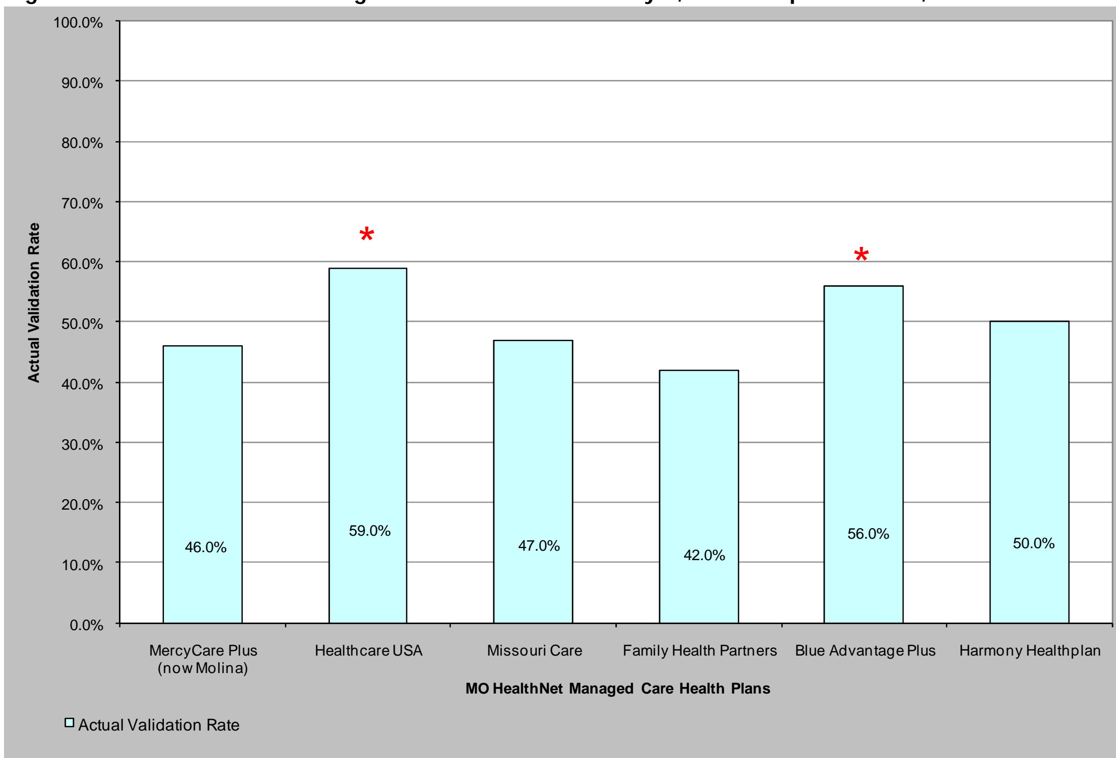
Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, January 2008.
BHC, Inc. 2008 External Quality Review Validation of Encounter Data.

For the validation of the diagnosis, 50.0% matched the diagnosis found in the SMA encounter claims extract file across all MO HealthNet Managed Care health plans (see Figure 38 and Table 41). This was a significant decrease from the 2006 audit when the EQRO found that 70.56% matched the diagnosis found in the SMA encounter claims extract file, but an increase from 2007 when only 47.0% matched the diagnosis found in the SMA file.

For the 2008 audit, MO HealthNet Managed Care health plan match rates ranged from 42.0% (Children's Mercy Family Health Partners) to 59.0% (HCUSA) of the medical records or claim forms for diagnosis codes. Two MO HealthNet Managed Care health plans (Blue-Advantage Plus of Kansas City, 56.0%, z = 1.38, 95% CI: 49.71,62.29; p<.01and HCUSA, 59.0%, z = 1.25, 95% CI: 52.71, 65.29; p<.01) had match rates significantly higher than the rate for all MO HealthNet Managed Care health plans; while all others had rates consistent with the All Health Plan rate. The CMS Protocol suggests a greater than 90% validity criterion.[18] No MO HealthNet Managed Care health plan met that validity criterion.

[18] Validating Encounter Data, A protocol for use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Final Protocol, Version 1.0, May 1, 2002.

Figure 38 - Encounter Data Diagnosis Validation Rate- July 1, 2008– September 30, 2008



Note: * Indicates values are significant at the 95% level of significance, two-tailed z-test. See corresponding tables for 95% confidence intervals.
Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, January 15, 2008. BHC, Inc. 2008 External Quality Review Validation of Encounter Data.

Table 41 – Encounter Data Diagnosis Validation Rate- July 1, 2008 – September 30, 2008

MC+ MCO	Number Encounters Requested	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	z	p	LCL	UCL
MercyCare Plus (now Molina)	100	83	46	55.42%	46.00%	54.00%	0.7554936	0.935	39.71%	52.29%
Health Care USA	100	100	59	59.00%	59.00%	41.00%	1.2541194	0.000	52.71%	65.29%
Missouri Care	100	76	47	61.84%	47.00%	53.00%	1.6501571	0.055	40.71%	53.29%
Family Health Partners	100	91	42	46.15%	42.00%	58.00%	-0.5359485	0.003	35.71%	48.29%
Blue Advantage Plus	100	100	56	56.00%	56.00%	44.00%	0.8360796	0.921	49.71%	62.29%
All MC+ MCOs	**500**	**450**	**250**	**55.56%**	**50.00%**	**50.00%**	0.7741478	0.968	43.71%	56.29%

Note: Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by MO HealthNet Managed Care health plan providers for validation; Number Validated = Number of encounters for which there was a similar or matching procedure code or description on the claim form, or adequate documentation in the medical record to support the procedure code as judged by a professional medical coder. Rate Validated of Medical Records Received = Number Validated/Number Medical Records Received; Actual Rate Validated = Number Validated/Number Encounters Sampled; LCL = Lower Confidence Limit at the 95% confidence level; UCL = Upper Confidence Limit at the 95% confidence level.

Source: Missouri Department of Social Services, Division of MO HealthNet encounter claims extract file, January 2008.
BHC, Inc. 2008 External Quality Review Validation of Encounter Data.

What Types of Errors Were Noted?

An error analysis for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA encounter claims extract file were incorrect information (n = 27), missing information (n = 167) and upcoded (n = 5). Incorrect information included that the diagnosis code listed did not match the descriptive information in the record. Missing information included the coders being unable to find a diagnosis code or diagnosis description in the medical records received for review.

For the procedure code in the medical record, the reasons for procedure codes in the SMA encounter claims extract file not being supported by documentation in the medical record were missing information (n = 105), upcoding (n=12), downcoding (n=1) and incorrect codes (n = 27). Examples of incorrect information included: incorrect codes (n = 20) and codes that did not match the procedure description (n = 7).

What Problems Are There With How Files Are Compiled and Submitted by the MCHP?

The EQRO had no problems with how files are compiled and submitted by each MO HealthNet Managed Care health plan.

What Are the Data Quality Issues Associated With the Processing of Encounter Data?

The EQRO had no data quality issues with SMA and MO HealthNet Managed Care health plan encounter data during the course of conducting the EQRO. This was only the third year of the EQR that the EQRO has received all encounter data in the format requested.

4.5 Conclusions

Strengths

1. All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet Managed Care health plans. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.
2. All MO HealthNet Managed Care health plans submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.
3. The examination of the level, volume, and consistency of services found significant variability between MO HealthNet Managed Care health plans in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), with no patterns of variation noted by Region or type of MO HealthNet Managed Care health plan.
4. MO HealthNet Managed Care health plan members received a substantially larger portion of all Outpatient services delivered in Missouri during the 2008 measurement period versus the 2007 measurement period.
5. There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all Managed Care health plans.
6. Unpaid claims represent less than .0001% of all claims submitted to the SMA.

Areas for Improvement

1. For all MO HealthNet Managed Care health plans, all unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA.
2. The Procedure Code field in the Outpatient Home Health, Outpatient Hospital and Outpatient Medical claim types included some invalid information. Most of this was due to blank fields or fields containing ".00".
3. The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.

4. The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type procedures were 59.20%, although an increase over 2007 (52.0%), a significant decrease from the 2006 match rate of 73.24%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.
5. The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type diagnoses were 50.0%, although an increase over 2007 (47.0%), this is significantly lower than the 2006 match rate of 70.56%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

RECOMMENDATIONS

1. It is recommended that the SMA institute additional edits for the Medical, Inpatient and Outpatient Hospital claim types to edit claims with blank fields or dummy values (e.g., "000" and "99999999").
2. The SMA should continue to provide timely feedback to MO HealthNet Managed Care health plans regarding the rate of acceptance of each claim type and the types of errors associated with rejected claims.
3. Additional analysis on the rate of consistency of services should examine demographic (e.g., age and gender distribution), epidemiological (diagnostic variables), and service delivery (e.g., number of users per month, rate of procedures or claim types, units of service rates) characteristics to explain variation across MO HealthNet Managed Care health plans or Regions.
4. MO HealthNet Managed Care health plans' medical record reviews should be targeted toward validation of diagnosis and procedure codes and/or descriptors.
5. The SMA should clarify the expectations for MO HealthNet Managed Care health plans in the level of completeness, accuracy, and validity and which data fields are required (e.g., Diagnosis Code fields 2 through 5); provide timely feedback to MO HealthNet Managed Care health plans when standards are not met; and develop corrective action plans when standards are not met within a reasonable amount of time established by the SMA.

6. The MCHP should investigate and report to the SMA the reasons for and corrective action to prevent the substantial decline in medical records matches for both diagnoses and procedures between the 2007 and 2008 EQR reports.
7. The MCHPs should submit all requested records for Encounter Data Validation, those records not submitted represented 10% of the total requested.

5.0 MO HealthNet MCHP COMPLIANCE WITH MANAGED CARE REGULATIONS

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5.1 Purpose and Objectives

The External Quality Review (EQR) is conducted annually in accordance with the Medicaid Program: External Quality Review of the Medicaid Managed Care Organizations Final Rule, 42 CFR 438, Subpart E." The original objective of this portion of the 2003 review was to analyze and evaluate the MO HealthNet Managed Care Health Plans to assess their level of compliance with federal regulations regarding quality, timeliness and access to health care services. In the two subsequent years, beginning in 2004 and culminating in 2005, the objective was to complete follow-up reviews to ensure improved and continued compliance with these regulations on the part of the MO HealthNet MCHPs. To complete this process, the Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol) requirements were applied to the review process, with an emphasis on areas where individual MCHPs failed to comply or were in only partial compliance at the time of the prior reviews. Specifically, the MCHPs were reviewed to assess MO HealthNet MCHP compliance with the federal Medicaid managed care regulations; with the State Quality Strategy; with the MO HealthNet contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous review year. To enhance this process in 2006 two additional activities occurred. A case review of Grievance and Appeal files, following up on findings from 2004 and 2005, was completed. A second case review focusing on Behavioral Health Case Management files, a follow-up from the 2003 External Quality Review occurred.

The current 2008 report on compliance with federal regulations is follow-up to the compliance reviews conducted in 2006 and 2007. However, as previous reviews revealed the MO HealthNet Managed Care Health Plans have nearly reached full compliance with completing written policy and procedures that meet both the requirements of the federal regulations and the MO HealthNet Division (MHD), which is the State agency administering the federal Medicaid program (SMA). To enhance this review it was decided to complete in-depth interviews with Member Services staff and Case Management staff, and separately with Health Plan Administrators. The Member Services staff and Case Managers have direct contact with members and are responsible for communicating the services available to members, members' rights and responsibilities, assessing members for Case Management services, and ensuring that

members have appropriate access to quality and timely health care. These interviews were designed to validate that the actual practices occurring at the MO HealthNet Managed Care Health Plans were compliant with the written policy and procedures developed by the Health Plans and approved by the SMA. Additionally, the interview tools were based on information included in the Health Plans' 2008 Annual Reports to the SMA, and the SMA's Quality Strategy.

5.2 Technical Methods

PLANNING COMPLIANCE MONITORING ACTIVITIES

Establishing Contact with the MO HealthNet Health Plans

All MO HealthNet Managed Care Health Plans were contacted during November 2008 to prepare them for the 2008 External Quality Review. All MO HealthNet Managed Care Health Plan quality management staff and/or plan administrators were contacted to discuss the onset of External Quality Review Organization (EQRO) activities and to schedule training teleconferences for December. The Health Plans were explicitly requested to have those staff or subcontractors available who were responsible for obtaining and submitting the data required to complete all validation processes. During the teleconferences, all aspects of the EQR were discussed and details provided regarding all data submissions that would be required.

The training teleconference agenda, methods and objectives, and schedule were sent to all MO HealthNet Managed Care Health Plans, with approval from the State Medicaid Agency (SMA), prior to their scheduled conference. SMA staff arranged to participate in these conference calls allowing time for presentation of information, clarification, and questions.

Gathering Information on the MO HealthNet MCHP Characteristics

During the 2008 review year there were six MO HealthNet Managed Care Health Plans contracted with the State Medicaid Agency (SMA) to provide MO HealthNet Managed Care in three Regions of Missouri. The Eastern Region includes St. Louis City, St. Louis County, and twelve surrounding counties. These MO HealthNet Members are served by three MO HealthNet Managed Care Health Plans: Molina Healthcare of Missouri, Healthcare USA (HCUSA), and Harmony Health Plan of Missouri (HHP). The Western Region includes Kansas

City/Jackson County and twelve surrounding counties. These MO HealthNet members are served by four MO HealthNet Managed Care Health Plans: Children's Mercy Family Health Partners (CMFHP), Blue-Advantage Plus (BA+), Molina Healthcare of Missouri (Molina), and Healthcare USA (HCUSA). The Central Region includes twenty-eight counties in the center of the state. These MO HealthNet members are served by three MO HealthNet Managed Care Health Plans: Missouri Care (MOCare), Molina Healthcare of Missouri (Molina) and Healthcare USA (HCUSA). Molina Healthcare of Missouri and Healthcare USA operated in all three Regions.

Determining the Length of Visit and Dates

On-site compliance reviews were conducted in two days at each MO HealthNet Managed Care Health Plan, with several reviewers conducting interviews and activities concurrently. Document reviews occurred prior to the complete on-site review at all MO HealthNet Managed Care Health Plans. Document reviews and the Validation of Performance Measures interviews were conducted on the first day of the on-site review. Interviews, presentations, and additional document reviews were scheduled throughout the second day, utilizing all team members for Validating Performance Improvement Projects, and Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs). The time frames for on-site reviews were determined by the EQRO and approved by the SMA before scheduling each MO HealthNet Managed Care Health Plan. The first review week was spent reviewing the MO HealthNet Managed Care Health Plans located in the Eastern Region. The second review week was spent in the Western Region. The final visit occurred with the Health Plan located in the Central Region. The following schedule lists the dates of the on-site reviews:

- July 6 & 7, 2009 – Harmony Health Plan
- July 8 & 9, 2009 – Healthcare USA
- July 8 & 10, 2009 – Molina Healthcare of Missouri
- July 13 & 14, 2009– Children's Mercy Family Health Partners
- July 13 & 15, 2009 – Blue-Advantage Plus
- July 20 & 21, 2009 – Missouri Care

Reviewers

Two reviewers conducted the Compliance Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director conducted backup activities, including assistance during the interview process, and oversight of the Compliance Protocol team. The Assistant Project Director was conducting her fifth review. She has experience with the MO HealthNet Managed Care Program implementation and operations, interviewing, program analysis, and Medicaid managed care programs in other states. The second reviewer participated in seven previous MO HealthNet Managed Care Program EQRs and on-site visits. This reviewer was knowledgeable about the MO HealthNet Managed Care Program through her experience as a former SMA employee responsible for quality assessment and improvements, as an RN, and a consultant. All reviewers were familiar with the federal regulations and the manner in which these were operationalized by the MO HealthNet Managed Care Program prior to the implementation of the protocols.

Establishing an Agenda for the Visit

An agenda was developed to maximize the use of available time, while ensuring that all relevant follow-up issues were addressed. A sample schedule was developed that specified times for all review activities including the entrance conference, document review, Validating Performance Improvement Project evaluation, Validating Performance Measures review, conducting the interviews for the Compliance Protocol, and the exit conference. A coordinated effort with each MO HealthNet Managed Care Health Plan occurred to allow for the most effective use of time for the EQRO team and Health Plan staff. The schedule for the on-site reviews was approved by the SMA in advance and forwarded to each Health Plan to allow them the opportunity to prepare for the review. Appendix 11 provides a sample agenda for the on-site reviews.

Providing Preparation Instructions and Guidance to the MO HealthNet MCOs

A letter (see Appendix 12) was sent to each MO HealthNet Managed Care Health Plan indicating the specific information and documents required on-site, and the individuals requested to attend the interview sessions. The Health Plans scheduled their own staff to ensure that appropriate individuals were available and that all requested documentation was present during the on-site review day.

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occurred with individuals from the SMA from October 2008 through June 2009 to prepare for the on-site review, and obtain information relevant to the review prior to the on-site visits. Individuals from the SMA included in these meetings were:

Susan Eggen – Assistant Deputy Director, MO HealthNet Managed Care

Andrea Smith – Quality Nurse Reviewer

In February 2009, Compliance Review team members requested the contract compliance documents prepared annually by the SMA. The information on Health Plan compliance with the July 1, 2006 MO HealthNet Managed Care contract was reviewed, along with required annual submission and approval information. This documentation was only used as a guide for the 2008 review due to the work the SMA was conducting to implement a new contract that began on July 1, 2009. Due to the overlap in the contract time frames, the documentation received during the 2007 review, and updates that were available early in 2009 were utilized in assessing policy completion. All documentation gathered by the SMA was clarified and discussed to ensure that accurate interpretation of the SMA findings was reflected in the review comments and findings. SMA expectations, requirements, and decisions specific to the MO HealthNet Managed Care Program were identified during these discussions.

Document Review

Documents chosen for review were those that best demonstrated each MO HealthNet Managed Care Health Plan's ability to meet federal regulations. Certain documents, such as the Member Handbook, provided evidence of communication to members about a broad spectrum of information including enrollee rights and the grievance and appeal process. Provider handbooks were reviewed to ensure that consistent information was shared regarding enrollee rights and responsibilities. SMA MO HealthNet Managed Care contract compliance worksheets, and specific policies that are reviewed annually or that are yet to be approved by the SMA, were reviewed to verify the presence or absence of evidence that required written policies and procedures existed meeting federal regulations. Other information, such as the Annual Quality Improvement Program Evaluation was requested and reviewed to provide insight into the

Health Plan's compliance with the requirements of the SMA Quality Improvement Strategy, which is an essential component of the MO HealthNet Managed Care contract, and is required by the federal regulations. Health Plan Quality Improvement Committee meeting minutes were reviewed. Case Management and Member Services policies and instructions, as well as training curriculum were reviewed. In addition interviews, based on questions from the SMA and specific to each Health Plan's Quality Improvement Evaluation, were conducted with direct services staff and administrative staff to ensure that local procedures and practices corresponded to the written policies submitted for approval. When it was found that specific regulations were "Partially Met," additional documents were requested of each Health Plan. In addition, interview questions were developed for Member Services and Case Management staff to establish that practice directly with members reflected the Health Plans' written policies and procedures. Interviews with Administrative staff occurred to address the areas for which compliance was not fully established through the pre-site document review process, and to clarify responses received from the staff interviews.

The following documents were reviewed for all MO HealthNet MCHPs:

- State contract compliance ratings from 2007 and updated policies accepted through February 2009
- Results, findings, and follow-up information from the 2007 External Quality Review
- 2008 Annual MO HealthNet MCHP Evaluation, submitted April 2009

CONDUCTING INTERVIEWS

After discussions with the SMA, it was decided that the 2008 Compliance Review would include in-depth interviews with Member Services and Case Management Staff. The goal of these interviews was to validate that practices at the Health Plans, particularly those directly affecting members' access to quality and timely health care, were in compliance with the approved policies and procedures. After completing the initial document review, it was clear that the MO HealthNet Managed Care Health Plans had made significant progress in developing appropriate and compliant written policies and procedures. The interview questions were developed using the guidelines available in the Compliance Protocol, and focused on areas of concern based on each Health Plan's Annual Evaluation. Previous interviews, generally conducted with

administrative and management level Health Plan staff, did enable reviewers to obtain a clearer picture of the degree of compliance achieved through policy implementation. Corrective action taken by each Health Plan was determined from previous years' reviews. This process revealed a wealth of information about the approach each Health Plan took to become compliant with federal regulations. The current process of a document review, supported by interviews with front line and administrative staff, was developed to provide evidence of systems that delivered quality and timely services to members, and the degree to which appropriate access was available. The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. Additionally, this approach would continue to provide follow-up from previous EQRO evaluations. A site visit questionnaire for Member Services and Case Management staff, and a separate interview tool for Administrators was developed for each Health Plan. The questions were developed to seek concrete examples of activities and responses that would validate that these activities are compliant with contractual requirements and federal regulations.

Collecting Accessory Information

Additional information used in completing the compliance determination included: discussions with the EQR reviewers and MO HealthNet Health Plan QI/UM staff regarding management information systems; Validating Encounter Data; Validating Performance Measures; and Validating Performance Improvement Projects. The review evaluated information from these sources to validate Health Plan compliance with the pertinent regulatory provisions within the Compliance Protocol. These findings were documented on the BHC MO HealthNet Managed Care Compliance Review Scoring Form (Appendix 13), and were used to assist in making final rating recommendations.

Analyzing and Compiling Findings

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MO HealthNet Managed Care Health Plan's contract compliance. This information was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions were prepared, based on the

need to investigate if practice existed in areas where approved policy was or was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each Health Plan's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision. This information was recorded on the MO HealthNet Managed Care scoring form and can be found in the protocol specific sections of this section of the report.

REPORTING TO THE STATE MEDICAID AGENCY

During the August 2009 meeting with the SMA, preliminary findings and comparisons to the ratings from the 2006 and 2007 review were presented. Discussion occurred with the SMA staff to ensure that the most accurate information was recorded and to confirm that a sound rationale was used in rating determinations. The SMA approved the process and allowed the EQRO to finalize the ratings for each regulation. Sufficient detail is included in all worksheets to substantiate any rating lower than "Met." The actual ratings are included in this report.

COMPLIANCE RATINGS

From January 2009 through June 2009, the MO HealthNet Managed Care Compliance Review Scoring Form for each Health Plan was updated to reflect their current level of MO HealthNet Managed Care contract compliance. The Scoring Form continued to present a crosswalk of contract references that created compliance with each federal regulation. The SMA instructed the EQRO to utilize the Compliance Rating System developed during the previous review. This system was based on a three-point scale ("Met," Partially Met," "Not Met") for measuring compliance, as determined by the EQR analytic process. The determinations found in the Compliance Ratings considered SMA contract compliance, review findings, Health Plan policy, ancillary documentation, and staff interview summary responses that validate Health Plan practices observed on-site. In some instances the SMA MO HealthNet Managed Care contract compliance tool rated a contract section as "Met" when policies were submitted, even if the policy had not been reviewed and "finally approved." If the SMA considered the policy submission valid and rated it as "Met," this rating was used unless practice or other information

called this into question. If this conflict occurred, it was explained on the Compliance Review Scoring Form. The scale allowed for credit when a requirement was Partially Met. Ratings were defined as follows:

Met:	All documentation listed under a regulatory provision, or one of its components was present. MO HealthNet Managed Care health plan staff was able to provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the health plan was in full compliance with regulatory provisions.
Partially Met :	There was evidence of compliance with all documentation requirements, but staff was unable to consistently articulate processes during interviews; or documentation was incomplete or inconsistent with practice.
Not Met:	Incomplete documentation was present and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

5.3 Findings

ENROLLEE RIGHTS AND PROTECTIONS

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of heath plans for the provision of information to enrollees in an understandable form and language: written policies regarding enrollee rights and assurance that staff and contractors take them into account when providing services; and requirements for payment and no liability of payment for enrollees. There was only one item across all MO HealthNet Managed Care Health Plans that was rated as "Not Met" (see Table 42). Across all Health Plans 94.87% of the regulations were rated as "Met." This maintains the 2007 rating and the overall improvement over the 90.77% "Met" rating in 2006. Five of the Health Plans (Children's Mercy Family Health Partners, Missouri Care, Molina Healthcare of Missouri, Healthcare USA, and Blue-Advantage Plus) were found to be 100% compliant. One Health Plan (Harmony Health Plan) was rated as 69.2% "Met." This is the second year that Harmony Health Plan is being rated for Compliance with the MO HealthNet Managed Care contract and the federal regulations. They have submitted policies, but these have not yet met all the SMA and federal requirements. Harmony has developed strong practices in many areas, but the complete system is not yet in place.

Table 42 – Subpart C: Enrollee Rights and Protections

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.100(a) Enrollee Rights: General Rule	2	2	2	2	2	2	6	0	0	100.0%
438.10(b) Enrollee Rights: Information Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2	2	2	2	6	0	0	100.0%
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2	2	2	2	6	0	0	100.0%
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2	2	2	2	6	0	0	100.0%
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2	2	2	2	6	0	0	100.0%
438.10(f) Information for All Enrollees: Free Choice, etc.	2	1	2	2	2	2	5	1	0	83.3%
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2	2	2	2	6	0	0	100.0%
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2	2	2	2	6	0	0	100.0%
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	0	2	2	2	2	5	0	1	83.3%
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	1	2	2	2	2	5	1	0	83.3%
438.100(b)(3) Right to Services	2	1	2	2	2	2	5	1	0	83.3%
438.100(d) Compliance with Other Federal/State Laws	2	2	2	2	2	2	6	0	0	100.0%
Number Met	13	9	13	13	13	13	74	3	1	94.87%
Number Partially Met	0	3	0	0	0	0				
Number Not Met	0	1	0	0	0	0				
Rate Met	100.0%	69.2%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCHPs Protocols.

All Health Plans had procedures and practices in place to ensure that members: receive pertinent and approved information [438.100(a) and 438.10(b)]; were addressed in their prevalent language [438.10(c)(3)]; have access to required interpreter services [438.10(c)(4,5)]; that all information is provided in an easily understood format [438.10 (d)(1)(i)/438.10(d)(1)(ii) & (2); that members are treated with respect and dignity and receive information on available treatment options and alternatives [438.100(b)(2)(iii)/438.10(g)]; and the that the Health Plans are in compliance with other state requirements [438.100(d)].

A number of Health Plans (Children's Mercy Family Health Partners, Missouri Care, Molina Healthcare of Missouri, Blue-Advantage Plus, Healthcare USA) utilized EQR tools, including the MO HealthNet Managed Care Compliance Review Scoring Form, to assist them in ensuring completion of required policy as well as meeting the requirements of the federal regulations. Improvement was noted in the attention the majority of the Health Plans gave to meeting all standards of compliance. Tracking systems were put in place, and in some situations staff members were assigned to monitor compliance issues. The Health Plans stressed their heightened awareness of the need for positive interdepartmental communication. These efforts focused on strengthening communication to enhance the organizations' ability to serve members needs.

Two of the Health Plans (Children's Mercy Family Health Partners, Blue-Advantage Plus) utilized a Member Advisory Committee to provide insight into the issues faced by members in trying to obtain Healthcare services. The Health Plans incorporated member suggestions into their operations and marketing materials. These activities were indicators of the Health Plans' commitment to member services and to ensuring that members have quality Healthcare.

All Health Plans continued to operate programs for the provision of behavioral health services. Four of the Health Plans subcontract with Behavioral Health Organizations (BHO) for these services. Two Health Plans (Missouri Care, Harmony Health Plan) utilize an "in-house" model for the provision of behavioral health services. One of these plans (Missouri Care) does case management and maintenance of the provider delivery system within their Health Plan structure. One Health Plan (Harmony) utilized a subsidiary of their parent company to provide behavioral health services during 2008.

All Health Plans provided active oversight, if not direct involvement, of their behavioral health subcontractors. Behavioral Health Services have evolved into an important resource for MO HealthNet Managed Care members. A majority of the Health Plans' subcontracted behavioral health partners (MHNet, Missouri Care, New Directions Behavioral Health, and Harmony Behavioral Health) approved the use of in-home services to reach members who would not attend appointments in an office setting. This not only ensured that members obtained the help they needed, but also prevented missed appointment for providers. One BHO (New Directions Behavioral Health) serves members from Children's Mercy Family Health Partners and Blue-Advantage Plus. This BHO continues to contract with a provider agency that delivered short-term intensive in-home services in an effort to avert crisis that may lead to inpatient treatment, and to work with members to utilize all available community resources. This service is available to both Health Plans. Two Health Plans (Molina Healthcare of Missouri, Healthcare USA) reported on initiatives to engage members who were pregnant, in an attempt to identify any mental health issues that might affect the mother and/or baby. These efforts also focused on prevention of postpartum depression. One Health Plan (Children's Mercy Family Health Partners) described an initiative where in-home services were provided to members following any inpatient treatment to ensure effective follow-up services. The BHO contracted with specific providers who were skilled at working in intensive in-home settings. The BHO absorbed the cost of unreimbursed services, such as after-hours telephone support, in an effort to reduce readmissions for these members. MO HealthNet Managed Care Health Plans and BHOs described a number of interventions that met members' needs, but were extraordinary in normal Medicaid programs. This reflected a level of performance indicative of their strong commitment to access and quality services for all members.

COMPLIANCE INTERVIEWS – MEMBER SERVICES STAFF AND CASE MANAGEMENT (BEHAVIORAL HEALTH)

Interviews were held at each Health Plan with Member Services staff and Case Management staff. Subsequently an interview occurred with Administrative staff to obtain clarification on issues identified from the policy and document reviews, and additionally to clarify some responses received from the direct service staff. Interview tools, developed from the questions received from the SMA and arising from review of each Health Plan's Annual Quality Evaluation, were developed for each group. The interview questions utilized at each Health Plan are included in the individual sections of this report.

The Member Services staff and the Case Managers interviewed exhibited a sense of commitment and professionalism when interacting with clients. At four Health Plans (Molina Healthcare of Missouri, Missouri Care, Children's Mercy Family Health Partners, and Blue-Advantage Plus) the Member Services representatives and the Case Managers are located in their Missouri offices and were familiar with the regions they served. At one Health Plan (Healthcare USA) the Member Services representatives are located off-site and were available by telephone. The Case Managers are based at the Missouri office. At one Health Plan (Harmony Health Care) both the Member Services representatives and the majority of Case Managers are located off-site. On Harmony Case Manager is located in Missouri and is assigned to MO HealthNet Managed Care cases. Two Health Plans (Molina Healthcare of Missouri and Healthcare USA) serve all three MO HealthNet Managed Care regions. Each of these plans locates Case Management staff in each region.

The responses received from staff reflected sound knowledge of each Health Plans' policies and procedures, and of their organization's focus regarding member services. Member Services staff makes every effort to ensure that they provide MO HealthNet members with the information they need to make informed health care choices. They are trained to inform Health Plan members of the providers and services available and how to access these services. These Health Plan staff members are experienced in ensuring that MO HealthNet members have access to someone who speaks their language, or have access to a method of communication that enables them to obtain complete and thorough information. In most instances Member Services staff members gave concrete examples of assisting members by calling providers

directly, immediately contacting Case Management staff to obtain assistance for a member, or making another contact to ensure that members received appropriate and timely health care.

Case Managers reported a clear understanding of the referral process. They were familiar with Health Plan procedures ensuring that Case Managers received referrals from all sources. Case Managers described processes for contacting new referrals and the activities required for existing members cases. One Health Plan (Molina Healthcare of Missouri) refers all pregnant members for case management. The OB Case Managers discussed the referral sources, and the assessment process that ensures that members receive the types and frequency of services required. The Case Managers understand that accepting their services is a choice for members, but state that most members are willing to accept case management, although some do have reservations. If a Health Plan member refuses case management services initially, they can request these services at a future date. Treatment planning occurs with the member to ensure that they understand their service issues and additional assistance that will be provided. Providing a written copy of the treatment plan to Health Plan members did not occur regularly.

The Case management staff, in general, exhibited an understanding of community resources and of alternative service systems that may assist members with service needs beyond health care. At one Health Plan (Harmony Health Plan) the Case Managers interviewed had information available that was in their system. They did not exhibit the profound understanding of ancillary services and alternative resources available throughout the MO HealthNet Managed Care region they serve. The Case Managers did describe a methodology and provided concrete examples of coordination of care with behavioral health team members or Behavioral Health Organization (BHO) staff. They were aware of the need to ensure that Primary Care Providers were involved when members were receiving both physical and mental health services.

Both Case Managers and Member Services staff were keenly aware of members' rights and responsibilities. These Health Plan staff members shared a commitment to providing services to members in the least restrictive environment and most respectful manner possible.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: ACCESS STANDARDS

Subpart D of the regulatory provision for Medicaid managed care sets forth 17 regulations governing access to services. These regulations call for: the maintenance of a network of appropriate providers including specialists; the ability to access out-of-network services in certain circumstances; adequate care coordination for enrollees with special Healthcare needs; development of a method for authorization of services, within prescribed timeframes; and the ability to access emergency and post-stabilization services. There were no items rated as "Not Met" (see Table 43). Across all MO HealthNet Managed Care Health Plans, 90.2% of the regulations were "Met," which is a slight decrease from the rate of 92.16% achieved in 2007. Four of the MCHPs (Children's Mercy Family Health Partners, Blue-Advantage Plus, Healthcare USA, and Missouri Care) were found to be 100% compliant. One Health Plan (Molina Healthcare of Missouri) is rated at 88.2%. They are making changes in their system and processes to regain full compliance, but all efforts are not yet complete. One Health Plan (Harmony Health Care of Missouri) is rated as 52.9%. This is the second year that Harmony Health Plan is subjected to the full compliance review. They are in the process of submitting written policy and procedures to the SMA and are working on completing required revisions. Practice in this area is stronger that observed during the previous review, but the Health Plan has not yet achieved complete compliance.

Table 43 – Subpart D: Quality Assessment and Performance Improvement: Access Standards

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	1	2	2	2	2	5	1	0	83.3%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	1	2	2	2	2	5	1	0	83.3%
438.206(b)(3) Second Opinions	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(1)(i-vi) Timely Access	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	2	2	2	6	0	0	100.0%
438.208(b) Care Coordination: Primary Care	1	1	2	2	2	2	4	2	0	66.7%
438.208(c)(1) Care Coordination: Identification	2	1	2	2	2	2	5	1	0	83.3%
438.208(c)(2) Care Coordination: Assessment	2	1	2	2	2	2	5	1	0	83.3%
438.208(c)(3) Care Coordination: Treatment Plans	1	1	2	2	2	2	4	2	0	66.7%
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	1	2	2	2	2	5	1	0	83.3%
438.210(b) Authorization of Services	2	1	2	2	2	2	5	1	0	83.3%
438.210(c) Notice of Adverse Action	2	2	2	2	2	2	6	0	0	100.0%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	2	2	2	6	0	0	100.0%
438.210(e) Compensation of Utilization Management Activities	2	2	2	2	2	2	6	0	0	100.0%
438.114 Emergency and Post-Stabilization Services	2	2	2	2	2	2	6	0	0	100.0%
Number Met	15	9	17	17	17	17	92	10	0	90.20%
Number Partially Met	2	8	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	88.2%	52.9%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCHPs Protocols.

All MO HealthNet Managed Care health plans had policies and practice that reflected the members' right to a second opinion and a third opinion if the first two disagreed [438.206(b)(3)]. Other areas where all health plans were 100% compliant with complete and approved policy were Adequate and Timely Service and Cost Sharing for Out of Network Services; Timely Access to Care, Provider Cultural Competency; Timeframes for Decisions for Expedited Authorizations, Utilization Management Activities, and Emergency and Post-Stabilization Services. Throughout this review period, all Health Plans reported incidents where they found providers who were familiar with members' cultural and language needs. Sensitivity to and respect for members' cultural needs was an area where the health plans excelled. All Health Plans were fully compliant in having SMA approved notifications of adverse actions [438.210(c)]. There were no identified incidents of incentivizing staff or contractors for utilization management decisions that were in the favor of the MO HealthNet Managed Care health plans. All policies and practices in this area [438.210(e)] were compliant.

The area of access to care was a primary focus of improvement for all the health plans during 2008. Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. Health Plans in all three MO HealthNet Managed Care regions reported the addition of urgent care centers, and physicians with extended hours of services. The need to ensure that members received appropriate referrals to PCPs and specialty providers was clearly reflected in Member Service Staff and Case Management interviews. Required documentation and approved policies did exist in all areas for all health plans but one (Harmony Health Plan of Missouri). Five of the MO HealthNet Managed Care health plans (Molina Healthcare of Missouri, Healthcare USA, Missouri Care, Children's Mercy Family Health Partners, and Blue-Advantage Plus) had complete policy and practices, and Provider Manual language in the area of emergency and post-stabilization services [438.114]. One MO HealthNet Managed Care health plan (Harmony Health Plan of Missouri) continues to have policy under review awaiting final approval by the SMA. The Health Plans made efforts to ensure that the problems they experienced did not affect services to members. All Health Plans provided evidence of strong relationships with their providers and maintained strong communication with them particularly in solving member service problems. Harmony Health Plan reported they are continuing active recruitment efforts in the outlying counties in the region. However, their network has improved during the past year of operation.

The Health Plans make a concerted effort to ensure that members have appropriate and timely access to services. They continued to express concern over the shortage of specialists in the areas of orthopedic surgery, pediatric neurology, rheumatology, and child/adolescent psychiatrists. All Health Plans reported utilizing out-of-network providers and often paying commercial or higher rates to obtain these services. One Health Plan (Children's Mercy Family Health Partners) had a number of specialists who requested that they not be included on the MO HealthNet MCHP's published network, but readily agreed to serve members when requested, at the MO Healthcare Managed Care rate. Two of the Health Plans (Healthcare USA, Missouri Care) continued to partner with teaching hospitals in their Regions, in order to increase their available surgical and specialist capacity. All Health Plans had an internal system that could provide specialist services, even in specialties that were normally difficult to access, when required to meet members' Healthcare needs.

All Health Plans exhibited a commitment to delivering and providing oversight of behavioral health services. One Health Plan (Missouri Care) no longer uses a subcontracted network for behavioral health. This Health Plan recognized a number of advantages in directly supervising the provision of behavioral health services. They are able to recruit additional providers through the use of solo practices, particularly those who provided in-home treatment services. Some of the benefits identified included: reducing the use of inpatient treatment; more timely and complete prior authorizations; and improved multi-disciplinary case management, when members require both physical and mental health treatment. They did experience some difficulties in motivating the smaller providers to comply with timely claims submission requirements, but through training are seeing improvements in this area. This Health Plan's case managers also reported that communicating with behavioral health case managers, and coordinating services between behavioral health providers and PCPs improved with this new service delivery system.

The area of care coordination continues to be an aspect of services where improvement is needed. Four Health Plans (Healthcare USA, Missouri Care, Children's Mercy Family Health Partners, and Blue-Advantage Plus) were rated as 100% compliant. One Health Plan (Molina Healthcare of Missouri) is rated at 88.2%, and one Health Plan (Harmony Health Care) is rated at 52.9%. Molina Healthcare of Missouri is in the process of making changes in their system and

in their processes, which they admitted negatively impacts their ability to ensure 100% compliance in the area of care coordination. Harmony Health Plan continues to need to have approved policy in place. Interviews indicated that they are making strong efforts to ensure coordinated care for members, but this area continues to lack full compliance. All Health Plans related some concern about the area of care coordination. In several instances the care coordination was very strong with members who receive in-network services. However, when use of out-of-network providers is required, the amount of communication with providers and coordination of care suffered.

Member Service Staff and Case Manager Interviews

Member Services and Case Management staff both reflect that one of the key aspects of their role in ensuring that members receive proper health care is coordinating adequate access to health care. These staff members report that they answer many questions regarding identification of PCPs and their address, assisting in changing PCPs for new members particularly if an auto-assignment occurred, and in ensuring that members receive timely appointments. These personnel also assist members in identifying and obtaining appointments with specialists. They respond to questions about authorization for services, and assist members in finding physicians who meet members' cultural and language needs. These staff members were animated in their discussion about finding the best physician or medical provider for Health Plan members with special needs. Their responses reflected a sincere desire to assist members in their access to care issues, and a sense of accomplishment when this occurred in a timely and efficient manner.

Quality Assessment and Performance Improvement: Structure and Operation Standards

There are 10 Structure and Operations Standards for ensuring compliance with State policies and procedures for the selection and retention of providers, disenrollment of members, and accountability for activities delegated to subcontractors. There were no items across MO HealthNet Managed Care health plans that were rated as "Not Met." Across MO HealthNet Managed Care Health Plans, 95% of the regulations were "Met," which a decrease from 2006 when health plans achieved a rate of 98% compliance in this area, but remains constant with the 2007 review (see Table 44).

Table 44 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	1	2	2	2	2	5	1	0	83.3%
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	1	2	2	2	2	5	1	0	83.3%
438.214(d) Provider Selection: Excluded Providers	2	2	2	2	2	2	6	0	0	100.0%
438.214(e) Provider Selection: State Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2	2	2	2	6	0	0	100.0%
438.56(c) Disenrollment Requested by the Enrollee	2	2	2	2	2	2	6	0	0	100.0%
438.56(d) Disenrollment: Procedures	2	2	2	2	2	2	6	0	0	100.0%
438.56(e) Disenrollment: Timeframes	2	2	2	2	2	2	6	0	0	100.0%
438.228 Grievance System	2	1	2	2	2	2	5	1	0	83.3%
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2	2	2	2	6	0	0	100.0%
Number Met	10	7	10	10	10	10	57	3	0	95.0%
Number Partially Met	0	3	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	70.0%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCHPs Protocols.

The Provider Services departments of all MO HealthNet Managed Care Health Plans exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and MO HealthNet Managed Care requirements. Five of the MO HealthNet Managed Care health plans (Children's Mercy Family Health Partners, Blue-Advantage Plus, Missouri Care, Molina Healthcare of Missouri and Healthcare USA) were 100% compliant with all regulations. The final health plan (Harmony Health Plan of Missouri) met 70% of the regulations. Seven of the individual regulations were 100% met. This included Provider Selection [438.214(d) and 438.214(e)]. The staff at each Health Plan understood the requirements for disenrollment. They were 100% "Met" for the applicable regulations for timeframes [438.56(e)]. All of the Health Plans met all regulations for disenrollment procedures. Five of the Health Plans achieved 83.3% compliance (Children's Mercy Family Health Partners, Blue-Advantage Plus, Missouri Care, Molina Healthcare of Missouri, and Healthcare USA) and had appropriate grievance systems in place meeting the requirements of this regulation [438.228]. Two of the health plans (Healthcare USA, and Blue-Advantage Plus) described credentialing and re-credentialing policies that exceeded the requirements of the regulations. All Health Plans report that they are in the process of developing policy and procedures that all comply with NCQA criteria. Providers were willing to submit to these stricter standards to maintain network qualifications in both the Health Plans and other commercial networks. Overall, five (83.3%) of the Health Plans had all required policies and practices in place regarding credentialing. One health plan (Harmony Health Plan of Missouri) continued to have outstanding policy in the area of credentialing, non-discrimination and sub-contractual relationships (438.214 (a,b)/438.214(c)/438.230)(a,b).

All Health Plans understood the required oversight of subcontractors. The compliance rate for this regulation [438.230(a,b)] improved from previous review and has maintained the 2007 rate of 95%.

All previous deficiencies for Structure and Operation Standards related to a lack of submitted or approved policies or subcontractor agreements. The Health Plans exhibited a significantly improved understanding and attention to these details and requirements during this review. Interviews revealed that Member Services staff quickly identifies problems if they receive calls related to these issues. However, it is their responsibility to refer these issues and questions to

the Provider Services staff as quickly as possible. The Member Services staff make notes of all of their telephone contacts in the Health Plans' internal systems and make appropriate referrals. These processes were described in detail and are clearly understood by the staff involved.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: MEASUREMENT AND IMPROVEMENT

There are 12 Measurement and Improvement Standards addressing the selection, dissemination, and adherence to practice guidelines; the implementation of performance improvement projects; the calculation of performance measures; the evaluation of the availability of services and assessment techniques for enrollees with special Healthcare needs; and the maintenance of information systems that can be effectively used to examine service utilization, grievances and appeals, and disenrollment. All items were either "Met" or "Partially Met" for compliance with Measurement and Improvement (see Table 44). A total of 89.4% of the criteria were "Met" by the MO HealthNet Managed Care health plans, which continues to indicate improvement in meeting federal requirements, over past years and maintenance of the 2007 rates. This number again reflects that one health plan (Harmony Health Care of Missouri) is continuing to submit policy for SMA approval and to enhance practice. Five health plans (Missouri Care, Children's Mercy Family Health Partners, Molina Healthcare of Missouri, Healthcare USA, and Blue-Advantage Plus) met all the requirements (100%) in this area.

It is noted that all Health Plans have a Case Management system in place. These systems have greatly improved staff's abilities to follow a member's care regardless of who in the system interacts with the case. The Case Managers receive referrals, get updates on member's demographics, can view authorization information, claims information, and maintain their case notes. The Case Managers and Member Services staff all report that this enhancement has been a significant improvement to managing member services.

Table 45 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

	MO HealthNet MCHP						All MO HealthNet MCHPs			
Federal Regulation	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	Molina	2	2	2	2	2	5	0	0	100.0%
438.236(c) Practice Guidelines: Dissemination	2	2	2	2	2	2	6	0	0	100.0%
438.236(d) Practice Guidelines: Application	2	2	2	2	2	2	6	0	0	100.0%
438.240(a)(1) QAPI: General Rules	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2	2	2	2	6	0	0	100.0%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	1	2	2	2	2	5	1	0	83.3%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	1	2	2	2	2	5	1	0	83.3%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	1	2	2	2	2	5	1	0	83.3%
438.242(b)(3) Health Information Systems: Basic Elements	2	1	2	2	2	2	5	1	0	83.3%
Number Met	11	4	11	11	11	11	59	7	0	89.4%
Number Partially Met	0	7	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	36.4%	100.0%	100.0%	100.0%	100.0%				

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable to the MO HealthNet Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCHPs Protocols.

During previous reviews the area of practice guidelines was problematic for two health plans (Molina Healthcare of Missouri and Healthcare USA). Both had relatively new Medical Directors, who identified resistance on the part of the medical community in the St. Louis area to the acceptance or implementation of practice guidelines. The specific requirements of the regulations were related to both health plans. Both of these health plans improved in this area during the 2007 review. During the on-site review in 2008 practice guidelines were discussed as part of normal operations. It appears that these guidelines have been implemented as part of Health Plan daily operations. Practice guidelines are in place and the Health Plans are monitoring providers to ensure their utilization. Currently all six of the health plans (100%) met all the requirements for adopting, disseminating and applying practice guidelines. In the Western Region, staff from the health plans meets with a quality enhancement group in the Healthcare community (Kansas City Quality Improvement Consortium). Regional standards and practices were discussed and regionally specific standards, that met or exceeded nationally accepted guidelines, were developed. All Health Plans related that they expected providers to use the practice guidelines combined with their experience and patient knowledge in their decision-making. When conflicts occurred, the Medical Director reviewed the situation and consulted with the provider in an effort to ensure that the services that were provided were in the members' best interested.

Five of the Health Plans (83.3%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the health plans reported using included the InterQual Clinical Decision Support Tool, LOCUS/CALOCUS (Level of Care Utilization System/Child and Adolescent Level of Care Utilization System) for utilization management decisions in the provision of behavioral health services and the Milliman Care Guidelines. These sources provided evidence-based criteria and best practice guidelines for Healthcare decision-making. The Health Plan staff was able to articulate how they utilized these tools and apply them to member Healthcare management issues. The MO HealthNet Managed Care Health Plans used all information available to them to ensure that evidence-based practice ensuring member safety while controlling medically unnecessary care. All Health Plans report that members do occasionally request treatment procedures, particularly in the instance of member with asthma. Members were provided with this information that assisted in ensuring that their children obtained appropriate levels of information.

The Health Plans were actively involved in developing and improving their Quality Assessment and Improvement Programs. Two of the health plans (Blue-Advantage Plus, Children's Mercy Family Health Partners) utilized community based advisory boards, one of which (Children's Mercy Family Health Partners) included members. These groups assisted the Health Plans in assessing member needs and barriers to services. Both health plans utilized the recommendations of these groups in their operations, member information, and daily activities. All of the Health Plans developed internal systems for monitoring, analysis and evaluation of their own programs. Five (83.3%) had a program and all required policy and procedures in place to meet the requirements of the federal regulations [438.240(a)(1)]. Harmony Health Plan continues to work with the SMA on submission and approval of all required policy.

All Health Plans' compliance improved in the section of the protocol involving Validating Performance Improvement Projects, Validating Performance Measures, Validating Encounter Data, and Health Information Systems. Detailed findings and conclusions for these items are provided in previous sections of this report and within the MO HealthNet Managed Care health plan summaries.

GRIEVANCE SYSTEMS

Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) sets forth 18 requirements for notice of action in specific language and format requirements for communication with members, providers and subcontractors regarding grievance and appeal procedures and timelines available to enrollees and providers. Five of the six Health Plans excelled (100%) in their compliance with the regulations related to grievances and appeals (see Table 46). There were no items rated as "Not Met." These five health plans (Molina Healthcare of Missouri, Healthcare USA, Children's Mercy Family Health Partners, Missouri Care, and Blue-Advantage Plus) were found 100% in completing required policy, procedure, and practice in their Grievance Systems.

One Health Plan (Harmony Health Care of Missouri) continued to have policy and procedures that required approval by the SMA. The six health plans overall score for this section is 84.3%. This number reflects that Harmony Health Plan of Missouri has not completed the policy submission and approval process.

Table 46 – Subpart F: Grievance Systems

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	FHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.402(a) Grievance and Appeals: General Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	1	2	2	2	2	5	1	0	83.3%
438.404(a) Grievance System: Notice of Action - Language and Format	2	1	2	2	2	2	5	1	0	83.3%
438.404(b) Notice of Action: Content	2	1	2	2	2	2	5	1	0	83.3%
438.404(c) Notice of Action: Timing	2	1	2	2	2	2	5	1	0	83.3%
438.406(a) Handling of Grievances and Appeals: General Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	1	2	2	2	2	5	1	0	83.3%
438.408(a) Resolution and Notification: Basic Rule	2	1	2	2	2	2	5	1	0	83.3%
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	1	2	2	2	2	5	1	0	83.3%
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	1	2	2	2	2	5	1	0	83.3%
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2	2	2	2	6	0	0	100.0%
438.410 Expedited Resolution of Appeals	2	1	2	2	2	2	5	1	0	83.3%
438.414 Information about the Grievance System to Providers and Subcontractors	2	1	2	2	2	2	5	1	0	83.3%
438.416 Recordkeeping and Reporting Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	1	2	2	2	2	5	1	0	83.3%
438.424 Effectuation of Reversed Appeal Resolutions	2	1	2	2	2	2	5	1	0	83.3%
Number Met	18	1	18	18	18	18	91	17	0	84.3%
Number Partially Met	0	17	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	5.6%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCHPs Protocols.

Grievance and Appeal reports for both members and providers were reviewed for 2007, as submitted to the SMA. The Health Plans reported different numbers and types of concerns. The number of member grievances and appeals varied between the Health Plans. However, the numbers were proportional to Health Plan enrollment. Provider complaints, grievances, and appeals also varied but were not disproportional to the provider network.

In analyzing the 2007 Grievance System report, the most frequent issues included:

Member - Grievances and Appeals	Provider – Complaints, Grievances, and Appeals
• Transportation	• Authorizations – Denied/Late/None
• Prescription Drug Issues	• Billing Problems
• Appointment Availability/Continuity of Treatment	• Contractual Issues
• Treatment by Provider/Staff	• Untimely Submission of Claims
• Service Category/Prior Auth. (denial)	• Uncovered Benefit
• Claims Issue/Uncovered Benefit	• Additional Information Required
• Inability to Find PCP/Specialist – or Obtain an Appointment	• Medical Necessity Question
• State Fair Hearing Request	

During the 2008 on-site review questions were asked at each Health Plan relating to the Grievance and Appeal system. Information related did not indicate any new deficiencies in this area. The Health Plans relate a strong knowledge of the issues regarding Grievances and Appeals and believe their system and method of dealing with these issues continue to be effective and efficient.

There were no deficiencies in the Grievance System policy submission for five of the six Health Plans. The Health Plans are diligent in maintaining policies and practices in this area to ensure that these systems are up-to-date and comply with the SMA contract requirements and federal regulations. Appropriate practice for addressing member grievance and appeals, and provider complaints, grievances and appeals appeared to be in place for all Health Plans.

Interview results reflect that the Health Plans have specific units or persons who respond to member grievances and appeals and provider complaints grievances and appeals. Member Services staff are often the first individuals to hear about issues that members have with either providers or with the Health Plan itself. They assist the member in making an informed decision

about filing a grievance or appeal, and they refer the issue to the appropriate person or unit in their Health Plan. They do not process grievances or appeals for members. However, most plans described a case management system where the number and type of cases or issues are reflected in the notes that staff record on all member contacts. These processes are resulting in timely processing of the complaints, grievances and appeals. Staff is aware that it is the member's decision to file a grievance or appeal. However, they record their conversations regardless of the choices made. Staff states that if a member chooses not to file a grievance or appeal, and it appears that the Health Plan or a provider had an issue with a member, they send these notes on to the Grievance and Appeal Unit, and/or to Provider Services for follow-up to ensure that all issues are resolved.

5.4 Conclusions

Across all MO HealthNet Managed Care Health Plans there continues to be a commitment to improving and maintaining compliance with federal regulations. There was only one regulation rated as "Not Met." All other individual regulations were rated as "Met" or "Partially Met." Four of the Health Plans were 100% compliant with all requirements. One Health Plan was 100% compliant with the exception of the Access Standards, which was in the process of undergoing internal enhancements. The remaining Health Plan was only 5.6% compliant with the regulations related to Grievances; 69.2% compliant with Enrollee Rights and Protections; 52.9% compliant with Access Standards; 70% compliance with Structure and Operations; and 36.4% compliant with Measurement and Improvement. This Health Plan was undergoing their second compliance review. All of the Health Plans exhibit attention to becoming and remaining compliant with the State SMA contractual requirements and the corresponding federal regulations. All sources of available documentation, interviews, and observations at the on-site review were used to develop the ratings for compliance. The EQRO comments were developed based on review of this documentation and interview responses. Several of the Health Plans made it clear that they used the results of the prior EQR to complete and guide required changes. One Health Plan (Molina Healthcare of Missouri) continues to make improvements and stated that they utilized the compliance protocol as a tool to develop their performance and improve services to members. This Health Plan achieved improved

compliance to 100% in all but one category. The following summarizes the strengths in the areas of Access to Care, Quality of Care and Timeliness of Care.

Recommendations are based on the findings utilizing the Protocol for Determining Compliance with Medicaid Managed Care Regulations.

QUALITY OF CARE

Nine of the 13 regulations for Enrollee Rights and Protections were 100% "Met." Communicating MO HealthNet Managed Care Members' rights to respect, privacy, and treatment options, as well as communicating, orally and in writing, in their own language or with the provision of interpretive services is an area of strength for all health plans. The MO HealthNet Managed Care Health Plans communicated that meeting these requirements with members and providers, created an atmosphere with the expectation of delivering quality Healthcare. The Health Plans maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining Healthcare. The Health Plans responded to physical, emotional and cultural barriers experienced by members with diligence and creativity. The Health Plans were aware of their need to provide quality services to members in a timely and effective manner.

Seven of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, and network maintenance, subcontractual relationships, and delegation. The Health Plans had active mechanisms for oversight of all subcontractors in place. All Health Plans improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their MO HealthNet Managed Care Members.

ACCESS TO CARE

There are seventeen (17) regulations pertaining to Access Standards. Nine of these regulations were found to be 100% compliant by all of the Health Plans. Four of the MO HealthNet Managed Care Health Plans (HealthCare USA, Missouri Care, Children's Mercy Family Health Partners, and Blue Advantage Plus) were fully compliant with the 17 federal regulations concerning Access Standards. These nine regulations found to be fully compliant included:

- Second Opinions;
- Utilization of out-of-network services, including cost sharing and adequate and timely coverage;
- Timely access to care;
- Cultural Competency in Provider Services;
- Timeliness for decisions and expedited authorizations;
- Compensation of utilization management activities; and
- Timeliness of decisions regarding care and emergency and post-stabilization services.

All six MO HealthNet Managed Care Health Plans monitored high risk MO HealthNet Managed Care Members and had active case management services in place.

- The Case Management staff at each Health Plan described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs.
- Examples of case management programs that exceeded the strict requirements in the MO HealthNet Managed Care contract were described during interviews.
- All six Health Plans could describe efforts to participate in community events and forums that provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that are required.
- The Health Plans were acutely aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members.

One area of concern is care coordination. Four of six Health Plans had all required policy in place. The Health Plans do admit that practice in this area can be strengthened.

TIMELINESS OF CARE

There are twelve (12) regulations for Measurement and Improvement that address the need for timeliness of care. Four of these were found to be 100% compliant by all of the Health Plans. Five of the six MO HealthNet Managed Care Health Plans (Molina, HealthCare USA, Missouri Care, Children's Mercy Family Health Partners, and Blue Advantage Plus) met all of these regulatory requirements.

- All six Health Plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members.
- The Health Plans used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.
- The Health Plans continue to exhibit improvement in the utilization of data and demographics in their systems to track and trend information on members to assist in determinations of risk and prevention initiatives.
- Several Health Plans began using member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery.
- The Member Services and Case Management departments had integral working relationships with the Provider Services and Relations Departments of the Health Plans.
- All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of Health Plan members.
- The Health Plans all provided examples of how these relationships served to ensure that members received timely and effective healthcare. An example is that at each Health Plan staff contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

All 18 regulations for Grievance Systems were 100% "Met" for five of the Health Plans. One Health Plan (Harmony Health Care of Missouri) continues to work toward completion of adequate and approved policy with the SMA and enhanced practice. The five remaining Health Plans were 100% compliant with the requirements for policy, procedure and practice in the area of Grievance Systems. The Health Plans provided examples of how timely decision-making

allowed members to obtain their Healthcare quickly and in the most appropriate setting. The Health Plans understood that maintaining this system was an essential component to ensuring timely access to Healthcare.

MO HealthNet Managed Care Health Plans remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best Healthcare in the least invasive manner to their members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be available to members. The Health Plans observed that these efforts combined to create a system that allowed members timely access to quality Healthcare.

RECOMMENDATIONS

1. MO HealthNet Managed Care Health Plans must continue to recognize the need for timely submission of all required policy and procedures. The majority of the Health Plans put a tracking or monitoring system into place to ensure timely submission of documentation requiring annual approval. These systems must be maintained to ensure that this process remains a priority for all Health Plans.
2. MO HealthNet Managed Care Health Plans identified the need for continuing to monitor provider availability in their own networks. Although most Health Plans had the number of primary care providers (PCPs) and specialists required to meet the contractual and Missouri Department of Insurance requirements, they admit that many of the PCPs do have closed panels and were not accepting new patients. Ensuring that there is adequate access for all members, including new members, should be a priority for all Health Plans. The Health Plans admit to struggling with recruitment of certain specialty physicians so availability in this area must be a focus of continued improvement.
3. MO HealthNet Managed Care Health Plans identified continued need to enhance their Quality Assessment and Improvement programs. These programs were described as strengths for their ability to provide adequate and effective services to members. These efforts must be relentlessly continued to ensure that the organizations remain aware of areas for growth and improvement. The efforts to ensure that the quality, timeliness

and access to care required for member services is maintained at an exceptional level must continue.

4. MO HealthNet Managed Care Health Plans identified the need for additional dental providers. Recruitment was largely delegated to subcontractors. Becoming actively involved in recruitment activities would benefit members and improve the quality of and access to care.
5. The use of data for quality improvement purposes and examination of Healthcare outcomes has increased dramatically. Continued growth in the utilization of all of the data available to drive Healthcare practice and initiatives is required to improve quality and access to care.

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6.0 Blue-Advantage Plus of Kansas City

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This section of the 2008 EQRO report summarizes health plan specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for the MO HealthNet Managed Care Health Plan members. Please refer to the main report for detailed technical objectives, methods and presentation of data that are referenced here for the MO HealthNet Managed Care Health Plan.

6.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Blue Advantage Plus supplied the following documentation for review:

- NCQA Quality Improvement Activity Form: Ambulatory Follow-Up after Hospitalization for Mental Health Disorders for BA+ Members
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Blue-Advantage Plus

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 15, 2009 during the on-site review. Interviews included the following:

Judy Brennan – Director State Programs BA+, Plan Administrator
Tee-Ka Johnson – Special Programs Coordinator
Cheryl Banks – Manager, Quality Performance Measurement
Shelly Bowen – Assistant Vice President Quality Management
Lisa Woodring – Senior Director, Care Management NDBH
Garth Smith – NDBH
Paula McFall -- NDBH

Interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- What study questions were used?
- What instruments were used for data collection?
- How were the accuracy, consistency, and validity assured?
- What interview instruments were used?
- Why were the projects valid for continuation and used as PIPs for this project year?
- What findings were relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

Several questions were presented during the on-site review and the Health Plan requested time to provide additional information. This information was received and considered in the final validation process.

FINDINGS

The first PIP evaluated was Ambulatory Follow-Up after Hospitalization for Mental Health Disorders for BA+ Members. This project was submitted for the second time as a clinical performance improvement project. This clinical project focused on improving the number of members who complied with the HEDIS measure requiring follow-up services within seven (7) and thirty (30) days after hospitalization for mental health services. The health plan identified this as a problem based on the results of their HEDIS reviews of previous years. Revised information provided the basis for making the choice to embark on this project. This decision was based on HEDIS/NCQA standards and the literature review supporting the importance of compliance with timely follow-up care in reducing the risk of readmission to inpatient mental health treatment services. The information supporting the rationale for the study is fully integrated into topic description on local issues and needs.

The study choice is supported as a relevant area of clinical care. How the study relates to issues relevant to Blue Advantage Plus members is well defined. The documentation gave a sound argument for not only impacting a key aspect of member care, but also related this choice to meeting health care mandates for BA+ members. It did provide the information meeting the EQR protocol requirements. All enrollees between the ages of six and 65 were included in this

study. No members were excluded based on the need for special health care services. Why this population is specified is delineated in the narrative.

The study question submitted was, "Will follow-up care and coordination with members who are discharged from inpatient care increase the rate of follow-up through ambulatory appointments within seven and thirty days?" The concept of the need for follow-up care and coordination is included in the explanation supporting the study questions. The process of jointly identifying opportunities to improve performance between the Health Plan and the Behavioral Health Organization (BHO) is also described. The study indicators for all measures are defined. Baseline information and goals for achievement are presented in significant detail. The Health Plan states that they use a HEDIS-like measurement methodology to obtain their quarterly indicators. The measurements are based on and defined by the HEDIS specifications. Collecting this data quarterly allowed them to obtain data more frequently, which assists in providing insight into project progress and in meeting protocol standards.

The study did present clearly defined indicators that were measurable. Information provided defined the numerators and denominators that would be used to calculate success. The indicators were directly based on the HEDIS methodology. Due to inconsistencies in obtaining HEDIS data from the BHO, or subcontractor providing these services, a "HEDIS like" measurement was developed to compare to the actual HEDIS statistics gathered. The HEDIS-like measure utilized the technical specifications of what and how to measure the follow-up rates. The data from this quarterly measure will be analyzed and compared to the actual certified HEDIS data when it becomes available on an annual basis. Detailed demographic characteristics were presented in the narrative. It noted that no portion of the population was excluded from the study. The focus of this study includes Blue Advantage Plus members only. The indicators measured the occurrence of timely adherence to aftercare plans.

The population included in the study are all members, ages 6 through 65 with a HEDIS qualifying diagnosis, discharged from inpatient psychiatric treatment during each study year. The Health Plan used the HEDIS specifications in defining this population. No sampling was used to determine who would be included.

The data sources described were specific. The additional information received explained the methodology for data collection. The sources of data included claims and encounter data that are sampled on a yearly basis. Quarterly runs occurred and were updated at the time of each data collection period. The details of these sources were provided with adequate detail to produce confidence in their reliability and validity. The methodology remained constant across all time periods studied. The data included information exclusive to MO HealthNet Managed Care members.

The data collection and analysis plans included a detailed definition regarding how the HEDIS and HEDIS-Like methodologies were used for internal monitoring of the follow-up service compliance. This explanation includes a narrative explanation of the case management process to be employed for improving this measure. An in-depth data analysis plan was detailed in the documentation including a plan for quantitative and qualitative analysis. This plan provided information on how results would be presented and compared.

The information provided did include data representing the baseline data, 1/1/05 through 12/31/05, for each intervention, and the results of two follow-up periods, which were 1/1/06 through 12/31/06, and 01/01/07 through 12/31/07. HEDIS-Like data was included for the periods form 01/01/08 to 12/31/08. Overall improvement was identified, although the stated goals of the project and comparison benchmarks were not completely met throughout this period.

The interventions utilized and the barriers to success were documented in great detail. Interventions, barriers, and opportunities for improvement were included for both facility issues and member issues. A discussion of methods or plans to improve or enhance these interventions to obtain a more successful outcome was included. The information included did provide confidence that this project can continue to have substantive impact on member's compliance with obtaining the follow-up care required after a hospitalization for mental health services.

The second PIP evaluated was the BA+ individualized approach to the Statewide PIP "Improving Adolescent Well-Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The rationale presented was thorough and clearly based on the need to enhance the approach to improving adolescent well-care on a statewide basis. The BA+ project, based on individualized interventions pertinent to their members was supported with Health Plan specific data in this section of the project documentation. The narrative information effectively made the argument that this non-clinical approach to a performance improvement project was focused on improving the key aspects of member services. The BA+ narrative further hypothesized that an added positive consequence that improving adolescent well-care may also improve adolescent compliance with immunizations and improve their understanding of living a healthy lifestyle.

The study question for this project is, "Will a coordinated statewide improvement effort, with Health Plan specific intervention, improve the HEDIS rate of adolescent well care?" The study question is clear, concise, and conveys the intent of the project. The primary indicator is an improvement in the Adolescent Well-Care (AWC) HEDIS measure. This measure and its technical specifications were discussed in detail. The BA+ specific information included their most recent HEDIS rate, 32.6%, and their goal for improvement of 5%. The indicators were constructed to focus on improving the process of care and associating this with improved health care outcomes for adolescents. A caveat pertaining to the required length of enrollment criteria, which may impact reporting positive data, was included.

The study design specified that administrative data will be used to calculate the Health Plan rate for adolescent well care. The Health Plan will submit this information to VIPs, the NCQA certified vender used to calculate their HEDIS rate. The information provided ensured that all data in this system was valid and reliable. It also identified all information to be submitted to ensure that all relevant claims and encounters were used in the appropriate calculations.

A baseline methodology was provided and included pertinent measures for each indicator. A detailed data analysis plan was part of this documentation. This plan explained all data to be utilized and the qualitative and quantitative analysis that will occur to complete all required data analysis. Statistical testing for each measurement period was described. The analysis will include barrier analysis, and improvements identified.

Interventions described included:

- Statewide interventions completed by all Health Plans;
- EPSDT Reminder Letters, which is an ongoing;
- Letters to new members, with reminders to their PCP, which is ongoing;
- Education and retraining of BA+ staff regarding EPSDT compliance, and on printing and sending reminder letters; and
- Decreasing denied encounters, which is ongoing.

The PIP submission included the planned interventions for the on-going project for 2009 and 2010.

Data analysis, including the baseline rate, the re-measurement rates, and statistical significance were included. A description of the barriers to success was provided. Causes and possible solutions were also described. The findings for baseline year and two follow-up years, one utilizing the statewide interventions, and the second utilizing the BA+ specific interventions were included. A detailed quantitative and qualitative analysis was provided in the narrative. The analysis described the measures meeting the study goals, and those that indicated some improvement without reaching the desired outcome. This analysis provided a discussion about variables that intervened in reaching the desired goals. Enhancements to improve these interventions were also described. The analysis identified initial and repeat measurements, statistical significance, and internal and external validity.

This study has potential for producing credible findings. The two re-measurement cycles included in the information presented covered the two years post-baseline. The second year did indicate a statistically significant improvement based on the interventions implemented. The discussion presented described the effectiveness of the intervention, including which interventions provided positive results and one that had little positive impact on the outcome. A detailed barrier analysis was included in this section of the report.

While this project is not complete, it does indicate potential for success. There was a discussion regarding the observed performance improvement, which is thought to be true improvement based on the interventions that occurred. The format used to document the study findings included sound documentation and thoughtful narrative. The narrative included detailed explanation about the process of developing the project and the activities that occurred, as well as plans for future interventions.

CONCLUSIONS

QUALITY OF CARE

These PIPs focused on creating quality and adequate services to members in both the clinical and non-clinical approach. A quality approach to assisting members, educating members and facilities, and improving internal processes were evident throughout the documentation provided for both PIPs. By including an active case management process to assist any member who had inpatient mental health treatment, the quality of life and approach to providing services were an obvious component for the clinical PIP. Continued allocation of resources and process improvement were evident throughout the non-clinical PIP. In both projects the Health Plan sought to improve the quality of services, or the quality of internal processes, which will result in improved member care.

ACCESS TO CARE

Both Performance Improvement Projects submitted by the Health Plan had a focus that addressed improved access to health care services. The first PIP, regarding improved compliance with obtaining mental health aftercare services, exhibited a clear understanding that access to these services was essential to assisting members in achieving positive mental health outcomes. Efforts were made to ensure that adolescent members were aware of the type and necessity of preventive health care to improve their quality of life was evident in the efforts made in the non-clinical project. By addressing both inpatient facility barriers, as well as member issues, the Health Plan made a concerted effort to improve access for members. By ensuring that the health plan system itself encouraged members to get the health care services needed, access is improved.

TIMELINESS TO CARE

Both projects had a distinct focus on timely and adequate care. In the first PIP regarding follow-up care after inpatient mental health treatment, the Health Plan sought to ensure that members obtained outpatient treatment within the seven and thirty day time frames required by HEDIS specifications. In the second PIP regarding improving adolescent well care there was attention to timely notification and encouragement of the use of benefits to assure that the services needed by the member could be delivered in a timely fashion. The focus of both projects were to ensure that the most timely care be available to members, and to ensure that internal processes or other barriers did not hinder this outcome.

RECOMMENDATIONS

1. Ensure that the original narratives include discussion on how the PIP process can be enhanced to improve outcomes based on the barriers and opportunities recognized to create improved outcomes. Include steps in the information available. The inclusion of this information ensures that the plan for these ongoing PIPs is clarified.

2. Continue using the expanded written format made available in the additional information submitted and in the information provided after the on-site review to communicate the intentions, planning, and processes utilized in developing and implementing the PIPs.

3. Utilize the Conducting Performance Improvement Project protocol to assist in the process of project development and reporting.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Blue-Advantage Plus of Kansas City. Blue-Advantage Plus of Kansas City submitted the requested documents on January 20, 2009. The EQRO reviewed documentation between January 20, 2009 and June 30, 2009. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Blue-Advantage Plus of Kansas City
- Ernst & Young's NCQA HEDIS 2008 Compliance Audit Report
- Letters of communication between the EQRO and Blue-Advantage Plus of Kansas City
- Blue-Advantage Plus of Kansas City policies pertaining to HEDIS 2008 rate calculation and reporting
- Blue-Advantage Plus of Kansas City Information Services (IS) policies on disaster recovery
- Blue-Advantage Plus of Kansas City's HEDIS implementation work plan and HEDIS committee agendas for 2008
- Data warehouse validation procedures for the CRMS software
- DB2 data warehouse models of the interim data warehouse
- Appendix Z – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

The following are the data files submitted by Blue-Advantage Plus of Kansas City for review by the EQRO:

- BCBSKC ADV SQL results.xls
- BCBSKC ASM SQL results.xls
- BCBSKC AWC SQL results.xls
- BCBSKC ADV SQL results.xls
- BCBSKC ASM SQL results.xls
- BCBSKC AWC SQL results.xls

The requested denominator files were not submitted to the EQRO by Blue-Advantage Plus of Kansas City. Instead, the EQRO received two copies of each of the numerator files.

INTERVIEWS

The EQRO conducted on-site interviews with Cheryl Banks, UM Training and Compliance Manager at Blue-Advantage Plus of Kansas City in Kansas City, MO on Wednesday, July 15, 2008. Ms. Banks was responsible for overseeing the calculation of the HEDIS performance measures. The objective of the visit was to verify the data, methods, and processes behind the calculation of the three HEDIS 2008 performance measures. This included both manual and automatic processes of information collection, storing, analyzing, and reporting.

FINDINGS

Blue-Advantage Plus of Kansas City used the Administrative Method for calculation of the HEDIS 2008 Adolescent Well-Care Visits, Use of Appropriate Medications for People With Asthma, and Annual Dental Visits measures. MO HealthNet Managed Care health plan to MO HealthNet Managed Care health plan comparisons of the rates for Adolescent Well-Care Visits, Use of Appropriate Medications for People With Asthma, and Annual Dental Visits were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The reported rate for Blue-Advantage Plus of Kansas City for the HEDIS 2008 Adolescent Well-Care Visits measure was 34.79%, which is comparable to the statewide rate for MCHPs (38.64%; z = -0.40, 95% CI: 27.62%, 41.96%; n.s.). The rate for this measure has increased over time, from 31.20% in 2004 to 31.54% in 2007 to 34.79% in 2008 (see Table 47 and Figure 39).

The reported rate for Blue-Advantage Plus of Kansas City for the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure was 88.63%, comparable to the statewide rate for all MCHPs (87.23%; z = 0.44, 95% CI: 60.08%, 117.18%; n.s.). This rate was last audited by the EQRO in the 2004 report; the health plan's rate has increased from 67.39% in 2004 to 88.63% in 2008, an increase of 21.24% over four years (see Table 47 and Figure 39).

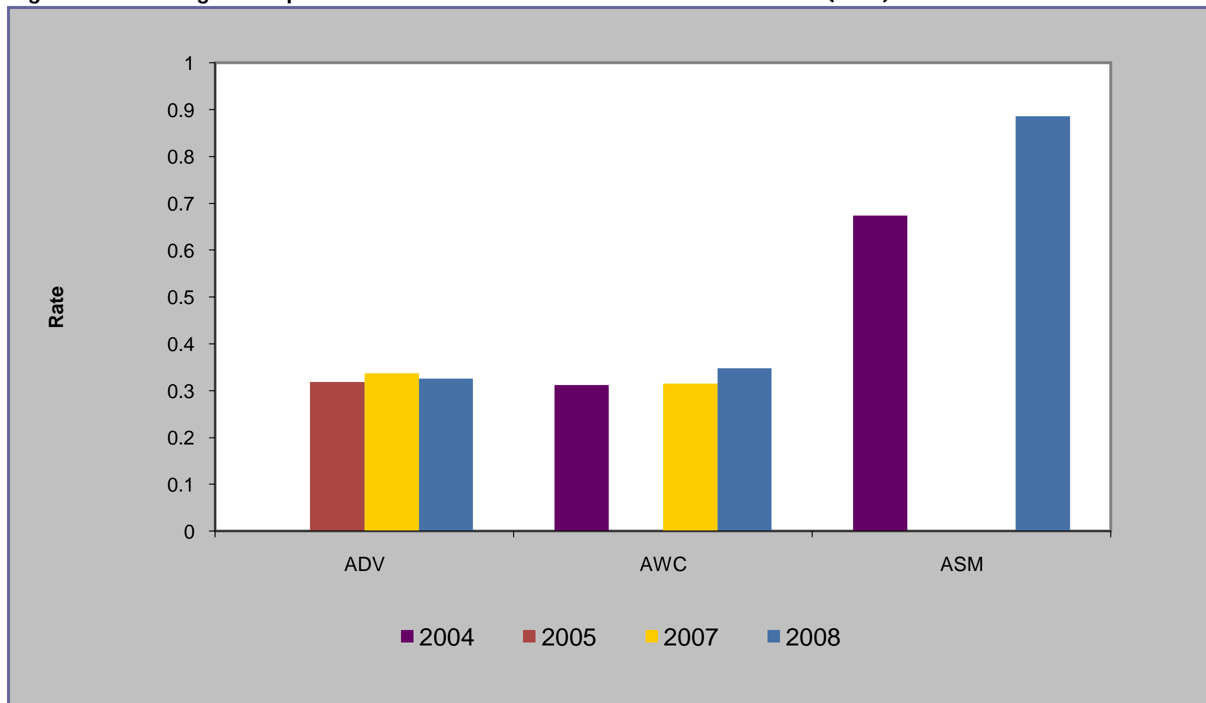
The HEDIS 2008 combined rate for Annual Dental Visits reported by Blue-Advantage Plus of Kansas City was 32.54%, comparable to the statewide rate for MCHPs (34.71%, z = 0.26; 95% CI: 26.30%, 38.77%; n.s.). This reported rate is a decrease over the rate (33.72%) reported by this health plan in the 2007 EQR report, but a slight increase from the rate (31.79%) reported in the 2005 EQR findings (see Table 47 and Figure 39).

Table 47 – Reported Performance Measures Rates Across Audit Years (BA+)

Measure	HEDIS 2004 Rate	HEDIS 2005 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate
Annual Dental Visit (ADV)	NA	31.79%	33.72%	32.54%
Use of Asthma Medications (ASM)	67.39%	NA	NA	88.63%
Adolescent Well-Care Visits (AWC)	31.20%	NA	31.54%	34.79%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 39 – Change in Reported Performance Measure Rates Over Time (BA+)



Sources: BHC, Inc. 2004, 2005, 2007, and 2008 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

DATA INTEGRATION AND CONTROL

Blue-Advantage Plus of Kansas City used a NCQA-certified vendor application (MedMeasures) for calculation of rates for the HEDIS 2008 measures. The EQRO was given a demonstration of the data flow and integration mechanisms for external databases for these measures, and provided with a layout of the data structure of the internally-developed data warehouse for storing interim data. For the three measures calculated, Blue-Advantage Plus of Kansas City was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Blue-Advantage Plus of Kansas City transferred data into the repository used for calculating the HEDIS 2008 measures of Adolescent Well-Care Visits, Use of Appropriate Medications for People With Asthma, and Annual Dental Visits.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Blue-Advantage Plus of Kansas City met all criteria that applied for the three measures validated. Blue-Advantage Plus of Kansas City did utilize statistical testing; BA+ continues to partner with Ernst & Young to best assess how to utilize the information that they obtain from the statistical analysis process.

PROCESSES USED TO PRODUCE DENOMINATORS

Blue-Advantage Plus of Kansas City did not meet all criteria for the processes employed to produce the denominators of the performance measures validated (see Attachment X: Denominator Validation Findings). This involves the selection of eligible members for the services being measured. Although the systems reviewed by the EQRO appeared appropriate for the production of proper Denominator data, the health plan did not provide correct denominator files in the data submission sent for review. Therefore, the EQRO was unable to validate the denominators to report if the final data files were consistent with those reported on the DST for the three measures validated.

For the Adolescent Well-Care Visits measure, a total of 4,613 members eligible were reported, but the EQRO was unable to validate these members.

There were 225 eligible members reported for the denominator of the Use of Appropriate Medications for People With Asthma measure; 0 were validated.

There were 14,138 eligible members reported for the denominator of the Annual Dental Visit measure. None of these were validated.

PROCESSES USED TO PRODUCE NUMERATORS

The measures validated included the appropriate data ranges for the qualifying events (e.g., well-care visits, medication-dispensing events, and dental visits) as specified by the HEDIS 2008 criteria (Attachment XIII: Numerator Validation Findings). The numerators for Blue-Advantage Plus of Kansas City were unable to be fully validated as the eligible population could not be determined; however, the EQRO calculated hits and rates from the supplied data assuming all eligibility requirements had been met for the purposes of data and rates comparison.

For the HEDIS 2008 Adolescent Well-Care Visit measure, there were a total of 1,558 administrative hits reported by Blue-Advantage Plus of Kansas City and 1,553 validated by the EQRO. The rate validated by the EQRO for Adolescent Visits was 34.68%, an observed bias of 0.11%.

The Use of Appropriate Medications for People With Asthma measure was reported as having 343 administrative hits; 341 of these hits were validated by the EQRO. The reported rate was 88.63%. The EQRO validated rate was 88.11%, an observed bias of 0.52%.

The number of hits reported for the combined rate for Annual Dental Visit was 4,188; all 4,188 were validated by the EQRO. The reported rate was 32.54% and the validated rate was 32.54%, resulting in no observed bias.

SAMPLING PROCEDURES FOR HYBRID METHODS

No medical record reviews were conducted or validated. CMS Protocol Attachments XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

SUBMISSION OF MEASURES TO THE STATE

Blue-Advantage Plus of Kansas City submitted the DST for all three measures validated to the SPHA (the Missouri Department of Health and Senior Services: DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

As noted earlier, some bias was calculated in the HEDIS 2008 Adolescent Well-Care Visits and Use of Appropriate Medications for People With Asthma measures evaluated. Both of these measures were overestimated. However, the bias observed was minimal (less than 1% in each case). The rate validated for each measure fell within the 95% confidence interval reported by the MCHP for that measure.

Table 48 - Estimate of Bias in Reporting of BA+ HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	0.11%	Overestimate
Annual Dental Visit	No Bias	N/A
Use of Appropriate Medications for People With Asthma	0.52%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. Blue-Advantage Plus supplied no denominator data for any of the three measures audited; therefore, each of the measures was rated as Not Valid, as the denominators could not be validated.

Table 49 - Final Audit Rating for BA+ Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Not Valid
Annual Dental Visit	Not Valid
Use of Appropriate Medications for People With Asthma	Not Valid

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, or measures for which the submission data was incomplete and therefore could not be fully validated by the EQRO; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the health plan. All three were consistent with the average for all MO HealthNet Managed Care health plans.

QUALITY OF CARE

Blue-Advantage Plus of Kansas City's calculation of the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure was not valid. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care

delivered. The health plan's reported rate was consistent with the average rate for all MO Health Net Managed Care health plans, as well as being higher than the National Medicaid Average. The reported rate was lower than the National Commercial Average. The health plan is delivering a level of care comparable to that received by both the average MO HealthNet Managed Care member in Missouri and the average Medicaid member across the nation, but slightly lower than the level of care received by the average National Commercial member. However, the plan's reported rate for the HEDIS 2008 measurement period was significantly higher than the same plan's rate for the HEDIS 2004 measurement period (the last period in which this measure was reviewed by the EQRO).

The EQRO was unable to validate this rate within the reported 95% confidence interval and therefore is unable to specify substantial confidence in the calculated rate.

ACCESS TO CARE

The Annual Dental Visit rate for Blue-Advantage Plus of Kansas City was not valid; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The rate validated for the health plan was comparable to the overall rate calculated for all MO Health Net Managed Care health plans. Blue-Advantage Plus of Kansas City's members are receiving a level of care consistent with that received by the average MO HealthNet Managed Care member in Missouri. However, the rate is lower than the National Medicaid Average rate, indicating members are receiving a lower level of care than those on a national level. The health plan's rate is a slight decrease over the rate reported for the 2007 EQR report (the last year this measure was audited by the EQRO), but higher than the 2005 EQR audit reported rate.

The EQRO was unable to validate this rate within the reported 95% confidence interval and therefore is unable to specify substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2008 Adolescent Well-Care measure was not valid. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was again consistent with the average across all MO Health Net Managed Care health plans. Therefore, Blue-Advantage Plus of Kansas City's members are receiving similar access to and timeliness of care for this measure as the average MO HealthNet Managed Care members. This rate was below both the National Medicaid and National Commercial averages, indicating the health plan's members are receiving a lower level of service than those on a national level. However, the MCHP's dedication to improving these services is evident from the increase in this rate over the past 3 EQR audit periods.

The EQRO was unable to validate this rate within the reported 95% confidence interval and therefore is unable to specify substantial confidence in the calculated rate.

RECOMMENDATIONS

1. Blue-Advantage Plus of Kansas City should utilize hybrid methods where HEDIS specifications recommend using the hybrid approach.
2. Continue work with Ernst & Young to conduct and document statistical comparisons on rates from year to year.
3. The Annual Dental Rate showed a decrease over the previous year's rate. The EQRO recommends that the health plan monitor this decrease and attempt to determine the possible reasons for this decline.
4. The EQRO recommends that the health plan continue to monitor trending in rates from year to year and responding to those trends by increasing efforts for those rates that do not increase or only increase slightly.
5. Blue-Advantage Plus of Kansas City should supply complete data to the EQRO in the format requested so that the reported rates may be adequately validated.

6.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 90,423 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field 92.5% complete, accurate and valid. The remaining fields (n= 6748) were blank (incomplete, inaccurate, and invalid).
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 63.3% complete, accurate and valid.
9. The second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual. Each of these Diagnosis Code fields fell well below the 100% threshold established by the SMA for this validation. The second, third, fourth and fifth Diagnosis Code fields were 49.6%, 11.4%, 4.8%, and 0.00% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 9,928 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All of the fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were 83 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All of the fields examined were 100.00% complete, accurate and valid except the Procedure Code and second through fifth Diagnosis Code fields. The Procedure Code field was 69.9% complete and accurate and valid. The remaining fields (n = 25) were blank. The second, third, and fourth Diagnosis Code fields were 48.64%, 45.8%, 9.6% and 6.0% complete, accurate, and valid, respectively. All remaining fields were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were 13,265 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete, accurate and valid.
5. The Discharge Date field was 100.00% complete accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 72.4% complete, accurate and valid. The remaining fields (n = 3655) were blank.
9. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (13.9%, 52.1%, 39.6%, and 29.7%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 100.0% complete, accurate and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 37,449 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields examined were 100.00% complete, accurate, and valid except for the Procedure Code and first through fifth Diagnosis Code fields. The Procedure Code fields were 85.3% complete and accurate. The remaining fields were blank (n = 5500). The Procedure Code fields were 84.98% valid with incorrect codes (n=125). The first, second, third, fourth and fifth Diagnosis Code fields fell well below the

100% threshold for completeness, accuracy, and validity established by the SMA (89.0%, 61.4%, 26.6%, 13.0% and 6.5%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were zero (0) claims paid by the SMA for the period July 1, 2008 through September 30, 2008. It is important to note that the MCHP had pharmacy claims "carved-out" of their contract with the SMA that began on July 1, 2008. This explains the extremely low numbers of encounter claims during the time period reviewed.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Blue-Advantage Plus of Kansas City, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. Dental claim type critical fields examined were 100.00% complete, accurate, and valid. For Home Health and Outpatient Medical claims, the Procedure Code field was the only critical field to contain invalid data.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Blue-Advantage Plus of Kansas City demonstrated rates consistent with the average for all MCHPs for the Outpatient Hospital and Dental claim types; and a significantly higher rate for Home Health and Inpatient encounter claims. These findings suggest moderate to high access to care for Outpatient Hospital, Dental, Inpatient and Home Health Care services for Blue-Advantage Plus of Kansas City members.

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MCHP were randomly selected from all claim types for the period July 1, 2008 through September 30, 2008 for medical record review.

Of the 137,883 Outpatient encounter claim types in the SMA extract file for July 1, 2008 through September 30, 2008, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 100 medical records (100.0%) submitted for review. This was an improvement over all prior years' submissions.

For the 2007 review, Blue-Advantage Plus' match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 59.0%, with a fault rate of 41.0%. For this year's review, Blue-Advantage Plus' match rate for procedures was 67.0%, with a fault rate of 33.0%, the match rate for diagnoses was 56.0%, with a fault rate of 44.0%.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure and diagnosis, was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were blank or missing (n = 35) and upcoded (n=3). For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 20), incorrect code (n=10), and upcoded (3). Examples of missing information included no code; code is wrong for place of service; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Blue-Advantage Plus of Kansas City included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MCHP encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the MCO denied for payment, unpaid claims do not include claims paid via a capitation plan.

For all Outpatient Claim Types (Medical, Dental, and Hospital), 137,800 "paid" encounters 789 "denied" and 120 "unpaid" claims were submitted. All paid encounter claims matched with the SMA encounter claim extract file. The 789 denied claims and 120 unpaid claims were not present in the SMA database (as expected); there was a "hit" rate of 99.43% between BA+ submitted encounter claims and the SMA encounter data.

For the Inpatient Claim Type, the State database contained 13,265 BA+ encounter claims of "paid" status and BA+ submitted additional claims in the amounts of 108 "denied" and 25 "unpaid" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied and unpaid claims were not present in the SMA database.

Why are there unmatched claims between the MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care health plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet Managed Care health plan data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care health plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of five of the six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Dental claim type was 100.00% complete, accurate, and valid.
4. The rate of Home Health and Inpatient encounter claims was significantly higher than the average for all MO HealthNet Managed Care health plans.

AREAS FOR IMPROVEMENT

1. For the Home Health and Outpatient Hospital and Medical claim types, the Procedure Code fields contained invalid entries.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the UB-92 file layout for the Outpatient Procedure Code and Discharge Date fields
2. Run validity checks after the programming of new edits.

6.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). This ensures that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations. On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. Interviews occurred with the Member Services and Case Management Staff, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds the federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additional document review, including reading and evaluating the Health Plan's 2008 Annual Appraisal of the Quality Improvement Program, occurred prior to the on-site review. The Health Plan assisted the on-site review team by providing additional documents at that time. This process was used to validate that practices and procedures were in place to guide organizational performance and were in compliance with the State contract and federal regulations.

Initial interviews were conducted with the Member Services and Case Management Staffs who directly serve the member population. These interactions and responses were compared to policy requirements and to the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff.

A detailed interview tool, individualized for Member Services and Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an interview tool was constructed for Administrative staff to validate and clarify these practices and to follow-up on questions raised from the direct staff interviews, and to respond to questions that arose from the document review. This interview tool was constructed using the BA+ Annual Appraisal of the Quality Improvement Program and the SMA's Quality Improvement Strategy.

Document Review

The MO HealthNet Division supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- BA+ Annual Appraisal of the Quality Improvement Program

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2008 Marketing Plan and Educational Material Development Policy
- Staff Training curriculum and attendance records
- Case Management and Member Services Policies or instructions
- 2008 Quality Improvement Committee minutes
- Prior Authorization time frames/policy/processes

Additional documentation made available by Blue Advantage Plus included:

- Blue Advantage Plus of Kansas City Organizational Chart
- BA+ Brochures – English/Spanish versions
- Doral Credentialing report
- New Directions Behavioral Health -- Compliance with ADHD Guidelines
- CAHPS Survey results
- Customer Service Standard Operating Procedures
- "Well Aware" Newsletters

Interviews

Interviews were conducted with the following group:

Plan Administration

Judy Brennan – Director, State Programs, Plan Administrator
Dr. Loretta Britton – VP, Medical Director
Sandy Wederquist, RN – Director, Medical Management
Shelly Bowen – AVP, Quality Management
Dennis Radio – Director, Professional Services
Randy Meyer – Director, Hospital Services
Thutam Trieu – Director, Member Services
Sandy Wederquist – Director, Medical Management
Tee-Ka Johnson – Special Programs Coordinator

Member Services and Case Management Interviews

Thatum Trieu – Director, Member Services
Patricia Mahurin, Supervisor, Member Services
Lanna Golliglee, Tech Specialist
Melinda Armstead – Case Manager 0 - 6
Loretta Britton – VP, Medical Director
Sandy Wederquest – Director, Medical Management
Carla Reimche – Project Lead/Population Management

INTERVIEW QUESTIONS

Administrative Interviews

- Give examples of measures that the Health Plan implemented to improve follow-up processes for members included in the State's Special Needs report.
- Why is the number of special healthcare case management assessments small (36), when compared to the total number of special healthcare needs children (585) on the State List?
- Does BA+ use any mechanism to identify member language or literacy needs, other than the State Eligibility File?
- Can you provide updated information regarding current Quality Indicators that addresses the "non-reports" indicated in the Annual Appraisal? The report indicates 35% regarding adolescent well-care.
- Trends were reported in the section "Trends in Missouri Medicaid Quality Indicators." These trends identify significant changes for certain indicators. Were these positive or negative trends? Are comparisons to previous year's figures available?
- Give examples of activities that the Health Plan has initiated to improve the number of specialists available to members.
- Discuss any follow-up that has occurred to address the issue of non-compliant primary care physicians in regard to after-hours access to services? What were the outcomes?
- What actions has BA+ taken to provide an optimum number of open PCP practices?
- What is the percentage of physicians surveyed for provider satisfaction that are actually BA+ providers?
- What recommendations for improvement were made following the assessment of 2007-2008 physician medical record review?
- Did BA+ conduct any site reviews for credentialing in 2008? What were the outcomes?
- What is the case load for the RN dedicated to case manage the BA+ 0 – 6 year old

population?
- Describe any evidence that providers are conducting outreach to their patients who are not in compliance with preventive case or disease management guidelines.
- Discuss initiatives or other issues in the New Directions 2008 Work Plan.
- What improvements were made in 2008 to co-case manage as a result of the BA+/NDBH audit/review activity?
- Has New Directions evaluated the addition of respite care for children and adolescents? What are their outcomes?
- Discuss the outcomes of the Medication Overdose Safety Program initiated by NDBH. What outcomes have been identified?
- What were the results of the case management review of NDBH? (Page 8 of report contains some conflicting information – ask questions.)
- Discuss the findings of Fraud and Abuse cases that were identified in 2008. A report of findings was not included in the annual report.
- Describe actions that have occurred to meet or exceed the timeframe for resolution of member grievances and appeals?
- How do the Case Management and Utilization Review departments work together?
- What is your response to criticisms that CM is just another method of UR?
- What feedback has the Health Plan received from outreach activities?
- Discuss the outcomes of the "Take 5" program initiated by Doral Dental?
- How many grievance and appeals received in 2008 were related to dental issues? What were the outcomes? Discuss Doral Dentals compliance with required timeframes.

Member Services/Case Management Staff Interviews
- Are you familiar with the results of the CAHPS surveys?
- Has the Health Plan made efforts to increase member satisfaction through the Member Services sections? Describe the efforts that have occurred during 2008.
- What actions are taken to assist members in finding PCPs in their geographic area? How often do members complain that all the PCPs they contact have closed panels?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Describe activities that have occurred during 2008 to improve the process of contacting and providing services to members included in the State's report of members with Special Healthcare Needs.
  - What additional action is taken to identify members with special needs?
- Are you aware that the number of special healthcare case management assessments was small (36), when compared to the total number of special healthcare needs children (585) on the State List? Why would this occur?
- There is an RN dedicated to case manage the BA+ 0 – 6 population? Has this been effective? Give examples.
- Does BA+ use any mechanism to identify member language or literacy needs, other than the State Eligibility File?
- How do the Case Management and Utilization Review departments work together?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members with mental health care needs.

FINDINGS

Enrollee Rights and Protections

Blue Advantage Plus continued to exhibit commitment and enthusiasm toward ensuring that member rights and protections are in place. There was a significant change in the atmosphere, which seemed to empower the Blue Advantage Plus (BA+) administrator and to involve front line staff in the operations of the program. The Annual Appraisal of Quality Improvement included an informative discussion of cross-departmental integration. It served to emphasize the corporate approach to management of BA+, and supported the management philosophy of BA+. Review of the meeting minutes indicated the corporate involvement of the staff from BA+ and a support for the growth of BA+ programs.

Members Services staff indicated pride in their record in contacting new members quickly after the Health Plan learned of enrollment. A variety of continued contacts are made if initial attempts fail. Written information was provided in English or Spanish. If additional interpretive services were required, this was arranged for the member. They also report that several staff do speak Spanish. Translators and interpreters are available, and the BA+ staff often use AT & T linguists.

Both Case Managers and Member Services staffs were aware of the CAHPS survey, and stated that the results are shared, but the direct services staff is not included in discussions about the outcomes of the survey. They were aware of changes made as the results of survey responses. The Health Plan's ID cards are not directly mailed by BA+. They are continuing to improve this initiative to ensure that members receive these cards in a timely fashion. The Member Services staff reports that they continue to improve and enhance the Welcome Call process and now have dedicated Case Managers to whom they can make direct referrals. This assists in ensuring that members receive specialized services in a timely fashion.

The Member Services staff and Case Managers report that improving the process for case management referrals created an environment where much more inter-departmental information sharing occurs. Members are enrolled earlier into case management or special programs if these services are indicated. They described their process as a Health Management approach, which decreased the silos between the two departments. The Members Services staff

stated that their goal was to get members enrolled into case management as soon as possible. They stated that often "members don't know they need case management," and viewed it as their responsibility to discuss these needs and make efficient and effective referrals for their members.

Member Services staff also responded that they do help members locate appropriate PCPs. They realize there has been some criticism regarding PCPs with closed panels, but they find that this occurs most often when the member is assigned a PCP by the Enrollment Broker. If a member has a specific PCP in mind, the Members Services Representative will call the provider office directly and they are able to validate that the provider will accept new members. They did recognize that members often call provider offices and report that they are on Medicaid. When the office learns they have BA+ services, appointments are available. These barriers often exist for members who are auto-assigned, and the choice of the PCP occurs through this process rather than through a discussion with BA+ staff.

Case Managers focus on ensuring members assigned to them are referred to all available services. They believe that care coordination and case management are synonymous in their system, and that all members receiving case management services do receive care coordination. They try to think "outside the box" when interacting with members and make all types of referrals, including to community based organizations that can meet more than medical needs. The Case Managers described their role as including community-based problem solving. They make referrals to Head Start, WIC, and a number of educational programs. The Health Plan shares their resources, pamphlets about their programs, and other information with the community-based agencies to ensure that members are informed about what is available.

Typical case management activities include researching the member's location and contact information, and learning about their service needs. Internal referrals come from Prior Authorization nurses, Member Services, Utilization Review, the Health Information line, and the Medical Director. After making contact with members, the Case Manager assesses the member's acuity level, and reviews medical information. Case Managers are also responsible for checking emergency room reports, reviewing the claims system and MOSAIC to obtain information about member activity, and conducting outreach. They attend member case conferences and conduct follow-up as required.

The Case Managers gave an example of working with a family whose child had a liver/bowel/pancreatic condition requiring extensive treatment. The family was staying at a Ronald McDonald House during the child's hospitalization. There was a dispute and they were evicted over this misunderstanding. The Case Manager realized these were young parents and they did not know how to talk about their issues with the individuals in charge of the facility. The Case Manager coached them on what was appropriate and how to discuss issues, while transitioning the family into another facility. A tailor-made care plan was developed, and the Case Manager continued to assist the parents with communication issues. The Case Manager remained involved, at all hours, for over one month. At the end of the hospitalization the parents contacted the Case Manager to express their thanks for the intervention provided and care coordination received for their child.

The Case Managers reported that the Health Plan has developed a member satisfaction survey for their services. They are receiving feedback through this process, and at this point it has been largely positive. The Case Managers do plan to utilize this resource to inform their work with members, and as a method to improve their processes. The staff was asked about utilizing the report from the SMA regarding members with special health care needs. The Health Plan has an RN who attempts to make contact with everyone on this report who is not currently enrolled in case management. When members are contacted the Case Manager updates all contact information, assesses the member for needed services, and collects information about PCPs or specialists that the member is currently seeing. They then make additional referrals, inform the member regarding transportation that is available, and attempt to resolve any barriers to effective service provision. The Case Manager then develops an action plan with the member regarding continued contact and intervention. One of the areas common to many members is their inability to negotiate pharmacy obstacles. BA+ continues to provide improved access to information through their data warehouse regarding members with special health care needs. The BA+ list of members is run through the data warehouse looking for a diagnosis if something occurs that is not routine. When a problem is identified, the member is referred to case management for follow-up contacts and services. This report is run for lead case management and cases relating to the Jackson County Consent Decree. The health plan utilizes the State Health Needs Assessment, which is helpful in identifying members who need behavioral health services, and those who are pregnant.

The Case Manager provides education and assistance as needed by the member. The staff was asked about the discrepancy in the number of members on the SMA list (585), and the number of assessments (36) conducted on these members. They explained that many children appearing on the list are in state custody. These children have care managers, and are already in the BA+ Case Management system. In other cases the family was already enrolled in case management through other referral sources.

Blue Advantage Plus made changes in a number of processes to make service delivery easier for members. Communication is requested between physicians, with the goal of contact occurring between specialists and PCPs, within one day. If the situation is an emergency the Medical Director, Dr. Loretta Britton, is involved. Dr. Britton is sometimes involved if a timely appointment cannot be made. Quality improvement staff monitors appointment access regularly to insure that this important component meets all requirements.

A complex case management program has been added to the already available catastrophic case management program. Nurses will now get regular reports from the emergency rooms and from hospitals. Nurses review all emergency room visits within one week. If a visit is not urgent, contact is made with the member to educate them on obtaining PCP care regularly and to provide assistance in overcoming barriers to the member utilizing PCP services. These case managers also review claims histories to assess where healthcare is received. Outreach to PCPs requesting their contact with members to engage them in utilizing their medical home is also made. BA+ is working with American Academy of Family Practice (AAFP) to support members in maintaining a medical home.

BA+ operates the Healthy Companion program, which is an umbrella for healthy living initiative that includes prevention, disease management, and a relationship with a nurse case manager. This information is available to all BA+ members. The case manager schedules calls at the member's convenience. Outreach additionally occurs when a problem arises, such as a negative laboratory report. The program includes an interface with local public health departments and a monitoring program for diabetics and members with hypertension. The system is shared with New Directions Behavioral Health the health plan's behavioral health subcontractor. Feedback is provided regarding the medical perspective on consultations for members with multiple problems. This process ensures timely access to follow-up care when referrals are made.

The Health Plan continues use of a predictive modeling tool, Care Advance, to search through data and detect members who are at risk of needing care management services. Data used by the case managers included claims, pharmacy utilization, laboratory results, and self-reported information. Follow-up contact with members occurs with all at-risk members detected, particularly those with diabetes, heart disease, and COPD. These Case Managers receive prompts to: make medical appointments; identify the need for chronic disease treatment; and to create comparisons to best practice guidelines for the members. The Case Managers perform assessments to submit to involved providers. Tutorials for chronic diseases, such as asthma and diabetes are available and providers will be able to use this information, as well as tracking patient information.

Member Services staff report that they make welcome calls to all new members to review benefits and to discuss the member's medical needs. The assigned PCP is discussed with the member to ensure that this is the provider of choice. Changes are made if necessary. The Member Services staff member also contacts the PCP to ensure that the member is in their panel and that there will be no problem when an appointment is sought. The Member Services staff also reminds members of the right to transportation services, and ensures that they know how to request this service should it be necessary. Member Services staff discusses cultural issues, if appropriate, ensure that the member is comfortable with the PCP, and asks about language or other cultural considerations.

BA+ has one Case Manger dedicated to working with children ages 0 – 6. They relate that this has been an effective use of resources, as this population has a number of specific needs. In one example a father called upset because his child was scheduled for surgery the following day and he was unsure of why. The Member Services representative connected the Case Manager, while the father was on the phone and immediately connected them. They looked into the situation and helped him to continue asking questions until he understood what the procedure involved, and the reason for the immediate scheduling. She instructed the father that it was appropriate to continue to ask questions until he was comfortable with the recommended treatment for his children.

Case Managers report that they work with the Utilization and Concurrent Review nurses regularly. These nurses are one of the case management referral sources, and are also the source for initiating care coordination for many members. The Health Plan has just started a new initiative to complete research on follow-up after discharge. The team includes a Case Manager, Physician, and Utilization Review nurse. The team reviews each case in a methodological manner, to initiate appropriate ongoing care and resource management. The Case Manager then contacts the member two days after release from the hospital to ensure that they do have a follow-up appointment, to identify any immediate health issues that may need to be addressed, and to ensure that the member has required instructions and medications. The Case Managers reflect that this project exemplifies the way the Health Plan conducts interdepartmental initiatives.

The rating for Enrollee Rights and Protections (100.0%) reflects Blue Advantages Plus' ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the third consecutive year and have practices in place that reflect these policies. The Health Plan provided evidence of their practice throughout the on-site review process. It appears that the health plan is in compliance with all MO HealthNet Managed Care contract regulations and federal requirements.

Table 50 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2006	2007	2008
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

New Directions Behavioral Health continues to provide mental health services to BA+ members. NDBH was not interviewed on site during this review. The BA+ staff was asked about accuracy and timelines of claims issues, which was raised as an issue in the BA+ annual report. The Health Plan explained that they had taken steps to improve in this area. The BHO now meets with provider office managers quarterly and all transactions are handled electronically. They have a broad network of providers, but this situation has improved and claims are being submitted and paid in a timely manner after corrective action was implemented.

New Directions Behavioral Health continued to jointly operate the Parents and Children Together (PACT) program with the Gillis Center. The PACT program has been in place for nine years. This program provides intensive interventions for members and their families, with follow-up services within the community. Gillis Center now employs 26 trained therapists for this program. The BHO estimates that between twenty and thirty percent of members receiving sub-acute level care are referred for PACT services. PACT provides direct services and assists the family with community resources. For example, the program connects members and their family with their Community Mental Health Clinic (CMHC) for wrap around services or other beneficial interventions. Referrals are also made to Marillac Center for coordination with school programs and residential placement, if this becomes necessary. This service usually lasts only slightly longer than average inpatient treatment stays, and avoids court-involved out-of-home placement. These services, exceptional to the requirements of the MO HealthNet Managed Care contract, assists members leaving in-patient care, and in some cases prevents in-patient care. Providing this type of support mechanism allowed the health plan to increase ambulatory follow-up for members leaving in-patient services at the seven and thirty-day time frames.

NDBH has continued to develop their collaborative efforts with PCPs. They ensure that the PCP is notified immediately if a member enters inpatient treatment. Anytime there is a drug overdose reported, the BHO ensures that the PCP receives notification.

The BHO has developed clinical guidelines that are posted on their website. These are reviewed annually by the BA+ Quality Improvement Team. They have also developed ADHD guidelines for providers and members, which are also posted on the BHO website. They have been unable to produce this information at the sixth grade reading level, so are unable to distribute to all MO HealthNet Managed Care members. However, these are mailed to members any time they are requested.

Quality Assessment and Performance Improvement

Access Standards

Blue Advantage Plus continues to have an extensive provider network available. The health plan reports that having regular access to orthopedic surgeons, neurologists and urologists was difficult. Blue Advantage Plus continues to have out-of-network agreements with orthopedic surgeons at Truman Medical Center. Three urologists from the Kansas City area, and one from the Warrensburg area, were added to their network in 2006 and continue to provide services to BA+ members in 2008. The Health Plan reports that specialists remain dissatisfied with the MO HealthNet Managed Care reimbursement rates. Blue Advantage Plus does utilize specialists from their commercial network and reimburses them at twenty percent over the MO HealthNet Managed Care fee schedule. Provider Relations staff continues active recruitment efforts for specialty medical providers. Urgent care centers associated with OSCO Drugs and Walgreens are now available to BA+ members as well. The Administrative staff report that several additional urgent care centers, providing after-hours care, have opened. A number of physicians are now providing after-hours coverage as well.

The Health Plan reported that their relationships with providers continued to improve during 2008. They are always anxious to recruit new providers. Obstetricians have been added to the network who are located in Eastern Jackson County and now provide services there and in the surrounding counties. The Health Plan reports that they continue to have a very stable network of providers, but continue to work on finding new resources. They recognize that having psychiatrists in every county is a struggle.

Blue Advantage Plus does operate a providers' advisory committee that they utilize for review of internal policies and activities. Provider representatives meet with provider office staff monthly. They use these resources to obtain feedback on policy issues and to obtain input on pilot programs. Physician complaints and member satisfaction surveys were used to trigger corrective actions and educational opportunities with providers. Provider Relations representatives contact any office that is found to be out of compliance with the after-hours access requirements. All member complaints regarding lack of after-hours access are forwarded to provider relations. The appropriate representative contacts the provider office and provides educational information to staff. The Blue Advantage Plus requirements are reviewed and coaching is provided about what type of after-hours directions for members must be in place.

Follow-up continues until all corrective action is taken. Additionally, the five representatives visit their assigned providers quarterly. The Health Plan does monitor to assure that PCPs have open panels. Member Services staff assist in identifying a problems. They also track a new provider or PCP to ensure that this information is available to members.

Blue Advantage Plus also reported initiating corrective action with their transportation subcontractor, MTM. A corrective action plan was developed to reduce call abandonment and to improve call response time. These efforts resulted in improvement in services. The Health Plan does continue to meet quarterly with MTM to review call information and to provide follow-up on complaints or problems experienced.

Case Managers are involved to ensure that members have access to quality and timely health care on a daily basis. They assist members in locating specialists, in obtaining appointments, in securing normal health care services, as well as extra ordinary services when they are required. Through the Care Coordination programs and the Healthy Companion Program, members with specific diseases obtain regular and adequate health care.

Ratings regarding Access Standards regulations (100%) reflect that Blue Advantage Plus submitted all required policy and procedures to the SMA for their approval for the fourth consecutive year. During the on-site review all practices observed indicated that the health plan made a concerted effort to ensure that they were compliant with the MO HealthNet Managed Care contract requirements and all federal regulations.

Table 51 – Subpart D: Quality Assessment and Performance Improvement:: Access Standards Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2006	2007	2008
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Blue Advantage Plus provided regular oversight to all subcontractors. The health plan meets with New Directions Behavioral Health, and MTM at regular Delegated Oversight Quality Meetings. They continue to meet with Doral Dental on a monthly basis to monitor a correction action plan that is in place.

Blue Advantage Plus implemented CareGuide QI software. This tool allowed for more efficient documentation of the Milliman Criteria and has allowed nursing staff to make more informed medical management decisions. Using this tool in collaboration with provider discussions allowed for the most appropriate authorization of inpatient services. The Milliman Criteria provided a guide for medical practice. The Health Plan also used specific practice guidelines from the American College of Obstetricians and Gynecologists (ACOG) and the Academy of Pediatrics. Practice guidelines are distributed by the Provider Relations Representatives. This group also assesses if the practice guidelines are in place and utilized. All providers were encouraged to recognize best practices and follow nationally accepted guidelines.

The credentialing policies and procedures were reviewed and found to be compliant with SMA contract requirements and federal regulations. BA+ follows NCQA criteria for credentialing and site reviews are included. Medical record reviews are conducted in compliance with HEDIS requirements. A list of all providers and their credentialing dates is maintained by the Health Plan to assure that re-credentialing is completed as required.

The Blue Advantage Plus Customer Service operation has continued to improve. Customer representatives offer members options for care, especially after hours. A scripting matrix was added so representatives can look up procedures pertaining to the member's inquiry, and provide adequate information. The system incorporates prompts for staff to insure that language and level of explanation meet member needs. Talking points are highlighted in all links. Cross training of this system occurs with Member and Customer Services so they can provide back up.

Ratings for compliance with Structure and Operation Standards regulations (100%) reflect that Blue Advantage plus has completed all policy and procedural requirements of the SMA for the third consecutive year. All practice observed during the on-site review supported that the health plan has made every effort to be compliant with both the MO HealthNet Managed Care contract requirements and federal regulations.

Table 52 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2006	2007	2008
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	10
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met *Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.*

Measurement and Improvement

Blue Advantage Plus took extra effort to deal with the issue of Fraud and Abuse in 2006 and these efforts continued in 2007 and 2008. They moved their Special Investigation Unit into Audit Services to assist in facilitating the process of identifying and rectifying fraud and abuse. When fraud and abuse is suspected, the Health Plan does not renew provider contracts at their next renewal date. Other actions involve education of providers regarding problem areas identified. The professional investigation unit, originally established in 2004, was active throughout 2008. This unit continues to assist when a suspected problem arises. The Administrative staff was asked about follow-up to cases identified in 2008. They reported that there was one member report of an individual forging prescriptions. The member was placed on pharmacy lock-in and the situation was reported to the SMA. There was one situation where a nurse mid-wife obtained a provider number utilizing a physician's name. Corrective action and repayment was initiated, with continued monitoring occurring to date.

The Health Plan reports that their network includes more than 1600 physicians. They are experiencing fewer complaints each year. Blue Advantage Plus staff believes this is due to the longevity of the relationships with most of these providers. The health plan employs a Physicians Advisory Committee and provides information and training prior to making policy and procedural changes. This group assists in communicating necessary changes within the provider community. Physician profiling occurs and incentives are in place through the Health Plan's Quality Program. Quarterly audits are completed and communicated to all providers.

Blue Advantage Plus is involved in the community-based Kansas City Quality Improvement Consortium. This group developed clinical practice guidelines for diabetes and asthma. The group has also completed obesity guidelines. The Health Plan continues to encourage all providers to use practice guidelines accepted by national organizations, as well as those based on local standards. The Health Plan uses the Provider's Office Guide and provider newsletters to disseminate information about practice guidelines to the provider community.

Blue Advantage Plus submitted information to complete the Validation of Performance Measures. This information was not received in the format requested. This issue is dealt with in the appropriate section of this report. They continue to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The details regarding these areas of validation can be reviewed within specific sections of this report.

Ratings for the Measurement and Improvement sections were found to be (100%) for the fourth consecutive year, which reflects that all required policy and practice meets the requirements of the MO HealthNet Managed Care contract and the federal regulations.

Table 53 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2006	2007	2008
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

The Grievance and Appeals system was moved under the umbrella of Blue Advantage Plus in 2007 to facilitate improved response time to member and provider complaints, grievances and appeals. The health plan reports that this change has had positive results to date. The grievance and appeal processes have now changed from manual folders to uploading all information into FACETS the Health Plans case management and information system. Information is now routed electronically which is a more efficient method of tracking. The Complaint Analyst reports that this process assists in meeting all timeliness guidelines.

BA+ Grievance and Appeals unit was trained on the Member Grievance and Appeals process during 2008, in an effort to assist members more appropriately. The training was supported with revised corporate policy. The Health Plan also reports that they continue to monitor New Directions Behavioral Health's compliance regarding Provider Complaints and Member Grievances. The review conducted in October 2008 resulted in NDBH receiving 100% compliance.

The Health Plan utilizes a Medical Member Appeal Panel, which is staffed by the Medical Director, two policy holders, and a Blue Advantage Plus representative, who serves as a neutral team member. Decisions are made by the panel. If an appeal is not overturned by the panel, the appeal is sent out for review by an independent review organization.

Grievances involving subcontractors are sent to the Quality of Care Committee. When the issue involves a provider, the health plan's provider relations staff investigate and then assist in addressing the problem. BA+ reports that 38 appeals, during 2008, were related to dental issues. Thirty-three (33) of these were upheld, all as the result of issues related to orthodontia, and the member not meeting the medically necessary requirements. Doral Dental continues to struggle to meet grievance and appeal timeframes, although they are being closely monitored by BA+. BA+ staff contacts Doral Dental with reminders if a case is nearing a timeframe. This has assisted in complying with timeframe requirements.

Both Case Managers and Member Services staff are aware of all the requirements of the Grievance and Appeals system. They assist members in making referrals and negotiating the system, as necessary.

Rating for compliance with Grievance System regulations (100%) remained complete as occurred for four consecutive program years. The health plan takes pride in their Grievance and Appeal policy and procedures. All practice witnessed at the time of the on-site review, was in compliance.

Table 54 – Subpart F: Grievance Systems Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2006	2007	2008
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols

Conclusions

Blue Advantage Plus has excelled in meeting all policy, procedure, and practice areas of compliance with both the MO HealthNet Managed Care contract requirements, and the federal regulations for the fourth consecutive year. The Health Plan strengthened their programs, and engaged in a number of initiatives that served to improve the quality, access and timeliness of service to their members. Blue Advantage Plus pointed to their member loyalty as proof of their focus on meeting member needs. The Health Plan continues to operate, expand, and create initiatives, several in conjunction with the Behavioral Health Organization, that go beyond the strict requirements of their contract. These initiatives focus on prevention in an effort to avoid more intrusive treatment for members. Blue Advantage Plus dedicated resources enabling staff to be responsive and supportive to members by ensuring that their healthcare needs were met in an effective and efficient manner.

QUALITY OF CARE

The quality of healthcare services produced through Blue Advantage Plus remains high as the result of their commitment to continuing quality improvement. The Health Plan utilizes advisory groups. This includes one comprised of community member and another of physicians, to ensure that they have a sound perspective on methods that work and where improvements are necessary. The Health Plan subcontracts with New Directions Behavioral Health. Quality services are produced and are reflected in their exceptional initiatives, such as coordination of case management activities, the PACT, and Personal Transition Services (PTS) programs.

ACCESS TO CARE

Blue Advantage Plus exhibits their commitment to access to care through their enhanced service initiatives. They have developed new initiatives that improve member services and utilize health plan resources, such as Care Advance, a project that uses BA+ data to inform them about member issues. They participate in community activities to ensure that members have the best information on primary care providers and specialists.

TIMELINESS OF CARE

Blue Advantage Plus demonstrates their commitment to ensure the timeliness of healthcare by the improvement projects they undertake and new initiatives started each year. The Case Managers and Member Services staff is keenly aware of the need to assist members in obtaining timely health care and make every effort to intervene if they can assist. Examples of these programs include the BA+ Complaint Process, "Race for Resolution," which is a well constructed and important initiative that improved the health plan's responsiveness and timelines to both member grievances and appeals, and provider complaints, grievances, and appeals.

RECOMMENDATIONS

1. Continue development of projects utilizing available resources and data to justify and assist in understanding member service needs.
2. Continue development and use of products, such as CareAdvance, in predictive modeling and supporting empowerment of members to seek appropriate health interventions.
3. Continue efforts to improve behavioral health services and behavioral health case management practices, to ensure a coordinated approach to member care.
    1. Continue to recruit additional network providers with open panels, specialists, and psychiatrists to ensure access to services is available throughout the Health Plan region.

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7.0 Children's Mercy Family Health Partners

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7.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Children's Mercy Family Health Partners supplied the following documentation for review:

- Improving Dental Utilization Rates
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Children's Mercy Family Health Partners

The health plan supplied data at the time of the on-site review providing additional information and data analysis. Some additional information was supplied after the on-site review as a final submission of statistical analysis.

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 14, 2009, during the on-site review, and included the following:

Ma'ata Touslee – Chief Clinical Officer
Jenny Hainey – Manager, Quality Management
KaMara Sams – Project Manager, Health Improvement
Greg Hanley – Manager, Health Improvement
Johanna Groves – Senior Quality Management Nurse
Melody Martin – Accreditation Manager

Interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Discuss the study population.
- How were the accuracy, consistency, and validity assured?
- What findings were relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

FINDINGS

The first PIP evaluated was "Improving Dental Utilization Rates." The study topic was well developed. It was well documented and referenced. The topic justification includes comparisons of national, state, and local data. The Health Plan identified barriers for members and utilized this information to assist in defending their topic selection. The study focused on correcting deficiencies in care of members who are ages 2 – 20, and should be obtaining annual dental screenings. No members were excluded based on having special health care needs. The topic choice and rationale were well supported by a review of local issues and comparisons to state and national trends. A thorough literature review was conducted and the outcomes included in the documentation submitted.

The hypotheses utilized was that Health Plan participants, ages 2 – 20, residing in Jackson and Clay Counties receiving educational postcards will be more likely to schedule a dental screening.

The study was designed to answer the question: "Do educational postcards to CMFHP eligible children from the ages of 2 through 20 years old, who reside in Jackson or Clay counties, result in a 10% increase in dental screenings?" The approach utilized allowed the Health Plan to analyze if this single intervention is effective, prior to addressing broader causes or barriers to members receiving these services.

The study indicator is the rate of members in the identified age group who have had at least one dental examination after the intervention is concluded. The indicator looks at a change in health status and is focused on the issue of improving preventive care. The issues that can be tracked are delineated in the hypotheses. The query group was defined as children within a specific age range. The members involved in this study were from two specific counties in the MO HealthNet Western region that comprised 80% of the member population who had not received dental screenings in the baseline period of January 01, 2007 through December 31, 2007.

The study planned to collect data according to the American Dental Academy's (ADA) Current Dental Terminology (CDT). The database report was to be generated from the dental subcontractor's (Bridgeport) claims system. Specific data collection specifications were

included. The narrative clearly defined the sources of data and a systematic approach to obtaining data that provided confidence that it would be valid and reliable. A prospective data analysis plan was documented. It was based on the measurement of increased dental screenings post intervention. The data to be collected was presented clearly and understandably through the entire discussion of the study design and the prospective data analysis plan. It is noted that the study design was developed in cooperation with Bridgeport Dental. The development of the study design included input from Health Plan and subcontractor staff. This approach to the study design provides evidence of the Health Plan's commitment to improve access to preventive care available to members.

Proposed interventions, barrier analysis, data analysis and the quality improvement processes were described and explained in a manner that enhanced project analysis. A reasonable and simple intervention was developed. The Health Plan and Bridgeport Dental mailed educational postcards to members in Jackson and Clay counties. The approach provided education to each member or their family regarding the importance of scheduling dental screenings, and the availability of Health Plan sponsored transportation.

The documentation received included a detailed analysis, including initial and repeat measurement factors that included comparability, and threats to internal and external validity. This was an in-depth analysis on the information available to date. The information provided did indicate a considerable success. The graphs and charts provided were clear and understandable. They did correlate to the narrative explanation. The information provided compared the baseline and re-measurement data. The analysis provided did explain the data and the results. The enhanced information submitted after the on-site review indicates testing for statistical significance. These tests determined that there was a positive impact as the result of implemented interventions. The results indicated that 33.4% of participants in the study were obtaining annual dental screenings.

The documentation did include a plan for improvement, particularly for the oldest age group, who had the smallest improvement as the result of the original intervention. The intervention is considered to have had a positive impact of the Health Plan's HEDIS rate, which have increased from 37.07% in 2006 to 38.99% in 2009. The plan for improvement indicates that new

interventions are planned to create additional positive results, including continued improvements in the HEDIS 2010 rate. The Health Plan plans to develop a dental quality improvement team to discuss missed opportunities and to identify additional interventions to ensure that members receive annual dental screenings.

The second PIP evaluated was the Children's Mercy Family Health Partners individualized approach to the Statewide PIP "Improving Adolescent Well Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The rationale presented included information relating this topic to the needs of Health Plan members. Children's Mercy Family Health Partners chose an individualized intervention pertinent to their members and supported this with plan specific data in the project documentation. They identified the adolescent population as one that poses challenges to serve. This project documentation reflected a desire to improve health care to the adolescent population. It looked at the topic as a serious attempt to solve a performance problem that will enhance preventive health care services to members. It is also based on a desire to improve the ability of members to access health services.

The CMFHP study question for the 2008 intervention was: "Will educational postcards sent to CMFHP participants from the ages of 12 through 21 increase adolescent well care (AWC) visits by 10% among the participants in this study population and also impact the CMFHP AWC HEDIS rate?" The question was clear and measurable. The indicators are the Statewide and CMFHP HEDIS rates. This HEDIS measure and its technical specifications were explained. The information provided focused on improving the process of care and associating this with improved outcomes for adolescents.

The study population included all Health Plan members ages 12 through 21, which is comparable to the HEDIS requirements, and who had at least one comprehensive well care visit with a PCP or OB/GYN. The Health Plan noted that this was a constant as each Health Plan implemented individualized interventions during the 2008 measurement year. The same study population, as previously measured in 2007 was included.

The study design described the specific data to be collected. It highlighted the differences in the combined study approach, where each Health Plan will use its own NCQA certified software, and how this might impact data collection and measurement. The Health Plan specific information identified the Health Plan's MC400 claims database, and the process utilized to monitor and report outcomes. HEDIS technical specifications will continue to be used throughout the project. The Health Plan will query their MC400 claims database, and store the information extracted in Excel spreadsheets for tracking. They identified the CPT and ICD9 codes that will be utilized to identify member claims. The Health Plan will utilize a quarterly tracking process and analysis to ensure that progress relating to their intervention is occurring. They did include a prospective data analysis plan in the narrative provided.
The planned intervention included sending "age-specific" educational postcards to participants from the ages of 12 through 21 years old. The postcards explained the importance of obtaining a well care exam and provided information on transportation services available. The intervention was described in detail and included post-intervention planning.

Data analysis was completed for the baseline year 2007 and the re-measurement year 2008. The Health Plan reported on the actual number of members obtaining AWC exams post intervention. Tables and graphs were used to illustrate results throughout the PIP submission. They were somewhat confusing as they reflected the actual number of members obtaining AWC exams. Percentages reflected this number and did not reflect the HEDIS results. The population of members included was tracked. The actual 2006 HEDIS rate was 33.09%. It improved in 2007 to a rate of 42.82%, but declined each year thereafter. The 2009 HEDIS rate, reflecting calendar year 2008 data, was 39.42%. This decrease is noted in the documentation provided. The analysis does not include clear numbers. At one point the narrative states "HEDIS rates have improved by 15%." How this was determined is unclear. The analysis discusses data collection issues which may reflect some disparity in the numbers. They cite a lack of continuity in the data collection process that may skew the data, but no corrective action is recommended. The Health Plan states that it will utilize a quarterly review process in the future to identify areas of improvement before the annual HEDIS data is reported.

CMFHP collaborated with all MO HealthNet Managed Care Health Plans in an attempt to impact a problem with a population that is traditionally difficult to serve. They used an educational approach to make changes in their members' behavior. They individualized their approach and analysis to comply with the direction of the Statewide Performance Improvement Project. Although their results are not mature enough to assess statistical significance, the Health Plan believes they are seeing improvement in the real numbers of members taking advantage to the screenings available. The project has the probable potential to have a positive impact on member services.

CONCLUSIONS

QUALITY OF CARE

Quality services are provided in the most appropriate environment, and in a preventive manner, whenever possible. These two projects reported on here embodied these values and sought to enhance the services available to the MO HealthNet Managed Care members. Quality health care is evident in the types of interventions used in these projects. The strong reliance on member education in informing members about the services available to them, particularly with a focus on preventive care, is evidence of the Health Plan's commitment to quality services to members.

ACCESS TO CARE

The focus of both of the Performance Improvement Projects developed by the Health Plan indicated a strong commitment to improving access to and knowledge about the preventive health care services available to members. In the first PIP the Health Plan provided education about the importance of accessing preventive dental care services. In the second project reviewed the health plan provided member education regarding the availability of adolescent well care screenings. Both projects enhanced members' knowledge about the availability of services and enhanced their access these services.

Timeliness to Care

The PIP regarding Dental Screenings concentrated on timely preventive care for children in this age range. The educational approach taken by this PIP empowers families to make sound decisions that can lead to continued efforts to obtain timely preventive healthcare services on an ongoing basis. The PIP that focused on improving adolescent well care services directly impacted members' knowledge about the availability of timely healthcare. The project sought to ensure that members had transportation services available in both projects.

Recommendations

1. Continue the work the Health Plan is doing with the statistician to perfect PIP methodology and data analysis. Ensure that results are reported with clarity.

2. Ensure that data analysis reflects the data that needs to be measured. Interpret this data, whether it reflects a successful intervention or not, and investigate any negative results to build upon this knowledge.

3. Include the names, titles, and responsibilities of all health plan staff involved in the PIP.

4. Provide clear, understandable graphs and tables to illustrate PIP findings.

7.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Children's Mercy Family Health Partners. Children's Mercy Family Health Partners submitted the requested documents on January 20, 2009. The EQRO reviewed documentation between January 20, 2009 and June 30, 2009. On-site review time was used to-conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Children's Mercy Family Health Partners for the HEDIS 2008 data reporting year
- Qualis Health's NCQA HEDIS Compliance Audit Report for HEDIS 2008
- Children's Mercy Family Health Partners' information systems (IS) Policies and Procedures pertaining to HEDIS 2008 rate calculation
- Children's Mercy Family Health Partners' information services (IS) policies on disaster recovery
- Children's Mercy Family Health Partners' HEDIS committee agendas for 2008
- Children's Mercy Family Health Partners' HEDIS 2008 Training Manual for the medical record review process
- System edits for the claims management system
- Appendix Z – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

The following are the data files submitted by Children's Mercy Family Health Partners for review by the EQRO:

- CMFHP2008_ADV_Enrollment.txt
- CMFHP2008_ADV_NUM_DENOM.txt
- CMFHP2008_ASM_Enrollment.txt
- CMFHP2008_ASM_NUM_DENOM.txt
- CMFHP2008_AWC_Enrollment.txt
- CMFHP2008_AWC_MR.txt
- CMFHP2008_AWC_NUM_DENOM.txt
- CMFHP2008_AWC_NUM_DENOM_RESUBMIT.txt

INTERVIEWS

The EQRO conducted on-site interviews with Janet Benson, IT Analyst; Tish Fisher-Krings; Johanna Groves, Senior Quality Management Nurse; Bob Clark, Director, IT/IS; and Jenny Hainey, QM Manager at the Children's Mercy Family Health Partners in Kansas City, MO on Tuesday, July 14, 2009. This group was responsible for calculating the HEDIS performance measures. The objective of the visit was to verify the data, methods and processes behind the calculation of the three HEDIS 2008 performance measures.

FINDINGS

Children's Mercy Family Health Partners used the Administrative Method for calculation of the Use of Appropriate Medications for People With Asthma and Annual Dental Visit measures. The Hybrid Method was used for the calculation of the Adolescent Well-Care Visit measure. MO HealthNet MCHP to MCHP comparisons of the rates of Use of Appropriate Medications for People With Asthma, Adolescent Well-Care Visits, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) were reported.

The rate for the HEDIS 2008 Adolescent Well-Care Visit reported to the SMA and the State Public Health Agency (SPHA) by Children's Mercy Family Health Partners was 41.61%. This was comparable to the statewide rate for MO HealthNet Managed Care health plans (38.59%; z = 0.51 95% CI: 35.07%, 48.14%; n.s.). This reported rate is a slight decrease from the rate (42.82%) reported by this health plan in the most recent 2007 EQR report, but an increase from the EQR 2004 report rate of 32.93% (see Table 55 and Figure 40).

The reported rate for Children's Mercy Family Health Partners for the 2008 HEDIS measure Use of Appropriate Medications for People With Asthma was 89.73%. This rate was comparable to the statewide rate for MO HealthNet Managed Care health plans (87.23%; z = 0.48, 95% CI: 61.18%, 118.28%; n.s). This rate was a significant improvement (23.16% higher) over the HEDIS 2004 rate (66.57%) which was the last time this measure was audited by the EQRO (see Table 55 and Figure 40).

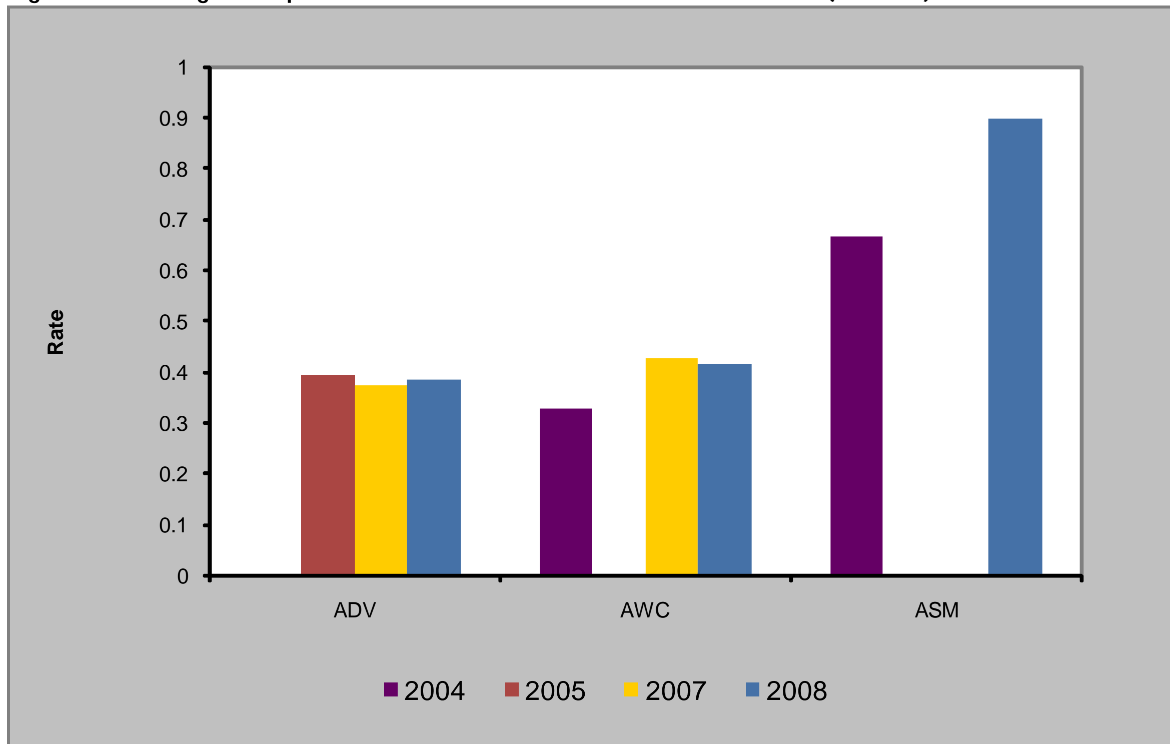
The HEDIS 2008 combined rate for Annual Dental Visits reported by Children's Mercy Family Health Partners was 38.59%, which is significantly higher than the statewide rate for MO HealthNet Managed Care health plans (34.71%, z = 1.04; 95% CI: 32.35%, 44.83%; $p > .95$). This reported rate is lower than the rate reported by the health plan in 2005 (39.09%) but higher than the reported rate in 2007 (37.49%; see Table 55 and Figure 40).

Table 55 – Reported Performance Measures Rates Across Audit Years (CMFHP)

Measure	HEDIS 2004 Rate	HEDIS 2005 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate
Annual Dental Visit (ADV)	NA	39.09%	37.49%	38.59%
Use of Asthma Medications (ASM)	66.57%	NA	NA	89.73%
Adolescent Well-Care Visits (AWC)	32.93%	NA	42.82%	41.61%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 40 – Change in Reported Performance Measure Rates Over Time (CMFHP)



Sources: BHC, Inc. 2004, 2005, 2007, and 2008 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of MedMeasures software system. The accompanying MedCapture system was also demonstrated; this system allows for the calculation

of the Hybrid hits from the input medical record data.

For all three measures, Children's Mercy Family Health Partners was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which they transferred data into the repository used for calculating the HEDIS 2008 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate (See Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Children's Mercy Family Health Partners met all criteria applicable for all three measures. Children's Mercy Family Health Partners does utilize statistical testing and comparison of rates from year to year.

PROCESSES USED TO PRODUCE DENOMINATORS

Children's Mercy Family Health Partners met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of eligible members for the services being measured. For the Use of Appropriate Medications for People With Asthma, a total of 740 eligible members were reported and validated by the EQRO. For the denominator of the Adolescent Well-Care Visits measure a sample of 411 eligible members were reported and validated. The Annual Dental Visit denominator included 23,456 reported and EQRO-validated eligible members. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2008 criteria.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, medication dispensing events and dental visits) as specified by the HEDIS 2008 criteria (see Attachment XIII: Numerator Validation Findings).

Children's Mercy Family Health Partners used the Hybrid Method to calculate HEDIS 2008 Adolescent Well-Care Visits measure. All 30 of the medical records requested were received, and all 30 were able to be validated by the EQRO. As a result, the medical record review validated 30 of the 30 hybrid hits reported. The health plan reported 141 administrative hits; of these, the EQRO was able to validate all 141. Based on the number of hits validated by the EQRO, the rate calculated was 41.61%, as was the reported rate. There was no observed bias in the rate reported by the health plan.

For the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure, the EQRO was unable to fully validate the numerator hits reported. The data submitted to the EQRO did not contain service dates for the codes listed. However, the data was still reviewed (assuming all service dates were valid) to provide a rate for comparative analysis. Of the 664 administrative hits reported by the health plan, the EQRO found 588 hits. Almost all of the administrative hits unable to be validated by the EQRO were due to invalid numerator service codes in the data. The rate reported by the health plan was 89.73% and the rate calculated by the EQRO was 79.46%, with a bias of 10.27%: an overestimate by the health plan in the reporting of the measure.

Review of the administrative hits for the combined rate of the Annual Dental Visit measure validated 9,029 of the 9,052 hits found by the health plan. The rate reported by the health plan was 38.59%; the rate validated by the EQRO was 38.49%. The total estimated bias for the Annual Dental Visit measure was a 0.10% overestimate of the rate.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. Children's Mercy Family Health Partners was compliant with all specifications for sampling processes.

SUBMISSION OF MEASURES TO THE STATE

Children's Mercy Family Health Partners submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following tables summarize the estimated bias in reporting each of the measures and the final validation findings. Table 56 shows no bias for the Adolescent Well-Care measure, a small overestimate (inside the 95% confidence interval) for the Annual Dental Visit measure, and a substantial overestimate for the Use of Appropriate Medications for People With Asthma measure.

Table 56 - Estimate of Bias in Reporting of CMFHP HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	0.00%	No Bias
Annual Dental Visit	0.10%	Overestimate
Use of Appropriate Medications for People With Asthma	10.27%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet. Table 57 shows the final audit findings for each measure. The Use of Appropriate Medications for People With Asthma measure was found to be Not Valid by definition, as the service dates were not provided and there was significant bias (outside the 95% confidence intervals) associated with the overestimated rate. The Adolescent Well-Care Visits measure was Fully Compliant, while the Annual Dental Visit measure was Substantially Compliant.

Table 57 - Final Audit Rating for CMFHP Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Fully Compliant
Annual Dental Visit	Substantially Compliant
Use of Appropriate Medications for People With Asthma	Not Valid

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, or where incomplete data was submitted such that the EQRO could not fully validate the rate; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the health plan. Two of these rates were consistent with; and one was significantly higher than the average for all MO HealthNet Managed Care health plans.

QUALITY OF CARE

Children's Mercy Family Health Partner's calculation of the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure was not valid according to specifications. The rate able to be validated by the EQRO was outside the 95% confidence interval. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The health plan's reported rate was consistent with the overall MO HealthNet Managed Care health plans calculated rate. Therefore, Children's Mercy Family Health Partners' members are receiving a quality of care for this measure equal to the care delivered to the average MO Health Net Managed Care member. The rate was reported as higher than the National Medicaid Rate, but lower than the National Commercial Rate. Therefore, CMFHP is delivering a slightly higher level of quality than that received by the average Medicaid member, but slightly lower quality care than that received by the average Commercial member across the nation. The rate reported in the HEDIS 2008 measurement year was also significantly higher than the last time this measure was validate (HEDIS 2004) which shows an improvement in the quality of services provided to members over the past four years.

The EQRO was not able to validate this rate within the reported 95% confidence interval and thereby is unable to specify substantial confidence in the calculated rate.

ACCESS TO CARE

The calculated rate by Children's Mercy Family Health Partners for the HEDIS 2008 Annual Dental Visit rate was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The health plan's reported rate for this measure was significantly higher than the average for all MO HealthNet Managed Care health plans,; the rate is higher than the rate reported by the health plan in 2007, but lower than the rate reported in 2005. CMFHP members are receiving a quality of care that is higher than the level of care delivered to the average MO HealthNet Managed Care member.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2008 Adolescent Well-Care Visits measure was fully compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was consistent with the overall MO HealthNet Managed Care health plans calculated rate; this rate was slightly lower than the rate reported by the health plan in 2007, but higher than the rate reported in 2004. Children's Mercy Family Health Partners' members are receiving the timeliness of care for this measure at a level equal to the care delivered to all other MO HealthNet Managed Care members. This rate was lower than both the National Commercial Rate and the National Medicaid Rate, indicating that Children's Mercy Family Health Partners' members are receiving the timeliness of care for this measure at a lower level than the average Commercial or Medicaid member across the nation.

The EQRO was able to fully validate this rate and thereby has extreme confidence in the calculated rate.

RECOMMENDATIONS

1. Continue to conduct and document statistical comparisons on rates from year to year.
2. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
3. The health plan experienced a reduction in the Adolescent Well-Care Visit rate between the rate reported in 2007 and the rate reported for 2008; the EQRO recommends that the health plan focus on this rate to reverse this trend.
4. Children's Mercy Family Health Partners should supply complete data to the EQRO in the format requested so that the reported rates may be adequately validated.

7.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 126,141 encounter claims paid by the SMA for the period July 1, 20087 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete accurate and valid.
6. The Outpatient Procedure Code field was 89.5% complete, accurate and valid. The remaining fields (n=13,185) were blank.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 61.5% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, and fourth Diagnosis Code fields were well below the SMA threshold of 100.00% completeness, accuracy and validity. The second, third, fourth and fifth Diagnosis Code field were (27.7%, 0.4%, 0.0% and 0.0%) complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 24,641 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields were 00.00% complete, accurate and valid.

For the Home Health claim type, there were seven (7) encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields were complete, accurate and valid except Diagnosis Code fields two through five, these fields were all blank and therefore, incomplete, inaccurate and invalid.

For the Inpatient claim type, there were 14,187 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate; and valid.
5. The Discharge Date field was 100.00% complete and accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 85.8% complete, accurate and valid. The remaining fields (n = 3429) were blank. (incomplete, inaccurate, and invalid).
9. All other Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA. The second, third, fourth, and fifth Diagnosis Code fields were 72.2%, 0.5%, 0.0%, and 0.0% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 100.0% complete, accurate, and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 83,249 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Hospital Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 87.6% complete and accurate, and 86.71% valid. This field requires five alphanumeric characters. There were 10,293 blank fields and 772 invalid fields.
7. The Outpatient Hospital Revenue Code field was 100.00% complete and accurate, and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields were well below the 100% threshold for completeness, accuracy and validity set by the SMA. The second, third, fourth and fifth Diagnosis Code fields were 45.7%, 0.01%, 0.0% and 0.0% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 19 claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields examined were 100.00% complete, accurate and valid data for all fields examined. It is important to note that the MCHP had pharmacy claims "carved-out" of their contract with the SMA that began on July 1, 2007. This explains the extremely low numbers of encounter claims during the time period reviewed.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Family Health Partners, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. The critical fields examined for the Dental and Pharmacy claim type fields were 100.00% complete, accurate, and valid (see previous findings). The Outpatient Procedure Code fields and Diagnosis field codes in the Medical and Hospital claim types contained invalid procedure codes.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rates of Inpatient, Home Health, and Medical claim types were consistent with the average for all MO HealthNet Managed Care health plans, while the rates for Dental and Outpatient Hospital claim types were significantly higher than the average for all MO HealthNet Managed Care health plans. This suggests that the data are complete and that there is better utilization of dental services and high rates of access to preventive and acute care among Children's Mercy Family Health Partners members.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care health plan were randomly selected from Medical claim types for the period of July 1, 2008 through September 30, 2008 for medical record review. Of the 234,038 Outpatient encounter claim types in the SMA extract file for July 1, 2008 through September 30, 2008, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 91 medical records (91.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated.

During the 2007 review, the match rate for procedures was 51.0%, with a fault rate of 49.0%. The match rate for diagnoses was 47.0%, with a fault rate of 53.0%. For this review, the match rate for procedures was 50.0%, with a fault rate of 50.0%. The match rate for diagnoses was 42.0%, with a fault rate of 58.0%.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file was missing information (n =39) with 10 records containing incorrect information. Incorrect information included the diagnosis code listed did not match the descriptive information in the record and the documentation sent was not complete.

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 25), incorrect (n=12), and upcoding (n=4). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

What Problems are there with How Files are Compiled and Submitted by the MO HealthNet MCHP?

Since Children's Mercy Family Health Partners included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the MCHP denied for payment, unpaid claims do not include claims paid via a capitation plan.

MO HealthNet Managed Care health plans were requested to submit data, as specified by the EQRO (see Appendix 6), for the Members represented in the encounter claim sample selected for validation.

For all Outpatient Claim Types (Medical, Dental, Home Health and Hospital), the State extract file contained 234,038 CMFHP submitted "paid" encounters and 239 "denied" claims. All paid encounter claims matched with the SMA encounter claim extract file. The 239 denied claims were not present in the SMA database (as expected); there was a "hit" rate of 99.99% between CMFHP's encounter claims and the SMA encounter data.

For the Inpatient Claim Type, the State extract file contained CMFHP submitted 14,187 encounter claims of "paid" status and 222 "denied" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims were not present in the SMA database. This produced a "hit" rate of 98.43% between CMFHP's encounter claims and the SMA encounter data.

Why are there unmatched claims between the MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care health plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet Managed Care health plan data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care health plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of two claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The rate of Dental claim types were significantly higher than the average for MO HealthNet Managed Care health plans, suggesting high rates of encounter data submission and at least moderate access to preventive and acute care.

AREAS FOR IMPROVEMENT

1. The Outpatient Procedure Code fields in the Outpatient Hospital claim type contained invalid codes.
2. The match rate between the medical record and SMA encounter claims data was comparable to the average for all MO HealthNet Managed Care health plans for the procedure code.
3. The Inpatient, Outpatient Medical, and Outpatient Hospital first Diagnosis code fields contained missing codes.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that the first Diagnosis code fields are complete and valid for all claim types, and institute error checks to identify invalid data.
3. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis.

7.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO HealthNet Division (MHD). On-site review time was used to conduct interviews with those who oversee the daily practices of the Health Plan. Interviews occurred with the Member Services and Case Management Staff, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additional document review, including reading and evaluating the Health Plan's Managed Care Annual Evaluation, occurred prior to the on-site review. The Health Plan assisted the on-site review team by providing additional documents at the time of the on-site visit. This process was utilized to validate that the practices occurring while serving members were also in compliance with federal and state regulations.

Initial interviews were conducted with the Member Services and Case Management staff who directly serves the member population. These interactions and responses were compared to policy requirements and the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff.

A detailed interview tool, individualized for Member Services and Case Management staff was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally an individualized tool was constructed for Administrative staff to validate and clarify these practices and to follow-up on questions raised from the direct staff

interviews, and to respond to questions arising from the document review. This interview tool was constructed using Children's Mercy Family Health Partners Annual Appraisal Fiscal Year 2008 Report and the SMA's Quality Improvement Strategy.

Document Review

The following documents pertaining to Children's Mercy Family Health Partners were reviewed prior to and at the on-site visit:

The MO HealthNet Division supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- Children's Mercy Family Health Partners Annual Appraisal Fiscal Year 2008

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2008 Marketing Materials
- Case Manager Job Description
- 2008 Community Project Report – "Bringing It Together"
- Prior Authorization Regulations
- Case Management Acuity Scale
- Case Management Philosophy and Standards of Practice
- Policies regarding Documentation Standards, Case and Care Management, and Children with Special Health Care Needs
- Staff Training Curriculum for: New Staff Orientation, Custom Service, Community Relations, Health Improvement, Corporate Compliance, Finance Orientation, Data Quality, and Claims/Payment and Denial

Additional documentation made available by Children's Mercy Family Health Partners included:

- 2008 Marketing Plan
- Children's Mercy Family Health Partners' Organizational Chart
- Connection – Member Newsletter
- New Directions Behavioral Health – Referral to the Prevention Team Policy & Care

Interviews

Interviews were conducted with the following group:

Plan Administration

Ma'ata Touslee – Director of Health Services
Jenny Hainey – Manager, Quality Management
Dr. Elizabeth Peterson – Medical Director
Jenny Hainey – Manager, Quality Improvement
Steve Cupp – Manager, Customer Service
Chris Beurman – Manager, Community Relations
Juanita Prieto – Manager, Provider Relations
Sally Sequeira – Manager, Utilization Management
Melody Martin – Accreditation Manager
Johanna Groves – Senior Quality Management Nurse
Lesa Castillo – Manager, Credentialing
Doug Greig – Manager, Claims

Member Services and Case Management Staff

Ma'ata Touslee – Director of Health Services
Lisa Gable – Manager, Clinical Services
Mark Van Blaricum – Compliance Officer
Steve Cupp – Member Services Staff
Jenny Hainey – Manager, Quality Improvement
Chris Beurman – Manager – Community Relations
Greg Hanley – Manager – Health Improvement
Christy Roberts – Supervisor, Care Managers
Eyvette Corner – Customer Service Supervisor
Jackie Hodge – Customer Service Representative
Theresa Harvey – Customer Service Coordinator
Augusta Amadi – ER Care Manager
Melody Derks – Lead Care Manager
Sheryl Kennard – Pediatric Care Manager
Sydney Mackesty – OB Care Manager
Pam Runyon – asthma Health Coach
Renee Arensberg – Healthy Lifestyles Health Coach
Melody Martin – Accreditation Manager
Johanna Groves – Senior Quality Management Nurse

INTERVIEW QUESTIONS

The following are the interview questions used in the Administrative Interviews and the Member Services/Case Management Interviews at Children's Mercy Family Health Partners Health Plan:

Administrative Interviews

- Give examples of measures that the Health Plan implemented to improve follow-up process for members included in the State's Special Needs report.
- Please discuss the Smile Central program with Bridgeport Dental.
- How has the Health Plan expanded translation services during the past year? Have these efforts been effective? Give examples.
- What has the Health Plan learned from the Medical Home project regarding this practice in Missouri?
- Give examples of activities that the Health Plan has initiated to improve the number of specialists available to members
- What efforts have occurred to increase access to services in Polk and other smaller counties in the Region?
- The report discusses a large number of calls received regarding closed panels. What activities have occurred to remedy this issue?
- The Health Plan reported that it incorporated an ongoing lead screening outreach initiative into its daily practices. The original 2007 PIP indicated positive outcomes. The blood level testing in 2008 decreased. Has this problem been analyzed? What actions have occurred?
- What changes were made in the Health Plan's approach to member outreach educational activities in 2008?
- Describe any evidence that providers are conducting outreach to their patients who are not in compliance with preventive case or disease management guidelines.
- Discuss initiatives or other issues in the New Directions 2008 Work Plan.
- What was the outcome of office site reviews completed through the credentialing process in 2008? (We would like to see at least 2 delegation reports.)
- Discuss the findings of any Fraud and Abuse cases that were identified in 2008.
- The report discusses the PIP for improving Non-Emergency Transportation Services. What action occurred as the result of the most frequent grievance – provider no-shows?
- How do the Case Management and Utilization Review departments work together?
- What is your response to criticisms that CM is just another method of UR?
- What feedback has the Health Plan received from outreach activities?
- What was the outcome of the evaluation to partner with home health agencies in rural areas?
- CMFHP has had prescription drug coverage carved out of the service array for several years. How are issues, such as asthma and the overuse of rescue inhalers, tracked? How are problems in this area identified and tracked?
- Can the Health Plan provide a summary write-up of best practices?

Member Services/Case Management Staff Interviews

- Are you familiar with the results of the CAHPS surveys?
- Has the Health Plan made efforts to increase member satisfaction through the Member Services sections? Describe the efforts that have occurred during 2008.
- What actions are taken to assist members in finding PCP's in their geographic area? How often do members complain that all the PCP's they contact have closed panels?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Describe activities that have occurred during 2008 to improve the process of contacting and providing services to members included in the State's report of members with Special Healthcare Needs.
  -- What additional action is taken to identify members with special needs?
- How do the Case Management and Utilization Review departments work together?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members with mental health care needs.
- Discuss the Smile Central Project and any effects it has had on services to members.

FINDINGS

Enrollee Rights and Protections

The staff at Children's Mercy Family Health Partners (CMFHP) continue to exhibit a strong commitment to ensuring that member rights are protected. The Health Plan utilizes interpreter services, pre-translated written materials, including the Member Handbook and all brochures, and a variety of methods for those members who spoke a language other than English. The Health Plan provides alternatives to members who may have reading, vision, or hearing problems that enabled them to obtain required information about the Health Plan or the services they can expect to receive. Member Services staff set up alternatives for individuals with any barrier to obtaining services and work diligently to ensure that they receive necessary assistance. The Health Plan is using a new translation service called Propio. This agency provides more diversity, and also employs a linguist who assists in identifying which language and dialect a member may be speaking. In addition to Spanish, the Health Plan is finding increasing numbers of members who speak Vietnamese and Low German.

During the interview process the Case Managers and Member Services' staff interacted in a collaborative manner and exhibited comfort in working together to solve members' problems. One Member Services representative gave an example of receiving calls from new members

with complex problems. The representative referred the member for case management, but maintained contact and learned that the Case Manager had made a home visit to meet the member. The Member Services staff related that collaboration is not always apparent in written policy, but clearly exists in practice within the Health Plan.

Both Member Services and Case Management staff relate that they are aware of the results of the CAHPS survey. When informed of some of the results of the 2008 Survey, they made changes in the areas where member satisfaction decreased. The staff was included in an effort to create a plan for changing internal process to improve member perceptions. The Health Plan conducted a "post call survey" for members, and also initiated a random customer call-back program. The Member Services staff attended training on important basic issues, which they described as "reminding us why we are here." The Health Plan continues to document member needs, to conduct quality reviews and to seek measures to improve service. The staff believes there has been a positive impact from all of these efforts. The most recent post-call survey indicated a satisfaction rate of 94.7%.

Case and Care Managers discussed the differences in their roles. The two levels of service are virtually synonymous when accepting referrals for service. The staff shared information describing case management as open to all members. Any member exhibiting a need for assistance in negotiating the health care system is eligible for case management. One supervisor explained that the Health Plan is moving to a system with some differentiation in levels of service. Care and Case Managers will accept members based on their expressed or assessed needs. The Care Management staff will work with members who have more short term and manageable needs. Complex Case Managers and Disease Managers will work with members whose level of care is described as acute, or who have specific long-term diagnosis associated with their health issues.

The Case Managers explained that they receive both internal and external referrals. Referrals come from utilization review nurses, physicians' offices, the emergency room, members themselves, and internal sources. The staff explains that their current case management system provides an excellent source of electronic communication when a member is identified as having a problem resulting in a need for case management services.

Staff described a variety of services available through the Health Plan to enhance their availability to members. Several years ago the Health Plan initiated a cell phone program to improve communication with OB (obstetrics) Case Management. A cell phone is provided to OB Case Management members. These phones are preprogrammed with the Case Manager's number, the NICU, the Family Support Agency, and other agencies that are relevant to the member's needs. This service has been expanded to any case management member who does not have telephone access. These phones can be programmed so that the member can only make calls to the case manager, transportation services, the pharmacy, mental health, 911, WIC, and other agencies that may be pertinent to a member's specific service needs. Bills are then reviewed to ensure that members are making contacts appropriately.

Case managers reported that their case loads are adjusted based on an internally defined acuity level. OB case loads average in the forties (40). The case load may be slightly larger depending on the time of year, or the complexity of cases. Generally all other case managers carry a caseload of forty (40) to sixty (60). One level of case management pertains to Healthy Lifestyles. These members receive home visits from their care coordinators, who carry approximately thirty (30) cases each.

Case Managers reported that they review the SMA generated report regarding children with special health care needs monthly as it is received, and attempt to contact every member listed. In some cases they find the members are previously enrolled in case management. If they have difficulty locating the member, they pursue other methods of contact such as looking at hospital records and claims data. These members are offered case management services and do receive an assessment when located. The case managers report that the availability of the services is promoted in the Member Handbook and members do make contact as the result of this information.

The Health Plan continues to exhibit its strong commitment to the member advisory committee. During the 2007 review it was learned that the Health Plan has added consumer advocates as committee members to enhance community generated information. Membership now includes school nurses, social workers, Head Start teachers, and Parents as Teachers advocates. Quarterly meetings of this group are continuing and attendance has improved

significantly. Monthly meetings of the Consumer Advisor Meetings occur in Bolivar, Missouri to encourage participation in the expansion counties of the Western MoHealthNet Managed Care Region. Topics of these meetings included disease management programs and benefits. Information from the presentation was included in a member newsletter, at the recommendation of a committee member.

Children's Mercy Family Health Partners continues to participate in community events including back-to-school fairs, work with area churches, the Chamber of Commerce, and events targeting the Latino and African American communities. They work with two groups specifically, El Central and CoHo. A Latino staff member attends many of these events to ensure appropriate information is shared with members about access to care. One case manager described their relationship with members as "their advocate." The Health Plan and staff are involved in the community and a number of activities. An example was provided to illustrate how responsive the community has been to members. A care manager conducted an in-home assessment with a member. In addition to the medical interventions that were indicated, the care manager identified the need for a smoke alarm and a stair rail. Community agencies responded and installed both the smoke alarm and stair rail, and also replaced a door with peeling paint.

When a new referral is received it is reviewed within 48 hours. A review of utilization activity and claims activity is performed. A parent may be called for information and clarification if a child is involved. The case manager meets with the member, completes an assessment and formulates a treatment plan. Permission is obtained from parents when a care plan is written for a child. Case Managers are aware that a member may refuse these services. When this choice occurs, the case managers report that they work within the system to assist the member without direct contact being required.

Ratings for Compliance with Enrollee Rights and Protections (100%) reflected policy and procedures that were submitted and approved by the SMA for the third year in a row. All written information has been submitted and approved. All practice observed, as well as additional documentation viewed while on-site, indicated that the Health Plan is fully compliant in this area.

Table 58 – Subpart C: Enrollee Rights and Protections Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2006	2007	2008
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCO Protocols.

Behavioral Health

CMFHP began contracting with New Directions Behavioral Health (NDBH) for the provision of behavioral health services for members during 2007. The approach to Member Services and case management by the BHO is very supportive of members, accepting of the need to provide adequate services, and doing so in a timely manner. NDBH is known for providing in-home services, and for contracting with a local provider who provides intensive in-home treatment for members to ensure that the family has a full array of in-home services and supports. This service is extraordinary to those expected by the MO HealthNet Managed Care contract. These services are available to CMFHP members. The Case Managers described NDBH as an advocate for members. NDBH staff does serve on the Consumer Advisory Meetings.

Co-Case Management meetings with NDBH occur regularly. Currently the Health Plan and BHO are looking at a Depression Disease Management program and collaboration on training tools. The depression tool is utilized with members receiving OB and post partum care services. The Health Plan is also working with NDBH on engaging school nurses in making referrals if they suspect depression or other behavioral health issues.

The two agencies are exploring more effective ways to document services and progress with members. They are developing a plan to ensure that reports are received in a timely manner, and to improve the number of members who are effectively receiving 7-day follow-up after hospitalization.

Quality Assessment and Performance Improvement

Access Standards

CMFHP continued to have a strong provider network throughout the MO HealthNet Managed Care Region. The Health Plan has worked one-on-one with providers, including specialists who agreed to become panel members. The Health Plan recognizes a continued need for neurosurgeons and orthopedic surgeons. CMFHP continues to work with specialists who agreed to be in the network, but requested to remain silent and not be published in the Provider Manual. These providers saw members when contacted directly by Health Plan staff. CMFHP paid a higher fee to OB, orthopedic surgeons, urologists, and neurologists outside of their network to ensure adequate access to these specialties. CMFHP continues to monitor their PCP availability and continues recruitment to ensure that adequate open panels are available. They are actively recruiting and adding physicians in the Southwest area of the MoHealthNet Managed Care Region to ensure coverage in the expansion counties. The Health Plan currently has a provider representative who lives in the Joplin, Missouri area and who is actively working to add providers in this area. Providers are becoming more responsive and eager to become part of the Health Plan's network.

Member Services staff reports that they do receive calls requesting PCP changes. The Health Plan began tracking members who requested changes in PCPs, pharmacy data through Cyber Access, and emergency room utilization to identify if drug seeking was a contributor to this

problem. The monitoring produced some useful information. Several members chronically missed appointments and were asked to find a new physician. The Health Plan continues monitoring efforts to identify problems and to address them quickly and efficiently.

The Health Plan continues to use member surveys and on-site reviews to monitor access standards. When deficiencies were identified they were dealt with in writing. Direct provider contact occurred where required. Re-audits occurred to ensure that improvement was sustained.

Member Services staff reports that they assist members with a number of access issues. They supply information on available providers and their location. They instruct members on utilization of the handbook to identify providers, including those that speak other languages or provide special services. If a provider contract is terminated, members receive a letter. Follow-up by telephone occurs, particularly if a member's information indicates that they have literacy difficulties. Staff also discussed the efforts they make to assist member in obtaining copies of their medical records. If there is a problem with provider compliance, the Member Services staff intervenes, but also makes a referral to Provider Relations for follow-up. Member Services staff often keeps a member on the line, calls the PCP office to clarify member information, and directly assists the member in obtaining an appointment.

Case Managers also become involved in assisting members in accessing appropriate medical care. They ensure coordination of services, and ensure that all levels of health care required are available. The CMFHP case managers meet quarterly with BHO case managers to ensure that they are serving clients appropriately when they have multiple service needs. Case managers also receive a listing twice a year that identifies all members who have not seen their PCP in a year. Contact is made by letter, and additional outreach occurs to ensure that health care services are received, and to identify changes that may be needed.

CMFHP also reports that PCP offices are not conducting outreach to the extent that the Health Plan would prefer. They are considering the placement of care coordinators in offices to coordinate outreach, particularly to members who are not obtaining preventive services, EPSDT visits, and necessary immunizations.

Ratings for compliance with Access Standards (100%) reflected completion of all required written policies and procedures for the third year in a row. Observations and interviews that occurred during the on-site review provided additional evidence that Health Plan practices and operations appear to be compliant with the MO HealthNet Managed Care Contract and federal regulations.

Table 59 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2006	2007	2008
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCO) 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCO Protocols.

Structures and Operation Standards

CMFHP members have open access to specialists, with no referral from the PCP required. In some cases members receive assistance with referrals from the Health Plan's case managers. When a member has a specific problem, and care coordination is needed between clinicians, this service is provided by the appropriate case manager. The Health Plan continues the formal means of facilitating communication between PCPs and specialists initiated in 2006. They report that letters detailing the care provided flow between the two. Case managers facilitate this communication, with member approval, to ensure that pertinent information is shared.

CMFHP formed a committee during the 2007 to discuss the best methodology for making information about advance directives available to members. The goal was to have this information available at PCP offices. Education and materials were provided to PCPs on this topic. Two areas that remained problematic were accurate completion of all required documentation and proper recording in medical records. The Health Plan continues to work with PCP offices to improve these areas.

CMFHP credentialing policies were reviewed. NCQA standards are followed. Site visits and record keeping reviews are conducted on initial credentialing of PCPs and OB/GYNs. Re-credentialing is conducted every three years. Sanctions and quality are reviewed monthly. Credentialing policies and procedures were approved by the Health Plan oversight committee, and were approved by the SMA in June 2006. Information reviewed indicated that a delegated review of University Physicians Associated, Bridgeport Dental, Children's Hospital and Physicians, New Directions and HealthFirst were conducted in 2008 and all were found 100 percent compliant. All these policies and procedures were continued during 2008.

The Case Managers continued to participate in an OB forum that began several years ago. They report having three or four successful meetings with good information sharing between case management staff and physicians attending. The Case Managers attend a forum in St. Louis annually. This has been a helpful tool in expanding their knowledge about issues that confront members.

Member Services staff discussed their awareness of issues such as members requesting disenrollment. They do enter these requests into the Health Plan's system, and assist the member through the process. Reason codes are tracked and reviewed at Oversight Committee meetings. They also seek feedback from the SMA regard disenrollment information to ensure that adjustments and changes are made if a service delivery issue is the cause of these requests.

The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the third year. The Health Plan appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

Table 60 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2006	2007	2008
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

CMFHP continued to be an active member of the Kansas City Quality Improvement Consortium (KCQIC) and utilized the practice guidelines developed and supported by that group. The local guidelines that were used by the Health Plan continued to meet or exceed nationally accepted standards. The KCQIC has developed guidelines on obesity treatment. CMFHP is now using these guidelines. All clinical guidelines used are reviewed through Clinical Criteria Committee prior to implementation. The Health Plan utilizes Milliman Care Guidelines as a primary resource for pre-certifications, Utilization Review, and Care Management nurses for medical necessity determinations.

CMFHP continues to send providers a quarterly report card covering lead and EPSDT rates. This is used as an incentive to increase the screening rates. Solo-practice PCPs have the best rates in the Health Plan. They are reporting completion rates of 77%-84%. The Health Plan is discussing adding additional HEDIS components to the report card in the future.

CMFHP did submit two Performance Improvement Projects (PIPs) for validation. Specific details of these projects can be found in the appropriate section of the report. It was noted that the Health Plan utilized projects that had been started, and perfected these projects in an effort to create improved services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation.

The Health Plan submitted all required information to complete the Validation of Performance Measures, as requested. CMFHP continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The details of each of these areas of validation can be reviewed within specific sections of this report.

The Case Managers and Member Services staff report that the Health Plan's internal communication system is available so everyone has access to needed information. All of these staff can enter updates regarding members and send this information to Medical Management as necessary. They report that the system has been developed to be member focused and is very useful. They also report of new technology developed for the Health Plan's website. There is now an audio program available for members to obtain education regarding benefits.

Neither Case Managers nor Member Services staff report having involvement in this portion of Health Plan operations. They were asked if members ever requested practice guidelines. Both replied that they had not, but that if this occurred, or there was an identified need, this information would be shared with members.

Ratings for the Measurement and Improvement sections were found to be (100%), which reflects that all required policy and practice meets the requirements of the MO HealthNet Managed Care contract and the federal regulations for the third consecutive year.

Table 61 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2006	2007	2008
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of HEALTH PLAN Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCOs quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Ratings for compliance with the Grievance Systems regulations (100%) indicate that the Health Plan completed all requirements regarding policy and practice. This is the fifth consecutive year that the Health Plan is fully compliant in this section of the review.

Member Services staff was aware of the grievance process and related that they do provide assistance to members who contact them with concerns. When a member calls, the staff tries to assist them so they know what questions to ask, and how to get answers to these questions throughout the grievance process. If a member does not realize that their concern is a grievable issue, the staff advises them further on negotiating this system and the importance of filing a grievance.

Case Managers report that they become involved when members receive an adverse authorization decision. The case managers then refer the member to the Grievance/Appeal Department. Case managers are aware that the information is available in the Member Handbook, but assist members in any way that they can.

Table 62 – Subpart F: Grievance Systems Yearly Comparison (CMFHP)

Federal Regulation	MCP		
	2005	2006	2007
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	10	0	0
Rate Met	100%	100%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols

Conclusions

Children's Mercy Family Health Partners continues their strong commitment to meeting all policy, procedure, and practice areas of compliance with both the MO HealthNet Managed Care contract requirements and the federal regulations. The Health Plan exhibits a meticulous attention to meeting all the details of the regulations, submitting policy and procedural updates in a timely fashion, and utilizing the prior External Quality Reviews as a guideline for meeting required standards. The CMFHP staff exhibit a sincere commitment to excellence in serving MO HealthNet Managed Care members. They demonstrated respect and dignity toward members, while meeting their healthcare service needs efficiently and effectively. The Health Plan goes beyond the strict requirements of their contract to ensure that members are able to have a voice in the design of their healthcare system. The system created at CMFHP is responsive and strives to assist its members in overcoming the barriers often encountered in the areas of quality, access and timeliness of healthcare services.

Quality of Care

CMFHP has initiated a number of programs to ensure that members from the diverse population in their area have access to providers and information in their language and in a manner that is understandable to them. They work diligently to ensure that providers are serving members in a quality manner. The Health Plan monitors their service delivery system, including providers, regularly to produce quality services from the organization, and from the healthcare providers involved. CMFHP has demonstrated a number of creative approaches to engaging providers, particularly in hard-to-reach specializations. They actively engage new health management programs to benefit members. The Health Plan has a strong relationship with the community to obtain feedback on their programs and ensure that quality care and services are achieved.

ACCESS TO CARE

Children's Mercy Family Health Partners demonstrates its commitment to ensuring access to care for members throughout their organization. For example, their focus on development and utilization of a Member Advisory Committee in various areas of the region they serve to ensure that members have a forum to discuss access issues directly with the Health Plan. Their willingness to assist members' attendance, by creating reminders and providing transportation highlights this effort. The Health Plan demonstrates its sincerity in these efforts by implementing suggestions that come from these meetings. The Health Plan has also made many accommodations to ensure that members have access to the array of specialists they require to obtain quality healthcare services.

TIMELINESS OF CARE

The Health Plan has ensured that the treatment of members and providers during the grievance and appeal process is of primary importance. They examine the reasons for grievances and appeals to ensure that their processes are not causing a problem. If this is the case, the Health Plan is willing to take steps to rectify the problem, thus ensuring that timely care takes place for members. CMFHP continues their vigilant attention to continuous improvement within the organization and attention to improving services to members.

RECOMMENDATIONS

1. Continue to develop an organization that can exhibit energy and enthusiasm for its mission.
2. Continue to actively monitor providers and subcontractors and to develop corrective action initiatives when a problem is identified, such as advance directive utilization.
3. Continue to look for creative methods to use as motivators, such as available incentives, to encourage member utilization of Health Plan resources, particularly for high-risk populations.
4. Continue to ensure that Member Services staff and Case Management staff are integral members of the Health Plan team, as they are most keenly aware of member needs, and difficulties in obtaining appropriate health services.

5. Continue monitoring CAHPS and other consumer satisfaction surveys and responding to results with internal corrective action.
6. Work with New Directions Behavioral Health to ensure that documentation of services occurs in a timely manner that clearly reflects all members interventions.

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8.0 Harmony Health Plan of Missouri

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8.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Harmony Health Plan supplied the following documentation for review:

- Performance Improvement Project 2007: Lead Screening
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Harmony Health Plan

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 7, 2009 during the on-site review, and included the following:

Dr. Tammaji Kulkarni – Medical Director
Terri Pokraka – Senior Quality Analyst
Lisa Wieda – Missouri Quality Analyst
Danny Sharpe – Manager, Data Warehouse
Sharon Nisbet – Senior Director, Quality Improvement

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the Project Leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What was the intervention?
- What was the time period of the study?
- Was the intervention effective?
- What does Harmony Health Plan want to study or learn from their PIPs?

The PIPs submitted for validation included a substantive amount of information. Additional analysis occurred between the time of the original submission of information and the time of the on-site review. The Health Plan was instructed that they could submit additional information that included enhanced outcomes of the intervention. Additional clarifying written information was received after the on-site review.

FINDINGS

The first PIP evaluated was titled "Lead Screening Performance Improvement Project." This study was considered clinical and focused on improving the rates of lead screening for young children ages 0 - 2. The project narrative clearly identified how complying with screening requirements is associated with enhanced preventive services and improved healthcare outcomes. The decision to enact this study was well defined and supported by both state and national data sources. The information presented was based on a substantial literature review that compared both national and regional standards. This review and analysis provided a substantial argument for the topic choice, and also for the interventions identified. The approach to this Performance Improvement Project was not just to present a clinical study, but to implement successful interventions to improve health care service to members with the overarching goal of improving health outcomes for the children affected.

The study question presented was "Will targeted Health Plan interventions for members and providers increase the rates of lead testing in members reaching their second birthday and meeting the HEDIS study population description for Lead Screening in Children?" The question framed the content and intention of this study. Indicators for this study were included and defined with substantive information about how they were to be counted and analyzed. The indicators did include quantifiable information. The information provided clearly led the reader to understand that the focus of the study is to improve compliance with recommended lead screening guidelines in an effort to improving health outcomes for children. The population served by this study includes all members' children in the age range and does not exclude any member with special health care needs.

The data collection methodology was included. Data will be obtained from programmed pulls from claims and encounter files. Data sources were described. There were questions about validating the reliability of the data, based on a lack of information provided. These planned pulls are to occur one time per year. The enhanced information provided did attempt to describe some information relating to a study design. However, the narrative did not include sufficient detail to ensure that there is confidence in the plan and the process. The additional information does supply information on the data collection process and accurate data collection over time. A prospective data analysis plan was not specifically included, but could be inferred in the additional information received. Additional detail would be helpful in this aspect of the project.

A description of the planned interventions was included for the 2008 project year, and also enhanced interventions to be implemented during 2009. The interventions planned are focused on education of members through articles and children's community events. The Health Plan also initiated interview sessions with staff. The focus of the project is to work with providers and their staff, community groups, and parents of members that have not reached their second birthday and are still in need of lead screening. How the various interventions will impact member behavior is not defined. There are a large number and a vast array of interventions listed. It will be difficult to evaluate which intervention had the most significant impact on member behavior. Barriers and other issues that may affect outcomes were identified and discussed, particularly in how they impact member behavior.

The desired outcomes and the evaluation process were included. The narrative included the baseline data and one year of re-measurement. The ultimate goal of the proposed interventions was detailed in the information submitted. The project has reached a level of maturity that enables initial evaluation of its success at this point. The Health Plan did present data that indicated success in the first re-measurement year. The narrative did not include an assessment of the impact on the interventions on the success achieved.

The second PIP evaluated was the Harmony Health Plan individualized approach to the Statewide PIP "Improving Adolescent Well Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The rationale presented was thorough and clearly based on the need to enhance the approach to improving adolescent well care on a statewide

basis. The Harmony Health Plan project cited their need for improvement on this measure, but did not elaborate on the rationale for individualizing their approach based on specific member needs.

The study question presented was: "Will a focused effort, with Health Plan specific interventions, improve the HEDIS rate of adolescent well care?" The study question was clear, concise and measureable. It did focus on improving the HEDIS measure and provided no argument for improving the availability of preventive services or health care for members. The primary indicator for adolescent well care is the HEDIS measure. The technical specifications defining the measure and its calculation were included. The Health Plan did include its 2007 HEDIS rate of 21.61% with the observation that this was 13.39 percentage points below the NCQA 25th percentile. They did not identify an actual goal for improvement. The study population included all members ages 12 – 21 years of age, with no exclusions based on special health care needs.

The study design is based on the information provided in the Statewide Combined Report. It specified that administrative data will be used to calculate the Health Plan rate for adolescent well care. The Health Plan did not describe their NCQA certified software, or specifics based on internal planning within the organization. The Health Plan indicated that they began enrolling members in June 2006 and that HEDIS 2008, which is data from calendar year 2007, was their first reportable year. They did not distinguish any difference from the information included in the Statewide Report. Reference is made to yearly comparisons to identify statistically significant increased from the previous year and from the baseline. However, there is no indication of the instruments used in this determination or of an actual prospective data analysis plan.

The Health Plan included an extensive list of interventions to be implemented. The 2008 interventions included:

Member Level

- Educational article on Well Child Visits for member newsletter
- Participation in two Health Kids Club events providing age specific information to members and their families

Community Level

- Increasing awareness of the importance of adolescent well child visits at community events. The Quality Improvement Nurses participated in four community events providing one on one assistance and education to stress the importance of well child visits in all age groups including adolescents

Provider Level

- Educational articles in Providers' Newsletter and Health Service Newsletter with education on components of a well child visit and also capturing missed opportunities
- Over 350 provider and provider office staff educational site visits that included information on adolescent well child visits, documentation tools, billing methodologies, parental and adolescent education, components of a well child visit occurred. Ongoing education on EPSDT at provider visits incorporating AWC components
- Introduction of a Pay for Quality Program (June 2008) rewarding providers with greater than fifty (50) members and group practices with greater than one hundred (100) members that reach NCQA HEDIS AWC benchmarks. Many providers have increased their outreach to non-compliant members as a result of this program.

The information submitted did included new interventions for the on-going project for 2009.

There is a data analysis plan incorporated into this section of the report. Actual data analysis has not yet occurred. If this plan is followed there is potential to produce successful results for the interventions underway. Harmony Health Plan considers 2008 their first reportable year for HEDIS data. They did conduct a barrier analysis and reflected this in the interventions chosen. The Health Plan's membership has expanded, as have the counties where their members reside. They are broadening their focus to reflect their new and additional population. The data to be collected was defined in the narrative. The Health Plan recognized that they did have baseline data and one re-measurement year. There was no interpretation of the results in the documentation provided. The Health Plan did not include any observations regarding the effectiveness of the interventions employed. Due to the number and array of interventions, it is difficult to speculate on what may be the most effective, if improvements are noted.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The non-clinical PIP did have the stated focus of improving the Health Plan's HEDIS rates. However, if the interventions are effective, this will improve the health care provided to their adolescent members, as well. The interventions described in the clinical PIP are clearly targeted to improve the quality and effectiveness of preventive services for children improving health care outcomes. By educating providers and members in accessing available and appropriate lead screening services, the Health Plan will ensure that preventive and the most effective services will be in place.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members who were eligible for lead screening received these services in an efficient manner. By undertaking the methodology involved in the Performance Improvement Project the access to care will enhance the members' ability to appropriately utilize these services. The non-clinical PIP also included the theory that by educating members, the community, and providers better health care will be available to the adolescent member population. The narrative did make the case of ensuring that this goal was addressed through the PIP process.

TIMELINESS OF CARE

The services and interventions used in the clinical PIP did have the specific outcome of improving the timeliness of appropriate preventive services for children. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcome was focused on improving the availability and awareness of the need for services so they would be received in a timely manner. The non-clinical PIP considered timeliness in looking at timely well care visits for adolescent members. The narrative provided included limited discussion about how these interventions would improve timely services to members. It should be noted that timely access to care was a stated and implied goal of both projects.

RECOMMENDATIONS

1. Harmony Health Plan has attempted to improve the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The focus on improving services to members through the PIP process needs to be reflected in the outcome of these studies to ensure that these goals are met in and efficient and effective manner.

2. The Health Plan should explicitly address how their projects are extended to and pertinent to the entire MO HealthNet Region served.

3. The Health Plan should indicate how these activities will be incorporated into regular agency processes if they indicate success. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.

4. The Health Plan should include an assessment of how the interventions used in their PIPs contributed to their success.

8.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Harmony Health Plan. Harmony Health Plan submitted the requested documents on January 21, 2009. The EQRO reviewed documentation between January 21, 2009 and June 30, 2009. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Harmony Health Plan for the HEDIS 2008 data reporting year
- HealthCareData Company's NCQA HEDIS Compliance Audit Report for HEDIS 2008
- Harmony Health Plan's information systems (IS) Policies and Procedures pertaining to HEDIS 2008 rate calculation
- Harmony Health Plan's information services (IS) policies on disaster recovery
- Harmony Health Plan's HEDIS committee agendas for 2008
- Harmony Health Plan's HEDIS 2008 Training Manual for the medical record review process
- Appendix Z – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

The following are the data files submitted by Harmony Health Plan for review by the EQRO:

- WellCare_ADV_File1.txt
- WellCare_ADV_File2.txt
- WellCare_AWC_File1.txt
- WellCare_AWC_File2.txt
- WellCare_AWC_File3.txt

INTERVIEWS

The EQRO conducted on-site interviews with Sharon Nisbet, Sr. Director, Quality Improvement; Danny Sharpe, Manager, Data Warehouse; and Esther Morales, VP UM and Operations at the Harmony Health Plan in St. Louis, MO on Wednesday, July 8, 2009. This group was responsible for calculating the HEDIS performance measures. The objective of the visit was to verify the data, methods and processes behind the calculation of the three HEDIS 2008 performance measures.

FINDINGS

The Administrative Method of calculation was used by Harmony Health Plan for the Use of Appropriate Medications for People With Asthma and Annual Dental Visit measures. The Hybrid Method was used for the calculation of the Adolescent Well-Care Visit measure. MO HealthNet MCHP to MCHP comparisons of the rates of Use of Appropriate Medications for People With Asthma, Adolescent Well-Care Visits, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) were reported.

Harmony Health Plan's reported rate for the HEDIS 2008 Adolescent Well-Care Visit reported to the SMA and the State Public Health Agency (SPHA) was 25.06%. This was significantly lower than the statewide rate for MO HealthNet Managed Care health plans (38.59%; $z = -1.52$ 95% CI: 18.53%, 31.60%; $p < .05$).

The reported rate for Harmony Health Plan for the 2008 HEDIS measure Use of Appropriate Medications for People With Asthma was 0%. The measure was reported in compliance with regulations, but no members currently were eligible for inclusion in this calculation.

The HEDIS 2008 combined rate for Annual Dental Visits reported by Harmony Health Plan was 16.94%, which is significantly lower than the statewide rate for MO HealthNet Managed Care health plans (34.71%, $z = -1.74$; 95% CI: 10.70%, 23.18%; $p < .05$).

Harmony Health Plan of Missouri is a relatively new MO HealthNet Managed Care health plan, so there is no data from previous EQR reports with which to compare the rates at this time.

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of MedMeasures software system. The accompanying MedCapture system was also demonstrated; this system allows for the calculation of the Hybrid hits from the input medical record data.

For all three measures, Harmony Health Plan was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which they transferred data into the repository used for calculating the HEDIS 2008 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate (See Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Harmony Health Plan met all criteria applicable for all three measures. Harmony Health Plan does utilize statistical testing and comparison of rates from year to year.

PROCESSES USED TO PRODUCE DENOMINATORS

Harmony Health Plan met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of eligible members for the services being measured. For the Use of Appropriate Medications for People With Asthma, no members were identified as eligible; therefore, no members were validated by the EQRO. For the denominator of the Adolescent Well-Care Visits measure a sample of 411 eligible members were reported and validated. The Annual Dental Visit denominator included 1.582 reported and EQRO-validated eligible members. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2008 criteria.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, medication dispensing events, and dental visits) as specified by the HEDIS 2008 criteria (see Attachment XIII: Numerator Validation Findings). A medical record review was conducted for the Adolescent Well-Care Visit measure.

For the Adolescent Well-Care Visit measure, Harmony Health Plan reported 92 administrative hits from the sample of the eligible population; the EQRO's validation of the data yielded 102 hits. For the medical record review validation, the EQRO requested 11 records. A total of 11 records were received for review, and all 11 of those were validated as hits by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 27.49%, while the plan reported a total rate of 25.06%. This represents a bias of 2.43%, an underestimate by the health plan.

For the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure, the health plan reported no hits, as there were no members identified in the eligible popluation. Therefore, the EQRO did not receive any data to validate.

For the HEDIS 2008 Annual Dental Visit measure, the EQRO validated 270 hits from administrative data, while 268 were reported. The health plan's reported rate was 16.94% and the EQRO validated rate was 17.07%, resulting in a bias (underestimate by the health plan) of 0.13%.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Harmony Health Plan submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following table shows the estimated bias and the direction of bias found by the EQRO. The Adolescent Well-Care Visits and Annual Dental Visit measures were slightly underestimated, but these results still fell within the 95% confidence interval reported by the health plan for these measures. There was no calculation of bias performed for the Use of Appropriate Medications for People With Asthma measure, as the health plan did not have any eligible members for this audit period.

Table 63 - Estimate of Bias in Reporting of Harmony HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	2.43%	Underestimate
Annual Dental Visit	0.13%	Underestimate
Use of Appropriate Medications for People With Asthma	N/A	N/A

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet. Table 57 shows the final audit findings for each measure. The Use of Appropriate Medications for People With Asthma measure was found to be Not Applicable by definition, as there were no eligible members identified. The Adolescent Well-Care Visits and Annual Dental Visit measures were Substantially Compliant.

Table 64 - Final Audit Rating for Harmony Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Annual Dental Visit	Substantially Compliant
Use of Appropriate Medications for People With Asthma	Not Applicable

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Two rates were validated for the health plan; the third measure did not have a reported rate. Both of these rates were significantly lower than the average for all MO HealthNet Managed Care health plans.

QUALITY OF CARE

There were no comparison calculations performed for Harmony Health Plan for the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure. The measure was not applicable, as no members were identified in the eligible population. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. However, no conclusions can be drawn at this time regarding the quality of care received by Harmony Health Plan' members based upon this measure.

ACCESS TO CARE

The calculated rate by Harmony Health Plan for the HEDIS 2008 Annual Dental Visit rate was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The health plan's reported rate for this measure was significantly lower than the average for all MO HealthNet Managed Care health plans. Harmony members are receiving a quality of care that is lower than the level of care delivered to the average MO HealthNet Managed Care member. This rate is also lower than the National Medicaid Average, indicating the health plan's members receive a lower access to care than the average Medicaid member nationwide.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2008 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was significantly lower than the overall MO HealthNet Managed Care health plans calculated rate. Harmony Health Plan' members are receiving the timeliness of care for this measure at a lower level than the care delivered to all other MO HealthNet Managed Care members. This rate was lower than both the National Commercial Rate and the National Medicaid Rate, indicating that Harmony Health Plan' members are receiving the timeliness of care for this measure at a lower level than the average Commercial or Medicaid member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. Both of the rates validated for this health plan were significantly lower than the MO HealthNet averages. The EQRO recommends that the health plan focus on these rates to reverse this trend.
2. Both of the rates validated for this health plan showed biases of underestimation. The EQRO recommends that the health plan review their data collection, integration, and measure calculation practices to help alleviate this issue.
3. Continue to conduct and document statistical comparisons on rates from year to year.
4. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.

8.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

Harmony Health Plan of Missouri only had 14,929 encounters in the State extract file supplied to the EQR. These paid encounters were all Pharmacy claims.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Pharmacy claim type, there were 14,929 claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All critical fields examined were 100.00% complete, accurate and valid data for all fields examined.

For the Medical, Hospital, Dental, Home Health, and Inpatient claim types, there were zero (0) encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Harmony Health Plan of Missouri , an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. All critical fields were 100.00%.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Harmony Health Plan of Missouri demonstrated rates statistically lower than the average for all MO HealthNet Managed Care health plans for all claim types, except Pharmacy, the Pharmacy rates were comparably to the average of all MO HealthNet Managed Care health plans. This was the second year that Harmony participated in the EQR and they had some issues with compatibility between their encounter claims system and that of the SMA.

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each health plan were randomly selected from all Outpatient claim types for the period July 1, 2008 through September 30, 2008 for medical record review. Harmony did not have any claims in the Outpatient file, therefore no records were reviewed.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Harmony Health Plan included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan. No "unpaid" claims were submitted by Harmony.

CONCLUSIONS

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of all claim types submitted resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.

AREAS FOR IMPROVEMENT

1. The rate for five of the six encounter claim types was significantly lower than the average for all MO HealthNet Managed Care health plans.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the UB-92 file layout for the Outpatient Procedure Code and Discharge Date fields
2. Run validity checks after the programming of new edits.
3. Continue to work with the SMA to resolve the compatibility issues between the Encounter claims system so that the MCHP can submit and be paid for all member encounters.

8.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Harmony Health Plan is in its third year of operation as a MO HealthNet Managed Care Health Plan. It began operations in the State of Missouri, upon receiving a contract with the MO HealthNet Division (MHD) on July 1, 2006. A full compliance audit was not conducted on Harmony Health Care in 2006. During 2007 and 2008 the Health Plan did submit policy and procedures for review by the State Medicaid Agency (SMA). Prior to the 2008 External Quality Review (EQR) site visit, documentation was received and reviewed regarding the Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MHD. On-site review time was used to conduct interviews with the Member Services and Case Management staff, and with the Administrative staff to ensure that the practices that are in place are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to review policy compliance by the Health Plan. Additional document review, including reading and evaluating the Health Plan's Managed Care Annual Evaluation, occurred prior to the on-site review. The Health Plan assisted the on-site review team by providing additional documents at the time of the on-site visit.

On-site review time was used to complete the document review process and to conduct interviews with Member Services' staff and supervisors and with Case Management staff and supervisors. This approach was utilized to validate that practices occurring while serving members were in compliance with policy requirements are conducted in a manner that meets or exceeds State requirements and federal regulations. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of Quality Standards, and to validate information received from the direct services staff.

A detailed interview tool, individualized for Member Services and Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an individualized interview tool was constructed for administrative staff to validate and clarify these practices, to follow-up on questions raised from the direct staff interviews, and to respond to questions arising from the document review. This interview tool was constructed using Harmony Health Plan of Missouri's Annual Quality Report, and the SMA's Quality Improvement Strategy.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- 2008 Harmony Health Plan of Missouri's Managed Care Annual Evaluation

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2008 Marketing Plan and Materials
- 2008 Case Management and Member Services Training Modules
- Staff Training Logs
- Case Management Policies
- 2007 – 2008 Quality Improvement Program Evaluation
- Prior Authorization Policy
- 2008 Quality Improvement Committee Minutes

Additional documentation made available by Harmony Health Plan included:

- Marketing Plan and Educational Material Development Policy
- Harmony Care Organizational Chart

Interviews

Interviews were conducted on-site at Harmony Health of Missouri's St. Louis offices on July 7, 2009 with the following group:

Plan Administration

Dr. Tammaji Kulkarni – Medical Director
Tina Gallagher – Health Plan Administrator
Carol Ouimet – Manager, Regulatory Affairs
Sharon Nisbet
Tom Clegg
Gracy Diaz
Dania Neal
Nancy Westbrook
Janet Green
Francoise Culley-Trotman
Lori Dunne
Terri Pokraka, Senior QI Analyst
Lisa Wieda, Missouri QI Analyst
Steve Aguirre – Director, Operations
Brian Gibson – Manager, Case Management

Member Services Staff
Steve Aguirre – Director, Operations
Kendra Graham (T)
Bill Gaither – Document Control Specialist
Carol Ouimet – Manager, Regulatory Affairs
Jason Bollent (T) – Sr. Manager, Medicaid Customer Services
Cary Izquierda – Customer Services Staff
Grise Gallegas – Customer Services Staff

Case Management Staff
Brian Gibson – Manager, Case Management
Kevin Cassidy (T) – Case Manager
Robin Clark (T) – Case Manager
Carolyn Mather (T) – Case Manager
Jeff McCann (T) – Case Manager
Leslie Reseman (T) – Case Manager
Doug Quinto (T) – Case Manager
Heather Scalia – Director, Utilization Management and Quality Improvement

INTERVIEW QUESTIONS

The following are the interview questions used during each interview at Harmony Health Plan of Missouri:

Administrative Interviews

- How does Harmony track the ethnicity of members?
  - How do you deal with members who have alternate language needs, or visual/hearing difficulties?
- What issues have the Health Plan identified causing members to opt out?
- Give examples of any measures the Health Plan implemented to improve the follow-up process for members included in the State's Special Needs report.
- Utilization Management: What additional studies or changes have been recommended in the past year to improve the UM and UM reports?
  - How have these reports enhanced UM capabilities?
- What were the results of Provider CAHPS to improve after-hours availability and provider closed panels?
  - Describe the results of the Health Plan initiatives to improve consumers' access to providers.
- What actions has the Health Plan taken to improve the accuracy of claims and encounter data?
- Give examples of activities that the Health Plan has initiated to improve the numbers of grievances/appeals, and the process, during 2008.
- The report information presented a pie-chart representing grievance from July 2007 to August 2008. The largest percentage is grievances/appeals from PCP/Specialists. Please elaborate of the reasons for these grievances/appeals.
- What corrective actions have been taken to correct this problem?
- Describe any evidence that providers are conducting outreach to their patients who are not in compliance with preventive case or disease management guidelines.
- Have any additional provider-types been added to the provider profiling initiative?
- Elaborate and give examples of the activities of the Consumer Advisory Work Group during 2008.
- What was the outcome of office site reviews completed through the credentialing process in 2008?
- Describe the standards used by the Health Plan for credentialing/recredentialing and delegated oversight. (The Annual Report mentions URAC, but it does not state that these are the standards utilized by Harmony Health Plan of Missouri.)
- Discuss the findings of any cases of Fraud and Abuse that were identified in 2008.
- Describe efforts taken during 2008 to improve the 7 and 30-day follow-up after hospitalization for mental/behavioral health disorders.
- Has the Health Plan undertaken initiatives to reduce the number of mental/behavioral health practitioners in the outlying counties?
  - Give examples of these initiatives.
- How do the Case Management and Utilization Review departments work together?
- What is your response to criticisms that Case Management is just another method of Utilization Management?

- Has the Pay for Quality approach been implemented for providers? What outcomes are related to this program?
- What feedback has the Health Plan received from outreach activities?
    - What feedback has the Health Plan received from coordination with school nurses?

Member Services/Case Management Staff Interviews

- Are you familiar with the results of the CAHPS surveys?
- Are you aware of the Health Plan's efforts to increase member satisfaction through the Members Services sections? Describe the efforts that have occurred during 2008.
- What actions are taken to assist members in finding PCP's in their geographic area? How often do members complain that all the PCP's they contact have closed panels?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Describe activities that have occurred during 2008 to improve the process of contacting and providing services to members included in the State's report of members with Special Healthcare Needs.
- What additional action is taken to identify members with special needs?
- How do the Case Management and Utilization Review departments work together?
- Describe any efforts that have taken place to improve members' receiving 7 & 30-day follow-up after hospitalization for mental/behavioral health issues.
- Have any activities occurred to reduce the readmission rate for persons with mental health conditions?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members in general, and specifically members with mental health care needs.
- Are you aware of initiatives to work more closely with school nurses? What have the outcomes been?
- Give examples of activities that have occurred to encourage members to take advantage of the service of applying dental sealants and varnish for children.

After the document review some additional questions were posed regarding the training process for both case managers and member services, and the use of practice guidelines.

FINDINGS

Enrollee Rights and Protections

Harmony Health Plan of Missouri is a part of WellCare Health Plans, Inc., due to a corporate merger that occurred in 2004. Harmony has been providing Medicaid Managed Care Services in states other than Missouri for a number of years. The behavioral health organization providing services is another WellCare subsidiary, Harmony Mental Health. This group assumed responsibility for providing behavioral health services on September 1, 2007 and is reported to be working satisfactorily. However, the Health Plan did report that Harmony Mental Health has been purchased by Magellan, Inc. and services will change in the future.

The Health Plan reported having approximately 13,000 members at the time of the on-site review. The predominant Health Plan population continues to be pregnant women according to Harmony data. The majority of members reside in St. Louis City and County, but their member population and their provider network is expanding to all of the counties in their service area. The Health Plan is striving to upgrade their service delivery system and to ensure that staff and programs provide quality care for their members. The Health Plan reports that they track the ethnicity of members through use of the enrollment questionnaires, from questions asked during Welcome Calls, and other personal contacts made with members. They utilize the TTY-TDD lines available through AT&T when they learn that a member is more comfortable communicating in a language other than English. Harmony does employ staff with different language capabilities, but they use all the tools available, such as the AT&T capabilities to ensure that language needs are met. Harmony staff participated in cultural sensitivity training during 2008. The Health Plan believes they are able to deal effectively and efficiently with language and alternative reading issues that they may encounter with a member.

The Health Plan medical director, Dr. Tammaji Kulkarni, MD, is an active member of the Health Plan team. He shared that the Health Plan strives to promote a culture of compliance. It is the Harmony Health Plan's goal to improve community partnerships, to enhance staff engagement, and to lay ground work for future growth. One opportunity the Health Plan has employed is the use of the Medical Advisory Committee. This Committee provides oversight of Customer Service Initiatives, such as the development and use of the Customer Satisfaction Survey. During 2008 the Health Plan asked members questions, such as their most difficult challenge in obtaining health services. They also asked "What is the best way to get access to PCP's?" They

learned that members often experience roadblocks when they contact physicians directly. The Health Plan learned that there are often communication barriers, such as the member being refused after stating that they have "Medicaid" coverage. When the PCP's office learns that they have Harmony Health Plan coverage they begin providing services to members. The Medical Advisory Committee reports its findings to the Physicians' Committee, which has led them to believe there continues to be a need for outreach and provider education.

The Health Plan continues to operate a Consumer Advisory Work Group. This Group reviewed the information provided by the Customer Satisfaction Survey. They assisted in developing training topics for the Customer Service Representatives, including Empathy Training. One of the specific initiatives during the past year included intervening when members' telephone calls are cut off. The Health Plan is now using caller identification, and returning the call to the member so they do not have to negotiate the answering system to speak to their original Customer Service Representative. This initiative reduces complications for members and reduces member wait time when calling the Health Plan. This Group also recommended that the Customer Service Staff contact physicians for members when they are struggling to obtain a timely appointment. The Customer Service Representatives report that they are now calling offices for members when there is a perceived problem and are obtaining appointments for members.

The Health Plan has Member Services staff that is assigned to their Missouri population. These staff members are based in Chicago, Illinois. They have back-up staff available from the Illinois and Kentucky programs, which have been trained on the MO HealthNet Managed Care program. Harmony nursing staff, as well as their Pharmacy Director, has met with physicians in Missouri. During these visits they promoted the EPSDT program and encouraged the completion of screenings, and assessments to assist in the identification of members with special health care needs.

The Case Management Team is located at the Health Plan facility in Tampa, Florida. Case Management specialties include lead, special health care needs, and intensive case management. Members receive case management at their request or if referred by a provider, hospital staff, or from the information listing received from the SMA. There is one case manager located in the Missouri offices of the Health Plan who does make community and direct member contact when a member's situation dictates this level of intervention.

Member Services staff related that calls received in their department were often for PCP changes. They have specific policies and procedures in place for handling PCP changes. When a member calls, the Member Services staff helps them locate a PCP in their area using zip codes. The Member Services staff often calls the new PCP directly to ensure that the member is accepted and can get an appointment. Member Services staff state that they experience a lot of member frustration because the PCP office does not understand the differences between "Medicaid" eligibility and Health Plan Membership. The Member Services staff state that they periodically get calls from members complaining about a desired PCP who has a closed panel. In these cases the Member Services staff member attempts to assist the member in finding an acceptable alternative that is geographically convenient.

Member Services and Case Management staff were asked if they were familiar with the results of the CAHPS survey. The Case Managers were aware of the survey and some of the results. They did relate that the Quality Department analyzes the results and suggests areas of improvement. The CAHPS survey was one of the motivators for the Health Plan to develop their own Member Satisfaction Survey. This tool provides quicker access to information and feedback on their work and their internal processes. The survey is given to all members discharged from case management. If the survey is not returned, the Health Plan continues to attempt to contact the member to obtain feedback. Improvements in the Care Coordination process are an example of changes resulting from survey feedback.

Case Managers receive referrals from internal and external sources. They complete an assessment on each member referred. Contact information remains the most significant barrier to timely and effective member engagement. Most member contact with case managers is by telephone. The Case Managers discussed the importance of gaining and maintaining contact with members who are considered as High Risk/Obstetrics (OB) patients. The Case Manager

ensures that the member is obtaining services and that a care plan is in place. The Case Managers state that they communicate with other members of the Health Plan staff, such as concurrent review nurses, primarily when they are a referral source. They are not limited in their work by the utilization review process. The OB Case Managers work with the member and provide follow-up to make appointments, arrange transportation, refer to the Women, Infants, and Children (WIC) program, and to enroll them in the Harmony HUGS program.

The Case Managers relate that their primary focus is obtaining new referrals and contacting and engaging the member. They receive referrals from physicians, clinics, FQHCs, concurrent review nurses, Member Services staff, and members themselves. They provided several concrete examples of their activities with members.

In one case a pregnant member had chronic renal disease. The Case Manager coordinated services with the specialists involved to ensure that the member had all necessary appointments and services. The member also obtained counseling, and needed family support to make informed decisions about her pregnancy. The Harmony staff believed that the level of Case Management services allowed the member to get the type of health care services she required in a very difficult situation.

Another example included a pregnant member who was enrolled in methadone treatment to overcome her heroine addiction. This member received obstetric services, behavioral health services, and addiction treatment. All service providers, including the case manager, maintained contact with one another to coordinate services and to locate the member whenever necessary.

The Case Managers explained that most of their cases, when not pregnancy related, are open to assist members with chronic illnesses, such as childhood diabetes. They contact and coordinate services with the physician, and they ensure that parents have needed education. They may have to contact schools, make doctor's appointments, and engage in a variety of services to ensure proper care and service coordination. If a member's illness is under control they may be referred to disease management for long term interventions.

Harmony does have an active Obstetrics Program for pregnant women. They send out OB notification forms, conduct direct member outreach, and complete a thorough needs

assessment. Home visits occur for members identified as high risk. The Health Plan reports that it makes an immediate referral for behavioral health services when a need is assessed, and also makes referrals for postpartum support. The Harmony network does include Peoples Clinic and Grace Hill, two St. Louis area Federally Qualified Health Centers (FQHCs). The Health Plan regards their relationship with the FQHCs as vital to ensuring adequate access to care for members. Provider Representatives conduct monthly visits to the FQHCs to maintain this resource.

Harmony Health Plan has developed a system where they provide lists to PCPs and Provider Groups of members who are not compliant with EPSDT examinations and/or immunizations. Providers are requested to ensure that records are up-to-date. They are asked if examinations or immunizations have occurred, if they are aware of updated contact information, and if they have contacted the member regarding preventive health needs. The FQHCs also participate in this process. The providers are approached about the need to contact members to encourage them to obtain these services. In some instances nurses from the Health Plan meet with providers one-on-one to educate them regarding participation in actively providing preventive health care services.

The Health Plan states that they have had some problems in the past with the Case Management and Utilization Review departments being too interconnected. They believe they have actively worked to empower Case Managers to make member focused decisions, while working collaboratively with UR nurses when appropriate. The two departments' communications have improved with the implementation of the EMMA case management system.

The rating for Enrollee Rights and Protections (69.2%) reflects a lack of complete and approved policy and procedures. It is to be noted that this is the Health Plan's second full compliance review. They have submitted policy to the SMA who reports that completing the approval process has been difficult. The Health Plan had not established tracking and internal processes to ensure responses to the SMA and completion of all required policy, at the time of the on-site review. Harmony Health Plan exhibited a businesslike approach and commitment to continue their efforts to improve in the area of policy submission and completion. They state the goal of partnering with the SMA to ensure compliance with the State contract and with all required federal regulations.

Table 65 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
	2007	2008
438.100(a) Enrollee Rights: General Rule	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	1	1
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	0	0
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	1
438.100(b)(3) Right to Services	1	1
438.100(d) Compliance with Other Federal/State Laws	2	2
Number Met	9	9
Number Partially Met	3	3
Number Not Met	1	1
Rate Met	69.2%	69.2%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Quality Assessment and Performance Improvement

Access Standards

Harmony Health Plan of Missouri continues to make an effort to improve in the area of access standards. The Health Plan has submitted policies and procedures to the SMA for annual review as required. They are actively working to increase their provider panel throughout the MO HealthNet Managed Care Eastern Region, including active recruitment in the expansion counties. They reported that they are meeting the number of providers needed in Lincoln County at 95%, according to the Department of Insurance data. The Behavioral Health Provider Network has increased significantly in both Lincoln and Perry counties.

The Administrative staff reports that they analyzed the results of their most recent CAHPS survey to identify needs, and recruiting providers and urgent care centers with after-hours access became a primary concern. The physicians were contacted regarding their contractual requirements to provide after-hour access to services. A number of physician groups hired additional doctors. Additionally, the Health Plan was able to contract with urgent care centers that provide after-hours access to care. Educational counseling was also conducted with PCPs and other physicians regarding providing adequate access to care.

Member Services staff reports that when a member reports difficulty in obtaining access to their PCP, their medical records, or in obtaining an appointment, they contact the PCP office and intervene on the member's behalf. When a member calls and reports that they have difficulty obtaining services after-hours or on weekends, the member is provided with information on accessing urgent care centers and the nurse-advice line. Member Services staff attempt to resolve the problem and document information, which is then forwarded to the Provider Services and/or Grievance Departments. Member Services staff reports that if they receive a call for emergency services, they "assist as needed" and arrange transportation as required.

Case Managers relate that they do assist members in obtaining appointments and locating the health care services the member requires. They also discussed how they handle situations when a member reports receiving an adverse action decisions regarding an authorization. The Case Manager explains member benefits, and assists the member in contacting the Appeals Department. The Case Managers remains on the telephone with the member and provides advocacy and assistance as needed.

Ratings for compliance with Access Standards (52.9%) reflect that there have been some continued efforts by the Health Plan to submit required policy that meets the requirements of the MO HealthNet Managed Care contract and federal regulations. It also reflects that this process is not yet complete. This is the second year that all required policy and procedure were to completed and submitted for the approval process. Harmony Health Plan voiced their willingness continue their efforts to develop necessary policy and practice to be in full compliance and to obtain full compliance. Observations made at the time of the on-site review

indicated that these efforts were continuing and that practice is being developed that will support both the State contract requirements and the federal regulations. The Health Plan expresses the desire to be in full compliance with these requirements, but continue to have work to complete to satisfy this goal.

Table 66 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
	2007	2008
438.206(b)(1)(i-v) Availability of Services: Provider Network	1	1
438.206 (b) (2) Access to Well Woman Care: Direct Access	1	1
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2
438.206(c)(1)(i-vi) Timely Access	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	1	1
438.208(c)(1) Care Coordination: Identification	1	1
438.208(c)(2) Care Coordination: Assessment	1	1
438.208(c)(3) Care Coordination: Treatment Plans	1	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	1
438.210(b) Authorization of Services	1	1
438.210(c) Notice of Adverse Action	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2
438.210(e) Compensation of Utilization Management Activities	2	2
438.114 Emergency and Post-Stabilization Services	2	2
Number Met	9	9
Number Partially Met	8	8
Number Not Met	0	0
Rate Met	52.9%	52.9%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Harmony Health Plan of Missouri continues to develop their credentialing standards. The Health Plan assures that all providers maintained licensure and the right to practice in Missouri. The Health Plan developed a work plan to ensure that the remaining provider list would be current during the coming year. The Health Plan reported that they are current on all providers due for credentialing and that NCQA standards are utilized in conducting credentialing audits. Delegated credentialing is utilized with the Sisters of St. Mary (SSM) and the St. Louis University (SLU) networks. All credentialing requires an on-site review. The Health Plan was not required to initiate any corrective action plans with providers during 2008.

The Health Plan operates a dedicated quality improvement program that includes an active Medical Advisory Committee. They also operate physician outreach and education programs to enhance their ability to communicate and support providers. This includes one-on-one physician education sessions, as well as group training sessions. They utilize provider newsletters and other outreach activities to provide information and feedback to the provider network. Harmony Health Plan has also developed a "Pay for Quality (PFQ) Program" for providers. This program is measured by NCQA/HEDIS standards. The Health Plan reports that 2009 will be the first year this tool is available in Missouri. They are waiting for the 2009 HEDIS results, as the pay for quality continues to be based on providers meeting HEDIS benchmarks.

Member Services staff reports a sound knowledge of the policies and procedures to utilize if a Health Plan member calls and requests disenrollment. They do ask questions to reason with members and to identify the type of problem and if a resolution is possible. The staff relates that the often find that the genesis of the call is dissatisfaction with a provider. When they can assist with the problem they often find that the resolution creates an environment where the member no longer wishes to pursue disenrollment. Another cause of members' request for "opt outs" is daily eligibility and auto assignments. The members give the Health Plan staff the reason as "network issues, or they cannot go to the PCP or Specialist of their choice."

The rating for Structure and Operation Standards (70.0%) reflects the efforts the Health Plan has made for their first two years of submission of policy to the SMA for their review and approval. The Health Plan has made an effort to submit all required policy, but has not returned corrected policy in a timely manner. The Health Plan understood that continued efforts in this

area is required and that validation of all practice in this area cannot be considered compliant until approved policy is in place. Observations at the time of the on-site review support that Harmony Health Plan of Missouri has a commitment to completing and improving areas that may be viewed as problematic.

Table 67 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
	2007	2008
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	1
438.214(c) and 438.12 Provider Selection: Nondiscrimination	1	1
438.214(d) Provider Selection: Excluded Providers	2	2
438.214(e) Provider Selection: State Requirements	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2
438.56(d) Disenrollment: Procedures	2	2
438.56(e) Disenrollment: Timeframes	2	2
438.228 Grievance System	1	1
438.230(a,b) Subcontractual Relationships and Delegation	2	2
Number Met	7	7
Number Partially Met	3	3
Number Not Met	0	0
Rate Met	70%	70%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Harmony Health Plan has developed and implemented specific practice guidelines with providers at the time of the 2008` review. The Health Plan reports that they actively employ and distribute clinical practice guidelines for Adult Prevent Services, Asthma, Chronic Health Failure, Diabetes Mellitus in Adults, Hypertension, Cholesterol Management, Chronic Kidney Disease, Adult and Pediatric Obesity, Pediatric Preventative Health and Preconception Perinatal Care. These guidelines are reviewed and approved by the Medical Advisory Committee prior to implementation. This information and methods for utilizing these guidelines are distributed to all Health Plan providers.

Harmony Health Plan instituted a number of Quality Assessment and Performance Improvement activities during 2007, which have continued throughout 2008. Their Quality Improvement group meets regularly and includes local physicians who actively participate. The Health Plan's goal of providing quality services to members was the focus of the group's discussions. The Health Plan reports that the Quality Improvement section is an active and essential part of operations.

Harmony Health Plan did submit two Performance Improvement Projects (PIPs) for validation. Although these PIPs lacked complete maturity to allow for validation, they indicated that the Health Plan does utilize this process as a tool for Health Plan growth. The structure of both PIPs followed the federal protocol and showed a great deal of potential. These PIPs indicated an understanding of the importance of the PIP process in improving Health Plan operations and health care services to members.

The Health Plan was required to submit information for Validation of Performance Measures for validation. Only two of the three Measures were available for validation. Harmony Health Plan continued to operate a health information system within the guidelines of that protocol. Encounter Data was not available for validation as requested. The complete details of each of these areas of validation can be reviewed within specific sections of this report.

The rating for Measurement and Improvement (36.4%) reflects the fact that this complete submission of policy and procedures for the Health Plan has not occurred to the satisfaction of the SMA. The Health Plan is actively engaged in the revision and approval process with the SMA. Although the Harmony Health Plan exhibits practices that appear to be in accordance with the State contract requirements, and the federal regulations, they cannot be considered as fully compliant until approved policy is in place.

Table 68 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Harmony)

Federal Regulation	Harmony	
	2007	2008
438.236(b)(1-4) Practice Guidelines: Adoption	2	2
438.236(c) Practice Guidelines: Dissemination	2	2
438.236(d) Practice Guidelines: Application	2	2
438.240(a)(1) QAPI: General Rules	1	1
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	1	1
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	1	1
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	1	1
438.242(b)(1,2) Health Information Systems: Basic Elements	1	1
438.242(b)(3) Health Information Systems: Basic Elements	1	1
Number Met	4	4
Number Partially Met	7	7
Number Not Met	0	0
Rate Met	36.4%	36.4%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Information regarding a member's grievance is recorded and forward to the Grievance Department in Tampa, Florida. Member Service staff relate the information contained in the Member Handbook to the member and assist as needed with filing a written grievance. If a member calls with an issue that appears to be a grievance, but they do not wish to file a grievance, the staff relates that they will record the information shared, and forward it to the Grievance Department, with a note that the member did not request further action.

Written information from members regarding grievances and appeals are received by fax, mail and e-mail. The information is logged in the Health Plan's information system, the member is contacted to obtain clarification and additional information, and an acknowledgement letter is sent to the members. If a provider is involved, the Provider Relations office is notified. If the issue is actually an appeal, the information is then forward to the Appeals Department. Grievances are also referred to the Service Escalation Unit, which works with dissatisfied customers. WellCare has separated their units into Medicaid and Medicare specialties. This unit attempts to resolve member issues or assist the member in understanding the outcome of the process.

Case Management staff relates that they most often become involved if a member receives an adverse reply to a request for authorization. The Case Managers explain the member benefits, and assists the member in contacting the Appeals Department. The Case Managers feel that they remain involved, if possible, acting as a member advocate through both the grievance and appeals processes.

The rating for the Grievance System (5.6%) reflects a lack of approval of the majority of policy and procedures required to meet MO HealthNet Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that Harmony Health Plan has an understanding regarding operation of a grievance and appeals system. However, policy submission, revisions, and approval are not complete.

Table 69 – Subpart F: Grievance Systems Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
	2007	2008
438.402(a) Grievance and Appeals: General Requirements	1	1
438.402(b)(1) Grievance System: Filing Requirements - Authority	1	1
438.402(b)(2) Grievance System: Filing Requirements - Timing	1	1
438.402(b)(3) Grievance System: Filing Requirements - Procedures	1	1
438.404(a) Grievance System: Notice of Action - Language and Format	1	1
438.404(b) Notice of Action: Content	1	1
438.404(c) Notice of Action: Timing	1	1
438.406(a) Handling of Grievances and Appeals: General Requirements	1	1
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	1	1
438.408(a) Resolution and Notification: Basic Rule	1	1
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	1	1
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	1	1
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2
438.410 Expedited Resolution of Appeals	1	1
438.414 Information about the Grievance System to Providers and Subcontractors	1	1
438.416 Recordkeeping and Reporting Requirements	1	1
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	1	1
438.424 Effectuation of Reversed Appeal Resolutions	1	1
Number Met	1	1
Number Partially Met	17	17
Number Not Met	0	0
Rate Met	5.6%	5.6%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols

Conclusions

Harmony Health Plan is the newest Health Plan in the MO HealthNet Managed Care system. The Health Plan continues to emerge as an important option in the Eastern MO HealthNet Managed Care Region. The staff is able to articulate their Health Plan's goals and the requirements for service delivery associated with the SMA contract and the federal guidelines. Through involvement in other Medicaid Managed Care markets, the Health Plan is familiar with the requirements in meeting all written policies and procedures. They are not compliant in submitting policy that is specific to the MO HealthNet Managed Care contract or that satisfies the SMA by meeting all requirements of written policy and procedures.

QUALITY OF CARE

The Harmony staff is keenly aware of their responsibility to ensure adequate access to quality healthcare in a timely manner. They realize that obtaining full compliance is an essential component in the compliance process. The Health Plan's efforts and commitment to provide quality of services to members was apparent in meeting with Administrative staff, and in interviewing Member Services and Case Management staff during the on-site review. The Health Plan must continue to strive to meet all the SMA requirements. They voiced their awareness that creating an environment where all member services meet their quality standards must continue. The Health Plan staff could cite areas of improvement, yet voiced their awareness of areas where continued efforts are needed.

ACCESS TO CARE

Harmony Health Plan has improved their provider network and continues to fully develop all service delivery in their MO HealthNet Managed Care region. The Health Plan has not met policy and procedure requirements in this area of operation. The Member Services and Case Management staff do express an understanding of the importance of access to care for members and provide concrete examples of their efforts in meeting this requirement. The information obtained during the on-site review reflects improved collaboration between departments within the Health Plan. The Health Plan hopes that this will lead to members experiencing a more coordinated or collaborative approach to problem solving.

Timeliness of Care

Harmony Health Plan is aware of the importance of timeliness in the provision of health care to members. This is an area where complete and approved policy is the foundation for ensuring that members receive services in a timely fashion, have a timely response to question, and a timely turnaround on issues such as grievances and appeals. Harmony Health Plan has strong goals, supported by Health Plan leadership, and communicated throughout the organization to meet all of the requirements for policy development and implementation that will ensure that they will become fully compliant in this area, and ensure timely delivery of health care services to members.

Recommendations

1. Continue to develop the atmosphere within Harmony Health Plan that motivates the attention to compliance with contractual requirements and federal regulations.
2. Continue to enhance internal communication enabling front line staff to have a coordinated and collaborative work environment that supports adequate information sharing.
3. Continue to utilize the resources at Harmony Health Plan to complete all necessary policy documentation and submission to the SMA.
4. Utilize the Performance Improvement Project process to assess and enhance operations and member services. Submit all PIP topics to the SMA for evaluation when requested.
5. Continue to support front line staff in their efforts to be primary advocates for members and to provide an atmosphere based on the desire to provide excellent health care services to members.
6. Continue to utilize available data and member information in order to drive, change, and measure performance.
7. Continue active efforts to development adequate PCP and specialist networks in the entire Eastern MoHealthNet Managed Care region.
8. Continue development of efforts to improve community relations.
9. Provide oversight for behavioral health services to ensure that members maintain provider relationships, and continue to receive the services required.

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9.0 Healthcare USA

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9.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

HealthCare USA supplied the following documentation for review:

- Readmission Performance Improvement Project
- Statewide Performance Improvement Project – Improving Adolescent Well Care HealthCare USA

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 9, 2008 during the on-site review, and included the following:

Jackie Inglis – VP Health Services
Laura Fraser – Supervisor, Quality Improvement
Rudy Brennan – Quality Improvement Coordinator

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the Project Leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What was the intervention?
- Was the intervention effective?
- What does HCUSA want to study or learn from their PIPs?

The PIPs submitted for validation included a substantive amount of information. Additional analysis has occurred between the time of the original submission of information and the time of the on-site review. The Health Plan was instructed that they could submit additional information that included enhanced outcomes of the intervention. Additional clarifying written information was received after the on-site review from HealthCare USA.

FINDINGS

The first PIP evaluated was the clinical PIP submission entitled "Readmission Performance Improvement Project." The study topic presentation explained the research completed in justifying the decision for topic selection. The narrative included national, state and HCUSA specific data that provided support for topic choice. The topic choice was well documented, particularly explaining the impact on members. The topic discussion identified possible reasons leading to hospital readmissions. Some are planned such as the need for chemotherapy or follow-up surgery. They recognized that unplanned readmissions, such as post-operative infections or pregnancy complications, were often avoidable and based on a member's lack of understanding, poor follow-up, and non-adherence to medical instructions. They defined the preventable causes as well as factors that preventive services may not impact. The focus of this project was to improve the process of care. This factor and the need to identify patients "at risk" were well defined.

The study questions presented were: 1) "Will early (prior to discharge) identification, screening and appropriate referrals of all hospitalized members for case and disease management by concurrent review nurses, result in a reduction in hospital readmissions as evidenced by a 2% reduction in the HCUSA member readmission rate and the HCUSA multi-readmission rate?" 2) "Will developing and implementing a hospital admission and readmission morbidity assessment tool for all members enrolled in case or disease management prior to hospitalization be successful to identify preventable and actionable reasons for readmission that are identified in the literature, such as lack of a usual source of care, lack of adherence to discharge instructions, and/or member lack of understanding or knowledge, result in the ability to implement strategies that prevent readmissions, as evidenced by any reduction in the readmission rate for those enrolled in case or disease management programs?" These questions are complex, but certainly

include enough detail to ensure that any member that might be included in this project is served. It appears that these are measureable questions, and are directed to reflect the planned interventions.

Indicators are defined and constructed to provide measures of improvement. The study design information provides an argument that utilizing a "rate" measurement, rather than focusing on or following individual members is most appropriate, due to the variation found in the member population. The narrative presented information on the data available through the Coventry Data Warehouse (CDW), and through the Multi-Admission Report (MAR) a Coventry report pulled from the IDX system, an authorization and referral database. This does open the question about the need to track individuals receiving case and disease management, pertinent to this study, to report on the outcomes of the interventions implemented. The Health Plan reports that tracking the data will be sufficient. The data collection plan outlined ensured the inclusion of all appropriate information. It is noted that beginning in 2009 the Health Plan, using the Morbidity Assessment Tool, will collect member specific data, which will be used to establish a new baseline, and provide expanded outcome information.

The included population and how they will be identified is provided in specific detail. The methodology is designed to capture all members to whom the questions apply.

The data collection and analysis process is provided in specific detail. The data to be collected was defined in the narrative. The Health Plan included a description of how information is gathered and tracked on their health care information systems. The Health Plan does define exclusion criteria, which is explicit and defendable. The data was categorized according to the interventions. The Health Plan staff extracted data and the PIP included very specific definitions about the analysis of the data and the manner in which they intended to evaluate the data. The study included a systematic method for ensuring that valid and reliable data will be collected. This methodology included an explanation of capturing all information pertinent to this project. The study did not include a detailed prospective data analysis plan although it is woven throughout the explanation of the data collection process. The PIP team members, by their titles and roles were described. The processes and methodology to be used was also described.

Planned interventions were described in detail in the information provided. The study was initiated in 2007. The results and planned changes to enhance the study in 2009 were included. The data gathered for 2007 and 2008 was included. The description of each intervention, how they will be measured, and barriers identified were all described in the documentation. An analysis of the results to date was completed that did follow the data analysis plan. The analysis identified the initial and repeat measurements. References to barrier analysis indicated that more information might be available. Outcome information was included. The data was analyzed for each factor, or disease tracked. Overall PIP results did not show a major reduction in readmissions, except for the members receiving disease management. The Health Plan recognized that with the early identification of risk factors, and the implementation of case and disease management, they will begin seeing positive results from this project. The narrative indicated that the Health Plan maintains a commitment to this process, and believes the desired results will be seen as the project continues.

The second PIP evaluated was the HealthCare USA approach to the Statewide PIP "Improving Adolescent Well Care." This study is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP combined report documentation. The application of this topic to HCUSA members was included in the topic selection narrative. The topic selection criteria focused on improving a key aspect of member care, and explained the importance of improving the rates of adolescent well care screenings as an aspect of preventive care. All members of the age group studied, individuals between the ages of 12 – 21 are included. No members are excluded based on the existence of special health care needs.

The HCUSA specific study question is "Will provider reminders improve the HEDIS rate of adolescent well care? Will member reminders improve the HEDIS rate of adolescent well care?" "Will member and provider reminders in tandem improve the HEDIS rate of adolescent well care?" The Health Plan specific questions relate this study to their members, and are focused on improving their outcomes. They framed the content and intention of this study. Indicators for this study were included and defined with substantive information about how they were to be counted and analyzed. The indicators concentrated on the HEDIS rates which are quantifiable. There was no discussion included about the importance of this measure in

improving the quality of member health care. The information provided clearly led the reader to understand that the focus of the study is to improve compliance with obtaining well care screenings, which implies improving outcomes regarding better adolescent health care. The population served by this study includes all three MO HealthNet Managed Care regions. Results are to be defined by region.

The initial study design information relies on the information developed for the statewide combined report. The Health Plan did include a discussion of how the Coventry Data Warehouse (CDW) will be utilized. How data will be extracted and reported is available. This data will be tracked and analyzed quarterly. The Health Plan uses NCQA certified software to calculate their HEDIS results, ensuring consistent and accurate data collection. No specific prospective data analysis plan was defined. The narrative stated that in addition to the quarterly tracking, the information gathered will include any "counts, trends, and effectiveness of the interventions as applicable." This information is helpful but does not constitute a prospective data analysis plan.

The Health Plan specific intervention implemented was sending birthday reminders for all well-child visits, sent to members one month prior to their birthday and sending reminders to members without a claim for three months after sending the birthday reminder. The intervention is simple and measurable. The Health Plan did include their planned enhancements for 2009 in the documentation provided. The information did not include a barrier analysis and how this might impact the study or the expected outcomes.

An analysis of the findings was included. This analysis did include a data analysis plan. This plan could not be considered "prospective." The analysis was completed according to the plan provided. Details of the postcard reminders, and the missed appointment reminders that were sent each quarter was included. The Health Plan speculated that fewer missed appointment reminders were needed, subsequent to the birthday reminders being in place. In the third quarter of 2008 the number of missed appointments spiked. The analysis did not evaluate how this impacts the earlier assumption regarding the effectiveness of the birthday reminders. The Health Plan reported some success in each MO HealthNet Managed Care region. The 2009 HEDIS rates (based on 2008 data) increased in the Eastern Region, decreased in the Central

Region, and remained flat in the Western Region. These outcomes were reported and analyzed in the information presented. The narrative provided the Health Plans' perspective about which interventions were effective and which were not. They also discussed factors that may have affected the validity of the findings. The Health Plan identifies that overall there has been improvement in their HEDIS rates. They attribute this to the combination of the statewide interventions and the HCUSA specific interventions. They plan to continue implementing the Health Plan specific interventions in the hope that the approach will sustain improvement. At the time of the on-site review additional information and clarifications were made available. All information presented was well documented, labeled and explained.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The non-clinical PIP seeks to improve the rates of adolescent well care screenings that occur for Health Plan members. If the health plan continues to engage in appropriate follow-up it may be able to identify members who are not receiving screenings and continue to positively impact their behavior. The interventions described in the clinical PIP are clearly targeted to improve the quality and effectiveness of health care services for members who had a hospitalization and may be at risk of infection or hospital readmission. By assisting members with case and disease management services, and thereby avoiding the hospital readmission, the Health Plan will ensure that preventive and the most effective services will be in place.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members received case and disease management services to ameliorate issues that created a risk for readmissions. By undertaking the methodology involved in the Performance Improvement Project to ensure alternative health care services were in place, the Health Plan made outpatient and preventive services more accessible to the members involved. The non-clinical PIP also included the theory of improving services by ensuring that members received well care screenings for a population that has been previously hard to serve. The supporting documentation indicating how these PIPs would improve access to services was evident throughout the project.

TIMELINESS OF CARE

The services and interventions used in the clinical PIP did have the specific outcome of improving the timeliness of appropriate services for any member who has been hospitalized and may be at risk for readmission. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcome was focused on improving the availability of medical care and follow-up services after hospitalization. Timely access to care was a main focus of this project and the interventions utilized had the effect of decreasing the number of members who required re-admittance to the hospital. The non-clinical PIP considered timeliness in looking at the members obtaining adolescent well care screenings yearly. The narrative provided discussed how the interventions employed would improve the members' awareness of the need for annual screenings, and reduce barriers to obtaining these services.

RECOMMENDATIONS

1. HealthCare USA has attempted to improve the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The non-clinical project information provided the implied goal for improving services and benefits to members in a timely manner. The non-clinical PIP did not include a prospective data analysis plan in the project planning documentation submitted after the time of the on- site review.

2. The format of all PIPs should contain complete narrative information on all aspects of the project to ensure that the project is understandable and complete.

3. The Health Plan should continue to address how their projects are extended to and pertinent to all the MO HealthNet Regions served. Projects involving HEDIS measures assist in this as rates are provided for each Region.

4. The Health Plan indicated that the processes described in both PIPs are to be incorporated in the regular agency processes. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis

9.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for Healthcare USA. Healthcare USA submitted the requested documents on January 20, 2009. The EQRO reviewed documentation between January 20, 2009 and June 30, 2009. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Healthcare USA Baseline Assessment Tool (BAT) for the HEDIS 2008 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2008
- Healthcare USA's information systems policies and procedures with regard to calculation of HEDIS 2008 rates
- Healthcare USA meeting minutes on information system (IS) policies
- A sample of Catalyst's production logs and run controls
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies
- Data field definitions & claims file requirements of the Coventry Corporate Data Warehouse
- Data files from the Coventry Corporate Data Warehouse containing the eligible population, numerators and denominators for each of the three measures.
- HEDIS 2008 Data Submission Tool
- HEDIS 2008 product work plan
- Appendix Z – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

The following are the data files submitted by Healthcare USA for review by the EQRO:

- ADV_Denominator and numerator file.txt
- ADV_Enrollment.txt
- ASM_Denominator and numerator file.txt
- ASM_Enrollment.txt
- AWC_Denominator and numerator file.txt
- AWC_Enrollment.txt

INTERVIEWS

The EQRO conducted on-site interviews at Healthcare USA in St. Louis on Wednesday, July 8, 2009 with Laura Fraser, Q.I. Coordinator. Also available by phone were Rena David-Clayton and Geoff Welsh, who represented the software vendor Catalyst Technologies. This group was responsible for calculating the HEDIS 2008 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2008 performance measures.

FINDINGS

Healthcare USA calculated all three of the HEDIS 2008 measure being reviewed using the Administrative method. MO HealthNet MCHP to MCHP comparisons of the rates of Annual Dental Visit, Adolescent Well-Care Visits, and Use of Appropriate Medications for People With Asthma measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The reported Adolescent Well-Care Visit rate was 39.10%; this is comparable to the statewide rate for all MO HealthNet Managed Care health plans (38.59%; z = 0.20, 95% CI: 32.57%, 45.64%; n.s.). This reported rate is higher than the rate (36.37%) reported by the health plan during the 2007 EQR review, but not quite as high (39.31%) as the 2004 EQR rate (see Table 70 and Figure 41).

The rate reported for the Use of Appropriate Medications for People With Asthma measure by Healthcare USA was 86.87%, which is comparable to the statewide rate for all MO HealthNet Managed Care health plans (87.23%; z = 0.40, 95% CI: 58.33%, 115.42%; n.s.). This rate was also 23.55% higher than the rate (63.32%) reported by the health plan during the last period this measure was audited in HEDIS 2004 (see Table 70 and Figure 41).

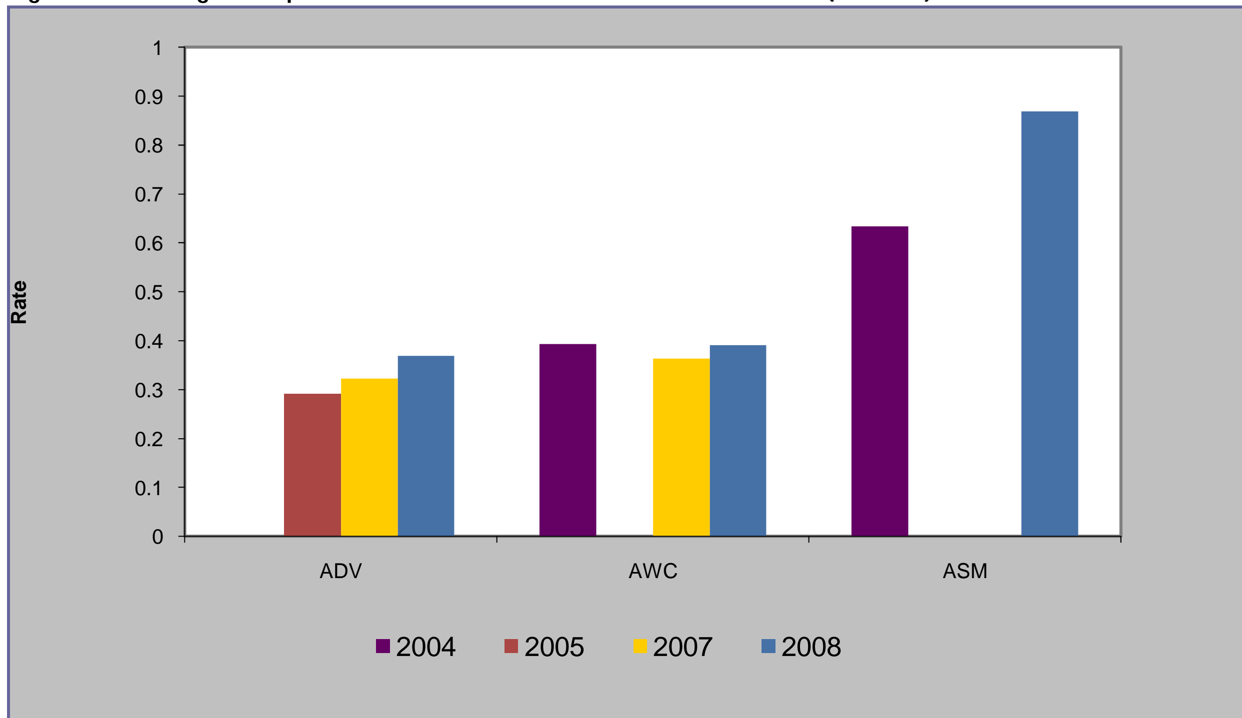
The combined rate for the HEDIS 2008 Annual Dental Visit measure reported by Healthcare USA to the SMA and the State Public Health Agency (SPHA) was 36.93%. This was significantly higher than the statewide rate for all MO HealthNet Managed Care health plans (34.71%, z = 0.82; 95% CI: 30.69%, 43.16%; $p > .95$). This rate has trended steadily higher over the past three EQR report years: from 29.04% in 2005 to 32.23% in 2007 to 36.93% in 2008 (see Table 70 and Figure 41).

Table 70 – Reported Performance Measures Rates Across Audit Years (HCUSA)

Measure	HEDIS 2004 Rate	HEDIS 2005 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate
Annual Dental Visit (ADV)	NA	29.04%	32.23%	36.93%
Use of Asthma Medications (ASM)	63.32%	NA	NA	86.87%
Adolescent Well-Care Visits (AWC)	39.31%	NA	36.37%	39.10%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 41 – Change in Reported Performance Measure Rates Over Time (HCUSA)



Sources: BHC, Inc. 2004, 2005, 2007, and 2008 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. For all three measures, Healthcare USA was found to meet all the criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no

biases or errors found in the manner in which Healthcare USA transferred data into the repository used for calculating the HEDIS 2008 measures. Healthcare USA used an NCQA-certified software vendor, Catalyst, for the HEDIS 2008 measure calculation process.

Documentation of Data and Processes

Although Healthcare USA uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Healthcare USA met all criteria that applied for all three measures.

Processes Used to Produce Denominators

Healthcare USA met all criteria for the processes employed to produce the denominators of the performance measures validated (see Attachment X: Denominator Validation Findings). This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the dates of birth ranges were valid.

A total of 37,166 eligible members were reported and validated for the Adolescent Well-Care Visits measure.

A total of 2,857 eligible members were reported and validated for the denominator of the Use of Appropriate Medications for People With Asthma measure.

There were 98,716 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures were calculated using the Administrative Method. Measures included the appropriate data ranges for the qualifying events (e.g., well-child visits, medication dispensing events, or dental visits) as specified by the HEDIS 2008 Technical Specifications (see Attachment XIII: Numerator Validation Findings). No medical record reviews were conducted or validated.

For the HEDIS 2008 Adolescent Well-Care Visits measure, there were a total of 14,532 administrative hits reported and 14,260 hits found. This resulted in a validated rate of 38.37%; with a reported rate of 39.10%, this is an overestimate of 0.73%.

The number of administrative hits reported for the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure was 2,482; the EQRO found 2,474. This resulted in a reported rate of 86.87% and a validated rate of 86.59%. This represents a bias (overestimate) of 0.28% for this measure.

Healthcare USA reported a total of 36,451 administrative hits for the Annual Dental Visit measure; 33,709 of these hits were validated by the EQRO. This resulted in a reported rate of 36.93% and a validated rate of 34.15%, an overestimate of 2.78%.

SAMPLING PROCEDURES FOR HYBRID METHODS

No medical record reviews were conducted or validated. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

SUBMISSION OF MEASURES TO THE STATE

Healthcare USA submitted the DST for each of the three measures to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

As is shown in Table 71, the health plan overestimated the Use of Appropriate Medications for People With Asthma, Adolescent Well-Care Visits and Annual Dental Visit measures.

Table 71 - Estimate of Bias in Reporting of HCUSA HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	0.73%	Overestimate
Use of Appropriate Medications for People With Asthma	0.28%	Overestimate
Annual Dental Visit	2.78%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure (see Table 72). The rates for the Use of Appropriate Medications for People With Asthma, Adolescent Well-Care Visits, and Annual Dental Visit measures were overestimated, but all fell within the confidence intervals reported by the health plan.

Table 72 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Use of Appropriate Medications for People With Asthma	Substantially Compliant
Annual Dental Visit	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Two of the three of the health plan's performance measure reported rates were consistent with the average for all MO HealthNet Managed Care health plans; the remaining rate was higher than the average.

QUALITY OF CARE

Healthcare USA's calculation of the HEDIS 2008 Follow Use of Appropriate Medications for People With Asthma measure was substantially complaint with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. HCUSA's rate for this measure was consistent with the average for all MO HealthNet Managed Care health plans. The health plan's members are receiving the quality of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. This rate was only very slightly below the National Medicaid Average, and below the National Commercial Average for this measure. The health plan's members are receiving a quality of care for this measure almost even with the average National Medicaid member but below the average National Commercial member across the country. However, this rate was significantly higher than the rate reported by the health plan during the audit of the HEDIS 2004 measurement year, indicating an improvement in the quality of services received by members over the past four years.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

ACCESS TO CARE

The Annual Dental Visit measure was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. Healthcare USA's rate for this measure was significantly higher than the average for all MO HealthNet Managed Care health plans. This rate was higher than the rate reported by the health plan during both the 2005 and 2007 reports, thereby showing that HCUSA members are receiving more dental services than during the 2005 & 2007 HEDIS reporting

years. The health plan's dedication to improving this rate is evident in the consistently increasing averages. HCUSA's members are receiving the quality of care for this measure higher than the level of care delivered to all other MO HealthNet Managed Care members. This rate was below the National Medicaid Average for this measure; the health plan's members are receiving a lower access to care than the average National Medicaid member.

The EQRO was able to fully validate this rate and thereby has extreme confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2008 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was consistent with the average for all MO HealthNet Managed Care health plans. The rate was higher than the rate reported for the 2007 EQR report year; however, the rate has not yet returned to the level seen for the same measure during the 2004 report. HCUSA's members are receiving the timeliness of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. However, this rate was lower than both the National Medicaid and National Commercial averages for this measure. The health plan's members are receiving a lower timeliness of care than the average Medicaid or Commercial member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. Improvement was seen in the Adolescent Well-Care Visits rate from 2007 to 2008, but the rates have not yet returned to the rate seen in 2004. The EQRO recommends the health plan continue to focus efforts on improving this rate, as interventions have been successful in increasing the rate.
2. The health plan should consider the use of medical record review (when allowed by HEDIS specifications) as a way to improve reported rates.
3. Work to increase rates for all measures; although most measures were consistent with the average for all MO HealthNet Managed Care health plans, they were at or below the National Medicaid averages.

9.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 650,211 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete and accurate, and valid.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 91.00% complete and accurate, and 90.9% valid. The following are the three invalid entries found: J7602 (n=13); J7603 (n=33); 99261 (n=1).
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first, second and third Diagnosis Code fields were 100.0% complete, accurate valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the fourth, and fifth Diagnosis Code fields fell well below the 100.00% threshold set by the SMA for completeness, accuracy and validity. The Diagnosis Code fields were 6.2%, and 0.00% complete, accurate and valid respectively. All the remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 68,602 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were sixteen (16) encounter claims paid by the SMA for the period July 1, 2008 through September 1, 2008. All fields except the Procedure code and Fifth Diagnosis Code fields examined were 100.00% complete, accurate and valid. The Procedure code field was 0.00% complete, accurate and valid. The Fifth Diagnosis Code field was 43.7% complete, accurate and valid. The remaining fields (n=9) were blank.

For the Inpatient claim type, there were 71,814 encounter claims paid by the SMA for the period July 1, 20087 through September 1, 2008.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, and valid. The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 98.28% (with 1,109 entries of "99999999"); thereby the Discharge Date field was 98.28% accurate and valid.
5. The Bill Type field was 100.00% complete, accurate and valid.
6. The Patient Status field was 100.00% complete and accurate, and valid.
7. The first Diagnosis Code field was 100.0% complete, accurate and valid.
8. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (99.99%, 99.92%, 89.40%, and 65.0%, respectively).
9. The First Date of Service field was 100.00% complete and accurate, and valid.
10. The Last Date of Service field was 100.00% complete and accurate, and valid.
11. The Revenue Code field was 100.00% complete, accurate, and valid.
12. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 262,394 encounter claims paid by the SMA for the period July1, 2008 through September 30, 20087.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete, accurate and valid.
4. The Last Date of Service field was 100.00% complete, accurate and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 99.9% complete, accurate, and 38.93% valid. There were 159,782 invalid entries of ".00", 305 invalid entries of "250", 1 entry of "0159T", 8 entries of "900" and 145 entries of "90776".
7. The first Diagnosis Code field was 100.00% complete, accurate and valid.
8. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (99.99%, 99.90%, 53.50%, and 24.1%, respectively).

For the Pharmacy claim type, there were 314,752 claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for HealthCare USA, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. The Inpatient claim type contained invalid data in the Discharge Date fields. The Revenue Code field contained blank entries. For the Outpatient Hospital claim type, the Outpatient Procedure Code fields contained invalid entries.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rate of Medical Encounter claims was significantly higher than the average for all MO HealthNet Managed Care health plans. All other encounter claim types were consistent with the average for all MO HealthNet Managed Care health plans. This suggests average rates of encounter data submission and good access to preventive and acute care. This could also be a function of the fact that HCUSA has the greatest number of encounter claims processed for all plans and thereby the outliers (if there are any) are not as prominent.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care health plan were randomly selected from all claim types for the period of July 1, 2008 through September 30, 2008 for medical record review.

Of the 981,223 Outpatient encounter claim types in the SMA extract file for July 1, 2008 through September 30, 2008, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 100 medical records (100.0%) submitted for review.

The 2007 match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 39.0%, with a fault rate of 61.0%. During this review, the match rate for procedures was 74.0%, with a fault rate of 26.0% and the match rate for diagnoses was 59.0% with a fault rate of 41.0%.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing or illegible information (n = 34) and incorrect (n=7). For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 16), incorrect (n=5) and upcoded (n=1). Examples of missing information included no code; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since HealthCare USA included internal control numbers that matched those of the SMA, the planned analysis of comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file was performed. The SMA defined "unpaid claims" as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy and Inpatient Claim types, all encounter data submitted to the EQRO were of "paid" status. For both claim types, there were no unmatched claims that were in the HCUSA encounter file and absent from the SMA data. Thus, 100.00% of the HCUSA submitted encounters matched with the SMA encounter records.

For the Outpatient Hospital and Medical Claim Types (n= 912,605), 27 "denied" and 23 "unpaid" claims were submitted by HCUSA but all other encounter claims were of "paid" status. Of the encounter claims submitted by HCUSA, 54 records were unmatched with the SMA encounter data. There was a "hit" rate of 99.99% between HCUSA encounter claims and the SMA encounter data.

For the Dental Claim type, HCUSA submitted 68,602 encounter claims. Only 4 of these encounter claims were of "denied" status; all other claims were of "paid" status. There were 00 unmatched records between HCUSA and the SMA, yielding a 99.99% "hit" rate.

Why are there unmatched claims between the MO HealthNet Managed Care health plan and SMA data files?

For all claim types, the unmatched encounters were missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, there were no documented "missing" claims from the SMA database.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care health plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet Managed Care health plan data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care health plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS

STRENGTHS

1. All encounter data was submitted in the specified format and included internal control numbers (ICNs) which allowed the EQRO to conduct planned comparisons of the MO HealthNet Managed Care health plan and SMA data files.
2. The critical field validation of four of the six claim types (Outpatient Medical, Inpatient, Dental and Pharmacy) resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Inpatient, Dental and Pharmacy claim types were 100.00% complete, accurate and valid.
4. The health plan had a significantly higher rate of Encounter Data Diagnosis and Procedure Validation than all MO HealthNet Managed Care health plans.

AREAS FOR IMPROVEMENT

1. For the Medical claim type, there were invalid entries for the Procedure Code fields.
2. For the Outpatient Hospital claim type, there were invalid data in the Outpatient Procedure Code field.
3. For the Home Healht claim type, there were invalid data in the Outpatient Procedure Code field.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that Admission Date, Discharge Date, and Diagnosis fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.

9.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO HealthNet Division (MHD). On-site review time was used to conduct interviews with those who oversee the daily practices of the Health Plan. Interviews occurred with the Member Services and Case Management Staff, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additional document review, including reading and evaluating the Health Plan's Annual Evaluation Report, occurred prior to the on-site review. The Health Plan assisted the on-site review team by providing additional documents at the time of the on-site visit. This approach was utilized to validate that practices occurring while serving members, were in compliance with approved policy, as well as with state and federal regulations.

Initial interviews were conducted with the Member Services and Case Management staff who directly serve the member population. These interactions and responses were compared to the Health Plan's Annual Evaluation and the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and to validate information received from the direct services staff.

A detailed interview tool, individualized for Member Services' staff and Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an interview tool was constructed for the Administrative staff to validate and clarify practices and to follow-up on questions raised during direct service staff interviews.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)
- HealthCare USA Annual Evaluation Report (2008)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2007 Marketing Plan and Materials
- Training Program Curriculum – New Employee Training, Time Keeping, Communication Systems, Medicaid Basics, Federal Regulations, Forms, URAC, InterQual Training, BJC Levels of Care for Nurseries, Health Services Policies, Medical Management, Pre-certification, Concurrent Review, and Notice of Action Letters
- Training Curriculum was viewed for Case Management, Disease Management, and Member Services
- Preauthorization Policy and Training regarding NICU and Utilization Management and Discharge Planning

Additional documentation made available by HealthCare USA included:

- HCUSA of Missouri Organizational Chart Care Management: Case Management, Complex Case Management, and Disease Management Policy
- HCUSA Quality Management Work Plan 2008
- Assessment of Members with Special Health Care Needs policy
- Case Management/Concurrent Review Policy

Interviews

Interviews were conducted with the following group:

Plan Administration

Jackie Inglis, VP Health Services
Dr. Daniel Murphy, VP of Medical Affairs
Resmi Jacob-Schrieber, Director of Provider Relations
Gene Poisson, Director of Network Development
Laura Frasier, Supervisor, Quality Improvement
Julie Graves, Director, Community Development

Member Services and Case Management Staff
Paula DiSabatina, Manager, Member Services
Tina Dabler, Member Services Staff
Theresa Campbell – Member Services Representative
Taylor Bordelon – Member Services Representative
Rita Tate – Member Services Representative
Stephanie Wise, RN – Disease Case Manager
Cynthia James, RN – Case Manager
Valerie Walter, RN – Complex Case Manager
Janet Wilson, RN – Complex Case Manager
Debbie Backfish, LPN – Special Needs Coordinator
Joy Winder, RN – Case Manager

INTERVIEW QUESTIONS

The following are the interview questions used in the Administrative Interviews and the Member Services/Case Management Interviews at HealthCare USA.

Administrative Interviews

- What prompted the implementation of "routine care management rounds" with one of the high-volume FQHCs?
    - Describe the outcomes.
- Discuss the NICU graduates pilot program. Elaborate on the outcomes.
- Give examples of measures that the Health Plan implemented to improve follow-up process for members included in the State's Special Needs report.
- According to the table provided regarding members with special healthcare needs, there was an increase in numbers with the county expansion in the first quarter of 2008. In the second quarter there was a decrease in numbers in the Central Region. Has the Health Plan analyzed these changes? What are the findings?
- What were the results of Provider CAHPS to improve after-hours availability and provider closed panels?
    - Describe the results of the Health Plan initiatives to improve consumers' access to providers.
- The annual report indicates that the data reflects that members opt out of the Health Plan for better benefits and better providers. Has the Health Plan analyzed this information and taken any action to resolve member concerns?
- Give examples of activities that the Health Plan has initiated to improve the number of specialists available in each Region served by the Health Plan.
- The report mentions barriers identified in 2008. What are these barriers and what has been done to address their removal?
    - One specific barrier mentioned was a "potential access barrier" to early prenatal care, and this was further cited as a reason for a decrease in the care rate from 2006 to 2007. What actions were taken to address this trend?

- What changes were made in the Health Plan's approach to member outreach educational activities in 2008?
- Describe any evidence that providers are conducting outreach to their patients who are not in compliance with preventive case or disease management guidelines.
- What factors contributed to the decline in member in the Eastern and Western regions in 2008? Have any activities occurred to change this trend?
- What was the outcome of office site reviews completed through the credentialing process in 2008?
- Discuss the findings of any cases of Fraud and Abuse cases that were identified in 2008.
- What success has the Health Plan had in improving the rate of post partum visits in the Eastern Region?
- Has the Health Plan undertaken initiatives to reduce the number of mental/behavioral health practitioners in the each region?
    - Give examples of these initiatives.
- How do the Case Management and Utilization Review departments work together?
- What is your response to criticisms that CM is just another method of UR?
- What feedback has the Health Plan received from outreach activities?
- Have any initiatives occurred to increase dental care in all three regions? If so, describe.

Member Services/Case Management Staff Interviews

- Are you familiar with the results of the CAHPS surveys?
- Are you aware of the Health Plan's efforts to increase member satisfaction through the Members Services sections? Describe the efforts that have occurred during 2008.
- What actions are taken to assist members in finding PCP's in their geographic area? How often do members complain that all the PCP's they contact have closed panels?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Describe activities that have occurred during 2008 to improve the process of contacting and providing services to members included in the State's report of members with Special Healthcare Needs.
    - What additional action is taken to identify members with special needs?
- How do the Case Management and Utilization Review departments work together?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members with mental health care needs.
- Give examples of activities that have occurred to encourage members to take advantage of the service of applying dental sealants and varnish for children.

FINDINGS

Enrollee Rights and Protections

A strong commitment to member rights continues to be a cornerstone of HealthCare USA's service philosophy. The emphasis placed on continuous quality improvement by the Health Plan was apparent in both the documentation reviewed and throughout staff interviews. Quality services to members, with a particular emphasis on families and children, were observed within the organization. HealthCare USA views cultural diversity as an essential component of their interactions with members. The Health Plan maintains cultural diversity as a cornerstone of initial and ongoing staff training. HealthCare USA employs staff that speaks different languages and is able to provide written materials in languages other than English. Maintaining the ability to serve a culturally diverse population with a variety of special service needs is exhibited in the Health Plan's approach to their work and to their interactions with members.

HealthCare USA has expanded their ability to communicate with visually and reading impaired members by contracting to produce their member handbook and other materials into Braille and on CD. They have information translated into other languages as well.

Member Services staff and Case Managers were asked about their familiarity with the CAHPS survey. Both Case Managers and Member Services staff were familiar with the CAHPS survey and its results. They report that they use the information gained from the survey to inform how they perform their job duties. The staff learns what may or may not be working with members. In 2008 staff states that the results of the CAHPS survey lead to HCUSA providing motivational interview training and updated cultural competency training for all staff. These two training modules are now provided for all new staff as well. The Case Managers explained that the motivational interview training has assisted them in learning how to engage members more effectively, allowing them to work with a greater number of members.

The Member Services staff received additional training called "In Touch." The focus of this training initiative was to heighten consideration for members and the issues they were encountering. The staff experienced on-line and classroom training on empathy, consideration and assisting members through difficult circumstances. The Member Services staff sends out brochures with cards for members to record physician visits. After the fifth visit they receive a

gift. Members are given additional information on transportation availability and about the possibility of gas reimbursement. The Member Services staff states that this also heightened their awareness about members' needs to receive help with physicians.

The Member Services staff report that they often assist members in identifying PCP locations. They also go through the Member Handbook with them so the member is aware of all aspects of service availability. The Member Services staff receives an indicator online to ensure that a PCP panel is open, and what languages are spoken in each office. The Member Services staff contacts the physician's office to assist members in obtaining appointments and is aware of member preferences, such as referrals to an obstetrician for pregnant members. A specific example was provided about a family who moved to Missouri from Arkansas with a child who has a pulmonary problem. They originally wanted to return to Arkansas for medical care, which was not out of the question. However, the Member Services representative found a pediatric pulmonologist in the Jefferson City area. Originally they were told that the practice was full, but he agreed to see this child with contact from the Health Plan and within a week the family had a follow-up appointment scheduled.

Staff was asked how a member becomes eligible for care coordination or case management services. They report that certain conditions automatically trigger a referral for Case Management, but more often, opening a case management case is in response to a situational need or medical condition. After any referral is received, Case Management contacts the member. Any type of referral creates a trigger for the Case Manager assigned to apply their algorithm and the completion of an assessment. The algorithm provides a baseline for the degree of intervention that a member will require. The Case Managers relate that they use all means necessary to contact the member. They believe their persistence positively impacts their success.

Member Services provided an example of a parent who called because they were unable to get their son's ostomy supplies. The Member Services staff worked with her to enable her to purchase these supplies using her Health Plan card, and then referred the family to Case Management. After a contact with the PCP office from the Case Manager, a nurse from that office made a home visit to the family. The Health Plan then authorized Pediatric nursing visits

for ostomy training. They also worked with the family to identify a specialist to ensure that the child had all the equipment and medical care that he required.

Typical case management activities include locating members and assessing their medical and ancillary needs. The Case Managers often make referrals for members to community based services that will assist them. This often includes working with a Social Worker, who is on-site at HCUSA, from MHNet to ensure that mental health referrals are fulfilled in a timely fashion. The Case Managers and Social Worker believe this has contributed to improvement in their ability to achieve care coordination for members.

An example provided involved a grandmother who has custody of two grandchildren. The grandson had been sexually abused, and there was concern about the safety of the granddaughter. The Case Manager made a mental health referral immediately, and the MHNet Social Worker provided follow-up information to the grandmother to ensure that the family received safety information as well as the counseling services required.

The Case Managers are in the process of developing a NICU program that will provide case management for the transition of newborns being released from the hospital to home. They are collaborating with nurses at St. Louis Children's Hospital on this project, and on a project for children diagnosed with Sickle Cell Anemia. An active outreach program is in place through the Post-Partum Department to ensure that follow-up services are in place as needed. Another outreach program is in place to inform members about services related to ADHD.

The Case Managers also described their Baby Shower program that is now available in the more rural areas of the Health Plan's regions. These "Showers" are held at physician's offices and clinics. Transportation is provided and vendors are present, including representatives from Parents as Teachers, and the SIDS prevention program. A bank representative is included to assist members in setting up savings accounts for infants. Other community resources are included and information is given to all members present. They also provide gifts, as approved by the SMA, to all members who attend. The Case Managers believe this program sets members up to have success with their newborns and small children, as it assists the member in becoming aware of resources available to them.

The Case Managers relate that they work to maintain a strong relationship with PCPs. In one example a PCP phoned the Case Manager because if was believed that a member was in need of specialist care. The specialist recommended was not an HCUSA provider. The member expressed a desire to remain within the Health Plan so the Case Manager found a specialist within the HCUSA network that was acceptable to the PCP and the member. They reported that the member's treatment was successful.

The Health Plan has continued efforts to impact members experiencing high risk pregnancies or with a history of premature birth. HealthCare USA reports that their members are producing 850 births per month. A percentage of these babies go to the neonatal intensive care unit (NICU), and a percentage experience congenital birth defects. The Health Plan continues to make every attempt to identify women at risk by using the Global Risk Assessment scale at the onset of pregnancy problems or premature birth. High risk pregnancies receive the most intensive level of case management. They are now beginning to do data analysis, including outcome and process measures, for these members. The Medical Director completes "rounds" regularly with these Case Managers. They visit high volume providers and also send a special OB newsletter to providers. This is assisting the Health Plan in finding at-risk members and measuring the effectiveness of their interventions.

HealthCare USA is making efforts to leverage community relations in all three MO HealthNet Managed Care regions. They work with the FQHCs in these regions and have developed a number of special projects. The Health Plan is working with LINC in the Western MO HealthNet Managed Care region, which is the local community partnership group, and the Spanish Center to ensure that they are addressing the needs that might be peculiar to the Kansas City population. They are working with community groups in the MO HealthNet Managed Care Central Region to address issues specific to the rural population. One example is that HealthCare USA providers are conducting dental screening at community based activities.

As a follow-up on their asthma initiatives, the Health Plan provided information on a project that is occurring in all three MO HealthNet Managed Care Regions. The Health Plan monitors member adherence to physician visits and medication. When a member does visit their physician or pharmacy, they are asked to verify all contact information and future commitment

to keeping appointments. After attending so many appointments, they receive a gift card, with information on "Kids' Health" aimed at parents, teens, and younger children.

HealthCare USA was asked about their EPSDT program as a follow-up from the prior year's review. The update provided information that members in all three MO HealthNet Managed Care regions receive reminders and post cards. When a member has an overdue EPSDT examination a "pop-up" occurs and the Case Manager sends a reminder to the member, and makes a referral to the PCP. The Case Managers consider this an opportunity to re-inform members to community programs. These programs include the Obesity Cookbook, Baby Showers, and the "BIB" program offered by the Health Plan. The Health Plan also attempts to engage the individual in the "Members as Mentors" program, which assists in member education on obtaining sound preventive care. The Case Managers report that discussing available programs, the PCP, needed health care services, and other needs, creates an interactive environment with the member. The Health Plan staff continues to conduct record reviews. Coventry, the Health Plan's parent company, developed reminder letters that are generated automatically to ensure that appointment reminders are sent to members on a regular basis.

The Health Plan has developed and is utilizing a Member Advisory Committee in all three MO HealthNet Managed Care regions.

Case Managers and the social worker in their department also exhibited a strong sense of collaboration and coordination. This collaborative effort includes the MHNet case manager, with whom they exchange information freely. The social worker provides a linkage with community based agencies that can provide the members with services that may exceed their health care needs.

The staff reports that an administrative assistant processes the report received from the SMA regarding children with special health care needs. After locating the members appearing on the list, their chart is flagged and information is forwarded to the Case Manager regarding the member's specific needs. The Case Manager contacts these members to ensure that they attend scheduled appointments, and to provide additional information regarding available services. The Health Plan may also contact other agencies such as WIC and the Family Support

Division to ensure that they have accurate contact information and are aware of needed services.

The Case Managers maintain communication with the Disease Management Nurses, and the Concurrent Review Nurses to make sure that they obtain timely referral information. The Member Services staff often identifies members with special health care needs during Welcome Calls. This information is sent to the Case Managers immediately after a call is completed. The Case Managers' members who are in their Case Management program often refer friends and others who then self-refer. The Case Managers always interview these individuals and complete an assessment, which often leads to the identification of a need for case management services. The Case Managers and Member Services staff both insists that they perform a variety of activities to maintain the referral and identification process. This information is reviewed and updated with members every ninety days. All members with a special health care need also have a written treatment plan. These are completed in coordination with the member's physician. The member has access to the treatment plan and will receive a copy if requested.

The Health Plan does have Case Management staff located in all three MO HealthNet Managed Care regions. They utilize the Health Risk Assessment received through the SMA as much as possible. The Health Plan reports that community connections, particularly in the rural areas, and provider referrals are more effective in identifying members with special health care needs.

Ratings of compliance with Enrollee Rights and Protections (100%) indicate that HealthCare USA continues to make a concerted effort to improve their compliance in this area. The Health Plan completed all required policies and these were approved by the SMA. Interviews with administrative, Member Services and Case Management staffs indicate a commitment to ensure that all approved policies are operationalized in daily work activities. They actively seek to maintain this level of success, and further to ensure that these policies are operationalized in interactions with Health Plan members. The Health Plan had a stated goal of 100% compliance with SMA contract requirements and federal regulations, which was achieved for the third year.

Table 73 – Subpart C: Enrollee Rights and Protections Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2006	2007	2008
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

The liaison social worker from the behavioral health subcontractor, MHNet, was included in the Member Services/Case Managers interview during this on-site review. Questions were asked of the Health Plan to follow-up on information from prior reports. The Behavioral Health Organization's (BHO) system underwent enhancements to capture baseline information on members receiving behavioral health services. MHNet continues the practice of authorizing family therapy, in addition to required individual therapy, for all children under age 21 who need behavioral health services. This additional resource is thought to assist in ensuring that each family had an understanding of issues facing their child that the entire family would be working together to ameliorate problems, and that the family would understand the child's emotional

functioning. The BHO, it is reported, works closely with HealthCare USA to identify expectant mothers to ensure that required behavioral health services were in place in an effort to prevent post partum problems. The BHO continues its concerted effort to ensure that information and educational material is translated into different languages. Multilingual providers are available to members.

The Health Plan, in collaboration with MHNet, reports making a concerted effort to offer adequate case management services between the two agencies. They provide case management to any member requiring a hospital admission, who attempts suicide, during and immediately after pregnancy, who has a history of non-compliance, and/or those with serious disease management issues. Case managers maintain regular phone contacts to ensure coordinated and necessary services and supports, such as transportation, are in place. HealthCare USA reports that having a MHNet liaison on-site has improved coordination of care issues.

Quality Assessment and Performance Improvement

Access Standards

HealthCare USA continues to work with both members and providers to ensure proper access to services is available. The Health Plan maintains a large provider network throughout all three MO HealthNet Managed Care Regions. They continue to recruit providers to expand available services, particularly in the Central Missouri area. This network enables members to have an adequate choice of both PCPs and specialty providers. The Health Plan does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

The Health Plan used the results of the Provider CAHPS survey to improve after-hours availability. A number of new urgent care centers opened in St. Louis, which are now contracted with HCUSA. The Health Plan has also recruited within its own network. They now have a number of PCPs with weekend and evening hours. This information is published in brochures that are distributed to members. Members, in some cases, are now assigned to physicians' groups, rather than to just one PCP, which assists in the availability of convenient appointment times, and sometimes eliminates the message that a specific PCP has a closed panel. This practice enables members to see the PCP of their choice in close proximity to their home.

The Health Plan admits that earlier in 2008 they received complaints about PCPs with closed panels. The provider set-up in the HCUSA system was assigning specific PCP's rather than the clinics chosen by the member. This was particularly true if it was a specialty clinic. The change to allow clinic assignment has improved the availability of the desired provider to the member. The Health Plan reports that with the availability of both the Washington University and St. Louis University systems, specialists, particularly in the area of orthopedics, has greatly improved. The Case Managers in the Western and Central Regions work with their hospitals to identify a specialty provider for specific member's needs. They relate that finding behavioral health providers in the MoHealthNet expansion counties was previously a problem, but this has greatly improved during 2008.

Case Managers reported that both the Washington University and St. Louis University Clinics are efficient at arranging timely appointments for members. The Administrative staff admitted that the Case Managers are a valuable asset in this process. The Case Managers clearly identify the medical services needed, including specialty care, and use the Health Plan's information system to find available providers. The Health Plan also finds that their PCPs are engaging specialists into their practices, which is expanding member resources.

A continuing effort by HCUSA is recruiting dental providers. They report that their work with Doral Dental has created positive results in all three regions. The Health Plan did propose a project of including a dental provider on-site at an FQHC for pregnant women. The FQHC did not agree to be involved. Doral continues to participate in expansion activities with the Health Plan. They are improving their customer service network, and adding administrative services with HCUSA. Doral Dental has focused efforts in the Central MoHealthNet Managed Care region with success. Doral Dental placed a provider representative in the Central Region to ensure that ample recruitment occurred and that a representative was available locally to assist in problem solving when this was required. They have also recruited a number of dentists who ensure availability to HCUSA members. HealthCare USA Provider Relations worked with Doral to ensure that the subcontractor had assistance as needed. Special attention was given to the issue of transportation while this network development continues. The Health Plan paid for mileage when a member had a vehicle, or another method of transportation to attend dental appointments, when they occurred at an excessive distance. This assisted in increasing the

availability of services. Another method utilized by the Health Plan was the negotiation of an alternative fee schedule for providers reluctant to participate due to reimbursement issues. This fee schedule is to be used when no alternatives are available.

The Health Plan continues its efforts to monitor their provider network for accessibility and availability of both primary care physicians and specialists in all three MO HealthNet Managed Care Regions. They report that they have recruited a new orthopedic group in the Eastern Region, which has greatly improved access to these services for their members. The Health Plan has "non-par" provider agreements that they utilize as needed. HCUSA reports that they have this type of agreement with an orthopedic group in the Central Region with the University of Missouri Health Care System. They are working to recruit them into their network.

The Health Plan makes an effort on behalf of members to share information about changes in provider availability, and to provide assistance in making appointments or identifying an appropriate provider if necessary. This activity was reported by both the Member Services staff and the Case Managers interviewed. HCUSA has developed community based programming in all three Regions. These include programs dealing with back pain, asthma, and the baby showers. The Case Managers also report that they get a reminder when a member is overdue for an EPSDT examination. This information is then relayed to the member and their PCP. The Health Plan is also participating in member events, such as Back to School Fairs, to provide information about the availability and accessibility of services. In the Western MO HealthNet Managed Care Region, an FQHC, Swope Health Services, is providing school physicals, dental screenings, and vision screenings for children. HIV screens and mammograms are provided for adults.

The Health Plan has done analysis of members' requests to opt out of the Health Plan. A number of members who chose to opt out of MO HealthNet Managed Care were actually receiving SSI (Supplemental Security Income), or other benefits. These members and their children were eligible to opt out of this system of service and they made that choice for a variety of reasons. In some cases they realized how different it is to receive health care in a fee-for-service system, and then choose to opt back into the Health Plan to obtain continued medical management and coordinated care.

Member Service staff could relate examples of issue that arise regarding members' access to care. They also shared situations when members call to request disenrollment. They discuss the request with members to determine if the member understands all Health Plan benefits, and to discern if they actually need help with, or if they are having a problem with, a provider. They relate that occasionally members call because another family member is enrolled in a different Health Plan, or they are having a provider issue. In some instances, Member Services staff relates that they are able to find a provider who is more acceptable to a member, or can assist in resolving other issues. When this occurs the member sometimes rescinds their request to dis-enroll. In other instances they process the request and ensure that the correct unit receives the request and all necessary information to process the request.

Case Managers discussed their efforts to ensure that members obtain timely and appropriate services. They directly contact PCPs and specialists if barriers exist to obtaining appointments or other necessary services. Case Managers also discussed members' rights to refuse case management services. When this occurs, the Case Managers attempt to educate members on other community services available, and how to work with their providers. The Case Manager then sends a post card with their name and a message that they can be available again if the member has future service needs.

Ratings of compliance with Access Standards regulations (100%) are excellent for the second year, and reflect the fact that all HealthCare USA policies have been submitted, reviewed, and approved by the SMA, and that the practice validated at the on-site review supports that all requirements are occurring. The Health Plan has improved in this area each year, and continues to strive to meet all required SMA contract requirements and federal regulations.

Table 74 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2006	2007	2008
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	1	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	16	17	17
Number Partially Met	1	0	2
Number Not Met	0	0	0
Rate Met	94.11%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

HealthCare USA instituted a number of measures to improve practice in this area in previous years that have continued during 2008. The Health Plan holds quarterly oversight meetings with all subcontractors in each region to discuss service provision and to monitor their activities. The meetings are used to monitor key performance indicators and to review provider panels. Annual evaluations are completed on each subcontractor and daily contact is maintained. HealthCare USA reported this increased contact and monitoring allows them to address administrative and member issues in a timely and effective manner.

On-site reviews were also conducted by Provider Relations staff during 2008 to assess providers' use of practice guidelines, and to review that all required documentation is in place. This has been effective in ensuring the quality and timely provision of care. The Health Plan is currently URAC accredited, and are actively seeking NCQA accreditation. On site visits, to complete credentialing, occur at least annually for PCPs and OB/GYNs. An on-site visit occurs with any office where a complaint has been reported. The Health Plan review areas related to member safety and cleanliness, which reflect the majority of issues. Some delegated credentialing occurs with larger providers, such as Cox and St. John's in Springfield, Missouri. Provider Relations maintains oversight of these practices and facilities. This process began in November 2008. People's Health (FQHC) had some problems during 2008. These seemed to be the result of new staff, rather than actual deficiencies. Corrective action occurred and these issues have been resolved.

HealthCare USA created a provider advisory group, which began functioning in the Eastern Region, but is now operational in all three MO HealthNet Managed Care regions. The committee is made up of high volume providers and representatives from across specialties. The sharing of ideas and information pertaining to any member dissatisfaction is encouraged. These groups seek provider feedback and provide information in a framework that allows the Health Plan to develop a true partnership with their provider network.

Member Services staff and Case Managers do not have a lot of impact in the area of Structure and Operation Standards. However, they both related that they do assist members if they have provider issues or problems. They then refer these issues to Provider Relations for follow-up.

Ratings for compliance with Structure and Operation Standards (100%) reflected completed and approved policy and procedures in this area for the second year.

Table 75 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2006	2007	2008
438.214(a,b) Provider Selection: Credentialing/Re-recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

The MO HealthNet Managed Care Health Plan continued to use InterQual as a guide for decision-making in terms of utilization review. InterQual criteria were originally cited when asked about practice guidelines. However, the Health Plan has instituted a number of practice guidelines and has instituted a number of initiatives to ensure their distribution to and use by providers. HealthCare USA's Medical Director ensures that monitoring utilization of practice guidelines is occurring at the provider level.

HealthCare USA continued to have a well developed internal written quality assessment and improvement program. The Health Plan shared their Quality Management Charter and minutes from meetings with reviewers. The Quality Management Program focused on monitoring, assessment, and evaluation of clinical and non-clinical service delivery. The result has been the implementation of quality programs that targeted members with special healthcare needs, but also provided enhanced services to all members. HealthCare USA indicated that they

recognized the need to stratify data by MO HealthNet Managed Care region. The Quality Management charter ensured that meetings occur at least quarterly on a regular schedule and had representatives from all sections of the organization, as well as including providers. The quality management process ensured that the Health Plan maintained a record of activities, recommendations, accomplishments, and follow-up.

The Health Plan did report data for Validating Performance Measures, which is validated in the appropriate section of this report. The Health Plan did submit clinical and non-clinical Performance Improvement Projects. The details of the audit are located in the appropriate section of this report. The Health Plan continued to operate a health information system that meets required standards. Encounter data was submitted in the format requested so that appropriate validation could occur. The details of this process are located in the Validating Encounter Data section of this report.

Ratings for compliance with Measurement and Improvement regulations (100%) reflect the completion of all policy and procedures in this area for the second year. The Health Plan did submit all data in requested formats, allowing the proper validation process to occur.

Table 76 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2006	2007	2008
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Rating for compliance with Grievance Systems regulations (100%) indicates that the Health Plan completed all requirements regarding policy and practice in their grievance system. This is the fifth year that HealthCare USA has been 100% compliant in the area of Grievance Systems and reflects that the Health Plan considers this an important aspect of compliance in both policy and practice. Out-of-network providers are informed of policies and procedures regarding complaints, grievances and appeals through the Provider Manual and Web Link.

The Health Plan resolves to obtain timely grievance resolution for both members and providers. The grievances are placed in their health information system, which tracks timeframes and generates notices and letters. Specific staff is assigned to appeals for members. They assist in obtaining the most complete information to present to an appeals committee. The member is notified by telephone and in writing of any decision to ensure that they have the information as quickly as possible. HealthCare USA utilizes an appeals form for members and does provide assistance with the written request for an appeal.

Member Services staff indicate that they receive information or contact from members that they immediately recognize as grievances and appeals. They listen to members, record information and refer the situation to the Grievance Department. The Member Services staff shared that sometimes a member does not wish to pursue the issue as a grievance or appeal, but they make a referral with a notation that the member does not wish to have their name revealed. These usually concern provider issues that will need follow-up to resolve. They also relate that grievances and appeals are reviewed in quarterly meetings. There is a great deal of communication between departments regarding the findings and analysis.

During the Member Services and Case Management interviews it was learned that these staff are not integrally involved in the Grievance and Appeal process. They are aware of their role in the referral process. They reported that the Health Plan receives approximately sixty grievances per month, forty appeals per month, and 1-2% may become a State Fair Hearing. They estimated that 75% of calls come directly from members.

Outside physicians are utilized for review of the case and responsible for the final appeal decision. The Compliance Analysts all reported that adverse decisions are often the result of a lack of complete medical information. When additional information is available the denial is often overturned. All decisions are recorded in the Health Plan system, and appropriate correspondence is sent to members and providers.

Table 77 – Subpart F: Grievance Systems Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2006	2007	2008
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	1	0
Number Not Met	0	0	0
Rate Met	100%	100%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols

Conclusions

HealthCare USA continued to exhibit a commitment to completing, submitting and gaining approval of required policy and procedures by the SMA, and developing operations that ensure that these procedures are reflected in daily operations. The Health Plan maintained improvements to achieve 100% compliance in all sections of the protocol for the third year. The operations and practices revealed during interviews at the on-site review indicated a commitment by HealthCare USA to provide quality healthcare services to its members. Health Plan activities focused on: enhancing preventative services; creating new approaches to providing access to services, such as the development of after-hours clinics; obtaining member input on issues; engaging provider input regarding improving and delivering services effectively; and to responding to prior authorizations and grievances in a timely and efficient manner.

The Health Plan incorporated methods to track required policy submission into daily administrative practice and took this process seriously. The practice observed at the time of the on-site review provided confidence that the Health Plan made service to members their primary focus and that there was a commitment to comply with the requirements of the MO HealthNet Managed Care contract and federal regulations.

It is also noted that all staff interviewed reflected the Health Plan's culture of respect for members and the priority for meeting member service needs. Staff members were open and animated in their responses. They were eager to give examples of how they assist members in normal and extraordinary circumstances.

Quality of Care

The staff at HealthCare USA exhibits a commitment to excellence that creates an atmosphere where both members and providers experience quality services. The provider relations staff made regular contacts with providers to troubleshoot problems that may be reported by members, and to assist provider staff in making interactions with members and the Health Plan less complicated. Efforts within the communities served, involvement with FQHCs, and with Community Mental Health Clinics, are examples of HCUSA's working to produce quality care in the most convenient environment, and working to improve access to care for members. These

relationships have also allowed education to occur that improves the quality of services for both the member and organizational level. Member Services and Case Management staff related the importance placed on training and collaboration to ensure that they are aware of issues that may arise and can respond quickly and efficiently to ensure that members have access to quality health care.

ACCESS TO CARE

HealthCare USA provided numerous examples of initiatives they are involved in to ensure that members have information on obtaining services and have adequate access to services. Several projects were explained that bring providers directly to places where members are available. The Health Plan has also undertaken provider recruitment and retention efforts that ensure that providers are available to members throughout all three MoHealthNet Managed Care Regions served.

Internally HealthCare USA, as an organization, has made efforts to ensure interdepartmental integration to create thorough knowledge of their service delivery system thus enabling staff to assist members effectively. Staff exhibited enthusiasm in describing the services they deliver and a desire to ensure that members' health care needs are met in spite of the barriers sometimes experienced.

TIMELINESS OF CARE

The Health Plan was able to complete all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations. The focus on obtaining timely health care services and responses to member needs reflects the attention needed to effectively provide a managed system of services to members. HealthCare USA has also initiated a number of practices that enhanced timely response and resolution of grievances and appeals for both members and providers. This decision-making process enables members to obtain the healthcare they require in a timely manner. The Health Plan recognizes the importance of timely and adequate services.

RECOMMENDATIONS

1. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the Health Plan.
2. Continue Health Plan development in the area of utilization of available data and member information to drive change and support opportunities for organizational growth and development.
3. Continue to track policies and other materials required for annual review.
4. Continue the commitment to oversight of subcontractors, such as MHNet and Doral Dental. Quarterly reviews ensure that member services are at the level the MCO requires.
5. Maintain involvement in community-based services and activities.
6. Continue training efforts with front line staff to ensure that they are versed in Health Plan policy and procedures and remain confident in their interactions with and advocacy for members.

10.0 Mercy CarePlus

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It should be noted that Mercy CarePlus became Molina Healthcare in October 2008. Performance Measures Data and Encounter Data were obtained prior to the change, and the health plan is therefore referred to as Mercy CarePlus in these sections. Performance Improvement Projects and Compliance reviews were conducted after this change, and therefore the plan is referred to in these sections as Molina Healthcare.

10.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Molina HealthCare of Missouri supplied documentation for review of two Performance Improvement Projects.

- Members at High Risk for Cesarean Wound Infection
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Molina Healthcare of Missouri

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 10, 2009 during the on-site review. Interviews included the following:

Joanne Volovar – Plan President
Robert Profumo, MD – Chief Medical Officer
Jennifer Goedeke – Director, Quality Improvement
Christine Cybulski – Quality Improvement Analyst
April Gross – Clinical Case Manager II
Mary Luley – Manager, Complex Case Management

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who were the members of the staff involved with the project and what were their roles?
- How was the topic identified and the choice justified ensuring that the PIP truly addressed an important aspect of member care and services?
- How was the study question determined?
- What were the interventions?
- What was the time period of the study and is it complete?
- What were the findings?
- Were the interventions effective?
- What does Molina HealthCare of Missouri want to study or learn from their PIPs?

The PIPs presented did not originally provide enough documentation to allow for a thorough validation of the findings. Additional time was provided following the on-site review for Molina HealthCare of Missouri to supply an update of both Performance Improvement Projects prior to final evaluation.

FINDINGS

The first PIP evaluated was Members at High Risk for Cesarean Wound Infection. This PIP was submitted as the clinical Performance Improvement Projects (PIP). This project grew from the previous PIP, which has developed into the Health Plan's practice of providing case management services to all pregnant members. The original PIP "Early Intervention in Prenatal Case Management and the Relationship to Very Low Birth Weight Babies," was evaluated in the 2006 and 2007 EQR. The current PIP looks at members who require a cesarean section at the time of delivery and have risk factors for wound infection. The concept is presented with background concerning Health Plan members. The research includes the methodology for determining the risk factors. The Health Plan's Clinical Quality Improvement Committee reviewed the data relating to the number of members identified with post-operative wound infection. This topic was identified as a serious issue regarding member health and a costly issue for the Health Plan. The Committee recommended conducting a Performance Improvement Project to study effective innovations to address this problem. Reference and research information was provided, but the topic selection was largely generated by recognizing that as a serious health care issue for members that could be impacted by a Health Plan activity.

The topic selection is defined as a key aspect of member care. It recognizes that "prolonged recovery time for post-partum mothers, and in some instances that may require further surgical interventions," as not in the members' best interest.

The revised hypothesis presented is as follows:

The incidence and severity of Cesarean Section Wound Infection (CSWI) could be reduced via increased home health nursing visits and member education on care, and would create a decreased rate of re-hospitalization.

The objective of the study is to reduce the number of CSWIs and improve women's recovery time. It will include all women having a cesarean section, with identified risk factors. The study question is: "Will increased home care visits and member education provided to high risk members decrease the rate of re-hospitalizations due to cesarean section wound infection?" The documentation discusses why this population was chosen, and potential interventions. It is measurable.

The Health Plan defines their measurable indicator as any member receiving a cesarean section. This notification will trigger a review of health and case management history. When CSWI risk factors are identified, additional home health care and educational activities are put in place. These activities promise to have a positive impact on member health care. The Health Plan has clearly defined all members to whom the study question applies, and has implemented a data collection approach to capture all appropriate members.

The study design was described in detail. It grew out of the previous PIP regarding case management for pregnant women (OBCM). All sources of data to be included in this plan were included. The members in the OBCM program are tracked in a specific case management system. These members are tracked and services are maintained, unless the member "opts out" of the program voluntarily. This system will also track members having a Cesarean section, and service interventions will be recorded there. The Health Plan will also utilize their claims system to ensure that all eligible members are identified. The Health Plan defined the system it plans to use to compile statistics regarding the outcomes of the project. It does appear that

they will collect valid and reliable data. The Health Plan could provide additional detail the will ensure the collection of accurate and consistent data over time occurs.

The study design and prospective data analysis plan are further detailed in the data collection section of their report. This information includes data collection and barrier analysis descriptions. The interventions and improvement strategies listed are as follows:

- Promote communication and advocacy with OBCM between members and providers in identifying members having one or more of the seven risk factors identified.
- Provide tools and educate members about post partum wound infection prior to discharge and/or during the first home visit.
- Assess Members' educational level and understanding on proper wound care as well as signs and systems of infection.
- Identify language barriers and provide translation when needed for members during education on wound care.
- Assess the member's ability to cleanse and care for wound through demonstration.
- Provide tools for providers to disperse to members who are at risk of developing post cesarean wound infection and/or delayed tissue healing with one or more of the identified risk factors.
- Track and trend providers and facilities to ensure that the CSWI rate is not due to individual issues requiring more focused educational efforts.
- Educate Provider Relations in promoting provider compliance in completing pre-natal assessment forms and returning to the Health Plan to assist with identifying members "at risk."
- Inform providers using the Health Plan newsletter, on the purpose of this PIP and the importance of Health Plan notification of members with potential risk.

The project is not mature enough to provide an in-depth analysis to date. The Health Plan did include a diagram of how risk is determined. The Health Plan believes that the approach, which mirrors the case management approach in the previous PIP, is sound and has produced solid measureable outcomes. This PIP is based on that methodology. Consequently the Health Plan predicts that they will experience positive outcomes in this project as well.

The second PIP evaluated was the Molina Healthcare of Missouri individualized approach to the Statewide PIP "Improving Adolescent Well Care." This is a non-clinical project. The decision to choose the study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. In addition the Health Plan included information about how this subject is relevant to Molina Healthcare of Missouri members. The Molina Healthcare plan stated that it was focused on correcting a deficiency in health care. Their

population base is members ages 12 – 21 as detailed in the Statewide PIP and in the HEDIS technical specifications.

The study question stated by the Health Plan is "Will a coordinated statewide improvement effort, with Health Plan specific interventions, improve the HEDIS rate of adolescent well care? MHMO had the stated goal to reach the 50th percentile for the 2009 and the 75th percentile for the 2010 data set?" The question was formulated using the Statewide PIP as a foundation, while including Health Plan specific goals as well. The question does focus on the goal of improving the HEDIS rate, rather than improving health care for members. The identified indicator is the MHMO HEDIS rate for the Adolescent Well Care measure. The information provided describes an objective measure, which indicates an improvement in the process of data collection. There is no information that indicates that the Health Plan is seeking an improvement in the process of care and how this will impact member health care. The study population, specific to MHMO members is defined. The narrative indicates that all data will be collected in accordance with the HEDIS technical specifications.

The study design does clearly indicate the data to be collected and its sources. This includes claims information and the specific CPT and ICD9 codes. The Health Plan will use the hybrid methodology to calculate their HEDIS rates so the utilization of a medical record review is discussed. The study design does not specify a systematic method of collecting valid and reliable data, but this is implied with the inclusion of information from the Statewide PIP. This portion of the documentation discusses data collection within the scope of the HEDIS specifications. The Health Plan did not include any information regarding data collection instruments. During the first year of re-measurement data (2008) the Health Plan was not using NCQA certified software. No information regarding this issue is included in the documentation. The Health Plan discusses the use of the hybrid methodology, but did not include a medical record abstraction tool in the information provided.

The data analysis plan for MHMO includes specific interventions, which consists of collecting and measuring quantitative data, which is how the HEDIS AWC measure is calculated. The stated interventions, individualized for the Health Plan, are:

- Treating AWC as a hybrid measure, therefore, requiring a medical record review to determine a more accurate HEDIS rate.
- Developing and distributing "EPSDT At-A-Glance."
- Continue to mail Welcome Packets with Immunization Schedules and the need for well-care visits.
- Continue to send notices to members reminding them that it is time for an EPSDT examination.

The PIP narrative did not elaborate on the challenges to engaging adolescents needing well care examinations. The first intervention is actually changing the way that the Health Plan calculates its HEDIS rates, and is not actually a PIP intervention. The remaining interventions are not specific to the population defined in this PIP. They are activities that regularly occur with all Health Plan members.

The PIP narrative does include some analysis of the Health Plan's 2007, 2008, and 2009 HEDIS rates. The Health Plan's assessment is that by utilizing the hybrid methodology to calculate this HEDIS measure, MHMO was able to significantly improve their rates. There is no analysis regarding the other stated interventions. The assessed improvement was not the result of any intervention implemented to engage members or providers in improving the number of adolescent well care screenings performed. It can be noted that the improvement in the HEDIS rates is real. However, it was not the result of an intervention focused on improving the number of AWC screenings that occurred.

CONCLUSIONS

QUALITY OF CARE

The best care in the most appropriate environment is the focus of the first PIP. The interventions attempted to incorporate methods to ensure that members obtained services in a timely and appropriate manner, which will improve the quality of their lives as well as of the care received. There is evidence that Molina Healthcare of Missouri is utilizing the PIP process to inform the organization about the most effective methods to improve and provide quality health care. The Health Plan states a desire to incorporate positive outcomes from the PIP into organizational operations. They articulate plans to use the PIP process to assist in program enhancement and organizational development in an effort to improve member services.

In the second PIP the Health Plan made few efforts that actually improved the quality of care of members. They did improve their reportable HEDIS rates, but only through calculating them using a different methodology.

ACCESS TO CARE

The focus of the first PIP does address access to care, and it is an overtly stated goal of the project. The intention of the interventions is to ensure that members' have in home services that provide good health care and education to improve members' quality and access to care. By ensuring that members have access to additional services to prevent more complex and invasive health care, and using an in-home method of providing this services, greatly improves access to care.

The second PIP did nothing to enhance members' access to care.

TIMELINESS OF CARE

The educational efforts of the first PIP were implemented in an attempt to encourage members to engage in the best self-care possible. Members received in-home treatment regularly as soon as they were home from the hospital. Appointments were made prior to the member leaving the hospital which additionally enhanced the timeliness of care.

In the second PIP the issue of timeliness was not addressed.

RECOMMENDATIONS

1. The study design of Performance Improvement Projects should link the questions, the interventions, and the proposed outcomes to determine whether or not an intervention was effective. This can be accomplished by developing a logic model for the PIPs at the planning stage, and ensuring that adequate narrative accompanies the data and information presented to make all necessary connections.

2. Continue to use quarterly measurements. This will provide information on the ongoing effects of the planned program. Data analysis should incorporate methods to ensure that any resulting change, or lack of change, was related to the intervention.

3. Provide enough narrative to ensure that the reader understands the problem, the proposed interventions, the goals and outcomes hoped for, and how the data presented relates to all these issues and either supports program improvement, or is not effective. Narrative should also be provided to defend the conclusions and defined outcomes of the study. This will provide justification, particularly if the process is to be an ongoing change in the health plan operations.

4. Create interventions that address the needs of members or that enhance their ability to utilize the services available.

10.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Mercy CarePlus. Mercy CarePlus submitted the requested documents on January 20, 2009. The EQRO reviewed documentation between January 20, 2009 and June 30, 2009. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Mercy CarePlus (prepared by Novasys)
- Healthcare Research Associates' (HRA) HEDIS 2008 Compliance Audit Report
- NovaSys Health Network, LLC, policies and procedures related to the HEDIS rate calculation process.
- NovaSys Health Network, Mercy CarePlus electronic eligibility process
- Data files from the HEDIS repository containing eligible population, numerators and denominators for each of the three measures
- Decision rules & queries in the HEDIS 2008 repository used to identify eligible population, numerators and denominators for each of the three measures
- Query result files from the repository
- Appendix Z – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

The following are the data files submitted by Mercy CarePlus for review by the EQRO:

- A (01) EASTERN AWC File 1 Export to BHC.txt
- B (01) CENTRAL AWC File 1 Export to BHC.txt
- C (01) WESTERN AWC File 1 Export to BHC.txt
- D (01) EASTERN ADV File 1 Export to BHC.txt
- E (01) CENTRAL ADV File 1 Export to BHC.txt

- F (01) WESTERN ADV File 1 Export to BHC.txt
- G (01) EASTERN ASM File 1 Export to BHC.txt
- H (01) CENTRAL ASM File 1 Export to BHC.txt
- I (01) WESTERN ASM File 1 Export to BHC.txt
- J (01) EASTERN AWC File 2 Export to BHC.txt
- K (01) CENTRAL AWC File 2 Export to BHC.txt
- L (01) WESTERN AWC File 2 Export to BHC.txt
- M (01) EASTERN AWC File 3 Export to BHC.txt
- N (01) CENTRAL AWC File 3 Export to BHC.txt
- O (01) WESTERN AWC File 3 Export to BHC.txt
- P (01) EASTERN ASM File 2 Export to BHC.txt

INTERVIEWS

The EQRO conducted on-site interviews with Mike Albornos, Director HEDIS Ops, Molina Corp; Vicki Cuevas-Sobschak, Director Quality Improvement, Molina Corp; Jennifer Goedeke, Quality Improvement Manager, Ainette Martinez (representing Bridgeport Dental) and Michael Boone (representing Novasys) on Monday, July 7, 2009. Michael Boone of Novasys was responsible for calculating the HEDIS 2008 performance measures of Use of Appropriate Medications for People With Asthma and Adolescent Well-Care Visits, and Bridgeport Dental provided the Annual Dental Visit rate.

FINDINGS

Mercy CarePlus calculated the Annual Dental Visit and Use of Appropriate Medications for People With Asthma measures using the administrative method. The Adolescent Well-Care Visits measure was calculated using the hybrid method. MO HealthNet MCHP to MCHP comparisons of the rates of the three measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The HEDIS 2008 rate for Mercy CarePlus for the Adolescent Well-Care Visits measure was 34.83%, which was consistent with the statewide rate for all MCHPs (38.59%; z = -0.33, 95% CI: 28.29%, 41.36%; n.s.). This rate was much higher than the rates reported by this health plan during the 2004 (18.75%) and 2007 (29.49%) EQR reports (see Table 78 and Figure 42).

The HEDIS 2008 rate for the Use of Appropriate Medications for People With Asthma measure reported to the SMA and the State Public Health Agency (SPHA) by Mercy CarePlus was 84.16%. This rate was consistent with the statewide rate for all MO HealthNet Managed Care health plans (87.23%; z = 0.32, 95% CI: 55.61%, 112.71%; n.s.). This rate was also substantially higher (23.53%) than the rate reported for HEDIS 2004 (60.63%), which was the last year this measure was audited by the EQRO (see Table 78 and Figure 42).

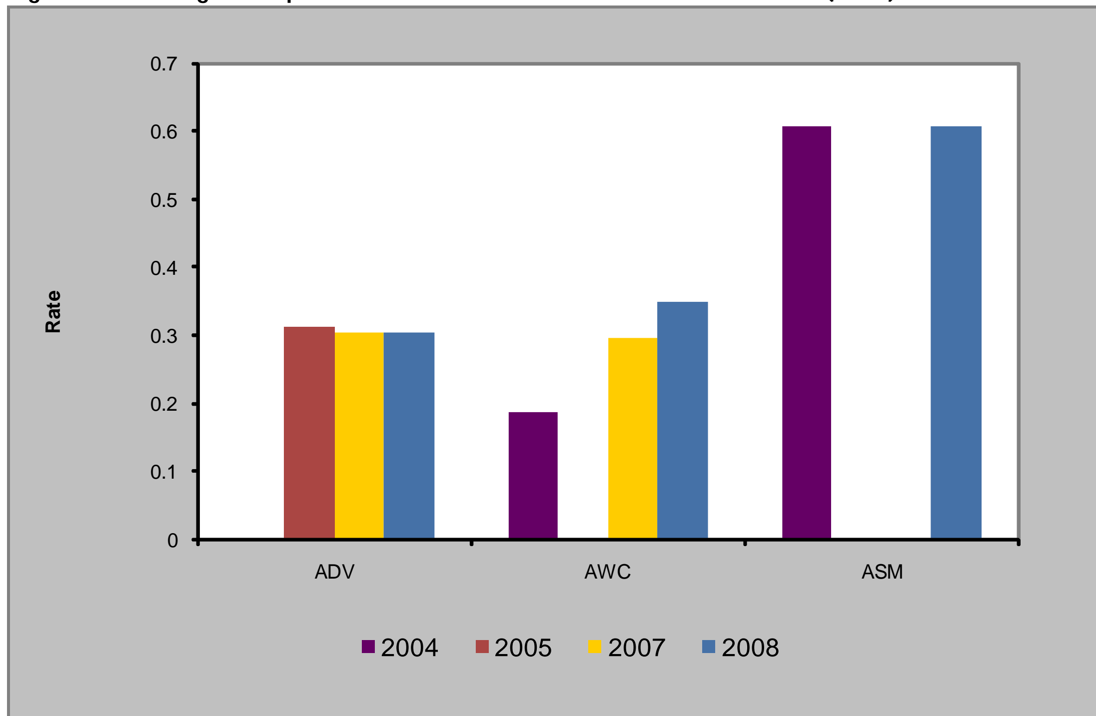
The reported rate for Mercy CarePlus for the Annual Dental Visit rate was 30.53%. This was consistent with the statewide rate for MO HealthNet Managed Care health plans (32.50%, z = 0.00; 95% CI: 24.30%, 36.77%; n.s.). This rate is this rate is lower than the rate (31.13%) reported by the health plan during the 2005 review, but slightly higher than the rate (30.45%) reported in the 2007 review (see Table 78 and Figure 42).

Table 78 – Reported Performance Measures Rates Across Audit Years (MCP)

Measure	HEDIS 2004 Rate	HEDIS 2005 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate
Annual Dental Visit (ADV)	NA	31.13%	30.45%	30.53%
Use of Asthma Medications (ASM)	60.63%	NA	NA	84.16%
Adolescent Well-Care Visits (AWC)	18.75%	NA	29.49%	34.83%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 42 – Change in Reported Performance Measure Rates Over Time (MCP)



Sources: BHC, Inc. 2004, 2005, 2007, and 2008 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

Information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of the HEDIS repository. This was done through a remote connection from the Mercy CarePlus location in St. Louis to Little Rock, Arkansas and Los Angeles, California.

For all three measures, Mercy CarePlus was found to meet all of the criteria for having procedures in place to produce complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Mercy CarePlus transferred data into the repository used for calculating the HEDIS 2008 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Mercy CarePlus met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

Mercy CarePlus met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of members eligible for the services being measured.

The Well-Care Visits measure contained an eligible population of 13,869. The EQRO found the age ranges, dates of enrollment, medical events, and continuous enrollment criteria were programmed to include only those members who met HEDIS 2008 criteria.

For the Use of Appropriate Medications for People With Asthma measure, a total of 423 eligible members were reported and validated by the EQRO.

A total of 36,231 eligible members were reported and validated for the Annual Dental Visit measure.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate administrative data ranges for the qualifying events (e.g., well-care visits, medication dispensing events, or dental visits) as specified by the HEDIS 2008 criteria (see Attachment XIII: Numerator Validation Findings).

For the Adolescent Well-Care Visits measure, Mercy CarePlus used the Hybrid Method of calculation. All 30 of the medical records requested were received, and 26 were able to be validated by the EQRO. As a result, the medical record review validated 28 of the 32 hybrid hits reported. The health plan reported 178 administrative hits; of these, the EQRO was able to validate 176. Thus, the rate validated by the EQRO was 33.79% and the rate reported by the health plan was 34.83%, resulting in a bias of 1.04%., an overestimation of the rate by the health plan.

The Use of Appropriate Medications for People With Asthma measure rate contained a total of 356 administrative numerator events reported, of which 343 were able to be validated by the EQRO. Thus, the rate validated by the EQRO was 81.09%, and the rate reported for this measure by the health plan was 84.16%. This indicates a bias (overestimate) of 3.07%.

The number of Annual Dental Visit hits reported by the health plan was 11,063; the EQRO was able to validate a total of 11,055. The rate reported by the health plan was 30.53% and the rate validated by the EQRO was 30.51%; this resulted in a 0.02% estimated bias (overestimate) by Mercy CarePlus.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Mercy CarePlus submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following table shows the estimated bias and the direction of bias found by the EQRO. All three measures reviewed were slightly overestimated, but these results still fell within the 95% confidence interval reported by the health plan.

Table 79 - Estimate of Bias in Reporting of Molina HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	1.04%	Overestimate
Use of Appropriate Medications for People With Asthma	3.07%	Overestimate
Annual Dental Visit	0.02%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources summarized in the Final Performance Measure Validation Worksheet for each measure.

Table 80 - Final Audit Rating for Molina Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Use of Appropriate Medications for People With Asthma	Substantially Compliant
Annual Dental Visit	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

Conclusions

Three rates were validated for the health plan. All three of these rates were consistent with the average for all MO HealthNet Managed Care Health Plans.

Quality of Care

Mercy CarePlus's calculation of the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. Molina's rate for this measure was consistent with the average for all MO HealthNet Managed Care health plans. This rate was also lower than both the National Medicaid and National Commercial averages; the health plan's members are receiving a lower quality of care than the average Medicaid or Commercial member across the country. However, this rate was higher than the same health plan's reported rate during the HEDIS 2004 audit, showing that the quality of care provided to members has improved over the past four years.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

Access to Care

Mercy CarePlus's calculation for the HEDIS 2008 Annual Dental Visit measure was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The rate reported by Molina for this measure was consistent with the average for all MO HealthNet Managed Care health plans. Molina's members are receiving a quality of care that is consistent with the care delivered to the average MO HealthNet Managed Care member. While this rate was higher than the rate reported by the health plan during the 2007 EQR, it was still lower than the rate reported during the 2005 EQR audit. The rate was also lower than the National Medicaid average rate, indicating the health plan's members are receiving lower access to care than the average Medicaid member.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

TIMELINESS OF CARE

Mercy CarePlus's calculation of the HEDIS 2008 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. Molina's reported rate for this measure was consistent with the average for all MO HealthNet Managed Care health plans. Therefore, Molina's members are receiving the same level of care for this measure as the level of care delivered to the average MO HealthNet Managed Care health plan member. This rate was much higher than the rates reported in the last two years this measure was audited (2004 and 2007). However, the rate was below both the National Medicaid and National Commercial averages; the health plan's members are receiving a lower timeliness of care than the average Medicaid or Commercial member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. Continue to utilize statistical comparisons of rates from one year to another to assist in analyzing rate trends.
2. Continue the use of medical record review (when allowed by HEDIS specifications) as a way to continue to improve reported rates.
3. The health plan's rates for Adolescent Well-Care Visits have trended upward over each of the past three review periods in which this rate was audited. The health plan should explore reasons for this continued increase trend and make every effort to apply similar practices to improve other rates.
4. Work to increase rates for all measures; although most measures were consistent with the average for all MO HealthNet Managed Care health plans, they were below the National Medicaid averages.

10.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 193,579 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate, and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete, accurate, and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.0% complete, accurate and 97.40% valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, all of these areas fell well below the 100% threshold set by the SMA. The completeness, accuracy, and validity of the second, third, fourth, and fifth Diagnosis Code were 49.16%, 26.419%, 14.84%, and 0.00% respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 32,352 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there was zero (0) encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

For the Inpatient claim type, there were 3,338 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete, accurate and valid.
5. The Discharge Date field was 100.00% complete, accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Discharge Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100% complete, accurate and valid.
9. The remaining Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA. The second, third, fourth, and fifth Diagnosis Code fields were found to be 86.82%, 68.53%, 54.15%, and 42.32% complete, accurate, and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate, and valid.
11. The Last Date of Service field was 100.00% complete and accurate, and valid.
12. The Revenue Code field was 100.00% complete, accurate and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 78,279 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete and accurate, and 80.73% valid. There were 15,979 entries of 69 invalid codes.
7. The Revenue Code field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they all fell well below the 100% threshold set by SMA for completeness, accuracy and validity. The second, third, fourth, and fifth Diagnosis Code files were 48.1%, 24.5%, 11.7%, and 6.2% respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 116,801 claims paid by the SMA for the period July 1, 2008 through September 30, 2008. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Mercy CarePlus, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. The Hospital Outpatient Procedure Code field contained a large proportion of invalid entries. These invalid codes ranged from 250-990.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Mercy CarePlus demonstrated significantly lower rates than the average for all MO HealthNet Managed Care Health Plans for the Inpatient claim types. This may be a function of provider panel composition or claims administration. The possibility of incomplete data cannot be ruled out given the consistent pattern of low rates across this claim type. Other possible explanations are less access to care for members, or a healthier member population.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care Health Plan were randomly selected from Medical claim types for the period of July 1, 2008 through September 30, 2008 for medical record review. Of the 304,210 Outpatient encounter claim types in the SMA extract file for July 1, 2008 through September 30, 2008, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 83 medical records (83.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated.

For the 2007 review, the match rate for procedures was 54.00%, with a fault rate of 46.0%. The match rate for diagnoses was 41.0%, with a 59.0% fault rate.

For this review year, the match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 46.0%, with a 54.0% fault rate.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure, diagnosis, drug name, and drug quantity was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing (n = 35), incorrect (n=6) and upcoded (n=2).

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 27) and upcoded codes (n = 4). Examples of missing information included no code; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Mercy CarePlus included internal control numbers that matched those of the SMA, the planned analysis of comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file was performed. The SMA defined "unpaid claims" as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For all claim types, the health plan only submitted claims with a status of "paid". The EQRO matched all of these claims to the files contained in the SMA database. Thus, 100.00% of the MCP submitted encounters matched with the SMA encounter records

What Problems are there with How Files are Compiled and Submitted by the MO HealthNet Managed Care health plan?

The analysis of comparing Mercy CarePlus (MCP) encounter data to the SMA encounter claim extract file was conducted based on the file submitted by MCP that contained all claims for the selected sample of DCNs. While MCP did submit the data in the requested format (see Appendix 7) for the MO HealthNet Managed Care Members represented in the encounter claim sample selected by the EQRO for validation, there were no unpaid or denied claims submitted. There were no unmatched claims that were in the MCP encounter file and absent from the SMA data. Thus, 100.00% of the MCP submitted encounters matched with the SMA encounter records.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

There are no data quality issues specific to this MO HealthNet Managed Care health plan. The data quality issue that continues to be a challenge for the EQRO is the lack of a unique identifier to match unpaid or denied claims to claims data present in the SMA database.

CONCLUSIONS

STRENGTHS

1. All encounter data was submitted in the specified format and included internal control numbers (ICNs) which allowed the EQRO to conduct planned comparisons of the MCHP and SMA data files.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental, Pharmacy and Inpatient claim types were 100.00% complete, accurate and valid.
4. The critical fields examined for Outpatient Hospital and Outpatient Medical were 100% complete and accurate.
5. Data was submitted in the requested format for encounter validation and all claim types were accessed.
6. Claim Status (Paid, Denied, & Unpaid) was submitted.

AREAS FOR IMPROVEMENT

1. Mercy CarePlus has the lowest rate of access per 1,000 members in the encounter category of Inpatient claim types).
2. Mercy CarePlus did not have any Home Health claims during the period reviewed.
3. The Outpatient Hospital procedure code field was 80.73% valid. There were 50,979 entries of 69 invalid codes.
4. The health plan reported no Home Health encounter claims during the review period.

RECOMMENDATIONS

1. The health plan should examine the rate of claims per 1,000 members across claim types and the rate of rejected claims for each claim submission format (UB-92, NSF/CMS 1500, NCPDP 3.0) over time to examine the consistency in claims submission and identify issues for data submission. The access to care should also be examined as a possible reason for the lower rates of encounter claims per 1,000 members.
2. The SMA should examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout and run validity checks after the programming of new edits.
3. For the Outpatient Hospital claim type, improve the rate of valid procedure codes.
4. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis.

10.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO HealthNet Division (MHD). Molina Healthcare of Missouri is in its first full year of operations as a MO HealthNet Health Plan. This Health Plan previously operated under the names of Community CarePlus and Mercy CarePlus. This change became effective in 2008, and the Health Plan operated under the current MO HealthNet Managed Care contract that went into effect on July 1, 2006. The new Health Plan, Molina Healthcare of Missouri currently has contracts to provide services in all three MO HealthNet Managed Care Regions, although their largest population remains in the Eastern MO HealthNet Region with approximately 61,000 members. They currently report having over 6,100 members in the Central Region, which is a substantial increase over the previous two years. In the Western Region the Health Plan continues to serve nearly 8,200 members, which is an increase over of the member population served in 2006 and 2007. They continue to develop their emerging census in all three service regions. The MO HealthNet Managed Care Health Plan discussed in this report will be compared to the Health Plan formerly named Community CarePlus and Mercy CarePlus when required.

On-site review time was used to conduct interviews with Member Services' staff and Case Management staff, and separately with Administrative staff. This approach was utilized to validate that practices occurring while serving members are compliant with approved policies. These interactions and responses were compared to policy requirements to ensure that both are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations. Both interviews were constructed with questions derived from the Health Plan's Annual Evaluation and the SMA's Quality Improvement Strategy.

A detailed interview tool, individualized for Member Services' staff and Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an interview tool was constructed for the Administrative staff to validate and clarify these practices and to follow-up on questions raised during direct service staff interviews.

Document Review

The following documents pertaining to Molina Healthcare of Missouri were reviewed prior to and at the on-site visit:

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)
- Molina HealthCare of Missouri Annual Evaluation FY 2008

The following documents were requested and reviewed on-site:

- Member Handbook
- 2008 Marketing Plan and Materials
- Provider Handbook
- Medical Management Policy and Training Curriculum including Customer Training Program and New Staff Orientation
- Case Management Policy

Additional documentation made available by Mercy CarePlus included:

- Organizational Chart
- Communication Plan
- Wellness Handbook
- "Focus on Community Outreach" Program Initiative
- Utilization Management Program Description
- Quality Improvement Committee Meeting Minutes

The medical management and credentialing policy reviewed indicates that Molina Healthcare of Missouri is working to meet NCQA Standards. All of these policies have been submitted to the SMA for their final approval. It was detailed and appeared to comply with federal regulations. Quality Improvement Committee Meeting Minutes were also reviewed. They contained reports of monthly activities which related to the actual goals of the Health Plan.

Documents reviewed indicated that the Health Plan is moving toward NCQA accreditation and indicated a significant change in quality focus.

Interviews

Interviews were conducted with the following group:

Plan Administration
Joanne Volovar – Plan President
Robert Profumo, MD – Chief Medical Officer
Nancy Zmuda – Director, Utilization Management
Tracy Hay – Director, Community Outreach
Jennifer Goedeke – Director, Quality Improvement
Pat Southern – Director, Member Services

Member Services and Case Management Staff
Jennifer Goedeke – Director, Quality Improvement
LaShonda Kahill – Manager, Member Services
Stacy Harris, Member Services Representative
Betsy Santiago – Appeals Coordinator
Cherie Brown, Manager, Case Management
April Gross, Complex Case Manager II
Diane Jellison, Complex Case Manager I

INTERVIEW QUESTIONS

Administrative Interviews

- "The purpose of the QIC is…." (Page 4 – 8 dot points). Give specific examples of actions or activities that exemplify how the QIC accomplishes these goals.
- Utilization Management Subcommittee: What additional studies or changes have been recommended in the past year to improve the reports available for review?
    - How have these reports enhanced UM's capabilities?
- What recommendations were made to improve relationships with member and community providers?
- Professional Review Committee: Give examples of member concerns and/or complaints as they related to individual providers and how these were resolved.
- Your annual report talks about the clinical and non-clinical PIPs in progress. How is the decision made to utilize the PIP process? Are any new PIPs in progress?
- Describe the system developed to "consider, investigate and respond to good faith reports of instances of suspected non-compliance.
- The report states that an opportunity for improvement is the Health Plan's "Continued effort to increase CAHPS scores through Member Services and Provider Relations." What changes or enhancements were developed to respond to this need?
- Discuss the Fraud and Abuse cases that were identified in 2008. Nine cases were identified, plus 16 members with pharmacy abuse. What occurred, what corrective action was taken?
- The report indicates 2,285 PCPs. How many have open panels?
- The report mentions a process provided clear concise direction in addressing issues related to "provider complaints, appeals, claims processing, contracting, credentialing, member services and outreach.

    - What is this process?
    - How has it worked?
    - What issues have been addressed?
- Discuss the current credentialing process. How is this working? Have issues or problems been identified. Currency?
- "MHMO has a process to assess and improve, as needed, the quality of medical record keeping." What is the process? What are the results?
- Please discuss the "processed timely" statistics regarding member and provider grievances/appeals.
- How do the Case Management and Utilization Review departments work together?
- What is your response to criticisms that CM is just another method of UR?
- Utilization Management: In the areas of Outpatient Visits, Over/Under Utilization, Inter-Rater Reliability, Timeliness of Care Delivery, and Timeliness of Prior Authorization Certification of Decision Making – The report states "MHMO does not have the ability to track this data at this time." Tracking this information is required. How are these items reported?

Member Services/Case Management Staff Interviews
- Are you familiar with the results of the CAHPS surveys?
- Are you aware of the Health Plan's efforts to increase member satisfaction through the Members Services sections? Describe the efforts that have occurred during 2008.
- What actions are taken to assist members in finding PCP's in their geographic area? How often do members complain that all the PCP's they contact have closed panels?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Discuss cases that occurred during 2008 resulting from interventions provided through the case management process described on Pg. 20 of the report. How have these interventions benefited members? Give examples.
- How do the Case Management and Utilization Review departments work together?
- What information are you required to track? How is this information utilized by MHMO? What reports do you receive and how do you use information provided?

FINDINGS

Enrollee Rights and Protections
Molina Healthcare of Missouri continued their efforts to track and monitor all policy required to be submitted to and reviewed by the SMA. This included policy and procedures for initial and annual approval, as well as marketing materials. Additionally, the Health Plan developed an inventory of all written materials or purchased materials that must be approved by the SMA prior to being shared with members. A binder including all Annual Marketing Materials and the Annual Marketing Plan was compiled and shared during the on-site review.

The Member Handbook was approved by the SMA and continues to be recorded in a format to be shared with members who are visually impaired or have other challenges with written material. Certified interpreters for deaf or non-English speaking members are provided as needed. The International Institute and the Language Access Metro Project (LAMP) are the primary resources used for interpretive services by Molina Healthcare of Missouri. The Health Plan reports receiving a number of calls every month that required interpretive services, these calls have been handled in a routine manner.

Training is regularly provided to ensure that the Molina Healthcare of Missouri staff is knowledgeable about members' rights and responsibilities. A review of the Customer Training Program was conducted. The program provided a solid overview of how staff should address member issues and how to meet their needs. Examples of potential issues and problems were included and were used to generate thought and discussion about appropriate problem solving strategies. Staff was also given self-help materials to utilize in their daily activities. All tools were compiled in a desk reference format that included information on Amisys System usage, member benefits, grievances and appeals, and claims. It was clear from the attendance records that all staff attended the New Staff Orientation. In addition they attend monthly staff meetings are held within Member Services, Case Management, and Utilization Management. Attendance was recorded and the in-service educational programs utilized were available for review. These training sessions focused on customer services and medical management with a focus on members' rights and responsibilities. Incoming calls are monitored and additional in-service training and coaching is provided based on information gathered.

Member Services staff exhibits a strong degree of advocacy in providing services to Health Plan members. They make concerted efforts to support new members with information and assistance. Member Services staff provides names, geographic locations and availability of providers and other supportive health care services to members during telephone interactions . They encourage members to ask questions and provide answers, or obtain necessary information for other sections of the Health Plan to adequately respond to the member. Staff reports that they always attempt to go through the Member Handbook with the new Health Plan members to ensure familiarity with all sections and create an understanding of the

information provided. They inform members about the Health Plan website. The Member Services staff reports that members are using the website in increasing numbers.

Molina Healthcare of Missouri understands the need to enhance case management services to members with special needs. They review a number of sources to identify members in need of case management, including the State supplied report of members who potentially have special health care needs, and provide them with individual attention as quickly as possible. Case managers provide direct services and track all pregnant members. Pregnant members receive varying levels of case management services, based on an assessed level of risk. The members with a moderate or high level of risk receive enhanced case management throughout their pregnancy and post partum with the goal of reducing the number of low birth weight babies. The rate of Obstetrical Case Management has increased across all three MO HealthNet Managed Care Regions. The Health Plan has tracked statistics indicating that babies born at 28 to 36 weeks are living, which has increased the number of newborn inpatient days in the hospital.

Member Services staff was familiar with the CAHPS survey. They report that they look at the questions related to the Call Center and reception, and through survey responses make changes that will improve their services from the members' perspective. The Quality Improvement Committee uses the CAHPS survey responses to identify methods to improve Health Plan services. Case Managers report using the survey results to identify areas for corrective action, such as network additions. Case Managers explain that they receive messages from Member Services to respond to member issues if there is any indication that additional services may be required. Both Case Managers and Member Services staffs responded that they use the CAHPS survey as a method to hear honestly from members about issues of concern to them.

Member Services staff expanded their responses to discuss methods they use to improve member satisfaction. When a member telephones the Health Plan they are always asked to update their contact information to ensure that the most current residency and telephone

number are reflected in the on-line member data. They are informed during Welcome Calls about available services including transportation, dental, and mental health service. Members are questioned about service needs in an attempt to appropriately identify those needing case

management or disease management interventions. The current information system has the capacity to refer the member for additional assistance. The Member Services staff looks at the Complaints and Grievances system information. When problems in a member's response are identified, the Member Services staff creates corrective action plans which are reported to the Operations Committee. They reported that they are in the process of developing "score cards" as an additional method for assessing their system's need for change.

Case Managers reported receiving referrals from a variety of sources. These include Member Services staff, Pre-authorization staff, providers, the SMA system, concurrent review nurses, behavioral health case managers, and members. They explain that any member with a need for help is considered for case management. Any member identified as having a need for additional service, or requiring follow-up care is referred for complex case management. These additional services may be hospice care, complex OB cases, or children who are seriously ill, such as requiring a ventilator full time. The case managers do outreach. They go to members' homes, to care conferences, and to physician offices to promote case management. The Case Managers gave an example of going on a home visit, and finding an asthmatic child in a house heated with a wood stove. The Case Manager counseled the family, and assisted them in finding an alternate heat source.

Case managers also described their efforts to decrease inappropriate use of Emergency Room services. They contact members to discuss information from ER visits within twenty-four (24) hours of the visit. The Case Managers find that they do have success in assisting members with finding urgent care centers and in making PCP appointments in a timely manner. When talking with members they discuss the use of the Nurse-Advice line as an alternative to visiting the ER. The Case Managers do review all calls to ensure that there is no conflict and that members are visiting the Emergency Room appropriately.

Case Managers were asked to describe typical activities with members. They described their role as providing member support, particularly in finding the correct health and ancillary resources to help the member meet their healthcare needs. These activities were described as the foundation of case management at Molina Healthcare of Missouri. The Case Managers provide community resource guides, make referrals, ensure that members have access to appropriate providers, and that they are aware of additional services such as WIC, and transportation. The families of infants, such as NICU babies, are referred to an array of community services such as Parents as Teachers (PAT), which provides in-home services. Each member receives a resource guide with their Welcome Packet. The Case Managers also attend public events to educate members about the case management services available through the Health Plan. They also visit PCP offices and attend care conferences whenever possible.

Examples of activities were provided. In one case a thirty-nine year old mother with metastasized breast cancer, desperately wanted to be at home so her daughter would stay in school. Arrangements were made for home health, meals on wheels, and oxygen to be available. The Case Manager worked with the home health agency when additional needs were identified. They located a number of community-based agencies who assisted in providing services to assist the family.

In another example the Case Manager was working with a pregnant woman who had nine children. The mother was deaf so they used interpreter services available through LAMP. This enabled the Case Manager to involve the extended family, and to learn that the woman needed home health assistance. The mother was able to obtain the needed OB assessments, stay at home, and obtain follow-up services from the Case Manager.

Member Services also is involved with pregnant members. They provide follow-up calls and provide additional information beyond the normal Welcome Call. They maintain contact to ensure that the member can be located and that all identifying information is current. The Member Services staff reports that this ensures that the member is getting all provider services, and that there is a smooth transition if the member changes Health Plans during the pregnancy. Member Services and Case Management both make referrals for mental health services as well. They have a specific liaison with the Health Plan's Behavioral Health Subcontractor, MHNet.

This MHNet Case Manager maintains regular, daily contact with the Health Plan staff, particularly on complex cases.

When questioned about their relationships with the Utilization Review Department, the Case Managers responded that they receive referrals from the UR Nurses, and that they utilize the clinical expertise from that department when consultation is needed. The Case Managers related that this process assists in continuity of care and complete information sharing. The two departments update one another regarding demographic and contact information. The Case Managers also receive referrals from the concurrent review nurses on Emergency Room cases.

The Case Managers did discuss that members have the right to accept or refuse both case management and any medical treatment offered. They make every effort to ensure that members have access to special services and required medical treatment. They could also provide examples of the methods they utilize to ensure that members are aware of their right to have an impact on treatment planning. These staff exhibit a clear commitment to the members they serve.

The rating for Enrollee Rights and Protections (100.0%), maintains the significant increase the Health Plan made over their 2006 rate (53.8%). This improvement indicates that Molina HealthCare of Missouri continues to exhibit success in their efforts to have approved written policies and procedures, and to exhibit activities that indicate that services are available to members. Molina Healthcare of Missouri exhibited a businesslike approach and commitment to continue their efforts to maintain completion and submission standards of required policies and procedures.

Table 81 – Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	Molina Healthcare of Missouri		
	2006	2007	2008
438.100(a) Enrollee Rights: General Rule	1	2	2
438.10(b) Enrollee Rights: Information Requirements	1	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	1	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	1	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	1	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	1	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	7	13	13
Number Partially Met	6	0	0
Number Not Met	0	0	0
Rate Met	53.8%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

MHNet is the Behavioral Health Organization (BHO) that subcontracts with Molina Healthcare of Missouri for mental and behavioral health services for members. This was the second full year of the BHO's relationship with Molina HealthCare of Missouri. The Health Plan reported a smooth transition and no specific problems occurring in terms of members accessing services during the 2008 program year. The BHO makes an effort to assist members to obtain timely access to services. Members are encouraged to contact the BHO to make appointments, particularly if they have contacted providers directly without success. Providers are listed on the BHO website in an effort to ensure that members have access to this information. The Health Plan reports that the BHO has developed an adequate provider network in both the

Central and Western Regions, as well as the network that already exists in the Eastern Region. The BHO continues to make an effort to improve coordination between behavioral health providers and the member's primary care physician. They are committed to continuing improvement in this area.

Quality Assessment and Performance Improvement

Access Standards

Molina Healthcare of Missouri continues to make improvements in the area of access standards during 2008. The Health Plan conducted a survey of providers in 2008. The providers were questioned about 24-hour service availability and enhancements were made in this area. They also improved the Health Plan Concurrent Review Guidelines for Authorizations. The Health Plan reports that this has improved their feedback to providers and enhanced services available to members. Other changes that occurred include use of InterQual Guidelines, improved corporate guidelines for provider interactions, and concurrent review guidelines. These updates were developed to improve services to members, meet community needs, and to interact more effectively with providers.

Molina Healthcare of Missouri staff measured the requests and accompanying information against InterQual criteria. If the decision was to deny the authorization, the information was reviewed by the medical director prior to entry into the Health Plan's system. All authorizations are tracked and monitored. The Health Plan reports that there is a system in place to ensure that communication with providers is efficient and that members obtain needed services in a timely manner. Molina Healthcare of Missouri has decreased the timeframes for responding to authorization requests. Tracking and trending of information occurred and is reviewed on a monthly basis.

Administrative staff report that Case Managers are not experiencing problems with finding PCPs with open panels that are willing to serve Molina Healthcare of Missouri members. Most providers agree to see siblings of children who are already members or patients. Assignments are done with the consultation of the member whenever possible. If auto assignments are required, distance is the main consideration. Direct contact with physicians to assist members

with appointments is made whenever necessary. The Health Plan reports adding physicians groups in all three MO HealthNet Regions. These additions have enhanced the Health Plan's ability to serve all MO HealthNet members. They also state that their new member management system will assist with providing up-to-date and accurate information directly to the Case Managers. Case Managers report that if they are having difficulty locating a physician for a specific member, they ask for assistance from Member Services who spends time finding an office for the member that is agreeable to them. This example is one of several received during the on-site review that exhibits the integrated nature of the work done a Molina HealthCare.

In response to a question regarding support and assistance to providers, Molina's Administrative staff provided an example of their current project designed to produce complete medical records. The Health Plan has added a staff position to develop and maintain a complete program for accurate and complete medical records. The intent is to be able to track an encounter claim through the entire medical intervention and payment process. The Health Plan hopes that this project will improve communications and payment efforts for providers.

Molina Healthcare of Missouri admits that they are continuing to work to have a complete network of specialty providers, particularly pediatric neurologists, rheumatologists, and orthopedic surgeons. The Health Plan does negotiate for these services because the Provider Relations staff developed individualized relationships with providers. They did report paying orthopedic surgeons 100% of billed charges. They also discussed that they are now contracting with an entire provider group in the Central Region at a rate that allows them to have a complete array of PCPs and specialists available to members.

The Health Plan continues to assess provider availability annually when producing their report to the Missouri Department of Insurance. The Health Plan has improved the availability of 24-hour coverage by providers, as required in their MO HealthNet Managed Care Contract. The Health Plan also continues monitoring activities that include review of provider telephone logs, blind telephone testing, and obtaining input directly from providers. The Health Plan continues provider education. They report that they are contracted with all of the Federally Qualified Health Centers (FQHCs) in the three MO HealthNet Managed Care regions. This effort improved daytime and some after-hours access.

Member Services staff was asked about service availability. They gave examples of providing members with information about all services available, and the location of urgent care centers and physicians who have after-hours clinics. They also gave examples of directly contacting providers to ensure that members obtain timely appointments, to clarify information, and to locate specialists. The Member Services staff also contacts Provider Relations to update them when issues arise concerning members' inability to obtain services.

Member Services staff also described activities within the Health Plan to obtain information and feedback from members, such as return telephone contacts and surveys. They utilize this information to improve customer service and to assess member satisfaction. The Member Services staff reports that they have learned how to listen to members and identify if a family member has special needs. They immediately refer these members for case management and more in-depth services. The referral and need for information is recorded in the Health Plan system so all involved staff members are aware of the member's needs and follow-up contact data.

Case Managers discussed their efforts to ensure that members have access to all the services required, specifically for members with special health care needs. They encourage members to utilize the nurse help line and educate them on all health care resources that are available. The Case Managers contact providers, review utilization, and participate in treatment planning to ensure that members have access to all required health care services. The case managers explained that the member supplies the information necessary to develop a treatment plan, and the case manager ensures that there are no gaps in providing treatment services. Coordination of services, with medical providers, and with behavioral health services, is an essential component of this process as related by the Case Managers.

The rating for Compliance with Access Standards (88.2%) is a decrease from the 100% compliance reported in 2007. The 2007 figure reflected the Health Plans efforts to comply with required policies and procedures. However, during 2008 report interviews it was learned that in the areas of care coordination and treatment planning the Health Plan has not yet been able

to operationalize all activities. Molina Healthcare of Missouri is continuing efforts to ensure that all required policy is in place, and is approved by the SMA. Observations made at the time of the on-site review indicated that these strong efforts are being made to become fully compliant.

Member Services added two Spanish speaking and one Bosnian speaking staff members when the Central and Western Regions were added to their contract in 2007. They also have one staff member who speaks four (4) languages including German. The Health Plan believes they have adequate diversity and provides members enough alternatives to be comfortable when contact is made.

Table 82 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Molina Healthcare of Missouri)

Federal Regulation	Molina		
	2006	2007	2008
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	1	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	1
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	1	2	2
Number Met	15	17	15
Number Partially Met	2	0	2
Number Not Met	0	0	0
Rate Met	88.2%	100.0%	88.2%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Molina Healthcare of Missouri continued to develop their credentialing standards. They report that credentialing of providers involves the review of the history of complaints regarding any specific activity related to Health Plan members. The Health Plan is following NCQA guidelines regarding the credentialing process. They complete follow-up visits to physician offices if specific interventions are required. The Credentialing Team looks at all trends regarding adverse events, reviews records, and implements a corrective action plan if necessary.

The Health Plan no longer allows provisional credentialing. Provider Relations staff visits all provider locations, including delegated providers, to ensure that they are meeting all requirements. The Health Plan continues to provide in-service training to larger providers as required. Utilization Management staff and Case Managers also visit provider offices to discuss issues and services directly. The Health Plan assured that all providers maintained licensure and the right to practice in Missouri. Source One was employed to run a monthly data scan against licensing listings. This process enabled the Health Plan to maintain current licensure information. The Health Plan maintains a work plan to ensure that the provider list is current regarding all credentialing issues. Delegated credentialing is granted to the SSM hospital system and to the BHO MHNet. Certification of the delegated credentialing is completed by Source One.

During 2008 an after-hours survey was conducted that indicated problems in several areas. One of these was telephone access to twenty-four hour primary care physician (PCP) availability. During 2008 Molina HealthCare of Missouri continued to work toward making after-hours services available to prevent the unnecessary use of emergency rooms. The Health Plan provided education to members on the use of the Team Health Nurse Advice Line, and contacted PCPs directly if problems were not resolved.

Molina HealthCare of Missouri continues to create a more rigorous approach to training than was available in previous years. This change was implemented to ensure that staff is aware of new policies and procedures. The Health Plan relates that improved training initiatives leads to improved services and enhanced interdepartmental communications.

Member Services staff report being aware of the policies and procedures to utilize if a Health

Plan member calls and requests disenrollment. They do ask questions to ensure that the call is not the result of an issue that can be resolved, or referred on as a grievance or appeal. When the member is adamant the process for disenrollment is started immediately. This does not occur with any regularity, but they state that they attempt to be as helpful and accommodating as possible. If the member calls regarding the need for an authorization, or any other activity that should occur immediately, Member Services obtain as much information as possible, then make the appropriate referral for the member. This referral may be to case management, utilization management, or the grievance and appeals unit. The staff members interviewed gave examples that make it clear that they understand these processes and that they act in the members' behalf.

In addition to care coordination, case managers discussed the use of practice guidelines and other information used to ensure that special issues are addressed in serving members. The Case Management staff works with the Utilization Review section and with the concurrent review nurses to ensure that all members receive the health care services needed.

The rating for Structure and Operation Standards (100%) reflects the submission and approval of policy to the SMA, as well as the ability to validate the existence of operations supporting this policy. The Health Plan understands that continued efforts in this area of practice will be needed. Their progress in this area of compliance is noteworthy. Observations at the time of the on-site review support the Health Plan's success at identifying and improving areas that had previously been problematic.

Table 83 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Molina Healthcare of Missouri)

Federal Regulation	Molina		
	2006	2007	2008
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	1	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	8	10	10
Number Partially Met	2	0	0
Number Not Met	0	0	0
Rate Met	80.0%	100.0%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Molina Healthcare of Missouri had developed and implemented specific practice guidelines with providers at the time of the 2008 review. The Health Plan has instituted the National Heart, Lung, and Blood Guidelines for asthma care for adults and children. NIH clinical guidelines and Kansas City guidelines were adopted for several other areas of healthcare delivery. This information and methods to utilize these guidelines have been distributed to all Health Plan providers.

Molina Healthcare of Missouri reports that they are in the process of modifying and improving the Quality Improvement Committee (QIC) structure. They are developing smaller groups with specific responsibilities that report to the larger QIC. The committees all monitor various data, such as that gathered through the Performance Improvement Project (PIP) process, satisfaction surveys, and HEDIS rates. They hope to clarify the mission of each group, and assist the

subcommittees focused on specific topics to review. The explanation of the new structure revealed a strong commitment to the Quality process. The operations and specific roles and duties are under development. The Health Plan's goal of providing quality services to members was the focus of the group's discussions. Administrative staff viewed this initiative as having a positive effect on the performance and focus of the Health Plan. The Health Plan hopes to use this information to ensure that all members have adequate access to health care services.

Molina Healthcare of Missouri submitted two Performance Improvement Projects (PIPs) for validation. Although these PIPs lacked complete maturity, they indicated substantial improvement in utilization of this process as a tool for Health Plan growth. The structure of both PIPs followed the federal protocol and showed a great deal of potential. These PIPs indicated an increased degree of understanding of the importance of the PIP process in improving Health Plan operations and health care services to members.

The Health Plan submitted all required information to complete the Validation of Performance Measures for all three measures, as requested. The specific outcomes of the Performance Measure are discussed in the appropriate section of this report. Molina Healthcare of Missouri continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The complete details of each of these areas of validation can be reviewed within specific sections of this report.

The rating for Measurement and Improvement (90.9%) reflects a continued diligence toward meeting the requirements of the MO HealthNet Managed Care contract and federal regulations. These policies and procedures are in place. The Quality Improvement Committee enhancements appear to be strength, but continue to be under development.

Table 84 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Molina Healthcare of Missouri)

Federal Regulation	Molina		
	2006	2007	2008
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	10
Number Partially Met	0	0	1
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	90.90%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Molina Healthcare of Missouri has approved policy and procedures for their Grievance System compliant with MO HealthNet Managed Care contract requirements and federal regulations. The Health Plan put processes in place to capture member and provider contacts. They continue to report that they are working smarter and have developed better communication between internal departments. This enhanced their ability to track and respond to member grievance and appeals, as well as provider complaints, grievances, and appeals. The Health Plan developed an on-line tracking system that contributes to timely responses in the complaint, grievance and appeal process.

Member Services staff reports that they receive many calls regarding member concerns. They request a brief overview of the issue, record pertinent information in their tracking system, and immediately refer the issue. As soon as they have enough information to identify a member grievance the issues is documented and sent to the Grievance/Appeal Manager. The Member Services staff relates that the Grievance/Appeal Manager then contacts the member and discusses the grievance and appeals process with the member, and assists the member in negotiating the system. The Member Services staff is aware of the State Fair Hearing process and has only received a few requests for a State Fair Hearing. Corrective action within the Health Plan occurs as necessary as the result of review of the grievances and appeals received.

Case Managers were aware of the Health Plan's grievance and appeals process. They related that they are often contacted when an authorization is denied and the member receives this information in writing. They then coach the member about the process and further available actions. They also attempt to provide an explanation of the decision. The Case Managers advocate for the members through this process, including directly contacting the Medical Director for further input and assistance in the decision review. The Case Managers report that they do receive information from the Grievance and Appeal Manager about the outcomes, and further action required for the members they serve.

The Administrative staff reported that many provider grievances concerned balanced billing issues. There is a new supervisor for complaints and grievances. New staff has been hired to ensure that both member and provider issues are handled efficiently. The supervisor is auditing all grievance files, and ensuring that the processes used are in compliance with NCQA standards. A third level of review is planned for the Medical Appeals Section within the Health Plan.

The rating for the Grievance System (100%) reflects approval of the Health Plans policy and procedures required to meet MO HealthNet Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that Molina HealthCare of Missouri was meeting all requirements of operating a functional Grievance System for both providers and members.

Table 85 – Subpart F: Grievance Systems Yearly Comparison (Molina Healthcare of Missouri)

Federal Regulation	Molina		
	2006	2007	2008
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols

Conclusions

Molina Healthcare of Missouri was 100% compliant in all areas in 2007. In 2008 the Health Plan remained substantially compliant in all areas measured. In several areas they are rated as "Partially Met." This reflects changes in practice that were observed at the Health Plan during the on-site review. These changes and enhancements are focused on improving services to members, and improving their Quality initiatives. At the time of this review improvement in many areas of performance were observed. Molina Healthcare of Missouri continues their commitment to members and to providing healthcare services in an effective manner by demonstrating an atmosphere of respect and dignity toward members. The Health Plan's efforts to become fully compliant in both having approved policy and verifiable approved practice is evidence of their continuing efforts to growth and development within the organization. These improvements will provide a sound foundation for continued efforts to make the changes required to achieve and maintain full compliance in the future.

QUALITY OF CARE

During the previous on-site review Molina Healthcare of Missouri indicated that they recognized the need to improve in the development of policies and procedures, and to continue to review and upgrade their organization's performance. They continue to exhibit the commitment to these goals, and provided sound examples of the progress made during 2008. These discussions took place in the context of providing quality care and services to members. The Health Plan exhibits a distinct recognition of the importance within the organization of the need for clear communication between departments to effectively meet members' service needs. Quality services at the Health Plan and provider levels were evident in the information presented. It should also be noted that this Health Plan maintains a system of regular direct contact with providers. Provider Relations staff makes regular in-person visits, at approximately six week intervals, to provider offices. This enhances the quality of relationships between the Health Plan and their providers, enabling them to troubleshoot, educate, and ensure that members receive the healthcare services they require. It is also recognized that the Health Plan staff who have

the greatest direct contact with members, Member Services and Case Management, are integrally aware of how their departments interact with and are supported by the other departments within the organizational structure. This enhances the staff's ability to serve members in an efficient and quality manner.

ACCESS TO CARE

Molina Healthcare of Missouri did make a number of changes during the past two years to improve access to care for members. They were able to contract with a number of hospitals and physician groups that were previously not in their network. Their provider panel has expanded in the availability of primary care physicians and specialists. The Health Plan instituted a method of contacting primary care physicians for members when members experience problems obtaining appointments. All of these activities, as well as improvements and training for Member Services staff, and additions in resources for Case Managers have created an atmosphere where assuring access to care is an essential aspect of the Molina Healthcare of Missouri program.

TIMELINESS OF CARE

An attention to the issue of timeliness of care was also evident at the Health Plan. They have improved significantly in the area of timely and complete policy submission. Changes and improvements of internal processes have also made timely response to member and provider issues a priority. Timeliness of healthcare improved as the result of changes and expansions within the organization. Both Case Managers and Member Services staff report that timely and adequate health care services are of primary importance in their involvement with members. These staff gave concrete examples of making direct contact with providers to ensure that appointment and services were delivered in a timely manner to illustrate this as an essential value supported by Molina Healthcare of Missouri.

RECOMMENDATIONS

1. Maintain improvements in the area of timely submission of policy and procedures for SMA approval. This is an important factor in establishing continued confidence in the Health Plan's operations.
2. Continue to develop and enhance the Quality Improvement program within the Health Plan.
3. Continue to utilize the new Case Management system to ensure that treatment planning and care coordination reach optimal levels of operation.
4. Continue to support front line staff in their efforts to be primary advocates for members and to provide an atmosphere based on the desire to excellent healthcare services to members.
5. Continue to utilize available data and member information in order to drive, change, and measure performance.

11.0 Missouri Care

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11.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Missouri Care supplied the following documentation for review:

- WIC Collaboration to Increase Well-Child Visits
- Statewide Performance Improvement Project – Improving Adolescent Well Care Missouri Care

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 21, 2009. during the on-site review, and included the following:

Dr. Andrew Matera – Chief Medical Officer
Katie Dunne – Senior Quality Coordinator
Elizabeth Opland – Quality Management Manager
Christina Schmidl – Quality Coordinator

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who were the staff involved in this project and what were their roles?
- How were the topics identified? Expand on why they are important to the Health Plan and its members.
- Discuss the findings and how they were interpreted.
- How were the interventions determined and why did the Health Plan choose this approach?
- Are these studies ongoing?
- Discuss the effects of these interventions and how they impacted services to members.
- What does Missouri Care want to study or learn from their PIPs?

Both of the PIPs submitted for validation were not of adequate maturity to allow for a thorough evaluation. However, the Health Plan was instructed during the site visit that they could submit additional information that included updates to the outcomes of the interventions or additional data analysis. Additional information was received for these PIPs.

FINDINGS

The first PIP evaluated was, "Partnership to Improve WIC Participation and Increase Well-Child Rates." This PIP was identified as a clinical project. This PIP was designed as a creative approach to improve a relevant area of member care. The rationale for the topic study choice was well documented in the information presented. The topic was justified in terms of providing sound local and national literature and research supporting the assertion that it would improve health outcomes for Health Plan members. It included information on the population and provided a strong argument for choosing the topic for a performance improvement project. The overarching goal of the project was clearly focused on improving the knowledge about and availability of preventive health care services. To accomplish this goal the PIP project planned to work with WIC (Women, Infants, and Children) offices in a collaborative approach to ensure that members had access to a valuable resource, while increasing the number of members who obtain well child screenings. This approach will have another positive consequence, improving the number of children in compliance with childhood immunizations, lead screenings, and other

preventive services. The Health Plan hypothesizes that by participating in community partnerships they will "improve education, awareness and preventive health screening rates" in the MO HealthNet Managed Care population.

This project focused on five counties in the Health Plan's MO HealthNet Managed Care region. When questioned about this choice they explained that they worked with the WIC offices who expressed an interest and volunteered to be part of this project. It is hoped that with positive results for both the Health Plan and WIC, additional offices will ask to be included in the process in the future.

The PIP sought to answer two study questions. They are: 1) "Will the parents of members not enrolled in a WIC program decide to join WIC after receiving a letter from the Health Plan about the value of WIC participation?" and 2) "Can Missouri Care Health Plan successfully educate parents on the importance of yearly well-child checkups through partnerships with local WIC offices, as measured by a significant increase in well-child visit rates?" The presentation of the study questions provided an understanding of the basis of the study and planned interventions. The question and supporting information provided confidence in the proposed methodology and anticipated outcomes.

The definitions of each indicator were linked to the study question. Numerators and denominators were defined for each indicator, including how they are calculated. The objectives were clearly identified and well-defined. The indicators were set up to measure the improvement in the number of Health Plan members enrolling in the WIC program, as well as the number of members, who are WIC participants who obtain well-child checkups in the 12-month period following the intervention. The health plan did define their population as children ages 0 – 4.5 years of age, who live in the participating counties. This is the age range of children eligible for the WIC program. For the second study question the population was comprised of members enrolled in WIC who had not received a well-child checkup in the six months prior to the intervention. The PIP included a rationale for excluding these members. No member was excluded based on the existence of special health care needs.

The interventions included were:

- A Health Plan developed letter to parents encouraging the enrollment in the WIC program, including information about the local WIC office, including an educational brochure.
- A Health Plan developed flyer and health education card utilized by WIC staff to encourage well-child checkups, and a health education card detailing the importance of well-child checks and the schedule recommended by MO HealthNet.

The interventions were constructed to provide direct feedback to the Health Plan about the members who participated in the project. Specific member tracking occurred at the Health Plan.

The study design clearly identified the data to be collected and the sources of this data. The study design specifically collected data on WIC enrollment and well-child checkups. The methodology and internal process were described in detail. The Missouri Care IT staff performed the QMAS/QNXT queries for all required data. The query rules were included. The Quality staff provided oversight and data analysis. The Health Plan employed a rigorous process of data collection that was well documented. This information was available to both Health Plan and WIC staff. The update received after the on-site review provided the details of how the data was pulled, and how they ensured that consistency is an essential component of their measurement techniques and interpretations. Time frames for collection and analysis were provided in enough detail to give confidence in the methodology used. An assumption can be made, as a result of the original and updated information included, that the Health Plan is collecting data in a consistent and accurate manner. The information provided contained enough narrative telling the evaluator how consistency and accuracy is achieved.

A prospective data analysis plan was described in detail, including all planned analysis and a prospective look at the definition of success of the intervention. The plan includes the goal of a 10% increase in member enrollment in the WIC program. The measure of success for the well-child checkups was an increase of 20% of the children who received the flyer and then received a checkup within 90 days post receipt. The confidence level in all data obtained and evaluated was discussed.

The planned interventions were described in enough detail to ensure a thorough understanding of the rationale presented, and to create confidence in the expected outcomes to be achieved by this study. Data from the three campaigns, conducted in July 2007, January 2008, and July 2008 was included. The July 2007 data serves as the baseline for this project. Statistical significance testing was utilized to determine if the project produced meaningful improvement. Barrier analysis was conducted to ensure that changes could occur throughout the project to enhance potential success. The documentation provided included improved processes for the project going forward. The information also included conclusions based on the interventions. The Health Plan does conclude that their hypothesis that engaging in a community partnership and educating members was confirmed by increased WIC enrollment and well-child visit rates. This conclusion was substantiated by the rigorous data analysis and narrative that was included.

The second PIP evaluated was the Missouri Care individualized approach to the Statewide PIP "improving Adolescent Well Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided in the MO HealthNet Managed Care Statewide PIP documentation. The topic selection also included information making this information specific to Missouri Care and its members. The topic selection narrative focused on the issue of improving adolescent well care as a key aspect of member health care as an important area of prevention. The Health Plan used their current HEDIS performance rates compared to the NCQA benchmarks and MOHealthNet's required reporting on this measure a basis for evaluating the effectiveness of their individual project. The Missouri Care stated hypothesis is that member and provider education, as carried out by the Health Plan's individualized interventions, will lead to an increase in the HEDIS Adolescent Well Care Visit rate.

The study question presented was "Can outreach to network providers and eligible members improve the HEDIS Adolescent Well Care Visit rate?" The study question was well constructed and is measurable.

The study used indicators based on the requirements of the HEDIS measures and included a rolling 12-month AWC "HEDIS-like" rate to track data on a monthly basis, which they reported quarterly. The indicators were clearly tied to the issues addressed in this study. The methods

prescribed to track and enumerate these measures were included in the narrative provided. The Health Plan implemented a number of individualized interventions in addition to those included in the Statewide PIP. These Health Plan specific interventions include:

2007
Provider Preventive Care Toolkit
Come In For Care Campaign
EPSDT Reminder Postcards

2008
Expansion County Campaign
Come In for Care Campaign
Provider Preventive Care Toolkit
EPSDT Reminder Postcards
Teen health Campaign: Letter and Card

The details of these interventions were provided in the narrative. They were related to the goal of this project.

The data collection and analysis approach was well planned to capture all required information to evaluate this study. The narrative clearly described how data would be collected and analyzed. The study described the process the Health Plan will utilize to extract data monthly and report quarterly. The specific elements of the HEDIS technical specifications that relate to AWC measure were included. Claims data for the study will be queried from the QNXT system, which is Missouri Care's claims processing system. Applicable CPT and ICD9 codes were specified. The Health Plan does utilize the hybrid method for calculating their HEDIS rates, which does include medical record review. The reviewers, their qualifications, and the interrater reliability requirements were included. The HEDIS-like 12 month rolling calculations are administrative rates. The narrative included enough specificity to ensure confidence that this process was thorough and complete. A prospective data analysis plan was presented. It included a plan for ensuring that attention to all issues were addressed, and also explained the methodology to be employed. It outlined a plan to compare subsequent year's data to the 2007 baseline statistics. Statistical calculations to produce the 95% confidence level calculated in the HEDIS methodology will be used to monitor the ongoing process. All data sources were clearly defined and the prospective data analysis plan was followed. The updated documentation did provide details about the staff who are involved in this project, their roles, and qualifications.

The study results were provided in the update received after the on-site review. In 2008 the quarterly percentages were tracked and trended using the HEDIS 2008, Quarter 3, as the baseline. The quarterly rates were used to monitor and success of the interventions prior to obtaining the results of the annual HEDIS measurement timeframes. The quarterly rates for five re-measurement periods indicated a statistically significant increase in the AWC rates as compared to the baseline period. However, the Health Plan's HEDIS 2009 data indicated a decrease in the rates. There were increases for Indicator 2 in the HEDIS-like measurements. The Health Plan concludes that while they continue their current interventions, they will need to enhance their approach and implement new interventions to regain earlier reported improvement in the AWC HEDIS measure.

This PIP was well-constructed. It has matured to a level where an initial evaluation could occur. The data evaluated provided potential for positive performance improvement. The plan included information on additional strategies for the 2010 measurement year. The analysis was planned and the documentation provided confidence that continued efforts on this project will be completed as described. The format and presentation led to ease in evaluating the project. Information was clear, organized, and understandable, all adding to the confidence in the potential outcomes.

CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the two PIPs undertaken by this Health Plan. The quality of health care, and the overarching issue of the quality of life of Health Plan members, were both addressed in these PIPs. Enacting measures to improve education about the need to utilize opportunities for primary preventive care enhances the quality of services received by members. In both projects the Health Plan stated their planned intention to incorporate these interventions into normal daily operations as the data indicated positive outcomes. Undertaking performance improvement projects that will develop into enhanced service provisions for members indicates a commitment to quality service delivery.

ACCESS TO CARE

The study topics presented in these PIPS addressed issues that will create improved services and enhanced access to care for the Health Plan members. Although each PIP approached the respective problems differently, each created a potential for improved access to appropriate services, in the least restrictive environment.

TIMELINESS OF CARE

A major focus of these performance improvement projects was ensuring that members had timely access to care. Implementing strategies to ensure that members obtain well child visits, and adolescent well care screenings positively impacts timely access to care. The projects indicate that the Health Plan has a commitment to assisting members in engaging in timely treatment. By working with providers to encourage patients to make timely appointments it enables better health care outcomes.

RECOMMENDATIONS

1. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the studies submitted has improved significantly. Both studies provide evidence that there was a great deal of thought and consideration put into planning these studies, developing appropriate interventions, and creating a positive environment for the potential outcomes. This process will also ensure that as the studies are completed, effective data collection and analysis will occur.

2. Continue to utilize a creative approach to development projects and implement interventions that will produce positive outcomes. Ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.

11.2 Validation of Performance Measures

METHODS

Objectives, technical methods, and procedures are described under separate cover. This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Missouri Care. Missouri Care submitted the requested documents on January 20, 2009. The EQRO reviewed documentation between January 20, 2009 and June 30, 2009. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Missouri Care
- MEDSTAT's NCQA HEDIS Compliance Audit Report for 2008
- Missouri Care's HEDIS Data Entry Training Manual
- Missouri Care's Policies pertaining to HEDIS rate calculation and reporting
- Appendix Z – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

The following are the data files submitted for review by the EQRO:

- EQRO_ADV_2009.txt
- EQRO_ADV_2009_Enroll.txt
- EQRO_ASM_2009.txt
- EQRO_ASM_2009_Enroll.txt
- EQRO_AWC_2009.txt
- EQRO_AWC_2009_Enroll.txt
- EQRO_AWC_Hybrid.txt

INTERVIEWS

The EQRO conducted on-site interviews with Elizabeth Opland, Manager, Quality Management; Christina Schmidl, Quality Coordinator; Mark Kapp, Quality Coordinator; Heather Mrowiec, HEDIS, Aetna; and Alan Boyett, HEDIS, Aetnaat Missouri Care Health Plan in Columbia, MO on Monday, July 20, 2009. This group was responsible for the process of calculating the HEDIS 2008 performance measures. The objective of the on-site visit was to verify the methods and processes behind the calculation of the three HEDIS performance measures. This included both manual and automatic processes of information collection, storing, analyzing and reporting.

FINDINGS

Missouri Care calculated the Use of Appropriate Medications for People With Asthma and Annual Dental Visit measures using the administrative method. The hybrid method was used to calculate the Adolescent Well-Care Visits measure.

MO HealthNet MCHP to MCHP comparisons of the rates of Adolescent Well-Care Visits, Use of Appropriate Medications for People With Asthma, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The HEDIS 2008 rate for Missouri Care for the Adolescent Well-Care Visits measure was 49.54%, which was significantly higher than the statewide rate for all MO HealthNet Managed Care Health Plans (38.59%; $z = 1.48$, 95% CI: 43.00%, 56.07%; $p > .95$). This rate was also higher than the rates reported in both the 2004 (41.19%) and 2007 (44.91%) EQR audits for this same measure (see Table 86 and Figure 43).

The Use of Appropriate Medications for People With Asthma measure rate reported to the SMA and the State Public Health Agency (SPHA) by Missouri Care was 86.96%. The rate reported was consistent with the statewide rate for all MO HealthNet Managed Care Health Plans (87.23%; $z = 0.40$, 95% CI: 58.41%, 115.50%; n.s.). The rate was also 21.82% higher than the same rate reported for the HEDIS 2004 audit (65.14%; see Table 86 and Figure 43).

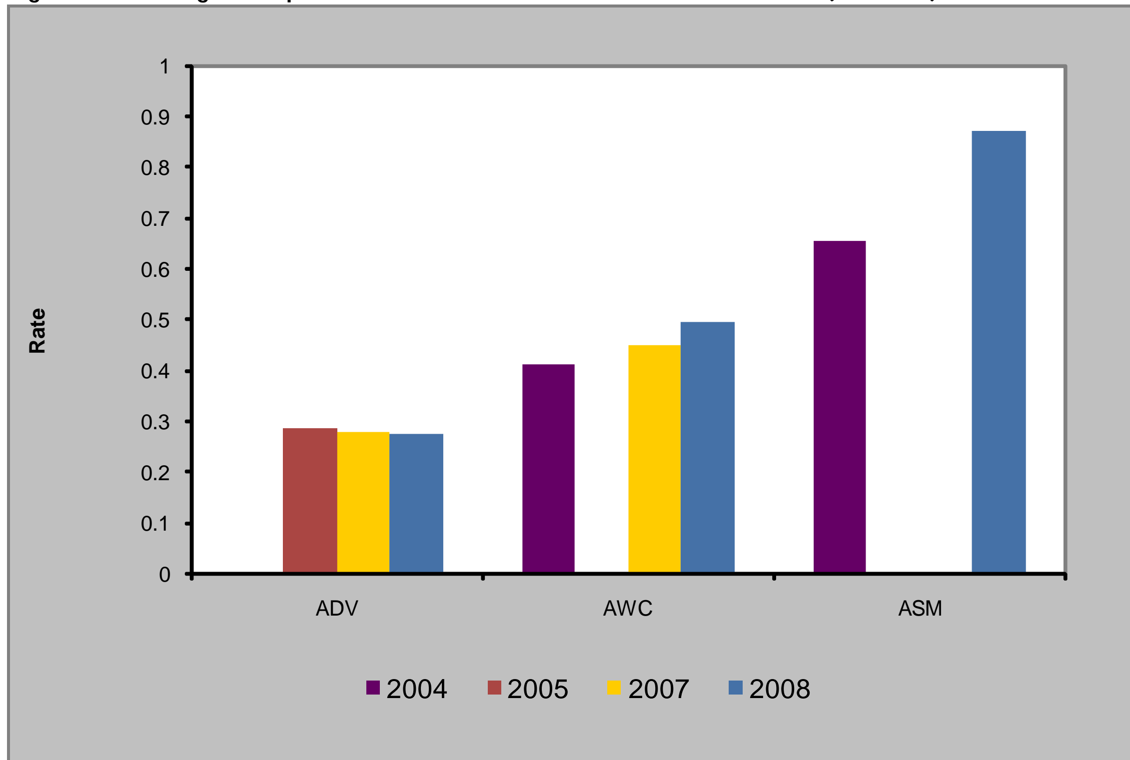
The reported rate for Missouri Care for the Annual Dental Visit rate was 27.50%; this was comparable to the statewide rate for MO HealthNet Managed Care Health Plans (34.71%, z = -0.38; 95% CI: 21.27%, 33.74%; p < .05). This rate is also lower than the rates reported in both the 2005 and 2007 EQR report years; 28.66% and 27.76%, respectively (see Table 86 and Figure 43).

Table 86 – Reported Performance Measures Rates Across Audit Years (MOCare)

Measure	HEDIS 2004 Rate	HEDIS 2005 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate
Annual Dental Visit (ADV)	NA	28.66%	27.76%	27.50%
Use of Asthma Medications (ASM)	65.14%	NA	NA	86.96%
Adolescent Well-Care Visits (AWC)	41.19%	NA	44.91%	49.54%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 43 – Change in Reported Performance Measure Rates Over Time (MOCare)



Sources: BHC, Inc. 2004, 2005, 2007, and 2008 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems (IS) management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. For all three measures, Missouri Care was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Missouri Care transferred data into the repository used for calculating the HEDIS 2008 measures.

DOCUMENTATION OF DATA AND PROCESSES

Missouri Care used Catalyst, an NCQA-certified software program in the calculation of the HEDIS 2008 performance measures. The EQRO was provided a demonstration of this software, as well as appropriate documentation of the processes and methods used by this software package in the calculation of rates. The EQRO was also provided with an overview of the data flow and integration mechanisms for external databases for these measures. Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Missouri Care met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

Missouri Care met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of members eligible for the services being measured.

Missouri Care employed a 5% oversample for the Adolescent Well-Care Visits measure. No records were excluded for contraindications, making for a total sample of 432. This is within the specified range and allowable methods for proper sampling.

For the HEDIS 2008 Adolescent Well-Care Visits measure, there were a total of 4,888 eligible members listed by the health plan and validated by the EQRO. The DST showed a denominator of 432 eligible members after a 5% oversample. There were no exclusions allowed for the measure, and no exclusions or replacements reported. There were no duplicate member names, identification numbers or dates of birth. The dates of birth were within the valid range and the dates of enrollment and codes for well care visits were provided.

For the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure, the DST showed a total of 299 eligible members for the denominator. The file of all administrative records supplied by the health plan contained 299 eligible members. There was no duplication of members and the dates of birth and dates of enrollment were within the valid range.

For the HEDIS 2008 Annual Dental Visit measure, there were a total of 14,103 eligible members reported and validated by the EQRO. There were no duplicate members and the dates of birth were in the valid range. The dates of enrollment were valid.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, medication dispensing events, and dental visits) as specified by the HEDIS 2008 criteria (see Attachment XIII: Numerator Validation Findings). A medical records review was conducted for the Adolescent Well-Care Visit measure.

For the Adolescent Well-Care Visit measure, Missouri Care reported 189 administrative hits from the sample of the eligible population; the EQRO was able to validate 181 of these hits. For the medical record review validation, the EQRO requested 25 records. A total of 25 records were received for review, and all 25 of those were validated by the EQRO. Therefore, the

percentage of medical records validated by the EQRO was 100.00%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 47.69%, while the rate reported by the health plan was 49.54%. This represents a bias of 1.85%, an overestimate by the health plan for this measure.

For the HEDIS 2008 Use of Appropriate Medications for People With Asthma, the health plan reported 260 administrative hits from the eligible population; the EQRO was able to validate 259 of these hits. The reported rate was 86.96%, and the rate validated by the EQRO was 86.62. This represents an overestimate reported bias of 0.33%.

For the HEDIS 2008 Annual Dental Visit measure, the EQRO validated all 3,879 reported administrative hits. The health plan's reported rate was the same as the EQRO validated rate of 27.50%, showing no reported bias.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Missouri Care submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following table shows the estimated bias and the direction of bias found by the EQRO. There was no bias observed in calculation of the Annual Dental Visit measure. The Adolescent Well-Care Visits and Use of Appropriate Medications for People With Asthma measures were slightly overestimated, but these results still fell within the 95% confidence interval reported by the health plan for these measures.

Table 87 - Estimate of Bias in Reporting of MOCare HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	1.85%	Overestimate
Use of Appropriate Medications for People With Asthma	0.33%	Overestimate
Annual Dental Visit	0.00%	No Bias

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. The table below summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.

Table 88 - Final Audit Rating for MOCare Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Use of Appropriate Medications for People With Asthma	Substantially Compliant
Annual Dental Visit	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

Conclusions

Three rates were validated for the health plan. One of these rates was significantly higher than and two were consistent with the average for all MO HealthNet Managed Care Health Plans.

Quality of Care

Missouri Care's calculation of the HEDIS 2008 Use of Appropriate Medications for People With Asthma measure was substantially complaint with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The health plan's rate for this measure was consistent with the average for all MO HealthNet Managed Care Health Plans. Therefore, Missouri Care's members are receiving the quality of care for this measure that is comparable to the average MO HealthNet Managed Care Health Plan member. This rate was higher than the National Medicaid rate, indicating that Missouri Care's members are receiving a higher quality of care for this measure than the average Medicaid member across the nation. The rate was lower than the National Commercial rate, indicating that the health plan's members are receiving a lower quality of care than the average Commercial member in the country. However, the rate was significantly higher than the last time this measure was audited (HEDIS 2004), showing an increase in the quality of care received by members for these services over the past four years.

The rate was able to be validated within the reported 95% confidence intervals and thereby the EQRO has substantial confidence in the calculated rate.

Access to Care

The HEDIS 2008 Annual Dental Measure for Missouri Care was fully compliant with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The rate reported by the health plan for this measure was consistent with the average for all MO HealthNet Managed Care Health Plans. Therefore, Missouri Care's members are receiving a quality of care for this measure that is on level with the average MO HealthNet Managed Care member. However, this rate was much lower than the National Medicaid rate for this same measure, indicating the health plan's members are

receiving a lower access to care than the average Medicaid member across the nation. Additionally, this rate was lower than the same rate reported by the health plan during both the 2005 and 2007 reviews, indicating that Missouri Care members are receiving lower quality of care for this measure than their counterparts were during the HEDIS 2005 and HEDIS 2007 measurement years.

The EQRO was able to validate the rate fully and therefore is extremely confident in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2008 Adolescent Well-Care Visits measure was substantially compliant with specifications. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was significantly higher than with the average for all MO HealthNet Managed Care Health Plans. Therefore, Missouri Care's members are receiving a higher timeliness of care for this measure than the care delivered to the average MO HealthNet Managed Care member. This rate was also higher than both the National Medicaid Rate and the National Commercial Rate; Missouri Care is delivering a higher level of care than that received by the average Medicaid or Commercial member across the nation. Additionally, the rate reported was higher than the rate reported by the health plan during both the 2004 and 2007 review periods.

The rate was able to be validated within the reported 95% confidence intervals and thereby the EQRO has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. The health plan's rates for the Annual Dental Visit measure have fallen over each of the past three review periods in which the measure was audited. The EQRO recommends the health plan concentrate efforts to improve this rate and reverse this trend.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Continue to participate in training of health plan staff involved in the oversight of coordination of performance measure calculation.
4. Continue to perform hybrid measurement on those measures that are available for this method of calculation. The Adolescent Well-Care measure rate was significantly higher than those health plans that did not use the hybrid methodology.

11.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 115,316 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 96.4% complete, accurate and valid. The remaining values were blank (n= 4128).
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second diagnosis code was 100.00% complete, accurate and valid.
10. The third, fourth and fifth Diagnosis Code fields were well below the SMA threshold of 100.00% for completeness, accuracy and validity. The Diagnosis Code fields were 12.2%, 11.38%, and 0.00% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate and invalid).

For the Dental claim type, there were zero encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

For the Home Health claim type, there was one (1) encounter claim paid by the SMA for the period July 1, 20087 through September 30, 2008. All required fields, except the fifth diagnosis field were 100% complete, accurate and valid.

For the Inpatient claim type, there were 15,406 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, and valid.
5. The Discharge Date field was 100.00% complete, accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first, second and fourth Diagnosis Code fields were 100.0% complete, accurate and valid.
9. The third and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (59.84% and 24.10% respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 100.00% complete, accurate, and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 77,501 encounter claims paid by the SMA for the period July 1, 2008 through September 30, 2008. Missouri Care had 100.00% complete, accurate and valid data for all fields examined, except the Procedure Code, third, fourth and fifth Diagnosis Codes.

1. The Procedure Code field was 66.32% valid. The remaining fields were blank (n=26101.
2. The third Diagnosis Code field was 19.68% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).
3. The fourth Diagnosis Code field was 12.01% complete, accurate, and valid. The remaining Diagnosis Code fields were blank (n = 68193).
4. The fifth Diagnosis Code field was 3.85% complete, accurate and valid. All remaining Diagnosis Code fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 44,776 claims paid by the SMA for the period July 1, 2008 through September 30, 2008. Missouri Care had 100.00% complete, accurate and valid data for all fields examined.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Missouri Care, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. All critical fields for the Inpatient, Home Health and Pharmacy claim types were 100.00% complete, accurate, and valid (see previous findings). The Outpatient Hospital and Medical Claim types had invalid data in the Procedure Code fields.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rates for Outpatient Hospital claim types were significantly higher than the average for MO Health Net Managed Care Health Plans. The rate for Dental claims was significantly lower than the average for MO HealthNet Managed Care Health Plans. The rates for all other claim types were

consistent with the average for MO HealthNet Managed Care Health Plans. This suggests high rates of encounter data submission and access to preventive and acute care.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care Health Plan were randomly selected from all claim types for the period July 1, 2008 through September 30, 2008 for medical record review.

Of the 192,818 Outpatient encounter claim types in the SMA extract file for July 1, 2008 through September 30, 2008, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 76 medical records (76.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated.

For the 2007 review, the match rate for procedures was 58.0%, with a fault rate of 42.0%. The match rate for diagnoses was 60.0%, with a fault rate of 40.0%.

For this review, the match rate for procedures was 53.0%, with a fault rate of 47.0%. The match rate for diagnoses was 47.0%, with a fault rate of 53.0%.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed was conducted.

For the procedure codes in the medical record, the reasons for diagnosis codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 24) and incorrect information (n = 4). For the procedure codes in the medical record, the reasons for procedure codes in the SMA extract file not being supported by

documentation in the medical record was missing information (n = 17), downcoding (n =1) and incorrect (n = 4). Examples of incorrect information include codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Missouri Care included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet Managed Care Health Plan encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type, all encounter data submitted to the EQRO was of "paid" status. There were zero unmatched claims that were in the MOCare encounter file and absent from the SMA data. Thus, 100.0% of the EQRO submitted encounters matched with the SMA encounter records.

For all Outpatient Claim Types (Medical, Dental, and Hospital), MOCare submitted 192,818 "paid" encounters, 378 "denied" claims and 30 "unpaid" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims and unpaids claim were not present in the SMA database (as expected); there was a "hit" rate of 99.89% between MOCare encounter claims and the SMA encounter data.

For the Inpatient Claim Type, MOCare submitted 15,406 encounter claims of "paid" status and 4 "denied" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims were not present in the SMA database.

Why are there unmatched claims between the MO HealthNet Managed Care Health Plan and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care Health Plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the health plan data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care Health Plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format and even included internal control numbers which enabled BHC to conduct the planned comparisons between the MO HealthNet Managed Care Health Plan and the SMA extract files.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental, Home Health and Pharmacy claim types were 100.00% complete, accurate and valid.
4. The rates for Outpatient Hospital claims were significantly higher than the average for MO HealthNet Managed Care Health Plans, suggesting high rates of encounter data submission and at least moderate access to preventive and acute care.

AREAS FOR IMPROVEMENT

1. The Outpatient Medical Procedure Code fields contained invalid entries.
2. The health plan reported only one Home Health encounter claims during the review period.
3. The Outpatient Hospital Procedure Code fields contained invalid entries.
4. The health plan submitted significantly less medical records for review then in years passed.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that Revenue Code fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
3. Include all State issued ICN numbers for all encounters to allow more accurate matching of encounters between the MO HealthNet Managed Care Health Plan and SMA extract files.

Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis.

11.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the Health Plan's compliance with the MO HealthNet Managed Care contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO Health Net Division (MHD). On-site review time was used to conduct interviews with those who oversee the daily practices at the Health Plan. Additionally, interviews occurred to ensure that the practices in place are within the scope of the State contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additional document review, including reading and evaluating the Health Plan's 2008 Annual Evaluation, occurred prior to the on-site review. The Health Plan assisted the on-site review team by providing additional documents at the time of the on-site visit. This approach was utilized to validate that practices occurring while serving members, were in compliance with the approved policy, as well as with state and federal regulations.

Initial interviews were conducted with the Member Services and Case Management staff who directly serve the member population. These interactions and responses were compared to the Health Plan's Annual Evaluation and the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff.

A detailed interview tool, individualized for Member Services staff and Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an interview tool was constructed for the Administrative staff to validate and clarify practices and to follow-up on questions raised during the direct service staff interviews.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)
- Missouri Care Health Plan 2008 Annual Evaluation

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2008 Marketing Plan and Materials
- Prior Authorization Time Frames/Policy/Processes
- Staff Training Curriculum and attendance records
- Case Management and Member Services Policies or Instructions
- 2008 Quality Improvement Committee minutes

Additional documentation made available by Missouri Care Health Plan included:

- Marketing Plan and Educational Material Development Policy
- Missouri Care Organizational Chart
- Missouri Care Provider Directory
- 2008 Member and Provider Newsletters
- Case Management and Member Services Training Packets including: Bio-Psycho-Social Model of Care; Managing Difficult Relationships with Members; Introduction to Behavioral Health; Recovery and Resiliency: Implications for Care Management; and Complex Case Rounds

Interviews

Interviews were conducted with the following group:

Plan Administration

Pamela Johnson, CEO
Dr. Andrew Matera, Chief Medical Officer
Dr. Ron Lacey, Behavioral Health Medical Director
Elizabeth Opland, Quality Management Manager
Debby Langley, Member Services Manager
Brenda Moore, Manager, Medical Management
Melody Dowling, Behavioral Health Manager
Mike Dunne, Provider Relations Manager
Christina Schmidl, Quality Coordinator
Carole Mosley, Compliance Officer

Member Services and Case Management Staff

Debby Langley, Manager, Member Services
Michelle Sandbothe, Customer Service Representative
Chiquita Chatmon, Customer Service Representative
Brenda Moore, Medical Management
Mary Strada, Case Management Nurse
Amanda Lucas, Case Management Nurse
Janette Hagan, Case Management Nurse
Melody Dowling, Behavioral Health Manager
Angie Lucas, BH Care Planner
Archie Hamilton, BH Care Planner
Cla Stearns, BH Care Management

INTERVIEW QUESTIONS

Administrative Interviews

- Give examples of measures that the Health Plan implemented to improve the follow-up process for members included in the State's Special Needs report.
- There was a quality of care case that was reported at a "Level III." Provide a summary of the issue and the outcome of the review.
- In the discussion of the actions of the Compliance Committee, the annual report cites instances of non-compliance. For example, in "Reportable Compliance Issues," the report states that there was one reportable item, but it was resolved. What was this issue? What was the outcome?
- Please provide information regarding the reported corrective action taken with one delegate regarding credential requirements? What was the problem? How was it resolved?
- Has the Health Plan noted any increase in access to dental care with Doral Dental as the new subcontractor? Discuss any corrective action or improvements made by Doral Dental.
- What actions are occurring to monitor and improve dental access? What is the ratio of dental providers to members in the expansion counties?
- The Annual Report noted 29 security incidents. What was the level of security risk with these system issues? Describe the corrective action that has occurred.
- What is the status of changes to the Missouri Care data management system to allow the capture of information regarding ethnicity?
- The annual report discusses the issue of over-utilization of emergency departments. Can you elaborate?
    - What strategies are planned to reduce the use of emergency services in an inappropriate manner?
- Give examples of activities that the Health Plan has initiated to improve the number of specialists available to members.
- Discuss any follow-up that has occurred to address the issue of non-compliant primary care physicians in regard to after-hours access to services? What were the outcomes?
- Did Missouri Care conduct any site reviews for credentialing in 2008? What were the outcomes?

- Who is responsible for the credentialing process? What guidelines does Missouri Care employ?
- Describe any evidence that providers are conducting outreach to their patients who are not in compliance with preventive case or disease management guidelines.
- The report identifies 20 cases of provider fraud and abuse. What action was taken to address this issue?
- What trends surfaced from analyzing member grievances and appeals? What action has been taken to impact these issues?
- What changes to operations/member services were brought about in 2008 as the result of the work of the Utilization Management Program staff?
- How do the Case Management and Utilization Review departments work together?
- What is your response to criticisms that CM is just another method of UR?
- Has Crown Optical resolved the "problem of receiving claims from outside providers?" What occurred? Has it been effective?
- How has Missouri Care addressed the MTM "no show" issue? Have these actions been effective?
- What issues surfaced from the provider complaint, grievance, and appeal process that warranted Health Plan action? What action was taken?
- The majority of information included in the report regarding "Behavioral Care Management" relates to prior authorization and the managed care provided. How does this serve the member?
- How does the internal Behavioral Health System interact with the case management system? The written information implies that Behavioral Health Case Management supersedes regular Case Management. What is the relationship between these departments? How does this enhance services to members?

Member Services/Case Management Staff Interviews

- Are you familiar with the results of the CAHPS surveys?
- Has the Health Plan made efforts to increase member satisfaction through the Member Services sections? Describe the efforts that have occurred during 2008.
- What actions are taken to assist members in finding PCPs in their geographic area? How often do members complain that all the PCPs they contact have closed panels?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Describe activities that have occurred during 2008 to improve the process of contacting and providing services to members included in the State's report of members with Special Healthcare Needs.
    - What additional action is taken to identify members with special needs?
- How do you determine if a member is having problems? Do you receive any reports that might indicate a red flag in member care? What actions are you required to take?
- How do the Case Management and Utilization Review departments work together?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members with mental health care needs.

- Where is your Nurse Line located? How is information obtained there, shared with local staff?
- Discuss the effectiveness of behavioral health services for members? Are members obtaining adequate behavioral health services? Why do you say this?

FINDINGS

Enrollee Rights and Protections

Missouri Care has an assigned compliance officer who maintains a record of all internal policies and presents reminders to appropriate staff when annual reviews are required. Compliance reviews are conducted every other month. Records included all initial approval dates to ensure that timely monthly reminders were produced. Revisions were made as necessary. Internal approval included the Quality Management Oversight Committee, Managers, the Chief Medical Director, and the Executive Director prior to submission to the SMA.

The Member Services and Case Management staff were aware that the Health Plan utilized the CAHPS survey. This information had been summarized and a formal presentation to direct service staff was planned. They were not really able to articulate an understanding of the results of this survey at the time of the on-site review. The Member Services staff explained that member satisfaction is discussed during their unit meetings. They are coached on working with members and how to "go the extra mile," when providing assistance. Both Case Managers and Member Services reflected that they are always encouraged to provide services to members that are effective and efficient. In previous reviews the Health Plan identified dissatisfaction expressed by members with provider communication. This was originally identified in the 2005 CAHPS Survey. Missouri Care uses their newsletters to members and providers to discuss the issue of positive communication techniques. The Administrative staff identified a reduction in the complaints from members.

When asked about assisting members in finding PCPs the Member Services staff explained that they receive reports including any member without an identified PCP. They contact the member, or family, and ask if the family would prefer a pediatrician or family practioner. The Member Services representative asks the member about the desired location, and assists them in making an informed choice of physicians. The Member Services staff reports that they receive

support from the Case Management and Behavioral Health staff in assisting members if there is a specific problem or complication. The staff has a clear focus on reaching out to members to assist them in identifying a PCP and ensuring that the member is aware of the need to obtain all of the health care services available.

Case Management staff focus on referrals received from a variety of sources, but particularly from the Member Services or Behavioral Health sections. They report that when interacting with members both Member Services and Behavioral Health recognized members' needs for additional case management. The Case Management section utilizes their predictive modeling system to identify the need for an assessment, but also asks questions of members to evaluate a need for services. The Case Managers also related that certain diagnoses trigger the referral for case management, such as identifying a member with asthma.

The Case Managers gave an example to explain typical case management activities. In this situation a family was identified who had special needs that were not being treated. The family was on the list of members with special health care needs sent from the SMA. The father reported that both children, ages 5 and 7, were autistic. After contacting the father, who was very defensive, the Case Manager made an effort to build rapport. The Case Manager suggested some additional testing, and it was learned that the children had a genetic disorder. A referral was made to the Thompson Center for Autism and Neurodevelopmental Disorders. The Thompson Center provides intensive in-home services. The Case Manager contacted the Family Support Division for the family, got them into services with the Department of Mental Health Regional Center, and the Bureau of Special Health Care Needs. The children were enrolled in school. In addition, one of the children was fitted with a hearing aide, and both children were set up with the appropriate specialists that effectively met their health care needs. The parents became very receptive to services and gained an understanding of how to use available resources.

The Case Managers described a number of members as having problems with pain management. In these cases they consult with the Medical Director, who has often denied the member for narcotic medication. The Case Manager works with the member to utilize a pain management

clinic or specialist. They do extensive follow-up and focus on education and coordination of care needs for these members.

The Case Managers discussed another situation where a member was referred to their behavioral health program. The member had a number of physicians and no care coordination. The Behavioral Health Case Manager became the case lead, but both Case Managers remained involved and informed regarding member services. The member went into substance abuse treatment, attempted suicide, and was self-medicating. Through the combined effort of the Case Managers involved, the member went into a C-STAR program for 90 days. The member successfully completed the program, is now in daily support groups, utilizes the Health Plan's transportation resource, and is planning on entering a Vocational Rehabilitation program. The Case Managers reported that the combined, tenacious efforts from both the behavioral and physical health staff assisted in creating a positive outcome for this member.

Missouri Care continues to participate in community-based programs throughout their MO HealthNet Managed Care region. They were involved in school-based health clinics whenever possible. The Health Plan participated in a back-to-school fair where they not only contacted member families directly, but were able to network with regional primary care physicians (PCPs). Additionally, outreach calls were made to all eligible children. One local Federally Qualified Health Center (FQHC) conducts evening appointments to do Pap tests and adolescent EPSDT examinations. Through efforts with the Columbia Public Schools, the Health Plan targeted a campaign to increase EPSDT examinations in the Boone County section of the region. EPSDT examinations for high school students were planned at the new Family Health Clinic satellite location near the Frederick Douglas High School building. A quarterly newsletter for school nurses was developed and continues to be distributed by the Health Plan.

The Case Managers report that they do a lot of research regarding community based services as the result of their large and diverse service area. They utilize the Internet, the local Family Support Division offices, the county libraries, local churches and food pantries, all as sources of information and assistance for their members. The Case Managers discussed their relationship with the Nurse Help Line, which is located out-of-state through Aetna, their parent company. They reported that this resource is working effective for Health Plan members due to training

about the Missouri program. The Case Managers inform the Nurse Line staff about Missouri resources. The Nurse Line sends a daily report of their calls and contacts, and makes direct referrals for case management. The Case Managers explained that a number of members call the Nurse Line regularly and seem to need a lot of support. The Behavioral Health Case Managers also report receiving referrals from the Nurse Line.

The rating for Enrollee Rights and Protections (100%) reflects that the Health Plan complied with the submission and approval of all policy and procedures to the SMA. All practice observed at the on-site review indicated that the Health Plan appears to be fully compliant with MO HealthNet Medicaid Managed Care Contract requirements and federal regulations in this area.

Table 89 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2006	2007	2008
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

Missouri Care Health Plan reports that their Behavioral Health system continues to improve. The use of an "in-house" model of Behavioral Health has led to an integrated system of case management. In all cases the Case Managers involved make a decision about who will take the lead in working with the member to avoid confusion, but both the physical and mental health staff remain involved and aware of the services needs of the member. The staff participates in weekly case presentations with both Medical Directors. The Case Managers from both departments attend monthly training sessions. This training focuses on health issues that are common to both, and on working together in an interdisciplinary approach. The staff reports that communication is strength, and that they consider their method a bio-social-psychological model.

Missouri Care continues to use tele-psychiatry services in six counties in the Central Missouri region. This service creates access in outpatient offices for use by specialist psychiatrists. Face-to-face sessions with the member's behavioral health provider are required. Pediatric and adolescent psychiatrists are available through this method in outlying counties, where these services would normally not exist. In some cases, the parent and Case Manager participated in sessions with the member and psychiatrist. This innovation creates a more comprehensive approach to treatment for a number of members.

Missouri Care reports that provider availability continues to improve. There is a large network using smaller in-home provider groups, as well as independent providers. The Health Plan reports that through working directly within the Central Region communities they have been able to identify and recruit mental health providers that are regionally based. These providers are often keenly aware of community and family issues and assist members in obtaining the best service in the most convenient environment. The Health Plan finds that issues such as drug overdoses are now treated appropriately. In the past, members were seen in an emergency room and released. Efforts to educate providers have created an atmosphere where the Health Plan is notified and follow-up services are put in place in an expedient manner.

Members who require inpatient treatment are served directly by Behavioral Health Case Management staff. Case Managers assist the member in obtaining an inpatient bed, and work to ensure that appropriate aftercare services are arranged. They continue to work to improve the availability of aftercare services.

Case Managers have access to all member information, whether it comes from a physical or mental health source through their case management system. The system is linked to the authorization and claims system. All demographics and PCP identification are automatically added to the member's screens. This system is connected to Case Tracker, the behavioral health case management system, which assists in identification of service need and delivery. The Health Plan reports that it is developing a clearer understanding of member needs, which leads to the most effective levels of care for members. Missouri Care believes these processes reduce inappropriate inpatient admissions, and ensure that the most appropriate level and amount of care is received.

Quality Assessment and Performance Improvement

Access Standards

The Health Plan continues to work to develop new and additional resources for their members. The Missouri Care network includes Kansas City Children's Mercy Hospital, St. Louis Children's Hospital, and the University of Missouri Health Care System. These resources make specialties, such as orthopedic services accessible to members. Pediatric cardiology and neurology are available at the University of Missouri Hospital and Clinics.

The Health Plan contracts with Doral Dental that does have an extensive network, which includes providers in the rural counties. Missouri Care describes Doral Dental's network as having a national presence. The company understands the Health Plan's population. Missouri Care has a liaison from Doral who understands local needs and issues, and is able to effectively improve the local network. The Health Plan reports that dental providers are more satisfied with the current system and do not report problems working with Doral. The Doral Dental staff responds to members needs in a timely manner. If a member is not able to obtain an appointment the dental subcontractor will contract with a non-network provider to allow quick

access to services. Doral Dental has also developed a strong working relationship with PCPs in the area, which is a benefit for members.

The Health Plan uses a predictive model to identify candidates for Case Management. This model, Pathways, gives a profile which assists in identifying the potential for case management. Through the information obtained from this system, the Case Manager can determine the reasons for accessing care in the emergency room. Other categories of care explored include the providers utilized, the amount and types of pharmacy usage, and the durable medical equipment authorized and purchased. Through the daily patient census, a drill down can provide reasons for admission such as maternity, behavioral health verses physical health, as well as identifying the inpatient facility used and the length of stay. This program refreshes every three hours and is linked to Milliman Guidelines for the utilization review purposes. A link does exist to review notes. The model gives a quick look at member activity for a one year timeframe. The Health Plan relates that the model is useful to both Case Management staff and providers. Another advantage is providing information to the Medical Director to discuss a case with the Primary Care Physician. This often enables the physicians to ask and resolve questions quickly.

Prenatal case management continues to be a focus of the care provided to Health Plan members. The Case Managers continue to use the global OB form, which includes risk factors. The information generates a notice regarding members when they are identified as pregnant. The system generates a packet of information, educational material for members, and notices for visits that can be used as incentives to maintain scheduled appointments.

The rating for Access Standards (100%) indicates that the Health Plan has actively worked toward becoming fully compliant with all MO HealthNet Managed Care requirements and the federal regulations. All practice in this area observed at the time of the on-site review indicated that Missouri Care worked toward ensuring that members have access to all the healthcare services that they may require.

Table 90 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2006	2007	2008
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Credentialing policies and practices were reviewed on-site. All credentialing performed by Missouri Care meets NCQA standards and complies with federal and state regulations, and the SMA contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS OIG/OPM (Office of Inspector General/Office of Personnel Management) web site. The Health Plan reports that in the credentialing process they review malpractice and complaint history. The physician write up explains specific information on each issue revealed in

the investigation. The review did look at credentialing reports and notes that provided detailed information where issues were explained, and then gave recommendations to the Credentialing Committee from the Medical Director.

Internal information regarding grievances and quality issues are monitored. Compliance with policies relating to advance directives is monitored. The advance directives are to be in the records of primary care providers prior to re-credentialing (for PCP, hospital, home health agency, personal care provider or hospice). Confidentiality, nondiscrimination and rights to review files and to appeal are all included. Delegation agreements are developed in accordance with Missouri Care policy. The delegation of responsibility must include all delegated activities and the organization's accountability for those activities.

The Health Plan does monitor the subcontractors, including MTM Transportation, Crown Optical, and Doral Dental. Detailed histories, problem resolution, and performance improvement are reviewed each year.

The rating for Structure and Operations (100%) reflects full compliance with the MO HealthNet Managed Care contract requirements and federal regulations. The Health Plan submitted all required policy for approval, and all practice observed at the time of the on-site review indicated compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete and all subcontractor requirements were met.

Table 91 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2006	2007	2008
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Missouri Care operated a Quality Management Oversight Committee made up of the Chief Executive Officer, Plan Administrator, Chief Medical Officer, and department managers. The goal of this group was to provide oversight of all operations and Health Plan initiatives. Missouri Care adopted and disseminated practice guidelines in the area of diabetes, asthma, chronic obstructive pulmonary disease (COPD), ADHD, and congestive heart failure. This information was available to all providers on the Health Plan website. Missouri Care indicated that they most recently developed practice guidelines for depression management. Disease management is directed from the Health Plan Corporate Office and covers asthma treatment, COPD, diabetes and CHF. Co-case Management can occur when it is in the member's best interest.

The Health Plan's annual report identified twenty-nine (29) security incidents regarding the health information system. They explained that the system contains specific and detailed rules to protect security and information. The incidents referred to in the report occurred in the Aetna system, which also has strict protocols for remaining on-line and system utilization. These incidents were related to time out, and explainable occurrences, rather than breaches of security or inappropriate information sharing. Sentinel events and quality of care issues are tracked to identify patterns that may evolve. Any suspected issue is taken to committee for discussion. If a problem is identified or suspected, follow-up occurs immediately. Outside review is then requested. Potential issues with providers in a facility have been addressed by facility staff.

The data management system was not capturing all demographic information, such as ethnicity during 2008. The system will now capture this information, which will be utilized to expand the Health Plan's cultural competency program. Missouri Care recognizes that these improvements will allow them to capture useful data that will inform the Health Plan as they expand into additional MO HealthNet Managed Care regions in the future. The Health Plan Administrative staff did mention that they planned on incorporating these changes into a future Performance Improvement Project. (PIP).

The Health Plan did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation. All Performance Measurement data and medical records requested were submitted for validation within requested timeframes. Missouri Care did have a health information system (HIS) capable of meeting the MC+ Medicaid Managed Care program requirements. Missouri Care also submitted all required encounter data in the format requested. The specific details can be found in the appropriate sections of this report.

The Health Plan discussed instances of fraud and abuse discovered during 2008. In most of these cases an investigation uncovered billing errors as the causal factor. The Health Plan did conduct follow-up through the Provider Relations unit. One situation was problematic and was reported through appropriate channels to the SMA. If the Health Plan receives a referral from the SMA, it is logged into the Health Plan system and the Compliance Section investigations the allegations. The Health Plan did find a physician who was writing a large number of narcotic

scripts, and who also had unusual office hours. This information was documented and referred through appropriate channels.

The rating for the Measurement and Improvement section (100%) reflects that all required policy and procedure had been submitted to the SMA for their approval. It appeared that all practice observed at the time of the on-site review met the requirements of the MC+ Medicaid Managed Care contract and the federal regulations.

Table 92 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2006	2007	2008
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100%	100%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

The grievance system operated efficiently in this office. The Health Plan did report that when they receive provider complaints, these are reviewed by the provider representatives in the provider offices. They find that most of these complaints are the result of claims issues, such as timely filing. Many of these resulted from behavioral health providers who do not submit invoices within prescribed timeframes. Missouri Care reports that this issue will be resolved with training and continued support from the provider representatives. The Medical Director is maintaining regular communications with the providers, resulting in fewer calls or formal complaints being filed.

The Health Plan maintains a data base that is available to Member Services staff for reviewing grievances and appeals. Trends are identified and discussed quarterly. The Health Plan staff looks at repeated complaints regarding any specific provider or clinic. When a problem, such as inability to obtain timely appointments, is identified the provider relations unit does follow up with that office. Updates and expansion is planned for this system in the coming year.

The rating for Grievance Systems (100%) reflects that all policy and practice met the requirements of the MO HealthNet Managed Care contract and federal requirements.

Table 93 – Subpart F: Grievance Systems Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2006	2007	2008
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). 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. Final Protocol Version 1.0.; BHC, Inc., 2008 External Quality Review Monitoring MCOs Protocols

Conclusions

Missouri Care continues to maintain compliance in all areas of policy, procedure, and practice required by the MO HealthNet Managed Care contract and the federal regulations. The Health Plan utilizes a proactive approach to identifying issues discussed in previous External Quality Reviews, internal monitoring and their Quality Improvement program to ensure that required written materials were submitted to the SMA in a timely and efficient manner.

The staff at Missouri Care exhibits a commitment to quality and integrity in their work with members. The Health Plan utilizes unique processes, such as bringing the provision of behavioral health services into the organization, as a method for improving the access, quality and timeliness of member services. Missouri Care has created tools to educate and inform the community and providers, evidenced by the efforts made to improve EPSDT examination numbers. The Health Plan demonstrated an attitude of respect toward their members in a number of outreach initiatives, as well as efforts to utilize software tools to better identify special health care needs. Missouri Care attempted to create a health care service system that was responsive and assisted members in overcoming the barriers they encounter in a largely rural area.

QUALITY OF CARE

Quality of care is a priority for Missouri Care. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are evidence of the commitment to quality healthcare. Missouri Care completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements. A commitment to obtaining quality service for members is evident in interviews with Health Plan staff, who express enthusiasm for their roles in producing sound healthcare for their members.

ACCESS TO CARE

Missouri Care has made concerted efforts to ensure that members throughout their MO HealthNet Managed Care Region have adequate access to care. They have recruited additional hospitals and individual providers into their network. The Health Plan has participated in community events to promote preventive care and to ensure that members are aware of available services. This MO HealthNet Managed Care Region covers a diverse geographic area and the Health Plan exhibits an awareness and commitment to resolving issues that are barriers to member services.

TIMELINESS OF CARE

Missouri Care has developed procedures to ensure that policy is submitted in a timely manner and that all tracking tools are up-to-date. They are utilizing case management software and systems tools to have the most accurate and up-to-date information available on members to support them in obtaining appropriate healthcare services in a timely manner. The Health Plan has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

RECOMMENDATIONS

1. Continue Health Plan development in the area of utilization of available data and member information. This will drive change and create opportunities for further service development.
2. Continue working with school districts and other community-based entities throughout the Central Region to contact members for educational opportunities.
3. Continue monitoring access to dental care and assist in recruitment of providers throughout the Central Missouri Region.
4. Continue to develop and improve the multi-disciplinary approach to working with members that have complex health care issues.

Appendices

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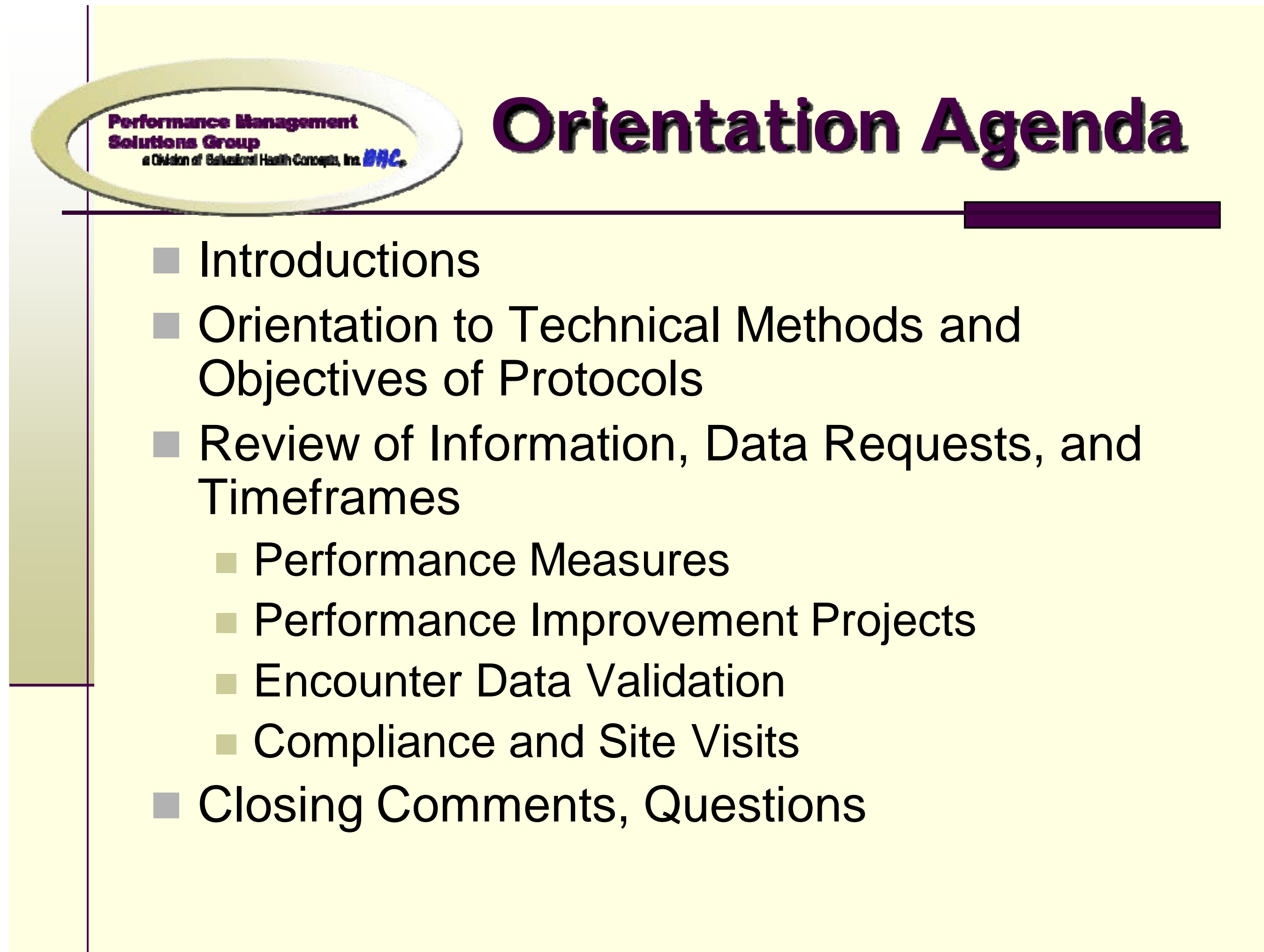
Appendix 1 – MCHP Orientation PowerPoint Slides



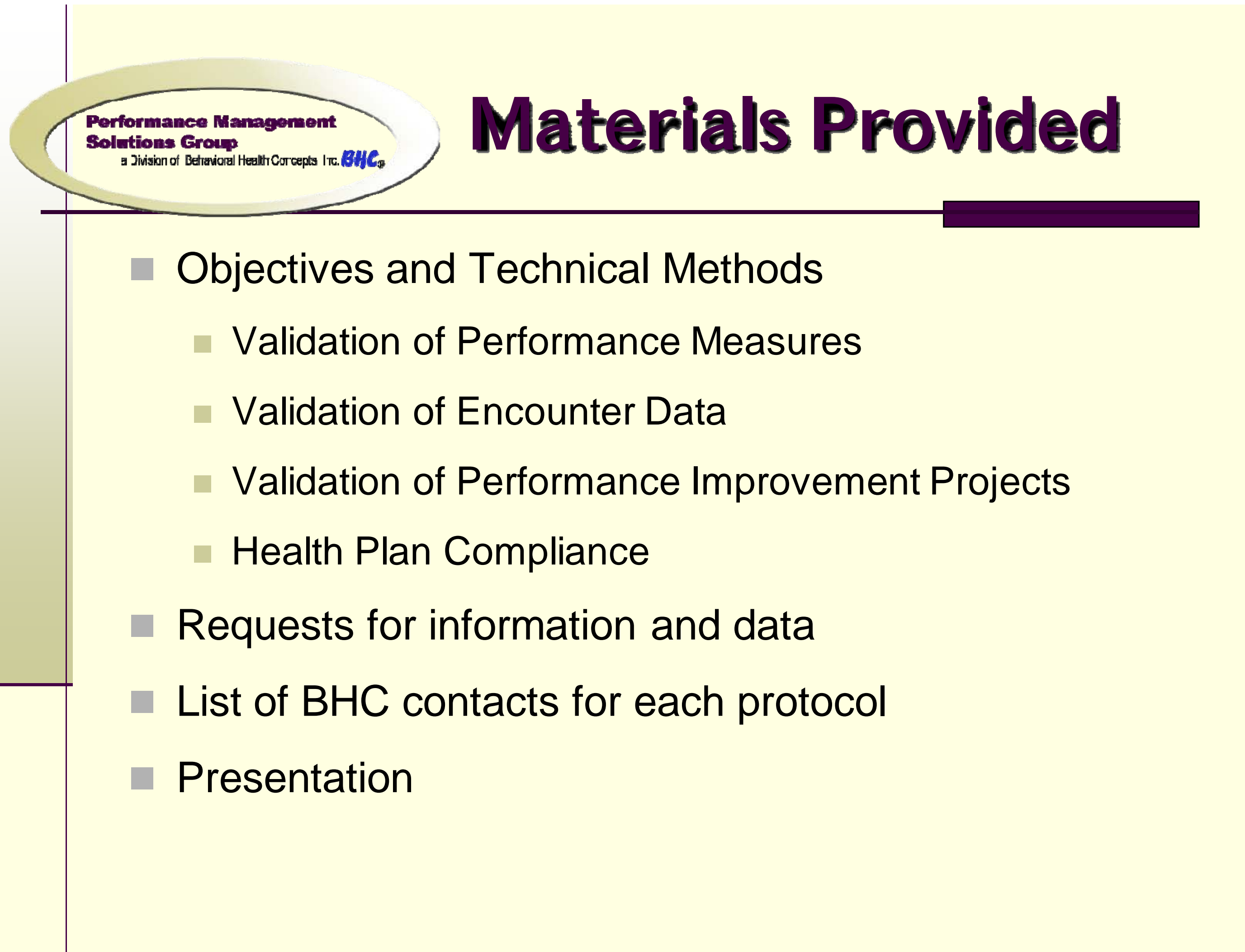
2008 External Quality Review for the MO HealthNet Managed Care Program

Behavioral Health Concepts, Inc.

Performance Management Solutions Group

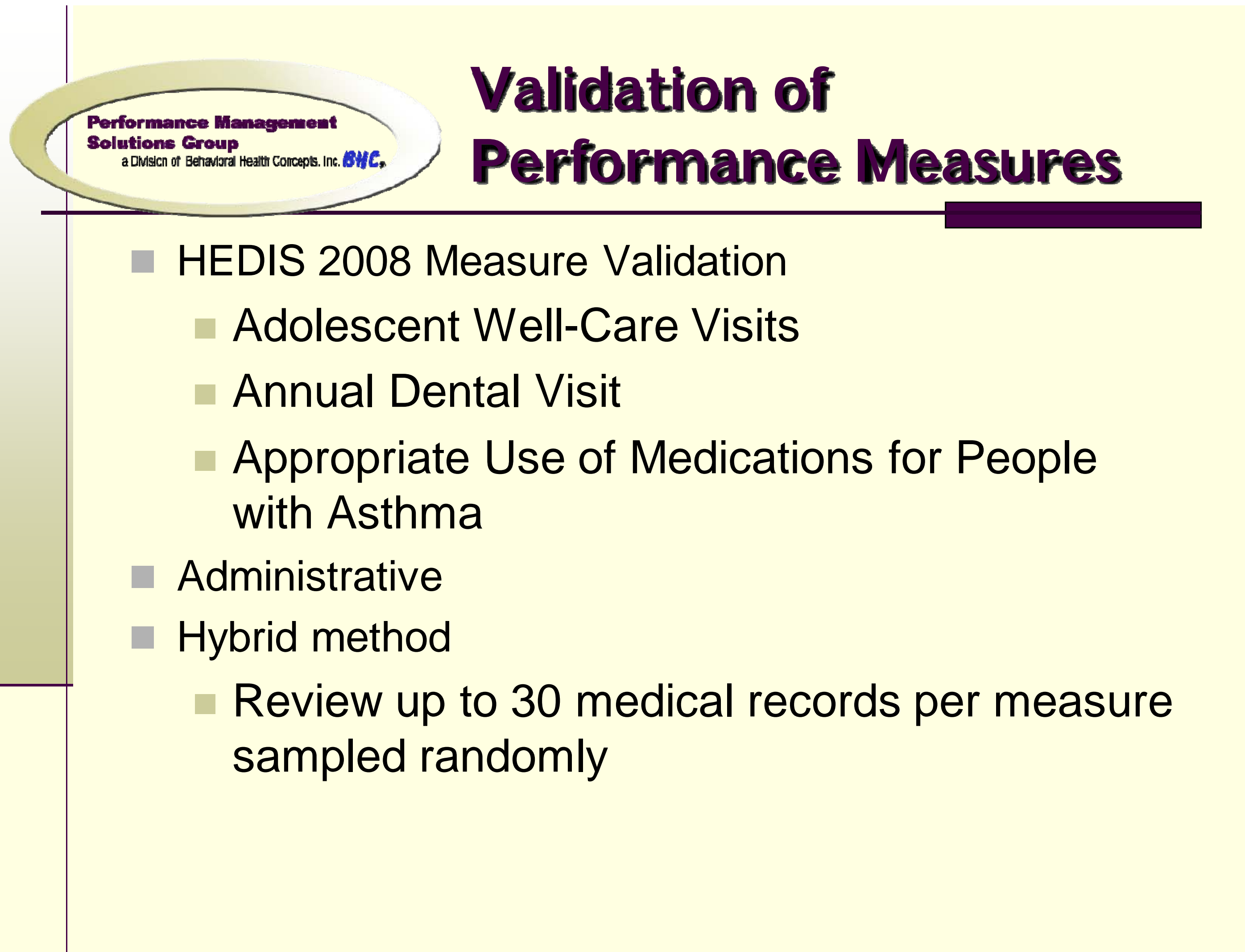
Amy McCurry Schwartz, Esq., MHSA

EQRO Project Director


Performance Management Solutions Group
a Division of Behavioral Health Concepts Inc. BHC
Materials Provided
Objectives and Technical Methods
Validation of Performance Measures
Validation of Encounter Data
Validation of Performance Improvement Projects
Health Plan Compliance
Requests for information and data
List of BHC contacts for each protocol
Presentation

Overview

- Protocol Activities
- Information and Data Requests
- Contact Persons


Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Validation of Performance Measures
HEDIS 2008 Measure Validation
Adolescent Well-Care Visits
Annual Dental Visit
Appropriate Use of Medications for People with Asthma
Administrative
Hybrid method
Review up to 30 medical records per measure sampled randomly

Submission Requirements for PM Validation

For each of the three measures:

- 2008 HEDIS Audit Report
- Baseline Assessment Tool for HEDIS 20088BHC EQRO Performance Measure Checklist (Method for Calculating HEDIS Measures; Table 1.xls)
- List of cases for denominator with all HEDIS 2008 data elements specified in the measures
  - Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
  - Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
  - Listing of fields names and descriptions of fields (i.e., data dictionary)
- List of cases for numerators with all HEDIS 2008 data elements specified in the measures
  - Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
  - Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
  - Listing of fields names and descriptions of fields (i.e., data dictionary)
- List of cases for which medical records were reviewed, with all HEDIS 2008 data elements specified in the measures
- BHC will request Health Plans gather up to 30 records per measure, based on a random sample, and Health Plan will send copies
- Sample medical record tools used for hybrid methods for HEDIS 2008 measures and instructions.
- All worksheets, memos, minutes, documentation, policies and communications within the Health Plan and with HEDIS auditors regarding the calculation of the selected measures
- Policies, procedures, data and information used to produce numerators and denominators
- Policies, procedures, data used to implement sampling
- Policies and procedures for mapping non-standard codes
- Others as needed

Validation of Encounter Data

- State encounter claim database
- Randomly selected encounters from medical claims, with service dates July 1, 2008 – September 30, 2008
- Review Health Plan supplied medical records for matching claims
- Match state and Health Plan claims databases for all encounters

Purpose and Objectives

1. To assess the State encounter claim database quality (completeness, accuracy, and reasonableness).
2. To validate the State encounter claims (paid) data against medical record documentation and obtain a fault rate.
3. To examine the match between Health Plan claims (paid) and the State encounter claims database.

Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

Sampling

1. All State Encounter Claims, July 1, 2008 – September 30, 2008

2. State Medical Encounter Claims (N = 100 per Health Plan)

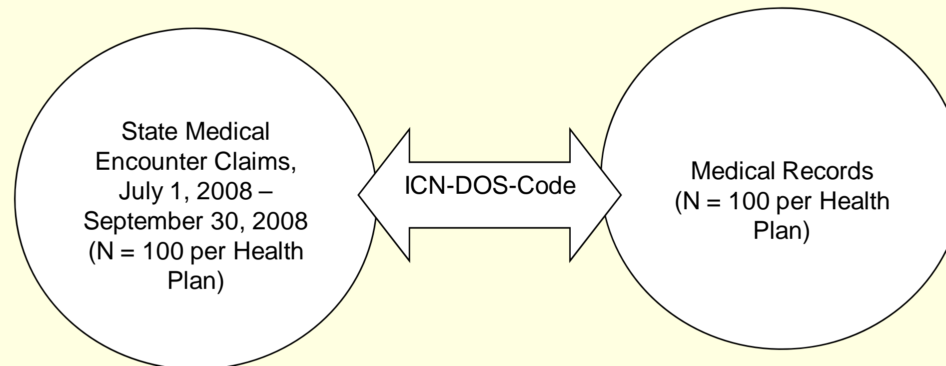
3. All Health Plan encounter claims, July 1, 2008 – September 30, 2008 (N = 100 cases per Health Plan)

Analyses: 1

Critical fields will be examined for completeness (data in field), accuracy (correct type and length of data), and reasonableness (valid data for field) for each Health Plan. This will be conducted for all encounters in the specified time frame.

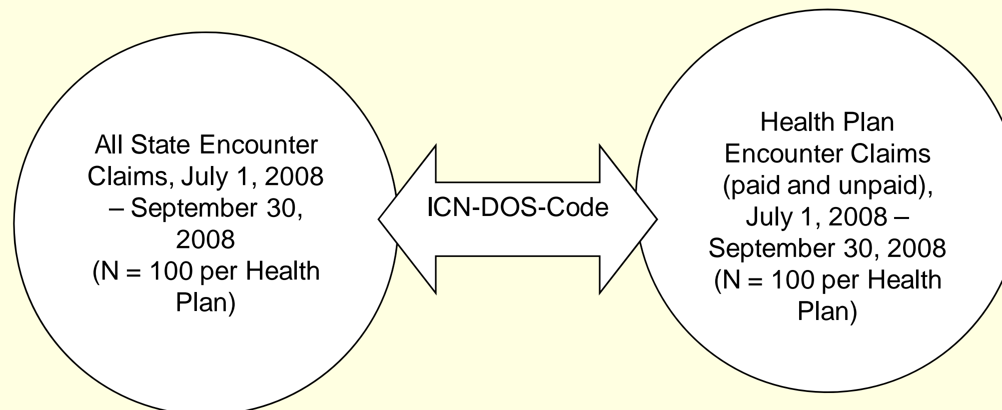
Analyses: 2

BHC will abstract the medical records and claims history/forms for each patient for the medical service provided during the entire time frame, enter into a database, and determine the rate(s) of matches, omissions and commissions between the medical record and the State encounter claims for each Health Plan. Matches will be cases that are consistent on patient ICN, date of service, and diagnosis or procedure code.



Analyses: 3

BHC will determine the rate(s) of matches, omissions and errors between the State encounter claims and Health Plan encounter claims for each Health Plan for the sample of selected cases.



Encounter Data Validation Submission

- File 1: Provider mailing address and contact information for sampled claims (service dates July 1, 2008 to September 30, 2008). This will be used for validation of the State medical encounter claims database against the medical record.
- File 2: All inpatient encounters from July 1, 2008 to September 30, 2008 for selected members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
- File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from July 1, 2008 to September 30, 2008 for selected members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
- File 4: All pharmacy encounters from July 1,2008 to September 30, 2008 for selected members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.

NOTE: "unpaid claims" are those claims that the Health Plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

Medical Record Reviews

- Encounter
  - Encounter sample provided to Health Plan
  - Health Plan to develop Files 1 (2 weeks from receipt of sample)
  - Health Plan to develop Files 2, 3, 4 (6 weeks from receipt of sample)
  - Health Plan to submit medical record request to providers (1 week from development of File 1)
  - Health Plan s to ensure providers supply medical records to BHC (4 weeks from submission of request to providers)
- HEDIS
  - Medical record samples requested from Health Plans for 1 possible hybrid measure (N $\leq$ 30 per measure; 4 weeks)

Medical Record Reviews (Cont'd)

- Health Plan will request and obtain Medical Records from providers
  - Letter from Sandra Levels
  - Instructions for submitting records
  - Encounter claim supporting information, dates, notes, claims information
  - Explanation of Confidentiality, storage of files
  - Explanation of HIPAA, Business Associate Agreement, Health Oversight Authority

Medical Record Reviews (Cont'd)

- Reviewed and abstracted by experienced and certified medical coders
- Standard abstraction tools
- Matching ICN, Date of Service, Diagnosis Code, Procedure Code

Validation of Performance Improvement Projects

- Two Performance Improvement Projects underway in 2008
  - One clinical
  - One non-clinical (Statewide PIP)

Validation of Performance Improvement Projects and Submission Requirements

PIP Checklist Elements

- Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocol, Validation of Performance Measures[1]
- Phase-in/timeframe for each phase of each PIP[1]
- Problem identification
- Hypotheses
- Evaluation Questions
- Description of intervention(s)
- Methods of sampling, measurement
- Planned analyses
- Sample tools, measures, surveys, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Raw data files (if applicable, on-site)
- Medical records or other original data sources (if applicable, on-site)
- Additional data as needed

[1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (2002) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS A protocol for use in Conducting Medicaid External Quality Review Activities: Final Protocol Version 1.0 May 1, 2002

Health Plan Compliance

- Enrollee Rights
- Grievances and Appeals
- Quality Improvement
- Submission Requirements TBD
  - Mental Health Case Management

Site Visits

- Target for July 2009
- Health Plan Compliance Reviews
- On-site activities
  - Performance Measure Validation
  - Performance Improvement Project Validation
  - Information Systems Capabilities Assessment

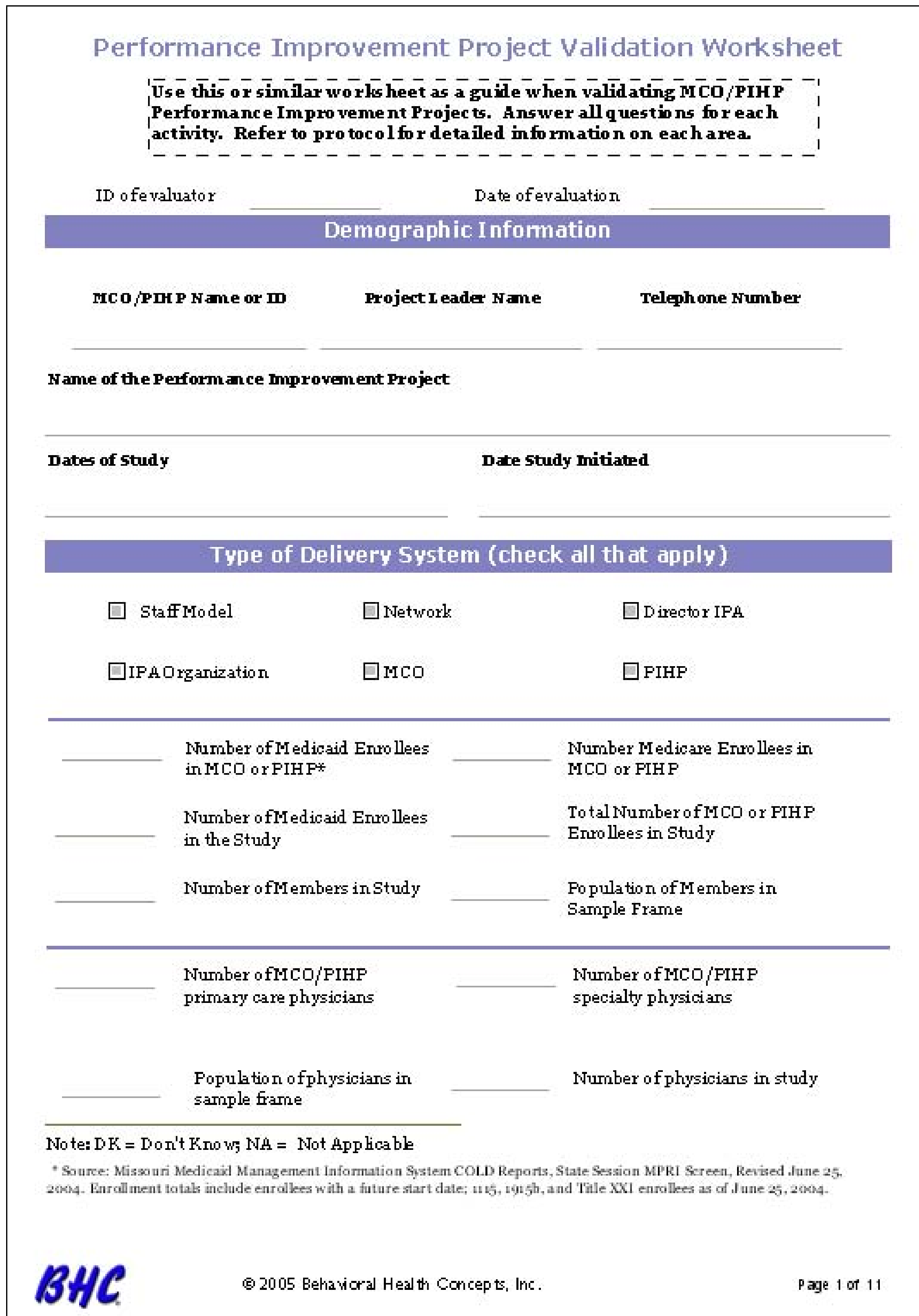
Final Report

- Health Plan to Health Plan Comparisons:
  - Encounter data match/fault rates for diagnoses and procedures
  - Performance Measure audit findings and rates
  - Performance Improvement Project element compliance
  - Health Plan Compliance follow-up

BHC Team and Coordination

Protocol/ Activity	**BHC Contact** Behavioral Health Concepts, Inc. 2716 Forum Blvd., Suite 4a Columbia, MO 65203 Tel. 573-446-0405 Fax 573-446-1816	Health Plan Contact
Performance Measures (HEDIS 2008)	Amy McCurry Schwartz amccurry@pmsginfo.com	
Performance Improvement Projects	Amy McCurry Schwartz amccurry@pmsginfo.com Mona Prater Assistant, Project Director mprater@pmsginfo.com	
Encounter Data	Amy McCurry Schwartz amccurry@pmsginfo.com	
Compliance	Mona Prater mprater@pmsginfo.com	
Site Visits	Amy McCurry Schwartz amccurry@pmsginfo.com Mona Prater mprater@pmsginfo.com	
Medical Records	Amy McCurry Schwartz amccurry@pmsginfo.com	

Appendix 2 – Performance Improvement Project Worksheets



Performance Improvement Project Validation Worksheet

Use this or similar worksheet as a guide when validating MCO/PIHP Performance Improvement Projects. Answer all questions for each activity. Refer to protocol for detailed information on each area.

ID of evaluator ____________ Date of evaluation ____________

Demographic Information

MCO/PIHP Name or ID ____________ **Project Leader Name** ____________ **Telephone Number** ____________

Name of the Performance Improvement Project ____________

Dates of Study ____________ **Date Study Initiated** ____________

Type of Delivery System (check all that apply)

☐ Staff Model ☐ Network ☐ Direct or IPA

☐ IPA Organization ☐ MCO ☐ PIHP

____ Number of Medicaid Enrollees in MCO or PIHP* ____ Number Medicare Enrollees in MCO or PIHP

____ Number of Medicaid Enrollees in the Study ____ Total Number of MCO or PIHP Enrollees in Study

____ Number of Members in Study ____ Population of Members in Sample Frame

____ Number of MCO/PIHP primary care physicians ____ Number of MCO/PIHP specialty physicians

____ Population of physicians in sample frame ____ Number of physicians in study

Note: DK = Don't Know; NA = Not Applicable

* Source: Missouri Medicaid Management Information System COLD Reports, State Session MPRI Screen, Revised June 25, 2004. Enrollment totals include enrollees with a future start date; 1115, 1915b, and Title XXI enrollees as of June 25, 2004.

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Activity 1: ASSESS THE STUDY METHODOLOGY

Step 1. Review the selected study topics(s)

1.1 The topic was selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Topic or problem statement

Clinical

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☐ High volume services
☐ High risk conditions

Nonclinical

☐ Process of accessing or delivering care

Comments

1.2 MCO's/PIHP's PIPs, over time, addressed a broad spectrum of key aspects of enrollee care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Project must be clearly focused on identifying and correcting deficiences in care or services rather than on utilization or cost alone.

Comments

1.3 MCO's/PIHP's PIPs over time, included all enrolled populations: i.e., did not exclude certain enrollees such as those with special health care needs.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population

Age ______
Gender ______
Race ______
Payor
MC+ ______
Commercial ______

Comments

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Step 2: Review the study question(s)

2.1 Study question(s) stated clearly in writing

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Study question(s) as stated in narrative:

Comments

Step 3. Review selected study indicators(s)

3.1 The study used objective, clearly defined, measurable indicators.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Indicators (list):

Comments

3.2 The indicators measured changes in health status, functional status or enrollee satisfaction; or process of care with strong association with improved outcomes.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Long term outcomes implied or stated: ☐ Yes ☐ No

Health status: ______ Satisfaction (members): ______
Functional status: ______ Satisfaction (providers): ______

Comments

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Step 4: Review the identified study population

4.1 MCO/PIHP clearly defined all Medicaid enrollees to whom the study questions and indicators are relevant.

☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population sampled: ______ Age ______ Race ______ MC+ ______ Gender ______ Commercial

Did it include:

1115	☐ Yes	☐ No	☐ Unable to determine	☐ NA
1915b	☐ Yes	☐ No	☐ Unable to determine	☐ NA
Children in state custody	☐ Yes	☐ No	☐ Unable to determine	☐ NA
Consent Decree (Western)	☐ Yes	☐ No	☐ Unable to determine	☐ NA

Comments

4.2 If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?

☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Methods of identifying participants: ☐ utilization data ☐ referral ☐ self-identification ☐ other ______

Comments

Step 5: Review sampling methods

5.1 Sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of the error that will be acceptable.

☐ Met ☐ Partially met ☐ Not me ☐ Not applicable ☐ Unable to determine

Previous findings from:

☐ literature review ☐ baseline assessment of indices ☐ Other ______

Comments

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5.2 The MCO/PIHP employed valid sampling techniques that protected against bias.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

The type of sampling used:

☐ Probability ☐ Nonprobability ☐ Random ☐ Simple ☐ Stratified

☐ Convenience ☐ Judgment ☐ Quota ☐ Cluster

Comments

5.3 Sample contained sufficient number of enrollees.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

_______ N of enrollees in sampling frame

_______ N of sample

_______ N of participants (i.e., return rate)

Comments

Step 6: Review data collection procedures

6.1 Study design clearly specified the data to be collected.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

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6.2 The study design clearly specified the sources of data.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Source of data:

☐ Member ☐ Claims ☐ Provider ☐ Other ________________

Comments

6.3 The study design specified a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

6.4 The instruments for data collection provided for consistent, accurate data collection over the time periods studied.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Instrument(s) used:

☐ Survey ☐ Medical Record Abstraction Tool ☐ Other ________________

Comments

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6.5 The study design prospectively specified a data analysis plan.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

6.6 Qualified staff and personnel were used to collect the data.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Name ____________________ Title ____________________

Role(s) of Project Leader ____________________

Comments

Step 7: Assess improvement strategies

7.1 Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes undertaken.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Describe Intervention: ____________________

Comments

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Step 8: Review data analysis and interpretation of study results

NA if study is not yet complete

8.1 An analysis of the findings was performed according to data analysis plan.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Not met if study is complete and no indication of a data analysis plan (see step 6.5)

Comments

8.2 The MCO/PIHP presented numerical PIP results and findings accurately and clearly.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

☐ Are tables and figures labeled? ☐ Labeled clearly, accurately?

Comments

8.3 The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurement, and factors that threaten internal and external validity.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Indicate time periods of measurements: __________

Indicate statistical analyses used: __________

Indicate statistical significance level or confidence level used: ☐ 99% ☐ 95% ☐ Unable to determine

Comments

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8.4 Analysis of study data included an interpretation of the extent to which its PIP was successful and follow-up activities.

☐ Met ☐ Partially met ☐ Not me
☐ Not applicable ☐ Unable to determine

Limitations described: ______

Conclusions regarding the success of the interpretation: ______

Recommendations for follow-up ______

Comments

Step 9: Assess whether improvement is "real" improvement

Note: NA only if study period is not yet complete: otherwise "Unable to Determine" or "No"

9.1 The same methodology as the baseline measurement was used when measurement was repeated.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Same source of data	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same method of data collection	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same participants examined	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same tools used	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine

Comments

9.2 There was a documented, quantitative improvement in process or outcomes of care.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

☐ increased ☐ decrease

Statistical significance ______ Clinical significance ______

Comments

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9.3 The reported improvements in performance have "face" validity: i.e., the improvement in performance appears to be the result of the planned quality improvement intervention.

☐ Met ☐ Partially met ☐ Not me
☐ Not applicable ☐ Unable to determine

Degree to which the intervention was the reason for change: ☐ No relevance ☐ Small ☐ Fair ☐ High

Comments

9.4 There is statistical evidence that any observed performance improvement is true improvement.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

☐ Weak ☐ Moderate ☐ Strong

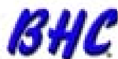
Comments

Step 10: Assess sustained improvement

10.1 Sustained improvement was demonstrated through repeated measurements over comparable time periods.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments



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ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND RECOMMENDATIONS

Conclusions

Recommendations

Check one:

- ☐ High confidence is reported
- ☐ Low confidence level is reported in MCO/PIHP PIP results
- ☐ Moderate confidence is reported MCO/PIHP PIP results
- ☐ Reported MCO/PIHP PIP results not credible
- ☐ Not Applicable, study not complete

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Appendix 3 – Performance Measures Request Documents

Performance Measure Validation

General Instructions

Mail Binder To:
Attn: External Quality Review Submission
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4
Columbia, MO 65203

Due Date: January 19, 2009 (Due in BHC offices by 3pm)

When applicable, submit one for each of the three measures:

- Annual Dental Visit (ADV)
- Use of Appropriate Medications for People with Asthma (ASM)
- Adolescent Well-Care Visits (AWC)

Unless otherwise indicated, please send all documents in hard copy, using the enclosed binder and tabs. If an item is not applicable or not available, please indicate this in the tab.

Electronic Data Submission Instructions:

- Data file formats all need to be ASCII, and readable in a Microsoft Windows environment. Please be sure to name data columns with the same variable names that appear in the following data layout descriptions.
- Make all submissions using compact disk (CD) formats. Data files submitted via e-mail will not be reviewed. Insure that files on the CD are accessible on a Microsoft Windows workstation prior to submitting.
- All files or CDs must be password protected. Do not write the password on the CD. Please email the password separately to amccurry@pmsginfo.com. Do not include the password anywhere on the CD, or in any correspondence sent with the CD.
- Use an appropriate delimiter (e.g., @, tab) for data that may contain commas or quotation marks, and please specify in a readme file or write on the CD what that delimiter is.
- Please ensure that date fields either contain a null value or a valid date.
- Files will be accepted only in the specified layout. Please avoid adding extra columns or renaming the columns we have requested.

  There should be 3 separate files submitted for each measure:

  File 1. Enrollment Data
  File 2. Denominator and numerator file
  File 3. Sample selection (cases that were selected for medical record review); this file is submitted for *Hybrid measures only*

The file layouts to be used for each measure are detailed on pages 2-7 of this document.

Please contact BHC prior to the submission deadline if you have any questions regarding these layouts or the data submission requirements, and we will be happy to assist you.

Annual Dental Visit (ADV)
(Administrative Only)

File 1. Enrollment Data
Please provide all enrollment periods for each eligible MOHealthNet Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	ADV	Annual Dental Visit
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	ADV	Annual Dental Visit
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet Member date of birth
SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of service
SER_CODE	Any basic text and/or numbers	Code used to identify numerator event
CODING_TYPE	C, H, or I	Type of coding system: C=CPT Codes; H=HCPCS/CDT-3 Codes*; I=ICD-9-CM Codes.
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
EXCLUD	Y or N	Was the case excluded from denominator Y=Yes; N=No
EXCLUD_REASON	Any basic text and/or numbers	Reason for exclusion

* CDT is the equivalent dental version of the CPT physician procedural coding system.

Use of Appropriate Medications for People with Asthma (ASM)

(Administrative Only)

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MOHealthNet Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	ASM	Use of Appropriate Medications for People with Asthma
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	ASM	Use of Appropriate Medications for People with Asthma
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet Member date of birth
ED_SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Emergency Department service
ED_SER_CODE	Any basic text and/or numbers	Code used to identify Emergency Department Visit
IN_DIS_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Inpatient Discharge
IN_DX_CODE	Any basic text and/or numbers	Code used to identify asthma as principal diagnosis
OUT_SER_DATE_1	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Outpatient Asthma service
OUT_SER_CODE_1	Any basic text and/or numbers	Code used to identify asthma as diagnosis
OUT_SER_DATE_2	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Outpatient Asthma service
OUT_SER_CODE_2	Any basic text and/or numbers	Code used to identify asthma as diagnosis
OUT_SER_DATE_3	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Outpatient Asthma service
OUT_SER_CODE_3	Any basic text and/or numbers	Code used to identify asthma as diagnosis

OUT_SER_DATE_4	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Outpatient Asthma service
OUT_SER_CODE_4	Any basic text and/or numbers	Code used to identify asthma as diagnosis
RX_SER_DATE_1	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Asthma medication dispense
RX_SER_CODE_1	Any basic text and/or numbers	Name of Rx or NDC code for Asthma Medication
RX_SER_DATE_2	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Asthma medication dispense
RX_SER_CODE_2	Any basic text and/or numbers	Name of Rx or NDC code for Asthma Medication
RX_SER_DATE_3	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Asthma medication dispense
RX_SER_CODE_3	Any basic text and/or numbers	Name of Rx or NDC code for Asthma Medication
RX_SER_DATE_4	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Asthma medication dispense
RX_SER_CODE_4	Any basic text and/or numbers	Name of Rx or NDC code for Asthma Medication
PREF_SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of Preferred Asthma Therapy medication dispense
PREF_SER_CODE	Any basic text and/or numbers	Name of Rx or NDC code for Preferred Asthma Therapy Medication
CODING_TYPE	C, I, or U	Type of coding system: C=CPT Codes; I=ICD-9-CM Codes; UB Revenue Codes.
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
EXCLUD	Y or N	Was the case excluded from denominator Y=Yes; N=No
EXCLUD_REASON	Any basic text and/or numbers	Reason for exclusion

Adolescent Well-Care Visits (AWC)

(Administrative or Hybrid)

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MOHealthNet Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
Measure	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet Member date of birth
SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of service
SER_CODE	Any basic text and/or numbers	Code used to identify numerator event
CODING_TYPE	C or I	Type of coding system: C=CPT Codes; I=ICD-9-CM Codes
DATA_SOURCE	A or MR	For Hybrid Method ONLY Please specify source of data: A = Administrative; MR = Medical Record Review
HYBRID_HIT	Y or N	For Hybrid Method ONLY Hybrid numerator event (positive event "hit"): y=yes; n=no
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
NUMERATOR_ID	0 or 1	Please indicate if this case was counted toward: 0 = 0 visits numerator; 1 = 1 visit numerator;

Adolescent Well-Care (AWC)

(Administrative or Hybrid)

File 3. For Hybrid method ONLY - please provide a listing of the cases selected for medical record review. Use the following layout:

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet Member date of birth
MR_STATUS	R or NR or S	Medical record review status: R = reviewed; NR = not reviewed; S = substituted
PROVIDER_NAME	Any basic text and/or numbers	Primary Care Provider who supplied the record
PROVIDER_ID	Any basic text and/or numbers	Primary Care Provider identification number

Please see the Performance Measure Validation Submission Requirements and the Summary of Calculation Methods for Performance Measures.

2008 External Quality Review of the MOHealthNet Managed Care Program

Performance Measure Validation Submission Requirements

Instructions: The following listing includes relevant source data for the EQR process. Submit paper print outs or photocopied items in the EQR 2008 binder supplied; use the associated tabs. Within each tab, include information specific for each of the three measures for the MOHealthNet population. Some items may not apply. For example, if you do not use a HEDIS vendor and perform measure calculations on site, then you may not have documentation on electronic record transmissions. These items apply to processes, personnel, procedures, databases and documentation relevant to how the MCHP complies with HEDIS measure calculation, submission and reporting.

If you have any questions about this request, contact Amy McCurry Schwartz, EQRO Project Director, amccurry@pmsginfo.com.

Key	
Check submitted	Use this field to indicate whether you have submitted this information. If you are not submitting the particular information, please indicate "NA". You may have submitted the content by other means either on the BAT or as part of some other documentation. If so, indicate "submitted", and reference the document (see below).
Name of Source Document	Please write the name of the document you are submitting for the item. If you are submitting pages from a procedure manual, indicate so by writing "HEDIS submission manual, pages xx – xx."
MCHP Comments	Use this space to write out any concerns you may have or any clarification that addresses any issues or concerns you may have regarding either the items requested or what you submitted in the response.
Reviewed By (BHC use)	This space will be for BHC staff use. The purpose will be for tracking what is received and what is not received. It will not indicate whether the documents actually address the specific issue.

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
1.	HEDIS 2008 Data Submission Tool (MO DHSS 2008 Table B HEDIS Data Submission Tool) for all three measures for the MOHealthNet Managed Care Population only. Do not include other measures or populations.				
2.	HEDIS 2008 Audit Report. This is the HEDIS Performance Audit Report for the MOHealthNet Managed Care Program product line and the three MOHealthNet measures to be validated (complete report). If the three measures to be validated were not audited or if they were not audited for the MOHealthNet Managed Care Program population, please send the report, as it contains Information Systems Capability Assessment information that can be used as part of the Protocol.				
3.	Baseline Assessment Tool (BAT) for HEDIS 2008. The information submitted for the BAT will include descriptions of the process for calculating measures for the MOHealthNet Managed Care Program population.				
4.	List of cases for denominator with all HEDIS 2008 data elements specified in the measures.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
5.	List of cases for numerators with all HEDIS 2008 data elements specified in the measures, including fields for claims data and MOHSAIC, or other administrative data used. Please note that one of the review elements in the Protocol is: The "MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced."				
6.	List of cases for which medical records were reviewed, with all HEDIS 2008 data elements specified in the measures. Based on a random sample, BHC will request MCHPs to gather a maximum of 30 records per measure and submit copies of the records requested to BHC.				
7.	Sample medical record tools used if hybrid method(s) were utilized for HEDIS 2008 Adolescent Well Care Visits measures for the MOHealthNet Managed Care Program population; and instructions for reviewers.				
8.	All worksheets, memos, minutes, documentation, policies and communications within the MCHP and with HEDIS auditors regarding the calculation of the selected measures. **(please limit this to 30 (two-sided) pages in the binder – all other information can be reviewed onsite).**				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
9.	Policies, procedures, data and information used to produce numerators and denominators.				
10.	Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of: a. Statistical testing of results and any corrections or adjustments made after processing. b. Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology. c. Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance.				
11.	Policies and procedures for mapping non-standard codes.				
12.	Record and file formats and descriptions for entry, intermediate, and repository files.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
13.	Electronic transmission procedures documentation. (This will apply if the Health Plan sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry.)				
14.	Descriptive documentation for data entry, transfer, and manipulation of programs and processes.				
15.	Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.				
16.	Documentation of proper run controls and of staff review of report runs.				
17.	Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such corrections or adjustments.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
18.	Documentation of sources of any supporting external data or prior years' data used in reporting.				
19.	Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.				
20.	Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.				
21.	Procedures used to link member months to member age.				
22.	Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the MCHP's/PIHP's process to re-draw a sample or obtain necessary replacements.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
23.	Procedures to capture data that may reside outside the MCO's/PIHP's data sets (e.g. MOHSAIC).				
24.	Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)				

Performance Measures to be Calculated for MOHealthNet Members			
METHOD FOR CALCULATING HEDIS 2008 PERFORMANCE MEASURES			
Please complete this form and place in the HEDIS 2008 section of the binder supplied by BHC. Please direct any questions to Amy McCurry Schwartz.			
Health Plan			
Date Completed			
Contact Person			
Phone			
Fax			
NCQA Accredited for MOHealthNet Product (Yes/No)			
Certified HEDIS Software Vendor and Software			
Record Abstraction Vendor			
What was the reporting Date for HEDIS 2008 Measures?			
What was the Audit Designation (Report/No Report/Not Applicable)?			
Was the measure publicly Reported (Yes/No)?			
Did denominator include members who switched MCHPs (Yes/No)?			
Did denominator include members who switched product lines (Yes/No)?			
Did the denominator include 1115 Waiver Members (Yes/No)?			
Were proprietary or other codes (HCPC, NDC) used?			
Were exclusions calculated (Yes/No)?			
On what date was the sample drawn?			
Were exclusions calculated (Yes/No)?			
How many medical records were requested?			
How many medical records were received?			
How many medical records were substituted due to errors in sampling?			
How many medical records were substituted due to exclusions being measured?			

Appendix 4 – Performance Improvement Project Request Documents

Performance Improvement Project Validation

General Instructions

Mail All Required Information to:

Attn: External Quality Review Submission
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4
Columbia, MO 65203

Due in BHC Office no later than: 3:00 p.m., March 2, 2009

Please refer to Performance Improvement Project Validation Submission Requirements and the health plan Performance Improvement Project Summary.

2008 External Quality Review of the MO HealthNet Managed Care Program

Performance Improvement Project Validation Submission Requirements

Instructions: The following listing includes relevant source data for the EQR process. Submit paper printouts or photocopied items using the associated tabs for each of the two Performance Improvement Project selected for review from the topics submitted. Please refer to the enclosed health plan Performance Improvement Project Summary. Place information behind the associated cover sheet and complete the form below. You may also mark PIP sections if desired. Use the separate cover sheets and summary sheets for each PIP.

If you have any questions about this request, contact Amy McCurry, EQRO Project Director, amccurry@pmsginfo.com.

Key	
Check submitted	Use this field to indicate whether you have submitted this information. If you are not submitting the particular information, please indicate "NA". You may have submitted the content by other means or as part of some other documentation. If so, indicate "submitted", and reference the document (see below).
Name of Source Document	Please write the name of the document you are submitting for the item. If you are submitting pages from a procedure manual, indicate in writing.
Health Plan Comments	Use this space to write out any concerns you may have or any clarification that addresses any issues or concerns you may have regarding either the items requested or what you submitted in the response.
Reviewed By (BHC use)	This space will be for BHC staff use. The purpose will be for tracking what is received and what is not received. It will not indicate whether the documents actually address the specific issue.

Name of PIP:______________________________

Tab		✓ if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
1.	Cover letter with clarifying information (optional)				
2.	Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocols, Validation of Performance Improvement Projects and Conducting Performance Improvement Projects. We will be looking for the following information in the Performance Improvement Project descriptions. a. Name and date of inception for each project. b. Problem identification, including data collection and analysis justifying the chosen topic based on enrollee needs, care and services. c. Hypotheses d. Study question evaluation e. Selected study indicators f. Description of intervention(s) g. Methods of sampling, measurement h. Data collection procedures i. Planned analyses j. Sample tools, measures, surveys, etc. k. Baseline data source and data l. Improvement strategies m. Assessment of improvement and sustainability				

Note: BHC may request raw data files, medical records, or additional data.

Appendix 5 – Performance Measures Worksheets

Final Performance Measure Validation Worksheet: HEDIS 2008 Use of Appropriate Medications For People with Asthma

The percentage of members age 5 - 56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	5 -56 years of age by December 31 of measurement year.		
Enrollment	Continuous enrollment: The measurement year and the year prior to the measurement year.		
Gap	No more than one gap of up to 45 days during each year of continuous enrollment.		
Anchor date	December 31 of measurement year.		
Benefit	Medical. Pharmacy during measurement year.		
Event/diagnosis	Step 1: Identify members as having persistent asthma. Based on four criteria. Step 2: A member identified as having persistent asthma because of at least four asthma med. dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also meet one of the additional criteria listed in HEDIS Tech Specs.		

Sampling - Not Applicable to this measure, calculated via Administrative calculation methodology only			
Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.
Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
Not Applicable = No MC+ Members qualified

Note: 2 = Met; 1 = Partially Met; 0 = Not Met

Final Performance Measure Validation Worksheet: HEDIS 2008 Adolescent Well-Care Visits

The percentage of enrolled members who were 12 - 21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN during the measurement year.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	12 -21 years as of December 31, 2007.		
Enrollment	Continuous during 2007.		
Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled as of December 31, 2007.		
Benefit	Medical		
Event/diagnosis	None		
Sampling			
Sampling was unbiased.			
Sample treated all measures independently.			
Sample size and replacement methods met specifications.			
Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Documentation tools used were adequate.			
Integration of administrative and medical record data was adequate.			
The results of the medical record review validation substantiate the reported numerator.			

Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.
Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: HEDIS 2008
Annual Dental Visit

The percentage of enrolled MC+ Managed Care Program Members who were 2 -21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	2 -21 years of age as of December 31, 2007. The measure is reported for each of the following age stratifications and as a combined rate: * 2 -3 year-olds * 4 -6 year-olds * 7-10 year-olds * 11 - 14 year-olds * 15 - 18 year-olds * 19 - 21 year-olds		
Enrollment	Continuous during 2007		
Gap	No more than one gap in enrollment of up to 45 days during 2006. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled as of December 31, 2007		
Benefit	Medical		
Event/diagnosis	None		
Sampling - Not Applicable to this measure, calculated via Administrative calculation methodology only			

Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.
Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Appendix 6 – Encounter Data Minimum Criteria

Recommended Encounter Data Validation Criteria

Data Element	Expectation	Validity Criteria
Enrollee ID	Should be valid as found in the State's eligibility file.	100% valid
Principal Diagnosis	Well-coded lead-related diagnoses (or well-child visit)	> 90% non-missing and valid codes.
Date of Service	Dates should be evenly distributed across time	If looking at a full year of data 5-7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% non-zero <70% should be one if CTP code in range of 99200-99215, 99241-99291
Procedure Code	This is a critical element and should always be coded. Will be assessed only for presence of code except for lead-related codes which will be validated with medical records.	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.

Source: Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data:: Second Edition

Appendix 7 – Encounter Data Request Documents

Encounter Data Validation Submission Instructions

Mail To:

Behavioral Health Concepts, Inc.
Attn: Amy McCurry Schwartz
2716 Forum Blvd., Suite 4
Columbia, MO 65203

Label the package **CONFIDENTIAL**

Due Date (due in BHC's offices by 3pm):
File 1 (Provider information) **Monday, April 6, 2009**
Files 2, 3, 4 **Friday, May 15, 2009**

General data submission instructions
Data file formats all need to be ASCII, and readable in Microsoft Windows environment. Use an appropriate delimiter (e.g., @) for data that may contain commas or quotation marks. Ensure that date fields either contain a null value or a valid date. Make all submissions using compact disk (CD) formats and mail it to BHC, Inc. No files will be accepted via e-mail. Ensure that files on the CD are accessible on a Microsoft Windows workstation prior to submitting.

Specific data submission instructions
Please provide documentation for each electronic file being submitted.

Encounter Data Request

There should be 4 files submitted to BHC:

1. File 1: Mailing address and contact of the provider associated with each Internal Control Number (ICN) for sampled claims (service dates July 1, 2008 to September 30, 2008). Although MCOs will be doing medical record requests, BHC needs to have detailed provider information for tracking purposes.

2. File 2: All inpatient encounters from July 1, 2008 to September 30, 2008, for selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
ICLAIM_TYPE	Claim type: I = Inpatient
ICLAIM_STATUS	P=Paid U=Unpaid D=Denied
IICN	State assigned Internal Control Number (ICN)
IPAID-AMT	This field indicates the amount of money paid to the hospital for the billed services.
IRECIP-ID	The Missouri Medicaid recipient identification number.
ILAST	Recipient last name
IFIRST	Recipient first name
IACCT_NUM	The recipient's account number used by the doctor's office.
IADMIT_TYPE	Admission Type The only valid values are: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information Not Available
IADM_DT	The date the recipient was admitted to the hospital. This date cannot exceed the current

	date.
IDSCH_DT	The date the recipient was discharged from the hospital. If the patient is still in the hospital, the latest date of service that applies to the claim.
IBILL_TYPE	Valid bill type codes are: Inpatient 11x 12x 18x Outpatient 13x 14x 71x (Rural Health) 81x (Hospice) 82x (Hospice) Home Health 30x 31x 32x 33x 34X 35x 36x 37x 38x 39x
ISTAT	The code that represents the condition under which the recipient was discharged. 01 Home 02 Hospital 03 Skilled Nursing Facility (SNF)

	04 Intermediate Care Facility (ICF) 05 Institution (Inst) 06 Home Health Agency (HHA) 07 Left 08 Other 20 Death 30 Still A Patient 50 Discharge from Hospice to Home 51 Discharge from Hospice to Another Medical Facility 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
IPROV_NUM	The Health Plan's 9-digit provider number.
IPRIM_DX	The recipient's primary diagnosis. Decimal points are implied.
IDX_2	Second diagnosis. Decimal points are implied.
IDX_3	Third diagnosis. Decimal points are implied.
IDX_4	Fourth diagnosis. Decimal points are implied.
IDX_5	Fifth diagnosis. Decimal points are implied.
IKEY	A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill. 3 = No, patient does not have other insurance.
IFDT_SVC	The date that the billing period begins.

ILDT_SVC	The date that the billing period ends.
IREVENUE_CD	The three-digit code from 100 to 999 that represents the services that are billed on this particular line item. The combined total number of accommodation and ancillary services billed cannot exceed 28 lines per claim. Accommodation revenue codes range from 10X through 21X. Ancillary revenue codes range from 22X through 99X. NOTE: Emergency Room (rev 450 and 459) and Ambulance (rev 540 to 549) may only be billed as inpatient if the patient is admitted to the hospital.
IUNITS_SVC	The number of days per room rate for both covered and non-covered accommodations (revenue codes 100 through 239). Whole numbers only are accepted for the days.

3. File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from July 1, 2008 to September 30, 2008 for selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
OCLAIM_TYPE	O=Outpatient M=Medical L=Dental H=Home Health
OCLAIM-STATUS	Claim Type: O, M, L, H P=Paid U=Unpaid D=Denied
OICN	State assigned Internal Control Number (ICN)
OPAID_AMT	Claim Type O, M, L, H This field is informational only and reflects what FFS would pay.
ORECIP_ID	Claim Type: O, M, L, H The Missouri Medicaid recipient identification number.
OLAST	Claim Type: O, M, L, H Recipient last name

OFIRST	Claim Type: O, M, L, H Recipient first name
OACCT_NUM	Claim Type: O, M, L, H The recipient's account number used by the doctor's office. This field may be left blank or used for other purposes, such as the Health Plan Claim Internal Control Number.
OPROV_NUM	Claim Type: O, M, L, H The Health Plan's 9 digit provider number.
OPRIM_DX	Claim Type: O, M, L, H The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_2	Claim Type: O, M, L, H Second diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_3	Claim Type: O, M, L, H Third diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_4	Claim Type: O, M, L, H Fourth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_5	Claim Type: O, M, L, H Fifth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
O_KEY	Claim Type: O, M, L, H A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
OFIRSTDT_SVC	Claim Type: O, M, L, H This is the first date the service was performed. This date cannot exceed the current date.
OLASTDT_SVC	Claim Type: O, M, L, H This is the last date the service was performed. This date cannot exceed the current date.
OPLACE_SVC	Claim Type: M, L

	C-14 PLACE OF SERVICE 03 School 04 Homeless Shelter 05 Indian Health Service Free-Standing Facility 06 Indian Health Service Provider-Based Facility 07 Tribal 638 Free-Standing Facility 08 Tribal 638 Provider-Based Facility 11 Office 12 Home 13 Assisted Living Facility 14 Group Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance - Land 42 Ambulance - Air or Water 49 Independent Clinic 50 Federally Qualified Health Center (FQHC) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility - Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residence Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Facility 57 Non-Residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 97 Parochial/Private Schools 98 Schools 99 Other Unlisted Facility Claim Type: O, H Not applicable
OUTPAT-UNITS-SVC	Claim Type: O, M, L, H The number of units of services performed. Whole numbers only.
ODTL-PROC	Claim Type: M, L, H

	The procedure code that represents the service preformed. Claim Type: O For outpatient claims, a procedure code is required only when the revenue code range for outpatient services is 300 through 319. This revenue code range represents laboratory services. The appropriate CPT procedure code range for laboratory services is 80048 through 89399. All other outpatient services must be designated by revenue code.
ODTL-PROC-MOD-P	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL-PROC-MOD-I	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL-DIAG-CODE	Claim Type: O, M, L, H The diagnosis code of the recipient's diagnosis. Decimal points are implied.
OREVENUE_CD	Claim Type: O The three digit code from 100 to 999 which represents the services that are billed on this particular line item. A revenue code is required on all Outpatient claims. For those revenue codes representing lab services (300-319), a procedure code must also be submitted. Claim Type: M, L, H Not applicable

4. File 4: All pharmacy encounters from July 1, 2008 to September 30, 2008, for the selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
PH_TRANSACTION-CD	This field shows the number of claims being billed on the record. Valid values are: 01 - 1 Claim 02 - 2 Claims 03 - 3 Claims 04 - 4 Claims (maximum)
PHCLAIM_STATUS	P=Paid U=Unpaid D=Denied
PHICN	State assigned Internal Control Number (ICN)
PH_PROV-NUM	The Health Plan's 9-digit provider number
PH_NABP-NUM	This field will always contain the 7-digit National Association of Boards of Pharmacy (NABP) identification number assigned to the pharmacy. The NABP number must be in the first 7 positions of the 9-digit field (left justified).
PHRECIP_ID	The Missouri Medicaid recipient identification number.
PHKEY	A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid

	values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
PH_FIRST-DT-SVC	The dispense date.
PH_LAST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_FIRST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_PRESCRIP-NUM	The prescription number of the prescription filled or refilled.
PHREFILL-IND	The only valid values are: Original - 00 (zero) Refill - 01-99
PHDRUG-QTY	The metric or non-metric quantity of the drug being dispensed. For example: A quantity of 100 would be 0100.
PHDAYS-SUPPLY	The estimated number of days the dispensed amount represents. A days supply greater than 365 is invalid.
PHCOMPOUND-IND	An indicator identifying the prescription as a non-compound or as an ingredient of a compound prescription. A value of '0' or '1' is used to indicate non-compound prescriptions or the FIRST ingredient of a compound prescription. A value of '2' is used to indicate any additional ingredients of a compound prescription.
PHARM-DRUG-NDC-CODE	The National Drug Code designated for the drug dispensed. The field is 5-4-2 format no hyphens or spaces
PHPROV-NUM	The Medicaid, DEA number, or name of the prescribing physician. If not available, enter the dispensing pharmacy NABP number unless you are a pharmacy having FQHC status.
PHEPSDT-IND	A code indicating whether or not a drug was dispensed to a recipient under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program. Y = yes

Appendix 8 – Medical Record (MR) Request Letters

PERFORMANCE MEASURES MR REQUEST LETTER

Behavioral Health Concepts, Inc.
Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203
(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com

February 10, 2009

Subject: 2008 External Quality Review Performance Measure Validation Protocol Medical Records Request (hybrid methodology only).

Due Date: March 19, 2009 by 3:00pm

Dear <MCHP Contact Person>,

We have reviewed <health plan>'s HEDIS 2008 Adolescent Well Care Measure.

Please find attached a file containing a listing of the cases related to this HEDIS Measure that have been selected for medical record review. Behavioral Health Concepts, Inc. (BHC) requests copies of all medical records for these sampled cases. Each medical record supplied should contain all the information that contributed to the numerator for the given HEDIS 2008 Measure. Please forward copies of these medical records to BHC at the address listed above, and mark the package as confidential.

If you have any questions, please contact BHC's External Quality Review team at (573) 446-0405 or via e-mail: amccurry@bhcinfo.com

Thank you,

Amy McCurry Schwartz
EQRO Project Director

Attachment:
1) File containing a sample of cases for medical record review

cc: Ms. Susan Eggen, Assistant Deputy Director, MO HealthNet Division, Missouri Department of Social Services

ENCOUNTER DATA MR REQUEST LETTER

Behavioral Health Concepts, Inc.
Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203
(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com

March 22, 2009

Re: 2008 External Quality Review Encounter Data Validation Protocol

Dear MO HealthNet MCO Encounter Data Validation Contact:

As discussed with MCO staff during the 2008 EQR orientation meeting over teleconference, BHC is requesting the following information for Encounter Data Validation from each MCO:

5. File 1: Mailing address and contact information of provider associated with each Internal Control Number (ICN) for the sampled claims (service dates July 1, 2008 to September 30, 2008). BHC requires this information for tracking purposes. **Due by 3pm: Monday, April 6, 2009.**

Attached via email is a document containing a file of the sample of encounters. This file contains claim ICNs (Internal Control Number) and patient identifying information. Please use this sample to request medical records from providers. The password for this CD-ROM is contained in the email I sent to you with the subject line: 2008 Encounter Data Request.

We are allowing up to seven business days for preparation of the medical record requests. The requests must be submitted to providers by April 10, 2009. This will allow the providers 5 weeks to gather records. Providers should supply records directly to BHC, Inc. by **3pm, Friday, May 15, 2009**.

MO HealthNet Managed Care Health Plans are extended an additional week to submit records that are collected from providers. Records not received by **3pm, Friday, May 22, 2009** will be considered undocumented encounters. Please be advised that BHC and/or MO HealthNet Division do not provide reimbursement for the cost of photocopying or mailing records.

During the past four years BHC provided a status report to MCHPs indicating the submission rate of records during the collection process. This practice is intended to facilitate a higher return rate. In order to provide this service, BHC must obtain requested provider information. Please return provider contact information to BHC, in the requested format, by **April 6, 2009.**

To assist with the medical record request process, we have also enclosed medical records submission instructions, and a letter from Susan Eggen detailing information regarding federal and state requirements for adherence to HIPAA and the External Quality Review.

If you have any questions, please contact BHC's External Quality Review team at 573-446-0405.

Thank you,

Amy McCurry Schwartz, Esq., MHSA
EQRO Project Director

Encl:

1. Encounter Data Validation File Layout and Instructions
2. Medical Records Submission Instructions
3. Letter from Susan Eggen
4. Sample of encounters for encounter data validation (via email)

CC:
Ms. Susan Eggen, Assistant Deputy Director, MO HealthNet Managed Care, Missouri Department of Social Services, MO HealthNet Division

Appendix 9 – Table of Contents for Medical Record Training Manual

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Appendix 10 – Abstraction Tools

ENCOUNTER DATA MEDICAL RECORD ABSTRACTION TOOL

Medical Record Abstraction Tool

Record ID	Primary Key	
Patient Name	OUTPAT_RECIP_LAST_NAME	OUTPAT_RECIP_FIRST_NAME
Date of Birth	OUTPAT_RECIP_BIRTHDATE	
Patient DCN	OUTPAT_PROCESSED_RECIP_ID	
Provider Name	FIELD	
Clinic Name	FIELD	
Clinic Address		
First Date of Service	FIELD	

Abstractor Initials [ ]

Date of abstraction

m	m	d	d	y	y	y	y

Data entry operator initials [ ]

Start Time

h	h	m	m
	:		

Examine only the information provided in physician and professional documentation. **DO NOT** use the CMS-1500, any claim forms, or any claim histories.

Medical Record										
Element	**Comparison**								**Match**	**Error Type**
Date of Service	**OUTPAT_FIRST_DT_SVC** m	m	d	d	y	y	y	y	0 = No 1 = Yes	Code only 1, 8, 9, or 0
Missing = 99999999										
Comment (Required if Error Type = Other)										

Primary Diagnosis	**OUTPAT_DX_1**						0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.								
Missing = 99999								
Comment (Required if Error Type = Other)								
Primary Diagnosis Description	**DX_DESCRIPTION**						0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Add description from medical record; Required if Error Type = Other)								

Patient Name	OUTPAT_RECIP_LAST_NAME	OUTPAT_RECIP_FIRST_NAME
Date of Birth	OUTPAT_RECIP_BIRTHDATE	
Patient DCN	OUTPAT_PROCESSED_RECIP_ID	

Element	**Code**				
Procedure Code	**To be coded by reviewer**				
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.					
Not Enough Information = 22222					
Comment (Required if Error Type = Other)					
Procedure Description	**To be coded by reviewer**				
Comment (Add description from medical record; Required if Error Type = Other)					

Referrals Documented in the Medical Record (check all that apply; only if not related to the claim validated)
❑ None (0) ❑ Laboratory (1) ❑ Pharmacy (2) ❑ Specialist (3) ❑ Radiology (4) ❑ Other (5) List ____________________

See next page for the procedure code and procedure code description to be validated.

Does the medical record documentation adequately support the procedure code and description?

- ❑ Yes (1)
- ❑ No (0)

If no, Reason (check only one):

- ❑ Not enough information (e.g., the date of service and information are present, but there is not enough information to make a determination) (1)
- ❑ Upcoded (2)
- ❑ Incorrect (3)
- ❑ Missing (9)
- ❑ Other (4) _________________________________

Comment

Patient Name OUTPAT_RECIP_LAST_NAME OUTPAT_RECIP_FIRST_NAME
Date of Birth OUTPAT_RECIP_BIRTHDATE
Patient DCN OUTPAT_PROCESSED_RECIP_ID

Examine the CMS-1500 or any claim forms. If there is no claim form or history, code as missing.

Claim Form or History										
Element	**Comparison**								**Match**	**Error Type**
Date of Service	**OUTPAT_FIRST_DT_SVC**								0 = No 1 = Yes	Code only 1, 8, 9, or 0
	m	m	d	d	y	y	y	y		
Missing = 99999999										
Comment (Required if Error Type = Other)										
Primary Diagnosis	**OUTPAT_DX_1**								0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.										
Missing = 99999										
Comment (Required if Error Type = Other)										
Primary Diagnosis Description	**DX_DESCRIPTION**								0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Required if Error Type = Other)										
Procedure Code	**OUTPAT_DTL_PROC**								0 = No 1 = Yes	Code only 1,3,8, or 9
Comment (Required if Error Type = Other)										
Procedure Description	**OUPT_DESCR**								0 = No 1 = Yes	Code only 3,8, or 9
Comment (Required if Error Type = Other)										

	h	h	m	m
End Time		:		

Medical record protocols
Abstraction tool
Need to preprint selected encounters to be validated, with primary diagnosis and CPT code
Need spaces for additional encounters
Record referrals, prescriptions, and lab procedures
Experienced clinical coders

Requests
Docs need to include billing information, i.e., primary diagnosis code, CPT code, etc.
June 1, 2006 to September 1, 2006
All documentation of encounter claim data, to include progress notes, lab sheets, referrals, prescriptions, flow sheets, forms, and dates of services.
Provider identification number, place of service, etc..
Photocopy of claim form
Printout of electronic medical record
notes

PERFORMANCE MEASURES MEDICAL RECORD ABSTRACTION TOOL - AWC

Adolescent Well-Care Visits (AWC) Abstraction Tool

Patient Name

Last

First

Date of Birth (m m d d y y y y)
Missing = 11119999

Provider Name

Last

First

Name of MCHP (Check only one)

- ❑ Mercy CarePlus (1)
- ❑ Healthcare USA (2)
- ❑ Harmony Health Plan (3)
- ❑ Missouri Care (4)
- ❑ Family Health Partners (5)
- ❑ Blue-Advantage Plus (6)

Abstractor Initials

Date of abstraction (m m d d y y)

Data entry operator initials

Start Time

h h : m m

Search the medical record for a well care visit during the calendar year

Source of Documentation:

- ❑ Medical Record (1)
- ❑ Claim Form (2)
- ❑ Both (3)
- ❑ None (0)

Documented Components of Well Care Visit:
(Check all that apply)

Health and Developmental History
- ❑ Yes (1)
- ❑ No (0)

Physical Exam
- ❑ Yes (1)
- ❑ No (0)

Anticipatory Guidance
- ❑ Yes (1)
- ❑ No (0)

Date of Well Care Visit
Unless ALL components above are checked, code Missing = 11119999

m m d d y y y y

Procedure Code

Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

Acceptable Procedure Codes:

99383, 99384, 99385, 99393, 99394, 99395

See list to the right of Procedure Codes. Does procedure code match one of these?

Procedure Code Match

- ❑ Yes (1)
- ❑ No (0)

Acceptable Diagnosis Codes:

V20.2	V70.5	V70.9
V70.0	V70.6	
V70.3	V70.8	

Diagnosis Code

Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.

Missing = 99999

Insufficient Information = 22222

Don't Know = 88888

Notes:

Diagnosis Code Match

- ❑ Yes (1)
- ❑ No (0)

h h : m m

End Time

Were three Hep Bs completed by the members' 13th birthday?

Was one dose of the two-dose regimen and 2 other doses of Hep B completed by the members' 13th birthday?

Appendix 11 – Agenda for Site Visits

SITE VISIT AGENDA

Date Here – Morning

TIME	ACTIVITIY	ATTENDEES	LOCATION
9:30 – 12:30	Compliance Document Review	Mona Prater Myrna Bruning	Conference Room – Quiet Location
9:30 – 11:30	Validation of Performance Measures	Amy McCurry Schwartz Health Plan Attendees	

Date Here – Morning & Afternoon

Time	Activity	Attenddees	location
8:30 – 9:00	Introduction -- Opening	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
9:00 – 11:00	Compliance Review – Interviews with Member Services and Case Management Staff	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
11:00 – 11:30	Lunch Break		
11:30 – 1:30	Compliance Review – Interviews with Administrative	BHC, Inc. – Amy McCurry	

	Staff	Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
1:30 – 1:45	Break		
1:45 – 3:00	Validation of Performance Improvement Projects	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
3:00 – 3:15	Exit Conference Preparation	BHC, Inc. Staff	
3:15 – 4:00	Exit Conference	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	

Appendix 12 – Site Visit Information Request Letter

June 11, 2009

<Plan Administrator>
<Plan Name>
<Address>

RE: SITE VISIT AGENDA AND DOCUMENT REVIEW

Dear _________________:

We are finalizing plans for the on-site review of each Health Plan. The following information is being provided in an effort to make preparations for the on-site review as efficient as possible for you and your staff. The following information or persons will be needed at the time of the on-site review at <Health Plan Name> on July XX, 2009.

Performance Improvement Projects

Time is scheduled in the afternoon to conduct follow-up questions, review data submitted, and provide verbal feedback to the Health Plan regarding the planning, implementation, and credibility of findings from the Performance Improvement Projects (PIPs). Any staff responsible for planning, conducting, and interpreting the findings of PIPs should be present during this time. The review will be limited to the projects and findings submitted for 2008. Please be prepared to provide and discuss any new data or additional information not originally submitted.

Performance Measure Validation/ ISCA Review

As you know, BHC is in the process of validating the following three performance measures:

- HEDIS 2008 Annual Dental Visit (ADV)
- HEDIS 2008 Use of Appropriate Medications for People with Asthma (ASM)
- HEDIS 2008 Adolescent Well-Care Visits (AWC)

BHC is following the CMS protocol for validating performance measures. The goals for this process are to:

- Evaluate the accuracy the of Medicaid performance measures reported by the Health Plan; and
- Determine the extent to which Medicaid-specific performance measures calculated by the Health Plan followed specifications established by the MO HealthNet Division. These specifications consist of the HEDIS 2008 Technical Specifications.

To complete this process we will review the following documents while on-site:

- **Data Integration and Processes Used to Calculate and Report**

1. Documentation of the performance measure generating process
2. Report production logs and run controls
3. Documentation of computer queries, programming logic, or source code (if available) used to create denominators, numerators and interim data files - for each of the three measures
4. Code mapping documentation
5. Documentation of results of statistical tests and any corrections with justification for such changes, if applicable - for each of the three measures
6. Documentation showing confidence intervals of calculations when sampling methodology used – for each of the three measures
7. Description of the software specifications or programming languages instructions used to query each database to identify the denominator, and/or software manual
8. Source code for identifying the eligible population and continuous enrollment calculation – for each of the three measures
9. Description of the software specification or programming languages used to identify the numerator
10. Programming logic and/or source code for arithmetic calculation of each measure to ensure adequate matching and linkage among different types of data

- **Sampling Validation**

1. Description of software used to execute sampling sort of population files
2. Source code for how samples for hybrid measures were calculated
3. Policies to maintain files from which the samples are drawn in order to keep population intact in the event that a sample must be re-drawn or replacements made
4. Documentation that the computer source code or logic matches the specifications set forth for each performance measure, including sample size and exclusion methodology
5. Documentation of “frozen” or archived files from which the samples were drawn
6. Documentation assuring that sampling methodology treats all measures independently, and there is no correlation between drawn samples

Performance Measure Interviews
In addition to the documentation reviews, interviews will be conducted with the person(s) responsible for:

- Overseeing the process of identifying eligible members from Health Plan data sources for the measures to be validated;
- Programming the extraction of required elements from the Health Plan data sources for the measures to be validated;
- Integrity checks and processes of verifying the accuracy of data elements for the measures to be validated;
- Overseeing the process of medical record abstraction, training, and data collection for the measures to be validated; and
- Contractor oversight and management of any of the above activities.

On-site activities may also include, but are not limited to, the following:

- Demonstration of HEDIS software
- Demonstration of the process for extracting data from Health Plan databases
- Possible data runs for identifying numerator and denominator cases

Compliance Review
The final activity to prepare for during the on-site visit will be the compliance review. Documentation review and interviews with MO HealthNet Divison staff have occurred prior to the on-site visit. This will enable BHC to use the time at the Health Plan as efficiently as possible. The following information will be needed at the time of the on-site review:

Compliance Documents

- Member Handbook
- 2008 Marketing Plan and materials
- Prior authorization time frames/policy/processes
- Staff training records
- Case Management and Member Services Policies or Instructions
- 2008 Quality Improvement Committee minutes

Compliance Interviews
The attached agenda requests an interview in the morning with case management and member services staff. These interviews are focused on staff members who interact directly with members, and who provide case management or disease management services.

In some circumstances it may be necessary to conduct these interviews by telephone. In these instances, we request that speaker-phone equipment be available in the conference room being utilized by the review team. Please ensure that representative staff are available in their location at the identified interview time.

Interviews in the late morning are scheduled to include administrative staff. It would be helpful to include the following staff:

- Plan Director
- Medical Director
- Quality Assurance Director
- Provider Services/Provider Relations Director
- Member Services Director
- Utilization Management Director

This year we have attempted to eliminate concurrent activities and interviews during the full on-site review date. These interviews, including required telephone interviews can be scheduled in a convenient location in your offices. On the day that document reviews are scheduled for the compliance review, a separate conference room or meeting space will be needed to conduct the performance measure interviews and document review. Also, the on-site review team will need to order a working lunch on the full day visit. If lunch facilities are not available, please provide the name and telephone number of a service in your vicinity that can accommodate ordering lunch. Your assistance will be appreciated.

The Health Plan staff involved in any of the referenced interviews or activities, or anyone identified by the Health Plan, is welcome to attend the introduction and/or the exit interview.

Again, your assistance in organizing the documents, individuals to be interviewed, and the day's activities is appreciated. If you have questions, or need additional information, please let me know.

Sincerely,

Mona Prater
Assistant Project Director

Cc: Amy McCurry Schwartz, Esq., Project Director
Susan Eggen, MO HealthNet Division

Attachment:
On-Site Review Agenda

Appendix 13 – Compliance Review Scoring Form

2008 BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form

This document is used to score the number of items met for each regulation by the health plan.

1. Review all available documents prior to the site visit.
2. Follow-up on incomplete items during the site visit.
3. Use this form and the findings of Interviews and all completed protocols to complete the Documentation and Reporting Tool and rate the extent to which each regulation is met, partially met, or not met.

Scores from this form will be used to compare document compliance across all health plans.

0 = Not Met: Compliance with federal regulations could not be validated.
1 = Partially Met: Health Plan practice or documentation indicating compliance was observed, but total compliance could not be validated.
2 = Met: Documentation is complete, and on-site review produced evidence that health plan practice met the standard of compliance with federal regulations.

	Contract Compliance Tool	Federal Regulation	Description	Comments	2008 Site Visit and Findings	2006 Rating 0 = Not Met 1 = Partially Met 2 = Met	2007 Rating 0 = Not Met 1 = Partially Met 2 = Met
	Subpart C: Enrollee Rights and Protections						
1	2.6.1(a)1-25, 2.2.6(a), 2.6.2(j)	438.100(a)	Enrollee Rights: General Rule				
2	2.6.1(a)1, 2.9, 2.6.2(j), 2.6.2(n)	438.10(b)	Enrollee Rights: Basic Rule				
3	2.15.2(e), 2.8.2	438.10(c)(3)	Alternative Language: Prevalent Languages				
4	2.8.2, 2.8.3, 2.6.2(n)(2)	438.10(c)(4,5)	Language and format: Interpreter Services				

5	2.6.1(a)1, 2.6.2(n)1	438.10(d)(1)(i)	Information Requirements: Alternative Formats				
6	2.6.1(a)1, 2.6.2(n)2 - dot point 35, 2.6.2(q), 2.8.2, 2.8.3	438.10(d)(1)(ii)and (2)	Information Requirements: Easily Understood				
7	2.3.5, 2.6.1(a)2/3, 2.6.2(k)1, 2.6.2(n), 2.6.2(n)(2), 2.6.2(q)	438.10(f)	Enrollee Rights: Information, Free Choice				
8	2.6.2(n)(2)	438.10 (g)	Information to Enrollees: Physician Incentive Plans				
9	2.4, 2.4.5, 2.4.5(a)2-4, 2.20.1(all), 3.5.3(f)	438.10(i)	Liability for Payment and Cost Sharing				
10	2.2.6(a), 2.2.6(b), 2.6.1(a)(3), 2.6.2(j), 2.9.1	438.100(b)(2)(iii)	Specific Enrollee Rights: Provider-Enrollee Communications				
11	2.6.2(j), 2.30.1, 2.30.2, 2.30.3	438.100(b)(2)(iv,v)	Right to Services, including right of refusal. Advance Directives				
12	2.6.2(j), 2.4.8, 2.13, 2.14	438.100(b)(3)	Right to Services				
13	2.2.6, 2.14.3, 2.14.8, 2.14.9	438.100(d)	Compliance with Other State Requirements				

		Total Enrollee Rights and Protections					
	Subpart D: Quality Assessment and Performance Improvement						
	Subpart D: Quality Assessment and Performance Improvement: Access Standards						
14	2.3.1, 2.6.2(j), 2.14.3, 2.7.1(g), 3.5.3	438.206(b)(1)(i-v)	Availability of Services: Provider Network				
15	2.7.1(e), 2.7.1(f), 2.14.8	438.206(b)(2)	Access to Well Woman Care: Direct Access				
16	2.13	438.206(b)(3)	Second Opinions				
17	2.3.2, 2.3.18, 2.7.1(bb), 2.12.3, 2.12.4, 2.14.5	438.206(b)(4)	Out of Network Services: Adequate and Timely Coverage				
18	2.4, 2.20.1(d)	438.206(b)(5)	Out of Network Providers: Cost Sharing				
19	2.3.14(a)2, 2.14.1, 2.14.4(a-f), 2.17.1, 3.5.3	438.206(c)(1)(i-vi)	Timely Access				
20	2.2.6(a)1-3, 2.17.1	438.206(c)(2)	Cultural Considerations				
21	2.14.11, 2.3.5(e)	438.208(b)	Primary Care and Coordination of Healthcare Services				
22	2.6.2(m), 2.14.11, 2.5.3(e)	438.208(c)(1)	Care Coordination: Identification				

23	2.12.10, 2.14.2(c), 2.14.11, 2.17.5, Attachment 3 - Children with Special Healthcare Needs	438.208(c)(2)	Care Coordination: Assessment				
24	2.7.1, 2.12, 2.14.11	438.208(c)(3)	Care Coordination: Treatment Plans				
25	2.3.8, 2.3.7, 2.6.1(k)(3), 2.14.6, 2.14.7	438.208(c)(4)	Access to Specialists				
26	2.2.1(i), 2.3.7, 2.7.4, 2.9.2, 2.10.2, 2.14.1, 2.14.2(a-h), 2.14.2(d)1-2	438.210(b)	Authorization of Services				
27	2.15.4, 2.14.2(d)6	438.210(c)	Notice of Adverse Action				
28	2.6.2(k)(3), 2.14.2(d)6, 2.15.4(a-c), 2.16.3(e)	438.210(d)	Timeframe for Decisions				
29	2.17.5(b)	438.210(e)	Compensation for Utilization Management Decisions				
30	2.4.8, 2.7.1, 2.7.1(y), 2.7.3(v), 2.14.2	438.114	Emergency and Pos-stabilization pgs 24/25 Rev. Checklist				

	Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards						
31	2.17.2(n), 2.17.5(c), 2.30.2	438.214(a,b)	General Rules for Credentialing and Recredentialing				
32	2.2.6(b)(c)	438.214(c) and 438.12	Nondiscrimination and Provider Discrimination Prohibited				
33	2.31.5	438.214(d)	Excluded Providers				
34	2.3.9, 2.3.17	438.214(e)	Other State Requirements: Provider Selection				
35	2.6.2(n)(2), 2.6.2(s)(all), 2.6.2(u)	438.226 and 438.56(b)(1-3)	Disenrollment: Requirements and Limitations				
36	2.5.1, 2.5.2, 2.5.6, 2.6.1(g), 2.6.2®	438.56(c)	Disenrollment Requested by Enrollee				
37	2.6.2(r,s-1,t)	438.56(d)	Procedures for Disenrollment -- Pgs 29/30 Rev. Checklist				
38	2.6.2(u)	438.56(e)	Timeframe for Disenrollment Determinations				
39	2.15, 2.15.3(a,b)	438.228	Grievance Systems				
40	2.6.1(a)(18), 2.16.2(c), 2.31.2(a)8,	438.230(a,b)	Subcontractual Relationships and Delegation				

	2.31.3, 3.5.1, 3.5.2, 3.5.3						
	Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement						
41	2.17.2(d)	438.236(b)(1-4)	Adoption of Practice Guidelines	There is very little in the contract compliance tool regarding practice guidelines.			
42	2.17.2(d)	438.236(c)	Dissemination of Practice Guidelines				
43	2.17.2(d,f)	438.236(d)	Application of Practice Guidelines -- Pgs 32/33 of Rev. Checklist				
44	2.17.1, 2.17.5	438.240(a)(1)	Quality Assessment and Improvement Program				
45	2.17.5(d)	438.240(b)(1) and 438.240(d)	Basic Elements of MCO QI and PIPs				
46	2.17, 2.17.3, Attachment 6	438.240(b)(2)(c) and 438.204(c)	Performance Measurement				
47	2.17.5(b)	438.240(b)(3)	Basic elements of MCO QI and PIPs: Monitoring Utilization				
48	2.17.5	438.240(b)(4)	Basic elements of MCO QI and PIPs				
49	Attachment 6 - State Quality Strategy	438.240(e)	Program Review by State				

50	2.25	438.242(a)	Health Information Systems				
51	2.25(all) - 2.25.1, 2.25.2(a,b), 2.25.3, 2.25.4	438.242(b)(1,2)	Basic Elements of HIS				
52	2.26.1, 2.29.1	438.242(b)(3)	Basic Elements of HIS				
		Total Quality Improvement and Assessment					
	Subpart F: Grievance Systems						
53	2.15	438.402(a)	Grievance and Appeals: General Requirements				
54	2.15.2, 2.15.5(a), 2.15.6(a)	438.402(b)(1)	Grievance and Appeals: Filing Authority				
55	2.15.6(a)	438.402(b)(2)	Grievance and Appeals: Timing				
56	2.15.2(a), 2.15.5(a), 2.15.6(a,b)	438.402(b)(3)	Grievance and Appeals: Procedures				
57	2.15.2(e), 2.15.4(a),2.6.2(q)	438.404(a)	Notice of Action: Language and Format				
58	2.15.4(b)	438.404(b)	Notice of Action: Content				

59	2.15.4(c)	438.404(c)	Notice of Action: Timing				
60	2.15.5(b,c,d), 2.15.6(h,i,j)	438.406(a)	Handling of Grievances and Appeals: General Requirements				
61	2.15.6(g) 2.15.6(h) 2.15.6(i) 2.15.6(j)	438.406(b)	Handling of Grievances and Appeals: Special Requirements				
62	2.15.5(e), 2.15.6(k)	438.408(a)	Resolution and notification: Grievances and Appeals - Basic rule				
63	2.15.5(e,f), 2.15.6(k-l)	438.408(b,c)	Resolution and notification: Grievances and Appeals - Timeframes and extensions				
64	2.15.5(e), 2.15.6(k,m)	438.408(d)(e)	Resolution and notification: Grievances and Appeals - Format and content				
65	2.15.2(i), 2.15.6(m)	438.408(f)	Resolution and notification: Grievances and Appeals - Requirements for State fair hearing				
66	2.15.6(n,o)	438.410	Expedited resolution of appeals				

67	2.15.2(c), 3.5.3(c)	438.414	Information about the grievance systems of providers and subcontractors				
68	2.15.3	438.416	Recordkeeping and reporting				
69	2.15.6(p)	4388.420	Continuation of Benefits while the MCO/PIHP Appeal and the State Fair Hearing are Pending				
70	2.15(q,r)	438.424	Effectuation of reversed appeals				
		Total All Items					

This protocol was developed using the CMS MCO Compliance protocol worksheet and cross-matching the State of Missouri Eastern/Central Region contract and the State supplied Compliance Tool for 2004.