2013

MO HealthNet Managed Care Program

External Quality Review

Report of Findings

Amy McCurry Schwartz, Esq., MHSA, EQRO Project Director

Mona Prater, MPA, EQRO Assistant Project Director

Contract Number: C312155001

Review Period: January 1, 2013 to December 31, 2013

Draft Submitted on: October 1, 2014

Final Submitted on: December 15, 2014

Submitted by: Behavioral Health Concepts, Inc.

Prepared and Submitted by:

The Performance Management Solutions Group
Is a division of Behavioral Health Concepts, Inc.

4250 East Broadway, Ste. 1055
Columbia, MO 65201
(573) 446-0405 :Local Ph.
(866) 463-6242 :Toll-free Ph.
(573) 446-1816 :Fax
http://www.PMSGinfo.com
http://www.BHCinfo.com
Email: amccurry@bhcinfo.com

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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 (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Managed Care Health Plans (MCHPs) and their contractors to participants of Managed Care services. The CMS rule[1] specifies the requirements for evaluation of Medicaid Managed Care programs. These rules require a desk review as well as an on-site review of each MCHP.

The State of Missouri contracts with the following MCHPs represented in this report:

MCHP	**MCHP Parent Company**	**Date Contract Began**
HealthCare USA (HCUSA)	Aetna, Inc.	September 1995
Home State Health Plan (Home State)	Centene Corporation	July 2012
Missouri Care (MO Care)	WellCare Health Plans, Inc.	March 1998

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

1) Validating Performance Improvement Projects[2]
2) Validation of Performance Measures[3]
3) Compliance with Medicaid Managed Care Regulations[4]
4) Special Project – Case Management Record Review.

[1] 42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations
[2] Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September, 2012. Washington, D.C.: Author.
[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, D.C.: Author.
[4] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, D.C.: Author.

1.2 Validating Performance Improvement Projects

The EQRO validated two PIPs (one clinical and one non-clinical) for each MCHP that were underway during 2013. A total of six PIPs were validated. Eligible PIPs for validation were identified by the MCHPs, SMA, and the EQRO. The final selection of the PIPs for the 2013 validation process was made by the SMA in February 2014. The SMA requested the EQRO validate the statewide PIP, Improving Oral Health, as the non-clinical PIP for each MCHP.

HealthCare USA	Reducing the Re-admission Rate for Asthma Patients Project Improving Oral Health
Home State Health Plan	Notification of Pregnancy Form Receipt Improvement Improving Oral Health
Missouri Care	Post Mental Health Hospitalization Follow-Up Care Within 7 Days of Discharge Improving Oral Health

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 MCHPs' contracts with the State of Missouri, each MCHP is required to have two active PIPs, one of which is clinical in nature and one non-clinical.

The EQRO reviews each PIP to determine if it was designed, conducted, and reported in a methodologically sound manner. The EQRO incorporates document review, interview, and observation techniques to fully evaluate the components of each PIP. Specific feedback and technical assistance was provided to each MCHP by the EQRO during on-site visits. The technical assistance focuses on improving study methods, data collection, and analysis.

A summary of compliance for all evaluated PIPs is included in Table 1.

Table 1 – Summary Performance Improvement Validation Findings, by MCHP
Note: This table is a summary of the data contained in Table 3 of this report, found in Section 2.3.

PIP Title	Overall Compliance Rating
HCUSA Reducing the Re-admission Rate for Asthma Patients Project	100%
HCUSA Improving Oral Health	100%
Home State Notification of Pregnancy Form Receipt Improvement	100%
Home State Improving Oral Health	64.42%
MO Care Post Mental Health Hospitalization Follow-Up Care Within 7 Days of Discharge	100%
MO Care Improving Oral Health	54.17%

HealthCare USA

HCUSA submitted PIPs that met all requirements of the PIP validation process as defined by the CMS Protocol Validating Performance Improvement Projects (PIPs). The clinical PIP, Reducing Re-admission Rate for Asthma Patients Project, identified a problematic issue for members. This issue negatively impacted members' quality of life and health. Research and study development led HCUSA to collaborate with a home health partner and create an approach to address the issue, which included enhanced in-home asthma education in collaboration with ongoing telephonic case management. This approach was intended to impact member behavior and improve health outcomes. The PIP documentation supplied to the EQRO included narrative that explained each component of the study and made it understandable and easy to evaluate.

HCUSA has taken a leadership role in the development and implementation of the Statewide PIP: Improving Oral Health. Their data indicates improvement in outcomes. HCUSA's HEDIS rates were 34.85% when the project started. The 2014 HEDIS rate is 50.67% statewide, which exceeds the MHD CY 2013 statewide goal of 48.79%, determined by MDH's commitment to meet the CMS

goal of improving the State's aggregate HEDIS ADV rate by 10% by the end HEDIS 2016. HCUSA plans to sustain the improvements made by developing new strategies and interventions each year, and maintaining the strategies that have proven successful. HCUSA has developed a staff PIP team. This team works with their dental subcontractor, DentaQuest to ensure that all interventions and improvement strategies are implemented. The PIP documentation provided included details on new approaches, such as ER Re-Route collaboration and the Smiling Stork Program for Pregnant members that are active initiatives to see that members receive excellent dental care, beginning with obtaining an annual dental visit.

The PIP provided the criteria they will use to make future assessments of project outcomes. The approach HCUSA is taking indicates that there is a high probability that this performance improvement project will maintain the current level of success, and continue to improve in the future. HCUSA documentation sites new initiatives designed to ensure that the outcomes achieved to date are sustained.

Home State Health Plan

The clinical PIP, Notification of Pregnancy Form Receipt Improvement, submitted by Home State met all of the requirements of the PIP validation process. This PIP was completed at the end of 2013 and has retired as an active PIP. This PIP proved to have a positive impact on Home State functions, which led to a significant improvement in member outcomes. Home State identified a problematic issue and resolved it using the PIP process, as an effective method of achieving change in member and provider behavior. The analysis of all interventions and outcomes was provided in convincing detail even though this study was completed in 16 months. Barriers were addressed, and Home State understands the need to continue to monitor their success and to implement any actions necessary to maintain their current level of achievement. One of the primary measures of success is that Home State has incorporated the activities developed to achieve these changes into regular organizational processes. Home State will continue to use these processes, and improve them, in an effort to further improve healthcare outcomes for pregnant women.

The baseline for receipt of forms in August 2012 was 58.4%. Through the interventions applied, the average receipt rate for 2013 improved to 84.33%, exceeding the 25% improvement target that Home State set for the PIP. Home State identified additional positive effects resulting from these improved processes. These include a decline from 9.8% to 6.3% for newborns in neonatal intensive care; and a decrease in low birth weight infants from 2.4% to 1.6% in 2013. Home State expects to

sustain these positive outcomes, as they have incorporated the PIP interventions into their organizational processes. They are maintaining both member and provider training initiatives.

The non-clinical PIP and Home State's individual approach to the Statewide PIP focused on Improving Oral Health did not meet the requirements of the PIP validation process as the study design, data analysis and interpretation, and tying improvement strategies to outcomes were not complete. The foundation of an effective PIP was presented in Home State's original submission, and was repeated with the update received after the on-site review. Home State used information available from the Statewide PIP and incorporated this into their planning. They included data available to them through the development of a HEDIS-Like data initiative to inform the PIP process. This process was to be in place until Home State had actual HEDIS results in June 2014. The interventions employed, and the barrier analysis included, indicate a commitment to the Statewide PIP project goals. Technical assistance was provided during the on-site review regarding areas of this PIP that can be improved. These included: study design; tying improvement strategies to outcomes; and detailed data analysis. The PIP rating reflects deficiencies in these same areas as no additional data or new analysis was included. Although the 2014 HEDIS ADV rate was provided in one table when the updates were submitted.

Missouri Care

The clinical PIP, Post Mental Health Hospitalization Follow-Up Care Within 7 Days of Discharge, submitted by MO Care met all of the requirements of the CMS PIP Protocol. This PIP addresses an important concern for members' mental health. Current interventions are beginning to produce the desired results. The 2006 baseline rate was 17.65%, but this only included the Central MHD Managed Care Region. The MHD Central Region HEDIS 2014 rate of 44.67% does reflect improvement for MO Care. It does not meet their goal of 48.37% for CY 2013, which was based on the National Committee for Quality Assurance (NCQA) Effect Size Table, a tool that assists the user to set goals based on current rates, rather than a fixed percentage increase. During HEDIS 2012 (CY 2011) MO Care began serving all three MHD Managed Care Regions and producing aggregate HEDIS results. A new baseline, based on these regional additions was developed. HEDIS 2013 became a new baseline year for this project using the aggregate rate, which was 37.04% for that measurement year. HEDIS 2014 results were reported with the update received after the on-site review. The new aggregate rate for this measure is 39.36%, which was statistically equal to the previous year's results based on the statistical significance testing completed. However, it does maintain the upward trend previously experienced by MO Care since implementing this PIP. MO

Care will continue the successful interventions in place as the result of this PIP. In addition, new interventions will be added and evaluated to help "improve and sustain the rate of follow-up after hospitalization".

The PIP is well constructed. The interventions, including cooperation and planning between the behavioral health case manager and utilization management specialist regarding discharge planning, contributed to the improvements MO Care experienced according to their outcome analysis. MO Care delivered a plan to monitor all current initiatives and to implement new strategies for improvement with a goal of creating further success for their members.

The results submitted for the non-clinical PIP contained significant deficits. The study question was not updated and the stated goal did not reflect the expectations of the Statewide PIP. The study design did not include a data analysis plan. The results of MO Care's 2014 HEDIS data were included, but no analyses of the results were presented. MO Care's baseline HEDIS rate from 2008 was 27.24%; the HEDIS 2010 was 38.21%. MO Care experienced incremental improvements through HEDIS 2013 achieving a rate of 43.19%. However, the 2014 HEDIS rate, reflecting data from CY 2013 is 31.39%. This is nearly a 12 point decrease in the HEDIS rate, but MO Care made no comments, or hypotheses about the cause of this decline.

MO Care does continue to implement new interventions annually. Their narrative claims that they track and trend their initiatives so additional improvement can be achieved. There is no evidence of this type of analysis for the 2013 non-clinical PIP. MO Care has used the PIP process as a method to obtain improved performance in previous years. They achieved a minimal (2.19%) improvement for 2012 and then a 12 point decrease in 2013. Some narrative or analysis of this decline is needed to understand the lack of success of the current interventions. MO Care must present an appraisal of declining rates, what contributed to this outcome, and present a proposal for shifting trends.

Final Assessment

The EQRO is tasked with reporting how Medicaid Managed Care members access care, the quality of care members receive, and the timeliness of this care. The EQRO reports on these three focuses in each area of validation.

Quality of Care

Topic identification was an area that provided evidence of the attention paid to providing quality services to members at all MCHPs. Intervention development for PIPs also focused on the issue of quality services. The PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MCHP or in the direct provision of services delivered. PIPs included interventions that addressed barriers to quality care and targeted improved health outcomes. Interventions included: in-home care in collaboration with enhanced telephonic case management, behavioral health case management that begins collaboration with utilization management as soon as a member enters in-patient care, and targeted initiatives to get members enrolled in OB case management early in their pregnancy. All of these interventions exemplify an attention to quality healthcare services.

Access To Care

Access to care was an important theme addressed throughout the PIP submissions. A major goal of the Statewide non-clinical PIP is improved access to dental care. This goal was reflected in the individual oral health PIP projects developed by each MCHP. Access to care was also an important focus in the clinical PIPs. Each of the MCHPs focused on assisting and educating members in developing PCP and specialist relationships. The clinical PIPs focused on providing access by introducing intensive and/or early case management, with in-home services whenever possible. The clinical PIP topics focused on early access to prenatal care, case management interventions to facilitate access to early follow-up after hospitalization for mental health issues, and intensive case management linked to in-home services for members with asthma who have had an inpatient hospitalization. All of these projects have the potential to lead to improved preventive and primary care for members. The EQRO's on-site discussions with MCHP staff indicated that improving access to care is an ongoing aspect of all projects that are developed.

Timeliness of Care

Timeliness of care was also a major focus of the PIPs reviewed. These projects addressed early involvement in prenatal care, immediate services prior to release from hospitalization, and

immediate management of members' health when hospitalized as the result of asthma. The projects addressed the need for timely and appropriate care for members to ensure that services are provided in the best environment quickly and efficiently. The PIPs related to Improved Oral Health included a focus on obtaining timely screenings and recognized that this is an essential component of effective preventive care. The need for timely access to preventive and primary health care services was recognized as an essential component of each project. Projects reflected this awareness, as they addressed internal processes and direct service improvement.

CONCLUSIONS

The MCHPs have made significant improvements since the EQRO measurement process began. In 2004 during the first year the PIPs were reviewed against the requirements of the CMS protocols, the MCHPs earned an aggregate rating of 25.1%. In 2013 the MCHPs aggregate rating has increased to 86.82% for meeting all the requirements of PIP Validation Rating. The MCHPs use the PIP methodology to design studies and quality improvement processes that improve services to members. Although the MCHPs implement projects that focus on quality, both MO Care and Home State submitted narrative write ups and data analysis of their PIPs that lacked detail and depth during this review period.

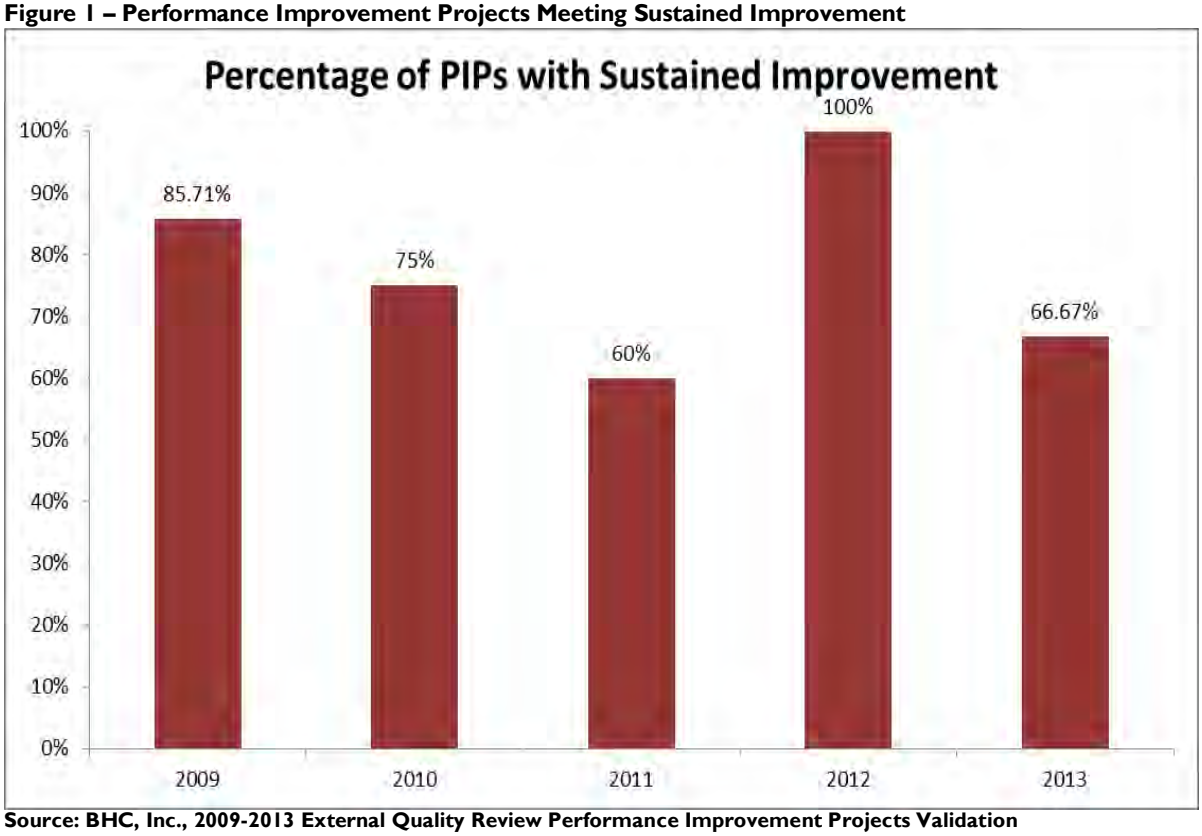
Figure 1 depicts an essential element of validating these projects, analyzing the projects' ability to create sustained improvement. This is determined by evaluating a number of factors including:

- Calculating the degree to which the MCHPs' interventions have produced statistically significant results, or at least a sustained upward (or downward) trend in desired results;
- Reviewing reported outcomes and submitted data for quality indicators that indicate "meaningful change in performance relative to the performance observed during the baseline measurement;" and
- Observing changes in the fundamental processes of healthcare delivery demonstrating sustained improvement, which includes baseline and repeated measurements over comparable periods of time indicating that the desired improvements have occurred.

In 2009 this measure was rated at 85.71% for the projects mature enough to complete this evaluation. In 2010, only four PIPs were considered mature enough to evaluate their ability to produce sustained improvement. Of those four PIPs three were considered likely to sustain improvement, thereby the PIPs were rated as 75% compliant for the 2010 review. This **declined** for the 2011 review to 60%, as five PIPs where considered mature enough to evaluate for sustained

improvement and three of those five received ratings that showed sustained improvement. In both 2012 and 2013, three PIPs were considered mature enough to evaluate the possibility of sustained improvement. In 2012 all three received ratings that showed sustained improvement. In 2013, only 2 PIPs showed sustained improvement for a rate of 66.67%. The one PIP that did not show sustained improvement for 2013 included follow-up activities and new interventions planned for 2014, yet it completely failed to address data reflecting the 2013 outcomes.

Figure 1 – Performance Improvement Projects Meeting Sustained Improvement



Source: BHC, Inc., 2009-2013 External Quality Review Performance Improvement Projects Validation

1.3 Validation of Performance Measures

The Validation of Performance Measures Reported by the MCO Protocol requires the validation or calculation of three performance measures at each MCHP by the EQRO. The measures selected for validation by the SMA are required to be submitted by each MCHP on an annual basis. The measures were also submitted to the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS). For the HEDIS 2013 evaluation period (Calendar Year 2012), the three performance measures selected for validation were Annual Dental Visits (ADV), Childhood Immunization Status, Combo 3 (CIS3), and Follow-Up After Hospitalization for Mental Illness (FUH). 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 and can be found in their technical manual.[5] The EQRO examined the information systems, detailed algorithms, MCHP extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol.

Due to contract changes effective July 1, 2012, only two of the seven MCHPs that provided coverage for some part of 2012 were active for the entire year. Continuous enrollment requirements for HEDIS measures, necessitates that only those two plans were included in the HEDIS analysis for this report.

QUALITY OF CARE

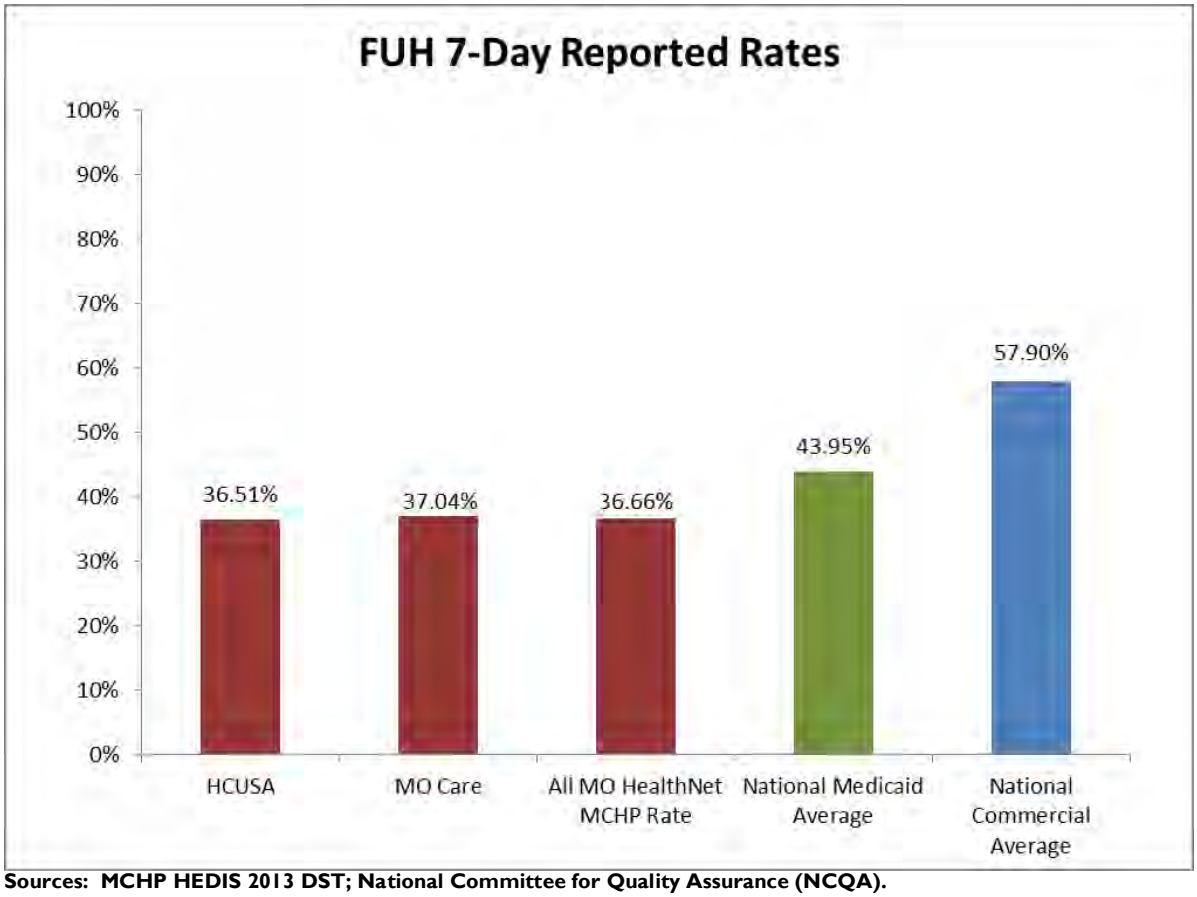
The HEDIS 2013 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the quality of care received by MCHP members.

Of the two MCHPs that were fully validated by the EQRO, one (MO Care) was Fully Compliant with the specifications for calculation of this measure and one (HCUSA) was Substantially Compliant. (see Tables 13, 14, 15)

[5] National Committee for Quality Assurance (NCQA), *HEDIS 2013 Volume 2: Technical Specification,* 2012.

For the 7-day follow up rate, no MCHPs reported rates were higher than the National Medicaid Average (43.95%) for this measure. The rate for this measure is consistent across the two MCHPs, at about 37% for each plan. This is approximately 7 points less than the National Medicaid Average, and a drop of almost 10 points compared to 2012.

Figure 2 - Managed Care Program HEDIS 2013 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



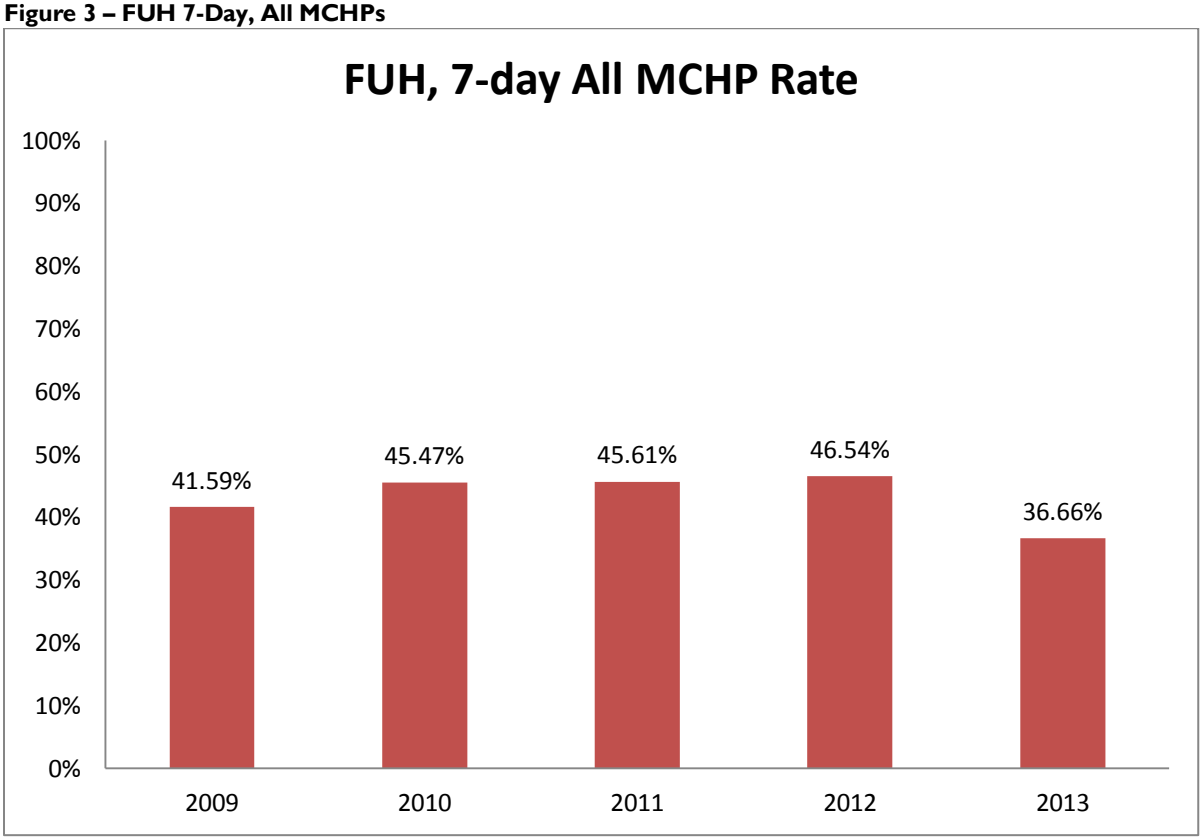
Sources: MCHP HEDIS 2013 DST; National Committee for Quality Assurance (NCQA).

The rate of 36.51% for HCSA represented approximately a 13 point decrease from the 2012 rate of 49.63% and the rate of 37.04% for MO Care represented 2.38 point decrease from the 2012 rate of 40.42%.

This measure has been audited by the EQRO annually since 2009. The 7-Day reported rate for all MCHPs in 2013 (36.66%) interrupts a previously stable trend. During the on-site visits, both MCHPs were questioned by the EQRO about the decreases in their prior year's rates. Only HCUSA was able to fully explain the reduction in their rate. The MCHP stated that the decreased rate was attributable to a software glitch in their NCQA-certified software, Inovalon. It was explained that the date of service was not being pulled accurately by the software. Specifically, if a claim form had more than one date of service, the system was not capturing all of the dates of service. This error has since been corrected and HCUSA assures the EQRO that the rate will show a significant improvement for HEDIS 2014. Unfortunately, HCUSA is unable to correct the rates with NCQA, as they do not accept corrected rates.

MO Care was unable to fully explain their rate's decrease, the EQRO provided technical assistance regarding discharge planning and the use of alternate providers in order to aid the MCHP in improving future rates.

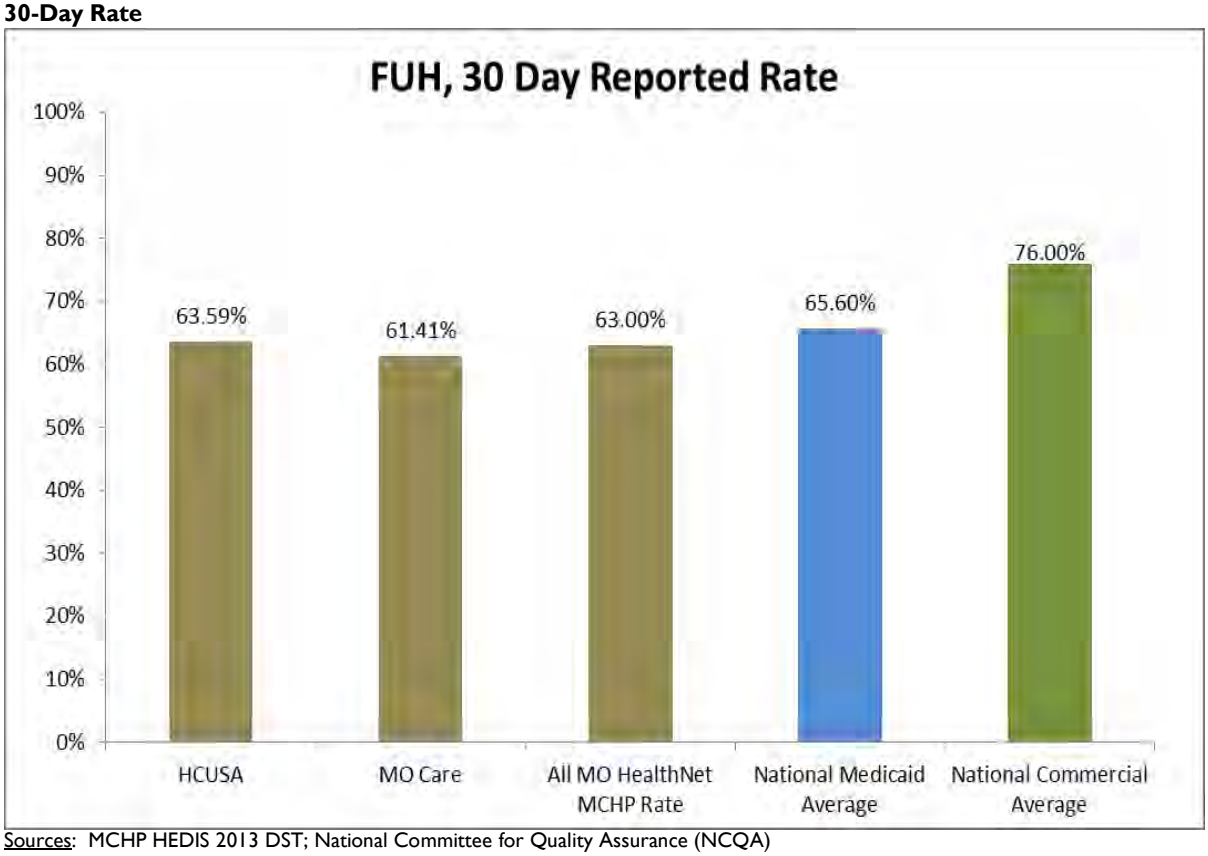
Figure 3 – FUH 7-Day, All MCHPs



Source: BHC, Inc. 2009-2013, External Quality Review Performance Measure Validation

The rate for the 30-day follow up rate is consistent across the two MCHPs. The average of the two MCHPs is 13 points below the National Commercial Average and 2.6 points below the National Medicaid Average.

Figure 4 - Managed Care Program HEDIS 2013 Follow-Up After Hospitalization (FUH) for Mental Illness, 30-Day Rate

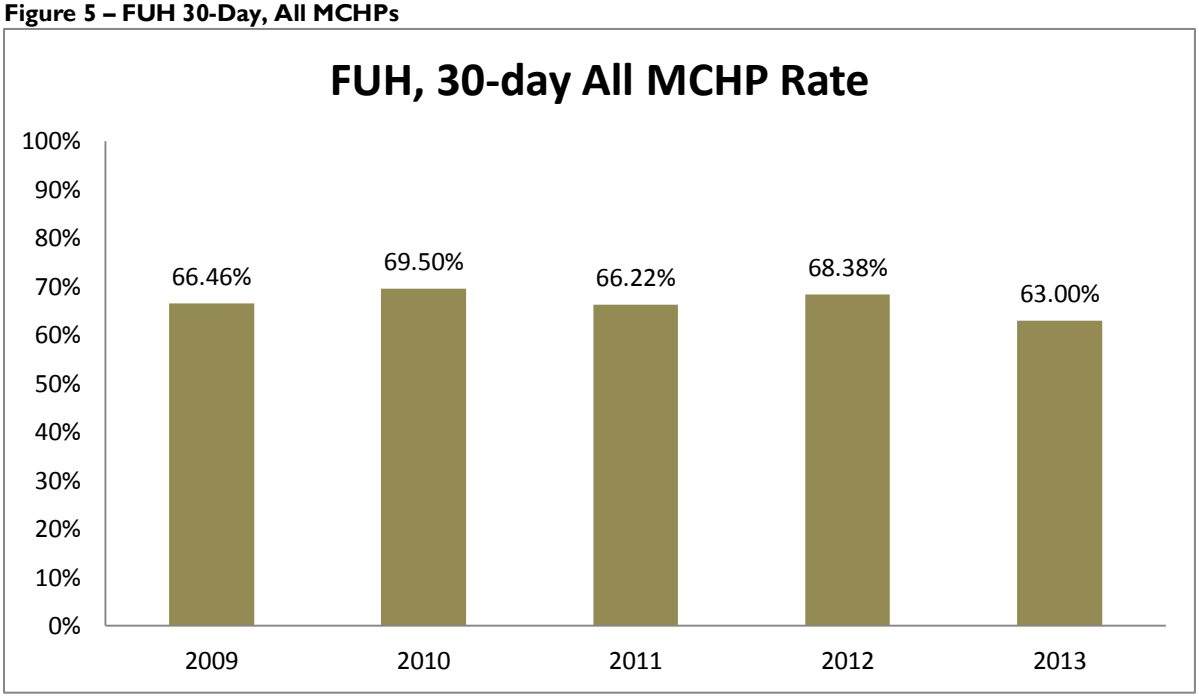


Sources: MCHP HEDIS 2013 DST; National Committee for Quality Assurance (NCQA)

The rate of 63.59% for HCUSA represented a 8.08 point decrease from the 2012 rate of 71.67% and the rate of 61.41% for MO Care represented a 13.75 point increase from the 2012 rate of 47.66%.

This measure has been audited by the EQRO annually in five of the last six years. The 30-Day reported rate for all MCHPs in 2013 is the lowest rate reported for this measure since the EQRO began analyzing the measure. Again, the issue with HCUSA's NCQA certified software played a role in that MCHP's rate decrease.

Figure 5 – FUH 30-Day, All MCHPs



Source: BHC, Inc. 2009-2013, External Quality Review Performance Measure Validation

From examination of these rates, HCUSA's rate was negatively affected by the software issue, so a true rate was not calculated by the software and therefore, a true picture of the quality of care received for these measures is difficult to ascertain.

Additionally, it should be noted that although no bias was observed in the calculation of either MCHPs' FUH rates, the software glitch and the significant decrease in HCUSA's rates caused the EQRO to adjust their overall validation rate accordingly.

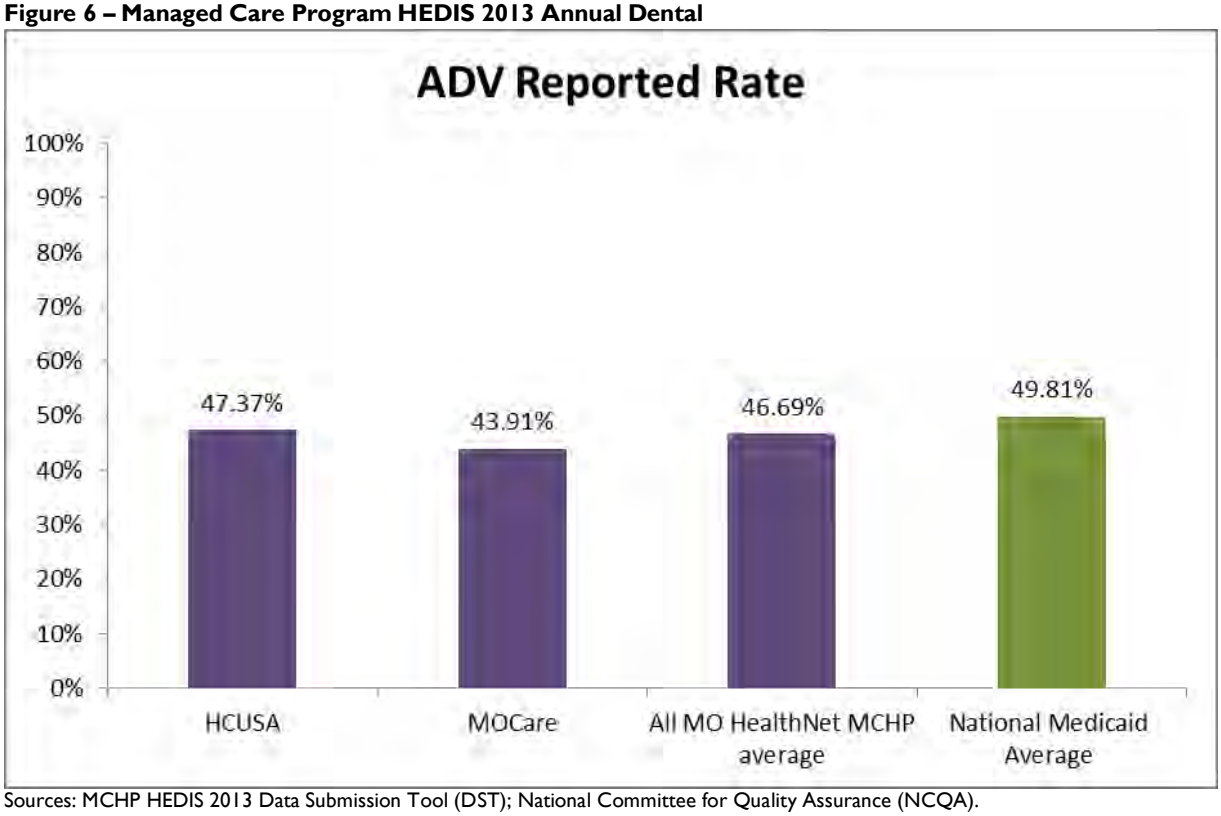
ACCESS TO CARE

The HEDIS 2013 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.

Of the two MCHPs that were fully validated by the EQRO, both were Fully Compliant with the specifications for calculation of this measure.

The Annual Dental Visit measure has been reviewed for the last seven audit years, the data for the last four years: 2010, 2011, 2012 and 2013 are analyzed here. Over the course of these review periods, the rates for all MCHPs have improved and the 2013 rate was the highest rate seen in Missouri at 46.69%. However, in 2013, none of the MCHPs reported rates higher than the National Medicaid Average of 49.81%.

Figure 6 – Managed Care Program HEDIS 2013 Annual Dental

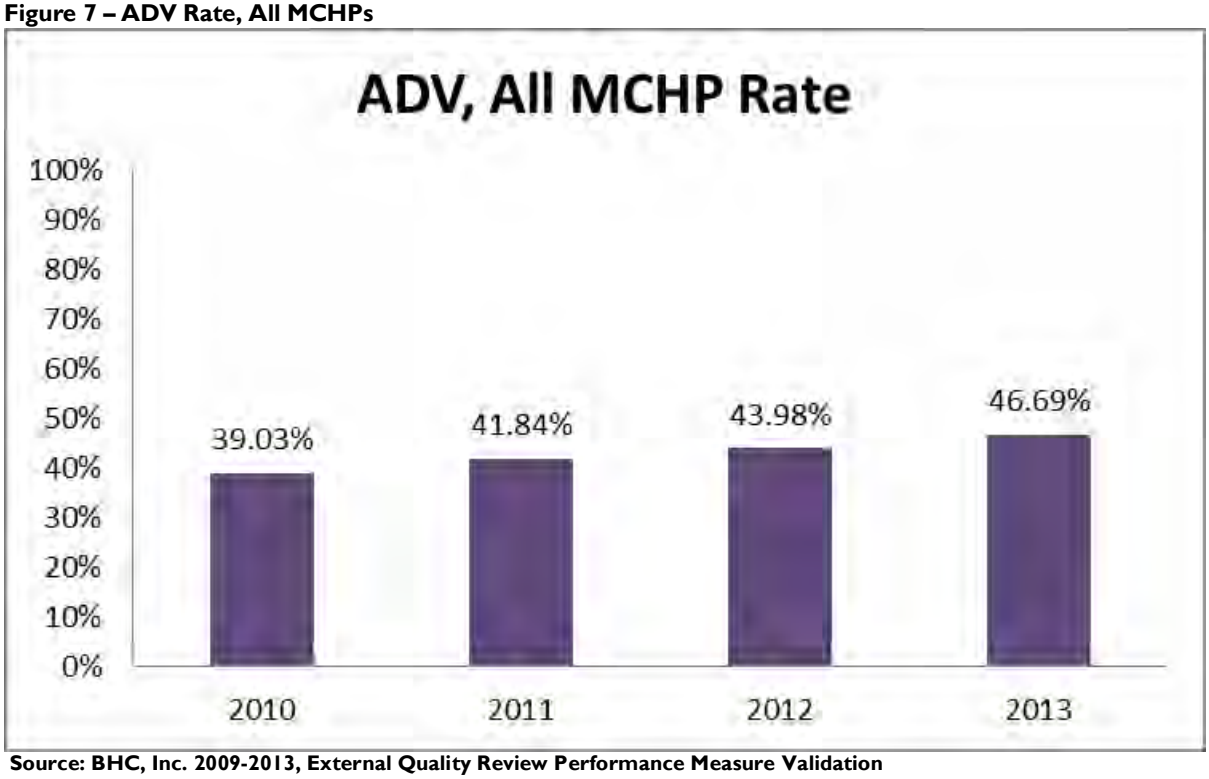


Sources: MCHP HEDIS 2013 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

HCUSA's rate of 47.37% represented a 1.08 point increase from the 2012 rate of 46.29% and the rate of 43.91% for MO Care represented an almost 1 point increase from the 2012 rate of 42.97%.

This increase in the ADV rate shows an increased level of dental care received in Missouri by members, illustrating an increased access to care for these services at about 3-4 points per year since 2010. The EQRO largely attributes the continued increase in the ADV rate to the SMA's concentration on a Statewide Oral Health initiative that has fostered a statewide PIP.

Figure 7 – ADV Rate, All MCHPs



Source: BHC, Inc. 2009-2013, External Quality Review Performance Measure Validation

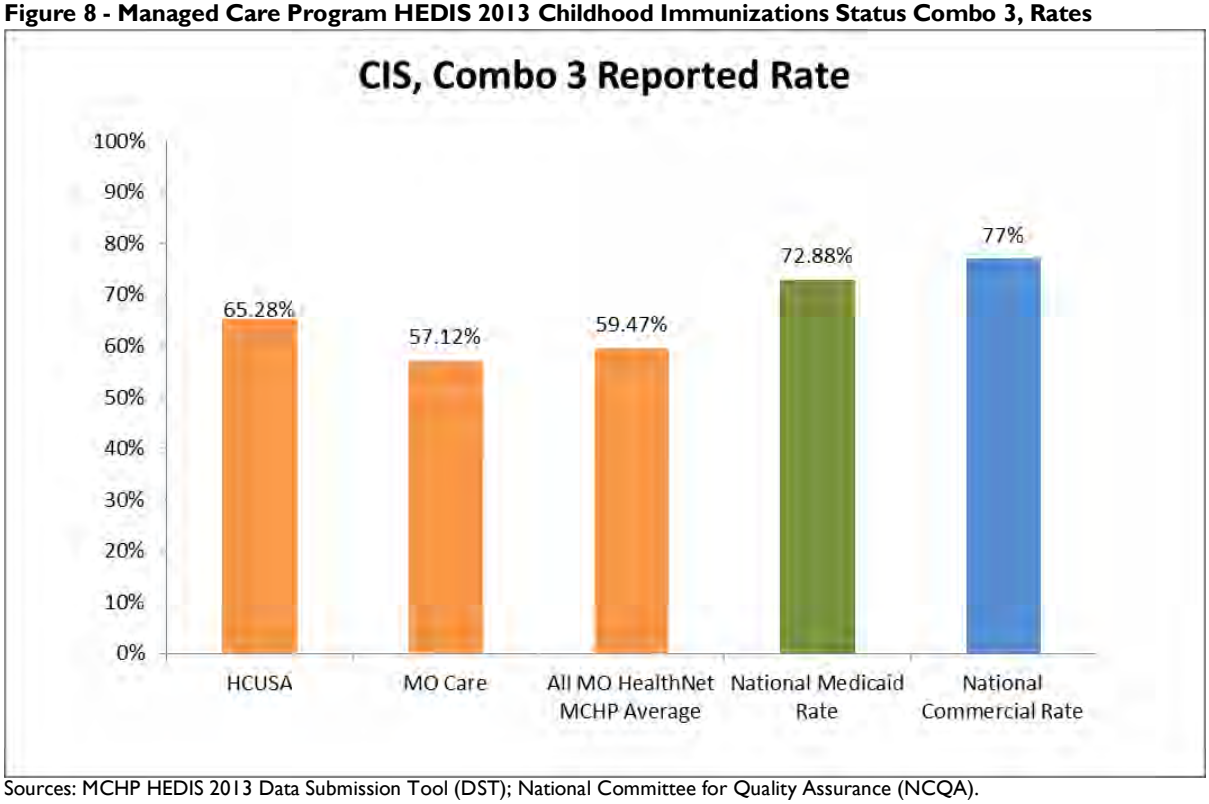
TIMELINESS OF CARE

The HEDIS 2013 Childhood Immunizations Status measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. To increase the rates for this measure, members must receive a series of services within a very specific timeframe (i.e. prior to age 2).

Of the two MCHPs validated by the EQRO, one (MO Care) was Fully Compliant with the specifications for calculation of this measure and the other (HCUSA) was Substantially Compliant with the specifications for calculation. The Substantially Compliant MCHP provided 29 of the 30 requested medical records, this negatively impacted the validation of their rate.

Both MCHPs fell well short of the National Medicaid Average of 72.88% and the National Commercial Average of 77%.

Figure 8 - Managed Care Program HEDIS 2013 Childhood Immunizations Status Combo 3, Rates



Sources: MCHP HEDIS 2013 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

HCUSA's rate of 65.28% represented a 4.28 point increase from the 2012 rate of 61.56% and the rate of 57.12% for MO Care represented a 9.23 point decrease from the 2012 rate of 66.44%.

This illustrates a timeliness of care for immunizations delivered to children in Missouri that is lower than the timeliness of care received by other Medicaid members across the nation.

Combination 3 for this measure was audited in 2011 and 2012, therefore trend analysis was examined for this 2013 audit year. However, the statewide rate fluctuates within a 4 point range, showing no clear trends. The statewide rate in 2013 (59.47%) was **lower** than the 2012 rate (61.27%), but the 2013 rate was **higher** than the rate reported in 2011 (57.47%).

Figure 9 - Childhood Immunizations Status Combo 3 Rates, All MCHPs

Source: BHC, Inc. 2011-2013, External Quality Review Performance Measure Validation

1.4 Compliance with Medicaid Managed Care Regulations

The purpose of the protocol to monitor MCHP Compliance with Managed Care Regulations is to provide an independent review of MCHP activities and assess the outcomes of timeliness and access to the services provided. The CMS 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 MCHP personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MCHP.

The policy and practice in the operation of each MCHP was evaluated against the 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 MCHP's policy to determine compliance with the requirements of the Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO.

This year's review (calendar year 2013) is a follow-up review to the full compliance review that was completed in the prior year's report. The SMA reviewed current policies and procedures to ensure that they were in compliance with the current contractual requirements, as well as federal regulations. The EQR Compliance Review focused on implementation of policies and procedures, as required in the Case Management processes. The review included case record reviews and interviews with Case Management and Administrative staff. The results of the Case Management review are reported in detail in section 5.0 of this report as a "Special Project". The interview tools used were based on information obtained from each MCHPs' 2013 Annual Report to the SMA and the SMA's Quality Strategy.

The EQRO's review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MCHP'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 MCHP's compliance. All information gathered was assessed, re-reviewed, and translated into recommended compliance ratings for each regulatory provision.

Quality of Care

For all the MCHPs, all of the 13 regulations for Enrollee Rights and Protections were 100% "Met." These regulations address member rights to privacy and treatment, accommodations for language and cultural needs, and accommodations for physical and emotional barriers. The MCHPs demonstrated an awareness of Enrollee Rights and Protections by having standards and practices in place that were compliant and evident in discussions with staff who interact directly with members.

For all the MCHPs, all of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. This is the second year in a row that these MCHPs maintained a 100% rating in this set of regulations.

The MCHPs improved significantly in compliance with this set of regulations.

Access to Care

All plans performed below expected levels with regard to the Access Standards, although one plan, Home State, showed an improvement compared to 2012. Home State was rated at only 70.59% compliant. The remaining MCHPs were both found to be less compliant with these standards than in 2012.

There were 4 regulations rated as "Not Met" for both the 2013 and 2012 reviews. However, across all MCHPs, the rate of regulations "Met" for the 2013 review (74.51%) is a decline from the 2012 review (83.67%) and the 2011 rate of 75.49%. One MCHP (HCUSA) was found to be 82.35% compliant and the other two MCHPs (Home State and MO Care) were 70.59%.

The EQRO observed that all of the MCHPs had case management services in place. However, the case management records requested did not always contain information to substantiate these on-site observations.

Each MCHP described measures they used to identify and provide services to MO HealthNet Managed Care members who have special healthcare needs. All of the MCHPs could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required. The EQRO observed instances when specialty care should have been offered to members in Case Management and no such offer was extended.

TIMELINESS OF CARE

This is an area of decline in compliance for all the MCHPs. Nine of the eleven applicable regulations for Measurement and Improvement were 100% "Met." However, none of the three MCHPs met all of the regulatory requirements. All of the MCHPs adopted, disseminated and applied practice guidelines and used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. However, lower Performance Measure rates and missing Performance Improvement Project analyses contributed to this decline.

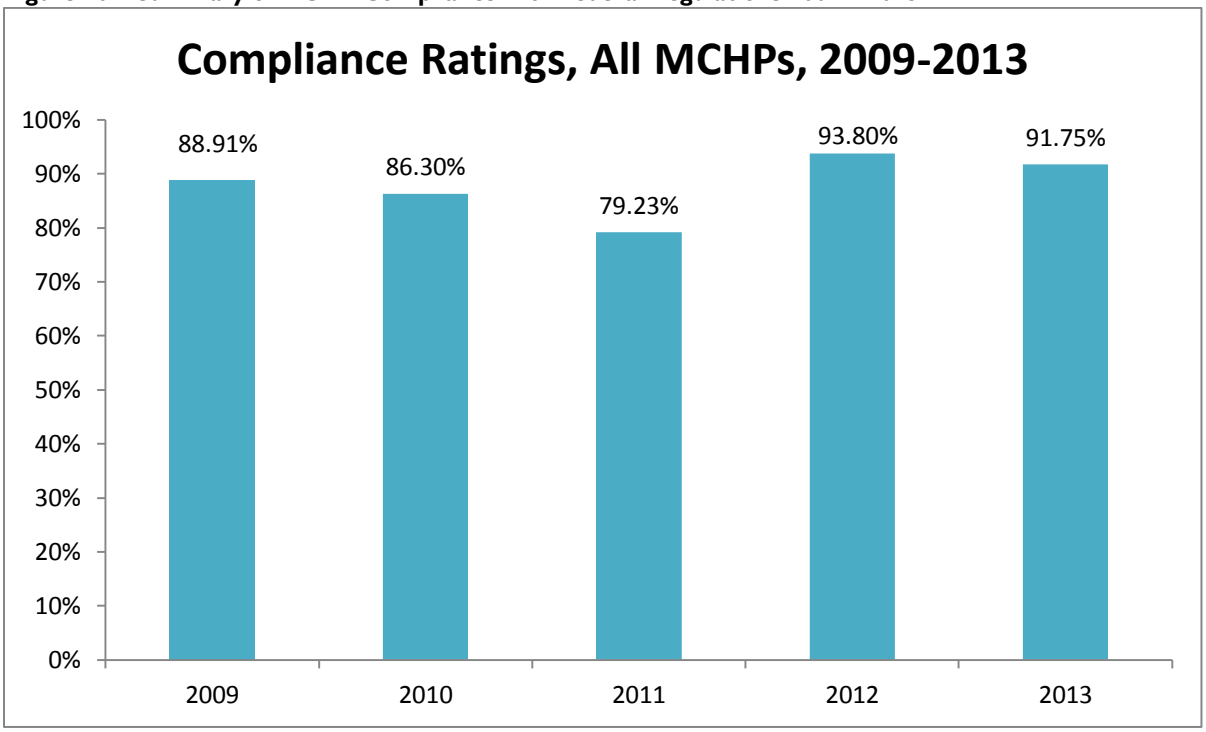
The MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs. This was not always evident in the documentation reviewed.

All of the regulations for Grievance Systems were 100% "Met" for all of the MCHPs. These regulations all pertained to the written policy and procedure of the MCHPs.

CONCLUSIONS

Since 2004, when the EQRO began reviewing compliance, the MCHPs have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially in 2004 the MCHPs did not have complete and approved written policies and procedures and MCHP processes did not exhibit compliance with contractual and regulatory requirements. This 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. The MCHPs have used previous EQR report recommendations to ensure compliant and member focused procedures. However, after reaching a high of 93.80% compliance in 2012, the All MCHPs rate of compliance has decreased for 2013.

Figure 10 – Summary of MCHP Compliance with Federal Regulations 2009 – 2013



Source: BHC, Inc., 2009-2013, External Quality Review Compliance Validation

Across all MCHPs there are only a few regulations rated as "Not Met." All other individual regulations were rated as "Met" or "Partially Met." All MCHPs were 100% compliant with three of the compliance areas validated during this review year. For the fourth year in a row, none of the three MCHPs were 100% compliant with all requirements. The 2013 overall rating of 91.75% compliance for all MCHPs is a 2.05 percentage point decrease from 2012. This is attributable to the results of the MCHPs' PIPs, PMs and the Case Management Special Project reviews.

1.5 MO HealthNet MCHP Special Project – Case Management Performance Review

In 2010 the EQRO began conducting a special project to follow up on the MCHP compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and record keeping. The EQRO also evaluated the MCHPs' compliance with the federal regulations and the Managed Care contract as it pertained to Case Management.

The focus of this review was:

- Assessing the MCHPs' attention and performance in providing case management to:
    a. Pregnant members;
    b. Members with special health care needs; and
    c. Children with elevated blood lead levels.
- Evaluating compliance with the case management requirements of MHD Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases reported as open in each MCHP system.

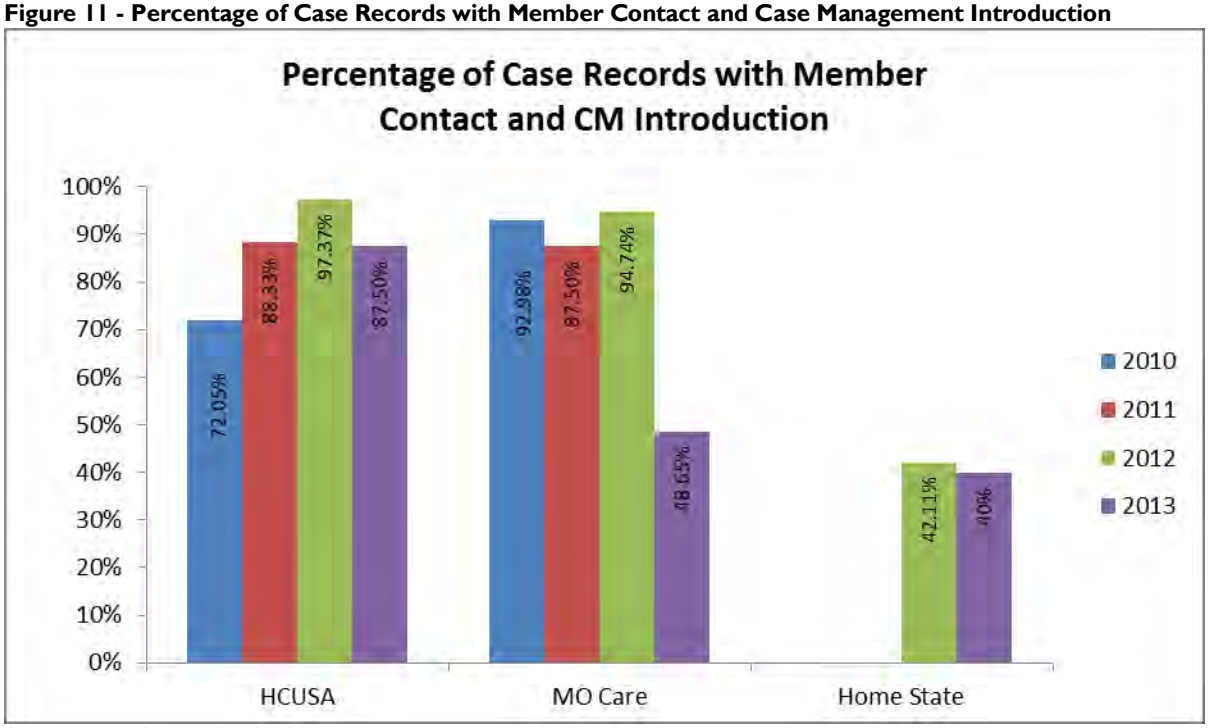
OBSERVATIONS AND CONCLUSIONS

Introduction to Case Management

There are four standards used to assess the category of Introduction to Case Management. The records and recording must include:

1. Identifying information used to locate and maintain contact with the member;
2. Case opening – after receipt of referral was a case opened for assessment and service delivery;
3. Introduction to Case Management – did the case manager explain the case management process to the member; and
4. Acceptance of Services – did the member indicate they agreed to the MCHP providing case management services allowing on-going involvement.

Figure 11 - Percentage of Case Records with Member Contact and Case Management Introduction



Source: BHC, Inc. 2013, Case Management Record Review

In 2013 all three MCHPs declined in providing all introductory information or recording these conversations with members. MO Care and Home State are at an unacceptable level of performance in this standard. HCUSA and MO Care's performance did trend upward in previous years. These increases appeared to indicate that the efforts to contact members and explain the case management process were successful. However, during the 2013 review several factors were noted that contributed to the decline:

- MO Care changed ownership, which created a complication where all case management record information was not available or consistent. The converted records did not contain introductory and assessment forms, although case management notes were available. Comparing records reviewed in 2012 to the records received for the 2013 review, this change had a negative impact on the number of cases containing a complete record of the introduction to case management.

- HCUSA did contact, explain case management, and obtain the member's cooperation in providing services in 100% of the cases reviewed for pregnant women. This is in compliance with their contractual obligations. These records did reflect efforts to locate and develop communication with these members that were successful.

- The MCHPs fell short of meeting acceptable levels of making timely contacts with members in Lead related cases.

    - In 54% of HCUSA's and 75% of MO Care's open Lead Case Management files no contact with the family was observed. Computer generated information, such as assessment forms and care plans were in the files were in the records received. They included regular monthly case notes with a record of contacts regarding the member. However, no direct contact was made with the family or member. Contacts and tracking occurred through the local health department and sometimes through the assigned PCP's office.

    - Lead case management is required for any child who appears on the DHSS listing for children with an EBLL over the minimum level of 10V. Prior to 2010 this list only included children under the age of six. It now includes children over age six (6), who became MCHP members, but may have had a previously reported elevated blood lead level that was never retested, or found to be under the minimum BLL of 10V. These members and their families were unresponsive to repeated attempts to contact them. In 38% of HCUSA, 33% of MOCare, and 27% of Home State files families refused or did not present themselves for updated testing. The MCHPs do maintain active case management records whether the family agrees to case management or not.

- Home State was in its second year of providing services during CY 2013. Case management records reviewed indicated that staff are contacting members and providing case management services. In the records reviewed there was marginal improvement in holding or recording conversations where case management was explained to the member. Home State did not show improvement in recording how case managers obtained the member's willingness to accept services in 63% of the cases reviewed.

- Case managers and program coordinators from all MCHPs reported during on-site review interviews that they are aware of the need to explain case management, why the member may benefit from the service, and the member's right to choose the service. Case managers, who carry special health care needs and pregnant women's cases, described taking a proactive approach with members and state that the majority of the members who are approached accept

case management services. In only four of the cases reviewed did the member or parent state during the original contact that they were not interested in case management.

- Case managers are required to explain the nature of the case management relationship, the contact(s) they will have with the member, and the services available. Case managers must request approval to discuss the case with a third party, if appropriate. Case managers must discuss the availability of a complaint process and explain any contacts with the providers involved.

    - This activity occurred in 67% of the cases reviewed for HCUSA and 52% of the MO Care cases. Even though these numbers indicate a slight majority, it is clear that if this issue is being explained, it is not recorded or reflected in the case record information with the member's agreement to accept services nearly as often as required.

    - At Home State only two of the forty records (5%) reviewed contained any evidence that the case manager discussed the issue of third party disclosure with the member or their representative while attempting to obtain permission to talk to a family member or other party about the case.

- Cases that were referred to Home State due to Elevated Blood Lead Levels (EBLL) continued to indicate a lack of urgency in making initial contacts and providing follow-up case management services. Members were contacted within the required time frames only 55% of the time. In the area of Lead Case Management only four of eleven cases (36%) contained any notes regarding the explanation of services, the member's agreement to accept services, or other introductory information.

    - In two cases, referrals were received in May and July of 2013. The first contacts with the family occurred in February and March 2014, a full nine months and eight months respectively. One lead case was opened because the mother requested case management for her twins, but only referrals for lead testing occurred. In one case there was no contact and a case was not opened.

- Locating members and maintaining working telephone numbers or even viable addresses continues to be a concern voiced by all three MCHPs. All have put practices in place, such as contracted agencies that go to the home to attempt to find the member or someone who can verify the member's actual address. The case managers and customer relations staff utilize PCP office staff, concurrent review nurses when a member is hospitalized, and every resource they can find to locate members. They all describe a tenacious approach to locating members with limited success. In reviewing EQRs from other states and Managed Medicaid research this does not appear to be the pervasive problem described in Missouri. A systematic field-based approach to case management has produced positive results in locating and engaging potential members for social services, substance abuse treatment and even corrections related agencies.

- Case managers receive referrals from a variety of sources internal and external to the MCHP. The referral systems are well developed and have shown improvement with each review.

    - Case managers from all three MCHPs describe obtaining referrals from PCP and specialist offices, hospitals and concurrent review nurses, pre-authorization staff, disease management nurses, nurse-advice line staff, intake and customer support staff. They speak regularly with the local health departments, Federally Qualified Health Centers (FQHC) staff, and other community resources. The case managers relate that these sources all make direct referrals to case management. All of this information is available from case manager interviews. Although, the MCHP systems may capture the actual referral source, this information was not available in the records reviewed.

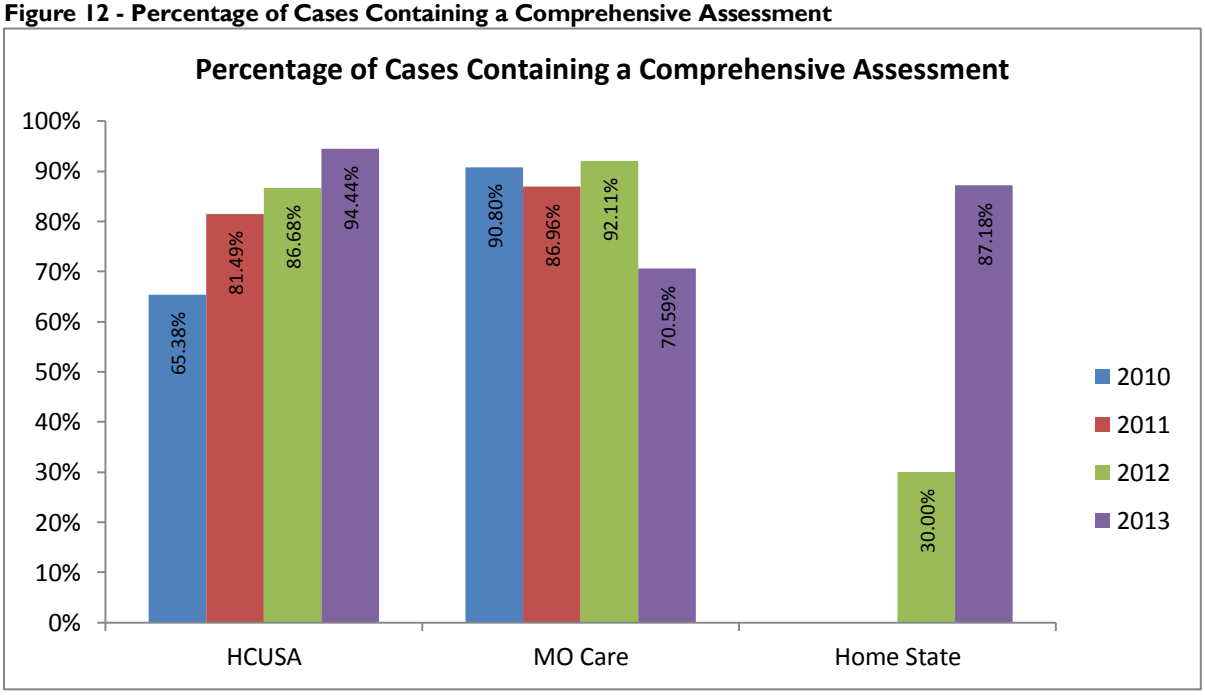
    - The case managers describe using the written and traditional lists that create referrals such as the Lead referrals from Missouri Department of Health and Senior Service (MDHSS) and the Special Health Care Needs (SHCN) listing from MHD. The MCHPs have a process to generate member contacts when these lists are received.

    - The case managers explained that they receive self-referrals from members, or concerned family members, friends, teachers, or other sources. The MCHPs also have "triggers" in place, which create an alert to the case management staff to contact a member to assess that member and their need for services. These triggers include, for example, a member going to the emergency room more than three times in a quarter.

- Case managers, in the Lead cases opened for older children who had EBLL with no retesting, and no member contacts, did make attempts to contact members. Information found in these records included references to educational materials sent, notes regarding contacts with the assigned PCP, the local health department, and other sources. Case managers had a very difficult time engaging these families or getting any type of cooperation. These cases remain open, with periodic contact attempts to the member or family, per state policy and contract requirements. (HCUSA – 38%; MO Care – 33%; Home State – 27% of total lead cases reviewed.)

Assessment

Figure 12 - Percentage of Cases Containing a Comprehensive Assessment



Source: BHC, Inc. 2013, Case Management Record Review

The assessments found in records are computer generated forms that case managers are required to complete at the beginning of each case assignment. In this manner the contractual requirements regarding assessments are met. During the on-site review interviews, case managers were asked by the EQRO if these forms met their needs in determining the services and resources that individual members need. The responses received indicated that case managers go beyond completing these required forms to ensure that they are aware of the members' true needs and to guarantee that

appropriate services are in place. This response was received at all three MCHPs, even when the level of experience varied.

Completion of the assessment forms and inclusion of assessments in the records reviewed did improve at HCUSA and Home State during 2013. The specific data and the standards used to evaluate the assessment of the member's service needs are as follows:

1. Completion within specified time frames:

- Two of the MCHP's records showed improvement in including the assessment tool in the records reviewed. HCUSA records included an assessment tool or questions within case notes 94.44% of the time. This is an increase of 29 percentage points since the case management reviews started.

- Home State showed a dramatic upward trend going from a finding of 30% in 2012 to locating assessment tools in 87.18% of the records reviewed in 2013. An increase of 57.18 percentage points is noted. The interviews and evidence in the record review indicate that this is due to the case managers' increased understanding of their system and how to include information for review.

- The number of assessments in the case records from MO Care decreased. The number of cases containing assessments or notes indicating assessment information went from the highest level MO Care had achieved of 92.11% in 2012 to an all-time low of 70.59% in 2013. This is a difference of 23.36%. When the records were delivered, the MO Care staff explained that as the result of the change in ownership some records did not include computer generated forms such as assessments and case plans, which the previous owner considered proprietorial. Cases requested that were open during the transition did not include all required information. In some cases the EQRO gave credit for assessments being completed based on information available in case notes, even if the actual assessment form was missing. In spite of this the resulting score remained low. MO Care understood the requirements of a complete case management record at the time they were planning for these changes. Maintaining the integrity of case management records should have been a priority in the transition planning to ensure that members' healthcare needs were not overlooked.

2. Inclusion of a comprehensive assessment is required in each file:

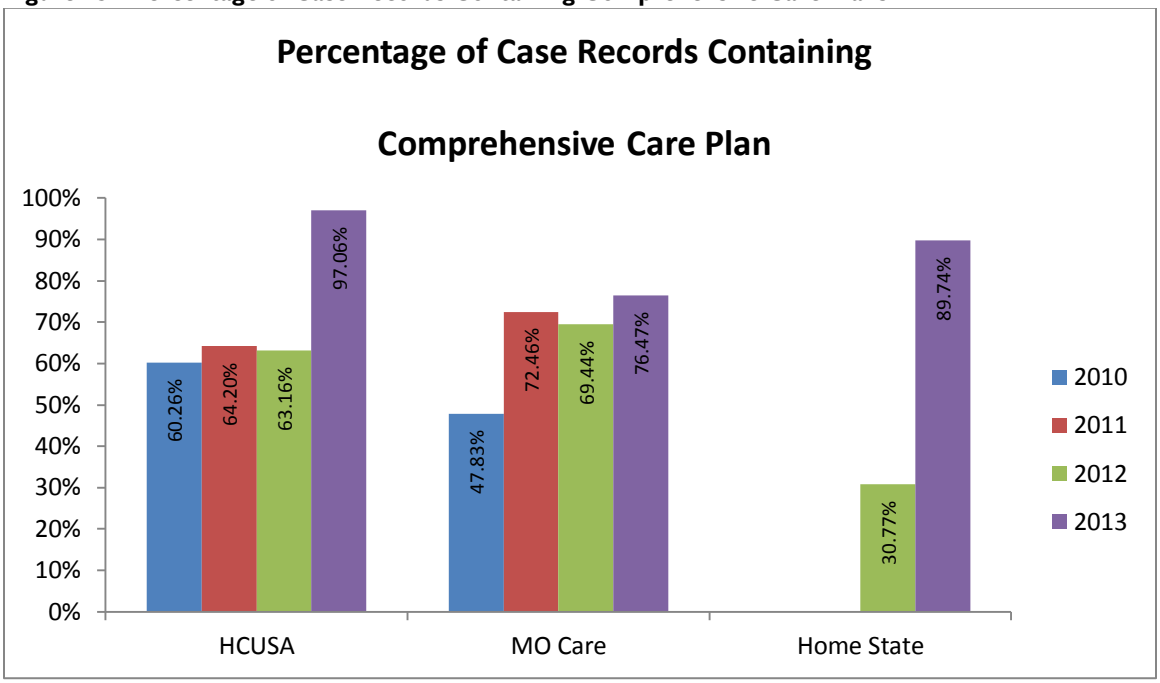
- In the cases from all MCHPs that included assessment tools, standardized questions were asked of all members. Notes were included by two of the MCHPs. In cases reviewed from HCUSA additional information explaining how the case manager evaluated member answers and utilized this information in developing care plans were found in 42.49% of the files. MO Care records included additional case notes explaining or pertaining to the assessment process 40.94% of the time. Additional assessment information in the form of explanatory notes was previously not found in records from HCUSA and MO Care.

- Case managers were asked about the standardized assessment tools. HCUSA case managers report that they find many questions irrelevant to specific members. The case managers describe the assessment tool as cumbersome and less than informative for some members. The case managers explain that in these cases it is difficult to evaluate individual members' problems. The case managers have learned how to use the forms in the most effective manner, finding the issues that are pertinent to the individual member, and creating care plans that meet those members' needs.

- At Home State all of the SHCN cases (100%), and 92.86% of the OB case management cases included a systems generated assessment form. It appeared, through information in the case notes, that these were completed with the members' cooperation, even when no introductory information was available.

Care Planning

Figure 13 - Percentage of Case Records Containing Comprehensive Care Plans



Source: BHC, Inc. 2013, Case Management Record Review

All three MCHPs improved by including care plans in more case records than during prior reviews. HCUSA improved from a rate of care plan inclusion in 2012 of 63.16% to 97.06% in 2013, an increase of 33.9 percentage points. MO Care showed a slight increase in 2013 to 76.47% or up 6.96 points. Home State included care plans in 89.74% of the cases reviewed. This was an improvement of 58.97 percentage points. These care plans are system-generated directly from the assessment form, and are easily included in the records. This does allow the MCHPs to comply with their contractual obligations regarding care planning.

The standards used to evaluate appropriate care planning require:

1. A care plan in all records:

- The 2013 review included more records with care plans than in the three previous reviews as stated above. These care plans included updated and member specific information. Case managers at all three MCHPs explained that this process is time-consuming and difficult. They want to include goals that are pertinent to the member in each care plan. The case managers are required to rewrite the care plans to achieve this outcome. The system-generated plans produce goals that are sometimes absurd for the member involved, and these goals must be manually deleted by the case manager.

2. A process to ensure that the primary care provider, member, or their primary care giver (parent or guardian), and any specialists treating the member is involved in the development of the care plan.

- Member involvement in care plan development was identifiable in 87.18% of the HCUSA care plans reviewed. This information was included in progress notes and in updates. The correspondence section included the letters to members with opening information including copies of the initial agreed upon care plan. In cases that were open for longer periods of time, updates sent to the member were also found.

- At Home State, system generated care plans were found in 89.74% of the cases reviewed. However, member involvement in discussing or developing the care plan was only found in 64.10% of the care plans.

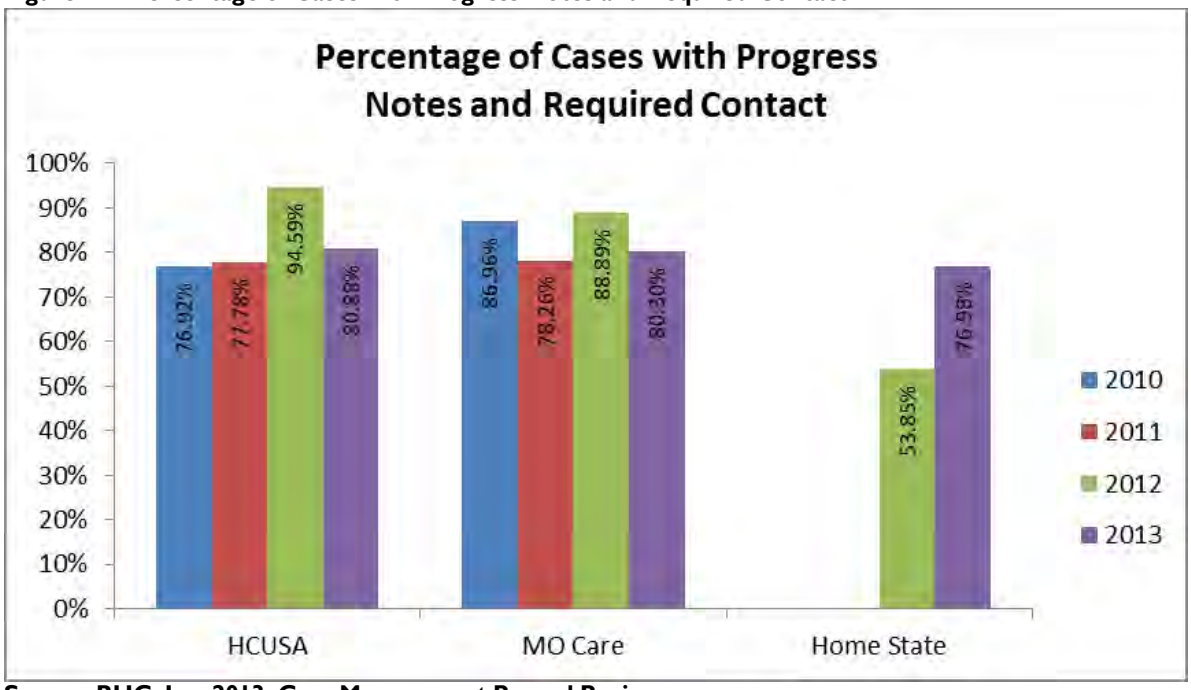
- Member involvement was found in 61.11% of the cases reviewed at MO Care. This included careful review of all case notes available.

- The case managers at all three MCHPs explained that their practice is to send an opening letter to PCPs or specialists' offices, with the initial care plan. They state that their practice is to include their contact information and a request that someone from the office contact them if there is a concern, such as a medical issue the member did not disclose. The case managers reported that they also contact the PCP or specialists' offices to obtain additional information.

Cases reviewed from HCUSA indicated that PCPs were informed and sent copies of the care plan 87.18% of the time. At MO Care the review found 69.44% of the cases had PCP involvement in care plan development, or that the care plan was sent with appropriate correspondence as soon as it was complete. The cases reviewed at Home State provided evidence of PCP involvement only 25.64% of the time.

Progress Notes and Required Contacts

Figure 14 - Percentage of Cases with Progress Notes and Required Contact



Source: BHC, Inc. 2013, Case Management Record Review

There are two standards used to assess maintenance of proper contact with members.

1. Case records are to contain progress notes updated at each contact or at least every thirty (30) days.
2. Case managers are required to have at least three substantive contacts with a member prior to case closing, and these contacts are to be reflected in the progress notes.

- HCUSA and MO Care declined in this area in 2013.
    - HCUSA had progress notes in the records reviewed in required time frames in 91.18% of the cases reviewed. Evidence was found substantiating required contacts with members in 70.59% of these records.
    - In 93.94% of MO Care cases reviewed, the required progress notes were included. Only 54.55% contained information that required contacts occurred.
- Home State improved by providing monthly progress notes in over 90% of the cases reviewed, but made contacts with members, as required, only 61% of the time.

- Progress notes are completed in the MCHPs' case management systems. The case managers report that the process for recording attempted and actual contacts with members, providers, or others involved with the member is easier than in the past. This was evident in the information provided. In general, it was informative and substantive.

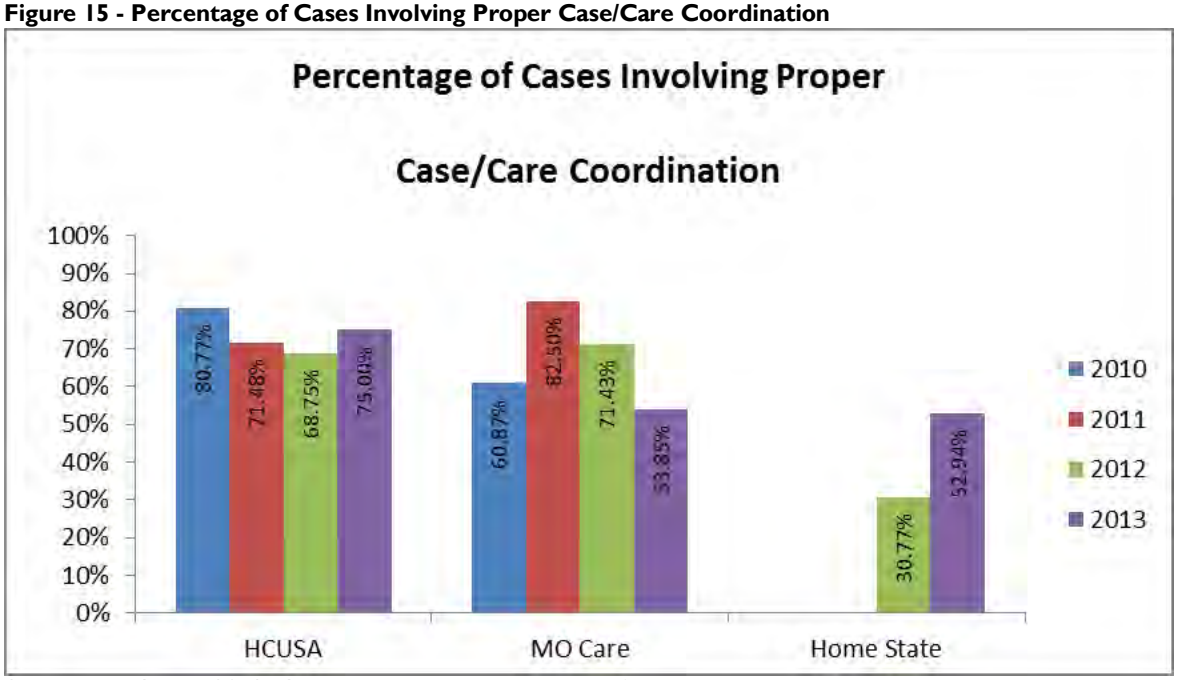
Case managers continue to report difficulty in maintaining engaged relationships with members. They believe this is a barrier to having substantial contacts with them. Reviewers used all resources available, both the progress notes and any contact sheets included, to count the actual and attempted contacts with members.

Case/Care Coordination

There are two standards used to assess the category of case/care coordination.

1. Case managers are to recognize the need for coordination of services with other providers involved with the members. This includes following MCHP policy regarding advocating for and linking members to services as necessary across providers and settings, and ensuring that there is communication between providers regarding members healthcare and service needs; and
2. Case managers are to ensure that the availability of behavioral health services is discussed with the member.

Figure 15 - Percentage of Cases Involving Proper Case/Care Coordination



Source: BHC, Inc. 2013, Case Management Record Review

- At HCUSA case managers recognized the need for care coordination 75.00% of the time when this service was needed. This is a turn-around from a two year decline. Progress notes reflected members' needs for care coordination. In cases where care coordination was indicated it did occur and the case notes reflected the methods used to work with other agencies to share information and resources.

- For Home State there was an improvement in the number of cases reviewed that indicated that some type of care coordination occurred. The improvement to 52.94% is a 22.17 percentage point increase. It is not yet to an acceptable standard but the rate of improvement is

noteworthy. Interviews with the case managers indicate they are engaging in more care coordination, but it remains an area needing improvement.

- MO Care declined in the aggregate area of care and case coordination at the rate of 24.61%. Case notes did not reflect the open information sharing between behavioral health and medical case managers evidenced in previous reviews. The cases reviewed did include evidence that a need for care coordination was present in 78.57% of the cases reviewed. Actual care coordination only occurred 53.85% of the time.

- In the 2012 review a major area of concern for reviewers was the number of cases reviewed with a need for behavioral health services, such as the report of depression or a bi-polar condition during the assessment. These admissions during assessment appeared to receive no follow-up, offer of referral for services, or a direct referral as the result of a serious situation regarding the member's admitted problems.

  - During the 2013 review this trend continued. In 30.56% of the cases reviewed for all MCHPs, where depression and/or bi-polar conditions were identified at the time of the assessment, the case records reflected no referrals to behavioral health; or no follow-up to ensure that a member acted upon a referral if a therapist's name was provided to a member. There continues to be a lack of attention to the need for medical case management and the need to incorporate a more holistic approach to ensuring that members' needs are being met. If no referral or subsequent care coordination occurs, case notes should explain why this part of the assessment was ignored.

- When the MCHPs successfully recognized and acted upon the members' needs for complex case management, there was active coordination of care. In these cases member received many unique services often resulting in positive healthcare outcomes. These cases include members with multiple co-morbidities, seeing more than one specialist, requiring as much as daily in-home care, and a variety of types of durable medical equipment. These members require case management interventions several times each week. In some cases they require periodic in-patient hospitalization. The cases reviewed included multiple contacts with a variety of providers, the PCP, and specialists, and assisting members in understanding and negotiating all the systems of service involved. In one case, after months of work not only advocating for the member, but assisting the mother in understanding the system, the case was closed as all

services were in place and running smoothly. The family was aware that they could ask for case management again should the need arise.

Final Assessment

The EQR is tasked with reporting how "Medicaid Managed Care participants access care, the quality of care participants receive, and the timeliness of this care." The EQRO reports on those three areas in each area of validation.

Quality of Care

When members are properly introduced to and engaged in case management the quality of service delivery improves. Case managers maintain contact and in some cases advocate strongly for services for their members.

- In 2013, reviewers observed a lack of attention about including all necessary information in case notes. At MO Care introductory information was not available in over one half of the records reviewed. MO Care believes this was the result of lost information, but this is difficult to assess. At Home State a lack of attention to the introductory process, including noting the member's agreement to accept case management, and an acknowledgement that they have explained third party disclosure or asked about this issue, continues to be a concern. Even if this is a record keeping problem, it is a problem at the beginning of the case management process and reflects negatively on attention to member needs.
- At all MCHPs case management services provided referrals and ensured that members were aware of available resources and how to access needed services. The case managers referred members to MCHP sponsored services. They linked members to community resources. These efforts lead to outcome of improved member health.
- The MCHPs are committed to ensuring that members' PCPs and specialists are aware of their involvement with the member. It is standard practice to include a letter to the PCP or specialist as soon as a care plan is completed so the provider is aware of the case manager's involvement with the member. This assists in ensuring that the member has the advocacy or attention needed with their PCP, specialists, behavioral health providers, and other community resources to meet their healthcare needs.
- Case managers report during interviews that they communicate with PCPs and specialists or their staff.
- Case managers assisted members in achieving their goals and stabilizing their health care conditions.

In case records indicating contact with the PCP or specialists' office, case notes reflected a depth of knowledge about the member that appears essential in providing comprehensive case management.

- These cases included many contacts with the physician's nurse or nurse practitioners.
- Physicians responded directly to inquiries and questions from the case managers.
- When contacts occur the case notes indicate better and more complete service delivery.

A number of issues that impact quality were observed that continue to need improvement. These include:

- Ensuring that all members are properly introduced to the case management process and all permissions and agreements are reflected in the case notes;
- Informing or including the PCP in care plan development;
- Ensuring that all members expected to receive face-to-face contacts have access to this service;
- Completing and communicating a transition plan with members that provides direction and information; and
- Informing the PCP and other providers when case management ceases.

Quality of care is improved when services included care coordination in complex cases.

- Case managers identified members with high risks and multiple issues requiring more than one provider or case manager to be involved with a member's care. Ongoing case management, facilitated discussions between providers, and having ancillary services in place all led to members' positive quality health care outcomes.
- Members with multiple issues and complex cases were identified and case management initiated.

In the area of lead case management, member's quality of care was negatively affected.

- Lead case management is required for all children with an identified elevated blood lead level – even if testing was not recent. At all MCHPs many cases opened for older children have been difficult to serve. Families and members are unresponsive and often refuse retesting. These cases show little progress and are difficult to manage.
- Lead cases are not treated with the same urgency seen in other types of case management. Renewed attention to the services needed in these cases would benefit members and their families.

ACCESS TO CARE

Access to care was enhanced when case managers actively worked with families. Reviewers observed creative efforts to locate members. MCHPs are often using contractors who "drive by" members reported addresses to learn if the member is actually living there and to obtain forwarding information whenever possible. The case managers contact a variety of sources to track members' whereabouts and make required contacts. In many instances the MCHPs are partnering with home health agencies to ensure that members follow through on their part of a case plan and obtain the services they need.

Access is improved by the case managers' efforts to obtain services, community or provider based, which uniquely meet members' needs.

Access was improved when case managers remained in contact with members receiving OB services. This ensured members' access to services such as a follow-up with their OB-GYN, and a first visit to the pediatrician for the baby.

The following problems were observed and negatively impacted members' access to services and health care:

- Case managers lost contact with members who had newborns at the end of the case management process and no transition plan was developed.
- Face-to-face contacts are still not occurring as often as necessary and even when a contracted provider is authorized they are not always seeing or reporting on contact with the member. In some of these cases the member did not receive services as needed, which negatively impacted health care outcomes.
- When consistent case/care coordination occurred case managers avoided duplication of services, and maximized MCHP resources. However, a lack of these practices negatively affected members' access to care when it did not occur.

TIMELINESS OF CARE

When case managers are actively serving a member fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

When case management occurred in the OB cases reviewed (including the sixty (60) days postpartum), follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within these time frames. Parents who received these services often enrolled their babies with the MCHP and ongoing preventive care could occur.

Case managers continue to report that they are unable to create a useful transition plan with the member when it appears the case should be closed.

- It often appears that after members' healthcare needs are met, the member loses interest in case management and no longer returns calls or responds to letters requesting they contact the case manager. Case managers at all MCHPs find this troubling, but have had little success in changing member behavior. They do point out that they often hear from members months later when a new problem arises. The members tell them "that I still have your card and number."

Information sharing with PCP offices and sending a letter at case closing requires improvement. (Closing letters are sent to the PCP at the following rates: HCUSA – 81.25%; MOCare – 63.64%; Home State - .13%)

- Case managers' lack of attention to this aspect of service delivery negatively impacts members' ability to obtain needed services in a timely manner.
  - Case notes reflect that in many instances instructions are given to the member, with the hope that they will take responsibility for follow-up and timely self-care.
  - The case managers admit that when they have a relationship with the PCP or specialist's office it benefits their work with their members.
  - Timeliness is greatly improved by ensuring that members, particularly members with special health care needs, obtain all necessary medical services with some oversight.
  - Case managers believe there is information available that was not found in the case notes. They say they are talking to provider offices regarding most of their members regularly. If this is actually an issue of appropriately using their case management/case note system, this must be corrected.

1.6 Managed Care Heath Plan Report Card

Table 2 – 2013 Managed Care Report Card

MCHP	PIPs	PM Validation 1	PM Validation 2	Compliance	Case Management	Overall Score	Grade
HealthCare USA	100%	97.62%	77.24%	94.20%	80.61%	89.93%	**B+**
Home State Health Plan	86.05%	N/A	N/A	91.18%	57.81%	78.35%	**C+**
Missouri Care	74.42%	100%	73.18%	89.86%	68.25%	78.78%	**C+**

The MCHPs were given scores in each of the validated areas, these scores were averaged in order to award each MCHP an Overall Score and Grade.

The scores for each validation area were calculated as follows:

Performance Improvement Projects – This score is an average of the ratings awarded by the EQRO for each of the two PIPs validated. For the scores awarded on each PIP, please see Table 3 in Section 2.0 of this report.

Performance Measures – This score is an average of the following:

1. Average of ratings received for Final Validation of each Performance Measure (see Tables 13, 14, 15 in Section 3.0 of this report).
2. Weighted rate for each PM (weighted with the Medicaid 90th Percentile)
   (Average of ratings received for PM calculation) + (PM Reported Rates weighted on a scale with the Medicaid 90th Percentile)/2

Compliance – This score is an average of the ratings awarded by the EQRO for each of the Compliance standards. For the scores awarded on each standard, please see the MCHP Individual sections of this report (Sections 6.0 – 8.0).

Case Management - This score is an average of the ratings awarded by the EQRO for each of the Case Management components. For the scores awarded on each component, please see Section 5.0 of this report.

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2.0 VALIDATING 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 MCHP 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 2013. This included evaluating the Statewide Project entitled "Improving Oral Health." The Statewide Project's aggregate report was the foundation of each individual MCHP's PIP. These responses and interventions were examined as individual PIPs.

2.2 Purpose and Objectives

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 MCHPs' contracts with the State of Missouri, each MCHP is required to have two active PIPs, one of which is clinical in nature and one non-clinical.

The EQRO reviews each PIP to determine if it was designed, conducted, and reported in a methodologically sound manner. The EQRO incorporates document review, interview, and observation techniques to fully evaluate the components of each PIP. Specific feedback and technical assistance was provided to each MCHP by the EQRO during on-site visits. The technical assistance focuses on improving study methods, data collection, and analysis.

2.3 Findings

The PIPs identified for validation at each MCHP are:

HealthCare USA	Reducing the Re-admission Rate for Asthma Patients Project Improving Oral Health
Home State Health Plan	Notification of Pregnancy Form Receipt Improvement Improving Oral Health
Missouri Care	Post Mental Health Hospitalization Follow-Up Care Within 7 Days of Discharge Improving Oral Health

The findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validating Performance Improvement Projects are located in Table 1.

Table 3 – Performance Improvement Validation Findings, by MCHP

Performance Improvement Project Validation Findings By Health Plan									
Steps		HCUSA			Home State			MO Care	
		Reducing Re-Admissions for Asthma Patients	Improving Oral Health		Notificaiton of Pregancy Forms	Improving Oral Health		Follow-Up After Hospitalization for Mental Iness -- 7 Days	Improving Oral Health
	1.1	2	2		2	2		2	2
	1.2	2	2		2	2		2	2
1: Selected Study Topics	1.3	2	2		2	2		2	2
2: Study Question	2.1	2	2		2	2		2	1
	3.1	2	2		2	2		2	2
3: Study Indicators	3.2	2	2		2	2		2	2
	4.1	2	2		2	2		2	2
4: Study Population	4.2	2	2		2	2		2	2
	5.1	NA	NA		NA	NA		NA	NA
	5.2	NA	NA		NA	NA		NA	NA
5: Sampling Methods	5.3	NA	NA		NA	NA		NA	NA
	6.1	2	2		2	2		2	2
	6.2	2	2		2	2		2	2
	6.3	2	2		2	2		2	2
	6.4	2	2		2	2		2	2
	6.5	2	2		2	1		2	1
6: Data Collection Procedur	6.6	2	2		2	2		2	2
7: Improvement Strategies	7.1	2	2		2	1		2	2
	8.1	2	2		2	1		2	0
	8.2	2	2		2	1		2	0
8: Analysis and Interpretatic	8.3	2	2		2	1		2	0
of Study Results	8.4	2	2		2	1		2	0
	9.1	NA	2		2	NA		NA	0
	9.2	NA	2		2	NA		NA	0
	9.3	NA	2		2	NA		NA	0
9: Validity of Improvement	9.4	NA	2		2	NA		NA	0
10: Sustained Improvement	10..1	NA	2		2	NA		NA	0
Number Met		19	24		24	13		19	13
Number Partially Met		0	0		0	6		0	2
Number Not Met		0	0		0	0		0	9
Number Applicable		19	24		24	19		19	24
Percent Met		100%	100%		100.00%	64.42%		100.00%	54.17%

STEP 1: SELECTED STUDY TOPICS

Study topics are selected through data collection and the analysis of comprehensive aspects of member needs, care, and services. They are to address a broad spectrum of key aspects of member care and services. In all cases the topics are to include all enrolled populations pertinent to the study topic without excluding members with special health care needs. In 2013 the clinical PIPs addressed: decreasing post-hospitalization readmissions for members who diagnosed with asthma; increasing early notification and initiation of services to pregnant women; and improving follow-up care within seven (7) days to members who have been hospitalized needing mental health services. All three non-clinical projects addressed improving oral health through MCHP specific interventions, as extensions of the Statewide PIP.

Table 1 shows the ratings for each item and PIP by MCHP. All six (6) PIPs provided a rationale demonstrating the extent of the need for the PIP and provided information to support selection of the study topic. All Study Topic presentations employed a literature or research review that supported the planned performance improvement activities. This research provided some benchmark comparison data. This section met the study methodology criteria required 100% of the time. All of the MCHPs addressed a broad spectrum of key aspects of member care and services (100.0%). An array of the aspects of enrollee care and services were included in these studies. (Steps 1.1 and 1.2)

Utilization or cost issues may be examined through a PIP, but are not to be the sole focus of any study. In the topic presentations the focus was clearly on improving health care services to members. The MCHPs were able to identify that some measures would benefit the use of financial resources by employing a preventive approach, but this was not the driving force for the topic choice.

There were descriptions of the member populations targeted for intervention in the PIPs. These three MCHPs focused only on the SMA member populations, although parent companies may serve a variety of additional populations. The PIPs reviewed in 2013 were all developed to enhance services to the SMA members served. PIPs should specifically indicate whether all enrolled populations within the SMA Managed Care Program are included in the interventions. Finally, age and demographic characteristics should be described. All six PIPs (100.00%) "Met" these criteria (Step 1.3).

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. The study questions should be specific enough to suggest the study methods and the outcome measures. The MCHPs did develop study questions and relate them to the hypotheses and topic selected. Five (83.33%) of the PIPs included clearly stated and goal directed 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 the studies presented. One MPHC (MO Care) did not accurately reflect the goals for the non-clinical PIP. These goals were agreed upon by all MCHPs as part of the Statewide Task Force, and were determined as the result of a directive sent to all states by the Center for Medicaid and Medicare Services (CMS).

Table 4 – Summary of Performance Improvement Project Validation Ratings by Item, All MCHPs

Step	ALL HEALTH MCHPS					
	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	6	0	0	6	100.00%
	1.2	6	0	0	6	100.00%
	1.3	6	0	0	6	100.00%
Step 2: Study Questions	2.1	5	1	0	6	83.33%
Step 3: Study Indicators	3.1	6	0	0	6	100.00%
	3.2	6	0	0	6	100.00%
Step 4: Study Populations	4.1	6	0	0	6	100.00%
	4.2	6	0	0	6	100.00%
Step 5: Sampling Methods	5.1	NA	0	0	0	NA
	5.2	NA	0	0	0	NA
	5.3	NA	0	0	0	NA
Step 6: Data Collection Procedures	6.1	6	0	0	6	100.00%
	6.2	6	0	0	6	100.00%
	6.3	6	0	0	6	100.00%
	6.4	6	0	0	6	100.00%
	6.5	4	2	0	6	66.67%
	6.6	6	0	0	6	100.00%
Step 7: Improvement Strategies	7.1	5	1	0	6	83.33%
Step 8: Analysis and Interpretation of Study Results	8.1	4	1	1	6	66.67%
	8.2	4	1	1	6	66.67%
	8.3	4	1	1	6	66.67%
	8.4	4	1	1	6	66.67%
Step 9: Validity of Improvement	9.1	2	0	1	3	66.67%
	9.2	2	0	1	3	66.67%
	9.3	2	0	1	3	66.67%
	9.4	2	0	1	3	66.67%
Step 10: Sustained Improvement	10.1	2	0	1	3	66.67%
Number Met		**112**	**8**	**9**	**129**	**86.82%**

Note: Percent Met = Number Met/Number Applicable; Item refers to the Protocol specifications.

Source: BHC, Inc., 2013 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

During past EQRs the MCHPs produced PIPs that "Met" the criteria for defining and describing the calculation of study indicators most of the time. In 2013, six (100%) of the PIPs met the criteria for using objective, clearly defined, and measurable indicators (Step 3.1). In these PIPs the calculation of measures was described and explained. Even when well-known measures were used (e.g., Healthcare Effectiveness Data and Information Set—HEDIS), there was a detailed description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Because MCHPs vary in their method of calculation, details regarding the measures and methods of calculating those measures should be included in PIPs. Both HCUSA and MO Care have experience in the development and presentation of this aspect of their PIPs. Home State requested some technical assistance during the previous year, but presented well documented information on the use of their indicators in their 2013 PIPs. It should be noted that Home State did not have HEDIS data available in 2012, as they were in their first six months of operation. The MCHP did include their HEDIS 2014 (CY 2013) ADV rate with their updated results for this report. The clinical PIP did not rely on HEDIS rates and the MCHP developed data measures based on their own operations that provided confidence that they were preparing and reporting on reliable study indicators. All six PIPs (100%) 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. The link between the interventions and the outcomes measured by these PIPs was explicit in the narratives presented.

STEP 4: STUDY POPULATIONS

The MCHPs successfully met the criteria for adequately defining the study population. This step asks if all members to whom the study question(s) and indicator(s) were relevant are included. All MCHPs included adequate information that allowed the EQRO to make this determination (Step 4.1). The selection criteria clearly described the Managed Care member populations included in the PIPs and their demographic characteristics. All six PIPs (100%) described data collection approaches indicating that data for all members to whom the study questions applied were collected (Step 4.2). A description was presented in the narratives reviewed that 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.

STEP 6: DATA COLLECTION PROCEDURES

All six PIPs (100%) described the data to be collected with adequate detail and description of the units of measurement used (Step 6.1). All six PIPs (100%) clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). The reviewers looked for a methodology that provides a structure for reporting measures and data sources. In some instances there is more than one source of data. It is important that the MCHP specifically state the sources of data for each measure. The MCHPs provided adequate narrative and explanation to allow for validation of each PIP. All six PIPs (100%) 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. The PIPs in the 2013 review used data collection instruments that were described in detail. This step requires that data be presented utilizing instruments that allow consistent and accurate data collection over time (Step 6.4). Six of the PIPs (100%) met this element of the required study submissions.

Four of the six PIPs (66.67%) included a complete data analysis plan, while two PIPs were rated "Partially Met" (Home State and MO Care) for failing to specify a prospective data analysis plan (Step 6.5). The prospective data analysis plan should be developed prior to the implementation of the PIP; be based on the study questions; explain the anticipated relationship between the intervention(s) and outcome(s) being measured (i.e. independent and dependent variables); include the method(s) of data collection; and describe the nature of the data (e.g., nominal, ordinal, scale). The two PIPs rated as "Partially Met" failed to supply adequate information to meet this requirement.

Six (100%) of the PIPs identified the project leader and the leader's qualifications in the narrative submitted. They identified who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). MCHP staff interviewed on-site also included team members who were involved and knowledgeable about the PIPs and methods.

STEP 7: IMPROVEMENT STRATEGIES

Five of the six (83.33%) PIPs included reasonable interventions to address the barriers identified through data analysis and the quality improvement processes undertaken. One of the PIPs included interventions coded as "Partially Met" in this requirement. The non-clinical PIP from Home State did not include any analysis or explanation of why the interventions were chosen. There was no information presented on the rationale for choosing the interventions.

STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

All six PIPs were mature enough to include data analysis. The four PIPs (66.67%) that were in place long enough to allow the MCHP to conduct an analysis were analyzed according to the data analysis plan (Step 8.1). The non-clinical PIP conducted by Home State did not include updates as requested during the site visit. There was not a prospective data analysis plan, precluding this element from being "Met." The non-clinical PIP submitted by MO Care was found to be "Not Met" beginning with the lack of a prospective data analysis plan. No analyses of the results of the CY 2013 data presented were included in the PIP narrative.

In four PIPs (66.67%) there was a complete and thorough analysis of the data presented. These PIPs presented baseline and re-measurement data as available. In the clinical PIP conducted by Home State there was a monthly analysis presented from the beginning of the PIP in September 2012 through the end 2013 when the PIP was retired. All numerical findings were provided accurately and clearly (Step 8.2). Axis labels and units of measurement should be reported in Tables, and in Figures. The legends accompanying this information should be clearly identifiable to the reader. All tables should be part of the body of the PIP and include a narrative explanation of the results. This occurred throughout these four PIPs. The non-clinical PIP from one MCHP (Home State) did not include narrative analysis of their results. The non-clinical PIP from one MCHP (MO Care) was considered "Not Met" as the result of a lack of inclusion of the CY 2013 results in any analysis presented.

Four of the six PIPs (66.67%) presented at least one re-measurement period that included data for all of the measures identified in the study (Step 8.3). These four PIPs presented findings describing the effectiveness of their interventions (8.4).

The Home State non-clinical PIP did show a significant increase in outcomes. The MCHP included a brief assessment of the results and attributed the increase to having a full year of data to include in

their report. The information states the MCHP also had a full year during which they continued to develop, enhance, and implement their interventions to "drive improvements and increases for this measure." The narrative provided did include these factors, which may have influenced comparability of their two years of data. They did not discuss how external factors may have threatened internal or external validity, or the need to include statistical significance testing. The narrative did not provide an interpretation of how the improvement strategies influenced the outcomes.

The non-clinical PIP presented by MO Care includes the current HEDIS rates, which reflect the outcome of CY 2013 activities. In two of three Regions the MCHP experienced a severe downturn in their HEDIS rates and the MCHP's aggregate HEDIS rate dropped as well. The drop in HEDIS rates is not mentioned. The EQRO coded this entire section as "Not Met" because the MCHP failed to provide any analysis or to even venture a guess as to why the rate dropped.

STEP 9: VALIDITY OF IMPROVEMENT

Three of the six PIPs used re-measurement points and were mature enough to evaluate the validity of their improvement . Two of these PIPs (66.67%) used the same method at re-measurement as used in the baseline measurement (Step 9.1). The re-measurement should use the same methodology as the baeline measurement to ensure validity of reported improvement and comparability of the measurement over time. The same source of data used in the baseline measure should be used at each re-measurement point.

Two of the three PIPs (66.67%) that were mature enough to include data analysis employed statistical significance testing to document quantitative improvements in care (Step 9.2). These two included the non-clinical PIP from HCUSA and the clinical PIP from Home State. These PIPs were able to show improvement over the re-measurement points available. These two PIPs (66.67%) reported improvements that had face validity, meaning that the reported improvement was judged as related to the intervention applied (Step 9.3). These PIPs provided some discussion or interpretation of findings by the MCHPs. The narrative provided in these two PIPs was sufficient to ensure proper evaluation of all data and information provided. When reporting findings some interpretation of the relationship of the intervention, or other factors, to the outcomes must occur. This information should note improvement, decline, or lack of change as the result of the interventions introduced. The two PIPs (66.67%) reaching this level of maturity did provide statistical evidence that the observed improvement was true improvement (Step 9.4). Barriers were

identified and addressed for the next cycle of one PIP (HCUSA non-clinical); or reasons for discontinuing or retiring the PIP should be described (Home State clinical).

The review of the non-clinical PIP presented by MO Care resulted in negative ratings. The MCHP presented information based on HEDIS 2013 (CY 2012) and failed to include any interpretation of the data provided for HEDIS 2014 (CY 2013). The MCHP discussed their ongoing "successful interventions," and failed to address the serious downward trend in their HEDIS rates.

STEP 10: SUSTAINED IMPROVEMENT

Three PIPs were mature enough to evaluate their potential for sustained improvement. For two of the PIPs (66.67%) the EQRO was able to make an assessment regarding sustained improvement. One PIP (HCUSA/non-clinical) demonstrated repeated measurements over time that created confidence in the sustainability of the improvements achieved. This PIP used statistical significance testing to demonstrate improvement. The PIP narrative provided arguments for continuing the improvement efforts leading to success, and reasoning for maintained sustainability. The MCHP is continuing this PIP, as part of the Statewide initiative, and hopes for continued success with new approaches. The MCHP will maintain the strategies in place that have assisted in achieving the success experienced to date.

One PIP (Home State/clinical) has achieved the results hoped for when the project began. The MCHP experienced both intended and unintended positive consequences as the result of the efforts made in this PIP. These include members obtaining services and case management earlier in their pregnancy, a decline in the rate of infants admitted into neo-natal intensive care (NICU), and a decrease in the number of very low birth weight infants. The MCHP believes it will sustain and increase improved rates through continued efforts to stay informed about members' healthcare status, continued training and relationship building with providers, and a willingness to implement additional initiatives as needed.

The non-clinical PIP presented by MO Care included follow-up activities and new interventions planned for 2014, yet it completely failed to address the facts presented through the data reflecting their 2013 outcomes. This section was coded as "Not Met."

2.4 Conclusions

Across all MCHPs the range in proportion of criteria that were "Met" for each PIP validated was 66.67% through 100%. Across all PIPs validated statewide, 86.82% 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 most of the cases, there was enough information provided to validate the PIPs. On-site interviews and subsequent information revealed an in-depth knowledge of the PIPs.

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 MCHPs intended to use this process to improve organizational functions and the quality of services available or delivered to members. In at least two cases, the performance improvement project interventions had already been incorporated into MCHP 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 MCHP regarding the need to address barriers to implementation. MCHP personnel involved in PIPs had experience in clinical service delivery, quality improvement, and monitoring activities. It was clear, in the PIPs reviewed, that the MCHPs had made a significant 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, all of the MCHPs had active and ongoing PIPs as part of their quality improvement programs. The newer MCHP (Home State) did not have long term results to report. However, they have made an effort to utilize the PIP process to identify and resolve issues that impact member services. HCUSA submitted exemplary PIPs.

An improved commitment to the quality improvement process was observed during the on-site review at the three MCHPs. The three PIPs rated with “High Confidence” are on-going and active PIPs. These projects were presented well and exhibited excellent planning and reporting. Even though they are not complete, the information presented was methodologically sound and the results of their success are attributed to the interventions employed.

Table 5 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Reducing Re-admission for Asthma Patients (HCUSA)	High Confidence
Improving Oral Health (HCUSA)	High Confidence
Notification of Pregnancy Form Receipt (Home State)	High Confidence
Improving Oral Health (Home State)	NA
Follow-Up After Hospitalization for Mental Illness within 7 days (MO Care)	Moderate Confidence
Improving Oral Health (MO Care)	Low 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.
Source: BHC, Inc., 2013 External Quality Review Performance Improvement Project Validation.

The EQRO voices a continuing concern regarding the ongoing development of new PIPs at each MCHP. At the onset of the review year the MCHPs are asked to submit a listing of all PIPs underway during the previous year. HCUSA did not submit a large number of clinical PIPs to choose from. However, it is noted that the clinical PIP chosen this year is new, and the MCHP had asked for technical assistance on a second new PIP to get underway in 2014. HCUSA is exhibiting a renewed interest in using the PIP process to define issues to be addressed and then developing methods of resolving those issues. Home State has also sought technical assistance in the area of PIP development. During the on-site review there were a number of projects revealed that were prime projects to become an actual study. These were pointed out to the MCHP. It is hoped that they will utilize this Technical Assistance to develop more projects into PIPs in the future. Missouri Care again submitted a listing of 28 PIP topics, most of which had become NCQA improvement strategies. The MCHPs must be aware that they are to continue to develop and carry out the PIP process to ensure compliance with their contract and the federal protocols as part of their quality strategy.

Final Assessment

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

Quality of Care

Topic identification was an area that provided evidence of the attention paid to providing quality services to members at all MCHPs. Intervention development for PIPs also focused on the issue of quality services. The PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MCHP or in the direct provision of services delivered. PIPs included interventions that addressed barriers to quality care and targeted improved health outcomes. Interventions included: in-home care in collaboration with enhanced telephonic case management, behavioral health case management that begins collaboration with utilization management as soon as a member enters in-patient care, and targeted initiatives to get members enrolled in OB case management early in their pregnancy. All of these interventions exemplify an attention to quality healthcare services.

Access to Care

Access to care was an important theme addressed throughout the PIP submissions. A major goal of the statewide non-clinical PIP is improved access to dental care. This goal was reflected in the individual oral health PIP projects developed by each MCHP. Access to care was also an important focus in the clinical PIPs. The clinical PIP topics focused on early access to prenatal care, case management interventions to facilitate access to early follow-up after hospitalization for mental health issues, and intensive case management linked to in-home services for members with asthma who have had an inpatient hospitalization. All of these projects have the potential to lead to improved preventive and primary care for members. The EQRO's on-site discussions with MCHP staff indicated that improving access to care is an ongoing aspect of all projects that are developed.

Timeliness of Care

Timeliness of care was also a major focus of the PIPs reviewed. These projects addressed early involvement in prenatal care, immediate services prior to release from hospitalization, and immediate management of members' health when hospitalized as the result of asthma. The projects addressed the need for timely and appropriate care for members to ensure that services are provided in the best environment quickly and efficiently. The PIPs related to Improved Oral Health

included a focus on obtaining timely screenings and recognized that this is an essential component of effective preventive care. The need for timely access to preventive and primary health care services was recognized as an essential component of each project. Projects reflected this awareness, as they addressed internal processes and direct service improvement.

The MCHPs have made significant improvements since the EQRO measurement process began. In 2004 during the first year the PIPs were reviewed against the requirements of the CMS protocols, the MCHPs earned an aggregate rating of 25.1%. In 2013 the MCHPs aggregate rating has increased to 86.82% for meeting all the requirements of PIP Validation Rating. The MCHPs use the PIP methodology to design studies and quality improvement processes that improve services to members. Although the MCHPs implement projects that focus on quality, both MO Care and Home State submitted narrative write ups and data analysis of their PIPs that lacked detail and depth during this review period.

RECOMMENDATIONS

1. It is recommended that MCHPs continue to refine their skills in the development and implementation of new Performance Improvement Projects. There is a need to identify clinical topics that are areas for improvement and to develop interventions to impact these issues. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available. Ensuring that a variety of topics are recognized each year and that more than one PIP is in process is essential.
2. 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.
3. Ongoing PIPs should include new and refined interventions. Next steps should be included in the narrative and planning for all on-going PIPs. On-going PIPs should include necessary data and narrative. Data analysis is not just the presentation of graphs and tables. What the data tells us, and how it is interpreted by the MCHP is essential in the development of an effective project and should be reflected in the narrative. Documentation must discuss how external factors threaten internal or external validity, and what was learned from statistical significance testing. The narrative must clearly provide an interpretation of how the improvement strategies influenced the outcomes.

4. The MCHPs must ensure that adequate narrative is presented explaining and interpreting the PIP outcomes and how these outcomes are related to the interventions employed.

5. Efforts to improve outcomes related to the Statewide PIP topic should be continued. The MCHPs must evaluate the success or lack of success of current interventions, maintain those that are successful, and develop new strategies when others do not work.

6. The MCHPs are all involved in an effort to update the Statewide PIP and improve its focus and meet the goals proposed by CMS. It is recommended that all three MCHPs maintain their involvement and commitment to this process.

7. It appears that the MCHPs conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs and to develop new PIPs as tools to improve the organizations ability to serve members is recommended.

8. MCHPs must remember that utilizing the PIP process as part of organizational development must be ensured to maintain compliance with the State contract and the federal protocols. Use of NCQA improvement strategies does not replace Performance Improvement Projects as an essential component of the Quality Improvement Program.

3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Purpose and Objectives

The EQRO is required by the Validating Performance Measures Protocol to evaluate three performance measures reported by each MCHP. These measures are selected by the SMA each year. For the HEDIS 2013 evaluation period, the three performance measures selected for validation were Annual Dental Visit (ADV); Childhood Immunizations Status, Combination 3 (CIS3); and Follow-Up After Hospitalization for Mental Illness (FUH). Each of these measures has been previously reviewed by the EQRO:

- The Annual Dental Visit measure HEDIS 2012, 2011, 2010, 2009, 2008, and 2007.
- The Follow-Up After Hospitalization for Mental Illness measure HEDIS 2012, 2011, 2010, 2009, 2007, and 2006 review periods.
- The Childhood Immunizations Status, Combination 3 measure HEDIS 2012 and 2011.

Protocol activities performed by the EQRO for this audit included: 1) Review of the processes used by the MCHPs 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 MCHPs are based upon accurate calculations.

The objectives for validating performance measures were to: 1) evaluate the accuracy of Medicaid performance measures reported by, or on behalf of the MCHPs; and 2) determine the extent to which MCHP-specific performance measures calculated by the MCHPs (or by entities acting on behalf of the MCHPs) 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).

3.2 Findings

Due to contract changes effective July 1, 2012, only two of the seven MCHPs that provided coverage for some part of 2012 were active for the entire year. Continuous enrollment requirements for HEDIS measures, necessitates that only those two plans were included in the HEDIS analysis for this report. Thereby, only HCUSA and MO Care are included in the All MCHP rates presented in this section.

The method of calculation used by each MCHP is detailed in Table 5.

Table 6 – Summary of Method of Calculation Reported and Validated by MCHPs

MO HealthNet MCHP	Annual Dental Visit	Childhood Immunizations Status, Combo 3	Follow-Up After Hospitalization for Mental Illness
Healthcare USA	Administrative	Hybrid	Administrative
Missouri Care	Administrative	Hybrid	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 SMA and SPHA, the Final Audit Ratings, and conclusions.

HEDIS 2013 Annual Dental Visit

Data Integration and Control

The objective of this activity was to assess the MCHPs' 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 2013 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. All MCHPs met all criteria for every audit element.

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.

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. Both MCHPs met all validation for the process used to produce denominators.

Processes Used to Produce Numerators

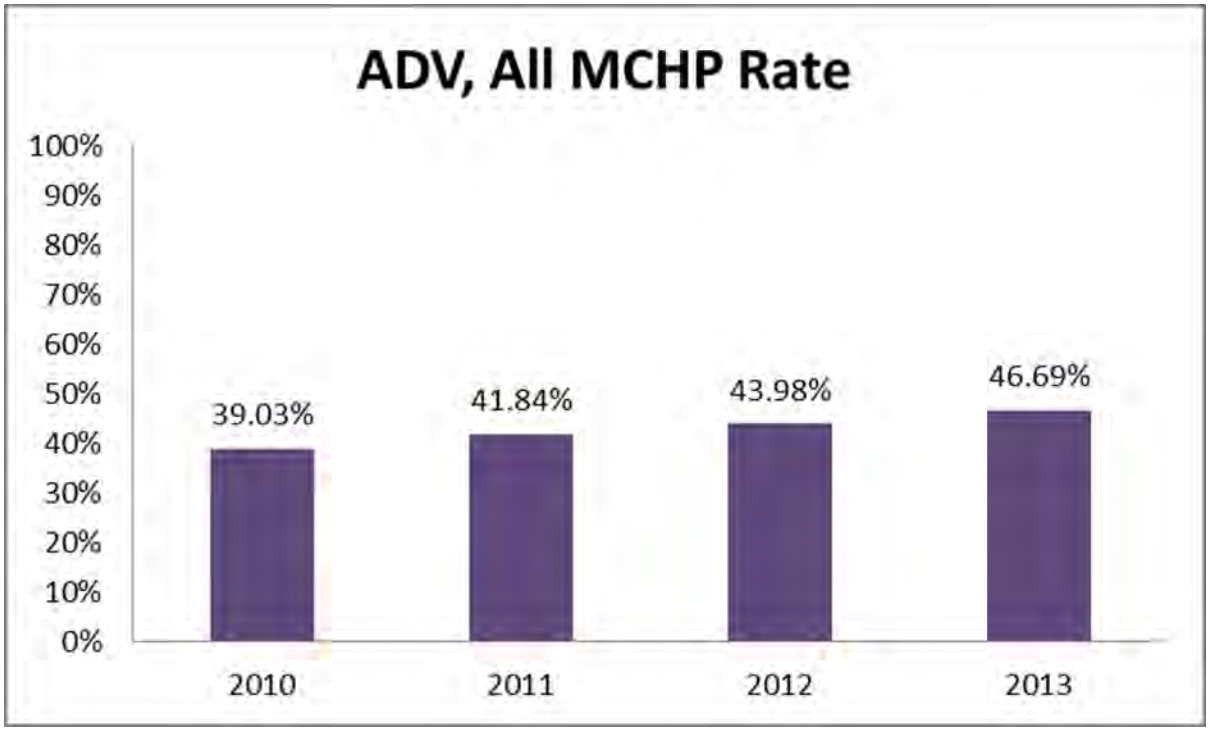
The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the MCHP's ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. The Technical Specifications for the HEDIS 2013 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply. Table 6 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DST for the HEDIS 2013 Annual Dental Visit measure. It is the task of the EQRO to compare MCHP to MCHP on a statewide level. Therefore, for all MCHPs who reported rates by region (e.g. MO Care), the regional numbers were combined to create a plan-wide rate.

Table 7 - Data Submission and Final Validation for HEDIS 2013 Annual Dental Visit (combined rate)

Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
HealthCare USA	105,949	50,188	47.37%	50,188	47.37%	0.00%
Missouri Care	26,158	11,487	43.91%	11,487	43.91%	0.00%
All MCHPs	**132,107**	**61,675**	**46.69%**	**61,675**	**46.69%**	**0.00%**

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc);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: MCHPs' HEDIS 2013 Data Submission Tools (DST).

Figure 16 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit



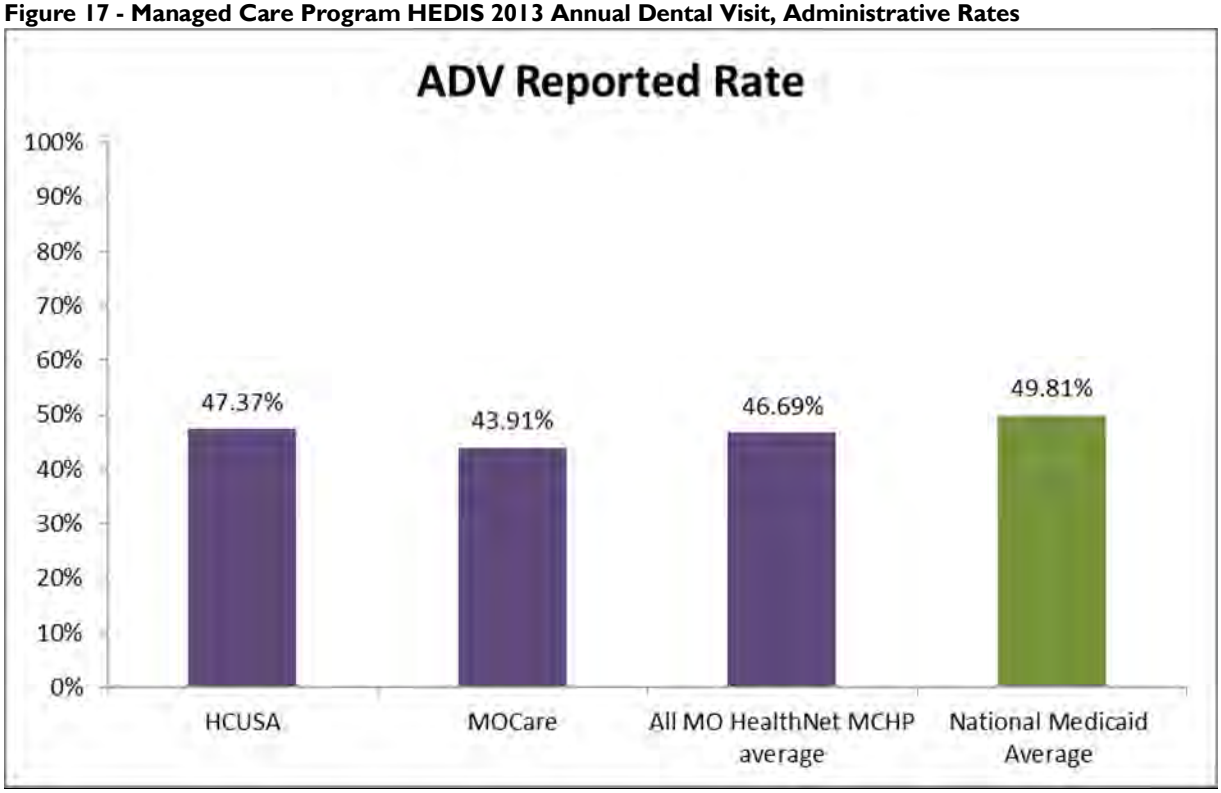
Source: BHC, Inc., 2010-2013 External Quality Review Performance Measure Validation

The Annual Dental Visit measure has been reviewed for the last seven audit years, the data for the last four years: 2010, 2011, 2012 and 2013 are analyzed here (see Figure 16). The rates for all MCHPs were 39.03%, 41.84%, 43.98% and 46.69% in 2010, 2011, 2012 and 2013 respectively. This indicates an increase in access to dental visits over time within the MO HealthNet Managed Care population. This steady increase in statewide rates is supported by the Statewide Performance Improvement Project that was discussed in Section 2 of this report.

In all of these audits, many of the MCHPs reported individual rates lower than the National

Medicaid Average. The combined average rate for all MCHPs has also been lower than this average. However, the National Medicaid Average has increased over time, as has the combined rate for all MCHPs. The 2013 MCHP rates ranged from 43.39% (MO Care) to 47.37% (HCUSA; see Figure 17). For HEDIS 2013, no MCHP reported a rate higher than the National Medicaid Average.

Figure 17 - Managed Care Program HEDIS 2013 Annual Dental Visit, Administrative Rates



Sources: MCHP HEDIS 2013 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2013 Annual Dental Visit measure. All MCHPs calculated and submitted the measure to the SPHA and SMA. All MCHPs in the State of Missouri are required to calculate and report the measure to the SPHA, and MCHPs are required to report the measure to the SMA.

Final Validation Findings

For the two MCHPs fully validated by the EQRO, no bias was found between the reported and EQRO calculated rates. The EQRO validated rates for the two MCHPs were found to be accurate and no bias exists.

HEDIS 2013, Childhood Immunization Status, Combo 3

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources for the calculation of the HEDIS 2013 Childhood Immunizations Status measure, specifically for Combination 3. It is related to the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2013 Childhood Immunizations Status Combo 3 measure, the sources of data included enrollment, eligibility, claim files, and medical record reviews. The rate of items that were Met was calculated across MCHPs and from the number of applicable items for each MCHP. No data integration and control issues were discovered by the EQRO. Only two of the three MCHPs that were operating during the 2012 Calendar Year had numbers that required reporting of this measure. Thereby, only these two MCHPs were subject to the full validation of Performance Measure Data. These two MCHPs met all criteria for every audit element.

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 2013 Childhood Immunizations Status Combo 3 measure.

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 2013 Childhood Immunizations Status Combo 3 measure, the sources of data include enrollment, eligibility, and claim files. Both MCHPs met all validation for the process used to produce denominators.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' 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 2013 Childhood Immunizations Status Combo 3 measure, the

sources of data included enrollment, eligibility, claim files, and medical records. Table 6 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DSTs. The "combined" rates for Missouri Care was calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western). The denominator for each MCHP is the Final Sample Size as approved by HEDIS Technical Specifications. The rate for all MCHPs was 59.47%.

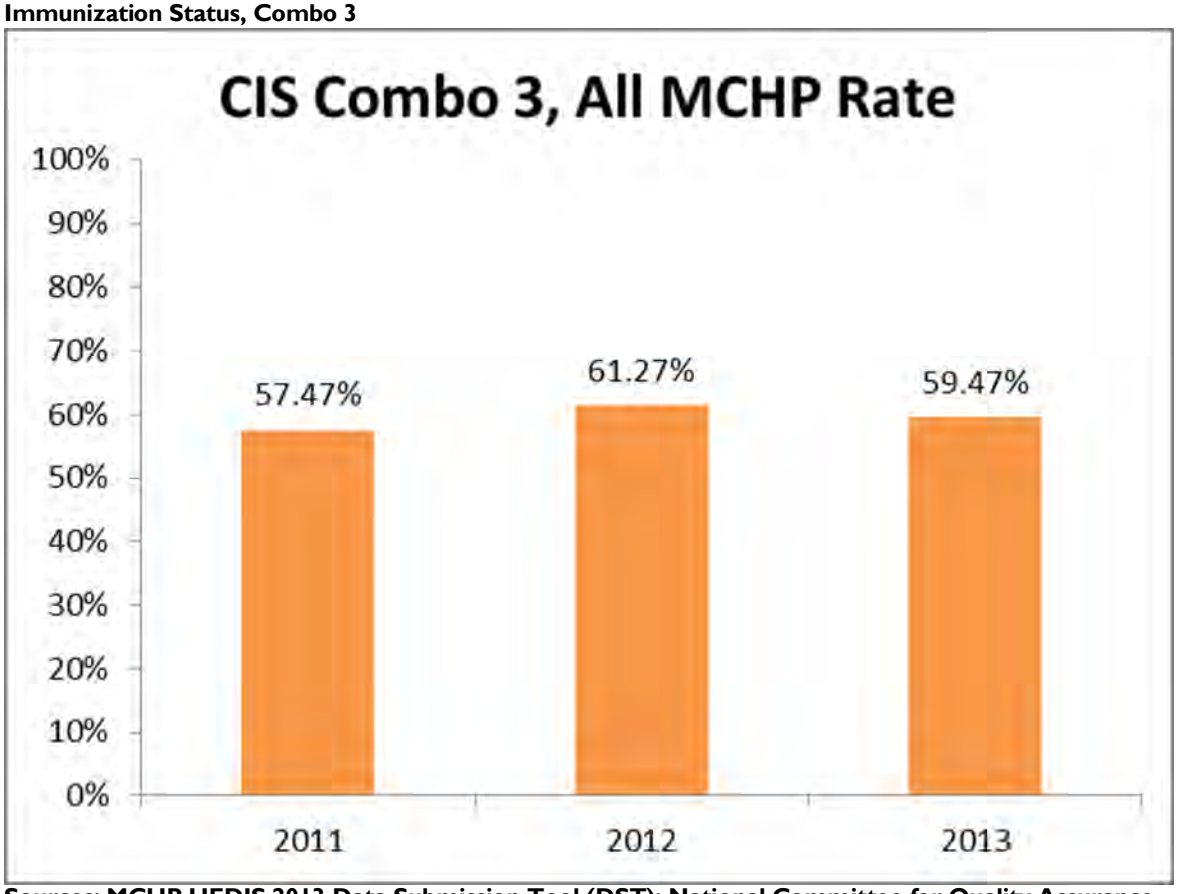
Table 8 - Data Submission for HEDIS 2013 Childhood Immunizations Status Combo 3 Measure

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)
HealthCare USA	Hybrid	432	213	69	282	65.28%
Missouri Care	Hybrid	1,068	363	247	610	57.12%
All MO HealthNet MCHPs		**1,500**	**576**	**316**	**892**	**59.47%**

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.). The statewide rate for all 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: MCHPs' HEDIS 2013 Data Submission Tools (DST)

Table 8 illustrates the rates reported by the MCHPs and the rates of administrative and hybrid hits for each MCHP. The rate reported by each MCHP was compared with the rate for all MCHPs.

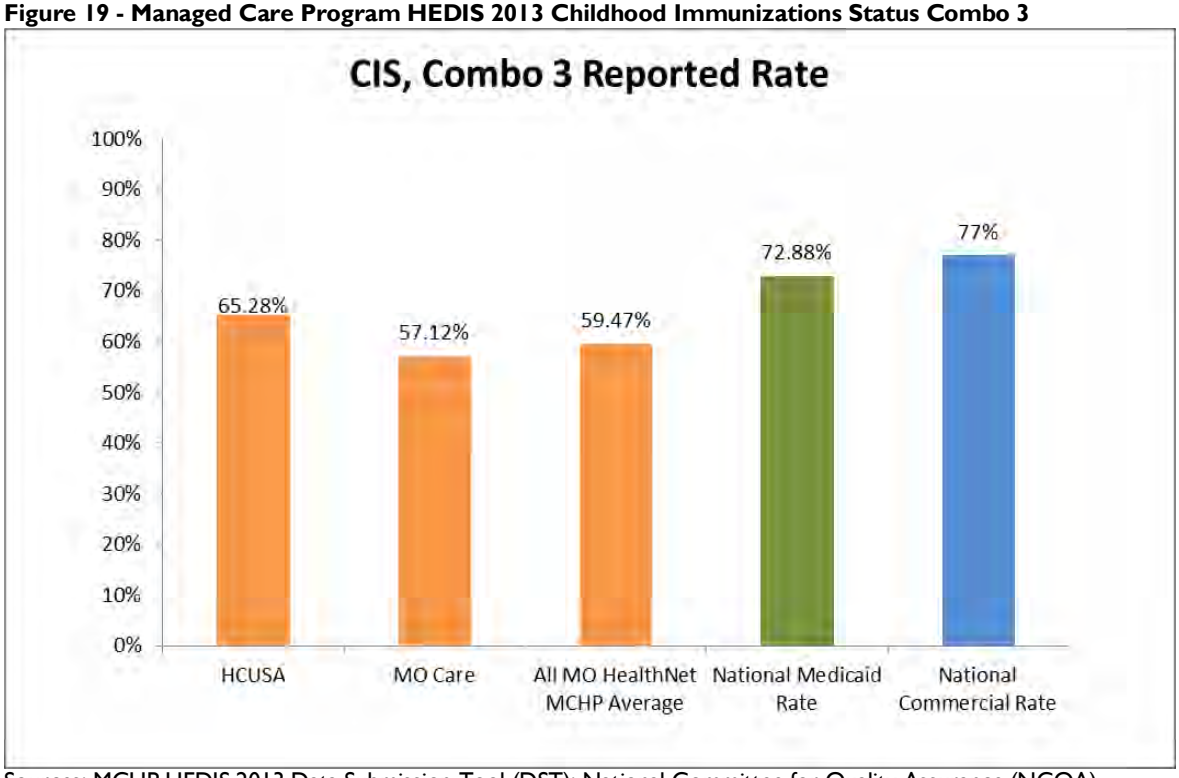
Figure 18 - Managed Care Program Statewide Rate Comparison for HEDIS Measure: Childhood Immunization Status, Combo 3



Sources: MCHP HEDIS 2013 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Combination 3 for this measure was audited in 2011 and 2012, therefore trend analysis was examined for this 2013 audit year. However, the statewide rate fluctuates within a 4 point range, showing no clear trends. The statewide rate reported for Childhood Immunizations Status, Combination 3 measure in 2013 (59.47%) was **lower** than the 2012 rate (61.27%), but the 2013 rate was **higher** than the rate reported in 2011 (57.47%).

Figure 19 - Managed Care Program HEDIS 2013 Childhood Immunizations Status Combo 3



Sources: MCHP HEDIS 2013 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

HCUSA's rate of 65.28% represented a 4.28 point increase from the 2012 rate of 61.56% and the rate of 57.12% for MO Care represented a 9.23 point decrease from the 2012 rate of 66.44%.

The rate for all MCHPs (59.47%) was lower than the 2012 rate of 61.27%, but higher than the 2011 rate of 57.47%. The 2013 rate was also lower than both the National Medicaid rate (72.88%) and the National Commercial Rate (77%) (see Figure 20).

Each MCHP calculated the Childhood Immunizations Status measure using the hybrid method for calculation. There were no statistically significant differences between the average for all MCHPs found in these rates. Table 9 summarizes the findings of the EQRO medical record review validation. HCUSA and MO Care operate in multiple regions. For this review HCUSA supplied the EQRO with a calculated statewide rate, however, MO Care did not. Therefore, for MO Care, the sample sizes selected for each region were combined to represent the overall MCHP rates. A total of 60 of the 316 medical record hybrid hits reported by these two MCHPs were sampled for validation by the EQRO. Of the records requested, 59 were received for review. The EQRO was able to validate all 59 of the records received, resulting in an Error Rate of 1.67% across all MCHPs. The number of False Positive Records (the total amount that could not be validated) was 5 of the 316 reported hits. This shows no bias in the estimation of hybrid rates for the MCHPs based upon medical record review. Table 9 shows the impact of the medical record review findings.

Table 9 - Medical Record Validation for HEDIS 2013 Childhood Immunizations Status Combo 3 Visits Measure

MCHP Name	Denominator (Sample Size)	Numerator Hits by Medical Records (DSTs)	Number Medical Records Sampled for Audit by EQRO	Number of Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of records received	Accuracy Rate	Error Rate	Weight of Each Medical Record	False Positive Records	Estimated Bias from Medical Records
HCUSA	432	69	30	29	29	100%	96.67%	-3.333%	0.0145	2.3	0.033333
MOCare	1068	247	30	30	30	100%	100%	0.00%	0.004	0	0
All MCHPs	1500	316	60	59	59	100%	98.33%	-1.667%	0.0032	5.26667	0.016667

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: MCHP Data Submission Tools (DST); BHC, Inc. 2013 External Quality Review Performance Measures Validation.

Table 10 - Impact of Medical Record Findings, HEDIS 2013 Childhood Immunizations Status Combo 3 Measure

Audit Elements	MCHP Name	
	HCUSA	MOCare
Final Data Collection Method Used (e.g., MRR, hybrid,)	Hybrid	Hybrid
Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	3.33%	0.00%
Is error rate < 10%? (Yes or No)	Yes	Yes
If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	Passes	Passes
If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	NA
Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	432	1,068
Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	NA	NA
Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA
Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA
Estimated Bias in Final Rate (The amount of bias caused by medical record review)	0.0333%	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MCHP; Administrative Method was used by the 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. 2013 External Quality Review Performance Measure Validation.

One MCHP (MO Care) received a rating of 100% as all the applicable criteria for calculating numerators were met. One MCHP (HCUSA) received a rating of 90.91% as this MCHP did not supply a completed medical record for one of the requested medical records in the extract. The MCHP received a rating of "Partially Met" for Item 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 records for applicable performance measures." Each of the MCHPs 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. The MCHPs met 95.45% of criteria for calculating the numerator for the HEDIS 2013 Childhood Immunizations Status, Combination 3 measure.

Sampling Procedures for Hybrid Method

The objective of this activity was to evaluate the MCHPs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Across all MCHPs, the criteria for sampling were met 100.0% of the time. All MCHPs used the Hybrid Method of calculating the HEDIS 2013 Childhood Immunizations Status Combination 3 measure and all met 100.0% of the criteria for proper sampling.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2013 Childhood Immunizations Status Combination 3 measure. All MCHPs reported the measure to the SPHA and SMA.

Final Validation Findings

One MCHP received a rating of Substantially Compliant and the other MCHP received a rating of Fully Compliant with the CIS 3 Performance Measure. A small bias was found in the rates reported by these two MCHPs (see Table 9).

HEDIS 2013 Follow-Up After Hospitalization For Mental Illness

Data Integration and Control

The objective of this activity was to assess the MCHPs' 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 2013 Follow-Up After Hospitalization for Mental Illness measure, the sources of data included enrollment, eligibility, and claim files. Only two of the three MCHPs that were operating during the 2012 Calendar Year had numbers that required reporting of this measure. Thereby, only these two MCHPs were subject to the full validation of Performance Measure Data. These two MCHPs met all criteria for every audit element.

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.

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. Both MCHPs met all validation for the process used to produce denominators.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the MCHP's 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 2013 Follow-Up After Hospitalization for Mental Illness measure, the procedures for the Hybrid Method did not apply, as HEDIS 2013 technical specifications allow only for the use of the Administrative Method of calculating the measure.

One MCHP observed a software glitch in their NCQA-certified software, Inovalon. This glitch was discovered when the MCHP observed a significant decrease in their rates from HEDIS 2012

– 2013. The MCHP eventually discovered that the date of service was not being pulled accurately by the software. Specifically, if a claim form had more than one date of service, the system was not capturing all of the dates of service. This error has since been corrected and the MCHP expects rates to show a significant improvement in their FUH rates for HEDIS 2014.

Table 10 and Table 11 show the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DST for the Follow-Up After Hospitalization for Mental Illness measure. HCUSA and Missouri Care reported regional rates (Eastern, Central, and Western); the EQRO combined these rates to calculate a MCHP combined rate.

Table 11 - Data Submission and Final Data Validation for HEDIS 2013 Follow-Up After Hospitalization for Mental Illness Measure (7 days)

Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
HealthCare USA	1,939	708	36.51%	708	36.51%	0.00%
Missouri Care	710	263	37.04%	263	37.04%	0.00%
All MCHPs	**2,649**	**971**	**36.66%**	**971**	**36.66%**	

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc). 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: Managed Care Organization HEDIS 2013 Data Submission Tools (DST).

Table 12 - Data Submission and Final Data Validation for HEDIS 2013 Follow-Up After Hospitalization for Mental Illness Measure (30 days)

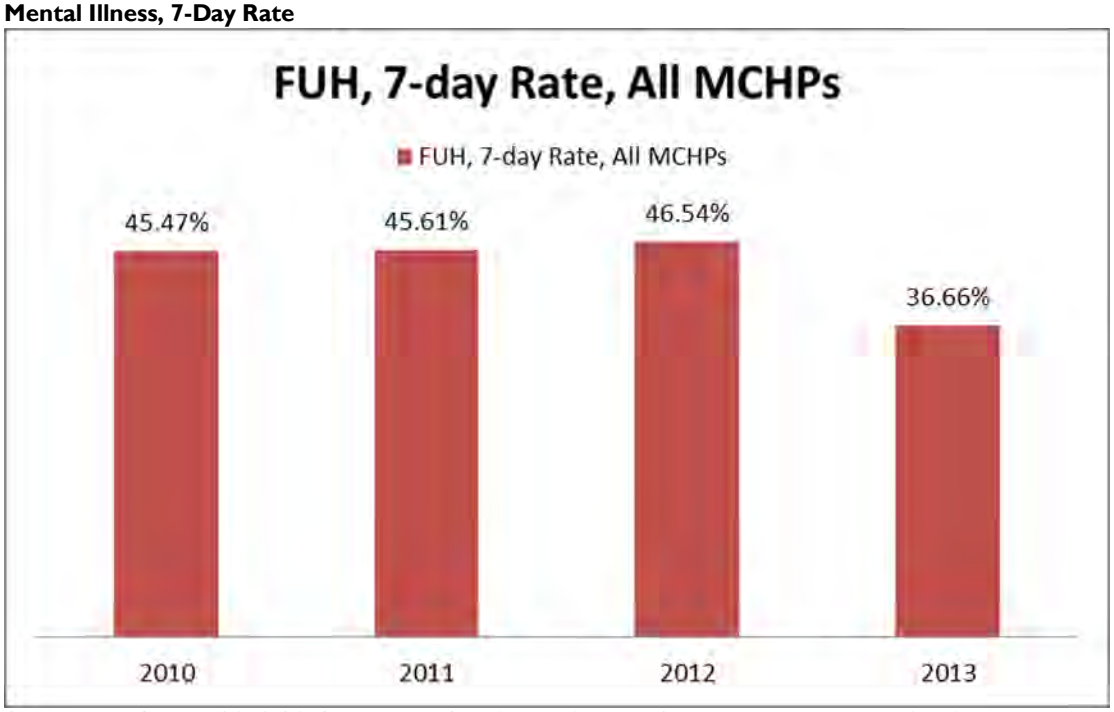
Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
HealthCare USA	1,939	1,233	63.59%	1,233	63.59%	0.00%
Missouri Care	710	436	61.41%	436	61.41%	0.00%
All MCHPs	**2,649**	**1,669**	**63.00%**	**1,669**	**63.00%**	

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc). 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: Managed Care Organization HEDIS 2013 Data Submission Tools (DST).

This measure was previously audited by the EQRO in five of the last six years. The analysis contained here will include 2010-2013 data (see Figure 21).

The 7-Day reported rate for all MCHPs in 2013 (36.66%) was **significantly lower** than the 2012 rate of 46.54% and the rate reported in 2011 (45.61%).

Figure 20 – Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness, 7-Day Rate

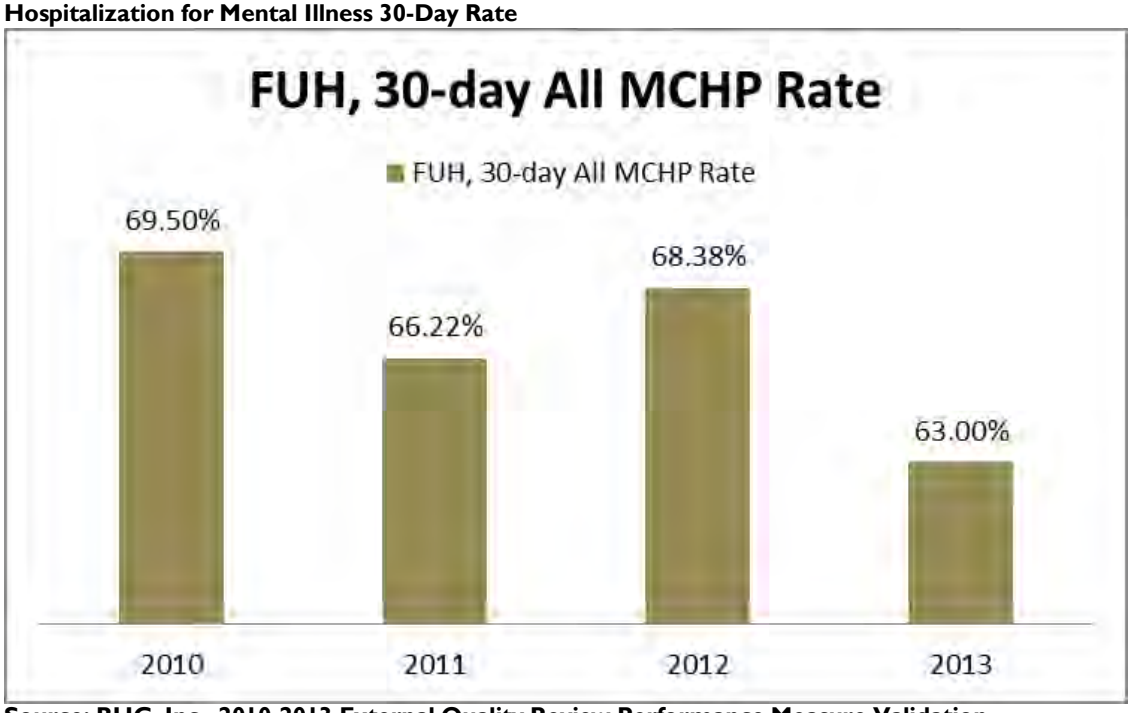


Source: BHC, Inc., 2010-2013 External Quality Review Performance Measure Validation

During the on-site visits, both MCHPs were questioned by the EQRO about the decreases in their prior year's rates. Only HCUSA was able to fully explain the reduction in their rate. The MCHP stated that the decreased rate was attributable to a software glitch in their NCQA-certified software, Inovalon. It was explained that the date of service was not being pulled accurately by the software. Specifically, if a claim form had more than one date of service, the system was not capturing all of the dates of service. This error has since been corrected and HCUSA assures the EQRO that the rate will show a significant improvement for HEDIS 2014. Unfortunately, HCUSA is unable to correct the rates with NCQA, as they do not accept corrected rates.

The 30-Day reported rate for all MCHPs in 2013 (63.0%) was a **significant decrease** from the 2012 rate (68.38%). The 2013 rate is the lowest rate reported during all the years of analysis.

Figure 21 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 30-Day Rate

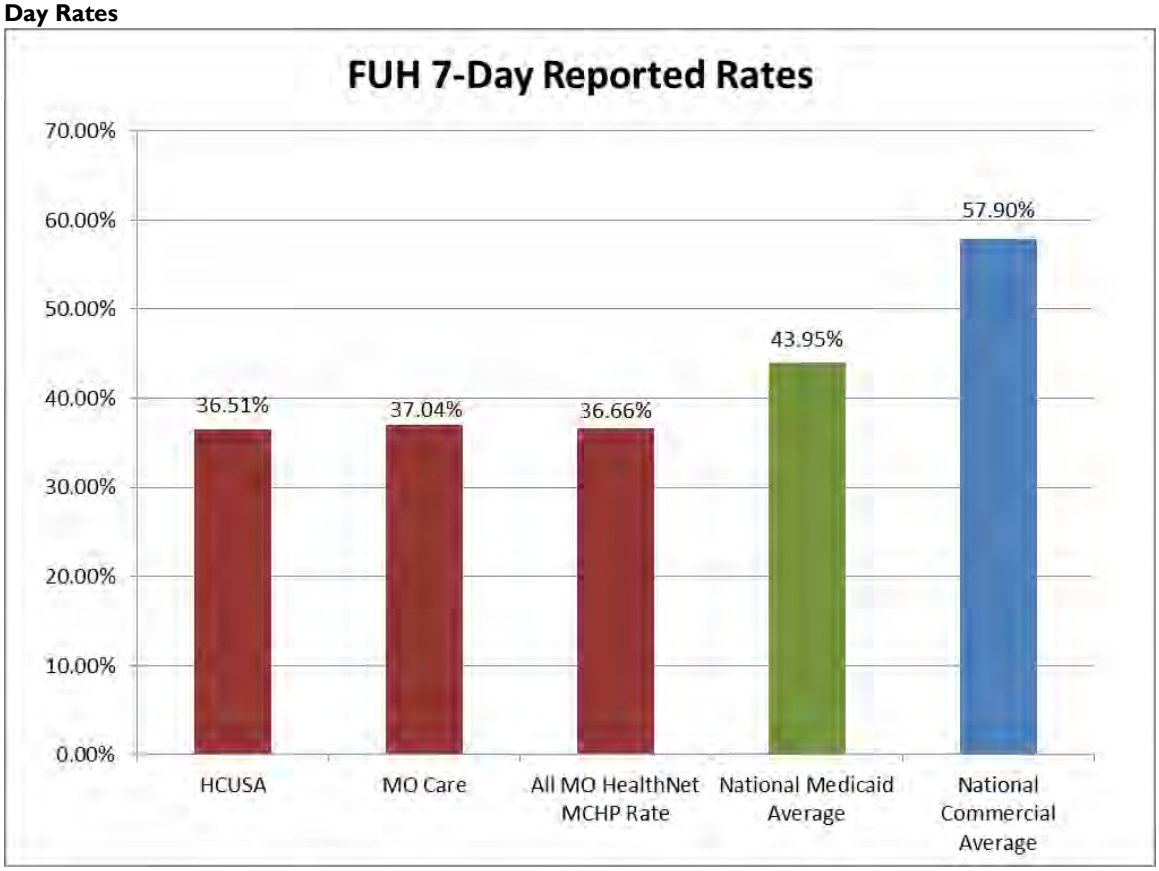


Source: BHC, Inc., 2010-2013 External Quality Review Performance Measure Validation

Figure 22 and Figure 23 illustrate the 7-Day and 30-Day rates reported by the MCHPs. The rate reported by each MCHP was compared with the rate for all MCHPs.

The 7-Day rates reported were **significantly lower** than the National Medicaid Rate (43.95%), and the National Commercial Rate (57.9%).

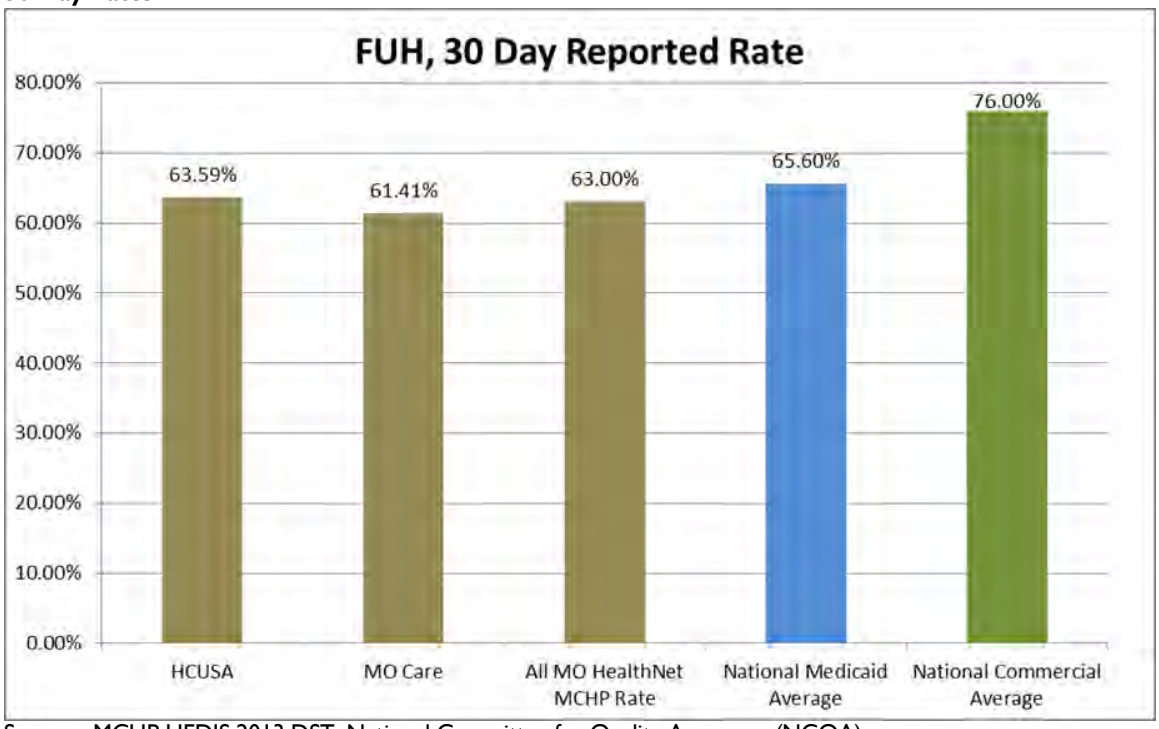
Figure 22 - Managed Care Program HEDIS 201 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Sources: MCHP HEDIS 2013 DST; National Committee for Quality Assurance (NCQA).

The National Medicaid and National Commercial Average rates decreased for HEDIS 2013 from the HEDIS 2012 rates. However, the 30-Day rates reported by the MCHPs were **significantly lower** than both the HEDIS 2013 National Commercial Average (76%) and **slightly lower** than the National Medicaid Rate of 65.6%.

Figure 23 - Managed Care Program HEDIS 2013 Follow-Up After Hospitalization for Mental Illness, 30-Day Rates



Sources: MCHP HEDIS 2013 DST; National Committee for Quality Assurance (NCQA)

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2013 Follow-Up After Hospitalization for Mental Illness Measure. All MCHPs calculated and submitted the measure to the SPHA and SMA.

FINAL VALIDATION FINDINGS

Table 13, Table 14, and Table 15 provide summaries of ratings across all Protocol Attachments for each MCHP and measure validated. The rate of compliance with the calculation of each of the three performance measures across all MCHPs was 100% for Annual Dental Visits; 98.96% for Childhood Immunizations Combo 3; and 100% for Follow-Up After Hospitalization for Mental Illness.

Table 13 - Summary of Attachment Ratings, HEDIS 2013 Annual Dental Visit Measure

All Audit Elements	All MCHPs HCUSA	All MCHPs MO Care	All MCHPs
Number Met	30	30	***60***
Number Partially Met	0	0	***0***
Number Not Met	0	0	***0***
Number Applicable	30	30	***160***
Rate Met	100%	100%	***100.0%***

Note: Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2013 EQR Performance Measure Validation

Table 14 - Summary of Attachment Ratings, HEDIS 2013 Childhood Immunizations Status Measure

All Audit Elements	All MCHPs HCUSA	All MCHPs MO Care	All MCHPs
Number Met	47	48	***95***
Number Partially Met	1	0	***1***
Number Not Met	0	0	***0***
Number Applicable	48	48	***96***
Rate Met	97.92%	100%	***98.96%***

Note: Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2013 EQR Performance Measure Validation

Table 15 - Summary of Attachment Ratings, HEDIS 2013 Follow-Up After Hospitalization for Mental Illness Measure

All Audit Elements	All MCHPs HCUSA	All MCHPs MO Care	All MCHPs
Number Met	46	48	***94***
Number Partially Met	0	0	***0***
Number Not Met	2	0	***2***
Number Applicable	48	48	***96***
Rate Met	95.83%	100%	***97.92%***

Note: Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2013 EQR Performance Measure Validation

Table 16 summarizes the final audit ratings for each of the performance measures by MCHPs. 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 MCHP 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 MCHPs on the DST.

Table 16 - Summary of EQRO Final Audit Ratings, HEDIS 2013 Performance Measures

MCHP	Annual Dental Visit	Childhood Immunization Status Combo 3	Follow-Up After Hospitalization for Mental Illness (7 day)	Follow-Up After Hospitalization for Mental Illness (30 day)
Healthcare USA	Fully Compliant	Substantially Compliant	Substantially Compliant	Substantially Compliant
Missouri Care	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Source: BHC, Inc. 2013 EQR Performance Measure Validation

MO Care was found to be Fully Compliant in the calculation of all the measures, whereas HCUSA was Fully Compliant for Annual Dental Visit rate, but found to be Substantially Compliant in the calculation of the Childhood Immunization Status Combo 3 rate and the Follow-Up After Hospitalization for Mental Illness rate.

3.3 Conclusions

In calculating the measures, all of the MCHPs have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2013 measures validated.

Among MCHPs there was good documentation of the HEDIS 2013 rate production process. The rate of medical record submission for the one measure allowing the use of the Hybrid Methodology was good, with the EQRO receiving all except one of the medical records requested. This review also marked the third review year in which all contracted MCHPs performed a hybrid review of the measure selected, allowing for a complete Statewide comparison of those rates.

QUALITY OF CARE

The HEDIS 2013 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the quality of care received by MCHP members.

Of the two MCHPs that were fully validated by the EQRO, one was Fully Compliant with the specifications for calculation of this measure and one was Substantially Compliant.

For the 7-day follow up rate, although the National Medicaid Average did drop over 2.5 percentage points from 2012 to 2013, the statewide rate saw a drop of almost 10 percentage points. The statewide rate for all MCHPs (36.66%) was also lower than the National Medicaid Average. The 7-Day reported rate for all MCHPs in 2013 (36.66%) interrupts a previously steadily increasing trend.

For the 30-day follow up rate, no MCHPs reported rates that were above than the National Medicaid Average (65.60%) for this measure. This measure was previously audited by the EQRO in audit years 2009, 2010, 2011, and 2012. The 30-Day reported rate for all MCHPs in 2013 is the lowest rate reported for this measure since the EQRO began analyzing the measure.

During the on-site visits, both MCHPs were questioned by the EQRO about the decreases in

their prior year's rates. Only HCUSA was able to fully explain the reduction in their rate. The MCHP stated that the decreased rate was attributable to a software glitch in their NCQA-certified software, Inovalon. It was explained that the date of service was not being pulled accurately by the software. Specifically, if a claim form had more than one date of service, the system was not capturing all of the dates of service. This error has since been corrected and HCUSA assures the EQRO that the rate will show a significant improvement for HEDIS 2014. Unfortunately, HCUSA is unable to correct the rates with NCQA, as they do not accept corrected rates.

MO Care was unable to fully explain their rate's decrease. The EQRO provided technical assistance regarding discharge planning and the use of alternate providers in order to aid the MCHP in improving future rates.

Access to Care

The HEDIS 2013 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.

Of the two MCHPs that were fully validated by the EQRO, both were Fully Compliant with the specifications for calculation of this measure.

The Annual Dental Visits measure has been audited annually in five of the last six external quality reviews. Over the course of these review periods, the rates for all MCHPs have improved steadily and the 2013 rate was the highest rate seen in Missouri at 46.69%. However, in 2013, none of the MCHPs reported rates higher than the National Medicaid Average of 49.81%.

This continued increase in the ADV rate shows an increased level of dental care received in Missouri by members, illustrating an increased access to care for these services for the HEDIS 2013 measurement year. The EQRO largely attributes this continued increase to the focus that has been placed on this measure by the Statewide PIP, Improving Oral Health.

TIMELINESS OF CARE

The HEDIS 2013 Childhood Immunizations Status measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. To increase the rates for this measure, members must receive a series of services within a very specific timeframe (i.e. prior to age 2).

Two MCHPs were fully validated by the EQRO, one was Fully Compliant with the specifications for calculation of this measure and the other was Substantially Compliant with the specifications for calculation. The Substantially Compliant MCHP provided 29 of the 30 requested medical records, this negatively impacted the validation of their rate.

Combination 3 for this measure was previously audited in 2011and 2012. The statewide rate reported for Childhood Immunizations Status, Combination 3 measure in 2013 (59.47%) was **lower** than the 2012 rate (61.27%), but the 2013 rates was **higher** than the rate reported in 2011 (57.47%). None of the MCHPs reported a rate in 2013 higher than the National Medicaid Average of 72.88% or the National Commercial Average of 77%.

This illustrates a timeliness of care for immunizations delivered to children in Missouri that is lower than the timeliness of care received by other Medicaid members across the nation.

RECOMMENDATIONS

1. The SMA should continue to encourage the use of the Hybrid Method of calculation for HEDIS measures that allow these reviews. The Hybrid review process produces higher rates on average than an Administrative method alone.
2. Both MCHPs had significantly lower administrative hits for two of the three measures validated. The MCHPs should closely examine the potential reasons for fewer services identified. This may be due to member characteristics, but is more likely due to administrative 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. MCHPs should run query reports early enough in the HEDIS season so that they may

effectuate change in rates where interventions could easily be employed, these reports should be closely reviewed.

5. When submitting medical records to the EQRO for validation, the MCHP must ensure that all documentation is accurately submitted.
6. The impact of the HEDIS 2013 data should be considered thoughtfully as the State-wide rate only included continuously eligible members from two MCHPs.

4.0 COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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4.1 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 EQRO uses the Assessment of Compliance with Medicaid Managed Care Regulations (Compliance Protocol) requirements during the review process, with an emphasis on areas where individual MCHPs have previously failed to comply or were partially compliant at the time of the prior reviews. Specifically, the MCHPs were reviewed to assess MCHP compliance with the federal Medicaid managed care regulations; with the State Quality Strategy; with the MO HealthNet Managed Care contract requirements; and with the progress made in achieving quality, access, and timeliness to services from the previous review year.

This year's review (calendar year 2013) is a follow-up review to the full compliance review that was completed in the prior year's report. The SMA reviewed current policies and procedures to ensure that they were in compliance with the current contractual requirements, as well as federal regulations. The EQR Compliance Review focused on implementation of policies and procedures, as required in the Case Management processes. The review included case record reviews and interviews with Case Management and Administrative staff. The results of the Case Management review will be reported in detail in another section of this report as a "Special Project".

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occurred with individuals from the SMA from February 2014 through June 2014 to prepare for the on-site review, and obtain information relevant to the review prior to the on-site visits.

During this follow up review, the Compliance Review team members conducted a special project to follow up on the Managed Care MCHPs' (MCHP) compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and recording keeping. The EQRO also evaluated the MCHPs' compliance with the federal regulations and the Managed Care contract as it pertained to Case Management.

Document Review

Documents chosen for review were those that best demonstrated each MCHP'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 at each MCHP to ensure that consistent information was shared regarding enrollee rights and responsibilities. Managed Care contract compliance worksheets and case management policies were reviewed as a basis for interview questions that made up the main focus of the 2013 Compliance Review. Other information, such as the Annual Quality Assessment and Improvement Evaluation was requested and reviewed to provide insight into each MCHPs' compliance with the requirements of the SMA Quality Improvement Strategy, which is an essential component of the Managed Care contract, and is required by the federal regulations. MCHPs' Quality Improvement Committee meetings minutes were reviewed. Grievance and Appeal policies and procedures were reviewed and used in discussions with MCHP staff. In addition, interviews based on questions from the SMA and specific to each MCHP's Quality Improvement Evaluation, were conducted with 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 MCHP. 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 MCHPs:

- State contract compliance ratings from 2013 and updated policies accepted through June 2014
- Results, findings, and follow-up information from the 2012 External Quality Review
- 2013 MCHP Annual Quality Assessment and Improvement Evaluation

Conducting interviews

After discussions with the SMA, it was decided that the 2013 Compliance Review would include interviews with Case Management Staff (under the guidelines of the "Special Project") and Administrative Staff. The goal of these interviews was to validate that practices at the MCHPs, 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 MCHPs had made significant progress in developing appropriate and compliant written policies and procedures.

Interviews were held at each MCHP with case management and administrative staff to obtain clarification on issues identified from the policy and document reviews, and to clarify some responses received from the case managers. Case Management interview questions were developed from the review of each MCHP's case management policy and from the case records reviewed prior to the time of the on-site review. Administrative interview questions were developed from the review of each MCHP's Annual Report, Member Handbook, and Quality Committee meeting minutes. These interview questions were specific to each MCHP, and focused on issues that might compromise compliance with required case management or administrative activities. The specific findings of the Case Management interviews are reported in the "Special Project" section of this report.

The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. A site visit questionnaire specific to each MCHP was developed. 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.

Analyzing and Compiling Findings

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MCHP'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 MCHP's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision.

Reporting to the State Medicaid Agency

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. The actual ratings are included in this report.

Compliance Ratings

The EQRO continues to utilize a Compliance Rating System that was developed during previous reviews. This system was based on a three-point scale ("Met," Partially Met," "Not Met") for measuring compliance, as determined by the EQRO analytic process. The determinations found in the Compliance Ratings considered SMA contract compliance, review findings, MCHP policy, ancillary documentation, and staff interview summary responses that validate MCHP practices observed on-site.

If the SMA considered the policy submission valid and rated it as complete, this rating was used unless practice or other information called this into question. If this conflict occurred, it was explained in the narrative included in the individual MCHPs Compliance Section. 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. MCHP 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 MCHP 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.

4.2 Findings

Enrollee Rights and Protections

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of health 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. Across all MCHPs 100% of the regulations were rated as "Met". This is comparable to the 2012 and 2010 review years and higher than the 2011 review year when 83.3% of the regulations were rated as "Met".

All MCHPs had procedures 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 that the MCHPs are in compliance with other state requirements [438.100(d)]. All MCHP's were also found to have practices that met these requirements.

All MCHPs continued to operate programs for the provision of behavioral health services. Two of the MCHPs subcontract with Behavioral Health Organizations (BHO) for these services, however, both subcontracted entities are part of each MCHPs corporate organization. One MCHP (MO Care) utilizes an "in-house" model for the provision of behavioral health services. MO Care uses a system of integrated case management and maintenance of the provider delivery system within their MCHP structure.

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 4 regulations rated as "Not Met" for both the 2013 and 2012 reviews. However, across all MCHPs, the rate of regulations "Met" for the 2013 review (74.51%) is a decline from the 2012 review (83.67%)and the 2011 rate of 75.49%. One MCHP (HCUSA) was found to be 82.35% compliant and the other two MCHPs (Home State and MO Care) were 70.59%.

- Home State improved over their 2012 rate of 64.71%.
- HCUSA and MO Care both saw decreases in their rate from the 2012 rate of 88.24%.

The rating for the Access Standards compliance rate is directly attributable to the findings of the Case Management Special Project (this is discussed in greater detail in Section 5 of this report).

All MCHPs 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 MCHPs 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; and Emergency and Post-Stabilization Services. Throughout this review period, all MCHPs 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 MCHPs excelled.

Table 44. Subpart D: Quality Assessment and Performance Improvement: Access Standards.

Table 17 – Subpart D: Quality Assessment and Performance Improvement: Access Standards

Federal Regulation	MO HealthNet MCHP			All MO HealthNet MCHPs			
	HCUSA	MOCare	Home State	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2	3	0	0	100.0%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2	3	0	0	100.0%
438.206(b)(3) Second Opinions	2	2	2	3	0	0	100.0%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	3	0	0	100.0%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	3	0	0	100.0%
438.206(c)(1)(i-vi) Timely Access	2	2	2	3	0	0	100.0%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	3	0	0	100.0%
438.208(b) Care Coordination: Primary Care	1	0	0	0	1	2	0.0%
438.208(c)(1) Care Coordination: Identification	1	1	1	0	3	0	0.0%
438.208(c)(2) Care Coordination: Assessment	2	1	1	1	2	0	33.3%
438.208(c)(3) Care Coordination: Treatment Plans	2	1	1	1	2	0	33.3%
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	0	0	0	1	2	0.0%
438.210(b) Authorization of Services	2	2	2	3	0	0	100.0%
438.210(c) Notice of Adverse Action	2	2	2	3	0	0	100.0%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	3	0	0	100.0%
438.210(e) Compensation of Utilization Management Activities	2	2	2	3	0	0	100.0%
438.114 Emergency and Post-Stabilization Services	2	2	2	3	0	0	100.0%
Number Met	14	12	12	38	9	4	74.51%
Number Partially Met	3	3	3				
Number Not Met	0	2	2				
Rate Met	82.35%	70.59%	70.59%				

Note: 0 = Not Met; 1= Partially Met; 2 = Met Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2012). Assessment of Compliance with Medicaid Managed Care Regulations, Protocol 1, v. 2.0, September 1, 2012; BHC, Inc., 2013 External Quality Review Monitoring MCHPs Protocols.

Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. However, in the area of Care Coordination all three MCHPs decreased. The need to ensure that members received appropriate referrals to PCPs and specialty providers was clearly reflected in the interviews, but was not always documented in the case records. Additionally, the EQRO observed instances where a specialist was warranted, but was not provided. Required documentation and approved policies did exist in all areas for all MCHPs. All of the MCHPs had complete policy and Provider Manual language in the area of emergency and post-stabilization services [438.114].

Quality Assessment and Performance Improvement: Structure and Operations 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, grievance systems, and accountability for activities delegated to subcontractors. Across all MCHPs 100% of the regulations were rated as "Met". This is consistent with the 2012 and 2010 review year ratings of 100% and an improvement over the 2011 rating of 84.31% compliance.

It was evident through on-site interviews, that the Provider Services departments of the MCHPs exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and Managed Care requirements. All of the MCHPs were 100% compliant with these regulations. This included Provider Selection [438.214(d) and 438.214(e)]; timeframes [438.56(e)]; and disenrollment. The staff interviewed at each MCHP understood the requirements for disenrollment. All of the MCHPs described credentialing and re-credentialing policies that exceeded the requirements of the regulations. All MCHPs have developed policy and procedures that comply with NCQA criteria. Providers were willing to submit to these stricter standards to maintain network qualifications in both the MCHPs and other commercial networks. All of the MCHPs (100.0%) had all required policies and practices in place regarding credentialing.

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 PIPs; 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. A total of 87.5% of the criteria were "Met" by the MCHPs. This is a decrease from the 2012 rate of 93.8% and 2010 (93.9%). It is an increase over the 2011 review year, when 81.82% of the criteria were "Met" by all MCHPs.

No MCHP met all requirements in this area. One MCHP (HCUSA) met 90.9% of the requirements. The MCHPs received "Partially Met" ratings in Performance Measures and Performance Improvement Projects. The issues in these areas are discussed in more detail in

sections 2.0 and 3.0 of this report. However, lower Performance Measures rates and missing analysis in the MCHPs' Performance Improvement Project narratives were the EQRO's largest concerns.

Table 18 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

Federal Regulation	MO HealthNet MCHP			All MO HealthNet MCHPs			
	HCUSA	Home State	MOCare	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2	3	0	0	100.0%
438.236(c) Practice Guidelines: Dissemination	2	2	2	3	0	0	100.0%
438.236(d) Practice Guidelines: Application	2	2	2	3	0	0	100.0%
438.240(a)(1) QAPI: General Rules	2	2	2	3	0	0	100.0%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	2	1	1	1	2	0	33.3%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	NA	1	0	2	0	0.0%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2	3	0	0	100.0%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2	3	0	0	100.0%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	2	2	3	0	0	100.0%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2	3	0	0	100.0%
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2	3	0	0	100.0%
Number Met	10	9	9	28	4	0	87.5%
Number Partially Met	1	1	2				
Number Not Met	0	0	0				
Rate Met	90.9%	90.0%	81.82%				

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: BHC, Inc., 2013 External Quality Review Monitoring MCHPs Protocols.

During the on-site reviews it was evident to the reviewers that practice guidelines have become a normal part of each MCHPs' daily operation. Practice guidelines are in place and the MCHPs are monitoring providers to ensure their utilization. All of the MCHPs met all the requirements for adopting, disseminating and applying practice guidelines.

All MCHPs (100.0%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the MCHPs 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 MCHP staff was able to articulate how they utilized these tools and apply them to member healthcare management issues.

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. All three MCHPs were found 100% compliant with the Grievance Systems requirements.

4.3 Conclusions

Across all MCHPs there continues to be a commitment to improving and maintaining compliance with federal regulations. There are only a few regulations rated as "Not Met." All other individual regulations were rated as "Met" or "Partially Met." All MCHPs were 100% compliant with three of the compliance areas validated during this review year.

For the fourth consecutive year, none of the MCHPs were 100% compliant with all requirements. This is attributable to the in-depth review of the MCHPs' Performance Improvement Projects and the Case Management Special Project review. All MCHPs were unable to demonstrate case management information that fully exhibited compliance with the aspects of care coordination.

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. All of the MCHPs made it clear that they used the results of the prior EQR to complete and guide required changes, this was evident

in many of the areas that the EQRO noted improvement. The following summarizes the strengths in the areas of Access to Care, Quality of Care and Timeliness of Care.

Quality of Care

The 13 regulations for Enrollee Rights and Protections were 100% "Met" by all MCHPs. Communicating 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 MCHPs. These MCHPs were aware of their need to provide quality services to members in a timely and effective manner.

The 10 regulations for Structure and Operations Standards were 100% "Met" by all MCHPs. These included provider selection, and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. This is the fourth consecutive year that all of the MCHPs maintained a 100% rating in this set of regulations.

Access to Care

Only one MCHP **improved** in their compliance with the 17 federal regulations concerning Access Standards during this year's review. However, this MCHP was rated at only 70.59% compliant. The remaining MCHPs were both found to be less compliant with these standards than in the 2012 review.

There were 4 regulations rated as "Not Met" for both the 2013 and 2012 reviews. However, across all MCHPs, the rate of regulations "Met" for the 2013 review (74.51%) is a decline from the 2012 review (83.67%) and the 2011 rate of 75.49%. HCUSA was found to be 82.35% compliant and Home State and MO Care were 70.59%.

The EQRO observed that all of the MCHPs had case management services in place. However, the case management records requested did not always contain information to substantiate onsite observations.

Each MCHP described measures they used to identify and provide services to MO HealthNet Managed Care members who have special healthcare needs. All of the MCHPs could describe

efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required. One area of concern is care coordination. The EQRO observed instances when specialty care should have been offered to members in Case Management and no such offer was extended.

TIMELINESS OF CARE

This is an area of decline in compliance for all the MCHPs. Nine of the eleven applicable regulations for Measurement and Improvement were 100% "Met." However, none of the MCHPs met all of the regulatory requirements. All of the MCHPs adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. These MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. However, lower Performance Measure rates and missing Performance Improvement Project analyses contributed to this decline.

The MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs. However, this was not always evident in the documentation reviewed. The MCHPs all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The MCHP staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services, this practice was observed in the case records reviewed.

All of the regulations for Grievance Systems were 100% "Met" for all of the MCHPs. These regulations all pertained to the written policy and procedure of the MCHPs.

RECOMMENDATIONS

1. MCHPs should continue to submit all required policy and procedures in a timely manner. This is only the second review year when all MCHPs have approved policy and procedures. This improvement is likely due to the requirement that all MCHPs be NCQA accredited.
2. All MCHPs need to examine their case management programs. Attention to the depth and quality of case management services should be a priority for every MCHP. Goals should be established for the number of members in case management and the outcomes of the delivery of case management services. Continued attention must be applied to ensure the EQRO receives documentation as requested to validate that these services are occurring.
3. Accuracy in submission of Performance Measure medical records and Case Management records continue to adversely affect the Compliance ratings awarded to each MCHP. The MCHPs must be sure that all information is submitted accurately for all data requests from the EQRO.
4. Concerns remain about the number of cases actually opened for case management. Locating and identifying these members, and engaging them in the case management process, is critical to meeting members healthcare needs. Ensuring that MCHP members actually have access to case management services remains a concern.

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5.0 MO HealthNet MCHP SPECIAL PROJECT CASE MANAGEMENT PERFORMANCE REVIEW

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5.1 Case Management– Special Project

The SMA asked the EQRO to conduct a special project to follow up on the MCHP compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and recording keeping. The EQRO also evaluated the MCHP's compliance with the federal regulations and Managed Care contract as it pertained to Case Management.

The focus of this review was:

- Assessing the MCHPs' attention and performance in providing case management to:
    a. Pregnant members;
    b. Members with special health care needs; and
    c. Children with elevated blood lead levels;
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases they report as open in their system.

METHODOLOGY

The review included the following components:

- Review of each MCHP's case management policy and procedures;
- Case record reviews of forty (40) cases per MCHP, sampled from case listings that were received from each MCHP. These case listings included open and active cases sorted by category: lead; perinatal/ob; and special healthcare needs; [open in the third quarter of 2013]; and
- On-site interviews with case management staff and MCHP administrative staff.

The SMA staff reviews and approves all MCHP policy. Questions developed by the EQRO in the case record review process focused on compliance with the requirements of case management as set out in the Managed Care contract, compliance with MCHP policy, and were developed from the case record review. Case review results reflected how well individual files met both the MCHP's policy requirements and those of the Managed Care contract.

Case Record Reviews

A listing of open and active cases from the third quarter of 2013 was requested from each MCHP, organized by category. For each MCHP a random sample of fourteen (14) cases were identified from the listings provided for the category of Special Health Care Needs; fourteen (14) cases for Pregnant Women; and twelve (12) cases were identified from the listings and provided for the category of lead. All cases requested for review were received. The records were reviewed by EQRO Consultant Lisa Heying, R.N, and EQRO Assistant Project Director, Mona Prater. A case review form, pre-approved by the SMA, was used to assess the quality of the medical case records received.

On-Site Interviews

The purpose of the on-site interviews was to:

- Evaluate the case managers' knowledge of the State of Missouri contractual requirements of their position; and
- Determine methods used by case managers to operationalize policy in their daily activities.

The interviews occurred at each MCHP as follows:

1. Interviews were conducted during the on-site review. Interview questions were based on the Managed Care contract requirements and the outcome of the record reviews. Each interview tool addressed issues specific to the MCHP's review results and included general questions for each MCHP's staff.

2. Interviews were conducted with direct service staff at each MCHP. Each interviewee's presence was requested prior to the date of the on-site review. If staff was not available, substitutions were accepted.

DOCUMENT REVIEW

Case Management Record Review

The case management record review was designed to verify that case management activities were conducted in compliance with the Managed Care contract and with all applicable federal policies. The results are divided into categories that summarize these reviews. A comparison with the results of the 2010, 2011, and 2012 case record review, for each category, is part of this evaluation. The comparison results available for Home State Health Plan are based on the findings of the 2012 and 2013 reviews.

The case files were evaluated based on the Case Management requirements found in the October 1, 2012 Managed Care contract as amended.

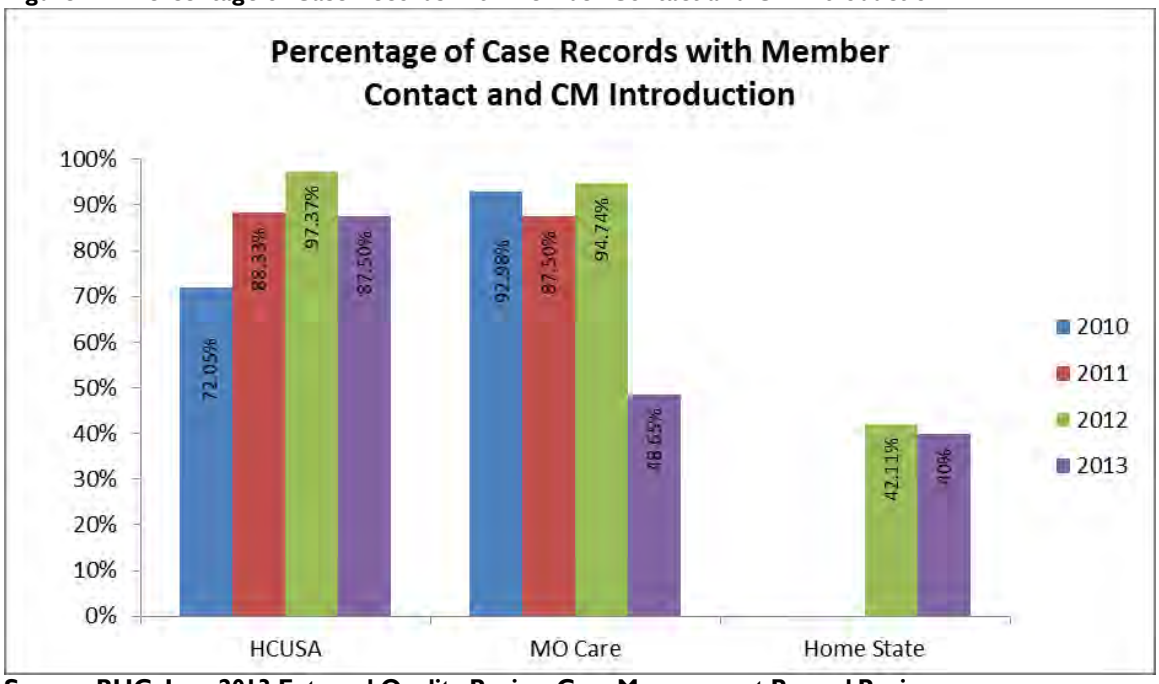
5.2 Findings

The findings include the results of the case management record review and on-site interviews for all three MCHPs. The charts in this section include the results of the case record reviews and the information obtained during the case manager interviews.

CASE RECORD REVIEW RESULTS

Introduction to Case Management

Figure 24 - Percentage of Case Records with Member Contact and CM Introduction



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

There are four standards used to assess the category of Introduction to Case Management. The records and recording must include:

1. Identifying information used to locate and maintain contact with the member;
2. Case opening – after receipt of referral was a case opened for assessment and service delivery;
3. Introduction to Case Management – did the case manager explain all aspects of the case management process to the member;
4. Acceptance of Services – did the member indicate they agreed with the MCHP providing

case management services allowing on-going involvement and give approval to speak to a third party about the case if necessary.

In 2013 all three MCHPs declined in providing all introductory information or recording these conversations with members. MO Care and Home State are at an unacceptable level of performance in this standard. HCUSA and MO Care's performance did trend upward in previously years. These increases appeared to indicate that the efforts to contact members and explain the case management process were successful. However, during the 2013 review several factors were noted that contributed to the decline:

- MO Care changed ownership, which created a complication where all case management record information was not available or consistent. The converted records did not contain introductory and assessment forms, although case management notes were available. Comparing records reviewed in 2012 to the records received for the 2013 review, this change had a negative impact on the number of cases containing a complete record of the introduction to case management.

- HCUSA did contact, explain case management, and obtain the member's cooperation in providing services in 100% of the cases reviewed for pregnant women. This is in compliance with their contractual obligations. These records did reflect efforts to locate and develop communications with the members that were successful.

- The MCHPs fell short of meeting acceptable levels of making timely contacts with members in Lead related cases.

    - In 54% of HCUSA's and 75% of MO Care's open Lead Case Management files no contact with the family was observed. Computer generated information, such as assessment forms and care plans were in the records received. They included regular monthly case notes with a record of contacts regarding the member. However, no direct contact was made with the family or member. Contacts and tracking occurred through the local health department and sometimes through the assigned PCP's office.

- Lead case management is required for any child who appears on the DHSS listing for children with an EBLL over the minimum level of 10V. Prior to 2010 this list only included children under the age of six. It now includes children over age six (6), who became MCHP members, but may have had a previously reported elevated blood lead level that was never retested, or found to be under the minimum BLL of 10V. These members and their families were unresponsive to repeated attempts to contact them. In 38% of HCUSA, 33% of MOCare, and 27% of Home State files families refused or did not present themselves for updated testing. The MCHPs do maintain active case management records whether the family agrees to case management or not.

- Home State was in its second year of providing services during CY 2013. Case management records reviewed indicated that staff are contacting members and providing case management services. In the records reviewed there was marginal improvement in holding or recording conversations where case management was explained to the member. Home State did not show improvement in recording how case managers obtained the member's willingness to accept services in 63% of the cases reviewed.

- Case managers and program coordinators from all MCHPs reported during on-site review interviews that they are aware of the need to explain case management, why the member may benefit from the service, and the member's right to choose the service. Case managers, who carry special health care needs and pregnant women's cases, described taking a proactive approach with members and state that the majority of the members who are approached accept case management services. In only four of the cases reviewed did the member or parent state during the original contact that they were not interested in case management.

- Case managers are required to explain the nature of the case management relationship, the contact(s) they will have with the member, and the services available. Case managers must request approval to discuss the case with a third party, if appropriate. Case managers must discuss the availability of a complaint process and explain any contacts with the providers involved.

- This activity occurred in 67% of the cases reviewed for HCUSA and 52% of the MO Care cases. Even though these numbers indicate a slight majority, it is clear that if this issue is being explained, it is not recorded or reflected in the case record information with the member's agreement to accept services nearly as often as required.

- At Home State only two of the forty records (5%) reviewed contained any evidence that the case manager discussed the issue of third party disclosure with the member or their representative while attempting to obtain permission to talk to a family member or other party about the case.

- Cases that were referred to Home State due to Elevated Blood Lead Levels (EBLL) continued to indicate a lack of urgency in making initial contacts and providing follow-up case management services. Members were contacted within the required time frames only 55% of the time. In the area of Lead Case Management only four of eleven cases (36%) contained any notes regarding the explanation of services, the member's agreement to accept services, or other introductory information.

  - In two cases, referrals were received in May and July of 2013. The first contacts with the family occurred in February and March 2014, a full nine months and eight months respectively. One lead case was opened because the mother requested case management for her twins, but only referrals for lead testing occurred. In one case there was no contact and a case was not opened.

- Locating members and maintaining working telephone numbers or even viable addresses continues to be a concern voiced by all three MCHPs. All have put practices in place, such as contracted agencies that go to the home to attempt to find the member or someone who can verify the member's actual address. The case managers and customer relations staff utilize PCP office staff, concurrent review nurses when a member is hospitalized, and every resource they can find to locate members. They all describe a tenacious approach to locating members with limited success. In reviewing EQRs from other states and Managed Medicaid research this does not appear to be the pervasive problem described in Missouri. A systematic field-based approach to case management has produced positive results in

locating and engaging potential members for social services, substance abuse treatment and even corrections related agencies.

- Case managers receive referrals from a variety of sources internal and external to the MCHP. The referral system seems well developed and has shown improvement with each review.

  - Case managers from all three MCHPs describe obtaining referrals from PCP and specialist offices, hospitals and concurrent review nurses, pre-authorization staff, disease management nurses, nurse-advice line staff, intake and customer support staff. They speak regularly with the local health departments, Federally Qualified Health Centers (FQHC) staff, and other community resources. The case managers relate that these sources all make direct referrals to case management. All of this information is available from case manager interviews. Although, the MCHP systems may capture the actual referral source, this information was not available in the records reviewed.

  - The case managers describe using the written and traditional lists that create referrals such as the Lead referrals from Missouri Department of Health and Senior Service (MDHSS) and the Special Health Care Needs (SHCN) listing from MHD. The MCHPs have a process to generate member contacts when these lists are received.

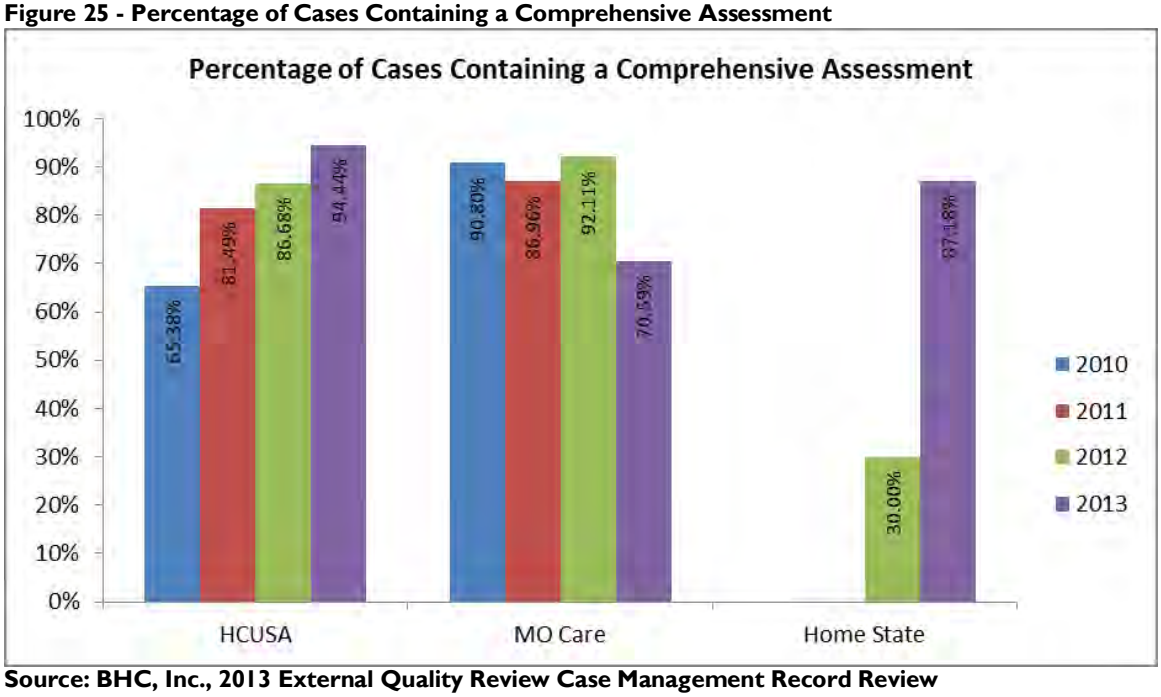
  - The case managers explained that they receive self-referrals from members, or concerned family members, friends, teachers, or other sources. The MCHPs also have "triggers" in place, which create an alert to the case management staff to contact a member to assess that member and their need for services. These triggers include, for example, a member going to the emergency room more than three times in a quarter.

  - Case managers, in the Lead cases opened for older children who had EBLL with no retesting, and no member contacts, did make attempts to contact members. Information found in these records included references to educational materials sent, notes regarding contacts with the assigned PCP, the local health department, and other sources. Case managers had a very difficult time engaging these families or getting any type of cooperation. These cases remain open, with periodic contact attempts to the member or family, per state policy and contract requirements. (HCUSA – 38%;

MOCare – 33%; Home State – 27% of total lead cases reviewed.)

Assessment

Figure 25 - Percentage of Cases Containing a Comprehensive Assessment



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

The assessments found in records are computer generated forms that case managers are required to complete at the beginning of each case assignment. In this manner the contractual requirements regarding assessments are met. During the on-site review interviews, case managers were asked by the EQRO if these forms met their needs in determining the services and resources that individual members need. The responses received indicated that case managers go beyond completing these required forms to ensure that they are aware of the members' true needs and to guarantee that appropriate services are in place. This response was received at all three MCHPs, even when the level of experience varied.

Completion of the assessment forms and inclusion of assessments in the records reviewed did improve at HCUSA and Home State during 2013. The specific data and the standards used to evaluate the assessment of the member's service needs are as follows:

1. Completion of assessment within specified time frames.

- In two of the MCHP's records showed improvement in including the assessment tool in the

record reviewed. HCUSA records included an assessment tool or questions within the case notes 94.44% of the time. This is an increase of 29 percentage points since the case management reviews started.

- Home State showed a dramatic upward trend going from 30% in 2012 to locating assessment tools in 87.18% of the records reviewed in 2013. An increase of 57.18 percentage points is noted. The interviews and evidence in the record reviews indicate that this is due to the case managers' increased understanding of their system and how to include information for review.

- The number of assessments in the case records from MO Care decreased. The number of cases containing assessments or notes indicating assessment information went from the highest level MO Care had achieved of 92.11% in 2012 to an all-time low of 70.59% in 2013. This is a difference of 23.36%. When the records were delivered, the MO Care staff explained that as the result of the change in ownership some records did not include computer generated forms such as assessments and case plans, which the previous owner considered proprietorial. Cases requested that were open during the transition did not include all required information. In some cases the EQRO gave credit for assessments being completed based on information available in case notes, even if the actual assessment form was missing. In spite of this the resulting score remained low. MO Care understood the requirements of a complete case management record at the time they were planning for these changes. Maintaining the integrity of case management records should have been a priority in the transition planning to ensure that members' healthcare needs were not overlooked.

2. Inclusion of a comprehensive assessment is required in each file.

- In the cases from all MCHPs that included assessment tools, standardized questions were asked of all members. Notes were included by two of the MCHPs. In cases reviewed from HCUSA additional information explaining how the case manager evaluated member answers and utilized this information in developing care plans were found in 42.49% of the files. MO Care records included additional case notes explaining or pertaining to the assessment process 40.94% of the time. Additional assessment information in the form of explanatory notes was previously not found in records from HCUSA and MO Care.

- Case managers were asked about the standardized assessment tools. HCUSA case managers report that they find many questions irrelevant to specific members. The case managers describe the assessment tool cumbersome and less than informative for some members. The case managers explain that in these cases it is difficult to evaluate individual members' problems. The case managers have learned how to use the forms in the most effective manner, finding the issues that are pertinent to the individual member, and creating care plans that meet those members' needs.

- At Home State all of the SHCN cases (100%), and 92.86% of the OB case management cases included a systems generated assessment form. It appeared, through information in the case notes, that these were completed with the members' cooperation, even when no introductory information was available.

There continue to be areas of concern that arise from review of the assessment process:

- Reviewers continue to find cases at all three MCHPs where initial information obtained in the screening or assessment do not lead to services being offered to the member. This was found in 16.67% of all of the cases reviewed. Examples include:

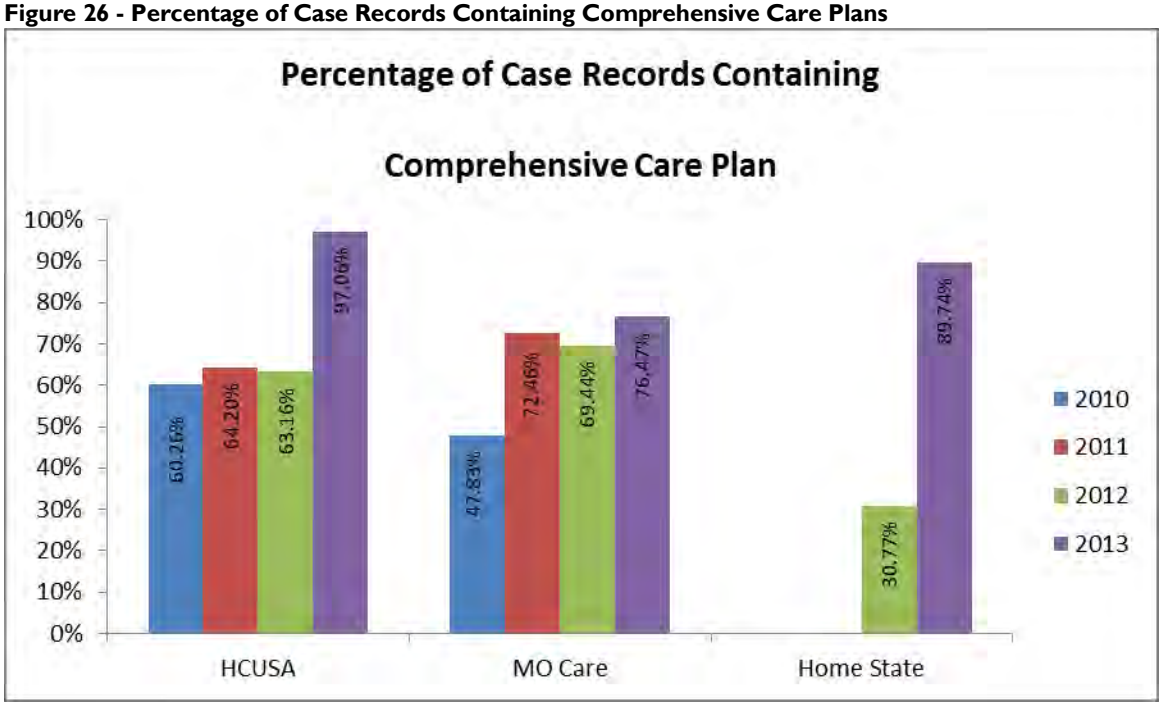
    - Assessments and notes from initial contacts with members indicate a need for behavioral health services, but no referrals to any behavior health provider are found;
    - Multiple medical problems are identified, such as a member reporting to have asthma. There is no indication that educational information was sent, or that a referral to disease management, even at case closure, was made. Case notes did not indicate this condition was ever discussed with the member's PCP;
    - During an initial screening a pregnant member is considered "high acuity," but during the case management assessment there is "no" need for case management and this contradiction is never explained;
    - A member's mother and grandmother request services in a very complex situation, yet the initial screening form under "eligible for Case Management" was answered "No." Case management did occur but how the referral to case management came about or the time frames were not explained.

Assessments are in records because a computer generated form exists, case managers are

required to fill them out, and this then creates a computer generated care plan. In this manner many of the contractual requirements regarding case management are met. During interviews case managers report actions that go beyond completing these required forms, ensuring they are cognizant of members' healthcare needs.

Care Planning

Figure 26 - Percentage of Case Records Containing Comprehensive Care Plans



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

All three MCHPs improved by including care plans in more case records than during prior reviews. HCUSA improved from a rate of care plan inclusion in 2013 to 97.06% and increase of 33.9 percentage points. MO Care showed a slight increase in 2013 to 76.47% or up 6.96 points. Home State included care plans in 89.74% of the cases reviewed. This was an improvement of 58.97 percentage points. These care plans are system-generated directly from the assessment form, and are easily included in the records. This does allow the MCHPs to comply with their contractual obligations regarding care planning.

The standards used to evaluate appropriate care planning require:

1. A care plan in all records:

- The 2013 review included more records with care plans than in the three previous reviews as stated above. These care plans included updated and member specific information. Case managers at all three MCHPs explained that this process is time-consuming and difficult. They want to include goals that are pertinent to the member in each care plan. The case managers redo most care plans. The system-generated plans produce goals that are sometimes absurd for the member involved, and these goals must to be manually deleted by the case managers.

2. A process to ensure that the primary care provider, member, or their primary care giver (parent or guardian), and any specialists treating the member are involved in the development of the care plan.

- Member involvement in care plan development was identifiable in 87.18% of the HCUSA care plans reviewed. This information was included in progress notes and in updates. The correspondence section included the letters to members with opening information including copies of the initial, agreed upon care plan. In cases that were open for longer periods of time, updates sent to the member were also found.

- At Home State, system generated care plans were found in 89.74% of the cases reviewed. However, member involvement in discussing or developing the care plan was only found in 64.10% of the care plans.

- Member involvement was found in 61.11% of the cases reviewed at MO Care. This included careful review of all case notes available.

- The case managers at all three MCHPs explained that their practice is to send an opening letter to PCPs or specialists' offices, with the initial care plan. They state that their practice is to include their contact information and ask for the office to contact them if there is a concern, such as a medical issue the member did not disclose. The case managers reported that they also contact the PCP or specialists' offices to obtain additional information.

Cases reviewed from HCUSA indicated that PCPs were informed and sent copies of the care

plan 87.18% of the time. At MO Care the review found 69.44% of the cases had PCP involvement in care plan development, or the care plan was sent with appropriate correspondence as soon as it was complete. The cases reviewed at Home State provided evidence of PCP involvement only 25.64% of the time.

Additional information provided by the case managers during on-site interviews included:

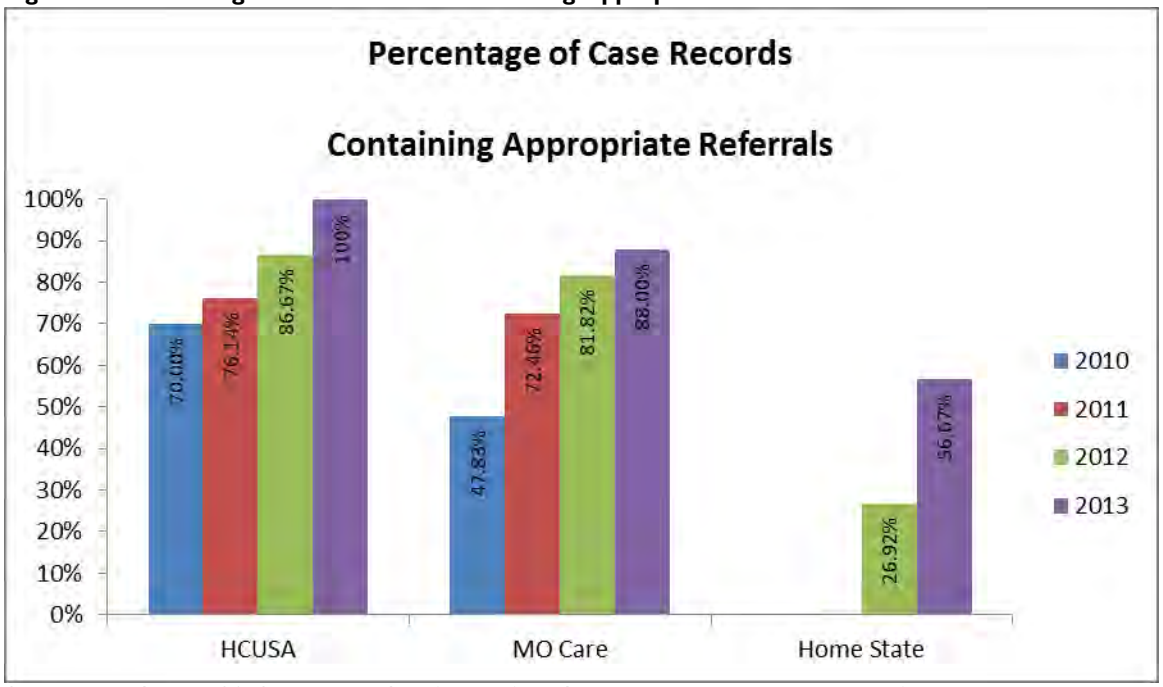
- Case managers at HCUSA report reviewing care plans every 30 to 45 days to ensure that goals remain reasonable and appropriate to meet member needs. If changes are made, a copy of the updated form is sent to the member or parent/representative and the PCP or specialist. The case managers explained that their system provides suggested goals, but allows them to ask questions of members ensuring the care plan reflects the members' true needs. Follow-up and revisions are triggered by reminders from the system. If a member is hospitalized, the case manager revises the care plan prior to discharge whenever possible. Home health providers are used to contact members to ensure appropriate goal are in place at least one time in each case.

- Case managers at Home State use the system generated care plans and state that with their input the care plans are meeting member needs. They use home health and other contracted agencies to make home visits ensuring that the correct goals are in place for members. The case managers verbalized their understanding of the process of developing and assisting the member in obtaining the correct and needed medical services in a timely and efficient manner. They described ongoing training addressing care planning and other skills required of case managers.

- Case managers at MO Care were asked about their system generated care plans. Comments reflected a system that is burdensome and time consuming. They rewrite care plans to meet members' needs. The case managers attempt to enlist the member's input and to inform the PCP or appropriate specialist when they are working with a member. Care plans are not system generated for their perinatal or OB cases. Case managers are able to develop their own problems and goals after they complete the assessment. Case managers described this process as working well enabling them to obtain member and provider input.

Referrals

Figure 27 - Percentage of Case Records Containing Appropriate Referrals



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

The standards concerning appropriate referrals require that the case manager assess members' needs and make referrals as appropriate.

1. The MCHP must ensure that members have referrals to all required providers, physicians, and specialists.
2. Case managers are required to discuss available services: both in the community and MCHP sponsored, such as transportation.

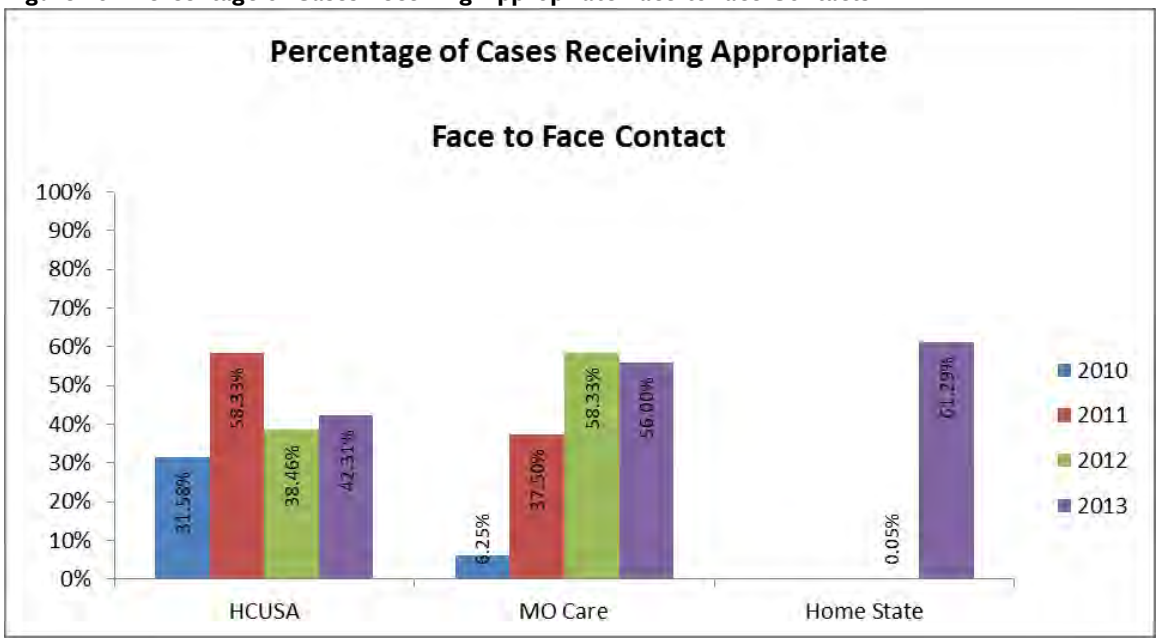
- All three MCHPs improved in 2013 in the area of making referrals for members.
    - HCUSA made referrals and discussed available services, including assisting members in making appointments for transportation, in all cases reviewed.
    - MO Care improved in ensuring that members had the information necessary to obtain services needed. Case managers called community resources for members, told members about available services, explained where they were located, and how members could access the services. They only failed to make referrals, or record this

information in 12% of the cases reviewed.

- Home State doubled the number of cases reviewed where the case managers explained available services. This is an increase from 26.92% in 2012 to 56.67% in 2013. Although this is an improvement it continues to reflect a lack of knowledge about available resources in all regions. Case managers did not exhibit a thorough understanding of the need to make referrals for members, or to educate members about available resources. Case managers acknowledged that they are continuing to learn about available services so they can communicate these benefits to members.

Face-to-Face Contacts

Figure 28 - Percentage of Cases Receiving Appropriate Face-to-face Contacts



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

The Managed Care contract contains standards that require specific face to face contacts for members in lead case management; it states that there should be face to face contacts for members who are pregnant; and in other cases as deemed necessary.

- HCUSA's overall percentage of making face-to-face contacts improved. In the area of SHCN's, where face-to-face contacts are options, HCUSA ensured that members received these services 87.5% of the time when the need was indicated. Face-to-face contacts were

made with members with EBLL in 33.33% of the cases reviewed. The MCHP only requested and ensured that face-to-face contacts occurred in 16.67% of the OB cases reviewed.

- During on-site interviews HCUSA staff indicated that they use contracted agencies to make home visits, and always have. This is not always reflected in their case notes. Case managers report that they make referrals to home health agencies, but members are often uncooperative. They are now recording these efforts in their case notes to more adequately reflect the MCHPs commitment to utilizing in-home services.

- Home State began to utilize face to face contacts to actively support their case management services. These in-home services assist the case managers in locating members and engaging them in case management. They are using different home health agencies in different regions. Case managers explain that they are also trying to utilize agencies without language barriers to better communicate with members, also providing culturally sensitivity. Some of the benefits that Home State has identified include:

    - Better assessment of care gaps to truly meet medical needs;
    - Timely effective antepartum and postpartum assessment for physical and mental health needs;
    - Lead home visits for assessment and education with parents;
    - Direct member services to high risk SHCN members to assess their physical and mental health needs and to provide assistance in arranging PCP visits and follow-up care;
    - Support in navigating community resource requirements; and
    - Providing assistance to pregnant members needing 17P injections or other treatment and education creating improved communication and leading to members obtaining their own follow-up services.

- Home State ensured that face-to-face contacts occurred in 83.33% of the SHCN's records reviewed. In Lead case management records face-to-face contacts occurred, as required, 45.45% of the time. OB records reviewed face-to-face contacts occurred 64.29% of the time.

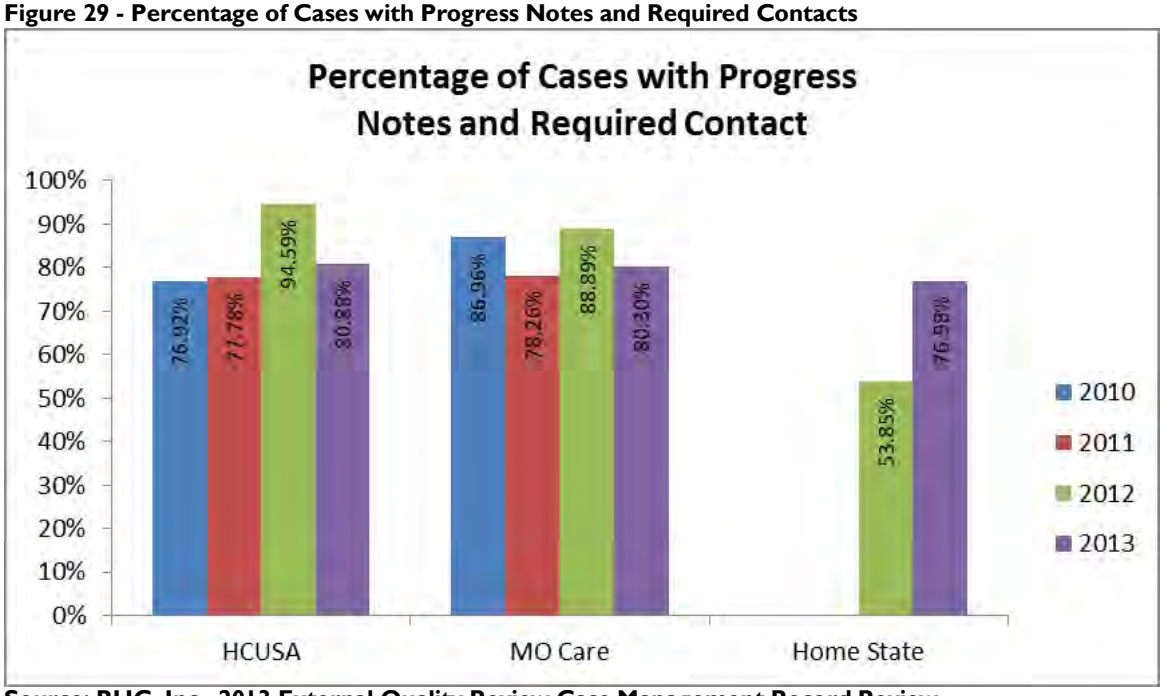
    - MO Care had a slight decrease in the number of cases where face-to-face contacts

occurred (MO Care).

- In the OB/Perinatal cases reviewed 66.67% indicated that face-to-face contacts occurred or had been requested. This is an improvement over the 2012 review.
- In Lead cases reviewed only 33.33% included evidence that an in-home assessment or visit was requested or occurred. This is a decrease from previous reviews.
- In three (3) of four (4) SHCN cases (75%) where home health or other in-home services were needed, they were provided.

Contact with Members

Figure 29 - Percentage of Cases with Progress Notes and Required Contacts



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

There are two standards used to assess maintenance of proper contact with members.

1. Case records are to contain progress notes updated at each contact or at least every thirty (30) days.
2. Case managers are required to have at least three substantive contacts with a member prior to case closing, and these contacts are to be reflected in the progress notes.

- HCUSA and MO Care declined in this area in 2013.
    - HCUSA had progress notes in the records reviewed in required time frames in 91.18%

of the cases reviewed. Evidence was found substantiating required contacts with members in 70.59% of these records.

- In 93.94% of MO Care cases reviewed, the required progress notes were included. Only 54.55% contained information that required contacts occurred.

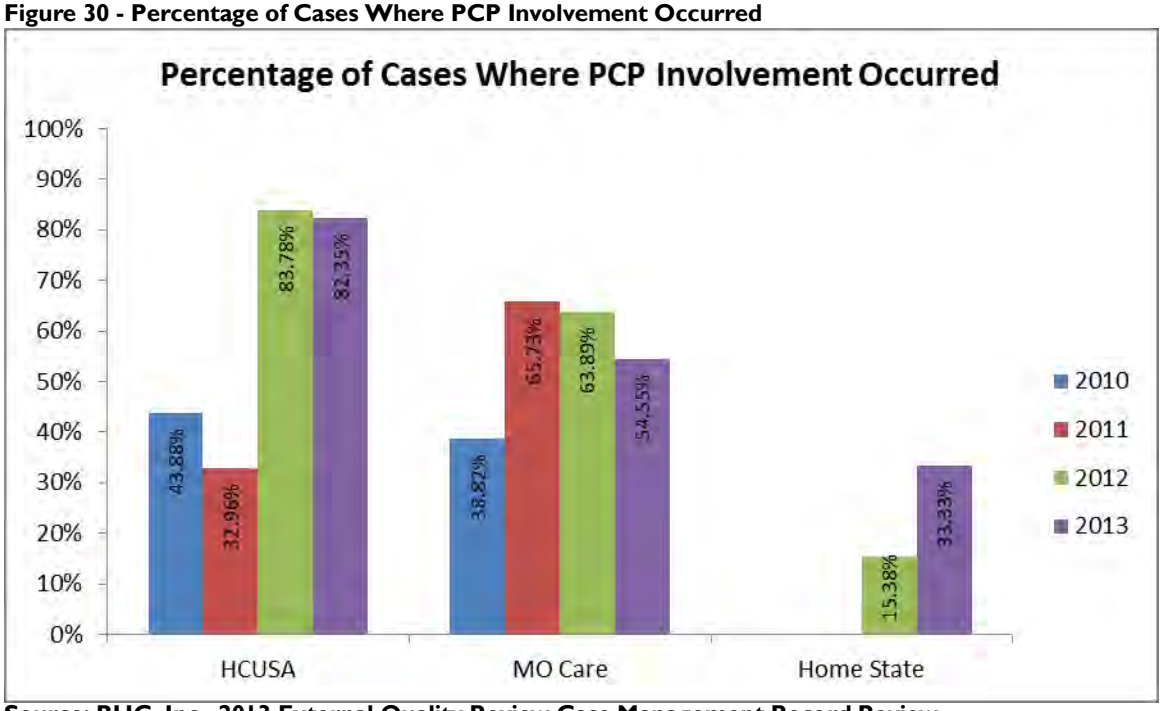
- Home State improved by providing monthly progress notes in over 90% of the cases reviewed, but made contacts with members, as required, only 61% of the time.

- Progress notes are completed in the MCHPs' case management systems. Case managers report that the process for recording attempted and actual contacts with members, providers, or others involved with the member is easier than in the past. This was evident in the cases reviewed, which contained substantive information.

Case managers continue to report difficulty in maintaining engaged relationships with members. They believe this is a barrier to having substantial contacts with them. Reviewers used all resources available, both the progress notes and any contact sheets included, to count the actual and attempted contacts with members.

PCP Involvement

Figure 30 - Percentage of Cases Where PCP Involvement Occurred



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

1. The case manager is to maintain contact with the member's PCP or primary physician.

- HCUSA declined slightly in maintaining contact with PCPs or providers. They continue to properly inform PCPs about their involvement with members. Case managers report this as an important aspect of their involvement with members. The reviews did not provide evidence that information sharing with the PCPs was always occurring after the initial "Welcome" letter and care plan. Closing letters copied to PCP offices were not always in the records reviewed. All Lead cases showed adequate involvement with the PCP or provider. The overall decline was 1.71%. The information obtained during the case manager interviews did not indicate a change in their view regarding this aspect of their work.

- MO Care decreased in providing information regarding their interactions with PCP offices. Case managers report regular contact and good relationships with providers. However, the information available for review did not validate these comments. This is a 14.61% decline.

- Home State did show an improvement of 17.95 percentage points. However, only 33.33%

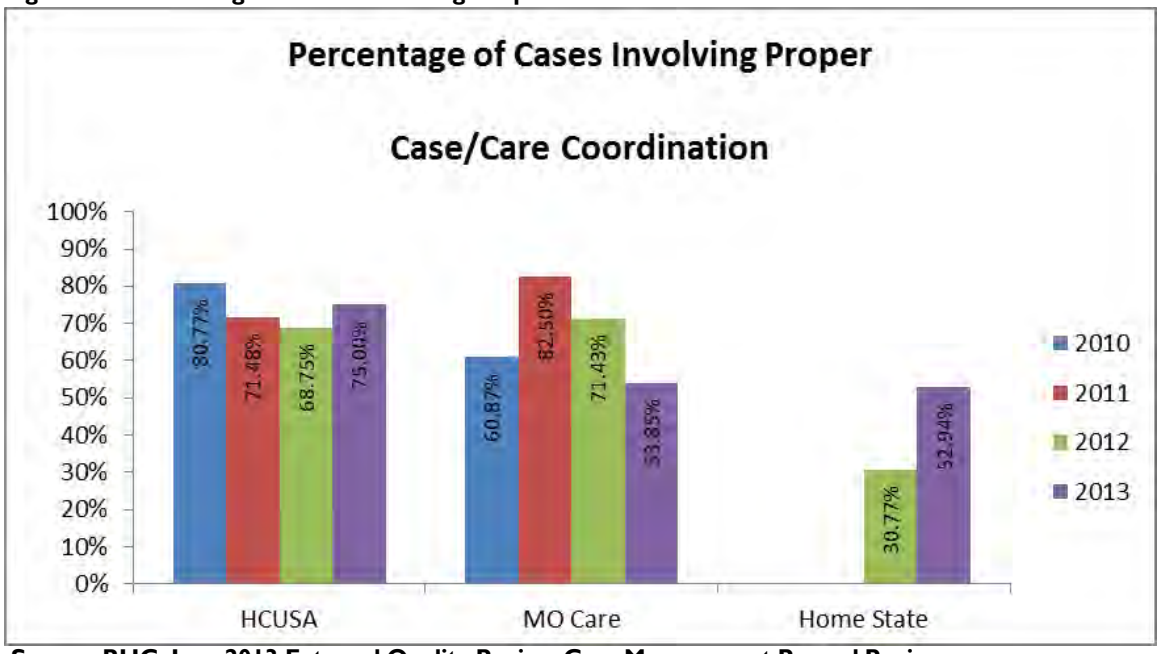
of the records reviewed included information indicating any PCP contacts. Case notes did not reveal relationships with PCPs or their office staff. One record continued to note that the PCP was not contacted due to "HIPAA restrictions." During on-site interviews case managers reported that they have received re-education in the area of PCP and specialist involvement. They now report actively involving PCP and OB offices, and specialists in providing services to members.

2. Case Managers are to inform the PCP at case closing or when the MCHP is no longer providing case management services to the member.

- When cases close, a letter is sent to the member. Cases are often closed due to loss of contact with the member.
- Records reviewed from HCUSA indicate that PCPs and specialists are informed about case closure 81.25% of the time. MO Care cases reviewed indicated that in 61.9% of the cases the PCP or specialist is contacted at case closure. At Home State PCPs and specialists are being informed about case closure 13.33% of the time.

Case/Care Coordination

Figure 31 - Percentage of Cases Involving Proper Case/Care Coordination



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

There are two standards used to assess the category of case/care coordination.

1. Case managers are to recognize the need for coordination of services with other providers involved with the members. This includes following MCHP policy regarding advocating for and linking members to services as necessary across providers and setting, and ensuring that there is communication between providers regarding members healthcare and service needs; and

2. Case managers are to ensure that the availability of behavioral health services is discussed with the member.

- At HCUSA case managers recognized the need for care coordination 75.00% of the time when this service was needed. This is a turn-around from a two year decline. Progress notes reflected members' needs for care coordination. In cases where care coordination was indicated it did occur, and the case notes reflected the methods used to work with other agencies to share information and resources.

- For Home State there was an improvement in the number of cases reviewed that indicated that some type of care coordination occurred. The improvement to 52.94% is a 22.17

percentage point increase. It is not yet to an acceptable standard but the rate of improvement is noteworthy. Interviews with the case managers indicate they are engaging in more care coordination, but it remains an area needing improvement.

- MO Care declined in the aggregate area of care and case coordination at the rate of 24.61%. Case notes did not reflect the open information sharing between behavioral health and medical case managers evidenced in previous reviews. The cases reviewed did include evidence that a need for care coordination was present in 78.57% of the cases reviewed. Actual care coordination only occurred 53.85% of the time.

- In the 2012 review a major area of concern for reviewers was the number of cases reviewed with a need for behavioral health services, such as the report of depression or a bi-polar condition during the assessment. These admissions during assessment appeared to receive no follow-up, offer of referral for services, or a direct referral as the result of a serious situation regarding the member's admitted problems.

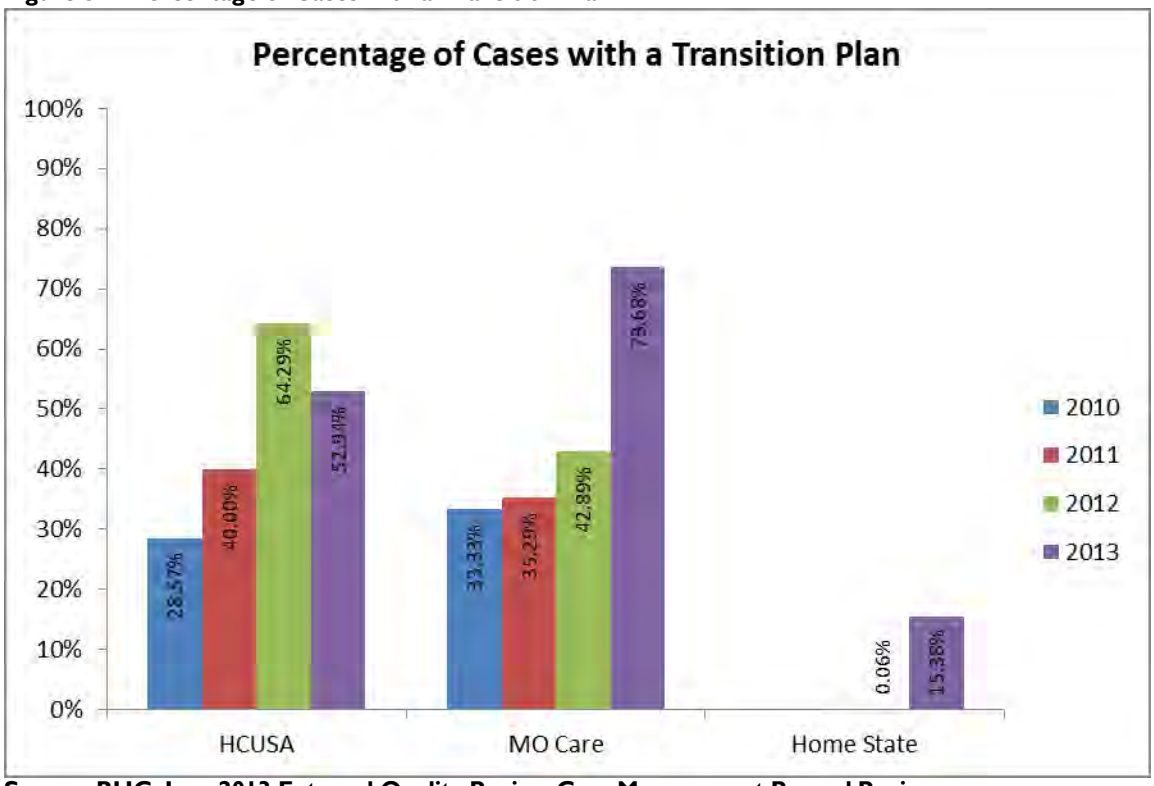
    - During the 2013 review this trend continued. In 30.56% of the cases reviewed for all MCHPs, where depression and/or bi-polar conditions were identified at the time of the assessment, the case records reflected no referrals to behavioral health; or no follow-up to ensure that a member acted upon a referral if a therapist's name was provided to a member. There continues to be a lack of attention to the need for medical case management and the need to incorporate a more holistic approach to ensuring that members' needs are being met. If no referral or subsequent care coordination occurs, case notes should explain why this part of the assessment was ignored.

- When the MCHPs successfully recognized and acted upon the members' needs for complex case management, there was active coordination of care. In these cases member received many unique services often resulting in positive healthcare outcomes. These cases include members with multiple co-morbidities, seeing more than one specialist, requiring as much as daily in-home care, and a variety of types of durable medical equipment. These members require case management interventions several times each week. In some cases they require periodic in-patient hospitalization. The cases reviewed included multiple contacts with a variety of providers, the PCP, and specialists, and assisting members in understanding and negotiating all the systems of service involved. In one case, after months of work not

only advocating for the member, but assisting the mother in understanding the system, the case was closed as all services were in place and running smoothly. The family was aware that they could ask for case management again should the need arise.

Transition at Closing

Figure 32 - Percentage of Cases with a Transition Plan



Source: BHC, Inc., 2013 External Quality Review Case Management Record Review

There are three standards included in appropriately terminating case management services.

1. The case manager must be assured that the member has achieved all stated care plan goals.

2. A transition plan must be developed and the member informed.

- MO Care made significant improvement (71.79%) in making contact with members prior to closing the case management case, and ensuring that they met all the goals developed in the care plan. The members received appropriate correspondence at the time of case closing.

- Home State made improvement in this area. In 2012 closing transition plans were only

found in .06% of the cases reviewed, while in 2013 this improved to 15.36%. This does not approach the desired standard. Case managers verbalize an awareness of the need to continue to expand their member contacts, planning, and communication at case closing.

- HCUSA declined in this area of performance by 17.65%. The cases reviewed did not include case notes indicating preparation for case closing was occurring with members, other than the approved closing letters.

- At all three MCHPs there were cases without transition plans that did include "Unable to Contact" approved form letters to the member indicating potential case closure. There were no attachments or other information sent to the member, or to involved providers, explaining the members' options or plans for them to maintain their independence. This is not in itself transition planning.

3. The case management services must ensure that the proper case closing criteria exist based on the type of case management received.

- Language in approved closing letters stressed the importance of the member maintaining a relationship with the PCP, reminded the member of the availability of the MCHP's nurse advice line, and let the member know they had the ability to contact their case manager. This should not be construed as an actual transition plan, although it does provide useful information to the member.

- OB cases are required to remain open for 60 days after the baby's birth, which coincides with the member's continued eligibility for MHD contract requirements. This is an area where MO Care showed improvement. In its closed OB cases all necessary information was included in the case notes, and there was appropriate correspondence with the member in 81.82% of the records reviewed.

- Home State routinely closed these cases right after the birth of the child at the time of the 2012 review. During the 2013 review follow-up postpartum services were occurring more frequently (28.57%), but all closing information required was not available in the records received.

5.3 Observations for All MCHPs

The EQR is tasked with reporting how "Medicaid Managed Care participants access care, the quality of care participants receive, and the timeliness of this care." The ERO reports on those three areas in each are of validation.

QUALITY OF CARE

When members are properly introduced to and engaged in case management the quality of service delivery improves. Case managers maintain contact and in some cases advocate for extraordinary services to meet members healthcare needs.

- In 2013, reviewers observed a lack of attention to including all necessary information in case notes. At one MCHP (MOCare) introductory information was not available in over one half (48.65%) of the records reviewed. The MCHP believes this was the result of lost information after a change in ownership, but this is difficult to assess. At one MCHP (Home State) a lack of attention to the introductory process, including noting the member's agreement to accept case management, and an acknowledgement that they have explained third party disclosure or asked about this issue, continues to be a concern (occurred in 5% of the cases reviewed). Even if this is a problem regarding case recording, it is a problem at the beginning of the case management process and reflects negatively on attention to member needs.
    - At all MCHPs case management services provided referrals and ensured that members were aware of available resources and how to access needed services. This reflects a commitment to ensuring that members receive quality care and supportive services, as well as excellent health care. They used MCHP sponsored services, linked members to community resources, and ensured the outcome of improved member health was met.
    - The MCHPs are committed to ensuring that members' PCPs and specialists are aware of their involvement with the member. It is standard practice to include a letter to the PCP or specialist as soon as a care plan is completed so the provider is aware of the case manager's involvement with the member. This assists in ensuring that the member has the advocacy and attention needed to meet their health care needs.
    - Case managers report that they communicated with the physicians or their staff regularly.

- Case managers assisted members in achieving their goals and stabilizing their health care conditions.

- In case records indicating contact with the physician's office, case notes reflected a depth of knowledge about the member that appears essential in providing comprehensive case management.
  - These cases included many contacts with the physician's nurse or nurse practitioners.
  - Physicians responded directly to inquiries and questions from the case managers.
  - When contacts occur the case notes indicate better and more complete service delivery.

- A number of issues that impact quality were observed that continue to need improvement. These include:
  - Ensuring that all members are properly introduced to the case management process and all permissions and agreements are reflected in the case notes;
  - Informing or including the PCP in care plan development;
  - Ensuring that all members expected to receive face-to-face contacts have access to this service;
  - Completing and communicating a transition plan with members that provides direction and information; and
  - Informing the PCP and other providers when case management ceases.

- Quality of care is improved when services included care coordination in complex cases.
  - Case managers identified members with high risks and multiple issues requiring more than one provider or case manager to be involved with a member's care. Ongoing case management, facilitated discussions between providers, and ancillary services in place, all led to members having positive health care outcomes.
  - Members with multiple issues and complex cases were identified and case management initiated.
- In the area of lead case management, member's quality of care was sometimes negatively affected.
  - Lead case management is required for all children with an identified elevated blood lead level – even if testing was not recent. At all MCHPs many cases opened for older

children have been difficult to serve. Families and members are unresponsive, and often refuse retesting. These cases show little progress and are difficult to manage.

- Lead cases are not treated with the same urgency seen in other types of case management. Renewed attention to the services needed in these cases would benefit members and their families.

ACCESS TO CARE

- Access to care was enhanced when case managers actively worked with families. In a number of cases reviewers observed creative and relentless efforts to locate members. MCHPs are often using contractors who "drive by" members reported addresses to learn if the member is actually living there and to obtain forwarding information whenever possible. Case managers contact a variety of sources to track members' whereabouts and make required contacts. In many instances the MCHPs are partnering with home health agencies to ensure that members follow through on their part of a case plan and obtain the services they need.

- Access is improved by case managers' efforts to obtain services, community or provider based, which uniquely met members' needs.

- Access was improved when case managers remained in contact with members receiving OB services. This ensured members' access to services such as a follow-up with their OB-GYN, and a first visit to the pediatrician for the baby.

- The following problems were observed and had a less desirable effect on members' access to services and health care:
  - Case managers lost contact with members who had newborns at the end of the case management process and no transition plan was developed.
  - Face-to-face contacts are still not occurring as often as necessary, even when a contracted provider is authorized to see the member and reporting their contacts. In some of these cases the member did not receive services as needed, which negatively impacted health care outcomes.
  - When consistent case/care coordination occurred case managers avoided duplication of services, and maximized MCHP resources. However, a lack of these practices negatively affected members' access to care when it did not occur.

TIMELINESS OF CARE

When case managers are actively serving a member; fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

- When case management occurred in OB cases reviewed (including the sixty (60) days postpartum,) follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within these time frames. Parents who received these services often enrolled their babies with the MCHP and ongoing preventive care could occur.

- Case managers continue to report that they are unable to create a useful transition plan with the member when it appears the case should be closed.
  - It often appears that after members' health care needs are met, the member loses interest in case management and no longer returns calls or responds to letters requesting they contact the case manager. Case managers at all MCHPs find this troubling, but have had little success in changing member behavior. They do point out that they often hear from members months later when a new problem arises. The members tell them "that I still have your card and number."

- Information sharing with PCP offices and sending a letter at case closing requires improvement.
  - Case managers' lack of attention to this aspect of service delivery negatively impacts members' ability to obtain needed services in a timely manner.
    - Case notes reflect that in many instances instructions are given to the member, with the hope that they will take responsibility for follow-up and timely self-care.

    - The case managers admit that when they have a relationship with the physician's office it is beneficial to their work with the member.

    - Timeliness is greatly improved by ensuring that members, particularly members with special health care needs, obtain all necessary medical services with some oversight.

- Case managers believe there is information available that was not found in the case notes. They say they are talking to provider offices regarding most of their members regularly. If this is actually an issue of appropriately using their case management/case note system, this must be corrected.

RECOMMENDATIONS

1. Case managers should copy their own records when cases are requested or should ensure that all required information is submitted. The case notes should include information indicating an understanding of the information collected through the assessment process or tool, and explain how this drives the services provided to the member. Case managers reflect that they have access to a great deal of information in their case management systems. When cases were requested for the 2013 review, a reminder was included asking for all case documentation. It appeared that the records received did contain a great deal of information but case notes did not contain complete information.
2. The MCHPs should continue to invest in a model ensuring that members receive the face-to-face contacts required. This may be more direct contact with members, or better progress notes when a contracted entity is used. Many of the MCHPs "best practices" and PIP outlines reviewed by the EQRO include projects requiring in-home and intensive case management. This type of commitment should be available in the cases reviewed.
3. Lead Case Management should include active attempts to make a contact with the member or member's family. A relationship should be established. Opening a case in the system and checking on the member's progress with the local health department does not constitute case management services. However, if members truly cannot be located, follow-up with the local public health entity, PCPs, schools, and any other agency having contact with the member must be pursued to ensure that the child's lead exposure and EBLL are resolved.
4. Renewed attention is required of the lead case management program. Many of these cases include multiple children and often include additional medical issues. Complicating families' situations by failing to coordinate case assignments or contacts leads to a lack of cooperation and confusion, which is often perceived as a negative response from the member or family, rather than their being overwhelmed. Case managers may have

more success if there was one case manager per family, rather than one case manager per member, per medical issue.

5. Each MCHP must continue their commitment to finding "hard to locate members." These are often the members who will truly benefit from the receipt of case management services.
6. Complex case management, care coordination, and in some cases disease management, are not consistently defined at each MCHP. This creates confusion in requesting and reviewing cases.
7. Concerns remain about the number of cases actually opened for case management. Locating and identifying these members, and engaging them in the case management process, is critical to meeting members healthcare needs. Ensuring that MCHP members actually have access to case management services remains a concern.
8. Case notes should reflect attention to the services indicated as needed in initial and on-going assessments. If an assessment indicates multiple service needs, including behavioral health, how these needs are met must be reflected in the case notes. If an initial intake indicates that a member has "high" needs, and the complete assessment finds this is not accurate, this should be explained in the case record.

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6.0 Healthcare USA

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6.1 Performance Improvement Projects

METHODS

Document Review

HealthCare USA supplied the following documentation for review:

- Reducing the Re-Admission Rate for Asthma Patients Project
- Statewide Performance Improvement Project – Improving Oral Health

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 25, 2014, during the on-site review, and included the following:

Laura Ferguson – Director of Quality
Rudy Brennan (telephone) – Quality Improvement Coordinator
Carol Stephens-Jay – Senior Health Care Consultant
Dale Pfaff – Quality Improvement Coordinator
Beverly Chase – Quality Assessment & 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 and suggestions were addressed:

- Discuss the study topic choice and why this change will create an improved health outcome for members.
- Clarify the study indicators and how they will reflect improved member outcomes.
- How does HCUSA use the data available to inform the MCHP about the success of proposed interventions? How will external data, such as that received from a vendor, influence the outcome of the study?
- How is the MCHP updating studies from year to year to integrate information into their current processes and keep them current?

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. HCUSA was instructed that they could submit additional information including enhanced outcomes at the time of the on-site review. The final evaluation was based on the

updated information received.

FINDINGS

Clinical PIP – Decreasing Hospital Readmissions

Study Topic

The first PIP evaluated was the clinical PIP submission entitled "Reducing the Re-Admission Rate for Asthma Patients Project." The study topic presentation explained that the motivating factors of this study were to find new and unique tools to reduce unnecessary readmissions for MCHP members who had been hospitalized due to an asthma related illness. The research completed by HCUSA justifying the topic selection included national, state and MCHP specific data. This research provided support for the topic choice as asthma is a chronic and serious healthcare condition. The research looked at member needs and the severity of their concerns. This information was supported by all levels of the literature review. The presentation connects inadequate treatment and medication adherence to frequent emergency department visits at the local and national levels. HCUSA further supports the need to impact this issue by stressing the need to reduce morbidity for their membership while subsequently reducing unnecessary healthcare resource utilization at the State level.

Focusing HCUSA resources on reducing unnecessary hospital readmissions for members with asthma related illness is designed to ensure that members receive the appropriate services in the appropriate setting. It also aids in member understanding of the availability of services that best meet their healthcare needs.

Study Question

The original study question presented for this project was:

- Can the use of an in-home asthma education in collaboration with ongoing telephonic enhanced intervention, decrease the rate of hospital re-admissions within 30 days for members with a diagnosis of asthma?

The study question communicates its scope and goal. The study question is clear and measureable. Additional information was presented regarding how the home health vendor will be utilized as an integral member of this team. The benefits that will be targeted toward the members, assisting them in taking advantage of available resources and achieving the desired

goals were also defined.

Study Indicators

The study indicator and its goals were provided. The indicator information included a description of the numerator and denominator. The narrative explained how current data would be compared to the 2012 baseline data, and how this will be controlled and tracked in 2013, and in subsequent years. The baseline indicator and the specifications of its development were included. The information included adequate documentation explaining how data will be obtained and how the MCHP and ensure the validity of any vendor data utilized. They also described how they will determine that improvements in data are associated with improved member outcomes.

Study Population

The performance improvement project is focused on HCUSA members with an inpatient admission and a diagnosis of asthma. It is open to all MHD regions and all qualified members. Beginning in January 2013 the MCHP reviewed all admissions and re-admissions within thirty (30) days of discharge. The study included all members with a primary or secondary diagnoses of asthma (ICD-9-CM codes were provided).

Study Design and Data Collection Procedures

The study design presented explained the data collection methodology in detail. How claims are received, who will be included in the project, the services that are offered and all other pertinent information was included. The narrative description provided a detailed analysis of every aspect of the study design. It explained data collection, sources, and methodology. The study design further provided a detailed explanation of how vendor information will be collected and monitored to ensure compliance with the MCHP's QI processes. Referral information will be sent to the MCHP on a monthly basis, quarterly compliance meetings will be held, and quarterly reports run to ensure that all members who should be served are being served. After all aspects of gathering and utilizing systematic and reliable data are achieved, the QI Coordinator will analyze all numerators, denominators and rates for validity. The Project Lead then collects and analyzes the monthly, quarterly and annual QDWA (data warehouse) and home health vendor data reports.

A complete and detailed prospective data analysis plan was presented. The MCHP will use quantitative data representing the population having asthma and the number who have had an inpatient admission. This is compared to those receiving enhanced interventions and will be compared to the rate per 1,000 members with a re-admission in a 30-day period. This rate, each year will be compared to the baseline data for calendar year 2012. The goal of the PIP is to determine if the planned intervention made a significant difference, on the rate of plan members with asthma with hospital readmissions. The MCHP purports that an avoidance of an inpatient readmission directly and materially represents an improved health outcome for these members.

The name of the project leader was provided. All team members and their qualifications or roles in completion of the study were specified.

Improvement Strategies

The interventions utilized in this study, their rationale, and the manner in which they were implemented is described. The MCHP, in collaboration with the home health vendor will form an enhanced intervention team. This team will conduct a list of intense activities focused on ensuring that each member in this study has access to education and services that will prevent an unnecessary hospitalization. The MCHP prepared a detailed barrier analysis, which included a desired outcome to be achieved through the implementation of the improvement strategy. The narrative provided information allowing an assessment of what is being done, the desired outcome, the responsible staff for the intervention, and the date of implementation.

Data Analysis and Interpretation of Results

The MCHP conducted a thorough analysis that included all aspects presented in the prospective plan. The analysis included a discussion of the goal and the results based on the first year using the described intervention. The MCHP did a drill down explaining how members were compared, thusmaking the results clear and understandable. They tied the results to members' actions post hospitalization:

- Those who were referred to intensive intervention but did not participate due to refusal, a "bad" telephone number, or did not complete even one home visit (even though it was attempted);

- Those who were referred, but were re-admitted before the intervention began; and
- Those who were referred and completed at least one visit.

The analysis included statistical significance testing that indicated that this project has had a positive impact on members based on the data available.

Assessment of Improvement Process

The study presents information on the main barrier to impacting the member, which is the inability to contact them. The most common reason cited is a failure to capture a viable telephone number, or a member/parent who would not take the call from the home health provider. This group constituted 60% of the population discharged from inpatient treatment. The MCHP plans to continue this project with a new "Plan-Do-Check-Act" methodology woven into their intensive intervention plan. This will be the 2014 addition to this study.

Assess Real and Sustained Improvement

HCUSA has implemented a creative intervention in this project, and identified an enhancement to implement in the next project year. Although it is too early in the project to assess real or sustained improvement, the commitment to intensive and in-home case management has promise when compared to the research on effective in-home case management.

Conclusion

HCUSA identified an issue defined as problematic for members that negatively impacted their quality of life and health. The research and study development led them to collaborate with a home health partner and create a fresh approach to impact member behavior and improve health outcomes. The PIP documentation includes narrative that explains each component of the study in detail making it understandable and easy to evaluate. The EQRO encourages the MCHP to continue this approach.

Non-Clinical PIP – Improving Oral Health

Study Design

The second PIP evaluated was the MCHP's approach to the Statewide PIP "Improving Oral Health." This study is a non-clinical project clearly focused on improving members' health care. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP combined report documentation. HCUSA focused their topic discussion on the needs and circumstances of their members. Regional and national information was utilized from a literature review. The information presented included the connection between oral health and general health, and the importance of including good oral health for the prevention of serious physical health issues. The MCHP was an involved and instrumental member of the Oral Health Task Force that developed and updated this statewide project. Their commitment to this issue is evident in the statewide project as well as in the PIP representing their approach to impacting this area of concern.

Study Question

The original HCUSA specific question presented is:

- Statewide – "Will providing the proposed interventions to MO HealthNet Managed Care eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3% between HEDIS 2012 (data from calendar year 2011) and HEDIS 2013 (data from calendar year 2012)?"
- (Update 2013) "Will providing the proposed interventions to MO HealthNet Managed Care eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3% between HEDIS 2013 (data from calendar year 2012) and HEDIS 2014 (data from calendar year 2013)? The 3% increase in the Annual Dental Visit total rates will be measured both as an aggregate of all health plans as well as for each health plan individually on an annual basis. (Measurement from last year to year prior.)

The narrative points out that the 3% increase in the Annual Dental Visit total rates will be measured both as an aggregate of all MCHPs, as well as for each MCHP individually, as part of the statewide PIP initiative.

The updated HCUSA specific questions are:

- "Will member and provider reminders and education improve the HEDIS rate of annual dental visits as evidenced by a 3% increase in 2014 HEDIS annual dental visits?"
- "Will the addition of targeted provider-assisted, care-centered promotions and dental events improve the regional HEDIS rates for annual dental visits (ADV) by 3%?"

The inclusion of the second question expands HCUSA's focus to engaging providers in the

improvement process – for the benefit of plan members. The study questions are complete and clear. They recognize that HCUSA's success is part of the state total, and reflect their responsibility in generating improvement for their members.

Study Indicators

The indicator is presented and explained in the narrative in a clear and concise manner. It is concentrated on the HEDIS rate which is quantifiable and measureable. It draws a relationship between the interventions, their association with the study question, and the likelihood that a positive impact will occur. The numerator and denominator are provided. This PIP is focused on the process of care, improved Annual Dental Visits, and strongly associated with improved healthcare outcomes.

Study Population

The study population will consist of all MCHP eligible members from the ages of 2 through 20 in the measurement year, as defined by the HEDIS Technical Specifications for the ADV. No one is excluded.

Study Design

The study design presented all of the data to be collected and the methodology used. It specifies all data sources. A database report is generated from the subcontractor, DentaQuest's, claims system. This data is then loaded automatically into the Coventry Data Warehouse. It is sent through a series of system set-up controls and quality controls to ensure data accuracy. The narrative explains how the HEDIS Annual Dental Visit rate is calculated for the entire population, how this is loaded into NCQA certified software, with oversight by IT specialists. The narrative describes a systematic method for obtaining and assessing the data received. The HEDIS outcome reports are produced by a Coventry HEDIS team. Additional details, including the CPT codes to be queried, are all provided. Specifications for data analysis are included. The manner in which these outcomes are reported is provided. All numerators, denominators and rates are analyzed for validity and consistency.

HCUSA points out that their baseline data does not follow the HEDIS "allowable gap" criteria. The MCHP includes all members in the MHD managed care population in their education

regarding proper dental care. By providing education to all MCHP members, the HEDIS population will be captured.

The progress of each intervention will be tracked and updated on a quarterly basis. Coventry developed a new analysis tool in 2010 that allows HCUSA to review, analyze, and compare monthly HEDIS rates. For example, enhanced member and provider education and community outreach are part of the improvement strategy. If these areas need added attention through the measurement year this becomes evident and can be implemented in a timely manner.

The prospective data analysis plan is understandable, clearly presented, and provides confidence that the PIP was developed with these issues in mind. All barriers or inconsistences are addressed, including methods to overcome these barriers and complete a thorough data analysis. The MCHP presented a well-developed data analysis plan with updates for 2013. The team members, their responsibilities, and qualifications are described in detail.

Improvement Strategies

The original HCUSA specific interventions implemented included:

- Floating Dentists (dentists who agree to rotate through rural areas);
- Partnering with Community Advocates and Events;
- Collaboration with schools/nurses; and
- After hours/weekend scheduling.

In 2012 the MCHP developed subgroups based on their most effective interventions. These included:

- Collaborating with school administrators and school nurses, which started in 2009;
- Partnering with Community Advocates and Events, which started in 2010;
- Promoting providers with after-hours/weekend scheduling at Back-to-School fairs, which started in 2011;
- Collaborating with DentaQuest on the Smiling Stork initiative, started in 2012; and
- Mid-year 2013 HCUSA Teamed with the other MCHPs and the Oral Health Care Task Force Members to adopt consistent goals including providing preventive and oral sealant activities beginning in the last quarter of 2013.

Specific 2013 PIP interventions pursue the above-referenced categories. The MCHP then incorporated the following activities in concert with the Community Outreach Team:

- HCUSA collaborated with the Reach Out Dental Van to coordinate events targeting non-compliant members for preventive and sealant applications. They used the Dental Van at selected schools. HCUSA selected eight (8) schools and provided that list to the Reach Out team, who was able to go onsite to three (3) of the schools selected.
- The Project Lead supplied current DentaQuest Provider lists for several Back to School Fairs as a method of providing the parents a list of dental resources within their community.
- Continued to sponsor Doc Bear Days at willing dental provider locations.
- Outreach telephone call to members that have not yet seen a dental provider.

These interventions, their purpose, and a thorough barrier analysis were presented. The MCHP's reasoning and the history leading to the choices of these interventions were explained in detail.

Data Analysis and Interpretation of Results

The findings and their analysis were presented in the documentation submitted. The analysis did correlate to the prospective data analysis plan. The MCHP presented information including baseline and repeat measurements. It presented a barrier analysis and a discussion of environmental factors that might have an impact on outcomes. The analysis looked at the results regionally and analyzed statewide outcomes. The information discussed the validity of the interventions and their relationship to the outcomes.

The data supporting the improvements in the HEDIS rates was understandable. The data was presented for each region and statewide. This included the growth over the base year in percentage points and the percent increase over the base year. In all three regions the aggregate numbers indicate an improvement of 15.82 percentage points from the 2008 Statewide baseline rate to HCUSA's 2014 HEDIS ADV rate of 50.67%. The analysis asserts that the numbers reflect an increased access to providers, and the ability to track and trend information on a monthly basis. Statistical significance testing, using Chi Square analysis, indicating statistically significant change for each project year was included. The analysis presented included the baseline year, and a year to year, as well as an aggregate improvement rate regionally and statewide.

The narrative states that HCUSA has met the goal of 3% improvement each year. The MCHP continues to pursue methods to engage more of its membershipto take advantage of the

opportunity to obtain good dental care, which improves the ADV rate. The discussion relates the specific impact of these interventions to the success achieved. "The P values for all three regions for HEDIS 2014 (P=0) represents a statistically significant change. The data analyses for all three regions for the HEDIS years 2009-2013 have also calculated the P value as P=0. The P value for all three regions in the study is statistically significant." The statistical changes are attributable to the evolution of the interventions; primarily the consistence of provider and member education, mailed member reminders, and sponsored, provider-assisted clinical events (Doc Bear Days). All of this information was presented, and provided with a complete and thorough analysis.

Assessment of the Improvement Process

HCUSA has continued successful improvement strategies, built on these successes and introduced new methods to create additional success. Their current efforts focused on utilizing Community Relations staff to engage and educate members who had failed to obtain their annual dental visits in the past. They will continue to use collaborative initiatives in this process. The MCHP continues to enhance their efforts, and indicates an ongoing commitment to serving members effectively, while meeting state determined goals for this project. Their successful improvement strategies and ability to analyze areas where additional improvement can be achieved is evident. The data demonstrates continued increased rates for Annual Dental Visits. The initial and continued improvement points to the fact that the interventions utilized had a direct impact on member behavior.

HCUSA argues that real improvement depends upon continued education and ongoing change in member behavior. They are committed to continue to provide educational efforts for this purpose. They have devised new interventions to enhance the improvement already achieved. They plan to continue their efforts to maintain and escalate their success. The MCHP analyzes processes so they can maintain the correlation between the improvement activities and the ADV HEDIS rates.

Assess Sustained Improvement

HCUSA has made changes and enhanced efforts to create success throughout this PIP. The PIP Team developed new strategies and interventions. The MCHP is involved in the statewide PIP efforts and has acted in a leadership role for all the MCHPs in ensuring that this PIP remains successful. This investment in the success of this PIP is indicative of their commitment to improving oral health for members.

Conclusion

HCUSA intends to enhance efforts to ensure their members receive excellent dental care, beginning with obtaining their annual dental visit. They have efforts in place to collaborate with their subcontractor and to address this issue with MCHP staff. They provided the criteria they will use to make future assessments of project outcomes. HCUSA has made successful strategies part of their organizations' normal work activities and continues to devise new initiatives to ensure that the outcomes achieved to date continue.

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The clinical PIP began as a way to identify unmet member needs, and then developed into a focus on prevention of unnecessary inpatient services. The non-clinical PIP sought to significantly improve rates of annual dental visits. HCUSA has experienced success with the interventions developed in both areas. The focus of the clinical PIP was improving the quality of health care for members by improving members' ability to avoid hospital readmissions whenever possible. The MCHP recognizes the need to help members obtain services that meet their needs and are of the highest quality. Their goal is to help members access the most appropriate level of care at the right time in the right place.

Access to Care

The clinical PIP focuses on access to care by providing intensive and in-home services to members with asthma in an effort to avoid unnecessary re-admission to the hospital. The study sought to ensure that members receive services to enhance their knowledge of how to maintain and control their asthma in a preventive manner. The non-clinical PIP was based on the theory that improving availability and access to dental care will improve the overall health of the members served. The supporting documentation indicates that these PIPs will improve access to services.

Timeliness of Care

The clinical PIP improved the timeliness of appropriate services for members who required a hospital admission. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcomes indicate positive results. The MCHP will continue this PIP with new and enhanced interventions. Timely access to intensive in-home aftercare was an important focus of this PIP.

The non-clinical project also looked at timeliness. The narrative discussed how the interventions employed would improve the members' awareness of the need for annual dental screenings and how engaging and educating providers about their role, in ensuring that members come in for dental visits, is understood. The PIP focuses on reducing barriers to obtaining these services by partnering with the MCHP Community Outreach staff. HCUSA will continue to enhance members' ability to access services on a timely basis through their innovative approaches to providing member services.

RECOMMENDATIONS

1. The format of all PIPs should continue to contain complete narrative information on all aspects of the project to ensure that the project is understandable and complete. The data analysis included in these PIPs was excellent. This method of reporting outcomes enhances the evaluation process and should continue.
2. HCUSA continued to address how their projects are extended to and pertinent to all the MO HealthNet Regions served. Analysis of the regional differences would benefit the project evaluation and guide further interventions.
3. HCUSA indicated the processes described in both PIPs will be incorporated in the organization processes as success is determined. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.
4. HCUSA has continued their process of identifying quality issues that may benefit from being developed into a PIP. The MCHP presented new clinical PIP ideas for technical assistance during the past year. As these projects are developed and new ideas are generated, this technical assistance process should continue.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for HCUSA. HCUSA submitted the requested documents on or before the due date of March 4, 2014. The EQRO reviewed documentation between March 4, 2014 and June 17, 2014. 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 HCUSA NCQA RoadMap for the HEDIS 2013 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2013
- HCUSA's policies and procedures with regard to calculation of HEDIS 2013 rates
- HCUSA 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 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 2013 Data Submission Tool
- HEDIS 2013 product work plan

Data files were submitted by HCUSA for review by the EQRO, these included regional files for each of the three Performance Measures audited.

INTERVIEWS

The EQRO conducted on-site interviews at HCUSA in St. Louis on Tuesday, June 24, 2014 with staff responsible for calculating the HEDIS 2013 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2013 performance measures.

FINDINGS

Two of the HEDIS 2013 measures being reviewed (Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness) were calculated using the Administrative method, and the third measure (Childhood Immunizations Status) was calculated using the Hybrid method.

The combined rate for the HEDIS 2013 Annual Dental Visit measure reported by HCUSA to the SMA and the State Public Health Agency (SPHA) was 47.37%. This was higher than the statewide rate for all MCHPs (46.69%). This MCHP's rate has trended upward over the past three EQR report years, from 41.87% in 2010 to 47.37% in 2013 (see Figure 20 and Figure 33).

The reported Childhood Immunizations Status rate was 65.28% this was higher than the statewide rate for all MCHPs (59.47%). This is the third year the Childhood Immunizations Status (combination 3) measure has been audited by the EQRO, and HCUSA has shown a steady increase in this rate, with rates of 54.63%, 61.56%, and 65.28% reported in years 2011, 2012, and 2013 respectively (see Table 20 and Figure 33).

The 7-day rate reported for the Follow-Up After Hospitalization for Mental Illness measure by HCUSA was 36.51%, which is comparable to the statewide rate for all MCHPs (36.66%). Unfortunately, this is the second year in a row since the EQRO has validated this HEDIS measure, that it has decreased from the prior review year. This is the lowest rate reported by HCUSA for this measure since 2009 when the rate of 43.80% was reported. This measure was audited in HEDIS 2010, 2011, 2012 (48.41%, 50.25%, and 49.63% respectively) (see Table 20 and Figure 33.)

The Follow-Up After Hospitalization for Mental Illness measure 30-day rate reported by the MCHP (63.59%) was **higher** than the statewide rate (63.00%). This rate has fallen from 2012 when the highest rate was reported (71.67%) and is lower than the rate reported in 2009 of 69.62%; (see Table 20 and Figure 33).

At the on-site review, the decrease in these rates was discussed. The MCHP stated that the decreased rate was attributable to a software glitch in their NCQA-certified software, Inovalon. It was explained that the date of service was not being pulled accurately by the software.

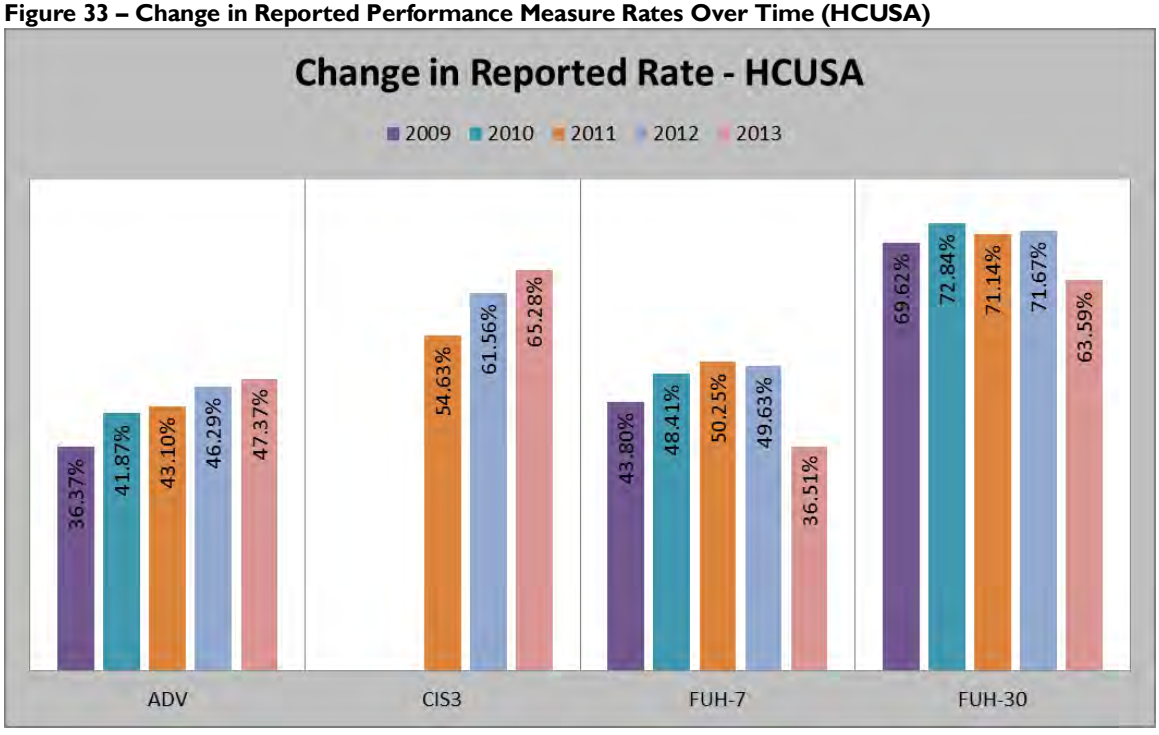
Specifically, if a claim form had more than one date of service, the system was not capturing all of the dates of service. This error has since been corrected and HCUSA assures the EQRO that the rate will show a significant improvement for HEDIS 2014. Unfortunately, HCUSA is unable to correct the rates with NCQA, as they do not accept corrected rates.

Table 19 – Reported Performance Measures Rates Across Audit Years (HCUSA)

Measure	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate	HEDIS 2012 Rate	HEDIS 2013 Rate
Annual Dental Visit (ADV)	36.37%	41.87%	43.10%	46.29%	47.37%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	NA	54.63%	61.56%	65.28%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	43.80%	48.41%	50.25%	49.63%	36.51%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	69.62%	72.84%	71.14%	71.67%	63.59%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year
Source: MCHP's DST's HEDIS 2009-2013

Figure 33 – Change in Reported Performance Measure Rates Over Time (HCUSA)



Sources: BHC, Inc. 2009-2013 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.

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, HCUSA was found to meet all the criteria for producing complete and accurate data. There were no biases or errors found in the manner in which HCUSA transferred data into the repository used for calculating the HEDIS 2013 measures.

Documentation of Data and Processes

Although HCUSA 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 acceptable. HCUSA met all criteria that applied for all three measures.

Processes Used to Produce Denominators

HCUSA met all criteria for the processes employed to produce the denominators of the performance measures validated. 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.

Processes Used to Produce Numerators

Two of the three measures were calculated using the Administrative Method (ADV and FUH). The third measure (CIS3) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g., well-child visits, follow-up visits, or dental visits) as specified by the HEDIS 2013 Technical Specifications. Appropriate procedures were followed for the sampling of records for medical record reviews.

HCUSA reported a total of 50,188 administrative hits for the Annual Dental Visit measure; 50,188 hits were validated by the EQRO. This resulted in both a reported rate and validated rate of 47.37%, representing no bias by the MCHP.

For the HEDIS 2013 Childhood Immunizations Status measure, there were a total of 213 administrative hits reported and all 213 hits were found. Thirty (30) medical records were requested and 29 of the medical records requested were received and were able to be validated by the EQRO. As a result, the medical record review validated 66 of the 69 total hybrid hits reported. Combined with the administrative rates, this yields a reported rate of 65.28% and a validated rate of 64.58%. This indicates an overestimate of the rate by the MCHP.

The number of administrative hits reported for the 7-day rate for the HEDIS 2013 Follow-Up After Hospitalization for Mental Illness measure was 708; the EQRO found all 708. This resulted in a reported and validated rate of 36.51%, indicating no bias.

The Follow-Up After Hospitalization for Mental Illness 30-day calculation showed 1,233 reported hits; the EQRO was able to validate all 1,233 of them. This yielded a reported rate and a validated rate of 63.59%, again indicating no bias.

Although no bias was observed in the FUH rates, the significant decrease in the rates was questioned by the EQRO at the on-site review. At that time, the MCHP stated that the decreased rates were attributable to a software glitch in their Inovalon software. It was explained that the date of service was not being pulled accurately by the software, if a claim form had more than one date of service, the system was not capturing all of the dates of service. This error has since been corrected and the MCHP expects rates to show an upward trend for HEDIS 2014.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunizations Status measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. HCUSA was compliant with all

specifications for sampling processes.

Submission of Measures to the State

HCUSA submitted the Data Submission Tool (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 20, the MCHP underestimated the Childhood Immunization Status rate. No bias was observed in the Annual Dental Visit, Follow-Up After Hospitalization for Mental Illness (7 day and 30 day) measures.

Table 20 - Estimate of Bias in Reporting of HCUSA HEDIS 2012 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	No bias	N/A
Childhood Immunizations Status (Combination 3)	3.33%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	No bias	N/A

Source: BHC, Inc., 2013 External Quality Review Performance Measure Validation

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 19). The rate for the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness (7 and 30 day) measures showed no bias and were therefore deemed Fully Compliant. The Childhood Immunization Status was underestimated, but still fell within the confidence intervals reported by the MCHP. Therefore, these measures were determined to be Substantially Compliant.

Table 21 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Fully Compliant
Childhood Immunizations Status	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	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 MCHP. 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 Managed Care Members qualified for the measure.

CONCLUSIONS

QUALITY OF CARE

HCUSA's calculation of the HEDIS 2013 Follow-Up After Hospitalization for Mental Illness measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the quality of care delivered.

HCUSA's rate for this measure was consistent with the average for all MCHPs. The MCHP's members are receiving the quality of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. Both the 7-day and 30-day rates were below the National Medicaid and National Commercial Averages for this measure. The MCHP's members are receiving a quality of care for this measure **less** than the average National Medicaid member or National Commercial member across the country. However, the 30-day rate continues to rise from the rates reported by the MCHP during the audit of the HEDIS 2009, 2010, 2011 and 2012 measurement years, indicating a continuing improvement in the quality of services received by members overall.

Additionally, it should be noted that although no bias was observed in the calculation of either MCHPs' FUH rates, the software glitch and the significant decrease in HCUSA's rates caused the EQRO to adjust their overall validation rate accordingly.

ACCESS TO CARE

The Annual Dental Visit measure was fully compliant with specifications. This measure is categorized as an Access/Availability 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. HCUSA's reported rate for this measure was **higher** than the average for all MCHPs. HCUSA's members are receiving a higher quality of care for this measure than that delivered to all other Managed Care members.

This rate was **higher** than the rates reported by the MCHP during the prior six years of EQR reports. This shows that HCUSA members are receiving more dental services than in the past. The MCHP's dedication to improving this rate is evident in the increasing averages. However,

this rate was below the National Medicaid Average for the measure. This indicates that the average HCUSA member is receiving a **lower** access to dental care than the average National Medicaid member.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2013 Childhood Immunizations Status measure was substantially compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. The MCHP's reported rate for this measure was **higher** than the average for all MCHPs. This rate has only been previously audited by the EQRO in 2011 and 2012, however, this MCHP's rate has shown an upward trend.

HCUSA's members are receiving care in a more timely manner, for this measure, than that of other MO HealthNet Managed Care members. However, this rate was **lower** than both the National Medicaid and National Commercial averages for this measure. The MCHP's members are receiving Childhood Immunization care in a manner that is **less** timely than the average Medicaid or Commercial member across the nation.

RECOMMENDATIONS

1. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Work to increase rates for the Childhood Immunizations Status measure; although it was higher than the average for all MCHPs, this rate was below both the National Medicaid and Commercial averages.
4. Both FUH measure rates were adversely affected by a software error in the MCHP's information system, incomplete claim form data containing dates of service was being loaded. This was not caught prior to the submission of the HEDIS 2013 rates, a more in-depth examination of any significant changes in HEDIS rates should be investigated as soon as identified. It is possible that this "software glitch" may have been able to be corrected prior to the submission of HEDIS rates if it was identified sooner by the MCHP.

6.3 MCHP Compliance with Managed Care Regulations

METHODS

HealthCare USA (HCUSA) was subject to a follow-up to the full compliance audit that was done in 2012. The content of this 2013 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

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

The Team utilized an administrative review tool which was developed based on the CMS Protocol Assessment of Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of HCUSA's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, HCUSA will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

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

PM = Partially Met
Documentation supports some but not all components were present.

N = Not Met
No documentation found to substantiate this component.

N/A = Not Applicable.
Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 20.

Table 22 - Comparison of HCUSA Compliance Ratings for Compliance Review Years

Measure	2009	2010	2011	2012	2013
Enrollee Rights and Protections	100%	100%	100%	100%	100%
Access and Availability	100%	76.5%	76.5%	88.24%	82.35%
Structure and Operations	100%	100%	100%	100%	100%
Measurement and Improvement	90.9%	90.9%	90.9%	100%	90.9%
Grievance Systems	100%	88.9%	94.4%	100%	100%

Source: BHC, Inc., 2013 External Quality Review Compliance Validation

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2013 review, HCUSA was rated by the review team to have met all 13 standards. This rating of 100% compliance, is consistent with the ratings received in 2010, 2011 and 2012.

The rating for Enrollee Rights and Protections (100.0%), reflects HCUSA's ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the seventh consecutive year and have practices in place that reflect these policies. The MCHP provided evidence of their practice throughout the on-site review process. It appears that HCUSA is in compliance with all Managed Care contract regulations and federal requirements.

A strong commitment to member rights continues to be a cornerstone of HCUSA's service philosophy. The emphasis placed on continuous quality improvement by the MCHP was apparent in both the documentation reviewed and throughout staff interviews. As observed in prior reviews, quality services to members, with a particular emphasis on families and children, were observed within the organization. HCUSA views cultural diversity as an essential component of their interactions with members. The MCHP maintains cultural diversity as a

cornerstone of initial and ongoing staff training. HCUSA employs staff that speaks different languages and is able to provide written materials in languages other than English. It was noted by the EQRO during the on-site review that in the MCHP's Annual Report more than 55% of the MCHP's population did not list a language spoken. The MCHP explained that this data comes from the SMA eligibility file and that the language field is not a required field to be populated. Thereby, the MCHP is limited in how they can identify what languages other than English may be necessary for their population.

The MCHP, in collaboration with MHNet, its Behavioral Health Contractor, reports making a concerted effort to offer adequate case management services between the two agencies. HCUSA reports that having a MHNet liaison on-site has improved coordination of care issues.

Access Standards

Access and Availability addresses 17 standards. For the 2013 review, HCUSA was rated by the review team to have met 14 standards. This is an overall rating of 82.35% compliance, **lower** than the prior year's review, which found 88.24% compliance.

The MCHP maintains a large provider network throughout all three Managed Care regions. They recruit providers to expand available services. The MCHP has identified some opportunities to improve access through physician panels. The MCHP has worked with providers to encourage them to open panels as more physicians are added to a practice. They also identified the Affordable Care Act (ACA) as a benefit in this area, stating that it has encouraged some providers to become more open. The MCHP does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

The rating regarding Compliance with Access Standards was affected by these factors:

- In reviewing records and interviewing staff full evidence of assessments and treatment planning for members was not available.
- Access to specialists was not reflected in all case management files where reviewers deemed it appropriate.

These findings are detailed more specifically in the Special Project, Section 5 of this report. During the on-site review a commitment to case management was observed, however, the

records reviewed did not always contain comprehensive assessments of member needs, evidence of treatment planning or referrals to specialists when appropriate.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2013 review, HCUSA was rated by the review team to have met all 10 standards. This rating is consistent with the ratings received in 2010, 2011 and 2012. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the seventh year. The MCHP appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

During the 2013 Calendar Year, the MCHP continued to follow NCQA standards regarding credentialing. On site visits, to complete credentialing, occurred at least annually for PCPs and OB/GYNs. Some delegated credentialing occurs with larger providers.

HCUSA's provider advisory group is 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 MCHP to develop a true partnership with their provider network.

During 2013, the MCHP reorganized their Quality Management Committee to make the meetings more productive. They now operate the meeting monthly with fewer staff persons and invite subject matter experts to attend the meeting as needed.

Measurement and Improvement

Measurement and Improvement addresses 11 applicable standards. For the 2013 review, HCUSA was rated by the review team to have met 10 of these standards. This is an overall rating of 90.9%, which is lower than the 100% compliance rating received in 2012, but consistent with 2010 and 2011.

HCUSA submitted information to complete the Validation of Performance Measures. However, two of these PMs were rated as Substantially Compliant, one of which was later discovered to have included incorrect data in the claims capture of dates of service. The details regarding these areas of validation can be reviewed within specific sections of this report.

HCUSA also submitted two Performance Improvement Projects (PIPs) for validation. It was noted that the MCHP utilized projects that had been started, and perfected these projects in an effort to improve services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation. Both of these PIPs received a 100% rating from the EQRO reviewers.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2013 review, HCUSA was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance, which is **consistent** with the rating received in 2012 and **higher** than the ratings received in 2011 (94.4%) and 2010 (83.3%).

Ratings for compliance with the Grievance Systems regulations indicate that the MCHP completed the requirements regarding policy and practice.

CONCLUSIONS

HCUSA continues 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 MCHP maintained improvements to achieve 100% compliance in four sections of the protocol.

The MCHP incorporates 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 services to members is their primary focus and that there was a commitment to comply with the requirements of the Managed Care contract and federal regulations.

However, issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Access to specialists where EQRO reviewers deemed appropriate.

Quality of Care

The HCUSA 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 MCHP less complicated. Case Managers relate 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.

However, the EQRO did not receive documentation of all the quality services described by MCHP staff. Treatment planning, assessments and care coordination were areas that the EQRO could not fully validate.

Access to Care

HCUSA 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 MCHP has also undertaken provider recruitment and retention efforts that ensure that providers are available to members throughout all three MO HealthNet Managed Care Regions served.

Internally HCUSA, 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

HCUSA 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.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested.
2. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the MCHP.
3. Maintain involvement in community-based services and activities.
4. Ensure that all relevant data is checked prior to submission to any auditing agency, make regular test runs of data to identify any issues as early as possible.

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7.0 Home State Health Plan

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7.1 Performance Improvement Projects

Methods

Document Review

Home State Health Plan supplied the following documentation for review:

- Increasing Notification of Pregnancy Risk Factors
- Statewide Performance Improvement Project – Improving Oral Health

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 26, 2014 during the on-site review. Interviewees included the following:

Shannon Bagley – CEO, Home State Health Plan
Wendy Faust – Vice President of Medical Management
Jean Bryan – Manager, Quality Improvement

Interviewees shared information on the validation methods, study design, and findings of PIPs.

The following questions were discussed:

- What instruments are used for data collection?
- How were the accuracy, consistency, and validity assured?
- Why was the clinical project continued for this project year?
- What did the MCHP learn from the findings relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions?
- What criteria are the MCHP using to determine which new issues might become a PIP?

The PIPs were submitted to the EQRO on time, however they required additional information. The MCHP requested technical assistance and had a number of questions regarding the interpretation of the requirements of the protocol. Information was shared regarding the initial

evaluation and the MCHP was provided the opportunity to resubmit the PIPs with additional data, including enhanced outcome information that was not originally available. This final evaluation is based on the updated submissions.

FINDINGS

Clinical PIP – Increasing Notification of Pregnancy Risk Factors

Study Topic

The first PIP evaluated was Increasing Notification of Pregnancy Risk Factors. This clinical project was implemented in September 2012 when the MCHP recognized they were not identifying pregnant members early in their pregnancy, interfering with implementation of early interventions when needed. This clinical project focused on increasing the receipt of Notification of Pregnancy (NOP) forms from providers and implementing services in a timely manner. The goal of the project was to engage members, particularly those at high risk, into case management. The MCHP also sought to ensure that all pregnant members had access to any needed care and services. The narrative information supported the determination that when early notification of the pregnancy occurs, it creates an environment leading to improved pregnancy outcomes. The topic selection data, and literature review, provided a description of the goals of the project. The use of data pertinent to Home State members and the effectiveness of early pregnancy interventions were described as part of the reasoning for choosing this topic. The importance of early intervention in pregnancy and the resulting benefits of that intervention were supported by the information presented.

The MCHP did not present an extensive literature review, but did provide a convincing argument that an essential issue for improvement was identified. Convincing evidence that members would experience fewer adverse events during pregnancy, give birth to healthier babies, and have positive outcomes during delivery was presented. The topic selection was focused on identifying and correcting deficiencies in member care and services. It included all pregnant MCHP members.

Study Question

The study question submitted is:

"Will education for members and providers on the processes for and importance of NOP completion, increase the rate of NOP receipt by 25% within 6 months?"

This study question is focused, measureable, specific, and understandable. It identifies the goal and the population to be served. The study question was enhanced from the original question. The scope was expanded and reflected current goals.

Study Indicators

The study indicator for this project is the rate of Home State pregnant members with a delivery authorization/NOP within eight (8) months prior to delivery. These forms are required for all deliveries. How the indicator is captured in the clinical information system, stored, and retrieved was explained in detail. The MCHP monitored the effectiveness of their interventions monthly to allow for immediate action if the rate decreased. The data is retrieved through the Enterprise Data Warehouse (EDW). This system houses all claims and authorizations for MCHP members.

The numerator and denominator were provided. The indicators presented were clear, concise, and measurable.

Study Population

The population included in the study is all known MCHP members with an authorization or notification for delivery documented in the clinical documentation system. The information provided by the MCHP defines "known" and the system used to identify these members. The MCHP used a "unique count of members" who had an NOP in their record. The approach used is described in detail.

Sampling

No sampling was used to determine who would be included.

Study Design and Data Collection Procedures

A study design is presented. Data collection from the clinical documentation system (TruCare) and the Enterprise Data Warehouse (EDW) are included. These systems and how data is retrieved was presented in a method that provided the detail required to ensure confidence that the data is valid and reliable. The information retrieved and how it is relevant to ongoing project assessment are defined. The method for data collection and how it will be analyzed is presented. The study design includes information in detail on all aspects of data collection and utilization. There is a description of how this data is used to generate reports on NOP receipt and risk factors. The sources of data identified in the study design include the NOP forms and information obtained from PCPs and members. It includes claims submission for prenatal services and with a pregnancy diagnosis. The MCHP then uses these sources, exclusive of the receipt of the NOP form, for outreach and targeted form completion.

The information presented by the MCHP includes the method for data collection and development of metrics for both the numerator and denominator. A procedure was been developed to ensure that the entire population is captured. The MCHP has made an effort to include the capture of all members at several points throughout their pregnancy. The narrative gave adequate information specifying a systematic method of data collection. An effort was made to include every detail of the process used in completing a detailed study that informs the MCHP about the effectiveness of their processes, and how to make improvements. Information was included to ensure that consistent and accurate data collection occurs throughout the study. The narrative provided information within the study design, to create confidence that the data collection would be consistent and accurate over time. This study was designed to be of a short duration, with the intention of impacting a problem and creating an ongoing solution. The design of the study and the factors included in the data development and collection process supported these intentions.

The study design included a prospective data analysis plan. The MCHP explained how it developed a baseline. During the second year of performance it tracked and trended the data to provide ongoing and immediate evidence that improvement strategies were having an impact on their performance. The MCHP used the information gathered to determine risk for the pregnant population, to initiate and tailor outreach to members, to ensure that appropriate interventions, including in-home visitation, occurred as needed. The data sources were to be

queried monthly to obtain the authorization/NOP percentages. A plan for statistical significance testing is presented. An explanation of how the MCHP will impact any barriers to obtaining the desired results was included.

The project manager and MCHP staff utilized in this study were included in the information provided.

Improvement Strategies

The interventions for the baseline year (2012) included:

- Member education efforts
- Outreach to pregnant members and providers. This is telephonic and in-person for both.
- Provider education
- CentAccount incentive program

The interventions utilized in 2013 included:

- Creation of the Healthy Moms and Babies report (members with no NOP, sent to providers and the MCHP management team).
- Follow-up with these members as they are identified.
- Quarterly review of any MCHP member who has a pregnancy claim and no NOP form so providers can be contacted and additional outreach can occur.
- Members are encouraged to contact the MCHP to begin case management, or the Smart Start program for their pregnancy as quickly as possible.

Planned interventions and barriers were presented. The improvement strategies were provided in a table that included all strategies implemented. Barriers were obtained through member and provider feedback. The MCHP utilized an intense early approach to change behaviors due to the importance of the issue of early pregnancy identification. Training occurred with providers to ensure they understood the importance of early notification to the.

Data Analysis and Interpretation of Results

An initial analysis of findings did occur at the end of 2012. It was determined that the improvement strategies had a positive impact in the first four months of this study. The ongoing and new improvement strategies were analyzed and proved to have a lasting positive effect on the receipt of the authorizations/NOP forms in a timely manner. All analysis was presented according to the prospective study design. The results were positive and consistent. The problem was impacted through implementation of this improvement strategy and has led to

positive healthcare outcomes for members. All interventions and the analysis presented were discussed in relation to the outcomes achieved.

The results were presented in figures and tables that were easy to interpret. The information presented was related to the outcomes achieved. There were monthly measurements, including initial and repeat measurements. The data presented covered the duration of the project. It indicated initial success in 2012) and continued improvement throughout 2013. Ongoing barriers and threats to success were discussed and will be considered as the activities used in this PIP become part of normal operating procedures.

Assessment of Improvement Process

Home State asserts that the NOP is one of the key mechanisms to identify pregnant members, providing the MCHP with the greatest amount of time to provide outreach and ongoing services to their pregnant members. Home State claims that additional impacts observed as the result of this initiative include a decline in the rate of infants admitted into neo-natal intensive care (NICU) and a decrease in the number of very low birth weight infants. Home State plans continued efforts to stay informed about members' healthcare status, continued training and relationship building with providers, and a willingness to implement additional initiatives as needed to increase the improvements seen thus far.

Conclusion

This PIP was completed at the end of 2013. It proved to significantly improve member outcomes. Home State identified an issue and resolved it using the PIP process. The analysis of all interventions and outcomes was provided in convincing detail even though this study was completed within sixteen months. Barriers were addressed, and Home State understands the need to continue to monitor success and to implement actions necessary to maintain their current level of achievement.

Non-Clinical PIP – Improving Oral Health

Study Topic

The second PIP evaluated was Home State's individualized approach to the Statewide PIP "Improving Oral Health." This is a non-clinical project. The rationale presented was thorough and based on the need to enhance their approach to Home State members. The study-topic is well written, understandable, and focused. It has scope and is related to the MCHP. 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 MCHP included information in the study topic presentation relating improved dental care to improved general health care.

Study Question

The study question for this project is:

"Will implementing the proposed interventions to Home State Health Plan members 2 through 20 years of age, increase the rate of annual dental visits per the HEDIS specifications by 3% between HEDIS 2013 statewide average and the Home State HEDIS 2014 results?"

Home State does not have a certified HEDIS 2013 rate for annual dental visits due to the MCHP's implementation start date of July 2012. Therefore, the MCHP established a HEDIS-like data collection mechanism, available through the plan's Quality Spectrum Insight (QSI) system – their HEDIS certified software. The system will be used to calculate the preliminary within-year rates as their study indicator. The data will be queried monthly to monitor the plan's progress. The HEDIS-like numbers use the HEDIS Technical Specifications for procedure codes, age ranges, and enrollment anchor date for the HEDIS ADV measure, but do not use the continuous enrollment criteria.

The study question is focused, includes a specific goal, and informs the reader of the intention of the PIP.

Study Indicators

The PIP narrative states that the indicator will be the rate of Home State members 2 through 20 years of age who had at least one dental visit during the measurement year. Home State will utilize the baseline data available in the Statewide PIP. The development of the locally scripted "HEDIS-like" measures is described in the "Study Question" above. This will enable the MCHP to report on their efforts and involvement in this project until the 2014 HEDIS data is available.

Home State will monitor this study indicator quarterly to evaluate the effectiveness of the interventions in place, and to determine if changes are needed.

Study Population

The study population includes all Home State members ages 2-20 ignoring the "allowable gap" criteria in the HEDIS technical specifications for the Annual Dental Visit measure.

Sampling

No true sampling was employed in this PIP.

Study Design and Data Collection Procedures

The study design specifies the data to be collected in detail. The data to be collected and the methodology to obtain this data are explained, including monthly and quarterly monitoring. The source of the data to be used will come from the MCHP's claims system. The MCHP uses an NCQA certified vendor to validate this data. Current dental CPT codes, formats, and data procedures were presented.

The methodology used to collect data, including the continuous enrollment information is explained. The method used will ensure that all members are included. This information provided confidence that valid and reliable data would be reported. The data collection and NCQA certified software described to validate the data produced was explained. The MCHP presented information stating that this data will be analyzed.

A prospective data analysis plan was implied in the presentation. The information provided a table showing outcomes to be reported. However, this was not a complete prospective data analysis plan. The EQRO presented this assessment to Home State who was given the opportunity to enhance this section of the PIP, but no changes were made following the on-site visit.

The Home State team leader, her qualifications and role in managing the PIP were presented. The other core work group positions were described, however, no qualifications or role definitions were provided. It did appear that the project leader would have adequate and qualified support to pursue all elements of the PIP.

Improvement Strategies

Interventions for 2012 included:

- EPSDT coordinator outreach/education;
- Birthday card mailings.

Interventions added in 2013 were:

- Member services provided directly by DentaQuest;
- "Prescription Pads" with reminders given out to high volume PCPs and Pediatricians serving as a member reminder to make dental appointments;
- Use of Dental Vans and Mobile Dentistry services in areas of high volume and low access;
- Distribution of non-compliant lists to PCPs;
- DentaQuest outreach to non-compliant members;
- Direct DentaQuest contact with any member seen in an emergency room for dental care; and
- Automated outreach calls to all members 2 – 20 each month who are in need of a dental visit.

The interventions were listed in a table and included the barriers they addressed. The presentation does not include any analysis or explanation of why these interventions were chosen. Additional information on the rationale for choosing these interventions would add clarity and depth to the presentation.

Data Analysis and Interpretation of Results

A complete prospective data analysis plan was not presented. The information available is generalized. Home State stated they planned to use previously determined statewide figures as their baseline. They presented the HEDIS data for both of the other contracted MCHPs, as well as the statewide HEDIS totals for HEDIS 2012, which is calendar year 2011. This was included in their previous PIP submission, but there is no explanation of why this year's data was chosen. The narrative states they will include their HEDIS-like data from calendar year 2012, which was included. The PIP narrative also stated that Home State would include their 2014 HEDIS ADV rate after June 15, 2014. Home State was given the opportunity to provide updates to their original PIP submission. An "updated" submission was received on July 31, 2014, and it did not include a table with the 2014 HEDIS ADV rate.

It should be noted that the MCHP did show a significant increase in the ADV rates from 2012 to 2013. At the end of their first six (6) months of operation in 2012, their HEDIS-like year-end

rate was 19.65%. The update provided indicates that Home State's 2014 HEDIS ADV rate is 42.27%. This is a 22.62 percentage point increase. They assess this outcome as the result of having a full year of data to include, and a full year to develop, enhance, and implement their interventions to "drive improvements and increases for this measure."

The narrative provided did include the above factors which influenced comparability of their two years of data. Home State did not discuss how external factors may have threatened internal or external validity, or the need to include statistical significance testing. The narrative did not attempt to provide any interpretation of how the use of the improvement strategies influenced the improvement experienced, or any plans for follow-up activities.

Assessment of Improvement Process

This one year of data, although extremely positive, is not enough to make an assessment about Home State's improvement strategies, and whether or not this is "real" and sustainable improvement. The MCHP is part of the statewide PIP initiative and is actively participating to ensure that this PIP continues in a productive manner.

Conclusion

The foundation of an effective PIP was presented in the MCHP's original presentation and has been continued. The MCHP used information available from the Statewide PIP and incorporated this into their planning. They included all of the data available to them to inform the PIP process and to enable them to continue to enhance their project. Home State did receive Technical Assistance during the EQRO's on-site review requesting enhanced information in the study design – prospective data analysis plan, linking improvement strategies to outcomes, and a detailed analysis. This was not included in updated information received.

Conclusions

Quality of Care

A quality approach to identifying and educating pregnant members, engaging member's participation in case management and educating providers was evident in the documentation provided in the clinical PIP. Each PIP indicated growth in the improvement strategies focused on providing quality healthcare to members. Both PIP initiatives indicate a commitment to quality care for members.

Access To Care

Both PIPs submitted by the MCHP addressed improved access to health care services. The first PIP used a direct approach by engaging pregnant members into an array of health services at the earliest possible point. In the non-clinical PIP, efforts were made to ensure that members were aware of the necessity of regular dental care, and then how to obtain this care. The MCHP implemented strategies that brought dental care directly to the members and communities making care truly accessible in rural areas. The attention to reminding members of available resources enhances member access and directly impacts outcomes. The MCHP's efforts were fresh and new, and expressed a clear goal of improving access to care.

Timeliness of Care

Both projects addressed timely and adequate care. The first PIP, regarding early notification of pregnancy and immediate engagement into services, indicates a strong commitment to timely healthcare. Another indicator of this focus is that this issue was identified in the first few months of Home State's operation. It was then developed into a PIP, and enhanced until the problem was resolved. The PIP interventions are now part of normal MCHP operations.

In the second PIP, there was attention to assisting the members in recognizing their need to identify a dental provider and obtain the oral health care available.

Recommendations

1. Continue to assess PIP activities during the project year to identify issues that may negatively affect outcomes.
2. Explore operational and service issues that arise and assess them for the need to develop into a PIP. Home State staff discusses issues that appear to include all of the properties required for PIP development. The QI staff does not always share these observations.
3. Request technical assistance, as needed, in PIP development.
4. Include adequate narrative in the PIP sections to explain Home State's intentions. Use the narrative or documentation to explain and discuss implications in the areas of development and analysis of the data obtained. Do not assume that the reader

understands or interprets the information presented exactly as the writer does.

5. Ensure that improvements are focused on enhancing member services. This should lead to better HEDIS results. The goal of a project should not be to obtain better HEDIS data rates.
6. Continue involvement with the Statewide PIP planning group. Continued commitment to this group is an important aspect of an evolving improvement process.

7.2 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 Home State. Home State did not submit HEDIS data for HEDIS 2013, therefore 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:

- Home State HEDIS meeting minutes

INTERVIEWS

The EQRO conducted on-site interviews at Home State in St. Louis on Tuesday, June 24, 2014 with staff responsible for monitoring the calculation of HEDIS performance measures, system integrity, and system security. The objectives of the visit were to verify the information contained in the documentation reviewed by the EQRO and to confirm the MCHP's readiness for calculation of performance measures.

Interviews were conducted with the follow:

- Jean Bryan, Quality Manager
- Michael Marrah, VP of Operations

FINDINGS

The MCHP was subject to the full Information Systems Capabilities Assessment (ISCA) validation during last year's review. The EQRO verified that the systems existed at the MCHP during this review and that the MCHP will have HEDIS 2014 data for review and audit during the next EQRO review.

7.3 MCHP Compliance with Managed Care Regulations

METHODS

Home State was subject to a follow up compliance audit during this on-site review. The follow up was to the 2012 calendar year audit that included all components of the Quality Standards as defined in 42 CFR 438.

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of Home State's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Home State will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

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

PM = Partially Met
Documentation supports some but not all components were present.

N = Not Met
No documentation found to substantiate this component.

N/A = Not Applicable.
Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 27.

Table 23 - Home State Compliance Ratings for Compliance Review Years (2012-2013)

Measure	2012	2013
Enrollee Rights and Protections	100%	100%
Access and Availability	64.71%	70.59%
Structure and Operations	100%	100%
Measurement and Improvement	90.0%	90.0%
Grievance Systems	100%	100%

Source: BHC, Inc., 2013 External Quality Review Compliance Validation

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2013 review, Home State was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance and is consistent with this MCHP's 2012 rating.

Home State has participated in community-based programs throughout all three Managed Care regions and have been involved in school-based health clinics whenever possible. The MCHP participated in back-to-school fairs and other events throughout each region.

The rating for Enrollee Rights and Protections (100%) reflects that the MCHP 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 MCHP appears to be fully compliant with Medicaid Managed Care Contract requirements and federal regulations in this area.

Access Standards

Access and Availability addresses 17 standards. For the 2013 review, Home State was rated by the review team to have met 12 standards. This is an overall rating of 70.59%, this is **higher** than the 2012 rating of 64.71%.

The increase in this rate is attributable to the MCHP's improvement in the area of Case Management. The MCHP provided treatment plans, identified persons for case management and improved their processes for documenting the case management services being delivered to members.

Home State submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing case management staff, full evidence of assessments and treatment planning for members was not available.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2013 review, Home State was rated by the review team to have met all 10 standards. The rating for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the second year. The MCHP 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.

The MCHP has received NCQA accreditation and follows NCQA standards regarding credentialing. All credentialing performed by Home State 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 MCHP has experienced some growing pains and would like to add more capacity in their provider network. At the time of the on-site review, the MCHP did not have contracts with hospitals in Marshall or Lake Ozarks area of Missouri. Although, they meet the access requirements of their Managed Care Contract, the MCHP has been utilizing these hospitals on a single-case agreement basis and is working to obtain contracts in these areas of the State.

The MCHP does monitor the subcontractors, detailed histories, problem resolution, and performance improvement are reviewed each year.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the second consecutive year, Home State was rated by the review team to have met 9 standards; two standards were "Partially Met"; and one standard was found to be Not Applicable. This is an overall rating of 90.0% compliance.

The MCHP did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation. The specific details can be found in the appropriate sections of this report.

The rating for the Measurement and Improvement section (90. 0%) 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 Managed Care contract and the federal regulations.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2012 and 2013 reviews, Home State was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance. Ratings for compliance with the Grievance Systems regulations (100%) indicate that the MCHP completed all of the requirements regarding policy and practice.

CONCLUSIONS

Home State was compliant in all areas of policy, procedure, and practice required by the Managed Care contract and the federal regulations. The MCHP utilizes a proactive approach to identifying issues, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to the SMA in a timely and efficient manner.

The staff at Home State exhibits a commitment to quality and integrity in their work with members. Home State has created tools to educate and inform the community and providers.

However, a few issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Although better PCP involvement was observed by the EQRO in the Case Management files, this area is still in need of improvement.
- Quality was lacking in one Performance Improvement Project.

Quality of Care

Quality of care is a priority for Home State. 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. They are making a concerted effort to extend this approach to all three MHD regions. Home State 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 MCHP staff, who express enthusiasm for their roles in producing sound healthcare for their members.

However, missing assessments and treatment plans in Case Management files indicates that an improvement can be made in this area to ensure that the evidence exists to support that the quality of care received by members in Case Management matches that delivered in other areas of the organization.

Access to Care

Home State has made concerted efforts to ensure that members throughout their MHD regions have adequate access to care. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services. The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

TIMELINESS OF CARE

Home State 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 MCHP has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of Home State 's **lower** rates in this year's review.
2. Make every effort to be involved in the community and to cultivate resources to help staff perform their job functions to the fullest potential.
3. Supply training regarding contract requirements to the Case Management staff to ensure compliance with all timelines and content standards.
4. Continue monitoring access to dental care and assist in recruitment of providers throughout all Regions.
5. Continue to request technical assistance in areas that require improvement. Performance Improvement Projects should be updated when given the opportunity prior to a final validation finding by the EQRO.
6. Continue to monitor provider and hospital networks for adequacy. Develop contracts were possible.

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8.0 Missouri Care Health Plan

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8.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Missouri Care supplied the following documentation for review:

- Post Mental Health Hospitalization Follow-Up Care Within 7 Days of Discharge
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team June 18, 2014, during the on-site review, and included the following:

- Mark Kapp, Senior Manager, Quality Improvement
- Vicki Mertz, Quality Improvement Project Manager
- Erin Dinkel, Manager, Quality Improvement
- Karen Einspahr, Quality Improvement Analyst

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

- Who were the staff involved in each project and what were their roles?
- Discuss the findings and how they were interpreted.
- How were the interventions determined and why did the MCHP choose this approach?
- Will the clinical study be ongoing?
- Discuss the effects of these interventions and how they impacted services to members.

The PIPs submitted for validation did contain significant information allowing initial evaluation. The MCHP was instructed during the on-site review that they could submit additional information including updates to the outcomes of the interventions and additional data analysis. Additional information was received for these PIPs.

FINDINGS

Clinical PIP – Post Mental Health Hospitalization Follow-Up Care Within 7 Days of Discharge

Study Topic

The clinical PIP focused on follow-up services after in-patient hospitalization for mental health. The MCHP had initiated a PIP several years ago to address this issue. The MCHP recognized that members failing to access follow-up care were again an issue, and they resurrected and enhanced this project to address current problems. MO Care utilized research on both the national and local level to inform the development of the current PIP. They found that mental health outcomes are significantly improved with appropriate follow-up care for inpatient mental health services. Their desired outcomes were supported by the information obtained in their literature review. The PIP is focused on the goal of improving members' mental health outcomes through education and ongoing interventions. The study population will include MO Care members six (6) years of age and older who were hospitalized for treatment of mental health disorders between January 1 and December 1 of the measurement year.

Study Question

The study question presented is:

"Will the implementation of case management and utilization of management activities, along with other health plan interventions, be successful [in] increasing the percentage of Missouri Care members who receive a follow-up appointment within 7 days of discharge from an acute inpatient setting with a principal mental health diagnosis?"

This study question is designed to explain the problem and establish the goal of the project. The question presented is measureable and specifies project goals. The MCHP stated in their explanation of the study question that they will determine the success of the project by reaching the goals defined by the "NCQA Effect Size Table to measure meaningful improvement."

Study Indicators

The study indicator that will be used is the Follow-Up After Hospitalization for Mental Illness within 7 days of discharge (FUH-7) HEDIS Rate. This indicator and why it is applicable to this PIP are explained. The HEDIS technical specifications are provided. The numerators and denominators, and how each is defined is included in the documentation. The MCHP believes that this indicator will reflect an improvement in the mental health status of members by improving their follow-up care after any in-patient hospitalization.

Study Population

The study population includes all members ages six (6) and older, from the date of discharge from a mental health inpatient hospitalization. All are eligible and will be sought out by the MCHP staff. All members of the MCHP are to be included that fall into this population. The data collection approach is consistent with the HEDIS requirements. An explanation of how this captures all appropriate members must be assumed, as it is not specifically presented. There is language about receipt of hospital notices. Additional explanation about how the MCHP will ensure that they are aware of members in the hospital, or leaving the hospital, prior to the seven (7) day window expiring would be beneficial.

Sampling

No sampling will be used in this PIP.

Study Design and Data Collection Procedures

The study design presents all data to be collected and the data sources. Details are provided about the MCHP's systems, the software used, and the methodology for system queries. This information is presented in detail. The QNXT system is used to house the encounter and claims information and is the primary source of information for data collection. The data elements are determined by the HEDIS technical specifications. Each indicator will provide data consisting of the measurement period, the numerator, the denominator, and the rate. The codes and the timeframes used to obtain data are included.

The MCHP asserts that it is their responsibility to provide valid and reliable data. They present a description of the NCQA certified software, and how it is used as part of the HEDIS process. The narrative provides confidence that all measures are in place to produce valid and reliable

data to report on the outcome of this project. MCHP staff maintains oversight of all processes and the PIP team reviews all information obtained and updates the PIP. Instruments used and the methodology employed by the team were explained in detail.

A prospective data analysis plan was included. This plan included the stated goal of the study. The MCHP wishes to show an improvement in members' health outcomes through implementation of new interventions. They state that coupled with educational efforts and on-going interventions, members' mental health outcomes are expected to improve. They intend to incorporate all interventions that prove successful into their regular operations. The data analysis plan goes into detail, not only about hoped for outcomes, but they explain how the results of this project will be evaluated. The MCHP will measure the impact of the PIP by tracking and testing for significant increases in indicator rates over time. They will also implement a continuous process improvement strategy to plan and implement changes if any successes seem to stagnate or decline.

The MCHP personnel involved in this study, including the project leader, their roles and qualifications were included. The study documentation also included corporate partners that have assisted, or will continue to assist in the progress of this project.

Improvement Strategies

The proposed improvement strategies that began in 2013-2014 include:

- New FUH-7 Day Member Incentive Program Flyer – The MCHP saw a slight decrease in follow-up in the Central Region during 2012, and reevaluated the Members Incentive Program during 2013. A work group formed to redesign the brochure and flyer to make this information understandable and to improve readability. These new documents were approved, and the MCHP began distributing them to members toward the end of 2013. The true impact of this new material cannot be assessed until the end of 2014, but was part of the 2013 improvement strategy.
- Behavioral Health Case Management/Utilization Management
    - MO Care's Behavioral Health Utilization Manager and Case Manager work together with the hospital discharge planner to arrange the member's outpatient appointment within 7 days post discharge.
    - Discharge planning begins at admission – immediate referral to case management,

and implementation of steps to ensure continuity of care with providers, and necessary services within 24 hours of admission. Collaboration within the MCHP to ensure all necessary care is available, including a plan for aftercare.

- Behavioral Health Inpatient Facility Collaboration – The BH Medical Director and Behavioral Health Liaison meet with facilities and discuss opportunities for improvement.
- Behavioral Health Home Visits – In-home therapy is a priority, but even if this is not possible, home health visits occur weekly for the first 30 days after discharge.
- Member Newsletter Articles – Encouraging members to get involved in case management which promotes regular follow-up after hospitalization.

The MCHP believes that this intensive approach, with case management involved as the anchor to ensuring that members are receiving and are involved with appropriate aftercare services will ensure that they receive the follow-up care needed. This will then create improved mental health outcomes for members. The MCHP continues to use a "Plan-Do-Study-Act" cycle to create continuous project improvement. The information presented included the 2012 and previous years' interventions that remain in place. They intend to enhance and continue these interventions during 2014 to have twelve full months of data with all interventions in place to measure success.

Data Analysis and Interpretation of Results

The MCHP presented results beginning with HEDIS 2006 (baseline) for the Central Region and included a yearly comparison through HEDIS 2014. The MCHP began incorporating the Eastern and Western Regions into their planning and analysis beginning with HEDIS 2012 (baseline) and presented results through HEDIS 2014. The information presented did comply with the prospective data analysis plan. They presented explanations for what would occur throughout their analysis. All data was clearly presented using tables and graphs, including a narrative explanation of the outcomes. The information included initial and repeat measurements, and statistical significance testing. The results of this testing were presented. The accompanying narrative described each year's initiatives, those that continue, and the new strategies for each year. A barrier and demographic analyses was presented. The information provided regarding the ongoing evaluation of strategies was clear and provided confidence that this project is well managed. During HEDIS 2012 the MCHP began evaluating progress in all MHD Regions. The

MCHP did experience a slight decline in the Central Region in HEDIS 2013, which stimulated the interest in enhancing and revitalizing this project. The HEDIS 2014 results are positive and indicate the initiatives started during calendar year 2013 are having the positive impact expected.

The narrative did include a plan to continue the process of analyzing the success of the PIP in all three regions through 2014. The MCHP acknowledges that they did not implement the new member incentive program flyer until the end of 2013. They plan to continue to evaluate the improvement and sustainability of this PIP, including the member incentive program, through 2014.

Assessment of Improvement Process

The MCHP recognizes that they must continue to explore new methods to positively impact the results pertinent to this population. They are committed to succeeding in reaching and sustaining their goal of improving member mental health outcomes by improving access to seven (7) day follow-up services. They have not reached a level that they consider "sustained improvement," but continue to make efforts to reach this goal.

Conclusion

This PIP is addressing an important concern for members' mental health. Current interventions are beginning to produce results. MO Care expresses a commitment to continuing the PIP process and efforts to ensure that all of their goals for improving members' mental health outcomes are achieved. The PIP includes measureable interventions unique to this project for MO Care. The efforts evident in the information provided indicate a strong commitment by MO Care to positively impacting this issue.

Non-Clinical PIP – Improving Oral Health

Study Topic

The second PIP evaluated was MO Care's individualized approach to the Statewide PIP "Improving Oral Health." 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 study topic description incorporates the documentation presented in the Statewide PIP into a discussion of its relevance to MO Care members. The narrative includes thorough problem identification pertinent to MO Care. MO Care states that it recognizes the

CMS recommendations for creating improvement in the area of improved access to dental care in their study topic discussion. A literature and research review occurred and the information relevant to MO Care members is included. This discussion is member focused and points out the importance that good dental care plays in preventing serious medical risks.

The study topic presentation includes the relevant population of members ages 2 – 20 and pregnant women. The stated goal of the PIP is to educate members on the importance of good dental health to overall health. MO Care intends to provide information to enable members to obtain necessary care.

Study Question

The study question presented for the 2013 PIP was:

"Will providing educational interventions concerning dental hygiene and the importance of annual preventive dental visits to Missouri Care members from the ages of 2 through 20 years old improve members' oral health and result in an increase of annual dental visits?"

The MCHP included a rationale for choosing this question, including the focus on improving overall health by maintaining good dental health. They acknowledge that their initial goal in 2010 was to increase their rate of annual dental visits by 3% over a three year period. They further this goal by stating, "Missouri Care set an additional goal to increase the rate another 3 percentage points over the next three years." The EQRO understands the actual goal set out by the Statewide PIP and the SMA's expectation of each MCHP to be an improved rate of 3% per year for each of the next three (3) years, considering HEDIS 2012 as the baseline year for the updated project.

The study question is considered "Partially Met" because the actual study question details the intention of the improvement strategies, although it fails to specify the measurement that will be used to calculate success. The supporting information does provide the goals identified by the MCHP, but they do not accurately reflect the Statewide PIP goals, or the goals agreed upon by the statewide task force that includes all MCHPs and the SMA.

Study Indicators

The primary study indicator will be improved rates in the ADV HEDIS measure. The MCHP explains that this is actually a reflection of improving members' overall health status. They

reflect that the effectiveness of their interventions is measured using the HEDIS ADV measure. Their explanation is direct and includes the importance of the measure on overall health care.

Study Population

These indicators are used to focus on members ages 2 – 20, which are defined by the HEDIS technical specifications. They explain that dental care is available as part of the EPSDT benefit. All dental services are covered, including diagnostic care, treatment and follow-up care. Dental benefits are covered for all members in the 2 – 20 age range. The MCHP also acknowledges the availability of dental care to pregnant women, and members with other chronic conditions related to oral health. However, these populations are not included in this PIP, or in the technical specifications for this HEDIS measure.

Sampling

There are no sampling techniques used in this study.

Study Design and Data Collection

The study design includes information on all data to be collected. The CPT codes and systems requirements applicable to this study and the specific elements of producing this data for the HEDIS measure are all defined. Claims information is received from the MCHP's subcontractor, DentaQuest. The information provided included sufficient detail naming the MCHP's QNXT system, and their claims processing system as the sources of data. The study described the process the MCHP will utilize to extract data monthly and report quarterly.

The specific elements of the HEDIS technical specifications that relate to the Annual Dental Visit measure were included. The database reports described will be generated from DentaQuest's claims processing system. This claims system and the MCHP's data system are to be queried. Information on the use of Inovalon, HEDIS certified software, and how it serves to reduce the threat of producing invalid data was explained. This information, in the study design, assists in providing confidence that valid and reliable data will be produced.

A partial prospective data analysis plan was presented. The success of this project is to be demonstrated through use of the HEDIS rate to determine the effectiveness of new interventions implemented during the PIP. After discussion during the on-site review, the

MCHP did add some information to this section of their project description. They did not actually provide a new prospective data analysis plan. The MCHP provided their intended goals of their interventions, and named the interventions to be employed. They stated that they would measure the impact of this PIP on an ongoing basis. They did not discuss how they intend to analyze the results, or what they will do with the positive or negative results of those outcomes.

The data collection staff and members of the PIP team, their roles, and qualifications are provided in detail. Members of the corporate structure, who will be involved, were also named.

Improvement Strategies

The interventions implemented in 2013 are:

Periodicity Letters – These letters were developed in 2013, and included a reminder to the member to obtain annual dental visit;

1. Dental Education Flyers – Flyers citing the importance of dental care,
2. HEDIS Provider Toolkit – The MCHP developed and distributed a new toolkit in 2013. This was distributed to help providers understand HEDIS measures including ADV.
3. Expanded Dental Month Campaign – Show Me Smiles – Work with local Boys and Girls club to expand the number of Head Start Partnerships to over 3500 Head Starts
4. Expanded Dental Van – Adding seven (7) new dental vans in the Central Region. This mobile unit provides both maintenance and preventative care to children.
5. "I Will" Campaign – (This was discontinued after the MCHP was purchased by Well Care). The marketing campaign was designed to empower members to take charge of their health with the simple statement "I will brush my teeth. You'll do it. Missouri Care will help." The flyer was used at health fairs, in magazines, newspapers, etc.,

The MCHP included all interventions beginning in 2009, indicating which actions are on-going or "continuous" interventions. They have built on past initiatives and have attempted to use what they learned from previous approaches to maintain a positive impact on members' behavior in obtaining their annual dental visit.

Data Analysis and Interpretation of Results

The study results from all years are provided. The HEDIS 2014 rates were included after the on-site review. The finding of "Not Met" throughout the Data Analysis section begins with an

incomplete Prospective Data Analysis Plan. The analysis that is included lacks depth and gives no insight into the results included for calendar year 2013. The narrative only outlines the numerical findings and results from HEDIS 2009 through HEDIS 2013. The data analysis was completed by region. This information did correspond with the partial data analysis plan presented. The Central Region used HEDIS 2009 as the baseline data year. The Eastern and Western Regions' baseline year was HEDIS 2011. The success of the project is determined by the demonstrated quantitative data reflecting an increase in the HEDIS ADV rates. It is noted that statistically significant increases were made in all three regions through HEDIS 2013.

A graph of the MCHP's annual dental visit rate from 2003 through HEDIS 2014 was presented for each region. This indicated a significant increase, particularly from HEDIS 2009 through HEDIS 2013 for the Central Region. The Central Region HEDIS 2013 rate is 47.46%, however, this rate declined for HEDIS 2014 to 36.85%. The successes experienced in the first five years of the project were overshadowed by a plummeting rate for HEDIS 2014. Factors that influenced these outcomes were not presented. The narrative does not discuss this downward trend. The validity of the data is not questioned. Neither the direct impact of the interventions nor the cause for this difference in the HEDIS rates in the Central Region, are addressed. This is not explained and considered in the overall analysis.

A separate analysis was completed for the Eastern and Western Regions. In these regions the baseline was HEDIS 2011. The Eastern Region baseline rate was 29.04% and the Western Region baseline rate was 29.18%. There are now three remeasurement periods reported. The results for HEDIS 2013 for the Eastern Region are a rate of 32.52%, indicating a slight decrease from the previous rated of 32.97%. The Eastern Region has experienced growth and the MCHP believes that the interventions introduced during calendar year 2012 did not impact members who were new to the plan. However, the HEDIS 2014 rate spiraled downward to 25.29%, below the baseline rate. The narrative points out that the MCHP did not meet the initial goal of a 3% increase for a 3 year period. It does not provide any theory about this startling negative trend in its HEDIS rates.

The Western Region's 2013 HEDIS ADV rate was 35.82%, which is a slight increase from the previous year. The report indicates that the 2014 HEDIS rate is 32.86%. Although this is a significant decrease, the MCHP did not experience the decline seen in the Central and Eastern

Regions.

The statewide HEDIS aggregate figures increased from 27.41% reported for HEDIS 2009 (CY2008) to the HEDIS 2013 (CY2012) rate of 43.91% for the MCHP. The HEDIS 2014 Aggregate rate is 31.39%.

During the 2012 EQR on-site visit the MCHP ventured that the Eastern Region did not meet its goal of a 3% increase because it was not able to consistently implement of all interventions in this region. They observed that the rates in the Western Region did not achieve the success of the Central Region, but they did show an increase. The MCHP viewed the interventions in place at that time, enhanced by the 2013 additions, as successful at impacting the members' ability to obtain good oral health care. They offered the theory that the rates reflecting their activities during the entire 2013 calendar year would show continued success.

The 2014 HEDIS rates do not support this contention. It is not clear why this change has occurred as there is no information provided by the MCHP to explain this change.

Assessment of Improvement Process

The narrative does include a section on improvement and sustainability. It also includes an interpretation of the effect of the interventions implemented on the outcomes through HEDIS 2013. This section states that "all three regions are showing an upward trend." The MCHP includes information through HEDIS 2013, but fails to address the decline experienced in HEDIS 2014 rate. Throughout this section of the report the MCHP discusses the ongoing successful interventions. The MCHP states, "Improvement and sustainability of this PIP will be impacted by maintaining interventions that have increased annual dental visits." They never address the serious downward trend experienced in the 2014 HEDIS rates. The MCHP provides no information or acknowledgement of the factors that might have created this issue. This factor leads the EQRO to rate Sections 9 and 10 of the PIP as "Not met."

A plan for follow-up activities and planned interventions for 2014 are included. The MCHP continues to assess their performance as indicating an overall improvement in the HEDIS ADV rate "due to the successful interventions previously mentioned". They state that they will sustain the success achieved. Some of this may be accurate, but it is disturbing that the MHCP

did not acknowledge the startling decline in HEDIS rates in the Central and Eastern Regions.

Conclusion

Although the MCHP has achieved success in making improvements earlier in this statewide initiative, they have not achieved their current, or Statewide goals. They continue to implement new interventions. Their narrative claims that they track and trend their initiatives so additional improvement can be achieved. However, there is no evidence of this type of analysis for the 2013 PIP. MO Care has used the PIP process as a method to obtain improved performance, but are not including the results of any current analysis of their 2013 outcomes in this submission. It is hoped that the MCHP will remain committed to the PIP process and to achieving all of its own stated outcomes. To do this they will have to present an appraisal of declining rates and how this reflects on their activities, as well as reporting on success.

Conclusions

Quality of Care

The issue of quality was a primary focus of the PIPs undertaken by this MCHP. The quality of health care and the issue of the quality of life of MCHP members were addressed in these PIPs. Implementing measures to ensure that members obtain mental health aftercare and using in-home and case management services exhibits the MCHP's commitment to quality healthcare for members. Both PIPs included an overarching goal of improving overall health care by focusing on an aspect that may have been neglected, and could lead to negative outcomes. The MCHP sought to provide opportunities for preventive care enhancing the quality of services received by members. In these projects the MPHC 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 programs 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 MCHP members. The clinical PIP stresses the importance of implementing case management as soon as a member enters an inpatient setting. This enables the MCHP to begin setting up all aftercare and follow-up services with the member's input before they return home. This ensures that they are aware of everything available to them, and

how to access it at the earliest possible point in time. The MCHP worked with their dental subcontractor, their providers, and members to gain knowledge about how and where to access services. The statistics for 2013 were not positive. However, the implementation of tools such as a Mobile Dental Unit in seven (7) rural cities and towns, where dental services were previously unavailable is a concrete example of improving access to care for MO Care members.

Timeliness of Care

These performance improvement projects focused on ensuring that members had timely access to care. Implementing strategies to assist members in obtaining important health care interventions in a timely manner is part of each PIP. The clinical PIP had a stated goal of ensuring that members leaving an inpatient setting had aftercare therapy in seven days; they supplied four (4) weekly in-home nurse visits, and intensive telephonic case management. The project indicates that the MCHP has this commitment and assists members in obtaining timely treatment. Working with providers, as has occurred in the Improving Oral Health PIP, to encourage patients to make timely appointments for their children will enable better health care outcomes.

Recommendations

1. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the clinical studies submitted continues to improve. Both studies provide evidence that there was thought and consideration put into planning, developing appropriate interventions, and creating a positive environment for the potential outcomes.
2. Improve the MCHP's commitment to completing a thorough in-depth analysis process. A study can have negative outcomes. When this occurs a thorough analysis of what occurred to create these conditions, or which interventions were less effective, is required. In presenting data address the issue in the accompanying narrative.
3. Continue the process of looking at MPHC statistics and data to analyze the best use of resources in creating performance improvement initiatives. Complete a true analysis. When reporting on outcomes ensure that the data presented is explained in detail.
4. Develop a process for evaluating the conclusions in the projects. Whether interventions are successful or not, draw conclusions based on the data. If an intervention does not achieve the desired result, continue to include information about

what happened and why.

5. Utilize a creative approach to developing projects and interventions that will produce positive outcomes. Ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.
6. Continue work on identifying clinical issues to be addressed through the PIP process. Ensure that areas of concern are considered to be developed into a Performance Improvement Projects.

8.2 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 MO Care. MO Care submitted the requested documents on or before the due date of March 4, 2014. The EQRO reviewed documentation between March 4, 2014 and June 16, 2014. 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 NCQA RoadMap submitted by MO Care
- MEDSTAT's NCQA HEDIS Compliance Audit Report for 2013
- MO Care's HEDIS Data Entry Training Manual
- MO Care's Policies pertaining to HEDIS rate calculation and reporting

The following are the data files submitted for review by the EQRO:

- ADV_FILE_1.txt
- ADV_FILE_2.txt
- CIS_FILE_1.txt
- CIS_FILE_2.txt
- CIS_FILE_3.txt
- FUH_FILE_1.txt
- FUH_FILE_2.txt

INTERVIEWS

The EQRO conducted on-site interviews in Columbia, MO on Tuesday, June 17, 2014 with the MO Care staff that were responsible for the process of calculating the HEDIS 2013 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

MO Care calculated the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures using the administrative method. The hybrid method was used to calculate the Childhood Immunizations Status measure.

The reported rate for MO Care for the Annual Dental Visit rate was 43.91%; this was **lower than** the statewide rate for all MCHPs (46.69%). This rate was a continuation of an upward trend of the rates reported in the 2010, 2011 and 2012 EQR report years (38.21%, 41.34% and 42.97% respectively); see Table 24 and Figure 34).

The HEDIS 2013 rate for MO Care for the Childhood Immunizations Status measure was 57.12%, which was comparable to the statewide rate for all MCHPs (59.47%). However, this rate continues a downward trend, with a 2012 rate of 62.69% and 2011 rate of 64.14%, as audited by the EQRO.

The Follow-Up After Hospitalization for Mental Illness measure 7-day rate reported to the SMA and the State Public Health Agency (SPHA) by MO Care was 37.04%. The rate reported was consistent with the statewide rate for all MCHPs (36.66%). However, the rate was significantly lower than the 2012 rate of 40.42%. The rate is however, higher than the rates of 29.20% and 38.42% reported in 2010 and 2011 respectively.

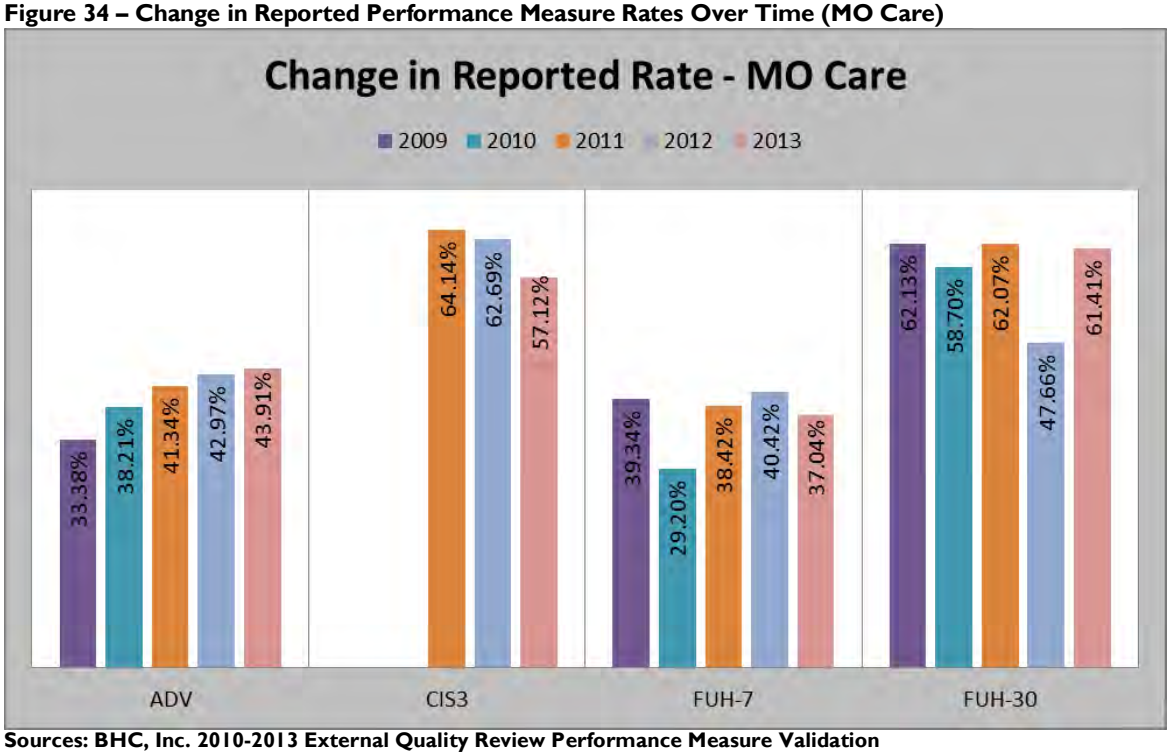
The 30-day reported rate was 61.41% which is **significantly higher** than the MCHP's 2012 rate of 47.66% and is comparable to the statewide rate for all MCHPs (63.00%). This rate was also lower than the rate reported in 2011 (62.07%) (see Table 24 and Figure 34).

Table 24 – Reported Performance Measures Rates Across Audit Years (MO Care)

Measure	HEDIS 2010 Rate	HEDIS 2011 Rate	HEDIS 2012 Rate	HEDIS 2013 Rate
Annual Dental Visit (ADV)	38.21%	41.34%	42.97%	43.91%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	64.14%	66.44%	57.12%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	29.20%	38.42%	40.42%	37.04%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	58.70%	62.07%	47.66%	61.41%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year
Source: MCHP's Data Submission Tools (DSTs) HEDIS 2010-2013

Figure 34 – Change in Reported Performance Measure Rates Over Time (MO Care)



Sources: BHC, Inc. 2010-2013 External Quality Review Performance Measure Validation

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 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, MO Care was found to meet all criteria for producing complete and accurate data. There were no biases or errors found in the manner in which MO Care transferred data into the repository used for calculating the HEDIS 2013 measures.

Documentation of Data and Processes

MO Care used Catalyst, an NCQA-certified software program in the calculation of the HEDIS 2013 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. MO Care met all criteria that applied for all three measures.

Processes Used to Produce Denominators

MO Care met all criteria for the processes employed to produce the denominators of all three performance measures. This involved the selection of members eligible for the services being measured.

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 2013 criteria. A medical record review was conducted for the Childhood Immunizations Status measure.

For the HEDIS 2013 Annual Dental Visit measure, the EQRO validated all of the 11,487

reported administrative hits. The MCHP's reported and validated rate was 43.91%, showing no bias.

For the Childhood Immunizations Status measure, MO Care reported 363 administrative hits; the EQRO validation showed 363 hits. For the medical record review validation, the EQRO requested 30 records. A total of 30 records were received for review, and all 30 of those were validated by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate reported and validated by the EQRO based on validated administrative and hybrid hits was 57.12%. This represents no bias by the MCHP for the calculation of this measure.

For the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure 7-day rate, the MCHP reported 708 administrative hits from the eligible population; the EQRO was able to validate all 708 of these hits. The reported and validated rates were therefore 37.04%, with no observed bias.

The 30-day rate showed the reported number of administrative hits as 710; the EQRO validated 710 hits. This represents a reported rate of 61.41% as well as a validated rate of 61.41%, again showing no bias for this measure.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunizations Status 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

MO Care submitted the Data Submission Tool (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 of the measures validated, Annual Dental Visit, Childhood Immunizations Status and Follow-Up After Hospitalization for Mental Illness measures were Fully Compliant.

Table 25 - Estimate of Bias in Reporting of MO Care HEDIS 2012 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	No bias	N/A
Childhood Immunizations Status (Combination 3)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (7-day)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	No bias	N/A

Source: BHC, Inc., 2013 External Quality Review Performance Measure Validation

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 following table summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.

Table 26 - Final Audit Rating for MO Care Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Fully Compliant
Childhood Immunizations Status	Fully Compliant
Follow-Up After Hospitalization for Mental Illness	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 MCHP. 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 Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the MCHP. The Childhood Immunizations Status rate was consistent with the average for all MCHPs, the Follow-Up After Hospitalization rates were consistent with the average for all MCHPs, and the Annual Dental rate was **lower** than the average for all MCHPs.

QUALITY OF CARE

MO Care's calculation of the HEDIS 2013 Follow-Up After Hospitalization for Mental Illness measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered.

The MCHP's 7-day and 30-day rates for this measure were consistent with the average for all MCHPs. Therefore, MO Care's members are receiving a similar quality of care for this measure as the average MCHP member.

Both the 7-day and 30-day rates were **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving a **lower** quality of care than the average Medicaid or Commercial member across the country. However, the 30-day rate is **higher** than the rate reported in the HEDIS 2012 audit, indicating the quality of care to members has risen over the past measurement year.

ACCESS TO CARE

The HEDIS 2013 Annual Dental Measure for MO Care was fully compliant with specifications; this measure is categorized as an Access/Availability 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 MCHP for this measure was **lower** than the average for all MCHPs. Therefore, MO Care's members are receiving a quality of care for this measure that is on level with the average Managed Care member. This rate was **lower** than the National Medicaid rate for this same measure, indicating the MCHP's members are receiving a **lower** access to care than the average Medicaid member across the nation. However, while the rate had continued to fall from 2007-2009, the last three HEDIS audit years (2010, 2011 and 2012) have shown

substantial improvement, indicating an improved access to care for MO Care members.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2013 Childhood Immunizations Status measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received.

The MCHP's reported rate for this measure was comparable to the average for all MCHPs. Therefore, MO Care's members are receiving a consistent level of timeliness of care for this measure than the care delivered to the average Managed Care member.

The rate was **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving Childhood Immunizations in a manner **less** timely than the average Medicaid or Commercial member across the country. Unfortunately, this rate shows a steady downward trend since 2011.

RECOMMENDATIONS

1. Although, the MCHP's rate for the Annual Dental Visit measure has risen substantially in the last four review periods, this year's rise was not as dramatic. The MCHP should examine the reasons for this decline in the trend.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Continue to participate in training of MCHP 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.
5. The 7-day Follow-Up After Hospitalization for Mental Illness measure has decreased again for this review year. The EQRO recommends that the MCHP focus on interventions to reverse this trend in rate.
6. The 30-day FUH rate responded significantly for HEDIS 2013, the interventions utilized for this rate may be able to be implemented in the 7-day rate as well.

8.3 MCHP Compliance with Managed Care Regulations

METHODS

Missouri Care (MO Care) was subject to a full compliance audit during this on-site review. The content of this 2013 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

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

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MO Care's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, MO Care will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

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

PM = Partially Met
Documentation supports some but not all components were present.

N = Not Met
No documentation found to substantiate this component.

N/A = Not Applicable.
Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 26.

Table 27 - Comparison of MO Care Compliance Ratings for Compliance Review Years

Measure	2010	2011	2012	2013
Enrollee Rights and Protections	100%	100%	100%	100%
Access and Availability	76.5%	82.35%	88.24%	70.59%
Structure and Operations	100%	100%	100%	100%
Measurement and Improvement	100%	90.90%	90.90%	81.8%
Grievance Systems	88.9%	100%	100%	100%

Source: BHC, Inc., 2013 External Quality Review Compliance Validation

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2013 review, MO Care was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2010, 2011 and 2012.

MO Care was acquired by Well Care during calendar year 2013. The MO Care staff feels that they have access to more resources from the Well Care corporate team and they have continued to participate in community-based programs throughout all three MHD regions. They were involved in school-based health clinics whenever possible. A quarterly newsletter for school nurses was developed and continues to be distributed by the MCHP.

The rating for Enrollee Rights and Protections (100%) reflects that the MCHP complied with the submission and approval of all policy and procedures to MO HealthNet. All practice observed at the on-site review indicated that the MCHP appears to be fully compliant with MHD Managed Care Contract requirements and federal regulations in this area.

Access Standards

Access and Availability addresses 17 standards. For the 2013 review, MO Care was rated by the review team to have met 12 standards. This is an overall rating of 70.59%, which is **lower**

than the 88.24%, in fact, this rating is the lowest received since the EQRO has been validating compliance in this area.

The lower rating in this area is mostly attributable to the Case Management record review performed by the EQRO. In the Case Management review, the EQRO found that MO Care did not obtain PCP participation as needed, a lack of treatment plans and assessments in case records were also observed.

MO Care submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff, full evidence of treatment planning for members was not available.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2013 review, MO Care was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2010, 2011 and 2012. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the seventh year. The MCHP 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.

During the 2011 Calendar Year, the MCHP became NCQA accredited and continues to follow NCQA standards regarding credentialing. All credentialing performed by MO 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 MCHP does monitor the subcontractors, detailed histories, problem resolution, and performance improvement are reviewed each year.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2012 review, MO Care was rated by the review team to have met 9 standards; two standards were "Partially Met"; and one standard was found to be Not Applicable. This is an overall rating of 81.8% compliance, which is **decrease** from the 90.90% compliance rating received in 2011 and 2012 and the 100% ratings received in 2009 and 2010.

MO Care continues to operate a Quality Management Oversight Committee. The goal of this group was to provide oversight of all operations and MCHP initiatives.

The MCHP did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation, however the quality of one of the PIPs was **lower** than the quality observed during prior reviews. A new HEDIS toolkit was developed and distributed to providers in 2013, the toolkit contained information on the HEDIS technical specifications and will be utilized in a Pay for Performance project in 2014. All Performance Measurement data and medical records requested were submitted for validation within requested timeframes. More specific details can be found in the appropriate sections of this report.

The rating for the Measurement and Improvement section 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 MHD Managed Care contract and the federal regulations.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2013 review, MO Care was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance, which is **higher** than the rating received in 2010 (88.9%) and consistent with the 100% rating received in 2011 and 2012.

Ratings for compliance with the Grievance Systems regulations (100%) indicate that the MCHP completed all of the requirements regarding policy and practice. This is the seventh out of eight years that the MCHP is fully compliant in this section of the review.

CONCLUSIONS

MO Care continues to maintain compliance in all areas of policy, procedure, and practice required by the MHD Managed Care contract and the federal regulations. The MCHP utilizes a proactive approach to identifying issues discussed in previous External Quality Reviews, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to the SMA in a timely and efficient manner.

The staff at MO Care exhibits a commitment to quality and integrity in their work with members. The MCHP 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. They are committed to this integrated approach where case managers utilize the areas of expertise of their team members, yet provide individualized services to members to eliminate confusion. MO Care has created tools to educate and inform the community and providers.

However, a few issues were identified during this year's review, including:

- Missing treatment plans and little involvement of PCPs in the Case Management files.
- Quality was lacking in one Performance Improvement Project.
- Lower rates in Performance Measures than in previous review years

QUALITY OF CARE

Quality of care is a priority for MO 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. They are making a concerted effort to extend this approach to all three MHD Regions. MO 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 MCHP staff, who express enthusiasm for their roles in producing sound healthcare for their members.

However, missing assessments and treatment plans in Case Management files indicates that an improvement can be made in this area to ensure that the evidence exists to support that the quality of care received by members in Case Management matches that delivered in other areas

of the organization.

ACCESS TO CARE

MO Care has made concerted efforts to ensure that members throughout their MHD Regions have adequate access to care. They have recruited additional hospitals and individual providers into their network. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services. The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

TIMELINESS OF CARE

MO 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 greatly improved 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 MCHP has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of MO Care's **lower** rates in this year's review.
2. Consider training with Case Management staff regarding treatment planning as this is an area that was lacking in the files reviewed by the EQRO.
3. Show all Performance Improvement Projects the level of commitment that has been granted in the past, successful PIPs can drive the MCHP's future.
4. Continue to develop and improve the multi-disciplinary approach to working with members that have complex health care issues.