Primaris
Healthcare Business Solutions

2018 External Quality Review

Annual Technical Report

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MoHealth Net

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1.0 Executive Summary

1.1 Purpose of Report

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).

MHD contracted with three MCOs under the new contract effective May 01, 2017: Home State Health, Missouri Care, and UnitedHealthcare. The MCOs 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 designated regions of the state of Missouri: Central, Eastern, Western, and Southwestern.

The MCOs' services are monitored for quality, enrollee satisfaction, and contract compliance. MHD requires participating MCOs 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 an 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 in accordance with 42 CFR 438.310 (a) and 42 CFR 438.310 (b). The EQR should result in a detailed annual technical report

that summarizes findings of access, timeliness and quality of care including all elements described in 42CFR 438.364(a).

Primaris Holdings, Inc. (Primaris) is MHD's current EQRO, and started its five-year contract in January 2018. To comply with the federal requirements, Primaris aggregated and analyzed Home State Health's and Missouri Care's performance data across mandatory and optional activities to prepare an Annual Technical Report. Based on MHD-EQRO contract 2.3.1(6)), UnitedHealthcare was not due for an annual review during EQR 2018. UnitedHealthcare was newly contracted on May 1, 2017, as a third MCO, and did not cover a full period of CY 2017. However, a Technical Assistance (TA) was provided onsite (July 23, 2018) to cover all the activities due for a review in EQR 2019. A separate report on 'TA for UnitedHealthcare' is submitted to MHD.

1.2 Overview of External Quality Review (EQR)

External quality review means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or their contractors furnish to Medicaid beneficiaries.

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.

Figure 1-1 Federal Requirement for the MCO

Primaris conducted an EQR 2018 for the two MCOs: Home State Health and Missouri Care. The first year covered CY 2017. The information used to carry out the EQR was obtained from 42 CFR 438.358, the protocols established by Secretary in accordance with 438.352 (ref: protocol 1, 2, 3, Appendix 5 of Centers for Medicare and Medicaid Services Version 2.0, September 2012) and MHD Managed Care Contract.

The EQR 2018 started in June and continued through August 2018 for Home State Health and Missouri Care. The evaluation was performed by requesting and analyzing policies and procedures, documentation, observations and on-site interviews.

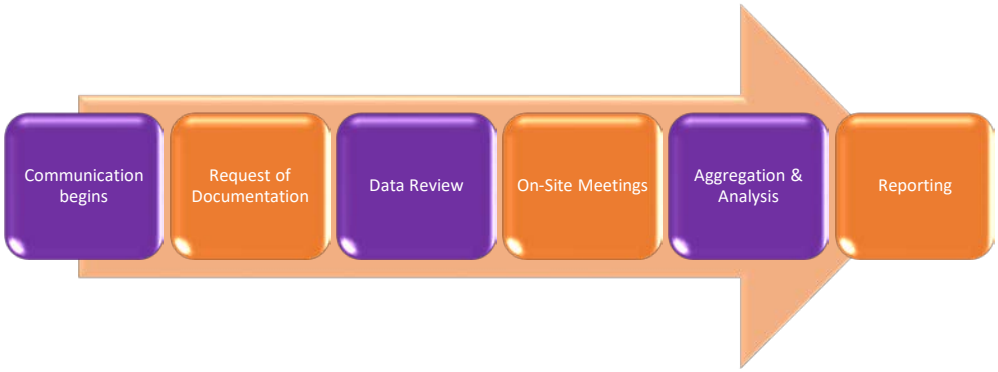


Figure 1-2 Process/Timeline of EQR for Home State Health and Missouri Care

This report includes Primaris' analysis and evaluation of the following activities for Home State Health and Missouri Care:

Mandatory

1. Compliance with Medicaid Managed Care Regulations.

2. Validation of Performance Measures (PMs).
   Information Systems Capabilities Assessment (ISCA).
3. Validation of Performance Improvement Projects (PIPs).

Optional

Care Management (CM) Review.

1.3 Overall Activities, Analysis and Recommendations

1.3.1 Compliance with Medicaid Managed Care 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. Section of the CFR 438.358(b) (iii), 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

§438.330 Quality Assessment and Performance Improvement Program.

During the EQR 2018, Primaris conducted a compliance review to evaluate Home State Health and Missouri Care for the following Federal Regulations 42 CFR 438 (Figure 3):

- 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 1-3 Compliance Evaluation for CY 2017

Compliance Ratings

The information provided by the MCOs was analyzed based on the 42CFR 438, Managed Care Regulations for Compliance, and 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 used a Compliance Rating System defined as follows (Table 1-1):

Table 1-1 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.

Analysis

Findings

- In EQR 2018, for the CY 2017, both Home State Health and Missouri Care met all sections evaluated for Compliance with an overall score of 100% (Table 1-2, 1-3).
- No regulatory standard was put on a corrective action plan during the previous year's EQR which required a review this year.
- None of the MCOs were put on a corrective action plan for EQR 2018.

Table 1-2 Summary of Evaluation-Compliance with Regulations: Home State Health

Standard	Standard Name	Total Sections	Score	Score %
§438.230	Subcontractual Relationships and Delegation	7	14	**100%**
§438.236	Practice Guidelines	6	12	**100%**
§438.242	Health Information Systems	7	14	**100%**
Total	**3**	**20**	**40**	**100%**

Compliance Score % = $\frac{\text{Total score X 100}}{\text{Total sections X 2 points}}$ = 100%

Table 1-3 Summary of Evaluation Missouri Care: Compliance with Regulations

Standard	Standard Name	Total Sections	Score	Score %
§438.230	Subcontractual Relationships and Delegation	7	14	**100%**
§438.236	Practice Guidelines	6	12	**100%**
§438.242	Health Information Systems	7	14	**100%**
Total	**3**	**20**	**40**	**100%**

Compliance Score % (combined for all three) = $\frac{\text{Total score X100}}{\text{Total Sections X 2 points}}$ = 100%

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 and Missouri Care. However, they both could succeed in increasing their compliance score to 100%.
- The overall Compliance Score of Home State Health and Missouri Care increased by 9.50% point from the CY 2016 despite the additional enrollees.
- Both MCOs continue to track additional member data to increase their knowledge of member utilization.
- There is a strong network of Providers working under the contractual terms to produce large MCOs covering the entire State of Missouri.
- Good communication exists between team member, including Compliance Committee, Medical Directors, Providers, Vendors, and Enrollees as well as MHD. MCOs' 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 the MCOs.
- Well written documents/policies and procedures, contracts for sub delegations, Clinical Practice Guidelines, Information Systems reports are in place.
- There is an excellent usage of electronic medical records and information tracking system.

Recommendation

Home State Health is recommended to update two sections from the evaluation tool (Table 3-2: 2b, 2c) used for Subcontractual Relationships and Delegation whereas Missouri Care is required to update one section (Table 4-2: 2c) based on the New Managed Care Rules for CY 2018 review. These Tables are placed in section 3.0 for Home State Health and 4.0 for Missouri Care.

1.3.2 (A) Validation of Performance Measures (PMs)

Validation of performance measures is one of three mandatory External Quality Review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. Primaris validated a set of performance measures identified by MHD (Table 1-4) that were calculated and reported by the MCOs for their Managed Care population. MHD identified the measurement period as CY 2017. Primaris conducted the validation in accordance with the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September, 2012.

Table 1-4 Performance Measures

Performance Measure	Method	Specifications Used	Validation Methodology
Prenatal Post-Partum Care (PPC)	Hybrid	HEDIS/MHD	Medical Record Validation
Emergency Department Visits (EVD)	Admin	MHD	Primary Source Verification
Emergency Department Utilization (EDU)	Admin	MHD	Primary Source Verification

Primaris' analysis of the performance measures included document reviews, staff interviews and onsite examination of information systems, processes and medical chart reviews. The information systems review examined how each managed care organization (MCO) captured and housed data for its members, its members' medical claims and its network and non-network providers. The EQRO team additionally reviewed how the MCOs integrated each system and used the data to produce the measures under review.

Various system demonstrations and queries were utilized to determine compliance with the performance measurement requirements.

Primaris utilized several documents to determine compliance with the performance measurement requirements:

- ISCA was reviewed to determine capabilities and data integration strategies.
- Policies and procedures surrounding systems capabilities and data management were collected and reviewed to determine if MCOs' objectives were consistent with MHD's expectations.
- NCQA's Data Submission Tool as submitted by each MCO for HEDIS 2018 (PPC Measure) was collected to determine if the measure was reportable by NCQA auditors.
- Inovalon's NCQA certification report for Prenatal and Post-Partum Care for HEDIS 2018 was collected to determine if the measure was certified by the approving authority and used by the MCOs.
- Inovalon's QSI software production logs was collected to determine if there were any issues with the production of the rates.
- MHD's EDV and EDU measure specifications were utilized as the basis to ensure the MCOs complied with the specification's intent.
- Medical charts for Prenatal Post-Partum Care (PPC) to determine compliance with the numerator events collected by each MCO.

Both MCOs were required to report the EDV and the EDU measures using the administrative method for reporting. The administrative method of reporting included services identified through claims submission only. For the EDV and EDU measures, a claim submission was required to be submitted to be counted in the numerator. A numerator event or positive "hit" was determined by comparing the claim information against the HealthNet specifications for each measure.

The MCOs utilized the same certified measures software vendor (Inovalon) to create the EDV and EDU measure counts, numerators and denominators. Primaris verified that the certified measures software captured the requirements as outlined in the Health Care Quality Data Instructions CY 2017 specifications for data elements 6.01-6.48.

Analysis

Findings

The performance measurement validation team reviewed samples (15) of administrative data and medical records (45) to verify the accuracy of the three measures under review. All three measures were found to be compliant and received a 'Met' designation.

Table 1-5 Key Review Findings and Audit Results for Home State Health and Missouri Care		
Performance Measures	**Key Review Findings**	**Audit Results**
Prenatal Post-Partum Care (PPC)	No concerns were identified	Met
Emergency Department Visits (EDV)	No concerns were identified.	Met
Emergency Department Utilization (EDU)	No concerns were identified	Met

EDV and EDU Measure

The EQRO conducted primary source verification, using a randomly selected set of numerator positive members for each measure, to determine compliance with the specifications. The rates for the EDV and EDU measure were verified through stepping through the claims and verifying the emergency room event, dates of service, diagnosis and revenue codes and patient age. Primary source verification on a randomly selected set of members ensures confidence in the reporting. The random selection verified for both MCOs resulted in 100% accuracy (Table 1-6).

Table 1-6 EDU and EDV Primary Source Verification Results – Home State Health and Missouri Care		
Measure Name	**Records Selected for Review**	**Records Passed Primary Source Verification**
EDU	15	15
EDV	15	15

EDU Measure

The Table 1-7 shows the ED utilization certified counts for Home State Health and Missouri Care. Both MCOs had relatively the same experience in each age cohort for ED utilization for mental health, substance abuse. However, Home State Health had more members in the ED for medical reasons than did Missouri Care.

Table 1-7 Emergency Department Utilization (EDU)						
Age	Mental Health		Substance Abuse		Medical	
	Home State Health	Missouri Care	Home State Health	Missouri Care	Home State Health	Missouri Care
0-17	936	984	94	108	76,260	68,503
18-64	842	888	452	511	26,244	24,801
65+	0	0	0	0	0	3
Total	1,778	1,872	546	619	102,504	93,307

EDV Measure

Members having an emergency department visit for medical reasons was significantly higher in Home State Health for the 0-17 age range (127,842) than did Missouri Care (75,149). All other age cohorts seemed to be consistent between both MCOs.

Table 1-8 Emergency Department Visits (EDV)						
Age	Mental Health		Substance Abuse		Medical	
	Home State Health	Missouri Care	Home State Health	Missouri Care	Home State Health	Missouri Care
0-17	1,367	1,420	103	117	127,842	75,149
18-64	1,221	1,245	590	632	56,713	52,491
65+	0	0	0	0	0	0
Total	**2,588**	**2,665**	**693**	**749**	**184,555**	**127,640**

Follow Up Emergency Department Visit for Mental Health

The compliance for follow up visits for members seeking mental health services in the emergency department (ED) was greater in the 30 day than in the 7 day timeframe. For Home State Health, the 30 days follow up rate was 37.28% versus 7 day follow up rate of 22.96%. Similarly for Missouri Care the 30 days follow up rate was 41.91% versus 7 day follow up rate of 27.01% (Table 1-9).

Table 1-9 Follow Up Emergency Department Visit for Mental Health- Home State Health & Missouri Care				
Age	**Home State Health**		**Missouri Care**	
	Rate 7	**Rate 30**	**Rate 7**	**Rate 30 day**
0-12	26.80	44.96	33.74	52.28
13-17	31.66	45.79	33.85	50.11
18-64	16.02	28.67	19.34	31.60
65+	0.00	0.00	0.00	0.00
Total	**22.96**	**37.28**	**27.01**	**41.91**

Emergency Department Follow up - Substance Abuse

Home State Health and Missouri Care rates were less than 20% for follow up EDV-substance abuse after 7 days and 30 days (Table 1-10). The rates reported for EDV measure was considered invalid by EQRO in the previous year, so there is no data available to assess progress.

Table 1-10 Follow Up Emergency Department Visit for				
Age	**Home State Health**		**Missouri Care**	
	Rate 7	**Rate 30**	**Rate 7**	**Rate 30 day**
0-12	9.09	9.09	8.33	8.33
13-17	2.70	5.41	13.51	14.86
18-64	11.03	16.20	13.39	18.75
65+	0.00	0.00	0.00	0.00
Total	**9.78**	**14.48**	**13.30**	**17.98**

PPC Measure

For the Prenatal Post-Partum validation, the team randomly selected 45 numerator positive records from the total numerator positive records abstracted during the HEDIS medical record validation process. The records selected were a combination of prenatal and post-partum numerator positive hits. These records were used to evaluate the abstraction accuracy and to validate the rates submitted for the PPC measure. Both MCOs successfully passed the medical record review validation without issue.

The MRR findings and final results are presented in Table 1-11, 1-12.

Table 1-11 2018 MRRV Results – Home State Health and Missouri Care			
Performance Measure	**Sample Size**	**Findings**	**Results**
Prenatal Post-Partum Care	45	45/45 Compliant	Pass

Table 1-12 PPC Rates Statewide and Region vide for Home State Health and Missouri Care						
Prenatal and Postpartum Care	**MCO**	**Aggregate**	**Central**	**East**	**West**	**Southwest**
Timeliness of Prenatal Care	***Home State Health***	**87.76%**	**90.45%**	**85.64%**	**73.35%**	**94.40%**
	Missouri Care	**81.51%**	**87.59%**	**79.56%**	**76.40%**	**92.94%**
Postpartum Care	***Home State Health***	**73.72%**	**75.22%**	**67.40%**	**66.01%**	**75.43%**
	Missouri Care	**57.18%**	**63.26%**	**54.26%**	**61.07%**	**68.61%**

Timeliness of Prenatal Care

Home State Health performed highest in the Central and Southwest regions at 90.45% and 94.40% respectively. Missouri Care also saw its best performance in the Central and Southwest regions at 87.59% and 92.94% respectively, compared to the East and West regions. The West region performed lowest overall for both MCOs.

Postpartum Care

Both MCO's performed best in the Southwest region, with Home State Health at 75. 43% and Missouri Care at 68.61% followed by the Central region at 75.22% for Home State Health and 63.26% for Missouri Care, leaving the East and West behind.

Quality, Timeliness and Access to Healthcare Services

- Home State Health and Missouri Care have no barriers to emergency care services nor for prenatal and post-partum care. Both the MCOs do not require authorization for access to either service.
- Home State Health and Missouri Care were able to demonstrate its ability to capture the specific diagnosis codes for each EDV and EDU visit/service.

Recommendations

- The MCOs should implement strategies to engage members in maternity care through outreach campaigns once they become aware of a pregnancy. MCOs should engage providers and immediately begin care management for pregnant members and encourage them to attend prenatal and post-partum care services.
- The MCOs should develop a process for capturing and housing current member demographic information collected through its provider network. Providers, often-times primary care physicians or urgent/emergent care centers should collect the most recent address and phone number information from the member. MCOs would benefit from setting up a process for capturing this pertinent information from the most recent office visit. Information from providers could be shared with MCOs on a case by case basis or more frequently to enhance its information currently processed through the daily enrollment files.
- Members should be encouraged to divert from ED to urgent care setting for non- emergent care services.

1.3.2 (B) Information Systems Capabilities Assessment

Primaris assessed Home State Health and Missouri Care's Information Systems, Resource Management, Data Processing, and Reporting Procedures. The purpose was to analyze interoperability and reveal the extent to which their information systems can support the production of valid and meaningful performance measures in conjunction with their capacity to manage care of their members.

Primaris based their methodologies directly on the CMS protocol, External Quality Review (EQR) APPENDIX V: Information Systems Capabilities Assessment. This consists of two attachments:

- Attachment A: Tools for Assessing Managed Care Organization (MCO) Information Systems; and
- Attachment B: Information System Review Worksheet and Interview Guide.

Data collection, review, and analysis were conducted for each review area via the ISCA data collection tools, interview responses, security walk-throughs, and claim/encounter data lifecycle demonstrations. Scores for the ISCA align with the other sections of this report (e.g., compliance with regulations) and are based on the standards for a Met, Partially Met, or Not Met criteria.

Analysis

Findings

Home State Health and Missouri Care passed the ISCA in all seven (7) areas as mentioned in Table 1-13, receiving a fully 'Met' score result for the overall ISCA. Both MCOs met all contractual obligations for information systems management and have well documented processes and procedures in place to allow their information systems to be adequately monitored and maintained. During the on-site review the team focused on data integrations and data integrity. Both the MCOs alleged that about 60% of the data is inaccurate or missing from the enrollment/eligibility files 834, received from the State. The lack of accurate data and their inability to update members' primary demographic information, creates hurdles for the delivery of quality care.

Table 1-13 Overall Score for Home State Health and Missouri Care

ISCA Section	Description	Score Result
Overall ISCA Score	Total Score	**Met** (pass)
Information Systems	Assess MCO's management of its information systems.	**Met** (pass)
IT Infrastructure	Assess MCO's network and physical infrastructure.	**Met** (pass)
Information Security	Assess the security level of MCO's information systems.	**Met** (pass)
Encounter Data Management	Assess MCO's ability to capture and report accurate	**Met** (pass)

	and meaningful encounter data.	
Eligibility Data Management	Assess MCO's ability to capture and report accurate and meaningful Medicaid eligibility data.	**Met** (pass)
Provider Data Management	Access MCO's ability to maintain accurate provider information.	**Met** (pass)
Performance Measures and Reporting.	Assess the MCO's performance measure and reporting process.	**Met** (pass)

Recommendation

A complete assessment of MCOs' Information System's documentation and related onsite activities revealed an opportunity for improvement concerning the data collection and integration structure around the 834 file. The 60% unusable data elements are not due to any systems integration issue but arise from the inability to bilaterally update member information obtained from the various other sources by the MCOs.

Primaris recommends that the State and both the MCOs work towards a collaborative solution for the ability to update and access more accurate and useful member contact data. This will create a complete data integration solution delivering trusted data from various sources.

1.3.3 Validation of Performance Improvement Projects (PIPs)

MHD requires the contracted MCO to conduct performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and interventions, a significant improvement, sustained over time, in clinical care and nonclinical care areas. The PIPs are expected to have a favorable effect on health

outcomes, member satisfaction, and improve efficiencies related to health care service delivery. (*Ref: MHD-Managed Care Contract 2.18.8 (d)).* Completion of the performance improvement project should be in a reasonable time period (a calendar year), so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

A statewide performance improvement project(s) is defined as a cooperative quality improvement effort by the Health Plan, the State Agency, and the External Quality Review Organization (EQRO) to address clinical or non-clinical topic areas relevant to the Managed Care Program. *(Ref: MHD-Managed Care Contract 2.18.8 (d) 2)*

The PIPs shall involve the following (Ref: 42 Code of federal Regulations (CFR) 438.330 (d)):

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

During calendar year (CY) 2017, MHD required Home State Health and Missouri Care to conduct two (2) PIPs-

- One (1) clinical: Improving Childhood Immunization Rates (Combo 10); and
- One (1) nonclinical: Improving Access to Oral Healthcare.

To ensure methodological soundness while meeting all State and Federal requirements, Primaris followed guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, EQR Protocol 3, Version 2: Validating Performance Improvement Projects.

The activities conducted for PIPs Validation were:

1. Assess the study methodology.
2. Verify PIP study findings (Optional) – (***Note****: Not conducted*).
3. Evaluate overall validity and reliability of study results.

Determining threats to validity, reliability, and PIP design is sometimes a judgment call, Primaris will report a level of confidence in its findings as follows: The PIPs will be rated as follows:

- High confidence = the PIP was methodologically sound, achieved the SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

- Confidence = the PIP was methodologically sound, achieved the SMART Aim goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible = The PIP methodology was not executed as approved.

Analysis

Findings for Clinical PIP: **Improving Childhood Immunization Rates (CIS) Combo 10**

Home State Health aimed to increase the CIS rate for Combo 10 by three (3) percentage points between CY 2016 and CY 2017 whereas Missouri Care aimed at increasing the CIS Combo 10 rate by three (3) percent for the measurement year (CY 2017).

Both the MCOs took HEDIS 2017 (CY 2016) CIS combo 10 rates as their baseline, the study population included all eligible members under age 2 years and HEDIS CIS Combo 10 rate was selected as the study indicator. There were multiple ongoing interventions. Some were new in CY 2017, implemented at varying times throughout the year.

Table 1-14 CIS Combo 10 Baseline Rate HEDIS 2017 (CY 2016)

Home State Health and Missouri Care

MCO	HEDIS Year	MCO Combo 10 Rate	NCQA 50th percentile
Home State Health	2017	24.04%	33.09%
Missouri Care	2017	26.39%	33.09%

Home State Health

The Statewide (STWD) CIS Combo 10 rate for Home State Health in CY 2017 (H2018) was 27.01% as compared to the rate in CY 2016 (H2017-24.04%), shown in the Figure 4. The rate increased by 2.97 percentage points, which is not statistically significant. The aim of the PIP to increase by 3% point could not be achieved. It fell short by 0.03% point. Home State Health is far too behind the contractual requirement to meet the goal of 90% rate.

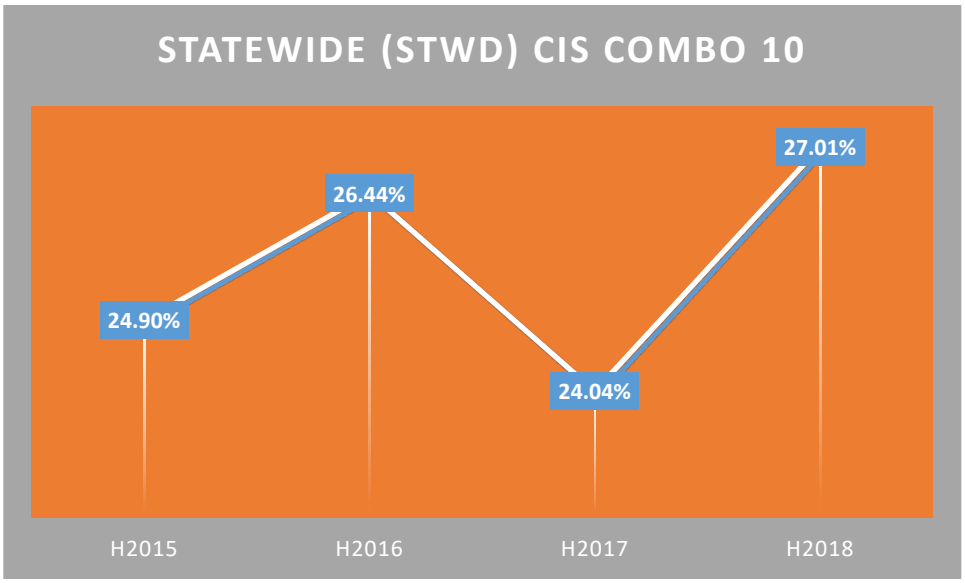


Figure 1-4 Trend in Home State Health for STWD CIS Combo 10 Rates H2015-H2018

Missouri Care

The Statewide CIS Combo 10 rate for Missouri Care in CY 2017 (H2018) was 26.52% as compared to the rate in CY 2016 (H2017-26.39%), shown in the Figure 1-5. The State aggregate CIS rate increased by 0.13% points or 0.4% from CY 2016. The aim of PIP to get a 3% increase is not met. There is no statistical significance of this increase. Missouri Care is far too behind the contractual requirement to meet the goal of 90% rate.

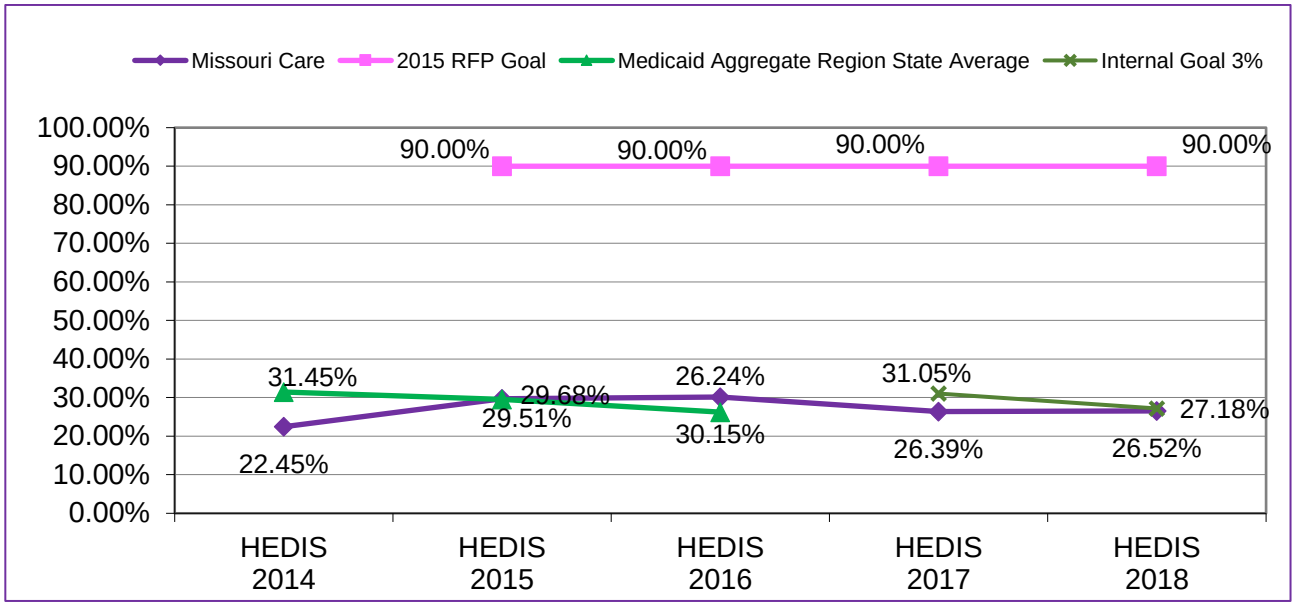


Figure 1-5 HEDIS Aggregate Childhood Immunization Status – Combo 10

Findings for Non Clinical PIP: **Improving Oral Health**

Home State Health aimed to increase the Annual Dental Visit (ADV) rate by three (3) percentage points between CY 2016 and CY 2017 whereas Missouri Care aimed at increasing the ADV rate by three (3) percent for the measurement year (CY 2017).

Home State Health considered HEDIS 2017 (CY 2016) ADV rate as their baseline, whereas Missouri Care considered HEDIS 2013 rate as their baseline. However, Primaris accepted HEDIS 2017 (CY 2016) ADV rates as baseline for the validation of this PIP, as the purpose of PIP is to see the improvement in quality care year over year.

The study population included all eligible members aged 2 through 20 years and HEDIS ADV rate was selected as the study indicator by both the MCOs. There were multiple ongoing interventions. Some were new in CY 2017, implemented at varying times throughout the year.

Table 1-15 Home State Health and Missouri Care ADV Baseline Rate HEDIS 2017(CY 2016)

MCO	HEDIS Year	MCO ADV Rate	NCQA 50th percentile
Home State Health	2017	39.91%	54.93%
Missouri Care	2017	46.97%	54.93%

Home State Health

The Statewide ADV rate for Home State Health in CY 2017 (H2018) was 41.63% as compared to the rate in CY 2016 (H2017-39.91%), shown in Figure 1-6. Between H2017 and H2018 (CY 2016 and CY 2017), Home State Health's statewide ADV rate increased by 1.72 percentage points which is statistically significant. However, the aim of the PIP to increase by 3% point could not be achieved.

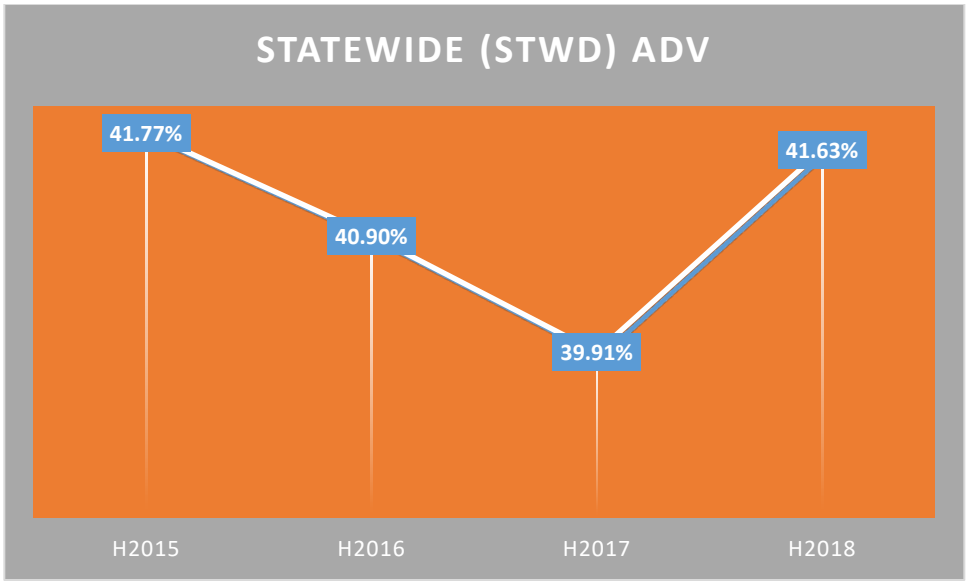


Figure 1-6 Trend in Home State Health for STWD ADV Rates H2015-H2018

Missouri Care

The State aggregate ADV rate for CY 2017 (measurement year) was 48.42%. This is an increase by 1.45% points or 3% from CY 2016 (46.97%). The aim of PIP to get a 3% increase is met (Figure 1-7).

PIPs Score

The following score was assigned to Home State Health and Missouri Care for CIS Combo 10 and Oral HealthCare PIPs:

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Quality, Timeliness and Access to HealthCare Services

Both the MCOs have seen an increase in CIS Combo 10 and ADV rates in CY 2017 from the previous year (CY 2016). They have attributed this to their planned quality multi-interventional improvement approach based on barrier analysis.

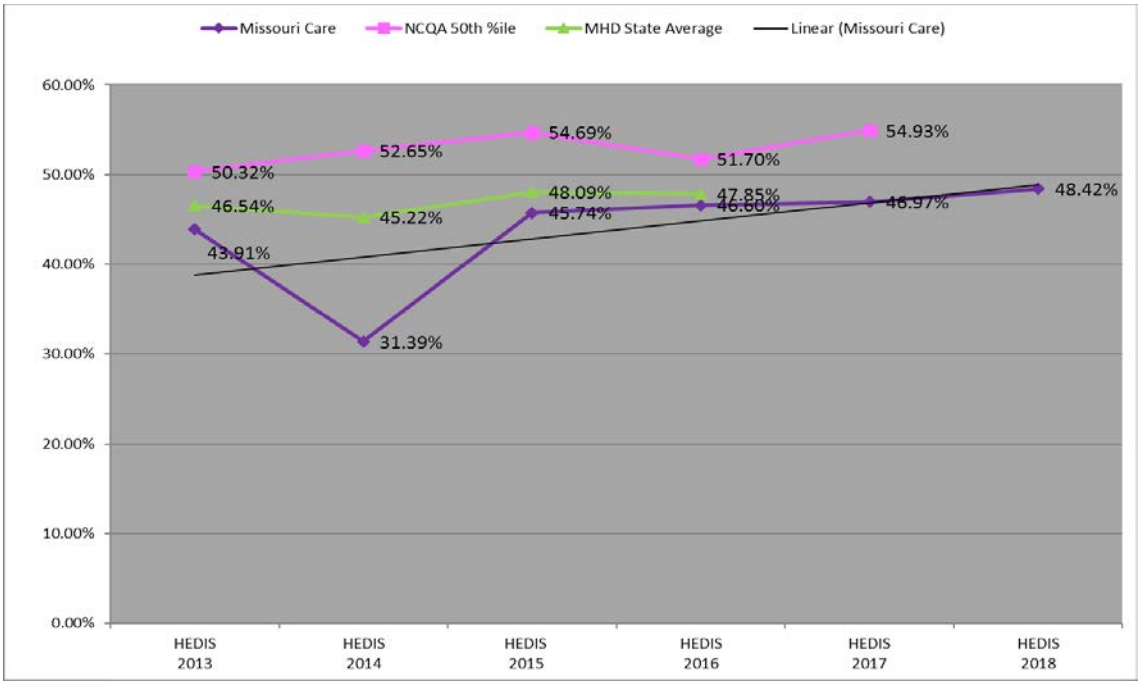


Figure 1-7 Aggregate (Statewide) Annual Dental Visit

Recommendation

Home State Health and Missouri Care must continue to refine their skills in the development and implementation of approaches to effect change in their PIP. A request for technical assistance from EQRO would be beneficial. Improved training, assistance and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.

1.3.4 Care Management Review

The Commission for Care Manager Certification (CCMC) defines “Care Management” as a process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

All the services described in the Care Management (CM) section (2.11) of the MO HealthNet Managed Care contract were used as a standard for evaluation of Care Management Program of Home State Health and Missouri Care. The aim of the Care Management review is to identify contributing issues and key drivers of the program. The guiding principle for Care Management is that the resources should be focused towards people receiving the services they need, not necessarily because the service is available.

The focus areas for evaluation of Care Management Program during EQR 2018, mandated by MHD were as follows:

1. Pregnant Members (OB);
2. Children with Elevated Blood Lead Levels; and
3. Serious Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder).

The methodology adopted for evaluation of CM program included:

1. Review of CM Policies and Procedures: Primaris reviewed the following Policies and Procedures to ensure that the MCOs met the requirements set forth in MHD Managed Care Contract (2.11).

- A description of the system for identifying, screening, and selecting members for care management services;
- Provider and member profiling activities;
- Procedures for conducting provider education on care management;
- A description of how claims analysis will be used;
- A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan;
- A process to ensure integration and communication between physical and behavioral health;
- A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned;
- A process to ensure that care plans are maintained and up-dated as necessary;
- A description of the methodology for assigning and monitoring care management caseloads that ensures adequate staffing to meet care management requirements;
- Timeframes for reevaluation and criteria for care management closure; and
- Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in herein.

2. Medical Record Review (MRR)

A sample of a minimum of 20 Medical Records (MR) for each focus area were reviewed during the onsite visit to ensure that they include, at a minimum, the following *(ref: MHD Managed Care Contract 2.11),* (Figure 1-8):

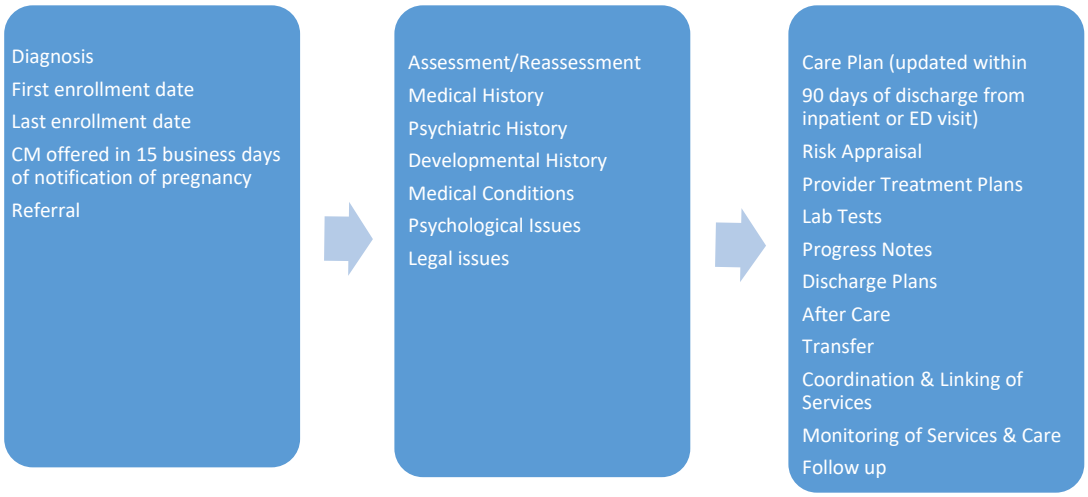


Figure 1-8 Elements for Validation of MR

Inter Rater Reliability: 10% of the MR from each focus area were reviewed by different auditors to assess the degree of agreement in assigning a score for compliance in the MRR.

3. Onsite interviews

The Officials from Home State Health and Missouri Care were interviewed to assess:

- The knowledge of MHD Managed Care contract and requirements for Care Management.
- The focus of Care Management services on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality, health, and cost impact; and creating opportunities and systems to enhance outcomes.

Collectively, a review was done on the overall Care Management process from end-to-end on electronic records integration.

Analysis

Findings

- Both Home State Health and Missouri Care have the policies and procedures which are 100% compliant with MHD Managed Care Contract requirements related to the CM Program.
- MRR: The medical records were audited to establish the rate of compliance for each section under evaluation. The results for the three CM programs for both the MCOs are as follows:

Table 1-16 Compliance % for Pregnant Members (OB) CM Program

% MRR Compliance	Home State Health	Missouri Care
100%	Diagnosis First Enrollment Date Last Enrollment Date CM within (15) business days of notification Referral Developmental History Medical Conditions Psychosocial Issues Legal Issues Lab Tests	First Enrollment Date Last Enrollment Date Referral Assessment Medical History Psychiatric History Developmental History Medical Conditions Psychosocial Issues Legal Issues Care Plans Care Plans updated in 90 days of discharge from inpatient stay or ED Visit Risk Appraisal Lab Tests Progress Notes Transfers Coordinating & Linking of Services Monitoring of Services & Care Follow up
90-95%	Assessment/ Reassessment Medical History Psychiatric History Care Plans	Diagnosis

	Care Plans updated in 90 days of discharge from inpatient stay or ED Visit Risk Appraisal Progress/Contact Notes	
60-70%	Discharge Plans Aftercare Transfers Coordination/Linking of Services Monitoring of Services and Care Follow-Up	CM within (15) business days of notification Discharge Plans After Care
0%	0 % Provider Treatment Plans	0 % Provider Treatment Plans

Table 1-17 Compliance % for Children with Elevated Blood Lead Levels CM Program

% MRR Compliance	**Home State Health**	**Missouri Care**
100%	Diagnosis Notification of Blood Level Initial Lead Level Referral for Visits Progress/Contact Notes Coordination/Linking of Services Monitoring of Services and Care Case Closure Documentation/Member Letter	Notification of Blood Level Initial Lead Level Referral for Visits Progress/Contact Notes Coordination/Linking of Services Monitoring of Services and Care Case Closure Documentation/Member Letter PCP Discharge Notification
90-95%	Assessment/ Reassessment	Diagnosis

	Medical History Psychiatric History Developmental History Medical Conditions Psychosocial Issues Legal Issues Testing and Follow-up Care Plans and Updates as Indicated Provider Treatment Plans	
70-90%		Testing and Follow-up
60-70%	Case Closure-PCP Discharge Notification	Psychiatric History Developmental History
≤50%	Offer Case Management per Guidelines with Assessment Face-to Face Encounters-Initial and Follow up Contact Exit Evaluation/Case Closure-Member	Assessment/Reassessment Medical History Medical Conditions Psychosocial Issues Legal Issues Contact Exit Evaluation/Case Closure-Member Offer Case Management per Guidelines with Assessment Care Plans and Updates as Indicated Provider Treatment Plans

Table 1-18 Compliance % for SMI CM Program

% MRR Compliance	Home State Health	Missouri Care
100%	Diagnosis First Enrollment Date Last Enrollment Date CM within thirty (30) days of enrollment for SMI CM within five (5) days of hospital admission Referral Testing Monitoring of Services and Care Member Participation Care Plans Assessment/ Reassessment Medical History Psychiatric History Developmental History Medical Conditions Psychosocial Issues Legal Issues Progress Notes	Diagnosis First Enrollment Date Last Enrollment Date CM within thirty (30) days of enrollment for SMI CM within five (5) days of hospital admission Referral Testing Monitoring of Services and Care Member Participation Care Plans Risk Appraisal Provider Engagement and Care Planning Assessment/ Reassessment Medical History Psychiatric History Developmental History Medical Conditions Psychosocial Issues Legal Issues Progress Notes Linking of Services Monitoring Care

90-95%	Provider Engagement and Care Planning Risk Appraisal Care Plans updated within 90 days Discharge Plans Aftercare Transfers Linking of Services Monitoring Care Follow-Up	Care Plans updated within 90 days
70-90%		Discharge Plans Aftercare Transfers Follow-Up

Quality, Timeliness and Access to Health Care Services

OB Care Management

- Overall compliance of Home State Health for the OB CM program was 86.04%. Their OB CM Program was evaluated in 24 areas during the MRR. Out of these, 10 areas scored 100%, 7 areas scored 95%, 6 areas scored 60-70% compliance rate, and 1 area (Provider Treatment Plan) scored zero (0). The providers do not respond or acknowledge the treatment plan sent by the Care Manager. They respond only when the Care Manager makes a call on a 'need basis.'

  Similarly, Missouri Care OB-CM Program was 91.25% compliant. The program was evaluated in 24 areas during the MRR. Out of these, 19 areas scored 100%, 1 area scored 90%, 3 areas were at 60-70% compliance and area (Provider Treatment Plan) scored zero (0).
- Home State Health was 89.1% compliant for 'outreach' to OB members in CY 2017 and Missouri Care was 93.3% compliant. On May 01, 2017 MCOs' membership expanded to cover the entire state.
- In the CY 2017, the rate of LBW for managed care population in Home State Health was 8-13%. The latest published data from The National Center for Health Statistics for Births is for the CY 2016. The

LBW rate for United States (US) was 8.2% and for the State of Missouri it was 8.7% which ranked at 14th place (rankings are from highest to lowest).

- For the Timeliness of Prenatal Care Measure, Missouri Care had achieved a rate of 81.51% in CY 2017. It improved by 4.46% point from the previous year. For the Postpartum Care Measure, Missouri Care had achieved a rate of 57.18% in CY 2017. It improved by 5.73% point from the CY 2016.
- Missouri Care approved 100% of the requested PAs (4.63 Vs 4.64 per 1000) in CY 2017, consistent with the % approvals in CY 2016. This is suggestive of access of care to the members.

Children with Elevated Blood Lead Levels Care Management

- Overall, Home State Health was 75.27% compliant for Elevated Blood Lead Levels CM Program. Home State Health Lead CM program was reviewed in 22 areas during MRR. Out of these, 18 areas scored 90% or higher for compliance. One (1) area, case closure-PCP notification was 67% compliant. One (1) area, offer case management within timeframe with assessment was 50% compliant. One (1) area, face-to-face-encounters scored 20-35%. Additionally, one (1) area for contact exit evaluation/case closure-member was 17% compliant.

  Similarly Missouri Care Lead CM program was 61.50% compliant. Their program was reviewed in 22 areas during MRR. Out of these, 9 areas scored 90% or higher for compliance. Nine (9) areas, were at 50-60%. Two (2) areas, care plans and provider engagement scored 40%. One (1) area, testing and follow-up was 85% compliant and One (1) area, face-to-face encounters was 17-22% compliant.
- Home State Health and Missouri Care had 100% outreach for children with elevated blood lead levels.
- Home State Health CY 2017 results are based on Hybrid methodology with the final audited Lead Screening in Children rate being 60.74%. This is 4.44 percentage points higher than CY 2016. The rates for Missouri Care in CY 2017 was 56.45%. This is a drop by 0.49% point from CY 2016.

SMI Care Management

- Overall compliance for SMI CM MRR was 98.2% for Home State Health and 97.3% for Missouri Care.
- Missouri Care had 100% approvals for Prior Authorizations for Behavioral Health (BH) members.
- Home State Health rates for diabetic screening for people with schizophrenia or bipolar disorder using antipsychotic medications (SSD) was 81.29% which was 1.24% point higher than the CY 2016.

Recommendation

A member should be considered as enrolled when the Care Manager makes an assessment of the need of the member. An outreach by a care coordinator should not be considered as enrollment. As per MHD Managed Care Contract, The initial care management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.

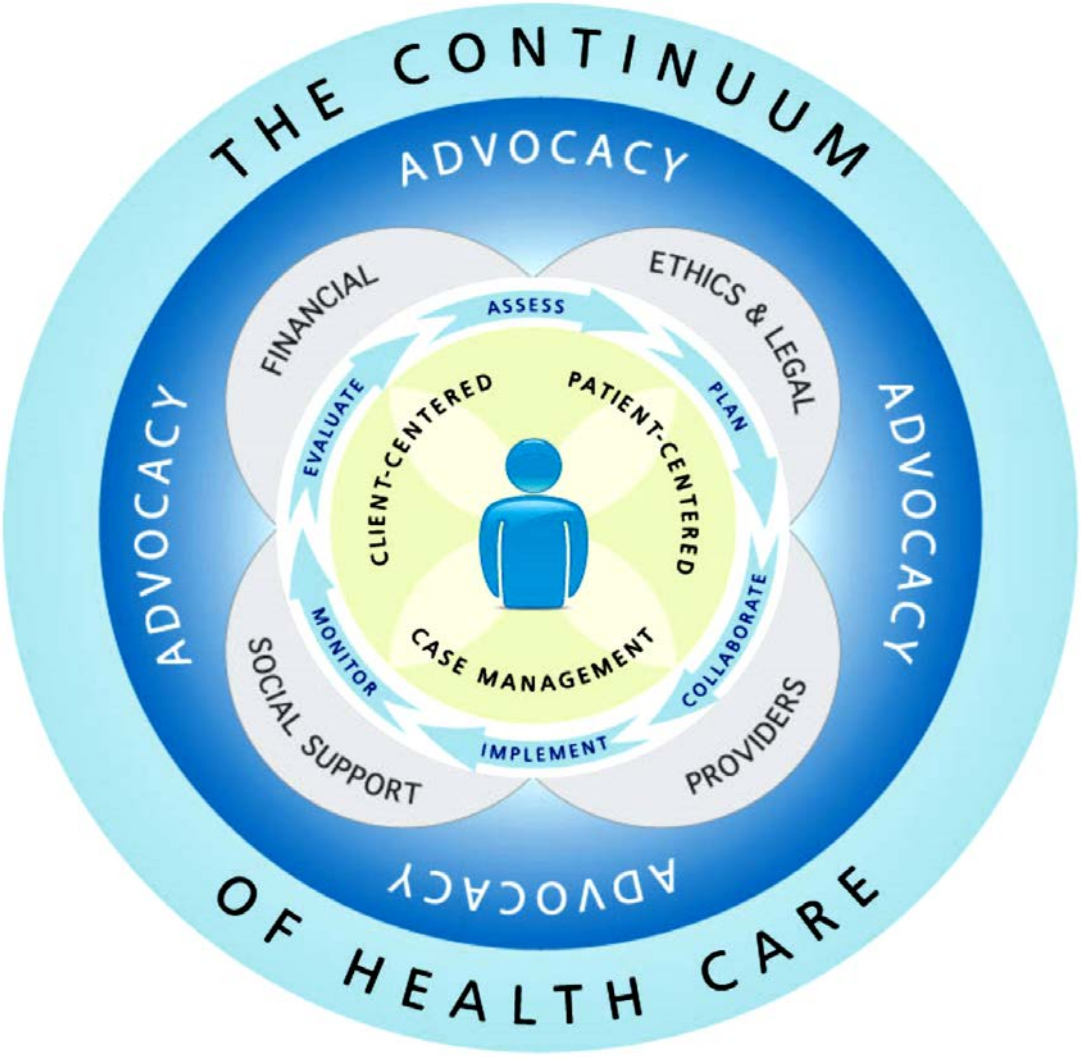


Figure 1-9 The Continuum of Health Care and Professional Case Management (Ref: Standards of practice for case management- CMSA case management society of America)

2.0 Missouri Managed Care Overview

2.1 Missouri HealthNet Managed Care

The State of Missouri has conducted a Managed Care Program since 1995, limited to certain regions (Central, Eastern, and Western) and counties of MO. Effective May 1, 2017, the Managed Care Program was extended statewide to include all 114 counties within Missouri and the City of St. Louis.

In the State of Missouri, the Department of Social Services, MO HealthNet Division is officially designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Family Support Division (FSD) is designated with the administration and determination of eligibility for the two programs. In addition to MO HealthNet Division's oversight, Centers for Medicare and Medicaid Services (CMS) also monitor MO HealthNet Managed Care activities through its Regional Office in Kansas City, Missouri and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland.

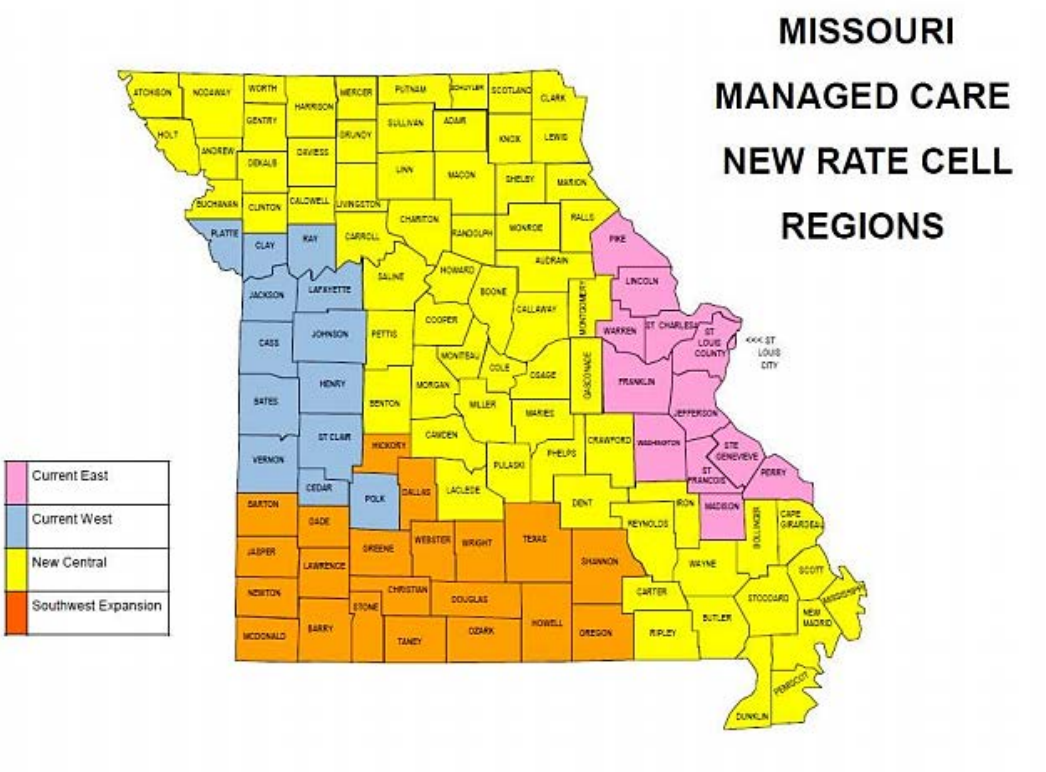


Figure 2-1 Missouri Managed Care New Regions

The Managed Care Program counties are organized into four (4) regions (Central, Eastern, Southwestern, and Western) for the purpose of rate setting. The goals are to improve access to needed services and the quality of health care services for the MO HealthNet Managed Care and State aid eligible populations, while controlling the program's rate of cost increase. The Missouri Department of Social Services, MO HealthNet Division intends to achieve these goals by enrolling MO HealthNet Managed Care eligibles in comprehensive, qualified health plans that contract with the State of Missouri to provide a specified scope of benefits to each enrolled member in return for a capitated payment made on a per member, per month basis. The Managed Care Organizations that deliver services are Home State Health, Missouri Care, and UnitedHealthcare.

The MO HealthNet Managed Care Program delivers services to individuals in the following eligibility groups:

1. Eligibility of Parents/Caretakers, Children, and Refugees. This group include the following:
    - Parents/Caretakers and Children eligible under the MO HealthNet for Families, and Transitional MO HealthNet Assistance;
    - Children eligible under MO HealthNet for Poverty Level Children;
    - Individuals eligible under Participants of Refugee MO HealthNet;
    - Individuals who are eligible under the above-referenced groups and are participants in the following Development Disabilities (DD) waivers:
        - Partnership for Hope;
        - DD Comprehensive;
        - DD Community Support; and
        - Autism.
2. Eligibility of Pregnant Women:
    - Women eligible under MO HealthNet for Pregnant Women and sixty calendar days post-partum; and
    - Low-income pregnant women and their unborn children with household income up to three hundred percent (300%) of the federal poverty level who are not eligible under MO HealthNet for Pregnant Women or the Show-Me Healthy Babies Program.
3. Eligibility of Other MO HealthNet Children in the Care and Custody of the State and Receiving Adoption Subsidy Assistance. This group includes:

- All children in the care and custody of the Department of Social Services (DSS);
- All children placed in a not-for-profit residential group home by a juvenile court;
- All children receiving adoption subsidy assistance; and
- All children receiving non-medical assistance (i.e. living expenses) that are in the legal custody of the DSS Individuals under twenty-six (26) years of age, who were in foster care on their eighteenth (18th) birthday, who were covered by MO HealthNet, and who meet other eligibility criteria are eligible under this category of assistance.

4. State Child Health Plan – Missouri has an approved combination State Child Health Plan under Title XXI of the Social Security Act (the Act) for the Children's Health Insurance Program (CHIP).

MHD has identified nine (9) guiding principles for the Managed Care Program as follows:

- All members must be linked with a primary care provider, as defined herein, of their choice;
- Attention to wellness of the individual (e.g., education) and prevention of disease;
- Chronic care management;
- Care management – (resources focused towards people receiving the services they need, not necessarily because the service is available);
- Utilization of the appropriate setting at the right cost;
- Emphasis on the individual person;
- Evidenced based guidelines for improved quality of care and use of resources;
- Encourage responsibility and investment on the part of the member to ensure wellness; and
- Participation in the Medicaid Reform and Transformation Program, which includes personal responsibility (member incentives), the Local Community Care Coordination Program (LCCCP) initiative, state provider incentive program, and requirements for increased accountability and transparency.

2.2 Quality Strategy and Quality Initiatives by MHD

MHD's Quality Improvement Strategy (QIS) 2013, has been evaluated, revised and submitted for approval to CMS in July 2018. It is a comprehensive plan incorporating monitoring, evaluation, and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to participants in the Managed Care Program. The QIS provides a framework to communicate the

State's vision, goals, objectives, and measures that address access to care, wellness and prevention, chronic disease care, cost effective utilization of services, and customer satisfaction.

The QIS is developed through collaborative partnerships with members, stakeholders, and other State Agencies (Departments of Mental Health; Social Services; Insurance, Financial Institutions, and Professional Registration; Elementary and Secondary Education; and Health and Senior Services), MCOs, and community groups.

The goal is to ensure that:

- Quality health care services are provided to Managed Care members;
- Established bench marks for outcomes are being met;
- MCOs are in compliance with Federal, State, and contract requirements; and
- A collaborative process is maintained to collegially work with the MCOs to improve care.

Some of the activities occurring at the MCO and Managed Care Program level that will contribute to the ability of the MCOs to achieve the goals, objectives, and measures outlined in the QIS and MHD Managed Care contract (2.18) are as follows:

Performance Improvement Projects

The MCOs are all required to participate in two statewide PIPs that have been selected by MHD to align with specific agency goals and priority areas. These statewide PIPs are discussed during QA&I meetings and are evaluated by the EQRO each year. The two statewide PIPs, both measured using HEDIS, are:

- Improving Oral Health, based on guidance from CMS's Oral Health Initiative; and https://www.medicaid.gov/medicaid/benefits/dental/index.html.
- Improving the rate of immunizations.

Accreditation

MHD requires the MCOs to obtain and maintain accreditation from NCQA. Home State Health and Missouri Care have been MO HealthNet MCOs for several years and have achieved accreditation. UnitedHealthcare is new to MHD Managed Care Program and has thirty months from their contract start date of May 1, 2017 to achieve accreditation; their status is currently classified as "interim".

Table 2-1 NCQA Accreditation Status for Current Missouri MCOs		
MCO Name	**Status**	**Expiration Date**
Home State Health	Accredited	8/7/2020
Missouri Care	Accredited	8/22/2020
UnitedHealthcare	Interim	6/19/2019

Source: https://reportcards.ncqa.org/#/health-plans/list

External Quality Reviews

Findings and recommendations by the EQRO are presented at an annual conference with MCO administrative and clinical management staff, at the QA & I meetings, and are written in Annual Report submitted to CMS and posted on MHD website (http://dss.mo.gov/mhd/mc/pages/eqro.htm).

Community Health Initiatives

All MCOs are required to participate in community health improvement initiatives in collaboration with the DHSS and local public health agencies. These initiatives must align with the Maternal and Child Health Program and DHSS strategic priorities. Mandatory activities include participation in regional or community Maternal and Child Health coalitions, planning and implementing health improvement programs, and providing feedback about the effectiveness of initiatives and plans.

Care Management

The MCOs will assess members for care management within a specified number of days after enrollment or diagnosis with specific conditions and/or risk factors and report this activity on a care management log each quarter.

The MCOs are required to ensure collaboration with MHD Section 2703 Health Homes Program for their members. MHD's Primary Care Health Home (PCHH) Program strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population (members who have two or more chronic health conditions including asthma/COPD, developmental disabilities, diabetes, cardiovascular disease, overweight/obesity, substance use disorder, depression, anxiety, and tobacco use) through providing clinical care and wrap around services. One aspect of the program includes the implementation and evaluation of the Patient Centered Medical Home model as a means to:

- Achieve accessible, high quality primary care;

- Demonstrate cost-effectiveness in order to validate and support the sustainability and spread of the model; and
- Support primary care practices by increasing available resources and improving care coordination thus improving the quality of clinician work life and patient outcomes.

The program also emphasizes the integration of primary care and behavioral health care in order to achieve improved health outcomes. Community Mental Health Centers (CMHCs) providing community psychiatric rehabilitation services are recognized by the Missouri Department of Mental Health to serve as CMHC Health Homes under Section 2703. CMHC Health Homes assist individuals in accessing needed health, behavioral health, and social services and supports; managing their mental illness and other chronic conditions; improving their general health; coordination with primary care; and developing and maintaining healthy lifestyles.

Show-Me ECHO

Show-Me ECHO (Extension for Community Healthcare Outcomes) is part of the University of Missouri's Telehealth Network. Show-Me ECHO uses videoconferencing technology to connect a team of interdisciplinary experts with primary care providers. The discussions with, and mentoring from, specialists help equip primary care providers to give their patients the right care, in the right place, at the right time.

MHD has required all MCOs to participate in this initiative since January 2018. The MCOs will collaborate with MHD to develop the focus of the project, create evidence-based goals and expected outcomes, and develop metrics to measure health outcomes and anticipated reduced health care costs. The primary focus is on the management of high-risk obstetrics cases, the reduction in the occurrence of neonatal abstinence syndrome, the management of opioid use disorder and the management of chronic pain. The MCOs will collaborate with the University of Missouri and MHD to promote Show-Me ECHO to the health care providers in the MCOs' contracted networks.

Medicaid Transformation

One of the guiding principles in the Managed Care Program is the Medicaid Reform and Transformation Program. This principle is supported through contract provisions that require the MCOs participate in three different types of initiatives.

- Member incentive programs that encourage personal responsibility related to health behaviors and outcomes;

- Provider incentive programs which involve financial rewards for achieving established goals such as reaching a target number of qualifying patient visits or other quality benchmarks; and
- Creation of a Local Community Care Coordination Program (LCCCP), which is another evidence-based patient-centered concept that incorporates MHD's Health Homes Program principles, thus providing a unified paradigm across MHD and its programs.

The Missouri Medicaid Management Information System (MMIS) supports the initial and ongoing operation and review of the Missouri QIS. In March 2018, CMS notified MHD that Missouri meets the criteria for a Transformed Medicaid Statistical Information System as it has met CMS production readiness criteria. CMS recognized Missouri for its commitment to improve data and data analytic capability. MHD is in the process of procuring a new MMIS which will provide the opportunity for even more improvement in this area.

Performance Withhold Program

Based on input from the MCOs and MHD's actuary, Mercer, the Performance Withhold Program will be transitioning to HEDIS-based outcome measures starting on July 1, 2019. This is because outcome measures have sufficient data for trending and are comparable to national or other benchmarks. Currently, the five performance indicators included in this program which started in year 2015 are considered "process measures."

Quality Rating System (QRS)

CMS is in the process of finalizing the QRS for Medicaid. It will be implemented in SFY 2019 and presented to the members to consider while selecting a MCO for enrollment.

The MCOs shall have a Quality Assessment and Improvement Program (QAPI) which integrates an internal quality assessment process that conforms to Quality Improvement System for Managed Care (QISMC) and additional current standards and guidelines prescribed by CMS. The QAPI will be composed of:

- An internal system of monitoring, analysis, evaluation, and improvement of the delivery of care that includes care provided by all providers;
- Designated staff with expertise in quality assessment, utilization management, and continuous quality improvement;

- Written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically analyzed and evaluated for impact and effectiveness;
- Results, conclusions, team recommendations, and implemented system changes which are reported to the health plan’s governing body at least quarterly; and
- Reports that are evaluated, recommendations that are implemented when indicated, and feedback provided to providers and members.

3.0 Home State Health

3.1 Overview

Home State Health was founded in 2012 by their parent company, Centene Corporation. It serves all 114 counties in MO effective May 1, 2017, serving about 265,310 Medicaid (by end of SFY 2018), 60,000 Marketplace and 360 Medicare members. Home State Health has four office locations (Chesterfield, Jefferson City, Kansas City, and Springfield) and over 300 employees in the State of Missouri.

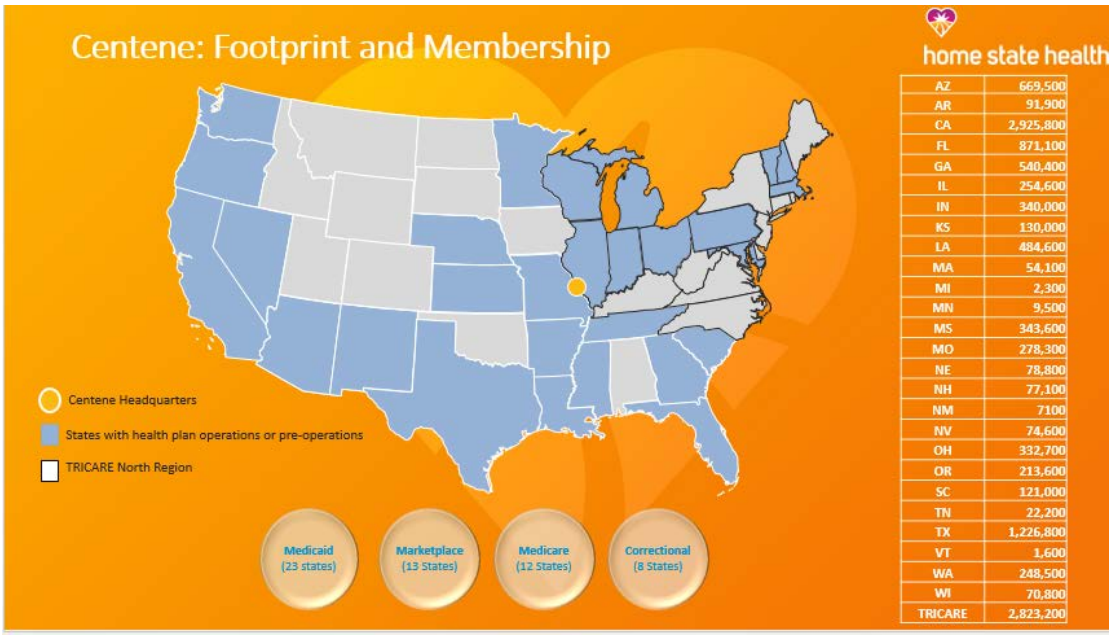


Figure 3-1

Goals

Ensure Medicaid recipients get the care they need in the most appropriate setting

- Increase primary-care visits and reduce unnecessary emergency room visits;
- Increase EPSDT screenings, prenatal/postpartum care and HEDIS rates;
- Identify and facilitate treatment for secondary conditions;
- Coordinate care to reduce duplication and waste;
- Reduce socioeconomic barriers to care; and
- Implement physician driven strategies that support a Medical Home.

Care coordination model utilizes integrated programs that can only be delivered effectively by a local staff. Home State Health's philosophy is that quality care is best delivered locally.

Figure 3-2 Outreach Team Efforts

3.2 Compliance with Medicaid Managed Care Regulations

3.2.1 Methodology

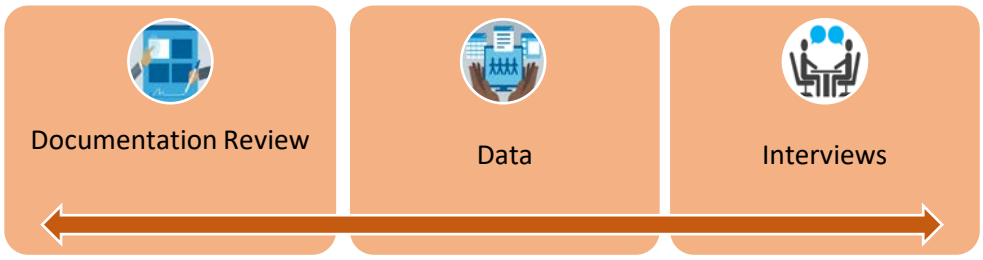


Figure 3-3 Sources of Information from Missouri Care

Data collection tools were created based on the MHD Managed Care Contract and 42CFR 438, subpart D for the three areas under evaluation (Ref. Table 3-2, 3-3, 3-4).

§438.230 Subcontractual relationships and delegation;

§438.236 Practice guidelines; and

§438.242 Health information systems.

In addition to these, an overview of all standards stated in 42 CFR 438 subpart D and Subpart E 438.330 was given. The Grievance and Appeal system (§438.228) was discussed in detail, which would be due for a review next year after approval from MHD.

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.

An on-site review was performed at the 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 3-1 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

3.2.2 Findings

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 3-2) as follows:

Table 3-2 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 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)).	Medical Transportation Management (MTM) Service Agreement-page 17 MTM Service Agreement-page 58 MTM Service Agreement-page 10 National Imaging Associates (NIA) MO Amendment-page 16 NIA MO Amendment-pages 22 and 26	● Met Partially Met Not Met

Findings: The 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:		
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
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. Home State Health contracts need to be updated to include the length of term of ten years for auditing rights 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.

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 HealthNet Managed Care Contract section 3.9).	MTM Service Agreement - page 11 NIA Service Agreement – page 14	● Met Partially Met Not Met
Findings: In the 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	MTM Service Agreement-pages 11, 13	● Met Partially Met Not Met

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 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).	NIA Service Agreement-pages 14, 16	

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.

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 3-3 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. . The 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 the 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.

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.

Table 3-4 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 Annual Quality Assessment and Performance Improvement Program Evaluation – Page 13	● Met Partially Met Not Met
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: The 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: The 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: The 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	Annual Quality Assessment and Performance Improvement Program Evaluation-Page 90	● Met Partially Met Not Met

providers are accurate and complete by: • 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.		

Overall Compliance of Home State Health with Medicaid Managed Care Regulations

Table 3-5 Home State Health Score for Compliance

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

Total Sections X 2 points

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 3-2: 2b 2c,) to meet the requirements of New Managed Care Rules for CY 2018 review.

Corrective Action Plan (CAP) Process

No regulatory standard was put on a corrective action plan during the previous year's EQR which required a review this year. Table 3-6 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:

Table 3-6 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 3.2.4

3.2.3 Conclusions

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.
- 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 needed.
- 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 the Home State Health.
- 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.
- 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.

Weaknesses

The following points were stated by Home State Health during an onsite visit:

- 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 the 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.

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 from the CY 2016 despite the additional enrollees.
- They continue to track additional member data to increase their knowledge of member utilization.

Improvements by MCO from Prior Year

- From Figure 3-4, 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.

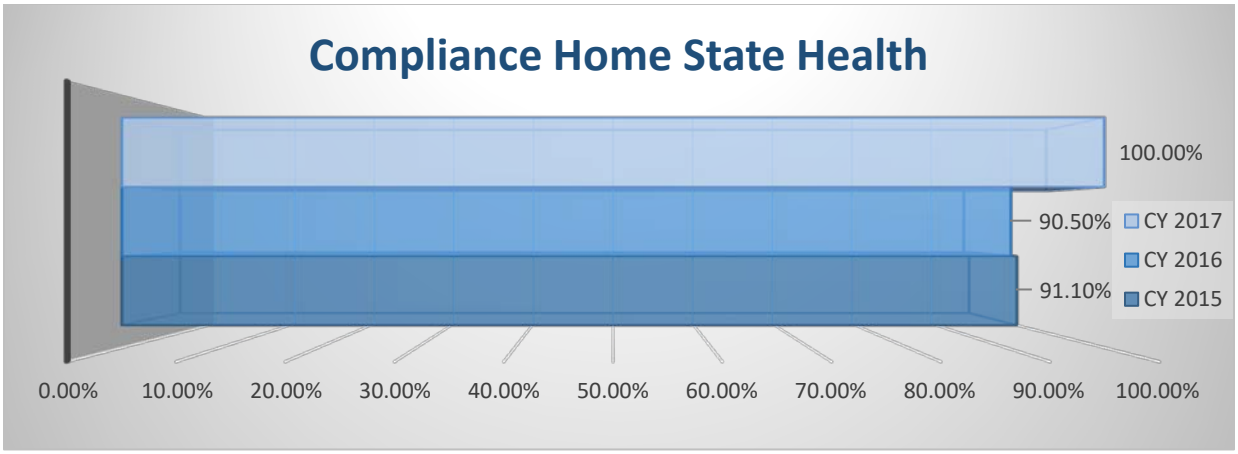


Figure 3-4 Compliance Scores for CY 2015-CY 2017

3.2.4 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 CFR wording warrants a consideration of including these elements.
- In 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 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.

3.3 (A) Validation of Performance Measures

3.3.1 Methodology

Primaris conducted an onsite visit at Home State Health for the validation of performance measures on July 10, 2018. The validation activities were conducted as outlined in the CMS EQR protocol 2, Validation of Performance Measures reported by the MCO.

Primaris validated rates for the following set of performance measures selected by MHD (Table 3-7). The measurement period was identified by MHD as calendar year (CY) 2017 for all the measures. Out of the three performance measures, only one measure required medical record validation, PPC. The additional two measures were administrative only which required primary source verification from the plan's claim system. MHD provided Primaris with the Healthcare Quality Data Template for CY2017 which consisted of instructions and specifications for the three measures required for validation.

Table 3-7 Performance Measures

Performance Measure	Method	Specifications Used	Validation Methodology
Prenatal Post-Partum Care (PPC)	Hybrid	HEDIS/MHD	Medical Record Validation
Emergency Department Visits (EVD)	Admin	MHD	Primary Source Verification
Emergency Department Utilization (EDU)	Admin	MHD	Primary Source Verification

Pre-Audit Process

Primaris prepared a series of electronic communications that were submitted to Home State Health

outlining the steps in the performance measure validation process. The electronic communications included a request for samples, medical records, numerator and denominator files, source code, if required, and a completed Information Systems Capability Assessment (ISCA).

Data Collection and Analysis

The CMS performance measure validation protocol identifies key components that should be reviewed as part of the validation process. The following bullets describes these components and the methodology used by Primaris to conduct its analysis and review:

- CMS's ISCA: Home State Health completed and submitted the required and relevant portions of its ISCA for Primaris's review. Primaris used responses from the ISCA to complete the onsite and pre-on-site assessment of information systems.
- Medical record verification**:** To ensure the accuracy of the hybrid data being abstracted by the Home State Health, random selection of 45 records were taken from the Home State Health's hybrid sample of 411 records for the measurement year 2017. The audit team conducted over-reads of the 45 medical records to validate compliance with both the specifications and abstraction process.
- Source code verification for performance measures: Home State Health contracted with a software vendor to generate and calculate rates for the two administrative performance measures, EDU and EDV. The source code review was conducted during the onsite audit sessions where Home State Health explained its rate generation and data integration processes to the Primaris review team.
- Additional supporting documents: In addition to reviewing the ISCA, Primaris also reviewed Home State Health's policies and procedures, file layouts, system flow diagrams, system files, and data collection processes. Primaris reviewed all supporting documentation and identified any issues requiring further clarification.
- Administrative rate verification**:** Upon receiving the numerator and denominator files for each measure from Home State Health, Primaris conducted a validation review to determine reasonable accuracy and data integrity.

On-Site Activities

An on-site visit activities are described as follows:

- Opening Conference: The opening meeting included an introduction of the validation team and key Home State Health staff members involved in the performance measure validation activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- Information System Compliance: The evaluation included a review of the information systems, focusing on the processing of claims and encounter data, provider data, patient data, and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the performance measure rates, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- ISCA Review, Interviews and Documentation: The review included processes used for collecting, storing, validating, and reporting performance measure rates. The review meetings were interactive with key Home State Health staff members, in order to capture Home State Health's steps taken to generate the performance measure rates. This session was used by Primaris to assess a confidence level over the reporting process and performance measure reporting as well as the documentation process in the ISCA. Primaris conducted interviews to confirm findings from the documentation review and to ascertain that written policies and procedures were used and followed in daily practice.
- Overview of Data Integration and Control Procedures: The data integration session comprised of system demonstrations of the data integration process and included discussions around data capture and storage. Additionally, Primaris performed primary source verification to further validate the administrative performance measures, reviewed backup documentation on data integration, and addressed data control and security procedures.
- Closing conference**:** The closing conference included a summation of preliminary findings based on the review of the ISCA and the on-site visit.

3.3.2 Findings

Based on all validation activities, Primaris determined validation results for each performance measure rate as defined in the Table 3-8.

Table 3-8 Audit Results and Definitions for Performance Measures	
Met	All documentation listed under a regulatory provision, or one of its components was present. MCHP 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 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.

According to the CMS protocol, the audit result for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "Met." It is possible for a single audit element to receive an audit result of "Not Met" when the impact of the error associated with that element biased the reported performance measure rate more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of "Partially Met".

The Table 3-9 shows the key review findings and final audit results for Home State Health for each performance measure rate.

Table 3-9: Key Review Findings and Audit Results for Home State Health		
Performance Measures	**Key Review Findings**	**Audit Results**
Prenatal Post-Partum Care	No concerns were identified	Met
Emergency Department Visits	No concerns were identified.	Met
Emergency Department Utilization	No concerns were identified	Met

As part of the performance measure validation process, Primaris reviewed Home State Health's data integration, data control, and documentation of performance measure rate calculations. The following describes the validation findings.

Data Integration

Met ●	Partially Met ☐	Not Met ☐

Data integration is an essential part of the overall performance measurement creation/reporting process. Data integration relies upon various internal systems to capture all data elements required for reporting. Accurate data integration is essential for calculating valid performance measure rates. Primaris reviewed Home State Health's actual results of file consolidations and extracts to determine if they were consistent with those which should have resulted according to documented specifications. The steps used to integrate data sources such as claims and encounter data, eligibility and provider data require a highly skilled staff and carefully controlled processes. Primaris validated the data integration process used by Home State Health, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

Data Control

Met ●	Partially Met ☐	Not Met ☐

Data control procedures ensure the accurate, timely, and complete integration of data into the performance measure database by comparing samples of data in the repository to transaction files. Good control procedures determines if any members, providers, or services are lost in the process and if the organization has methods to correct lost/missing data. The organization's infrastructure must support all necessary information systems and its backup procedures. Primaris validated the data control processes Home State Health used which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, Primaris determined that the data control processes in place at Home State Health were acceptable and received a "Met" designation.

Performance Measure Documentation

Met ●	Partially Met ☐	Not Met ☐

Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided necessary information to complete the audit, the majority of the validation review findings were based on documentation provided by Home State Health in the ISCA. Primaris' Information Technology Project Manager and Lead Auditor reviewed the computer programming codes, output files, work flow diagrams, primary source verification and other related documentations.

Primaris evaluated Home State Health's data systems for the processing of each data type used for reporting MHD performance measure rates. General findings are indicated below.

Medical Service Data (Claims and Encounters)

Home State Health utilized AMISYS as its primary claims processing system. This system has been operational for several years. AMISYS captured all relevant fields for performance measure validation reporting.

During the measurement year, there were no significant changes to the system other than usual maintenance and minor upgrades, limited to provider contract and benefit maintenance. The Home State Health continued to capture the majority of its claims electronically. The small amount of paper claims received were either for services that required additional documentation, such as medical records, or services rendered by out-of-network providers. Paper claims were submitted to Home State Health's vendor for scanning. The scanning vendor then transmitted the paper claims back to Home State Health in standard 837 electronic format for processing in AMISYS.

Home State Health had very little manual intervention for claims processing. Most of the manual steps in processing were due to high dollar claims that required supervisor approval. Primaris reviewed the coding schemes to determine if nonstandard coding was used. Home State Health did not use any nonstandard coding during the measurement year.

Home State Health's AMISYS system captured primary, secondary, and modifier codes appropriately. Coding updates to the AMISYS system were made annually to ensure the most recent coding schemes

were captured. The majority of Home State Health providers (99 percent) continued to be reimbursed on a fee-for-service (FFS) basis, which ensured that claims were submitted in a timely manner. Primaris reviewed the outstanding incurred but not reported (IBNR) report and found that the majority of all claims were received within 30 days during the measurement year. Home State Health's turnaround time statistics also showed that the majority of claims were processed within 30 days.

Enrollment Data

Home State Health's enrollment data were housed in the AMISYS system, and no changes to the enrollment process were made since the previous year's audit. Enrollment data was still received daily and monthly from the State. New members were processed and entered into AMISYS systematically. Occasionally, enrollment data was added manually upon request by the State. Home State Health's load program contained logic for cross-checking manually entered member information to avoid duplicate records. Home State Health performed monthly reconciliation of enrollment data to ensure all member information was complete and accurate. Additionally, Home State Health submitted enrollment files to its external vendors for processing.

New members were processed and entered into the AMISYS advance system. The systematic process of enrollment at Home State Health included translation and compliance validation of the 834 file and loading the data into AMISYS. The load program contained logic for matching manually entered members for newborns to avoid duplicate records.

Home State Health also processed enrollment changes. Enrollment changes were made primarily via the systematic loads after a change was received in the State files. Change requests submitted via telephone were updated manually by enrollment processors.

Primaris selected a sample of 15 members from a random selection of the subcategories of the EDV and EDU numerators. The reason for randomness was to evaluate the overall program compliance. It was verified that the members were compliant with the measure specifications. Primaris verified age, gender, and enrollment history along with diagnosis and procedure codes. There were no issues found during the system review.

There were no issues identified with Home State Health's enrollment data processes.

Provider Data

There were no changes to the provider process year over year. Home State Health continued to utilize two systems for provider processing, Portico and AMISYS. Provider files were first loaded into Home State Health's Portico system where the provider began the credentialing process. Once the provider was credentialed, the provider information was loaded into AMISYS. Home State Health had a process in place for validating provider information daily to ensure both systems contained the exact same demographic information. Specialties were validated in Portico and then matched with AMISYS.

The two systems used by Home State Health were linked by the unique provider identification number. No significant changes were made to the systems during the measurement year, other than provider maintenance.

Primaris selected a random provider from the PPC measure to verify specialty mapping from Portico to AMISYS and to validate that the two systems maintained accurate information. The audit team had no concerns upon inspection of the data as both provider systems matched perfectly. Additional verification of the provider specialties looked at the provider credentials to ensure they were appropriately captured in both Portico and AMISYS. The credentials review were also compliant and matched both systems.

AMISYS maintained all relevant information required for performance measure reporting. Both Portico and AMISYS contained unique identifiers and captured identical information as expected.

There were no updates or changes to Home State Health's provider data processes, including how it captured provider data through its delegated entities.

Final rate review did not reveal any issues with provider mapping for any of the performance measures.

Medical Record Review Validation (MRRV)

Home State Health was fully compliant with the MRR reporting requirements. Home State Health contracted with Altegra Health, a medical record vendor, to procure and abstract MRR data into Altegra Health's custom measure tools. Primaris reviewed Altegra Health's tools and corresponding instructions. The vendor's reviewer qualifications, training, and oversight were appropriate as defined by the NCQA abstraction qualification standards. Home State Health provided adequate oversight of its vendor and Primaris had no concerns.

The validation team randomly selected 45 numerator positive records from the total numerator positive records abstracted during the HEDIS medical record validation process. The records selected were a combination of prenatal and post-partum numerator positive hits. These records were used to evaluate the abstraction accuracy and to validate the rates submitted for the PPC measure.

Supplemental Data

Although supplemental data is allowed, Home State Health did not use supplemental data for reporting against the measures under review.

Data Integration

Home State Health's data integration process did not change from the previous year's review. Home State Health continued to use Inovalon software for performance measure production but migrated to the new version of Inovalon's QSI product called QSI Excel. Home State Health indicated that there were no significant issues with the migration and no concerns were identified during on-site primary source verification.

Home State Health consistently reviewed the data quality reports from QSI to ensure all data were captured and data errors were followed up on. Home State Health had a two-step validation process that logged records submitted with the file name and record counts. Files with the same name were matched against each other to determine if the record counts matched. The second-tier validation looked to determine error counts and error reasons.

Home State Health conducted a full refresh of data rather than doing an incremental data load. This process captured all changes that may have occurred after the initial data were loaded.

Primaris verified that hospice members were not included in any data files, as required by HEDIS specifications. All hospice members were flagged through claims using the HEDIS code sets for hospice. This flagging was done within Inovalon's software.

Members with duplicate identifiers were mapped to a unique member identifier in AMISYS and all claims were mapped to the new identifier, ensuring that all claims for a member were captured along with their continuous enrollment segments. Home State Health's corporate team, Centene, ran monthly reports from Inovalon's software to review data on a regular basis. Centene frequently produced month-over-month comparison reports to ensure data were complete and accurate.

Primaris conducted primary source verification for each measure's administrative numerators during the on-site audit. Primaris reviewed a minimum of three cases for each measure with an administrative hit to determine whether numerators met age, gender, diagnosis, and procedural compliance with the specifications. Primaris did not find any issues during the primary source review.

Home State Health backed up data nightly and weekly to ensure no data loss and denied having any significant outages during Year 2017. Home State Health's disaster recovery plan was sufficient to ensure data integrity.

No issues were identified with Home State Health's data integration processes.

Home State Health Measure Specific Rates

Table 3-10 Health Care Quality Data Report (HCQDR) for EDV and EDU		
HCQDR #	**Measure Name**	**Total**
6.01	Utilization_MH_ER_Age0-12_Count	424
6.02	Utilization_MH_ER_Age13-17_Count	512
6.03	Utilization_MH_ER_Age18-64_Count	842
6.04	Utilization_MH_ER_Age65+_Count	0
6.05	Utilization_SA_ER_Age0-12_Count	14
6.06	Utilization_SA_ER_Age13-17_Count	80
6.07	Utilization_SA_ER_Age18-64_Count	452
6.08	Utilization_SA_ER_Age65+_Count	0
6.09	Utilization_MED_ER_Age0-12_Count	60,956
6.10	Utilization_MED_ER_Age13-17_Count	15,304
6.11	Utilization_MED_ER_Age18-64_Count	26,244
6.12	Utilization_MED_ER_Age65+_Count	0
6.13	ER_Visits_MH_Age0-12_Count	559
6.14	ER_Visits_MH_Age13-17_Count	808
6.15	ER_Visits_MH_Age18-64_Count	1,221
6.16	ER_Visits_MH_Age65+_Count	0
6.17	ER_Visits_SA_Age0-12_Count	17

6.18	ER_Visits_SA_Age13-17_Count	86
6.19	ER_Visits_SA_Age18-64_Count	590
6.20	ER_Visits_SA_Age65+_Count	0
6.21	ER_Visits_MED_Age0-12_Count	104,384
6.22	ER_Visits_MED_Age13-17_Count	23,458
6.23	ER_Visits_MED_Age18-64_Count	56,713
6.24	ER_Visits_MED_Age65+_Count	0
6.25	ER_FollowUp_MH_Age0-12_Denominator	347
6.26	ER_FollowUp_MH_Age13-17_Denominator	439
6.27	ER_FollowUp_MH_Age18-64_Denominator	743
6.28	ER_FollowUp_MH_Age65+_Denominator	0
6.29	ER_FollowUp_7Days_MH_Age0-12_Count	93
6.30	ER_FollowUp_7Days_MH_Age13-17_Count	139
6.31	ER_FollowUp_7Days_MH_Age18-64_Count	119
6.32	ER_FollowUp_7Days_MH_Age65+_Count	0
6.33	ER_FollowUp_30Days_MH_Age0-12_Count	156
6.34	ER_FollowUp_30Days_MH_Age13-17_Count	201
6.35	ER_FollowUp_30Days_MH_Age18-64_Count	213
6.36	ER_FollowUp_30Days_MH_Age65+_Count	0
6.37	ER_FollowUp_SA_Age0-12_Denominator	11
6.38	ER_FollowUp_SA_Age13-17_Denominator	74
6.39	ER_FollowUp_SA_Age18-64_Denominator	426
6.40	ER_FollowUp_SA_Age65+_Denominator	0
6.41	ER_FollowUp_7Days_SA_Age0-12_Count	1
6.42	ER_FollowUp_7Days_SA_Age13-17_Count	2
6.43	ER_FollowUp_7Days_SA_Age18-64_Count	47
6.44	ER_FollowUp_7Days_SA_Age65+_Count	0
6.45	ER_FollowUp_30Days_SA_Age0-12_Count	1

6.46	ER_FollowUp_30Days_SA_Age13-17_Count	4
6.47	ER_FollowUp_30Days_SA_Age18-64_Count	69
6.48	ER_FollowUp_30Days_SA_Age65+_Count	0

Table 3-11 HEDIS 2017 PPC Rates					
Prenatal and Postpartum Care	**Aggregate**	**Central**	**East**	**West**	**Southwest**
Timeliness of Prenatal Care	87.76%	90.45%	85.64%	73.35%	94.40%
Postpartum Care	73.72%	75.22%	67.40%	66.01%	75.43%

3.3.3 Conclusions

Strengths

- Overall, Home State Health has an excellent oversight of all internal processes and systems, enabling it to collect and capture performance measurement specific items for reporting.
- Team work and coordination with providers, Medicaid case workers and members.
- Provider Engagement.
- Member engagement.
- Home State Health utilized an NCQA certified measures vendor to calculate the rates, ensuring there was additional oversight of the calculations.
- Home State Health's data repository was sufficiently managed and had frequent data backups to ensure no data was lost.
- The Home State Health team provided system experts during the onsite audit which enabled Primaris to easily understand its processes.

Weakness

- One area for concern is Home State Health's management of members' primary demographic information. Member information is captured daily through the state's enrollment file 834; however, many times, the member demographic information is not accurate. The information is

only as accurate as the most recent contact that the member has had with the Medicaid Case worker. Since Home State Health's population moves often and phone numbers are not reliable, this poses a significant barrier to member outreach.

Quality, Timeliness and Access to Healthcare Services

- Home State Health has no barriers to emergency care services nor for prenatal and post-partum care. Home State Health does not require authorization for access to either service.
- From a quality standpoint, members should be encouraged to divert non emergent care services from the ED to the lower level of care found in the urgent care setting.
- Home State Health was able to demonstrate its ability to capture the specific diagnosis codes for each EDV and EDU visit/service.
- Prenatal care is a significant concern for the Medicaid population. Early intervention for prenatal care greatly improves the opportunity for safe and healthy deliveries.

Improvement by MCO from Previous Year

- Home State Health was able to produce the EDV and EDU measure without any concerns this year. It appears that the Home State Health staff were able to understand the specifications better and made coding improvement over the previous review.
- Home State Health made significant improvements in the prenatal and post-partum care rates over a two year period. For Timeliness of Prenatal Care Home State Health increased 6.49 percentage points since the previous years reported rate of 81.27% (Figure 3-5).
- Home State Health had saw a 4.62 percentage point increase from 2016 to 2017 calendar year for Post-Partum Care (Figure 3-6).

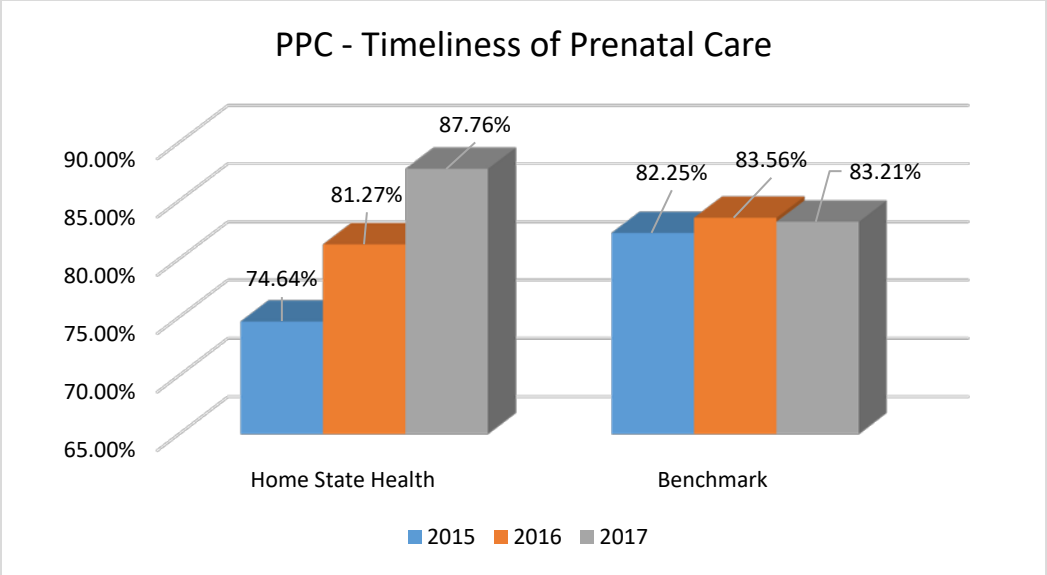


Figure 3-5 PPC (Timeliness)

2018 HEDIS 50th percentile benchmarks are reported by Home State Health

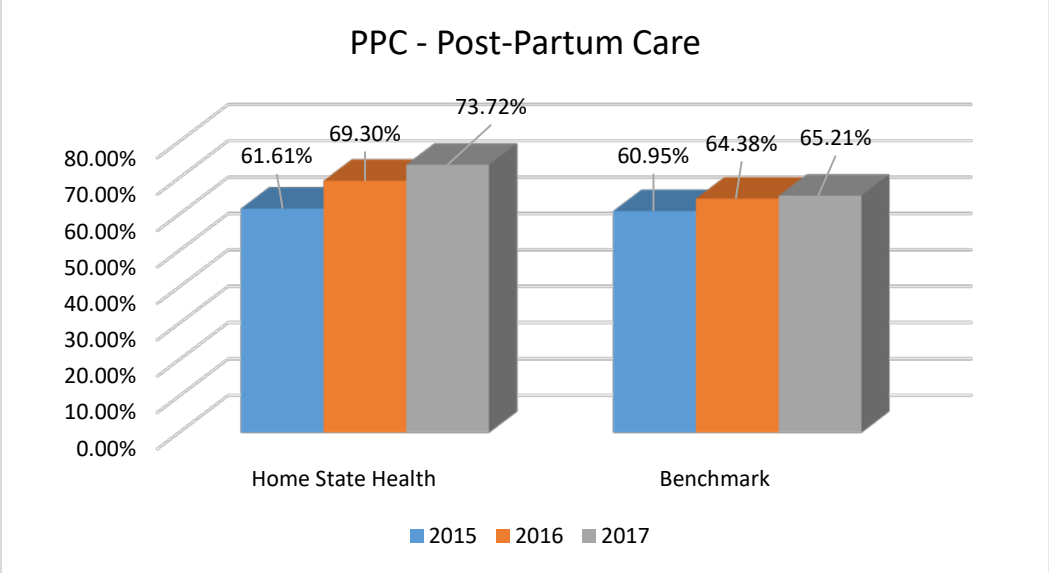


Figure 3-6 PPC (Post-Partum care)

2018 HEDIS 50TH percentile benchmarks are reported by Home State Health

3.3.4 Recommendations

- Home State Health should develop a process for capturing and housing current member demographic information collected through its provider network. Providers, often-times primary care physicians or urgent/emergent care centers should collect the most recent address and phone number information from the member. Home State Health would benefit from setting up a process for capturing this pertinent information from the most recent office visit. Information from providers could be shared with Home State Health on a case by case basis or more frequently to enhance its information currently processed through the daily enrollment files.
- Home State Health would benefit from implementing strategies to engage members in proper maternity care through outreach campaigns once they become aware of a pregnancy. Home State Health should engage providers and immediately begin care management for pregnancies to encourage moms to attend prenatal and post-partum care services.

3.3 (B) Information Systems Capabilities Assessment (ISCA)

3.3.1 (B) Methodology

Primaris assessed Home State Health's Information Systems, Resource Management, Data Processing, and Reporting Procedures. The purpose is to analyze interoperability and reveal the extent to which Home State Health's information systems can support the production of valid and meaningful performance measures in conjunction with their capacity to manage care of their members.

Primaris bases their methodologies directly on the CMS protocol, External Quality Review (EQR) APPENDIX V-Information Systems Capabilities Assessment. It has two attachments:

- Attachment A: Tools for Assessing Managed Care Organization (MCO) Information Systems; and
- Attachment B: Information System Review Worksheet and Interview Guide.

Data collection, review, and analysis were conducted for each review area via the ISCA data collection tools, interview responses, security walk-throughs, and claim/encounter data lifecycle demonstrations. Scores for the ISCA portion align with the other sections of this EQR and are based on the standards for a Met, Partially Met, or Not Met criteria.

Table 3-12 Scoring Key

Scoring Key	Description
Met (pass)	All necessary requirements were proven to be satisfied with supporting documentations, system demonstrations, and staff interviews.
Partially Met (pass)	Some supporting evidence and/or positive results that meet majority *(at least half plus one)* of the requirements and industry standards. *Example: MCO has well-structured documentation around information system processes, and mostly positive results. MCO is fully aware of their opportunity for improvement around their paper claims process and tracking. They have a plan in place working on improvement, provided evidence like meeting minutes, calendar invites, etc. All supporting active improvement activities.*
Not Met (fail)	No supporting evidence or positive results to meet requirements and industry standards. *Example: MCO has no documented processes in place to support their ability to track a claim, which was originally paper, back to its original source. In fact, in the on-site interviews 3 employee mentioned their lack of ability to backtrack as a pain point in their day-to-day activities.*

The ISCA review process consists of four phases:

Phase 1: The MCO's information systems standard information is collected. Primaris sends the ISCA data collection worksheet to the MCO with a deadline to be completed and returned electronically to Primaris prior to the scheduled on-site review activities.

Phase 2: Review of completed worksheets and supporting documentation. All submitted documentation is thoroughly reviewed, flagging answers that seem incomplete or indicated an inadequate process for follow-up. The follow-up questions and review happens during the on-site visit.

Phase 3: Onsite review and walk-throughs. Primaris utilizes time on-site to review any propriety material, live system and security walk-throughs, and interview other members of staff related to their information systems management.

Phase 4: Analysis of data collected during pre and on-site activities. Primaris compares and scores the findings directly against industry standards. Specific focus to 45 CFR Part 160 & 164, section 2.26 of MHD contact, and Medicaid Management Information Systems (MMIS).

Scoring Standards

Scoring Standards Table 3-13 presents the detailed Federal regulations, Missouri HealthNet Division (MHD) State contract requirements, and industry standards Home State Health was evaluated against.

Table 3-13 Scoring Standards

Citation	Source	Description
45 CFR Part 160	Health & Human Services (HHS)	Code of Federal Regulations for General Administrative Requirements' compliance and enforcement for maintaining security and privacy.
45 CFR Part 164 Subpart C	Health & Human Services (HHS)	Code of Federal Regulations Subpart C Security Standards for the Protection of Electronic Protected Health Information.
45 CFR Part 164 Subpart E	Health & Human Services (HHS)	Code of Federal Regulations Subpart E Privacy of Individually Identifiable Health Information.
42 CFR Part 438 Subpart E	Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS)	Code of Federal Regulations Subpart E Quality Measure and Improvement; External Quality Review.
42 CFR Part 438 Subpart H	Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS)	Code of Federal Regulations Subpart H Additional Program Integrity Safeguards.

Section 2.26 MHD Contract	Missouri Health Department (MHD)	Claims Processing and Management Information Systems section.
NIST	National Institute of Standards and Technology	"The Information Systems Group develops and validates novel computational methods, data/knowledge mining tools, and semantic services using systems-based approaches, to advance measurement science and standards in areas such as complex biological systems, translational medicine, materials discovery, and voting, thus improving the transparency and efficacy of decision support systems" **
ANSI ASC X 12	American National Standards Institute, the Accredited Standards Committee	"The American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for inter-industry electronic exchange of business transactions, namely electronic data interchange." ***

References: ** - *https://www.nist.gov/*

*** - https://www.edibasics.com/edi-resources/document-standards/ansi/

3.3.2 (B) Findings

1. Information Systems 

This section of the ISCA evaluates the MCO's management, policies, and procedures surrounding their

information systems. Detailed review is conducted to thoroughly assess the information systems capacity for collecting, filtering, transforming, storing, analyzing, and reporting Medicaid data.

Home State Health's claims data is housed in Amisys and is loaded into their Enterprise Data Warehouse (EDW) which runs on a Teradata warehouse appliance. The Home State Health utilizes Amisys Advanced as the primary claims system to administer medical claims which uses Oracle RAC as the backend DBMS. This is used for analytical, compliance and operational reporting. This data is continuously staged from Amisys to the EDW using Informatica PowerExchange, and then nightly batch loaded into the analytical and reporting layers. MicroStrategy is the primary tool used for reporting and executive dash boarding of the EDW data.

For HEDIS reporting, all claims and member data is loaded from EDW into the Catalyst Quality Spectrum Insight (QSI) application which utilizes MS SQL Server as a DBMS. Ingenix ImpactPro is another analytical tool used by Home State Health medical management for assessing gaps in care and acuity for Care Management of members. Encounter Data Manager (EDM) is a source for the data used to reconcile against claims payables to validate completeness and compliance encounters submission to the State Department of Health and Human Services.

Home State Health has a formal change control process and follows a detailed and documented procedure for changes to existing applications. The change request (CR) process is controlled through the use of a software change management solution which is a process workflow, approval, and documentation tool. All changes to Home State Health's applications are initiated with a CR. The CR requires the requestor to provide information regarding the change: type of change, description of systems, business areas affected, and the impact to IT and business areas. This information is used to evaluate the risk of the change and will determine the required levels of approval necessary before the change is completed and migrated into production. Both configuration and program changes are tested by Information Systems and the end user before they are submitted for migration into production. For programming changes, a staff person from the Release Team follows a checklist to ensure all are met prior to moving code into production. Home State Health has separate development, test and production environments used to control programming activities. To migrate a change between environments, specific approvals are required. The approval requirements are established through policy and process documentation and enforced through the change management system.

Data extracts, transformations and loads (ETL) are done using industry standard 4GL tools: Informatica PowerCenter and Microsoft SSIS products. Direct SQL is used where necessary to fine tune performance of the ETL. There are approximately 573 people (261 employees and 312 contingent workers) trained and capable of making changes to the programs.

Home State Health's programmers have diversified experience in programming languages systems such as SOAP, COBOL, Java, JavaScript using Node and Angular .NET, C#, and object oriented methodologies and operating systems such as UNIX, Linux. Home State Health provides training through outside training companies, and vendors to gain the skills necessary for the current IT environment as well as future technologies. They also provide internal training through Pluralsight and the Corporate University. In addition the programmers have been trained in Health Insurance portability and Accountability Act (HIPAA) and methodologies such as IT infrastructure Library (ITIL) and Agile development.

2. I T Infrastructure

This section of the ISCA evaluates the MCO's network infrastructure and ability to maintain its equipment and telecommunicates capacity to support end users' needs.

Centene, parent company of Home State Health, operates two data centers. Their primary data center is located in St. Charles County, Missouri and their disaster recovery back-up site is located in Sacramento County, California. Both data centers operate in a "hot backup" contingency mode for essential business functions. The primary data center is a LEED certified, Tier 3 site with capacity for 384 IT racks, and over 18,000 square feet of raised datacenter floor. Both facilities employ redundant environmental, power, and networking systems, and backup capability, and are hardened to withstand natural disasters (e.g., tornado, earthquake, fire). If a site-disabling event does occur in the Primary Datacenter, in which the Datacenter is destroyed or damaged, critical voice and networking processes would be redirected to the secondary data center in near real-time. The secondary data center can quickly recover critical voice network operations and resume essential business and IT functions including those related to key member care and provider payment services within 24 hours from the time the disaster is declared. In addition, the two data centers are connected by a fully redundant wide area network (WAN) to ensure that an outage by either telecommunication provider (AT&T and Verizon Communications) will not result in system unavailability.

Systems, storage and network infrastructure is based on a modern multi-tiered design. At the heart of this architecture design are three fundamental principles: reliability, scalability and flexibility. This design approach allows Home State Health to rapidly scale their infrastructure and capacity requirements to more easily adapt to growing business needs while also providing highly-available services to customers. This is accomplished via redundant hardware services and clustering technologies used in everything from enterprise storage to application servers and corporate network.

The claims processing systems are comprised of four integrated servers forming an application cluster. If any node, application, or database experiences a problem, the claim processing service would be redirected to one of the surviving nodes in the cluster thereby averting an outage. This same technology is used to help manage scheduled maintenance activities to reduce the outages for claims processing activities.

In addition, Centene has developed a comprehensive and secure business continuity/disaster recovery plan. Both of Centene's Business Continuity Plan (BCP) and a Disaster Recovery Plan (DRP) meet operational requirements. Once a disaster has been declared the necessary business recovery procedures would be invoked and restoration of all critical business functions would begin at the Secondary Datacenter recovery facility. Critical services would be recovered within 24-36 hours of the declared disaster. The BCP and DRP are updated and tested annually.

3. Information Security

This section of the ISCA evaluates the MCO's information systems and the safeguards in place to proactively avoid malicious access to facilities and/or data systems, intrusions, and breaches of protected health information (PHI) and personally identifiable information (PII).

The following provisions are in place for physical security of Home State Health's computer system and manual files:

a. Premises: The premises are guarded with security personnel, monitored surveillance cameras, and require authorized electronic badge access to gain entry to any area within the premises.

b. Documents: Have eliminated hard copies of patient records and secured the electronic data through multiple layers. This includes mechanisms designed to keep people from accessing systems, such as complex passwords, secure file systems, encryption, and strict policies and procedures surrounding the handling and use of PHI.

c. Computer facilities: Computer systems are maintained at the Centene Corporate Primary Datacenter facility in O'Fallon, MO.

d. Terminal access and levels of security: The Incident Response Operations Center (IROC) monitors network access attempts to protect systems and databases from unauthorized access. All of these measures work together to ensure the protection of data.

Providers have access to select Home State Health' systems. Providers with access through the Web to view data can access data through a secured process and view only a copy of the data provided through Home State's Operational Data Store processes. Strict controlled security measures are in place to prevent anyone from accessing core systems such as Amisys. Files for vendors and providers are posted on their SFTP site. These business partners are given logon and passwords in order to secure transactions and limit access to restricted data elements.

4. Encounter Data Management

This section of the ISCA evaluates the MCO's ability to capture and report accurate encounter data. Home State Health adheres to National Committee for Quality Assurance (NCQA), American Medical Association (AMA) coding, Uniform Billing (UB-04) Editor, National Council on Compensation Insurance (NCCI), and MHD standards regarding the definition and treatment of certain data elements captured on claims, use of standard codes (including CPT Category I and II, HCPCS Level II and ICD-10-CM), counting methods, units, etc. In addition to pre-adjudication edits, all claims that successfully pass the pre-processing edits are immediately loaded for adjudication into AMISYS Advance, the claims processing system. AMISYS Advance performs six primary steps of adjudication that a claim must successfully pass through in logical succession to reach a "finalized" (paid or denied) status, or internally pended status including: field and general edits, member data edits (e.g., eligibility for services), provider data edits (e.g., eligibility and status), prior-authorization validated when required, services are covered, pricing including member third party liability (TPL) or coordination of benefits (COB) financial responsibilities, copayments or deductible amounts, and provider specific contractual and financial agreements. The payment step also applies state reimbursement rules.

Home State Health processors cannot change the data that was submitted on the claim. If the provider submits incorrect information or wishes to change key data elements on the claim they are

required to submit a corrected claim in a timely manner. If the information provided on the claim is not valid, it is rejected before it makes it into the claim adjudication system.

All Medicaid claims are audited regularly, with the results reported monthly. A random sample of adjudicated claims is audited for financial, payment and processing accuracy. In addition, production standards are monitored by Claims Operations Management on a daily and monthly basis to ensure compliance to the following standards:

- 100% of clean claims will be finalized to a paid or denied status 30 calendar days from receipt.
- 99% of non-clean claims will be finalized to a paid or denied status 60 calendar days from receipt.
- 100% of claims, including adjustments will be processed and paid 90 calendar days from receipt.

Encounters are reviewed weekly for medical and vendor claims data. The response files (HIPAA 835 and NCPDP- National council for Prescription Drug Programs), are reviewed for completeness and acceptance by the state. The acceptance performance is tracked and reported weekly while rejections are reviewed for resubmission.

5. Eligibility Data Management

This section of the ISCA evaluates the MCO's ability to capture and report accurate Medicaid eligibility data.

Eligibility files-834, from the State are received daily/monthly and loaded into Home State Health's system processes. Additional eligibility files are loaded the day they are received. Home State Health does not have any change authority on any discrepancies noted. The files are all loaded electronically, eligibility is verified via the State's website when an issue arises around claims payment or access to services. Providers are expected to verify eligibility at time of service rendered.

Home State Health generates a Member ID based on Medicaid ID on the 834 file received. They also have reports to assist in identifying any duplicate members. If a duplicate member is confirmed, they merge the member in their system and retain both Medicaid IDs for that member. All membership history pertaining to that Medicaid member is retained within their information systems.

Members are dis-enrolled and re-enrolled per instruction from the state via the 834 enrollment files. The member will retain the same ID unless the state assigns a new Medicaid ID, in which case additional checks are used to identify potential duplicate members using member Social Security Number (SSN), Date of Birth (DOB), and Name.

6. Provider Data Management

This section of the ISCA evaluates the MCO's ability to maintain accurate and timely provider information.

Home State Health updates its hard copy provider directory in accordance with the state contract and typically on an annual basis, or more often if there are significant network changes or regulatory requirements. Provider directories are sourced from the Portico Provider Data Management System.

The web based provider directory is updated within 48 hours of a change being made to the provider database management system, Portico. Changes to provider demographic or payment information are not made unless the information is submitted in written format from the provider. Changes, Additions or Deletions are submitted to the Provider Relations team, from the Provider, and are used to update Portico. Once Portico has been updated, Find A Provider (FAP) webpage will be updated within 48 hours as stated above.

Medicaid fee schedules are maintained in the claims system and updated through communication from the State with weekly review of the published fee schedules and Medicaid bulletins.

7. Performance Measures and Reporting

This section of the ISCA evaluates the MCO's performance measure and reporting processes.

Medical claims data is generated from Amisys and stored in Home State Health's Enterprise Data Warehouse (EDW). Vendor data is also stored in EDW. EDW is the data repository to produce Medicaid Performance Reports. Report production logs and run controls are maintained by Home State Health's Computer Operations department. These logs document all jobs that are run, start times, run durations, complete times, abends, warnings, and input/output statistics. All of the performance measure reports are placed in schedules and are run based on the schedule requested. Medicaid report generation occurs from the online production database from AMISYS.

All programs and reports developed for Home State Health follow Software Development Life Cycle (SDLC), requiring complete documentation. Initially, new reports and changes to existing reports come from the state or internal business unit. Change tickets are submitted to the IT staff to work on new reports or changes to existing reports in a development environment. Report requirements are attached to the change ticket. As questions arise, IT personnel work with the business unit and the state

to resolve questions. Those resolutions/decisions are added as documentation to the change ticket. The reports are created or revised in a development environment.

When a new report or changes are made to an existing report, the IT staff performs an internal review on the report. This internal review includes ensuring that the report matches the specification, checking for misspellings, and checking that the data seems reasonable from a technical perspective. Once the report changes pass the internal review, the new report is sent to the business unit for review and approval.

For ongoing established reports, reasonableness and real count checks of abstracts from EDW to QSI are reviewed to ensure they reconcile. An external auditor verifies and certifies the data prior to submitting the final numbers to the state.

3.3.3 (B) Conclusions

Strengths

- Home State Health has policies, procedures, and robust training documentation readily available to all necessary staff.
- Testing processes and development methodologies meet and exceed industry standards.
- Change requests are processed in-house with strict guidelines and are managed by current staff members.
- Primary and back-up disaster recovery physical site servers.
- Comprehensive and secure business continuity/disaster recovery plan.
- Clear documented infrastructure allowing for comprehensive maintenance.
- Security policies are readily available, well documented, and well maintained.
- Home State Health provides HIPAA training and health care data best practices review.
- There are security procedures in place and documented for quick removal of a terminated employee.
- Home State Health has implemented adequate validation edits in its data processes.
- Encounter data is not altered by Home State Health, but sent back to source for correction.
- Consistent communication regarding upcoming changes.
- Unique members ID assignment and duplicate member safeguards.

- Uploads monthly and/or daily eligibility files, keeping information as updated as possible.
- Reporting in place to identify changes in eligibility status and reconcile.
- Home State Health has an active directory available to the public both in paper and online.
- Home State Health has the expertise and many experienced staff members for developing queries and reports.
- Robust processes and documentation is available regarding performance measure reports.

Weaknesses

Home State Health's staff alleged that about 60% of the members' primary demographic information included in the eligibility/enrollment file 834 is unusable; missing data, incorrect data. The lack of data on the eligibility/enrollment file creates a large bottle neck in processes and requires work arounds when storing new-found data. This weak point of data collection does affect other areas of Care Management as well. It creates additional work when trying to reach the members, especially when bound by a timeline constraint, directly contributing to poor performance score for Care Management.

3.3.4 (B) Recommendation

A complete assessment of Home State Health's Information System's documentation and related onsite activities revealed an opportunity for improvement concerning the data collection and integration structure around the 834 file routinely received from the State. The Home State Health officials alleged that the file has 60% of missing/incomplete/erroneous data related to members' primary demographic information.

These unusable data elements are not due to any systems integration issue but arise from the inability to bilaterally update member information obtained from the various other sources by Home State Health. Consequently, it impacts the quality of Care Management Home State Health is able to provide its members. This creates a need for extra resources in order to successfully contact a member, especially within an obligated short timeframe. The staff at Home State Health work diligently to contact members to the best of their ability, by contacting multiple times, leaving messages, having calendar reminders for follow up, and are often able to collect correct contact information for their members. Subsequently,

they have to store that information in a separate area to avoid its loss when they receive the next 834 file, as the 834 file overrides all the other previously stored data.

Primaris strongly recommends that the State and Home State Health work towards a collaborative solution for the ability to update and access more accurate and useful member contact data. This will create a complete data integration solution delivering trusted data from various sources. Efforts in this area will positively affect the number of Care Management offerings to members within effective timeframes. Improvement here will also increase the Home State Health's ability to reach the member with educational materials and important plan updates, thus improving their quality outcomes.

3.4 Validation of Performance Improvement Projects

3.4.1 Methodology

Primaris followed guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, EQR Protocol 3, Version 2: Validating Performance Improvement Projects.

During calendar year (CY) 2017, MHD required Home State Health to conduct two (2) PIPs-

- One (1) clinical: Improving Childhood Immunization Rates (Combo 10); and
- One (1) nonclinical: Improving Access to Oral Healthcare.

Primaris gathered information about the PIPs through:

- Documents Submission; and
- Interview: The following Home State Health officials were interviewed to understand their concept, approach and methodology adopted for the PIPs:
  Megan Barton, Vice President Medical Management.
  Dana Houle- Senior Director, Quality Improvement.
  Douglas H Watts Manger, Quality Improvement.

The activities conducted for PIPs Validation are as follows (details of all the activities and the corresponding findings are presented in the appendix A):

Activity 1. Assess the study methodology

This included a review of: the selected study topic(s), the study question(s), the identified study population, the selected study indicators, sampling methods (if sampling used), data collection procedure, data analysis and interpretation of study results.

Assessment of the following was done:

- The MCO's Improvement strategies;
- The likelihood that reported improvement is "real" improvement:
  - Benchmarks for quality specified by the State Medicaid agency or found in industry standards; and
  - Baseline and repeat measures on quality indicators will be used for making this decision.

  Note: *tests of statistical significance calculated on baseline and repeat indicator measurements was not done by EQRO.*
- The sustainability of documented improvement.

Activity 2. Verify Study Findings (Optional)

MHD may elect to have Primaris conduct on an ad hoc basis when there are special concerns about data integrity. *(**Note:** this activity was not done by EQRO and written as N/A).*

Activity 3. Evaluate and Report Overall Validity and Reliability of PIPs Results

The PIPs will be rated as: High confidence, Confidence, Low confidence, Reported PIP results were not credible- as defined earlier in the section 1.3.3 of this report.

3.4.2 Findings

(A) PIP Clinical: Improving Childhood Immunization Status (CIS Combo 10)

Description of Data Collected

For the purpose of this PIP, Home State Health assessed the immunization rates as defined by the NCQA HEDIS 2018 (H2018) Technical Specifications for Childhood Immunization Status (CIS), for the following vaccinations by their second birthday (NCQA CIS Combo 10):

NCQA Combo 10 includes:

- Four Diphtheria, Tetanus, and Acellular pertussis (DTaP);
- Three Polio (IPV);
- One Measles, Mumps, And Rubella (MMR);
- Three Haemophilus Influenza Type B (HiB);
- Three Hepatitis B (HepB);
- One Chicken Pox (VZV);
- Four Pneumococcal Conjugate (PCV) vaccinations;
- One Hepatitis A (HepA);
- Two Or Three Rotavirus (RV) vaccinations; and
- Two Influenza.

Aim: To increase the CIS rate for Combo 10 immunizations for CY 2017 by three (3) percentage points between CY 2016 and CY 2017.

Study Question: "Will directing targeted member and provider health promotion and awareness activities increase the percentage of Home State Health children under age two (2) who are immunized by three (3) percentage points between HEDIS 2017 (H2017) and HEDIS 2018 (H2018)?"

Study Indicator: the CIS rate of members under 2 years of age who meet the compliance requirements set forth in the NCQA HEDIS Childhood Immunizations (CIS) technical specifications applicable for the measurement year (CY 2017).

Study population: Includes all eligible Home State Health members under two (2) years of age.

Sampling: The HEDIS Technical Specifications dictate a systematic sampling scheme for hybrid measures such as CIS rate, for H2018, a random sample of 411 members was taken.

Baseline Data: The baseline for this PIP is Home State Health's Childhood Immunization (CIS) Combo 10 final rates for H2017 (CY 2016) as stated in Table 3-14.

Table 3-14 Home State Health CIS Combo 10 Baseline Rate (CY 2016)

HEDIS Year	Home State Health Combo 10 Rate	NCQA 50th percentile	NCQA 95th percentile
2017	24.04%	33.09%	51.82%

Procedure

CIS Combo 10 compliance was determined using administrative claims (using The American Medical Association's (AMA) Current Procedural Terminology (CPT) codes) and non-claims clinical data. Additionally, Home State Health retrieved medical records from a variety of providers in order to capture documentation of immunizations administered which might not have been submitted to the Missouri Department of Health and Senior Services' ShowMeVax immunization registry. These medical records are accounted for the HEDIS Hybrid Technical Specifications and are entered as non-standard administrative data in our HEDIS rates.

Home State Health uses Quality Spectrum Insight (QSI), an NCQA certified measure software, to analyze claims data to determine compliance with this measure. Missouri Health Plus sends non-claims, clinical files to Centene Corporation for Home State Health members on a monthly basis. These supplemental data files are loaded into Centene's Enterprise Data Warehouse (EDW).

HEDIS rates are reviewed each month from QSI flowchart run reports based on claims data, state immunization registry, non-claims-clinical data received electronically via data exchange. QSI generated care gap reports are used each month to assess members meeting the denominator criteria who have not yet met the measure specifications and pursue medical records from treating providers, clinics and/or health departments to retrieve medical documentation to support immunizations delivered but not captured via electronic means.

Following the current HEDIS Technical Specifications as applicable for the measurement year, the Centene Corporate HEDIS department runs an ETL (extract, transform, and load) process of Home State Health administrative data from the EDW into QSI on a monthly basis. The Home State Health's QI staff extract the monthly preliminary HEDIS results to analyze and determine effectiveness of interventions based on changes in the CIS rate. The Home State Health HEDIS team analyzes the CIS measure data to identify all members who are non-compliant for the measure for appropriate outreach.

Home State Health performs a HEDIS measurement at the end of each subsequent year using Quality Spectrum Insight (QSI), which includes the HEDIS Technical Specifications enrollment criteria. The quality measurement for this study includes:

- Denominator: Home State Health members under two (2) years of age, enrolled on 12/31 of the measurement year, who were continuously enrolled in the measurement year with no more than one gap in enrollment of up to forty-five (45) days during the measurement year.

- Numerator: Home State Health members in the denominator who met the measure specification requirements for CIS Combo 10 as defined by the H2018 Technical Specifications.
  Home State Health monitors this study indicator throughout the year (at minimum quarterly) to monitor the effectiveness of the interventions and to determine if additional interventions are needed. The annual report of this measure is audited by an NCQA certified HEDIS auditor.

Intervention and Improvement Strategies:

Home State Health have ongoing interventions from the past years, not limited to the following listed in Table 3-15:

EPSDT Program includes outreach to members at strategic milestones encouraging their engagement in wellness activities, including childhood immunizations. Through monthly assessment of member engagement, Home State Health outreaches members who have not obtained their immunizations in the following ways:

- Live and automated telephonic outreach;
- Member services inbound call interactions;
- Care management interactions; and
- Birthday card reminder mailings.

Home State Health's pay-for-performance improvement programs that were initiated in 2015 continue to date, and have evolved to increase the number of in-network participating providers.

Table 3-15 Home State Health Childhood Immunization Interventions based on Barrier Analysis

Date	Ongoing Interventions	Root Cause Addressed	Potential Impact	Outcome
2016 & ongoing	Implemented STL Medical New Mom and Traditional EPSDT tangible incentive and texting programs aimed at educating parents in their preferred mode of	Lack of parental awareness of the benefits of and access to immunizations for their children under 2 years of age.	Increasing the number of children who need vaccinations by their 2nd birthday.	In 2016, Home State Health distributed 3,751 Childhood Immunization education mailers to families with

	communication and incentivizing healthy behaviors, including childhood immunizations.			children eligible for this measure. In 2017, 6,6,81 mailers were sent.
Q2 2017	Implemented quarterly validation of provider database based on claims evidence.	Inconsistency of provider-member relationship attributed to imputed vs. assigned provider	Improving the ability to locate member medical records for compliant visits/immunizations	Home State Health identified that approximately 40% of membership have no discernable PCP relationship.
Q3 2017	Expanded electronic medical record (EMR) access to Home State Health Quality Improvement Department staff. Implemented utilization of HEDIS User Interface (HUI). It is an interactive and routinely updated database used for HEDIS reporting and a standardized mechanism to add non-standard supplemental data to demonstrate more accurate childhood immunization rates.	Compliant immunization data unavailable to Home State Health Insufficient processes/systems to support the reporting of immunization supplemental data following NCQA specification and auditor approval to support HEDIS reporting requirements.	Improving the ability to locate member medical records for compliant visits/immunizations Providing a more accurate and timely representation of HEDIS rates; supporting collection and oversight process available.	In 2017 Home State Health acquired EMR access to 8 providers servicing over 100,000 Home State Health members. For H2018, Home State Health utilized HUI for 3,741 immunization events that were not captured via claims or other supplemental data sources.

PIP Results

- The Statewide CIS Combo 10 rate for Home State Health in CY 2017 (H2018) was 27.01% as compared to the rate in CY 2016 (H2017-24.04%), shown in the Table 3-16. Between H2017 and H2018 (CY 2016 and CY 2017), the statewide CIS Combo 10 rate increased by 2.97 percentage points, which is not statistically significant. The aim of the PIP to increase by 3% point could not be achieved. It fell short by 0.03% point. Home State Health is far too behind the contractual requirement to meet the goal of 90% rate.
- The rates of CIS Combo 10 increased in each individual region between H2017 and H2018 (CY 2016 and CY 2017) from the 10th to the 25th percentile. Additionally, Home State Health demonstrated statistically significant increases in the rates of Combo 10 in the Western region between H2017 and H2018.

Table 3-16 Trends in Home State Health HEDIS CIS Combo 10 Rates H2015-H2018

HEDIS Year	Statewide (STWD)	Eastern Region (EMO)	Central Region (CMO)	Western Region (WMO)	NCQA Quality Compass 50th Percentile
H2015	24.90%	25.72%	28.77%	22.12%	34.18%
H2016	26.44%	28.61%	19.95%	19.95%	32.64%
H2017	24.04%	25.00%	18.51%	19.23%	33.09%
H2018	27.01%	25.55%	21.90%	27.49%	Not Reported

(B) PIP Non Clinical: Improving Access to Oral Healthcare

Description of Data obtained

Oral health is an integral component of children's overall health and well-being. Dental care is the most prevalent unmet health need among children. Statistics from the Centers for Disease Control and Prevention (CDC) reveal that over two-thirds of children have decay in their permanent teeth (ref: Children's Oral Health 2007,CDC Oral Health Resources).

The connection between oral health and general health is not often made by Medicaid recipients who frequently encounter other socioeconomic challenges Underutilization of dental services is not a problem specific to the Medicaid population.

Aim: To increase the Annual Dental Visit (ADV) rate by three (3) percentage points between CY 2016 and CY 2017.

Study Question: "will implementing the proposed interventions to Home State Health members between ages 2 through 20 increase the ADV rate per the HEDIS specifications by 3 percentage points between Home State Health's HEDIS 2017 (H2017) and HEDIS 2018 (H2018) results?"

Study Indicator: The rate of Home State Health members age two through twenty years old who had at least one dental visit during the measurement year (CY 2017) as measured by the HEDIS ADV total rate through the administrative method of measurement.

The study population: Includes all eligible Home State Health members ages two through twenty.

Sampling: No sampling was done. All members from age two through twenty were included in the PIP.

Baseline Data: The Home State Health baseline for this performance improvement project is the plan's ADV final rates for HEDIS Year 2017. For comparison purposes, the NCQA Quality Compass percentile targets for both the 25th and 50th percentile are referenced.

Table 3-17 Home State Health ADV Baseline Rate (CY 2016)

HEDIS Year	Home State Health ADV Rate	NCQA Quality Compass 25th percentile	NCQA Quality Compass 50th percentile
H2017	39.91%	46.27%	54.93%

Procedure

Home State Health uses QSI XL, an NCQA-certified HEDIS software, to analyze claims data to determine compliance with this measure. Administrative claims are gathered using the American Dental Association's (ADA) Current Dental Terminology (CDT) and the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes as well as non-claims administrative data. Envolve Dental sends Centene Corporation claims files for Home State Health members on a monthly basis. These supplemental data files are loaded into Centene's Enterprise Data Warehouse (EDW).

The H2018 Technical Specifications eliminated the Dental Visits Value Set, which is "the complete set of codes used to identify a service or condition included in a measure". This change now allows any visit with a dental practitioner during the measurement year to be counted in the ADV rate, rather than only particular types of visits, as before.

Following the current HEDIS Technical Specifications, the Centene Corporate HEDIS department runs an ETL (extract, transform, and load) process of Home State Health's administrative data from the Enterprise Data Warehouse into QSI XL on a monthly basis. Home State Health QI staff then extract the monthly preliminary HEDIS results to analyze and determine the effectiveness of interventions based on changes in ADV rate. The Corporate HEDIS team also runs the ADV measure without the continuous enrollment factor to allow Home State Health to determine all members who are non-compliant for the measure for appropriate outreach. In addition, the vendor contracted to conduct outreach calls to encourage members to utilize their dental benefits periodically provides data on their contact rates.

Home State Health performed a HEDIS measurement at the end of subsequent year using Quality Spectrum Insight XL (QSI XL), which included the HEDIS Technical Specifications enrollment criteria. The quality measurement for this study includes:

- Denominator: Home State Health members ages 2 through 20, enrolled on 12/31 of the measurement year, who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year.
- Numerator: Home State Health members in the denominator who had one or more dental visits with a dental practitioner during the measurement year.

Home State Health monitored this study indicator throughout the year - at minimum quarterly - to monitor the effectiveness of the interventions and to determine if additional interventions were needed. The annual report of this measure is audited by an NCQA certified HEDIS auditor.

Intervention and Improvement Strategies

- Home State Health's EPSDT program includes outreach to members at strategic milestones, encouraging their engagement in wellness activities, including oral health. Through monthly assessment of member engagement, Home State Health outreaches members who have not completed their annual dental visits in multiple ways:

- Live and automated telephonic outreach;
- Member Services inbound call interactions; and
- Care Management interactions and birthday card reminder mailings.

- In conjunction with the MO HealthNet contract effective May 1, 2017, Home State Health implemented a warm, telephonic outreach campaign with AlphaPointe, a sheltered workshop in Missouri. Following state approval of the Annual Dental Visits script on August 18, 2017, these calls were initiated in September and ran through the end of December, 2017.
- Table 3-18 lists interventions implemented in 2016 and 2017 to address specific barriers to reaching ADV rate goals.

Table 3-18 Home State Health Oral Health Interventions based on Barrier Analysis

Date Implemented	Ongoing Interventions	Barriers Addressed	Outcomes
Q2 2016	Existing eligible members received Primary Care Dental (PCD) assignment ID cards in the mail in June 2016. Newly eligible Adult PCD assignment ID cards mailed in July 2016.	Access to dentists and availability of appointments.	Plan to continue in H2018. At time of initial implementation, this was mailed to the entire eligible population. Newly enrolled members receive PCD assignment cards upon enrollment.
Q2 2017	Automated Static Telephonic Messaging sent to all Members identified as not having an annual dental	Member knowledge of dental benefit, access to dentists, and transportation benefit.	Plan to continue in H2019.

	visit in the past 365 days was deployed in June 2017.		
Q3 and Q4 2017	Members identified as not having received their annual dental visit were contacted by AlphaPointe, a contracted vendor, to be reminded of their dental benefit, preferred dentist and, if applicable, of their benefit to receive transportation to and from their dental visits.	Member knowledge of dental benefit, access to dentists, and transportation benefit.	Plan to continue in H2019.
Q4 2017	Oral Health Texting Campaign 11/16/17.	Member knowledge of dental benefit and recommended frequency for dental exams.	Plan to continue in H2019.
Q4 2017	Toothbrush Timer Texting and app for cell phones 12/28/17.	Member knowledge of dental benefit	Plan to continue in H2019.

PIP Results

- Outreach campaign with AlphaPointe had the following impact on members:
  - 9% (544/6,374) Members set up and completed their dental required visit after the AlphaPointe call;
  - 85% (5448/6,374) Members did not complete their dental required visit after the AlphaPointe call; and
  - 11% (700/6,374) Members opted into Home State Health's texting program which addresses wellness behaviors in general, including annual dental visits.

- The intervention about sending an automated static telephone message to all households where at least one Member in the eligible population had no evidence of completing an annual dental visit within the past 365 days as well as sending oral health related text messages to all households where texting Opt In has been documented, resulted in 10,700 Members who have opted into receiving text messages related to wellness behaviors.
- The Statewide ADV rate for Home State Health in CY 2017 (H2018) was 41.63% as compared to the rate in CY 2016 (H2017-39.91%), shown in Figure 3-19.
- Between H2017 and H2018 (CY 2016 and CY 2017), Home State Health's statewide ADV rate increased by 1.72 percentage points which is statistically significant. However, the aim of the PIP to increase by 3% point could not be achieved.
- There has been an increase in ADV rates in Eastern, Central and Western region of Missouri between H2017 and H2018 (CY 2016 and CY 2017). The largest increase has been in the Eastern region (2.83% point) which is statistically significant, where the plan is headquartered and where the largest concentration of members resides.
- The ADV rate in the new, Southwest Region (effective 5/1/17) was 52.82%, or 9.96 percentage points higher than the Eastern Region at 42.86%.

Table 3-19 Trends in Home State Health HEDIS ADV Rates H2015-H2018

HEDIS Year	Statewide (STWD)	Eastern Region (EMO)	Central Region (CMO)	Western Region (WMO)	Southwestern Region (SWMO)	NCQA Quality Compass 50th Percentile
H2015	41.77%	41.26%	40.31%	43.08%	N/A	52.65%
H2016	40.90%	41.37%	37.73%	40.95%	N/A	51.7%
H2017	39.91%	40.03%	39.83%	39.77%	N/A	54.93%
H2018	41.63%	42.86%	40.62%	40.10%	52.82%	Pending

3.4.3 Conclusions

PIPs Score

The following score was assigned to both the CIS Combo 10 and Oral HealthCare PIPs:

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Strengths

- The interventions are developed based on barrier analysis
- Home State Health was able to take up the challenge of almost 100% increase in the member population in May 2017, after the statewide expansion of Managed and yet achieve the highest rate for ADV measure (52.82%) in the southwestern (new region) as shown in the Table 3-19.

Weaknesses

PIPs' Approach

- The PIPs did not meet all the required guidelines stated in CFR/MHD contract (Ref: 42 Code of federal Regulations (CFR) 438.330 (d)/MHD contract 2.18.8 d 1):

Table 3-20 CFR guidelines for PIPs

CFR Guidelines	Evaluation
Measurement of performance using objective quality indicators	Partially Met
Implementation of system interventions to achieve improvement in quality	Met
Evaluation of the effectiveness of the interventions	Not Met
Planning and initiation of activities for increasing or sustaining improvement	Partially Met

- The aim was not clearly written. The baseline rate and rate to be achieved (aim) were not stated.

- The PIPs were not conducted over a reasonable time frame (A calendar year). They continued for years from the past and at varying times throughout the year.
- The interventions were not specifically designed for these PIPs. They were on going for years at State or corporate level, overlapped in the measurement year, thus the impact of an intervention could not be measured.
- Annual evaluation of HEDIS CIS/ADV rate was used as quality indicators, which is a requirement for performance measure reporting by MHD/CMS (Centers for Medicare and Medicaid Services)/NCQA (National Committee for Quality Assurance). The indicators were not specifically chosen to measure the impact of interventions.
- The HEDIS CIS/ADV rates could not be tied to any intervention.
- Monthly measurement of HEDIS rates is mentioned by Home State Health but data/run charts were not submitted.

PIP Results

- Home State Health's CIS Combo 10 rates did not increase as expected. Potential reasons submitted by Home State Health were:
  - Lack of focus of prior interventions on incentivizing and mobilizing members to seek out their immunizations; and
  - Insufficient reporting by providers of immunization administrations, as well as a need for enhanced capturing and validation of those that are reported.
- Home State Health's ADV rates did not increase as expected. Potential reasons include the following flaws in the interventions Home State Health has historically implemented:
  - Many of the interventions were forward looking and structural in nature.
  - The initiative with St. Louis Medical provided the member (parent) with a toothbrush, floss and toothpaste, along with a card informing the parent of how to locate a dental provider. This was informative, but did not actually create a visit to the dentist.
  - The utilization of Dental Vans did not yield a substantive increase in the ADV rate; although this intervention was designed to add convenience to an actual visit, the van providers refused to comply with billing standards that would become numerator compliant. Historically, dental vans have not contributed significantly to ADV rates.

- Affinia Healthcare, a large FQHC with over 90 dental chairs, had administrative and provider challenges which restricted forecasted volumes of treatments.

Quality, Timeliness and Access to HealthCare Services

CIS Combo 10

- Home State Health will to continue its infrastructure interventions. They will assess its more direct, member-facing interventions for effectiveness, focusing on increasing provider involvement, capturing immunization administrations, and validation of data output analysis.
- During CY 2017, Home State Health continued interventions started in 2016 about EPSDT program which aimed at increasing CIS rates and developed improved data flow with key partners.
- Throughout 2017, Home State Health continued to work toward a project agreement with Missouri Health Connection (MHC), a statewide health information exchange network. Home State Health seeks to collaborate with MHC to develop an agreement and scope of work to include bi-directional information sharing between Home State Health and MHC, including membership and clinical data. This will allow Home State Health to collect additional HEDIS data, including immunizations, and enable reporting through supplemental data. In 2018, Home State Health continues to work with MHC toward this collaborative data exchange.

Access to Oral HealthCare

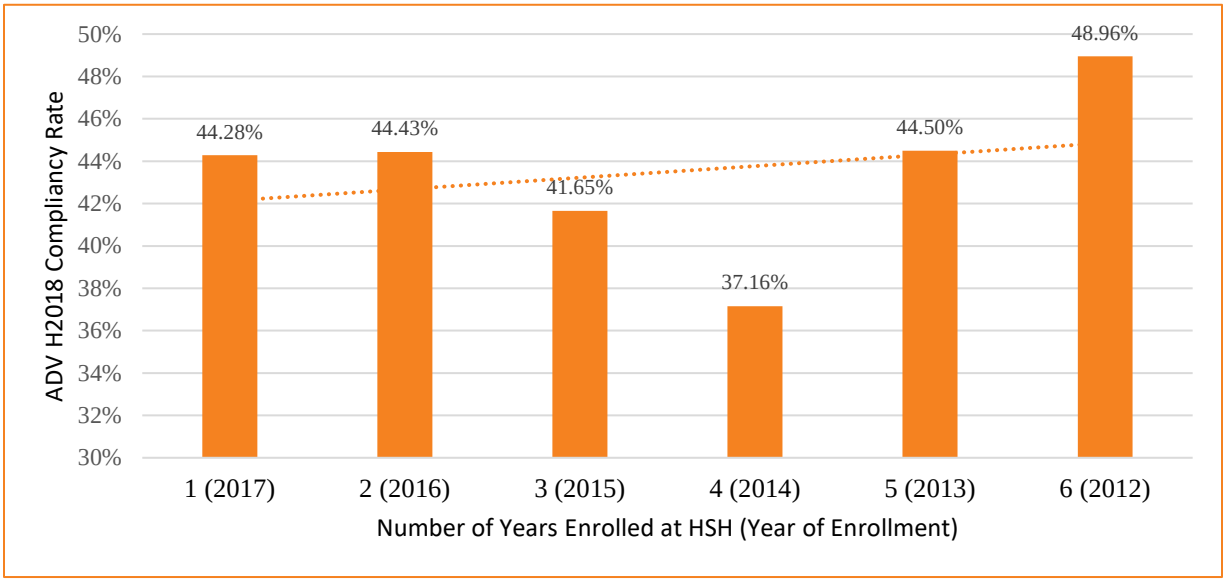
- Home State Health experienced an increase in ADV between H2017 and H2018. Home State Health has committed to a number of long term projects designed to empower providers with the ability to identify non-compliant members and to conduct assessments, treatments and referral of members with oral health problems.
- Home State Health has also promoted long-term plans for members to develop a dental home, receive electronic communication regarding oral health, receive fluoride varnish, and increase choices for dental access.
- Home State Health will continue to fully participate and collaborate with the Missouri Dental Task Force to develop innovative methods to provide dental services to the eligible population. Home State Health believes that the Quality Improvement Team's efforts in both HEDIS and EPSDT member outreach as well as the collaboration with the Missouri Coalition for Oral Health (MCOH)

and the Missouri Department of Health and Senior Services (DHSS) implementation of Women, Infants and Children (WIC) Program based oral health services will contribute to future ADV rates.

- The most likely reason reported by Home State Health for the lack of improvement in ADV rate, is its precipitous increase in membership, due to both auto enrollment as well as Home State Health's statewide expansion in calendar 2017 when the plan went from 109,000 members to over 270,000 members. Newer members may not be familiar with the managed care processes or have an established relationship with their MCO or their provider(s).

  Based on the graph below, Primaris noted that there is a minimal decrease of 0.15% point in ADV compliancy rate in CY 2017 in comparison to CY 2016. The explanation provided by Home State Health attributing the increase in members for the cause of low ADV rates, does not appear to be valid. Home State Health was able to maintain the compliancy rate from previous year.

Figure 3-7 Home State Health HEDIS ADV H2018 Compliancy Rate by Number of Years Enrolled



Improvement by MCO from the previous year (CY 2016)

- No improvement in the approach or methodology of PIPs was noticed in CY 2017. The report from the previous year's EQRO stated the same issues that were noticed by Primaris in EQR 2018. Home State Health continued to use ongoing interventions that have failed to create the anticipated change in these projects.

- The recommendations from previous EQRO were not followed. It was suggested that innovative approaches to positively impact the problems identified were necessary. As interventions are implemented, a method to measure each interventions' outcome must also be introduced. These elements were missing in the PIP for CY 2017 as well.
- However, the CIS combo 10 rate Statewide increased in CY 2017. Even though the goal/aim for PIP was not achieved, the ongoing interventions and the new ones together increased the rate from previous year by 2.97% point.

  Similarly, the ADV rate increased by 1.72% point statewide and in the three regions (Eastern, Central, and Western) from the CY 2016.

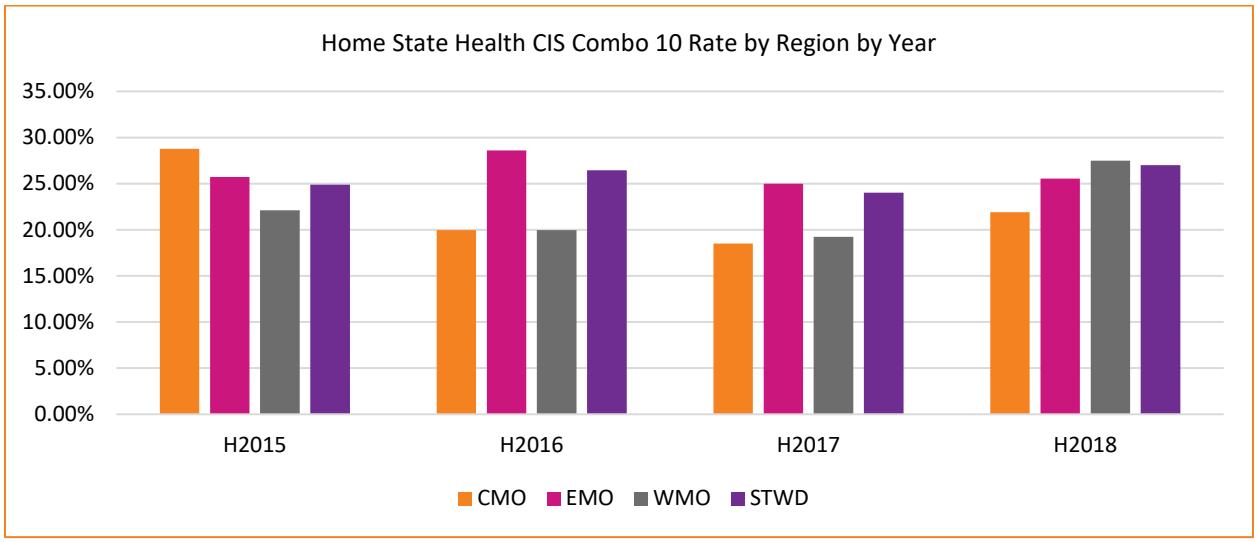


Figure 3-8 Trends in Home State Health HEDIS CIS Combo 10 Rates by Region

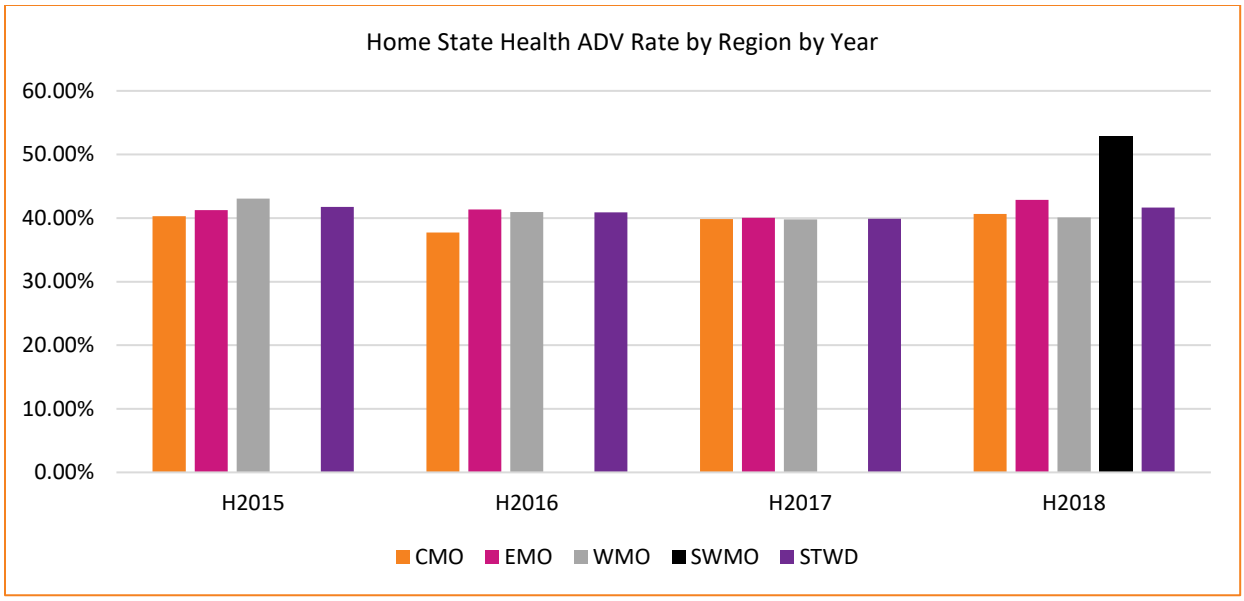


Figure 3-9 Trends in Home State Health HEDIS ADV Rates by Region

3.4.4 Recommendations

PIPs Approach

- Home State Health must continue to refine their skills in the development and implementation of approaches to effect change in their PIP.
- The aim and study question(s) should be stated clearly in writing (baseline rate, aim to achieve, % increase).
- PIPs should be conducted over a reasonable time frame (a calendar year) so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- The interventions should be planned specifically for the purpose of PIP required by MHD Contract and results, impact should be measured on a regular basis (minimum of 12 data points on the run chart should be shown).
- The results should be tied to the interventions.
- A request for technical assistance from EQRO would be beneficial. Improved training, assistance and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.

- Instead of repeating interventions that were not effective, evaluate new interventions for their potential to produce desired results, before investing time and money.
- Home State Health must utilize the PIPs process as part of organizational development to maintain compliance with the State contract and the federal protocol.

Improvement in CIS rate

Below are some of the interventions from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4927017/#b9-ptj4107426 which could be adopted by Home State Health to improve the CIS rate:

Table 3-21 Health Provider-Based Interventions to Improve Vaccination Compliance

Provide Parent and Patient Counseling
Be informed about vaccinations. Make strong recommendations. Provide patients with educational materials. Use proven communication strategies. Dispel myths about side effects. Inform parents about research. Give parents time to discuss concerns. Describe infections that vaccines prevent. Describe potential health and financial consequences of vaccine noncompliance. Provide a vaccination record with past and future vaccination visits. Provide patient reminders. Ask vaccine-hesitant parents to sign an exemption form. Inform parents that a missed dose will not require vaccine series to be restarted.
Maximize Opportunities for Vaccination
Administer vaccinations during sick or follow-up visits (postsurgical, post hospitalization). Issue a standing order to allow nurses to administer patient vaccinations.

Offer Combination Vaccines
Simplifies vaccination regimen. Minimizes the number of injections. Reduces need for return vaccination visits. Improves patient adherence.
Improve Accessibility to Vaccinations
Allow same-day appointments or walk-in visits. Make sure the office staff is friendly and supportive. Provide convenient office hours. Limit patient wait time.
Use Electronic Medical Records
Utilize consolidated electronic immunization records. Set electronic alerts for needed vaccinations. Follow up on electronic medical record alerts by contacting patient.

Table 3-22 Community- and Government-Based Interventions to Improve Vaccination Compliance

Public Education
Distribute educational materials that incorporate community input. Conduct public messaging campaigns. Use electronic communications to distribute health and safety information.
Public Reminder and Recall Strategies
Conduct centralized reminder and recall strategies through public agencies or payers. Use electronic communications, such as social media and text messaging, for reminder and recall programs.
Free Vaccines and Other Financial Incentives
Provide free vaccines to uninsured patients. Issue financial incentives, such as gift certificates.

Alternative Public and Private Venues for Vaccination
Day care facilities
Drop-in service at walk-in clinics
Pharmacies
Women, Infants, and Children (WIC) program offices
Emergency departments
Inpatient settings
Home visits

Improvement in Oral Health

Source: U.S. Department of Health and Human Services Oral Health Strategic Framework, 2014–2017 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765973/)

The following are the strategies and actions for each of the 5 goals listed below which would help to achieve improved Oral Health of the members.

1. Integrate Oral health and primary health care.
    - Advance inter professional collaborative practice and bidirectional sharing of clinical information to improve overall health outcomes.
    - Promote education and training to increase knowledge, attitudes, and skills that demonstrate proficiency and competency in oral health among primary care providers.
    - Support the development of policies and practices to reconnect the mouth and the body and inform decision making across all HHS programs and activities.
    - Create programs and support innovation using a systems change approach that facilitates a unified patient-centered health home.
2. Prevent disease and promote oral health.
    - Promote delivery of dental sealants in school-based programs and expand community water fluoridation.
    - Identify reimbursement strategies and funding streams that enhance sustainability of prevention programs.

- Coordinate federal efforts focused on strengthening the infrastructure and capacity of local, state, and regional oral health programs.
- Explore new clinical and financial models of care for children at high risk for developing caries, such as risk-based preventive and disease-management interventions.

3. Increase access to oral health care and eliminate disparities.

- Expand the number of health-care settings that provide oral health care, including diagnostic, preventive, and restorative services in federally qualified health centers, school-based health centers, Ryan White HIV/AIDS-funded programs, and IHS-funded health programs.
- Strengthen the oral health workforce, expand capabilities of existing providers, and promote models that incorporate other clinicians.
- Improve the knowledge, skills, and abilities of providers to serve diverse patient populations.
- Promote health professionals' training in cultural competency.
- Assist individuals and families in obtaining oral health services and connecting with a dental home.
- Align dental homes and oral health services for children.
- Create local, regional, and statewide partnerships that bridge the aging population and oral health systems.
- Support the collection of sex- and racial/ethnic-stratified data pertaining to oral health.

4. Increase the dissemination of oral health information and improve health literacy.

- Enhance data value by making data easier to access and use for public health decision making through the development of standardized oral health measures and advancement of surveillance.
- Improve the oral health literacy of health professionals through the use of evidence-based methods.
- Improve the oral health literacy of patients and families by developing and promoting clear and consistent oral health messaging to health-care providers and the public.
- Assess the health literacy environment of patient care settings.
- Integrate dental, medical, and behavioral health information into electronic health records.

5. Advance oral health in public policy and research.

- Expand applied research approaches, including behavioral, clinical, and population-based studies; practice-based research; and health services research to improve oral health.

- Support research and activities that examine the influence of health-care system organization, reimbursement, and policies on the provision of oral health care, including fostering government and private-sector collaboration.
- Address disparities in oral health through research that fosters engagement of individuals, families, and communities in developing and sharing solutions and behaviors to meet their unique needs.
- Promote the translation of research findings into practice and use.
- Develop policy approaches that support state Medicaid and CHIP to move from paying for volume to purchasing value, and from treating disease to preventing disease.
- Evaluate the impact of policy on access to care, oral health services, and quality.

3.5 Care Management Review

3.5.1 Methodology

The focus areas approved by MHD for evaluation of Care Management (CM) Program during EQR 2018 were as follows:

1. Pregnant Members (OB);
2. Children with Elevated Blood Lead Levels; and
3. Serious Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder).

Review of CM Policies and Procedures

Primaris reviewed the Home State Health's policies on Care Management, including but not limited to their enrollment, stratification processes, communication to members and providers, documentation processes, record-keeping, and standardized care management programs. Collectively, a review was done on the overall Care Management process from end-to-end on electronic records integration.

Medical Records Review (MRR)

Primaris assessed the Home State Health's ability to make available any and all pertinent medical records for the review.

A list of Members Care Managed in CY 2017 for the Pregnant Women (OB), Children with elevated Lead Levels, and Serious Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder) was submitted by the Home State Health and Primaris selected Medical Records (oversample for exclusions/exceptions) by using Stratified Random Sampling Method based on Appendix II of 2012, CMS EQR protocols (https://www.medicaid.gov/medicaid/qualityofcare/downloads/app2-samplingapproaches.pdf).

A sample of a minimum of 20 Medical Records (MR) for each focus area was reviewed during the onsite visit, July 09-13, 2018. A Care Management Medical Record tool was created and MR were reviewed to ensure that they include, at a minimum, the following *(ref: MHD Managed Care Contract 2.11, Excel workbooks are sent as separate attachments).*

- Referrals;
- Assessment/Reassessment;
- Medical History;
- Psychiatric History;
- Developmental History;
- Medical Conditions;
- Psychosocial Issues;
- Legal Issues;
- Care Planning;
- Provider Treatment Plans;
- Testing;
- Progress/Contact Notes;
- Discharge Plans;
- Aftercare;
- Transfers;
- Coordination/Linking of Services;

- Monitoring of Services and Care; and
- Follow-up.

Inter Rater Reliability: 10% of the MR from each focus area were reviewed by different auditors to assess the degree of agreement in assigning a score for compliance in the MR tool.

Onsite Interviews

The following persons were interviewed at Home State Health to gather information about the Care Management Program for Pregnant Members (OB), Children with Elevated Lead Levels, and Members with Severe Mental Illness (SMI).

OB: CM Program

- Anna Novoa, Medical Trainer;
- Jennifer Jackson, Supervisor CM;
- Chris Hoover, Supervisor CM; and
- Megan Barton, Vice President Medical Management.

Elevated Lead Level: CM Program

- Kelley Peters, Director CM;
- Tawania Jackson, Manager Case Management; and
- Stacey Schulte, Supervisor Case Management.

SMI: CM Program

- Dr. Susan Nay, Manager Clinical;
- Shannon McDermott Crandall, Supervisor Clinical; and
- Julie Mertzlufft, Supervisor CM.

Care Management Log

Home State Health submits a log of Care Management activities to MHD each quarter.

3.5.2 Overall Assessment of CM Program

The number of members enrolled in all CM programs in CY 2017 was 4010. The number of members enrolled in the programs under evaluation was:

Annual Technical Report

OB: 1930

BH: 836 *(note: this number is not for SMI)*

Elevated Blood Lead Levels: 287

Review of CM Policies and Procedures

The following Documents submitted by the Home State Health were reviewed to ascertain that they have Care Management policies and procedures to meet the contractual requirement of MHD Managed Care Contract (2.11). Home State Health was found to be 100% compliant (Table 3-23).

Table 3-23 Compliance with Policies & Procedures

Care Management Policy Review-Home State Health (ref: MHD Managed Care Contract 2.11)			
The health plan should have policies and procedures for Care Management. The policies and procedures shall include:	**Yes**	**No**	**Document Name (s)**
A description of the system for identifying, screening, and selecting members for care management services;	Yes		1. Predictive Modeling Methodology 2. Case Management Program Description 3.CM policy-CC.CM.06
Provider and member profiling activities;	Yes		1. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017 2. CM supporting document- provider manual

Procedures for conducting provider education on care management;	Yes		1. Case Management Program Description 2. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017
A description of how claims analysis will be used;	Yes		1. Case Management Program Description 2. Disease Management Programs
A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan;	Yes		1. Case Management Program Description
A process to ensure integration and communication between physical and behavioral health;	Yes		1. Case Management Program Description 2. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017
A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned;	Yes		1. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017

A process to ensure that care plans are maintained and up-dated as necessary;	Yes		1. Case Management Program Description
A description of the methodology for assigning and monitoring care management caseloads that ensures adequate staffing to meet care management requirements;	Yes		1. Case Management Program Description
. Timeframes for reevaluation and criteria for care management closure; and	Yes		1. Case Management Program Description
. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in herein.	Yes		1. Disease Management Programs 2.CM supporting document-provider manual
Additional Information about CM	Yes		1. Provider Reference Manual (CM page 49) 2.CM policy MO. CM.01-CM Program Description 3. Annual QAPI

3.5.2.1 OB Care Management

The Home State Health has an award winning program, The Start Smart for Your Baby® (SSFB), which is an effort to improve the health of mothers and their newborns.

The program consists of identifying pregnant members; stratifying them by risk level and impact ability; providing care management, care coordination, disease management and intervention as appropriate; and health education for all enrolled pregnant members. SSFB provides participants with the education and tools to reduce their risk of adverse pregnancy outcomes. Members are also eligible to receive incentives for attending their prenatal, postpartum, and well-child visits, based on health plan and state approval. The program helps pregnant members access medical care, educates them on their healthcare

needs, assists with social needs and concerns, and coordinates referrals to appropriate specialists and nurse OB Care Managers as needed.

Goals

The Start Smart for Your Baby® (SSFB) program has goals to improve outcomes:

- Low birth weight rates (<2500g, <1500g, <1000g);
- Neonatal and NICU admission rates and days/1000 births;
- Percentage of deliveries with a Notification of Pregnancy (NOP); and
- Prenatal and Postpartum (PPC) HEDIS rates.

Member Identification

One of the essential components of the program is the NOP process, which identifies pregnant members and their risk factors as early in pregnancy as possible in order to establish a relationship between the member, provider, and health plan staff. Early identification of pregnant members and their risk factors is the key to better birth outcomes. Receipt of an NOP screening assessment automatically enrolls a pregnant member in the Start Smart for Your Baby® program.

Additionally, members are identified as pregnant from multiple sources including, but not limited to:

- Claims;
- Community Agencies i.e. WIC;
- Disease Management Staff;
- Health Plan staff i.e. Care Manager, Community Health Services, Member Services;
- Hospital Care Manager;
- Inpatient and emergency department census reports;
- Medical Management Staff;
- Member or family member;
- Other Providers or Practitioners;
- Pharmacy Data;
- Primary care provider (PCP) or OB/GYN;
- Specialists;

- Start Smart internal Reports; and
- Daily 416 Reports- MHD notifications.

Member Stratification

Once pregnant members are identified and their risk factors collected in the NOP, members are stratified into low, medium, and high risk groups according to their NOP assessment results and claims data. Higher risk members are prioritized for outreach by health plan staff. Particular attention is paid to members with a history of prior preterm delivery. These members have a high risk of recurrent preterm delivery that could be improved by 17 alpha-hydroxyprogesterone caproate (17P) administration.

Workflow

Upon identification of a pregnant member, Home State Health begins Care Management within 15 business days. Members who are identified as 'high risk' per NOP form who are not currently engaged with care management have an additional outreach in efforts to engage them. For members who are not reachable on MHD provided phone numbers, Home State Health attempts to find them by outreaching to the OB office, calls to the pharmacy, and home visits at last known address. Home State Health offers field and telephonic OB care management.

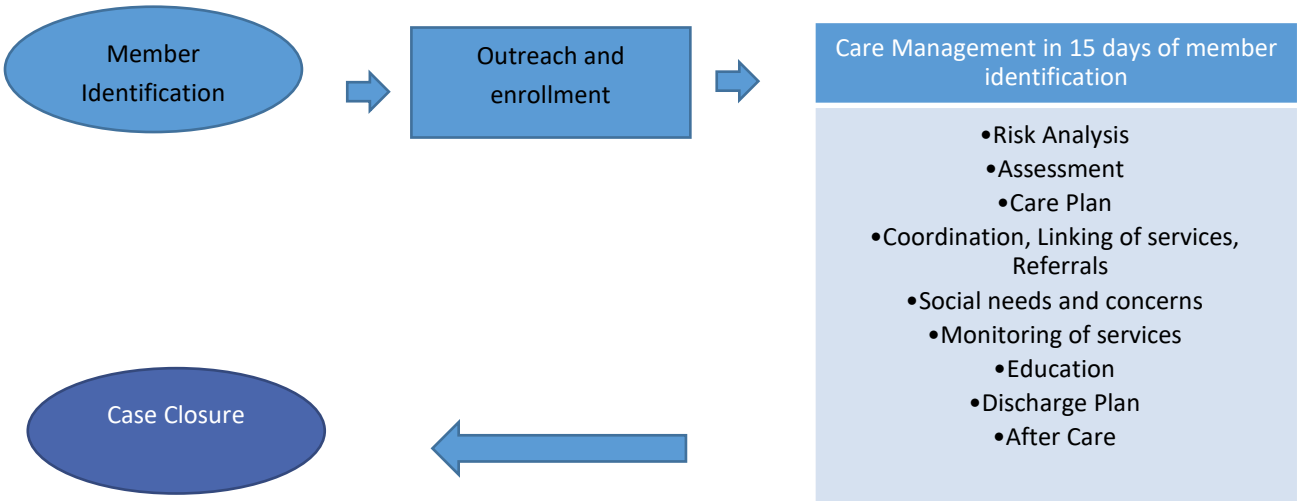


Figure 3-10 Work flow of Care Management

Member Interventions

- Home State Health mails one time each pregnancy, a letter encouraging members to complete the NOP form and to initiate prenatal care, a SSFB brochure, a NOP assessment, and envelope to facilitate return mailing of the NOP.
- Home State Health mails one time each pregnancy, a mailing of an incentive to members who have submitted a member NOP form, on the member web portal, or called the MCO to notify them of their pregnancy.
- Home State Health mails a 'newborn mailing' to members who have a valid date of birth entered in 'TruCare'. Members with a documented birth status of stillborn or adopted/foster care will not receive a mailing. The mailing contains a congratulations letter, a postpartum wellness survey to screen for postpartum depression, and *The Mother's Guide to Life after Delivery* book which contains newborn and postpartum care educational information. Members who have the opportunity to receive incentives determined by the health plan for completing required postpartum and well child visits also receive information on how to receive rewards in this mailing.
- The Perinatal Depression Screening Program is in place to screen members for perinatal depression as well as educate members in the perinatal period about the risks of depression, the signs and symptoms of depression, and accessing services for treatment of depression.
- The SSFB Breastfeeding program coordinates interventions throughout pregnancy, birth, and infancy to increase breastfeeding initiation and duration. Interventions include member education, providing a breast pump, and postpartum follow up and support.
- The 17P Care Management program consists of identification and evaluation of pregnant members who are potential candidates for 17P treatment in order to reduce their risk of repeat preterm delivery. Each health plan is responsible for identifying members who are eligible for 17P therapy and ensure they are in OB Care Management and contacted by their OB Care Manager or designee on a regular basis.
- High-risk health plan eligible moms and high risk health plan eligible babies are followed for the baby's first year of life as needed.
- Additional Start Smart educational books/resources include:
    - Start Smart for Your Baby® – Your Pregnancy Guide;

  - Start Smart for Your Baby® – A Guide to Your Baby's Care –The First Year;
  - Dad Little Word – Big Deal – Your Guide to the Father Situation;
  - Route to Health – Baby Fuel – Filling Your Baby's Tank with the Right Foods;
  - Darby Boingg and Friends Count to 10 – Board book promoting number and letter recognition;
  - Off the Chain: Teens & Pregnancy – Guide for pregnant teenagers; and
  - Body Well, Baby Well – Risks of Pregnancy, Drugs, Alcohol, and Smoking.
- Other efforts to identify and/or engage the pregnant members include:
  - Missed appointment outreach (from claims data)
  - Denying office visit payments to OBs who do not submit a NOP form
  - Free diapers to members who enroll in our Substance Use Field Case Management
  - Free app which offers 24hr access to a face-to-face (Skype) visit with a dietician or lactation consultant
  - Pre-loaded debit card for members who attend OB appointments

Findings of Medical Record Review

Primaris reviewed 31 MR to get the required sample of 20. Out of these 31, 11 had to be excluded due to following reasons (Table 3-24):

Table 3-24 Exclusions/Exceptions	Number of MR
Declined CM:	3
Unable to Contact (UTC):	5
No CM, Care Coordination:	3
Total	**11**

The Medical Record review for Home State Health OB CM program revealed the following information:

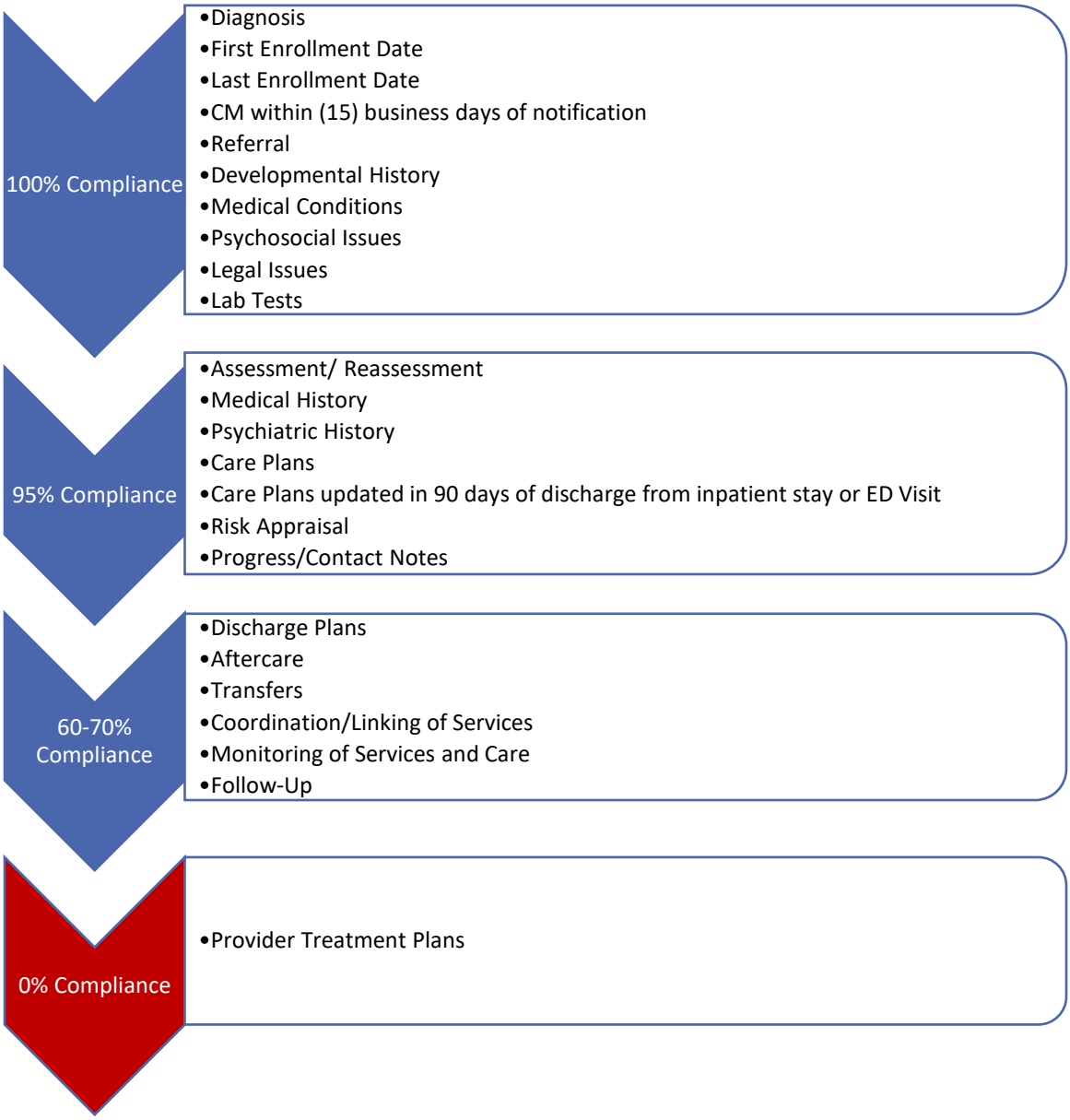


Figure 3-11 Compliance % for OB CM MRR

Conclusions

Primaris aggregated and analyzed findings from the Interviews, Policies and Procedures, MRR for the OB Care Management to draw conclusions about Home State Health's performance in providing quality, access, and timeliness of healthcare services to members. Overall, evaluation showed that Home State Health has Systems, Policies & Procedures, and Staff in place to ensure that its structure and operations support the processes for providing care and services while promoting quality outcomes.

Strengths

- Teamwork;
- Medication Management;
- Health Information Technology;
- Patient-Centered Medical Home;
- Establishing accountability and agreeing on responsibility;
- Communicating/sharing knowledge;
- Helping with transitions of care;
- Assessing patient needs and goals;
- Creating a proactive care plan;
- Monitoring and follow-up, including responding to changes in patients' needs;
- Supporting patients' self-management goals;
- Linking to community resources; and
- Working to align resources with patient and population needs.

Weaknesses

- The Medical Record review was done for 31 pregnant members: out of these 31, CM could not be done on 11 (35.5%). The Home State Health lost the opportunity to provide CM to eligible members due to following reasons (Table 3-25):

Table 3-25 Lost Opportunities

Reason	Number of Members	Notes
Declined CM	3	Member works, believe no need of CM, no time for CM.
UTC	5	MCO alleged that 60 % of primary demographic information received from State is incorrect/or incomplete.
Care Coordination (No CM)	3	Joined late at 34 weeks, needed resources only.

- Home State Health enrolls a member in their OB CM program on the day they make an attempt to contact the member. They call it as an 'outreach.' This is contradictory to the contractual requirements of MHD. A member should be considered as 'enrolled' on the day of assessment of their needs.
- The focus of Home State Health is more on 'Outreach' instead of 'Assessment' in order to meet the contractual requirement of 'offering CM in 15 days of notification of pregnancy.'
- The providers do not respond or acknowledge the treatment plan sent by the Care Manager. They respond only when the Care Manager makes a call on a 'need basis.'
- Coordination /Linking of services, Monitoring of Services and Care, Follow up could be done only in 70% cases as the Care Manager could not contact the members in spite of attempting to reach via telephone/letters.
- Discharge Plans and After Care was possible in only 60% of cases as members were not reachable near delivery.

Quality, Timeliness and Access to Health Care Services

- Home State Health OB CM Program was monitored in 24 areas during the MRR. Out of those, 10 areas scored 100%, 7 areas scored 95% for compliance, 6 areas scored 60-70% compliance whereas Provider Treatment Plan scored zero (0).

- After receiving enrollment information from MHD in 834 file, the Home State Health made efforts to verify the contact information and address of the members at the onset on successful outreach.
- Home State Health also contracted with a Home Health Agency for some time for Home Visits in CY 2017.
- Home State Health use multiple referral sources other than enrollment file to identify OB members; e.g., claims, provider notifications, lab reports, so that access to Care Management and coordination of services could be provided in a timely manner.
- The following information/data has been obtained from Home State Health to reflect their efforts for success of OB CM Program in CY 2017.

CY 2017 OB CM Outcomes

(On May 01, 2017 Home State Health's membership expanded to cover the entire state)

A. 15 day outreach to newly OB Members is 89.10% for the CY 2017 (Figure 3-11).

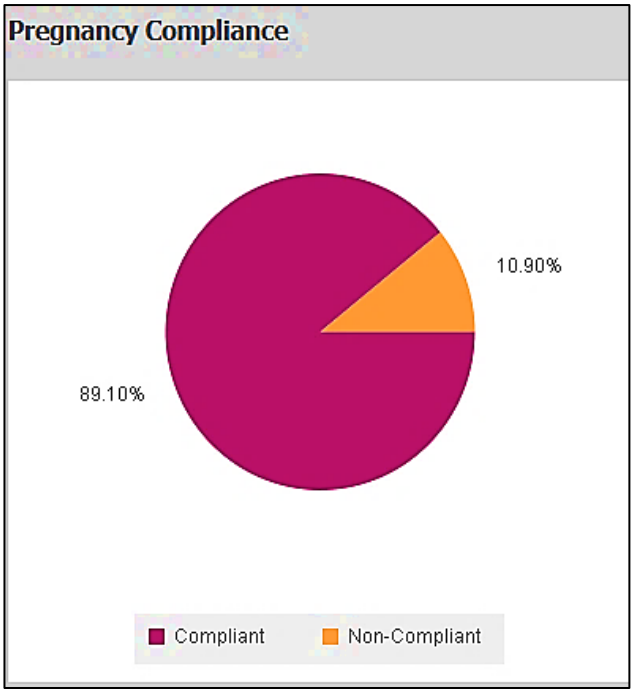


Figure 3-11 Outreach Compliance OB members

B. START SMART%

Table 3-26 START SMART %

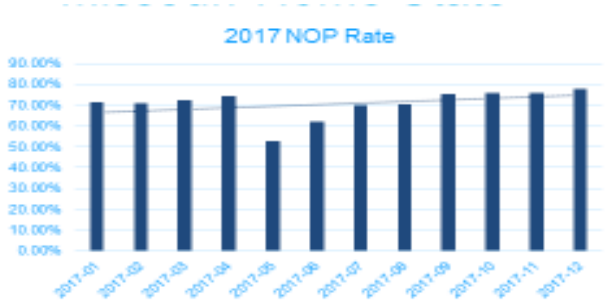
Start Smart (%)	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Total
Deliveries with NOP	70.9	70.8	69.8	73.2	51.9	61.2	68.4	69.4	74.2	74.2	74.9	77.6	69.3
Out reach in 7 days of receiving a High Risk NOP	100	95.6	96.7	93.7	96.5	95	99.1	94.6	91.7	83.5	90.9	100	94.3
Members in CM in 30 days of receving a High Risk NOP	19.7	14.4	14.6	23.2	18	16.3	17.2	21	19.7	24.8	23.8	29.2	19.3

The Table 3-26 shows that in CY 2017, 69.3% of deliveries were with a NOP and 94.3% of high risk NOP cases were outreached in within 7 days. However the % members who could be engaged in CM within 30 days were low (19.3%). There is a need for the MCO to have a different approach to get their pregnant members engaged in their CM program. The contractual requirement is to offer CM in 15 days of notification of pregnancy.

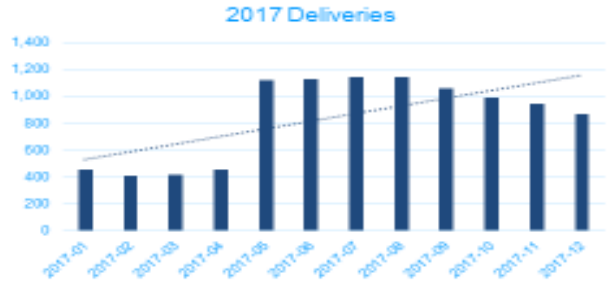
C. Figure 3-12 shows the graphical representations for the deliveries with NOP, number of deliveries in CY 2017 and Low Birth Weight (LBW) rate. In the CY 2017, the rate of LBW for managed care population in Home State Health was 8-13%.

The latest published data from The National Center for Health Statistics for Births is for the CY 2016. The LBW rate for United States (US) was 8.2% and for the State of Missouri it was 8.7% which ranked at 14th place (rankings are from highest to lowest).

LBW% was submitted by 26 states in FFY 2016 for Child Core Set Report to Centers of Medicare and Medicaid Services (CMS). 'Mean' was calculated as the unweighted average of all state rates which was 9% (measurement year was CY 2015).



A: NOP Rate



B: CY 2017 Deliveries

C: LBW Rate

Figure 3-12

Improvement by Home State Health

A comparison with previous year (CY 2016) was done to determine the extent to which Home State Health addressed effectively the recommendations for quality improvement made by the EQRO.

- Improvement was noticed for referrals (14.29% points), progress notes (8.16% points), Care Coordination (3.33% points), and Discharge Planning (7.37% points).
- Assessment and Care Plan decreased by 5% points. This was because the Home State Health lost contact with the patient after initial screening. The opportunity to do assessment during contact with the patient was not availed.
- The Table 3-27 and Figure 3-13 below show the trend data for a period of CY 2014-CY 2017 and change in % point from CY 2016.

Table 3-27 Trend Data for MRR: 2014-2017 EQR

%MRR Compliance %	2014	2015	2016	2017	% point Change
Assessment	93.75	100	100	95	-5
Referrals	100	82.35	85.71	100	14.29
Care Plan	93.75	95.99	100	95	-5
Progress Notes	96.15	94.74	86.84	95	8.16
Care Coordination	66.67	75	66.67	70	3.33
Discharge Planning	77.78	66.67	52.63	60	7.37

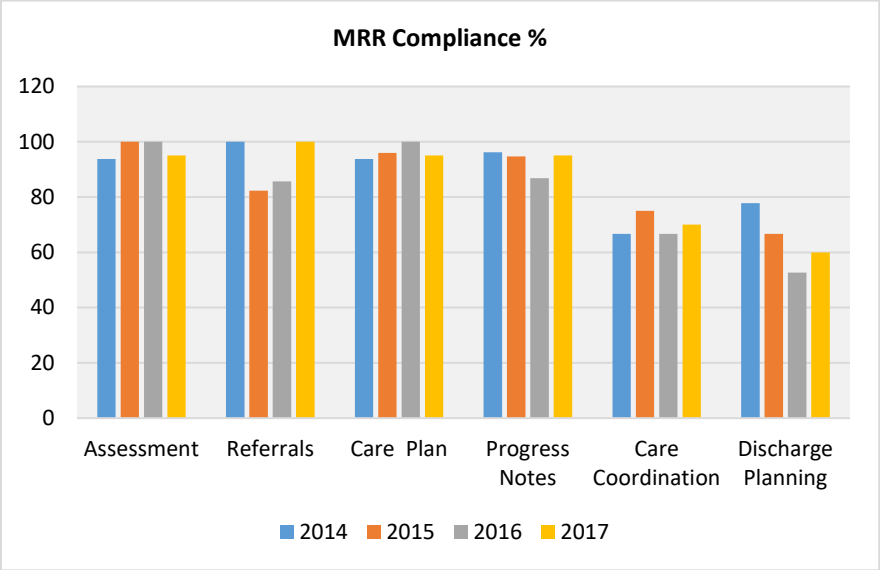


Figure 3-13 MRR Compliance trends (CY 2014-2017)

Recommendations

- Despite Home State Health's belief that merely reaching out to a member constitutes "enrollment" in care management, this is completely contrary to the contract language, and inconsistent with the expectations of MHD. Home State Health enrolls a member in the OB-Care Management program, on the day they make an attempt to contact a member. It is recommended that a member should be considered as 'enrolled' when the Care Manager makes an assessment of the need of the member. As per MHD Managed Care Contract, The initial Care Management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.

- The Assessment should be completed within 15 days of notification of pregnancy. Care management for pregnancy is included in the current Performance Withhold Program. This allows MHD to emphasize the importance of timely case management for this critically important condition.
- Face to face contact for complex cases.
- Before closing a case for UTC, at least three (3) different types of attempts should be made prior to closure for this reason. Where appropriate, these should include attempts to contact the member's family. Examples of contact attempts include (MHD Managed Care Contract 2.11f (1)):
    - Making phone call attempts before, during, and after regular working hours;
    - Visiting the family's home;
    - Checking with primary care provider, Women, Infants, and Children (WIC), and other providers and programs; and
    - Sending letters with an address correction request. (Post Offices can be contacted for information on change of address).
- The engagement of provider in the 'Care Plan'. The Home State Health sent letters to the providers about new patients' enrollment and Care Plan but no response was received from them. This opportunity to collaborate with provider at early stage can be tapped. Involving the provider in engaging members in their care would increase the success of pregnancy outcomes.
- Patient-centered education: https://www.managedcaremag.com/archives/2017/9/three-components-missing-many-population-management-strategies recommends:
  To assess and account for cognitive factors that affect member's ability to understand their health needs, care goals, and recommended interventions. Does a member have the cognitive ability to support her Care Plan? Does she or he have the knowledge necessary to understand not only what constitutes a Care Plan but also why and how it can be followed? Gaining this level of insight requires structured and timely interaction with the patient. Both must be embedded in the Care Management fabric of the OB Program. Only after there is a clear picture of a patient's cognitive skills and knowledge base is it possible to provide the patient with the appropriate level of educational information and outreach. If people truly understand their Care Plans, adherence improves and have better outcomes
- Patient-centered technology: https://www.managedcaremag.com/archives/2017/9/three-components-missing-many-population-management-strategies

Many Medicaid Managed Care Organizations have member portals—and nearly all of them have members who rarely, if ever, use the portals. The reason is remarkably basic: Most people in Medicaid plans use smartphones rather than home computers to connect to the Internet. Smartphone apps, *not* web-based member portals, is the way to serve Medicaid plans and their members.
By identifying how patients are willing to engage, the Home State Health can procure and configure technology that optimally support these preferred engagement channels. In turn, these expanded lines of communication between care teams and patients can ensure the timely flow of information and education.

- Frequency of follow-up, availability of psychosocial services, assistance with financial issues and active engagement of the care manager and the member are important characteristics of CM interventions.

3.5.2.2 Children with Elevated Blood Levels Care Management

Goals

- Identify all pediatric members who have an elevated blood lead levels.
- Educate guardians and/or members and providers on the importance of lead screening and treatments.
- Facilitate appropriate screening, testing, treatment repeat testing and follow-up per MHD guidelines.
- Facilitate guardians and/ or members towards increased self-management of lead values by assisting and increasing their knowledge and comfort level.

Lead Case Management Flow Process

Referrals and identification for Lead Case Management include but not limited to, the following:

- Primary Care Provider (PCP);
- Specialist/Specialty Medical Provider (SMP);
- Hospital Case Manager;
- Case/Care/Disease Management staff;
- Member’s parent or representative;

- Community agencies;
- Other providers, Department of Health (DOH), Department of Health and Human Services (DHHS), MO HealthNet Division (MHD); and
- MCO Lead File.

Screening and Identification of members for elevated lead levels:

- Any child under the age of six (6) years visiting for ten (10) hours per week or more, a high-risk area is tested annually for lead.
- All eligible children are blood tested for lead at age twelve (12) and twenty four (24) months of age.
- Members identified through a referral or data source with identified lead levels are enrolled in the Lead CM Program.
- Members are eligible for the Lead CM Program when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter (elevated blood lead level, or EBLL).

Identified Members

Lead CM outreach to offer care management services for those members with elevated blood levels occur within the following timeframes:

- 10 to 19 ug/dL within 1–3 days;
- 20 to 44 ug/dL within 1–2 days;
- 45 to 69 ug/dL within 24 hours; and
- 70 ug/dL or greater – immediately.

For the identified members, a lead CM coordinates with the PCP for an initial confirmation test, according to the following timeframes:

- 10-19 ug/dL - Within two (2) months;
- 20-44 ug/dL - Within two (2) weeks;
- 45-69 ug/dL - Within two (2) days; and
- 70+ ug/dL – Immediately.

The lead CM verifies that the follow-up testing for children with confirmed EBLL are performed as follows:

- 10-19 ug/dL - 2-3 month intervals;

- 20-70+ ug/dL -1-2 month intervals, or depending upon the degree of the EBLL, by physician discretion until the following three conditions are met:
  - BLL remains less than 15 ug/dL for at least 6 months;
  - Lead hazards have been removed; and
  - There are no new exposures.

Staffing Model

Home State Health Lead CM Program is organized in 3 tiers to best address and stratify the needs of this complex population. Members are stratified based on an initial assessment. An increase in complexity and need is exhibited as one travels up the triangle. Members, based on experience, the members typically do not stay in one tier but move down the triangle as conditions improve and move up the triangle if needs increase. Also, the experience and qualifications of staff increases from the bottom of the triangle to the top which enables the plan to best address the specific needs of each member.

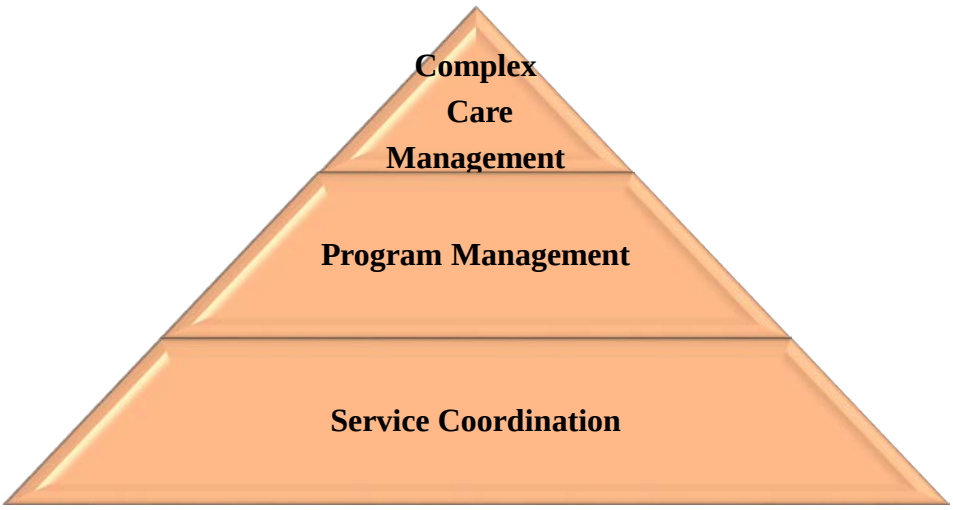


Figure 3-14 Lead Care Management Triangle

Findings of Medical Records Review

Primaris reviewed 36 MR and 20 of them were open for Care Management in CY2017. 16 out of 36 records were excluded for the following reasons (Table 3-28):

Table 3-28 EXCLUSIONS/ EXCEPTIONS	NUMBER OF MR
State notifies of increased capillary Blood Lead Level (BLL) followed by notification of decreased venous BLL	5
Venous level drawn and within normal parameters	6
Unable to contact member	2
Not enrolled in CM	3
TOTAL	**16**

The MRR for Home State Health Lead Care Management Program revealed the following information (Figure 3-15):

a. Offer Care Management and Assessments

Home State Health receives the notification/referral of the elevated blood level. The Care Manager then offers Care Management within the timeframe below according to the elevated blood lead levels:

- 10 to 19 ug/dL within 1–3 days;
- 20 to 44 ug/dL within 1–2 days;
- 45 to 69 ug/dL within 24 hours; and
- 70 ug/dL or greater – immediately.

Home State Health's initial 'outreach' attempts to contact the member/guardian for Lead Care Management was 100%. Although 'attempts' were done, the Care Managers success rate to contact the member/guardian to offer case management and perform an assessment was only 50%. They were 'unable to reach' due to 'no answer' and/or 'inaccurate member's contact information'. The Care Managers continued to contact outside sources to obtain correct contact information.

b. Member Engagement and Care Planning

The care managers face difficulty in member/guardian engagement for Care Management services. Welcome letters are initially sent to the member/guardian regarding Care Management. An educational pamphlet, "Lead Poisoning" is Included in the initial "Welcome" letter.

c. Provider Engagement and Care Planning

Care plans are implemented with members after the completion of the initial assessment. Communication with physician/physician staff for the member's care is ongoing during the Care

Management process. Care Managers notify the provider that the member is engaged in the Lead Care Management. Home State Health is 90% compliance for care plans.

d. Childhood Blood Lead Testing and Follow-Up

Home State Health is 95% compliant. The Care Managers educate the member/guardian the importance of follow-up blood testing.

e. Referrals

Home State Health maintains 100% compliance with referrals. The Care Managers made attempts for referrals for services. The participation of the member engagement remains a challenge.

f. Two (2) Face-to-Face Encounters

The initial face-to-face encounter within 2 weeks of receiving a confirmatory blood level is 35% compliance. The compliance for the second visit within 3 months is 20%. The Care Managers utilized outside sources such as home health, lead assessor to promote the face-to-face encounters. The barriers documented by the Care Managers are ‘unable to reach’ and ‘member/guardian refusal’. Initial visits for face-to-face encounters do not occur as frequently as required. Although referrals were initiated, the initial face-to face and follow-up encounters required continuous attention.

g. Coordination and Linking and Monitoring Services

The coordination, linking and monitoring of services are documented in the progress/contact notes with 100% compliance.

h. Discharge Plans/Case Closures

A member/guardian exit evaluation for case closure can occur via phone or face-to-face encounter. ‘Unable to reach member/guardian’ presents a challenge for meeting the criteria for conducting a contact exit evaluation. Member exit evaluation/case closure was 16.666%. In addition to meet the criteria for discharge plans, a case closure letter is required to be sent to member/guardian and PCP when applicable. The member closure letter criteria was 100%. PCP discharge notification was 66.666%.

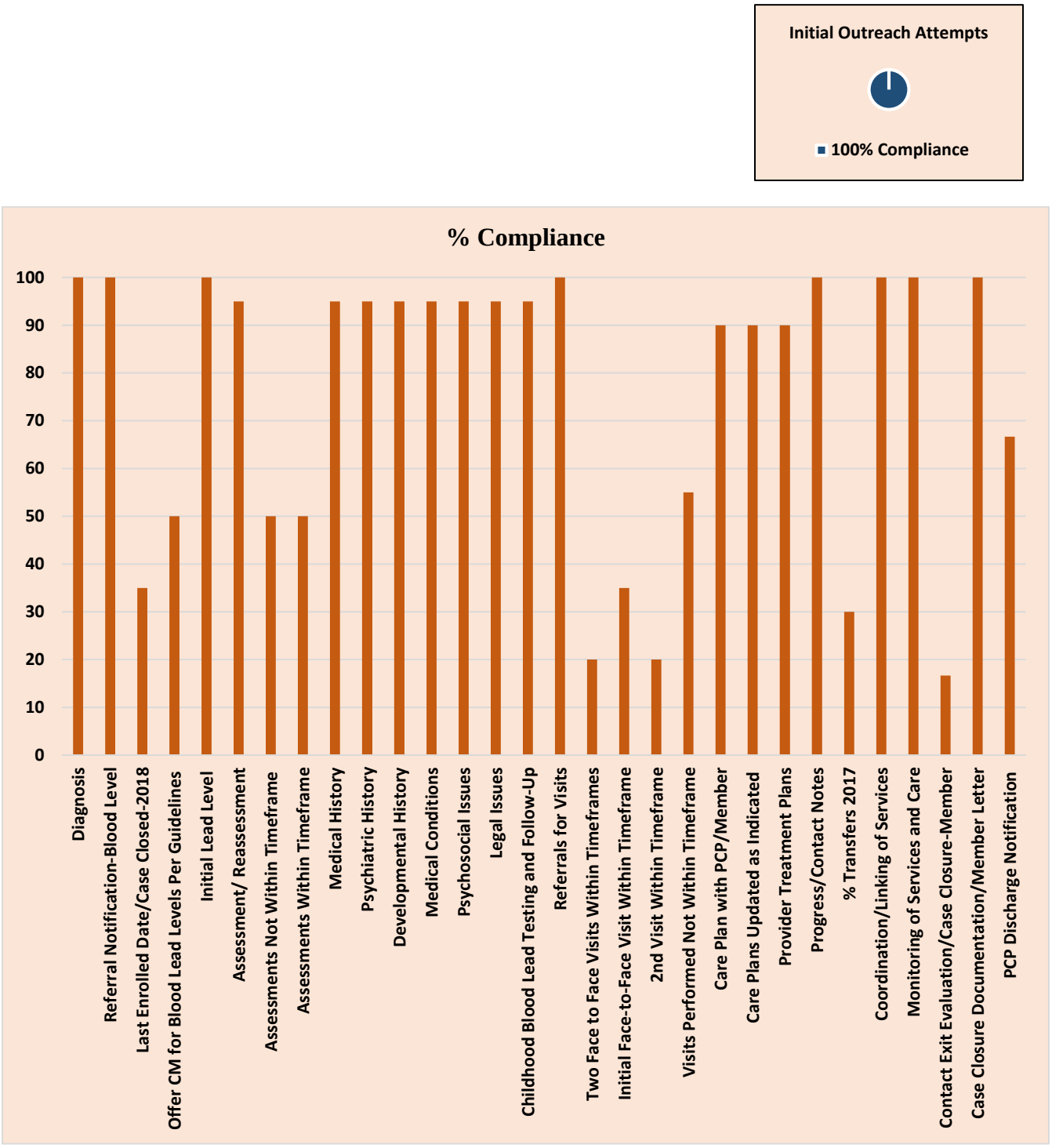


Figure 3-15 Compliance Graph for Lead Care Management MRR

Conclusions

Strengths/Key drivers

Table 3-29

Key Drivers	Intervention	Failure Mode & Effect Analysis
MCO Member Directory Care Coordination	Accurate Member Directory Contact Information Internal Process Changes within MCO	Unable to contact patient for care planning: Offer CM within timeframe with assessments Face-to-Face Encounters Follow-Ups Exit Evaluation/Case Closures
Coordination/Resources	Focused Member Outreach by the Targeted Provider Member Engagement/Member Outreach and Incentive	Unsuccessful member engagement: Member refuses Lack of investment in the member's healthcare needs Member is not aware of the importance of follow-up
Provider Engagement	Internal Process Changes at PCP Office Improve Provider Processes	Unsuccessful provider engagement and care planning

Weaknesses

Thirty six (36) MR were reviewed (oversampling due to exclusions/exceptions) to get the required sample of 20. Home State Health was unable to meet all the guidelines for Care Management for 31 cases eligible members due to the following reasons:

Table 3-30 Issues

Criteria/Guideline	Reason	Number of Members
Offer CM per Guidelines with Assessment	**Declined**	**1**
	UTC	**9**
Face-to-Face Encounters (Initial and/or Follow up)	**Declined**	**5**
	UTC	**11**
Discharge/Case Closure-Exit Evaluation with member	**UTC**	**5**
Total		**31**

Quality, Timeliness and Access to Health Care Services

Home State Health Lead CM program was reviewed in 22 areas during the medical record review. Eighteen (18) areas scored 90% or higher for compliance. One (1) area, case closure-PCP notification was 67% compliance. One (1) area, offer case management within timeframe with assessment was 50% compliance. One (1) area, face-to-face-encounters scored 20-35% compliance. In addition, one (1) area for contact exit evaluation/case closure-member was 17% compliance.

The use of these findings would help to understand the opportunities for improvement that would have a positive impact on the care, services, and outcomes for members.

Home State Health Lead Program Effectiveness: Program effectiveness is measured by the percent of eligible members screened. HEDIS reporting measures for lead are used as an additional measurement of effectiveness.

Outreach

In CY 2017, Home State Health achieved 100% in timely outreach to members with a confirmed blood lead level of greater than 10ug/dL. Timely outreach is defined as follows:

- 10 to 19 ug/dL within 1–3 days;
- 20 to 44 ug/dL within 1–2 days;
- 45 to 69 ug/dL within 24 hours; and

- 70 ug/dL or greater – immediately.

Table 3-31 Outreach in CY2017

Metric	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017
# of member with Elevated Blood Lead Level 10+	20	108	80	52
% of Timely outreach to members with Blood Lead Level 10+	100%	100%	100%	100%

Improving Childhood Lead Screening Rates:

In July of 2017, Home State Health began developing a performance improvement project (PIP) related to improving the childhood lead screening rates for their members under two (2) years of age.

For the purpose of this study, Home State Health will assess blood lead level rates in accordance with the HEDIS technical specifications for the next three measurement years. HEDIS 2017 (CY 2016) final Lead Screening in Children (LSC) are used as the baseline measurement. During this study Home State Health will determine if the implementation of the proposed interventions, focused on Home State Health members' ages 0 to 2 years, will increase the rate of blood lead level screenings completed on or before the second birthday by three (3) percentage points.

Home State Health has chosen the NCQA Quality Compass 50th percentile benchmark for this monitor from the H2017 version and will assess performance against these benchmarks for the duration of the study.

Home State Health H2018 (CY 2017) results are based on Hybrid methodology with the final audited LSC rate being 60.74% or 4.44 percentage points higher than H2017 (CY 2016). These findings reflect meeting the goal of increasing 3 percentage points year over year. Based on these findings, the interventions employed were effective and will be continued into H2019 (Table 3-32).

Table 3-32 Lead Screening Rates from H 2017-H 2018 (CY 2016-CY 2017)

HEDIS Year	Home State Health Lead Screening In Children (LSC) Rate	2017 NCQA Quality Compass 25th Percentile	2017 NCQA Quality Compass 50th Percentile	Year of Year Percentage Point Change
2017	56.30%	59.65%	71.38%	Baseline
2018	60.74%	59.65%	71.38%	4.44%

Improvement by Home State Health

A comparison with previous year (CY 2016) was done to determine the extent to which Home State Health addressed effectively the recommendations for quality improvement made by the EQRO. The details are provided in the Table 3-33 below:

- Referrals were improved from the previous years;
- 'Offer CM per the guidelines with an assessment' decreased;
- Face to Face encounters for initial visit and follow-up decreased; and
- Contact exit evaluation with member/guardian and PCP discharge notification decreased.

Table 3-33 Comparison Chart for Compliance Improvement from CY 2016

CY 2016 Data Elements Reviewed	CY 2016 % Compliance	CY 2017 Data Elements Reviewed	CY 2017 % Compliance	Notes
		Diagnosis	100%	Diagnosis documented
		Referral Notification of Blood Lead Level	100%	Referral for blood lead levels documented
		Case Closures in 2017	0%	No case closures in 2017
		Case Closures in 2018	35%	6 cases closed in 2018

		% Transition of Care Cases in 2017/Transfers	30%	6 cases for Transition of Care (TOC) in 2017 1 case for Transition of Care (TOC) in 2018
		Contact Exit Evaluation with Member/Guardian	16.67%	6 cases for case closures
		Case Closure Documentation to Member/Guardian	100%	6 cases for case closures
		PCP Discharge Notification	66.67%	6 cases for case closures
Transition/Closing	**100%**	***Total for Discharge Criteria***	***61%***	**Meeting criteria for exit/closure case**
		Initial Lead Levels from referral	100%	Initial lead levels documented
		Outreach 'Attempts'	100%	Initial 'Attempts' made within timeframe of blood lead levels
Intro to CM	**100%**	**Offer CM for Lead Levels per Guidelines with Assessment**	**50%**	**Direct contact with member/guardian to offer CM within guidelines and perform assessment**
Assessments	**95%**	**Total Assessment Performed (within and not within timeframe)**	**95%**	**Total assessments performed during care management process(within and not within initial direct contact to offer CM)**

		Medical History	95%	Documentation present on assessment
		Psychiatric History	95%	Documentation present on assessment
		Developmental History	95%	Documentation present on assessment
		Medical Conditions	95%	Documentation present on assessment
		Psychosocial Issues	95%	Documentation present on assessment
		Legal Issues	95%	Documentation present on assessment
		Childhood Blood Testing/Follow-Up	95%	Follow-up blood testing documented
Care Planning	**85%**	**Care Plans (Member/PCP Involvement)**	**90%**	**Care Plans documented**
Face-to face	**94.74%**	**Face-to-Face-Initial Encounter within 2 weeks**	**35%**	**Initial face-to face encounters performed**
		Face-to-Face-2nd Visit within 3 months of 1st encounter	**20%**	**2nd visits performed**
		Total visits performed within and not within timeframes	**50%**	**Total visits performed within and not within per guidelines**

Care Coordination	**0%**	**Member Engagement**	**50%**	**Member engagement/involvement**
PCP Involvement	**90%**	**Provider Treatment Plans**	**90%**	**Provider involvement with care**
		Coordination/Linking Services	100%	Documentation present
		Monitoring of Services and Care	100%	Documentation present
Referrals	**75%**	**Referrals**	**100%**	**Documentation present**
Progress Notes	**100%**	**Progress/Contact Notes**	**100%**	**Documentation present**

The Table 3-34 shows the % compliance of Medical Records from CY 2014- CY 2017 for the Children with Elevated Blood Lead Levels CM Program. Two areas 'offer CM within Time frame' and 'Referrals' have shown drastic decrease by 50% point and 25% point from the CY 2016.

Table 3-34 Compliance Trend % from CY 2014-2017

MRR Compliance %	2014	2015	2016	2017	% point change
Offer CM within Timeframe	58.33%	90.48%	100%	50%	-50
Assessment	58.33%	71.43%	95%	95%	0
Care Planning	83.33%	75%	85%	90%	5
Referrals	70%	44.44%	75%	100%	25
Face-to-Face Encounters	45.45%	71.43%	94.74%		
Face-to-Face Encounter Initial				35%	
Face-to-Face Encounter Follow up				20%	
Progress Notes	90.48%	72.09%	100%	100%	0
Discharge Planning	100%	55.56%	100%		
Contact Exit Evaluation/Case Closure				17%	
Case Closure Documentation/Member				100%	
PCP Discharge Notification				67%	

Recommendations

Suggested Methods to Contact Guardian/Member

- In cases where the member/guardian cannot be contacted by phone and no response to the initial letter, a visit should be made to the location.
- Language barriers may present obstacles for the initial contact of member/guardian. Local community-based resources may be necessary to facilitate initial contact and confirm effective follow-up.
- Different modes of outreach should be used at differing times of the days and different days of the week to increase opportunities of actually reaching the member/guardian to initiate the case management process.

Table 3-35 Methods for Contacting Members

Methods Used for Existing Contact Information	Methods to Verify/Update Contact Information
Call Send a letter Send a certified letter Make a home visit Text or email (follow agency policies; may require prior consent) Local community-based resources	Inquire WIC contact Inquire economic assistance contact Inquire Child Protection contact Inquire Primary Care Provider Inquire US Postal Service for forwarding address Inquire contact person listed at admission if applicable Call member/guardian at differing times and days

Suggested Methods for Member Participation

- Ensure anticipatory guidance to parents for blood levels approaching $\geq$ 10ug/dl.
- Children with blood levels below 10 ug/dl are important targets for educational interventions.
- Ensure that an elevated blood lead level environment health investigation is conducted.
- Encourage guardian to test siblings and household contacts for lead poisoning.

- Refer family to developmental and community resources such as: developmental programs, health, and housing and/or social services when appropriate.

Suggested Methods for Provider Participation

- Ensure a notification letter is sent to physician along with a copy of the member/guardian notification letter and informatics letters.
- Educating physician/staff on proper steps for capillary blood lead level (finger sticks) per the protocol.
- Suggest a main contact at provider office to engage in member/guardian's plan of care.

Continue Lead Poisoning Education

- Risks;
- How are children exposed to lead;
- Lead in products;
- Member/Guardian Jobs and Hobbies;
- Prevention Measures;
- Healthy Diets;
- Effects of lead on children, adults, and pregnant women;
- Testing and Reporting;
- Methods of testing; and
- Treatment.

3.5.2.3 Serious Mental Illness (SMI) Care Management

As per MHD Managed Care Contract (2.11), Serious Mental Illness (SMI) includes Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder.

Integrated Case Management Staffing Model of Home State Health

Care Coordination/Care Management (CC/CM) teams are comprised of multidisciplinary clinical and nonclinical staff (Nurse Case Managers, Program Coordinators, Social Workers, Behavioral Health

Specialists, and Connection Representatives). This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the Missouri licensed professional staff to focus on the more complex and clinically-based service coordination needs. The title "Care Manager" is for nurses and licensed social workers. Based on the diagnosis/needs of the member, a nurse or social worker is assigned as the "lead" for the management of that member. Staff are co-located and refer to each other as needed to maintain one point of contact with the member while being able to provide holistic and comprehensive care. Care managers also work closely with the concurrent review staff to coordinate care when members are hospitalized and assist with discharge planning. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives.

Screening and Assessment

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 30 days of identification for care management. Home State Health provides an assessment for all members experiencing one (1) of the events listed below within thirty (30) days of:

- The date upon which a member receives the projected discharge date from hospitalization or rehabilitation facilities:
    - After hospital readmission; or
    - After a hospital stay of more than two (2) weeks; and
    - After a psychiatric inpatient hospitalization.
- Receipt of a diagnosis of co-occurring behavioral health and substance abuse as identified through analysis of utilization data.
- Serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, recurrent major depression, and moderate to severe substance use disorder).
- Home State Health assesses members for CM within five (5) days of admission to a psychiatric hospital or residential substance abuse treatment program.

CM team obtain consent to complete the screening and/or initial assessment once member contact is made. The gathered information is reviewed to build a Care Plan. The initial assessment and Care Plan are completed no later than 30 days after a member, or caregiver acting on member's behalf, agrees to

participate in complex CM. Outreach may also occur to treating providers and individual practitioners when appropriate. Each CM team member contributes different skills and functions to the management of the member's case. Other key participants in the development of the care plan may include:

- Member;
- Member authorized representative or guardian;
- PCP and specialty providers;
- Home State Health Medical Directors;
- Hospital discharge planners;
- Ancillary providers (e.g., home health, physical therapy, occupational therapy);
- Behavioral health providers;
- Representatives from community social service, civic, and religious based organizations (e.g., United Cerebral Palsy; food banks; WIC programs; local church groups that may provide food, transportation, companionship); and
- Other non-health care entities (e.g., Meals on Wheels, home construction companies).

Findings of Medical Records Review

Primaris reviewed 23 MR (oversample) to audit 20 records for CM in CY2017. 3 out of 23 records were excluded for the following reasons:

Table 3-36 Exclusions	NUMBER OF MR
Dx not applicable: General Anxiety	1
Dx not applicable: Screening for Other Disorder	2
TOTAL (non SMI dx)	**3**

Of the 20 cases reviewed, 19 out of 20 cases had a diagnosis of SMI at the time of hospitalization. One (1) was self-referred through the help line (Figure 3-16).

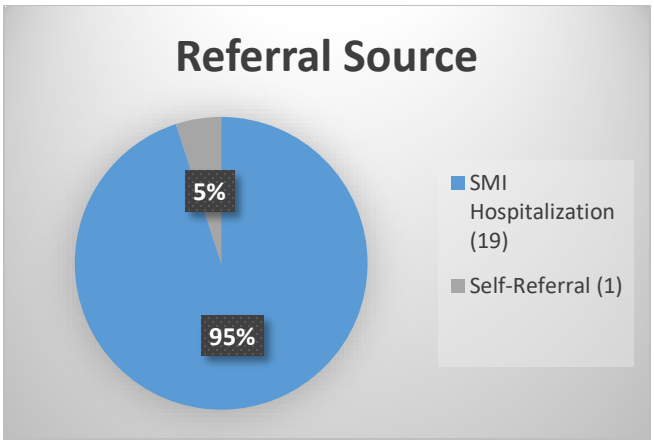


Figure 3-16 Distribution of the referral process to CM

Observations

- 19 out of 20 were open initially to assessment and CM.
- 1 left the hospital without consent.
- Many members had multiple cases opened during the calendar year of 2017.
- All were assessed within the timeframe (5 days), most were within the first 24 hours in inpatient stay.
- Most members concluded their case with a successful end.

Table 3-37 Observations for SMI CM

Reasons cases were closed	1 – Member noncompliance 1 – Member choice
Variances	Age Gender Diagnosis Pre-hospitalization to post-hospitalization dx Ability to get needed services/providers
Similarities	Open to Care Management Family seeking care/information

The Medical Record Review for Home State Health SMI Care Management program revealed the following information (Figure 3-17, 3-18):

a. Offer Case Management and Assessments (100% Compliance)

Home State receives the notification/referral of member hospitalization through the Utilization Management process:

- Behavioral health diagnosis meeting the serious mental health list.
- Medical diagnosis that reveals a co-morbidity of serious mental health.

Phone call made by member to the MCO member call line creates a member self-referral into Care Management.

b. Member Referral (100% Compliance)

The Care Manager refers the member to Care Management as well as other services they may need.

c. Assessment (100% Compliance)

The Care Manager assesses the member for services if the member agrees for Care Management. This step analyzes the member's needs and begins the Care Management process.

d. Provider Engagement and Care Planning (95% Compliance)

The Care Plan is implemented with members after the completion of the initial assessment. Communication with physician/physician staff for the member's care is ongoing during the Care Management process. Care Managers notify the provider that the member is engaged in the Serious Mental Illness Management and remain in communication with providers as allowed.

e. Testing (100% Compliance)

Testing in SMI is utilized on a need basis. When needed, compliance is high. Testing for risky behaviors is vital and Care Managers follow up with providers to document test results.

f. Discharge Plan (95% Compliance)

The Care Managers encourage the member/guardian to stay engaged until goals are met. At the end of the plan, there are additional steps created in case follow up or additional services are needed in the future. If the member needs to return to care, this step demonstrates how to get services as needed.

g. Aftercare (95% Compliance)

The ‘aftercare’ is the member’s responsibility to continue with services as recommended by the combination of providers, hospital, and case management. To get the ‘aftercare’ the member has to continue till the end the plan in full compliance and availability, as per the Care Plan.

h. Transfers (95%), Linking (95%) and Monitoring Services with Provider and Member Participation (100%) compliance.

The member’s connection to other available service organizations is a vital part of their plan. The providers, organizations, outpatient facilities, all work together to reach the plan goals.

i. Follow Up (90% Compliance)

A case closure letter is sent when a case is closed. The provider may also be notified. The Care Manager follow up is the final step of case closure to ensure the member feels the goals were met satisfactorily or they wanted the case to be closed for an agreed upon reason such as Care Management from another organization.

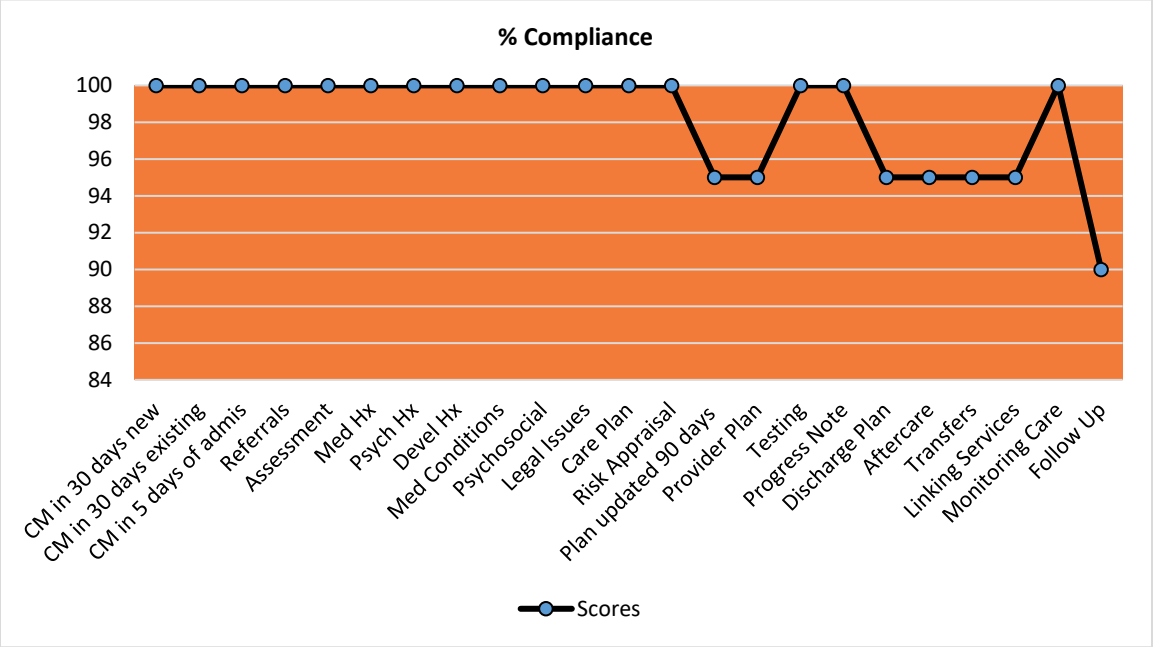


Figure 3-17 Compliance Graph for SMI CM MRR

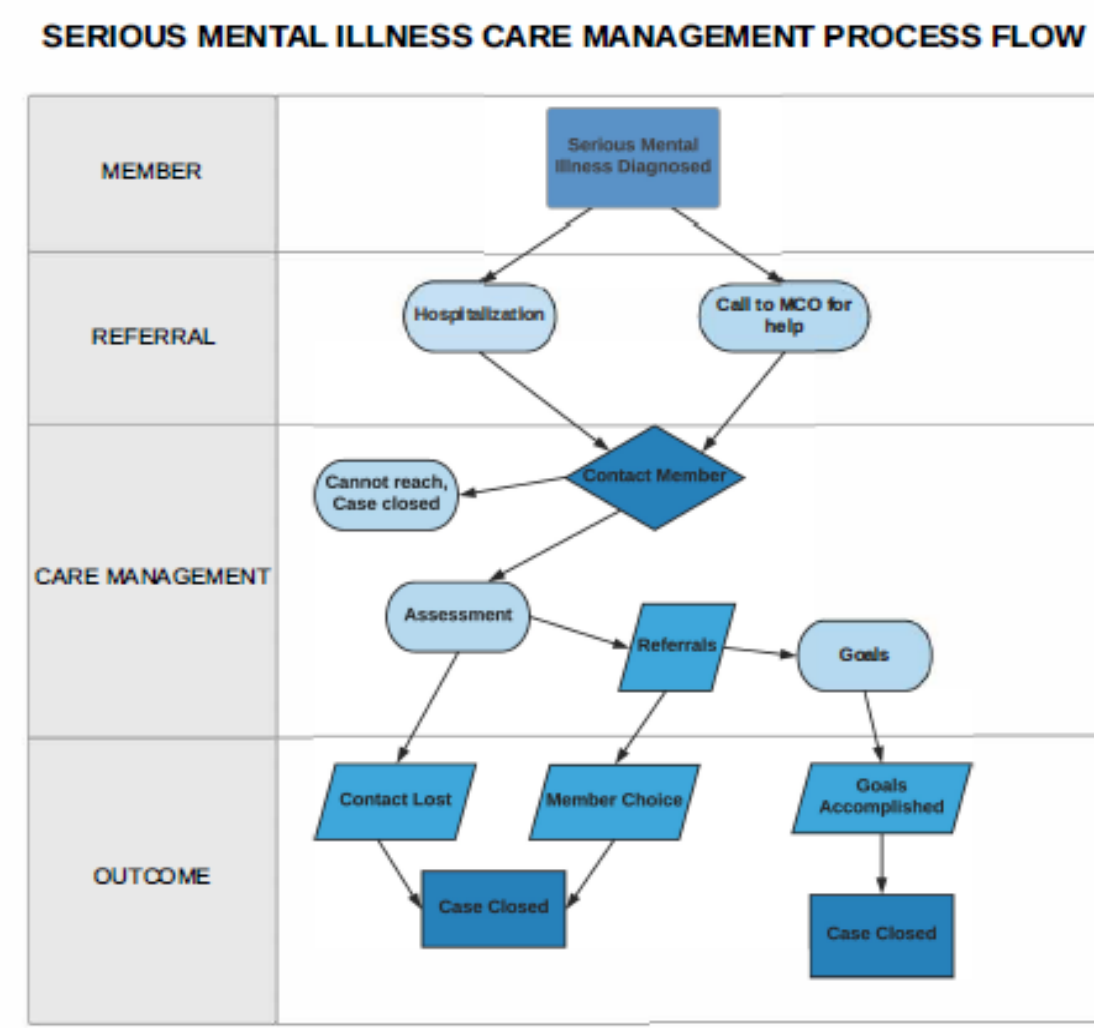


Figure 3-18

Conclusions

Strengths

- Team work and Coordination;
- Work to align with patient and population needs;
- Linking to community resources;
- Provider Engagement;
- Medication Management;
- Behavioral Health Home; and
- Supporting patients' self-management goals.

Weaknesses

- Identification of members for SMI CM: This remains a challenge as there is no guidance as to what constitutes SMI except for a list of diagnoses. In some cases, a member with a diagnosis on the list may be doing well while another member with a diagnosis not on the list may prove to be seriously ill and need help. e.g., a member with autism not on the list of diagnoses threatened the lives of others and earned an additional diagnosis on the list eventually during an inpatient stay. Another patient with major depression and substance abuse as co-morbidity may be doing well and may stay out of the hospital with little care need for all of the year because of good medical management and good family involvement despite qualifying for CM.
- Providers often do not share vital information with the MCO. They do not understand the role of the Care Manager in the member's care. There is often a lack of communication or teamwork.
- The cost and the resources for SMI CM sometimes become a limiting factor for the MCO to provide 100% quality care to its members.
- The ability of Care Manager to reach SMI members becomes an issue over time. These members often do not have accurate addresses. They change or refuse to provide phone numbers. They do not have emergency contact numbers. They often are not at home when Care Managers make appointments to visit or do not agree to home visits. The ability to stay in contact over a long term is a challenge in tacking member's care. The Care Manager utilized the connection with a member's provider if available. Sometimes the members got overwhelmed with too many people involved in their care. They lacked the understanding of their roles and opted out of CM.

Quality, Timeliness, and Access to Health Care Services

- Overall compliance for SMI CM MRR was 98.2%. Home State Health met most of the contractual requirements for managing the members with SMI.
- The members selected for CM were the hospitalized members. If a member had serious mental illness but was not hospitalized they did not receive care management.
- The Table 3-38 below shows all the BH services received by members in CY 2017.

Table 3-38 Number of Members receiving BH Services in CY 2017

MISSOURI	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
Members Receiving BH Services	1,863	1,778	1,967	1,915	6,369	5,828	5,370	6,143	6,085	6,630	6,345	5,707
Penetration Rate	1.8%	1.7%	1.9%	1.8%	2.3%	2.1%	1.9%	2.2%	2.2%	2.4%	2.3%	2.1%

Special needs of members with Serious and Persistent Mental Illness (SPMI): Home State Health collects data on the challenges surrounding coordination and continuity of care for members with serious and persistent mental illness through assessment of the HEDIS measure, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD). This measure assesses the percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Use of this measure is key to ensuring that members with high acuity special healthcare needs are receiving the proper monitoring and service coordination for both their behavioral and physical health conditions.

This metric is an important indicator of care provided for members who are impacted by both mental and physical health conditions. The high screening rate indicates that most members with a diagnosis of Schizophrenia or Bipolar Disorder are going to their physician on a regular basis.

HEDIS rates show an improvement from 2016 to 2017 for Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD). Home State Health primarily addresses the needs of this population through Care Management/care coordination interventions. Home State Health and the Managed Behavioral Health Organization (MBHO) have been working towards a more integrated care management model, which focuses equally on medical and behavioral health needs, regardless of which condition is primary, and works with members to help them understand that mental health impacts all areas of their health and quality of life.

Table 3-39

HEDIS MEASURE	2016	2017
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	**80.5%**	**81.29%**

Improvement by Home State Health

Home State Health tracks the co-morbidity of schizophrenia and bipolar patients who have diabetes as well. There are more co-morbidities that may be affecting these members long term. Ongoing efforts in this area would produce more data over time.

SMI CM Program was not reviewed during previous years by an EQRO, so no trend data is available for comparison purpose.

Recommendations

- Home State Health could expand its CM referral base to coordinate with Utilization Management and seek other means of finding SMI members other than through hospitalization. Members who have serious diagnoses through co-morbidity or frequent visits to providers or are taking multiple behavioral health medications could be sought out for additional CM profiling.
- The State could come up with a system to clarify SMI for the MCOs. Diagnoses alone often leaves members uncared for several of those who need attention. Also the list could be broadened to include other diagnoses that appear often on the co-morbidity list such as autism which can be a behavior disorder if severe enough. Family distress is a trigger as well which might be a measurement to identify the need.
- While it is agreed there is no acceptable scale to determine the scope of seriously mentally ill patients, a uniformity among members across the state would help devise a plan to better utilize services. There are some tools in place such as the Burden Assessment Scale or BAS created in 1994 for the state of New Jersey developed to help determine the burden placed on the families of these patients who have a serious mental illness. (https://www.sciencedirect.com/science/article/pii/0149718994900043).
- The Missouri Department of Mental Health has a number of systems in place that could be utilized and/or transposed for the purpose of creating a uniform system of diagnosing the seriously mentally ill and drawing attention the ones needing care management more rapidly to prevent or reduce inpatient stays. They have tools such as the Priority of Need (PON) system that enables them to decide a ranking of highest need (https://dmh.mo.gov/docs/dd/ponfaq.pdf).

4.0 Missouri Care

4.1 Overview

Missouri Care was established and designed to specifically to serve the MO HealthNet Program in 1998. WellCare Inc. acquired Missouri Care in the year 2013 and offered Managed Care plans in Missouri through Harmony Health Plan from the year 2006-2014. It serves 278,220 Medicaid members (by end of SFY 2018) across the State and have a local presence with offices in Springfield, Columbia and St. Louis and employs 170 people across the State.

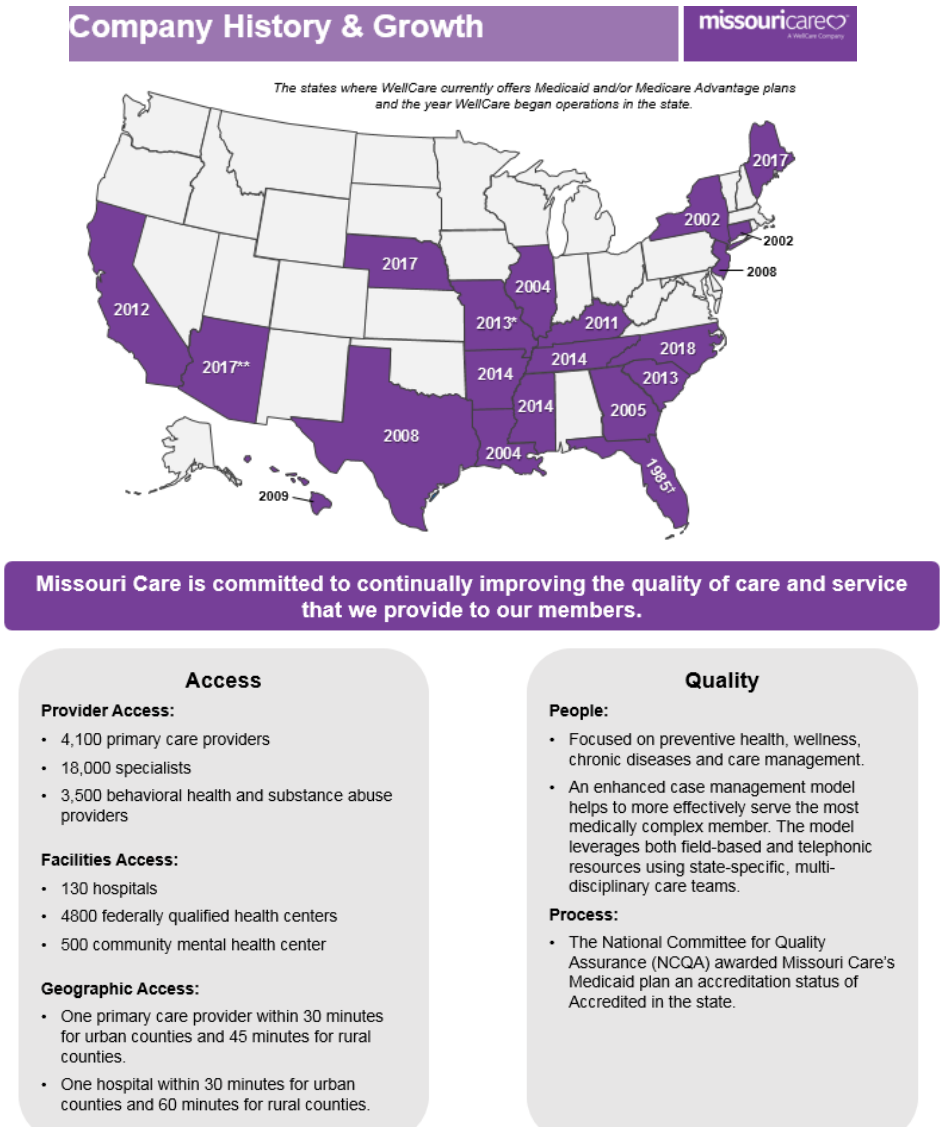


Figure 4-1

4.2 Compliance with Medicaid Managed Care Regulations

4.2.1 Methodology

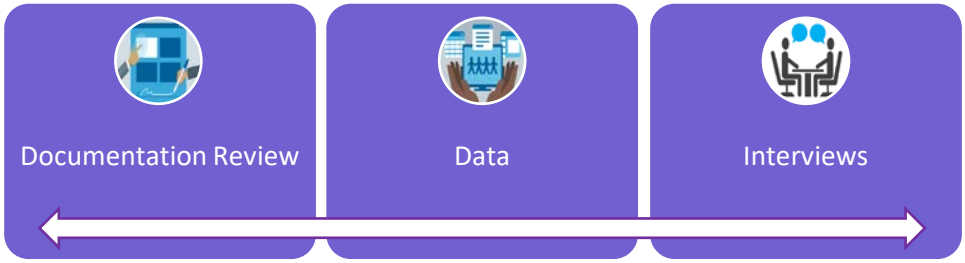


Figure 4-2 Sources of Information from Missouri Care

Data collection tools were created based on the MHD Managed Care Contract and 42CFR 438, subpart D for the three areas under evaluation (Ref: Table 4-2, 4-3, 4-4).

§438.230 Subcontractual relationships and delegation

§438.236 Practice guidelines

§438.242 Health information systems

In addition to these, an overview of all standards stated in 42 CFR 438 subpart D and Subpart E 438.330 was given. The Grievance and Appeal system (§438.228) was discussed in detail, which would be due for a review next year after approval from MHD.

The sources used to confirm Missouri Care'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 Assurance 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.

Missouri Care 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.

An on-site review was performed at the Missouri Care facility with the following people in attendance from Missouri Care for an interactive session on 'Compliance with Regulations':

- Russell Oppenborn, Senior Director, Regulatory Affairs;
- Tanesha Simmons, Field Regulatory and Compliance Specialist;
- Cannon Witt, Director, PCA; and
- Burt Walters, Project Analyst, Business Performance Management, EQR Team.

Table 4-1: MCO Information	
MCO Name:	Missouri Care
MCO Location:	4205 Philips Farm Rd, Suite 100, Columbia, MO 65201
On-site Location:	800 Market Street, 27th Floor, St. Louis, MO 63101
Audit Contact:	Russell Oppenborn
Contact Email:	Russell.Oppenborn@wellcare.com

4.2.2 Findings

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 3-2) as follows:

Table 4-2 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 MCO's entity's contract obligations. (iii) The contract or written arrangement must either provide for revocation of the delegation of	Missouri Medicaid/CHIP Requirements Addendum-page 1 Missouri Medicaid/CHIP Requirements Addendum-page 3 Master Services Agreement-page 8	● Met Partially Met Not Met

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: Missouri Care's Master Services Agreement for the subcontractor's delegations such as credentialing, care coordination, quality reporting, reporting of rates for compliance, adhering to the health plan's quality program, and other vendor agreements specifies provisions meeting all contractual requirements of the CFR. The contractors will follow all provisions of MHD contract and shall cooperate with Missouri Care in a reasonable manner with respect to Missouri Care's compliance with Missouri contracts and laws. If the MCO finds services rendered are not consistent with the contracts, remedies are in place including pricing, negotiation, and even termination. **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:		
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	Missouri Medicaid/CHIP Requirements Addendum-page 1 Missouri Medicaid/CHIP Requirements Addendum-page 2	● Met Partially Met Not Met

of amounts payable under the MCO's contract with the State.		
Findings: Master Services Agreement states that "Vendor shall permit and make available for inspection, evaluation and audit directly by Company, any applicable Government Payer(s), the Department of Health and Human Services ("DHHS"), the Comptroller General, the Office of the Inspector General of DHHS, the General Accounting Office, CMS and/or their designees, and as the Secretary of the DHHS may deem necessary to enforce Government Payer Contracts, as applicable, its and its subcontractors' premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems and any pertinent information including contracts (including any agreements between Vendor and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS and/or any applicable Government Payer(s) may require (collectively, "Books and Records"). [42 C.F.R § 422.504 (e) and (i) (2); 42 C.F.R. § 438.230(c) (3)]." 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 provided to members remaining in compliance with MO 2.30. Missouri Care also requires same information to be guarded under the federal HIPAA guidelines. **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.	Missouri Medicaid/CHIP Requirements Addendum-page 1 Master Services Agreement-page 8	● Met Partially Met Not Met

Findings: Missouri Care subcontract terms include a provision 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. (Also see findings for 2 a). **Required Actions:** None.		
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)).	Missouri Medicaid/CHIP Requirements Addendum-page 5 Master Services Agreement-page 3, 8	● Met Partially Met Not Met
Findings: In point 15 h of the addendum of the MO Medicaid Requirements, under "Medical Records", the wording states: "The subcontractor shall maintain comprehensive medical records for a minimum of five years. [MO Contract 3.9.6.f.]" The Master Services agreement shows a term of five years after the contract end for audit purposes. However, at another place in the Master Services Agreement, page 8 of 18, it is mentioned-"All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of the Agreement occurs or from completion of any audit or investigation, whichever is greater……..." **Required Actions:** It is recommended that Missouri Care should work with MHD to align audit rights and related record retention duration to 10 years in all the delegated subcontractor contracts based on the 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	Missouri Medicaid/CHIP Requirements Addendum-page 2 Master Services Agreement-page 5	● Met Partially Met Not Met

General may inspect, evaluate, and audit the subcontractor at any time.		
Findings: Missouri Care, in the Medicaid Requirements Addendum, states that contractors shall comply fully with all fraud, waste and abuse investigations. They also include that the HMO shall provide thorough training to the contractor to prevent fraud. MCO includes the right to full investigations referenced in 42 CFR Part 455, Subpart A (Medicaid Agency Fraud Detection and Investigation Program) subjecting the vendor to inspection at any time if fraud is suspected. **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 HealthNet Managed Care Contract section 3.9).	Missouri Medicaid/CHIP Requirements Addendum-page 5 Master Services Agreement-page 6	● Met Partially Met Not Met
Findings: Missouri Care Master Services Agreement includes with certainty, appropriate provisions and contractual obligations to ensure successful contract obligations. In the		

Missouri Care subcontractor regulations, the Indemnification clause spells out these contract terms with clarity. It includes attorney's fees and requirement of liability insurance. **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 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).	Missouri Medicaid/CHIP Requirements Addendum-page 5 Master Services Agreement-page 8	● Met Partially Met Not Met

Findings: Missouri Care subcontractor rules clearly include a clause to 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.

Regulation II—Practice Guidelines

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

Table 4-3 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;	Clinical Policy Guiding Document-page 1 Missouri Care Provider Manual-page 89	● Met Partially Met Not Met
Findings: Missouri Care 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. Providers have access to this through the provider portal and have the opportunity to challenge chosen guidelines as appropriate. The guidelines are based on a number of nationally accepted professional healthcare organizations. **Required Actions:** None.		
2. Consider the needs of the members;	Clinical Policy Guiding Document: Health Equity, Literacy, and Cultural Competency-page 1	● Met Partially Met Not Met

	2017 QAI Program Evaluation- page 12	
Findings: Missouri Care has updated guidelines to include national studies on health equity, health literacy, and cultural competency in their programs which are being implemented through their providers. Missouri Care updates 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. Missouri Care has several committees to study member engagement and implement improvement initiatives as needed to meet member need. **Required Actions:** None		
3. Are adopted in consultation with contracting health care professionals;	Missouri Care Provider Manual- page 88 Quality Improvement Committee	● Met Partially Met Not Met
Findings: Missouri Care utilizes a team of providers, including some contractors, to create the practice guidelines and then disseminates them to all the providers. There is a provision for discussion when necessary if policy contradicts provider thought. The Quality Improvement Committee is made up of Medical Directors who make practice guideline decisions. **Required Actions**: None.		
4. Are reviewed and updated periodically as appropriate; and	Clinical Policy Guiding Document: Clinical Coverage Guideline (CCG) / Claims Edit Guideline (CEG) Hierarchy – page 1	● Met Partially Met Not Met
Findings: Missouri Care practice guidelines are reviewed annually and are revised at least every two years. **Required Actions:** None		
5. Are disseminated to all affected providers, and upon	Clinical Policy Guiding Document – page 1	● Met Partially Met Not Met

request, to members and potential members.	Missouri Care Provider Manual-page 88	
Findings: Missouri Care Quality Improvement Committee including medical directors meet to create guidelines and updates to current guidelines as needed. The information is passed to subcontracted providers through the provider portal and education is given to the call center advocates for member questions. **Required Actions:** None.		
b. The health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	Clinical Policy Guiding Document: Quality Improvement -page 12	● Met Partially Met Not Met
Findings: Missouri Care utilizes quarterly compliance oversight meetings with representatives from various areas of the organization to make sure that their utlization management, care management, clinical management are based on the practice guidelines. **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, Missouri Care must use the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). Missouri Care submitted the 2017 QAI Program Evaluation under Utilization Management (Section x) and QIS CPGs for Behavioral Health to support their compliance for the above stated 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.		

Regulation III—Health Information Systems

In order to meet the contract compliance for this standard, Missouri Care should show effective use of a health information system for the purposes of tracking enrollee information, maintaining privacy, and tracking member utilization.

Table 4-4 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)).	Mo Health Net HIPAA Transaction Standard Companion Guide-page 17	● Met Partially Met Not Met
Findings: Missouri Care maintains a very detailed health information system to support data reporting sufficient to meet the State contract needs. . They allow multiple secure ways for vendors to connect to their Information System that offer security following HIPAA regulations (45 CFR § 162.915) for the purpose of tracking, analysis and claims payment. They require subcontractors to adhere to their standards of claims submissions and record storage compliant with CFR requirements. Subcontractors agree to be audited for a period of up to five years. **Required Actions:** None		
2. The MCOs health information system provides information on areas (42 CFR 242(a))including:		
a. Utilization.	Medical Record Review-page 20 WellCare Health Plans, Inc. 2018 Care Management Program Description-page 20	● Met Partially Met Not Met
Findings: Missouri Care gathers member utilization information through its health maintenance information systems and maintain information for seven years, following		

information requirements of MO 334.097 containing all member visit information for tracking purposes. The Quality Improvement Committee participates in quantitative and qualitative analysis of the results of the population assessment to identify characteristics and needs of the membership populations, including: membership demographic data such as age, gender, available ethnicity and language data and the needs of individuals with disabilities. **Required Actions:** None		
b. Grievances and appeals.	Missouri Grievances and Appeals-page 1	● Met Partially Met Not Met
Findings: Missouri Care HIS includes a detailed program 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. Reporting is enabled for providers, members, and the State. **Required Actions**: None.		
c. Disenrollment for other than loss of Medicaid eligibility.	MO Enrollment Screen Shot-page 1	● Met Partially Met Not Met
Findings: Missouri Care Health Information System is capable of tracking various ways member dis-enroll for e.g., loss of Medicaid eligibility, member choice, eligibility for another MCO, moving out of coverage area. **Required Actions**: None.		
3. The MCO collects data on:		
a. Enrollee characteristics.	Missouri Care Quality Assessment and Improvement Evaluation Report-page 18	● Met Partially Met Not Met
Findings: Missouri Care has a Cultural Competency Committee to watch member characteristics culturally. They have studies on population characteristics of their membership according to several areas including culture, special needs, languages spoken, and members opting out. **Required Actions**: None		

b. Services furnished to enrollees.	WellCare Health Plans, Inc. 2018 Care Management Program Description-page 13 Missouri Care Quality Assessment and Improvement Evaluation Report-page 7	● Met Partially Met Not Met
Findings: Missouri Care Health Information System is used to track services provided to enrollees and then documented for studies throughout the year. Initiatives were noted such as follow up on emergency department (ED) visits, dental exams, immunizations, lead toxicity studies, care management, and more. For additional follow up they tracked telephonic outreach, text messaging, utilization studies and others. **Required Actions**: None		
4. The MCOs health information system includes a mechanism to ensure that data received from providers are accurate and complete by: • 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	Well Care Enrollment and Eligibility System (EES) Process Flow Diagram-page 1 WellCare Health Plans, Inc. 2018 Care Management Program Description-page 20	● Met Partially Met Not Met

438.242(b) (2), 42 CFR 438.242(b) (3)).		
Findings: The integration system includes demographic conversion available in four formats to accommodate most provider EMRs for easy transfer of data compliant with CFR requirements via signed provider agreements in order to participate in the plan and receive reimbursement for services. Provider contracts allow MHD and Missouri Care access to medical records for audit. Missouri Care utilizes Well Care's (parent company) processes of health information system integration from provider networks into their information system to ensure all information is correct, appropriate, and accurate. **Required Actions**: None.		

Overall Compliance of Missouri Care with Medicaid Managed Care Regulations

Table 4-5 Missouri Care Score for Compliance

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 Score % (combined for all three) = $\frac{\text{Total score X100}}{\text{Total sections X2 points}}$ = 100%

For CY 2017 Missouri Care met all sections of Compliance Regulations, with an overall score of 100%. Missouri Care 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 one section of Subcontractual Relationships and Delegation is updated (Table 4-2: 2c), to meet the requirements of New Managed Care Rules for CY 2018 review.

Corrective Action Plan (CAP) Process

No regulatory standard was put on a corrective action plan during the previous year's EQR which required a review this year. Table 4-6 is used to define the noted areas of concern (if any) during the EQR 2018, for the CY 2017 and the need to take corrective actions by Missouri Care:

Table 4-6 Key Findings and Audit Results for Missouri Care

Compliance Standard	Key Review Findings	Number of sections Met	Audit Results
Subcontractual Relationships and Delegation	One section- 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 4.2.4

4.2.3 Conclusions

Strengths

- Missouri Care did an excellent job of providing data, documentation, and verbal confirmation for their Compliance processes. The staff is knowledgeable and assisted in gathering all the necessary information during onsite. 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.
- Missouri Care has a clear understanding of the Practice Guidelines requirement as shown through their Compliance Committee notes and undertakings. They utilize many nationally recognized authorities for basis of the guidelines and appear to review them quarterly. The process of disseminating information through the agency and provider network appears accessible and timely. Enrollees can access this information through a helpline if needed.

- Missouri Care 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. The member needs are documented and used in compliance and other areas of Missouri Care to offer quality programming updates.
- 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
- 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.

Weaknesses

The following points were stated by Missouri Care during an onsite visit:

- Missouri Care reported about 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 Missouri Care 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 Missouri Care, thus shifting the communication burden on the Missouri Care 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.

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 Missouri Care. However, Missouri Care could succeed in increasing their compliance score to 100%.
- Their overall Compliance Score increased by 9.5% point from the CY 2016 despite the additional enrollees.
- They continue to track additional member data to increase their knowledge of member utilization.

Improvements by MCO from Prior Year

- From the Figure 4-3, it is evident that Missouri Care has increasing compliancy with the Federal and State rules and regulations. There is a 9.5% point increase from previous calendar year.
- Missouri Care was not placed on CAP by the EQRO for CY 2016 and neither did Primaris initiate a CAP for the CY 2017.

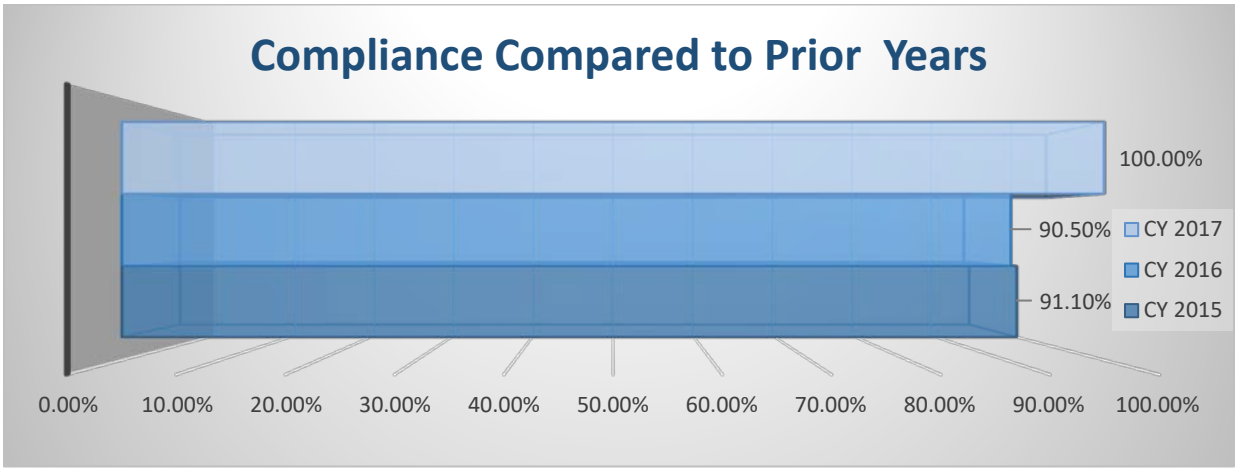


Figure 4-3 Compliance Scores for CY 2015-CY 2017

4.2.4 Recommendations

Suggested recommendations include the following:

- 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)).” Missouri Care 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.

4.3 (A) Validation of Performance Measures

4.3.1 Methodology

Primaris conducted an onsite visit at Missouri Care for the validation of performance measures on July 18, 2018. The validation activities were conducted as outlined in the CMS EQR protocol 2, Validation of Performance Measures reported by the MCO.

Primaris validated rates for the following set of performance measures selected by MHD (Table 4-7). The measurement period was identified by MHD as calendar year (CY) 2017 for all measures. Out of the three performance measures, only one measure required medical record validation, PPC. The additional two measures were administrative only which required primary source verification from the plan’s claim system. MHD provided Primaris with the Healthcare Quality Data Template for CY2017 which consisted of instructions and specifications for the three measures required for validation.

Table 4-7 Performance Measures			
Performance Measure	**Method**	**Specifications Used**	**Validation Methodology**
Prenatal Post-Partum Care (PPC)	Hybrid	HEDIS/MHD	Medical Record Validation
Emergency Department Visits (EVD)	Admin	MHD	Primary Source Verification
Emergency Department Utilization (EDU)	Admin	MHD	Primary Source Verification

Pre-Audit Process

Primaris prepared a series of electronic communications that were submitted to Missouri Care outlining the steps in the performance measure validation process. The electronic communications included a request for samples, medical records, numerator and denominator files, source code, if required, and a completed Information Systems Capability Assessment (ISCA).

Data Collection and Analysis

The CMS performance measure validation protocol identifies key components that should be reviewed as part of the validation process. The following bullets describes these components and the methodology used by Primaris to conduct its analysis and review:

- CMS's ISCA: Missouri Care completed and submitted the required and relevant portions of its ISCA for Primaris's review. Primaris used responses from the ISCA to complete the onsite and pre-on-site assessment of information systems.
- Medical record verification**:** To ensure the accuracy of the hybrid data being abstracted by the Missouri Care, random selection of 45 records were taken from the Home State Health's hybrid sample of 411 records for the measurement year 2017. The audit team conducted over-reads of the 45 medical records to validate compliance with both the specifications and abstraction process.
- Source code verification for performance measures**:** Missouri Care contracted with a software vendor to generate and calculate rates for the two administrative performance measures, EDU and EDV. The

source code review was conducted during the onsite audit sessions where Home State Health explained its rate generation and data integration processes to the Primaris review team.

- Additional supporting documents: In addition to reviewing the ISCA, Primaris also reviewed Missouri Care's policies and procedures, file layouts, system flow diagrams, system files, and data collection processes. Primaris reviewed all supporting documentation and identified any issues requiring further clarification.
- Administrative rate verification: Upon receiving the numerator and denominator files for each measure from Home State Health, Primaris conducted a validation review to determine reasonable accuracy and data integrity.

On-Site Activities

An on-site visit activities are described as follows:

- Opening Conference**:** The opening meeting included an introduction of the validation team and key Missouri Care staff members involved in the performance measure validation activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- Information System Compliance: The evaluation included a review of the information systems, focusing on the processing of claims and encounter data, provider data, patient data, and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the performance measure rates, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- ISCA Review, Interviews and Documentation**:** The review included processes used for collecting, storing, validating, and reporting performance measure rates. The review meetings were interactive with key Missouri Care staff members, in order to capture Missouri Care's steps taken to generate the performance measure rates. This session was used by Primaris to assess a confidence level over the reporting process and performance measure reporting as well as the documentation process in the ISCA. Primaris conducted interviews to confirm findings from the documentation review and to ascertain that written policies and procedures were used and followed in daily practice.

- Overview of Data Integration and Control Procedures: The data integration session comprised of system demonstrations of the data integration process and included discussions around data capture and storage. Additionally, Primaris performed primary source verification to further validate the administrative performance measures, reviewed backup documentation on data integration, and addressed data control and security procedures.
- Closing conference: The closing conference included a summation of preliminary findings based on the review of the ISCA and the on-site visit.

4.3.2 Findings

Based on all validation activities, Primaris determined validation results for each performance measure rate as defined in the Table 4-8 below.

Table 4-8 Audit Results and Definitions for Performance Measures

Met	All documentation listed under a regulatory provision, or one of its components was present. MCHP 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 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.

According to the CMS protocol, the audit result for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be “Met.” It is possible for a single audit element to receive an audit result of “Not Met” when the impact of the error associated with that element biased the reported performance measure rate more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of “Partially Met”.

The Table 4-9 shows the key review findings and final audit results for Missouri Care for each performance measure rate.

Table 4-9 Key Review Findings and Audit Results for Missouri Care		
Performance Measures	**Key Review Findings**	**Audit Results**
Prenatal Post-Partum Care	No concerns were identified	Met ●
Emergency Department Visits	No concerns were identified.	Met ●
Emergency Department Utilization	No concerns were identified	Met ●

As part of the performance measure validation process, Primaris reviewed Missouri Care's data integration, data control, and documentation of performance measure rate calculations. The following describes the validation processes used and the validation findings.

Data Integration

Met ●	Partially Met ☐	Not Met ☐

Data integration is an essential part of the overall performance measurement creation/reporting process. Data integration relies upon various internal systems to capture all data elements required for reporting. Accurate data integration is essential for calculating valid performance measure rates. Primaris reviewed Missouri Care's actual results of file consolidations and extracts to determine if they were consistent with those which should have resulted according to documented specifications. The steps used to integrate data sources such as claims and encounter data, eligibility and provider data require a highly skilled staff and carefully controlled processes. Primaris validated the data integration process used by Missouri Care, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

Data Control

Met ●	Partially Met ☐	Not Met ☐

Data control procedures ensure the accurate, timely, and complete integration of data into the performance measure database by comparing samples of data in the repository to transaction files. Good control procedures determines if any members, providers, or services are lost in the process and if the organization has methods to correct lost/missing data. The organizations infrastructure must support all necessary information systems and its backup procedures. Primaris validated the data control processes Missouri Care used which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, Primaris determined that the data control processes in place at Missouri Care were acceptable and received a "Met" designation.

Performance Measure Documentation

Met ●	Partially Met ☐	Not Met ☐

Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided necessary information to complete the audit, the majority of the validation review findings were based on documentation provided by Missouri Care in the ISCA. Primaris' Information Technology Project Manager and Lead Auditor reviewed the computer programming codes, output files, work flow diagrams, primary source verification and other related documentations.

Primaris evaluated Missouri Care's data systems for the processing of each data type used for reporting MHD performance measure rates. General findings are indicated below.

Medical Service Data (Claims and Encounters)

Missouri Care continued to use the Xcelys claims and encounter system. During the on-site review of the claims process, Primaris confirmed that ICD-10, revenue, CPT-4 and HCPCs coding was implemented appropriately. Primaris conducted system tests on Xcelys to verify diagnosis codes were appropriately paid and/or rejected based on the HIPAA ICD-10 implementation date. Primaris did not identify any issues during this validation and concluded that Missouri Care configured Xcelys to accept

claims with appropriate coding schemes. Further system demonstrations showed that Missouri Care's Xcelys system captured and allowed only standard industry codes with the appropriate specificity. Claims and encounter data were submitted either electronically or via paper from Missouri Care's external providers. Electronic data were submitted through clearinghouses and processed overnight in Xcelys. Paper claims and encounters were submitted directly to Missouri Care's vendor for scanning and conversion into the standard 837 format. Once converted, the data followed the same process as electronic claims and encounters. Missouri Care did not enter any claims and encounter data on-site or use any internal staff members to enter claims and encounters directly into the system. Missouri Care ensured only "clean" claims and encounters were captured in the system; any claims and encounters not passing the appropriate edits were promptly returned to the provider for correction.

Primaris also reviewed the outstanding incurred but not reported (IBNR) report during the on-site audit and found that the majority (greater than 98 percent) of all claims were received by April 2016, similar to the previous year's review. Outstanding claims or encounters did not have a significant impact on reporting.

Primaris had no concerns with Missouri Care's claims and encounter data processes.

Enrollment Data

Missouri Care received daily and monthly files from the State in standard 834 format for member enrollment. Daily files were reconciled against the full monthly file and loaded into Xcelys. No enrollment files were manually processed, and all files were handled in standard 834 transactions. No significant changes were made to the Xcelys system or the enrollment process during 2017, and Xcelys captured all relevant fields required for HEDIS processing. Primaris confirmed with Missouri Care staff that there were no backlogs or outages for the enrollment process during the measurement year. Primaris also confirmed that the assignment of member identification numbers was automatic in Xcelys, but that these identifiers were cross-checked prior to assignment to determine if an Xcelys identifier already existed. In the cases where a match was identified, the Member Services Department reviewed to determine if the member had an existing number or if a new number needed to be assigned.

Multiple queries were conducted onsite by the validation team to ensure that members that were reported as numerator compliant actually met the age and gender requirements. The queries did not reveal any deviation from expectations and numerator compliance was verified.

Missouri Care's system, Xcelys, was capable of identifying members with duplicate numbers and producing reports for enrollment staff to work. Duplicate identifiers, although not a frequent occurrence, were verified using the State enrollment files to ensure the most accurate information was captured. There were no issues identified with Primaris's enrollment data processes.

Provider Data

Missouri Care utilized Xcelys to capture its provider data for claims processing. Missouri Care utilized both direct contracted and delegated entities to enroll providers. Missouri Care used an internal software tracking mechanism (Omniflow) to manage its provider information. Omniflow was used to send provider data to Missouri Care's Credentialing department for provider management prior to loading into Xcelys. Once the provider information flowed through Omniflow, the data were then loaded into Xcelys. A unique provider identifier was created along with provider specialties. Missouri Care's credentialing staff ensured provider specialties were appropriate by validating the provider's education and specialty assignment authorized by the issuing provider board. Primaris verified that the required HEDIS reporting elements were present in Xcelys and that provider specialties were accurate based on the provider mapping documents submitted with Missouri Care's Roadmap.

Primaris reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. Primaris found Missouri Care to be compliant with the credentialing and assignment of individual providers at the Federally Qualified Health Centers (FQHCs). There were no changes to Missouri Care's provider data processes, including how it captured provider data through its delegated entities.

Final rate review did not reveal any issues with provider mapping with any of the performance measures.

Medical Record Review Validation (MRRV)

Missouri Care was fully compliant with the MRR reporting requirements. Missouri Care contracted with Altegra Health, a medical record vendor, to procure and abstract MRR data into Altegra Health's custom measure tools. Primaris reviewed Altegra Health's tools and corresponding instructions. The vendor's reviewer qualifications, training, and oversight were appropriate as defined by the NCQA abstraction

qualification standards. Missouri Care provided adequate oversight of its vendor and Primaris had no concerns.

The validation team randomly selected 45 numerator positive records from the total numerator positive records abstracted during the HEDIS medical record validation process. The records selected were a combination of prenatal and post-partum numerator positive hits. These records were used to evaluate the abstraction accuracy and to validate the rates submitted for the PPC measure.

Supplemental Data

Although supplemental data is allowed, Missouri Care did not use supplemental data for reporting against the measures under review.

Data Integration

Missouri Care continued to utilize the Green Plumb data warehouse to house and consolidate files prior to loading into Inovalon' s measure production software.

Primaris reviewed Missouri Care's processes around the Green Thumb data warehouse and determined that no significant changes occurred from the previous year's review. Missouri Care information technology staff continued to extract data monthly from its core systems. Missouri Care did extensive testing to ensure all data were complete and accurate, and ran two parallel processes in the software to ensure the rates matched.

Several internal data sources were consolidated to produce files for the software vendor. Internal data sources validated by Primaris included enrollment, claims, provider data, encounters, pharmacy, and laboratory files. These internal files were transformed and merged into the software vendor's file layouts and used to produce the performance measures.

Primaris conducted primary source verification for each measure's administrative numerators during the on-site audit. Primaris reviewed a minimum of three cases for each measure with an administrative hit to determine whether numerators met age, gender, diagnosis, and procedural compliance with the specifications. Primaris did not find any issues during the primary source review.

Missouri Care backed up data nightly and weekly to ensure no data loss and denied having any significant outages during 2015. Missouri Care's disaster recovery plan was sufficient to ensure data integrity. No issues were identified with Missouri Care's data integration processes.

Missouri Care Measure Specific Rates

Table 4-10 Health Care Quality Data Report (HCQDR) for EDV and EDU		
HCQDR #	**Measure Name**	**Total**
6.01	Utilization MH ER Age0-12 Count	418
6.02	Utilization MH ER Age13-17 Count	566
6.03	Utilization MH ER Age18-64 Count	888
6.04	Utilization MH ER Age65+ Count	0
6.05	Utilization SA ER Age0-12 Count	13
6.06	Utilization SA ER Age13-17 Count	95
6.07	Utilization SA ER Age18-64 Count	511
6.08	Utilization SA ER Age65+ Count	0
6.09	Utilization MED ER Age0-12 Count	53,695
6.10	Utilization MED ER Age13-17 Count	14,808
6.11	Utilization MED ER Age18-64 Count	24,801
6.12	Utilization MED ER Age65+ Count	3
6.13	ER Visits MH Age0-12 Count	578
6.14	ER Visits MH Age13-17 Count	842
6.15	ER Visits MH Age18-64 Count	1,245
6.16	ER Visits MH Age65+ Count	0
6.17	ER Visits SA Age0-12 Count	17
6.18	ER Visits SA Age13-17 Count	100
6.19	ER Visits SA Age18-64 Count	632
6.20	ER Visits SA Age65+ Count	0
6.21	ER Visits MED Age0-12 Count	85,486
6.22	ER Visits MED Age13-17 Count	22,658
6.23	ER Visits MED Age18-64 Count	52,491
6.24	ER Visits MED Age65+ Count	4
6.25	ER Follow Up MH Age0-12 Denominator	329

6.26	ER Follow Up MH Age13-17 Denominator	455
6.27	ER Follow Up MH Age18-64 Denominator	693
6.28	ER Follow Up MH Age65+ Denominator	0
6.29	ER Follow Up 7Days MH Age0-12 Count	111
6.30	ER Follow Up 7Days MH Age13-17 Count	154
6.31	ER Follow Up 7Days MH Age18-64 Count	134
6.32	ER Follow Up 7Days MH Age65+ Count	0
6.33	ER Follow Up 30Days MH Age0-12 Count	172
6.34	ER Follow Up 30Days MH Age13-17 Count	228
6.35	ER Follow Up 30Days MH Age18-64 Count	219
6.36	ER Follow Up 30Days MH Age65+ Count	0
6.37	ER Follow Up SA Age0-12 Denominator	12
6.38	ER Follow Up SA Age13-17 Denominator	74
6.39	ER Follow Up SA Age18-64 Denominator	448
6.40	ER Follow Up SA Age65+ Denominator	0
6.41	ER Follow Up 7Days SA Age0-12 Count	1
6.42	ER Follow Up 7Days SA Age13-17 Count	10
6.43	ER Follow Up 7Days SA Age18-64 Count	60
6.44	ER Follow Up 7Days SA Age65+ Count	0
6.45	ER Follow Up 30Days SA Age0-12 Count	1
6.46	ER Follow Up 30Days SA Age13-17 Count	11
6.47	ER Follow Up 30Days SA Age18-64 Count	84
6.48	ER Follow Up 30Days SA Age65+ Count	0

Table 4-11 HEDIS 2017 PPC Rates					
Prenatal and Postpartum Care	**Aggregate**	**Central**	**East**	**West**	**Southwest**
Timeliness of Prenatal Care	81.51%	87.59%	79.56%	76.40%	92.94%
Postpartum Care	57.18%	63.26%	54.26%	61.07%	68.61%

4.3.3 Conclusions

Strengths

- Overall, Missouri Care has an excellent oversight of all internal processes and systems, enabling it to collect and capture performance measurement specific items for reporting.
- Team work and coordination with providers, Medicaid case workers and members
- Provider Engagement
- Member engagement
- Missouri Care has centralized staff that are focused on quality measurement and analytics. The centralized team runs rates on a monthly basis to determine its needs and areas for improvement.
- Missouri Care provided system experts to demonstrate the system's infrastructure during the onsite audit. This allowed Primaris staff to understand the system and process flows accurately.

Weakness

- One area for concern is how Missouri Care manages its member demographic information. Member information is captured daily through the state's enrollment file, however, many times, the member demographic information is not accurate. The information is only as accurate as the most recent contact that the member has had with the Medicaid Case worker. Since Missouri Care's population moves often and phone numbers are not reliable, this poses a significant barrier to member outreach.

- Post-Partum Care compliance continues to be an issues with Missouri Care. The rates are not improving significantly as trended over three years (Figure 4-4).

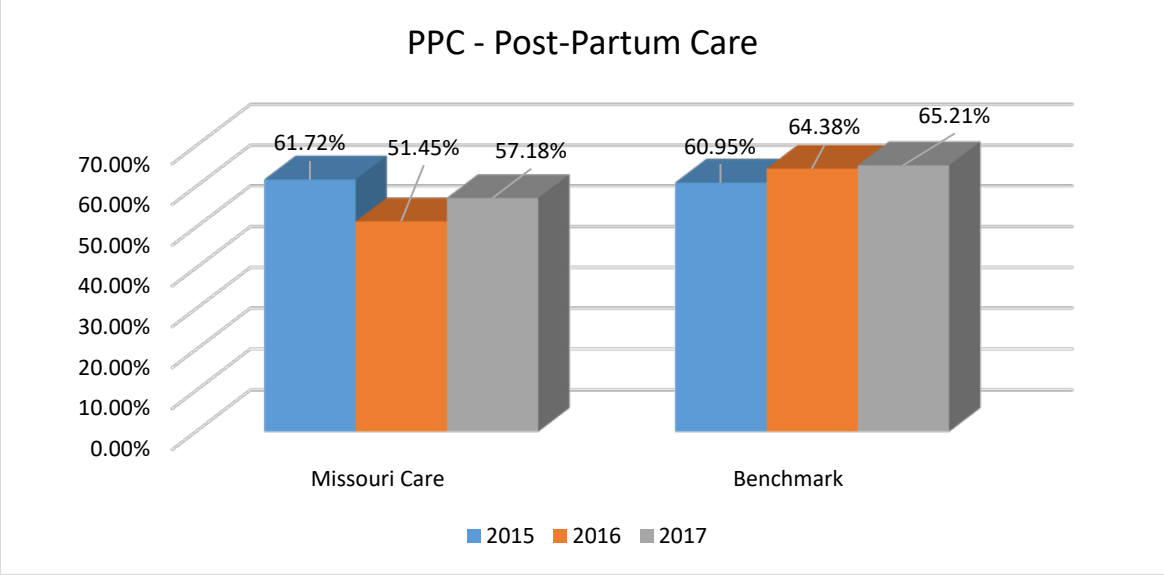


Figure 4-4 *2018 HEDIS 50th percentile benchmarks are reported by Missouri Care*

Quality, Timeliness and Access to Healthcare Services

- Missouri Care has no barriers to emergency care services nor for prenatal and post-partum care. Missouri Care does not require authorization for access to either service.
- From a quality standpoint, members should be encouraged to divert non emergent care services from the ED to the lower level of care found in the urgent care setting.
- Missouri Care was able to demonstrate its ability to capture the specific diagnosis codes for each EDV and EDU visit/service.
- Prenatal care is a significant concern for the Medicaid population. Early intervention for prenatal care greatly improves the opportunity for safe and healthy deliveries.

Improvement by MCO from Previous Year

- Missouri Care was able to produce the EDV and EDU measure without any concerns this year. It appears that the Missouri Care staff were able to understand the specifications better and made coding improvement over the previous review.

- Missouri Care made significant improvements in the prenatal care rates over a two year period. For Timeliness of Prenatal Care, Missouri Care was 1.7% points below the 50th percentile. However, Missouri Care increased 4.46 percentage points since the previous year's reported rate of 77.05% (Figure 4-5).

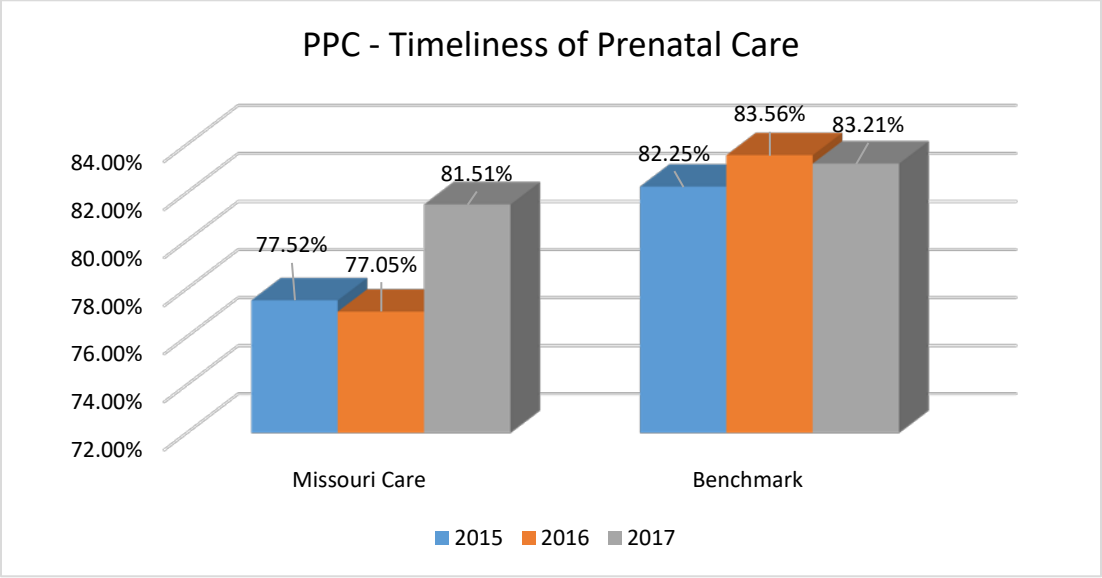


Figure 4-5 PPC (Timeliness)

2018 HEDIS 50th percentile benchmarks are reported by Missouri Care

4.3.4 Recommendations

- Missouri Care should develop a process for capturing and housing current member demographic information collected through its provider network. Providers, often-times primary care physicians or urgent/emergent care centers should collect the most recent address and phone number information from the member. Missouri Care would benefit from setting up a process for capturing this pertinent information from the most recent office visit. Information from providers could be shared with Missouri Care on a case by case basis or more frequently to enhance its information currently processed through the daily enrollment files.
- Missouri Care would benefit from implementing strategies to engage members in proper maternity care through outreach campaigns once they become aware of a pregnancy. Missouri

Care should engage providers and immediately begin care management for pregnancies to encourage moms to attend prenatal and post-partum care services.

4.3 (B) Information Systems Capabilities Assessment (ISCA)

4.3.1 (B) Methodology

Primaris assessed Missouri Care's Information Systems, Resource Management, Data Processing, and Reporting Procedures. The purpose is to analyze interoperability and reveal the extent to which Missouri Care's information systems can support the production of valid and meaningful performance measures in conjunction with their capacity to manage care of their members.

Primaris bases their methodologies directly on the CMS protocol, External Quality Review (EQR) APPENDIX V-Information Systems Capabilities Assessment. It has two attachments:

- Attachment A: Tools for Assessing Managed Care Organization (MCO) Information Systems; and
- Attachment B: Information System Review Worksheet and Interview Guide.

Data collection, review, and analysis were conducted for each review area via the ISCA data collection tools, interview responses, security walk-throughs, and claim/encounter data lifecycle demonstrations. Scores for the ISCA portion align with the other sections of this EQR and are based on the standards for a Met, Partially Met, or Not Met criteria.

Table 4-12 Scoring Key

Scoring Key	Description
Met (pass)	All necessary requirements were proven to be satisfied with supporting documentations, system demonstrations, and staff interviews.
Partially Met (pass)	Some supporting evidence and/or positive results that meet majority *(at least half plus one)* of the requirements and industry standards. *Example: MCO has well-structured documentation around information system processes, and mostly positive results. MCO is fully aware of their opportunity for improvement around their paper claims process and tracking. They have a plan in place working on*

	improvement, provided evidence like meeting minutes, calendar invites, etc. All supporting active improvement activities.
Not Met (fail)	No supporting evidence or positive results to meet requirements and industry standards. *Example: MCO has no documented processes in place to support their ability to track a claim, which was originally paper, back to its original source. In fact, in the on-site interviews 3 employee mentioned their lack of ability to backtrack as a pain point in their day-to-day activities.*

The ISCA review process consists of four phases:

Phase 1: The MCO's information systems standard information is collected. Primaris sends the ISCA data collection worksheet to the MCO with a deadline to be completed and returned electronically to Primaris prior to the scheduled on-site review activities.

Phase 2: Review of completed worksheets and supporting documentation. All submitted documentation is thoroughly reviewed, flagging answers that seem incomplete or indicated an inadequate process for follow-up. The follow-up questions and review happens during the on-site visit.

Phase 3: Onsite review and walk-throughs. Primaris utilizes time on-site to review any propriety material, live system and security walk-throughs, and interview other members of staff related to their information systems management.

Phase 4: Analysis of data collected during pre and on-site activities. Primaris compares and scores the findings directly against industry standards. Specific focus to 45 CFR Part 160 & 164, section 2.26 of MHD contact, and Medicaid Management Information Systems (MMIS).

Scoring Standards

Scoring Standards Table 4-13 presents the detailed Federal regulations, Missouri HealthNet Division (MHD) State contract requirements, and industry standards Home State Health was evaluated against.

Table 4-13 Scoring Standards

Citation	Source	Description
45 CFR Part 160	Health & Human Services (HHS)	Code of Federal Regulations for General Administrative Requirements' compliance and enforcement for maintaining security and privacy.
45 CFR Part 164 Subpart C	Health & Human Services (HHS)	Code of Federal Regulations Subpart C Security Standards for the Protection of Electronic Protected Health Information.
45 CFR Part 164 Subpart E	Health & Human Services (HHS)	Code of Federal Regulations Subpart E Privacy of Individually Identifiable Health Information.
42 CFR Part 438 Subpart E	Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS)	Code of Federal Regulations Subpart E Quality Measure and Improvement; External Quality Review.
42 CFR Part 438 Subpart H	Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS)	Code of Federal Regulations Subpart H Additional Program Integrity Safeguards.
Section 2.26 MHD Contract	Missouri Health Department (MHD)	Claims Processing and Management Information Systems section.
NIST	National Institute of Standards and Technology	"The Information Systems Group develops and validates novel computational methods, data/knowledge mining tools, and semantic services using systems-based approaches, to advance measurement science and standards in areas such as complex biological systems, translational medicine, materials

		discovery, and voting, thus improving the transparency and efficacy of decision support systems" **
ANSI ASC X 12	American National Standards Institute, the Accredited Standards Committee	"The American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for inter-industry electronic exchange of business transactions, namely electronic data interchange." ***

References: ** - *https://www.nist.gov/*

*** - https://www.edibasics.com/edi-resources/document-standards/ansi/

4.3.2 (B) Findings

1. Information Systems

This section of the ISCA evaluates the MCO's management, policies, and procedures surrounding their information systems. Detailed review is conducted to thoroughly assess the information systems capacity for collecting, filtering, transforming, storing, analyzing, and reporting Medicaid data.

Missouri Care uses Oracle and Microsoft SQL Server (MSSQL) for its relational data base management systems. *PL/SQL, SAS, COGNOS, Informatica, PostgreSQL* are the programming languages used to create Medicaid data extracts and/or analytic reports. IT uses a highly centralized model in which a pool of WellCare ((Missouri Care's parent company) employees and contractors execute programming tasks according to demand across all product lines, including Missouri. Approximately 200 employee programmers are trained and capable of modifying the utilized programs. WellCare's Quality Assurance team utilizes the ALM testing tool to document and track all defects found during the testing cycles for each project and release. Metrics are created for each project which include weekly and cumulative opened and closed defects with trending, open defect counts by status

and severity, closed defects by root cause, and defect ageing. These metrics are provided to the project team weekly to monitor progress of the testing effort and establish the risk levels of the delivery based on quantity and severity of defects found.

WellCare establishes project plans and expected completion times for all activities and tasks, including programmer activities. The estimated efforts and durations are established based on the complexity and scope of the task and the experience level of the individual. Actual delivery with respect to the established deadlines are one of the primary measures of productivity utilized to evaluate programmer performance. Peer code reviews are conducted prior to deployment to ensure code quality

All application source code is managed and maintained in Microsoft Team Foundation Server version control tool. Every change made to the code is versioned via checkout-check-in process and managed and tracked. Every deployment to non-production environment is captured in Work Item Tracking feature in TFS. This Work Item goes through the approval process from (DEV- QA- RM- Deployers) before any code is deployed.

All reports generated via Missouri Care systems are reviewed by the Business and IT Owners for completeness and accuracy. When issues are discovered, an incident ticket is created via the IT Service Desk and a project is undertaken to review and solution the issue(s) for correction. Following the IT software development life cycle (SDLC) process, a correction is developed and tested by IT. Once completed, the Business provides User Acceptance Testing to validate the issue(s) have been resolved. The incident generates a Request for Change (Change Order) which is reviewed and approved for deployment to the production environment by IT. The Business provides verification that the subsequently generated reports no longer reflect the issues of concern.

2. I T Infrastructure

This section of the ISCA evaluates the MCO's network infrastructure and ability to maintain its equipment and telecommunicates capacity to support end users' needs.

Missouri Care has access to its parent company, WellCare's original copies of all Medicaid source data from claims and encounters, in both the form submitted (paper or electronic) and an initial processing copy. As a result, all claim submissions are able to be re-executed if needed due to system failures or issues.

Claim and encounter applications are backed up on a nightly basis and database logs of the original systems are maintained. In addition, read-only replica copies are maintained on a real-time basis and are able to be utilized as a recovery source. Back up information is stored at a secure off site facility as the primary assurance of recovery capabilities, with recent copies being retained locally for faster, more convenient processing demands if needed. Quarterly backup recovery tests are conducted, as well as an annual Disaster Recovery test.

WellCare completes a formal Quality Assurance and User Acceptance testing process on all changes prior to deployment to protect against program errors. Further, WellCare's implementation of Virtual servers and built in redundancy in the infrastructure (power supplies, RAID disc strategies, and load balanced servers) provides for fully automated failover of primary components.

WellCare leverages a leading class data center that provides multiple environmental and physical controls. Environmental controls include N+1 redundant UPS's, N+1 Generators, N+1 HVAC systems to control temperature and humidity, multiple geographically diverse electrical substations, Shell within a shell building structure leveraging bullet proof glass and steel reinforced walls, Very Early Smoke Detection Apparatuses, and 24X7 systems monitoring from multiple locations. Physical controls include 24X7 onsite security, biometric restricted access, multi-level authorization protections, and video surveillance of facility and WellCare equipment.

3. Information Security

This section of the ISCA evaluates the MCO's information systems and the safeguards in place to proactively avoid malicious access to facilities and/or data systems, intrusions, and breaches of protected health information (PHI) and personally identifiable information (PII).

Missouri Care uses Wellcare's information security program consisting of policies, standards, and procedures that define how resources are provisioned and access controls are managed. Access control standards define the requirements for user account password policies and network access. Changes in the environment are reflected in security systems in a timely manner through both automated and manual processes. For each significant application, WellCare has documented and published Standards and Guidelines. The policies are approved by senior IT Management, located on a WellCare shared drive, and communicated to all IT Associates.

Access to IT computing resources is restricted by the implementation of identification, authentication, and authorization mechanisms. User authentication is required to access WellCare's applications, data, and key financial reports. The Provisioning Procedures document the formalized process for requesting, establishing, suspending, and closing a user account.

In order to access applications, data used in member load and premium reconciliation processing, and key financial reporting data, users must authenticate through the network layer. Access to any WellCare desktop or server requires a valid user ID (UID) and password in Microsoft Active Directory (Active Directory). Authentication rules are enforced through Active Directory including password minimum length, expiration, history, and account lockout

For external users, only active members and providers with an open contract with WellCare can register for portal access. Group and Independent Physician Associations (IPA) provider accounts are provisioned via Web Customer Support who verifies the provider information before setting up the account. Members are only allowed to view data (Eligibility, Claims, Authorizations, etc.) that pertains to themselves. Primary Care Physician (PCP) providers may view member data only for members that are assigned to them. Specialty providers may view member data for any member that belongs to a line of business for which they are contracted with WellCare. Group and IPA providers with administrative privileges may view information pertaining to any provider associated with the Group/IPA as indicated by WellCare's provider system of record. Missouri Care/WellCare employees may view member and provider data for any member or provider in WellCare's system.

4. Encounter Data Management

This section of the ISCA evaluates the MCO's ability to capture and report accurate encounter data. Missouri Care validates the consistency and integrity of procedure and diagnosis codes for both professional and institutional claims to ensure alignment with CMS and State specific rules. There are several areas in which these edits occur for both professional and institutional claims: a) SNIP b) Pre-processing edits in the Front End c) During the adjudication process prior to the accounts payable cycle.

All codes are compared to HIPPA codes sets via X-engine software purchased by WellCare from Edifecs. The codes sets are updated quarterly or as regulations are posted. Claims are rejected by Front-End Edits for missing, invalid or incomplete Codes. Paper Submitters get paper rejection letters. Electronic Data Interchange (EDI) submitters get appropriate 999 and 277/277U.

The completeness of the data varies based on the category of service. Most Dental, Professional, and Outpatient claims are adjudicated and paid within 3 to 6 months. Inpatient claims take the longest to complete since an individual may be hospitalized for an extended period of time. Inpatient claims are mostly complete after 6 months of run out is available. The completion factor is estimated by using lag triangles to determine the completion pattern using historical data. For more recent months, an alternative methodology such as the projection method may be used since the most recent months lack sufficient credibility. Completeness is defined as the ratio of claims paid to date, divided by the estimated incurred amount once all claims are adjudicated and paid.

WellCare conducts internal audits on Encounter processing every three years or more often as deemed necessary by the senior management team.

The hierarchy of claims adjudication edits results in a claim either auto-adjudicating to paid or denied status or suspended for manual review to resolve. The suspended claims are managed on a daily basis by the claims management team to ensure claims are processed accurately and within the 90% of claims processed within the 30 day regulatory time frame.

5. Eligibility Data Management

This section of the ISCA evaluates the MCO's ability to capture and report accurate Medicaid eligibility data.

Missouri Care receives an 834 file daily from the State. The files are loaded as received and files cannot be modified, the data sent on this 834 will update/override any stored information. Missouri Care expresses that 60% of the data is missing or incomplete.

Disenrollment and re-enrollment transactions are received via the 834 eligibility file according to the transaction provided by the State. The member retains the same Subscriber ID assigned from initial enrollment. In regards to continuous enrollment, this information is provided through Enrollment files which we upload to Inovalon (software vendor) as the Inovalon Quality Spectrum software handles the calculation.

Missouri Care processes the transactions received from the 834 eligibility file in order of receipt. If a term transaction is received, a termination date is applied to the eligibility span in Xcelys, a claims processing service, according to the data received on the file. If an additional transaction is received on the following day for a reinstatement with no gap in coverage, then plan will process the transactions

received from the 834 eligibility file and apply the update to the eligibility span according to the data received on the file. This action does not affect continuous enrollment calculations.

6. Provider Data Management

This section of the ISCA evaluates the MCO's ability to maintain accurate and timely provider information.

Missouri Care's online provider directory is updated on a daily basis. Printed directories are updated on a quarterly basis. The directories pull directly from Missouri Care's primary database. If the change is a non-critical demographic change (phone number, address, accepts new patients, bus route, hours of operation, handicap access) the Provider Operations Coordinator has change authority. For any other change only the Shared Services Configuration Department or the Shared Services Network Integrity Department have change authority.

Provider information maintained in the provider profile database includes: Name, Address, Phone number, Fax, Hours of operation, Handicap access, Buss route, Gender, Languages Spoken, Ages seen, specialty, Directory include, License, Medicaid ID, License Number, Social Security Number, Drug Enforcement Administration Number, National Provider Identifier, Date of Birth.

To stay informed about fee schedule and provider compensation rules, the WellCare Fee Schedule team monitors the MO DSS website using a Website Watcher application that sends out notification emails whenever new files are published. The site is also reviewed by this team manually to capture any updates or bulletins that Website Watcher may have missed. In addition, the Market sends emails to notify the Fee Schedule team about new fee schedules and bulletins. Only the Fee Schedule team has the authority to update fee schedule pricing in the system.

7. Performance Measures and Reporting

WellCare collects the data from multiple sources and loads it into a database and files are sent to Inovalon to load into Quality Spectrum Insight (QSI) that is used for all reporting. To ensure data merges are accurate and complete, historical trending and benchmarking are conducted, when possible, to check the reasonableness of data. Query results are also visually inspected for accuracy based on previous experience. When Possible, results are compared to similar measures. All processes are audited

throughout the data integration process. Trends are monitored on a monthly basis and any anomalies are investigated.

Inovalon: QSI rejects data if it does not pass the following edits:

- Correct and consistent record formatting;
- Blank and duplicate record identification;
- Unique keys (unique identifiers for every record) and referential integrity of key values;
- Duplicate key identification;
- Completeness and validity of required fields; and
- Length of data consistent with width of field.

The Xcelys ™ system has processes in place to handle erroneous data. The extract programs have error checking written into them, and the QSI software creates log files that are reviewed to identify errors. Erroneous data is then corrected, or omitted. Furthermore, a log is created at the end of each load/process. WellCare log files produce record counts for items that were loaded, as well as detailed error logs to indicate items that were not loaded. Users use these numbers to audit the process.

Inovalon Quality Spectrum Insight (QSI) and it is updated on a monthly basis. Missouri Care uses month over month and year over year comparisons to validate each monthly build. All anomalies are researched as they occur. Inovalon sends a check figures report with each build that is reviewed for any inaccuracies.

All data files are archived monthly and labeled with the year and month in question.

4.3.3 (B) Conclusions

Strengths

- Missouri Care has policies, procedures, and robust training documentation readily available to all necessary staff.
- Experienced IT staff.
- Testing processes and development methodologies meet and exceed industry standards.
- Change requests are processed in-house with strict guidelines and are managed by current staff members.
- Primary and back-up disaster recovery physical site servers.

- Comprehensive and secure business continuity/disaster recovery plan.
- Clear documented infrastructure allowing for comprehensive maintenance.
- Security policies are readily available, well documented, and well maintained.
- Missouri Care provides HIPAA training and health care data best practices review.
- Security procedures are in place and documented for quick removal of a terminated employee.
- Implemented adequate validation edits in its data processes.
- Encounter data is not altered by Missouri Care, but sent back to source for correction.
- Consistent communication regarding upcoming changes.
- Frequent internal audits.
- Unique members ID assignment and duplicate member safeguards.
- Uploads monthly and/or daily eligibility files, keeping information as updated as possible.
- Reporting in place to identify changes in eligibility status and reconcile.
- Has an active directory available to the public both in paper and online.
- Has a dedicated Fee Schedule Team monitoring updates.
- Experienced staff members and documentation for developing queries and reports.
- Robust processes and documentation is available regarding performance measure reports.

Weaknesses

Missouri Care has indicated the lack of data provided in the enrollment files creates many issues and hurdles when contacting eligible members. Staff alleged that about 60% of the data included on the eligibility/enrollment file is incorrect or missing. The lack of data creates a large bottle neck in processes and requires work arounds when storing new-found data. This weak point of data collection does affect other areas of care management as well. The lack of accurate data creates additional work for when trying to reach the members, especially when bound by a timeline constraint. The additional work and resources required to successfully contact a member tends to exceed the acceptable time frame, directly contributing to poor performance scores for Care Management.

4.3.4 (B) Recommendation

A complete assessment of Missouri Care's Information System's documentation and related onsite activities revealed an opportunity for improvement concerning the data collection and integration

structure around the 834 file routinely received from the State. The Missouri Care officials alleged that the file has 60% of missing/incomplete/erroneous data related to members' primary demographic information.

These unusable data elements are not due to any systems integration issue but arise from the inability to bilaterally update member information obtained from the various other sources by Missouri Care. Consequently, it impacts the quality of Care Management Missouri Care is able to provide its members. This creates a need for extra resources in order to successfully contact a member, especially within an obligated short timeframe. The staff at Missouri Care work diligently to contact members to the best of their ability, by contacting multiple times, leaving messages, having calendar reminders for follow up and are often able to collect correct contact information for their members. Subsequently, they have to store that information in a separate area to avoid its loss when they receive the next 834 file, as the 834 file overrides all the other previously stored data.

Primaris strongly recommends that the State and Missouri Care work towards a collaborative solution for the ability to update and access more accurate and useful member contact data. This will create a complete data integration solution delivering trusted data from various sources. Efforts in this area will positively affect the number of Care Management offerings to members within effective timeframes. Improvement here will also increase the Missouri Care's ability to reach the member with educational materials and important plan updates, thus improving their quality outcomes.

4.4 Validation of Performance Improvement Projects

4.4.1 Methodology

Primaris followed guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, EQR Protocol 3, Version 2: Validating Performance Improvement Projects.

During calendar year (CY) 2017, MHD required Missouri Care to conduct two (2) PIPs-

- One (1) clinical: Improving Childhood Immunization Rates (Combo 10); and
- One (1) nonclinical: Improving Access to Oral Healthcare.

Primaris gathered information about the PIPs through:

- Documents Submission; and
- Interview: The following Missouri officials were interviewed to understand their concept, approach and methodology adopted for the PIPs:
  Erin Dinkel BSN, RN, Manager, Quality Improvement.
  Dale Pfaff, QI Specialist, Associate.
  Vicki Mertz, QI Project Manager.

The activities conducted for PIPs Validation were as follows (details of all the activities and the corresponding findings are presented in the Appendix B):

Activity 1. Assess the study methodology

This included a review of: the selected study topic(s), the study question(s), the identified study population, the selected study indicators, sampling methods (if sampling used), data collection procedure, data analysis and interpretation of study results.

Assessment of the following was done:

- The MCO's Improvement strategies;
- The likelihood that reported improvement is "real" improvement:
  - Benchmarks for quality specified by the State Medicaid agency or found in industry standards; and
  - Baseline and repeat measures on quality indicators will be used for making this decision. ***Note:*** *tests of statistical significance calculated on baseline and repeat indicator measurements was not done by EQRO.*
- The sustainability of documented improvement.

Activity 2. Verify Study Findings (Optional)

MHD may elect to have Primaris conduct on an ad hoc basis when there are special concerns about data integrity. *(**Note:** this activity was not done by EQRO and written as N/A).*

Activity 3. Evaluate and Report Overall Validity and Reliability of PIPs Results

The PIPs will be rated as: High confidence, Confidence, Low confidence, Reported PIP results were not credible- as defined earlier in the section 1.3.3 of this report.

4.4.2 Findings

(A) PIP Clinical: Improving Childhood Immunization Status (CIS Combo 10)

Description of Data Collected

The evaluation of Childhood Immunizations Status (CIS Combo 10) is a MHD requirement, as well as a nationally recognized study through NCQA/HEDIS reporting. As required by the MHD contract Section 2.18.8 (d) 2, the MCO should attain a target rate of ninety percent (90%) for the number of two (2) year olds immunized.

Aim: To increase the CIS Combo 10 rate by 3% for the measurement year (CY 2017).

Study Question: "Will providing the proposed list of interventions to eligible members increase the number of children receiving Combo-10 by 3% for the measurement year by their 2nd birthday?"

Study Indicator: HEDIS Childhood Immunization Status (CIS) – Combo 10 Rate

Study Population: All Missouri Care members 2 years of age in the measurement year who had no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.

Sampling: Sampling was not done**.** The entire population was measured from an administrative standpoint and Hybrid rates were calculated using HEDIS Technical Specifications and NCQA-certified software.

Baseline Data: The HEDIS 2015 (CY 2014) rate is reported to be the baseline rate for Statewide CIS combo 10 rate. However for the purpose of evaluation of this PIP, Primaris would accept HEDIS 2017 (CY 2016) CIS Combo 10 rate as a baseline to measure the improvement.

Table 4-14 Missouri Care CIS Combo 10 Baseline Rate (CY 2016)

HEDIS Year	NCQA 50th percentile	Missouri Care Combo 10 Rates
HEDIS 2017	33.09%	26.39%

Procedure

The data collected includes the entire eligible population of CIS claims/encounter data according to HEDIS Technical Specifications by the members' second birthday. Sources of data used in this study included claims-based software and NCQA Certified Measures Software (Inovalon, Missouri Care's vendor). Claims data for the study were queried from the claims-based software and put into NCQA-certified measures software by Inovalon. Inovalon follows HEDIS Technical Specifications to calculate the CIS rate.

Annually, Missouri Care collects medical records to supplement the administrative claims data. This is known as a Hybrid Review or Medical Record Review (MRR), which uses a systematic sample of eligible members for the denominator. Missouri Care followed NCQA requirements for this hybrid measure, which includes a systematic sample of members (411) plus a 5% oversample (432 members) for each region, if available. Missouri Care used Inovalon and CHANGE Health vendor for MRR. Numerator hits were abstracted and tracked by CHANGE Health using Inovalon's Quality Spectrum Hybrid Reporter (QSHR) software. Missouri Care staff, along with contracted trained clinical staff, oversaw CHANGE Health's abstractors by over reading medical records to ensure quality review. Abstracted medical records were exported to a secure file transfer portal where WellCare's Care's Med Informatics team confirmed receipt of files, and then the data was downloaded to QSHR.

QSHR measure flowcharts included algorithmic assessments about numerators, denominators, contraindications and exclusions. During the annual HEDIS MRR, the Plan uploaded the administrative claims data on a monthly basis to further supplement the medical record data. At the end of the project, the Plan combined the administrative claims data and the medical record data to create the final HEDIS rate. Data was reviewed and validated by a HEDIS auditor.

The quality measurement for this study includes:

- Denominator: All children 2 years of age in the measurement year who had no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
- Numerator (Must include): Combo 10
    - At least 4 DTaP, 3 IPV, 3 HiB, and 4 PCV vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

- At least 3 Hep B vaccinations with different dates of service, 1 Hep A, 1 VZV, and 1 MMR on or before the child's second birthday.
- At least 2 doses of the two-dose Rotavirus vaccine or 3 doses of the three-dose Rotavirus vaccine or 1 dose of the two-dose rotavirus vaccine and 2 doses of the three-dose rotavirus vaccine all on different dates of service on or before the child's second birthday.
- At least 2 Influenza vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.

Intervention and Improvement Strategies:

Missouri Care have ongoing interventions from the past years as listed below, based on their barrier analysis:

Table 4-15 Missouri Care List of Interventions to Improve CIS Rates

Interventions	Status	Initiated
Care Management: Provide additional training for Care Managers to actively engage members on their immunization status and prevention visits to help educate members on the importance of childhood immunizations.	Ongoing	2017
CIS Provider Incentive: - Missouri Care's provider incentive program, Partnership for Quality, rewards providers with bonus dollars for increasing immunization for members. Providers who achieve certain threshold targets are eligible to receive additional bonus dollars. This Provider incentive increases members' vaccinations by taking every opportunity to educate members on the importance of immunizing members.	Ongoing	Revised 2017
Member Incentive: Missouri Care's Healthy Rewards member incentive program includes rewards for members who complete their recommended well-child visits.	Ongoing	Revised 2017
Flat-file Transfer - Scrapes immunization data directly from providers' EMR system into WellCare's database. In 2017, Missouri Care established Flat-file Transfer with 5 new provider groups.	Ongoing	Revised 2017

QPA Program: Using our Quality Practice Advisors (QPA) and available tools like our HEDIS Toolkit, we educate providers about the CIS measure, how to use our care gap reports to outreach to members, and how to address barriers such as lack of transportation. Providers can use these tools to reduce missed opportunities vaccinating members.	Ongoing	2014
Care Gap/EPSDT Reports: Missouri Care delivers PCP-specific utilization reports that include information about performance relative to peers and member-level information related to care gaps associated with CIS-measure. These reports include HEDIS care gap reports and EPSDT rosters. Combination of these interventions will have a greater impact outreaching members due for vaccinations.	Ongoing	2014
Centralized Telephonic Outreach - Performs outbound calls to members in need of wellness visits to help educate members on the importance of wellness visits and assist them in scheduling a visit	Ongoing	2014
MOHSAIC - Immunization registry data received quarterly. This provides adequate information on member's vaccinations which may be missed in claims or medical records.	Ongoing	2014
Transportation - Ensuring that non-emergency medical transportation adequately supports members' transportation needs.	Ongoing	2013
Audit and Feedback- Conduct annual medical record reviews on a sample of providers. As we identify opportunities to improve provider performance – documentation, capitalizing on missed opportunities– we note this in the audit findings and provide feedback and coaching to the provider. This offers providers education on the process of quality improvement and effectiveness in increasing members' vaccinations.	Ongoing	Active

Intervention List	Status	Initiated
Multi-touch Point to help educate members on the importance of childhood immunizations: - Missouri Care Member Handbook - New member orientation, My Health Matters to Me - Quarterly member newsletters - Community-based health fairs - Maternity program and the related activities and interventions (i.e. TEXT4BABY, Nurses for Newborns) - Written reminders about importance of/need for well-child visits through periodicity letters - Engaging members who have care gaps	Ongoing	Active

PIP Results

- The Statewide CIS Combo 10 rate for Missouri Care in CY 2017 (H2018) was 26.52% as compared to the rate in CY 2016 (H2017-26.39%), shown in the Table 4-16.

  The State aggregate CIS rate increased by 0.13% points or 0.4% from CY 2016. The aim of PIP to get a 3% increase is not met. There is no statistical significance of this increase. Missouri Care is far too behind the contractual requirement to meet the goal of 90% rate.
- The CIS Combo 10 rates increased in Central (4.14 % points or 15.47%), Western (1.95% points or 7.49%) and Eastern (1.92% points or 8.21%) regions between H2016-H2017 (CY 2016-CY 2017).

Table 4-16 HEDIS Rates H2016-H2018 (CY 2015-CY 2017)

Childhood Immunization Status – Combo 10

Regions	HEDIS 2016	HEDIS 2017	HEDIS 2018
Aggregate	30.15%	26.39%	26.52%
Central	26.02%	26.76%	30.90%
Western	21.95%	26.03%	27.98%
Eastern	30.10%	23.38%	25.30%

(B) PIP Non Clinical: Improving Access to Oral Healthcare

Description of Data obtained

The connection between oral health and general health is not often made by Medicaid recipients who frequently encounter other socioeconomic challenges. Underutilization of dental services is not a problem specific to the Medicaid population. The Kaiser Commission suggests that "oral disease has been linked to ear and sinus infection and weakened immune system, as well as diabetes, and heart and lung disease. Studies found that children with oral diseases are restricted in their daily activities and miss over 51 million hours of school each year" (ref: Dental Coverage and Care for Low-Income Children: The Role of Medicaid and SCHIP. August 2007. The Henry J. Kaiser Family Foundation).

Aim: To increase the number of children who receive an annual dental visit by 3% for the measurement year.

Study Question: "Will providing the proposed list of interventions to eligible members from the ages of two (2) through twenty (20) years old increase the number of children who receive an annual dental visit by 3% for the measurement year?"

Study Indicator: HEDIS Annual Dental Visit (ADV) Rate as per HEDIS Technical Specifications (eligible members have at least one dental visit during the measurement year For ADV, the period of time measured includes a full calendar year).

The study population: Members 2 through 20 years of age who had at least 1 dental visit during the measurement year and are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.

Sampling: No sampling technique was used in this study. All members 2 through 20 years of age were included in the study.

Baseline Data: HEDIS 2013 rate is reported to be the baseline for aggregate population all over the State. However for the purpose of evaluation of this PIP, Primaris will accept HEDIS 2017 (CY 2016) to measure the improvement.

Table 4-17 Missouri Care ADV Baseline Rate (CY 2016)

HEDIS Year	Missouri Care ADV Rate	NCQA 50 percentile
HEDIS 2017	46.97%	54.93%

Procedure

The data collected includes the entire eligible population of ADV claims/encounter data according to HEDIS Technical Specifications within a calendar year period. Sources of data used in this study includes claims-based software and NCQA Certified Measures vendor (Inovalon) to calculate the HEDIS ADV rate.

As part of its systematic method of collecting valid and reliable data, claims data for the study were queried from claims-based software and put into NCQA-certified software by Inovalon (Missouri Care's Vendor). Inovalon follows HEDIS Technical Specifications to calculate the ADV rate.

Missouri Care's 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. As part of the Data Analysis Plan, The Plan evaluates the success of the project by demonstrating an improvement in Missouri Care members' oral health outcomes through education and on-going interventions, as evidenced by at least a 3% increase in the HEDIS ADV rate.

According to HEDIS Tech Specs, the Study Indicator data pulled from the HEDIS ADV rate captures:

- Denominator: Members 2 through 20 years of age who are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.
- Numerator: Members 2 through 20 years of age identified as having one or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any code as per HEDIS dental value set.

This indicator will measure a change in the health status of the member by receiving an annual dental visit.

Intervention and Improvement Strategies

Throughout the course of the PIP, Missouri Care has implemented numerous interventions based on their barrier analysis.

Table 4-18 Missouri Care Oral Health Interventions

Intervention List	Status	Initiated
County Health Departments: Missouri Care provided a Micro Grant of $5,000 to the Missouri Coalition for Oral Health to use as a way to fund oral health supplies to Cape Girardeau, Lincoln County and Vernon County Health Departments, as identified by the Dental Task Force. This will provide a greater opportunity for members to receive dental services. Year 1 2017: Funds identified for the project Two of the 3 counties are within the expansion territory effective 5/1/2017.	Year 1: Completed	2017
ADV Member Incentive: - To help motivate members to complete an annual dental visit they will receive an incentive through our Healthy Rewards program.	Ongoing	2017
Care Management: Provide additional training for Care Managers to actively engage members on their dental care and prevention visits to help educate members on the importance of annual dental visits.	Ongoing	2017
Partnership with Affinia - Community Outreach collaborates with Affinia the East Region to provide dental services.	Ongoing	2016
Housing Authority Partnership - Missouri Care partners with local Housing Authorities to host Back to School and Health Fairs that will focus on providing dental screenings and education for participants.	Ongoing	2016
Dental Day at Local Community Health Center- Missouri Care and several community health centers in Missouri work together to open the clinic to Missouri Care members only for preventive dental services. In 2015, the program expanded.	Ongoing	Revised 2015
Centralized Telephonic Outreach - Performs outbound calls to members in need of dental care to help educate members on the importance of annual dental visits and assist them in scheduling a dental visit	Ongoing	2014

Dental Vans and Dental Providers at Health Fairs - Missouri Care continues to provide on-the-spot dental services to Health Fair participants especially in rural communities. Missouri Care will continue special outreach efforts to new member enrollees to schedule appointments for annual dental visits.	Ongoing	2013
Transportation Ensuring that non-emergency medical transportation adequately supports members' dental-related transportation needs.	Ongoing	2013
Multi-touch Point to help educate members on the importance of annual dental visits: Dental Due/Over-due Mailings Periodicity Reminders Prenatal Graduation Collaboration with Rural Schools ICAN Campaign Boys and Girls Club Partnership Show-Me Smiles Baby Showers Member Newsletter articles Member Handbook	Ongoing	Active

PIP Results

The State aggregate ADV rate for CY 2017 (measurement year) is 48.42%. This is an increase by 1.45% points or 3% from CY 2016 (46.97%). The aim of PIP to get a 3% increase is met.

The HEDIS 2018 (CY 2017) ADV results improved in Central, East, West, and Aggregate population. The ADV rates increased in Central (0.84% points or 1.5%), Western (1.61% points or 3.5%) and Eastern (1.9% points or 4.4%) regions between H2016-H2017 (CY 2016-CY 2017), as shown in the Table 4-19.

Table 4-19 Missouri Care ADV Rates H2016-H2018 for All Regions

Regions	HEDIS 2016	HEDIS 2017	HEDIS 2018
Aggregate	46.60%	46.97%	48.42%
Central	51.29%	52.86%	53.70%
Western	44.03%	45.91%	47.52%
Eastern	44.84%	43.00%	44.90%
Southwest	N/A	N/A	46.77%

4.4.3 Conclusions

PIPs Score

The following score was assigned to both the CIS Combo 10 and Oral HealthCare PIPs:

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Strengths

- The interventions are developed based on barrier analysis
- Missouri Care was able to take up the challenge of almost 100% increase in the member population in May 2017, after the statewide expansion of Managed and yet achieve increased ADV rates statewide and for all the previously existing regions (central, western, eastern), as seen in the Table 4-19. The ADV rate in the southwestern (new region) was more than the eastern region.

Weaknesses

PIPs' Approach

- The Aim set by the Missouri Care for both the PIPs is too low and will not be helpful in achieving the goals set for improving CIS Combo 10 rate or Improving Oral Health as stated in the MHD contract. They target to achieve an increase in CIS Combo 10 and ADV rates by 3% only, instead of

3% point. The aim statement was not clearly written. The baseline rate and rate to be achieved were not stated.

- In section 3.1.2, PIP Results for CIS Combo 10, Figure1 submitted by Missouri Care shows a decrease in the internal goal between CY 2016 (31.05%) and CY 2017 (27.18%). Setting a lower goal from past year is questionable and does not meet the purpose of a PIP.
- The PIPs did not meet all the required guidelines stated in CFR/MHD contract (Ref: 42 Code of federal Regulations (CFR) 438.330 (d)/MHD contract 2.18.8 d 1):

Table 4-20 CFR guidelines for PIPs

CFR Guidelines	Evaluation
Measurement of performance using objective quality indicators	Partially Met
Implementation of system interventions to achieve improvement in quality	Met
Evaluation of the effectiveness of the interventions	Not Met
Planning and initiation of activities for increasing or sustaining improvement	Partially Met

- The PIPs were not conducted over a reasonable time frame (A calendar year). They continued for years from the past and at varying times throughout the year.
- The interventions were not specifically designed for these PIPs. They were on going for years at State or corporate level, overlapped in the measurement year, thus the impact of an intervention could not be measured.
- Annual evaluation of HEDIS CIS/ADV rate was used as quality indicators, which is a requirement for performance measure reporting by MHD/CMS (Centers for Medicare and Medicaid Services)/NCQA (National Committee for Quality Assurance). The indicators were not specifically chosen to measure the impact of interventions.
- The HEDIS CIS/ADV rates could not be tied to any intervention.

PIP Results

- Missouri Care's CIS Combo 10 rates did not increase as expected. Missouri Care did not provide any explanation for not achieving the aim of PIP.

- Missouri Care stated that outreach to members through various means would have had a greater impact on members' health and rate of compliance with an annual dental visit.

Quality, Timeliness and Access to HealthCare Services

CIS Combo 10

- Increase from HEDIS 2017 to HEDIS 2018 CIS rates in all regions is attributed to planned quality multi-interventional improvement approach.
- As a part of integrated approach, Missouri Care incentivize members to complete EPSDT/Wellness visits, which includes completing immunizations. From a provider perspective, they not only incentivize providers to complete EPSDT/Wellness visits, but also to close gaps in care relating to needed childhood immunizations.
- Missouri Care have identified opportunities for future:
  - Increase participation in the Healthy Rewards member incentive program.
  - Increase member engagement.
  - Work towards infusing quality metrics, such as CIS and wellness visits, into provider contracts. They anticipate that through this initiative there would be an increase in members utilizing the Healthy Rewards Program and providers closing the gaps in care, resulting in an improved CIS Combo 10 rate.

Access to Oral Health

- There is an upward trend in HEDIS ADV Rates. This is a result of Missouri Care's planned quality multi-interventional improvement approach. Observed performance improvement is true improvement as evidenced by Missouri Care utilizing NCQA statistical testing, including upper and lower confidence intervals, to assess significant improvement.
- In July 2017, the newly revised Healthy Rewards Program was launched, which included a new ADV incentive and a new vendor with additional opportunities at various retail stores. Missouri Care members were notified of the new program through such means as New Member Welcome Packet, mailers, and Care Management Besides a more holistic approach to incentive measures, the new Program allows members to attest completed services through the vendor's website, calling customer service, or by mail. Members then receive a reloadable debit card, which can be redeemed at various retail stores.

Improvement by MCO from the previous year (CY 2016)

- No improvement in the approach or methodology of PIPs was noticed in CY 2017. The report from the previous year's EQRO stated the same issues that were noticed by Primaris in EQR 2018. Missouri Care continued to use and reuse interventions that have failed to create the anticipated change in these projects.
- The recommendations from previous EQRO were not followed. It was suggested that Innovative approaches to positively impact the problems identified were necessary. As interventions are implemented, a method to measure each interventions' outcome must also be introduced. These elements were missing in the PIP for CY 2017 as well.
- However, the CIS combo 10 rate increased Statewide in CY 2017. Even though the goal/aim for PIP was not achieved, the ongoing interventions and the new ones together increased the rate from previous year by 0.13% points or 0.4%. There was an increase noted in all regions in comparison to CY 2016.

  Similarly, the ADV rate increased by 1.45% points or 3% from CY 2016. There was an increase noted in all the three regions (Eastern, Central, and Western) from the CY 2016.

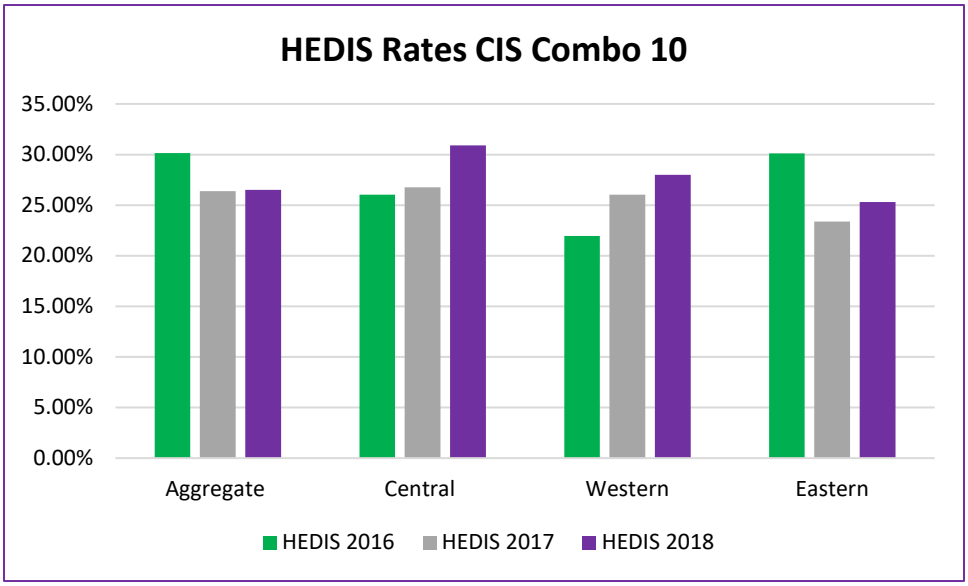


Figure 4-6 HEDIS Rates for All regions H2016-H2018

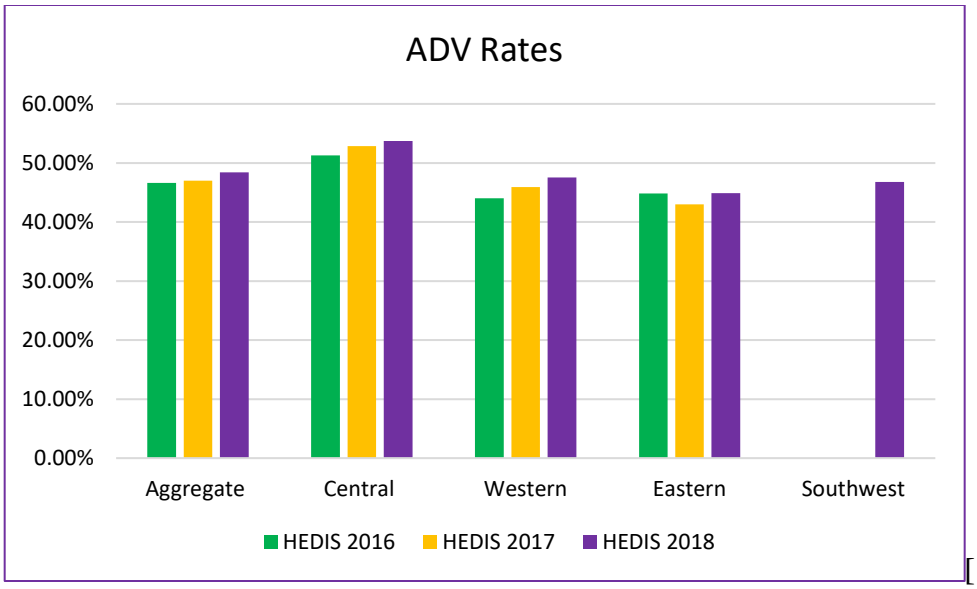


Figure 4-7 Missouri Care ADV Rates for All regions H2016-H2018

4.4.4 Recommendations

PIPs Approach

- Missouri Care must continue to refine their skills in the development and implementation of approaches to effect change in their PIP.
- The aim and study question(s) should be stated clearly in writing (baseline rate, aim to achieve, % increase).
- PIPs should be conducted over a reasonable time frame (a calendar year) so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- The interventions should be planned specifically for the purpose of PIP required by MHD Contract and results, impact should be measured on a regular basis (minimum of 12 data points on the run chart should be shown).
- The results should be tied to the interventions.
- A request for technical assistance from EQRO would be beneficial. Improved training, assistance and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.

- Instead of repeating interventions that were not effective, evaluate new interventions for their potential to produce desired results, before investing time and money.
- Missouri Care must utilize the PIPs process as part of organizational development to maintain compliance with the State contract and the federal protocol.

Improvement in CIS rate

Below are some of the interventions from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4927017/#b9-ptj4107426 which could be adopted by Missouri Care to improve the CIS rate:

Table 4-21 Health Provider-Based Interventions to Improve Vaccination Compliance

Provide Parent and Patient Counseling
Be informed about vaccinations. Make strong recommendations. Provide patients with educational materials. Use proven communication strategies. Dispel myths about side effects. Inform parents about research. Give parents time to discuss concerns. Describe infections that vaccines prevent. Describe potential health and financial consequences of vaccine noncompliance. Provide a vaccination record with past and future vaccination visits. Provide patient reminders. Ask vaccine-hesitant parents to sign an exemption form. Inform parents that a missed dose will not require vaccine series to be restarted.
Maximize Opportunities for Vaccination
Administer vaccinations during sick or follow-up visits (postsurgical, post hospitalization). Issue a standing order to allow nurses to administer patient vaccinations.
Offer Combination Vaccines

Simplifies vaccination regimen. Minimizes the number of injections. Reduces need for return vaccination visits. Improves patient adherence.
Improve Accessibility to Vaccinations
Allow same-day appointments or walk-in visits. Make sure the office staff is friendly and supportive. Provide convenient office hours. Limit patient wait time.
Use Electronic Medical Records
Utilize consolidated electronic immunization records. Set electronic alerts for needed vaccinations. Follow up on electronic medical record alerts by contacting patient.

Table 4-22 Community- and Government-Based Interventions to Improve Vaccination Compliance

Public Education
Distribute educational materials that incorporate community input. Conduct public messaging campaigns. Use electronic communications to distribute health and safety information.
Public Reminder and Recall Strategies
Conduct centralized reminder and recall strategies through public agencies or payers. Use electronic communications, such as social media and text messaging, for reminder and recall programs.
Free Vaccines and Other Financial Incentives
Provide free vaccines to uninsured patients. Issue financial incentives, such as gift certificates.
Alternative Public and Private Venues for Vaccination

Day care facilities
Drop-in service at walk-in clinics
Pharmacies
Women, Infants, and Children (WIC) program offices
Emergency departments
Inpatient settings
Home visits

Improvement in Oral Health

Source: U.S. Department of Health and Human Services Oral Health Strategic Framework, 2014–2017 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765973/)

The following are the strategies and actions for each of the 5 goals listed below which would help to achieve improved Oral Health of the members.

1. Integrate Oral health and primary health care.

- Advance inter professional collaborative practice and bidirectional sharing of clinical information to improve overall health outcomes.
- Promote education and training to increase knowledge, attitudes, and skills that demonstrate proficiency and competency in oral health among primary care providers.
- Support the development of policies and practices to reconnect the mouth and the body and inform decision making across all HHS programs and activities.
- Create programs and support innovation using a systems change approach that facilitates a unified patient-centered health home.

2. Prevent disease and promote oral health.

- Promote delivery of dental sealants in school-based programs and expand community water fluoridation.
- Identify reimbursement strategies and funding streams that enhance sustainability of prevention programs.
- Coordinate federal efforts focused on strengthening the infrastructure and capacity of local, state, and regional oral health programs.

- Explore new clinical and financial models of care for children at high risk for developing caries, such as risk-based preventive and disease-management interventions.

3. Increase access to oral health care and eliminate disparities.

- Expand the number of health-care settings that provide oral health care, including diagnostic, preventive, and restorative services in federally qualified health centers, school-based health centers, Ryan White HIV/AIDS-funded programs, and IHS-funded health programs.
- Strengthen the oral health workforce, expand capabilities of existing providers, and promote models that incorporate other clinicians.
- Improve the knowledge, skills, and abilities of providers to serve diverse patient populations.
- Promote health professionals' training in cultural competency.
- Assist individuals and families in obtaining oral health services and connecting with a dental home.
- Align dental homes and oral health services for children.
- Create local, regional, and statewide partnerships that bridge the aging population and oral health systems.
- Support the collection of sex- and racial/ethnic-stratified data pertaining to oral health.

4. Increase the dissemination of oral health information and improve health literacy.

- Enhance data value by making data easier to access and use for public health decision making through the development of standardized oral health measures and advancement of surveillance.
- Improve the oral health literacy of health professionals through the use of evidence-based methods.
- Improve the oral health literacy of patients and families by developing and promoting clear and consistent oral health messaging to health-care providers and the public.
- Assess the health literacy environment of patient care settings.
- Integrate dental, medical, and behavioral health information into electronic health records.

5. Advance oral health in public policy and research.

- Expand applied research approaches, including behavioral, clinical, and population-based studies; practice-based research; and health services research to improve oral health.

- Support research and activities that examine the influence of health-care system organization, reimbursement, and policies on the provision of oral health care, including fostering government and private-sector collaboration.
- Address disparities in oral health through research that fosters engagement of individuals, families, and communities in developing and sharing solutions and behaviors to meet their unique needs.
- Promote the translation of research findings into practice and use.
- Develop policy approaches that support state Medicaid and CHIP to move from paying for volume to purchasing value, and from treating disease to preventing disease.
- Evaluate the impact of policy on access to care, oral health services, and quality.

4.5 Care Management Review

4.5.1 Methodology

The focus areas approved by MHD for evaluation of Care Management (CM) Program during EQR 2018 were as follows:

1. Pregnant Members (OB);
2. Children with Elevated Blood Lead Levels; and
3. Serious Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder).

Review of CM Policies and Procedures

Primaris reviewed the Missouri Care's policies on Care Management, including but not limited to their enrollment, stratification processes, communication to members and providers, documentation processes, record-keeping, and standardized care management programs. Collectively, a review was done on the overall Care Management process from end-to-end on electronic records integration.

Medical Records Review

Primaris assessed the Missouri Care's ability to make available any and all pertinent medical records for

the review. A list of Members Care Managed in CY 2017 for the Pregnant Women (OB), Children with elevated Lead Levels, and Serious Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder) was submitted by the Missouri Care and Primaris selected Medical Records (oversample for exclusions/exceptions) by using Stratified Random Sampling Method based on Appendix II of 2012 CMS EQR protocols (https://www.medicaid.gov/medicaid/qualityofcare/downloads/app2-samplingapproaches.pdf).

A sample of a minimum of 20 Medical Records (MR) for each focus area was reviewed during the onsite visit, July 16-20, 2018. A Care Management Medical Record tool was created and MR were reviewed to ensure that they include, at a minimum, the following *(ref: MHD Managed Care Contract 2.11, Excel workbooks are submitted as separate attachments).*

- Referrals;
- Assessment/Reassessment;
- Medical History;
- Psychiatric History;
- Developmental History;
- Medical Conditions;
- Psychosocial Issues;
- Legal Issues;
- Care Planning;
- Provider Treatment Plans;
- Testing;
- Progress/Contact Notes;
- Discharge Plans;
- Aftercare;
- Transfers;
- Coordination/Linking of Services;
- Monitoring of Services and Care; and
- Follow-up.

Inter Rater Reliability: 10% of the MR from each focus area were reviewed by different auditors to assess the degree of agreement in assigning a score for compliance in the MR tool.

Onsite Interviews

The following persons were interviewed at Missouri Care to gather information about the Care Management Program for Pregnant Members (OB), Children with Elevated Lead Levels, and Members with Severe Mental Illness (SMI).

- Claudia Douds RN, BSN, MHA, VP Field Health Services.

OB: CM Program

- Rachel Ussery, RN BSN Supervisor Care Management.

Elevated Lead Level: CM Program

- Lori Wilson, RN BSN Supervisor Care Management

SMI: CM Program

- Erica Bruns, LPC, MPA Manager Behavioral Health; and
- Stacie Bryant, MSW, LCSW, Care Manager.

Care Management Log

Missouri Care submits a log of Care Management activities to MHD each quarter.

4.5.2 Overall Assessment of CM Program

The number of members enrolled in all CM programs in CY 2017 was 812. The number of members enrolled in the programs under evaluation was:

OB: 128

SMI: 61

Elevated Blood Lead Levels: 108

Review of CM Policies and Procedures

The following Documents submitted by Missouri Care were reviewed to ascertain that they have Care Management policies and procedures to meet the contractual requirement of MHD Managed Care Contract (2.11). Missouri Care was found to be 100% compliant.

Table 4-23 Compliance with Policies & Procedures

Care Management Policy Review- Missouri Care (ref: MHD Managed Care Contract 2.11)			
The health plan should have policies and procedures for Care Management. The policies and procedures shall include:	**Yes**	**No**	**Document Name (s)**
1. A description of the system for identifying, screening, and selecting members for care management services;	Yes		1. C7CM MD-1.2 PROCEDURE CM Selection for CM.pdf 2. MO29-HS-CM-003 POLICY CM Process.pdf 3. Appendix E_QIPD_CM Program Description.PDF 4. 2017 CM Log Template and Instructions (REVISED in 2016) 5.mo_caid_provider_manual_eng_11-2017_v2_R
2. Provider and member profiling activities;	Yes		1. Appendix E 2. C7QI-081 Behavioral Health Provider Medical Record Review Policy 3. Mo_caid-provider-manual-eng-11_2017_v2_R 4. Provider Manual
3. Procedures for conducting provider education on care management;	Yes		1. MO29-HS-CM-003 POLICY CM Process.pdf 2. C7CM MD-1.2 PROCEDURE CM Selection for CM

			3. QIPD CM Description 4. Provider Manual
4. A description of how claims analysis will be used;	Yes		1. Provider Manual 2. MO 29-HS CM-003 Policy CM Process 3. C7-QI-015 Medical Record Review.pdf
5. A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan;	Yes		1. MO29-HS-CM-003 POLICY CM Process.pdf. 2. C7QI-081 Behavioral Health provider Medical Record Review Policy 3. Provider Manual 4. MO 29 HS CM 004 interdisciplinary rounds 5. MO 29 HS CM 005 PR-001 Procedure health home care coordination 6. MO 29-OP-CS-001 Primary Care Provider
6. A process to ensure integration and communication between physical and behavioral health;	Yes		1. MO29-HS-CM-003 POLICY CM Process.pdf. 2. C7QI-081 Behavioral Health provider Medical Record Review Policy 3. Provider Manual 4. MO 29 HS CM 005 PR-001 Procedure health home care coordination

7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned;	Yes		1. C7CM MD-1.2-PROCEDURE CM-003 Ongoing Management.pdf
8. A process to ensure that care plans are maintained and up-dated as necessary;	Yes		1. C7CM MD-1.2 PROCEDURE CM Selection for CM.pdf
9. A description of the methodology for assigning and monitoring care management caseloads that ensures adequate staffing to meet care management requirements;	Yes		1. C7-CM-MD-1.2-PR-006 PROCEDURE CM Caseload.pdf 2.C7QI-081 Behavioral Health provider Medical Record Review Policy 3.MO29_HS-CM-001 Policy CM Lead Care Management 4. MO29-HS-CM-002 POLICY CM Perinatal CM.pdf
10. Timeframes for reevaluation and criteria for care management closure; and	Yes		1. 2017 CM log Template and Instructions (revised in 2016) 2. MO29-HS-CM-003 Policy CM process.pdf 3. CM 003
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in herein.	Yes		1. C7QI-026 Provider Clinical PracticeGuidelines.pdf 2.C7CM MD-1.2 PROCEDURE CM Selection

			for CM.pdf 3. Provider Manual
12. Additional Information about CM	Yes		1. Missouri Care Provider Manual.pdf 2. 2017 CM Log Template and Instructions. Pdf 3. DCNS Pregnancy Lead and SMI.xlsx 4. C7QI-081 Behavioral Health provider Medical Record Review Policy 5. MO29-HS-CM-001 POLICY CM Lead Care Management.pdf 6. MO29-HS-CM-002 POLICY CM Perinatal CM.pdf 7. MO29-HS-CM-003 POLICY CM Process.pdf 8. Care Management Post EQRO On-Site Response. pdf

4.5.2.1 OB Care Management

The Obstetrics Care Management program of Missouri Care is an integrated program offered to all identified pregnant women and is done through in-person or telephonic outreach, depending on the member's individual needs. Specially-trained OB Care Managers, supported by care coordinators outreach to all pregnant members, conduct assessments and offer Care Management.

Goals

- Missouri Care's goal is to engage high-risk pregnant women in Perinatal Care Management to reduce complications associated with identified conditions or substance use during pregnancy including Neonatal Abstinence Syndrome. An important piece of their Care Management program is the focus on screening for high risk pregnancy and to involve the member in high-touch care management.
- Reduce the rate of preterm and low birth weight deliveries.

Member Identification

Care Management members are identified via:

- The Law (proprietary algorithm);
- Utilization management team/ inpatient utilization reporting/discharge planner;
- Referral (provider, member/caregiver, community agencies, state agencies, 24 nurse line, crisis line);
- Claims data mining;
- State files (834/416 daily notifications); and
- Transition of care communications.

Member Stratification

Stratification of members to Low, moderate or high risk is based on the scoring.

Missouri Care utilizes a proprietary algorithm (also called The Law) to identify and stratify members for management. The model has several components including:

- Utilization and claims data;
- LACE tool-prediction of readmission risk for inpatient admissions;
- HRA risk score based on survey responses;
- Propensity to reach score-probability score of reaching a member during outreach based on predicative member demographic attributes;
- Decision Point-predictive algorithm score focused on disease progression predictions; and
- RxAnte-claims based algorithm that calculates a value of future medication adherence.

Work flow

Once a member is identified as pregnant, outreach attempts begin in order to explain the benefits of the program. Members are generally initially contacted by care coordinators to engage in the Care Management process and begin initial screening. Care coordinators also assist the Care Management team throughout the relationship by making reminder phone calls, scheduling appointments, arranging transportation and assisting with community referrals. After a member is enrolled in the Care Management program, educational materials, assistance in locating an obstetrician, information about pregnancy incentive program are provided and is encouraged to make and keep all prenatal and postpartum appointments.

Services address clinical, behavioral health, and socioeconomic needs. Assessments of both physical and behavioral health are completed with the member and Care Plans are developed based on the information obtained. Social and behavioral support services are also addressed and include smoking cessation classes, alcohol and substance use disorder treatment, services to address spousal/partner abuse and emotional or mental health concerns. Referrals are made and coordinated within the community to support the member's needs including WIC, C-STAR programs.

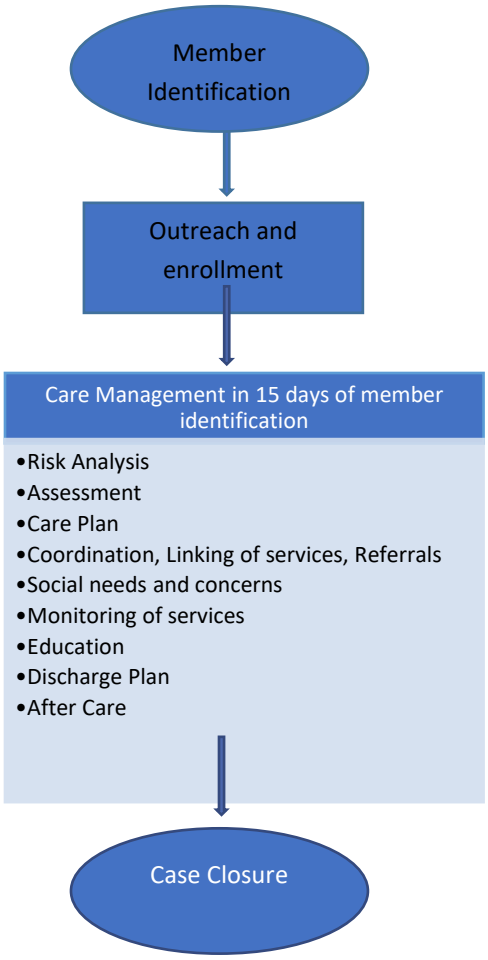


Figure 4-8 Work flow of Care Management

Member Interventions

- Missouri Care has partnered with *Nurses for Newborns* in the eastern region. The innovative, collaborative partnership allows them to outreach to both high and low risk OB members in St. Louis City and Jefferson Counties, areas where the rate of preterm and low birth weight deliveries are the highest in the state. Members in these two counties receive in-home services throughout their pregnancy, the intensity of which depends on the medical, social and behavioral health risk factors identified. In addition, services continue for the mother and her baby after delivery, up to the first two years of child's life. The focus of this program is to promote healthy full-term deliveries without complications for the baby or mother. Discussions are underway with similar organizations in other regions of the State to provide this highly personalized service to more members.
- Members are provided information on how to become eligible to participate in the CM Program, to use CM services, and to opt in or opt out, via the member handbook and newsletters. All members have access to CM at any time. The Member can self-refer to the program utilizing the following methods:
  - Member Services;
  - 24 hour nursing line; and
  - Care Management toll-free line.
- Missouri Care utilizes an intense community and social approach in care planning. The HealthConnections model gives care managers access to numerous resources to help find social supports and community-based services to eliminate barriers to wellness, including help with food insecurity, utility assistance, financial assistance, community-based prenatal assistance, and housing and homeless services and supports. Referrals to these community based providers are done through their integrated Care Management program and recorded on the member's record in the clinical management platform.

Findings of Medical Record Review

Primaris reviewed 33 MR to get the required sample of 20. 13 out of 33 had to be excluded due to following reasons (Table 4-24):

Table 4-24 Exclusions/Exceptions	Number of MR
Declined Care Management	2
Unable to Contact (UTC)	2
No Care Management (referral by UM nurse during term)	1
Data error	1
No Care Management in CY2017	7
TOTAL	**13**

The Medical Record review for Missouri Care OB CM program revealed the following information as in Figure 4-9:

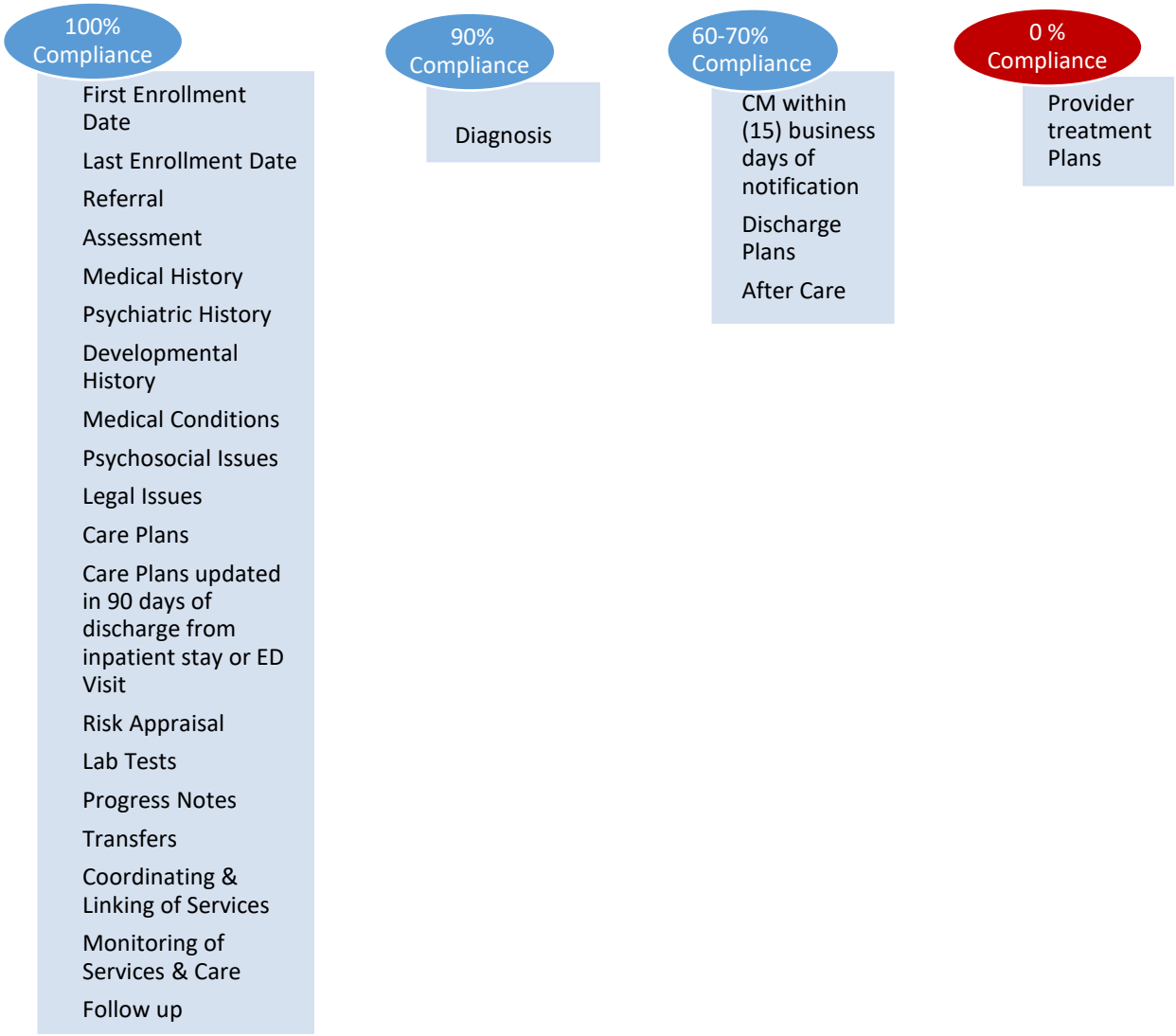


Figure 4-9 Compliance % for OB CM MR

Conclusions

Primaris aggregated and analyzed findings from the Interviews, Policies and Procedures, MRR for the OB Care Management to draw conclusions about Missouri Care's performance in providing quality, access, and timeliness of healthcare services to members. Overall, evaluation showed that Missouri Care has Systems, Policies & Procedures, and Staff in place to ensure that its structure and operations support the processes for providing care and services while promoting quality outcomes.

Strengths

- Teamwork;
- Medication Management;
- Health Information Technology;
- Patient-Centered Medical Home;
- Establishing accountability and agreeing on responsibility;
- Communicating/sharing knowledge;
- Helping with transitions of care;
- Assessing patient needs and goals;
- Creating a proactive care plan;
- Monitoring and follow-up, including responding to changes in patients' needs;
- Supporting patients' self-management goals;
- Linking to community resources; and
- Working to align resources with patient and population needs.

Weaknesses

- The Medical Record review was done for 33 pregnant members: Out of 33 pregnant members, CM could not be done on 5 of them (15.2%).Missouri Care lost the opportunity to provide CM to eligible members due to following reasons:

Table 4-25 Lost Opportunities

Reason	Number of Members	Notes
Declined Care Management	2	-
Unable to Contact (UTC)	2	MCO alleged that 60 % of primary demographic

		information received from State are incorrect/incomplete.
No Care Management	1	Missed Opportunity, referred by UM nurse at term.

- Over sampling had to be done to get the required 20 Medical Records. 13 out of 33 cases had to be excluded. In addition to those listed above, 7 were those who were not Care Managed in CY 2017. The members were enrolled in CY 2016 and CM was done in the same year, but closed in CY 2017. The information system at Missouri Care counted the members twice (both for CY 2016 and CY 2017). There is a scope of a better approach in this arena, so that a member is not counted twice in the system.
- 10% MR did not have a Primary Diagnosis on the electronic medical record, though the reason for referral was mentioned as 'Pregnancy'. This warrants education on part of Care Managers who maintain records.
- In 40% of the cases, CM was not offered within the time frame of 15 days of notification of pregnancy, which is contractually mandated by MHD.
- In 30% of the cases, Discharge Plans and After Care was not provided as the member could not be reached.
- The provider treatment plan was missing in all the MR resulting in 0% compliance. Missouri Care send letters to all OB providers about the member enrollment in CM program along with the Care Plan. They get a response from the provider only for certain cases after Care Managers make a phone call to the providers' offices.

Quality, Timeliness and Access to Health Care Services

- Missouri Care OB-CM Program was monitored in 24 areas during the MRR. Out of those, 19 areas scored 100% and 1 area scored 90% for compliance. Three (3) areas were at 60-70% compliance whereas Provider Treatment Plan scored zero (0).
- After receiving enrollment information from MHD in 834 file, the Missouri Care made efforts to verify the contact information and address of the members at the onset on successful outreach.

- Missouri Care also contracted with a Vendor (Alere) for outreach to pregnant members.
- Use of multiple referral sources other than enrollment file for e.g., claims, provider notifications, reports, identify OB members so that access to Care Management and coordination of services could be provided in a timely manner.
- The following information/data has been obtained from Missouri Care to reflect their efforts for success of OB CM Program in CY 2017. Effectiveness of the OB program is measured by monthly case manager chart audits, OB outreach rate, HEDIS metrics and Utilization metrics.

CY 2017 Care Management OB Outcomes

On May 01, 2017 Missouri Care's membership expanded to cover the entire state.

A. OB Outreach

Table 4-26 Outreach Rate %

REPORTING PERIOD	OUTREACH RATE
JAN 1-APRIL 30	91.00%
MAY 1-SEPT 30	95.30%
OCT 1-DEC 31	94.20%

B. Timeliness of Prenatal Care

For the Timeliness of Prenatal Care Measure, Missouri Care had achieved a rate of 81.51% in CY 2017 (HEDIS 2018). It improved by 4.46% point from the previous year. For the CY 2015 and CY 2016 Missouri Care slightly exceeded 25th Percentile of NCQA Quality Compass (Table 4-27).

Table 4-27 Timeliness of Prenatal Care (HEDIS Measure)

HEDIS Year	Timeliness of Prenatal Care %	2017 NCQA Quality Compass 25th Percentile	2017 NCQA Quality Compass 50th Percentile	Annual %point change
2016	77.51	74.21	82.25	
2017	77.05	77.66	83.56	-0.46

2018	81.51	76.89	83.21	4.46

C. Postpartum Care

For the Postpartum Care Measure, Missouri Care had achieved a rate of 57.18% in CY 2017 (HEDIS 2018). It improved by 5.73% point from the CY 2016 (HEDIS 2017). In the CY 2015 (HEDIS 2016), Missouri Care was above 50th Percentile of NCQA Quality Compass, but it dropped by 10.27% point in CY 2016, and was below the 25th Percentile of NCQA standard (Table 4-28).

Table 4-28 Postpartum Care (HEDIS Measure)

HEDIS Year	Postpartum care %	2017 NCQA Quality Compass 25th Percentile	2017 NCQA Quality Compass 50th Percentile	Annual % point change
2016	61.72	55.47	60.98	
2017	51.45	59.59	64.38	-10.27
2018	57.18	59.61	65.21	5.73

D. Neonatal Intensive Care Unit (NICU) Prior Authorizations (PA)

The Table 4-29 reveals that Missouri Care approved 100% of the requested PAs (4.63 Vs 4.64) in CY 2 017, consistent with the % approvals in CY 2016. This is suggestive of access of care to the members.

Table 4-29 NICU PA

NICU	2017 Total	2016 Total	2017 Q1	2017 Q2	2017 Q3	2017 Q4
Requested PA Per 1000	4.64	5.11	5.12	4.61	5.01	4.08
Approved PA Per 1000	4.63	5.09	5.09	4.61	5.01	4.07

E. Delivery (Birth) PA

The Table 4-30 reveals that Missouri Care approved 99.9% of requested PAs (40.77 vs 40.81) in CY 2017, consistent with the approvals in CY 2016. This is suggestive of access of care to the members.

Table 4-30 Delivery (Birth) PA

Birth	2017 Total	2016 Total	2017 Q1	2017 Q2	2017 Q3	2017 Q4
Requested PA Per 1000	40.81	42.35	54.93	41.85	40.18	34.71
Approved PA Per 1000	40.77	42.34	54.87	41.80	40.17	34.65

Improvement by Missouri Care

A comparison with previous year (CY 2016) was done to determine the extent to which Missouri Care addressed effectively the recommendations for quality improvement made by the EQRO.

- Improvement was noticed for Assessments (5% points), referrals (5.26% points), Care Plan (10% points), progress notes (17.5% points) and Care Coordination (16.67% points).
- There was a decrease in Discharge Planning compliance by 11.25% points. This was because the Missouri Care lost contact with the patient after initial screening.
- The Table 4-31 and Figure 4-10 below show the trend data for a period of CY 2014-CY 2017 and change in % point from CY 2016.

Table 4-31 Trend Data for MRR: 2014-2017 EQR

%MRR Compliance	2014	2015	2016	2017	% point Change
Assessment	100	83.33	95	100	5
Referrals	73.33	90	94.74	100	5.26
Care Plan	93.33	81.82	90	100	10
Progress Notes	87.1	94.74	82.5	100	17.5
Care Coordination	40	75	83.33	100	16.67
Discharge Planning	72.73	87.5	81.25	70	-11.25

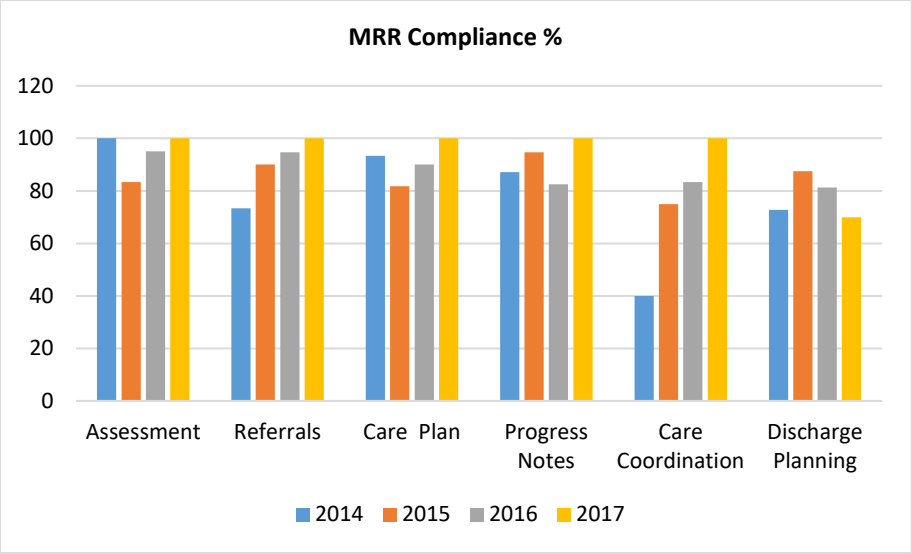


Figure 4-10 MRR Compliance trends (CY 2014-2017)

Recommendations

- A member should be considered as enrolled when the Care Manager makes an assessment of the need of the member. An outreach by a care coordinator should not be considered as enrollment. As per the MHD Managed Care Contract, The initial care management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.
- The Assessment should be completed within 15 days of notification of pregnancy. Care management for pregnancy is included in the current Performance Withhold Program. This allows MHD to emphasize the importance of timely case management for this critically important condition.
- Face to face contact for complex cases.
- Before closing a case for UTC, at least three (3) different types of attempts should be made prior to closure for this reason. Where appropriate, these should include attempts to contact the member's family. Examples of contact attempts include (MHD Managed Care Contract 2.11f (1)):
    - Making phone call attempts before, during, and after regular working hours;
    - Visiting the family's home;
    - Checking with primary care provider, Women, Infants, and Children (WIC), and other providers and programs; and
    - Sending letters with an address correction request. (Post Offices can be contacted for information on change of address).

- The engagement of provider in the 'Care Plan'. Missouri Care sent letters to the providers about new patients' enrollment and Care Plan but no response was asked or received from them. This opportunity to collaborate with provider at early stage can be tapped. Involving the provider in engaging members in their care would increase the success of pregnancy outcomes.
- Patient-centered education: https://www.managedcaremag.com/archives/2017/9/three-components-missing-many-population-management-strategies recommends:
  To assess and account for cognitive factors that affect member's ability to understand their health needs, care goals, and recommended interventions. Does a member have the cognitive ability to support her Care Plan? Does she or he have the knowledge necessary to understand not only what constitutes a Care Plan but also why and how it can be followed? Gaining this level of insight requires structured and timely interaction with the patient. Both must be embedded in the Care Management fabric of the OB Program. Only after there is a clear picture of a patient's cognitive skills and knowledge base is it possible to provide the patient with the appropriate level of educational information and outreach. If people truly understand their Care Plans, adherence improves and have better outcomes.
- Patient-centered technology: https://www.managedcaremag.com/archives/2017/9/three-components-missing-many-population-management-strategies
  Many Medicaid Managed Care Organizations have member portals—and nearly all of them have members who rarely, if ever, use the portals. The reason is remarkably basic: Most people in Medicaid plans use smartphones rather than home computers to connect to the Internet. Smartphone apps, *not* web-based member portals, is the way to serve Medicaid plans and their members. By identifying how patients are willing to engage, the Home State Health can procure and configure technology that optimally support these preferred engagement channels. In turn, these expanded lines of communication between care teams and patients can ensure the timely flow of information and education.
- Frequency of follow-up, availability of psychosocial services, assistance with financial issues and active engagement of the care manager and the member are important characteristics of CM interventions.

4.5.2.2 Children with Elevated Blood Levels Care Management

Lead Care Management Overview

Missouri Care's Lead Care Management Program includes all members with identified lead levels of 10 *ug/dL* or greater. Under the direction of the Lead Care Manager, a team approach is used that involves the primary care physician (PCP), Missouri Department of Health & Senior Services (DHSS), Home Health Agencies and/or the local Public Health Agencies. Outreach is conducted for members with elevated blood lead levels in the required time frames noted below:

- 10 to 19 ug/dL within one to three (1–3) business days;
- 20 to 44 ug/dL within one to two (1–2) business day;
- 45 to 69 ug/dL within twenty-four (24) hours; and
- 70 ug/dL or greater-immediately.

Upon successful contact, a screening/assessment is completed by Missouri Care's Lead Care Manager and Care Plans are developed that assist with the required coordination with a goal for a lead level of less than 10 *ug/dL*. Lead Care Management includes the coordination of home visits, environmental assessments and ongoing review of the member's lead levels with the PCP.

All members with noted lead levels are offered two home visits – one that occurs at the time of notification of the elevated lead level and a follow-up home visit that is offered within three months following the initial home visit. Missouri Care contracts with home health agencies and public health departments to assist with these home visits.

The initial visit includes an assessment of the member/family including recommending interventions to mitigate the lead poisoning and lead poisoning education. The follow-up visit includes an assessment and review of the member's progress and parental compliance with recommended interventions and reinforcement of the lead poisoning education. The DHSS Childhood Lead Poisoning Prevention Program Nurse's Lead Care Management Questionnaire is used by the Home Health Agencies and Public Health Departments in the initial home visit. All visit information is faxed to the lead care manager and is included in the member's open case file and used to coordinate the Care Plan.

The Care Manager also works closely with the PCP assuring that repeat lead levels are timely completed. The member's Care Plan and the information from the home health visit and the environmental assessment is shared with the PCP.

The Care Manager continues to work with the member/guardian and all parties involved, providing education, interventions and making adjustments to the Care Plan as needed until all lead hazards have been removed and the member's lead level decreases to a level of less than 10 *ug/dL*. Once this has occurred and the member is discharged from Lead Care Management, exit counseling is performed that includes the member's lab results, the discharge date of Care Management, the reason and a follow-up phone number for the Care Manager.

If, at any time, a member terminates with the MCO while enrolled in Lead Care Management, the transition of care process is completed. A member enrolling in another MCO will be notified of the member's lead level and status of care. For members transitioning to MO HealthNet, the Care Manager will notify the Public Health Agency where the member resides. The member/guardian and providers are notified of the termination of coverage and are provided with contact information for the receiving health plan or the public health agency.

All communications and interventions are documented in the member record in the Enterprise Clinical Management platform. In addition, Missouri Care completes documentation in MHD's web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application database.

Findings of Medical Records Review

Primaris reviewed 30 MR and 20 records were open for CM in CY2017. 10 out of 30 records were excluded for the following reasons:

Table 4-32 Exclusions/Exceptions	NUMBER OF MR
State notifies of increased capillary Blood Lead Level (BLL)	2
Venous level drawn and within normal parameters	4
Unable to contact member	1
Duplicate	1
No case management in 2017	1
Refused Care Management	1
TOTAL	**10**

The MRR for Missouri Care Lead CM program revealed the following information (Figure 4-11):

a. Offer Care Management and Assessments

Missouri Care receives the notification/referral of the elevated blood level. The Care Manager then offers CM within the timeframe below according to the elevated blood lead levels:

- 10 to 19 ug/dL within 1–3 business days
- 20 to 44 ug/dL within 1–2 business days
- 45 to 69 ug/dL within 24 hours
- 70 ug/dL or greater - immediately

Missouri Care's initial 'outreach' attempts to contact the member/guardian for Lead Care Management was 100%. Although 'attempts' were done, the Care Mangers success rate to contact the member/guardian to offer case management and perform an assessment was only 50%. They were 'unable to contact' due to 'no answer' and/or 'inaccurate member's contact information'. The Care Managers continued to contact outside sources to obtain correct contact information.

b. Member Engagement and Care Planning

The Care Managers face difficulty in member/guardian engagement for CM services. Welcome letters are initially sent to the member/guardian regarding CM.

c. Provider Engagement and Care Planning

The Care Plans are implemented with members after the completion of the initial assessment. Communication with physician/physician staff for the member's care is ongoing during the Care Management process. Care Managers notify the provider that the member is engaged in the Lead Care Management. Missouri Care is 40% compliance for Care Plans.

d. Childhood Blood Lead Testing and Follow-Up

The compliance rate is 85%. The Care Managers educate the member/guardian the importance of follow-up blood testing.

e. Referrals

Missouri Care is 100% compliant with referrals The Care Managers made attempts for referrals for services. The participation of the member engagement remains a challenge.

f. Two Face to Face encounters

The initial face-to-face encounter within 2 weeks of receiving a confirmatory blood level is 22.22% compliance. The compliance for the second visit within 3 months is 16.66%. The Care Managers

utilized outside sources such as home health, lead assessor to promote the face-to-face encounters. The barriers documented by the Care managers are ‘unable to contact’ and ‘member/guardian refusal’. Initial visits for face-to-face encounters do not occur as frequently as required. Although referrals were initiated, the initial face-to face and follow-up encounters required continuous attention.

g. Coordination, Linking and Monitoring Services

The coordination, linking and monitoring of services are documented in the progress/contact notes with 100% compliance.

h. Discharge Plans/Case Closures

A member/guardian exit evaluation for case closure can occur via phone or face-to-face encounter. ‘Unable to contact member/guardian’ presents a challenge for meeting the criteria for conducting a contact exit evaluation. A case closure letter is required to be sent to member/guardian and PCP when applicable which was 100% compliant. Case closure letter criteria to member was 100% compliance. Case closure criteria to PCP was 100%. Missouri Care had twenty (20) case closures in 2017. The contact exit evaluation to member/guardian was 55%.

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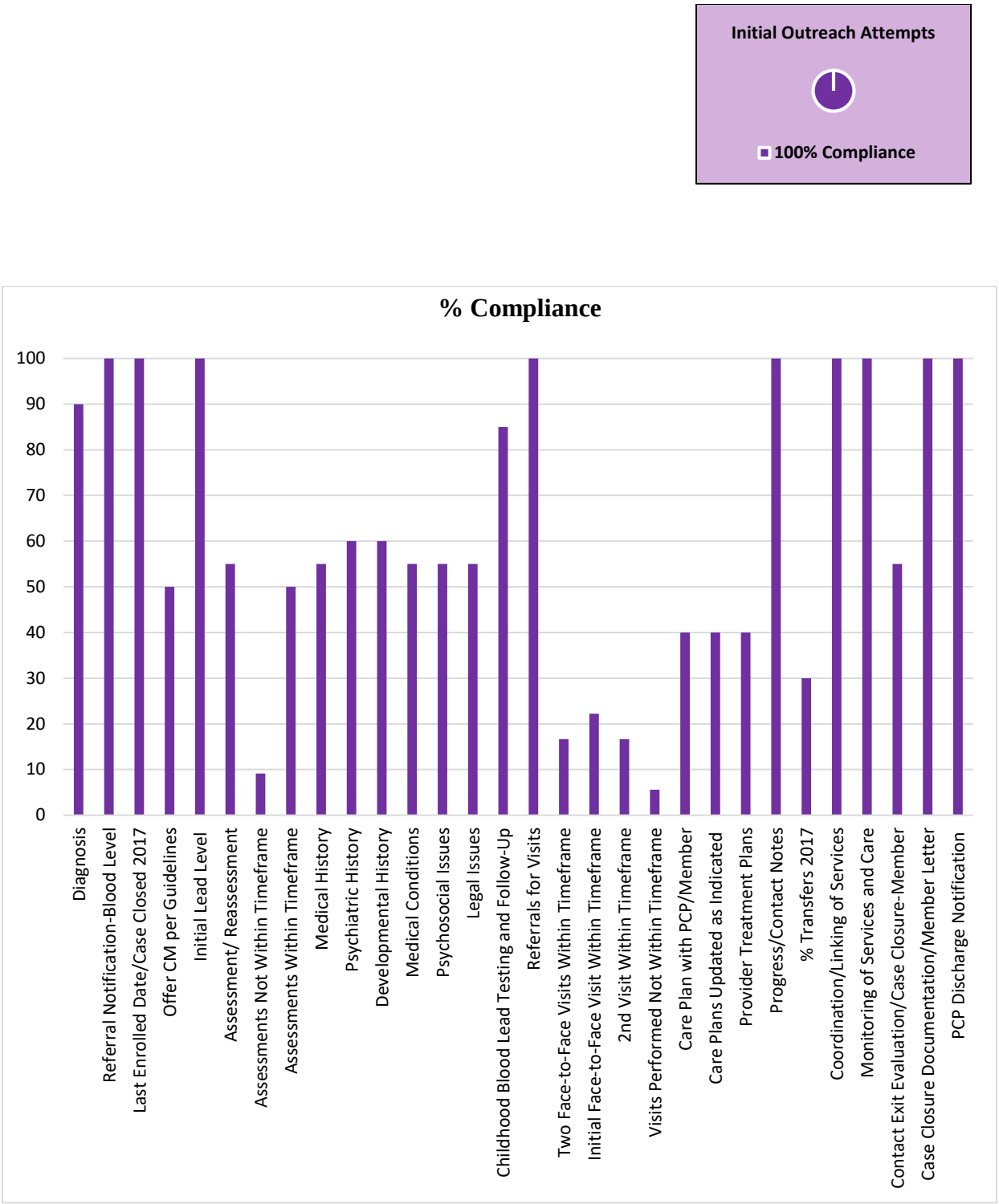

Figure 4-11 Compliance Graph for Lead Care Management MRR

Conclusions

Strengths/Key drivers

Table 4-33 Key Drivers

Key Drivers	Intervention	Failure Mode & Effect Analysis
MCO Member Directory Care Coordination	Accurate Member Directory Contact Information Internal Process Changes within MCO	Unable to contact patient for care planning: Offer CM within timeframe with assessments Face-to-Face Encounters Follow-Ups Exit Evaluation/Case Closures
Coordination/Resources	Focused Member Outreach by the Targeted Provider Member Engagement/Member Outreach and Incentive	Unsuccessful member engagement: Member refuses Lack of investment in the member's healthcare needs Member is not aware of the importance of follow-up
Provider Engagement	Internal Process Changes at PCP Office Improve Provider Processes	Unsuccessful provider engagement and care planning

Weaknesses

Missouri Care was ≤55% compliant in the following criteria/areas due to the single most reason 'UTC'.

Table 4-34 Issues

Criteria/Areas	Reason	Number of Members
Offer CM per Guidelines with Assessment	Unable to contact (UTC)	10
Face-to-Face Encounters (Initial and/or Follow up)	UTC	11
Discharge/Case Closure-Exit Evaluation with member	UTC	9

Another area for poor compliance was Provider Treatment Plans and Care Plans (40% compliance). There is a requirement of better provider engagement for care planning and provider treatment plans. Promoting provider education and participation is an ongoing process.

Quality, Timeliness and Access to Health Care Services

Missouri care Lead CM program was reviewed in 22 areas during the medical record review. Nine (9) areas scored 90% or higher for compliance. One (1) area, testing and follow-up was 85% compliance. Nine (9) areas, offer case management per guidelines with assessment, assessments, medical history, medical conditions, psychiatric history, developmental history, psychosocial issues, legal issues, contact exit evaluation/case closure-member were 50-60%. Two (2) areas, care plans and provider engagement scored 40%. One (1) area, face-to-face encounters were 17-22% compliance.

The use of these findings would help to understand the opportunities for improvement that would have a positive impact on the care, services, and outcomes for members.

Missouri Care Lead Program Effectiveness

The Care Management Department continuously monitors and evaluates the quality and effectiveness of the program structure and processes for opportunities for improvement. Measuring outcomes, goal attainment and member satisfaction is an integral part of the Care Management Program. The focus is on

identifying opportunities for improvement and applying a Continuous Quality Improvement (CQI) process as the approach to problem solving.

The approach includes, but is not limited to:

- Determine relevance of the issue to the population;
- Evaluation of baseline measure(s);
- Analysis to identify an opportunity for improvement;
- Analysis to identify possible root causes/barriers;
- Planning and implementation of actions to eliminate root causes;
- Evaluation of performance and effectiveness of the interventions by re-measuring after implementation of actions; and
- Continuous re-measurement to determine whether improvements are sustained

  The Program Measure of Effectiveness includes Member, Provider and Care Manager Value Drivers.

Table 4-35 Lead Screening Rates from H 2016-H 2018 (CY 2015-CY 2017)

HEDIS Year	Missouri Care Lead Screening In Children (LSC) Rate	2017 NCQA Quality Compass 25th Percentile	2017 NCQA Quality Compass 50th Percentile	Year over Year Percentage Point Change
2016	56.44%	56.44%	71.06%	
2017	56.94%	59.65%	71.38%	0.50%
2018	56.45%	Pending	Pending	-0.49%

Lead screening, as a HEDIS care gap, is discussed with primary care providers during Quality Care Gap meetings as well as during care management/ PCP communications.

Improvement by Missouri Care

A comparison with previous year (CY 2016) was done to determine the extent to which Missouri Care

addressed effectively the recommendations for quality improvement made by the EQRO. The details are provided in the Table 4-36:

- Referrals were improved from the previous years;
- Offer CM per the guidelines with an assessment decreased;
- Assessments decreased;
- Face to Face encounters for initial visit and follow-up decreased;
- Care Plans increased; and
- Contact exit evaluation/case closure decreased.

Table 4-36 Comparison Chart for Compliance Improvement from CY2016

CY 2016 Data Elements Reviewed	CY 2016 % Compliance	CY 2017 Data Elements Reviewed	CY 2017 % Compliance	Notes
		Diagnosis	90%	% of Diagnosis documented
		Referral Notification of Blood Lead Level	100%	Referral for blood lead levels documented
		Case Closures in 2017	100%	20 cases closed in 2017
		Case Closures in 2018	0%	0 cases closed in 2018
		% Transition of Care Cases in 2017/Transfers	30%	6 cases for Transition of Care (TOC) in 2017
		Contact Exit Evaluation with Member/Guardian	55.00%	20 cases for case closures

		Case Closure Documentation to Member/Guardian	100%	20 cases for case closures
		PCP Discharge Notification	100.00%	20 cases for case closures
Transition/Closing	**88%**	***Total for Discharge Criteria***	***85%***	**Meeting criteria for exit/closure case**
		Initial Lead Levels from referral	100%	Initial lead levels documented
		Outreach 'Attempts'	100%	Initial 'Attempts' made within timeframe of blood lead levels
Offer CM	**93%**	**Offer CM for Lead Levels per Guidelines with Assessment**	**50%**	**Direct contact with member/guardian to offer CM within guidelines and perform assessment**
Assessments	**73%**	**Total Assessment Performed (within and not within timeframe)**	**55%**	**Total assessments performed during care management process(within and not within initial direct contact to offer CM)**
		Medical History	55%	Documentation present on assessment
		Psychiatric History	60%	Documentation present on assessment
		Developmental History	60%	Documentation present on assessment

		Medical Conditions	55%	Documentation present on assessment
		Psychosocial Issues	55%	Documentation present on assessment
		Legal Issues	55%	Documentation present on assessment
		Childhood Blood Testing/Follow-Up	85%	Follow-up blood testing documented
Care Planning		**Care Plans**	**40%**	
Face-to face	**94.74%**	**Face-to-Face-Initial Encounter within 2 weeks**	**22%**	**Initial face-to face encounters performed**
		Face-to-Face-2nd Visit within 3 months of 1st encounter	**17%**	**2nd visits performed**
		Total visits performed within and not within timeframes	**22%**	**Total visits performed within and not within per guidelines**
Care Coordination	**0%**	**Member Engagement**	**40%**	**Member engagement/involvement**
PCP Involvement	**90%**	**Provider Treatment Plans**	**40%**	**Provider involvement with care**
		Coordination/Linking Services	100%	Documentation present
		Monitoring of Services and Care	100%	Documentation present

Referrals	**75%**	**Referrals**	**100%**	**Documentation present**
Progress Notes	**100%**	**Progress/Contact Notes**	**100%**	**Documentation present**

Table 4-37 shows the % compliance of Medical Records from CY 2014- CY 2017 for the Children with Elevated Blood Lead Levels CM Program. There was a decrease in 'Offer Care Management within Timeframe' by 43% point, decrease in 'Assessment' by 18% point in comparison to previous CY 2016, whereas an improvement was noticed in 'referrals' by 37% point.

Table 4-37 Compliance Trend % from CY 2014-2017

MRR Compliance %	2014	2015	2016	2017	%point
Offer CM within Timeframe	72.73%	30.77%	93%	50%	-43
Assessment	100.00%	83.33%	73%	55%	-18
Care Planning	100.00%	58%	27%	40%	13
Referrals	88%	54.55%	63%	100%	37
Face-to-Face Encounters	90.91%	45.45%	94%		
Face-to-Face Encounter Initial				22%	
Face-to-Face Encounter Follow up				17%	
Progress Notes	83.33%	55.00%	87%	100%	13
Discharge Planning	100%	33.33%	88%		
Contact Exit Evaluation/Case Closure				55%	
Case Closure Documentation/Member				100%	
PCP Discharge Notification				100%	

Recommendations

Suggested Methods to Contact Guardian/Member

- In cases where the member/guardian cannot be contacted by phone and no response to the initial letter, a visit should be made to the location.
- Language barriers may present obstacles for the initial contact of member/guardian. Local community-based resources may be necessary to facilitate initial contact and confirm effective follow-up.
- Different modes of outreach should be used at different times of the days and different days of the week to increase opportunities of actually reaching the member/guardian to initiate the case management process.

Table 4-38 Methods for Contacting Members

Methods Used for Existing Contact Information	Methods to Verify/Update Contact Information
Call Send a letter Send a certified letter Make a home visit Text or email (follow agency policies; may require prior consent) Local community-based resources	Inquire WIC contact Inquire economic assistance contact Inquire Child Protection contact Inquire Primary Care Provider Inquire US Postal Service for forwarding address Inquire contact person listed at admission if applicable Call member/guardian at different times and days

Suggested Methods for Member Participation

- Ensure anticipatory guidance to parents for blood levels approaching ≥ 10ug/dl.
- Children with blood levels below 10 ug/dl are important targets for educational interventions.
- Ensure that an elevated blood lead level environment health investigation is conducted.
- Encourage guardian to test siblings and household contacts for lead poisoning.
- Refer family to developmental and community resources such as: developmental programs, health, and housing and/or social services when appropriate.

Suggested Methods for Provider Participation

- Ensure a notification letter is sent to physician along with a copy of the member/guardian notification letter and informatics letters.
- Educating physician/staff on proper steps for capillary blood lead level (finger sticks) per the protocol.
- Suggest a main contact at provider office to engage in member/guardian's plan of care.

Continue Lead Poisoning Education

- Risks;
- How are children exposed to lead;
- Lead in products;

- Member/Guardian Jobs and Hobbies;
- Prevention Measures;
- Healthy Diets;
- Effects of lead on children, adults, and pregnant women;
- Testing and Reporting;
- Methods of testing; and
- Treatment.

4.5.2.3 Serious Mental Illness (SMI) Care Management

As per the MHD Managed Care Contract (2.11), Serious Mental Illness (SMI) includes Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder.

SMI Program Overview of Missouri Care

Behavioral health care management is integrated in the overall Care Model. The goals and objectives of the behavioral health activities are congruent with the Clinical Services Organization Health model and are incorporated into the overall Care Management model program description.

SMI population requires additional services and attention which lead to the development of special arrangements and procedures with the provider networks to arrange for and provide certain services. Some members require coordination of services after discharge from acute care facilities to transition back into the community. This includes coordination to implement or access services with Network Behavioral Health providers or Community Mental Health Clinics (CMHCs) also called Community Service Boards (CSB). Members with SMI may receive intense or targeted Care Management services by community mental health providers or integrated care from a Behavioral Health Home (BHH).

The MCO assesses members for Care Management within five (5) business days of admission to a psychiatric hospital or residential substance use treatment program, as well as members referred to the program, identified through data sources, or identified via The Law. Mental health status, including cognitive functions and psychosocial factors such as the ability to communicate, understand instructions and process information about their illness and substance abuse history are essential components of the

initial assessment. The PHQ-9 and CAGE or CRAFFT assessments are conducted to provide additional data within the assessment process.

Findings of Medical Records Review

Primaris reviewed 24 MR (oversample) to audit 20 records for CM in CY2017. 4 out of 24 records excluded for the following reasons (Table 4-39):

Table 4-39 EXCLUSIONS	NUMBER OF MR
Not SMI Dx	2
Unable to contact member	1
Duplicate	1
TOTAL	**4**

Of the 20 cases reviewed, 12 cases were hospitalized with the diagnosis of SMI, 1 was self-referred by member calling the help line, 1 was found as an outlier needing attention, and 4 were referred through Law (proprietary algorithm) which is the utilization management (UM) referral process. 2 were hospitalized for medical reasons at the time of admission, and diagnosed as a case of SMI (Figure 4-12).

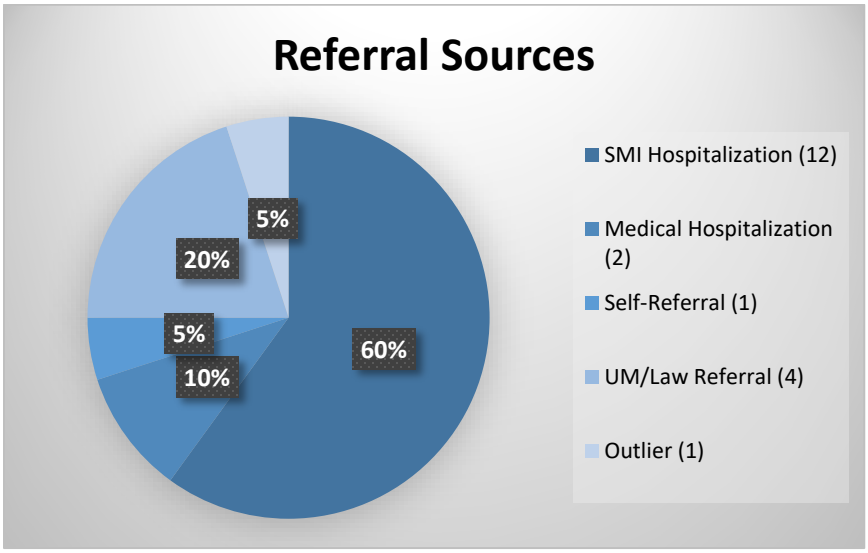

Figure 4-12 Distribution of the referral process to CM

Observations

- Many members had multiple cases opened during the calendar year of 2017.
- All SMI dx members were open to case management.
- All were assessed within the timeframe (5 days).

Table 4-40 Observations for SMI CM

Reasons cases were closed	2 – Loss of coverage 4 – Loss of Member contact 2 – Member choice
Variances	Age Gender Diagnosis Pre-hospitalization to post-hospitalization dx Ability to get needed services/providers
Similarities	Open to Care Management Family seeking care/information

The Medical Record Review for Missouri Care SMI CM program revealed the following information (Figure 4-13, 4-14):

a. Offer Care Management and Assessments (100% Compliance)

- Missouri Care receives the notification/referral of member hospitalization through the Utilization Management process:
  - Behavioral health diagnosis meeting the serious mental health list
  - Medical diagnosis that reveals a co-morbidity of serious mental health
- Phone call made by member to the MCO member call line that creates a member self-referral into care management.
- Referral from the Law Department of Missouri Care which refers for CM.

b. Member Referral (100% Compliance)

The Care Manager refers the member to CM as well as other services they may need.

c. Assessment (100% Compliance)

The Care Manager assesses the member for services if the member agrees for CM. This step analyzes the member's needs and begins the CM process.

d. Provider Engagement and Care Planning 95% (Compliance)

The Care Plan is implemented with members after the completion of the initial assessment. Communication with physician/physician staff for the member's care is ongoing during the CM process. Care Managers notify the provider that the member is engaged in the Serious Mental Illness Management and remain in communication with providers as allowed.

e. Testing (100% Compliance)

Testing in SMI is utilized on a needed basis. When needed, compliance is high. Testing for risky behaviors is vital and Care Managers follow up with providers to document test results.

f. Discharge Plan (85% Compliance)

The Care Managers encourage the member/guardian to stay engaged until goals are met. At the end of the plan, there are additional steps created in case follow up or additional services are needed in the future. If the member needs to return to care, this step demonstrates how to get services as needed.

g. Aftercare (83% Compliance)

The 'aftercare' is the member's responsibility to continue with services as recommended by the combination of providers, hospital, and case management. To get the 'aftercare' the member has to continue till the end the plan in full compliance and availability, as per the Care Plan.

h. Transfers (84%), Linking (100%) and Monitoring Services with Provider and Member Participation were (100%) compliant.

The member's connection to other available service organizations is a vital part of their plan. The providers, organizations, outpatient facilities, all work together to reach the plan goals.

i. Follow Up (89% Compliance)

A case closure letter is sent when a case is closed. The provider may also be notified. The Care Manager follow up is the final step of case closure to ensure the member feels the goals were met satisfactorily or they wanted the case to be closed for an agreed upon reason such as CM from another organization.

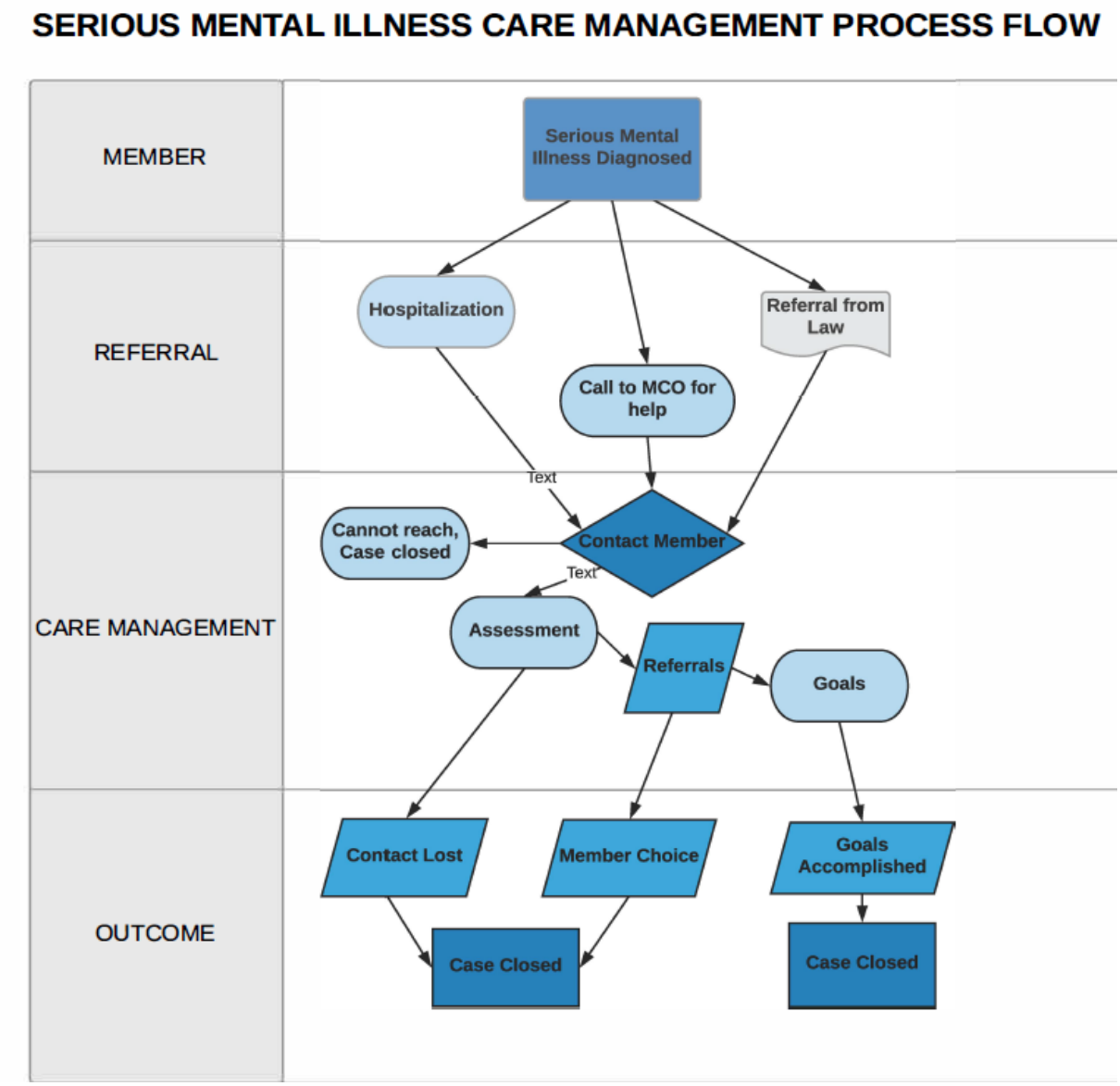
SERIOUS MENTAL ILLNESS CARE MANAGEMENT PROCESS FLOW
MEMBER
REFERRAL
CARE MANAGEMENT
OUTCOME
Serious Mental Illness Diagnosed
Hospitalization
Referral from Law
Call to MCO for help
Text
Cannot reach, Case closed
Contact Member
Text
Assessment
Referrals
Goals
Contact Lost
Member Choice
Goals Accomplished
Case Closed
Case Closed

Figure 4-13

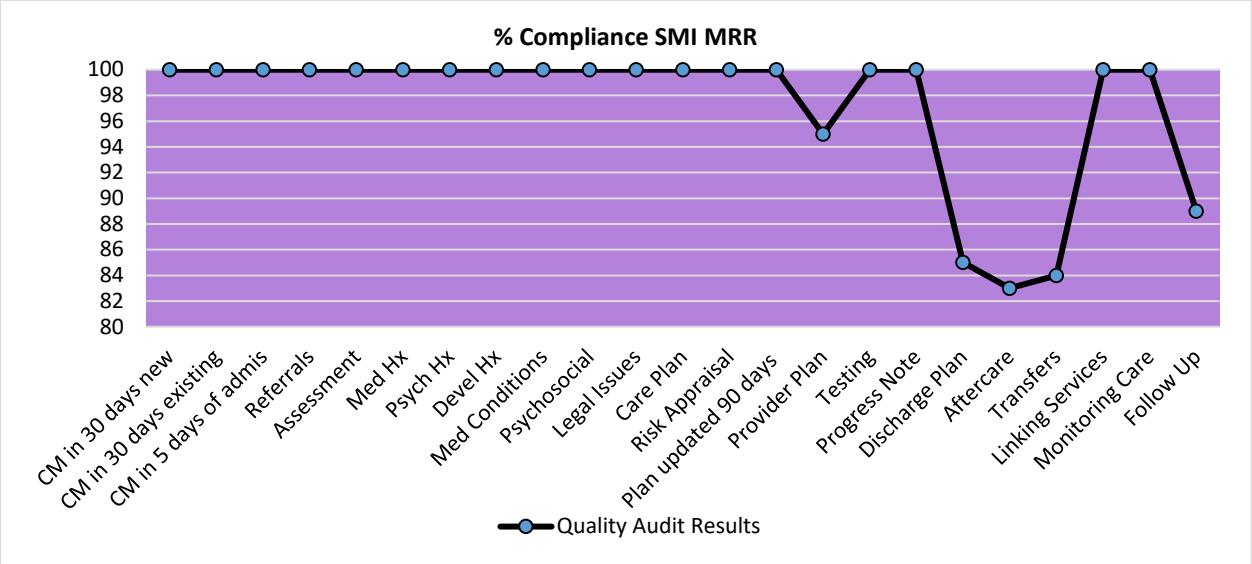

Figure 4-14 Compliance Graph for SMI CM MRR

Conclusions

Strengths

- Team work and Coordination;
- Work to align with patient and population needs;
- Linking to community resources;
- Provider Engagement;
- Medication Management;
- Behavioral Health Home; and
- Supporting patients' self-management goals.

Weaknesses

- Identification of members for SMI CM: This remains a challenge as there is no guidance as to what constitutes SMI. List of diagnoses is the only way to indicate that a member needs CM for SMI. Some of these members are well managed and do not need CM because they have good family support and medical interventions. On the other hand there are members with diagnoses not on the list, but need CM due to the risky behaviors as reported by their care takers. Such cases cannot be neglected by the MCO.

- Providers often do not share vital information with the MCO. They do not understand the role of the Care Manager in the member's care. There is often a lack of communication/teamwork.
- The cost and the resources for SMI CM sometimes become a limiting factor for the MCO to provide 100% quality care to its members.
- The ability of Care Manager to reach SMI members becomes an issue over time. These members often do not have accurate addresses. They change or refuse to provide phone numbers. They do not have emergency contact numbers. They often are not at home when Care Managers make appointments to visit or do not agree to home visits. The ability to stay in contact over a long term is a challenge in tacking member's care. The Care Manager utilized the connection with a member's provider if available. Sometimes the members got overwhelmed with too many people involved in their care. They lacked the understanding of their roles and opted out of CM.

Quality, Timeliness, and Access to Health Care Services

Overall compliance for SMI CM MRR was 97.3%.

Missouri Care met most of the contractual requirements for managing the members with SMI. The Care Managers completed assessments on a timely basis, usually within one week of contacting the member to initiate care. They had most updated Care Plans and progress notes that included documentation for medical, psychiatric, psychosocial, developmental and legal background of the member. There was a follow up once the goals were met.

Quality Outcomes

Missouri Care measures the effectiveness of the SMI program as well as the behavioral health components of the integrated model by utilization metrics, HEDIS metrics and monthly chart audits. From the Table 4-41 below it is evident that the MCO has almost 100% of approvals for Prior Authorization (PA) for BH.

Table 4-41 Prior Authorization for BH in CY 2016-CY 2017

BH Inpatient (BHI), BH Detox (BHD), BH CSU (BHS)	2017 Total	2016 Total	2017 Q1	2017 Q2	2017 Q3	2017 Q4
Requested PA Per 1000	15.77	15.89	16.50	15.81	15.67	15.53
Approved PA Per 1000	15.75	15.88	16.47	15.81	15.66	15.50
PA Benchmark			15.76	19.25	14.00	13.97
Requested Days Per 1000	81.53	79.71	86.31	84.61	79.36	79.19
Approved Days Per 1000	74.49	69.99	78.52	76.23	71.88	74.02
Days benchmark			68.65	83.85	60.97	60.85
PA % Not Meeting Criteria	0.1%	0.1%	0.2%	0.0%	0.1%	0.2%
Day % Not Meeting Criteria	9.0%	12.1%	8.9%	9.8%	10.3%	7.1%

Improvement by Missouri Care

Missouri Care has a well-defined system in place within their 'Law program.' They have improved communication from this group to manage members coming from different sources to make sure they all reach the Care Management Program.

SMI CM Program was not reviewed during previous years by an EQRO, so no trend data is available for comparison purpose.

Recommendations

- Missouri Care could work on a system to better track members from the time of initial contact to ensure contact with them through the entire SMI CM Program. If data were collected and stored at first introduction to include phone number, address, email address, and emergency contact information for one or two others that may help.

- Providers need better instructions/education on the importance of the Care Management Program. If they cooperate and work as a team, the member would have the best outcome and hopefully prevent inpatient readmission.
- The State could come up with a system to clarify SMI for the MCOs. Diagnoses alone often leaves members uncared for several of those who need attention. Also the list could be broadened to include other diagnoses that appear often on the co-morbidity list such as autism which can be a behavior disorder if severe enough. Family distress is a trigger as well which might be a measurement to identify the need.
- While it is agreed there is no acceptable scale to determine the scope of seriously mentally ill patients, a uniformity among members across the State would help devise a plan to better utilize services. There are some tools in place such as the Burden Assessment Scale or BAS created in 1994 for the state of New Jersey developed to help determine the burden placed on the families of these patients who have a serious mental illness. (https://www.sciencedirect.com/science/article/pii/0149718994900043).
- The Missouri Department of Mental Health has a number of systems in place that could be utilized and/or transposed for the purpose of creating a uniform system of diagnosing the seriously mentally ill and drawing attention the ones needing CM more rapidly to prevent or reduce inpatient stays. They have tools such as the Priority of Need (PON) system that enables them to decide a ranking of highest need (https://dmh.mo.gov/docs/dd/ponfaq.pdf).

5.0 Comparative Analysis of MHD Managed Care Organizations (MCOs)

This section provides a comparison of the two MCOs for each Mandatory and Optional activity conducted in EQR 2018.

1. Compliance with Medicaid Managed Care Regulations

Table 5-1 Compliance Score for MCOs

Standard	Standard Name	Home State Health	Missouri Care
§438.230	Subcontractual Relationships and Delegation	100%	100%
§438.236	Practice Guidelines	100%	100%
§438.242	Health Information Systems	100%	100%
	Total Score	**100%**	**100%**

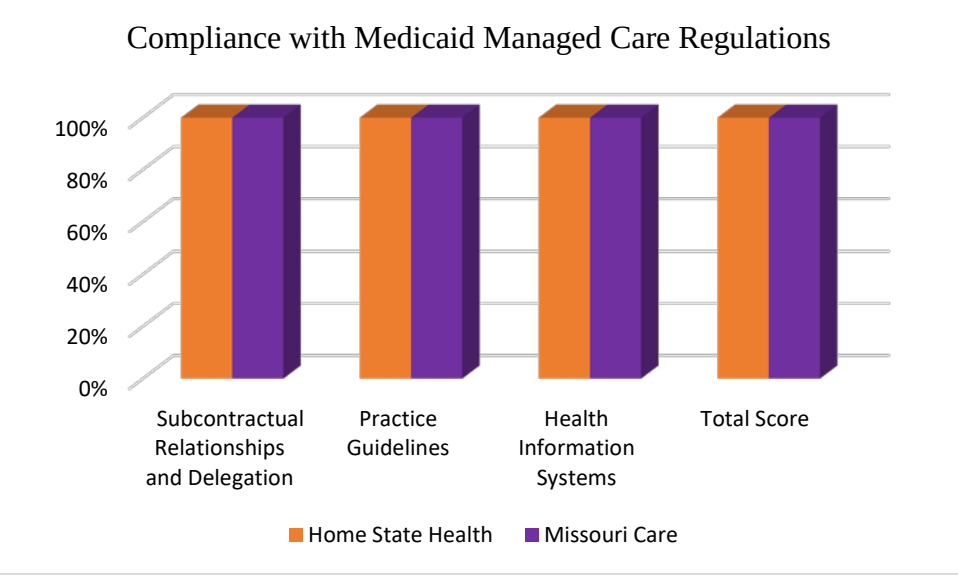

Figure 5-1

- For the Standard: Subcontractual Relationships and Delegation, Home State Health and Missouri Care achieved a score of 100%. Though both the MCOs have policies and procedures in place but it is recommended that the MCOs update the language as per the new Managed Care Rules (42 CFR 438, May 06, 2016) for CY 2018 review. The details have been provided in the report.

- Both the MCOs achieved a score of 100% for Standard: Practice Guidelines. These are developed, implemented and disseminated as per the regulatory requirements and support the aim of quality and access to healthcare services.
- Both the MCOs achieved a score of 100% for Standard: Health Information Systems demonstrating that they support business intelligence needs and have a robust system of collection, integration, tracking, analysis and reporting of data. This meets the aim of Timeliness of services.

2. (A) Validation of Performance Measures

Table 5-2 Results of Performance Measures for MCOs

Measures	Home State Health	Missouri Care
EDU (counts)*		
Mental Health	1,778	1,872
Substance Abuse	546	619
Medical	102,504	93,307
EDV (counts)*		
Mental Health	2,588	2,665
Substance Abuse	693	749
Medical	184,555	127,640
FU EDV (rate %) 7 days		
Mental Health	22.96	27.01
Substance Abuse	9.78	13.30
FU EDV (rate %) 30 days		
Mental Health	37.28	41.91
Substance Abuse	14.48	17.98
Prenatal and Postpartum Care %		
Timeliness of Prenatal Care	87.76	81.51
Postpartum Care	73.72	57.18

**the lower the better.*

EDU Measure

Both MCOs had relatively the same experience for ED utilization for mental health, substance abuse. However, Home State Health had more members in the EDU for medical reasons than did Missouri Care (the lower the better) (Figure 5-2).

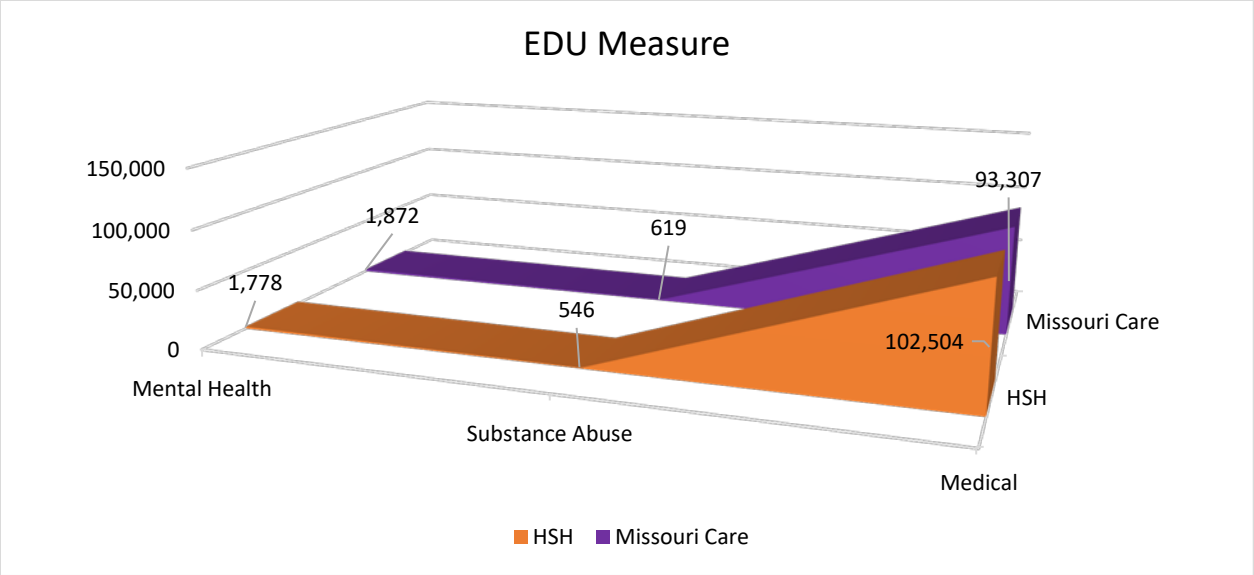

Figure 5-2

EDV Measure

The number of ED visits were much higher for Home State Health due to Medical reasons (184,555) in comparison to Missouri Care (127, 640), (the lower the better). ED visits for Mental Health and Substance Abuse were more or less the same for both MCOs (Figure 5-3).

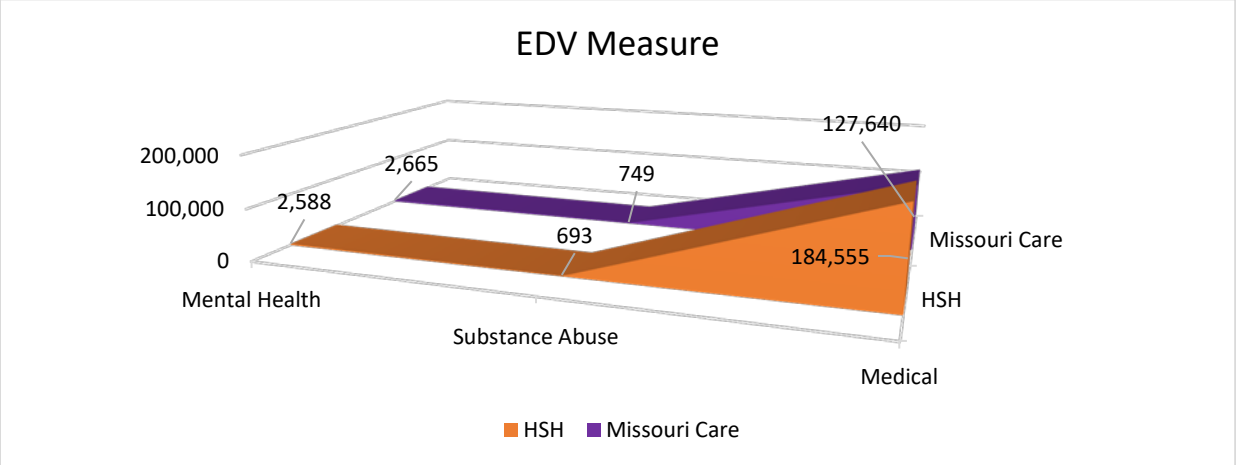

Figure 5-3

Follow Up Emergency Department Visit for Mental Health

A 7 day follow up rate for Home State Health was 22.96% vs 27.01% for Missouri Care. Overall, Missouri Care performed better compared to Home State Health (Figure 5-4). For Home State Health, the 30 days follow up rate for Mental Health was 37.28% vs 41.91% for Missouri Care (Figure 5-5).

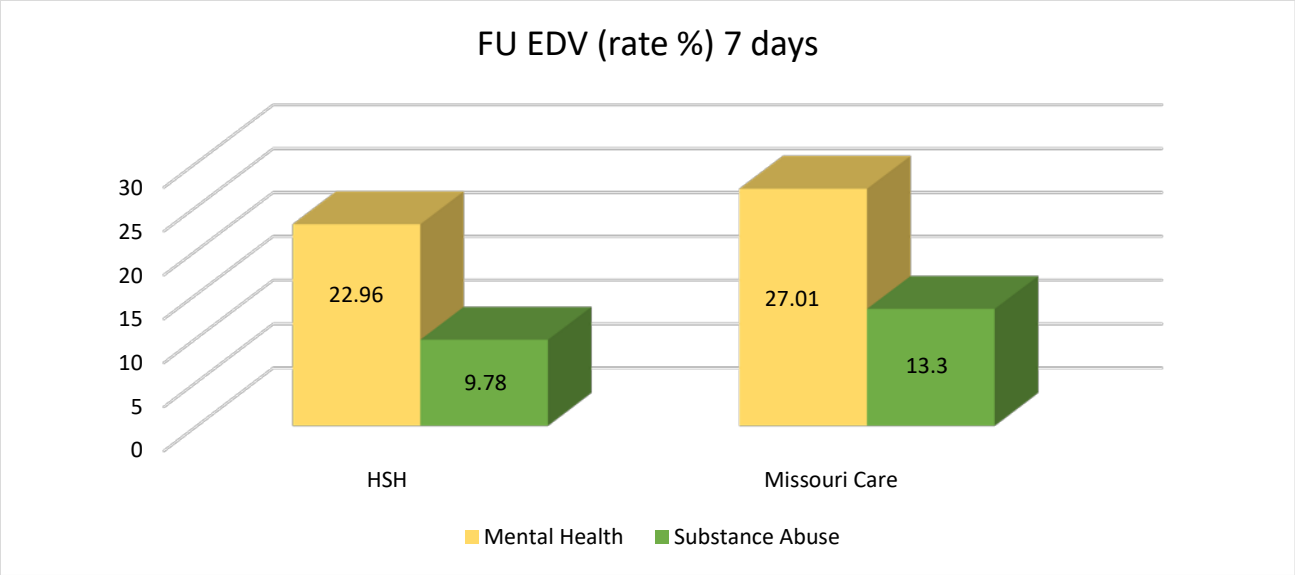

Figure 5-4

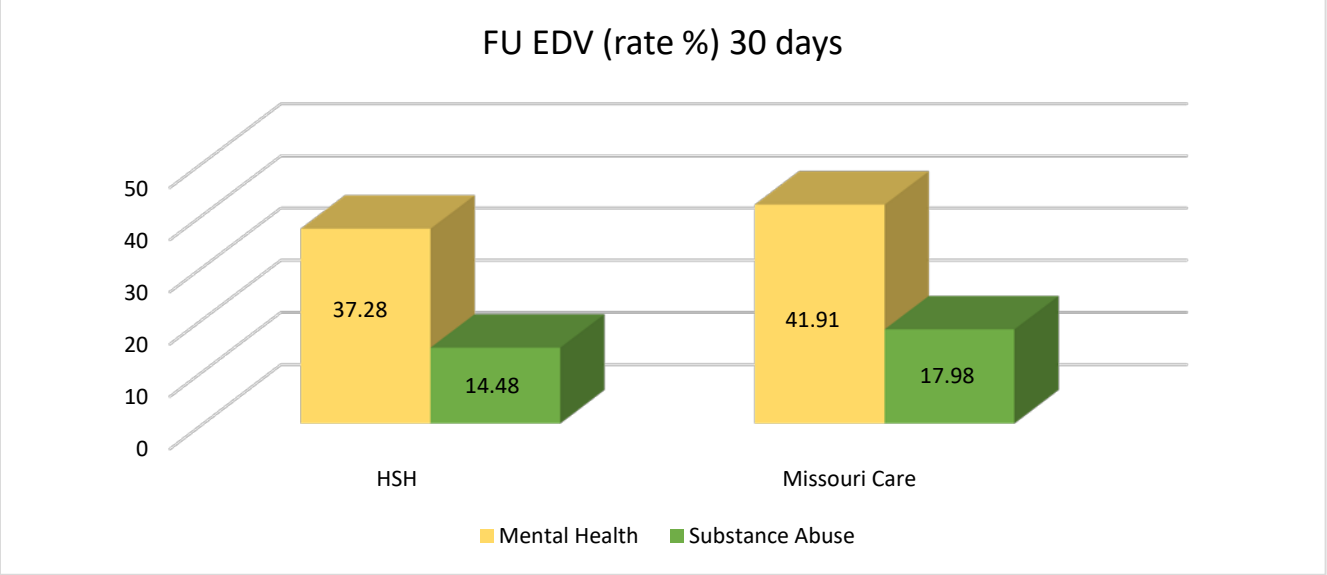

Figure 5-5

Follow up Emergency Department Visit for Substance Abuse

Overall, Missouri Care performed better at follow visits after and emergency department visit for substance abuse. Both plans performed poorly achieving a less than a 20% compliance rate for 30 days or 7 days follow up visits, combining all age cohorts together.

PPC Measure

The Home State Health outperformed Missouri Care for Timeliness of Prenatal Care by 6.25%points. Home State Health achieved a higher rate for the Post-partum care by 16.54% points versus Missouri Care.

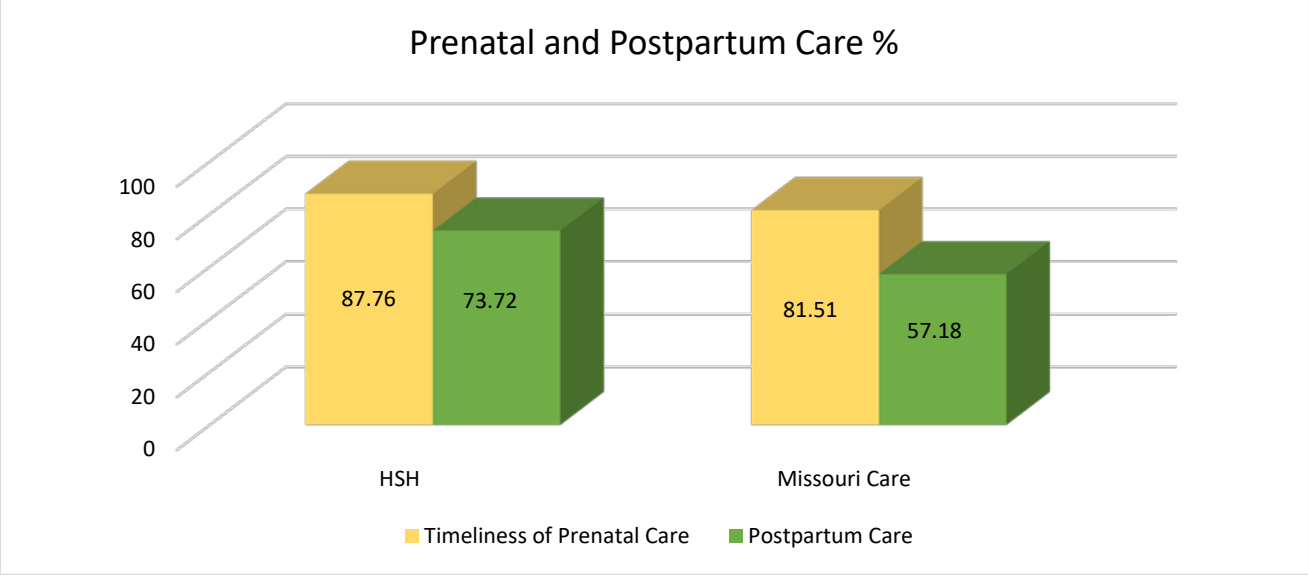

Figure 5-6

(B) Information Systems Capabilities Assessment

Both the MCOs received a fully met score for all the 7 areas evaluated as per the Table 5-3.

Table 5-3 ISCA Section	Score Result for MCOs	
Overall ISCA Score	**Home State Health**	**Missouri Care**
Information Systems	**Met** (pass)	**Met** (pass)
IT Infrastructure	**Met** (pass)	**Met** (pass)
Information Security	**Met** (pass)	**Met** (pass)

Encounter Data Management	**Met** (pass)	**Met** (pass)
Eligibility Data Management	**Met** (pass)	**Met** (pass)
Provider Data Management	**Met** (pass)	**Met** (pass)
Performance Measures and Reporting.	**Met** (pass)	**Met** (pass)

3. Validation of Performance Improvement Projects

Table 5-4	Home State Health			Missouri Care		
PIPs	**Aim/Goal**	**Confidence Level**	**HEDIS Rates**	**Aim/Goal**	**Confidence Level**	**HEDIS Rates**
Improving CIS Combo 10	Not Achieved	Low Confidence	27.01%	Not Achieved	Low Confidence	26.52%
Improving Oral Health (ADV)	Not Achieved	Low Confidence	41.63%	Achieved	Low Confidence	48.42%

Both MCOs were given a low confidence level after evaluation of clinical and nonclinical PIPs. The CIS combo 10 rates achieved by Home State Health was 27.01%, which is slightly higher than Missouri Care by 0.49%. On the other hand, the ADV rate achieved by Missouri Care was significantly high by 6.79% point than Home State Health.

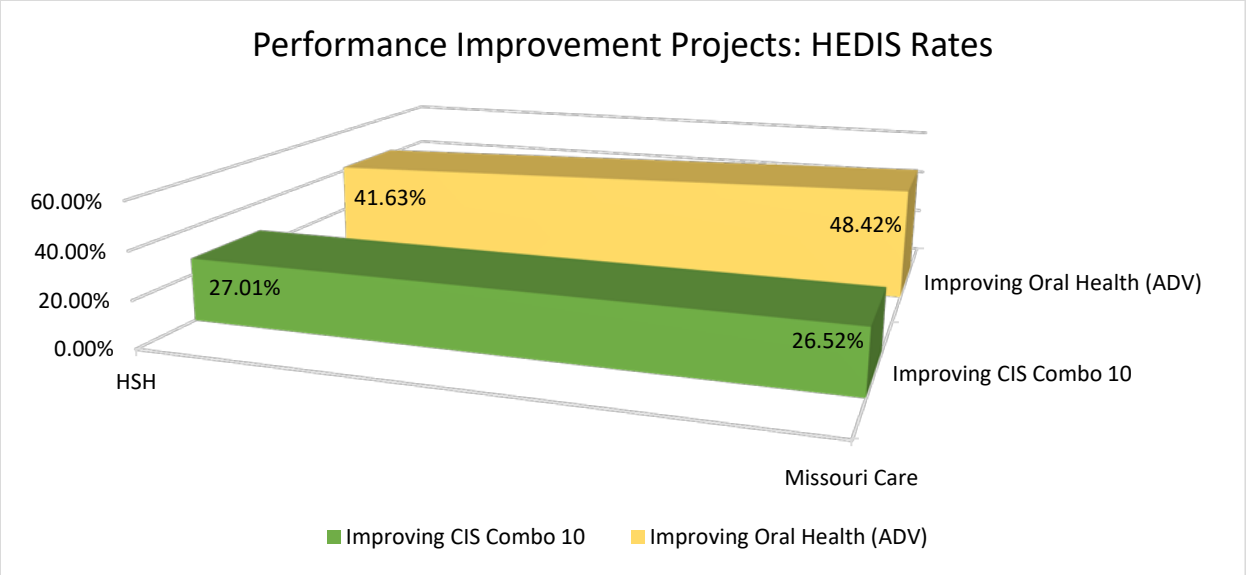

Figure 5-7

4. Care Management Review

Table 5-5 Overall Score for CM MRR for MCOs

CM Program	Home State Health	Missouri Care
OB	86.04%	91.25%
Elevated Blood Lead Levels	75.27%	61.50%
SMI	98.2%	97.3%
Total CM Compliance	**86.3%**	**83.0%**

The overall MRR compliance score for the three CM programs showed that Home State Health was at 86.3% which is 3.3% points greater than Missouri Care. Home State Health was ahead of Missouri Care for both Elevated Blood Levels CM and SMI CM by 13.77% points and 0.9% points respectively. However, for the OB program, Missouri Care (91.25%) was ahead of Home State Health by 5.21% points.

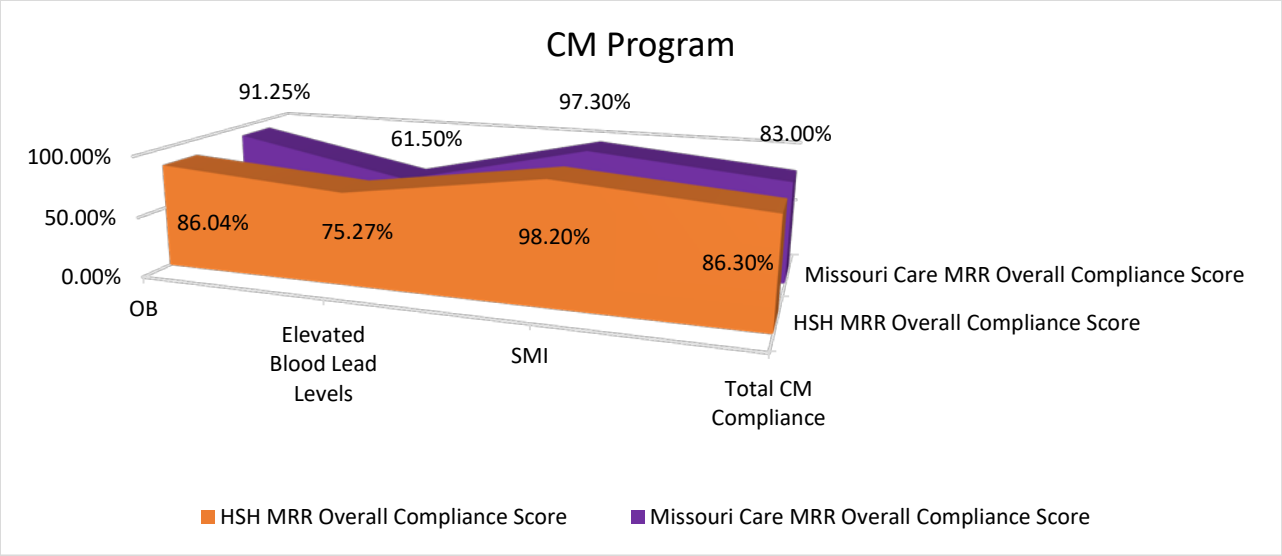
CM Program
91.25%
61.50%
97.30%
83.00%
100.00%
50.00%
0.00%
86.04%
75.27%
98.20%
86.30%
OB
Elevated Blood Lead Levels
SMI
Total CM Compliance
Missouri Care MRR Overall Compliance Score
HSH MRR Overall Compliance Score
HSH MRR Overall Compliance Score
Missouri Care MRR Overall Compliance Score

Figure 5-8

Appendix A: Home State Health PIPs Validation Worksheets

WORKSHEET (A1)

Date of evaluation: July 9, 2018

MCO Name:	Home State Health
Name of Performance Improvement Project:	Improving Childhood Immunization Status (CIS Combo 10)
Dates in Study Period:	Jan 1, 2017- Dec 31, 2017
Demographic Information:	Number of Medicaid/CHIP enrollees in MCO: 271,445 Medicaid/CHIP members included in the study: 5608

Score: **Met (M)** /**Not Met (NM)** / **Partially Met (PM)** /**Not Applicable (N/A)**

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 specific MCO enrollee needs, care, and services?	M	Home State Health developed the topic for this Childhood Immunization PIP using national, regional, and Home State Health's data. The Home State Health provided a thorough review of the literature and current MHD contract requirements to further analyze and support the PIP topic.
1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M	18% of the Home State Health's members were children under the age of two (2). Year-over-year analysis of Home State Health's Combo 10 childhood immunization rates demonstrates that less than 30% of these children have evidence of receiving the required immunizations.

1.3 Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	Home State Health included all members that met the H2018 (CY 2017) HEDIS Technical Specifications for inclusion in the Combo 10 CIS measure. Members with special health needs were not excluded from this PIP.
1.4 Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	M	Home State Health's CIS PIP recognizes that immunizations are a fundamental aspect of childhood care and services, and affirms the importance of preventive services.
1.5 Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	All members who were eligible for immunizations were addressed in this PIP. Consistent with the MHD contract requirement and using the HEDIS Technical Specifications, this PIP was structured to address Home State Health membership under the age of two (2).

Step 2: Review the Study Question(s)

Component/Standard	Score	Comments
2.1 Was/were the study question(s) measurable and stated clearly in writing?	PM	The study question was measurable but not clearly stated. The measurement year, baseline year and the rates for baseline year and goal for measurement year, should be clearly written. The study question was as follows: 'Will directing targeted member and provider health promotion and awareness activities increase the percentage of Home State Health children under age two (2) who

		are immunized by three (3) percentage points between HEDIS 2017 (CY 2016) and HEDIS 2018 (CY 2017)?'

Step 3: Review the Identified Study Populations

Component/Standard	Score	Comments
3.1 Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	All Home State Health members under two (2) years of age, enrolled on Dec 31 of the measurement year (CY 2017), who were continuously enrolled with no more than one gap in enrollment of up to forty-five (45) days during the measurement year were included as denominator.
3.2 If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	The enrollment "allowable gap" criteria was not used for the intervention population. Interventions were applied to all eligible members, under two years of age, at the time of each intervention.

Step 4: Review Selected Study Indicator(s)

Component/Standard	Score	Comments
4.1 Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	HEDIS CIS (Combo 10) rate was the indicator used to assess the outcome of PIP. Administrative and Hybrid data was used to determine annual CIS (combo 10) rate.
4.2 Did the indicators track performance over a specified period of time?	PM	Home State Health stated that the performance for CY 2017 was tracked on a quarterly and annual basis, but not submitted. It should be measured and

		plotted on a run chart to show the impact of interventions.
4.3 Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	PM	HEDIS CIS (combo 10) measure was used to provide an answer to the study question. The purpose of PIP is to determine measurable improvement through interventions and see the impact of each of them on the healthcare services and benefits to the members, which was not measured in this PIP.

Step 5: Review Sampling Methods

Component/Standard	Score	Comments
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 acceptable margin of error?	M	Home State Health utilized a random sample of 411 members for CY 2017, as per 2018 HEDIS Technical Specifications' systematic sampling methodology for the Combo 10 CIS hybrid measure.
5.2 Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	M	Random Sampling as per 2018 HEDIS Technical Specifications was used.
5.4 Did the sample contain a sufficient number of enrollees?	M	411 members

Step 6: Review Data Collection Procedures

Component/Standard	Score	Comments
6.1 Did the study design clearly specify the data to be collected?	M	Home State Health provides a description and explanation of how HEDIS data was obtained and numerators and denominators

		were included as per HEDIS 2018 Technical Specifications.
6.2 Did the study design clearly specify the sources of data?	M	Home State Health defined the sources of data including internally obtained administrative data and year-round medical record retrieval. Home State Health utilizes an independent contractor for hybrid medical record review and evaluation.
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?	M	Home State Health's oversight processes include the utilization of NCQA-certified HEDIS auditors to validate both administrative and hybrid methodology.
6.4 Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	Home State Health uses QSI XL, an NCQA-certified HEDIS software, to analyze claims data to determine compliance with this measure. Also utilizes an NCQA-certified medical record retrieval abstraction vendor to complete the hybrid data process. The annual report of this measure is also audited by an NCQA-certified HEDIS auditor.
6.6 Were qualified staff and personnel used to collect the data?	M	Certified Professionals in HealthCare Quality holding degree in Nursing were involved in the data collection.

Step 7: Review Data Analysis and Interpretation of Study Results

Component/Standard	Score	Comments
7.1 Was an analysis of the findings performed according to the data analysis plan?	M	Home State Health measured success according to the data analysis plan

		evaluating CY 2016 (baseline) and CY 2017 performance for CIS (combo 10) rates.
7.2 Were numerical PIP results and findings accurately and clearly presented?	M	Home State Health displayed results and findings clearly and accurately through tables and graphs, as well as providing a narrative qualitative analysis.
7.3 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?	M	Home State Health utilized chi square statistical significance testing to evaluate performance. Home State Health demonstrated statistically significant increases in the rates of Combo 10 in the Western region between CY 2016 and CY 2017. No threats to external validity exist. Due to the random sampling methodology, no threats to internal validity existed. Results were measured for CIS (combo 10) HEDIS rate annually and compared from previous years.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	M	Home State Health's CIS rates (combo 10) did not increase as expected. The MCO plans to continue the infrastructure interventions, however, Home State Health will assess its more direct, member-facing interventions for effectiveness, and begin focusing on increasing provider involvement, capturing immunization administrations, and validation of data output analysis.

Step 8: Assess Improvement Strategies

Component/Standard	Score	Comments
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	PM	Home State Health provided a narrative explanation about the interventions undertaken to address barriers. However, some of them were ongoing from previous years and others were implemented in later quarters of CY2017. So specific interventions for CY 2017 PIP and their impact could not be measured in the given time frame.
8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	PM	Though Home State Health specifically outlined the root causes/barriers addressed, potential impact, and outcome obtained/anticipated for ongoing interventions, the impact of each intervention could not be measured and the interventions started at different times throughout the year at the State level.
8.3 Are the interventions culturally and linguistically appropriate?	Met	For EPSDT outreach programs, Home State Health adhere to fourth grade level readability standards on all materials and scripts. The EPSDT postcard utilized in the outreach program in particular contains verbiage that directs members to information in their preferred language. In addition, Home State Health contracts with the language interpreter service, Voiance, to provide language translation services to members who call Home State Health.

Step 9: Assess Whether Improvement is "Real" Improvement

Component/Standard	Score	Comments
9.1. Was the same methodology as the baseline measurement used when measurement was repeated?	M	Home State Health utilized the same methodology for member eligibility, data collection, and analysis.
9.2. Was there any documented, quantitative improvement in processes or outcomes of care?	NM	Between H2017 and H2018 (CY 2016 and CY 2017), the statewide CIS Combo 10 rate increased by 2.97 % points which is not statistically significant, and the rates in each individual region increased as well.
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)?	NM	The interventions could not be tied to the improvement. Home State Health did not meet the established goal for this PIP. However, Home State Health experienced Combo 10 CIS rate increases in all regions that could be attributed to the improved access to, collection of, and reporting of non-standard supplemental data.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	NM	The increase in Statewide CIS combo 10 rate is not statistically significant.

Step 10: Assess Sustained Improvement

Component/Standard	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	NM	Home State Health experienced increases in Combo 10 rates statewide and in all regions between CY 2016 and CY 2017. These results could not be attributed to the interventions for CY 2017, specific to this PIP.

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
1.1 Were the initial study findings verified upon repeat measurement?	N/A	

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

Result:
- ☐ High confidence in reported PIP results
- ☐ Confidence in reported PIP results
- ☒ Low confidence in reported PIP results
- ☐ Reported PIP results not credible

Summary:

Between H2017 and H2018 (CY 2016 and CY 2017), the statewide CIS Combo 10 rate increased by 2.97 percentage points which is not statistically significant. The rates in each individual region increased as well. But the aim of the PIP to increase the CIS Combo 10 rate Statewide by 3% point could not be achieved. Multiple interventions were in place from the past years as well as throughout the measurement year. Impact of an intervention could not be evaluated. For these reasons the PIP is assigned a **Low confidence**= (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

WORKSHEET (A2)

Date of evaluation: July 9, 2018

MCO Name or ID:	Home State Health
Name of Performance Improvement Project:	Improving Access to Oral Healthcare
Dates in Study Period:	Jan 1, 2017- Dec 31, 2017
Demographic Information:	Number of Medicaid/CHIP enrollees in MCO: 271,445 Number of Medicaid/CHIP enrollees in Study: 62,979

Score: **Met (M)** 🟢**/Not Met (NM)** 🔴**/ Partially Met (PM)** 🟡**/Not Applicable (N/A)**

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 specific MCO enrollee needs, care, and services?	M 🟢	Home State Health developed the topic for this Oral Health PIP using the Statewide Improving Oral Health Initiative as the basis, analyzed population data pertinent to their membership to enhance the discussion surrounding the importance of and access to annual dental visits.
1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M 🟢	86% of Home State Health's members were children under 20 years of age. Year-over-year analysis of Home State Health's ADV rates demonstrate less than 50% of these children have evidence of having completed an annual dental visit.
1.3 Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M 🟢	All members between 2 and 20 years of age with no evidence of an annual dental visit are provided education and guidance related to the importance of oral health care and the benefits of completing at least one annual dental visit.

		Home State Health included all members that met the H2018 HEDIS technical specifications for inclusion in the ADV measure. Members with special health needs were not excluded from this PIP.
1.4 Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	M	Home State Health's Oral Health PIP is in coordination with the statewide Improving Oral Health Initiative and is focused on increasing the ADV rates and improving deficiencies in oral health care of our members.
1.5 Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	All members eligible for dental care were addressed in the PIP. Consistent with the Statewide Oral Health Initiative, and using the HEDIS Tech Specifications, this PIP was structured to address members ages 2-20.

Step 2: Review the Study Question(s)

Component/Standard	Score	Comments
2.1 Was/were the study question(s) measurable and stated clearly in writing?	PM	The study question was measurable but not clearly stated. The measurement year, baseline year and the rates for baseline year and goal for measurement year, should be clearly written. The study question was as follows: 'Will implementing the proposed interventions to Home State Health members between ages 2 through 20 increase the ADV rate per the HEDIS specifications by 3 percentage points between Home State Health's HEDIS 2017 (H2017) and HEDIS

		2018 (H2018) results?'

Step 3: Review the Identified Study Populations

Component/Standard	Score	Comments
3.1 Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	All Home State Health members ages 2 through 20, enrolled on Dec 31 of the measurement year (CY 2017), who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year were included as denominator.
3.2 If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	The data collection procedures were consistent with the use of HEDIS methodologies.

Step 4: Review Selected Study Indicator(s)

Component/Standard	Score	Comments
4.1 Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	HEDIS ADV rate (Administrative measure) was the indicator used to assess the outcome of PIP.
4.2 Did the indicators track performance over a Specified period of time?	PM	The performance for CY 2017 was tracked on a quarterly and an annual basis as stated by Home State Health, but quarterly data was not submitted. It should be measured and plotted on a run chart to show the impact of interventions on a more frequent basis. The analysis of the effectiveness of telephonic outreach completed by AlphaPointe was

		depicted weekly for the duration of the initiative following the implementation on September 19, 2017.
4.3 Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect Necessary data?	PM	HEDIS ADV rate was the indicator used to answer the study question. No other indicator was used to assess the impact of interventions.

Step 5: Review Sampling Methods

Component/Standard	Score	Comments
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 acceptable margin of error?	N/A	No sampling methods were used in this PIP.
5.2 Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	N/A	Same comment as above.
5.4 Did the sample contain a sufficient number of enrollees?	N/A	Same comment as above.

Step 6: Review Data Collection Procedures

Component/Standard	Score	Comments
6.1 Did the study design clearly specify the data to be collected?	M	The administrative method for collecting HEDIS data from Envolve Dental claims files and ingest that data into the Centene Enterprise Data Warehouse and ultimately, QSI XL is stated in the PIP.

6.2 Did the study design clearly specify the sources of data?	M	The sources of data, its collection is explained. Dental claims data are gathered end loaded into the Centene Enterprise Data Warehouse.
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?	M	Administrative data is used to produce the HEDIS ADV rates.
6.4 Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	Home State Health uses QSI XL, an NCQA-certified HEDIS software, to analyze claims data to determine compliance with this measure. The annual report of this measure is also audited by an NCQA-certified HEDIS auditor.
6.5 Did the study design prospectively specify a data analysis plan?	M	Administrative claims were gathered using the American Dental Association's (ADA) Current Dental Terminology (CDT) and the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes as well as non-claims administrative data. Envolve Dental sends Centene Corporation claims files for Home State Health members on a monthly basis. These supplemental data files are loaded into Centene's Enterprise Data Warehouse (EDW).
6.6 Were qualified staff and personnel used to collect the data?	M	Certified Professionals in HealthCare Quality holding degree in Nursing were involved in the data collection.

Step 7: Review Data Analysis and Interpretation of Study Results

Component/Standard	Score	Comments
7.1 Was an analysis of the findings performed according to the data analysis plan?	M	Home State Health completed analysis of the study outcomes as per their submission of data analysis plan.
7.2 Were numerical PIP results and findings accurately and clearly presented?	M	Tables and Figures represent the results of the AlphaPointe outreach as well as year over year HEDIS rates focusing on H2017 compared to H2018.
7.3 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?	M	Home State Health utilized chi square statistical significance testing to evaluate performance There were no threats to either internal or external validity. Results were measured for HEDIS ADV rates annually and compared from previous years. Repeat measurements at regular intervals were not submitted.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	M	From analysis of the raw HEDIS ADV data, Home State Health's ADV rates did not increase as expected. The potential reasons have been explained in the narrative submitted by Home State Health.

Step 8: Assess Improvement Strategies

Component/Standard	Score	Comments

8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	PM	Home State Health provided a narrative explanation about the interventions undertaken to address barriers. However, some of them were ongoing from previous years and others were implemented in later quarters of CY2017. Specific interventions for CY 2017 PIP and their impact could not be measured in the given time frame.
8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	PM	Though Home State Health specifically outlined the root causes/barriers addressed, potential impact, and outcome obtained/anticipated for ongoing interventions, the impact of each intervention could not be measured and the interventions started at different times throughout the year at the State level.
8.3 Are the interventions culturally and linguistically appropriate?	M	Home State Health employees are provided training on cultural sensitivity and member experience. The success of Home State Health's mission of "Transforming the health of the community one person at a time" hinges on our being culturally aware in our verbal and written member communications.

Step 9: Assess Whether Improvement is "Real" Improvement

Component/Standard	Score	Comments
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	M	The study used administrative methodology from the HEDIS Technical Specifications for both the baseline and repeat measurements.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	M	Between H2017 and H2018, Home State Health's statewide ADV rate increased 1.72 percentage points, and the rate in each individual region increased as well. Chi-square testing revealed that the increases statewide and in the Eastern region between H2017 and H2018 – were both statistically significant.
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)?	NM	Based on the increase in ADV rates in the statewide as well as 3 regional rates, it appears the increased compliance performance reported is valid. However, It is not clear that the percentage point increases are directly related to the planned quality improvement interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	M	Chi-square testing, revealed that the increase in statewide and in the Eastern region between H2017 and H2018 – were both statistically significant.

Step 10: Assess Sustained Improvement

Component/Standard	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	NM	Despite decreases in ADV rates the previous two years, Home State Health experienced an increase in ADV between H2017 and H2018. Home State Health has committed to a number of long term projects designed to empower providers with the ability to identify

		non-compliant members and to conduct assessments, treatments and referral of members with oral health problems. Home State Health has also promoted long-term plans for members to develop a dental home, receive electronic communication regarding oral health, receive fluoride varnish, and increase choices for dental access.

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
1.1 Were the initial study findings verified upon repeat measurement?	N/A	

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

Result:

- ☐ High confidence in reported PIP results
- ☐ Confidence in reported PIP results
- ■ Low confidence in reported PIP results
- ☐ Reported PIP results not credible

Summary

Between H2017 and H2018 (CY 2016 and CY 2017), the statewide ADV rate increased by 1.72 % points which is statistically significant, and the rates in each individual region increased as well. But the aim of the PIP to increase by 3% point could not be achieved. Multiple interventions were in place from the past years as well as throughout the measurement year. Impact of an intervention could not be evaluated. For these reasons the PIP is assigned a **Low confidence**= (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Appendix B: Missouri Care PIPs Validation Worksheets

WORKSHEET (B1)

Date of evaluation: July 16, 2018

MCO Name or ID:	Missouri Care
Name of Performance Improvement Project:	Childhood Immunization Status- Combo 10 (CIS)
Dates in Study Period:	Jan 1, 2017-Dec 31, 2017
Demographic Information	Number of Medicaid/CHIP enrollees in MCO: 284,395 Medicaid/CHIP members included in the study: 3645

Score: **Met (M)** 🟢**/Not Met (NM)** 🔴**/ Partially Met (PM)** 🟡**/Not Applicable (N/A)**

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 specific MCO enrollee needs, care, and services?	M🟢	Missouri Care developed the topic for this Childhood Immunization PIP using national, regional, and Missouri Care's data. The MCO provided a thorough review of the literature and current MHD contract requirements to further analyze and support the PIP topic.
1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M🟢	Missouri Care has noted that its members have a low compliancy rate for CIS Combo 10, well below NCQA's 50th Percentile benchmarks.

1.3 Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	The PIP considers all enrollees 2 years of age including, but not limited to members with special needs and physical or behavioral health conditions.
1.4 Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	M	Missouri Care states that by increasing the number of children receiving recommended immunizations, children's overall health should improve by protecting from deadly and debilitating diseases.
1.5 Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	All members who were eligible for immunizations were addressed in this PIP. Consistent with the MHD contract requirement and using the HEDIS Technical Specifications, this PIP was structured to address Missouri Care membership under the age of two (2).

Step 2: Review the Study Question(s)

Component/Standard	Score	Comments
2.1 Was/were the study question(s) measurable and stated clearly in writing?	PM	The study question was measurable but not clearly stated. The measurement year, baseline year and the rates for baseline year and goal for measurement year, should be clearly written. The study question was as follows: "Will providing the proposed list of interventions to eligible members increase the number of children receiving Combo-10 (as defined below) by 3% for the measurement year by their 2nd birthday?"

Step 3: Review the Identified Study Populations

Component/Standard	Score	Comments
3.1 Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	The study population includes all Missouri Care members 2 years of age in the measurement year who had no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
3.2 If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	Based on the current HEDIS Technical Specification applicable for the measurement year, all enrollees who received the recommended vaccinations on or before their second birthday were included.

Step 4: Review Selected Study Indicator(s)

Component/Standard	Score	Comments
4.1 Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	HEDIS CIS (Combo 10) rate was the indicator used to assess the outcome of PIP. Administrative and Hybrid data was used to determine annual CIS (combo 10) rate.
4.2 Did the indicators track performance over a specified period of time?	M	The ADV rates were tracked on a quarterly basis.
4.3 Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	PM	HEDIS CIS (combo 10) measure was used to provide an answer to the study question. The purpose of PIP is to determine measurable improvement through interventions and see the impact of each of them on the healthcare services and benefits

		to the members, which was not measured in this PIP.

Step 5: Review Sampling Methods

Component/Standard	Score	Comments
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 acceptable margin of error?	N/A	The entire population is measured from an administrative standpoint and Hybrid rates are calculated using HEDIS Technical Specifications and NCQA-certified measure software.
5.2 Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	N/A	Same as above
5.4 Did the sample contain a sufficient number of enrollees?	N/A	Same as above

Step 6: Review Data Collection Procedures

Component/Standard	Score	Comments
6.1 Did the study design clearly specify the data to be collected?	M	Missouri Care provided a description and explanation of how HEDIS data was obtained and numerators and denominators were included as per HEDIS Technical Specifications.
6.2 Did the study design clearly specify the sources of data?	M	Sources of data used in this study included claims-based software and NCQA Certified Measures vendor (Inovalon) to calculate HEDIS CIS-Combo 10 rate. CHANGE

		Health vendor was utilized for medical record review.
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?	M	Claims data for the study were queried from the claims-based software and put into NCQA-certified software. Inovalon uses the HEDIS Technical Specifications to calculate the CIS rate.
6.4 Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	Missouri Care used NCQA Certified Measures vendor (Inovalon) and CHANGE Health vendor for medical record review. Numerator hits were abstracted and tracked by CHANGE Health using Inovalon's Quality Spectrum Hybrid Reporter (QSHR) software.
6.5 Did the study design prospectively specify a data analysis plan?	M	The information for the data came from claims/encounter data and medical record review, which is where the HEDIS data is obtained. The HEDIS CIS-Combo 10 rate is calculated using NCQA certified measure vendor (Inovalon).
6.6 Were qualified staff and personnel used to collect the data?	M	Quality improvement specialists and Nurses under the direction of Medical Director was involved in this PIP.

Step 7: Review Data Analysis and Interpretation of Study Results

Component/Standard	Score	Comments
7.1 Was an analysis of the findings performed according to the data analysis plan?	M	Information from claims/encounter data and medical record review, was calculated using NCQA Certified Measures Software.

7.2 Were numerical PIP results and findings accurately and clearly presented?	M	The results were provided region wise and aggregate Statewide accurately through tables and graphs, along with a narrative of qualitative analysis.
7.3 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?	M	There are no factors that influenced comparability of initial and repeat measurements or threatened internal and external validity of data.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	M	Though the aim of the PIP was not met, Missouri Care attributed the success to their ongoing interventions started for last several years. They stated the future opportunities for further improvement.

Step 8: Assess Improvement Strategies

Component/Standard	Score	Comments
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	M	Missouri Care has a cross-functional HEDIS workgroup with representation from a wide variety of disciplines and service areas. The workgroup brainstorms, analyzes HEDIS data, and works to identify root causes for gaps in care. Through this active workgroup, barriers and interventions are continuously evaluated in an effort to sustain ongoing improvement in HEDIS rates for the members.

8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	PM	Though Missouri Care specifically outlined the barriers and addressed them in their ongoing interventions, the impact of each intervention could not be measured and the interventions started at different times throughout the year at the State level.
8.3 Are the interventions culturally and linguistically appropriate?	Met	To ensure interventions meet and support members cultural and linguistic needs, Missouri Care's offers 6th grade reading level and language translation option available on all member materials/calls.

Step 9: Assess Whether Improvement is "Real" Improvement

Component/Standard	Score	Comments
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	Met	The methodology of the source for data analysis, members examined and tools used have remained the same since HEDIS 2015 baseline year.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	NM	The State aggregate CIS rate increased by 0.13% points or 0.4% from CY 2016. The aim of PIP to get a 3% increase is not met. There is no statistical significance of this increase.
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)?	NM	The interventions could not be tied to the improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	NM	The increase in Statewide CIS combo 10 rate is not statistically significant.

Step 10: Assess Sustained Improvement

Component/Standard	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	NM	No sustained improvement seen

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
1.1 Were the initial study findings verified upon repeat measurement?	N/A	

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

Result:

- ☐ **High confidence in reported PIP results**
- ☐ **Confidence in reported PIP results**
- ■ **Low confidence in reported PIP results**
- ☐ **Reported PIP results not credible**

Summary

Between H2017 and H2018 (CY 2016 and CY 2017), the statewide CIS Combo 10 rate increased by 0.13 percentage points or 0.4% which is not statistically significant. The aim of the PIP to increase the CIS Combo 10 rate Statewide by 3% point could not be achieved. Multiple interventions were in place from the past years as well as throughout the measurement year. Impact of an intervention could not be evaluated. For these reasons the PIP is assigned a **Low confidence**= (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

WORKSHEET (B2)

Date of evaluation: July 16, 2018

MCO Name or ID:	Missouri Care
Name of Performance Improvement Project:	Improving Oral Health
Dates in Study Period:	Jan 1, 2017-Dec 31, 2017
Demographic Information	Number of Medicaid/CHIP enrollees in MCO: 284,395 Medicaid/CHIP members included in the study: 62,893

Score: **Met (M)** 🟢**/Not Met (NM)** 🔴**/ Partially Met (PM)** 🟡**/Not Applicable (N/A)**

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 specific MCO enrollee needs, care, and services?	M 🟢	Evaluation of the most current 2018 HEDIS ADV rate, showed that less than 50% of Missouri Care's eligible members received an annual dental visit. Additionally, the Statewide Improving Oral Health Initiative was taken as basis of this PIP.
1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M 🟢	The HEDIS ADV measure evaluates members 2–20 years of age who had at least one dental visit during the measurement year. This is consistent with the demographics and epidemiological needs of Missouri Care's population, which primarily includes children and pregnant women and is a covered benefit as part of Missouri Care's Medicaid contract.

1.3 Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	The PIP includes all enrollees from 2-20 years of age including, but not limited to members with special needs and physical or behavioral health conditions.
1.4 Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	M	Missouri Care states that by members receiving a preventive annual dental visit, it can improve members' overall oral health by reducing chronic or acute oral health conditions.
1.5 Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	Same as 1.3

Step 2: Review the Study Question(s)

Component/Standard	Score	Comments
2.1 Was/were the study question(s) measurable and stated clearly in writing?	PM	The study question was measurable but not clearly stated. The measurement year, baseline year and the rates for baseline year and goal for measurement year, should be clearly written. The study question was as follows: "Will providing the proposed list of interventions to eligible members from the ages of two (2) through twenty (20) years old increase the number of children who receive an annual dental visit by 3% for the measurement year?"

Step 3: Review the Identified Study Populations

Component/Standard	Score	Comments
3.1 Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	The study population included Missouri Care members 2 through 20 years of age who had at least 1 dental visit during the measurement year and are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.
3.2 If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	The data collection procedures were consistent with the use of HEDIS methodologies.

Step 4: Review Selected Study Indicator(s)

Component/Standard	Score	Comments
4.1 Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	HEDIS ADV rate (Administrative measure) was the indicator used to assess the outcome of PIP
4.2 Did the indicators track performance over a specified period of time?	PM	The performance for CY 2017 was tracked on a quarterly and annual basis. It should be measured and plotted on a run chart to show the impact of interventions on a more frequent basis.
4.3 Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	PM	HEDIS ADV rate was the indicator used to answer the study question. No other indicator was used to assess the impact of interventions.

Step 5: Review Sampling Methods

Component/Standard	Score	Comments
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 acceptable margin of error?	N/A	No sampling methods were used in this PIP.
5.2 Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	N/A	Same comment as above.
5.4 Did the sample contain a sufficient number of enrollees?	N/A	Same comment as above.

Step 6: Review Data Collection Procedures

Component/Standard	Score	Comments
6.1 Did the study design clearly specify the data to be collected?	M	Study Indicator data pulled from the HEDIS ADV rate captures: *Denominator:* Members 2 through 20 years of age who are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days. *Numerator:* Members 2 through 20 years of age identified as having one or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any relevant code as per HEDIS Dental Value Set.

6.2 Did the study design clearly specify the sources of data?	M	Sources of data used in this study includes claims-based software and NCQA Certified Software (Inovalon) to calculate the HEDIS ADV rate.
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?	M	Administrative data is used to produce the HEDIS ADV rates.
6.4 Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	As part of its systematic method of collecting valid and reliable data, claims data for the study were queried from claims-based software and put into NCQA-certified software (Inovalon). Inovalon follows HEDIS Technical Specifications to calculate the ADV rate.
6.5 Did the study design prospectively specify a data analysis plan?	M	The Plan evaluated the success of the project by demonstrating an improvement in Missouri Care members' oral health outcomes through education and on-going interventions, as evidenced by at least a 3% increase in the HEDIS ADV rate.
6.6 Were qualified staff and personnel used to collect the data?	M	Quality improvement specialists and Nurses under the direction of Medical Director was involved in this PIP.

Step 7: Review Data Analysis and Interpretation of Study Results

Component/Standard	Score	Comments
7.1 Was an analysis of the findings performed according to the data analysis plan?	M	Information from claims/encounter data and was calculated using NCQA Certified Measures Software as per the plan.
7.2 Were numerical PIP results and findings accurately and clearly presented?	M	The results were provided region wise and aggregate Statewide accurately through tables and graphs, along with a narrative of qualitative analysis.
7.3 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?	M	There are no factors that influenced comparability of initial and repeat measurements or threatened internal and external validity of data.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	M	The aim of the PIP was met. Missouri Care attributed the success to their ongoing interventions started for last several years. They stated the future opportunities for further improvement.

Step 8: Assess Improvement Strategies

Component/Standard	Score	Comments
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	PM	Missouri Care has a cross-functional HEDIS workgroup with representation from a wide variety of disciplines and service areas. The workgroup brainstorms, analyzes HEDIS data, and works to identify root causes for gaps in care, but specific interventions for CY 2017

		PIP and their impact could not be measured in the given time frame.
8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	PM	Though Missouri Care specifically outlined the barriers and addressed them in their ongoing interventions, the impact of each intervention could not be measured and the interventions started at different times throughout the year at the State level.
8.3 Are the interventions culturally and linguistically appropriate?	M	To ensure interventions meet and support members cultural and linguistic needs, Missouri Care's offers 6th grade reading level and language translation option available on all member materials/calls.

Step 9: Assess Whether Improvement is "Real" Improvement

Component/Standard	Score	Comments
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	M	The methodology of the source for data analysis, members examined and tools used have remained the same since HEDIS 2015 baseline year.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	M	The HEDIS 2018 ADV results show statistical significant improvements in Central, East, West, and Aggregate population.

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)?	NM	The interventions could not be tied to the improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	M	Same comment as 9.2

Step 10: Assess Sustained Improvement

Component/Standard	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	NM	No statistically significant sustained improvement seen.

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
1.0 Were the initial study findings verified upon repeat measurement?	N/A	

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

Result:

- ☐ **High confidence in reported PIP results**
- ☐ **Confidence in reported PIP results**
- ■ **Low confidence in reported PIP results**
- ☐ **Reported PIP results not credible**

Summary

Between H2017 and H2018 (CY 2016 and CY 2017), the statewide ADV rate increased by 1.45% points

or 3% which is statistically significant. The aim of the PIP to increase the ADV rate Statewide by 3% could be achieved. Multiple interventions were in place from the past years as well as throughout the measurement year. Impact of an intervention could not be evaluated. The aim set for the PIP is too low and does not meet the CMS goal for Oral Health as listed in MHD contract. For these reasons the PIP is assigned a **Low confidence**= (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.