Primaris
Healthcare Business Solutions

2018 External Quality Review

Compliance

home state health

Measurement Period: Calendar Year 2017

Validation Period: June-August 2018

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MoHealth Net

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Compliance with Medicaid Managed Care Regulations

1.0 Purpose and Overview

1.1 Background

The Department of Social Services, MO HealthNet Division (MHD) operates a Health Maintenance Organization (HMO) style Managed Care Program called MO HealthNet Managed Care. MHD contracts with Managed Care Organizations (MCOs) to provide health care services to Managed Care enrollees.

Effective May 1, 2017, Medicaid Managed Care (hereinafter stated "Managed Care") is operated statewide in Missouri. Previously, Managed Care was only available in certain regions (Central, Eastern, and Western). MHD extended the health care delivery program in the Central Region and added the Southwestern Region of the State in order to incorporate the Managed Care statewide extension for all the eligibility groups currently enrolled in MO HealthNet Managed Care. The goal was to improve access to needed services and the quality of health care services in the MO HealthNet Managed Care and state aid eligible populations, while controlling the program's cost.

The Managed Care Program enables Missouri to use the Managed Care System to provide Medicaid services to Section 1931 children and related poverty level populations; Section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. As of SFY2018 ending, total number of Managed Care enrollees in MO HealthNet were 712,335 (1915(b) and CHIP combined).

Home State Health, one of the three MCOs operating in Missouri (MO), shall provide services to individuals determined eligible by the state agency for the MO HealthNet Managed Care Program on a statewide basis in all Missouri counties in the following four (4) designated regions of the State of Missouri: Central, Eastern, Western, and Southwestern.

Home State Health services are monitored for quality, enrollee satisfaction, and contract compliance. MHD requires participating MCO to be accredited by the National Committee for Quality Assurance (NCQA) at a level of "Accredited" or better. An External Quality Review Organization (EQRO) evaluates MCO annually, as well.

MHD has arranged for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract. The Federal and State regulatory requirements and performance standards as they apply to MCOs are evaluated annually for the State in accordance with 42 CFR 438.310 (a) and 42 CFR 438.310 (b).

Primaris Holdings, Inc. (Primaris) is MHD's current EQRO, and started their five-year contract in January 2018. Their first year External Quality Review (EQR) covers Calendar Year (CY) 2017.

1.2 Description of Compliance with Regulations

The MCOs are audited annually 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. The EQR is conducted using the *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, Centers for Medicare and Medicaid Services Version 2.0, September 2012)* to meet the requirements of Code of Federal Regulations (CFR) 438.358(b) (iii). This section of the CFR requires a review to be conducted within the previous 3-year period, to determine the MCOs' compliance with standards set forth in subpart D of 42 CRF 438 and the quality assessment and performance improvement requirements described in § 438.330. These are listed as follows:

Subpart D-MCO, PIHP and PAHP Standards

§438.206 Availability of services;

§438.207 Assurances of adequate capacity and services;

§438.208 Coordination and continuity of care;

§438.210 Coverage and authorization of services;

§438.214 Provider selection;

§438.224 Confidentiality;

§438.228 Grievance and appeal systems;

§438.230 Subcontractual relationships and delegation;

§438.236 Practice guidelines; and

§438.242 Health information systems.

Subpart E-Quality Measurement and Improvement; External Quality Review

§438.330 Quality Assessment and Performance Improvement Program.

The overall goal of the Compliance with Standards review is to quantify Home State Health's adherence to the Federal and State requirements of offering:

- Quality Care;
- Highest level of Access to Care; and
- In a Timely Manner, for all of its Enrollees.

Figure 1: Federal Requirement for the MCO

Quality, (42 CFR 438.320 (2)), as it pertains to external quality review, means the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through:

(1) Its structural and operational characteristics.

(2) The provision of services that are consistent with current professional, evidenced-based-knowledge.

(3) Interventions for performance improvement.

Access, (42 CFR 438.320), as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care organizations successfully

demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).

Timeliness: Federal Managed Care Regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services.

For the EQR 2018 (CY 2017 review period), Primaris conducted an onsite compliance review for Home State Health on July 9 & 10, 2018. The evaluation of Compliance was done for the following Federal Regulations 42 CFR 438 (Figure 2):

- Overview of Compliance for Subpart D and Subpart E §438.330;
- §438.230 Subcontractual relationships and delegation;
- §438.236 Practice guidelines; and
- §438.242 Health information systems.

Figure 2: Compliance Evaluation for CY 2017

2.0 Methodology of Review

The primary objective of Primaris' review was to provide meaningful information to MO HealthNet and Home State Health regarding compliance with state and federal guidelines. Primaris collaborated with Home State Health and MHD to:

- Determine the scope of the review as well as the scoring methodology, data collection methods;
- onsite review agenda;
- Collect and review data and documents before, during and after the on-site review;
- Identify key issues through analyzing the data collected;
- Prepare the report related to the findings; and
- Review expectations for following calendar year audits.

The evaluation of Compliance was performed by requesting and analyzing policies and procedures, documentation, observations and on-site interviews.

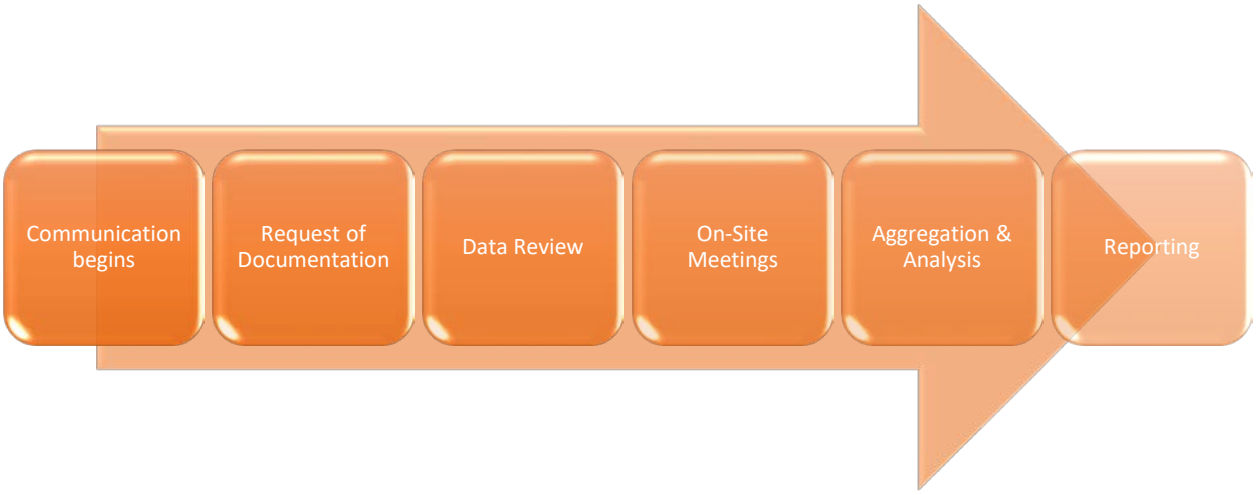


Figure 3: Process of Compliance Evaluation for Home State Health

Data collection tools were created based on MHD Managed Care Contract and 42CFR 438, subpart D for the three areas under evaluation (Ref: Table 4, 6, 8).

The sources used to confirm Home State Health's compliance with Federal regulations and State standards included the following:

- Procedures and methodology for oversight, monitoring, and review of delegated activities;
- Completed evaluations of entities conducted before delegation is granted;
- Ongoing evaluations of entities performing delegated activities;
- Practice Guidelines Adoption Manual, Policies and Procedures;
- Practice Guidelines Dissemination and Application Manual, Policies, and Procedures;
- Quality Assessment and Performance Improvement project descriptions, including data sources and data audit results Medicaid/CHIP and other enrollee grievance and appeals data;
- Analytic reports of service utilization;
- Information systems capability assessment reports;
- Policies and procedures for auditing data or descriptions of other mechanisms used to check the accuracy and completeness of data (internally generated and externally generated data) information system;
- Completed audits of data or other evidence of data monitoring for accuracy and completeness both for MCO data and information system; and
- Provider/Contractor Services policies and procedures manuals.

Home State Health submitted documentation via a secure website before and after the on-site visit to enable a complete and in-depth analysis of their Compliance Standard requirements.

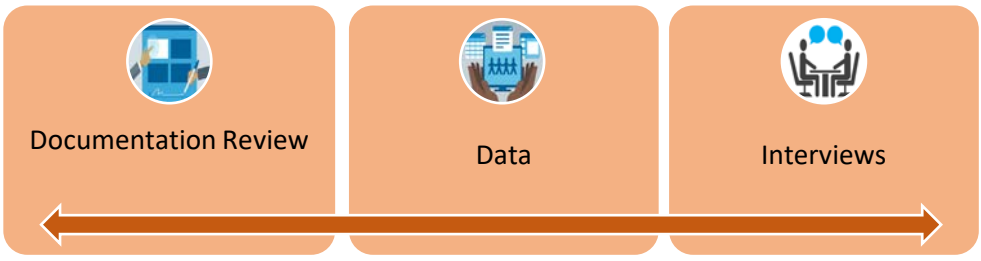


Figure 4: Sources of Information from Home State Health

On-Site Review Information

An on-site review was performed at Home State Health facility with the following people in attendance from Home State Health for an interactive session on ‘Compliance with Regulations’:

- Steve Jones, Senior Vice President, Operations; and
- Megan Barton, Vice President, Medical Management.

Table 2: MCO Information	
MCO Name:	Home State Health
MCO Location:	16090 Swingley Ridge Rd, Suite 300, Chesterfield, MO 63017
On-site Location:	16090 Swingley Ridge Rd, Suite 300, Chesterfield, MO 63017
Audit Contact:	Dana Houle
Contact Email:	Dhoule@Homestatehealth.com

During onsite visit, Primaris gave an overview of 'Compliance with Regulations for Managed Care' by explaining the procedure that would be followed for EQR in the coming years and the tentative areas under evaluation for the EQR 2019 (subjected to approval by MHD).
Home State Health was asked to describe in detail their policy and procedure for §438.228 Grievance and appeal systems.

Compliance Ratings

The information provided by Home State Health was analyzed based on the 42CFR 438, Managed Care Regulations for Compliance, and the MHD contract. An overall compliance score in percentage was given. All the sections in the tools were assigned 2 points each (denominator). They were scored as Met, Partially Met, or Not Met. Primaris utilized a Compliance Rating System defined in Table 2.

MHD and Home State Health may use the information and findings that resulted from Primaris' review to identify, implement and monitor interventions to improve the aspects of Quality, Timeliness and Access for Healthcare Services to its members.

Table 2: Compliance Rating System

●	**Met** (2 points): All documentation listed under a regulatory provision, or one of its components, was present. MCO staff could provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the MCO was in full compliance with regulatory provisions.
●	**Partially Met** (1 point): 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** (0 point): Incomplete documentation was present; and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

3.0 Performance Strengths and Areas Requiring Corrective Action

3.1 Summary of Overall Strengths and Areas Requiring Corrective Action

For CY 2017 Home State Health met all sections of Compliance Regulations, with an overall score of 100%. Home State Health was compliant in both technical review and completing the required steps with Primaris to gain the results of this review. However, it is recommended that two sections of Subcontractual Relationships and Delegation is updated (Table 4: 2b, 2c) to meet the requirements of New Managed Care Rules for CY 2018 review.

No regulatory standard was put on a corrective action plan during the previous year's EQR which required a review this year.

Table 3: Summary of Evaluation Home State Health: Compliance with Regulations

Standard	Standard Name	Number of Sections				Score	Score %
		Total	Met	Partial Met	Not Met		
§438.230	Subcontractual Relationships and Delegation	7	7	0	0	**14**	**100%**
§438.236	Practice Guidelines	6	6	0	0	**12**	**100%**
§438.242	Health Information Systems	7	7	0	0	**14**	**100%**
Total	**3**	**20**	**20**	**0**	**0**	**40**	**100%**

Compliance: Home State Health

Compliance Score % (combined for all three) = Total Score X100 = 100%

Total Sections X 2 points

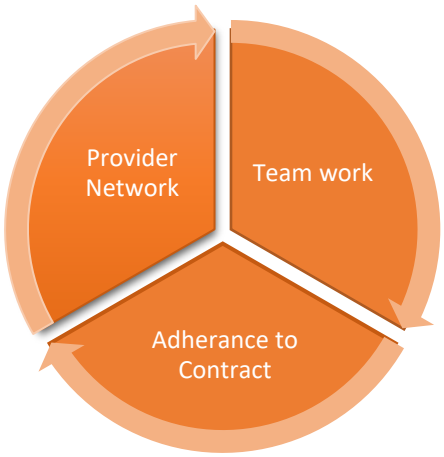


Figure 5: Strengths of Home State Health

Strengths

Home State Health appeared to be well organized and thorough in meeting their contractual requirements for "Compliance":

- A strong network of Providers working under the contractual terms to produce a large MCO covering the entire State of Missouri.
- Good communication between team members, including Compliance Committee, Medical Directors, Providers, Vendors, and Enrollees as well as MHD. Home State Health's Compliance Committee meets on a regular basis and monitors national healthcare organizations for good practice trends. There is dissemination of information down the line to the team in Home State Health.
- Well written documents/policies and procedures, contracts for sub delegations, Clinical Practice Guidelines, Information Systems reports in place.
- Excellent usage of electronic medical records and information tracking system.

Areas Requiring Corrective Action: None

3.2 Regulation I –Subcontractual Relationships and Delegation

Primaris understands that the date of applicability for this standard under the New Managed Care Rules (May 06, 2016) is for the contracts starting on July 01, 2017 or later. MHD Managed Care contract was awarded to the MCO on May 01, 2017. Since the EQR took place after July 01, 2018, more than a year following the date of applicability, the evaluation tool is based on the requirements under the New Managed Care Rules, for all the sections of "Subcontractual Relationships and Delegation." However, MHD did not include the requirement in its May, 2017 MCO contract. A subsequent amendment was made to adhere to the New Managed Care rule by July, 2018. Thus, the review focus was not applicable for CY 2017 and the expectation of all (MHD, MCOs and EQRO), is to have the EQRO rate the MCO on this standard in CY 2018.

For CY 2017, Primaris verified and reported the results (Table 4 and 5) as follows:

Table 4: Findings- Subcontractual Relationships and Delegation

Standard 8 – 42 CFR 438.230 Subcontractual Relationships and Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
1. If any of the MCO's activities or obligations under its contract with the State are delegated to a subcontractor— (i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. (ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the	Medical Transportation Management (MTM) Service Agreement – page 17 National Imaging Associates (NIA) MO Amendment – page 16 MTM Service Agreement – page 58 MTM Service Agreement – page 10 NIA MO Amendment – pages 22 and 26	● Met Partially Met Not Met

MCO's entity's contract obligations. (iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO determine that the subcontractor has not performed satisfactorily. (438.230 (c) (1)).		
Findings: Home State Health contracts specify provisions meeting all contractual requirements of the CFR. The examples provided demonstrate reporting responsibilities of the vendors in compliance with the State contract. There are remedies in place for unsatisfactory performance and/or termination of contracts to protect the MCO and State if the subcontractor has not performed satisfactorily. There is even a clause for insolvency or other cessation of operations, disenrollment, or fraud that may require remedy. **Required Actions:** None.		
2. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, agreeing that:		

Compliance: Home State Health

a. The State, CMS, the HHS Inspector General, or their designees, have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State.	MTM Service Agreement-page 8 NIA Service Agreement – page 10 NIA MO Amendment – page 27	● Met Partially Met Not Met
Findings: The NIA MO Amendment states that the provider shall allow the HMO and all other regulatory authorities to have access to their books, records, financial information, and any documentation of services of provided to members remaining in compliance with MO 354.600 and MO 354.636. NIA Service Agreement states that "Vendor shall, and shall require Participating Radiology Providers to, upon requests which comply with procedural prerequisites, provide the Comptroller General of the United States, the Secretary of the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the DOI, State Agency, and their designees or duly authorized agents, access to this Agreement, and those books, documents, subcontracts, and records as are deemed necessary by HMO or the government to verify the nature and extent of the costs of Medicaid or Medicare services, as applicable, provided to Covered Persons." **Required Actions:** None.		

b. The subcontractor will make available, for purposes of an audit, evaluation, or inspection (42 CFR 430.230(c)(3)(ii)) its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.	MTM Service Agreement – page 7 NIA Service Agreement – page 10 NIA MO Amendment – page 27	● Met Partially Met Not Met
Findings: Home State Health contract terms show that Providers will meet State contract standards to make available for audit: all books, records, payment history, and other information regarding Medicaid enrollees as needed according to the terms of Federal regulations. Home State Health has included in the MTM and NIA contracts that auditing can be done at any time including, but not limited to, confidential records pertaining to "any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the state." **Required Actions:** It is recommended that Home State Health should work with MHD to add the specific terminology of "computer or electronic systems" to cover all aspects of this requirement in their vendor agreements. It is currently implied that all records be accessible but the new CFR wording warrants a consideration of including these elements.		
c. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later (42 CFR 430.230(c)(3)(iii)).	NIA Mo Amendment – page 26 NIA Mo Amendment – page 27 MTM Service Agreement—page 46 MO COMP.21.Oversight of delegated vendors—page 2	● Met Partially Met Not Met

Compliance: Home State Health

Findings: In point 8 of the addendum of the NIA contract with Home State Health under "Compel to Furnish Records", the contract wording states: "As required by the agreement, Contracted Provider shall furnish to HMO all documentation required by HMO to monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of Contracted Provider to provide all Covered Services to Covered Persons." Point 13 d, Providers are to allow access to all records for a term of five years following the end of all contract terms. Similarly, MO COMP.21 document page 2 states access to all records for 7 years. Also, MTM Service Agreement on page 68 states 5 years, but page 46 mentions that "Provider must maintain all records and documentation, including driver logs, trip sheets, and billing reports pertaining to MTM services for ten (10) years, from the end of the calendar year during which services were provided, and retained further if the records are under review or audit until the review or audit is complete." **Required Actions:** It is recommended that Home State Health should work with MHD to align audit rights and related record retention duration to 10 years in all the delegated subcontractor contracts consistently at all places as per the new CFR.		
d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	MTM Service Agreement - page 8,9 NIA Service Agreement - page 10 NIA Mo Amendment - page 22 MO.COMP.16 FWA - page 2 MTM Mo Amendment – page 4	● Met Partially Met Not Met
Findings: Home State Health, in the NIA Amendment, states that "Provider shall comply with all fraud and abuse provisions outlined in the State Contract." In the MTM MO Amendment, the statement in point 8, Compel to Furnish Records, is made that the provider is to furnish all records as needed at any time. In the MTM Service Agreement, it is specified that even in the case of contract termination, access must be given to the HMO for all records at any time.		

Compliance: Home State Health

MTM Service Agreement states that "Upon reasonable notice, Vendor shall cause Vendor Providers to cooperate with any inspections of the Vehicles, if and when requested by HMO, accreditation bodies, or by authorized government officials, including, but not limited to, the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, the DOI, and applicable State or federal agency(ies) with jurisdiction over HMO and/or responsibility for the administration of a government-sponsored program. In connection with any such inspection, Vendor shall cause Vendor Providers to furnish inspectors with such documents, data or other information as may be required to evidence Vendor Providers' compliance with this Agreement or as otherwise requested by the applicable regulatory body." **Required Actions:** None.		
3. Any subcontracts for the products/services described herein must include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by the health plan and the State of Missouri and to ensure that the State of Missouri is indemnified, saved, and held harmless from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract in those matters described in the contract between the State of Missouri and the health plan (MO	MTM Service Agreement - page 11 NIA Service Agreement – page 14	● Met Partially Met Not Met

HealthNet Managed Care Contract section 3.9).		
Findings: In Home State Health subcontractor agreements, the Indemnification clause spells out these contract terms with clarity to protect MHD and Home State Health from harm. It includes attorney's fees. **Required Actions:** None.		
4. Health Plan Disputes With Other Providers: All disputes between the health plan and any subcontractors shall be solely between such subcontractors and the health plan. The health plan shall indemnify, defend, save, and hold harmless the State of Missouri, the Department of Social Services and its officers, employees, and agents, and enrolled MO HealthNet Managed Care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of the contract because of any breach of the contract by the health plan, its subcontractors, agents, providers, or employees, including but not limited to any	MTM Service Agreement – pages 11 and 13 NIA Service Agreement – pages 14 and 16	● Met Partially Met Not Met

negligent or wrongful acts, occurrence or omission of commission, or negligence of the health plan, its subcontractors, agents, providers, or employees (MO HealthNet Managed Care Contract 3.9.1).		
Findings: Home State Health subcontractor contracts appear to fully indemnify the State and hold harmless any other parties of the government in an appropriate manner to cover negligence or wrongful acts that might harm any party involved as third parties to the subcontractor relationship. **Required Actions:** None.		

Table 5: Compliance Score-Subcontractual Standards and Delegation						
Total	Met	=	7	X 2	=	14
	Partial Met	=	0	X 1	=	0
	Not Met	=	0	X 0	=	0
Numerator	Score Obtained				=	14
Denominator	Total Sections	=	7	X 2	=	14
Score						**100%**

3.2.1 Performance Strengths

Home State Health did an excellent job of providing data, documentation, and verbal confirmation for their Compliance processes. The staff is knowledgeable and assisted in gathering all necessary information. They have detailed requirements of their vendors which cover the quality, timeliness and accessibility concerns of these standards. Their contracts include additional safeguards to protect the State from liability and provide open access to providers' medical records and other needed information while still maintaining HIPAA requirements.

3.2.2 Areas Requiring Corrective Action

There is no area of concern for which corrective action plan is required. However, Primaris recommends Home State Health to work with MHD to consider updating the language as per section 2b and 2d to fully comply with Managed Care Regulations (ref. Table 4 and 6.0 Recommendations).

3.3 Regulation II—Practice Guidelines

Home State Health must have evidence-based, clinical practice guidelines in the areas of chronic and preventive care as well as behavioral health.

Table 6: Findings-Practice Guidelines

Standard 9 - 42 CFR 438.236 Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
Practice Guidelines (MO HealthNet Managed Care Contract 2.18.5)		
1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	Preventative Health and Clinical Practice Guidelines Adopted Clinical Practice and Preventive Health Guidelines (Quality Improvement (QI) Policy_MO.QI.08)– page 2	● Met Partially Met Not Met
Findings: Home State Health has a committee of board certified physicians who make practice guidelines based on a consensus of many outside widely viewed experts in their appropriate fields. Home State Health QI designee, in coordination with the Corporate Clinical Policy Committee (CPC), is responsible for the research of evidence-based guidelines. Home State Health adopts preventive and clinical practice guidelines (CPG) from recognized sources, for the provision of acute, chronic and behavioral health services relevant to the		

populations served. Practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. Guidelines are presented to Home State Health Quality Improvement Committee (QIC) for appropriate physician review and adoption then disseminated to other teams. **Required Actions:** None.		
2. Consider the needs of the members;	Adopted Clinical Practice and Preventive Health Guidelines – page 2	● Met Partially Met Not Met
Findings: Home State Health update their guidelines at least every two years and prioritizes top goals based on member utilization. They also have procedures in place to give members access to practice guidelines. Home State Health also tracks member engagement and utilization to create updates and new programs as appropriate. **Required Actions:** None		
3. Are adopted in consultation with contracting health care professionals;	Adopted Clinical Practice and Preventive Health Guidelines – page 3	● Met Partially Met Not Met
Findings: Home State Health utilizes a team of providers, including some contractors, to create the practice guidelines and then disseminates them to the rest of the providers. There is a provision for discussion when necessary if policy contradicts provider ideals. **Required Actions**: None		
4. Are reviewed and updated periodically as appropriate; and	Adopted Clinical Practice and Preventive Health Guidelines – page 3 Quality Assessment and Performance Improvement (QAPI) Program Description – page 15	● Met Partially Met Not Met
Findings: Home State Health indicates that their practice guidelines are updated as changes are made and reviewed in its entirety at least every two years.		

Required Actions: None.		
5. Are disseminated to all affected providers, and upon request, to members and potential members.	Adopted Clinical Practice and Preventive Health Guidelines – page 3	● Met Partially Met Not Met
Findings: The CPC meets to create changes to the practice guidelines. Home State Health indicated that they pass these updates along to the providers on a timely basis, including new providers insuring none are missed. There are provider communications and postings to the provider portal as changes to practice guidelines are implemented. Call center advocates are trained for member purposes. There is a member process to make sure members are aware of practice guidelines. **Required Actions:** None.		
b. The health plan shall ensure that decisions for utilization management, member education, coverage of services, & other areas to which the guidelines apply are consistent with practice guidelines.	Adopted Clinical Practice and Preventive Health Guidelines – page 3	● Met Partially Met Not Met
Findings: Home State Health utilizes evidence-based clinical practice guidelines, preventive health guidelines, and/or other scientific evidence, as applicable, in the development, implementation and maintenance of clinical decision support tools used to support utilization and care management. **Comment**:MHD Quality Improvement Strategy requires the MOC to have Clinical Practice Guidelines for 1. Inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, 2. Psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, Home State Health must use the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). Home State Health submitted Annual UM Program Evaluation (Information on		

page 8) and document Specialty Pediatric Hospital Screening Criteria. These were found to be complaint with MHD requirements

Required Actions: No actions are required for compliance, however it is **recommended** that MHD and all MCOs in MO collaborate for some of the CPGs related to high risk conditions/diseases prevalent in their member population.

Table 7: Compliance Score: Practice Guidelines						
Total	Met	=	7	X 2	=	14
	Partial Met	=	0	X 1	=	0
	Not Met	=	0	X 0	=	0
Numerator	Score Obtained				=	14
Denominator	Total Sections	=	7	X 2	=	14
Score						**100%**

3.3.1 Performance Strengths

Home State Health has a clear understanding of the Practice Guidelines requirement as shown through their Compliance policy. They utilize many nationally recognized authorities for basis of the guidelines and update them on a two yearly basis or sooner, for any updates. The process of disseminating information through the agency and provider network appears accessible and timely. Enrollees can access this information through a helpline if required.

3.3.2 Areas Requiring Corrective Action

There are no areas of concern.

3.4 Regulation III—Health Information Systems

In order to meet the contract compliance for this standard, Home State Health should show

effective use of a health information system for the purposes of tracking enrollee information, maintaining privacy, and tracking member utilization.

For this EQR 2018, Primaris did a complete evaluation of Information Systems Capabilities Assessment (ISCA) for Home State Health and a separate report is generated for submission to MHD.

Table 8: Findings- Health Information Systems

Standard 10 – 42 CFR 438.242 Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
1. The MCO maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data (§438.242(a)).	QI Policy_QI.MO.01 – page 31	● Met Partially Met Not Met
Findings: Home State Health maintains health records in accordance with data reporting and collection rules. They require providers to maintain records following privacy act requirements and audit at a minimum of every three years. **Required Actions:** None.		
2. The MCOs health information system provides information on areas (42 CFR 242(a))including:		
a. Utilization.	Annual Quality Assessment and Performance Improvement Program Evaluation – Page 9	● Met Partially Met Not Met

	Annual Quality Assessment and Performance Improvement Program Evaluation – Page 13	
Findings: Home State Health tracks member utilization information through its health maintenance information systems. They track membership numbers quarterly, access to care, timeliness, and other characteristics of members and report information tracked. Home State Health studies member utilization needs such as: languages spoken, cultural backgrounds, age and gender, and other demographics. **Required Actions:** None.		
b. Grievances and appeals.	Home State HealthMOv3memberhandbook2018613.pdf – page 29	● Met Partially Met Not Met
Findings: Home State Health Member Handbook details how grievances and appeals are filed following the regulatory requirements for the collection, acknowledgment, notification, investigation, resolution, timeliness and reporting of complaints/grievance and appeals as well as a follow up with member grievances and appeals. It identifies the time frames to file a grievance and how to file for a State Hearing when that is warranted. **Required Actions**: None		
c. Disenrollment for other than loss of Medicaid eligibility.	Home State HealthMOv3memberhandbook2018613.pdf – page 45	● Met Partially Met Not Met
Findings: Home State Health Member Handbook explains to members ways that they can be disenrolled other than loss of eligibility. Some ways of losing coverage are through: member choice, member noncompliance, member relocation or reassignment to another plan such as foster care, and the member could lose coverage due to behaviors that could cause the provider to request the member to be removed. There are limited reasons that a member cannot be disenrolled and a process by which the MCO has to notify the patient (while inpatient). **Required Actions**: None.		

3. The MCO collects data on:		
a. Enrollee characteristics.	Annual Quality Assessment and Performance Improvement Program Evaluation – Page 13	● Met Partially Met Not Met
Findings: Home State Health conducted two population assessments in 2017. Their findings included: area growth due to doubling in population during the calendar year, membership age range, membership nationalities served, patient language needs, and member participation according to varying ratios. **Required Actions**: None.		
b. Services furnished to enrollees.	Annual Quality Assessment and Performance Improvement Program Evaluation – Page 19 Annual Quality Assessment and Performance Improvement Program Evaluation – Page 20	● Met Partially Met Not Met
Findings: Home State Health's Health Information System is used to track services provided to enrollees and documented for studies throughout the year. Initiatives were noted such as follow up on emergency department (ED) visits, dental exams, immunizations for children, lead toxicity studies, and data collected from the HIS. Also noted was additional information such as tracking the texting program, transportation for members to visits, and telephonic outreach. **Required Actions**: None.		
4. The MCOs health information system includes a mechanism to ensure that data received from providers are accurate and complete by:	Annual Quality Assessment and Performance Improvement Program Evaluation – Page 90	● Met Partially Met Not Met

• Verifying the accuracy and timeliness of reported data. • Screening the data for completeness, logic, and consistency. Collecting service information in standardized formats to the extent feasible and appropriate. • Making all collected data available to the State and upon request to CMS (42 CFR 438.242(b) (2), 42 CFR 438.242(b) (3)).		
Findings: Home State Health has enacted a provision to audit the provider's records at a minimum of every three years and requires them to be open to audit at any time by any State agent per the contractual agreement. They utilize a complex Management Information System called Centelligience to monitor accuracy, collect data, and communicate across departments using six separate platforms that speak to one another to relay necessary information and ensure data correctness. **Required Actions**: None.		

Table 9: Compliance Score: Health Information Systems						
Total	Met	=	7	X 2		14

Compliance: Home State Health

	Partial Met	=	0	X 1		0
	Not Met	=	0	X 0		0
Numerator	Score Obtained					14
Denominator	Total Sections	=	7	X 2		14
Score						**100%**

3.4.1 Performance Strengths

Home State Health has detailed documentation of their MCO health information system. They track appropriate member demographics, utilization and member enrollment information as required by the contract terms. This information is readily available and stratified by region and enrollee usage. They offer additional tracking statistics by the State such as enrollee language spoken, cultural demographics, and age/gender dispersion. Member utilization is well documented and applied to other areas of Home State Health to improve the quality of care throughout Home State Health.

3.4.2 Areas Requiring Corrective Action

There are no areas of concern for this review.

4.0 Corrective Action Plan (CAP) Process

Table 10 is used to define the noted areas of concern (if any) during the EQR 2018 and the need to take corrective actions by Home State Health:

Compliance: Home State Health

Table 10: Key Findings and Audit Results for Home State Health			
Compliance Standard	**Key Review Findings**	**Number of sections Met**	**Audit Results**
Subcontractual Relationships and Delegation	No concerns were identified however two sections 2b, 2c needs an update*	7/7	Met
Practice Guidelines	No concerns were identified	6/6	Met
Health Information Systems	No concerns were identified	7/7	Met

***** Recommendations Section 6.0

5.0 Conclusions

5.1 Issues and Key Drivers

Issues identified by Home State Health

- Home State Health alleged that the 834 file for member eligibility received from MHD, has about 60% of missing/incomplete/erroneous data related to members' primary demographic information. These unusable data elements do not get updated by the correct member information obtained from various other sources by the MCO. Consequently, it impacts the quality of Care Management provided to Home State Health members.
- Home State Health reported the difficulty in tracking members who change their locations and phone numbers rapidly. Their electronic medical records are not updated with the current member information, thus Home State Health loses track of their patients.
- There are many providers over a large area (the entire state of Missouri) with multiple EMRs. Keeping their data current, keeping them informed of current practice trends, and gaining information back from them is often difficult. Not all providers see the need to update information or reach out to Home State Health, thus shifting the communication burden on Home State Health primarily.

- Compensation rates are often lower than other Health Insurance Managed Care Plans, so the providers choose to favor others instead of Medicaid.
- Some of the providers fill appointments quickly creating a barrier to access to timely care.
- Some of the providers complain that they are bound to have a contractual relationship with MHD/MCO to provide services to enrollees. They have to wait to get paid for their services.

Key Drivers

- Updated knowledge and staying vigilant about regulatory compliance standards.
- Strong collaboration with the State and Federal body in region VII.
- Strong provider network and dissemination of updates related to CPGs, Regulations for Medicaid Managed Care.
- Excellent data tracking through their IT systems.
- Increase in Medicaid Reimbursement rate.
- Staff training and education.
- Ongoing monitoring: it provides a process to assess organizational performance against regulatory requirements and established internal performance standards. Also, provides guidance and standards for monitoring plan activities such as claims processing, customer service, and enrollment functions.

5.2 Quality, Timeliness, and Access to Healthcare Services

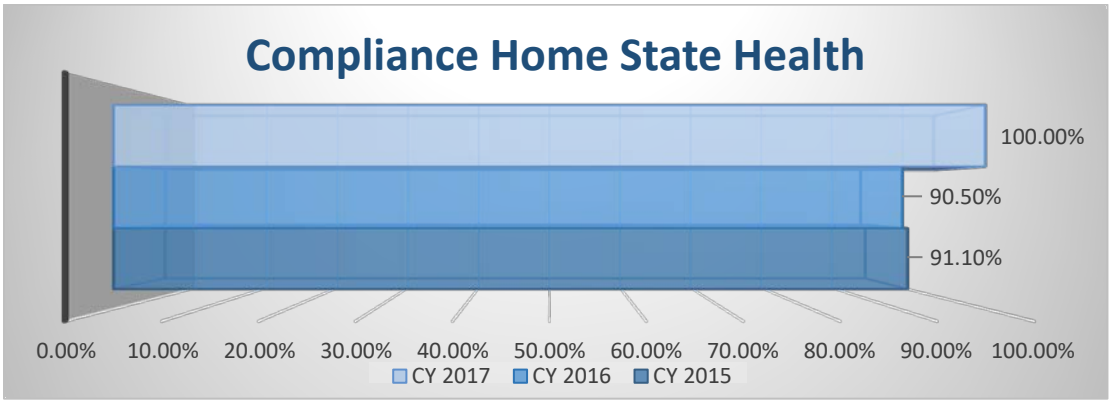
- MHD Managed Care expanded in midyear CY 2017 to cover the entire state by adding a significant area to extend the Central Region and a new Southwest Region. This increased their number of members to almost double which was a great challenge for Home State Health. However, they could succeed in increasing their compliance score to 100%.
- Their overall Compliance Score was increased by 9.5% point despite the additional enrollees.

- They continue to track additional member data to increase their knowledge of member utilization.

5.3 Improvements by Home State Health

- From Figure 6, it is evident that Home State Health has increasing compliancy with the Federal and State rules and regulations. There is a 9.5% point increase from previous calendar year.
- Home State Health was not placed on CAP by the EQRO for CY 2016 and neither did Primaris initiate a CAP for the CY 2017.

Figure 6: Comparative Compliance Scores for CY 2015-CY 2017



6.0 Recommendations

Suggested recommendations include the following:

- In Subcontractual Relationships and Delegation, 2b, Home State Health should work with MHD to consider adding the specific terminology of “computer or electronic systems” to cover all aspects of this requirement in their vendor agreements. It is currently implied that all records be accessible but the CFR wording warrants a consideration of including these elements.
- Subcontractual Relationships and Delegation, 2c, states, “ the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any

audit, whichever is later (42 CFR 430.230(c) (3) (iii)).” Home State Health should work with MHD to align audit rights and related record retention expectations and it is recommended that the 10 years duration be specified in all the delegated subcontractor contracts.

- Regarding Health Information Systems, member information is captured daily through the state’s enrollment file. The information is often inaccurate since this member population tends to be mobile. Providers, Care Managers, and Medicaid member enrollment brokers should assist in providing current information about the members so as to keep the records as updated as possible thus enabling increased member access to care.
- MHD and all MCOs in MO should collaborate for some of the CPGs related to high risk conditions/diseases prevalent in their member population. This would bring consistencies in medical management. As the member population switches between the MCOs on a frequent basis for varying reasons, their treatment plan would (potentially) not get affected.