2015

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

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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.BHCinfo.com
Email: amccurry@bhcinfo.com

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1.0 EXECUTIVE SUMMARY

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I.1 Introduction

The United States Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (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**
Aetna Better Health of Missouri (Aetna Better Health)	Aetna, Inc.	September 1995
Home State Health (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 (PIPs)[2]
2) Validation of Performance Measures[3]
3) Compliance with Medicaid Managed Care Regulations[4]
4) Optional Activity: 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 a total of six PIPs that were conducted during 2015. The focus of PIPs is to study the effectiveness of clinical or non-clinical interventions. 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 are provided to each MCHP by the EQRO during on-site visits. The technical assistance focuses on improving study methods, data collection, and analysis.

Eligible 2015 PIPs for validation were identified by the MCHPs, State Medicaid Agency: Missouri Department of Social Services, MO HealthNet Division (MO HealthNet), and the EQRO. The final selection was made by MO HealthNet in February 2016. Improving Oral Health, a statewide PIP, was selected as the non-clinical PIP for all of the MCHPs.

A list of all evaluated PIPs and brief summary of compliance is included in Table 1.

Table 1- Summary Performance Improvement Validation Findings, by MCHP

PIP Title	Overall Rating
Aetna Better Health Improving Childhood Immunizations	93.33%
Aetna Better Health Improving Oral Health	75%
Home State Improving Immunization Rates in Home State Members in the First 2 Years of Life	100%
Home State Improving Oral Health	76.19%
MO Care Post Mental Health Hospitalization Follow-Up Care within 7 Days of Discharge	90.91%
MO Care Improving Oral Health	87.50%

Note: This table is a summary of the data contained in Table 3 of this report, found in Section 2.3.

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

QUALITY OF CARE

The topics identified by all MCHPs for their PIPs provide evidence of their commitment to providing quality services to their members. However, the interventions for these PIPs were less thorough and well-developed than seen in previous years. The PIPs did focus on improving direct services to members. Some PIP interventions were designed to address barriers to quality care. These included; partnering with Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs). These initiatives targeted members who were not utilizing their benefits in the areas of childhood immunizations, follow-up after hospitalizations for mental health issues, and annual dental visits.

Other PIPS did not identify effective or current interventions specific to the 2015 review. This is an area to be addressed in future PIPs. All of the PIPs reviewed included the stated goal of providing

quality healthcare services. The MCHPs must focus on new and creative initiatives that help them meet this goal.

Access To Care

The MCHPs developed projects that targeted improved availability to obtain dental care, childhood immunizations, and mental health services following an inpatient hospitalization in access to care PIPs. All of these projects have the potential to create improved preventive and primary care for members. At the time of this review, all the clinical PIPs were too new to assess their success. Conversely, the non-clinical PIPs regarding improved annual dental visits had some measurable success. However, these non-clinical PIPs have not yet reached their goals of improving by 3% each year. The EQRO's on-site discussions with MCHP staff indicated that improving access to care is an underlying goal of all the projects they develop.

Timeliness of Care

Timeliness of care was also addressed in the PIPs reviewed. Projects addressed timely access to follow-up mental health services and childhood immunizations. The projects concentrated on the need for timely and appropriate care for member. The PIPs related to Improved Oral Health included interventions to improve timeliness of care. Examples of these interventions include: engaging a new FQHC to partner in providing dental services; identifying new providers; new approaches to member engagement; developing "dental homes" so members are aware of their provider; and activities to ensure access to services when they are needed.. These interventions and discussions with MCHP staff reflect an awareness of the importance of timely healthcare.

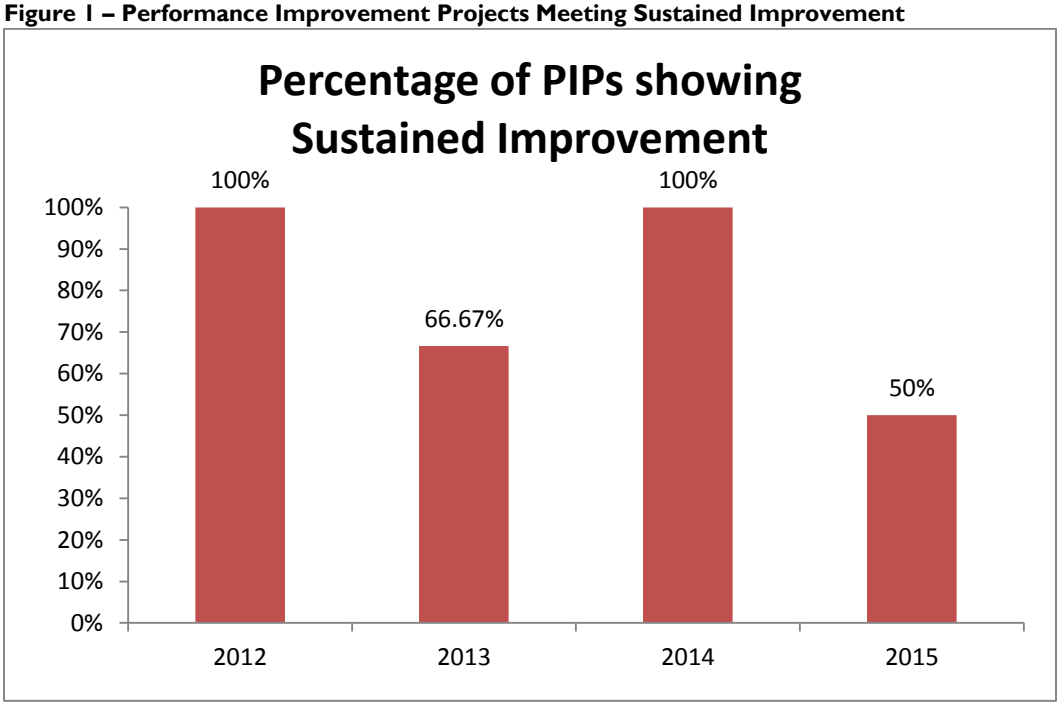
Conclusions

The aggregate rating for meeting all the requirements of PIP Validation Rating has increased substantially from the 25.1% rating received the first year PIPs were reviewed (2004); the 2015 review year saw a decrease to 86.89% from the 2014 rating of 99.10%. The MCHPs are using the PIP methodology to design studies that incorporate quality improvement principles to enhance members' services. A renewed focus by all MCHPs on implementation of new interventions each year creates an environment that produces quality healthcare for members. This is an area where the MCHPs need continued development.

Figure 1 depicts an essential element of validating these projects. That is the projects' ability to create sustained improvement, or produce repeated improvement over more than one measurement period. For this element, the EQRO assesses each PIP to determine if real change is the result of improvement in the fundamental processes of the MCHPs' health care delivery system; or if change is only a "one time" alteration that can be attributed to accidental occurrences or random chance. This is determined by evaluating a number of factors, including:

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

Figure 1 – Performance Improvement Projects Meeting Sustained Improvement



Source: BHC, Inc., 2012-2015 External Quality Review Performance Improvement Projects Validation

In 2015, two PIPs were considered mature enough to evaluate for sustained improvement. These were Aetna Better Health and MO Care's Improving Oral Health PIPs. Aetna Better Health's PIP was determined to have reached sustained improvement in each of the last four years. MO Care's Improving Oral Health non-clinical PIP received a rating of "Partially Met" for this element in 2015. The MCHP failed to include any analysis of one region where the HEDIS measure rate had declined.

MO Care's submission for this PIP was considered to have reached sustained improvement in the 2012 and 2014 review years. Although MO Care's PIP was mature enough to evaluate in 2013, data issues prevented the PIP from meeting all the requirements necessary to achieve sustained improvement during that review year. Additionally, in each of the prior years, one clinical PIP met the requirements of achieving sustained improvement. In 2012, it was the Comprehensive Diabetes clinical PIP submitted by MO Care; in 2013 it was the Notification of Pregnancy Form clinical PIP submitted by Home State; and in 2014 it was Aetna Better Health's Reducing Readmission Rate for Asthma Patients clinical PIP that met the requirements of reaching sustained improvement.

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 MO HealthNet 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 2015 evaluation period, the three performance measures selected for validation included:

1. HEDIS 2015 measure Childhood Immunizations Status, Combination 3 (CIS3);
2. Emergency Department Visits (EDV); and
3. Emergency Department Utilization (EDU).

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.

QUALITY OF CARE

The Emergency Department Utilization measure was first audited during this review year. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Use. This information is useful to the MCHPs to determine if the ED is being utilized properly by its members. The MCHPs can also use this information to ensure that the quality of care necessary for members is available in the ED for the non-medical categories.

All three MCHPs received ratings of Substantially Compliant with the specifications for calculation of this measure (See Table 5). However, the EQRO is only confident in the rate validated for MO Care, as this rate had an estimated bias of only 0.04%. The EQRO is not confident in both the Aetna Better Health and Home State rates as neither MCHP's eligibility file could be substantiated and the EQRO was unable to validate the companion rate of EDV-medical.

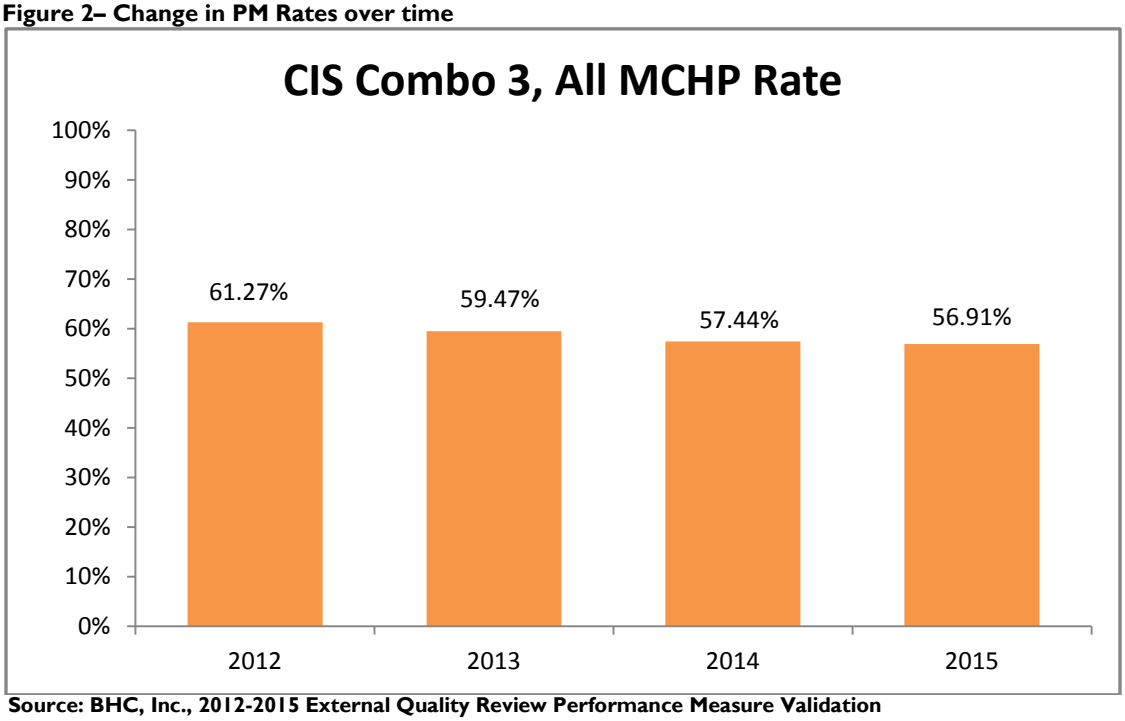
Access To Care

This Emergency Department Visits (EDV) measure is intended to measure the number of ED visits recorded for the MCHP. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Use.

Two of the three MCHPs (Aetna Better Health and Home State) had the EDV measure rated as Not Valid by the EQRO. One MCHP (MO Care) was Substantially Compliant with the specifications for calculation of this measure.

This was the first year for a review and audit of the EDV measure. The EQRO did not receive the same quality of data in the requested files from the two MCHPs who were rated as Not Valid. Aetna Better Health supplied a file containing 115,823 records, but they reported to MO HealthNet a total of 207,717 EDV-medical visits. The records supplied did not substantiate that number. Home State supplied records that indicated almost twice as many hits as they reported to MO HealthNet. Only MO Care supplied records that were consistent with the measure specifications. When analyzed these records produced results that were in line with the reported number of hits.

Figure 2– Change in PM Rates over time



Source: BHC, Inc., 2012-2015 External Quality Review Performance Measure Validation

TIMELINESS OF CARE

The HEDIS 2015 CIS3 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).

All three MCHPs validated by the EQRO were Fully Compliant with the specifications for calculation of this measure. However, all MCHPs fell well short of the National Medicaid Average of 70.4% and the National Commercial Average of 78%.

Aetna Better Health's rate of 64.72% represented a 1.95 point decrease from the 2014 rate of 66.67%. MO Care's rate of 62.77% represented an 11.84 point increase from the 2014 rate. However it is a 3.67 point decrease since 2012. Home State's rate of 51.53% was a 4.79 percentage point decrease from their 2014 rate of 56.32%.

CIS3 has been audited yearly since 2011; therefore, trend analysis was examined for this 2015 audit year. It was found that the statewide rate has steadily decreased since 2012.

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 MO HealthNet 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 Quality Assessment and Improvement category was further subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, MO HealthNet 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 2015) is a full compliance review and will have two follow-up years in 2016 and 2017. The SMA reviewed current policies and procedures to ensure they were in compliance with the both current contractual requirements and federal regulations. The EQR Compliance Review focused on implementation of policies and procedures. The review also included a focus on Case Management including 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 MCHP's 2015 Annual Report to MO HealthNet and MO HealthNet's Quality Strategy.

The EQRO's review process included gathering information and documentation from MO HealthNet 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 practices 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.

For the sixth consecutive year, none of the MCHPs were able to demonstrate 100% compliance with all requirements related to case management and care coordination.

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.

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 fifth consecutive year that all of the MCHPs maintained a 100% rating in this set of regulations.

Access To Care

Two MCHPs (Aetna Better Health and Home State) were consistent in their compliance with the 17 federal regulations concerning Access Standards during this year's review, although this remains one of the lowest rated areas. These two MCHPs received the highest rating received in this area at 76.47% compliance with the required standards.

For the 2015 review, there was one regulation rated as "Not Met" for all three MCHPs and one additional regulation rated as "Not Met" for one MCHP (MO Care). This is a decrease from the 2014 review, where none of the regulations were found to be "Not Met" and is consistent with both the 2012 and 2013 reviews, when 4 regulations were rated as "Not Met". Across all MCHPs, the rate of regulations "Met" for the 2015 review (72.55%) is a decrease from the 2014 and 2013 rates of 78.43% and 74.51%, respectively. Aetna Better Health and Home State were found to be 76.47% compliant and MO Care was 64.71% compliant.

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 described efforts to participate in community events and forums to provide education to members regarding special programs available.

Timeliness of Care

Timeliness of care is an area of decline in compliance for all the MCHPs. Nine of the eleven applicable regulations for Measurement and Improvement were 100% "Met." 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. The MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. However, lower Performance Measures and PIP performance contributed to this decline.

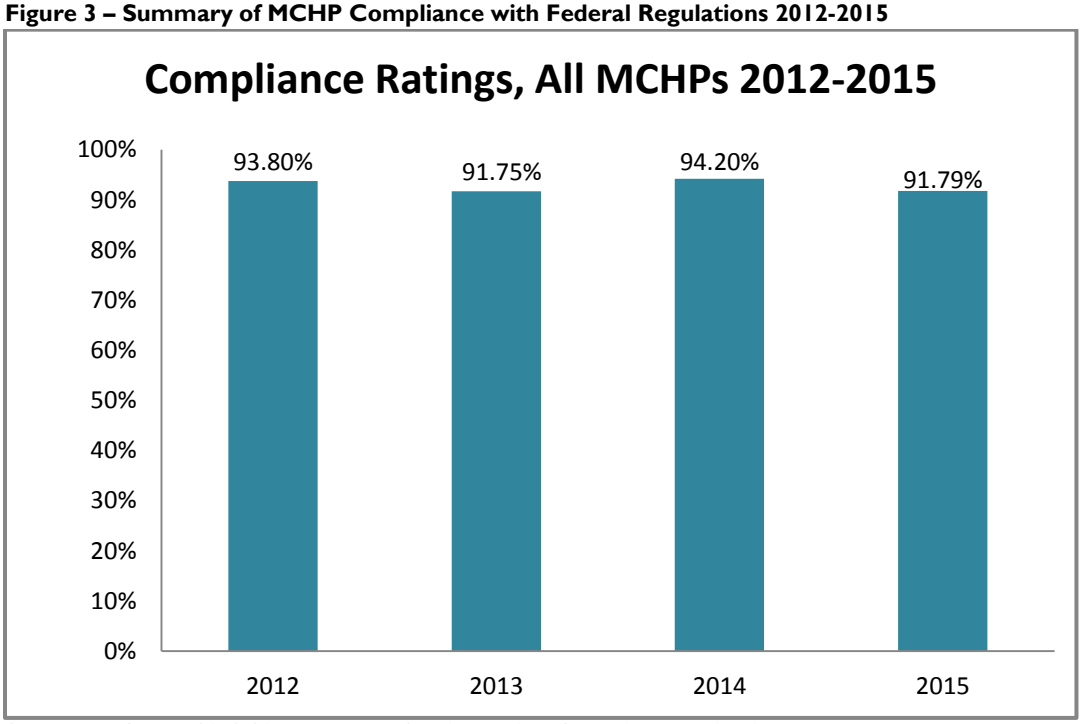
The MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs.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

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 the EQRO began reviewing compliance in 2004, the MCHPs have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially, 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.

Figure 3 – Summary of MCHP Compliance with Federal Regulations 2012-2015



Source: BHC, Inc., 2012-2015, External Quality Review Compliance Validation

All MCHPs were 100% compliant with three of the compliance areas validated during this review year. For the sixth year in a row, none of the three MCHPs were 100% compliant with all requirements, due in large part to the issues the EQRO found in the MCHP's compliance with Case Management requirements and the Provider Availability study. The 2015 overall rating is a 2.41 percentage point decrease from the 2014 overall rating of 94.20%, which was the highest overall compliance rating received by the MCHPs to date.

1.5 MO HealthNet MCHP Case Management Performance Review

In 2010 the EQRO began conducting a special project related to the provision of Case Management services by the MCHPs. 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. This involved the evaluation of the MCHPs' compliance with the federal regulations and the Managed Care contract as it pertained to Case Management.

The focus of this review was as follows:

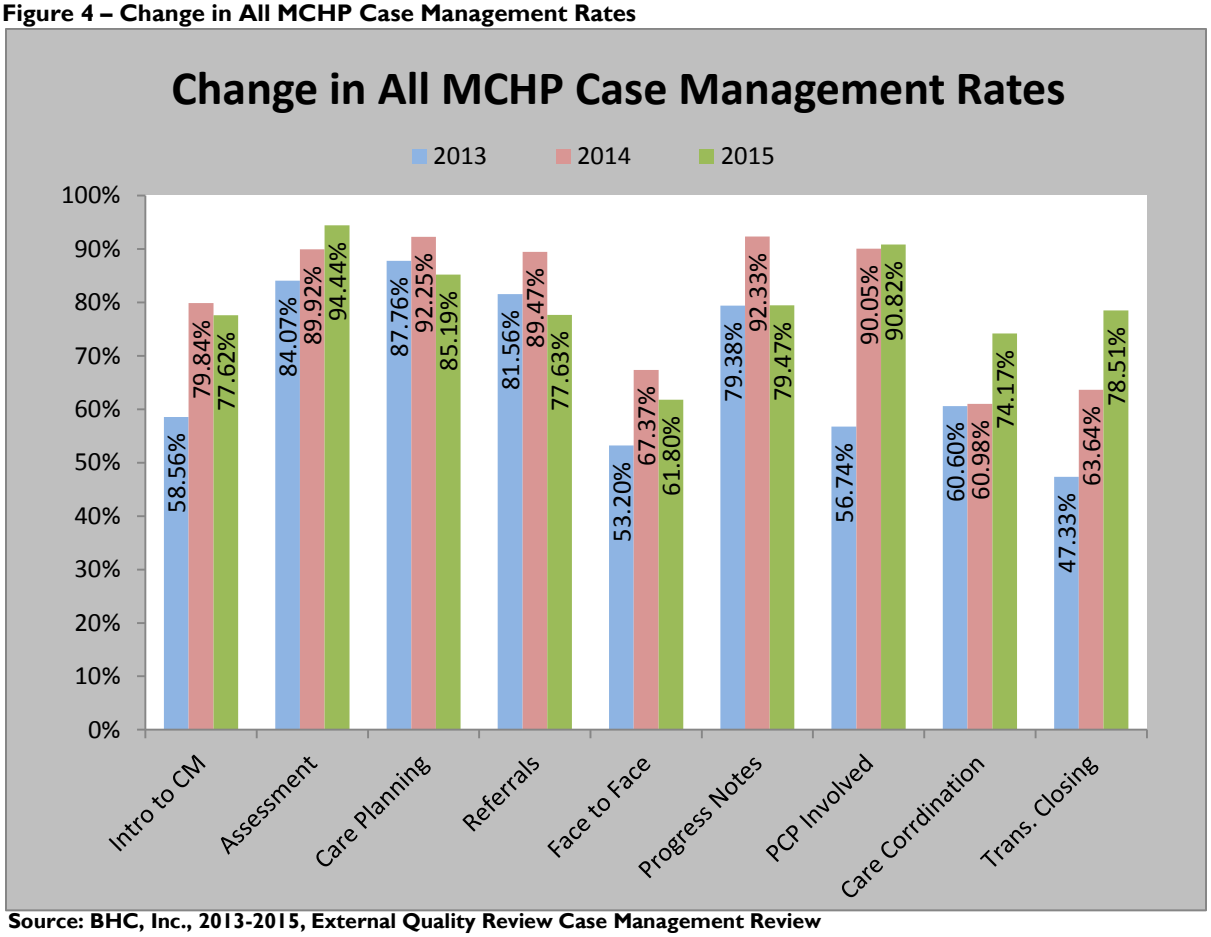
- Assessing the MCHPs' attention to and performance in providing case management to:
    a. Pregnant members;
    b. Members with special health care needs; and
    c. Children with elevated blood lead levels.
- Evaluating compliance with the case management requirements of MHD Managed Care contract;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

There are nine categories in which each MCHP is evaluated for compliance with the Case Management requirements of their MHD Managed Care Contract. These contract categories include:

- Introduction to Case Management
- Assessment
- Care Planning
- Referrals
- Face to Face Contacts
- Progress Notes
- PCP Involvement
- Care Coordination
- Transition At Closing

The following figure depicts the change in Case Management ratings received for all MCHPs between 2013 and 2015.

Figure 4 – Change in All MCHP Case Management Rates



Source: BHC, Inc., 2013-2015, External Quality Review Case Management Review

QUALITY OF CARE

When members are properly introduced to and engaged in case management the quality of service delivery improves. For example, case managers maintain contact with the members they serve throughout the case management process. Case record reviews and interviews substantiate that in some cases the case manager advocates for extraordinary services to meet a member's healthcare needs.

- Aetna Better Health improved in four of the nine areas measured. The MCHP has dedicated case management staff. These case managers exhibit their commitment to providing quality care to members when responding to inquiries during the on-site interview process. However, the

MCHP has not created new or innovative approaches that foster the improvements needed throughout their case management program. The declining numbers observed during 2015 indicate that requirements of the case management program are not receiving the attention necessary to maintain previous accomplishments. Problems within six standards of the Lead case management program were identified. These deficiencies must be addressed.

- Missouri Care improved in two of the nine areas measured in this review. There is a need for improvement in all aspects of member services. One specific area of concern is Lead Cases. Deficiencies in these cases resulted in declining numbers throughout the review. The MCHP partners with the Children's Mercy Pediatric Care Network (PCN) in the Western Region. These PCN cases indicated a high standard of case management services that promoted quality care for members.
- Home State improved in five of the nine areas measured. The MCHP remains committed to improving case management and developing quality member services. In two of the areas where the MCHP improved, introduction to case management and assessment, indicate a strong effort to contact and engage members into case management. Assessment forms were found in 100% of the records reviewed. Comprehensive assessments were found in 80% of the cases, which indicates a need to better identify and articulate members' healthcare needs.

Access To Care

Access to care was enhanced when case managers actively worked with families. Reviews indicated that the creative efforts used to locate members have diminished. MCHPs continue to use 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 need to contact a variety of sources to track members' whereabouts and make required contacts. In some 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 when case managers make an active effort to assist members in obtaining services, community or provider based, which uniquely meet members' needs. Case managers are knowledgeable about available resources. Fewer attempts to connect members to these resources were observed during 2015.

- 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 report their contacts. The MCHPs all declined in making referrals for face-to-face contacts. A specific area of concern is in Lead cases. In lead cases in-home services are required. The number of members who received a referral for face-to-face services in lead cases ranged from 33.37% for Aetna Better Health to 71.43% for Home State. The difficulty of engaging families into the lead case management program is recognized. However, these figures reflect a percentage of cases where there was no referral for in-home services even when a contact was made with the family.
  - When consistent case/care coordination occurred case managers avoided duplication of services, and maximized MCHP resources. Care coordination improved for two MCHPs. The case records reviewed included notes and documentation that this service increased to 80% for Aetna Better Health and 84.62% for MO Care. Home State declined by 3.65 percentage points.

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.

- In the OB the cases reviewed, where there was evidence of active case management, follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within specified time frames. Parents who received these services often enrolled their babies with the MCHP and ongoing preventive care was initiated.
- 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. Creating a transition plan prior to case closing improved for two MCHPs, Aetna Better Health and MO Care, by nearly 20 percentage points. Case managers were diligent in maintaining contact through case closure. One MCHP,

Home State, declined by 5.94 percentage points. Their case records indicated a failure to complete a transition plan or send a closing letter to members.

- In past reviews it appeared that after members' health care needs are met, the member lost interest in case management and no longer returned calls or responded to letters requesting they contact the case manager. This remains a problem but is in fewer cases reviewed. Case managers at all MCHPs find this troubling and continue their efforts to maintain a relationship with members through closing their case. The case managers continue to experience members contacting them 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 continues to require attention. However, Aetna Better Health did improve in this area reaching a rate of 94.23%. MO Care and Home State rates remained consistent with the previous year's report.
  - 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 report that speaking with provider offices regarding most of their members regularly. Some of these contacts were found in case notes, but this is an area that requires continued attention.

1.6 Managed Care Heath Plan Report Card

Figure 5– 2015 Managed Care Report Card

MCHP	PIPs	PM Validation	Compliance	Case Management	Score	Grade
Aetna Better Health	82.05%	50%	91.30%	81.32%	76.17%	**C**
Home State	86.49%	50%	89.86%	73.59%	74.99%	**C**
MO Care	89.13%	66.67%	94.20%	75.62%	81.41%	**B-**

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

*For the scores awarded on each PIP, please see Table 5 in Section 3.0 of this report.

Note: Each Fully Compliant rating received 2 points, Each Substantially Compliant rating received 1 point and each Not Valid rating received 0 points.

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.

2.0 VALIDATING PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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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 State Medicaid Agency (SMA: the Department of Social Services, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2015. This included evaluating the Statewide Project entitled "Improving Oral Health."

2.1 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 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 were provided to each MCHP by the EQRO during on-site visits.

2.2 Findings

The PIPs identified for validation at each MCHP are:

Aetna Better Health	Improving Childhood Immunizations Improving Oral Health
Home State	Improving Immunization Rates in Home State Members in the First 2 Years of Life Improving Oral Health
MO 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 2.

Table 2 - Performance Improvement Validation Findings, by MCHP

Steps		Aetna Better Health		Home State		MO Care	
		Improving Childhood Immunizations	Improving Oral Health	Immunization Rates in Home State Members in the First 2 Years of Life	Improving Oral Health	Follow-Up Care within 7 Days of Discharge	Improving Oral Health
1: Selected Study Topics	1.1	2	2	2	2	1	2
	1.2	2	2	2	2	2	2
	1.3	2	2	2	2	2	2
2: Study Question	2.1	2	2	2	2	2	2
3: Study Indicators	3.1	2	2	2	2	2	2
	3.2	2	2	2	2	2	2
4: Study Population	4.1	2	2	2	2	2	2
	4.2	2	2	2	2	1	2
5: Sampling Methods	5.1	NA	NA	NA	NA	NA	NA
	5.2	NA	NA	NA	NA	NA	NA
	5.3	NA	NA	NA	NA	NA	NA
6: Data Collection Procedures	6.1	1	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	2	2	2
	6.6	2	2	2	2	2	2
7: Improvement Strategies	7.1	2	1	2	2	2	2
8: Analysis and Interpretation of Study Results	8.1	NA	2	2	2	2	2
	8.2	NA	2	NA	1	2	2
	8.3	NA	1	NA	1	2	1
	8.4	NA	1	NA	1	2	1
9: Validity of Improvement	9.1	NA	2	NA	1	2	2
	9.2	NA	1	NA	1	2	2
	9.3	NA	1	NA	NA	2	2
	9.4	NA	1	NA	NA	NA	2
10: Sustained Improvement	10..1	NA	2	NA	NA	NA	1
Number Met		14	18	16	16	20	21
Number Partially Met		1	6	0	5	2	3
Number Not Met		0	0	0	0	0	0
Number Applicable		15	24	16	21	22	24
Percent Met		93.33%	75%	100%	76.19%	90.91%	87.50%

CLINICAL PIPS

Aetna Better Health

Aetna Better Health's clinical PIP was developed to improve the rate of childhood immunizations for MCHP members up to 2 years of age. They recognized that the MCHP had a problem with the number of children who were receiving the correct vaccinations throughout their early childhood. Vaccinations are a primary method to provide preventive healthcare to their members. The MCHP found that an important outcome of childhood immunization is preventing illness for their members. To expand on this, they provided research pointing out that increasing the number of children who are vaccinated provides another layer of protection to the community. When most of the members of a community are immunized against a contagious disease, there is little opportunity for an outbreak of that disease.

Aetna Better Health created a PIP with plan-specific interventions that address a complete set of vaccinations required. The data analysis will audit compliance rates for all 14 vaccinations in addition to Combo 3. The goal of this PIP is to increase the compliance rate of each of the sub-measures within the Combo 3 vaccinations to 90% by the second year of the PIP.

Focusing MCHP resources on increasing the number of children receiving all necessary immunizations will improve their goal of increasing preventive services. The baseline year for this PIP is calendar year (CY) 2015. Interventions were developed to begin in January 2016. Their interventions will be developed to address the following barriers:

Member Barriers:

- Parents or caregivers do not support immunizations
- Parents are unaware of the need to schedule immunizations for their children
- Some parents are unable to get to a doctor's office or health department during routine hours
- Fear of vaccinations causing Autism or Mercury Poisoning

Provider Barriers:

- PCPs do not provide immunizations causing the member to find another site and a second visit to obtain them

- Provider offices do not remind patients or schedule routine visits in the future

Plan Barriers:

- Aetna Better Health is not informed if a member obtains immunizations through their local health department. Local health departments do not necessarily bill for immunizations and therefore these actions are not captured in HEDIS administrative data. Aetna Better Health also performs a hybrid review, but unreported health department activities are not available for a record pull. Some health departments are not aware of the importance of the HEDIS reporting process.
- The MCHP does not have access to the DHSS immunization registry, and files sent by the State have not been consistent Up to this point the DHSS has not readily shared registry data with the MCHPs. Aetna Better Health has experienced a data flow problem from the State database to the MCHP database. During 2016, a quarterly submission of this information, generated by MHD began, which may improve data sharing in the future.
- Aetna Better Health lacks a consistent process ensuring that files received are entered into their HEDIS system.
- There is an overall lack of consistent data regarding which children receive immunizations.

The interventions planned as the result of this barrier analysis include:

- Use of text messaging to remind parents of newborn children to get their child immunized
- Use of the current mailer that is sent to children's households between the ages of 12 and 15 months of age to target immunization information
- Targeted phone call outreach to parents/guardians of members from birth to 15 months of age who have missed well child visits, and consequently immunizations
- Collaboration with Head Start programs and County Health Departments to identify intervention opportunities

Aetna Better Health has established their baseline using HEDIS 2016 rates. The Quality Improvement team continues to meet to establish more material interventions and to assess all potential barriers. The full implementation of this PIP begins in January, 2016. The MCHP recognizes that the problems outlined in their Study Topic continue to exist, and will use this PIP to remediate the issues addressed.

Home State

Home State's clinical PIP was implemented in July, 2015. The MCHP recognizes that childhood vaccinations protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough at a time in their lives when they are most vulnerable to disease. The goal of this project is to ensure that members receive all appropriate immunizations by age 2. The MCHP is implementing this PIP to attain a target rate of 90% for the number of 2 year olds who receive the required vaccinations by the completion of this project.

Home State identified that a lack of parental knowledge, and misinformation regarding the benefits of immunizations, hinder members from obtaining their vaccinations. These include:

- Lack of knowledge and a belief that immunizations do not protect children from serious illness
- A belief that immunizations are not safe and effective at protecting children from disease
- A lack of knowledge that immunizations are required for school and child care activities
- A lack of knowledge about the importance of each child obtaining immunizations to protect the community

Home State designed the following interventions to assist in ameliorating this problem:

- Member education and outreach to provide information regarding strategic milestones and wellness activities including immunizations.
- Monthly assessment of member engagement, and additional member outreach.
- An EPSDT Pilot using text messaging and tangible incentives on a sample of 3,000 members. The MCHP achieved success in improving immunization rates for members who participated. They are now seeking approval to expand this pilot statewide.
    - The MCHP considers this pilot a success. Invitations were sent to 3,000 members and 50% responded and registered for the incentive program. The number of members obtaining their wellness visits and immunizations was 13.99% of the pilot group. Plans are to implement this incentive program in all regions in 2016 with MHD approval.
- In the 4th quarter of 2015 Home State began a provider incentive program encouraging the closure of all member gaps in care, including the childhood immunizations. Nine FQHCs participated, and closed all care gaps for 246 members.

- FQHCs are currently contacting the MCHP to partner in the program to expand member engagement outside of the incentive program.

Home State has developed new programs to be implemented during CY 2016. They trust that they will continue to achieve success by expanding these programs and implementing new interventions during 2016.

The result of the CY 2015 efforts was a slight increase in both Combo 3 and Combo 10 rates from 2014 to 2015 (1.37 percentage points for Combo 3; 1.54 percentage points for Combo 10). Home State experienced a 32% increase in membership during CY 2015 as the result of auto assignment of cases, which brought them in line with the State mandated 20% membership floor in each region. They believe that as these new members experience the benefits of the MCHP and are introduced to wellness programs additional improvement will be experienced.

Missouri Care

MO Care's clinical PIP focused on improving follow-up after hospitalization for mental illness within seven (7) days. This PIP was originally implemented in 2005 and was enhanced and reviewed in 2013. The MCHP updated the interventions used. They intend to improve its members' mental health outcomes through education and ongoing interventions. One of the projects started in 2015 was a pilot program that introduced provider incentives at three community mental health centers. The MCHP also implemented case management, utilization management and other health plan interventions to improve members' mental health outcomes. Inpatient stay may be necessary to reduce a danger to the member or others. However, the MCHP found that the probability of long-term recovery is enhanced when patients utilize both inpatient and outpatient resources effectively. Follow-up therapy has been found to be a preventive factor against readmission.

MO Care chose a multi-faceted approach to ensure that members and providers were both engaged in improving services to members. Interventions implemented during 2015 included:

- Member engagement –
  - Health Rewards Program
  - Krames On-Demand
  - Missouri Coalition of CMHCs

- Provider engagement –
    - Behavioral Health Provider Incentive Program Pilot
    - HEDIS Behavioral Health Toolkit
    - Participation in the Behavioral Health Partnership
    - Education
    - "Gold Card" Project

The HEDIS rates did improve from the rate of 32.78% in CY 2014 to 35.46% in CY 2015. MO Care insists that their dual approach initiatives will impact both providers and members to improve members' mental health outcomes by receiving the necessary follow-up appointments. The success of the provider and member incentive programs are continuing to be evaluated for their positive impact on this measure. According to MO Care implementation of case management and utilization management programs, and other interventions employed for this PIP are having a positive impact on members. The MCHP has confidence that their multi-interventional approach will ensure that rates continue to improve.

MO Care continues to experience lower rates than those reported in CY 2012 and 2013. The large decline in CY 2014 was attributed to an internal data error where their system was not pulling all diagnosis codes correctly. However, they did not return to the rates observed in prior years. The results of each year are as follows:

- CY 2012 – 37.04%
- CY 2013 – 39.36%
- CY 2014 – 32.78%
- CY 2015 – 35.46%

The increase experienced in CY 2015 did not meet the MCHP's goal of 38.78%. They contend that some of the improvement is the result of their provider incentive program involving three of the largest CMHCs in the state.

MO Care reiterates that they have confidence in their multi-interventional approach to creating improvement in the 7-day follow-up after a mental health inpatient hospitalization HEDIS rate. They plan to continue all of these efforts and have developed new interventions to improve and sustain this HEDIS measure.

NON- CLINICAL PIPS

Each of the MCHPs had a non-clinical PIP that focused on the Statewide PIP initiative "Improving Oral Health."

Aetna Better Health

Aetna Better Health's non-clinical PIP included information related to the statewide PIP and addressed the MCHP's population individually.

The following interventions were added to their previously successful project for CY 2015:

- Working with a new FQHC in the Hannibal area, Clarity Healthcare, to identify non-compliant members affiliated with this FQHC. Clarity would contact these members/parents to remind them of the need for dental care and assist in making appointments
- Continued work with Head Start. Aetna Better Health conducted dental education with children during the day, and with parents at a monthly meeting at Head Start. These programs intended to inform both children and their parents about the existing dental benefits that MHD and the MCHP offer. The programs also reminded members of the importance of good oral hygiene as it relates to children's overall health.
- Work began on building a relationship with one large FQHC, Affinia Healthcare in St. Louis, MO. The MCHP independently and in collaboration with the Dental Task Force, began developing a relationship with the FQHC to ready them for new 2016 initiatives. This FQHC has a new dental facility with 92 dental chairs and is staffed full time. This includes students from A. T. Still University Dental School

The MCHP's HEDIS 2016 results are as follows:

- Eastern Region - Improvements of .73 percentage points;
- Central region – Decreased by .42 percentage points;
- Western region – Decreased by 2.65 percentage points;
- Statewide aggregate – remained the same as the previous year at 50.23%

Aetna Better Health did not meet the HEDIS year goal of 51.74%. This is the second year that the MCHP has failed to meet the 3% annual improvement goal. Data is presented about the

outcomes of this PIP, which include increases through CY 2014. There is discussion about the data and how the figures are analyzed. Aetna Better Health does not provide any reasons or theories about why their approach or interventions have failed to produce the desired outcome. Aetna Better Health recognizes a need for change in future improvement efforts. The narrative explains that the Project Lead will conduct an internal meeting to discuss the current outcomes and the HEDIS 2016 audited data. Major revisions to the PIP to reframe interventions by age-specific categories are proposed. Other progressive changes include strengthening referral practices by medical home PCPs to dental providers; and developing a more robust process of collaborating with the FQHCs throughout the state in an effort to identify and contact non-compliant members. These plans, at the time of the up-dated PIP submission in July were "conceptual in nature," and conversations at the MCHP indicated "promise" toward revitalization of the PIP interventions and outcomes.

Home State

Home State presented information related to the statewide PIP study topic and included reasons explaining how this project was pertinent to their members. The study topic presentation was thorough and focused on enhancing available preventive dental care.

The interventions underway in 2015 were:

- Health Plan Interventions:
    - Collaborate with" St. Louis Medical" on developing a member incentive program, encouraging annual dental visits
    - Developing a Patient Centered Dental Homes model
    - Pilot STL Medical – revised: During 2015 the original pilot focused on dental and was amended to EPSDT. It did retain the initial incentive of a toothbrush, toothpaste, and a clear plastic zipper case. A card was included with instructions on how to register and make well-child appointments before 12/1/2015.
    - Discuss Patient-Centered Primary Care Dentist assignment
    - Developing a Provider Incentive for Care Gap Closure

- Provider Interventions:
    - Dental Health and Wellness Traveling Dental Mobile Units used at MCHP community outreach events
    - Fluoride Varnish application program via a school nurse program
    - November 2015 Home State and Dental Health Wellness attended Affinia Healthcare health fair
    - Initiate a Provider Incentive for Care Gap Closure
- Member Interventions:
    - Issuing Primary Care Dental (PCD) assignment ID cards.

Home State has developed interventions to impact this issue for three full years. They now have three years of results. In CY 2014 the MCHP used HEDIS-like data, and audited HEDIS data for 2015.

The statewide HEDIS rates for these three years were:

- CY 2013 – 42.27%
- CY 2014 – 41.77%
- CY 2015 – 41.11%

There is a decrease of 1.16 percentage points from CY 2013 through CY 2015. This is not a huge decline, although it does give the appearance of a negative trend. When the MCHP began their participation in this pilot they experienced increases in their dental rates. They attributed this to their educational efforts, and an increased familiarity with members and their healthcare needs.

Home State Health provided several reasons why they have experienced declining numbers. In 2015 Home State Health experienced a 33.60% increase in new members with no historical claims data. This was the result of auto-assignment to bring the MCHP in line with the state mandated 20.00% membership. Home State Health contends that the majority of the new members were not exposed to their oral health initiatives for the entire measurement year. Home State Health also noted that they were not able to identify members who had an annual dental visit prior to their becoming Home State Health members. The EQRO finds that this

explanation is problematic as the HEDIS measure only includes members who have been continuously enrolled with the MCHP for the entire calendar year. Therefore, members who came to Home State Health throughout 2015 are not included in the results presented for HEDIS 2016. The MCHP also hypothesizes that "member participation in wellness activities tends to improve" their use of their member benefits as they become more familiar with everything available. Although no data is presented to support this assertion, it does appear to be a logical conclusion.

Home State Health continued innovative approaches that they are confident contributed to their early success. They did recognize that some of their programs such as collaboration with mobile dentistry providers, and engaging school nurses statewide to assist with providing member reminders regarding needed dental care are no longer producing the positive results originally achieved. They are focusing CY 2016 efforts on assigning dental homes and mailing Dental ID cards with assigned dentists to members. This activity and new direct approaches are hoped to create incentives for members to obtain their annual dental visit. Home State Health further asserts that traditional telephonic and paper outreach is not as effective in creating member change as was originally thought. In 2016 new interventions have been implemented to attempt to reach the HEDIS rates that Home State Health wants to achieve.

Missouri Care

MO Care's individualized approach to the Statewide PIP "Improving Oral Health" has the goals to: Improve members' oral health outcomes through education and on-going interventions. Their research found that dental care is the most prevalent unmet health need among children. Access to dental services is an ongoing challenge for their members. The MCHP intends to improve its members' oral health outcomes through education and on-going interventions.

In order to achieve this goal new interventions were implemented during 2015 including:

- Provider Engagement –
    - Missouri Health + Partnership (2015/2016 implementation)
    - Dental Home Pilot Project
    - Black Health Care Coalition
    - Dental Day at Local Community Health Centers (Initiated in 2012 and revised in

2015)

MO Care supplied HEDIS rates for each region as well as the aggregate data. The MCHP achieved the goal of a 3% improvement for the calendar year 2014. The rates and data presented indicate a statistically significant improvement over the previous year. The current HEDIS rates are the highest achieved by the MCHP.

The aggregate rates for the MCHP are:

- CY 2012 – 43.91%
- CY 2013 – 31.39%
- CY 2014 – 45.74%
- CY 2015 – 46.60%

MO Care experienced an increase of .31 percentage points. They did not meet the goal of increasing the ADV rate by 3% in CY 2015. The only decline reported occurred in the Western region where the 2014 HEDIS rate was 45.01%, and the 2015 HEDIS rate was 44.03%. MO Care mentions this outcome several times in their analysis, but has no hypotheses about the cause of this decline.

MO Care did provide a narrative about the outcomes achieved in all three regions, and on the statewide basis for the past 4 years. They assert that the initiatives they have put in place are directly responsible for the improvement attained, even though they did not achieve the 3% increase sought in CY 2015. MO Care states that they will continue to monitor the effectiveness of current interventions, as well as assessing the outcomes of new interventions. The discussion states that the MCHP identified an opportunity to improve member participation by attending dental health fairs. They contend that low participation is related to the inability to contact members due to incorrect telephone numbers. The MCHP plans to partner with providers to reach members with the goal of increasing the member involvement in activities and benefits offered. No other correlations are drawn between the interventions in place and the improvements or lack of improvement in this study. The MCHP is implementing new interventions based on the multi-dimensional approach used in the past. The MCHP's planned interventions include:

- A partnership with A.T. Still Dental School;
- Expanding the dental home pilot program;

- Partnering with the Housing Authority to host back to school health fairs; and
- A No Cavity Club, which includes a fun and interactive program for members, in partnership with DentaQuest their dental subcontractor.

VALIDATION STEPS

Each PIP is validated based on ten steps that are identified in Table 3. This table also provides a summary of how each of these steps was addressed in the studies submitted. In the 2015 review, eight elements were not completely met. The sections considered "Partially Met" are:

MO Care – Clinical PIP

- Step 1.1: This PIP has been in place since 2005, and was reviewed in 2013. No update about current relevance to MCHP members, or what interventions have accomplished was presented.
- Step 4.1: The MCHP did not define or explain an exception to the data to be tracked that was named in the PIP narrative.

MO Care – Non-Clinical PIP

- Step 8.3: The PIP analysis did not include any reason or factors that influenced the Western Region declining outcomes.
- Step 8.4: The discussion recognized the decline in Western Region HEDIS 2016 rates, but provided no explanation or information about the causes.
- Step 10.1: The evaluation regarding sustained improvement cannot be completed due to the lack of analysis of the Western Region decline

Aetna Better Health – Non-Clinical PIP

- Step 7.1: The MCHP did not establish concrete interventions for 2015 that could be measured to assess success for this project year.
- Step 8.3: The PIP did not include information to explain the factors that affect validity or why the interventions employed did not create positive outcomes.
- Step 8.4: The PIP did not provide an interpretation of the extent or how the interventions led to the outcomes achieved.
- Step 9.2: The PIP did not achieve quantitative improvement and the MCHP did not meet their improvement goal of 3% for the past two years.

- Step 9.3: The PIP did not discuss how the interventions in place contributed to the success, or lack of success, in achieving the anticipated outcomes.
- Step 9.4: The PIP did not provide evidence that the observed improvement was true improvement. The PIP did not achieve success for 2 years, and the outcomes are not tied to the interventions in place.

Home State Health – Non-Clinical PIP

- Step 8.2: The MCHP presented tables presenting different outcomes for the same data. This was not explained or corrected.
- Step 8.3: The rationale for a declining HEDIS rate was attributed to the influx of new members. However, this analysis is based on a false premise regarding compiling the HEDIS rate denominator.
- Step 8.4: There was confusion about a correlation of the number of new members and how the HEDIS denominator is determined. Home State Health did think it was using the same baseline and repeat measurements. However, there was a misinterpretation of the HEDIS measure development.

For further information and specifics, including the completed PIP Validation Tool for each MCHP's response to these steps, please see the sections identified above.

Table 3 - Summary of Performance Improvement Project Validation Ratings by Item – All MCHPs

	All MCHPs					
Step	**Item**	**Number Met**	**Number Partially Met**	**Number Not Met**	**Total Number Applicable**	**Rate Met**
Step 1: Selected Study Topics	1.1	5	1	0	6	83.33%
	1.2	6	0	0	6	100%
	1.3	6	0	0	6	100%
Step 2: Study Questions	2.1	6	0	0	6	100%
Step 3: Study Indicators	3.1	6	0	0	6	100%
	3.2	6	0	0	6	100%
Step 4: Study Populations	4.1	6	0	0	6	100%
	4.2	5	1	0	6	83.33%
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%
	6.2	6	0	0	6	100%
	6.3	6	0	0	6	100%
	6.4	6	0	0	6	100%
	6.5	6	0	0	6	100%
	6.6	6	0	0	6	100%
Step 7: Improvement Strategies	7.1	5	1	0	6	83.33%
Step 8: Analysis and Interpretation of Study Results	8.1	5	0	0	5	100%
	8.2	3	1	0	4	75%
	8.3	1	3	0	4	25%
	8.4	1	3	0	4	25%
Step 9: Validity of Improvement	9.1	3	1	0	4	75%
	9.2	2	2	0	4	50%
	9.3	2	1	0	3	66.67%
	9.4	1	1	0	2	50%
Step 10: Sustained Improvement	10.1	1	1	0	2	50%
Number Met		**106**	**16**	**0**	**122**	**86.89%**

Note: Percent Met = Number Met/ Number Applicable; Item refers to the Protocol specifications.
Source: BHC, Inc., 2015 External Quality Review Performance Improvement Project Validation.

2.3 Conclusions

Across all MCHPs the range in proportion of criteria that were "Met" for each PIP validated was 25% through 100%. Across all PIPs validated statewide, 86.89% 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. On-site interviews and subsequent information revealed an in-depth knowledge of the PIPs by the MCHP staff developing and monitoring the results.

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. 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 made a significant investment in designing studies. During 2015, there was evidence that sound data collection methods were used. Implementation of effective interventions for change, and data analysis methods were not as well developed as seen in previous reviews.

Based on the PIP validation process, all of the MCHPs had active and ongoing PIPs as part of their quality improvement programs. A need to revitalize a commitment to the quality improvement process was observed when evaluating the outcomes of the PIPs. Two PIPs were new and had no results to report. Four of the PIPs were rated as producing "Moderate Confidence" that the PIP was directly responsible for the reported outcomes. The PIPs submitted exhibited sound planning, but reporting needs improvement. Even though the PIPs are not complete and some sections were coded as "Partially Met", the information presented was informative and provided adequate information to complete the required analysis. Additional work is needed to be able to attribute the success achieved to the interventions employed.

All the PIPs submitted that had reportable outcomes included some narrative in the data

analysis. How the interventions contributed to success, or analysis of why interventions did not create the desired changes, was not included. This type of evaluation is as important as the data analysis presented.

Table 4 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Improving Childhood Immunizations (Aetna Better Health)	Unable to Determine
Improving Oral Health (Aetna Better Health)	Moderate Confidence
Improving Immunization Rates in HSH Members in the First 2 Years of Life (Home State)	Unable to Determine
Improving Oral Health (Home State)	Moderate Confidence
Post Mental Health Hospitalization – FUH – 7 (MO Care)	Moderate Confidence
Improving Oral Health (MO Care)	Moderate 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. Unable to Determine: The PIP is new and has not yet produced results.
Source: BHC, Inc., 2015 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 and very few clinical PIP topics are submitted. It is noted that the MCHPs did request technical assistance in the area of clinical PIP topic development during 2015. 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

The topics identified by all MCHPs for their PIPs provide evidence of their commitment to providing quality services to their members. However, the interventions for these PIPs were less thorough and well-developed than seen in previous years. The PIPs did focus on improving

direct services to members. Some PIP interventions were designed to address barriers to quality care. These included; partnering with Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs). These initiatives targeted members who were not utilizing their benefits in the areas of childhood immunizations, follow-up after hospitalizations for mental health issues, and annual dental visits.

Other PIPS did not identify effective or current interventions specific to the 2015 review. This is an area to be addressed in future PIPs. All of the PIPs reviewed included the stated goal of providing quality healthcare services. The MCHPs must focus on new and creative initiatives that help them meet this goal.

Access to Care

The MCHPs developed projects that targeted improved availability to obtain dental care, childhood immunizations, and mental health services following an inpatient hospitalization in access to care PIPs. All of these projects have the potential to create improved preventive and primary care for members. At the time of this review, all the clinical PIPs were too new to assess their success. Conversely, the non-clinical PIPs regarding improved annual dental visits had some measurable success. However, these non-clinical PIPs have not yet reached their goals of improving by 3% each year. The EQRO's on-site discussions with MCHP staff indicated that improving access to care is an underlying goal of all the projects they develop.

Timeliness of Care

Timeliness of care was also addressed in the PIPs reviewed. Projects addressed timely access to follow-up mental health services and childhood immunizations. The projects concentrated on the need for timely and appropriate care for members. The PIPs related to Improved Oral Health included interventions to improve timeliness of care. Examples of these interventions include: engaging a new FQHC to partner in providing dental services; identifying new providers; new approaches to member engagement; developing "dental homes" so members are aware of their provider; and activities to ensure access to services when they are needed.. These interventions and discussions with MCHP staff reflect an awareness of the importance of timely healthcare.

RECOMMENDATIONS

1. MCHPs must continue to refine their skills in the development and implementation of new Performance Improvement Projects. 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. When evidence is identified that interventions are not achieving the desired results, the MCHP should adjust activities to produce outcomes that have a positive impact on members.
4. 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.
5. 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. The narrative must also interpret how the interventions in place during the project year contributed to success or the lack of success.
6. Document how external factors threaten internal or external validity, and what was learned from statistical significance testing.
7. 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 and implement new strategies when others do not work.
8. 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.
9. 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.

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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 MO HealthNet each year. For the 2015 evaluation period, the three performance measures selected for validation included:

1. HEDIS 2015 measure Childhood Immunizations Status, Combination 3 (CIS3);
2. Emergency Department Visits (EDV); and
3. Emergency Department Utilization (EDU).

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 MO HealthNet 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

All MCHPs used the Administrative method to calculate the EDV and the EDU measures. The Hybrid method was used by all MCHPs to calculate the CIS3 measure.

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 submission of the measures to SMA and SPHA, the Final Audit Ratings, and conclusions.

The EQRO is required by the CMS Protocol to assess each performance measure in the areas of:

- Data Integration and Control
- Documentation of Data and Processes
- Processes Used to Produce Denominators
- Processes Used to Produce Numerators
- Sampling Procedures (for Hybrid Method)
- Submission of Measures to the State

The EQRO assesses these areas based on the methodology and technical methods described in their Supplemental Report of Technical Methods, which is available on the MO HealthNet website.

All MCHPs met all criteria for every audit element in the area of data integration and control, documentation of data and processes, sampling procedures, and submission of measures to the State. The Processes Used to Produce Denominators and the Processes Used to Produce Numerators were problematic for both Aetna Better Health and Home State Health. The specific issues with these elements are included in the discussion that follows in this section.

Overall Validation Findings

The rate of compliance with the calculation of each of the three performance measures across all MCHPs was 83.33% for Emergency Department Visits; 100% for Childhood Immunizations Combo 3; and 83.33% for Emergency Department Utilization.

Table 5 summarizes the final audit ratings for each of the performance measures by MCHP. 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 HEDIS Data Submission Tool (DST).

Table 5 - Summary of EQRO Final Audit Ratings, HEDIS 2015 Performance Measures

MCHP	Childhood Immunization Status Combo 3	Emergency Department Visits (EDV)	Emergency Department Utilization (EDU)
Aetna Better Health	Fully Compliant	Not Valid	Substantially Compliant
Home State Health	Fully Compliant	Not Valid	Substantially Compliant
Missouri Care	Fully Compliant	Substantially Compliant	Substantially Compliant

Source: BHC, Inc. 2015 EQR Performance Measure Validation 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.

HEDIS 2015, Childhood Immunization Status, Combo 3

The CIS3 measure is defined as an Effectiveness of Care measure by HEDIS. It measures the percentage of children 2 years of age who had four diphtheria tetanus and a cellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.

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 2015 CIS3 measure, the sources of data included enrollment, eligibility, claim files, and medical records. A statewide rate for Home State was calculated by the EQRO based on combining the numerators and denominators 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 56.91%.

Table 7 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.

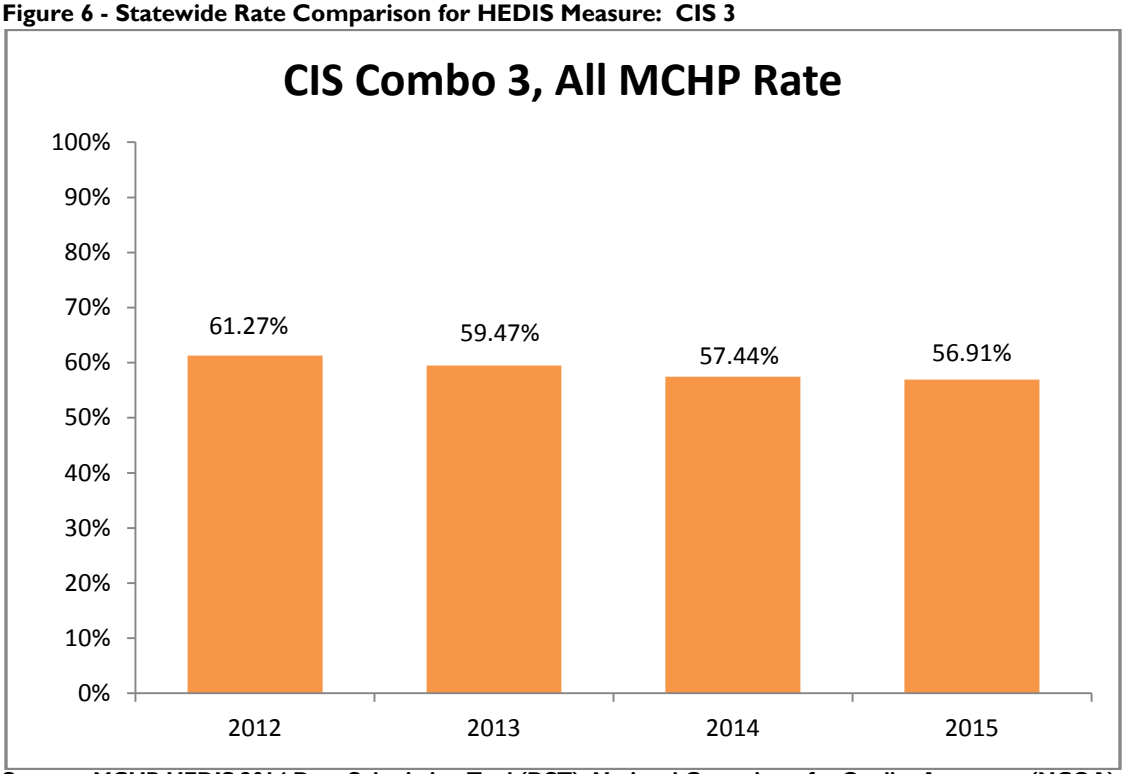
Table 6 - Data Submission for HEDIS 2015 Childhood Immunizations Status Combo 3 Measure

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)
Aetna Better Health	Hybrid	411	221	45	266	64.72%
Home State Health	Hybrid	1044	391	187	538	51.53%
Missouri Care	Hybrid	411	197	61	258	62.77%
All MO HealthNet MCHPs		**1,866**	**809**	**293**	**1,062**	**56.91%**

Note: The statewide rate for all Home State was calculated by the EQRO using the sum of numerators divided by sum of denominators. Source: MCHPs' HEDIS 2015 Data Submission Tools (DST)

CIS3 has been audited since 2011; therefore, trend analysis was examined for this 2015 audit year. The statewide rate has steadily decreased since 2012. The statewide rate reported for CIS3 in 2015 (56.91%) was **lower** than all the rates reported since 2012.

Figure 6 - Statewide Rate Comparison for HEDIS Measure: CIS 3

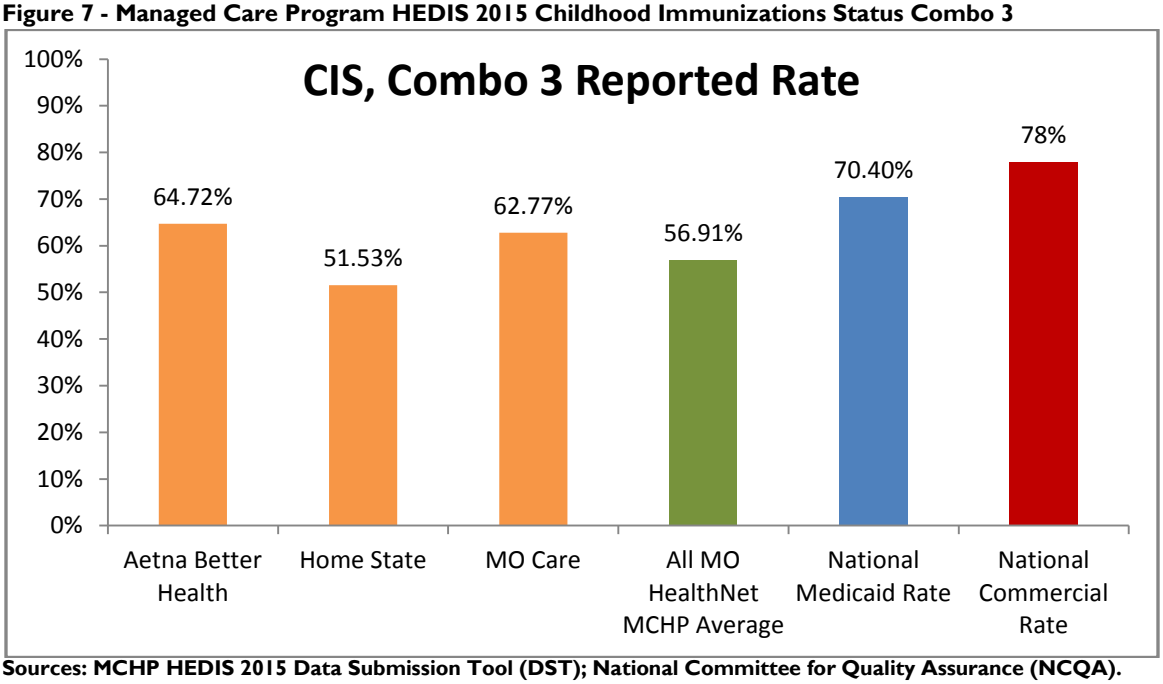


Sources: MCHP HEDIS 2014 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Aetna Better Health's rate of 64.72% represented a 1.95 percentage point decrease from their 2014 rate of 66.67% and a 0.56 percentage rate decrease from their 2013 rate of 65.28%. The

2015 rate represents a 3.16 point increase from the 2012 rate of 61.56%. MO Care's rate of 62.77% is an11.84 percentage point increase from their 2014 rate of 50.93%. However it is a 3.67 point decrease from their 2012 rate of 66.44%. This was only the second year that Home State reported the CIS rate and the 2015 rate of 51.53% is a 4.79 percentage point decrease from their 2014 rate of 56.32%.

Figure 7 - Managed Care Program HEDIS 2015 Childhood Immunizations Status Combo 3



Sources: MCHP HEDIS 2015 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

The rate for all MCHPs (56.91%) was lower than both the National Medicaid rate of 70.4% and the National Commercial Rate of 78% (See Figure 7).

Each MCHP calculated the Childhood Immunizations Status measure using the hybrid method for calculation. There were no statistically significant differences between the rates reported and the average for all MCHPs. All MCHPs operate in multiple regions. For this review Aetna Better Health and MO Care supplied the EQRO with an audited statewide rate; however, Home State did not. Therefore, for Home State, the sample sizes selected for each region were combined to represent the overall MCHP rates. A total of 90 of the 293 medical record hybrid hits reported by the MCHPs were sampled for validation by the EQRO. Of the records requested, 90 were received for review. The EQRO was able to validate all 90 of the records received, resulting in an Error Rate of 0% across all MCHPs. There were no False Positive Records (the total amount that could not be validated). This shows no bias in the estimation of

hybrid rates for the MCHPs based upon medical record review.

All three MCHPs met all validation for the process used to produce numerators.

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 2015 Childhood Immunizations Status Combination 3 measure and all met 100.0% of the criteria for proper sampling.

2015 Emergency Department Visits

The EDV measure is defined as an Access to Care measure. The EDV measure reflects the count of emergency department visits that occurred during the measurement year. These visits are then stratified by age and presenting diagnosis (Behavioral Health; Medical; or Substance Use).

The calculation of the EDV-Medical measure is based upon the Ambulatory Care (AMB) measure from the HEDIS 2015 Technical Specifications. The AMB specifications require a count of every visit to an Emergency Department that does not result in an inpatient stay, regardless of the duration or intensity of the visit. The measure was calculated with one modification, which included sorting the results into age groupings as specified by MO HealthNet. The EDV-Medical measure does not include emergency department visits for any mental health or chemical dependency diagnoses or service.

The calculation of the EDV- Behavioral Health measure is based on the Mental Health Utilization (MPT) measure from the HEDIS 2015 Technical Specifications. The MPT measure is designed to count all visits made by members who received mental health services in an Emergency Department (ED) setting. The MPT specifications were modified to separate Outpatient and ED visits. All visits for this measure are required to have a valid mental health diagnosis. Additionally, the place of service (POS) for all ED services was limited to acceptance of only the POS=23 code.

The calculation of the EDV-Substance Use measure is based on the Identification of Alcohol and Other Drug Services (IAD) measure from the HEDIS 2015 Technical Specifications. The IAD measure is designed to count all visits made by members with an alcohol and other drug claim who received chemical dependency services in an Emergency Department (ED) setting. All visits for this measure are required to have a valid chemical dependency diagnosis. Additionally, the place of service (POS) for all ED services was limited to acceptance of only the POS=23 code.

The SMA requested that the EQRO validate the number of Emergency Department Visits that were reported by each MCHP to MO HealthNet in a special request report that is presented to MO HealthNet by June 30 of each calendar year. This report was first due on June 30, 2015 and was required to contain 2014 data. The SMA requested that the EQRO request the data used by each MCHP to complete the report and recalculate the number of visits from the data supplied to the EQRO. The EQRO sent a request for data to each of the MCHPs on February 2, 2016. Each MCHP provided the EQRO with a response to that data request by March 15, 2016.

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. Table 7 shows the number of EDVs reported with a primary medical diagnosis to DHSS on June 30, 2015 and the number of EDVs validated by the EQRO based on the data supplied to the EQRO by the MHPs in March 2016.

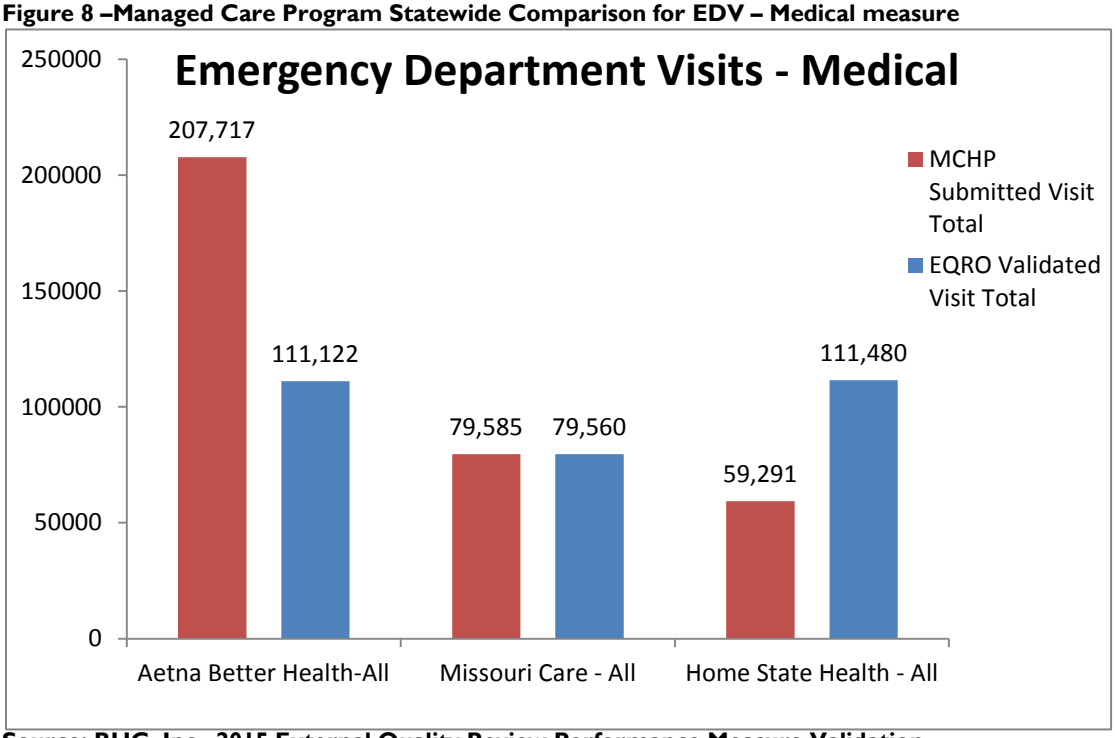
Emergency Department Visits for Medical diagnoses

Table 7 - Data Submission and Final Validation for 2015 EDV Medical report (combined rate)

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	207717	86.14%	111122	46%	40.06%
Home State Health	74890	59291	79.17%	111480	149%	-69.69%
Missouri Care	102918	79585	77.33%	79560	77%	0.02%
Total	418954	346593	82.73%	302162	72%	10.61%

Note: 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 - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014

Figure 8 –Managed Care Program Statewide Comparison for EDV – Medical measure



Source: BHC, Inc., 2015 External Quality Review Performance Measure Validation

Aetna Better Health reported to MO HealthNet a total number of EDV-medical visits of 207,717, however, the data they provided to the EQRO only contained a total of 115,823 records to analyze. Therefore, making it impossible for the EQRO to find and validate a total of 207,717 EDV-medical hits. The difference of 96,595 hits is an overestimate of 40.06% and can only be attributed to missing records or an incorrect number of hits reported to MO HealthNet on the June 30, 2015 report.

Home State supplied a total of 113,689 records for the EQRO to analyze. Of those, the EQRO found 111,480 EDV- medical hits. However, Home State reported to MO HealthNet a total number of EDV-medical hits of 59,291, for a difference of 52,189 hits. The difference of 52,189 EDV-medical hits is an underestimate of 69.69% and could be attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Missouri Care provided a file containing 81,159 records. The EQRO found 79,560 hits in the records as submitted to the EQRO. Missouri Care reported to MO HealthNet a total number of EDV-medical hits of 79,585. The difference of only 25 records is an overestimate of only 0.02%.

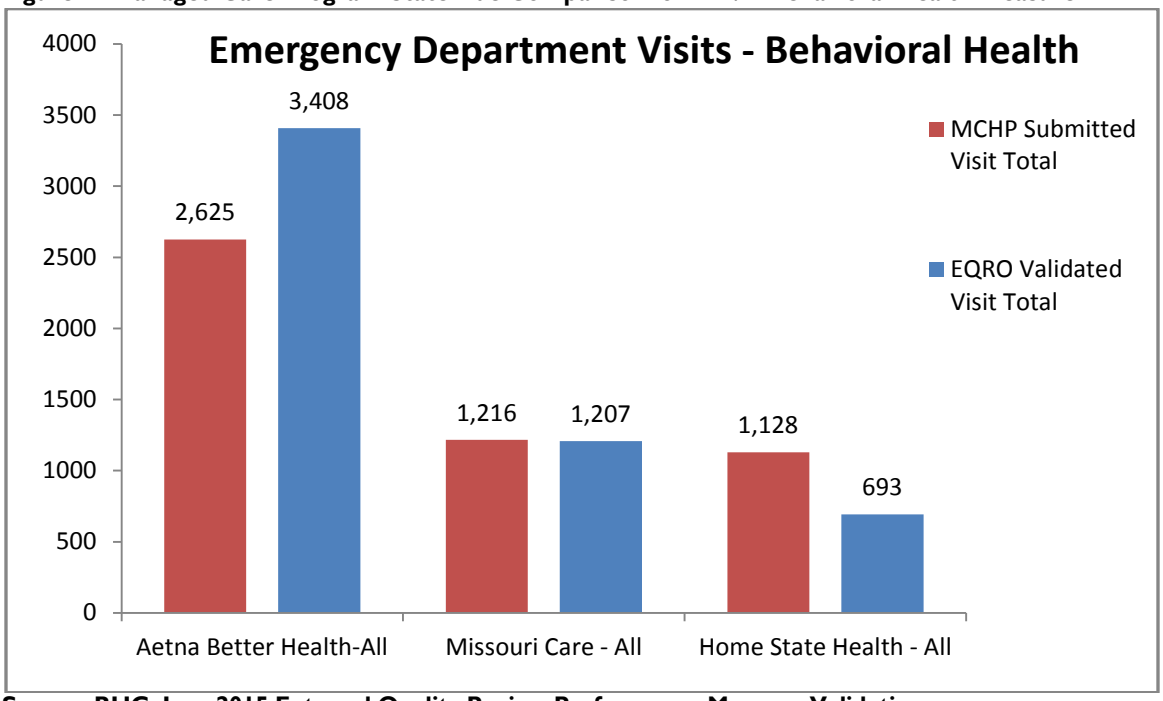
Emergency Department Visits for Behavioral Health diagnoses

Table 8 - Data Submission & Final Validation for 2015 EDV Behavioral Health report (combined rate)

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	216151	2625	1.21%	3408	1.58%	-0.36%
Home State Health	71476	1128	1.58%	693	0.97%	0.61%
Missouri Care	97996	1216	1.24%	1207	1.23%	0.01%
Total	385623	4969	1.29%	5308	1.38%	-0.09%

Note: 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 - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014

Figure 9 –Managed Care Program Statewide Comparison for EDV – Behavioral Health measure



Source: BHC, Inc., 2015 External Quality Review Performance Measure Validation

For Aetna Better Health EDV-Behavioral Health findings, the EQRO validated 3,408 hits, whereas the MCHP submitted 2,625 hits to MO HealthNet on the June 30, 2015 report. This difference of 783 hits is an underestimate of 0.36%. The EQRO cannot be certain of the reason for the differences between the two rates of hits, but the EQRO is certain that the data provided to them for validation did not produce the number of hits reported by the MCHP for the June 30, 2015 SMA report.

For the Home State EDV-Behavioral Health findings, the EQRO validated 693 hits, whereas the MCHP submitted 1,128 hits to MO HealthNet on the June 30, 2015 report. This difference represents an underestimate of 0.61%. Again, the EQRO is not certain of the reason for the differences between the two rates of hits, but is certain the data provided was not capable of producing the 1,128 hits reported to MO HealthNet.

A difference of only nine records was found between the EQRO validated hits (1,207) and the Missouri Care submitted hits (1,216). This overestimate of 0.01% may be due to an incorrect service code being included in the MCHP's number of hits.

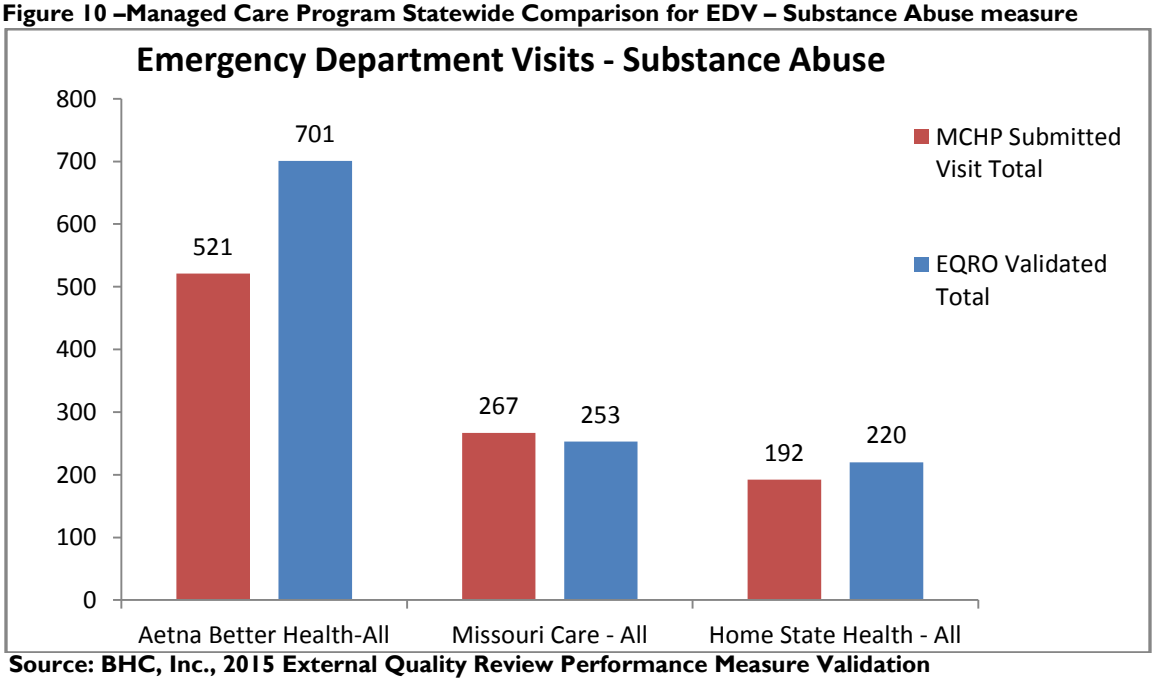
Emergency Department Visits for Substance Abuse diagnoses

Table 9 - Data Submission and Final Validation for 2015 EDV Substance Abuse report (combined rate)

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	521	0.22%	701	0.29%	-0.07%
Home State Health	74890	192	0.26%	220	0.29%	-0.04%
Missouri Care	102918	267	0.26%	253	0.25%	0.01%
Total	418954	980	0.23%	1174	0.28%	-0.05%

Note: 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 - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014

Figure 10 –Managed Care Program Statewide Comparison for EDV – Substance Abuse measure



Source: BHC, Inc., 2015 External Quality Review Performance Measure Validation

For Aetna Better Health EDV-Substance Abuse findings, the EQRO validated 701 hits, whereas the MCHP submitted 521 hits to MO HealthNet on the June 30, 2015 report. This difference of 180 hits is an underestimate of 0.07% which is much closer to the rate validated than the other sub-measures (EDV - Medical and Behavioral Health). However, the EQRO cannot be certain of the reason for the differences between the two rates of hits. The EQRO is certain that the data provided for validation did not produce the number of hits reported by the MCHP in the June 30, 2015 SMA report.

For the Home State EDV-Behavioral Health findings, the EQRO validated 220 hits, whereas the MCHP submitted 192 hits to MO HealthNet on the June 30, 2015 report. This difference represents an underestimate of 0.04%. Again, the EQRO is not certain of the reason for the differences between the two rates of hits.

A difference of 14 records was found between the EQRO validated hits (253) and the Missouri Care submitted hits (267). This overestimate of 0.01% may be due to an incorrect service code being included in the MCHP's submitted number of hits.

Due to the inability of the EQRO to validate most of the hits claimed by two of the MCHPs, these two MCHPs did not meet all validation elements for the process used to produce numerators. One MCHP (MO Care) did meet all the validation elements regarding accuracy and completeness of data sources for the numerator.

2015 Emergency Department Utilization (EDU)

The EDU measure is defined as an Access to Care measure. The EDU measure reflects the percentage of members who had at least one emergency department visit that occurred during the measurement year. These visits are then stratified by age and presenting diagnosis (Behavioral Health; Medical; or Substance Use).

The calculation of the EDU-Medical measure is based upon the Ambulatory Care (AMB) measure from the HEDIS 2015 Technical Specifications. The AMB specifications require a count of every visit to an Emergency Department that does not result in an inpatient stay, regardless of the duration or intensity of the visit. The measure was calculated by taking the EDV-Medical result set and counting one visit for each unique member and was modified by sorting the results into age groupings as specified by MO HealthNet. The EDU-Medical measure does NOT include emergency department visits for any mental health or chemical dependency diagnoses or service.

The calculation of the EDU- Behavioral Health measure is based on the Mental Health Utilization (MPT) measure from the HEDIS 2015 Technical Specifications. The MPT measure is designed to count all visits made by members who received mental health services in an Emergency Department (ED) setting. The measure was calculated by taking the EDV- Behavioral Health result set and counting one visit for each unique member and was modified to separate Outpatient and ED visits. All visits for this measure are required to have a valid mental health diagnosis. Additionally, the place of service (POS) for all ED services was limited to acceptance of only the 23 code for POS.

The calculation of the EDU-Substance Use measure is based on the Identification of Alcohol and Other Drug Services (IAD) measure from the HEDIS 2015 Technical Specifications. The IAD measure is designed to count all visits made by members with an alcohol and other drug claim who received chemical dependency services in an Emergency Department (ED) setting. The measure was calculated by taking the EDV- Substance Abuse result set and counting one visit for each unique member. All visits for this measure are required to have a valid chemical dependency diagnosis. Additionally, the place of service (POS) for all ED services was limited to acceptance of only the 23 code.

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. Table 10 shows the number of EDUs reported with a primary medical diagnosis to DHSS on June 30, 2015 and the number of EDUs validated by the EQRO based on the data supplied to the EQRO by the MHPs in March 2016.

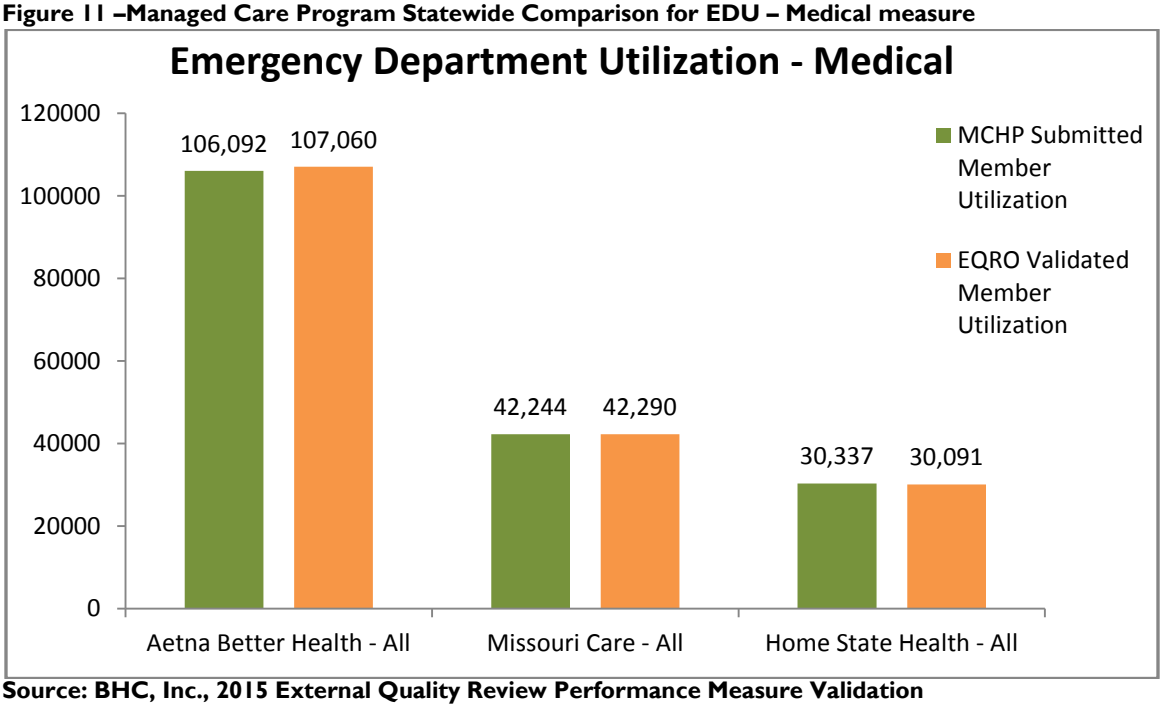
Emergency Department Utilization for Medical diagnoses

Table 10 - Data Submission and Final Validation for 2015 EDU Medical report (combined rate)

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	106092	43.99%	107060	44.40%	-0.40%
Home State Health	74890	30337	40.51%	30091	40.18%	0.33%
Missouri Care	102918	42244	41.05%	42290	41.09%	-0.04%
Total	418954	178673	42.65%	179441	42.83%	-0.18%

Note: 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 - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014

Figure 11 –Managed Care Program Statewide Comparison for EDU – Medical measure



Source: BHC, Inc., 2015 External Quality Review Performance Measure Validation

Aetna Better Health reported to MO HealthNet a total number of EDU-medical visits of 106,092, the EQRO validated 107,060 hits. The difference of 968 hits is an underestimate of 0.40% and could be attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Home State supplied a total of 113,689 records for the EQRO to analyze. Of those, the EQRO found 30,091 EDU- medical hits. However, Home State reported to MO HealthNet a total number of EDU-medical hits of 30,337, for a difference of 246 hits. The difference of 246 EDU-medical hits is an underestimate of 0.33% and could be attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Missouri Care provided a file containing 81,159 records. The EQRO found 42,290 hits in the records as submitted to the EQRO. Missouri Care reported to MO HealthNet a total number of EDU-medical hits of 42,244. The difference of only 46 records is an underestimate of only 0.04%.

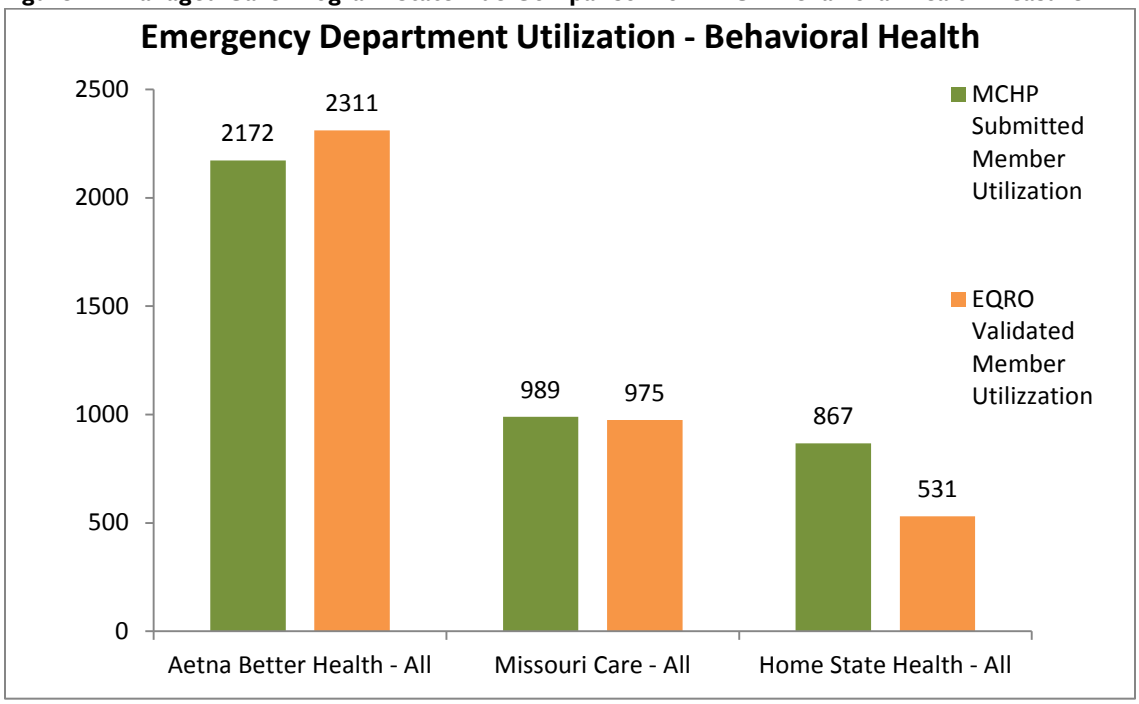
Emergency Department Utilization for Behavioral Health diagnoses

Table 11 - Data Submission & Final Validation for 2015 EDU Behavioral Health report (combined rate)

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	216151	2172	1.00%	2311	1.07%	-0.06%
Home State Health	71476	867	1.21%	531	0.74%	0.47%
Missouri Care	97996	989	1.01%	975	0.99%	0.01%
Total	385623	4028	1.04%	3817	0.99%	0.05%

Note: 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 - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014

Figure 12–Managed Care Program Statewide Comparison for EDU – Behavioral Health measure



Source: BHC, Inc., 2015 External Quality Review Performance Measure Validation

Aetna Better Health reported to MO HealthNet a total number of EDU-behavioral health visits of 2,172, the EQRO validated 2,311 hits. The difference of 139 hits is an overestimate of 0.06% and could be attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Home State supplied a total of 113,689 records for the EQRO to analyze. Of those, the EQRO found 531 EDU- behavioral health hits. However, Home State reported to MO HealthNet a total number of EDU-behavioral health hits of 867, for a difference of 336 hits. The difference of 336 EDU-behavioral health hits is an overestimate of 0.47% and could be attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Missouri Care provided a file containing 81,159 records. The EQRO found 975 hits in the records as submitted to the EQRO. Missouri Care reported to MO HealthNet a total number of EDU-behavioral health hits of 989. The difference of only 14 records is an overestimate of only 0.01%.

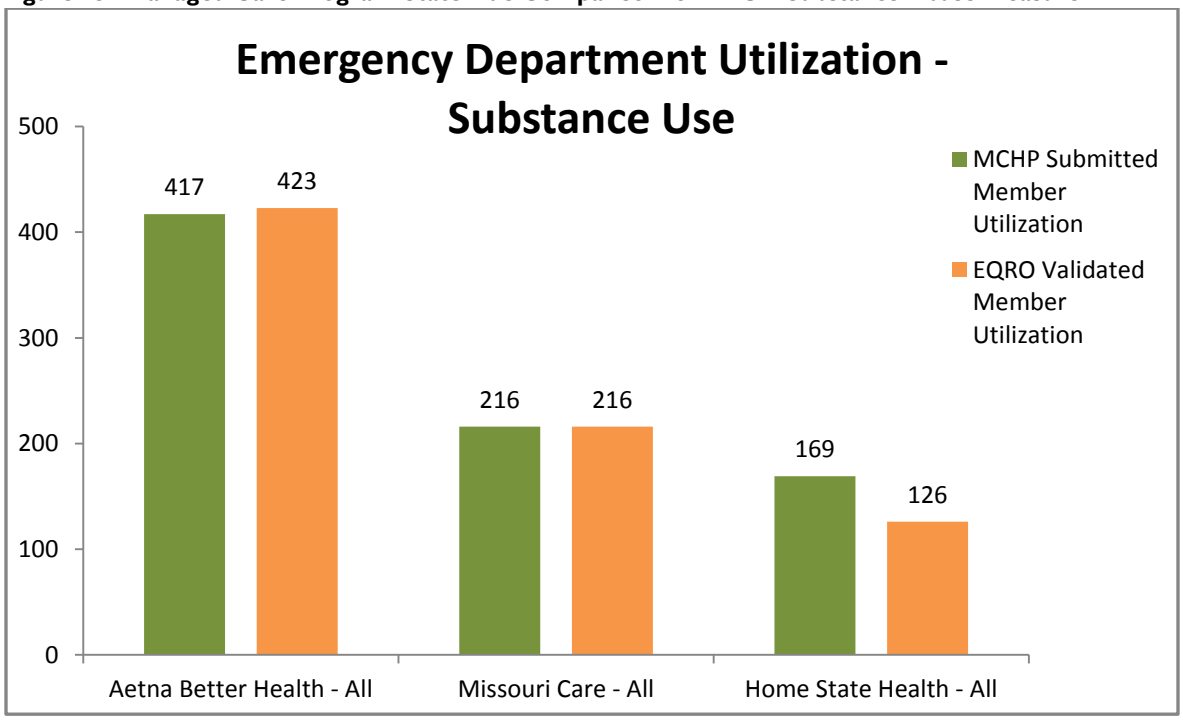
Emergency Department Utilization for Substance Abuse diagnoses

Table 12 - Data Submission & Final Validation for 2015 EDU Substance Abuse report (combined rate)

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	417	0.17%	423	0.18%	0.02%
Home State Health	74890	169	0.23%	126	0.17%	0.06%
Missouri Care	102918	216	0.21%	216	0.21%	0.00%
Total	418954	802	0.19%	765	0.18%	0.01%

Note: 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 - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014

Figure 13 –Managed Care Program Statewide Comparison for EDU – Substance Abuse measure



Source: BHC, Inc., 2015 External Quality Review Performance Measure Validation

Aetna Better Health reported to MO HealthNet a total number of EDU-substance use visits of 417, the EQRO validated 423 hits. The difference of 6 hits is an overestimate of 0.02% and could be attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Home State supplied a total of 113,689 records for the EQRO to analyze. Of those, the EQRO found 126 EDU- substance abuse hits. However, Home State reported to MO HealthNet a total number of EDU-substance abuse hits of 169, for a difference of 43 hits. The difference of 43 EDU-substance abuse hits is an overestimate of 0.06% and could be attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Missouri Care provided a file containing 81,159 records. The EQRO found 216 hits in the records as submitted to the EQRO. Missouri Care reported to MO HealthNet a total number of EDU-substance abuse hits of 216. There was no bias found in this data submission.

Two MCHPs (Aetna Better Health and Home State) did not meet all validation for the process used to produce numerators. One MCHP (MO Care) did meet the validation element regarding accuracy and completeness of data sources for the numerator. MO Care was the only MCHP to produce a measure that contained no bias when recalculated and validated by the EQRO.

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 measures validated. However, two of the MCHPs (Aetna Better Health and Home State) were unable to pull the information as requested from their information systems in order to enable the EQRO to recalculate the EDV and EDU measures,

Among MCHPs there was good documentation of the HEDIS 2015 rate production process. The rate of medical record submission for the one measure allowing the use of the Hybrid Methodology was 100%; the EQRO received all the medical records requested. This review also marked the fourth 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 Emergency Department Utilization measure was first audited during this review year. This measure serves to provide a count of the individual number of members who access the ED for

various issues, over the course of the measurement year. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Use. This information is useful to the MCHPs to determine if the ED is being utilized properly by its members. The MCHPs can also use this information to ensure that the quality of care necessary for members is available in the ED for the non-medical categories.

All three MCHPs received ratings of Substantially Compliant with the specifications for calculation of this measure (See Table 5). However, the EQRO is only confident in the rate validated for MO Care, as this rate had an estimated bias of only 0.04%. The EQRO is not confident in both the Aetna Better Health and Home State rates as neither MCHP's eligibility file could be substantiated and the EQRO was unable to validate the companion rate of EDV-medical.

Access to Care

The Emergency Department Visits (EDV) measure is intended to measure the number of ED visits recorded for the MCHP. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Use.

Two of the three MCHPs (Aetna Better Health and Home State) had the EDV measure rated as Not Valid by the EQRO. One MCHP (MO Care) was Substantially Compliant with the specifications for calculation of this measure.

This was the first year for a review and audit of the EDV measure. The EQRO did not receive the same quality of data in the requested files from the two MCHPs who were rated as Not Valid. Aetna Better Health supplied a file containing 115,823 records, but they reported to MO HealthNet a total of 207,717 EDV-medical visits. The records supplied did not substantiate that number. Home State supplied records that indicated almost twice as many hits as they reported to MO HealthNet. Only MO Care supplied records that were consistent with the measure specifications. When analyzed these records produced results that were in line with the reported number of hits.

Timeliness of Care

The HEDIS 2015 CIS3 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).

All three MCHPs validated by the EQRO were Fully Compliant with the specifications for calculation of this measure. However, all MCHPs fell well short of the National Medicaid Average of 70.4% and the National Commercial Average of 78%.

Aetna Better Health's rate of 64.72% represented a 1.95 point decrease from the 2014 rate of 66.67%. MO Care's rate of 62.77% represented an 11.84 point increase from the 2014 rate; however it is a 3.67 point decrease since 2012. Home State's rate of 51.53% was a 4.79 percentage point decrease from their 2014 rate of 56.32%.

CIS3 has been audited yearly since 2011; therefore, trend analysis was examined for this 2015 audit year. It was found that the statewide rate has steadily decreased since 2012.

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. 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.
3. 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.
4. The MCHP should submit data in response to data requests in the format requested. Additional data is not necessary and can hamper the validation. Not submitting data as requested contributed to the lower validation ratings for EDV and EDU.

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 their compliance with the federal Medicaid managed care regulations; the State Quality Strategy; the MO HealthNet Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous review year.

This year's review (calendar year 2015) is a full compliance review that 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 SMA reviewed submitted policies and procedures at each MCHP to ensure that they were in compliance with contractual requirements and federal regulations. The EQRO conducted on-site reviews to verify that those policies and procedures reflect the everyday practice of the MCHPs.

During this full compliance review, the EQRO conducted a special project to review the MCHPs' 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 a review of Case Management by assessing the MCHPs' 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.

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occurred with individuals from MO HealthNet from February 2016 through June 2016 to obtain relevant information for the on-site visits.

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. 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 2015 Compliance Review. The Annual Quality Assessment and Improvement Evaluation was requested and reviewed to provide insight into each MCHPs' compliance with the requirements of MO HealthNet Quality Improvement Strategy; an essential component of the Managed Care contract and is required by the federal regulations. MCHPs' Quality Improvement Committee meeting minutes were reviewed. Grievance and Appeal policies and procedures were reviewed and used in discussions with MCHP staff.

The following documents were reviewed for all MCHPs:

- State contract compliance ratings from 2015 and updated policies accepted through June 2016
- Results, findings, and follow-up information from the 2014 External Quality Review
- 2015 MCHP Annual Quality Assessment and Improvement Evaluation

Conducting interviews

After discussions with MO HealthNet, it was decided that the 2015 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. 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.

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.

Analyzing and Compiling Findings

The review process included gathering information and documentation from MO HealthNet 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. 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 MO HealthNet staff to confirm that a sound rationale was used in rating determinations. MO HealthNet 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 utilizes a Compliance Rating System that was developed during previous reviews (see below). The determinations found in the Compliance Ratings considered contract compliance, review findings, MCHP policy, ancillary documentation, and staff interview summary responses related to MCHP practices observed on-site.

If MO HealthNet 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.

After completing the initial document review, it was clear that the MCHPs have developed appropriate and compliant written policies and procedures. The findings in Section 4.2 detail the EQRO's assessment of each MCHP's adherence to these written policies and procedures.

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 MCHPs addressing 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 2014, 2013 and 2012 review years.

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 found to have practices that met these requirements.

All MCHPs continued to operate programs for the provision of behavioral health services. All MCHPs utilize an "in-house" model for the provision of behavioral health services. Each MCHP has a BHO that is part of their parent company's 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. Across all MCHPs, the rate of regulations "Met" for the 2015 review (72.55%) is lower than the prior three years' review rates; 2014 (78.43%), 2013 (74.51%) and 2012 (83.67%). Two MCHPs (Aetna Better Health and Home State) were found to be 76.47% compliant and the other MCHP (MO Care) was 64.71% compliant.

- Home State was consistent with their 2014 rate of 76.47%, but improved over their prior year rates 70.59% (2013) and their 2012 rate of 64.71%.
- Aetna Better Health was consistent with their 2014 rate of 76.47%, but saw a decrease from their 2013 rate of 82.35% and their 2012 rate of 88.24%.
- MO Care saw a decrease from their 2014, 2013 and 2012 rates (82.35%, 70.59%, and 88.24% respectively).

The rating for the Access Standards compliance rate is directly attributable to the findings of the Case Management Special Project and a website accuracy and secret shopper survey the EQRO conducted for MO HealthNet. Further information regarding the Case Management Special Project may be reviewed in Section 5 of this report. Further information regarding the Website Accuracy Survey may be found at http://dss.mo.gov/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf. However, it is worth noting that during the secret shopper survey, the EQRO found that 42% of all MCHP providers who were listed as taking new patients were, in fact, not taking new patients.

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 13 - Subpart D: Quality Assessment and Performance Improvement: Access Standards

Federal Regulation	MO HealthNet MCHP			All MO HealthNet MCHPs			
	Aetna Better Health	MO Care	Home State	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	0	0	0	0	0	3	0%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2	3	0	0	100%
438.206(b)(3) Second Opinions	2	2	2	3	0	0	100%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	3	0	0	100%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	3	0	0	100%
438.206(c)(1)(i-vi) Timely Access	2	2	2	3	0	0	100%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	3	0	0	100%
438.208(b) Care Coordination: Primary Care	2	0	2	2	0	1	66.7%
438.208(c)(1) Care Coordination: Identification	1	1	1	0	3	0	0.0%
438.208(c)(2) Care Coordination: Assessment	2	1	2	2	1	0	66.7%
438.208(c)(3) Care Coordination: Treatment Plans	1	1	1	0	3	0	0.0%
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	1	1	0	3	0	0.0%
438.210(b) Authorization of Services	2	2	2	3	0	0	100%
438.210(c) Notice of Adverse Action	2	2	2	3	0	0	100%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	3	0	0	100%
438.210(e) Compensation of Utilization Management Activities	2	2	2	3	0	0	100%
438.114 Emergency and Post-Stabilization Services	2	2	2	3	0	0	100%
Number Met	13	11	13	**37**	**10**	**4**	**72.55%**
Number Partially Met	3	4	3				
Number Not Met	1	2	1				
Rate Met	76.47%	64.71%	76.47%				

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., 2015 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. In the area of Care Coordination, both Aetna Better Health and Home State increased the number of standards that were fully met, whereas MO Care reduced the number of standards that were fully met. 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 2013, 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 90.91% of the criteria were "Met" by the MCHPs, a decrease from the 2014 rate of 97.0% of the criteria being "Met" by the MCHPs.

One MCHP (MO Care) met 90.9% of the requirements in this area. Two MCHPs (Aetna Better Health and Home State) met 81.8% of the requirements. Both Home State and Aetna Better Health received a "Partially Met" rating in the Performance Measures standard. This was attributed to the EQRO's inability to validate data provided for the EDV and EDU measures, more information regarding these issues can be found in Section 3 of this report. Additionally, all three MCHPs received a "Partially Met" rating in Performance Improvement Projects due to low ratings on their Improving Oral Health PIPs.

Table 14 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

Federal Regulation	MO HealthNet MCHP						
	Aetna Better Health	Home State	MO Care	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%
438.236(c) Practice Guidelines: Dissemination	2	2	2	3	0	0	100%
438.236(d) Practice Guidelines: Application	2	2	2	3	0	0	100%
438.240(a)(1) QAPI: General Rules	2	2	2	3	0	0	100%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	1	1	1	0	3	0	0%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	1	2	1	2	0	33.3%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2	3	0	0	100%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2	3	0	0	100%
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%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2	3	0	0	100%
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2	3	0	0	100%
Number Met	9	9	10	**30**	**3**	**0**	**90.91%**
Number Partially Met	2	2	1				
Number Not Met	0	0	0				
Rate Met	81.82%	81.82%	90.91%				

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., 2015 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 MCHP's daily operation. Practice guidelines are in place and the MCHPs are monitoring providers to ensure their utilization. All 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

All regulations for all MCHPs were at least Partially Met. All MCHPs were 100% compliant with three of the compliance areas validated during this review year.

For the sixth consecutive year, none of the MCHPs were 100% compliant with all requirements. In particular, no MCHP was able to demonstrate case management information that was fully compliant with the standards related to care coordination. Additionally, provider availability was an issue for all MCHPs as evidenced by the results of the MO HealthNet Website Accuracy Survey. (See: http://dss.mo.gov/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf.)

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 change. 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.

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 fifth consecutive year that all of the MCHPs maintained a 100% rating in this set of regulations.

Access to Care

Two MCHPs (Aetna Better Health and Home State) were consistent in their compliance with the 17 federal regulations concerning Access Standards during this year's review, although this remains one of the lowest rated areas. These two MCHPs were the highest rated in this area with 76.47% compliance with the required standards.

For the 2015 review, there was one regulation rated as "Not Met" for all three MCHPs and one additional regulation rated as "Not Met" for one MCHP (MO Care). This is a decrease from the 2014 review, where none of the regulations were found to be "Not Met" and this is consistent with both the 2012 and 2013 reviews, when 4 regulations were rated as "Not Met". Across all MCHPs, the rate of regulations "Met" for the 2015 review (72.55%) is a decrease from the 2014 and 2013 rates of 78.43% and 74.51%, respectively. Aetna Better Health and Home State were found to be 76.47% compliant and MO Care was 64.71% compliant.

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 described efforts to participate in community events and forums to provide education to members regarding special programs available.

Timeliness of Care

Timeliness of care is an area of decline in compliance for all the MCHPs. Nine of the eleven applicable regulations for Measurement and Improvement were 100% "Met." 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. The MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. However, lower Performance Measures and PIP performance 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.

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 third review year for which all MCHPs had 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 Case Management records continues 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 locating and identifying members and engaging them in the case management process. Ensuring that MCHP members have access to case management services remains a concern.
5. The MCHPs must improve the accuracy of their websites in regards to providers. Provider availability was a major factor in the decline of compliance rates.
6. MCHPs should comply with data requests as written. Providing additional information or information in a file or format not requested only serves to hamper data analysis.

5.0 MO HealthNet MCHP CASE MANAGEMENT

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5.1 Case Management– Special Project

The EQRO conducted a special project to follow up on the MCHP compliance with federal regulations regarding quality, timeliness, and access to health care services as it relates to the provision of case management services. The objective of this special project is to complete an in-depth review of Case Management by assessing the MCHPs' service delivery and record keeping. The EQRO also evaluated each 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 (OB);
    b. Members with special health care needs (SHCNs); and
    c. Children with elevated blood lead levels (Lead);
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on open cases.

METHODOLOGY

The review included the following components:

- Review of each MCHP's case management policy and procedures;
- Case record reviews sampled from case listings from each MCHP. These case listings included open and active cases sorted by category in the fourth quarter of 2015; and
- On-site interviews with case management staff and MCHP administrative staff.

CASE RECORD REVIEWS

A listing of cases that were open and active during the fourth quarter of 2015 was obtained from each MCHP, organized by category (OB, SHCNs, and Lead). A random sample of cases was identified from the listings provided for each category. Case records were requested and received from each MCHP. The records were reviewed by EQRO Consultant Lisa Heying, R.N, and EQRO Assistant Project Director, Mona Prater. A pre-approved case review template based on the Case Management requirements found in the October 1, 2012 Managed Care contract, as amended, was used to assess the quality of the medical case records received.

The following reflects the number of submitted case records that meet these criteria:

Aetna Better Health – 20 Prenatal cases received; all were open during the 4th quarter of 2015
20 SHCN cases received; all were open during the 4th quarter of 2015
19 Lead cases received; 13 cases were open during the 4th quarter of 2015

MO Care – 20 Prenatal cases received; 11 cases were open during the 4th quarter 2015
20 SHCN cases received; 12 cases were open during the 4th quarter of 2015
20 Lead cases received; 13 cases were open during the 4th quarter of 2015

Home State – 20 Prenatal cases received; all were open during the 4th quarter of 2015
20 SHCN cases received; all were open during the 4th quarter of 2015
21 Lead cases received; 20 were open during the 4th quarter of 2015

The percentages in this report are figured on the open cases received.

In the EQRO Case Management data request the MCHPs were asked to submit a listing of cases defined as "special health care needs." The listings from Aetna Better Health and Home State included all cases opened in their system. MO Care did not accurately comply with the EQRO request. The MCHP only included cases from their system that were found on the monthly "special health care needs cases" report received from MHD. For the 2015 review a listing of 45 cases was received. In 2013 a listing of 148 SHCN cases was received, and in 2014 a listing of 130 SHCN cases was received. It was learned during the on-site review that only cases identified on the MHD monthly list were provided.

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;
- Determine the methods used by case managers to operationalize policy in their daily activities; and
- Validate that case management activities reflected in the case notes are the practice at each MCHP.

On-site review questions were developed by the EQRO during the case record review process. These questions focused on compliance with the requirements of case management as set out in the Managed Care contract; compliance with MCHP policy; and were developed to answer questions generated by the record review.

5.2 Findings

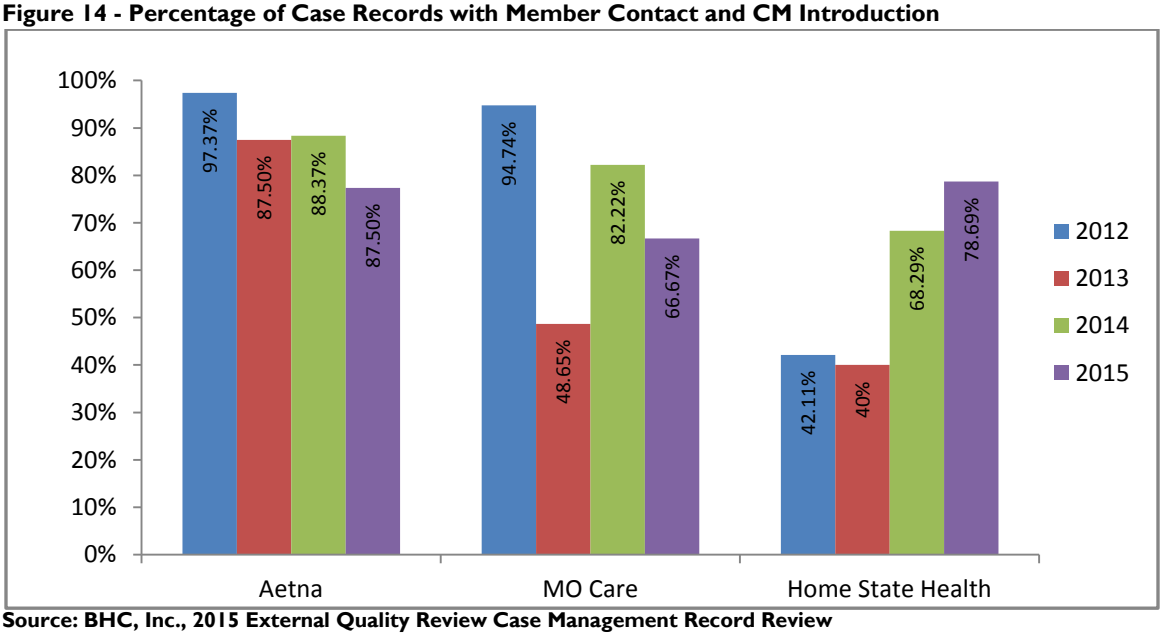
Case Record Review Results

Introduction to Case Management

There are four standards used to assess the category of Introduction to Case Management. The records 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; and
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.

Figure 14 - Percentage of Case Records with Member Contact and CM Introduction

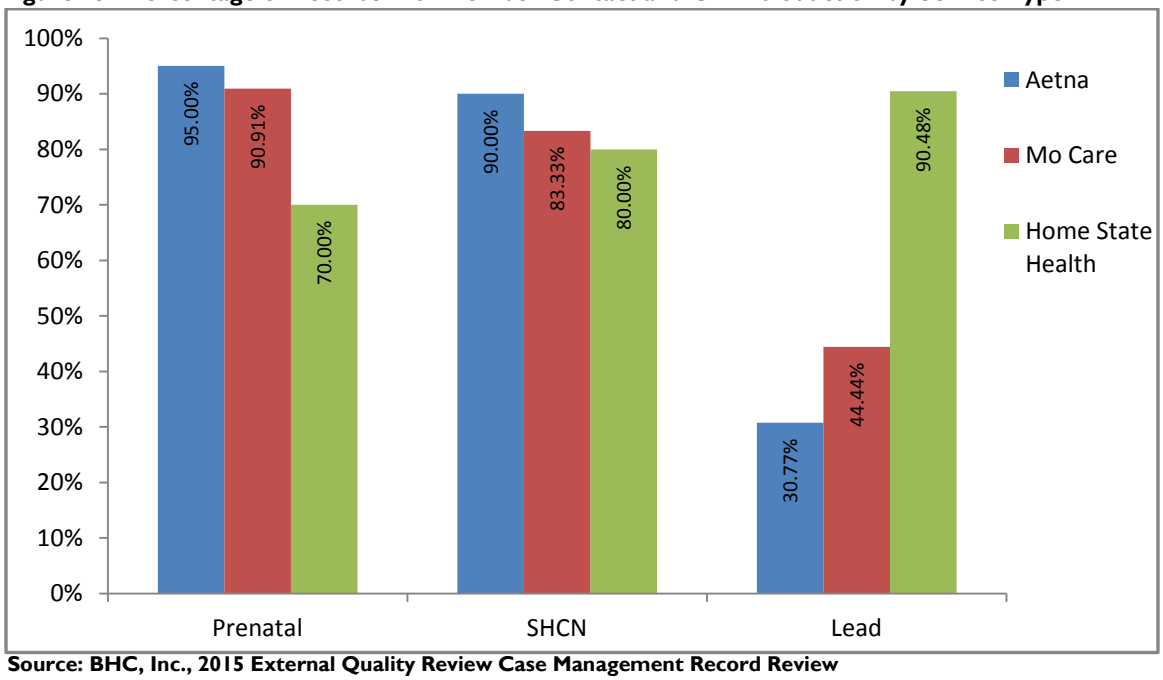


Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

In 2015, only one MCHP (Home State) improved in providing introductory information or recording these conversations with members (See Figure 14). The records reviewed for Home State exhibited a commitment to finding and contacting members. They were found to have provided and recorded the introductory discussions with members more frequently than in prior years.

Lead case management negatively affected the aggregate percentage of case records found to include introductory information to members for Aetna Better Health and MO Care. The percentages of introductory information provided for each MCHP, by case type, are as follows:

Figure 15 - Percentage of Records with Member Contact and CM Introduction by Service Type



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

Two MCHPs declined in providing or recording introductory discussions with members as the result of their performance with Lead cases. In these Lead cases the records did not contain a complete introduction or explanation of case management to members. Aetna Better Health's rate declined from 61.54% in 2014 to the current rate of 30.77%. MO Care's rate declined from 72.73% in 2014 to 44.44% in 2015 (See Figure 15).

Aetna Better Health failed to open 6 of the 19 lead cases provided for review to the EQRO. Attempts were made to contact these families, but no case management services were provided. Six additional cases were opened, but no contact was ever made with the member or family. In these cases all tracking and contacts regarding the member's blood lead level (BLL) were made with the local health department, the PCP office, or the Department of Health and Senior Services (DHSS) nurses.

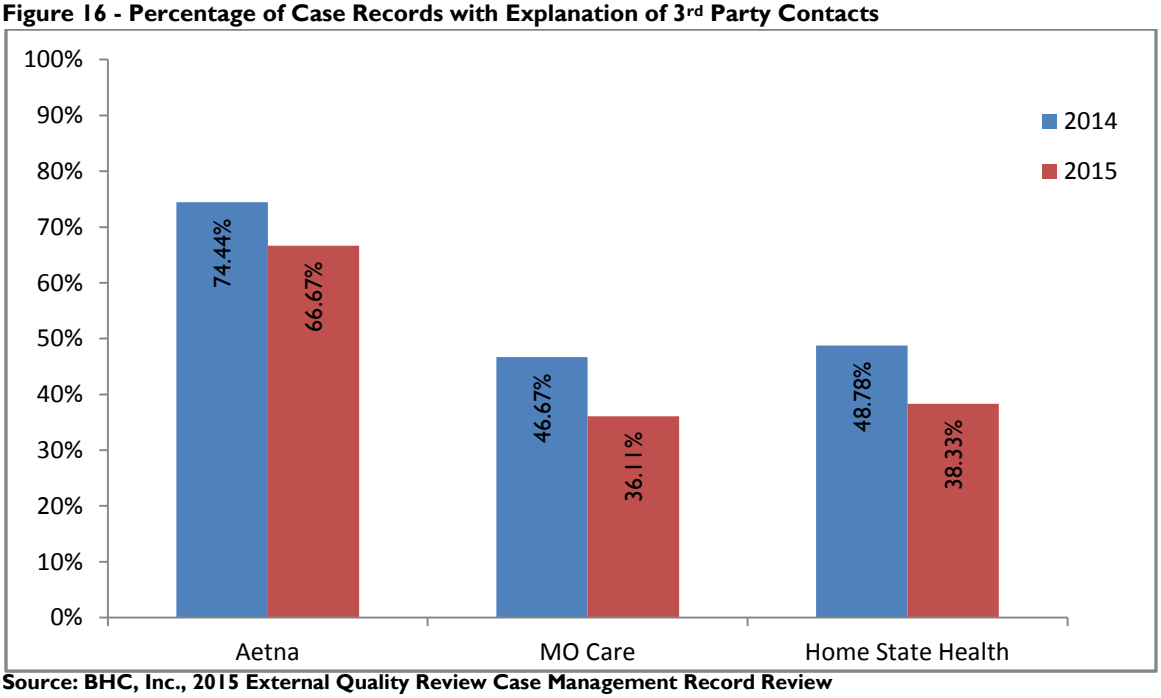
MO Care failed to open 7 of the 20 lead cases provided for review to the EQRO. They did

attempt to contact the member or their family, but these cases were closed prior to the BLL declining to an acceptable level (10V). These cases did not include any information regarding outcomes for the members involved. MO Care case managers attempted the required contacts. Three attempted contacts by letter or phone occurred. There was no evidence that the MCHP went beyond these efforts to locate members in the cases not opened for the 9 Prenatal, 8 SHCNs, or 7 Lead cases received for review.

One MCHP (Aetna Better Health) opened every case and made contact with the member, with the exception of lead cases. One MCHP (Home State) opened every case and made some contact with every member.

During 2014 compliance with one introductory area was identified as problematic: Obtaining member permission to speak to a third party about the case if necessary (see Figure 16). The case manager is required to ask the member if they have permission to speak to anyone else, such as another household or family member, about their healthcare issues. This continues to be an issue in 2015 where obtaining third party permission occurred in 56.59% of cases reviewed and declined for all three MCHPs. Percentages during 2014 and 2015 for each MCHP are represented here:

Figure 16 - Percentage of Case Records with Explanation of 3rd Party Contacts



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

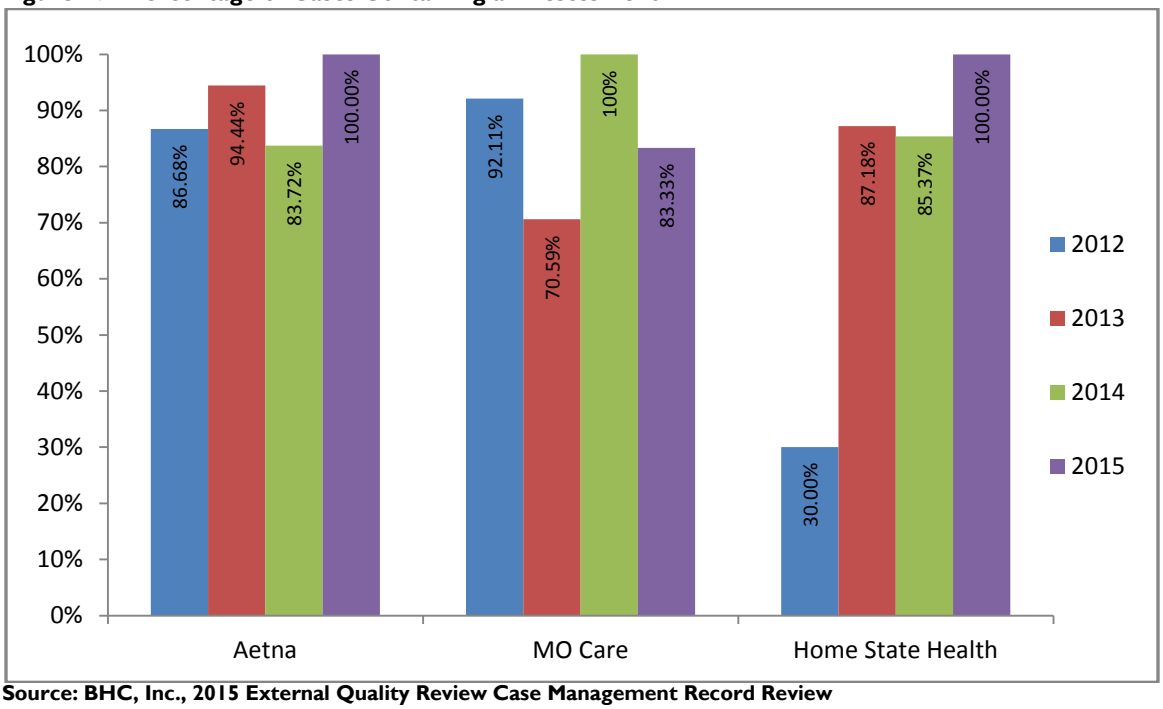
This, at best, reflects a continued lack of recording regarding this part of the discussion with members during the introduction to case management. However, the EQRO observed that this required element is not consistently discussed with the member.

Assessment

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

Figure 17 - Percentage of Cases Containing an Assessment



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

The assessments found in MCHP records are computer generated forms that case managers are required to complete at the beginning of each case assignment. The completion of this assessment satisfies the minimum contractual requirements regarding assessments at case openings. In the 2015 review the EQRO found assessment forms in the majority of cases, but they were not considered comprehensive. Case managers recognize that the forms do not always reflect the members' true needs.

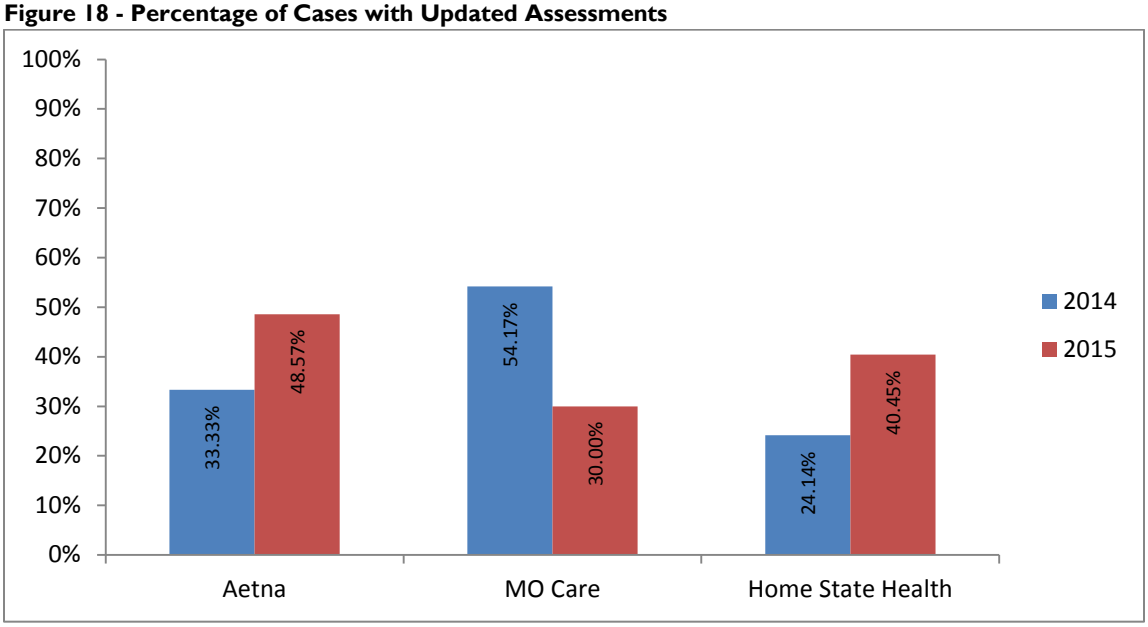
In the Aetna Better Health cases reviewed, case notes were found that described member needs and the issues to address or clarify, creating a comprehensive assessment. The notes in Aetna Better Health records clarified areas missed by the computer forms 82.20% of the time, which lead to improvement in completing comprehensive assessments (see Figure 17).

MO Care cases contained assessments in 83.33% of the cases reviewed, an overall decline of 16.67 percentage points (See Figure 17). The assessments found were considered comprehensive. However, three lead cases contained notes that a "MCHP assessment" was not necessary, as the Kansas City Health Department (KCHD) completed an assessment for these members. The KCHD assessment was not included in the records received by the EQRO, and these cases were therefore considered to have no assessment completed.

In cases reviewed for Home State, comprehensive assessments were found 80% of the time. All records included multiple forms titled "assessment." In 20% of the records reviewed the forms did not provide the information needed to define member service needs. For the assessment to be considered comprehensive it should provide direction to the case manager about what to include in the care plan. The forms in the record did not do this and case notes did not provide clarification.

The standards used to evaluate the assessment of the member's service includes completing the assessment within specified time frames, and obtaining additional information if the case situation changes. Updated information for all records reviewed was found in 41.10% of the cases in 2014. In 2015 this updated information was found in 42.68% of the cases. Figure 18 represents the 2014 and 2015 percentages for each MCHP.

Figure 18 - Percentage of Cases with Updated Assessments



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

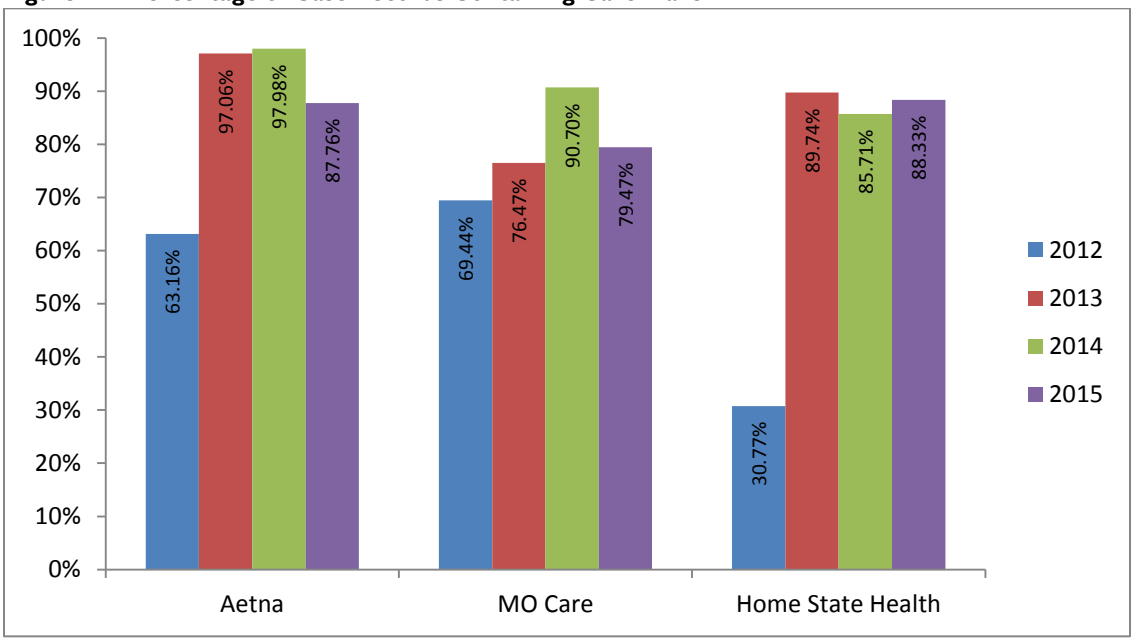
Both Aetna Better Health and Home State made improvements in updating assessments, while MO Care declined by 24.17 percentage points. This occurred in cases open over six months that contained no updated assessment or case notes. All three MCHPs completed updates in less than 50% of the cases reviewed. Continued improvement is needed.

Care Planning

The standards used to evaluate appropriate care planning require:

1. A care plan in all records; and
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.

Figure 19 - Percentage of Case Records Containing Care Plans



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

Both Aetna Better Health and MO Care had declining numbers from 2014 to 2015 in the area of care planning (see Figure 19). In 25% of the Aetna Better Health records reviewed the letters sent to the member or physician did not reflect the care plan found in the case notes. Case notes included care plans that reflected members' true service needs. The case notes also included documentation that more in-depth services were what members received. Care plans were updated when members' needs changed, and these updates were sent to members and PCPs.

The care plans found in MO Care records were developed using information from the member or obtained during the assessment. Member involvement in care plan development occurred in 74.50% of the care plans reviewed. This is a decline from the 88.33% rate from 2014.

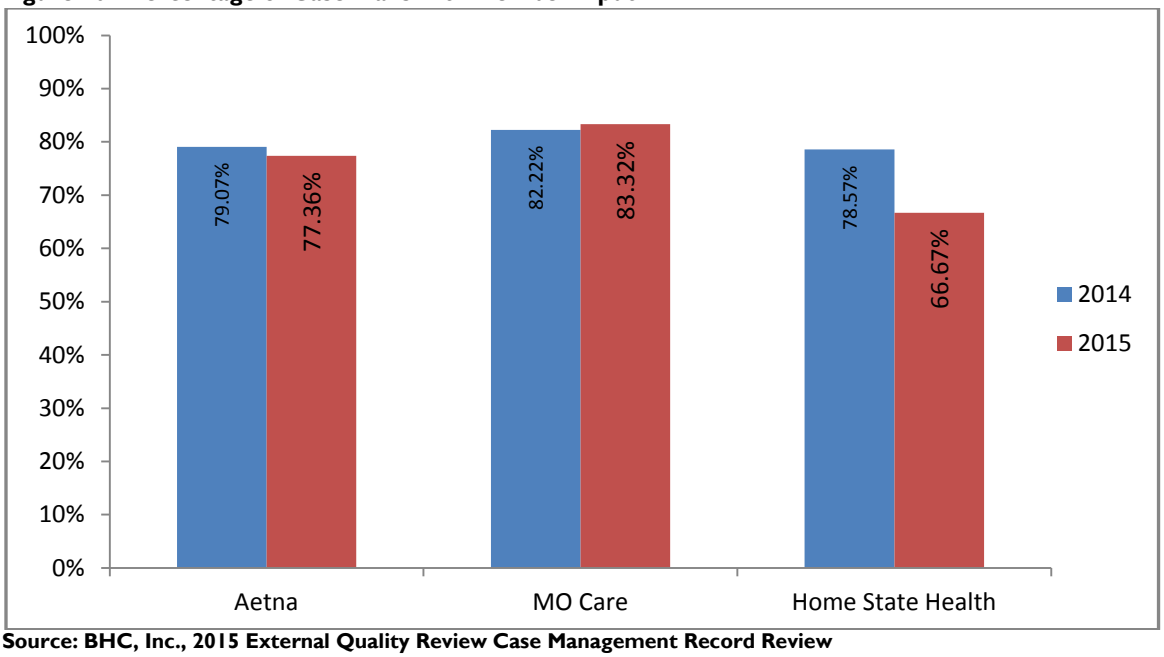
Home State included care plans in 88.33% of the cases reviewed which is a 2.62 percentage points increase over 2014.

One of the requirements of care plan development is including member input. In 2015 care plans included member input 74.50% of the time for all MCHPs.

While Aetna Better Health and MO Care showed slight changes in their level of member involvement, Home State declined by 11.90 percentage points in care plan development. Cases reviewed did not include evidence of the members' participation, as evidenced in Figure 20.

The MCHPs performed as follows:

Figure 20 - Percentage of Case Plans with Member Input



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

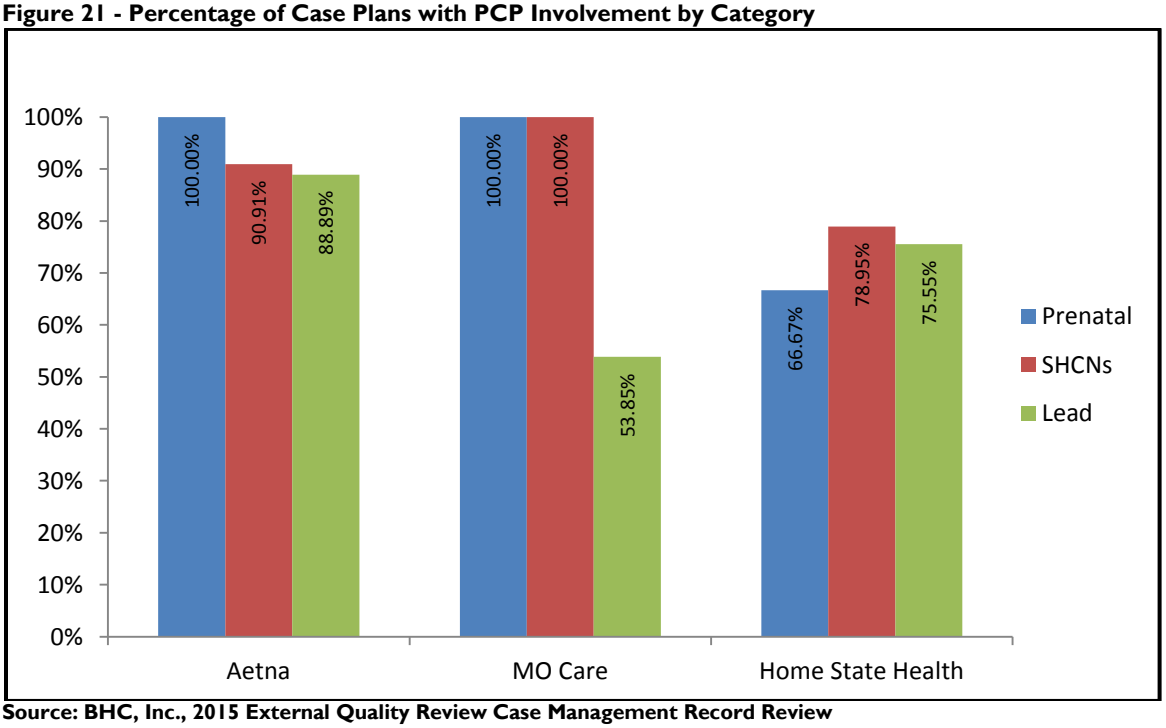
A second important aspect of this standard is the number of PCPs involved in or notified of the member's care plan.

The overall rate of PCP involvement/notification for Aetna Better Health was 92.45%, which is a slight decrease from the rate of 93.94% in 2014. Aetna Better Health informed the PCP of the care plan in 100.00% of OB cases, 90.91% of SHCNs cases, and 88.89% of Lead cases.

The overall rate of PCP involvement/notification for MO Care was 83.33%. This is an overall decrease from the 2014 rate of 88.89%. In both OB and SHCNs cases MO Care notified PCPs of their involvement with the member and sent the care plan 100% of the time. However, the rate of PCP involvement/notification in Lead cases reviewed was 53.85%, which negatively impacted the overall rating.

Figure 21 represents the percentage of case plans that included PCP involvement by case type. The overall rate of PCP involvement/notification for Home State was 73.33%. This is an increase from their 2014 rate of 58.54%. They informed the PCP of the care plan in 66.67% of OB cases, 78.95% of SHCN cases, and 75.55% of Lead cases.

Figure 21 - Percentage of Case Plans with PCP Involvement by Category



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

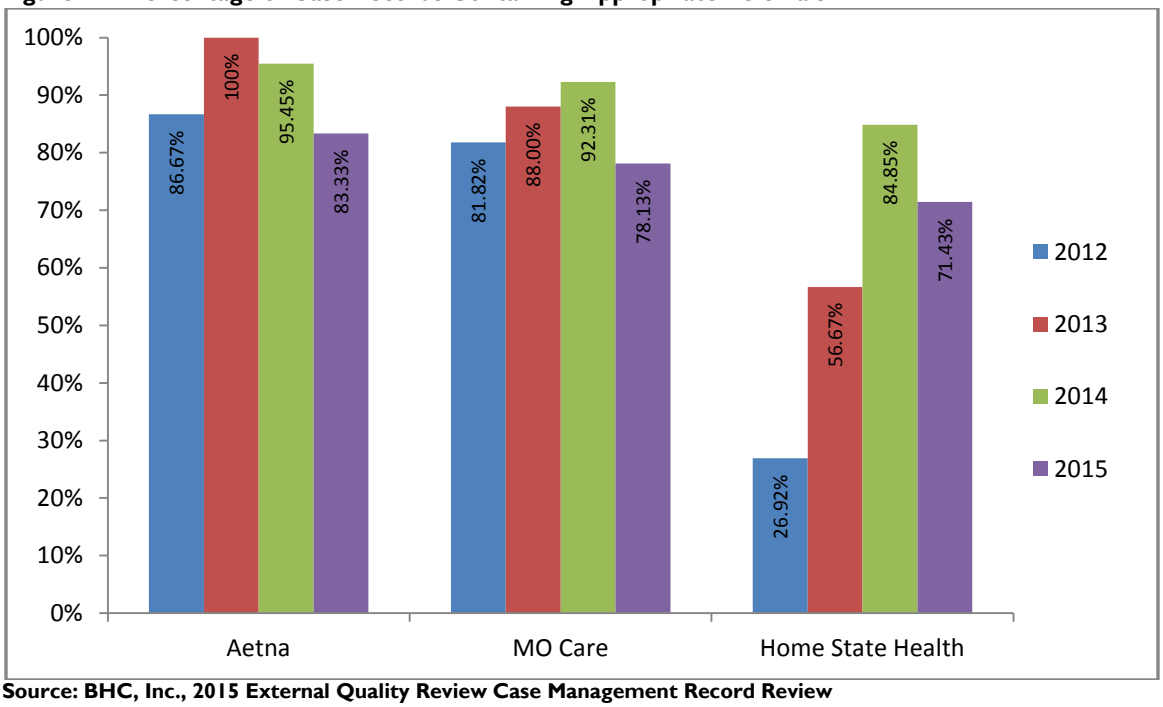
Lead cases negatively impacted the percentages for Aetna Better Health and MO Care for the standard overall. Both MCHPs must initiate case management with all Lead referrals and complete the care plan for these members. Home State's lowest percentage was in Prenatal cases, but the MCHP increased overall. Home State must continue to improve in this aspect of case management for all three categories.

Referrals

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.

Figure 22 - Percentage of Case Records Containing Appropriate Referrals

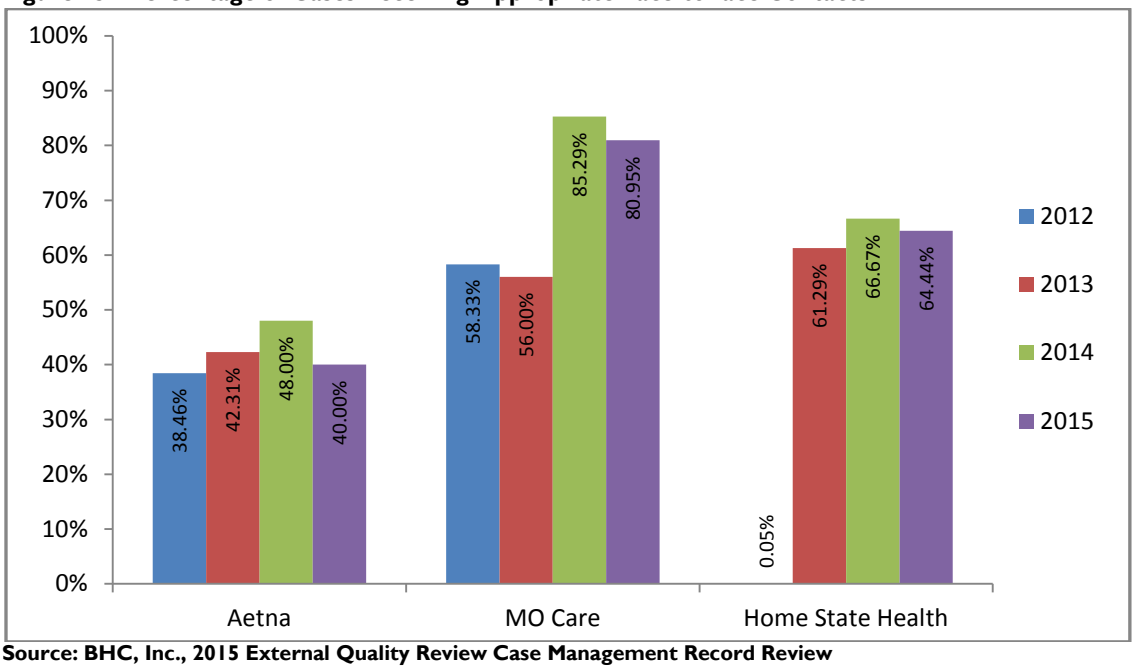


Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

All three MCHPs declined in the area of making appropriate medical and community based referrals for members (See Figure 22). This may be attributed to insufficient information being provided in case notes. Additionally, case managers may fail to make beneficial referrals. However, in the cases where the record indicates that referrals were made, detailed information was provided. It is clear from the records reviewed and interviews conducted that case managers are aware of resources in all of the communities they serve.

Face-to-Face Contacts

Figure 23 - Percentage of Cases Receiving Appropriate Face-to-face Contacts

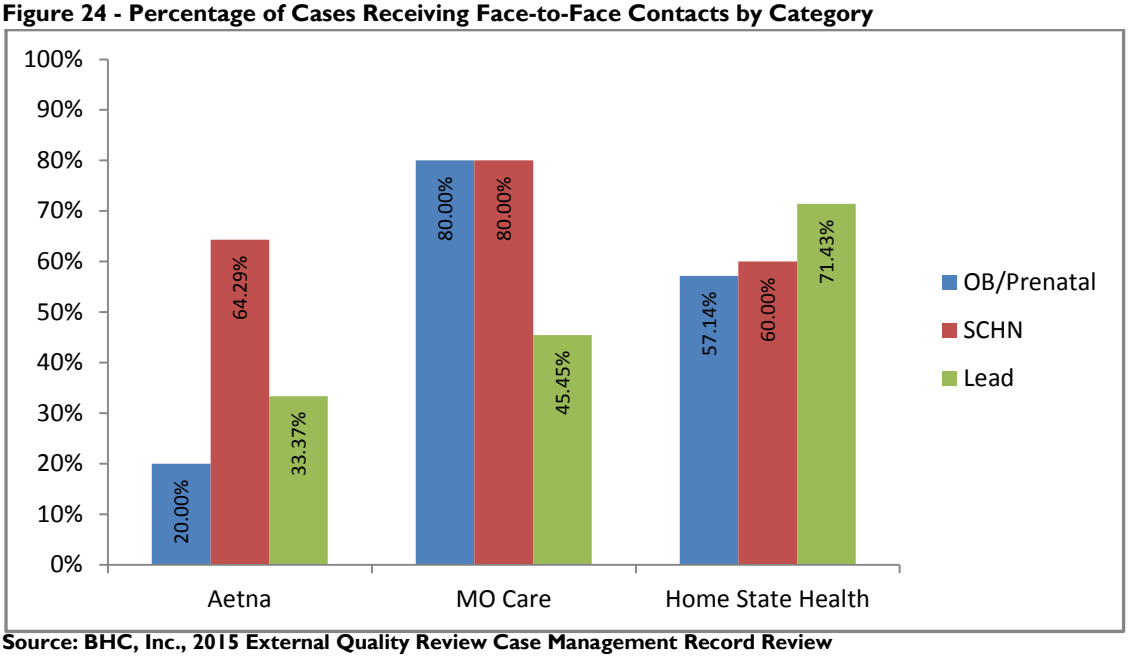


Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

The Managed Care contract contains standards that require specific face to face contacts for members in lead case management. It also states that there should be face to face contacts for members who are pregnant; and in other cases as deemed necessary. All three MCHPs declined in this standard (See Figure 23). Lower Aetna Better Health and MO Care percentages are attributed to Lead cases. Home State exhibited similar results for all three categories.

Home State had the highest percentage of home visits in Lead cases with 71.43% of the cases reviewed. This is well below the expectation of mandatory face-to-face contacts for all lead cases. All three MCHPs require improvement in providing this service to members. The rates presented in Figure 24 do not include cases where insufficient time had passed since opening to require face-to-face contacts. If a referral was made and the home health agency made attempts to provide these contacts, but the member did not allow or was never available for the contact, the case is considered positive and this is reflected in the numbers presented.

Figure 24 - Percentage of Cases Receiving Face-to-Face Contacts by Category



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

Although the contract language regarding prenatal cases states they "should have" a face-to-face contact, Aetna Better Health only referred two of 20 cases reviewed. The EQRO found a bias that encouraged this MCHP to refrain from referring members for a face-to-face visit. The review found eight records that contained case notes that indicated a need for face-to-face visits. These cases included serious medical situations or complex healthcare needs.

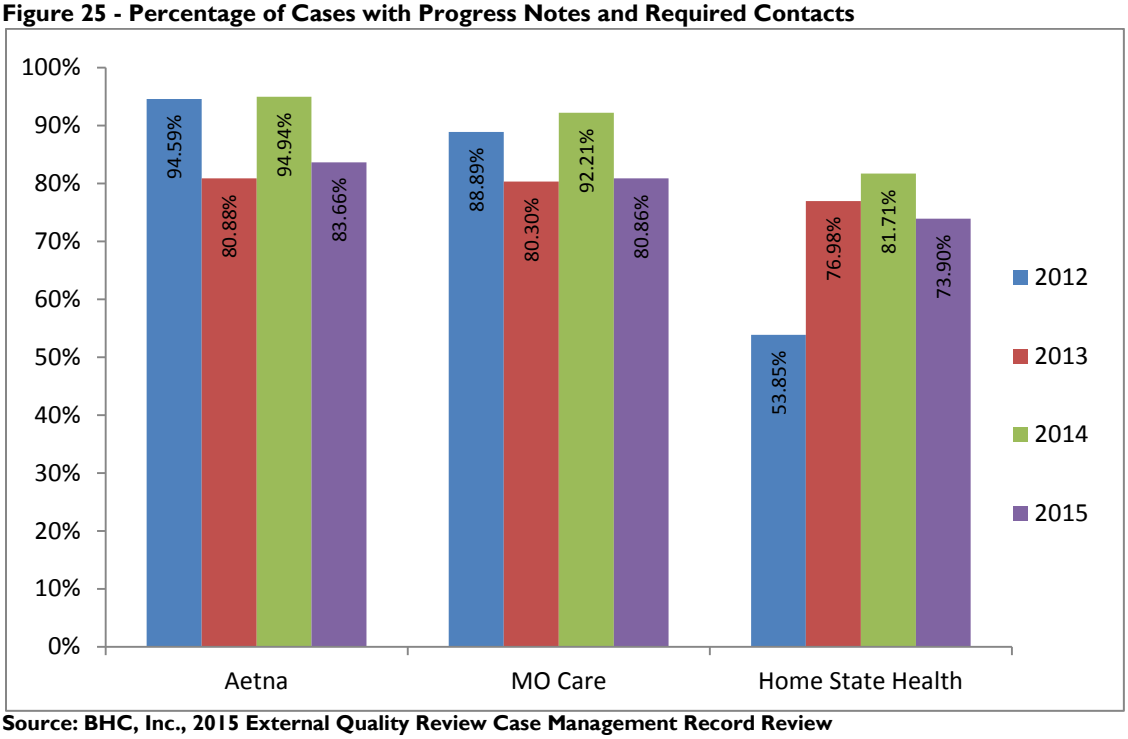
All three MCHPs did refer SHCNs cases for face-to-face contacts in over 60% of all records reviewed. These referrals are permissive, but are made, as needed, for members.

Contact with Members

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.

Figure 25 - Percentage of Cases with Progress Notes and Required Contacts

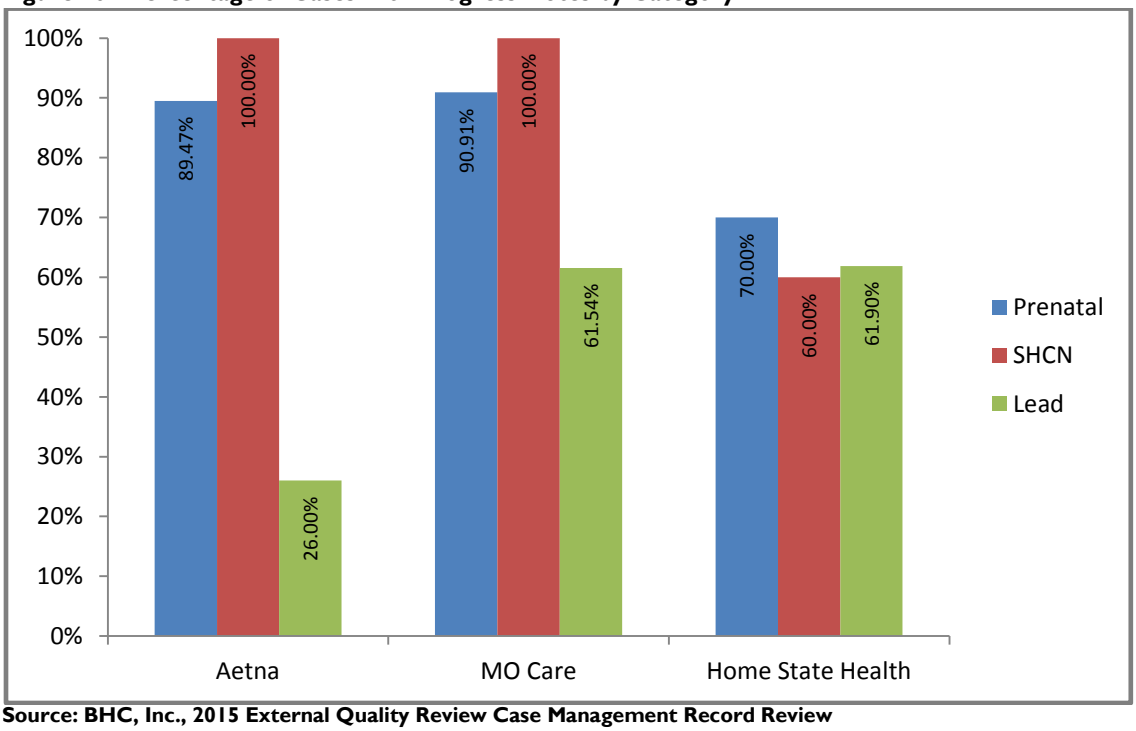


Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

All three MCHPs declined in this area (See Figure 25). Progress notes were included and up to date in 87.25% of the cases in 2015, compared to a rate of 96.12% of the cases reviewed in 2014. Members were contacted as required 70.29% of the time in 2015, compared to 72.00% of the time in 2014.

Aetna Better Health and MO Care Lead cases had the greatest deficiencies in progress notes. The area that was problematic for Home State was SHCNs. The rates for each MCHP, for each category of case management are detailed in Figure 26, below:

Figure 26 - Percentage of Cases with Progress Notes by Category



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

The second part of this standard requires that members be contacted at least three times during case management with the goal of developing a relationship with the member. Lead case management continued to negatively impact both Aetna Better Health and MO Care rates. Contacts were only made, as required, in 26.00% in the Aetna Better Health Lead cases reviewed. They contacted OB members at a rate of 89.47%, and SHCNs members in 100% in the cases reviewed.

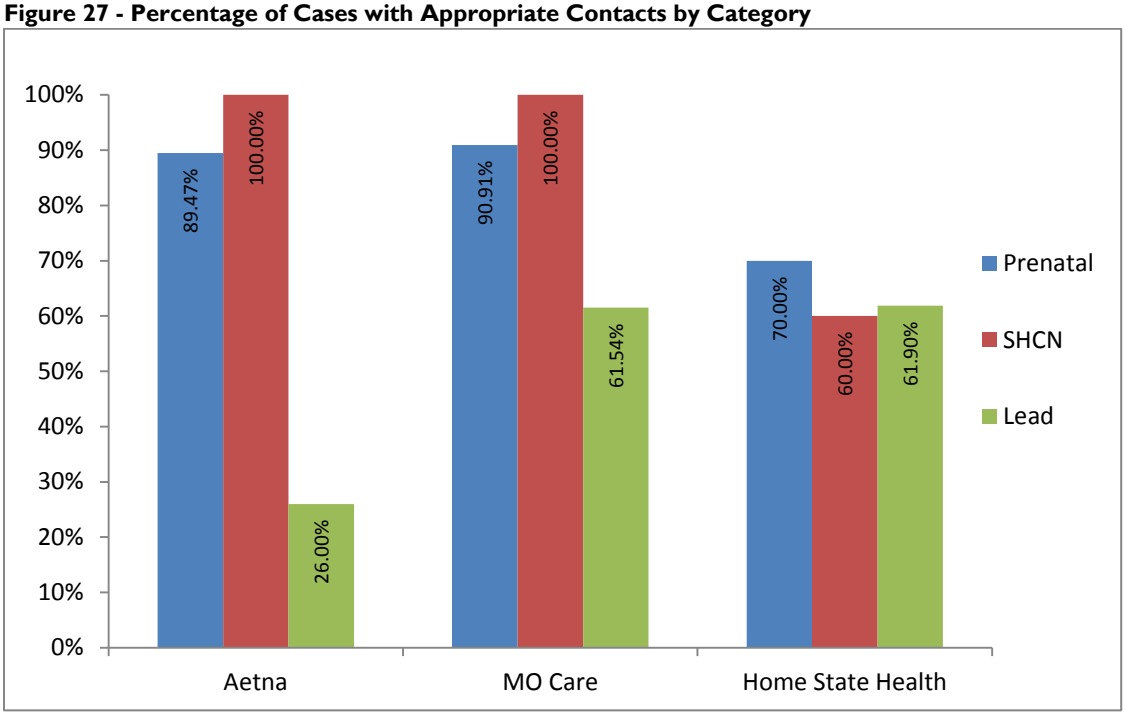
MO Care contacted members as required in 61.54% of the Lead cases reviewed. This is in contrast to OB cases where members were contacted in 90.91% of the cases reviewed, and SHCNs where members were contacted in 100% of the cases reviewed.

Home State made required contacts with members in 61.90% of the Lead cases reviewed and in 60% of the SHCNs cases. Prenatal members were contacted as required in 70% of the cases

reviewed. All three of these categories require improvement.

The percentages of cases reviewed, by category, are illustrated in Figure 27:

Figure 27 - Percentage of Cases with Appropriate Contacts by Category



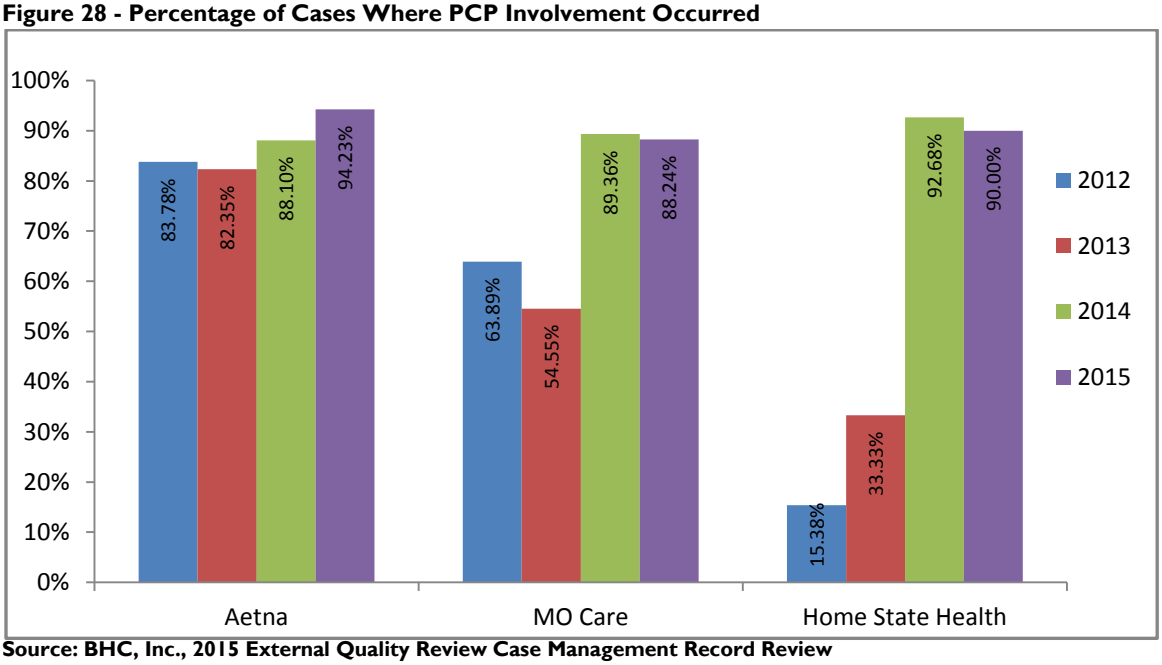
Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

PCP Involvement

The two standards used to evaluate this requirement are:

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

Figure 28 - Percentage of Cases Where PCP Involvement Occurred



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

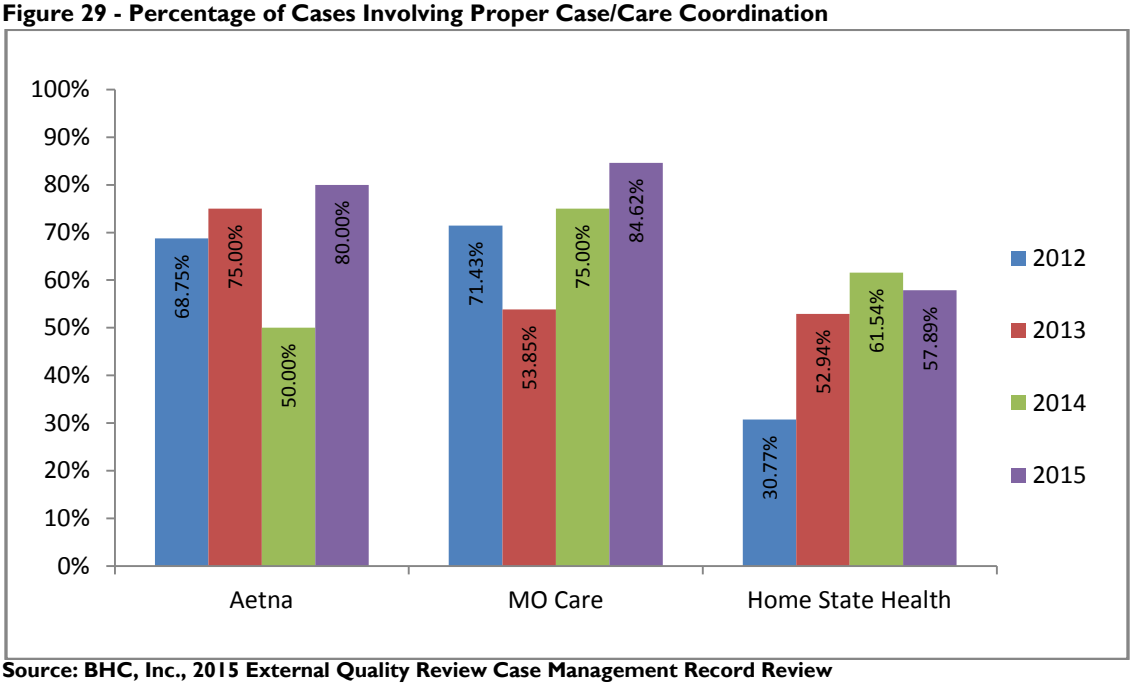
Aetna Better Health continued to improve in maintaining contact with the PCP or their office. Closing letters were copied to the PCP in 81.82% of the cases reviewed. Both MO Care and Home State remained consistent in contacting the PCP at case opening. MO Care sent closing letters to the PCP in 100.00% of the cases reviewed. Home State sent closing letters in 67.74% of the cases reviewed. The balance of the Home State cases (56.76%) remained open at the time the cases were identified for review.

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 29 - Percentage of Cases Involving Proper Case/Care Coordination



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

Aetna Better Health and MO Care case managers recognized the need for care coordination at an improved rate compared to the last three years (See Figure 29). Progress notes reflected members' needs for care coordination, and care managers efforts to provide this service. These case managers also questioned members regarding their need for behavioral health services.

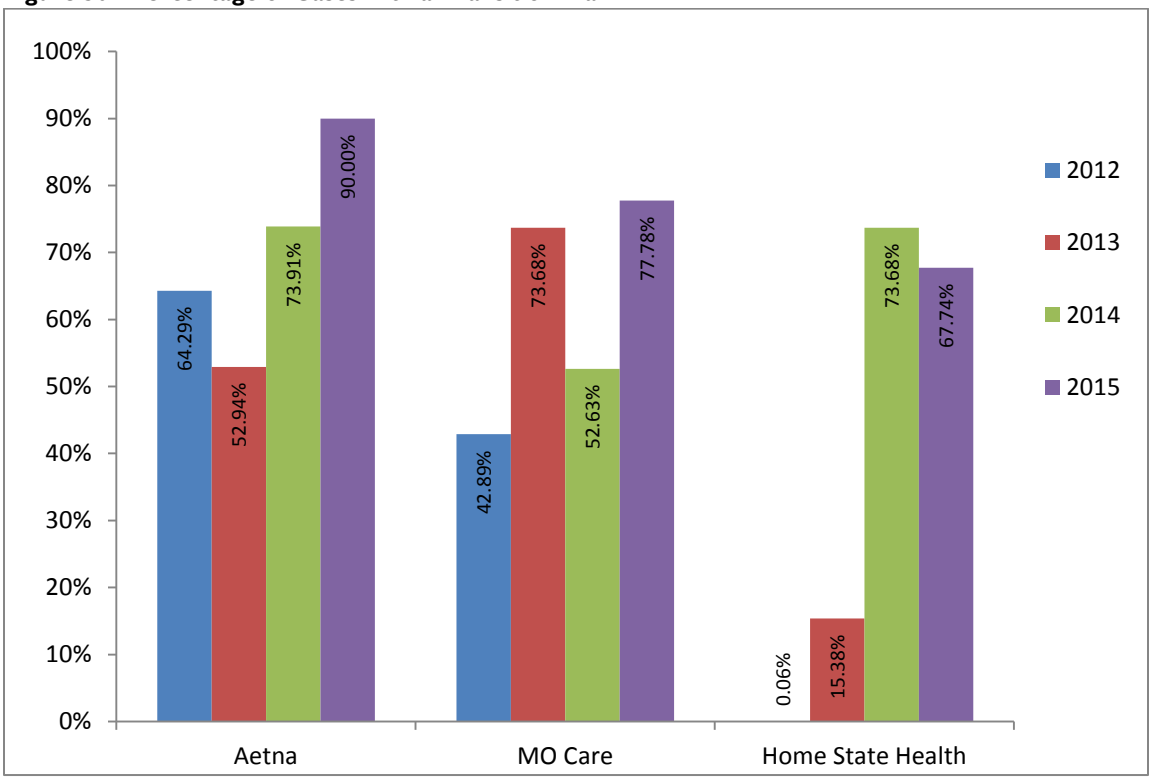
Home State declined by 3.65 percentage points. Case managers recognized the need for and provided care coordination in 75.55% of OB cases reviewed. The need for care coordination was recognized in 54.55% of the SHCNs cases reviewed. Only four lead cases indicated a need for care coordination. However, only two of these cases (50%) received this service.

Transition at Closing

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

Figure 30 - Percentage of Cases with a Transition Plan



Source: BHC, Inc., 2015 External Quality Review Case Management Record Review

Both Aetna Better Health and MO Care improved by including closing letters, and progress notes addressing proper criteria for case closure. The letters included additional information on referrals and case manager contact. .

Home State decreased by 5.94 percentage points. Case records either did not have case notes addressing the issues for closing case management, the development of a transition plan, or no closing letter could be located.

5.3 Observations for All MCHPs

QUALITY OF CARE

When members are properly introduced to and engaged in case management the quality of service delivery improves. For example, case managers maintain contact with the members they serve throughout the case management process. Case record reviews and interviews substantiate that in some cases the case manager advocates for extraordinary services to meet a member's healthcare needs.

- Aetna Better Health improved in four of the nine areas measured. The MCHP has dedicated case management staff. These case managers exhibit their commitment to providing quality care to members when responding to inquiries during the on-site interview process. However, the MCHP has not created new or innovative approaches that foster the improvements needed throughout their case management program. The declining numbers observed during 2015 indicate that requirements of the case management program are not receiving the attention necessary to maintain previous accomplishments. Problems within six standards of the Lead case management program were identified. These deficiencies must be addressed.
- Missouri Care improved in two of the nine areas measured in this review. There is a need for improvement in all aspects of member services. One specific area of concern is Lead Cases. Deficiencies in these cases resulted in declining numbers throughout the review. The MCHP partners with the Children's Mercy Pediatric Care Network (PCN) in the Western Region. These PCN cases indicated a high standard of case management services that promoted quality care for members.
- Home State improved in five of the nine areas measured. The MCHP remains committed to improving case management and developing quality member services. In two of the areas where the MCHP improved, introduction to case management and assessment, the MCHP made a strong effort to contact and engage members into case management. Assessment forms were found in 100% of the records reviewed. Comprehensive assessments were found in 80% of the cases, which indicates a need to better identify and articulate members' healthcare needs.

ACCESS TO CARE

Access to care was enhanced when case managers actively worked with families. Reviews indicated that the creative efforts used to locate members have diminished. MCHPs continue to use 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 need to contact a variety of sources to track members' whereabouts and make required contacts. In some 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 when case managers make an active effort to assist members in obtaining services, community or provider based, which uniquely meet members' needs. Case managers are knowledgeable about available resources. Fewer attempts to connect members to these resources were observed during 2015.
- 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 report their contacts. The MCHPs all declined in making referrals for face-to-face contacts. A specific area of concern is in Lead cases. In lead cases in-home services are a required. The number of members who received a referral for face-to-face services in lead cases ranged from 33.37% for Aetna Better Health to 71.43% for Home State. The difficulty of engaging families into the lead case management program is recognized. However, these figures reflect the percentage of cases where there was no referral for in-home services even when a contact was made with the family.
    - When consistent case/care coordination occurred case managers avoided duplication of services, and maximized MCHP resources. Care coordination improved for two MCHPs. The case records reviewed included notes and documentation that this service increased to 80% for Aetna Better Health and 84.62% for MO Care. Home State

declined by 3.65 percentage points.

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.

- In the OB the cases reviewed, where there was evidence of active case management, follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within specified time frames. Parents who received these services often enrolled their babies with the MCHP and ongoing preventive care was initiated.
- 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. Creating a transition plan prior to case closing improved for two MCHPs (Aetna Better Health and MO Care) by nearly 20 percentage points. Case managers were diligent in maintaining contact through case closure. One MCHP (Home State) declined by 5.94 percentage points. Their case records indicated a failure to complete a transition plan or send a closing letter to members.
    - In past reviews it appeared that after members' health care needs are met, the member lost interest in case management and no longer returned calls or responded to letters requesting they contact the case manager. This remains a problem but is in fewer cases reviewed. Case managers at all MCHPs find this troubling and continue their efforts to maintain a relationship with members through closing their case. The case managers continue to experience members contacting them 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 continues to require attention. However, Aetna Better Health did improve in this area reaching a rate of 94.23%. MO Care and Home State rates remained consistent with the previous year's report.
    - 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 report that speaking with provider offices regarding most of their members regularly. Some of these contacts were found in case notes, but this is an area that requires continued attention.

RECOMMENDATIONS

1. When case listings are requested three categories are defined. Two of these lists include all Prenatal/OB case records and Lead case records. The third category is entitled "Special Health Care Needs" (SHCNs) to comply with the language in the federal protocol. This includes all other types of case management cases open in the MCHP system. A comprehensive listing of open and active cases for all case management activities must be submitted. If there is a question about the cases to be included in listings, the MCHPs should contact the EQRO for clarification.

2. Case managers should copy their own records when cases are requested or should ensure that all required information is submitted.

3. 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. If a problem is reported during the assessment it should be addressed and activities recorded in the case notes. If there is a reason that a problem identified or a service is not addressed that information should be recorded.

4. The MCHPs should invest in a case management model that ensures that members receive the face-to-face contacts required. This may require more direct contact with members and better progress notes when a contracted entity is used. A number of the MCHPs' PIP outlines reviewed by the EQRO include projects requiring in-home and intensive case management. This type of commitment should be available in all the cases reviewed. When a case is complex and the member would benefit from face-to-face visits, this should be recognized and noted by the case manager. If there is a reason that

these visits were not authorized that should be recorded in the case notes.

5. Lead Case Management must 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 or the PCP offices 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. Case openings should occur in every lead case, and case notes should detail case management efforts to locate and contact members.

6. Minimum required efforts to locate members are defined by the MHD contract. In most cases received for review, the EQRO observed efforts to locate members by contacting PCP offices, or relatives who might be living at the original address provided. A number of agencies are contracted to do "drive-bys" to attempt to locate members who are difficult to locate. The MCHP must ensure that the results of these drive-bys are included in the case notes. It is anticipated that the rigorous efforts to locate members observed in some cases should be expanded to include all types of case management cases.

7. Renewed attention to the Lead case management program is required. Many of these cases include multiple children and often include additional medical issues. Complicating families' situations by failing to coordinate case assignments or contacts, can lead to a lack of cooperation and confusion, often perceived as a negative response from the member or family. Case managers may have more success if there is one case manager per family, rather than one case manager per member, or per medical issue. If the lead assessment indicates other medical issues, and these are not addressed by the lead case manager, case notes must reflect how these services are provided to the member or why they are not addressed.

8. 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.

9. Complex case management, and care coordination are not consistently defined at each MCHP. This creates confusion in requesting and reviewing cases. The MCHPs do not have to operate in exactly the same manner. Basic services should be defined and implemented consistently.

10. The number of cases actually opened for case management remains a concern. 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.

11. Case notes should reflect attention to the services indicated 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.

12. Continued efforts should be made to ensure that case managers make contact with the PCP, and keep them informed regarding case updates and changes.

6.0 Aetna Better Health of Missouri

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6.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Aetna Better Health of Missouri (Aetna Better Health) supplied the following documentation for review:

- Improving Childhood Immunizations
- 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 21, 2016, during the on-site review, and included the following:

Rudy Brennan (via telephone) – Quality Improvement Coordinator
Carol Stephens-Jay – Senior Health Care Consultant
Dale Pfaff – Quality Improvement Coordinator

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

- Study topic development and continued progress in creating improved health outcomes for members.
- Are study indicators reflecting improved member outcomes?
- The need to implement new and measureable interventions each year.
- PIP setup and the use of available data to inform the MCHP about the success of proposed interventions.
- Updating studies from year to year to integrate information into their current processes, and the need to continue to revise their studies keeping them current.

The PIPs submitted for validation included a substantive amount of information. The MCHP submitted information including all development and planning that has gone into the clinical PIP. This is a new study topic and interventions were not implemented until 2016. The updated information included the results of HEDIS 2016 (CY2015), the baseline year for this project. There are no outcomes to report.

The HEDIS 2016 outcome data for the non-clinical PIP was discussed at the time of the on-site review, which was used in the final evaluation of the PIP. The MCHP was provided the opportunity to provide additional updates to improve their PIP submissions.

FINDINGS

CLINICAL PIP – IMPROVING CHILDHOOD IMMUNIZATIONS

Aetna Better Health's clinical PIP was developed to improve the rate of childhood immunizations for MCHP members up to 2 years of age. They recognized that the MCHP had a problem with the number of children who were receiving the correct vaccinations throughout their early childhood. Vaccinations are a primary method to provide preventive healthcare to their members. The MCHP found that an important concept of childhood immunization is preventing illness for their members. To expand on this they provided research pointing out that by increasing the number of children who are vaccinated provides another layer of protection to the community. When most of the members of a community are immunized against a contagious disease, there is little opportunity for an outbreak of that disease.

Aetna Better Health created a PIP with plan-specific interventions that address a need to raise the number of children who obtain a complete set of required vaccinations. The data analysis will audit compliance rates for all 14 vaccinations in addition to Combo 3. The goal of this PIP is to increase the compliance rate of each of the sub-measures within the Combo 3 vaccinations to 90% by the second year of the PIP.

Focusing MCHP resources on increasing the number of children receiving all necessary immunizations will improve their goal of increasing preventive services. The baseline year for this PIP is calendar year (CY) 2015. Interventions were developed to begin in January 2016. Their interventions will be developed to address the following barriers:

Member Barriers:

- Parents or caregivers do not support immunizations
- Parents are unaware of the need to schedule immunizations for their children
- Some parents are unable to get to a doctor's office or health department during routine hours
- Fear that vaccinations cause Autism or Mercury Poisoning

Provider Barriers:

- PCPs do not provide immunizations causing the member to find another site and a second visit to obtain them

- Provider offices do not remind patients or schedule routine visits in the future

Plan Barriers:

- Aetna Better Health is not informed if a member obtains immunizations through their local health department. Local health departments do not necessarily bill for immunizations and therefore these actions are not captured in HEDIS administrative data. Aetna also performs a hybrid review, but unreported health department activities are not available for a record pull. Some Health Departments are not aware of the importance of the HEDIS reporting process.
- The MCHP does not have access to the DHSS immunization registry, and files sent by the State have not been consistent Up to this point the DHSS has not readily shared registry data with the MCHPs. Aetna Better Health has experienced a data flow problem from the State database to the MCHP database. During 2016 a quarterly submission of this information, generated by MHD began, which may improve data sharing in the future.
- Aetna Better Health lacks a consistent process ensuring that files received are entered into their HEDIS system.

There is an overall lack of consistent data regarding which children receive immunizations. The interventions planned as the result of this barrier analysis include:

- Use of text messaging to remind parents of newborn children to get their child immunized
- Use of the current mailer that is sent to children's households between the ages of 12 and 15 months of age to target immunization information
- Targeted phone call outreach to HEDIS measure Well-Child Visits within the first 15 months of life eligible members missing visits
- Collaborate with Head Start programs and County Health departments to identify intervention opportunities

The MCHP has established their baseline using HEDIS 2016 rates. The Quality Improvement team continues to meet to establish more material interventions and to assess all potential barriers. The full implementation of this PIP begins January, CY 2016. The MCHP recognizes that the problems outlined in their Study Topic continue to exist, and will use this PIP to remediate the issues addressed.

The following Validation Worksheet provides the details of how the project meets each PIP requirement:

Demographic Information		
Plan Name or ID: Aetna Better Health of Missouri		
Name of PIP: Improving Childhood Immunizations		
Dates in Study Period: January 1, 2016 to present		
I. ACTIVITY I: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**X** Met __Partially Met __Not Met __Unable to Determine	The study topic presentation is well-written and informative. It provides convincing evidence that this is a viable, important topic to address as a performance improvement project.
Clinical _xx_Prevention of an acute or chronic condition ___High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical ___Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	The goal of this PIP is to increase the number of members/children who complete their Combo 3 immunizations. They provide information that clearly addresses the fact that this is a key aspect of enrollee care.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	The members who are the focus of this study include all members up to 2 years of age. They will review all available data bases that identify members who are non-compliant, enrolled for over 90 days, and are within the age range that is the focus of the study.
Demographics: _xx_Age Range _____Race _____Gender Medical Population: _____Medicaid Only _____Commercial	Totals	**3** Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __Partially Met __Not Met __Unable to Determine	The study question is clear and understandable. The narrative states that the goal is to increase the compliance rate to 90% for Combo 3. This goal and the study population are stated in the study question.
Include study question(s) as stated in narrative: Will implementation of specific interventions increase the HEDIS rate of children from 6 weeks of life to 2 years of age who receive immunizations by two years of age, toward the goal of 90%?	Total	**1** Met ___Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	The discussion defines the numerator and denominator that will be used to measure the PIP outcomes. The discussion refers to Table 3, which provides the ICD codes to be used in this measure. How this information will be used making it pertinent to this study is explained.
List Indicators:		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met ___Partially Met __Not Met __Unable to Determine	The indicators imply the measurement of changes in health status strongly associated with improved outcomes. The HEDIS data, both administrative and hybrid will be used to measure the outcome of the interventions implemented – beginning in 2016.
Are long-term outcomes implied or stated: xx yes ___no xx Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	**2** Met ___Partially Met _____Not Met _____UTD

Component/Standard	Score	Comments
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP will review their internal database (QDWA) to identify members who are non-compliant with obtaining the Combo 3 immunizations. These members will be targeted for outreach interventions. It includes all members who are under 2 years of age. It also includes all members who are enrolled with Aetna Better Health for 90 consecutive days.
Demographics: birth to age 2 Age range _____Gender _____Race Medical Population: _____Medical Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	The data collection approach is focused on identifying all members who meet the criteria for this study. In table 2 the immunization group indicates Combo 2, but the study refers to Combo 3.
Methods of identifying participants: __xx__Utilization data _____Referral _____Self-identification __Xx__Other _____	Totals	**2** Met _____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	N/A
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	N/A
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	N/A
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	_____Met _____Partially Met _____Not Met _____UTD

Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	__Met **X** Partially Met __Not Met __Unable to Determine	The study design addressing clearly defining specific data to be collected does not appear to be specific to this study. As stated earlier Table 3 includes the immunizations included in Combo 10 and 3.
6.2 Did the study design clearly specify the sources of data?	**X** Met __Partially Met __Not Met __Unable to Determine	This section identifies the population, and explains that the baseline information (CY 2015) will include all members within are age range and will not apply the "allowable gap" criteria used in the HEDIS measure. All members who meet the age criteria will be included in this study population
Sources of data: ___Member xx Claims ___Provider xx Other: The BiQuery Data Warehouse Appliance (QDWA).		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	**X** Met __Partially Met __Not Met __Unable to Determine	The systems and methods for extracting valid and reliable data are described in detail. Individuals involved and their expertise is included.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	**X** Met __Partially Met __Not Met __Unable to Determine	The instruments used and how the data is accessed is detailed in the narrative. The information provided leads to confidence that consistent and accurate data will be collected and reported. Information included explains that the data presented is preliminary and will be updated by the time of the on-site visit.
Instruments used: ___Survey _____Medical Record Abstraction Tool Other:_____		Inclusion of a description of how medical records are accessed for the hybrid evaluation will be requested.
6.5 Did the study design prospectively specify a data analysis plan?	**X** Met __Partially Met __Not Met __Unable to Determine	The data analysis plan is presented. It is clear and understandable.
6.6 Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	The paragraph regarding staff involved includes all directly involved in the project, their qualifications, and role.
Project Leader Name: Dale Pfaff Title: QM Nurse Consultant Role: Responsible for all aspects of the PIP. Other team members: Names/Roles: Carol Stephens-Jay – data analysis Dr. Sidney Ross-Davis – Medical Director/oversight.	Totals	**5** Met **1** Partially Met _____Not Met _____UTD

Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP proposes to initiate interventions during 2016. They have a balance of interventions between members, providers, and themselves. They are continuing to assess the problem and develop best methods to impact it. The MCHP wants to effectively encourage parents to obtain immunizations as efficiently as possible,
Describe Intervention(s): **Member**: Create immunization fact mailer – send to all parents of newborns and all children on their 1st birthday. Text message to qualifying parents including immunization information. Send a mailer to parents of children 12-15 months. Inform all families about transportation. **Providers**: Share Provider Gap in Care reports identifying patients who need immunizations. **Plan**: Ensure registry info is received monthly. Collaborate with Mo Health Plus to obtain accurate /timely data when children receive immunizations at FQHCs.	Totals	**1** Met _____Partially Met _____Not Met _____UTD

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	Sections 8 – 10 are coded as "Not Applicable" as this PIP is new and the interventions are scheduled to begin in CY 2016. The PIP does include data from HEDIS 2016 (CY 2015) which is the baseline measurement year. The narrative does analyze how the data was collected, and what it represents. This PIP is developed on a sound foundation for data analysis when the HEDIS 2017 data is received.
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Are tables and figures labeled? ___yes ___no Are they labeled clearly & accurately? ___yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Indicate the time periods of measurements:_____ Indicate statistical analysis used:_____ Indicate statistical significance level or confidence level if available/known: _____99% ___95% ___Unable to determine		
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Limitations described:_____ Conclusions regarding the success of the interpretation: _____ Recommendations for follow-up: _____	Totals	_____Met _____Partially Met _____Not Met **4** Not Applicable _____UTD

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	
Was there: _____Increase _____Decrease Statistical significance ___yes ___no Clinical significance ___yes ___no		
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	
Degree to which the intervention was the reason for change ___No relevance ___Small ___Fair ___High		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	
_____Weak _____Moderate _____Strong	Totals	_____Met _____Partially Met _____Not Met ___Not Applicable _____UTD

Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__Met __Partially Met _Not Met _**X** Not Applicable __Unable to Determine	
	Total	_____Met _____Partially Met _____Not Met **_1_**Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:
This is the framework for an effective PIP. This PIP has the potential to meet the goals of the MCHP. Good analysis of information currently available. Well-developed study.

Recommendations: Continue the development of baseline data, and implementation of the proposed interventions. Continue to explore innovative interventions. Evaluate those that produced positive results and those that lacked impact.

There are not actual results available to date. The PIP provides a good study foundation, so it is expected that there will be confidence in future results.

Check one: ☐ High confidence in reported Plan PIP results
☐ Confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible
xx Unable to determine – the PIP is new and has produced no results

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Aetna Better Health's non-clinical PIP included information related to the statewide PIP and addressed the MCHP's population individually.

The following interventions were added to their previously successful project for CY 2015:

- Working with a new FQHC in the Hannibal area, Clarity Healthcare, to identify non-compliant members affiliated with this FQHC. Clarity would contact these members/parents to remind them of the need for dental care and assist in making appointments.
- Continued work with Head Start. The MCHP conducted dental education with children during the day, and with parents at a monthly meeting at Head Start. These programs intended to inform both children and their parents about the existing dental benefits that MHD and the MCHP offer. The programs also reminded members of the importance of good oral hygiene as it relates to children's overall health.
- Begin building a relationship with one large FQHC, Affinia Healthcare in St. Louis, MO. The MCHP independently and in collaboration with the Dental Task Force, begin developing a relationship with the FQHC to ready them for new 2016 initiatives. This FQHC has a new dental facility with 92 dental chairs and is staffed full time. This includes students from A. T. Still University Dental School.

Aetna Better Health's HEDS 2016 results are as follows:

- Eastern Region - Improvements of .73 percentage points;
- Central region – Decreased by .42 percentage points;
- Western region – Decreased by 2.65 percentage points;
- Statewide aggregate – remained the same as the previous year at 50.23%

The MCHP did not meet their HEDIS year goal of 51.74%. This is the second year that the MCHP has failed to meet the 3% annual improvement goal. Data is presented about the outcomes of this PIP, which included increases through CY 2014. There is discussion about the data and how the figures are analyzed. The MCHP does not provide any reasons or theories about why their approach or interventions have failed to produce the desired outcome. The MCHP recognizes a need for change in future improvement efforts. The narrative explains that

the Project Lead will conduct an internal meeting to discuss the current outcomes and the HY 2016 audited data. Major revisions to the PIP to reframe interventions by age-specific categories are proposed. Other progressive changes include strengthening referral practices by medical home PCPs to dental providers; and developing a more robust process of collaborating with the FQHCs throughout the state in an effort to identify and contact non-compliant members. These plans, at the time of the up-dated PIP submission in July were "conceptual in nature," and conversations at the MCHP indicated "promise" toward revitalization of the PIP interventions and outcomes.

The following Validation Worksheet provides the details of how the project meets each PIP requirement:

Plan Name or ID: Aetna Better Health of Missouri		
Name of PIP: Improving Oral Health		
Dates in Study Period: September 2009 – 2016		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	_X_ Met __Partially Met __Not Met __Unable to Determine	While this is a statewide PIP, the MCHP personalized their rationale for their members in designing this project. The study topic discussion was complete and focused on the needs and circumstances of health plan members. This was an excellent example of taking a statewide topic and creating applicability to Aetna Better Health members. Regional and national information was utilized from the literature review presented. This information presented evidence validating the need to improve in the area of annual dental visits. The narrative presented convincing evidence that this is an important area of concern.
Clinical ___Prevention of an acute or chronic condition ___High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical _xx_Process of accessing or delivering care		
1.2. Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	_X_ Met __Partially Met __Not Met __Unable to Determine	This is a non-clinical PIP that is clearly focused on improving members' healthcare.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3. Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	_X_ Met __Partially Met __Not Met __Unable to Determine	There is no exclusionary language in this presentation. This PIP is focused on all eligible children within the appropriate age ranges.
Demographics: _ages 2-20_Age Range _____Race _____Gender Medical Population: _xx_Medicaid Only _____Commercial	Totals	_3_Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	_X_ Met __Partially Met __Not Met __Unable to Determine	This study question is exactly the same as the 2014 PIP, with the exception of referring to HEDIS 2016 rates. The study question, which is well constructed and addresses the goal of a 3% increase goal from one measurement year to the next. The PIP will continue to target provider and members with this project year's interventions.
Include study question(s) as stated in narrative:"1. Will member and provider reminders and education improve the HEDIS rate of annual dental visits as evidenced by a 3% increase in 2016 HEDIS annual dental visits?" "2. Will the addition of targeted provide-assisted, care-centered promotions and dental events improve the regional HEDIS rates for annual dental visit (ADV) by 3%?"	Total	_**1**_Met ___Partially Met _____Not Met _____UTD

Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	_**X**_ Met __Partially Met __Not Met __Unable to Determine	Denominator: All Aetna Better Health of MO HEDIS eligible members from the ages of 2 through 20 as of December 31 of the measurement year. Numerator: All Aetna Better Health HEDIS eligible members from the ages of 2 through 20 who have had at least one dental visit in the measurement year.
List Indicators:		The indicator presented and explained in the narrative is clear, concise, and measurable. This includes defining the numerators and denominators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	_**X**_ Met __Partially Met __Not Met __Unable to Determine	This PIP is focused on the process of care -- Improved Annual Dental Visits -- that is strongly associated with improved healthcare outcomes.
Are long-term outcomes implied or stated: _xx_yes ___no _xx_Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	_**2**_Met _____Partially Met _____Not Met _____UTD

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __Partially Met __Not Met __Unable to Determine	All eligible MCHP members, ages 2-20, will be included. This is defined and coincides with the NCQA tech specs, as well as the population defined in the Statewide PIP.
Demographics: 2-20 Age range _____Gender _____Race Medical Population: __xx__Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	The study design section on data collection explains of the data collection approach captures all enrollees. It explains how using the HEDIS administrative data captures all enrollees.
Methods of identifying participants: __xx Utilization data _____Referral _____Self-identification _____Other _____	Totals	**2** Met _____Partially Met _____Not Met _____UTD

Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No sampling methodology was used in this PIP
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	_____Met _____Partially Met _____Not Met _____UTD

Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	X Met __Partially Met __Not Met __Unable to Determine	A complete study design was presented. It clearly defines all the data to be collect, and the methodology used.
6.2 Did the study design clearly specify the sources of data?	X Met __Partially Met __Not Met __Unable to Determine	Claims data is received from DentaQuest generated by the claims processing system. They use appropriate CDT codes indicating no dental claim.
Sources of data: ___Member _xx Claims ___Provider ___Other		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X Met __Partially Met __Not Met __Unable to Determine	The narrative explains how the HEDIS ADV rate is calculatedfor the entire population, how this is then loaded into NCQA certified software by trained IT specialists. The HEDIS outcome reports are produced.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X Met __Partially Met __Not Met __Unable to Determine	The administrative methodology is utilized to produce the ADV HEDIS rates. This is described in a manner to ensure that consistent and accurate data collection will occur. Who collects data, how it is input into the system, and who is involved in this entire process are included. .
Instruments used: ___Survey _____Medical Record Abstraction Tool Other:_____		
6.5 Did the study design prospectively specify a data analysis plan?	X Met __Partially Met __Not Met __Unable to Determine	The prospective data analysis plan that was presented Enhanced the analysis from 2014 through 2015. It was detailed and complete. The narrative includes the specific processes used to analyze data throughout the study year as well as how this data will be used to assess the success of the planned interventions...
6.6 Were qualified staff and personnel used to collect the data?	X Met __Partially Met __Not Met __Unable to Determine	All staff members, their areas of expertise, and rolls in the PIP are presented.
Project Leader Name: Dale Pfaff Title: UM Nurse Consultant Role: Responsible for all aspects of the PIP Other team members: Names/Roles: Carol Stephens-Jay – data analysis; Dr. Sydney Ross-Davis – Medical Director.	Totals	6 Met ____Partially Met _____Not Met _____UTD

Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	__Met **X** Partially Met __Not Met __Unable to Determine	The major intervention introduced in 2015 was working with internal MCHP groups (i.e. Community Outreach) to identify FQHCs to target members who have not been compliant in obtaining annual dental visits. The narrative also includes information about work to begin future interventions with a St. Louis based FQHC, Afinia Healthcare in 2017. The final intervention described educational activities with "Head Start." It is unknown if this is one Head Start pre-school, or all Head Starts throughout the state. Two of the intervention descriptions did not include any work with members, and did not specify how they hoped to impact members. The third intervention did include direct contact with members, but is not clear who or how many programs and members were involved. The plan did not establish concrete interventions that can be measured to assess success for this project year.
Describe Intervention(s): 1) Working with a new FQHC in the Hannibal area, Clarity Healthcare, to identify non-compliant members affiliated with this FQHC. Clarity would contact these members/parents to remind them of the need for dental care and assist in making appointments. 2) Continued work with Head Start. The MCHP conducted dental education with children during the day, and with parents at a monthly meeting at Head Start. These programs intended to inform both children and their parents about the existing dental benefits that MHD and the MCHP offer. The programs also reminded members of the importance of good oral hygiene as it relates to children's overall health. 3) Work on building a relationship with one large FQHC, Affinia Healthcare in St. Louis, MO. The MCHP independently and in collaboration with the Dental Task Force, begin developing a relationship with the FQHC to ready them for new 2016 initiatives.	Totals	_____Met __**1**__Partially Met ____Not Met _____UTD

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The analysis of the outcomes occurred using the data analysis plan.
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The results are presented clearly and accurately. All outcomes were presented from HEDIS 2008-2016. The information year to year comparisons. The initial table illustrates MHD goals, goal variance, and growth from the base year and the percentage of change,
Are tables and figures labeled? xx yes ___no Are they labeled clearly & accurately? xx yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	__Met X Partially Met __Not Met __Not Applicable __Unable to Determine	Data is presented analyzing outcome data from previous reports, and identifies all initial and repeat measurements. Chi square Test results are included. This section includes data through HEDIS 2016. There is not a discussion of the factors that affect validity or why the interventions employed did not create positive outcomes.
Indicate the time periods of measurements: Yearly HEDIS results indicate statistical analysis used: CHI Squared Indicate statistical significance level or confidence level if available/known:__99% xx 95% __Unable to determine		

8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met **X** Partially Met __Not Met __Not Applicable __Unable to Determine	The discussion relates that there is no actual overall improvement and the aggregate HEDIS rate remained flat. The MCHP did not meet the 3% goal in 2015. The narrative describes plans to ameliorate this outcome, by revising the PIP to reframe interventions by age-specific categories. There is also a statement about a plan to develop a more robust process of collaboration with the FQHCs to identify and contact non-compliant members.
Limitations described: Limited interventions which did not produce desired outcomes. Conclusions regarding the success of the interventions: There is a need to develop more specific and focused interventions that are include a greater number of FQHCs Recommendations for follow-up: The concept presented is changing the framework of the PIP. They plan to strengthen the referral practices from PCPs to dental providers, and develop a more robust process for collaborating with the FQHC communities in Missouri.	Totals	**2** Met **2** Partially Met _____Not Met ___Not Applicable _____UTD

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The same methodology was utilized throughout the project. Enhancements occurred when these were appropriate and effectively informed this PIP. Continued improvements are recognized. Updates occurred as necessary.
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__Met **X** Partially Met __Not Met __Not Applicable __Unable to Determine	Quantitative improvement did not occur and the MCHP did not meet the goal of 3% improvement for 2014 or 2015.The problem was documented and the efforts to ensure that change would occur were included. Methods to study the effectiveness of the interventions were presented.
Was there: _____Increase ____Decrease _xx No Change Statistical significance _xx_yes ____no Clinical significance ____ yes _xx_no		

9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met **X** Partially Met __Not Met __Not Applicable __Unable to Determine	Information is provided in the narrative. It is provides the number of outreach activities" that Community Outreach completed in 2016. The discussion does state that they hoped these outreach activities would create a connection between that intervention and the ADV rate. The planned intervention did not create the planned improvement.
Degree to which the intervention was the reason for change _xx_No relevance ___Small ___Fair ___High		Direct relevance between the outreach efforts and improved ADV rates.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met **X** Partially Met __Not Met __Not Applicable __Unable to Determine	The narrative describes the efforts made to inform members and providers of the importance of annual dental visits. The MCHP acknowledges the lack of success for the last two HEDIS measurement years. The narrative states that improved and enhanced community events are planned, and the MCHP hopes they will create an improved ADV rate.
_xx_ Weak _____Moderate _____Strong	Totals	**1** Met **3** Partially Met ___Not Met ___Not Applicable _____UTD

Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	X Met ___Partially Met __Not Met __Not Applicable __Unable to Determine	The information included focuses on past interventions that did create improvement for ADV rates. That improvement has been sustained. The HY 2016 rate was flat. It appears that the lack of specific interventions did impact this outcome.
	Total	_1__Met _____Partially Met _____Not Met ___Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:
SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:

The MCHP has been committed to initiating activities that lead to improved ADV rates. During 2015 specific and focused interventions were not implemented. This has stalled the improvements the MCHP experienced previously. Changes in the improvement strategy are planned for CY 2016. Hopefully after 2 consecutive years of failing to meet their goal of 3% per year improvement, the MCHP will make the changes necessary to achieve the goals set out in this project.

Recommendations:

1) Develop and implement changes to the intervention strategy that will impact performance.
2) Improving annual dental visits is a national and statewide concern. Develop a renewed commitment to meet MCHP and statewide goals.
3) When an approach does not generate the desired outcomes, analyze what did not work, why the intervention failed, and what steps are necessary to re-engage MCHP staff and providers in their efforts to create necessary changes.

Check one:

- ☐ High confidence in reported Plan PIP results
- ☐ Moderate Confidence in reported Plan PIP results
- ☐ Low confidence in reported Plan PIP results
- ☐ Reported Plan PIP results not credible
- ☐ Unable to Determine – PIP has not yet produced results

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The clinical PIP was developed to improve an essential component of preventive services. The non-clinical PIP sought to improve the MCHP's rate of annual dental visits. The clinical PIP does not yet have outcomes to report. However, interventions to begin in 2016 promise to produce the positive impact sought through implementation of this project. Aetna Better Health experienced success with the interventions previously implemented for the non-clinical project. They did not reach their goals for improvement in CY 2015, but have initiatives planned for the future that are hoped to produce the outcomes they seek. The focus of the clinical PIP was targeted at improving the quality of health care for members by enhancing member's ability to obtain childhood immunizations. Aetna Better Health recognizes the importance of helping members obtain services that meet their needs and are of the highest quality. Their goal is to provide quality services to members utilizing MCHP resources while collaborating with community based healthcare agencies to achieve this standard. One area of concern is the need to develop interventions and to analyze their impact on anticipated outcomes. To ensure that the quality of care is achieved it is necessary to relate how interventions worked, and what was not effective.

ACCESS TO CARE

The clinical PIP had a specific focus on accessing services by engaging providers to assist in making a preventive service available. The study sought to ensure that members' parents/guardians have all the resources necessary to obtain the immunizations their children need. The non-clinical PIP was based on the theory that improving availability, awareness, and access to dental care will improve the overall health of the members served. The supporting documentation indicates that these PIPs have the potential to improve access to services and that this remains an important focus for the Aetna Better Health.

TIMELINESS OF CARE

The services and interventions in the clinical PIP are planned to improve the outcome related to the timeliness of members obtaining required immunizations within a specific time frame. In this PIP, the areas of access, quality, and timeliness of care were of the utmost importance. The MCHP is developing projects that support their efforts to promote timely and appropriate

healthcare. The non-clinical project is working on efforts to improve timeliness of care. The MCHP is focused on reaching its goals for preventive care in the area of oral health by collaborating with community agencies to develop partners in assisting members in obtaining their annual dental visits. The interventions employed will improve the availability of providers, and expand methods of contacting members, so timely dental care can be achieved. The MCHP also employed measures to directly educate members regarding existing dental benefits and available providers. The PIP focused on reducing barriers to obtaining services by partnering with the MCHP Community Outreach staff and community based healthcare providers. The MCHP will continue to enhance this project to improve members' ability to access services on a timely basis through their innovative approaches.

RECOMMENDATIONS

1. The MCHP focused their efforts on developing strong new PIPs to impact an important aspect of preventive care. They need to continue to evaluate the effectiveness of PIP interventions throughout the calendar year to make adjustments in the approach when necessary.
2. The non-clinical project information supported the goal of improving services and benefits to members in a timely manner. However, the interventions in place did not achieve goals in CY 2014 and 2015. Assess how the interventions employed supported the project, and where they failed. Provide a narrative in the study to explain the impact of the interventions.
3. The format of all PIPs should continue to contain complete narrative information on all aspects of the project to ensure that it is understandable and complete. The data analysis included in these PIPs was excellent regarding analyzing and understanding the data itself. The method of reporting outcomes would be enhanced by analyzing the impact of the projects interventions each year.
4. The MCHP indicated that the successful processes described in both PIPs will be incorporated in the regular organization processes. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.
5. The MCHP continues their process of identifying quality issues that may benefit from being developed into a Performance Improvement Project. The MCHP presented new

clinical PIP ideas for technical assistance. 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 Aetna Better Health. Aetna Better Health submitted the requested documents on or before the due date of March 15, 2016. The EQRO reviewed documentation between March 15, 2016 and June 22, 2016. 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:

- NCQA RoadMap for the HEDIS 2015 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2015
- Policies and procedures with regard to calculation of HEDIS 2015 rates
- 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 2015 Data Submission Tool
- HEDIS 2015 product work plan
- Specifications for Measures to be Reported to MO HealthNet by the Managed Care Plans: Data Year 2014

Data files were submitted by Aetna Better Health for review by the EQRO; these included Statewide files for CIS3 and regional files for EDV and EDU performance measures.

INTERVIEWS

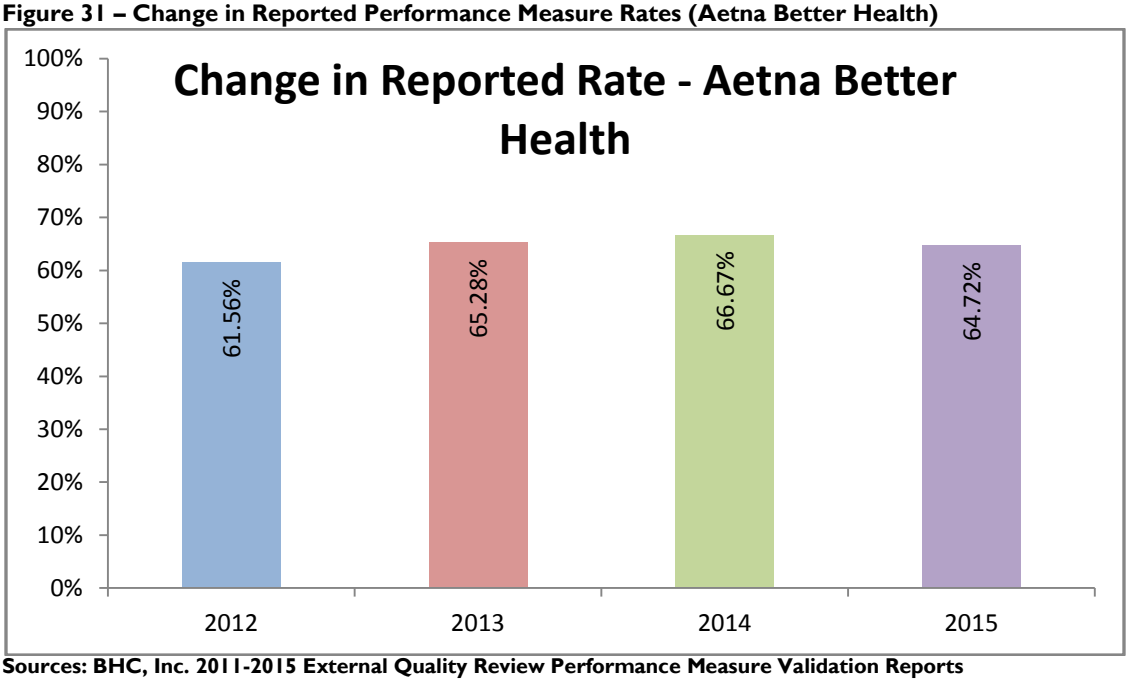
The EQRO conducted on-site interviews at Aetna Better Health in St. Louis on Tuesday, June 21, 2016 with staff responsible for calculating the HEDIS 2015 performance measures and the Measures Reported to MO HealthNet for Data Year 2014. The objective of the visit was to verify the methods and processes behind the calculation of the HEDIS 2015 performance measures and the measures reported to MO HealthNet in the June 30, 2015 report.

FINDINGS

Two of the measures being reviewed (Emergency Department Visits and Emergency Department Utilization) were calculated using the Administrative method, and the third measure (Childhood Immunizations Status 3) was calculated using the Hybrid method.

The reported CIS3 rate was 64.72% this was higher than the statewide rate for all MCHPs (56.91%). This is the fifth year the CIS3 measure has been audited by the EQRO. Aetna Better Health had shown a steady increase in this rate, from 61.56% in 2012 to 66.67% in 2014, however this year's rate of 64.72% is a slight decrease (see Figure 31).

Figure 31 – Change in Reported Performance Measure Rates (Aetna Better Health)



Sources: BHC, Inc. 2011-2015 External Quality Review Performance Measure Validation Reports

This was the first year that the EQRO was requested to validate the information provided by the MCHPs on the June 30 Measures to be Reported to MO HealthNet Report. The measures that the EQRO validated from this report were Emergency Department Visits (EDV) and Emergency Department Utilization (EDU). Both of these measures are stratified by presenting diagnosis (Behavioral Health; Medical; or Substance Use). These are modified measures for the 2015 HEDIS Technical Specifications for Ambulatory Care (AMB); Mental Health Utilization (MPT); and Identification of Alcohol and Other Drug Services (IAD).

The SMA requested that EQRO recalculate these measures and compare the calculations to the data submitted on the June 30 report. The objectives included determining if each MCHP was calculating the measure in the same fashion and determining if the MCHP was able to reproduce and provide the data used to calculate these modified HEDIS measures. The EQRO was unable to validate either the EDV or EDU measure calculations for Aetna Better Health. The data provided to the EQRO was recalculated and the same results were not obtained as were reported to MO HealthNet.

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 as 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, Aetna Better Health 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 Aetna Better Health transferred data into the repository used for calculating the 2015 measures.

Documentation of Data and Processes

Although Aetna Better Health 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 for the HEDIS measure CIS3. However, the data and processes used for calculation of the two non-HEDIS measures is uncertain and because the EQRO was unable to reproduce the numbers reported by Aetna Better Health to MO HealthNet for these measures, the EQRO cannot find that Aetna Better Health met all criteria that applied for all three measures.

Processes Used to Produce Denominators

Aetna Better Health 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 (EDV and EDU). The third measure (CIS3) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g., immunizations; emergency department services dates; inpatient admit dates) as specified by the HEDIS 2015 Technical Specifications and the modifications for the June 30 report. Appropriate procedures were followed for the sampling of records for medical record reviews.

Aetna Better Health reported a total of 207,717 administrative hits for the Emergency Department Visit-Medical measure; 111,122 hits were validated by the EQRO. This resulted in a reported rate of 86.14% and validated rate of 46%, representing an overestimate of 40.06% by the MCHP.

For the EDV-Behavioral Health measure, the MCHP reported a total of 2,625 administrative hits; 3,408 hits were validated by the EQRO. This resulted in a reported rate of 1.21% and a validated rate of 1.58%, representing an underestimate of 0.36% by the MCHP.

For the EDV-Substance Use measure, the MCHP reported a total of 521 administrative hits; 701 were validated by the EQRO. This resulted in a reported rate of 0.22% and a validated rate of

0.29%, representing an underestimate of 0.07%.

Aetna Better Health reported a total of 106,092 administrative hits for the Emergency Department Utilization–Medical measure; 107,060 hits were validated by the EQRO. This resulted in a reported rate of 43.99% and a validated rate of 44.40%, representing an underestimate of 0.40% by the MCHP.

For the EDU-Behavioral Health measure, the MCHP reported a total of 2,172 administrative hits; 2,311 hits were validated by the EQRO. This resulted in a reported rate of 1% and a validated rate of 1.07%, representing an underestimate of 0.06% by the MCHP.

For the EDU–Substance Use measure, the MCHP reported a total of 417 administrative hits; 423 were validated by the EQRO. This resulted in a reported rate of 0.17% and a validated rate of 0.18%, representing an overestimate of 0.02%.

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. Aetna Better Health was compliant with all specifications for sampling processes.

Submission of Measures to the State

Aetna Better Health submitted the Data Submission Tool (DST) for the HEDIS measure 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 MO HealthNet Quality Improvement Strategy. Aetna Better Health submitted data as requested for the June 30 MO HealthNet report.

Determination of Validation Findings and Calculation of Bias

As is shown in Table 12, no bias CIS3 measure, however, bias was observed in both the EDV and EDU measures.

Table 15 - Estimate of Bias in Reporting of Aetna Better Health HEDIS 2014 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunizations Status (Combination 3)	No bias	N/A
Emergency Department Visits - Medical	40.06%	Overestimate
Emergency Department Visits – Behavioral Health	0.36%	Underestimate
Emergency Department Visits – Substance Abuse	0.07%	Underestimate
Emergency Department Utilization - Medical	0.40%	Underestimate
Emergency Department Utilization – Behavioral Health	0.06%	Underestimate
Emergency Department Utilization – Substance Abuse	0.02%	Overestimate

Source: BHC, Inc., 2015 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 13). The rate for the Childhood Immunization Status measure showed no bias and was therefore deemed Fully Compliant. The Emergency Department Utilization measure was found to be both under and overestimated, but still fell within 1% of the hits reported, so was deemed Substantially Compliant. The Emergency Department Visits measure was found to be both over and under estimated, with the Medical visit measure having a bias of over 40%, this measure was found to be Not Valid.

Table 16 - Final Audit Rating for Aetna Better Health Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status	Fully Compliant
Emergency Department Visits	Not Valid
Emergency Department Utilization	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

Aetna Better Health's calculation of the Emergency Department Utilization measure was substantially compliant with specifications. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical; Behavioral Health; or Substance Use. This information is useful to the MCHPs to determine if the ED is being utilized properly by its members.

Aetna Better Health's rate for the EDU-Medical measure was higher than the average for all MCHPs, indicating that a higher percentage of Aetna Better Health's members are accessing the ED for Medical issues than that of the other MCHPs. Aetna Better Health's rates for the EDU-Behavioral Health and EDU-Substance Use measure were lower than the average for all MCHPs, indicating that a lower percentage of Aetna Better Health's members are accessing the ED for Behavioral Health and Substance Use issues less than that of the other MCHPs.

ACCESS TO CARE

The Emergency Department Visit measure was rated as Not Valid, as the EQRO was unable to reproduce the count of services reported by the MCHP. This measure is as an Access to Care measure as it measures the number of ED visits recorded for the MCHP. Although not validated, Aetna Better Health's rate for the EDV- Medical measure was higher than the average for all MCHPs, indicating that Aetna Better Health's members are accessing the ED for Medical issues at a rate higher than that of the other MCHPs. Aetna Better Health's rates for the EDV-Behavioral Health and EDV- Substance Use measure were lower than the average for all MCHPs, indicating that Aetna Better Health's members are accessing the ED for Behavioral Health and Substance Use issues less often than that of the other MCHPs.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2015 Childhood Immunizations Status measure was fully 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 been previously audited by the EQRO in the last four review years.

Aetna Better Health'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. Provide information as requested in the EQRO's data request.

6.3 MCHP Compliance with Managed Care Regulations

METHODS

Aetna Better Health of Missouri (Aetna Better Health) was subject to a full compliance audit. The content of this 2015 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 Aetna Better Health's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Aetna Better Health 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 of compliance for all evaluated Quality Standards is included in Table 17.

Table 17 - Comparison of Aetna Better Health Compliance Ratings for Compliance Review Years

Measure	2012	2013	2014	2015
Enrollee Rights and Protections	100%	100%	100%	100%
Access and Availability	88.24%	82.35%	76.47%	76.47%
Structure and Operations	100%	100%	100%	100%
Measurement and Improvement	100%	90.9%	100%	81.82%
Grievance Systems	100%	100%	100%	100%

Source: BHC, Inc., 2015 External Quality Review Compliance Validation

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 2014 review, Aetna Better Health was rated by the review team to have met all 13 standards. This rating of 100% compliance is consistent with the ratings received in 2012, 2013, and 2014.

The rating for Enrollee Rights and Protections (100%), reflects Aetna Better Health's ability to have all policy and procedures submitted and approved by MO HealthNet 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 Aetna Better Health is in compliance with all Managed Care contract regulations and federal requirements.

A strong commitment to member rights continues to be a cornerstone of Aetna Better Health'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. Aetna Better Health 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.

Access Standards

Access and Availability addresses 17 standards. For the 2015 review, Aetna Better Health was rated by the review team to have met 13 standards. This is an overall rating of 76.47% compliance, consistent with the 2014 review, but **lower** than the prior two years' reviews, which found 82.35% and 88.24% compliance, respectively.

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

- Availability of their provider network; specifically the accuracy of the provider website
- In reviewing records and interviewing staff, full evidence of assessments and treatment planning for members was not available.
- Case Managers did not recognize the need for Care/Case Coordination in many of the files reviewed.

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 Operations

The area of Structures and Operations addresses 10 standards. For the 2015 review, Aetna Better Health was rated by the review team to have met all 10 standards. This rating is consistent with the ratings received in 2012, 2013, and 2014. 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.

Aetna Better Health's provider advisory group is operational in all three MO HealthNet Managed Care regions. The committee consists 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.

Measurement and Improvement

Measurement and Improvement addresses 11 applicable standards. For the 2015 review, Aetna Better Health was rated by the review team to have met 9 of these standards. This 81.82% rate is lower than the 2014 and 2012 ratings of 100% and the 2013 rating of 90.9%.

Aetna Better Health submitted two Performance Improvement Projects (PIPs) for validation. One PIP was well-constructed and provided adequate information for validation. However, the Improving Oral Health PIP did not contain analysis of the study results nor was information regarding validity of improvement provided, this resulted in a lower rating.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2015 review, Aetna Better Health 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 2014, 2013 and 2012.

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

CONCLUSIONS

Aetna Better Health continues to exhibit a commitment to completing, submitting, and gaining approval of required policy and procedures by MO HealthNet, and developing operations that ensure that these procedures are reflected in daily operations. The MCHP achieved 100% compliance in three of the five sections of the Compliance 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, several issues were identified during this year's review, including:

- Lead case management program
- Use of face to face contacts

Quality of Care

The Aetna Better Health 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

Aetna Better Health 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 undertaken provider recruitment and retention efforts in an attempt to ensure that providers are available to members throughout all three MO HealthNet Managed Care Regions served. However, the EQRO did find the MCHP's website to be riddled with inaccuracies and fewer providers accepting new patients than reported. Further information regarding the Website Accuracy Survey may be found at http://dss.mo.gov/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf.

Timeliness of Care

Aetna Better Health 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. Continue to monitor provider and hospital networks for adequacy. Develop contracts were possible.

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7.0 Home State Health

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7.1 Performance Improvement Projects

Document Review

Home State supplied the following Performance Improvement Project (PIP) documentation for review:

- Improving Immunization Rates in Home State Members in the First 2 Years of Life
- Statewide Performance Improvement Project – Improving Oral Health

Interviews

Interviews were conducted with the project leaders for each PIP by the EQRO team on June 22, 2016 during the on-site review. Interviewees included the following:

Megan Barton – Vice President of Medical Management

Dana Houle – Director, Quality Improvement

Arica Evans – Director, Compliance

Interviewees shared information on the validation methods, study design, and findings of the PIPs. The following questions were discussed and technical assistance was provided by the EQRP to the MCHP:

- What instruments are used for data collection?
- How were accuracy, consistency, and validity assured?
- What did the MCHP hope to 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 so far?
- What criteria are being used to determine which new issues might become a PIP?

The MCHP was given an opportunity to provide an updated submission following the on-site review. The information evaluated here is based on the enhanced submissions and additional data that were supplied.

FINDINGS

CLINICAL PIP – IMPROVING IMMUNIZATION RATES IN HOME STATE HEALTH MEMBERS IN THE FIRST 2 YEARS OF LIFE

Home State's clinical PIP was implemented in July, 2015. The MCHP recognizes that childhood vaccinations protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough at a time in their lives when they are most vulnerable to disease. The goal of this project is to ensure that members receive all appropriate immunizations by age 2. The MCHP is implementing this PIP to attain a target rate of 90% for the number of 2 year olds who receive the necessary vaccinations by the completion of this project.

Home State identified that a lack of parental knowledge, and misinformation regarding the benefits of immunizations, hinder members from obtaining their vaccinations. These include:

- Lack of knowledge and a belief that immunizations do not protect children from serious illness
- Belief that immunizations are not safe and effective at protecting children from disease
- Lack of knowledge that immunizations are required for school and child care activities
- Lack of knowledge about the importance of each child obtaining immunizations to protect the community

The MCHP designed the following interventions to assist in ameliorating this problem:

- Member education and outreach to inform them regarding strategic milestones and wellness activities including immunizations
- Monthly assessment of member engagement, and additional member outreach
- An EPSDT Pilot using text messaging and tangible incentives on a sample of 3,000 members. The MCHP achieved success in improving immunization rates for members who participated. They are now seeking approval to expand this pilot statewide.
    - The MCHP considers this pilot a success. Invitations were sent to 3,000 members and 50% responded and registered for the incentive program. The number of members obtaining their wellness visits and immunizations was 13.99% of the pilot

group. Plans are to implement this incentive program in all regions in 2016 with MHD approval.

- In the 4th quarter of 2015 Home State began a provider incentive program encouraging the closure of all member gaps in care, including the childhood immunizations. Nine FQHCs participated, and closed all care gaps for 246 members.
    - FQHCs are currently contacting the MCHP to partner in the program to expand member engagement outside of the incentive program.

Home State Health has developed new programs to be implemented during CY2016. They trust that they will continue to achieve success by expanding these programs and implementing new interventions during 2016.

The result of the CY 2015 efforts was a slight increase in both Combo 3 and Combo 10 rates from 2014 to 2015 (1.37 percentage points for Combo 3; 1.54 percentage points for Combo 10). A factor that influenced the 2016 HEDIS rates was the population growth during the measurement period. The MCHP experienced a 32% increase in membership during CY2015 as the result of auto assignment of new members, which brought the MCHP in line with the State mandated 20% membership floor in each region. They believe that as these new members experience the benefits of the MCHP and are introduced to wellness programs additional improvement will be experienced.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Plan Name or ID: Home State Health		
Name of PIP: Improving Immunizations Rates in Home State Health Members in the First 2 Years of Life		
Dates in Study Period: July 1, 2015 – Present		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**X** Met __Partially Met __Not Met __Unable to Determine	The Study Topic discussion delves into the current statistics for children obtaining immunizations on the national, state, and MCHP levels. They provide a convincing argument for choosing this issue as an area where actions by the MCHP can improve the current immunization rates. At the very beginning of the discussion they recognize that this is a NCQA/HEDIS measure. However, the discussion clearly identifies the health care benefits to their members. The topic discussion exhibited depth in analyzing the data, and applying this information to improve member needs, care, and services.
Clinical xx Prevention of an acute or chronic condition xx High volume services ___Care for an acute or chronic condition ___High risk conditions		This PIP looks at a substantive method of preventing diseases that negatively affect children's health. "High Volume Services" is credited as they want to positively impact all children through age 2.
Non-Clinical ___Process of accessing or delivering care		
Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	Timely and complete immunizations are an essential aspect of member care/services. Focusing on these issues emphasizes the importance of preventive services.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	All members up to age 2. No children, including children with SHCNs are excluded.
Demographics: xx Age Range _____Race _____Gender Medical Population: xx Medicaid Only _____Commercial	Totals	**3** Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
Was the study question(s) stated clearly in writing?	**X** Met __ Partially Met __Not Met __Unable to Determine	The study question states that its goal is to "increase" rates. It does not provide a concrete percentage the MCHP wants to reach in the 1st year of the project within the study question. The overall goal is found in the additional narrative regarding the study question. It states that Home State "established an organizational goal to meet or exceed the NCQA 50th percentile." They state that their goal is to achieve improvement of 4 percentage points each year over 3 years. The documentation includes specific performance goals.
Include study question(s) as stated in narrative: "Does directing targeted member and provider health promotion and awareness activities increase the percentage of HSH children (aged birth to two years of age, who receive 4 diphtheria, tetanus, and acellular pertussis (DTaP) vaccinations; 3 polio (IPV)/ 1 measles, mumps, and rubella (MMR)/ 3 haemophilus influenza type B (HiB)/ 3 hepatitis B (HepB)/ 1 chicken pox (VZV)/ 4 pneumococcal conjugate (PVC)/ 1 hepatitis A (HepA)/ 2 or 3 rotavirus (RV)/and 2 influenza vaccinations by their 2nd birthday (NCQA Combo 10 Compliance)."	Total	**2** Met ____ Partially Met _____Not Met _____UTD

Step 3: Review Selected Indicators		
Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	The objective of the PIP is to improve the CIS HEDIS measure for members through age 2. The MCHP will use administrative and hybrid data to determine their HEDIS rate annually.
List Indicators: Annual HEDIS Rate for Combo 10		
Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP plans to use this HEDIS measure to evaluate outcomes from the efforts made in this PIP. The narrative states that they will monitor the indicators through the year, at least quarterly, to evaluate the effectiveness of their interventions. The PIP is designed to improve members' health status.
Are long-term outcomes implied or stated: xx yes ___no xx Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	**2** Met ___Partially Met _____Not Met _____UTD

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __Partially Met __Not Met __Unable to Determine	Members birth to 2 years of age – all members are included.
Demographics: _xx_ Age range _____Gender _____Race Medical Population: _xx_Medicaid Only _____Commercial		
If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	Interventions include all members ages birth though 2. The "allowable gap" criteria will not apply to members receiving interventions. All members in this age group are included.
Methods of identifying participants: _xx_Utilization data _____Referral _____Self-identification _____Other _____	Totals	**2** Met _____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No sampling methodology was used in this PIP
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals **(n/a)**	_____Met _____Partially Met _____Not Met _____UTD

Step 6: REVIEW DATA COLLECTION PROCEDURES		
Did the study design clearly specify the data to be collected?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP defined how they gathered the HEDIS data, why this is reliable, and how all data regarding this measure will be obtained.
Did the study design clearly specify the sources of data?	**X** Met __Partially Met __Not Met __Unable to Determine	The sources of data include both internally obtained administrative data, and a year round medical record retrieval. The MCHP is focused on evaluating this program, working with County Health Dept.'s, and rural providers to obtain all available documentation that will provide the outcomes after interventions are in place. Hybrid records are reviewed and evaluated by an independent contractor.
Sources of data: ___Member xx Claims ___Provider xx Other (medical records)		
Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	**X** Met __Partially Met __Not Met __Unable to Determine	Yes – the methods outlined above create a system that allows collection of valid and reliable data. This applies to the hybrid and administrative data.
Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	**X** Met __Partially Met __Not Met __Unable to Determine	All CPT codes used to determine compliance are identified. The methods and systems employed for data collection will provide consistent and accurate data. The medical record retrieval program is explained in detail.
Instruments used: ___Survey xx ___Medical Record Abstraction Process Other:_____ _____		
Did the study design prospectively specify a data analysis plan?	**X** Met __Partially Met __Not Met __Unable to Determine	All data to be collected, and where this data is located are included. Information is included about collecting data monthly using a number of sources. A monthly care gap report will be used to assess members who have not met the measure specifications. QI staff will extract monthly preliminary HEDIS results to analyze and determine the effectiveness of interventions in place. Results of medical record review will be integrated into the administrative data.
Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	The project leader, her role, and qualifications are included. The roles and positions of all other team are listed.
Project Leader Name: Dana Houle Title: Director of Quality Improvement Role: Project oversight, including data collection and interpretation Other team members: Names/Roles: Data Analyst –	Totals	**6** Met ____Partially Met _____Not

as HEDIS Coordinator_ QI Coordinator analysts, call center staff, marketing and communications staff and member connections staff complete the team.		Met _____UTD

Step 7: ASSESS IMPROVEMENT STRATEGIES		
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	The interventions listed were initiated and active during 2015. One intervention did not begin until the 3rd quarter of 2015. Results are included in Section 8.
Member education and outreach to inform them regarding strategic milestones, wellness activities – including immunization, Monthly assessment of member engagement, and additional member outreach Q3 – 2015 – Implementation of EPSDT Pilot Development of Provider Incentive Program – regarding care gap closure	Totals	**1** Met _____Partially Met ___ Not Met _____UTD

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
Was an analysis of the findings performed according to the data analysis plan?	**X** Met __Partially Met ___Not Met __Not Applicable __Unable to Determine	The plan for data analysis was followed. The data available includes the baseline year, 2014, and the first measurement year, 2015. The plan did experience initial success. They do credit this to a combination of the use of the hybrid method of data collection, and the interventions implemented to date. This is only an initial review, but the MCHP considers this as a sound foundation for obtaining their stated goals.
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
Were the PIP results and findings presented accurately and clearly?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Are tables and figures labeled? ___yes ___no Are they labeled clearly & accurately? ___yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?		
Indicate the time periods of measurements:_____ Indicate statistical analysis used:_____ Indicate statistical significance level or confidence level if available/known: _____99% _____95% _____Unable to determine		
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Limitations described:_____ Conclusions regarding the success of the interpretation: _____ Recommendations for follow-up: _____		

Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Limitations described:_____ _____ Conclusions regarding the success of the interpretation: _____ Recommendations for follow-up: _____	Totals	**1** Met _____Partially Met _____Not Met **3** Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
Was the same methodology as the baseline measurement, used, when measurement was repeated?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		

Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Degree to which the intervention was the reason for change ___No relevance ___Small ___Fair ___High		
Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
_____Weak _____Moderate _____Strong	Totals	_____Met _____Partially Met _____Not Met **4** Not Applicable _____UTD

Step 10: ASSESS SUSTAINED IMPROVEMENT		
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
	Total	_____Met _____Partially Met _____Not Met **1** Not Applicable _____UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:
The MCHP is working on an important aspect of preventive care. They have created a sound foundation for this PIP. Planned interventions are creative.

Recommendations:
Organize sections to comply with the PIP protocol. This PIP submission contained a lot of information. However, it was sometimes confusing because sections overlapped, or the discussion was in a section that concerned a different topic.
Analyze outcomes based on the effectiveness of the interventions. At times other factors do influence outcomes and this should be recognized in the analysis. However, it is important to link successful interventions to outcomes.
Discuss interventions that did not have the expected impact and analyze what did and did not work.

Check one:
☐ High confidence in reported Plan PIP results
☐ Confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible
xx Unable to determine – the PIP is new and has produced limited results

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Home State presented information related to the statewide PIP study topic and included reasons explaining how this project was pertinent to their members. The study topic presentation was thorough and focused on enhancing available and preventive dental care.

The interventions underway in 2015 were:

- Health Plan Interventions:
- Collaborate with" St. Louis Medical" on developing a member incentive program, encouraging annual dental visit
- Developing Patient Centered Dental Home model
- Pilot STL Medical – revised: The original pilot focused on dental and was amended to EPSDT. It did retain the initial incentive of a toothbrush, toothpaste, and a clear plastic zipper case. A card was included with instructions on how to register and make well child appoints before 12/1/2015.
- Discuss Patient-Centered Primary Care Dentist assignment
- Developing a Provider Incentive for Care Gap Closure.

Provider Interventions:

- Dental Health and Wellness Traveling Dental Mobiles used in MCHP community outreach events
- Fluoride Varnish application program via school nurse program
- November 2015 Home State and Dental Health Wellness attended Affinia Healthcare health fair
- Initiate a Provider Incentive for Care Gap Closure.
- Member Interventions:
- Issuing Primary Care Dental (PCD) assignment of ID cards

The MCHP has developed interventions to impact this issue for three full years. They now have three years of results. In CY 2014 the MCHP used HEDIS-like data, and audited HEDIS data for CY 2014 and 2015.

The statewide HEDIS rates for these three years were:

CY 2013 – 42.27% CY 2014 – 41.77% CY 2015 – 41.00%

There is a decrease of 1.16 percentage points from CY 2013 through CY 2015. This is not a huge decline, although it does give the appearance of a negative trend. When Home State began participation in this pilot they experienced increases in their dental rates. They attributed this to their educational efforts, and an increased familiarity with members and their healthcare needs.

Home State provided several reasons why they have experienced declining numbers. In 2015 the MCHP experienced a 33.60% increase in new members with no historical claims data. This was the result of auto-assignment to bring the MCHP in line with the state mandated 20.00% membership. Home State contends that the majority of the new members were not exposed to their oral health initiatives for the entire measurement year. Home State also noted that they were not able to determine the members who had an annual dental visit prior to their becoming MCHP members. These explanations are problematic as the HEDIS measure only includes members who have been continuously enrolled with the MCHP for the entire calendar year in the denominator. Members who came to Home State throughout 2015 are not included in the results presented for HY 2016. The MCHP also hypothesizes that "member participation in wellness activities tends to improve" their use of member benefits as they become more familiar with everything available. Although no data was presented to support this assertion, it does appear to be a logical conclusion.

Home State continued innovative approaches that they are confident contributed to their early success. They did recognize that some of their programs, such as collaboration with mobile dentistry providers, and engaging school nurses statewide to assist with providing member reminders regarding needed dental care are no longer obtaining their earlier results. They are focusing CY 2016 efforts on assigning dental homes and mailing Dental ID cards with the assigned dentists to members. This activity and new direct approaches are hoped to create incentives for members to obtain their annual visits. Home State further made an assessment that traditional telephonic and paper outreach are not effective in creating member change. In 2016 new interventions have been implemented to reach the HEDIS rates that Home State want to achieve.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Plan Name or ID: Home State		
Name of PIP: Improving Oral Health		
Dates in Study Period: 2012 - present		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**X** Met __Partially Met __Not Met __Unable to Determine	The information presented in the topic discussion is taken from the language of the Statewide Improving Oral Health Initiative. However, the MCHP used over-arching information and personalized it to address the needs of their members. The MCHP goals and focus is clear.
Clinical ___ Prevention of an acute or chronic condition __ High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical _xx_Process of accessing or delivering care		
1.4. Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	This is the MCHP response to the Statewide PIP initiative. It is focused on improving the rate of Annual Dental Visits and improving oral health. The intention of this project is to correct a deficiency in care.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.5. Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	All plan members who are eligible for dental care are recognized in the narrative. The statewide PIP (via the HEDIS tech specs) is set up to address members ages 2-20. The MCHP also recognizes the need to serve pregnant women and in some instances other members who are entitled to dental care. However, the interventions discussed here are focused on the children ages 2-20 population. The narrative included new innovations for 2015 to be introduced in early 2016.
Demographics: _2-20_Age Range _____Race _____Gender Medical Population: _xx_Medicaid Only _____Commercial	Totals	_**3**_Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	Additional narrative says "The previous goal of this project was to gain an increase of 1.28 percentage points from the HEDIS 2013 all-region Statewide average of 42.78%, to 43.03%." The goal of the statewide PIP is to "increase the number of children who receive an annual dental visit by 3% between HEDIS 2013 (CY2012) and HEDIS 2015 (CY2014)." The MCHP included their 2014 and 2015 HEDIS rates, and their plan to meet the State's goal of 3% improvement per year.
Include study question(s) as stated in narrative: "Will implementing the proposed interventions to Home State members 2 through 20 years of age, increase the rate of annual dental visits per the HEDIS specifications by 5% between Home State's HEDIS 2015 and 2016 results?"…	Total	**1** Met _____Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	The study indicators presented were clear and measurable. The numerator and denominator were defined. When measurements will occur, and how this data is derived, were all presented.
List Indicators:		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met __Partially Met __Not Met __Unable to Determine	The indicators measure a change in health status, and processes of care that are associated with improved health outcomes for members.
Are long-term outcomes implied or stated: xx yes ___no xx Health Status xx Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	**2** Met _____Partially Met _____Not Met _____UTD

STEP 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __Partially Met __Not Met __Unable to Determine	The project includes all MCHP members 2 – 20 years of age. The enrollment "allowable gap" criteria will not be applied to the intervention population. The MCHP plans make all interventions available to all eligible members in this age range, regardless of the ability to exclude those outside of the HEDIS tech specs.
Demographics: 2-20 Age range _____Gender _____Race Medical Population: xx Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	The data collection procedures described is consistent with the use of HEDIS data. This was clear and consistent and applies to all members to whom the study applies.
Methods of identifying participants: xx Utilization data _____Referral _____Self-identification _____Other	Totals	**2** Met _____Partially Met _____Not Met _____UTD
STEP 5: REVIEW SAMPLING TECHNIQUES		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No Sampling methods are used in this PIP.
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	N/A
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	_____Met _____Partially Met _____Not Met _____UTD

STEP 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	X Met __Partially Met __Not Met __Unable to Determine	The narrative explains the data to be collected, and the sources of the data. It explains the administrative method for gathering HEDIS data, and how they will integrate information from Missouri Health Plus and Dental Health and Wellness into their data systems.
6.2 Did the study design clearly specify the sources of data?	X Met __Partially Met __Not Met __Unable to Determine	The sources of all data and how it is gathered, is explained in detail. Data will be collected from various sources and loaded in the Centene Enterprise Data Warehouse.
Sources of data: ___Member _xx Claims ___Provider _xx_ Other		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X Met __Partially Met __Not Met __Unable to Determine	The methodology for collecting valid and reliable data was provided in detail.

6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X Met __Partially Met __Not Met __Unable to Determine	Everything used to collect and analyze data is presented. It is clear and understandable.
Instruments used: ___Survey Medical Record Abstraction Tool _____Other:_____		Data and how it is obtained and analyzed are presented.
6.5 Did the study design prospectively specify a data analysis plan?	X Met __Partially Met __Not Met __Unable to Determine	The MCHP will use administrative data that is gathered monthly. They will extract monthly preliminary HEDIS data to analyze and determine effectiveness of interventions based on observed changes in the ADV rate. The MCHP will also run the ADV measure without the continuous enrollment factor to determine all members who are non-compliant to enable outreach to occur in a timely fashion.
6.6 Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	Staff involved, their roles, and qualifications are included.
Project Leader Name: Dana Houle Title: Director of Quality Improvement Role: Project oversight, including data collection and interpretation Other team members: Names/Roles:	Totals	**6** Met ____Partially Met _____Not Met _____UTD

Data Analyst – as HEDIS Coordinator_ QI Coordinator analysts, call center staff, marketing and communications staff and member connections staff complete the team.		

Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	The listing of new interventions during 2015 includes a total of 10. This seems like an overwhelming number of interventions to analyze. The MCHP states that an integrated approach to care delivery is essential to increase members' access to care and improved wellness. Measuring the effectiveness of any specific intervention is impossible. The MCHP states that these initiatives are part of their "integrated strategy." The MCHP provides a convincing argument for their approach and has a firm commitment to use this method to make the improvements needed to meet their goals for improving their ADV rate.
Describe Intervention(s): **Health Plan Interventions**: 1) Collaborate with St. Louis Medical on developing member incentive program, encouraging annual dental visit. 2) Developing Patient Centered Dental Homes. 3) Pilot STL Medical – revised. 4) Discuss Patient centered PVD assignment. 5) Provider Incentive for Care Gap Closure. **Provider Interventions:** 1) Dental Health and Wellness Training 2) Fluoride Varnish application program. 3) November 2015 HSH and DHW attended Affinity health fair.4) Provider Incentive for Care Gap Closure. **Member Interventions:** 1) Primary Care Dental (PCD) assignment ID cards.	Totals	__**1**__Met ___Partially Met _____Not Met _____UTD

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	This analysis was based on the elements presented in the prospective data analysis plan. The analysis of the results of the HEDIS rates, and the interventions underway during 2015 is very thorough.
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	__Met X Partially Met __Not Met __Not Applicable __Unable to Determine	The tables included presented the results of the HEDIS like data for CY 2013, 2014 and 15. The actual HEDIS results for HEDIS 2015 and 2016 were included. The aggregate rate for the 3 years presented is relatively flat, although CY 2015 does indicate a slight decrease. However, the submission included different outcome information in different tables, which is confusing.
Are tables and figures labeled? _xx_yes ___no Are they labeled clearly & accurately? _xx yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	___Met X Partially Met __Not Met __Not Applicable __Unable to Determine	The results and the repeat measurements are all presented. The MCHP analyzed all the factors that influenced the outcomes achieved. The MCHP experienced a growth in the populations, particularly in the Central region. They attribute the decline in the HEDIS rate to the influx of new members. However, to be in the HEDIS denominator the member must be continuously enrolled for 12 months during the calendar year. This makes the argument presented inaccurate.
Indicate the time periods of measurements: Quarterly and annually Indicate statistical analysis used:_____???_____ Indicate statistical significance level or confidence level if available/known: _____99% _____95% _____Unable to determine		

8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met __x__ Partially Met __Not Met __Not Applicable __Unable to Determine	The MCHP stated that the interventions used in the past created an increase. One of the essential interventions beginning in 2015 was the implementation of the Primary Care Dentist. The entire intervention went into effect during the 1st quarter of 2016. Other interventions and their impact on the HEDIS rates were discussed. The MCHP does think that the changes and increases in membership – members who have not been influenced by the interventions in place during 2015, impacted the year's HEDIS rate. This analysis is inaccurate as the numbers in the HEDIS denominator are misconstrued or misinterpreted by the MCHP. Follow-up activities for 2016 were included and the MCHP provided an explanation of how they planned to have a greater effect on the rates for HEDIS 2017.
Limitations described: Limitations included changes in population as the result of a large number of auto-assigned members, and the inability to influence member behavior as planned. Conclusions regarding the success of the interpretation: The MCHP interprets the flat statistics as situational, rather than the failure of any specific intervention or their processes in general. Recommendations for follow-up: The MCHP provides follow-up measures for CY 2016.	Totals	__1__Met __3__ Partially Met _____Not Met ___Not Applicable _____UTD

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	__Met x Partially Met __Not Met __Not Applicable __Unable to Determine	The MCHP has 2 years of actual HEDIS data. However, for 2 previous years they produced HEDIS-like measures to evaluate their efforts in improving annual dental visits. The MCHP used the same systems to collect data. However, there is some confusion about what the HEDIS rates actually represent.
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__Met x Partially Met __Not Met __ Not Applicable __Unable to Determine	The MCHP did not experience a quantitative improvement in their HEDIS 2016 rates. However, the efforts made to improve their annual dental visits did improve the processes of care. They have collaborated with community members, dental providers, and PCPs to improve the methods available to identify non-compliant members, and to engage them in obtaining the dental care needed. The MCHP did not take into consideration the actual numbers included in developing the HEDIS rate. There was not an improvement in the actual rate, so this is an area that must be explored in the future.
Was there: ____Increase __xx__Decrease Statistical significance ___yes __xx_no Clinical significance ___yes __xx_no		
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met X Not Applicable __Unable to Determine	
Degree to which the intervention was the reason for change ___No relevance ___Small ___Fair ___High		
9.4 Is there any statistical evidence that any observed performance improvement is true	__Met __Partially Met __Not Met X Not Applicable	

improvement?	__Unable to Determine	
_____Weak _____Moderate _____Strong	Totals	_Met _2__Partially Met _____Not Met **_2** Not Applicable _____UTD
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__Met __Partially Met __Not Met **_X_** Not Applicable __Unable to Determine	
	Total	_____Met _____Partially Met _____Not Met **_1_**Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:

The MCHP has made positive changes to the PIP presented. The planning and planned interventions are documented. The MCHP needs to explore the way the HEDIS denominator is developed to better understand how this number is compiled to more accurately analyze the effectiveness of their interventions. Continued maturity of the PIP, with additional time, should prove to have positive outcomes. Although the ADV HEDIS rate did not improve, the MCHP has follow-up plans and is committed to make necessary changes to obtain the desired results.

Recommendations:

1) Continue work on the activities for 2016, and future years, as documented.
2) Continue to develop data analysis methods –ensure that conclusions are supported by the data provided. Focusing only on a part of the data does not necessarily indicate a success of the PIP overall.
3) Analyze and document how the interventions impacted the outcomes. Connect success or lack of success to the interventions. Analyze what activities worked and what did not.
4) Continue to improve organizing the report.
5) The report contained a lot of information. The detailed narrative is admirable. Some of the results could be represented in graphs/tables. This would help to visually impact the points made in the narrative discussion presented.

Check one:

☐ High confidence in reported Plan PIP results
XX Moderate Confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible

CONCLUSIONS

QUALITY OF CARE

These PIPs focused on providing quality services to members in both the clinical and non-clinical approaches. The choice to focus their clinical PIP on assisting members in obtaining immunizations will provide for quality healthcare. The goal of improving knowledge regarding establishment of a relationship with a PCP was directly focused on the best quality healthcare. Home State has allocated resources to create process improvement of these issues. Each PIP indicated growth in the improvement strategies focused on providing quality healthcare to members.

ACCESS TO CARE

Both PIPs submitted by Home State addressed improved access to health. The clinical PIP will assist in reducing the barriers members encounter when attempting to have their children immunized. In the non-clinical PIP, efforts were made to incentivize providers to assist members in having access to dental care. The MCHP developed a member incentive program to increase utilization of dental benefits through on-site availability of dental clinics. They implemented new strategies that bring dental care directly to the members and their communities, thereby making care truly accessible in rural areas. The attention paid to reminding members of available resources enhances member access and directly impacts outcomes. The MCHP's efforts were fresh and had a clear goal of improving access to care. They need to expand their analysis and understanding of the data to determine when interventions were or were not effective.

TIMELINESS OF CARE

Both projects addressed timely and adequate care. The clinical PIP focused on providing required immunizations for all eligible members. Strategies employed improve on members obtaining immunizations by age 2. Home State has made a serious effort to identify problem areas for members and find solutions that best meet the members' needs. In the non-clinical PIP, there was attention to assisting the members to recognize their need to identify a provider and obtain the oral health care available. The MCHP's efforts are focused on incentivizing providers and engaging community health providers, such the FQHC's, into providing members timely access to dental services.

RECOMMENDATIONS

1. Explore operational and service issues identified by the MCHP and assess them for future PIP studies. The MCHP staff continues to discuss issues that appear to include all of the properties required for PIP development. The QI staff should to be aware of these observations for program improvement.
2. Request technical assistance from the EQRO, as needed, in PIP development.
3. Continue to improve narrative PIP sections to explain the MCHP's intentions and activities. Organize the report sections to comply with the PIP protocol. When providing information ensue that it corresponds to the section under discussion.
4. Continue development of community healthcare collaboratives to ensure that members receive reminders from their dental providers, and have access to more providers.
5. Analyze interventions that did not produce expected outcomes and evaluate what was and was not effective.
6. Continue to develop data analysis methods that ensure conclusions are supported by the data provided. Focusing on part of the data does not necessarily indicate a success of the PIP overall.
7. The report contained a lot of information. The detailed narrative is important. Some of the results could be represented in graphs/tables. This would help to visually impact the points made in the narrative discussion presented.
8. Continue involvement with the Statewide PIP planning group. Home State has become an integral part of this group. Continued commitment to this group is an important aspect of an evolving improvement process.

7.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for Home State. Home State submitted the requested documents on or before the due date of March 15, 2016. The EQRO reviewed documentation between March 15, 2016 and June 22, 2016. 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:

- NCQA RoadMap for the HEDIS 2015 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2015
- Policies and procedures with regard to calculation of HEDIS 2015 rates
- 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 2015 Data Submission Tool
- HEDIS 2015 product work plan
- Specifications for Measures to be Reported to MO HealthNet by the Managed Care Plans: Data Year 2014

Data files were submitted by Home State for review by the EQRO; these included regional files for CIS3 and regional files for EDV and EDU performance measures.

INTERVIEWS

The EQRO conducted on-site interviews at Home State in St. Louis on Wednesday, June 22, 2016 with staff responsible for calculating the HEDIS 2015 performance measures and the Measures Reported to MO HealthNet for Data Year 2014. The objective of the visit was to verify the methods and processes behind the calculation of the HEDIS 2015 performance measures and the measures reported to MO HealthNet in the June 30, 2015 report.

FINDINGS

Two of the measures being reviewed (Emergency Department Visits and Emergency Department Utilization) were calculated using the Administrative method, and the third measure (Childhood Immunizations Status 3) was calculated using the Hybrid method.

The reported CIS3 rate was 51.53% this was lower than the statewide rate for all MCHPs (56.91%). This is the fifth year the CIS3 measure has been audited by the EQRO, but only the second year that Home State has reported the rate. Home State's 2015 rate decreased from the rate of 56.32% that was reported in 2014.

This was the first year that the EQRO was requested to validate the information provided by the MCHPs on the June 30 Measures to be Reported to MO HealthNet Report. The measures that the EQRO validated from this report were Emergency Department Visits (EDV) and Emergency Department Utilization (EDU). Both of these measures are stratified by presenting diagnosis (Behavioral Health; Medical; or Substance Use). These are modified from the 2015 HEDIS Technical Specifications for Ambulatory Care (AMB); Mental Health Utilization (MPT) and Identification of Alcohol and Other Drug Services (IAD).

MO HealthNet requested that EQRO recalculate these measures and compare the calculations to the data submitted on the June 30 report. The objectives included determining if each MCHP was calculating the measure in the same fashion and determining if the MCHP was able to reproduce and provide the data used to calculate these modified HEDIS measures. The EQRO was unable to validate either the EDV or EDU measure calculations for Home State. The data provided to the EQRO was recalculated and the same results were not obtained as were reported to MO HealthNet.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated and were 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, Home State 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 Home State transferred data into the repository used for calculating the 2015 measures.

Documentation of Data and Processes

Although Home State 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 for the HEDIS measure CIS3. However, the data and processes used for calculation of the two non-HEDIS measures is uncertain and because the EQRO was unable to reproduce the numbers reported by Home State to MO HealthNet for these measures, the EQRO cannot find that Home State met all criteria that applied for all three measures.

Processes Used to Produce Denominators

Home State substantially 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.

Processes Used to Produce Numerators

Two of the three measures were calculated using the Administrative method (EDV and EDU). The third measure (CIS3) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g., immunizations; emergency department services dates; inpatient admit dates) as specified by the HEDIS 2015 Technical Specifications and the modifications for the June 30 report. Appropriate procedures were followed for the sampling of records for medical record reviews.

Home State reported a total of 59,291 administrative hits for the Emergency Department Visit - Medical measure; 111,480 hits were validated by the EQRO. This represents an underestimate of 69.69% by the MCHP.

For the EDV- Behavioral Health measure, the MCHP reported a total of 1,128 administrative hits; 693 hits were validated by the EQRO. This resulted in a reported rate of 1.58% and a validated rate of 0.97%, representing an overestimate of 0.61% by the MCHP.

For the EDV-Substance Use measure, the MCHP reported a total of 192 administrative hits; 220 were validated by the EQRO. This resulted in a reported rate of 0.26% and a validated rate of 0.29%, representing an underestimate of 0.04%.

Home State reported a total of 30,337 administrative hits for the Emergency Department Utilization-Medical measure; 30,091 hits were validated by the EQRO. This resulted in a reported rate of 40.51% and a validated rate of 40.18%, representing an overestimate of 0.33% by the MCHP.

For the EDU-Behavioral Health measure, the MCHP reported a total of 867 administrative hits; 531 hits were validated by the EQRO. This resulted in a reported rate of 1.21% and a validated rate of .74%, representing an underestimate of 0.47% by the MCHP.

For the EDU-Substance Use measure, the MCHP reported a total of 169 administrative hits; 126 were validated by the EQRO. This resulted in a reported rate of 0.23% and a validated rate of 0.17%, representing an overestimate of 0.06%.

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. Home State was compliant with all specifications for sampling processes.

Submission of Measures to the State

Home State submitted the Data Submission Tool (DST) for the HEDIS measure 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 MO HealthNet Quality Improvement Strategy. Home State submitted data as requested for the June 30 MO HealthNet report.

Determination of Validation Findings and Calculation of Bias

As is shown in Table 12, no bias was found for the CIS3measure, however, bias was observed in both the EDV and EDU measures.

Table 18 - Estimate of Bias in Reporting of Home State HEDIS 2014 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunizations Status (Combination 3)	No bias	N/A
Emergency Department Visits - Medical	69.69%	Underestimate
Emergency Department Visits – Behavioral Health	0.61%	Overestimate
Emergency Department Visits – Substance Abuse	0.04%	Underestimate
Emergency Department Utilization - Medical	0.33%	Overestimate
Emergency Department Utilization – Behavioral Health	0.47%	Underestimate
Emergency Department Utilization – Substance Abuse	0.06%	Overestimate

Source: BHC, Inc., 2015 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 13). The rate for the Childhood Immunization Status measure showed no bias and was therefore deemed Fully Compliant. The Emergency Department Utilization measure was found to be both under and overestimated. However, the measure fell within 1% of the hits reported, so it was deemed Substantially Compliant. The Emergency Department Visits measure was found to be both over and under estimated, with the Medical visit measure having a bias of over 69.69%, this measure was found to be Not Valid.

Table 19 - Final Audit Rating for Home State Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status	Fully Compliant
Emergency Department Visits	Not Valid
Emergency Department Utilization	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

Three rates were validated for the MCHP. The Childhood Immunizations Status rate was **lower** than the average for all MCHPs, the Emergency Department Visits measure was **consistent** with the average for all MCHPs, and the Emergency Department Utilization rate was **consistent** with the average for all MCHPs.

QUALITY OF CARE

Home State's calculation of the Emergency Department Utilization measure was substantially compliant with specifications. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical; Behavioral Health; or Substance Use. This information is useful to the MCHPs to determine if the ED is being utilized properly by its members.

Home State's rate for the EDU-Medical measure was lower than the average for all MCHPs, indicating that a lower percentage of Home State's members are accessing the ED for Medical issues than that of the other MCHPs. Home State's rates for the EDU- Behavioral Health and EDU- Substance Use measure were higher than the average for all MCHPs, indicating that a higher percentage of Home State's members are accessing the ED for Behavioral Health and Substance Use issues than that of the other MCHPs.

ACCESS TO CARE

The Emergency Department Visit measure was rated as Not Valid, as the EQRO was unable to reproduce the count of services reported by Home State. Although not validated, Home State's rate for the EDV- Medical measure was lower than the average for all MCHPs, indicating that Home State's members are accessing the ED for Medical issues at a rate lower than that of the other MCHPs. Home State's rates for the EDV-Behavioral Health and EDV- Substance Use measure were higher than the average for all MCHPs, indicating that Home State's members are accessing the ED for Behavioral Health and Substance Use issues more than that of the other MCHPs.

TIMELINESS OF CARE

Home State's calculation of the HEDIS 2015 Childhood Immunizations Status measure was fully 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 **lower** than the average for all MCHPs. This rate has been previously audited by the EQRO in the last four review years.

Home State members are receiving care in a less timely manner, for this measure, than that of other MO HealthNet Managed Care members. Additionally, 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 conduct and document statistical comparisons of rates from year to year.
2. Continue to participate in training of MCHP staff involved in the oversight of coordination of performance measure calculation.
3. Continue to perform hybrid measurement on those measures that are available for this method of calculation.
4. Provide information for data requests in the format and file requested. If questions arise, contact the EQRO for clarification.

7.3 MCHP Compliance with Managed Care Regulations

METHODS

Home State was subject to a full compliance audit during this on-site review. The content of this 2015 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 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 20.

Table 20 - Home State Compliance Ratings for Compliance Review Years (2012-2014)

Measure	2012	2013	2014	2015
Enrollee Rights and Protections	100%	100%	100%	100%
Access and Availability	64.71%	70.59%	76.47%	76.47%
Structure and Operations	100%	100%	100%	100%
Measurement and Improvement	90%	90%	100%	81.82%
Grievance Systems	100%	100%	100%	100%

Source: BHC, Inc., 2015 External Quality Review Compliance Validation

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 2015 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 2014, 2013 and 2012 ratings.

Home State has participated in community-based programs throughout all three Managed Care regions and has 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 MO HealthNet. 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 2015 review, Home State was rated by the review team to have met 13 standards. This is an overall rating of 76.47%; this is **consistent** with their 2014 rating and **higher** than the 2013 rating of 70.59% and the 2012 rating of 64.71%.

Although Home State improved in the area of Case Management, their low rating in the Availability of Services: Provider Network category impacted the lack of increase in the Access and Availability standards overall.

The MCHP identified persons for case management, provided referrals, involved PCPs, and improved their processes for documenting the case management services being delivered to members. Home State submitted required policy and procedures to MO HealthNet for their approval. However, in reviewing records and interviewing case management staff, full evidence of comprehensive assessments and member involvement in treatment planning was not available. The areas of care coordination and case closing transition planning have decreased from 2015 rates.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2015 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 third 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.

Home State is 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 MO HealthNet 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.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. Home State was rated by the review team to have met 9 standards and partially met two standards; and one standard was found to be Not Applicable. This is an overall rating of 81.82% and is lower than their 2014 rate of 100% compliance and the 90.0% rating received in 2012 and 2013.

The MCHP submitted three Performance Measures (PMs) for validation and one of these PMs received a Fully Compliant rating, the other two were found to be Substantially Complaint and Not Valid. The MCHP also submitted two Performance Improvement Projects (PIPs) The clinical PIP received a rating of 100% compliance. The non-clinical PIP received a rating of 76.19% due to some problems with data analysis. The specific details can be found in the appropriate sections of this report.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2015 review, Home State was found to have met all 18 standards. This is an overall rating of 100% compliance and is consistent with the ratings received in 2014, 2013 and 2012. 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 MO HealthNet 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.

Issues were identified during this year's review with the lack of member input in treatment plans and less than comprehensive assessments from Case Management files. However, the MCHP improved in the areas of appropriately introducing members to case management and providing face-to-face contacts.

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.

However, missing comprehensive assessments and lack of member input into 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.

Although Home State made some improvement in the area of Case Management, their low rating in the Availability of Services: Provider Network category impacted the lack of increase in the Access and Availability standards overall.

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.
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 monitor provider and hospital networks for adequacy. Develop contracts where possible.
6. Maintain an update provider website with accurate information regarding provider availability.
7. Ensure that QI staff understands how HEDIS measures are developed and the parameters defined in the technical specifications.

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8.0 Missouri Care Health Plan

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8.1 Performance Improvement Projects

Document Review

Missouri Care supplied the following documentation for review:

- Follow-Up after Hospitalization for Mental Illness 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 July 7, 2016, 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 of the PIPs. Technical assistance regarding new study development, study design, and presentation of findings was provided by the EQRO. The following questions were addressed:

- How were the outcomes interpreted and linked to the interventions?
- How were the interventions determined and why did the MCHP choose this approach?
- Discuss the effects of these interventions and how they impacted services to members.

The MCHP was given the opportunity to submit updates to the outcomes of the interventions and additional data analysis. The information evaluated here is based on the enhanced submissions and additional data that were supplied.

FINDINGS

CLINICAL PIP – POST MENTAL HEALTH HOSPITALIZATION – FOLLOW-UP CARE WITHIN 7 DAYS OF DISCHARGE

MO Care's clinical PIP focused on improving follow-up after hospitalization for mental illness within seven (7) days. This PIP was originally implemented in 2005 and was enhanced and reviewed in 2013. The MCHP intends to improve its members' mental health outcomes through education and ongoing interventions. One of the projects started in 2015 was a pilot program involving provider incentives involving three community mental health centers. The MCHP also implemented case management, utilization management and other health plan interventions to improve members' mental health outcomes. Inpatient stay may be necessary to reduce a danger to the member themselves or others. However, the MCHP found that the probability of long-term recovery improves when patients utilize both inpatient and outpatient resources effectively. Follow-up therapy has been found to be a preventive factor against readmission.

The MCHP chose a multi-faceted approach to ensure that members and providers were both engaged in improving services to members. Interventions implemented during 2015 included:

- Member engagement –
    - Health Rewards Program
    - Krames On-Demand
    - Missouri Coalition of CMHCs
- Provider engagement –
    - Behavioral Health Provider Incentive Program Pilot
    - HEDIS Behavioral Health Toolkit
    - Participation in the Behavioral Health Partnership
    - Education
    - "Gold Card" Project

The HEDIS rates did improve from the rate of 32.78% in CY 2014 to 35.46% in CY 2015. The MCHP insists that their dual approach initiatives will impact both providers and members to improve members' mental health outcomes by receiving the necessary follow-up appointments. The success of the provider and member incentive programs are continuing to be evaluated for

their positive impact on this measure. According to MO Care implementation of case management and utilization management programs, and other interventions employed for this PIP are having a positive impact on members. The MCHP has confidence that their multi-interventional approach will ensure that rates continue to improve.

MO Care did experience some improvement in CY 2015, as opposed to the low rate reported in CY 2014, when the cause for decline was attributed to an internal data error However, they did not regain the CY 2013 rate of 39.36%. The results of each year are as follows:

- CY 2012 – 37.04%
- CY 2013 – 39.36%
- CY 2014 – 32.78%
- CY 2015 – 35.46%

The increase experienced in CY 2015 did not meet the MCHP's goal of 38.78%. They contend that some of the improvement is the result of their provider incentive program involving three of the largest CMHCs in the state.

The MCHP reiterates that they have confidence in their multi-interventional approach to creating improvement in the 7-day follow-up after a mental health inpatient hospitalization HEDIS rate. They plan to continue all of these efforts and have developed new interventions to improve and sustain this HEDIS measure.

FUH-7 Provider Incentive Pilot Program				
CMHC Provider Group	7/1/2014 – 9/30/2014		7/1/2015 – 9/30/2015	
	Rate	NCQA %ile	Rate	NCQA %ile
Burrell Behavioral Health	40.00%	25th	66.67%	90th
Truman Medical Center	37.50%	25th	30.00%	<25th
Compass Health Inc.	34.00%	25th	61.54%	75th

Two of the three provider groups show improvement from the NCQA 25th percentile to the 90th and 75th percentile. They evaluated the decline at Truman Medical Center and found that causes were related to a lack of engagement or understanding of the program. They are providing education and will provide opportunities for improvement.

The MCHP also attributes the multi-interventional to the success at improving 7-day follow-up after a mental health inpatient hospitalization. They plan to continue all of these efforts and have developed new interventions to improve and sustain this HEDIS measure.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Plan Name or ID: Missouri Care		
Name of PIP: Post Mental Health Hospitalization – Follow-up Care within 7 Days of Discharge		
Dates in Study Period: Original – 2005: Current – February 2016		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	__Met **X** Partially Met __Not Met __Unable to Determine	The information presented in the study topic narrative is based on the presentation delivered in the 2013 PIP. The 2016 submission includes a reference to the previous literature review and explains that this information generated a pilot program implemented in 2015. It focused on provider incentives involving 3 community mental health centers (CMHCs). In addition the narrative states that the MCHP will continue to provide improved member mental health outcomes through education and ongoing interventions. This PIP started in 2005. It was reviewed in 2013. No updates are provided to justify continuing this project, or explaining what previous interventions accomplished. The EQRO acknowledges that this is a valid and important issue to address, but no justification for continuing or enhancing the project is provided.
Clinical ___Prevention of an acute or chronic condition ___High volume services **xx** Care for an acute or chronic condition **xx** High risk conditions		
Non-Clinical ___Process of accessing or delivering care		
1.2Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	The PIP addressed a key aspect of member care and services. This is explained in the topic narrative from the previous submissions. It states that the MCHP will try to improve outcomes for members with mental health disorders (defined by the diagnosis codes included) during CY 2015.

Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		The information provided in the study topic focuses on correcting deficiencies in care. The discussion concentrates on improving the mental health of the members in this study, but the MCHP will use the HEDIS measure (FUH-7) to measure success.
1.3Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP will serve all members 6 years old and older who have had an inpatient hospitalization for treatment of a mental health disorder. No one is excluded.
Demographics: _xx_Age Range _____Race _____Gender Medical Population: _xx_Medicaid Only _____Commercial	Totals	**2** Met **1** Partially Met _____Not Met _____UTD
Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __Partially Met __Not Met __Unable to Determine	The question is stated clearly. However, this is the exact same study question as presented in the 2013 PIP. The narrative regarding the study question does explain the MCHP plans to show success by improving their HEDIS rate by 6 percentage points from HEDIS 2016 to HEDIS 2017.
Include study question(s) as stated in narrative: "Will the implementation of case management and utilization management activities, along with other health plan interventions, be successful increasing the percentage of MO Care members who receive a follow-up appointment within 7 days of discharge from an acute inpatient setting with a principal mental health diagnosis."	Total	**1** Met _____Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP will use the HEDIS measure regarding follow-up after hospitalization (FUH-7). The numerator and denominator, as defined by the HEDIS tech specs, are included. Additionally, the MCHP will use HEDIS-like data to evaluate the "data trends" on a quarterly basis.
List Indicators:		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met __Partially Met __Not Met __Unable to Determine	The improvement goal is an increase in the HEDIS rate by 6 percentage points. The narrative states that an improvement in the HEDIS rate will reflect an improvement in health status of members.

Are long-term outcomes implied or stated: ___yes __xx__no _____Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	__2__Met _____Partially Met _____Not Met _____UTD

Component/Standard	Score	Comments
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	__X__Met __Partially Met __Not Met __Unable to Determine	The plan uses the HEDIS definition of the population that is included in this study.
Demographics: __xx__Age range _____Gender _____Race Medical Population: __xx__Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	__Met __X__Partially Met __Not Met __Unable to Determine	It might be assumed that the entire eligible population will be captured through the HEDIS methodology. The PIP narrative does not define "selected disorders" except by providing a list of CPT and ICD-9 & 10 codes. Other coding is included. It does not explain any diagnosis not included.
Methods of identifying participants:__xx Utilization data _____Referral _____Self-identification _____Other	Totals	__1__Met __1__Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No sampling is used in this PIP.
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census		

used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	_____Met _____Partially Met _____Not Met _____UTD
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	**X** Met __Partially Met __Not Met __Unable to Determine	The explanation presented the information pertinent to HEDIS data collection. The study design and how it expects to impact members' healthcare is explained in the data analysis plan.
6.2 Did the study design clearly specify the sources of data?	**X** Met __Partially Met __Not Met __Unable to Determine	The sources of the data are claims data, software etc. are included.
Sources of data: ___Member _xx Claims ___Provider ___Other		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	**X** Met __Partially Met __Not Met __Unable to Determine	The narrative explains how the HEDIS tech specs and data are collected and used. The importance of utilizing NCQA certified software to reduce the threat of invalid data is included.

6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	**X** Met __Partially Met __Not Met __Unable to Determine	The narrative states that the MCHP used the HEDIS tech specs, and that they utilized NCQA certified software to reduce the threat of invalid data. No actual instruments are used.
Instruments used: ___Survey _____Medical Record Abstraction Tool Other:_____ _____		
6.5 Did the study design prospectively specify a data analysis plan?	**X** Met __Partially Met __Not Met __Unable to Determine	The section of the PIP titled "Data Analysis Plan" creates a valid study design and prospective data analysis plan. There is an explanation of how the data will be analyzed and what they hope to learn. It is mentioned that in 2013 "an opportunity was identified to evaluate state-wide trends." The MCHP is

		now using a HEDIS-like methodology to evaluate improvement throughout the study year. This process began in CY 2015.
6.6 Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	All staff members involved in this PIP are included. Their roles and areas of expertise are provided
Project Leader Name: Vicki Mertz Title: Quality Improvement Project Manager Role: Oversight of data analysis and tracking PIP results • Other team members: Chief Medical Officer: Justin R. Cramer, MD, MBA, FAAFP • Director, Quality Improvement: Mark Kapp, MBA, BSN, RN, CPHQ • Director, Clinical Behavior Health: Melody Dowling, MSW, LCSW • Manager, Case Management: Janette Hagan, RN • Manager, Quality Improvement: Erin Dinkel BSN, RN • Quality Improvement Analyst: Karen Einspahr, LPN, CPC WellCare quality and analytics personnel manage data validation, integrity, quality reporting, and oversee technical analysts. This includes trend reporting, data modeling, coding, report design, statistical analyses and queries, data mining, and program evaluation. HEDIS rates are collected and calculated using Inovalon NCQA certified software.	Totals	**6** Met _____Partially Met _____Not Met _____UTD

Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	X Met __Partially Met __Not Met __Unable to Determine	The MCHP engages in a multi-interventional approach to ensure that member and provider actions generate changes and provide the improvements desired. As interventions prove successful, they become ongoing, and are integrated into agency practice. This approach does make evaluating the effectiveness of any one intervention for its impact on the stated problem almost impossible. At this point the MCHP states that this approach will have the most impact on improving the outcomes they seek.
Describe Intervention(s): 1) Member Engagement: Health Rewards Program 2) Member Engagement: Krames On-Demand 3) Provider Engagement: Behavioral Health Provider Incentive Program Pilot 4) Provider Engagement: HEDIS BH Toolkit 5) Member Engagement: Missouri Coalition of CMHCs 6) Provider Engagement: Behavioral Health Partnership 7) Provider Engagement: Education 8) Provider Engagement: "Gold Card" Project	Totals	__1__Met _____Partially Met _____Not Met _____UTD
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The opening of the section titled "Data Analysis and Study Results" explains how the MCHP will use their analytic processes. This process was part of the prospective data analysis plan and is detailed here. This section explores the findings and analysis of the findings.
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		A barrier analysis listed by member and provider issues is included.
8.2 Were the PIP results and findings presented accurately and clearly?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The results are presented. The narrative describes the results (HEDIS scores) in a clear and accurate manner.
Are tables and figures labeled? __xx yes ___no Are they labeled clearly & accurately? xx_ yes ___no		

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	All of the factors concerning repeat measurements, statistical significance, etc., were addressed in the analysis presented.
Indicate the time periods of measurements: Annual for HEDIS and quarterly for HEDIS- Like measurements. Indicate statistical analysis used: NCQA HEDIS IDSS Submission Tool Indicate statistical significance level or confidence level if available/known: _____99% **xx** 95% _____Unable to determine		
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The analysis presents a direct correlation between the pilot programs developed and the improvement in the HEDIS rate. The MCHP is committed to continuing educational and other activities to create success, although no explanation of the problems encountered were included. The narrative discusses the multi-interventional approach and why the MCHP considers this approach essential to achieving their improved HEDIS 2016 results.
Limitations described: Please see barriers detailed in Section 7. Conclusions regarding the success of the interpretation: The improvement will be impacted by maintaining interventions that increase follow-up after hospitalization Recommendations for follow-up: Implement new interventions that have been in the planning stages to have a deeper impact on this measure.	Totals	**4** Met _____Partially Met _____Not Met ___Not Applicable _____UTD

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The methodology regarding the sources of data, members examined and tools used have remained the same since the inception of this PIP. All of these questions are answered in the narrative provided.
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		Yes
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	HEDIS 2016 reports an improvement in all three MHD regions and in the aggregate results. The MCHP did not reach the goal of 6 percentage points, but did improve their aggregate HEDIS rate.
Was there: _xx_Increase _____Decrease Statistical significance ___yes ___no Clinical significance ___yes ___no		
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The narrative indicates that through analysis and statistical testing the MCHP experienced improvement in their HEDIS rates. They did not reach the 6 percentage point goal. As the result of this fact, the narrative includes planned interventions and new strategies implemented during 2016 to make additional improvements.
Degree to which the intervention was the reason for change ___No relevance ___Small _xx_Fair ___High		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	This is considered "not applicable" at this time. There is no discussion, and the outcomes reported for CY 2015 do not appear to have produced the level of improvement the MCHP hopes to achieve.
_____Weak **_xx_**_Moderate _____Strong	Totals	**_3_**Met _____Partially Met _____Not Met **_1_** _Not Applicable _____UTD

Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	Since the most recent improvement is for one HEDIS period, the success experienced cannot be considered sustained at this time.
	Total	_____Met _____Partially Met _____Not Met **1** Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions: The PIP appears to have possibilities and in the most recent HEDIS year experienced success, although they did not reach their stated goal. Additional narrative would be helpful, particularly in the analysis sections. More detailed information about how the interventions directly influenced the outcomes achieved would provide incite regarding the success of the PIP.

Recommendations:

1) Update information about the continued relevance of the study topic every year. Include what has been achieved and what additional changes are planned to improve success rates.
2) Provide narrative explaining how the interventions employed impacted the outcome of the study. What generated improvements and why.

Check one:

- ☐ High confidence in reported Plan PIP results
- **XX** Moderate confidence in reported Plan PIP results
- ☐ Low confidence in reported Plan PIP results
- ☐ Reported Plan PIP results not credible

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

MO Care's individualized approach to the Statewide PIP "Improving Oral Health" has the goals to: Improve members' oral health outcomes through education and on-going interventions. Their research found that dental care is the most prevalent unmet health need among children. Access to dental services is an ongoing challenge for their members. The MCHP intends to improve its members' oral health outcomes through education and on-going interventions.

In order to achieve this goal new interventions were implemented during 2015 including:

- Provider Engagement –
  - Missouri Health+ Partnership (2015/2016 implementation)
  - Dental Home Pilot Project
  - Partnership with Black Health Care Coalition
  - Dental Day at Local Community Health Centers (Initiated in 2012 and revised in 2015) – Opening the local clinics to MO Care members who have not had their screening

MO Care supplied HEDIS rates for each region as well as the aggregate data. The MCHP achieved the goal of a 3% improvement for the calendar year 2014. The rates and data presented indicate a statistically significant improvement over the previous year. The current HEDIS rates are the highest achieved by the MCHP.

The aggregate rates for the MCHP are:

- CY 2012 – 43.91%
- CY 2013 – 31.39%
- CY 2014 – 45.74%
- CY 2015 – 46.60%

The MCHP experienced an increase of .31 percentage points. They did not meet the goal of increasing the ADV by 3%. The only decline reported occurred in the Western region where the HEDIS 2015 rate was 45.01%, and the HEDIS 2016 rate was 44.03%. MO Care mentions this outcome several times in their analysis, but has no hypotheses about the cause of this decline.

MO Care did provide a narrative about the outcomes achieved in all three regions, and on the statewide bases for the past 4 years. They assert that the initiatives they have put in place are directly responsible for the improvement received, even though they did not achieve the 3% increased sought for in CY 2015. The MCHP states that they will continue to monitor the effectiveness of current interventions, as well as assessing the outcomes of new interventions. The discussion states that the MCHP identified an opportunity to improve member participation by attending dental health fairs. They contend that low participation is related to the inability to contact members due to incorrect telephone numbers. The MCHP plans to partner with providers to reach members with the goal of increasing the member involvement in activities and benefits offered. No other correlations are drawn between the interventions in place and the improvements or lack of improvement in this study. The MCHP is implementing new interventions based on the multi-dimensional approach used in the past. The MCHP's planned interventions include:

- A partnership with A.T. Still Dental School;
- Expanding the dental home pilot program;
- A partnering with the Housing Authority to host back to school health fairs; and
- A No Cavity Club, which includes a fun and interactive program for members, in partnership with DentaQuest their dental subcontractor.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Plan Name or ID: Missouri Care		
Name of PIP: Improving Oral Health		
Dates in Study Period: January 2010 – June 2016 (present)		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X Met __Partially Met __Not Met __Unable to Determine	The Study Topic narrative is an informative write up that presents the foundation for initiating MCHP focused strategies. It is well written. The study topic information explains how the Statewide PIP relates to MCHP members.
Clinical _xx_Prevention of an acute or chronic condition xx_High volume services ___ Care for an acute or chronic condition ___ High risk conditions		
Non-Clinical _xx_Process of accessing or delivering care		
1.2Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X_ Met __Partially Met __Not Met __Unable to Determine	Good oral health, achieved through annual dental visits, is an essential aspect of member care and it was well documented in the information presented.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		The entire focus was on correcting deficiencies in care.
1.3Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	X_Met __Partially Met __Not Met __Unable to Determine	The entire population of members ages 2-20, those included in the HEDIS measure, are served in this PIP. The MCHP discusses the barrier of not including pregnant members who have an access to dental benefits, but are not included in the PIP.
Demographics: _2-20_ Age Range _____Race _____Gender Medicaid Population: _xx_ Medicaid Only _____Commercial	Totals	_3_Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	X Met __Partially Met __Not Met __Unable to Determine	The study question is clear and understandable. The ancillary information provided in the study question discussion defines the goal of a 3% annual increase.
Include study question(s) as stated in narrative: Will providing educational interventions concerning dental hygiene and the importance of annual preventive dental visits to MO Care members from the ages of 2 – 20 years old improve members' oral health and result in an increase of annual dental visits?	Total	__**1**__Met _____Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	X Met __Partially Met __Not Met __Unable to Determine	The HEDIS measure for Annual Dental Visits will be used. The measure, its technical specifications, and an explanation of how this will inform the results of their interventions, are included.
List Indicators:		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	_X_ Met __Partially Met __Not Met __Unable to Determine	The indicator does measure changes in the process of care, which is strongly associated with improved outcomes. The rational is included in the documentation presented.
Are long-term outcomes implied or stated: ___yes ___no _____Health Status _**X**_ Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	__**2**__Met _____Partially Met _____Not Met _____UTD

Component/Standard	Score	Comments
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	X Met __Partially Met __Not Met __Unable to Determine	The MCHP population included in the study will be members ages 2-20, which is consistent with the HEDIS tech specs.
Demographics: _xx_Age range _____Gender _____Race Medical Population:_xx_Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X Met __Partially Met __Not Met __Unable to Determine	The data collection approach, using the HEDIS methodology, will capture all enrollees for this study.
Methods of identifying participants: _xx_ Utilization data _____Referral _____Self-identification _____Other _____	Totals	**2** Met _____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No sampling is included in this PIP.
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	_____Met _____Partially Met _____Not Met _____UTD

Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	X Met __Partially Met __Not Met __Unable to Determine	The study design narrative discusses the claims/encounter data used to calculate the administrative HEDIS ADV rate. The tools used in this study included claims-based software and NCQA Certified Software (Inovalon) to calculate this rate.
6.2 Did the study design clearly specify the sources of data?	X Met __Partially Met __Not Met __Unable to Determine	The software and methodology discussed above clearly specifies the sources of data.
Sources of data: ___Member __xx__Claims ___Provider ___Other		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X Met __Partially Met __Not Met __Unable to Determine	The study design discusses the MCHP's method to identify the eligible population and the specific elements for the HEDIS measure. The use of 2009 HEDIS rate is considered the baseline year for the Central Region. The HEDIS 2011 rate is the baseline for West and East. This includes the entire population. The study design does delineate a methodology providing confidence that valid and reliable data representing the entire population are included.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X Met __Partially Met __Not Met __Unable to Determine	A description of the NCQA certified software used, and the claims/encounter codes identified, is all included. The methodology described is set up to provide for consistent accurate data over time. In calendar year 2013 the data reported was not entirely accurate or reliable. The MCHP explained the issues caused by a change of ownership/data sources, which have been rectified. The results of HEDIS 2015 and 2016 are hoped to provide evidence if this is indeed the case.
Instruments used: ___Survey Medical Record Abstraction Tool ____Other:_____ _____		
6.5 Did the study design prospectively specify a data analysis plan?	X Met __Partially Met __Not Met __Unable to Determine	The data analysis plan adjusted the goal for improvement to 3% annually, which also conforms to the expectations set out by CMS. A data analysis plan was presented explaining the continuous process improvement practices. This plan states that they intend to present evidence that they have achieved improvement in members' oral health which will be measured by each years' HEDIS rate. The MCHP will use a quarterly HEDIS-like methodology, added during HY 2015, to measure the effectiveness of current interventions during the study year.

		The data analysis plan included a statement that the MCHP identified an opportunity to provide a real-time assessment between the annual HEDIS measurement periods. To accomplish this, a quarterly HEDIS-like methodology was introduced to measure improvement over the prior year, and to provide an interim picture of the success of the current PIP.
6.6 Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	The roles and expertise of all team members were included.
Project Leader Name: Karen Einspahr____ Title: Quality Improvement Analyst Role: Project Leader – oversight of all data analysis and results. • Other team members: Chief Medical Officer: Justin R. Cramer, MD, MBA, FAAFP • Director, Quality Improvement: Mark Kapp, MBA, BSN, RN, CPHQ • *Sr. Manager, Marketing & Community Relations: Edward Williams* • Manager, Quality Improvement: Erin Dinkel BSN, RN • Project Manager, Quality Improvement: Vicki Mertz, MA WellCare quality and analytics personnel manage data validation, integrity, quality reporting, and oversee technical analysts. This includes trend reporting, data modeling, coding, report design, statistical analyses and queries, data mining, and program evaluation. HEDIS rates are collected and calculated using Inovalon NCQA certified software.	Totals	**6** Met ____Partially Met _____Not Met _____UTD

Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP hopes to improve their ability to engage members in the need to obtain annual dental visits with a multi-faceted array of interventions. All interventions implemented since 2009 are included in the PIP in a table providing details of each year's projects. During 2015 four interventions were initiated. They appear reasonable and address the causes/barriers outlined in the Study Topic section of the PIP. The MCHP states that these improvement strategies were developed as the result of the data analysis and the QI processes in place during the project year. The MCHP is aware that multiple interventions make it more difficult when assessing what is most effective in impacting member behavior. The PIP narrative explains and justifies this approach.
Describe Interventions: 1) Provider Engagement – Missouri Health + Partnership (2015/2016 implementation) 2) Provider Engagement – Dental Home Pilot Project 3) Provider Engagement – Black Health Care Coalition 4) Provider Engagement – Dental Day at Local Community Health Centers (Initiated in 2012 and revised in 2015)	Totals	__1__Met _____Partially Met _____Not Met _____UTD

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	This section - entitled "Data Analysis and Study Results," provides information explaining how the MCHP used their analysis. The MCHP uses 2013 as their baseline year when evaluating aggregate data. The narrative explains that this is the first year providing data on all three regions. They are reporting all information in accordance with the requirements of the Statewide PIP, and in accordance with their data analysis plan.
This Element is "Not Met" is study is complete and there is no indication of a data analysis plan (see step 6.5)		A barrier analysis is presented and is defined as member, provider and systems barriers. This clarifies the problems that exist for members when attempting to get their annual dental visits.
8.2 Were the PIP results and findings presented accurately and clearly?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The MCHP provided graphs and information for each year included in the study. This includes information regarding the negative impact of "transition" on their function, causing a severe decrease in their 2014 HEDIS rates. The outcomes including the HEDIS 2016 data indicates the improvements anticipated by the MCHP. All results and findings are presented accurately and clearly.
Are tables and figures labeled? xx yes ___no Are they labeled clearly & accurately? xx yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	__Met X Partially Met __Not Met __Not Applicable __Unable to Determine	Initial and repeat measures are presented. A complete analysis, including the results of the 2016 HEDIS, is included. Statistical significance testing was completed and results for each measurement period are presented. These graphs include the baseline year used for each Region. 2009 for Central/2011 for East/West. The aggregate shows a baseline year of 2013. This coincides with the Statewide PIP
Indicate the time periods of measurements: Annual HEDIS rate Indicate statistical analysis used: NCQA HEDIS IDSS Submission Tool Indicate statistical significance level or confidence level if available/known: _____99% xx 95% _____Unable to determine		The MCHP did see improvement. They did not reach their 3% goal. The results indicate that this improvement did show a statistical significance for the aggregate as well as the Central and Eastern Regions. The West did not reach this level of improvement. They made no assessment of why the Western region experienced a decline.

8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	___Met __X__Partially Met __Not Met __Not Applicable __Unable to Determine	A summary of findings is presented. This highlights the results of the HEDIS rates, and includes a narrative explanation, as well as tables and graphs. The summary states that since the initiation of the PIP in 2010 the MCHP has made "significant improvement" based on the current aggregate rate of 46.60%. The discussion recognized that there was a decline in rates in the Western Region for HEDIS 2016. It did not venture any theories or explanation about why this occurred
Limitations described: The decline in the HEDIS 2014 rate was explained – it was the result of a data issue, rather than members not receiving an annual dental visit. Conclusions regarding the success of the interpretation: A summary was included, but it did not draw actual conclusions. Recommendations for follow-up: The next step for this PIP (2016 interventions) were included and explained.	Totals	__2__Met __2__Partially Met _____Not Met ___Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	__X__ Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The method of data collection remained the same throughout this PIP. However, multiple baseline years are used. This actually creates some confusion when looking at the tables/graphs, but this information is explained throughout the PIP.
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__X__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	There was initial improvement from the inception of the PIP; however, HEDIS 2014 included a significant decrease, which was actually the result of data reporting problems. The MCHP is able to prove their theory about the effectiveness of their interventions by looking at the outcomes reflected in their HEDIS 2015 rates, which were the highest rates achieved since the inception of this PIP. HEDIS 2016 also showed improvement, with the exception of the Western Region. The overall improvement is reflected in the aggregate.
Was there: __xx__Increase _____Decrease Statistical significance __xx__yes ___no Clinical significance __xx__yes ___no		

9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	**X** Met __ Partially Met __Not Met __Not Applicable __Unable to Determine	The improvement appears to have face validity. The aggregate HEDIS 2016 rate shows improvement. There is a discussion outlining how the variety of interventions and strategies employed, have been successful at improving the MCHP's annual dental visits. It is the assertion of the MCHP that their approach has proved to be effective with their population.
Degree to which the intervention was the reason for change ___No relevance ___Small ___Fair _xx_High		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Statistical evidence is presented regarding the MCHP's improvement. The narrative sites the fact that the Eastern and Central regions and the aggregate show improvement that is statistically significant. The overall improvement, from the inception of the PIP through the current data, is evidence that this is true improvement.
_____Weak _xx_Moderate ___Strong	Totals	**4** Met _____Partially Met _____Not Met ___Not Applicable _____UTD

Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	_x_ Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The MCHP has shown improvement with the exception of one year, and in HEDIS 2016 one region. In general they have shown that their interventions have had a positive impact on their members. Some analysis of the decline in the Western Region should be included. However, the MCHP asserts that with the success they have achieved, plus the implementations of new interventions, they will continue to show improvement.
	Total	__Met __**I**__Partially Met _____Not Met ___Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:

The foundation of this PIP is sound and well-planned. THE EQRO had questions about the number of, and impact of the interventions shared during the initial review. These questions were addressed during the on-site review. The MCHP explained the negative impact that the 2014 HEDIS data issues that occurred. They were also able to explain the outcomes achieved in calendar year 2013 – resulting in decreased rates in HEDIS 2014. The outcomes achieved for HEDIS 2016 were clear, and understandable, with the exception of an explanation about the decline in the western region. All updated information improved the substance of this PIP. The MCHP has achieved success in making improvements using the structure of the statewide initiative. They continue to implement new interventions. The narrative indicates that they track and trend their initiatives so additional or immediate improvement can be achieved. The MCHP has used the PIP process as a method to obtain improved performance and is committed to continuing these initiatives.

Recommendations:

1) Continue enhancing narrative that explains the outcomes, and how the interventions contributed to this improvement.
2) If any downward trend occurs, explain it. A study, or specific interventions, can fail to produce positive results. Explain why an intervention may have failed to produce desired results.
3) Include follow-up plans that correct any problems.

Check one:

☐ High confidence in reported Plan PIP results
XX Moderate confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible

CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the PIPs undertaken by MO Care. Quality healthcare and improved quality of life for MCHP members were addressed. Implementing measures to ensure that members obtain follow-up mental health visits after an inpatient hospitalization is an example of this commitment. The PIPs sought to improve healthcare by focusing on aspects of care that may have been neglected, leading to negative outcomes. The MCHP provided opportunities for preventive dental care enhancing the quality of services received by members. They planned to incorporate effective interventions into normal daily operations and data indicates 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 MO Care members. The clinical PIP stresses the need for assistance for members requiring out-patient mental health interventions. The goal is to enable members to seek and obtain follow-up appointments within seven (7) days of leaving an inpatient stay. The MCHP put rewards in place to engage members and providers ensuring that these appointments occurred within the seven day time limit. MO Care worked with their dental subcontractor, their providers, and members to create new opportunities to access dental services. The statistics for CY 2014 and CY 2015 were generally positive, indicating that the MCHP corrected previous data issues and were able to report dental visit data correctly. The MCHP expanded availability of Mobile Dental Units, making services available where they did not previously exist. The MCHP acknowledges that this intervention may have achieved its maximum effect on member change. They are now moving to new types of initiatives to maintain improvement and achieve their stated goals.

Timeliness of Care

These performance improvement projects focused on ensuring that members had timely access to care. MO Care implemented strategies to assist members in obtaining mental health services within seven days of leaving an inpatient mental health hospitalization, enhancing the probability of better outcomes for members. The MCHP worked with providers and members to ensure that there was access to timely dental appointments.

Recommendations

1. Update information contained in the study topic to ensure continued relevance of the PIP. Identify what has been achieved and what remains to be accomplished to reach the goals of the study.
2. 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.
3. Work towards enhanced narrative that explains the outcomes, and how the interventions contributed to this improvement.
4. When a downward trend occurs, explain it. A study, or specific interventions, can fail to produce positive results. Explain why an intervention may have failed to produce desired results.
5. Define follow-up plans that correct problems experienced in the study process.
6. Continue the process of looking at MCHP statistics and data to analyze the best use of resources in creating performance improvement initiatives. Complete a true analysis to adequately report the outcomes achieved.
7. Continue the 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.
8. Continue work on identifying clinical issues to be addressed through the PIP process. Ensure that areas of concern are considered and incorporated into the 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 15, 2016. The EQRO reviewed documentation between March 15, 2016 and July 7, 2016. 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 2015
- MO Care's HEDIS Data Entry Training Manual
- MO Care's Policies pertaining to HEDIS rate calculation and reporting

Data files were submitted by MO Care for review by the EQRO; these included Statewide files for Childhood Immunization Status, Combo 3 (CIS3) and regional files for the Emergency Department Visits (EDV) and Emergency Department Utilization (EDU) measures audited.

Interviews

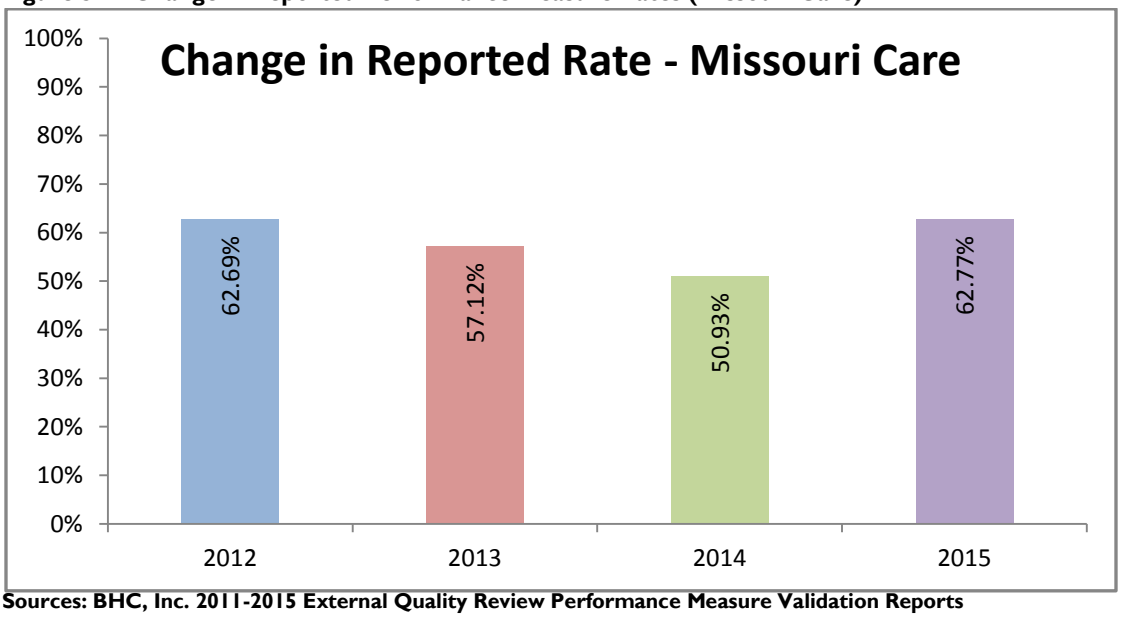
The EQRO conducted on-site interviews in Columbia, MO on Thursday, July 7, 2016 with the MO Care staff that were responsible for the process of calculating the HEDIS 2015 performance measures and the Measures Reported to MO HealthNet for Data Year 2014. The objective of the visit was to verify the methods and processes behind the calculation of the HEDIS 2015 performance measures and the measures reported to MO HealthNet in the June 30, 2015 report.

Findings

Two of the measures being reviewed (Emergency Department Visits and Emergency Department Utilization) were calculated using the Administrative method, and the third measure (Childhood Immunizations Status 3) was calculated using the Hybrid method.

The reported CIS3 rate was 62.77% this was higher than the statewide rate for all MCHPs (56.91%). This rate returns the MCHP back to a rate that is comparable to the 2012 rate of 62.69% and shows an upward move from the rates in 2013 and 2014 that were affected by the data issues that occurred during their transition from prior ownership during HEDIS year 2014 (see Figure 32).

Figure 32 – Change in Reported Performance Measure Rates (Missouri Care)



Sources: BHC, Inc. 2011-2015 External Quality Review Performance Measure Validation Reports

This was the first year that the EQRO was requested to validate the information provided by the MCHPs on the June 30, 2015 Measures to be Reported to MO HealthNet Report. The measures that the EQRO validated from this report were Emergency Department Visits (EDV) and Emergency Department Utilization (EDU). Both of these measures are stratified by presenting diagnosis (Behavioral Health; Medical; or Substance Use). These are modified measures for the 2015 HEDIS Technical Specifications for Ambulatory Care (AMB); Mental Health Utilization (MPT) and Identification of Alcohol and Other Drug Services (IAD).

MO HealthNet requested that EQRO recalculate these measures and compare the calculations to the data submitted on the June 30 report. The objectives included determining if each MCHP was calculating the measure in the same fashion and determining if the MCHP was able to reproduce and provide the data used to calculate these modified HEDIS measures. Missouri Care was the only MCHP that supplied records that were consistent with the measure

specifications. The data provided to the EQRO was recalculated and similar results were obtained as those reported to MO HealthNet by Missouri Care.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated as 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, Missouri Care 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 Missouri Care transferred data into the repository used for calculating the 2015 measures.

Documentation of Data and Processes

Although Missouri Care 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 for the HEDIS measure CIS3 and the non-HEDIS measures (EDV and EDU).

Processes Used to Produce Denominators

Missouri Care 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 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 (EDV and EDU). The third measure (CIS3) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g., immunizations; emergency department services dates; inpatient admit dates) as specified by the HEDIS 2015 Technical Specifications and the modifications for the June 30 report. Appropriate procedures were followed for the sampling of records for medical record reviews.

MO Care reported a total of 79,585 administrative hits for the Emergency Department Visit - Medical measure; 79,560 hits were validated by the EQRO. This resulted in a reported rate of 77.33% and a validated rate of 77%, representing an overestimate of 0.02% by the MCHP.

For the EDV- Behavioral Health measure, the MCHP reported a total of 1,216 administrative hits; 1,207 hits were validated by the EQRO. This resulted in a reported rate of 124% and a validated rate of 1.23%, representing an overestimate of 0.01% by the MCHP.

For the EDV-Substance Use measure, the MCHP reported a total of 267 administrative hits; 253 were validated by the EQRO. This resulted in a reported rate of 0.26% and a validated rate of 0.25%, representing an overestimate of 0.01%.

MO Care reported a total of 42,244 administrative hits for the Emergency Department Utilization-Medical measure; 42,290 hits were validated by the EQRO. This resulted in a reported rate of 41.05% and a validated rate of 41.09%, representing an underestimate of 0.04% by the MCHP.

For the EDU-Behavioral Health measure, the MCHP reported a total of 989 administrative hits; 975 hits were validated by the EQRO. This resulted in a reported rate of 1.01% and a validated rate of 0.99%, representing an overestimate of 0.01% by the MCHP.

For the EDU-Substance Use measure, the MCHP reported a total of 216 administrative hits; 216 were validated by the EQRO. This resulted in a reported and a validated rate of 0.21%, no bias observed.

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. Missouri Care was compliant with all specifications for sampling processes.

Submission of Measures to the State

Missouri Care submitted the Data Submission Tool (DST) for the HEDIS measure 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 MO HealthNet Quality Improvement Strategy. Missouri Care submitted data as requested for the June 30 MO HealthNet report.

Determination of Validation Findings and Calculation of Bias

As is shown in Table 12, no bias was found for the CIS3 measure, however, bias was observed in both the EDV and EDU measures.

Table 21 - Estimate of Bias in Reporting of Missouri Care HEDIS 2015 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunizations Status (Combination 3)	No bias	N/A
Emergency Department Visits - Medical	0.02%	Overestimate
Emergency Department Visits – Behavioral Health	0.01%	Overestimate
Emergency Department Visits – Substance Abuse	0.01%	Overestimate
Emergency Department Utilization - Medical	0.04%	Underestimate
Emergency Department Utilization – Behavioral Health	0.01%	Overestimate
Emergency Department Utilization – Substance Abuse	No bias	N/A

Source: BHC, Inc., 2015 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 13). The rate for the Childhood Immunization Status measure showed no bias and was therefore deemed Fully Compliant. The Emergency Department Visits and Emergency Department Utilization measures were found to be both under and overestimated, but still fell within 1% of the hits reported, so were deemed Substantially Compliant.

Table 22 - Final Audit Rating for Missouri Care Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status	Fully Compliant
Emergency Department Visits	Substantially Compliant
Emergency Department Utilization	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

Three rates were validated for the MCHP. The Childhood Immunizations Status rate was **higher** than the average for all MCHPs, the Emergency Department Visits measure was **lower** than the average for all MCHPs, and the Emergency Department Utilization rate was **lower** than the average for all MCHPs.

QUALITY OF CARE

MO Care's calculation of the Emergency Department Utilization measure was substantially compliant with specifications. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical; Behavioral Health; or Substance Use. This information is useful to the MCHPs to determine if the ED is being utilized properly by its members.

MO Care's rates for the EDU-Medical and Behavioral Health measures were lower than the average for all MCHPs, indicating that a lower percentage of MO Care's members are accessing the ED for Medical and Behavioral issues less often than that of the other MCHPs. MO Care's rates for the EDU-Substance Use measure was higher than the average for all MCHPs, indicating that a higher percentage of MO Care's members are accessing the ED for Behavioral Health and Substance Use issues than that of the other MCHPs.

ACCESS TO CARE

The Emergency Department Visit measure was rated as substantially compliant with specifications. This measure is as an Access to Care measure as it measures the number of ED

visits recorded for the MCHP. MO Care's rate for the EDV- Medical and Behavioral Health measure was lower than the average for all MCHPs, indicating that MO Care's members are accessing the ED for Medical and Behavioral issues at a rate lower than that of the other MCHPs. MO Care's rates for the EDV-Behavioral Health and EDV-Substance Use measure were higher than the average for all MCHPs, indicating that MO Care's members are accessing the ED for Substance Use issues more than that of the other MCHPs.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2015 Childhood Immunizations Status measure was fully 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 been previously audited by the EQRO in the last four review years.

MO Care 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 conduct and document statistical comparisons on rates from year to year.
2. Continue to participate in training of MCHP staff involved in the oversight of coordination of performance measure calculation.
3. Continue to perform hybrid measurement on those measures that are available for this method of calculation.
4. Continue to provide data in the format and file in which it is requested.

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 2015 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 23.

Table 23 - Comparison of MO Care Compliance Ratings for Compliance Review Years

Measure	2012	2013	2014	2015
Enrollee Rights and Protections	100%	100%	100%	100%
Access and Availability	88.24%	70.59%	82.35%	64.71%
Structure and Operations	100%	100%	100%	100%
Measurement and Improvement	90.91%	81.8%	90.91%	90.91%
Grievance Systems	100%	100%	100%	100%

Source: BHC, Inc., 2015 External Quality Review Compliance Validation

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 2014 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 2014, 2013, and 2012.

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 2015 review, MO Care was rated by the review team to have met 11 standards. This is an overall rating of 64.71%, which is **lower** than the 76.47%, rating received in 2014 and the 70.59% rating received in 2013.

The rating in this area is mostly attributable to the Case Management record review and the provider availability survey performed by the EQRO. In the Case Management review, the EQRO found that MO Care did not introduce case management; declined in including

assessments, care plans, and including or informing the PCP about the care plan. In lead case management the MCHP declined in providing face to face contacts; completing case notes; and making appropriate contacts with members. In the provider availability survey, the EQRO found that most of the providers listed on the MCHP's website were not taking new patients.

MO Care submitted required policy and procedures to MO HealthNet for their approval. In reviewing records and interviewing staff, the EQRO observed transition planning at case closure and providing care coordination improved over what was observed during the 2014 review.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2015 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 2014, 2013 and 2012. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the eighth 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, MO Care 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 MO HealthNet 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.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2015 review, MO Care was rated by the review team to have met 9 standards, one standard was rated as "Partially Met"; and two standards were found to be "Not Applicable". This is an overall rating of 90.91% compliance which is **consistent** with the 90.91% rating received in 2014 and 2012. It is higher than the 81.82% compliance rating received in 2013.

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.

MO Care did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation. These PIPs have areas that need improvement. The PIPs were well-constructed and responded to areas of member services in need of improvement.

All Performance Measurement data and medical records requested were submitted for validation within requested timeframes.

The rating for the Measurement and Improvement section reflects that all required policy and procedure had been submitted to MO HealthNet for their approval. It appeared that all practices 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 2015 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 consistent with the 100% rating received in 2012, 2013 and 2014.

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 eighth out of nine years that the MCHP has been 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 MO HealthNet in a timely and efficient manner.

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

- Failure to approve or report on face to face contacts in case management files.
- Not providing case management records as requested.
- Lead case management program.
- Provider availability issues regarding website accuracy and accepting new patients

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.

ACCESS TO CARE

MO Care 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.

However, the accuracy of the MO Care's website listings for providers is in need of attention. During a website accuracy and secret shopper survey the EQRO conducted for MO HealthNet, the EQRO found significant issues with the accuracy of provider information and availability on

the MCHP's website. Further information regarding the Website Accuracy Survey may be found at http://dss.mo.gov/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf.

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.
2. Consider training with Case Management staff regarding the requirements of lead case management.
3. Ensure that all relevant data is checked prior to submission to any auditing agency, and make regular test runs of data to identify any issues as early as possible.
4. Continue to develop and improve the multi-disciplinary approach to working with members that have complex health care issues.
5. Enhance provider websites and ensure accuracy of provider listings.
6. Improve adherence to case management policy including: providing face to face contacts; and informing PCPs regarding care plans.