Quality Improvement Strategy - 2018

State of Missouri

MO HealthNet Division

Prepared by

The Missouri Department of Social Services

MO HealthNet Division (Missouri Medicaid)

July 2018

History of Medicaid and Managed Care

The Medicaid Program, authorized by federal legislation in 1965, provides health care access to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children. Since that time, legislative options and mandates have expanded the categories of eligibility to include Medicaid coverage for children and pregnant women in poverty, refugees, and children in state care. The Missouri Medicaid program is jointly financed by the federal government and Missouri State Government, and is administered by the State of Missouri. The agency charged with administration of the Medicaid program is the MO HealthNet Division (MHD), a division within the Department of Social Services.

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. Effective May 1, 2017, Managed Care is operated statewide in Missouri. Previously, Managed Care was only available in certain regions https://dss.mo.gov/mhd/mc/pdf/geographic-expansion-mohealthnet-managed-care.pdf. For additional background on the operation of Managed Care in Missouri, please visit https://dss.mo.gov/mhd/mc/pages/overview.htm. The Fee-for-Service Program serves the aged, blind, and disabled population.

MO HealthNet Waiver Programs

In 1981, Congress enacted Section 2176 of Public Law 97-35 of the Social Security Act, entitled the Omnibus Budget Reconciliation Act. Through this enactment, certain statutory limitations have been waived in order to provide states who have received approval from the Department of Health and Human Services with the opportunity for innovation in delivering home and community based services to eligible persons who would otherwise require institutionalization in a nursing facility, hospital or intermediate care facility for the developmentally disabled (ICF/DD). Approved Missouri waivers to provide services are listed at the following webpage: https://dss.mo.gov/mhd/waivers/.

Children's Health Insurance Program (CHIP)

Missouri's Children's Health Insurance Program (CHIP) was a Medicaid expansion implemented on September 1, 1998 through a waiver under Section 1115 of the Social Security Act and a Title XXI Plan that covered children under the age of 19 in families with a gross income of 300 percent of the Federal poverty level (FPL). Currently, coverage is provided statewide through the Managed Care delivery system. Uninsured women losing their MHD eligibility sixty (60) days after the birth of their child are ~~were~~ covered for women's health services for an additional year, regardless of their income level. This population receives services through the MHD Fee-For-Service Program.

Show-Me Healthy Babies

Starting on January 1, 2016, Missouri added coverage to the state's separate CHIP to include pregnant women and unborn children from conception to birth. Eligible women have a household income up to 300% of the FPL when the mother is not eligible for Medicaid, CHIP or affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. Targeted women and unborn children receive a benefit package of essential, medically necessary health services identical to the MO HealthNet for Pregnant Women benefit package. The purpose is to provide pregnant women with access to prenatal care and an opportunity to connect individuals to longer-term coverage options.

Anticipated Benefits of the Managed Care Program

The goal of the Managed Care program is to furnish high quality health care services resulting in measurable improvements in population health to members while providing the State with significant cost efficiencies. The State recognizes that the keys to a successful Managed Care Program include the provision of effective high quality services, the satisfaction of members, and the involvement of stakeholders. Managed Care is an opportunity to deliver high quality, patient-centered evidence-based care in a way that also stabilizes costs and gains budget predictability by making payments on a predetermined, per-member-per-month basis while establishing specific expectations for quality outcomes. It also provides a more accountable, coordinated system of care for beneficiaries, with an emphasis on preventive and primary care services in addition to chronic disease services. Specifically, Managed Care provides:

- Integrated Care - Care coordination is a fundamental underlying principle of managed care. Care management focuses on enhancing and coordinating a member's care across an episode or continuum of care; obtaining and coordinating services and resources needed by members and their 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 impact; and creating opportunities and systems to enhance outcomes. Thus, Managed Care Organization (MCO) care managers emphasize health promotion through preventive care such as screenings, vaccinations, and evaluation of the home environment. Comprehensive transitional care includes follow-up from inpatient and other settings. When needed, referrals to community and support services are made. The care management requirements include qualifications for care managers, frequency of contact with beneficiaries, screening and preventative services, and outcome standards.

- Quality - MCOs are held to rigid quality metrics and performance measurements. Missouri 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) evaluated MCOs annually, as well.

- Access - One of the benefits of utilizing managed care is the requirement that each MCO provides members with access to health care services. MCOs are required to ensure that their provider networks consist of the right types and sufficient numbers of providers and specialists for their members. There are strict network adequacy standards that ensure all members have access to care, including specialty care that they need.

- Cost-Savings - MCOs place emphasis on preventive care services, and ensure coordination of care across the healthcare spectrum through an effectively managed provider network, allowing MCOs to provide cost-saving measures for MO HealthNet beneficiaries without compromising quality or access.

Overview of Managed Care Quality Management Structure

Under Managed Care, oversight responsibility is shared among the State, the MCOs, and their providers. The State has direct oversight of its contracted MCOs and establishes payment rates for these entities as well as the parameters governing the amount, duration, and scope of benefits covered in these contracts. The MCOs establish standards dictated by the State for medical care, prior authorizations, and initial referral policies, determine payment methods, and rates for MCO providers.

The focus of administrative activities such as member grievances and provider appeals shifts from direct contact with the State to customer service and provider relations divisions within the MCO. The MCOs are accountable for improving the well-being of the members. Customer service and care management functions provided by the MCO contribute to improved member involvement and better health outcomes and provide an opportunity to improve the quality of care being furnished.

The Quality Assessment & Improvement (QA&I) Advisory Group was created with the inception of Managed Care. The purpose of the QA&I Advisory Group is to impact service utilization and quality through collaborative monitoring and continuous quality improvement activities. The QA&I Advisory Group and its task forces assist in maintaining an open forum for collaboration and communication among MCOs, other stakeholders (e.g., advocates, consumers, and providers), and state agencies (the Departments of Mental Health; Social Services; Insurance, Financial Institutions, and Professional Registration; Elementary and Secondary Education; and Health and Senior Services). The QA&I Advisory Group meets at least twice annually.

The QA&I Advisory Group designate task forces as necessary to work on specific performance improvement initiatives. The initiative activities may include, but are not limited to, identification of indicators, trends, evaluation of outcomes, and development of recommendations for intervention strategies. The task forces exist for a specific designated period and are terminated when the desired outcome is reached. Reports of task force meetings, actions and outcomes are regularly presented to the QA&I Advisory Group. Task force members include MCO quality staff, other stakeholders, and state agency staff.

The QA&I Advisory Group task forces that have been convened include, but are not limited to: Maternal Child Health, Dental, Behavioral Health, and EQRO. The task force leader/facilitator works directly with and is accountable to the chair of the QA&I Advisory Group. The chair of the QA&I Advisory Group works directly with state agency staff.

Development, Review, and Revisions

Missouri's Quality Improvement Strategy (QIS) 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. This comprehensive plan incorporates the processes of monitoring, assessment, and improvement.

The QIS is developed through collaborative partnerships with members, stakeholders, other state agencies, MCOs, and community groups. This process is undertaken to ensure that:

- Quality health care services are provided to Managed Care members;
- Established benchmarks 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.

Development of the QIS is a multi-step process. A review of the prior QIS is conducted, and findings are discussed among MHD administrative, program, and quality staff. Input is solicited from key stakeholders, and all this information is considered when planning modifications to the QIS. After undergoing Departmental review, a draft is distributed to key stakeholders and the public for comment. The 2018 QIS will be posted to the MHD website marked "draft" and will not be marked "final" until CMS communicates with the MHD that their review is complete.

The QIS will be reviewed at least annually. The Missouri EQRO will conduct a systematic review of progress made toward identified goals, objectives, and measures. The added benefit of having the EQRO's contribution to this review is they can provide technical assistance and recommendations based on their expertise in the quality arena. The MHD will also assess progress made at the individual plan level and for Managed Care as a whole.

There are two categories of data used for these systematic reviews. First are the primary data sources that align with our established measures such as findings from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Reviews will also utilize data from the annual "Secret Shopper Survey", conducted by the EQRO. Network adequacy is assessed by the MHD's analysis of network access plans submitted by the MCOs annually. A number of measures that assess the cost effectiveness of healthcare services are provided to the MHD via a partnership with another cabinet-level agency, the Department of Health and Senior Services (DHSS).

The MHD has a structure to review other data regularly reported by the MCOs on items such as member complaints and appeals, care management, disease management, provider complaints and grievances, and prior authorizations. These data are important to view along with the primary data sources because they are often reported quarterly, which provides an opportunity to monitor trends, gaps, and successes on an ongoing basis. These supporting data can also contribute to the annual evaluation.

Results of these annual evaluations are reviewed and discussed with the MCOs and stakeholders at QA&I and other meetings where quality and outcomes are discussed. The QA&I and other meetings can be used to discuss the root causes of why each strategy and intervention is or is not effective. The public is invited to participate in these discussions at the QA&I meetings.

Results will be used internally to guide program planning and development. This may lead to changes in proposed activities and interventions, methods of analysis, or revision of the measures themselves. The MHD may also enlist the EQRO to provide technical assistance to one or more MCOs related to their performance.

The QIS will be revised at least every three years, as required by CMS. Significant changes to the operation or scope of MHD's Managed Care Program (defined as anything that impacts quality operations) will also result in a revision of the QIS. An example would be changes in carve-in or carve-out services or changes to models of care.

Evaluation of the 2013 QIS

The previous QIS, titled "State of Missouri MO HealthNet Quality Improvement Strategy – 2013" can be found at https://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/quality-improvement-strategy.pdf. A formal evaluation of the 2013 QIS is found in "Evaluation of the 2013 State of Missouri, MO HealthNet Quality Improvement Strategy". This document is a systematic evaluation of MCO progress toward meeting goals and objectives outlined in the 2013 QIS.

In creating the evaluation of the 2013 QIS, we found that the measures originally selected demonstrated three basic trends: approximately one-quarter of the measures met specific performance goals; approximately one-half of measures fluctuated, with improvements seen in some years but not all; and the last one-quarter of measures showed decreased performance across all three years of the review period.

We determined that the sheer number of measures diluted potential gains that could be achieved. It was difficult for MHD and the MCOs to successfully monitor, develop interventions, and focus on all of the disparate measures in the 2013 QIS. We therefore decided to reduce the number of measures in the new QIS, and our new 2018 QIS has been pared down to 29 measures, from 40 individual measures in the 2013 QIS. We eliminated

measures that were repetitive and addressed similar topics across different goals, and retained or enhanced measures that were helpful and still aligned with 2018 goals. The result is a more streamlined and representative plan for the next three years.

MHD is completing additional review to determine variables in reporting through review of national benchmarks and performance of MCOs throughout the country. It is necessary to review the landscape of provider requirements throughout Missouri in comparison with other states to assist with placing the outcomes in a broader perspective.

2018 QIS Goals, Objectives and Measures

The MO HealthNet 2018 QIS is designed to communicate, assess, and evaluate the Managed Care Program's progress toward meeting its goals, objectives, and target measures. This is intended as a roadmap for the Managed Care Program as a whole, with the understanding that individual MCO performance may vary from year to year for each measure. The QIS provides a framework to address access to care, wellness and prevention, outcomes, cost-effective utilization of services, and customer satisfaction. All of this is intended to support the Department's mission.

Mission Statement

The Mission of the Missouri Department of Social Services is to lead the nation in building the capacity of individuals, families, and communities to secure and sustain healthy, safe, and productive lives.

The 2018 QIS is divided into four goals. Included within each one of these goals are objectives and specific metrics that will be used to measure progress on a yearly and longer-term basis. The target for all measures outlined in Appendix 1 is to improve by two percentage points each year in order to achieve a six-percentage point improvement in three years. Alternatively, where national benchmarks are available, the target is for the measure to reach or exceed the national median when possible. Please refer to Appendix 1 for the full QIS Table of goals, objectives, and measures.

The 2018 QIS objectives were developed to connect the four main goals to the list of measures that were pared down and enhanced after reviewing the 2013 QIS. The measures also align with the HEDIS measures that will be incorporated into the Performance Withhold Program on July 1, 2019. Two of these HEDIS measures (timeliness of prenatal care and adequacy of postpartum care) are also Performance Measures evaluated by the EQRO each year, providing an extra layer of monitoring and assessment.

Activities

The following is a discussion of several activities that occur 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 2018 QIS. For each measure, it may take several different interventions and activities working together to drive change. Development, implementation, and assessment must occur along the way to ensure planned and novel strategies are effective in creating meaningful change. In addition to the 2018 QIS, which is a blueprint for the Managed Care Program as a whole, each health plan is required to implement a Quality Assessment and Improvement Strategy. According to the Managed Care contract, this includes components to monitor, evaluate, and implement the contract standards and processes to improve quality in thirteen different areas. These areas include quality management, care management, access and availability, and data collection, analysis, and reporting.

Performance Improvement Projects

Each health plan must conduct Performance Improvement Projects (PIPs) aimed at improving clinical and nonclinical care of their members. The state agency requires that the MCOs measure performance using objective quality indicators (typically, they use HEDIS measures), implement interventions designed to achieve improvement in quality, evaluate the effectiveness of their interventions, and make plans to sustain or increase improvement over time. PIPs are typically aimed at showing improvement within each contract year.

The MCOs are all required to participate in two statewide PIPs that have been selected by the 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 https://www.medicaid.gov/medicaid/benefits/dental/index.html.
- Improving the rate of immunizations for members by their second birthday.

Accreditation

The MHD requires the MCOs to obtain and maintain accreditation from NCQA. The accreditation status of the three current MCOs is included in the table below. Home State Health and Missouri Care have been MO HealthNet MCOs for several years and have achieved accreditation. United Healthcare is new to the 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".

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
United Healthcare	Interim	6/19/2019

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

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 and include topics such as increasing immunization rates, chronic disease prevention and management, and oral health promotion. Many of these topic areas also align with objectives and measures included in the 2018 QIS. 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.

External Quality Reviews

Primaris Holdings, Inc. is the MHD's current EQRO, and started their five-year contract in January 2018. The EQRO performs all federally mandated activities, as well as optional activities requested by MHD, such as the annual Secret Shopper Survey. Their findings and recommendations are presented at an annual conference with MCO administrative and clinical management staff, at the QA&I meetings, and in a written Annual Report. Previous EQR reports are available on the Department of Social Services, MO HealthNet Division website: http://dss.mo.gov/mhd/mc/pages/eqro.htm.

Care Management

1. The care management requirements are comprehensive and have evolved over time as newer data from MHD program evaluations have emerged to inform these requirements. Part of that evolution is the incorporation of the principles used in the MHD Section 2703 Health Home Program (see below). In addition to incorporating those principles, within the Managed Care contract, MCOs are historically required to assess members for care management within a specified number of days after enrollment or diagnosis with specific conditions and/or risk factors. Care management is 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. MCOs are required to report this activity on a care management log each quarter. For chronic diseases like diabetes and asthma, risk factors like smoking and obesity, and special healthcare needs, the required timeframe for offering case management is thirty calendar days.

   Special populations require more intensive care management. MCOs shall offer care management within fifteen business days of notification of pregnancy. Children with elevated blood lead levels shall be assessed for care management within these timeframes, depending on the degree of elevation:

   - 10 to 19 micrograms per deciliter (ug/dL) within one to three business days
   - 20 to 44 ug/dL within one to two business days
   - 45 to 69 ug/dL within twenty-four hours
   - 70 ug/dL or greater – immediately

   MHD recognizes that these lead levels are behind those endorsed by the CDC and is planning to move towards those national guidelines. The DHSS is currently working on a state statute that will align with national guidelines.

   Care management for pregnancy and for children with elevated blood lead levels younger than the age of six are included in the current Performance Withhold Program. This allows the MHD to emphasize the importance of timely case management for these critically important conditions.

2. In addition, MCOs are required to ensure collaboration with the MHD Section 2703 Health Homes Program for their members. MO HealthNet'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 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
- Support primary care practices by increasing available resources and improving care coordination thus improving the quality of clinician work life and patient outcomes

The PCHH initiative offers comprehensive care management services for Medicaid participants 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. 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.

Individuals covered by MO HealthNet are eligible to be served by a CMHC Health Home if they have:

- A serious mental illness (including children and adults receiving psychiatric rehabilitation services under the Medicaid Rehabilitation Option), or
- A mental health condition and a substance abuse disorder, or
- A mental health condition or a substance abuse disorder, and one of the following chronic conditions or risk factors: diabetes, asthma, COPD, cardiovascular disease, developmental disability, overweight, and/or tobacco use.

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.

The MHD has required all MCOs to participate in this initiative since January 2018. The MCOs will be collaborating with the 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. This may include activities such as attending meetings and engaging with existing projects.

The Show Me ECHO projects selected for MCO participation align with MHD concerns and priorities. These include 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 the MHD to promote Show-Me ECHO to the health care providers in Missouri, focusing on 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. First are member incentive programs that encourage personal responsibility related to health behaviors and outcomes. The second are provider incentive programs. Provider incentive programs involve financial rewards for achieving established goals such as reaching a target number of qualifying patient visits or other quality benchmarks. The third is the 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 the Division and its programs. LCCCPs have the following components:

- Every member has a PCP
- Care is provided by a physician-directed team that collectively cares for the member
- Care is coordinated across all aspects of health care
- Member Care Management includes care coordination, health promotion, transitional care, individual and family support activities, disease management, and referrals to local social support resources.

Performance Withhold Program

A performance withhold program was started with the MCOs in 2015 to improve performance on selected metrics. Specifically, the program addresses five categories of performance indicators, with individual measures that focus on:

- Encounter data completeness/accuracy
- Provider panel directory completeness/accuracy
- EPSDT screenings
- Case management for pregnant women and children with elevated lead levels
- Member and provider incentive programs
- Creation of and enrollment in a Local Community Care Coordination Program (LCCCP)

These five performance indicators are considered "process measures." As the MHD's actuary, Mercer has been helpful in pointing out, typically Performance Withhold Programs use outcome measures rather than process measures. This is because outcome measures have sufficient data for trending and are comparable to national or other benchmarks. Based on input from the MCOs and Mercer, the Performance Withhold Program will therefore be transitioning to HEDIS-based outcome measures starting on July 1, 2019.

Although the five performance indicators mentioned above are process measures and need to be changed, they were important for communicating the MHD's priorities to the MCOs. For example, having complete and accurate encounter data are necessary for rate setting and the calculation of a variety of quality metrics. Improvements to encounter data accuracy will assist Mercer, the MHD, and the MCOs in the end.

Another example is the inclusion of care management in the Performance Withhold Program. MCOs are required to provide care management for a variety of conditions and risk factors and report data on this activity in a quarterly log. Two especially vulnerable populations (pregnant women and children younger than six with elevated blood lead levels) were selected for the Performance Withhold Program, which allowed the MHD to assess MCO performance related to meeting required time frames for assessment. The MCOs and MHD are currently discussing improvements in the manner of reporting care management activities as we prepare to transition to the new outcome-based Performance Withhold Program.

The new Performance Withhold Program will be based on HEDIS measures that will eliminate issues related to reporting and analyzing individual measures at different intervals within the year. Instead, the new program will use HEDIS measures calculated and reported by MCOs' certified HEDIS vendors. The plan is to establish MCO-specific baselines for each metric and to structure the release of the withhold based on different strata of performance. Results will be compared to national MCO percentile and median data provided by the NCQA Quality Compass. The intended result is a more meaningful, customized, and impactful Performance Withhold Program that incentivizes MCO quality performance.

It is important to stress, however, that the original five process measures are still important deliverables in the Managed Care contract. The MHD will still monitor and evaluate performance; MCO noncompliance will be subject to liquidated damages.

Quality Rating System

In the coming years, the MHD will be developing a Quality Rating System (QRS) for its MCOs. The plan is for the QRS to use CAHPS and health outcome measures that reflect member experience and access to quality health care. MCOs will be incentivized to improve their quality related to customer satisfaction and health outcomes because the QRS will be presented for members to consider when selecting a health plan.

MO HealthNet Managed Care Standards

In accordance with 42 CFR 438.204, all state quality strategies must provide documentation of Managed Care contract provisions that incorporate the standards of Part 438, Subpart D. Table 1 provides a section-by-section comparison between Subpart D and the July 1, 2018-June 30, 2019 MO HealthNet Managed Care contract. Table 1 shows that the Managed Care contract's standards related to access to care, structure, operations, and quality measurement and improvement are all at least as stringent as the standards in Part 438, Subpart D. Below is a discussion about standards of particular importance to CMS, the MHD, and its members.

Special Health Care Needs

The Special Health Care Needs (SHCNs) population in the contract includes members with Autism Spectrum Disorder. Individuals with special health care needs are those individuals who without services such as private duty nursing, home health, durable medical equipment/ supplies, and/or care management may require hospitalization or institutionalization. The following groups of individuals are at high risk of having a special health care need:

- Individuals with Autism Spectrum Disorder.
- Individuals eligible for Supplemental Security Income (SSI).
- Individuals receiving foster care or adoption subsidy or other out-of-home placement.
- Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.

To identify persons with SHCN, the choice counselor at the beneficiary support center administers the Managed Care Health Risk Assessment (HRA) to the member during open enrollment periods. The choice counselor includes an HRA form for eligible members in each household in the enrollment packet. The choice counselor also administers the HRA via telephone at the time of a telephone enrollment or transfer request. If the mail-in enrollment information does not include a completed HRA, the choice counselor must make an attempt to contact the individual by telephone for the information. There should be a health risk assessment for each eligible in the household. The completed HRAs are provided nightly to the MCOs as they are collected. The MCO is required by contract to make their best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

The MHD plans to allow enrollment to be completed by telephone, mail, and a new web portal during the upcoming contract year (after July 1, 2018).

The HRA provides the MCO with important information about the health risks of new members. This provides opportunities for early identification of members who can be referred to case management or disease management. Members with identified health risks have or need one or more of the following:

- Pregnancy
- Special Health Care Needs
- Chronic conditions (asthma, diabetes, high blood pressure)
- Behavioral health treatment or counseling
- Substance use treatment of counseling
- Physical, speech, or occupational therapy
- Special equipment to help with moving, walking, talking, hearing, breathing, feeding, personal care, etc.

The MCOs have developed condition-specific detailed assessment forms. Based upon assessment results and in partnership with the member, a more detailed care plan may be developed or the appropriate frequency of follow–up outreach identified. Follow-up care may include, specialist referrals, accessing durable medical equipment, medical supplies, and home health services. Where appropriate, care managers provide coordination and continuity of services to members. MCOs are required to complete a treatment plan for all members meeting the requirements of persons with special health care needs as defined above. All treatment plans must comply with 42 CFR 438.208 and include requirements for direct access to specialists.

Race, Ethnicity, Primary Language, and Data Collection

Missouri updated its procedures for collecting racial and ethnic data consistent with the Office of Management and Budget (OMB) revised standards via Administrative Notice (A-14-2003) on September 11, 2003. Missouri follows the guidance presented in the OMB Administrative Notice for obtaining information when individuals fail to self-identify themselves. The two ethnic categories are: Hispanic or Latino and Non-Hispanic or Latino. The five racial categories are: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. During the application process, the applicant identifies race, ethnicity, and primary spoken language.

The Managed Care contract includes language requirements compliant with Federal regulations. The MCOs are notified of member enrollment/disenrollment information via a nightly enrollment file and a weekly enrollment reconciliation file. To facilitate care delivery appropriate to member needs, the enrollment file also includes race, primary language spoken, and selective health information. The MCOs utilize information on language to provide interpretive services, develop educational materials for employee training, and facilitate member needs in the context of their language requirements.

Table 1.

MO HealthNet Managed Care Contract Provisions that Incorporate the Standards of 42 CFR Part 438, Subpart D - Quality Assessment and Performance Improvement	
Federal Rule Section	**Managed Care Contract Section**
438.206 Availability of Services	2.3 Cultural Competency
	2.4 Provider Networks
	2.5 Service Accessibility Standards
	2.8 Second Opinion
	2.12.16 Member Handbook
	2.18.4 Credentialing
438.207 Assurances of Adequate Capacity and Services	2.4 Provider Networks
438.208 Coordination and Continuity of Care	2.4 Provider Networks
	2.5.8 Direct Access and Standing Referrals
	2.5.9 Transition of Care
	2.11 Member Care Management and Disease Management
	2.18 Quality Assessment and Improvement
	2.22.14 Special Healthcare Needs Report
438.21 Coverage and Authorization of Services	2.5.5 Prior Authorizations
	2.15.5f Grievance Process
	2.18 Quality Assessment - Utilization Management
438.214 Provider Selection	2.2.7d Discrimination Against High Risk Providers
	2.18 Quality Assessment and Improvement
	2.18.8c Provider Credentialing
438.224 Confidentiality	2.38 Business Associate Provisions
	3.16 Confidentiality
438.226* Enrollment and Disenrollment	2.12 Eligibility, Enrollment, and Disenrollment
438.228 Grievance systems	2.15 Member Grievance System.
438.23 Subcontractual Relationships and Delegation	2.22.15 Subcontractor oversight reports.
	3.9 Subcontrators
438.236 Practice Guidelines	2.18.5 Practice Guidelines
438.330** Quality Assessment and Peformance Improvement Program	2.18 Quality Assessment and Improvement
438.242 Health Information Systems	2.26 Claims Processing and Management Information Systems.
**This item may be removed from Subpart D in the Final Rule.*	
***Formerly located in Section 438.240.*	

Monitoring and Compliance

In accordance with 42 CFR 438.204, all state quality strategies must provide documentation of procedures that regularly monitor and evaluate Managed Care plan compliance with standards of Part 438, Subpart D.

The State's monitoring program consists of a variety of tools, activities, and reports. For a complete current list of MCO reporting requirements, please visit https://dss.mo.gov/business-processes/managed-care/.

The Managed Care contract also requires the MCOs to have internal quality assurance programs that the MHD regularly monitors. The MCOs, in turn, are responsible for communicating established standards to their network providers and subcontracted benefit management organizations. They monitor provider compliance, and enforce corrective actions as needed.

Within MHD, the Evidence-Based Decision Support Unit (EBDSU) evaluates process measures, clinical outcomes, and service utilization rates. Measures consist of nationally defined standards as well as locally developed metrics. In addition, the EBDSU houses the Behavioral Health Program, which conducts reviews of behavioral health services within Managed Care, covering a variety of indicators addressing network adequacy, utilization, timely service availability, and hospitalization follow-up, among others. The resulting data from these efforts drive program and policy decisions.

The EBDSU works closely with the Managed Care Policy, Contracts, and Compliance Unit (MCPCCU). This unit acts as a liaison with the MCOs regarding required reporting and takes necessary steps to ensure compliance. The Performance Withhold Program is housed within the MCPCCU, which works closely with EBDSU to compile data that are used to evaluate MCO performance. MHD is in the process of transitioning toward outcomes-based quality measures using HEDIS for the Performance Withhold Program.

Structure and Operations

The MCOs provide MHD with quarterly operational data on:

- Timeliness of Claim Adjudication
- Complaints, Grievances, and Appeals
- Disease Management Activities
- Call Center Activities
- Care Management Services
- Care Management Services Related Specifically to Pregnancy
- Foster Care Population Summary
- Prior Authorizations and Denials
- Third Party Savings

MHD analyzes the data for trends and areas of concern, which are discussed during monthly Quality Data Review Committee meetings. As MHD evaluates performance, it identifies areas of opportunity or weakness and works with the MCOs to improve performance. In addition, MHD uses corrective action plans to address deficiencies identified through evaluation of the MCOs. Additional follow-up with internal MHD staff and MCOs occurs when noncompliance or inconsistencies are discovered.

Quality Measurement and Improvement

DHSS compiles the *Maternal and Child Health Indicators and Trends Report* from publicly reported vital health statistics and hospital discharge data sets each year. Aggregate data from the Managed Care Program baseline (1995 to the present) are available for nine maternal/infant and four child health indicators. This is presented at a QA&I meeting annually.

The Maternal and Child Health (MCH) Indicators are also used to examine the impact of the Managed Care Program on maternal/infant and child health and to compare this progress with Non-Medicaid and MO HealthNet Fee-for-Service participant groups.

The QA&I Advisory Group monitors and reviews behavioral health metrics that are reported to the State on an annual basis. In addition, the State collaborates with the DMH to conduct annual Behavioral Health Reviews of each MCO and their behavioral health contractor. These consist of surveys and comprehensive on-site behavioral health operational reviews designed to monitor areas of particular concern such as case management, behavioral health provider availability, and other issues identified through routine monitoring activities. The reviews address the following areas:

- Adequacy of quality monitoring systems including oversight of staff performance; caseloads; network access; provider practice patterns; utilization; denial and complaint trends; and, other quality data.
- Involvement of the Medical Director in utilization and quality management.
- Effectiveness of executive management and MCO oversight and reports.
- Performance on a number of key metrics including telephone response, staff turnover, network access, and utilization and complaint rates.

Quality Data Review

The Quality Data Review (QDR) committee provides a consistently scheduled opportunity for managers and administrators to review the variety of quality data that are received, primarily in the quarterly data feeds, from the MCOs. The committee was formed to ensure data were reviewed and acted upon in a timely manner.

These are also disseminated to MHD staff designated to review and intervene in the various programs monitored by these data, including member grievances and appeals, member call center activity, claims adjudication, prior authorizations, fraud/waste/abuse, care management,

and disease management. The QDC meets monthly to review 3-4 of these reports each meeting, with the goal of reviewing all reports generated from the MCOs' quarterly data submissions over the course of that quarter. This allows for review of trends, formulation of questions/follow-up for the MCOs, and development of interventions to address problematic or recalcitrant findings. Additionally, review of data from the annual reporting cycle will be incorporated into the QDR Committee as well.

Access to Care

MCOs must comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration (DIFP) in 20 CSR 400-7.095 as amended. MCOs submit network files as part of the annual access plan required by DIFP, and the State uses these plans to calculate member access rates by county and statewide and to determine if the provider network is capable of meeting the needs of MCO members.

MCOs are required to meet certain Provider Panel Directory standards. The EQRO conducts a Secret Shopper Survey to assess MCO compliance with this requirement, which is one of the measures included in the Performance Withhold Program.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT is a comprehensive preventive and primary health program for Medicaid-eligible children. In Missouri, EPSDT is also known as the Healthy Children and Youth (HCY) Program. EPSDT/HCY is included in the Managed Care contract as a deliverable. The target measure for EPSDT/HCY performance in the contract is based on the participant ratio, which measures the extent to which members are receiving initial and periodic screening services throughout the year. The goal established in the contract is based on the CMS requirement of an 80% participant ratio for members under the age of 21.

The Performance Withhold Program includes a measure based on the EPSDT participant ratio. This measure will be phased out as of July 1, 2019 in favor of similar HEDIS-based outcomes such as well-child visits, dental visits, and immunizations. However, EPSDT will continue to be a contract deliverable and will be included in quality assessments in the future.

External Quality Review

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

Sanctions

In accordance with the 42 CFR 438.204, all state quality strategies must provide documentation of Managed Care contract provisions that incorporate the standards of Part 438, Subpart I related to the appropriate use of intermediate sanctions. Table 2 shows that the current Managed Care contract meets the requirements of subpart I of this Part 438.

Table 2.

MO HealthNet Managed Care Contract Provisions that Incorporate the Standards of 42 CFR Part 438, Subpart I - Sanctions	
Federal Rule Section	**Managed Care Contract Section**
438.700 Basis for Imposition of Sanctions	2.29.9 Basis for Imposing Intermediate Sanctions
438.702 Types of Intermediate Sanctions	2.29.10 Types of Intermediate Sanctions
438.730 Sanctions by CMS	2.29.13 Federal Sanctions

The Managed Care contract addresses sanctions in Section 2.29. For each working day that a report or deliverable is late, incorrect, or deficient, the MCO shall be liable to the state agency for liquidated damages as specified in the contract.

In the event the state agency determines the MCO failed substantially to provide one or more medically necessary covered services as required in the Managed Care contract, the state agency shall direct the MCO to provide such service. If the MCO continues to refuse to provide the covered service(s), the state agency shall authorize the members to obtain the covered service from another source and shall notify the MCO in writing that the MCO shall be charged (at the state agency's discretion) either the actual amount of the cost of such service or $500 per occurrence. In such event, the charges to the MCO shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the MCO. With such deductions, the state agency shall provide a list of the members with respect to whom payments were deducted, the nature of the service(s) that the MCO failed to provide, and payments the state agency made or will make to provide the medically necessary covered services.

Use of the remedy under this section shall not foreclose the state agency from imposing any other applicable remedy listed herein. The failure to provide a covered service timely (i.e., in accordance with the timeframes specified herein, or when not specified herein, with reasonable promptness) shall be considered a violation resulting in either the actual amount of the cost of the service or $500 per occurrence.

In the event of any failure by the MCO to provide any services under the contract (including both covered services and administrative services), the state agency may, in addition to any

other applicable remedies, require the MCO to submit and follow a corrective action plan in order to ensure that the MCO corrects the error or resumes providing the service.

Basis for Imposing Intermediate Sanctions

In addition to the above, the state agency may impose intermediate sanctions when a MCO acts or fails to act as specified below. Before imposing intermediate sanctions, the state agency shall give the MCO timely written notice that identifies the violation and explains the basis and nature of the sanction. A MCO is subject to intermediate sanctions if it:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the contract, to a member covered under the contract.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the MO HealthNet program.
- Acts to discriminate among members on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the state agency.
- Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
- Fails to comply with the requirements for PIPs.
- Distributes directly or indirectly through any agent or independent subcontractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.
- Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Types of Intermediate Sanctions

The types of intermediate sanctions that the state agency may impose upon the MCO include:

- Civil monetary penalties
- Appointment of temporary management for a MCO as provided in 42 CFR 438.706.
- Special Rules for Temporary Management

Information Systems Capabilities

MCO technical infrastructure has implications for all of the activities lined out within the 2018 QIS as well as the ability to measure whether these activities will be able to meet the strategy's goals and objectives. The EQRO conducts an Information Systems Capabilities Assessment every three years. Additionally, the EQRO evaluates encounter data related to performance measures. Currently, the encounter data selected cover Emergency Department Visits, Emergency Department Utilization, and Prenatal/Postpartum Care.

Missouri Medicaid Information System

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

Encounter data are used by the State for rate setting and quality improvement evaluation, and the State conducts a complex process for assuring validity of encounter claims submitted by the MCOs. This involves using software algorithms as well as conducting a review of medical records for a random sample of claims in order to assure completeness and accuracy of submitted data. Complete and accurate encounter data are important to ensure quality measures such as HEDIS and EPSDT are calculated, reported, and assessed correctly and fairly.

In addition, new data have been added to the encounter claims, in particular information regarding the performing provider for rendered services. Previously, that field was occupied with the MCO's ID, which rendered the data useless for identifying individual providers or running analyses based on associated provider characteristics, such as specialty, office location, etc. The inclusion of this field permits such analysis, as well as the combining of MCO data and FFS data to gain a broader picture of provider activities across both service models.

The Performance Withhold Program monitors and reports encounter data completeness and accuracy each quarter. Each MCO must meet a 98% encounter data acceptance rate for each health plan region for the withhold to be released. Work is underway by the MCOs and the MHD to improve encounter data submission and completeness. This is significant because encounter data will no longer be evaluated as part of the Performance Withhold Program after July 1, 2019.

The MHD seeks to be proactive so a workgroup that includes MCO and MHD subject matter experts has been convened to discuss ways to improve encounter data submissions. The MHD has enlisted its actuary, Mercer, to facilitate these discussions and to help make recommendations for how to proceed in the future.

Enrollment Broker

Missouri currently uses a Beneficiary Support Services Center to provide the following enrollment broker functionality:

- Creates and sends enrollment packets and letters to members
- Enrolls members into Managed Care health plans
- Forwards data from Health Risk Assessments received by members to MMIS (to compile) who then forwards info to health plans

- Performs choice counselor functionality assisting members with questions by phone regarding plan choices and enrollment into a Managed Care health plan
- Process opt-out and just-cause transfers initiated by members

The MHD is currently in the process of procuring a new Beneficiary Support Services Center, which will have the following additional functionality by July 1, 2019:

- Web Portal to assist members in enrolling with a health plan, transfers, and mailings to be printed or imported by members.
- Provider directory in the web portal for members to locate PCPs or pharmacies located near them.
- Auto assignment into health plans with an algorithm approved by the MHD.

The DSS Family Support Division is responsible for determining MO HealthNet eligibility and will be an important partner with the MHD on the new Beneficiary Support Services Center.

Conclusion

The MHD and its EQRO will conduct a systematic annual review of the QIS to document progress toward meeting goals, objectives, and measures outlined in Appendix 1. During this process, it will be important to consider the fact that the 2018 QIS is being implemented during a time of great change for Managed Care in Missouri. Managed Care was expanded statewide on May 1, 2017 after being operated regionally since its inception in Missouri. Many annual measures are still in the process of being collected and analyzed for the first year of statewide Managed Care at the time of this publication. Therefore, a baseline for evaluating MCO performance and Managed Care as a whole is still in development. At the same time, a new MCO joined the Managed Care Program.

In recognition of this changing environment, the MHD is seeking the input of its MCOs and other partners to improve the development of contract deliverables, reporting, and analysis. This will lead to opportunities for improvement. A perfect example of this are the changes underway to the Performance Withhold Program.

Performance Withhold Program

The new Performance Withhold Program will be based on HEDIS measures, which provide standardized data on outcomes, risk factors, and utilization of services. The MHD will be able to compare MCO and Managed Care Program results to national and regional trends using the NCQA Quality Compass. The intended result is a more meaningful, customized, and impactful Performance Withhold Program that incentivizes MCO quality performance. The MHD will still monitor and evaluate MCO performance related to the five process measures originally included in the Performance Withhold Program.

The intent of the new Performance Withhold Program is that financial incentives tied to specific measures (which are also QIS measures) will drive MCO decision making related to quality projects. Historically, PIPs have been evaluated by the MHD, EQRO, and were discussed at QA&I and task force meetings but typically fell short of meeting their targets. Starting on July 1, 2019, the new Performance Withhold Program will include HEDIS measures that are aligned with the required PIPs that address dental and immunizations outcomes. Similarly, the MCOs will be encouraged (but not required) to align their other PIPs with the HEDIS measures featured in the Performance Withhold Program, which are also included in the 2018 QIS.

Staffing

Within the MHD, the EBDSU and MCPCCU each play an important role in quality improvement on an ongoing and annual basis. To underscore the MHD's commitment to quality improvement, it has created two new positions in the MCPCCU to work on the Performance Withhold Program. These staff also collaborate with EBDSU on quality projects and contract compliance. The QDR committee includes staff from EBDSU and the MCPCCU, including these new staff. The MCPCCU is also cross training other staff to assist with quality improvement.

The EBDSU has improved the review and validation process subsequent to data submission to allow our MCOs to examine their data within the context of all three plans. By presenting side-by-side graphs, the MCOs can easily spot outlier performance and determine whether it reflects actual performance differences or is, rather, an error in calculation. We also provide similar tables showing the year-to-year change in values, so that the MCOs can easily target and inspect suspiciously large differences. Similarly, our quarterly data reporting process has seen significant improvements in validation processes, and while this often results in rejection of datasets from the MCOs, the quality of the data, once it passes all validation checks, is vastly improved.

Partnerships

The QA&I group continues to make recommendations to ensure the focus remains on developing meaningful quality improvement ideas. Meetings take place two to three times per year to review quality data analysis and evaluation activities to determine if improvements or new opportunities need to be explored. In order to generate greater discussion surrounding quality improvement processes by the plans, and expectations by MHD, agendas are modified to keep the group innovative. The QA&I group will continue to establish separate task forces if specific areas of improvement are identified. The QA&I has been helpful in developing strategies that the MHD can implement to drive quality improvement.

The MHD is starting a relationship with its new EQRO vendor, Primaris Holdings, Inc. In addition to completing EQR activities required by CMS, the MHD plans to utilize Primaris for special projects designed to improve quality at the agency and MCO level. The MHD may enlist Primaris to provide technical assistance on special topics that arise during implementation of the QIS. Primaris will be involved with the QA&I as well.

A major area of strength has been the ongoing partnerships with the DMH to improve health outcomes for those accessing behavioral health services. The MHD and DMH staff work together to perform the annual evaluation of each MCO's behavioral health operations regarding quality and utilization management. These reviews have proven to be valuable in determining opportunities for improvement. Collaborations with DHSS have been helpful to improve health outcomes for the Maternal and Child population. Additionally, we solicit input through our Consumer Advisory Committee (CAC) and other public meetings and continually monitor this feedback for opportunities for improvement.

MHD has recently extended a contract with the Center for Health Policy at the University of Missouri to provide Health Literacy training and supervision to MHD staff. Our goals are to improve the clarity and readability of documents that are provided to consumers who interface with the Managed Care Program. Several workshop-style trainings will be held in the coming year, and participants will receive individual review and feedback of their documents as they learn techniques and processes for improving the Health Literacy of their work.

Summary

The MHD intends to use the 2018 QIS to help drive quality improvement at many different levels. The MHD is optimistic that the measures included in the 2018 QIS and upcoming Performance Withhold Program will guide the MCOs as they plan and implement activities such as PIPs, care management, provider incentives, member incentives, and LCCCP participation.

The effort to align quality improvement activities with the goals, objectives, and measures featured in the 2018 QIS will be most effective if it is a collaborative process among the MHD, MCOs and stakeholders. The ultimate goal among the MHD and its partners is to improve members' appropriate access to care, wellness and prevention, cost-effective utilization of services, and satisfaction with experience of care.

The MHD is committed to continuous quality improvement designed to help achieve the Department's mission, to lead the nation in building the capacity of individuals, families, and communities to secure and sustain healthy, safe, and productive lives.

Quality Strategy
2018 Goals, Objectives, and Measures

Goals	Objectives	Measures
Goal 1 Ensure appropriate access to care.	Ensure timely access to care.	Percentage of Primary Care Provider offices that met the urgent appointment standard (24 hours for illness or injury requiring immediate care).
		Percentage of Primary Care Provider offices that met the routine appointment standard (30 days for routine care without symptoms).
		Percentage of psychiatrist offices that met the two-week appointment standard for routine behavioral health and substance use services without symptoms.
	Ensure an adequate healthcare network.	Percentage of primary care physician offices that meet mandated access standards.
		Percentage of specialist offices that meet mandated access standards.
Goal 2 Promote wellness and prevention.	Promote child health.	Well-Child Visits in the First 15 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.*
		Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: Assesses children 3–6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.
		Adolescent Well-Care Visits: Assesses adolescents and young adults 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.*
		Assesses Medicaid members 2-20 years of age with dental benefits, who had at least one dental visit during the year.*
		Assesses children 2 years of age who had one or more blood tests for lead poisoning by their second birthday.*
		Assesses children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.*
		Assesses adolescents 13 years of age who had one dose of meningococcal vaccine and one Tdap vaccine series by their 13th birthday.*
	Promote women's health.	Assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.*
		Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.**
		Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.**

Quality Strategy
2018 Goals, Objectives, and Measures

Goals	Objectives	Measures
Goal 2 (cont) Promote wellness and prevention.	Improve chronic disease management.	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had controlled HbA1c.*
		Medication Management for People With Asthma: Assesses children 0–18 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period.*
	Improve management of behavioral health and substance use disorder.	Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 30 days of discharge.*
		Use of Opioids from Multiple Providers. This measure assesses the rate of health plan members 18 years and older who receive opioids from multiple prescribers and multiple pharmacies.
Goal 3 Ensure cost-effective utilization of services.	Decrease readmission rates.	Rate of behavioral health inpatient readmissions.
	Decrease use of emergency rooms.	Rate of emergency room (ER) visits due to asthma among children younger than 4 years of age.
		Rate of emergency room (ER) visits due to asthma among children 4 to 17 years of age.
		Rate of emergency room (ER) visits among children younger than 18 years of age.
		Rate of emergency room (ER) visits among members 18 to 64 years of age.
	Decrease preventable hospitalizations.	Rate of preventable hospitalizations among children younger than 18 years of age.
		Rate of preventable hospitalizations due to asthma among children younger than 18 years of age.
Goal 4 Promote member satisfaction with experience of care.	Promote access to care.	Rate of always or usually getting needed care as soon as needed within the last six months.
		Rate of always or usually getting care quickly within the last six months.
	Promote rating of health care.	Percent rating the health care they received in the last six months at an 8, 9, or 10.

*Measures to be incorporated into the State Fiscal Year 2020 Performance Withhold Program.

**Performance measures evaluated by the External Quality Review Organization in 2018; also to be incorporated into the State Fiscal Year 2020 Performance Withhold Program.

Target is to improve by two percentage points each year and/or to improve six percentage points by June 30, 2021 or until reach the national median (where national benchmarks are available).