Primaris
Healthcare Business Solutions

2019 External Quality Review
Annual Technical Report

Measurement Period: Calendar Year 2018
Validation Period: Feb-Aug 2019
Publish Date: Dec 4, 2019

MoHealthNet

Table of Contents

1.0 Executive Summary

1.1 Purpose of Report

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

Managed Care is operated statewide in Missouri in the Central, Eastern, Western, and Southwestern regions. One of the most important priorities of Managed Care is to provide a quality program that leads the nation and is affordable to members. This program provides 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. The total number of Managed Care enrollees by the end of SFY 2019 are 596,646 (1915(b) and CHIP combined). This is a decrease of 16.24 % in comparison to enrollment by end of SFY 2018.

There are three MCOs operating in Missouri (MO) under MHD contract effective May 01, 2017: Home State Health, Missouri Care, and UnitedHealthcare. These MCOs provide services to eligible individuals determined by the state agency for the Managed Care Program on a statewide basis. MHD works closely with MCOs to monitor the services being provided to ensure goals to improve access to needed services and the quality of health care services in the Managed Care and state aid eligible populations are met, while controlling the program's cost.

The services rendered by the MCOs are monitored for quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods including, but not limited to, MCO's Healthcare Effectiveness Data and Information Set (HEDIS®) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review. 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 the MCOs annually as well.

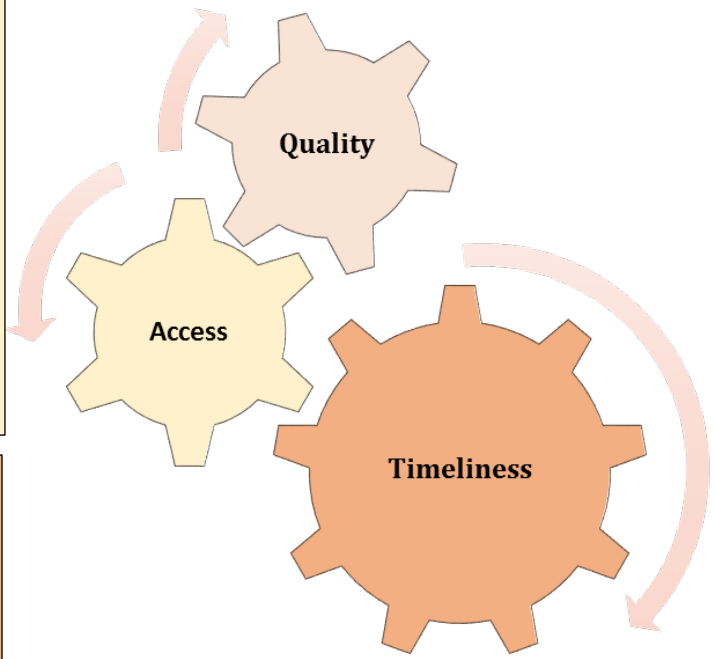
Primaris Holdings, Inc. (Primaris) is MHD's current EQRO and started their five-year contract in January 2018. The External Quality Review (EQR) 2019 covers a period for Calendar Year (CY) 2018.

1.2 Overview of External Quality Review

The EQR is 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 (Figure 1-1).

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.



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, evidence-based knowledge.
(3) Interventions for performance improvement.

Figure 1-1 Federal Requirement for the MCO

Primaris conducted an EQR 2019 for the three MCOs: Home State Health, Missouri Care, and UnitedHealthcare. 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 (protocol 1, 2, 3, Appendix 5 of Centers for Medicare and Medicaid Services Version 2.0, September 2012); MHD Managed Care Contract; and Quality Improvement Strategy (QIS).

The EQR 2019 activities started in February and continued through August 2019 for the three MCOs. The evaluation was performed by analyzing policies and procedures, documentations, observations and onsite interviews. Primaris provided Technical Assistance (TA) during the review period to help the three MCOs towards continuous improvement and excellence (Figure 1-2). To comply with the federal requirements per 42 CFR 438.364, Primaris aggregated and analyzed the performance data across mandatory

and optional activities to prepare an Annual Technical Report. This report includes Primaris' analysis and evaluation of the following activities for the MCOs:

Mandatory

1. Compliance with Medicaid Managed Care Regulations
2. Validation of Performance Measures (PMs)
   Information System Capabilities Assessment (ISCA)
3. Validating Performance Improvement Projects (PIPs)

Optional

Care Management (CM) Review

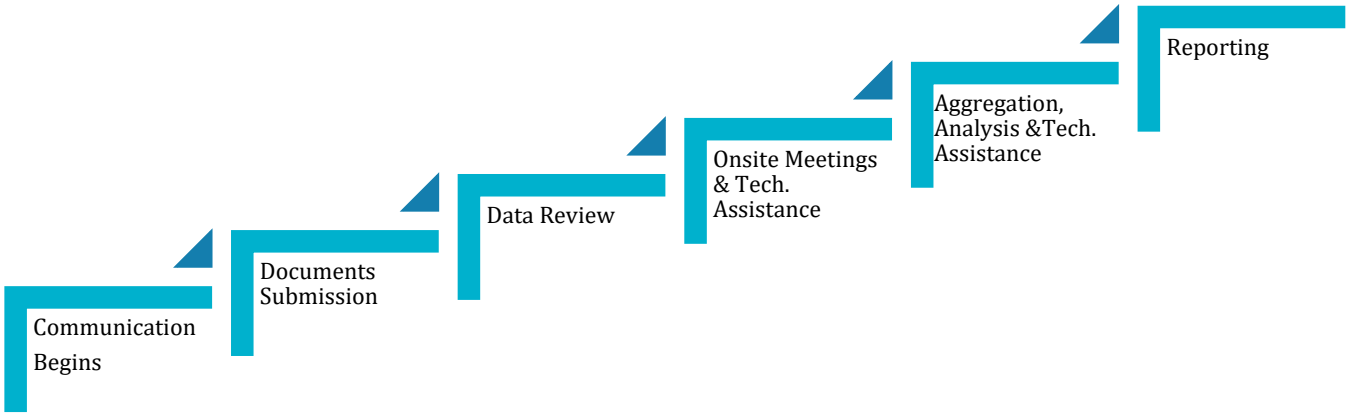


Figure 1-2 Evaluation Process for MCO

1.3 Overall Activities, Results, and Recommendations

1.3.1 Compliance with Medicaid Managed Care Regulations

Table 1-1 42 CFR 438 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

Code of Federal Regulations (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 CFR 438 and the quality assessment and performance improvement requirements described in § 438.330.

During EQR 2019, Primaris reviewed the standards from 42 CFR 438 Subpart D (Table 1-1) for the three MCOs. UnitedHealthcare was not included in the first year of compliance review cycle (EQR 2018), as it did not cover one full year with MHD. In order to bring all the three MCOs to the same level for a compliance review, three standards (due from previous year) were reviewed for UnitedHealthcare, additionally:

- §438.230 Subcontractual relationships and delegation
- §438.236 Practice guidelines
- §438.242 Health information systems

Evaluation tools were created using CMS EQRO Protocol 1 (Assessment of Compliance with Medicaid Managed Care Regulations, Centers for Medicare and Medicaid Services Version 2.0, September 2012), MHD contract, and Quality Improvement Strategy. The information gathered from the MCOs was analyzed. Each section/criteria in the tool was scored as Met (2 points); Partially Met (1 point); or Not Met (0 point) according to the Compliance Rating System per CMS EQRO protocol 1. (Details are present in section 3.1 of this report.)

Results

Table 1-2 Summary of Compliance Score for MCOs

Standard	Standard Name	Total Sections	Score Home State Health	Score Missouri Care	Score United Health care
§438.206	Availability of services	11	22	22	22
§438.207	Assurances of adequate capacity and services	10	20	20	20
§438.208	Coordination and continuity of care	17	34	34	34
§438.210	Coverage and authorization of services	22	44	44	42
§438.214	Provider selection	12	24	24	24
§438.224	Confidentiality	19	38	29	38
§438.228	Grievance and appeal systems	44	88	88	88
§438.230	Subcontractual Relationships and Delegation	7			14
§438.236	Practice Guidelines	6			12
§438.242	Health Information Systems	7			14
Total	**10**	**155**	**270**	**261**	**308**
Score %			**100**	**96.6**	**99.4**

Compliance Score % = Total Score X100 = 100%
Total Sections X 2 points

- An assessment was made for compliance with standards: Home State Health scored 100%; Missouri Care scored 96.6%; and UnitedHealthcare scored 99.4% (Table 1-2).
- Home State Health and UnitedHealthcare were not placed on a corrective action plan for any standard. However, UnitedHealthcare scored "Partially Met" for standard, "438.210 Coverage and authorization of services." Two criteria from this standard-42 CFR 441.20 and MHD contract 2.5.5h-are scored as "Partially Met." Missouri Care scored "Not Met" for standard, "42 CFR 438.224 Confidentiality." There are 3 sections within this standard scored as "Not Met" (MHD contract 2.38.3; CFR 164.504(e)(2)(i)(B); and MHD contract 2.38.3p) and 3 sections scored as "Partially Met" (MHD contract 3.16.1; 2.38.2c; and 2.38.2f). A corrective action plan was raised for Missouri care to meet the requirements for this standard.
- During the previous year (EQR 2018), the two MCOs under evaluation: Home State Health and Missouri Care were not placed on a corrective action plan for any standard which required a review this year.

Strengths

Adherence to MHD contract, team work, well written documents, policies and procedures, oversight through Quality Committees, knowledge of staff, business ethics and code of conduct, provider network, population health management strategy, Utilization Management program based on nationally recognized medical policies, clinical guidelines and criteria, prompt response to technical assistance by EQRO have enabled the MCOs to acquire above 95% score for any given standard under evaluation.

Weakness

For all the MCOs, some of the policies did not have updated information from the Final Rule 2016 (Medicaid and CHIP Managed Care) 42 CFR 438 Subpart D, consistently. Some of them had outdated information based on Oct 2015, 42 CFR 438.

Recommendations

- Primaris recommends that all the policies (wherever applicable) should be updated consistently to reflect the correct information based on "2016 Final Rule (Medicaid and CHIP Managed Care)."
- The revisions to the policies/documents as a result of technical assistance should be submitted to the MHD for approval.

- There is a need to educate PCPs on the appointment standards and develop tailored actions to ensure all PCP offices are compliant with availability standards.
- Missouri Care and UnitedHealthcare should work on the deficiencies as stated above to achieve 100% compliance with federal and state regulations.
- Specific recommendations for each MCO are stated in section 3.0 of this report.

1.3.2 (A) Validation of Performance Measures

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 1-3) that were calculated and reported by the MCOs for their Managed Care population. MHD identified the measurement period as CY 2018. 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, Version 2.0, September 2012.

Table 1-3 Performance Measures

Performance Measure	Method	Specifications Used	Validation Methodology
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Hybrid	HEDIS	Medical Record Validation
Chlamydia Screening in Women (CHL)	Admin	HEDIS	Primary Source Verification
Inpatient Mental Health Readmissions	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 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:

- Current or previous year's ISCAs were reviewed to determine information system's 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.
- Software certification reports for measures that were produced using NCQA measure certification process (W34 and CHL)
- Software production logs used to determine production issues and for rate verification.
- Software code utilized to create MHD's Inpatient Mental Health Readmissions measures.
- Medical records for W34 to determine compliance with the numerator events collected by each MCO.

All three MCOs were required to report CHL and Inpatient Readmissions for Mental Health using the administrative-only reporting methodology. The administrative-only reporting methodology required that each MCO identify services through claims and/or supplemental data sources (e.g., laboratory services, electronic medical records). For the administrative-only measures, each MCO was required to submit the entire list of numerator positive members from which Primaris selected a random sample. Primaris selected a random sample of 45 numerator positive members to conduct primary source verification. Primary source review involved reviewing claims data from internal and external (supplemental) data sources. The primary source, a claim submission in most cases, was reviewed to validate the codes submitted on the claim by matching the codes identified in the measure specifications. A numerator event or positive "hit" was determined to be compliant if the code matched one that was in the specifications, along with the date of service and member demographic information relevant to the measure. Each of the MCOs utilized certified software to determine numerator hits for both CHL and W34. The Inpatient Readmissions for Mental Health measure was not considered a certified measure from NCQA and the MCO had the option of producing its own source code or having the code outsourced to the software vendor. Primaris verified that each MCO captured the requirements as outlined in the Health Care Quality Data Instructions specifications for the Inpatient Readmissions for Mental Health data elements through its primary source verification process.

Results

The performance measurement validation team conducted primary source verification using a sample of 45 numerator positive hits for CHL and Inpatient Mental Health Readmissions and 45 medical records hits for W34 to verify the accuracy of the three

measures under review (Table 1-4, 1-5). All three measures from all three MCOs were found to be compliant and received a 'Met' designation (Table 1-6).

Table 1-4 CHL and Inpatient Readmissions for Mental Health Primary Source Verification Results–Home State Health , Missouri Care and UnitedHealthcare		
Performance Measure	**Sample Size**	**Final Result**
CHL	45	45/45 Pass
Inpatient Mental Health Readmissions	45	45/45 Pass

Table 1-5 W34 Medical Record Review Results–Home State Health, Missouri Care and UnitedHealthcare		
Performance Measure	**Sample Size**	**Final Result**
W34	45	45/45 Pass

Table 1-6 Key Review Findings and Audit Results for Home Health, Missouri Care and UnitedHealthcare		
Performance Measures	**Key Review Findings**	**Audit Result**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns were identified	Met
Chlamydia Screening in Women (CHL)	No concerns were identified	Met
Inpatient Mental Health Readmissions	Some concerns were identified for UnitedHealthcare which were corrected and resubmitted	Met

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Table 1-7 below shows the rates for the three MCOs for W34 hybrid measure: Missouri Care (61.48%), Home State Health (56.59%), and UnitedHealthcare (54.60%). Missouri Care had the highest weighted state averages. UnitedHealthcare (54.6%) was significantly lower than Missouri Care (> 5% points difference) but not significantly different from Home State Health. All three plans performed well below the NCQA national Medicaid average of 73% for CY 2018. It should be noted that UnitedHealthcare was a new MCO

under MHD (contracted in May 1, 2017). An indication of performance and member penetration could be better evaluated in CY 2019.

Table 1-7 Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)		
Home State Health	**Missouri Care**	**UnitedHealthcare**
56.59%	61.48%	54.60%
Higher rate indicates better performance		

Chlamydia Screening in Women (CHL)

Table 1-8 shows the screening results for Chlamydia for all three MCOs in CY 2018. Home State Health had the highest statewide, weighted average (45.48%) followed by UnitedHealthcare (43.53%) and Missouri Care (30.82%). The difference in rates between Home State Health and UnitedHealthcare were insignificant. Missouri Care's performance, however, was significantly lower than both Home State Health and UnitedHealthcare (greater than 5% point difference in comparison). For this measure, the higher rate indicates better performance. All three MCOs performed significantly lower than the national Medicaid average of 57.6% in CY 2018.

Table 1-8 Chlamydia Screening in Women (CHL) (Weighted Average)		
Home State Health	**Missouri Care**	**UnitedHealthcare**
45.48%	30.82%	43.53%
Higher rate indicates better performance		

Inpatient Mental Health Readmissions

Table 1-9 shows the counts of readmission for mental health diagnoses for all three MCOs during the CY 2018. The Inpatient Mental Health Readmission measure is a count of readmissions and not unique members that were readmitted. Members can be counted in this measure more than once if they had multiple readmissions. Missouri Care had the most readmissions (545) during the CY 2018 measurement period, followed by Home State Health (438) and last UnitedHealthcare (182).

Table 1-9 Inpatient Mental Health Readmissions (Total Count)		
Home State Health	**Missouri Care**	**UnitedHealthcare**
438	545	182
Lower count indicates better performance		

Strengths

All three MCOs were very knowledgeable regarding each measure. The MCOs have high levels of exposure to quality management and to the requirements for providing measure related information.

Each MCO was able to provide appropriate primary source documentation and medical records for review in a timely manner. MCO staff were engaged in the overall process and provided feedback when requested.

Weaknesses

All three MCOs are performing well below the national Medicaid averages for CHL and W34.

Recommendations

- Primaris recommends that all MCOs review the measures when selected by MHD for validation each year and provide feedback regarding their concerns. Early detection of concerns will alleviate any issues later during an onsite visit.
- Primaris also recommends that the MCOs verify all measure programming codes to ensure their accuracy prior to producing the rates for submission. Additional quality steps are necessary to ensure accurate reporting and alleviate any other unforeseen issues during primary source review.

1.3.2 (B) Information System Capabilities Assessment

Primaris conducts Information System Capabilities Assessment (ISCA) for each MCO during its validation of performance measures. Additionally, MHD requires Primaris to conduct a detailed assessment of each MCO's Information System once every three years. In EQR 2019, ISCA was performed for UnitedHealthcare. The other two MCOs were assessed in EQR 2018. A separate report on ISCA is submitted to MHD.

Primaris followed CMS protocol: External Quality Review (EQR) APPENDIX V-Information System Capabilities Assessment (ISCA) (Attachment A-Tools for Assessing Managed Care Organization (MCO) Information Systems; and Attachment B-Information System Review Worksheet and Interview Guide) as a basis for methodology.

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.

Results

UnitedHealthcare passed the ISCA in all seven (7) areas: information system; information technology infrastructure; information security; encounter data management; eligibility data management; provider data management; and performance measures and reporting. They received a fully 'Met' score for the overall ISCA.

Strengths

UnitedHealthcare has met all contractual obligations for information system management and have well documented processes and procedures in place to allow their information systems to be adequately monitored and maintained.

Weaknesses

None.

Recommendations

MHD and UnitedHealthcare should work towards a collaborative solution for updating and accessing more accurate and useful member demographic data. This will aid in keeping member information current and create a complete data integration solution delivering trusted data from various sources.

1.3.3 Validating Performance Improvement Projects (PIPs)

MHD requires the contracted MCOs 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. (*Ref: MHD-Managed Care Contract 2.18.8 (d)).* During calendar year CY 2018, MHD required Home State Health, Missouri Care, and UnitedHealthcare to conduct 2 PIPs:

- Improving Childhood Immunization Rates (Combo 10) (clinical PIP)
- One (1) nonclinical-Improving Access to Oral Healthcare (non-clinical PIP)

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 following activities were conducted for PIPs Validation:

1. Assess the study methodology
2. Verify PIP study findings (optional-not conducted)
3. Evaluate overall validity and reliability of study results

The findings were reported in terms of "level of confidence-high confidence, confidence, low confidence, results not credible" (definitions are stated in section 5.1 of this report.)

Results

Clinical PIP: Improving HEDIS® Childhood Immunization Rates (CIS) Combo 10

The three MCOs aimed at increasing the CIS combo 10 statewide by 3% points in CY 2018 from the previous year (CY 2017): Home State Health (27.01% to 30.01%); and Missouri Care (26.52% to 29.52%). UnitedHealthcare did not operate in MO for a full year in CY 2017 (contract effective May 1, 2017). Their CIS Combo 10 rate in CY 2017 (May-Dec) was 0.92%. Each MCO considered CY 2017 statewide rate as baseline for the purpose of measuring improvement.

Home State Health had two interventions for this PIP. They analyzed one intervention and submitted their results-"Allow the inclusion of corrective data submitted through the Supplemental Data System (SuDS) by Missouri Health Plus (MH+)." This intervention showed a positive impact on the member compliance for CIS immunization rates in HEDIS (H) 2019/CY 2018 by 4% to 8%. However, the statewide CIS Combo 10 rate decreased from 27.01% (in CY 2017) to 21.65% (in CY 2018).This is a drop by 5.36 percentage points and has a statistical significance (p value=0.0001). The aim of the PIP is not met.

Missouri Care had two interventions for CIS Combo 10 PIP: healthy rewards member incentive program for well child visits in first 15 months of life (W15); and provider incentive program. Neither of these interventions had shown a positive impact. There is a decrease (3.01% points) in member participation during CY 2018 with the Healthy Rewards Member Incentive Program. Similarly, the provider incentive program showed a decrease (3.5% points) in care gaps closed for CIS Combo 10. However, the statewide CIS Combo 10 rate in CY 2018 (27.49%) has increased (0.97% point) from CY 2017 (26.52%). The aim of the PIP is not met.

UnitedHealthcare implemented 18 interventions for CIS Combo 10 PIP during CY 2018 at different times of the year. The run chart was submitted. However, the impact of an intervention was not assessed. The statewide rate for CIS Combo 10 increased from 0.92 % in baseline year (May 2017-Dec 2017) to 21.65% during the measurement year (CY 2018) which is a rise of 20.73 % points. The aim of PIP is met.

Due to the maturity of UnitedHealthcare in MO and the technical specifications for this measure (children who turn 2 years of age during the measurement year and are continuously enrolled for 12 months prior to their 2nd birthday) data is limited and reflects a significantly low rate for the baseline year. Primaris will not comment on the performance of the PIP as UnitedHealthcare did not operate for an entire year in MO during CY 2017.

Table 1-10 summarizes CIS Combo 10 rates achieved by all the three MCOs operating under MHD during CY 2018.

Table 1-10 MCOs' HEDIS® CIS COMBO 10 Rates			
	HSH	MO Care	UHC
Baseline Year (CY 2017)	27.01%	26.52%	
Measurement Year (CY 2018)	21.65%	27.49%	21.65%
Aim of PIP Met/Not Met	Not Met	Not Met	Not Applicable*

*UHC did not have data for the entire CY 2017 (contract effective May 1, 2017)

Non-Clinical PIP: Improving Oral Health

Three MCOs aimed at increasing the HEDIS® Annual Dental Visit (ADV) rate statewide by 3% points in CY 2018 from the previous year (CY 2017): Home State Health (41.65% to 44.65%); and Missouri Care (48.42% to 51.42%). As stated earlier, UnitedHealthcare did not operate in MO for a full year in CY 2017, their ADV rate in CY 2017 (May-Dec) was 35.10%. Additionally, UnitedHealthcare studied two other indicators for their PIP: CMS 416 Preventive Services (baseline rate 26.47%) and CMS 416 Oral Sealants (baseline rate 9.53%). For both of these indicators the aim was to increase the rates by 3.33% points from the baseline year. Each MCO considered CY 2017 statewide rate as baseline for the purpose of measuring improvement.

Home State Health had three interventions for the PIP during CY 2018. Only one intervention-implementation of a warm, telephonic outreach campaign with AlphaPointe, a sheltered workshop in Missouri-was analyzed and result of impact was measured. This intervention had a minimal impact (0.34%) on the ADV rate statewide. The statewide HEDIS® ADV rate increased from 41.65% in CY 2017 to 47.82% in CY 2018 which is an increase by 6.17 percentage points. This increase is not statistically significant (p value=0.94). However, the aim of the PIP is met.

Missouri Care had tested one intervention for the PIP-healthy rewards member incentive program. There was a minimal increase of 0.45% in member participation during CY 2018 for ADV. However, the statewide ADV rate increased from 48.42% (CY 2017) to 52.72% (CY 2018) which is an increase of 4.3% points. The increase is of statistical significance and aim of PIP is met.

UnitedHealthcare applied 16 interventions throughout the entire year at different times. None of the interventions were tested for their impact on three indicators. However, the result of the three indicators were reported as follows:

1. HEDIS® ADV rates: The statewide ADV rate has increased from 35.10% (CY 2017) to 48.24% (CY 2018), which is an increase by 13.14% points.
2. CMS 416 Preventive Services: The overall rate of members who received CMS 416 preventive services in CY 2018 (35.73%) compared to the rate in the baseline year (26.47%) shows an increase by 9.26% points. The benchmark established per 2016 CMS 416 report was 32.66% and UnitedHealthcare exceeded the benchmark.
3. CMS 416 Oral Sealant: The overall rate of members who received CMS 416 oral sealant in CY 2018 (14.97%) compared to the overall rate in the baseline year (9.53%) shows an increase by 5.44% points. The benchmark established per 2016 CMS 416 report was 13.51% and UnitedHealthcare exceeded the benchmark.

The three indicators showed an improvement. The aim of the PIP is met, but statistical significance could not be determined due to lack of data for the entire baseline CY 2017. UnitedHealthcare exceeded the benchmark for the two CMS 416 indicators.
Table 1-11 summarizes ADV rates achieved by all the three MCOs operating under MHD during CY 2018.

Table 1-11 MCOs' HEDIS® ADV Rates

	HSH	MO Care	UHC
Baseline Year (CY 2017)	41.65%	48.42%	
Measurement Year (CY 2018)	47.82%	52.72%	48.24%
Aim of PIP	Met	Met	Not Applicable*

*UHC did not have data for the entire CY 2017 (contract effective May 1, 2017)

Overall PIPs Score:

The following score was assigned to Home State Health and Missouri Care for both 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.
Primaris assigned a score of "not credible," for both the PIPs for UnitedHealthcare. The decision was made because UnitedHealthcare did not have data for the full year which could have served as the baseline for the measurement year. Therefore, the data is incompatible for a meaningful comparison of baseline data of 8 months (May-Dec 2017) with measurement data of 12 months (CY 2018).

Strengths

- The three MCOs expressed their willingness to learn the right methodology per CMS EQRO protocol 3 for PIP during a Technical Assistance session. They responded by providing updates/additional information/corrections in order to align with the expectations of EQRO.
- Barrier analysis was done around the three categories-Member, Provider, and System. The interventions were designed to address at least one of three barriers.

Weaknesses

- 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).
- Annual evaluation of HEDIS®/CMS measures was used as quality indicators, in accordance with the requirements 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.
- Interventions could not be linked to the measured quality indicators. Multiple interventions were implemented throughout the CY 2018 and the impact of any individual intervention could not be judged.

Recommendations

Home State Health, Missouri Care, and UnitedHealthcare 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. Detailed recommendations for each MCO are stated in section 5.0 of this report.

1.3.4 Care Management Review

Primaris conducted an optional activity-Care Management review. The term “case” has been replaced by “care” in the MHD Managed Care contract (section 2.11), and hereinafter, stated as care management (CM). The aim of CM review was to identify contributing issues and key drivers of the program.

The Commission for Case Manager Certification (CCMC) defines “Case 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.

For EQR 2019, MHD required Primaris to evaluate three focus areas for the MCOs:

- Pregnant members (OB).
- Children with elevated blood lead levels (EBLLs).
- Behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

MHD contract section 2.11 was followed as a standard for evaluation for the CM program. The evaluation was carried out under the following headings:

Review of Care Management Policies and Procedures
Evaluation of Care Plan
Onsite Interviews
Medical Record Review (MRR)

Results

Table 1-12 Care Management Policy Review (MHD contract 2.11.1c 5)
A description of the system for identifying, screening, and selecting members for CM services.
Provider and member profiling activities.
Procedures for conducting provider education on CM.
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 updated as necessary.
A description of the methodology for assigning and monitoring CM caseloads that ensures adequate staffing to meet CM requirements.
Time frames for reevaluation and criteria for CM closure.
Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.

Review of CM Policies and Procedures: Primaris reviewed CM policies and procedures submitted by Home State Health, Missouri Care, and UnitedHealthcare to ensure compliance with the requirements set forth in MHD contract section 2.11,1c 5 (Table 1-12). The three MCOs were 100% compliant with the contractual requirement.

Review of care plan: MHD contract 2.11.1e provides guidelines for the "care plan." Primaris interviewed MCO officials and reviewed the care plans for all three CM focus areas at the time of medical record review. Primaris concluded that the MCOs have policies and procedures based on contractual guidelines for "care plan," and members are managed according to those guidelines. However, the "care plan" per se did not include all the components as listed in the contract. The care managers worked with the members and created goals based on the care gaps. Interventions were planned to close the care gaps. The care plan was updated once a month.

Medical record review (MRR): MHD required a review of 20 medical records for each-OB, EBLLs, and BH-CM Program. Primaris selected a sample of 30 medical records (maximum limit: required sample size of 20, plus 50% oversample for exclusions and exceptions) by using a stratified random sampling method based on Appendix II of 2012, CMS protocols for EQR). At a minimum, the following criteria were reviewed (Figure 1-3):

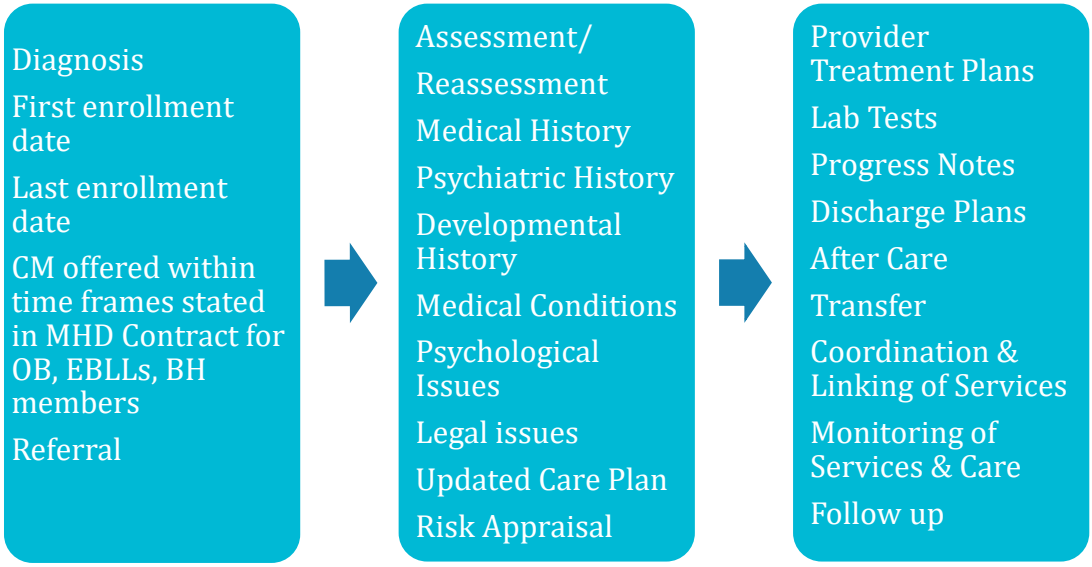


Figure 1-3 Criteria for Validation of Medical Records

The overall evaluation of CM program based on MRR for each MCO is as follows (Table 1-13). Detailed results are stated in section 6.2, 6.3, 6.4 of this report:

Table 1-13 Overall Compliance of CM

MCO	OB CM	EBLLs CM	BH CM
HSH	92%	82%	83%
MO Care	94%	82%	88%
UHC	71%	62%	66%

The following criteria are of significance per MHD contract in evaluating MCOs' CM program. The findings are based on MRR (Table 1-14).

Table 1-14 Specific CM Criteria	HSH	MO Care	UHC
1. The MCO must complete the initial care management needs assessments for pregnant women (either face-to-face or via the telephone) demonstrating either an eighty percent (80%) compliance rate or a 10 basis points growth in the percentage of assessments as required: Within 15 business days from the date effective with the MCO for newly eligible members; and Within 15 business days of notice of pregnancy for currently eligible members.	82%	100%	100%
2. Time frames for children with elevated lead levels must be met eighty percent (80%) of the time.	17%	55%	30%
3. The MCO assesses members for CM within (5) business days of admission to a psychiatric hospital or residential substance use Tx program.	13%	25%	20%

Strengths

- Home State Health and Missouri Care achieved a compliance level of above 90% for OB CM and above 80% for EBLLs CM and BH CM.
- All three MCOs met the contractual target of 80% for one criteria: offer CM for their OB members within 15 business days of notification of pregnancy for currently eligible members and within 15 business days from the date effective with the MCO for newly enrolled members.
- All three MCOs use evidence-based care for their CM program; they have a holistic, comprehensive, culturally competent approach with awareness and respect for diversity; possess a user friendly interface for Electronic Medical Records; demonstrated team work and coordinated care with care managers, members, providers, community resources; and align resources with the population needs.

Weaknesses

- The engagement of providers with the care plan was unsatisfactory (varying from 0%-70%) across the three MCOs regarding their CM program. The care plan was available to the providers through fax/mail/MCOs' website. No feedback or acknowledgement was received by the care managers. However, the providers responded to the care managers' call as and when needed.

- The MCOs were not able to offer the CM to children with EBLLs within the time frame in MHD contract (standard set at 80%). Home State Health scored 17%, Missouri Care was at 55%, and UnitedHealthcare was at 30%.
- The MCOs did not meet the requirement of assessing members for CM within (5) business days of admission to a psychiatric hospital or residential substance use Tx program. The score was: Home State Health at 13%; Missouri Care at 25%; and UnitedHealthcare at 20%.
- Members' engagement and motivation for CM program is an area recognized for improvement. Across the three MCOs, up to 50% of cases were closed as the care managers were unable to contact (UTC) the members.

Recommendations

A member should be considered as enrolled when the care manager makes an assessment of member's need. An outreach by a care coordinator or notification by any source (e.g., state, Utilization management system, reports, providers) should not be considered as enrollment of a member in the CM program. Educating, engaging, motivating members and providers for positive outcomes, collecting updated contact information of members through all possible sources, outreach to all available care settings and patient touch points may help improve in quality of care outcomes (Figure 1-4).

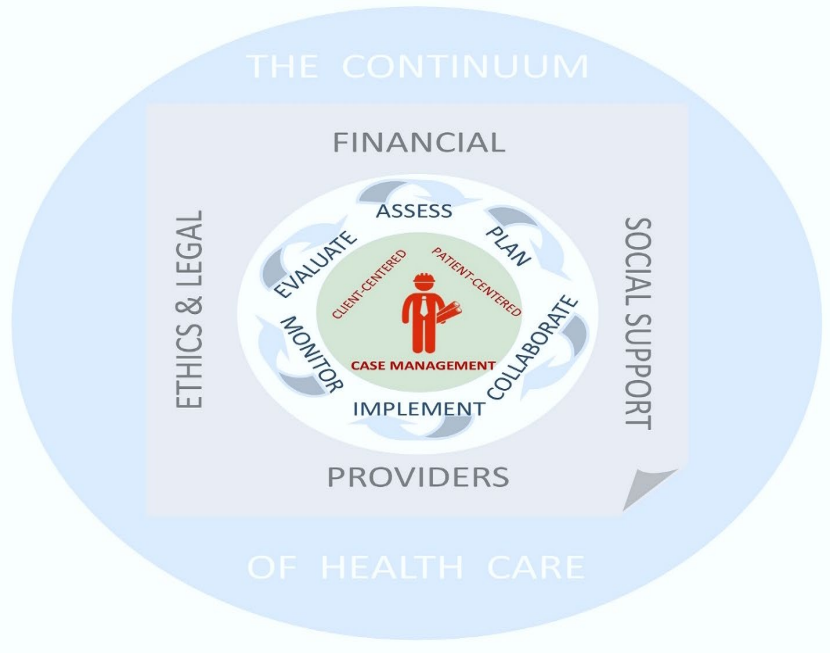


Figure 1-4: Care Management Continuum of Care

(Source: https://www.compalliance.com/case-management-is-it-a-profession-of-professionals/)

2.0 MO HealthNet Managed Care Overview

2.1 MO HealthNet Managed Care

In the State of Missouri, MHD 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 MHD's oversight, CMS also monitors 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.

MO HealthNet (Missouri's Medicaid Program): MHD provides health care access to low income individuals that are elderly, disabled, members of families with dependent children, children in low-income families, uninsured children, pregnant women, refugees, or children in state custody. Participants are categorized into Medical Eligibility (ME) groups based on their specific factors. Adult participants in ME categories for Aid to the Blind or pregnant women programs receive a full comprehensive benefit package including: primary, acute and preventive care, hospital care, dental, prescriptions, and vision. All other adult participants receive a limited benefit package of services depending on their ME category. Services are received through a Fee-For-Service (FFS) or Managed Care delivery system (Figure 2-1).

Figure 2-1 MO HealthNet Services (source: dss.mo.gov)

- FFS program: Serves eligible participants with disabilities, seniors, blind and visually impaired and women with breast or cervical cancer. All MO HealthNet providers may serve FFS participants. Participants may freely choose a provider for care under the FFS delivery system.
- Managed Care program: Serves eligible children, pregnant women and newborns, uninsured women and families in all Missouri counties. Managed Care participants may be seen by any FFS provider until their enrollment is effective in a MCO. Managed Care participants must select a MCO and a Primary Care Provider (PCP) within the MCO.

MO HealthNet for Kids: Refers to the statewide program for children in low-income families, uninsured children through CHIP, and children in the custody of the state. Children receive a full comprehensive package including primary, acute, preventive care, hospital care, dental, prescriptions, and vision. They receive their care through the Managed Care delivery system, unless they have opted out of Managed Care.

Missouri's Children's Health Insurance Program (CHIP): 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.

Missourians with developmental disabilities served through the Missouri Department of Mental Health, are not included in the Managed Care system and receive services through FFS. Uninsured women losing their MHD eligibility 60 days after the birth of their child are covered for women's health services for an additional year, regardless of their income level. This population receives services through FFS Program.

2.2 Quality Improvement Strategy

MHD revised the QIS in July 2018 with an aim to furnish high quality health care services resulting in measurable improvements in population health with significant cost efficiencies. The QIS was developed through collaborative partnerships with members, stakeholders, and other State Agencies (Departments of Mental Health; Social Services; Commerce and Insurance; Elementary and Secondary Education; and Health and Senior Services), MCOs, and community groups.
The goal is to:

- Ensure appropriate access to care
- Promote wellness and prevention
- Ensure cost-effective utilization of services

- Promote member satisfaction with experience of care

The following initiatives in CY 2018 are directed towards achieving these goals:
1. Integrated Care: The care managers should emphasize health promotion through preventive care such as screenings, vaccinations, and evaluation of the home environment. The MCO shall ensure integration between physical health care management and behavioral health care management. In addition, MCOs are required to ensure collaboration with the 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 through providing clinical care and wrap around services.

2. Medicaid Reform and Transformation: The MCO shall provide programs involving personal responsibility; promoting efficiency through state provider incentives; the Local Community Care Coordination Program designed to engage members, providers, and the MCO in transforming the state agency's service delivery system; and increasing accountability and transparency.
The MCO shall establish a member incentive program with the following activities in mind:

- To promote healthy behaviors and encourage members to take ownership of their health care by seeking early preventive care in appropriate settings.
- To promote the adoption of healthier personal habits including but not limited to tobacco use, behaviors that lead to obesity, control of asthma, control of diabetes, etc.
- To promote enhanced engagement and greater health literacy among members.
- To promote appropriate use of emergency room services.

The MCO shall ensure 10% of the defined providers participate in the provider incentive program by June 30, 2018.

3. Show Me ECHO (Extension for Community Healthcare Outcomes) is part of the University of Missouri's Telehealth Network. This program 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 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.
Beginning July 1, 2018, the MCO will participate in Show Me ECHO projects that address 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.

4. Accreditation: MCO shall obtain accreditation, at a level of "accredited" or better, for the MO HealthNet product from NCQA within twenty-four (24) months of the first day of the effective date of the contract. If the MCO is new to MHD Managed Care, the MCO shall obtain accreditation, at a level of "accredited" or better, for the MO HealthNet product from NCQA within thirty (30) months following the effective date of the contract.

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	Accredited*	5/21/2022

Source: https://dss.mo.gov/mhd/mc/pdf/managed-care-quality.pdf
*In CY 2018 the status was "Interim." It changed to Accredited in May 2019.

5. Community Health Initiatives
All MCOs are required to participate in community health improvement initiatives in collaboration with the Department of Health and Senior Services (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.

6. Network Adequacy Standards: Network adequacy is assessed by the MHD's analysis of network access plans submitted by the MCOs annually. To provide adequate access to care for members, health plans are responsible for making sure Primary Care, Specialty Care, and Behavioral Health networks comply with travel distance standards as set forth by the Department of Commerce and Insurance in 20 CSR 400-7.095. Additionally, MHD evaluates Network Adequacy anytime large providers are terminated (MHD contract, section 2.4.12).

7. A secret shopper survey is conducted by EQRO to assess provider directories to determine: if 80% of PCPs, Obstetrics and Gynecology providers, Dentists, and psychiatrists

are accepting new members; and if 90% accuracy of information posted on MCOs' and MHD's FFS websites is met. A separate report is submitted to MHD.

8. Program Integrity: MCOs must have written credentialing and re-credentialing policies and procedures for determining and assuring that all in-network providers are licensed by the state in which they practice and are qualified to perform their services. All network providers must be enrolled with MHD as a Medicaid provider as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b).

9. Missouri Medicaid Access to Physician Services (MO MAPS): Effective July 1, 2018 MO HealthNet established a program to improve access to primary care services for MO HealthNet participants. The MO MAPS Program applies to physician and certain non-physician practitioners employed by or affiliated with the University of Missouri Health System, Truman Medical Centers or University Physician Associates because these practitioners are key providers of primary care services to MO HealthNet participants. These providers will be eligible for enhanced payments for patient care services provided (MHD contract 2.6.23).

2.3 Managed Care Organizations

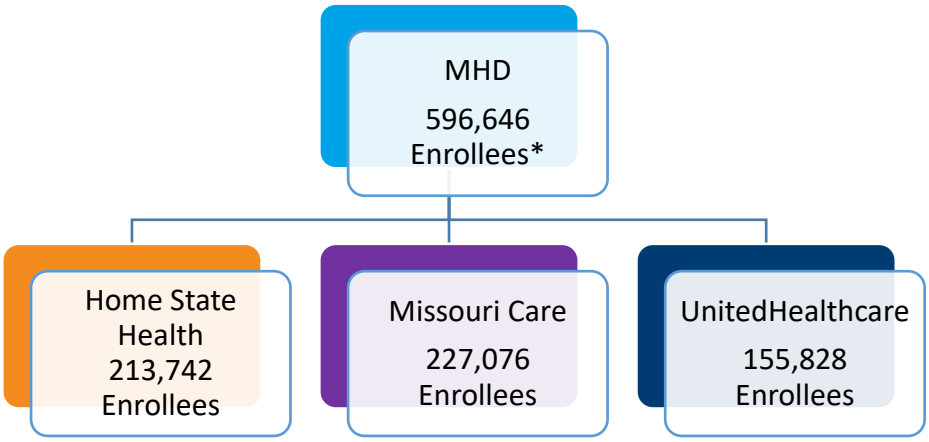


Figure 2-2 Managed Care Organizations (*Data: End of SFY 2019)

Home State Health

Home State Health was founded in 2012 by their parent company, Centene Corporation. The MCO operates in all 114 counties as of May 1, 2017, serving about 213,742 Medicaid (by end of SFY 2019), 90,000 Marketplace and 550 Medicare members (Figure 2-3). Compliance and care management processes followed by Home State Health are dipicted in Figures 2-4, 2-5.

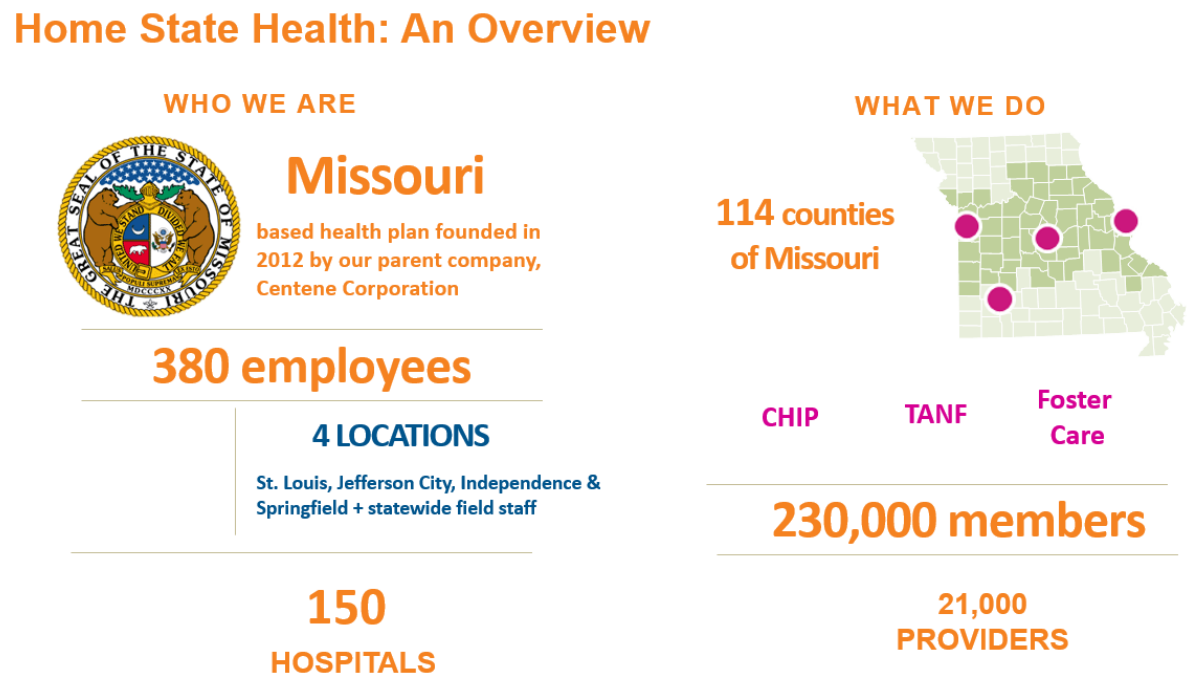


Figure 2-3 Overview of Home State Health

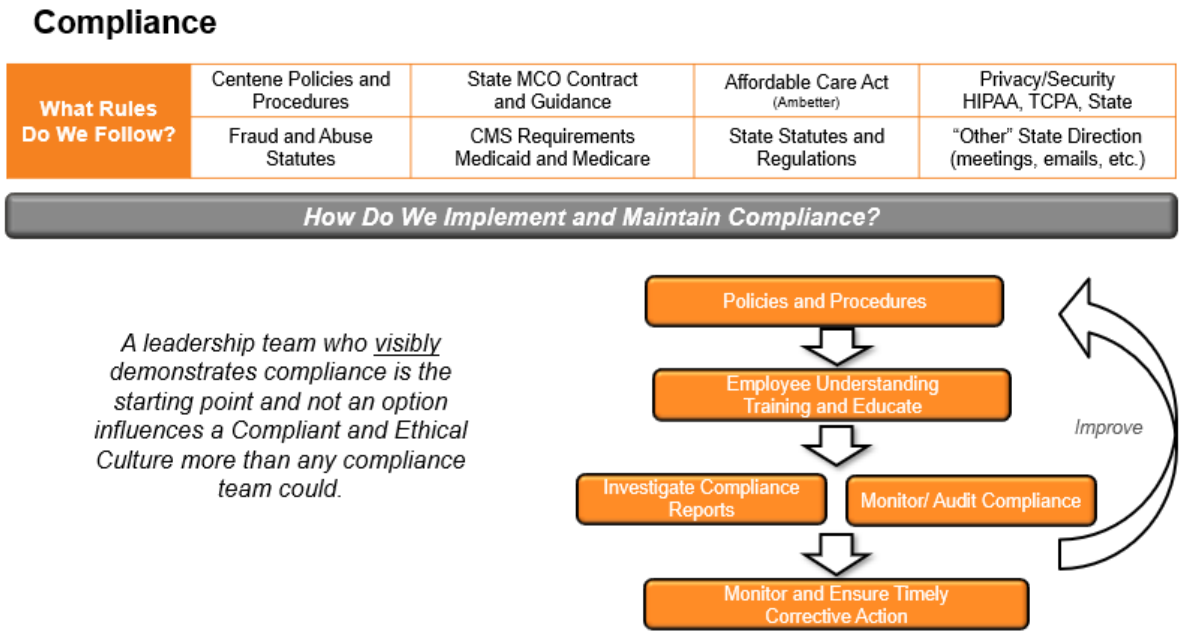


Figure 2-4 Compliance Process at Home State Health

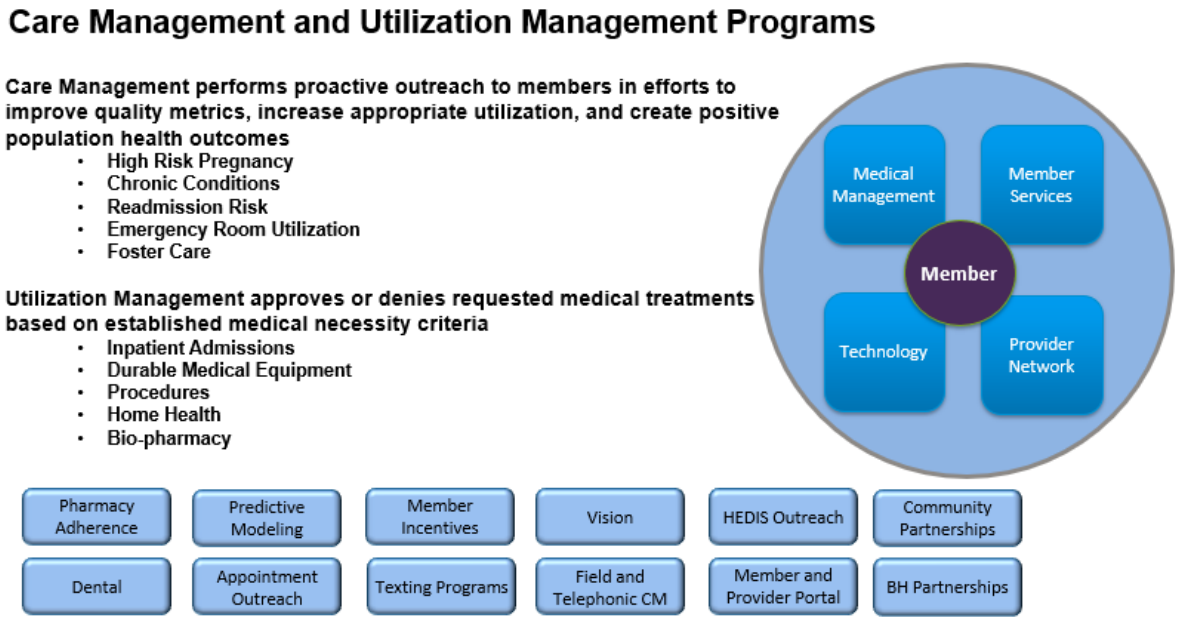


Figure 2-5 Care Management at Home State Health

Missouri Care

Headquartered in Tampa, Florida, WellCare Health Plans, Inc. focuses primarily on providing government-sponsored managed care through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, as well as individuals in the Health Insurance Marketplace. WellCare serves approximately 5.5 million members nationwide as of December 31, 2018. In Missouri, the MCO has served 227,076 enrollees by end of SFY 2019.

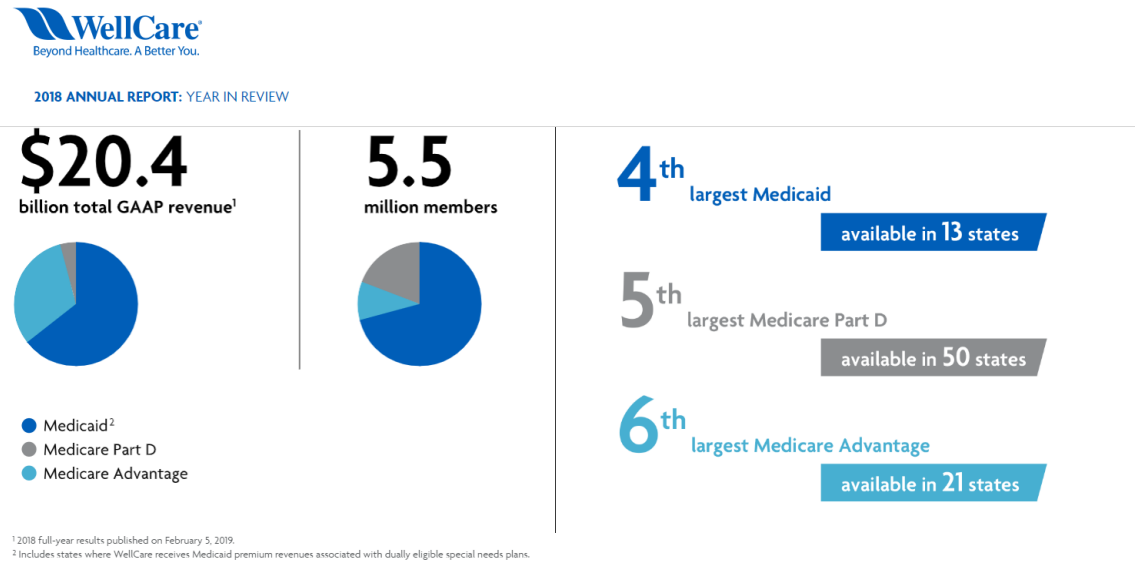


Figure 2-6 Overview of WellCare Health Plans, Inc. (Source: Missouri Care's website)

UnitedHealthcare

Under the new contract with MHD effective May 1, 2017, the MCO has served 155,828 enrollees by end of SFY 2019. (Figure 2-7 provides an overview and Figure 2-8, 2-9 describes the efforts of the MCO to build a successful CM program in Missouri.

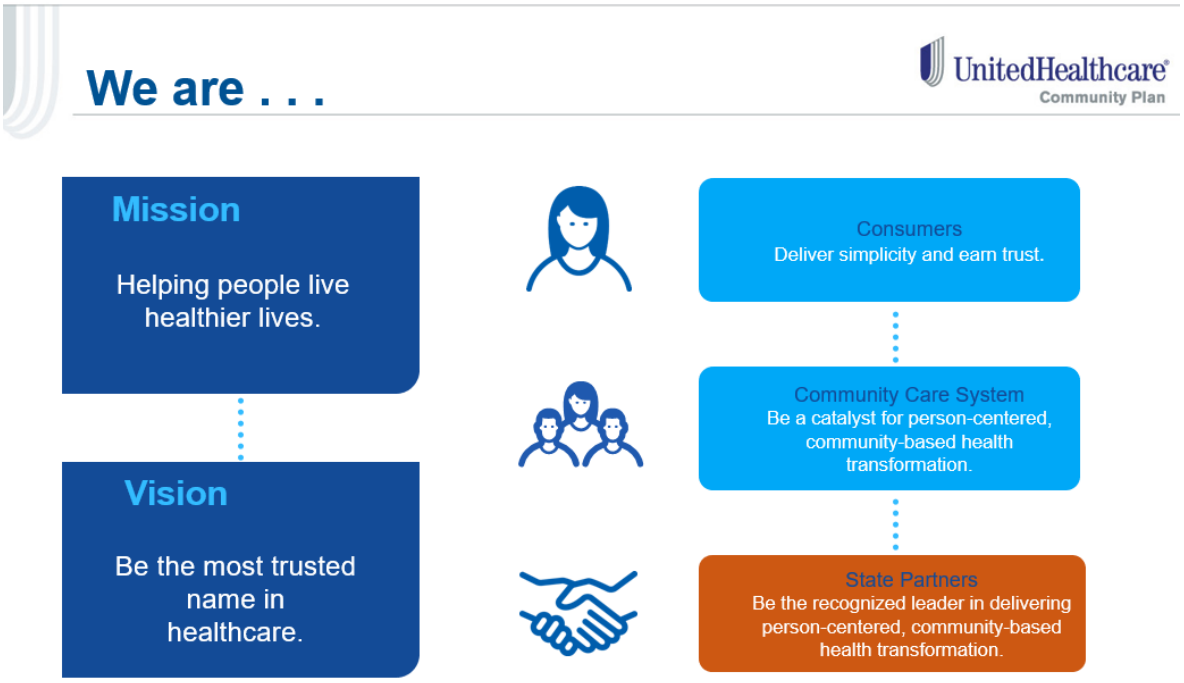


Figure 2-7 Overview of UnitedHealthcare

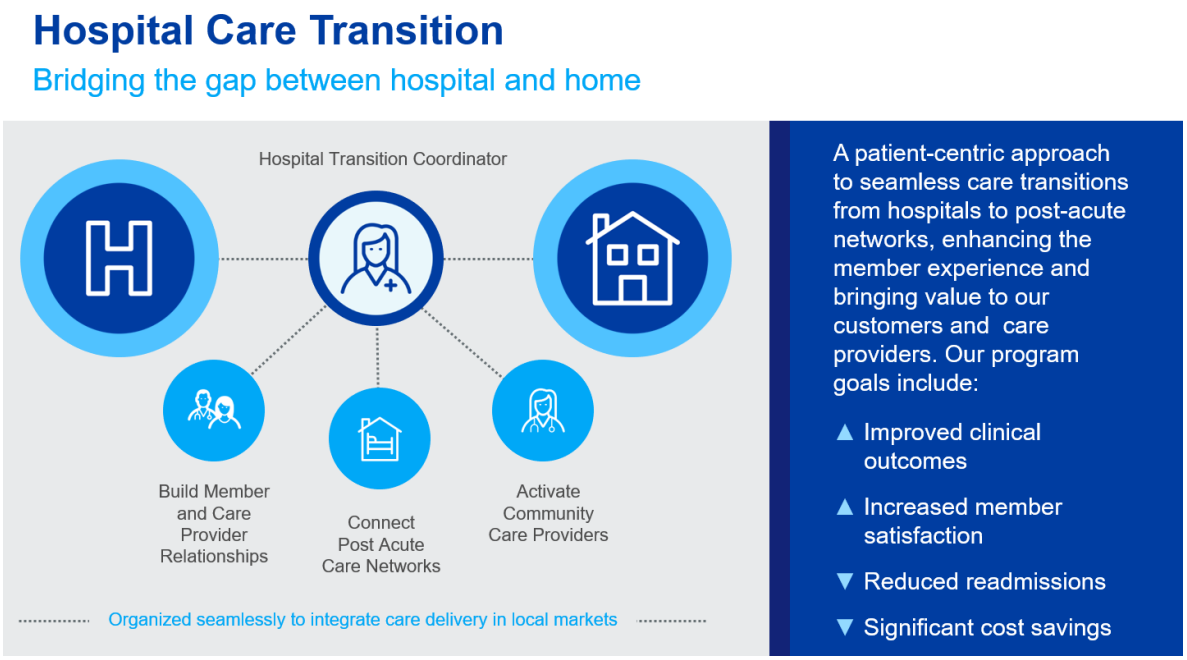


Figure 2-8 Care Transition Program UnitedHealthcare

Figure 2-9 Projected Outcomes of Care Transition Program UnitedHealthcare

3.0 Compliance with Medicaid Managed Care Regulations

3.1 Description and Methodology

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

In EQR 2019, Primaris reviewed the following 10 standards from 42 CFR 438 Subpart D (Table 3-1) for UnitedHealthcare. Home State Health and Missouri care were evaluated for the first 7 standards only- 438.206 to 438.228. The last 3 standards-438.230 to 438.242- were covered during EQR 2018. (Note: UnitedHealthcare was not included in EQR 2018 as it did not complete a full year period under MHD contract). This was done to bring all three MCOs to the same level for compliance activity during next EQR 2020.

Table 3-1: 42 CFR 438 Subpart D-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
- §438.242 Health information systems

The primary objective of Primaris' review is to provide meaningful information to MHD and the MCOs regarding compliance with state and federal guidelines. Primaris collaborated with each of the MCOs and MHD to:

- Determine the scope of the review, scoring methodology, and data collection methods.
- Finalize the onsite review agenda.
- Collect and review data and documents before, during and after the onsite review.
- Identify key issues through analyzing the data collected.
- Prepare the report related to the findings.
- Review recommendations from the previous CY audits.

Primaris conducted a compliance review in Feb-Apr 2019 (Figure 3-1). Evaluation tools were created based on MHD Managed Care Contract, 42CFR 438, subpart D, and QIS. The evaluation was performed by requesting and analyzing policies and procedures, documentations, observations and onsite interviews. Primaris provided Technical Assistance (TA) during the review period to help the MCOs towards continuous improvement and excellence.

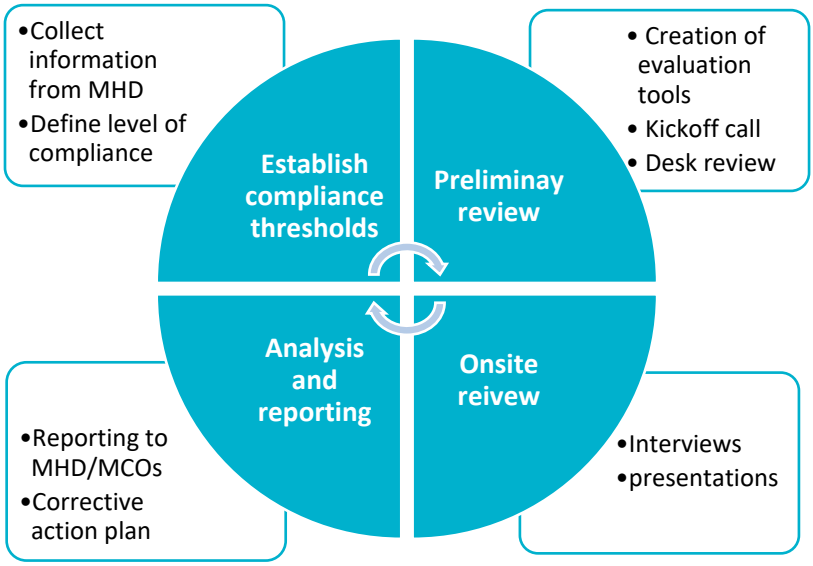


Figure 3-1 EQR Process for Compliance Review

The MCOs uploaded their documents at Primaris' secure website service to enable a complete and in-depth analysis of their compliance with standard regulations. These included the policies, procedures, protocols, manuals, logs, power point presentations, reports, print-screens, and training materials.

Compliance Ratings

The information provided by MCOs was analyzed and an overall compliance score (by percentage) was given. Each section of an evaluation tool was assigned 2 points

(denominator) and was scored as: Met, Partially Met or Not Met. Primaris utilized a compliance rating system as defined in Table 3-2. MHD and MCOs may use the findings that resulted from Primaris' review to identify, implement and monitor interventions to improve the aspects of Quality, Timeliness and Access for Healthcare Services to its members.

Table 3-2: Compliance Rating System

●	**Met** (2 points): All documentation listed under a regulatory provision, or component thereof, is present. MCO staff provide responses to reviewers that are consistent with each other and with the documentation. A state-defined percentage of all data sources–either documents or MCO staff–provide evidence of compliance with regulatory provisions.
●	**Partially Met** (1 point): All documentation listed under a regulatory provision, or component thereof, is present, but MCO staff are unable to consistently articulate evidence of compliance; or MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice; or any combination of "Met," "Partially Met" and "Not Met" determinations for smaller components of a regulatory provision would result in a "Partially Met" designation for the provision as a whole.
●	**Not Met** (0 point): No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with regulatory provisions; or no documentation is present and MCO staff have little to no knowledge of processes or issues that comply with key components (as identified by the state) of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

Corrective Action Plan (CAP) Process

For any areas of concern identified during evaluation, the MCO must identify, for each criteria that requires a corrective action ("Not Met"), the interventions it plans to implement to achieve compliance with the requirement, including how the MCO will measure the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities.

MHD in consultation with Primaris, will review and when deemed sufficient, approve MCOs' CAP to ensure the CAP sufficiently addresses the interventions needed to bring performance into compliance with the requirements. The MCO will be required to submit a CAP within 30 days of receiving final compliance report. Primaris does not raise a CAP for "partially met" criteria. However, all deficiencies are subject to re-evaluation during next EQR cycle.

3.2 Findings and Analysis Home State Health

Summary

- An assessment was done for 7 standards and Home State Health scored 100% on each one (Table 3-3).
- Home State Health is not put on a corrective action plan for any standard in EQR 2019.
- During the previous year (EQR 2018), Home State Health was not put on a corrective action plan which required a review this year.

Table 3-3 Score for Compliance Home State Health

Standard	Standard Name	Number of Sections				Score	Score %
		Total	Met	Partial Met	Not Met		
§438.206	Availability of services	11	11	0	0	**22**	**100**
§438.207	Assurances of adequate capacity and services	10	10	0	0	**20**	**100**
§438.208	Coordination and continuity of care	17	17	0	0	**34**	**100**
§438.210	Coverage and authorization of services	22	22	0	0	**44**	**100**
§438.214	Provider selection	12	12	0	0	**24**	**100**
§438.224	Confidentiality	19	19	0	0	**38**	**100**
§438.228	Grievance and appeal systems	44	44	0	0	**88**	**100**
Total	**7**	**135**				**270**	**100 %**

Compliance Score % = $\frac{\text{Total Score X100}}{\text{Total Sections X 2 points}}$ = 100%

Performance Strengths

§438.206	Availability of services	Met

Home State Health was evaluated for 11 criteria and scored "Met" for all of them resulting in 100% compliance.

Home State Health provides a robust service that meets all travel distance requirements, appointment standards, and scope of its network. In regard to cultural competency, they have shown numerous references throughout their infrastructure to ensure compliance and consideration to all enrollees, including those with limited English proficiency and

diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, or sexual orientation.

§438.207	Assurances of adequate capacity and services	Met

Home State Health was evaluated for 10 criteria and scored "Met" for all of them resulting in 100% compliance.

Home State Health has thoroughly demonstrated a wide range of preventive, primary care, and specialty services that are adequate for the number of enrollees in their service area. Their network consisted of multiple hospitals, physicians, advanced practice nurses, mental and behavioral health providers, substance use disorder providers, dentists, emergent and non-emergent transportation services, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), and all other provider types as required to ensure sufficient capacity to make all services available.

§438.208	Coordination and continuity of care	Met

Home State Health was evaluated for 17 criteria and scored "Met" for all of them resulting in 100% compliance.

Home State Health has ensured that they address all aspects of coordination and continuity of care such as transition of care requirements, initial screening, and coordination of all required services. Although they do not cover LTSS, they have shown (by multiple examples) a diverse range of options and services for special needs.

§438.210	Coverage and authorization of services	Met

Home State Health was evaluated for 22 criteria and scored "Met" for all of them resulting in 100% compliance.

Home State Health has a Utilization Management (UM) Program which defines the structure and processes within the Medical Management Department, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions and coordination of care for the health plan members. The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long term care, and ancillary care services.

The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing

cost trends. The UM Program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

§438.214	Provider selection	Met

Home State Health was evaluated for 12 criteria and scored “Met” for all of them resulting in 100% compliance.
Home State Health has substantial written credentialing and re-credentialing policies and procedures for selecting, monitoring, and maintaining a robust selection of providers. Furthermore, Home State Health makes significant efforts to collect, audit, and ensure data accuracy and provider compliance with their set standards and policies that are in line with the state’s requirements. Home State Health also concurrently monitors credentialing and reporting of their providers.

§438.224	Confidentiality	Met

Home State Health was evaluated for 19 criteria and scored “Met” for all of them resulting in 100% compliance.
Home State Health works to protect information assets through a number of technical and physical controls intended to prevent security incidents and reduce their potential impact. Examples of these controls include: enabling multi-factor authentication to access company systems; providing employee resources and training to promote information security awareness; implementing automated tools for detecting and responding to threats; ensuring appropriate encryption technology is in place for the secure storage and exchange of confidential data; ensuring passwords follow recommended complexity requirements and are updated regularly; verifying professional credentials before granting access to company systems or information; appropriately storing and disposing of both physical and digital documents containing sensitive information; following protocols for securely accessing Company systems; immediately reporting any security incidents or suspicious communications or behaviors to the Chief Security Risk Officer or the Corporate Ethics & Compliance Department.
Home State Health has policies and responsibilities with respect to the use, disclosure and maintenance of hard copy, electronic or oral communication of Protected Health Information (PHI) in order to protect the confidentiality of and to guard against unauthorized access to the same. Disclosures are made to a Business Associate (BA) with whom Home State Health has executed a Business Associate Agreement (BAA), or other written agreement containing Business Associate Provisions. In this agreement, the BA

provides satisfactory assurances that the BA will appropriately safeguard the Protected Health Information disclosed.

§438.228	Grievance and appeal systems	Met

Home State Health was evaluated for 44 criteria and scored "Met" for all of them resulting in 100% compliance.

Home State Health has a "grievance and appeal system" for members that meet all federal and state regulatory requirements, including a grievance process, an appeal process, and access to the State Fair Hearing (SFH) system. Home State Health's grievance and appeals process and related policies and procedures are approved by the Quality Improvement Committee (QIC). They are delegated by, and the direct responsibility of, the Board of Directors.

Home State Health refers all members who are dissatisfied with Home State Health or its subcontractors in any respect to contact the Member Services Department and, when applicable, the expression of dissatisfaction is forwarded to Home State Health's grievance and appeals coordinator (GAC) to review. The day-to-day responsibility for the coordination of the grievance process resides with the GAC. One of the responsibilities of the GAC is to ensure adherence to the various deadlines in accordance with state and federal laws. The content and substance of a grievance or appeal, including all clinical care aspects involved, are fully investigated and documented according to applicable statutory, regulatory, and contractual provisions and Home State Health's policies and procedures. Resolution and notification of such resolution is made as expeditiously as the member's condition warrants, but no later than the time frames as outlined in their policy or per state or contractual requirements.

Corrective Action Plan

No concern was identified for any standard under evaluation.

Weaknesses

A few weaknesses were noted after reviewing the policies/documents of Home State Health.

Grievance and Appeal System: Some of the policies had outdated information based on the 2015 Managed Care Rule (old CFR). For example:

- MO.UM.01.01 page 5 of 12: A member may request a State Fair Hearing within 90 calendar days from the health plan's notice of action.
- The definition of appeal: A request to change or reverse a previous adverse clinical decision is considered an appeal.

- UM description MHD approved 8-7-18: Members will be provided a reasonable time frame to file an appeal. This time frame is no more than 90 days from the date of Home State's notification of adverse determination.
- The term "action" is used in place of "adverse benefit determination" at some places.

Quality, Timeliness, and Access to Healthcare Services

Home State Health showed commitment and true diligence in compliance of availability of services. They continuously measure and analyze for quality and efficiency.

- Home Sate Health collects after-hours accessibility data on PCPs that cover 50% of their members. Home State Health conducts a telephone survey of PCP offices to assess for compliance with appointment accessibility standards which they then submit for analysis. The audit of PCPs for accessibility of routine non-symptomatic, routine symptomatic, and urgent care appointments found that they have met their goal of 90%, or only 1 in 372 PCPs contacted did not meet the appointment standards. Subsequently, a corrective action plan was put in place for the practitioner not able to meet the standards with consequences for not improving upon future surveys.
- Home State Health also monitors high volume specialists to ensure members have access to medical care 24/7. They surveyed 90% of their high-volume OB\GYNS for first, second, third trimester and high-risk pregnancy appointment standards and obtained a 98% compliance in the standard for appointments within 7 calendar days for first and second trimester, and 100% compliance for third trimester and high-risk pregnancies within 3 days of request.

State performance measures and HEDIS measures reporting constitutes the core of the information base that drives Home State Health's clinical quality performance efforts. Home State Health provides a holistic approach to integrated care coordination through the use of multi-disciplinary teams that focus on the whole person rather than just the diagnosis. Their goal is to ensure Medicaid recipients get the care they need in the most appropriate setting in the following ways:

- 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.
- Implement physician-driven strategies that support a Medical Home.

Improvement by Home State Health

- Home State Health has maintained 100% compliance with federal and state rules and regulations over the last two years (CY 2017 and CY 2018) (Figure 3-2).
- Home State Health was not placed on CAP by the EQRO for the last three consecutive years (CY 2016-CY 2018).

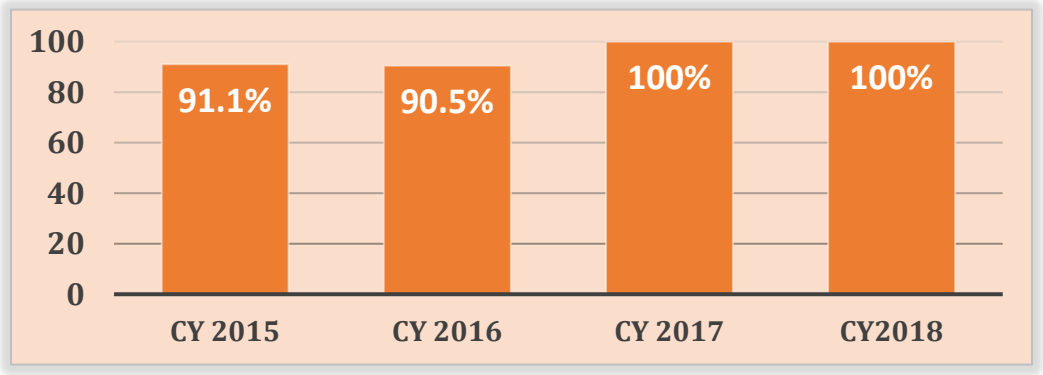


Figure 3-2: Compliance Score Trend CY 2015-CY 2018 (%) Home State Health

- Follow up on recommendations from last year:
  1. During the previous year (EQR 2018), Subpart D Standard 8-42 CFR 438.230 Subcontractual relationships and delegation was evaluated. A recommendation was made for section 2c of the evaluation tool which stated: "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 438.230(c) (3) (iii))."
  Home State Health has updated their standard subcontractor required provisions template to include "vendor and sub-contracted Vendor(s) shall maintain all medical records remaining under the care, custody, and control of the vendor and sub-contracted Vendor(s), or the Vendor and sub-contracted vendor(s)'s designee, for a minimum of 10 years from the date of when the last professional service was provided." (Ref. Vendor MOHealthNet 20181109 Pages 5, 9 of 9).
  Home State Health has stated that this template is currently in use for any new Medicaid related subcontractors and they are working to update this template with the existing subcontractors.

  2. In Subcontractual Relationships and Delegation, 2b, it was recommended that Home State Health should 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 CFR wording warrants a consideration to include these elements.
  Home State Health has updated their standard subcontractor required provisions template to include "computer or other electronic systems" (Ref. Vendor

MOHealthNet 20181109 Page 9 of 9). Home State Health has stated that this template is currently in use for any new Medicaid related subcontractors and they are working to update this template with the existing subcontractors.

3.3 Findings and Analysis Missouri Care

Summary

- An assessment was done for 7 standards. Missouri Care achieved an overall score of 96.6% (Figure 3-4).
- Missouri Care is put on a corrective action plan for one standard, "42 CFR 438.224 confidentiality."
- During the previous year (EQR 2018), Missouri Care was not put on a corrective action plan which required a review this year.

Table 3-4 Score for Compliance Missouri Care

Standard	Standard Name	Number of Sections				Score	Score %
		Total	Met	Partial Met	Not Met		
§438.206	Availability of services	11	11	0	0	**22**	**100**
§438.207	Assurances of adequate capacity and services	10	10	0	0	**20**	**100**
§438.208	Coordination and continuity of care	17	17	0	0	**34**	**100**
§438.210	Coverage and authorization of services	22	22	0	0	**44**	**100**
§438.214	Provider selection	12	12	0	0	**24**	**100**
§438.224	Confidentiality	19	13	3	3	**29**	**76**
§438.228	Grievance and appeal systems	44	44	0	0	**88**	**100**
Total	**7**	**135**				**261**	**96.6%**

Compliance Score % (combined for all seven) = Total Score X100 = 100%
Total Sections X 2 points

Performance Strengths

§438.206	Availability of services	Met

Missouri Care was evaluated for 11 criteria and scored "Met" for all of them resulting in 100% compliance.

Missouri Care has dedicated many resources and time towards the evaluation of their provider self-reported appointment surveys. They have identified barriers with non-compliant providers and have established mitigating factors. Such factors include the

ability for members to access urgent care centers without referral or prior authorization requirements and a nurse advice and crisis line available to members 24/7. Missouri Care provides an eclectic service that meets all travel distance requirements, appointment standards, and scope of its network. In regard to the cultural competency, they have provided multiple polices and examples of their due diligence with the requirements of the standard. In addition, they provide assistance and documentation in multiple languages representing all languages of their members.

§438.207	Assurances of adequate capacity and services	Met

Missouri Care was evaluated for 10 criteria and scored "Met" for all of them resulting in 100% compliance.
Missouri Care has demonstrated a wide range of preventive, primary care, and specialty services that are adequate for the number of enrollees in their network.
Their network consisted of multiple hospitals, physicians, advanced practice nurses, mental and behavioral health providers, substance use disorder providers, dentists, emergent and non-emergent transportation services, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), and all other provider types as required to ensure sufficient capacity to make all services available.

§438.208	Coordination and continuity of care	Met

Missouri Care was evaluated for 17 criteria and scored "Met" for all of them resulting in 100% compliance.
Missouri Care has a wide range of policies, procedures, and member and provider materials, demonstrating outstanding programs and services which ensured that they address all aspects of coordination and continuity of care, e.g., transition of care requirements, communicating with the transferring/receiving MCO, allowing pregnant women to receive services without prior authorization. In addition, special needs cases are identified, and risk stratified for care coordination and case management.

§438.210	Coverage and authorization of services	Met

Missouri Care was evaluated for 22 criteria and scored "Met" for all of them resulting in 100% compliance.
Missouri Care provides covered services according to the MO HealthNet Managed Care Contract, Section 2.7. The MCO complies with all state and federal laws pertaining to the provision of such services. Missouri Care's prior authorization function monitors the use of

designated services before the services are delivered in order to confirm that they are: provided at an appropriate level of care and place of service; included in the defined benefits, and are appropriate, timely, and cost-effective; coordinated as necessary with Medical Management, Behavioral Health Care Departments or functions, and information is communicated to applicable operations areas (e.g., Finance) or per contractual requirement with external vendors; and accurately documented in order to facilitate accurate and timely reimbursement.
Missouri Care's services are supported by policies and procedures that meet requirements that promote the access of prior authorization services 24 hours a day, 7 days a week via telephonic, electronic and/or web-based systems.

§438.214	Provider selection	Met

Missouri Care was evaluated for 12 criteria and scored "Met" for all of them resulting in 100% compliance.
Missouri Care's credentialing and re-credentialing policies and procedures for selecting, monitoring, and maintaining a robust selection of providers meet the requirement in this standard. Furthermore, Missouri Care makes significant efforts to collect, audit, and ensure data accuracy and provider compliance with their set standards and policies that are in line with the state's requirements. Missouri Care also concurrently monitors credentialing and reporting of their providers as required.

§438.224	Confidentiality	Not Met

Missouri Care was evaluated for 19 criteria and achieved a compliance score of 76%. They were assigned: "Met" for 13; "Partially Met" for 3; and "Not Met" for 3 of the 19 criteria.
Missouri Care manages Protected Health Information (PHI) as per Health Insurance Portability and Accountability Act (HIPPA) and Health Information Technology for Economic and Clinical Health Act (HITEC) which mandates protecting the integrity, confidentiality and availability of PHI regardless of how it is created or maintained including oral, written, and electronic forms. This standard is administered by the compliance department through the activities of the privacy officer and is intended to serve as a foundation for the privacy practices of WellCare (Missouri Care's parent company). Each associate is required to complete a HIPPA training program within 30 days of being hired and annually thereafter. When WellCare's HIPAA Compliance Program is modified, the privacy officer or designee will provide HIPAA training to those associates whose jobs are affected by such modifications.

§438.228	Grievance and appeal systems	Met

Missouri Care was evaluated for 44 criteria and scored "Met" for all of them resulting in 100% compliance.
Missouri Care has a Grievance and Appeal System for members that meets all statutory and regulatory requirements in 42 CFR § 438 Subpart F as controlling law. The Grievance and Appeal System includes a Grievance and Appeal Process and access to the State Fair Hearing (SFH). The member grievances and appeals are acknowledged and addressed within the specified time frames, in a manner that supports an equitable outcome and processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural grievances by the member. Member inquiries are monitored and addressed so as to validate the possibility of any inquiry actually being a grievance or appeal and to identify inquiry patterns. Missouri Care has policies that promote member education regarding grievance rights; facilitate the identification and resolution of issues that impact quality of care and services; provide for accurate maintenance of required documentation; and ensure compliance with reporting requirements.

Corrective Action Plan
A corrective action plan was raised for the noncompliance criteria. The policies and documentations submitted by Missouri care did not meet/partially meet the following criteria:

- Release of PHI to public will occur only after prior written consent to the state agency (MHD contract 3.16.1)-Partially Met.
- If required by the state agency, MCO and any required MCO personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request (MHD contract 3.16.2)-Not Met.
- MCO may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j) (1) (MHD contract 2.38.2c)-Partially Met.
- If applicable, the MCO may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B) (MHD contract 2.38.2f)-Not Met.
- The MCO may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so (MHD contract 2.38.2f)-Partially Met.
- The MCO shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s) or subcontractor(s) (MHD contract 2.38.3p)-Not Met.

Weaknesses

A few weaknesses were noted after reviewing the policies/documents of Missouri Care. Grievance and Appeal System: Some of the policies contain outdated information based on 2015 Managed Care Rule (old CFR), for example:

- MO 29 HS UM 002 Notice of action, page 4 of 12: The term "action" is used in place of "adverse benefit determination."
- PA fax provider authorization approval, page 3 of 4: A member may request a State Fair Hearing within 90 calendar days from the health plan's notice of action.

Quality, Timeliness, and Access to Healthcare Services

Missouri Care has a detailed and well thought-out process to evaluate timely access of services. Missouri Care demonstrated their procedure to Primaris during the onsite visit. Telephone surveys are conducted in a set of 2 rounds quarterly, by their contracted vendor. The various scripts address family practices, internal medicine, general practices, pediatrician practices, obstetrics and gynecology practices, oncology practices, behavioral health providers, and high-volume specialists (including ophthalmology, cardiology, general surgery, dermatology, neurology, orthopedic surgery, and ENT).

The following are evaluated:

- Provider Appointment Compliance Survey Results
- Review of Member Grievances Related to Provider Accessibility & Availability
- Member Services Telephone Accessibility
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) member survey feedback on experience with Getting Needed Care and Getting Care Quickly.

In order to mitigate issues with accessibility, Missouri Care offers a Nurse Advice Line and BH Crisis Line available to members all the time. Members may also access urgent care centers without referral or prior authorization requirements. At the same time, Provider Relations will continue to educate providers on the accessibility requirements.

Missouri Care's QI Program was considered effective for the CY 2018:

- Complaints, Grievances and Appeals department reviewed and resolved all grievances within the contractual time frames.
- A total of 1,450 new applicants were presented to the WellCare Credentialing Committee. Credentialing applicants were processed within 13 calendar days.
- Customer service average speed of answer for member calls during 2018 was 12 seconds, which exceeded the goal of < 30 seconds. The Average Abandonment Rate for member calls was 0.57%, which exceeded the goal metric of less than or equal to 5%.
- A decrease of 50% in the volume of member PCP change requests related to Auto Assigned PCP was noticed. One of the factors driving this decrease was a new CY

2018 process to use claims data to identify cases where a member was receiving care from a PCP other than their auto assigned PCP and to update the member's PCP of record in those cases.

- Converted Electronic Medical Records (EMR) transfer process to Electronic Supplemental Data (ESD) process to better capture provider's quality data (ESD/EMR increased to 40% of membership).

Improvement by Missouri Care

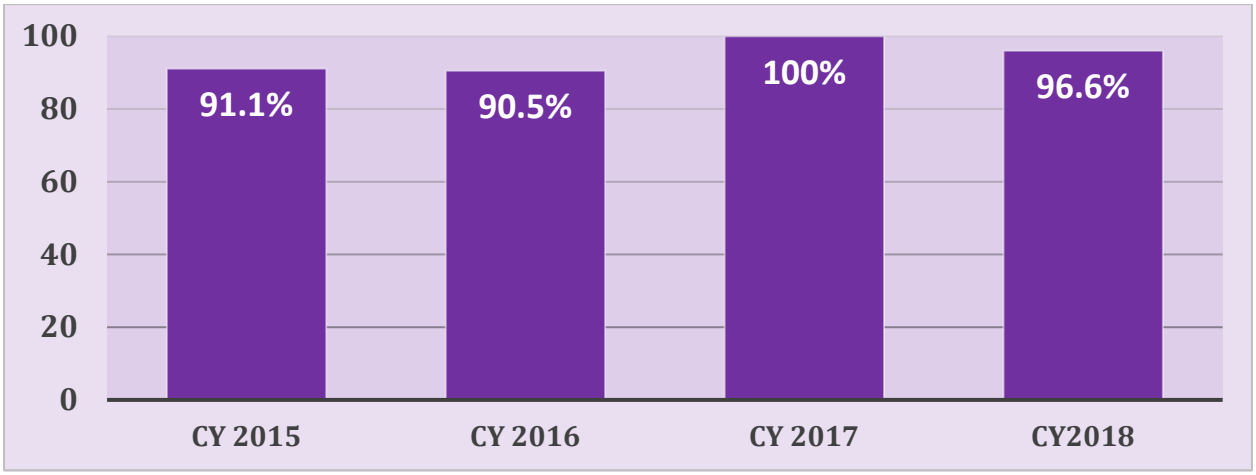


Figure 3-3: Compliance Score Trend CY 2015-CY 2018 (%) Missouri Care

- Missouri Care's compliance with federal and state rules and regulations for EQR 2019 (CY 2018) is 96.6%. This is a drop by 3.4% from previous year (CY 2017) (Figure 3-3).
- Follow up on recommendations from last year:
  During the previous year (EQR 2018), Subpart D Standard 8-42 CFR 438.230 Subcontractual relationships and delegation was evaluated. A recommendation was made for section 2c of the evaluation tool which stated: "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 438.238(c) (3) (iii), date of applicability, July 01, 2017)."
  Missouri Care was recommended to work with MHD to align audit rights and related record retention expectations to the 10 years duration in all the delegated subcontractor contracts.
  The documents submitted by Missouri Care reflected the "right to audit" from 5-10 years duration, at various places in their documents. These documents have not been updated consistently to reflect 10 years in all the subcontractors' agreement, pending amendment in MHD contract.

3.4 Findings and Analysis UnitedHealthcare

Summary

- An assessment was done for 10 standards. UnitedHealthcare achieved an overall score of 99.4 % (Table 3-5).
- UnitedHealthcare is not put on a corrective action plan for any standard. However, they have scored "Partially Met" for 2 of 22 criteria evaluated for §438.210 Coverage and authorization of services.
- Since UnitedHealthcare was not included in EQR 2018, there was no compliance review findings available from last year to assess an improvement or issues.

Table 3-5 Score for Compliance UnitedHealthcare

		Number of Sections					
Standard	**Standard Name**	**Total**	**Met**	**Partial Met**	**Not Met**	**Score**	**Score %**
§438.206	Availability of services	11	11	0	0	**22**	**100**
§438.207	Assurances of adequate capacity and services	10	10	0	0	**20**	**100**
§438.208	Coordination and continuity of care	17	17	0	0	**34**	**100**
§438.210	Coverage and authorization of services	22	20	2	0	**42**	**95.5**
§438.214	Provider selection	12	12	0	0	**24**	**100**
§438.224	Confidentiality	19	19	0	0	**38**	**100**
§438.228	Grievance and appeal systems	44	44	0	0	**88**	**100**
§438.230	Sub Contractual 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	**10**	**155**				**308**	**99.4 %**

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

Performance Strengths

§438.206	Availability of services	Met

UnitedHealthcare was evaluated for 11 criteria and scored "Met" for all of them resulting in 100% compliance.

UnitedHealthcare provides a full range of medical providers that consists of hospitals, primary care physicians, specialists, advanced practice nurses, safety net hospitals, FQHCs, Provider-Based Rural Health Clinics (PBRHCs), Independent Rural Health Clinics (IRHCs), local public health agencies, and tertiary care. In 2018 UnitedHealthcare expanded their provider network.

§438.207	Assurances of adequate capacity and services	Met

UnitedHealthcare was evaluated for 10 criteria and scored "Met" for all of them resulting in 100% compliance.

UnitedHealthcare examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time. Their programs provide interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, aiming to increase quality of life, improve access to health care and reduce expenses. Care management/coordination team aims to increase member engagement by offering resources to fill gaps in care and developing personalized health goals using evidence-based clinical guidelines.

§438.208	Coordination and continuity of care	Met

UnitedHealthcare was evaluated for 17 criteria and scored "Met" for all of them resulting in 100% compliance.

UnitedHealthcare provides timely and consistent determinations and notices for all out-of-network coverage requests and ensures consumers have needed information regarding alternatives for continuing care. UnitedHealthcare also provides a well-defined process for the transfer of relevant member information, including medical records and other pertinent materials, to another MCO upon notification of establishment of care.

UnitedHealthcare has further established a consistent process for assessment and the development of an evidence based, person centered plan of care for individuals identified and enrolled in case management. This includes outlining a process for monitoring, reassessment and ongoing management of the plan of care and defining a process to measure satisfaction with case management services.

§438.210	Coverage and authorization of services	Partially Met

UnitedHealthcare was evaluated for 22 criteria. They scored "Met" for 20 and "Partially Met" for 2 of 22 criteria resulting in 95.5 % compliance.

UnitedHealthcare has formal systems and workflows designed to process pre-service, post-stabilization, continued stay and post-service requests for coverage and authorization of

services provided to its enrollees by in-network (INN) and out-of-network (OON) practitioners, facilities and agencies. UnitedHealthcare's utilization management (UM) program establishes and maintains required expedited and standard time frames and extensions for administrative and clinical reviews conducted on a prospective, concurrent or retrospective basis. Staff members comply with the established time frame requirements or the more stringent/restrictive applicable accreditation, state and federal laws, contract, or government program requirements when conducting reviews. UnitedHealthcare ensures that UM decisions accommodate urgency and minimize disruption in the provision of health care, and that Clinical Certification and Notification staff will not engage in unnecessary repetitive contacts with providers or patients to obtain information, and all information relevant to a certification request is maintained with the electronic record.

§438.214	Provider selection	Met

UnitedHealthcare was evaluated for 12 criteria and scored "Met" for all of them resulting in 100% compliance.
UnitedHealthcare's credentialing and re-credentialing plan is well detailed and outlined. UnitedHealthcare also follows stringent sanctions as they actively monitor sanction alerts arising from review of information from government agencies and authorities including but not limited to, the Centers for Medicare and Medicaid Services (CMS), Medicaid agencies, state licensing boards, and the Office of the Inspector General (OIG). If such information is found (through rigorous monitoring), and relates to any of their providers, UnitedHealthcare has a plan of appropriate action which shall be taken in accordance with their provider participation agreements and credentialing policies.

§438.224	Confidentiality	Met

UnitedHealthcare was evaluated for 19 criteria and scored "Met" for all of them resulting in 100% compliance.
UnitedHealthcare, their business associates (BA), subcontractors, other business organizations (as applicable), adhere to HIPAA Privacy Policy (Manual) which operates in conjunction with the UnitedHealthcare's Personal Information Privacy and Data Protection Policy. These policies describe UnitedHealthcare's approach to the protection of information about individuals under applicable laws. UnitedHealthcare manages Protected Health Information ("PHI") responsibly and legally that serves their business objectives and helps build trust with stakeholders such as customers, partners, and regulators. UnitedHealthcare requires that a security risk assessment be performed at the onset of a new business arrangement or material change of services, prior to granting an external

party organization, or external party information technology systems, connectivity or access to UnitedHealth Group's information technology systems or information assets. The security exhibit external access agreement along with the business associate agreement (BAA) supplements any customer contracted service level agreements (SLA).
Enterprise Information Security is responsible for determining the scope of assessment that must be performed. The security assessment may include, but is not limited to, completion of the Information Security Assessment Survey and a review of the external party's network topology.

§438.228	Grievance and appeal systems	Met

UnitedHealthcare was evaluated for 44 criteria and scored “Met” for all of them resulting in 100% compliance.
UnitedHealthcare processes appeals and grievances submitted by members and by authorized representatives, including providers submitting on behalf of members in accordance with applicable state and federal regulatory requirements, and the member’s plan coverage documents. UnitedHealthcare maintains a full and fair review process for resolving member appeals of an adverse determination made by UnitedHealthcare and responding to member requests to review expressions of dissatisfaction unrelated to an adverse determination in accordance with 42 CFR 438.400.
In conducting the review, the Resolving Analyst (RA) and/or decision-maker(s) conduct(s) a full investigation of the substance of the appeal or grievance to include review of the member’s governing plan documents, Member Handbook, and as applicable, the state MO HealthNet contract, for an appeal the previous adverse benefit determination and follows the processing requirements.

§438.230	Subcontractual relationships and delegation	Met

UnitedHealthcare was evaluated for 7 criteria and scored “Met” for all of them resulting in 100% compliance.
UnitedHealthcare has an agreement with their subcontractors/vendors who are required to follow Missouri state program regulatory requirements. These requirements are related but not limited to: the covered services; Medicaid eligibility; accessibility standards; hours of operations, appointments; hold state harmless; indemnification; provider selection; restrictions on referrals; subcontracts; record retentions; record access; government audit and investigations; privacy, confidentiality; compliance with law; physician incentive plans; lobbying; excluded individual and entities; cultural competency; marketing; fraud, waste, and abuse prevention; data, reports; insurance requirements; licensure; quality; utilization management; transition of covered persons; continuity of care; termination; prohibited

services; Federally Qualified Health Centers; birth notifications; claims; consumer protections; national provider identifier; off-shoring; complaints and appeals; clinical laboratory improvement act (CLIA) certification or waiver; and attestations.

§438.236	Practice Guidelines	Met

UnitedHealthcare was evaluated for 6 criteria and scored "Met" for all of them resulting in 100% compliance.
UnitedHealthcare develops and adopts Clinical Practice Guidelines (CPG) and Preventive Health Recommendations (PHR) in collaboration with the UnitedHealth Coverage Determination Committee appropriate for the MCO population. They have established a process for the development, review, adoption, and distribution of CPG and PHR. Evidence-based national guidelines from recognized sources are utilized during development of CPG/PHR and address the provision of acute, chronic, behavioral, and preventive health care. When evidence-based guidelines are not available, consensus guidelines are used (appropriate specialist review required). CPGs are reviewed and/or revised annually whereas PHR are revised annually or more frequently if revisions are required. PHR may be distributed to the members in the following ways: periodic member mailings, internet posting, and targeted mailings. Members will be provided with a copy of PHR upon request.

§438.242	Health Information Systems	Met

UnitedHealthcare was evaluated for 7 criteria and scored "Met" for all of them resulting in 100% compliance.
UnitedHealthcare has a well-structured integrated management information system that supports the Missouri Medicaid program. Their state-of-the art, scalable platform integrates physical health, behavioral health, and social services. All inbound data from providers is validated through multiple edits and uses standard formats to the extent feasible and appropriate. Data will be rejected back to the provider if it does not meet minimum requirements for completeness, logic and consistency.

Corrective Action Plan
No corrective action is required.

Weaknesses
The following weaknesses were identified after reviewing policies/documents of UnitedHealthcare:
1. §438.210 Coverage and authorization of services. The two criteria below are assigned a score of "Partially Met."

- UnitedHealthcare's member handbook provides information about family planning services; however, the member handbook or their policies do not state that "family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20" (Partially Met).
- The MCO is responsible for payment of custom items (e.g. custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) that are delivered or placed within six (6) months of approval, even if the member's enrollment in the health plan ends (MHD contract 2.5.5h): UnitedHealthcare stated that they have not had any occurrences of this issue since May 01, 2017 (effective date of contract with MHD), and were unaware of a need for this policy. However, UnitedHealthcare has a new setup which pays for these custom items (Partially Met).
- Some of the policies had inconsistent information about the time frames that do not abide by the MHD contract in some instances: MO UM of behavioral health benefits policy, page 13 of 18, Turnaround Time for Standard Cases are incorrect:
    - The Care Advocate sends a Request for Information letter by mail to the enrollee/enrollee's authorized representative, provider within 5 calendar days of the request.
    - The recipient has 45 calendar days from receipt to submit the requested information.

2. §438.230 Sub Contractual Relationships and Delegation: "Right to audit for 10 years…." as per 42 CFR 438.230(c) (3) (iii) is not consistent for all subcontractors.

Quality, Timeliness, and Access to Healthcare Services

UnitedHealthcare has demonstrated a vast amount of resources available to its members which not only fulfill the compliance requirements but also simplify and effectively coordinate their services to their members. The following are some accomplishments during CY 2018 reported by UnitedHealthcare (Note: this data is not validated by EQRO). These reflect their aim to provide access to quality health services in a timely manner to its member population:

- Launched Member incentive program (Well-Child visits in third, fourth, fifth and sixth years of life, Adolescent Well-Care Visits, Annual Dental Visit & Comprehensive Diabetes Care).
- Achieved and exceeded the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) withhold goal of MHD in all four regions. The MCO must meet the required 65% participant ratio for the Categories of Aid and age groups (infants less than one year old and children ages one (1) through less than six (6)) specified for the

contract period. MHD withholds one percent (1.0%) of monthly capitation payments made to the MCO for this performance category. This is returned to the MCO in full, if the participant ratio is met in aggregate for the specified Categories of Aid and age groups.

- Developed and conducted a Provider Dental Barrier Analysis.
- Developed Population Health Management Strategy.
- Met and/or exceeded all goals for State P4P (Pay for Performance) program.
- Received Interim NCQA accreditation; (final accreditation onsite scheduled May 2019).
- Provider incentive program reached 52% of providers (State goal was 10%).
- Membership in Foster Care program doubled and expanded care management staffing to accommodate for membership growth.
- Expanded care management and changed to multi-disciplinary team approach.

Improvement by UnitedHealthcare

There is no data available for comparison from last year as UnitedHealthcare was not evaluated in EQR 2018.

3.5 Recommendations for MCOs

Table 3-6 Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Missouri Care	UnitedHealthcare
1.	✓	✓	✓
2.	✓	✓	✓
3.	✓		
4.		✓	✓
5.		✓	
6.		✓	
7.			✓
8.			✓

1 Primaris recommends that all the policies (wherever applicable) should be updated consistently to reflect the correct information based on "2016 Managed Care Final Rule."

2 The revisions to the policies/documents as a result of technical assistance should be submitted to the MHD for approval.

3 During onsite visit, Primaris and Home State Health mutually concluded that some areas of improvement include: educating PCPs on the appointment standards and developing tailored actions to ensure all PCP offices are compliant with availability

standards. It is further recommended that they do so on a more frequent basis than annually.

4 Missouri Care should update all of their subcontractors' agreement with the "right to audit for 10 years" as per 42 CFR 438.230(c) (3) (iii), consistently. (Date of applicability: July 1, 2017).

5 Missouri Care should have state specific (MO) policies, tailored to meet the requirements of MHD contract.

6 While Missouri Care has many examples of their compliance readily available upon request, Primaris recommends that for every practice performed, there should be a written procedure or policy which accompanies their statements/narratives.

7 While UnitedHealthcare has many examples of their compliance readily available upon request, we do recommend that for every practice performed to achieve 100% compliance, there is a written procedure or policy which accompanies their statements/narratives.

8 UnitedHealthcare may adopt the language used in CFR and MHD contract; however, they are advised to incorporate the guidelines/rules as their own organization's policy versus copying the exact language from the CFR and MHD contract which is for all MCOs, PIHPs, and PAHPs. Furthermore, using specific and relevant language pertaining to a particular MCO would help ensure full understanding of all requirements provided by the state.

4.0 Validation of Performance Measures

4.1 Description and Methodology

Primaris conducted performance measure validation activities as outlined in the CMS EQR protocol 2, Validation of Performance Measures reported by the MCOs.
The performance measures selected by MHD and the data collection specifications used for the measures are listed in Table 4-1.

Table 4-1: Performance Measures

Performance Measure	Method	Specifications Used	Validation Methodology
Chlamydia Screening in Women (CHL)	Admin	HEDIS	Primary Source Verification
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Hybrid	HEDIS	Medical Record Review Validation
Inpatient Mental Health Readmissions	Admin	MHD	Primary Source Verification

Out of the three performance measures selected by MHD, only one measure required medical record validation (hybrid)-Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34). The other two measures-Chlamydia Screening in Women (CHL) and Inpatient Mental Health Readmissions are administrative measures, which require primary source verification from each MCO's claim and/or encounter system.
For the hybrid measure, W34, a random selection of 45 medical records was taken from the MCOs' hybrid sample of 411 records. The 411 medical records were from the samples used by the MCOs to produce the W34 measure for HEDIS reporting in CY 2018. Primaris conducted over-reads of the 45 medical records to validate compliance with both the specifications and abstraction process.

Pre-Audit Process

Primaris prepared a series of electronic communications that were submitted to the MCOs outlining the steps in the performance measure validation process based on the CMS Performance Measure Validation Protocol 2. The electronic communications included a request for samples, medical records, numerator and denominator files, source code, if required and a completed Information System Capability Assessment (ISCA). Additionally, Primaris requested any supporting documentation required to complete the audit. Finally,

the communications addressed the medical record review methodology of selecting 45 records for over-read and the process for sampling and validating the administrative measure during the onsite audit. Primaris provided specific questions to the MCOs during the audit process to enhance the understanding of the ISCA responses during the onsite visit.

Primaris submitted an agenda prior to the onsite visit, describing the onsite visit activities and suggested that subject matter experts attend each session. Primaris exchanged several pre-onsite communications with each of the MCO to discuss expectations, audit session times, specific dates, and to answer any questions that MCOs' staff may have regarding the overall process.

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 describe these components and the methodology used by Primaris to conduct its analysis and review:

- CMS's ISCA. The MCOs completed and submitted the required and relevant portions of its ISCA for Primaris' review. Primaris used responses from the ISCA to complete the onsite and pre-onsite assessment of their information system.
- Medical record verification: To ensure the accuracy of the hybrid data being abstracted by the MCOs, Primaris requested the MCOs to participate in the review of a sample of 45 medical records for the W34 measure. Primaris used the results of the medical record validation to determine if the findings impacted the audit results for W34.
- Source code verification for performance measures: The MCOs contracted with a software vendor to generate and calculate rates for the two administrative performance measures, Inpatient Mental Health Readmissions and CHL. The source code review was conducted during the onsite audit sessions where the MCOs 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 MCOs' 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 the MCOs, Primaris conducted a validation review to determine reasonable accuracy and data integrity.
- Primaris took a sample of 45 records from each administrative measure, Chlamydia Screening in Women and Inpatient Mental Health Readmissions in order to conduct

primary source verification to validate and assess the MCOs' compliance with the numerator objectives.

Onsite Activities

Primaris conducted onsite visits for the three MCOs from Jun 24, 2019 to Jun 27, 2019. The information was collected using several methods, including interviews, system demonstrations, review of data output files, primary source verification, observation of data processing, and review of data reports. The onsite visit activities are described as follows:

- Opening Conference: The opening meeting included an introduction of the validation team and staff members of MCOs 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 staff members in order to capture MCOs' 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 onsite visit.

Validation Process

MHD provided Primaris with the Healthcare Quality Data Instructions for CY2018 which consisted of instructions and specifications for validation of Inpatient Mental Health Readmissions. HEDIS specifications were used for the CHL and W34 measures.
As part of the performance measure validation process, Primaris reviewed MCOs' data integration, data control, and documentation of performance measure rate calculations. .
The scores (Table 4-2) were assigned per CMS EQRO protocol 2.

Table 4-2: Scoring Criteria	
Met	The MCO's measurement and reporting process was fully compliant with State specifications.
Not Met	The MCO's measurement and reporting process was not compliant with State specifications. This designation should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include an explanation of the deviation in the comments section.
N/A	The audit element was not applicable to the MCO's measurement and reporting process.

Data Integration: 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.

Data Control: 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 determine 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.

Performance Measure Documentation: Sufficient, complete documentation is necessary to support validation activities. Primaris' Information Technology Operations Manager and Lead Auditor reviewed the computer programming codes, output files, work flow diagrams, primary source verification and other related documentations.

Performance Measure Specific Findings: The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the

number of audit elements determined to be "NOT MET." Consequently, it is possible that an error for a single audit element may result in a designation of "Not Reported (NR)" because the impact of the error biased the reported performance measure by more than "x" percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and, thus the measure could be given a designation of "Report (R)." The following definitions were used:
R = Report: Measure was compliant with State specifications.
NR = Not Reported: This designation is assigned to measures for which: 1) MCO rate was materially biased or 2) the MCO was not required to report.
NB = No Benefit: Measure was not reported because the MCO did not offer the benefit required by the measure.

4.2 Findings and Analysis Home State Health

The following describes validation findings of Home State Health:

Data Integration

Met ●	Not Met ☐	N/A ☐

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.

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 onsite 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 determined 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 onsite audit. Primaris reviewed forty-five (45) cases for each measure 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 2018. 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.

Data Control

● Met	Not Met ☐	N/A ☐

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	Not Met ☐	N/A ☐

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. Home State Health "Met" the requirements for this section.

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 continued to use the AMISYS system to capture all medical claims. Encounters, such as laboratory services, were captured in its data warehouse. Encounters and claims were combined to meet numerator compliance for the CHL measure. Home State Health's systems appropriately captured the required data elements to produce the measures under review. The AMISYS system has been operational with only minor upgrades, for many years.

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. Home State Health continued to capture greater than ninety-five percent (95%) of its claims through electronic means. 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%) 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 upwards of ninety-six percent (96%) 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 of receipt of claims at Home State Health.

Enrollment Data

There were no changes to the enrollment process from the previous year. Home State Health's enrollment data were housed in the AMISYS system, and no changes were made since the previous year's audit. Enrollment data were still received daily and monthly from

the State. New members were processed and entered into AMISYS systematically. Occasionally, enrollment data were 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 45 members using a systematic random selection for all three performance measures. During the primary source review, the membership and eligibility were verified to ensure members were active during the measurement period and 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 verified provider specialties and certification status for the W34 measure to ensure they were primary care specialties. 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 provider credentials review was compliant and matched both systems.

Primaris validated that all providers operating in Home State Health's network were licensed to operate under the Medicaid Managed Care contract for MHD.
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 industry standard 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 performance measurement medical record validation process. The records selected were numerator positive hits found during the abstraction process. These records were used to evaluate the abstraction accuracy and to validate the rates submitted for the W34 measure. The MRR findings and final results are presented in the Table 4-3.

Table 4-3: MRRV Results

Performance Measure	Sample	Findings	Results
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	45	45/45 Compliant	Pass

Supplemental Data

Primaris conducted a review of the supplemental process offsite and did not have any concerns with Home State Health's process.

Table 4-4 shows the key review findings and final audit results for Home State Health for each performance measure rate.

Table 4-4: Key Review Findings and Audit Results for Home State Health		
Performance Measures	**Key Review Findings**	**Audit Results**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Report
Chlamydia Screening in Women (CHL)	No concerns identified	Report
Inpatient Mental Health Readmissions	No concerns identified	Report

Home State Health Measure Specific Rates for CY 2016-2018 (Table 4-5 to 4-7)

Table 4-5 Well Child Visits in Third, Fourth, Fifth, and Sixth Years of Life

Region	2016	2017	2018	Trend	Change in % Point
Central	56.12%	63.95%	51.82%		-12.13%
East	60.28%	68.61%	66.39%		-2.22%
Southwest	NA	60.38%	52.66%		-7.72%
West	48.04%	54.74%	55.50%		0.76%

(Note: The southwest region was added under Managed Care on May 01, 2017, marked NA-not applicable)

Table 4-6 Chlamydia Screening in Women

Region	2016	2017	2018	Trend	Change in % Point
Central	44.04%	44.13%	39.14%		-4.99%
East	57.57%	54.86%	55.12%		0.26%
Southwest	NA	45.45%	36.04%		-9.41%
West	52.24%	53.23%	51.64%		-1.59%

(Note: The southwest region was added under Managed Care on May 01, 2017, marked NA-not applicable)

Table 4-7 Inpatient Mental Health Readmissions

Region	Age	2016	2017	2018	Trend	Change from 2017
Central	Age 0-12	3	13	28		15
Central	Age 13-17	12	30	50		20
Central	Age 18-64	4	22	18		-4
Central	Age 65+	0	0	0		NA
East	Age 0-12	6	20	43		23
East	Age 13-17	18	41	89		48
East	Age 18-64	39	55	74		19
East	Age 65+	0	0	0		NA
Southwest	Age 0-12	NA	9	27		18
Southwest	Age 13-17	NA	15	28		13
Southwest	Age 18-64	NA	8	19		11
Southwest	Age 65+	NA	0	0		NA
West	Age 0-12	20	24	17		-7
West	Age 13-17	20	37	26		-11
West	Age 18-64	12	22	19		-3
West	Age 65+	0	0	0		NA

The lower the better. Green Arrow indicates an increase and Red Arrow indicates a decrease from the previous year (CY 2017)

Strengths

- Home State Health staff was fully engaged in an onsite review and was well prepared to discuss the measures under review.
- Home State Health continued to update their systems with most current diagnoses and procedures as they became available during the year.
- Home State Health worked with a software vendor to report all measures. The software vendor was certified for reporting performance measures.

Weaknesses

- Well Child Visits in third, fourth, fifth, and sixth year of life has decreased in all regions except for a minor increase (0.76% point) in west region.
- Chlamydia screening in women dropped in Central (4.99% points) and Southwest (9.41% points) regions. A significant drop is 5% or greater percentage points change. The East region was the only region to see an insignificant increase (0.26% point) from last year. The higher the rate indicates better performance.

- Inpatient Mental Health Readmissions continued to increase from calendar year 2016-2018 for all regions except West. For the Inpatient Mental Health Readmission measure, lower admissions indicate better performance.

Quality, Timeliness and Access to Healthcare Services

- There were no issues or concerns found during the onsite audit. Home State Health did not appear to have any barriers to care services.
- Appropriate services such as laboratory, primary care and hospital access, were readily available in all regions. Admission to hospitalization would require proper authorization, however, participating hospitals were well informed on the process for obtaining authorizations from Home State Health.
- Home State Health was able to demonstrate its ability to capture the specific diagnosis codes for each Inpatient Mental Health Readmissions, CHL and W34.

Improvement by Home State Heath

- Home State Health continued to increase its administrative claims capture as well as improving its medical record review practices.
- Home State Health was better prepared for the system demonstrations and data walkthroughs than in the previous review.
- Home State Health continued to monitor and improve upon the data capture in both primary and supplementary data for numerator compliance.

4.3 Findings and Analysis Missouri Care

The following describes validation findings of Missouri Care:

Data Integration

● Met	Not Met ☐	N/A ☐

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.

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 consistently validated data extracts prior to loading the data to its performance measures software. The validation process ensured that all data were clean and appropriate for numerator and denominator compliance.
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 onsite 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 CY 2018. Missouri Care's disaster recovery plan was sufficient to ensure data integrity.
No issues were identified with Missouri Care's data integration processes.

Data Control

● Met	Not Met ☐	N/A ☐

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	Not Met ☐	N/A ☐

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. Missouri Care "Met" the requirements for this section.

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 onsite 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 onsite 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 interviewed and discussed the claim lags and incurred but not reported (IBNR) reporting. Ninety-six percent (96%) of all Missouri Care's claims were finalized and utilized in the measure production. The remaining four percent (4%) of outstanding claims did not materially impact any of the reported rates under review.
Primaris had no concerns with Missouri Care's claims and encounter data processes. Majority of claims were processed within 30 days of receipt of claims at Missouri Care.

Enrollment Data

Missouri Care continued to receive 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 2018, 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 Missouri Care'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 ISCA.

All providers were appropriately credentialed in their respective specialties. Missouri Care followed strict credentialing verification to ensure providers did not have any sanctions or criminal activity. In addition, all verification included background checks for each provider prior to committee approval. 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 industry standard abstraction qualifications. 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 numerator positive hits. These records were used to evaluate the abstraction accuracy and to validate the rates submitted for the W34 measure.
The MRR findings and final results are presented in the Table 4-8.

Table 4-8: MRRV Results

Performance Measure	Sample Size	Findings	Results
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	45	45/45 Compliant	Pass

Supplemental Data

Primaris conducted a review of the supplemental process offsite and did not have any concerns with Missouri Care's process.

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**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Report
Chlamydia Screening in Women (CHL)	No concerns identified	Report
Inpatient Mental Health Readmissions	No concerns identified	Report

Missouri Care Measure Specific Rates for CY 2016-2018 (Table 4-10 to 4-12)

Table 4-10 Well Child Visits in Third, Fourth, Fifth, and Sixth Years of Life

Region	2016	2017	2018	Trend	Change in % Point
Central	64.12%	67.15%	57.90%		-9.25%
East	59.52%	63.02%	64.58%		1.56%
Southwest	NA	67.92%	59.12%		-8.80%
West	60.79%	68.86%	64.35%		-4.51%

(Note: The southwest region was added under Managed Care on May 01, 2017, marked NA-not applicable)

Table 4-11 Chlamydia Screening in Women

Region	2016	2017	2018	Trend	Change in % Point
Central	24.39%	24.81%	22.23%		-2.58%
East	40.64%	43.12%	35.79%		-7.33%
Southwest*	NA	29.41%	19.61%		-9.80%
West	55.23%	54.80%	45.66%		-9.14%
*Missouri Care's denominator was 17 (<30 is small) and Numerator was 5 in CY 2017 in the Southwest Region					

(Note: The southwest region was added under Managed Care on May 01, 2017, marked NA-not applicable)

Table 4-12 Inpatient Mental Health Readmissions

Region	Age	2016	2017	2018	Trend	Change from 2017
Central	Age 0-12	15	22	72		50
Central	Age 13-17	13	66	77		11
Central	Age 18-64	14	40	32		-8
Central	Age 65+	0	0	0		NA
East	Age 0-12	25	29	30		1
East	Age 13-17	21	34	44		10
East	Age 18-64	66	54	29		-25
East	Age 65+	0	0	0		NA
Southwest	Age 0-12	NA	13	30		17
Southwest	Age 13-17	NA	16	31		15
Southwest	Age 18-64	NA	22	31		9
Southwest	Age 65+	NA	0	0		NA
West	Age 0-12	27	73	72		-1
West	Age 13-17	27	42	78		36
West	Age 18-64	8	14	19		5
West	Age 65+	0	0	0		NA

Green Arrow indicates an increase in admissions from the previous year
Red Arrow indicates a decrease in admissions from the previous year

Strengths

- Missouri Care staff was fully engaged in an onsite review and was well prepared to discuss the measures under review.
- Missouri Care continued to update their systems with most current diagnoses and procedures as they become available during the year.
- Missouri Care worked with a software vendor to report all measures. The software vendor is certified for reporting performance measures.
- Missouri Care staff continued to centralize measure reporting functions to ensure measures are subjected to enterprise quality validation processes.

Weaknesses

- Well Child Visits in third, fourth, fifth, and sixth year of life has decreased in all regions except for a minor increase (1.56% points) in East region. Two regions decreased significantly, Central (-9.25% points) and Southwest (-8.80% points).
- Chlamydia screening in women dropped significantly in the East (-7.33% points) and West (-9.14% points) regions. A significant drop is 5% or greater percentage point change. The Central region also decreased -2.58% points, however, this is not a significant change. The higher the rate indicates better performance.
- Missouri Care saw an increase in Inpatient Mental Health Readmissions (all ages combined) in the Central (53), Southwest (41) and West (40) regions compared to previous year. Only the East region saw a decrease of 14 admissions . For the Inpatient Mental Health Readmission measure, lower admissions indicate better performance.

Quality, Timeliness and Access to Healthcare Services

- There were no issues or concerns found during the onsite audit. Missouri Care did not appear to have any barriers to care services. Missouri Care was prepared for the onsite audit and asked questions in advance of the meeting which ensured a smooth and successful review.
- Appropriate services such as laboratory, primary care and hospital access, are readily available in all regions. Admission to hospitalization would require proper authorization, however, participating hospitals are well informed on the process for obtaining authorizations from Missouri Care.
- Missouri Care was able to demonstrate its ability to capture the specific diagnosis codes for each Inpatient Mental Health Readmissions, CHL and W34.
- Missouri Care increased the Chlamydia screening by 16.25% points from the previous year in the Southwest region.

Improvement by Missouri Care

- Missouri Care continued to monitor and improve upon the data capture in both primary and supplementary data for numerator compliance.
- Missouri Care indicated that they have increased outreach in certain regions to engage members to get the needed care, however, there were no result oriented studies used to indicate whether this had a significant impact on the overall rates.
- Missouri Care indicated through interviews that they continued to educate providers through targeted campaigns in order to increase compliance in several measures.

4.4 Findings and Analysis UnitedHealthcare

The following describes validation findings of UnitedHealthcare:

Data Integration

Met ●	Not Met ☐	N/A ☐

Primaris reviewed UnitedHealthcare'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 UnitedHealthcare, 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.

UnitedHealthcare utilized the CSP Facets system as well as its relational database/data warehouse to collect and integrate data for reporting. The CSP Facets production database contained claims, provider and member data. These data streams were extracted weekly and loaded into the data warehouse and consumed with vendor data (e.g. laboratory and vision providers). Facets and encounter data were linked using unique identifiers in Facets, linking all other identifiers from external sources such as state Medicaid identifiers and social security numbers. All identifiers were tracked and captured in a central data warehouse where they linked members with their encounter and claims transactions. UnitedHealthcare utilized senior analysts or managers to examine and approve code for quality and validation. Results were compared to prior year's metrics when available or Medicaid benchmarks to determine reasonableness of results. Per UnitedHealthcare's maintenance cycle, data was reviewed and validated by the assigned analyst and the business owner after requirements were verified and approved.

Although UnitedHealthcare utilized a source code quality validation process, it did not prevent a critical error from occurring. During Primaris' onsite validation process, a critical error was found in the Inpatient Mental Health Readmission measure. The numerator contained members that were not in the Medicaid population. The critical error also impacted several measures that needed correction, however, the additional measures were outside Primaris' scope of the audit. Ultimately the error was corrected for the Inpatient Mental Health Readmission measure prior to the submission date and the rates were finalized and approved.

There were no other concerns with UnitedHealthcare's ability to consolidate and report data.

Data Control

Met ●	Not Met ☐	N/A ☐

Primaris validated the data control processes UnitedHealthcare 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 UnitedHealthcare were acceptable and received a "Met" designation.

Performance Measure Documentation

Met ●	Not Met ☐	N/A ☐

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 UnitedHealthcare in the ISCA. UnitedHealthcare "Met" the requirements for this section.

Primaris evaluated UnitedHealthcare'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)

UnitedHealthcare's Facets system captured primary, secondary, and modifier codes appropriately. Coding updates to the Facets system were made annually to ensure UnitedHealthcare used standard claims and/or encounter forms when receiving administrative data from their hospital, physician, home health, mental health, and dental sources. UnitedHealthcare was able to distinguish between the primary and secondary coding schemes. Incomplete claims submitted from providers were promptly rejected back for additional information. The incomplete claims were not allowed in the claims system until all required fields were present and valid. UnitedHealthcare's pre-processing edits verified the accuracy of submitted information on all claims and encounters. Claims that contain errors such as invalid Current Procedural Terminology (CPT) or diagnosis codes are rejected and sent back to the provider of service for correction. There were no circumstances where a processor was able to update or change the values on a submitted claim.

All medical and behavioral claims were processed using an industry standard paper and electronic means.

Medicaid claims were audited regularly for financial and procedural accuracy. Thirtytwo (32) claims are randomly sampled on a weekly basis to validate accuracy and data quality. Quality errors are rectified, and additional training is provided to the claims examiners when issues arise.
Facets provided the claims examiner error messages when a potential authorization match or if a service requires an authorization and no authorization is on file. If the claim requires medical review it will be pended internally and routed to Utilization Management for review.
The current timeliness standard is meeting a 30-day turnaround time and current production standard is achieving a 14.2 claim per hour individual standard. Claim payment accuracy is 98.75%.
Primaris had no concerns with UnitedHealthcare's claims/encounter processing. Majority of claims were processed under 30 days of submission of claims at UnitedHealthcare.

Enrollment Data

UnitedHealthcare uniquely identified enrollees using the daily enrollment files provided by the state against the information found in Facets. Daily files are submitted to UnitedHealthcare from the State indicating changes, additions and deletions of member from the Medicaid plan. UnitedHealthcare processes the files within 24 hours and sends the roster information on to delegated vendors so they too will have the most updated member data.

Medicaid disenrollment and re-enrollment information is entered in the CSP Facets eligibility module. Once UnitedHealthcare receives notification of a member's disenrollment, a termination date is entered. If that same member is re-enrolled, the member is reinstated, and a new effective date is created. The member's enrollment spans were captured for reporting and combined to assess continuous enrollment.
There is only one circumstance where a Medicaid member can have multiple identifiers. If MHD sends a subscriber under different identification elements, the system may create a duplicate entry. A weekly report is run to identify members with more than one Subscriber ID record. If a member is found having more than one Subscriber ID record, the additional record is voided, and a note added with the correct CSP Subscriber ID.

Additional enrollment system criteria was evaluated under the ISCA report (details in section 4.5).
There were no issues identified with UnitedHealthcare's enrollment data processes pertaining to the performance measurement.

Provider Data

UnitedHealthcare updates their provider paper directories on a weekly basis. A weekly provider feed is sent to their vendor to update the most current provider data. This allows a member to get a current directory any time they request one via Customer Service. The data is a direct reflection of what is in the system with no manual manipulation to the data. Members can call Customer Service and request a weekly updated directory via mail. Rally is also available as a provider search tool online via UnitedHealthcare's website. Rally is updated daily except on Saturdays. Changes in directory information are driven by system updates to provider demographic information and newly loaded or terminated providers. Provider directories are refreshed with the most current provider data available at the time of the directory data inquiry. UnitedHealthcare's plan directory manager has change authority with approval from the health plan leadership.

UnitedHealthcare does maintain provider profiles in their information system. The Network Database (NDB) is used as their validity source for their provider directories and data entered there flows through UnitedHealthcare's other systems in a standard data flow process. There are 41 data elements maintained and displayed for both paper and online applications. The data elements include standard demographics/contact information, languages spoken and office accessibilities. UnitedHealthcare maintains provider specialties in accordance with professional licensing board and national taxonomy standards. Provider data are frequently compared to determine if providers are sanctioned and if provider specialties are not in sync.

Primaris reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. Primaris found UnitedHealthcare to be compliant with the credentialing and assignment of individual providers at the Federally Qualified Health Centers (FQHCs).
There were no concerns with UnitedHealthcare's provider processing.

Medical Record Review Validation (MRRV)

UnitedHealthcare was fully compliant with the MRR reporting requirements. UnitedHealthcare abstracted records in accordance with the standard specifications for each measure. UnitedHealthcare conducted initial and ongoing training for each abstractor and regularly monitored the accuracy through inter-rate reliability checks. UnitedHealthcare 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. These records were used to evaluate the abstraction accuracy and to validate the rates

submitted for the W34 measure. The MRR findings and final result are presented in the Table 4-13.

Table 4-13: MRRV Results			
Performance Measure	**Sample Size**	**Findings**	**Results**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	45	45/45 Compliant	Pass

Supplemental Data

Primaris conducted a review of the supplemental process offsite and did not have any concerns with their process.

Table 4-14 shows the key review findings and final audit results for UnitedHealthcare for each performance measure rate.

Table 4-14: Key Review Findings and Audit Results for UnitedHealthcare		
Performance Measures	**Key Review Findings**	**Audit Results**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Report
Chlamydia Screening in Women (CHL)	No concerns identified	Report
Inpatient Mental Health Readmissions	The numerator contained members outside of the Medicaid population. The issue was brought to the attention of the MCO during onsite which was rectified and resubmitted post-onsite. The measure was approved and reportable.	Report

UnitedHealthcare Measure Specific Rates for CY 2016-2018 (Tables 4-15, 4-16)
(UnitedHealthcare was not operational until May 01, 2017, therefore no data is available to compare prior years.)

Table 4-16 HEDIS Performance Measures				
Measures	**Central**	**East**	**Southwest**	**West**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	50.03%	60.10%	46.71%	61.56%
Chlamydia Screening in Women All Ages (CHL)	39.51%	56.77%	33.30%	44.54%

Table 4-15: Inpatient Mental Health Readmissions			
Region	**Measure**	**Age**	**Count***
Central	Inpatient Mental Health Readmissions (4.13)	Age 0-12	10
Central	Inpatient Mental Health Readmissions (4.14)	Age 13-17	26
Central	Inpatient Mental Health Readmissions (4.15)	Age 18-64	11
Central	Inpatient Mental Health Readmissions (4.16)	Age 65+	0
East	Inpatient Mental Health Readmissions (4.13)	Age 0-12	13
East	Inpatient Mental Health Readmissions (4.14)	Age 13-17	23
East	Inpatient Mental Health Readmissions (4.15)	Age 18-64	24
East	Inpatient Mental Health Readmissions (4.16)	Age 65+	0
Southwest	Inpatient Mental Health Readmissions (4.13)	Age 0-12	14
Southwest	Inpatient Mental Health Readmissions (4.14)	Age 13-17	11
Southwest	Inpatient Mental Health Readmissions (4.15)	Age 18-64	13
Southwest	Inpatient Mental Health Readmissions (4.16)	Age 65+	0
West	Inpatient Mental Health Readmissions (4.13)	Age 0-12	9
West	Inpatient Mental Health Readmissions (4.14)	Age 13-17	23
West	Inpatient Mental Health Readmissions (4.15)	Age 18-64	5
West	Inpatient Mental Health Readmissions (4.16)	Age 65+	0

*Lower readmissions indicate better performance

Strengths

- UnitedHealthcare staff was well prepared for an onsite and had all claims and preparation completed ahead of schedule.

- UnitedHealthcare was able to demonstrate and articulate their knowledge and experience of the measures under review.
- UnitedHealthcare continues to update their systems with most current diagnoses and procedures as they become available during the year.

Weakness

During the onsite primary source verification process, Primaris uncovered a numerator accuracy issue involving a member from another product line being counted in the Inpatient Mental Health Readmission measure. This discovery lead to UnitedHealthcare having to adjust their measure coding language to include only Medicaid members.

Quality, Timeliness and Access to Healthcare Services

- UnitedHealthcare did not appear to have any barriers to care services.
- UnitedHealthcare's policies and procedures addressed quality of care for its members.
- Appropriate services such as laboratory, primary care and hospital access, were readily available in all regions. Admission to hospitalization would require proper authorization; however, participating hospitals are well informed on the process for obtaining authorizations from UnitedHealthcare.
- UnitedHealthcare was able to demonstrate its ability to capture the specific diagnosis codes for each Inpatient Mental Health Readmissions, CHL and W34.

Improvement by UnitedHealthcare

This was UnitedHealthcare's first review under MHD and therefore there was no baseline to assess improvements.

4.5 Recommendations for MCOs

1 The MCOs would benefit from implementing strategies to engage members in proper screenings through outreach campaigns once they become aware of a female member becoming sexually active during the ages of 16-24 years.
The MCOs should engage providers and immediately begin testing for chlamydia once they have become aware of the member's sexual activity. Additionally, it is advisable that providers discuss the HPV vaccination at the same time, if this hasn't already been addressed.

2 The MCOs should consider incentivizing providers to meet with members for the W34 measure. This may positively impact the rates for future years.

3 Members should be encouraged to seek outpatient mental health services and follow up once a member is discharged from the hospital following an admission for mental health reasons.

4 Home State Health should consider taking a look at the members in the Eastern region as there were more mental health readmissions. This region has a significantly higher number of readmissions for mental health than the other regions. Additionally, Home State Health should focus on the primary reasons for readmission following a discharge for mental health in order to avoid readmissions. An integrated care management program with intense efforts to capture member information for outreach purposes may be helpful.

5 Missouri Care continues to engage members through outreach programs to ensure they are informed of upcoming service requirements. However, there are still concerns with reaching all members. Missouri Care's chlamydia screening rates are significantly lower in the Central and Southwest Regions. It seems that these two regions would be good candidates for deeper dives into why compliance is so low.

6 Missouri Care also is significantly lower in compliance in the Central and Southwest Regions for W34. A deeper dive into these two regions would lend itself well to determining if there are access issues or general quality of care issues within the provider network.

7 UnitedHealthcare should examine the measure specifications and programming language in more detail to avoid any inclusion or exclusion of members in the measures. It is recommended that UnitedHealthcare include a data quality review prior to final submission and onsite review.

8 UnitedHealthcare continues to engage members through outreach programs to ensure they are informed of upcoming service requirements. However, there are still concerns with reaching all members. UnitedHealthcare's chlamydia screening rates are significantly lower in the Central and Southwest Regions. It seems that these two regions would be good candidates for deeper dives into why compliance is lower than other regions.

9 UnitedHealthcare should investigate the root cause of low performance related to CHL measure in Central (39.51%) and Southwest (33.30%) regions as compared to East (56.77%) and West (44.54%) regions and mitigate the access issues or quality of care issues within the provider network.

Table 4-17 Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Missouri Care	UnitedHealthcare
1.	✓	✓	✓
2.	✓	✓	✓
3.	✓	✓	✓
4.	✓		
5.		✓	
6.		✓	
7.			✓
8.			✓
9.			✓

4.6 Information System Capabilities Assessment

Information System Capabilities Assessment (ISCA) was conducted for UnitedHealthcare in EQR 2019. Home State Health and Missouri Care were assessed in EQR 2018. MHD requires Primaris to perform a detailed evaluation of Information System of each MCO once every three years.

Primaris based their methodologies directly on the CMS protocol: EQR Appendix V- Information System Capabilities Assessment (ISCA). The ISCA review process consists of four phases:

Phase 1: The MCO's information system standard information is collected. Primaris sent the ISCA data collection worksheet to the MCO with a deadline to be completed and returned electronically to Primaris prior to the scheduled onsite review activities. (The deadline for submission of documents was Apr 6, 2019).

Phase 2: Review of completed worksheets and supporting documentation. All submitted documents were thoroughly reviewed, flagging answers that seemed incomplete or indicated an inadequate process for follow-up. The follow-up questions and review took place during an onsite visit (held on Jun 26, 2019).

Phase 3: Onsite review and walk-throughs. Primaris utilized time onsite 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 onsite activities. Primaris compared and scored the findings directly against industry standards, with specific focus on 45 CFR Part 160 & 164, section 2.26 of the MHD contact, and Medicaid Management Information System (MMIS).

Scoring Key

Each subsection of the ISCA was awarded one of the three scoring options: Not Met (fail), Partially Met (pass), or Met (pass). In the event a Partially Met or Not Met score was awarded, recommendations were provided to the MCO by Primaris. Additionally, the MCO had the option to request technical assistance from Primaris via MHD to assist with any recommended improvement activities. Scores for the ISCA align with other EQRO protocols (e.g., compliance with regulations) and are based on the standards for Met, Partially Met, or Not Met criteria.
Scoring Table 4-18 presents the scoring key used and descriptions.

Table 4-18 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 such as 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 onsite interviews 3 employees mentioned their lack of ability to backtrack as a pain point in their day-to-day activities.*

Scoring Standards

Scoring Standards Table 4-19 presents the detailed Federal regulations, Missouri HealthNet Division (MHD) State contract requirements, and industry standards against which UnitedHealthcare was evaluated.

Table 4-19 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/

Findings

UnitedHealthcare meets all contractual obligations for information system management and have well documented processes and procedures in place to allow their information systems to be adequately monitored and maintained (Table 4-20). During the onsite review the team focused on data integrations, data integrity, and data security.

Table 4-20 Section Score

ISCA Section	Description	Score Result
Overall ISCA Score	Total Score for UnitedHealthcare.	**Met** (pass)
A. Information System	Assess MCO's management of its information system.	**Met** (pass)
B. IT Infrastructure	Assess MCO's network and physical infrastructure.	**Met** (pass)
C. Information Security	Assess the security level of MCO's information systems.	**Met** (pass)
D. Encounter Data Management	Assess MCO's ability to capture and report accurate and meaningful encounter data.	**Met** (pass)
E. Eligibility Data Management	Assess MCO's ability to capture and report accurate and meaningful Medicaid eligibility data.	**Met** (pass)
F. Provider Data Management	Access MCO's ability to maintain accurate provider information.	**Met** (pass)
G. Performance Measures and Reporting.	Assess the MCO's performance measure and reporting process.	**Met** (pass)

A. Information System

This section of the ISCA evaluates the MCO's management, policies, and procedures surrounding information system. A detailed review was conducted to thoroughly assess the information systems capacity for collecting, filtering, transforming, storing, analyzing, and reporting Medicaid data. The results are reported in Table 4-21.

Strengths

- Policies and procedures readily available to all necessary staff.
- Availability of thorough and accurate information system mapping documents.
- A clear training and continued education program for their staff.

- Testing processes and development methodologies met and exceeded industry standards.
- Change requests processed in-house with strict guidelines and managed by current staff members.

Weaknesses

No weaknesses discovered or calculated for the Information System section of the ISCA.

Table 4-21 Information System Scoring Results

Sub-section	Issues	Score	Citation/Standard
IS Management Policies	None	●	45 CFR 160, 45 CFR 164, Section 2.26.8 MHD Contract
Reconciliation and Balancing	None	●	Section 2.26.5 MHD Contract
Training	None	●	45 CFR 164.132
Testing Procedures	None	●	NIST
System Changes and Version Control	None	●	NIST, Section 2.26.2 MHD Contract
EDI	None	●	45 CFR 164.312, ANSI, Section 2.26.5 MHD Contract
TOTAL SCORE	None	●	**Met – Pass**

B. IT 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 (Table 4-22).

Table 4-22 IT Infrastructure Score Results

Sub-section	Issues	Score	Citation/Standard
Redundancy	None	●	45 CFR 164.308, NIST, Section 2.27 MHD Contract
Data Center/Server Room	None	●	45 CFR 164.308
Backup	None	●	45 CFR 164.308, NIST
Network Availability	None	●	Section 2.26.8 MHD Contract
TOTAL SCORE		●	**Met - Pass**

Strengths

- Primary and back-up disaster recovery physical site servers.
- Comprehensive and proactive BCDR plan.
- Clearly documented infrastructure allowing for comprehensive maintenance.

Weaknesses

No weaknesses discovered or calculated for the Information System section of the ISCA.

C. Information Security

This section of the ISCA evaluates the MCO's information system 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) (Table 4-23).

Table 4-23 Information Security Score Results

Sub-section	Issues	Score	Citation/Standard
Physical Security	None	●	45 CFR 164.310, NIST, Section 2.26.4 MHD Contract
Security Policies	None	●	45 CFR 164.308, 164.312, NIST, Section 2.26.4 MHD Contract
Security Testing	None	●	NIST
Access Removal Policies	None	●	45 CFR 164.308, 164.312, Section 2.26.12 MHD Contact
Mobile Device Security and Policies	None	●	45 CFR 164.308, 164.312, NIST, Section 2.26.4 MHD Contract
TOTAL SCORE		●	**Met - Pass**

Strengths

- Security policies were readily available, well documented, and well maintained.
- UnitedHealthcare provided HIPAA training and health care data best practices review.
- There were security procedures in place for quick removal of a terminated employee.

Weaknesses

No weaknesses discovered or calculated for the Information Security section of the ISCA.

D. Encounter Data Management

This section of the ISCA evaluates the MCO's ability to capture and report accurate encounter data (Table 4-24).

Strengths

- UnitedHealthcare has implemented adequate validation edits in its data processes.
- Encounter data was not altered by UnitedHealthcare but sent back to source for correction.
- Consistent communication regarding upcoming changes.

Weaknesses

No weaknesses discovered or calculated for the Encounter Data Management section of the ISCA.

Table 4-24 Encounter Data Management Score Results

Sub-section	Issues	Score	Citation/Standard
Redundancy	None	●	45 CFR 164.308, NIST, Section 2.26.5 MHD Contract
Data Center/Server Room	None	●	45 CFR 164.308, Section 2.26.5 MHD Contract
Backup	None	●	45 CFR 164.308, NIST, Section 2.26.5 MHD Contract
Network Availability	None	●	Section 2.26.5 MHD Contract
TOTAL SCORE		●	**Met - Pass**

E. Eligibility Data Management

This section of the ISCA evaluates the MCO's ability to capture and report accurate Medicaid eligibility data (Table 4-25).

Strengths

- 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 reconciliation.

Weaknesses

No weaknesses discovered or calculated for the Eligibility Data Management section of the ISCA.

Table 4-25 Eligibility Score Results

Sub-section	Issues	Score	Citation/Standard
Eligibility Updates and Verification Process	UnitedHealthcare reported the eligibility 834-file received lacks current/correct demographic and contact information.	●	42 CFR 438.242, 438.608, Section 2.28.5 MHD Contract
Duplicate Management	None	●	42 CFR 438.242, 438.608
Eligibility Loss Management	None	●	42 CFR 438.242, 438.608
TOTAL SCORE		●	**Met - Pass**

F. Provider Data Management

This section of the ISCA evaluates the MCO's ability to maintain accurate and timely provider information (Table 4-26).

Strengths

UnitedHealthcare has an active/updated directory available to the public both in paper and online formats.

Weaknesses

No weaknesses discovered or calculated for the Provider Data Management section of the ISCA.

Table 4-26 Provider Data Management Score Results

Sub-section	Issues	Score	Citation/Standard
Provider Directory Management	None	●	42 CFR 438.242, 438.608, Section 2.12.17 MHD Contract
Payment Reconciliation	None	●	42 CFR 438.242, 438.608
TOTAL SCORE		●	**Met - Pass**

G. Performance Measures and Reporting

This section of the ISCA evaluates the MCO's performance measure and reporting processes (Table 4-27).

Strengths

- UnitedHealthcare employs many experienced staff members for developing queries and reports.
- Robust processes and documentation is available regarding performance measure reports.

Weaknesses

No weaknesses discovered or calculated for the performance measures and reporting section of the ISCA. However, a coding error (human error) was identified while validating one of the performance measures during an onsite visit (details are described in Performance Measures Validation report).

Table 4-27 Performance Measures and Reporting Score Results

Sub-section	Issues	Score	Citation/Standard
Performance Measure Processes	None	●	42 CFR 438.242, Section 2.29.3 MHD Contract
Validation of Performance Metrics	None	●	Section 2.29.3 MHD Contract
Documentation of Metrics	None	●	Section 2.29.3 MHD Contract
TOTAL SCORE		●	**Met - Pass**

Recommendation

A complete assessment of UnitedHealthcare's Information System's documentation and related onsite activities revealed an opportunity for improvement concerning the data collection and integration structure with the 834 file routinely received from MHD. Demographic data is often incorrect or missing as it comes to UnitedHealthcare. MHD's file feed is a one-way feed and therefore values that are incorrect or missing cannot be updated in the MCO's repository. Any information attempted to be updated is overwritten by the next load of the 834 file.

Primaris strongly recommends that MHD and UnitedHealthcare work towards a collaborative solution for the ability to update and access more accurate and useful member demographic data. This will aid in keeping member information updated and create a complete data integration solution delivering trusted data from various sources.

5.0 Validating Performance Improvement Projects

5.1 Description and Methodology

A statewide performance improvement project (PIP) is defined as a cooperative quality improvement effort by the MCOs, MHD, and 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 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 PIPs should be in a reasonable period (a CY), to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. 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.
- Planning and initiation of activities for increasing or sustaining improvement.

During CY 2018, MHD required the MCOs to conduct two (2) PIPs:

- Clinical: Improving Childhood Immunization Rates (Combo 10) (Table 5-1)
- Nonclinical: Improving Access to Oral Healthcare

Table 5-1 CIS Combo 10

CIS Combo 10	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
No. of Doses	4	3	1	3	3	1	4	1	2	2

The review period for validation of PIPs was from April 25-Jun 5, 2019. Primaris gathered information about the PIPs through:
Documents submission: Home State Health, Missouri Care, and UnitedHealthcare submitted their PIPs electronically to Primaris' secure system.
Interview: The MCOs' officials were interviewed via web based meetings to understand their concept, approach and methodology adopted for the PIPs. Technical Assistance was provided for improvements, corrections, and additional information.

Primaris followed guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, EQR Protocol 3, Version 2, Sept 2012: Validating Performance Improvement Projects. The activities conducted were as follows. Each activity in the PIPs was scored as Met/Partially Met/Not Met (Appendix A)
Activity 1: Assess the study methodology

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review the identified study population
4. Review the selected study indicators
5. Review sampling methods (if sampling used)
6. Review data collection procedures
7. Review data analysis and interpretation of study results
8. Assess the MCO's Improvement strategies
9. Assess the likelihood that reported improvement is "real" improvement
10. Assess the sustainability of documented improvement

Activity 2: Verify study findings (Optional).
This activity is not done by EQRO. MHD may elect to have Primaris conduct on an ad hoc basis when there are special concerns about data integrity.

Activity 3: Evaluate and report overall validity and reliability of PIPs results.
Primaris will report a level of confidence in its findings and 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, or for reasons beyond control of MCO.

5.2 Findings and Analysis Home State Health

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

Description of Data Obtained from Home State Health

Aim: The statewide CIS rate in H2019/CY2017 was 21.65%, the goal for Home State Health is to increase the CIS rate in H2019/CY2018 by 3 percentage points to 24.65%.

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® 2018 (H2018) and HEDIS® 2019 (H2019)?"

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

Study Population: The study population for this project includes Home State Health members under 2 years of age. The enrollment "allowable gap" criteria will not be used for the intervention population. Interventions will be applied to all eligible members under two years of age at the time of each intervention.

Sampling: No sampling is done for PIPs and interventions are applied statewide. However, the final rates provided for PIPs are based on HEDIS® hybrid methodology. The HEDIS® Technical Specifications dictate a systematic sampling scheme for hybrid measures such as CIS rate. For H2019/CY2018, this was a random sample of 411 members.

Baseline Data: H2018 (CY 2017) was the baseline year and CIS Combo 10 rate was 27.01% (NCQA 50th percentile: 25.46% and NCQA 95th percentile: 51.82%).

Methodology: CIS Combo 10 measure is determined using administrative claims and non-claims clinical data. Additionally, Home State Health retrieves 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 through the HEDIS® Hybrid Technical Specifications and are entered as non-standard administrative data in HEDIS® rates. Home State Health currently uses an NCQA certified Medical Record Retrieval (MRR) and Abstraction vendor to complete the Hybrid process. This vendor's work is transmitted electronically to Centene for inclusion in the HEDIS® rates using Quality Spectrum Insight (QSI), a nationally recognized HEDIS® software vendor. 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 who turned two years of age during the measurement year, who were continuously enrolled for the 12 months prior to their second birthday.

Numerator: Home State Health members in the denominator who met the measure specification requirements for CIS Combo 10 as defined by the H2019 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 final, audited HEDIS® rate are reported annually on June 15 per HEDIS® timelines and contractual requirements.

Table 5-2. Interventions and Improvement Strategies

Date	Ongoing Interventions	Root Cause Addressed	Potential Impact	Outcome
Q1 2018 and ongoing	Allow the inclusion of corrective data submitted through the Supplemental Data System (SuDS) by Missouri Health Plus: https://www.missourihealthplus.com/ a group of Federally Qualified Health Centers (FQHCs).	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 data for compliant visits/immunizations	See Figure 5-1 for outcome data
Q2 2018 and ongoing	Implementation of multi-departmental outreach/claims review initiative to address non-compliant EPSDT population. Both member and provider facing outreach was completed. Claims data was reviewed to determine if an EPSDT visit had in fact occurred, however, was coded erroneously per provider. Pay for Performance for Combo 10 implemented. This program pays providers for	Lack of parental awareness of the benefits of and access to immunizations for their children under 2 years of age. Coding errors resulting in compliant EPSDT visits not being accurately accounted for. Increasing provider engagement with	Increasing the number of children who received vaccinations by their 2nd birthday. Ensuring services are coded appropriately to ensure those members who received their vaccinations by their 2nd	The MCO must meet the 65% participation ratio in each region to receive the EPSDT withhold. As of 12/31/19, Home State Health achieved a participation ratio of 70% or higher in each region.

	completing set percentages of Combo 10 for their assigned membership	Home State membership	birthday are identified as compliant. Increase PCP utilization, well-visits and immunization rates	Outcomes are measured by HEDIS® percentages (Figure 5-1)

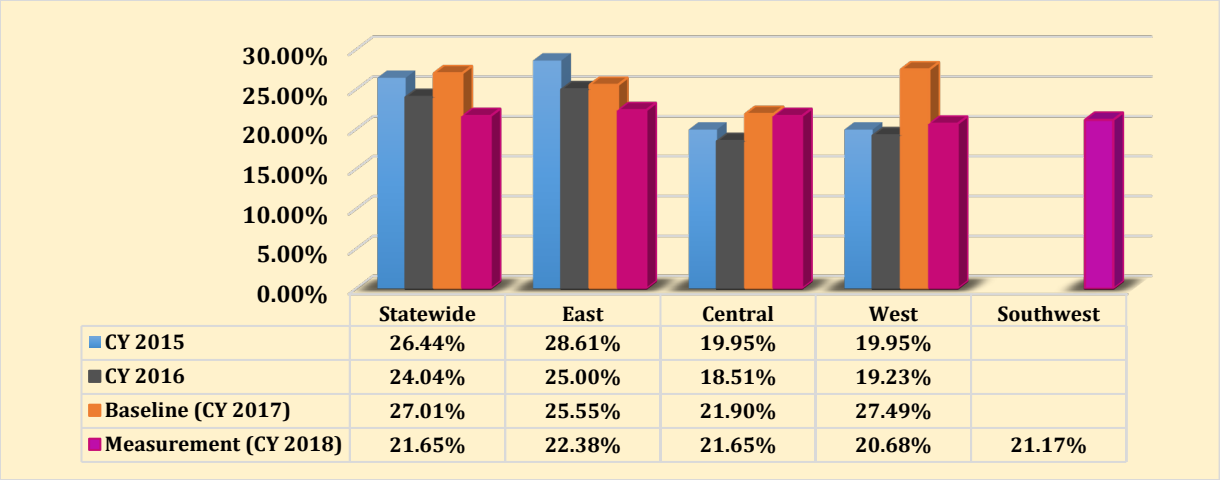
Interventions and Impact on PIP: Intervention-"Allow the inclusion of corrective data submitted through the Supplemental Data System (SuDS) by Missouri Health Plus (MH+)" (Table 5-2) has shown a positive impact (4%-8%) on the member compliance for CIS immunization rates in H2019/CY 2018 (Table 5-3).

Table 5-3. Trends in MH+ Compliant CIS Immunization Rates H2019/CY2018

CIS Immunization	MH+ Compliant Hits	Total Medicaid Compliant Hits	Percentage of MH+ Compliant Hits
DTaP	266	3886	7%
Influenza	213	2763	8%
Hepatitis B	251	3711	7%
Hepatitis A	462	5928	8%
H Influenza Type B	416	5252	8%
MMR	494	6492	8%
Pneumococcal Conjugate	129	3660	4%
OPV/IPV	245	4811	5%
Rotavirus	301	3956	8%
Chicken Pox	437	6417	7%

PIP Results

The statewide CIS Combo 10 rate has decreased from 27.01% (in CY 2017) to 21.65% (in CY 2018).This is a drop of 5.36% points with a statistical significance (p value=0.0001). Three regions (eastern, central, and western) noticed a drop in CIS Combo rates. The southwestern region does not have data for CY 2017 for comparison purpose (new region formed in May 2017) (Figure 5-1). Thus, the impact of the above stated intervention on the overall CIS Combo 10 rate is not noticed. Home State Health is below NCQA 25th percentile (27.74%).



	Statewide	East	Central	West	Southwest
CY 2015	26.44%	28.61%	19.95%	19.95%	
CY 2016	24.04%	25.00%	18.51%	19.23%	
Baseline (CY 2017)	27.01%	25.55%	21.90%	27.49%	
Measurement (CY 2018)	21.65%	22.38%	21.65%	20.68%	21.17%

Figure 5-1 HEDIS® CIS Combo 10 rates (CY 2015-CY 2018)

(B) PIP Nonclinical: Improving Access to Oral Healthcare

Description of Data Obtained from Home State Health

Aim: The Statewide ADV rate in H2018/CY2017 was 41.65% and the goal for Home State Health is to increase the ADV rate in H2019/CY2018 by 3 percentage points, to 44.65%.

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 HEDIS® 2018 and HEDIS® 2019 results?"

Study Indicator: Rate of Home State Health members ages 2 through 20 years old who had at least one dental visit during the measurement year as measured by the HEDIS® ADV total rate through the administrative method of measurement.

Study population: The study population for this project includes all Home State Health members ages 2 through 20 years. The enrollment "allowable gap" criteria is not used for the intervention population.

Sampling: No sampling is done. All members from age 2 through 20 are included in the project.

Baseline Data: Home State Health's HEDIS® ADV rate for CY 2017 is 41.65%. (NCQA 25th percentile: 46.27% and NCQA 50th percentile: 54.93%).

Methodology: The administrative method of measurement does not allow information to be gathered using direct chart review, but instead uses claims and enrollment information as data sources. As outlined in the H2019 technical specifications, these calculations will

use the procedure codes, age ranges, and enrollment anchor date of December 31 of the reporting year for the HEDIS® ADV measure, but not the continuous enrollment criteria.

Denominator: Home State Health members ages 2 through 20, enrolled on 12/31 of the measurement year (CY 2018), who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.

Numerator: Home State Health members in the denominator who had one or more dental visits with a dental practitioner during the measurement year.

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 Quality Spectrum Insight XL (QSI XL) on a monthly basis. QSI XL is Home State Health's certified HEDIS® software used to calculate the rates of this study indicator. QSI XL 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. This provides data on their contact rates. Analysis of this outreach data suggests that poor demographic information influences the ability to make successful outreach calls. Outreach calls will undergo analysis against actual ADV completed after the contact, to assess the effectiveness of interventions.

Table 5-4 Oral Health Barrier Analysis

Date	Ongoing Interventions	Barriers Addressed	Outcomes
Q2 2016 and Ongoing	Members are assigned a Primary Care Dental Provider in attempts to encourage them to go to a dental appointment. Members receive Primary Care Dental (PCD) assignment ID cards	Access to dentists and availability of appointments	Measured by HEDIS® data.
Q1 2018 and Ongoing	Automated text messages sent to all Members identified as not having an annual dental visit in the past 365 days. Message continues to be sent on a monthly basis unless we receive a dental claim. Artificial Intelligence embedded in some of the texts to encourage members to interact with the text	Communicating to members in a method they prefer. Member knowledge of dental benefit and ways to access dental care.	Measured by HEDIS® data. Opt-out methodology approved by the state in May 2019. By Q3 2019, texts will begin to go to all members instead of only members who have

			opted-in to receive texts.
Q3 2017 to 12/31/2018	Members identified as not receiving their annual dental visit contacted telephonically by AlphaPointe, a contracted vendor, to remind them of their dental benefit, preferred dentist and, if applicable, their benefit to receive transportation to and from their dental visits.	Personalized communication with members. Member knowledge of dental benefit, access to dental care and education on transportation benefit.	Minimal impact. Program ended December 2018.
Q3 2018	Health fair held in Cass/Harrisonville where dental visits were provided	Meeting members where they are.	Minimal impact. Will continue to hold Health Fairs and include dental to encourage members to access their dental benefit.

Interventions and Impact on PIP: Home State Health implemented a warm, telephonic outreach campaign with AlphaPointe, a sheltered workshop in Missouri on Aug 18, 2017 and ended on Dec 31, 2018. Data for Jul 2018 to Jan 2019 is outlined below in Table 5-5

Table 5-5 AlphaPointe Calls Jul 2018 – Jan 2019 Results

Call Result	Count	%Total
No Answer	44,031	22.03%
Hang Up	38,740	19.39%
Left VM Message	33,195	16.61%
Answering Machine	24,608	12.31%
Disconnected Number	18,875	9.45%
Message Delivered	17,028	8.52%
Wrong Number	8,468	4.24%
Automated Refusal	5,682	2.84%
Not Available	5,448	2.73%
Do Not Call (member requests for us not to call)	2,185	1.09%
Refused to Validate (member refuses to confirm HIPAA)	658	0.33%

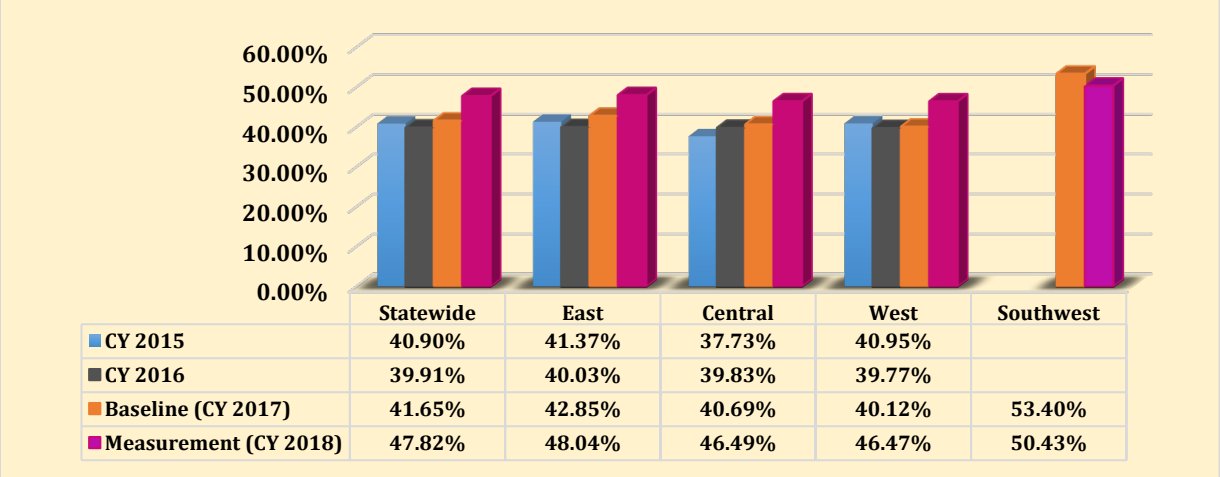
Member will contact (member states he/she will schedule an appointment)	511	0.26%
Fax/Modem	244	0.12%
Successful Transfer (Warm transfer to the dental office)	158	0.08%
Total	199,831	100.00%

Home State's eligible population for the Annual Dental Visit Measure was 156,353. AlphaPointe made a total of 199,381 outreach attempts that equals 1.28 calls per eligible Member (199,381/156,353). These attempts resulted in (Table 5-5):

- 158 successful warm transfers to dentist offices to schedule an appointment (0.08%).
- 511 (0.26%) members who agreed to contact the dentist themselves.
- 17,028 (8.52%) were left a message.

This is a minimal impact (0.34%) on the ADV rate, and the program ended in Dec 2018.

PIP Results



	Statewide	East	Central	West	Southwest
CY 2015	40.90%	41.37%	37.73%	40.95%	
CY 2016	39.91%	40.03%	39.83%	39.77%	
Baseline (CY 2017)	41.65%	42.85%	40.69%	40.12%	53.40%
Measurement (CY 2018)	47.82%	48.04%	46.49%	46.47%	50.43%

Figure 5-2 HEDIS® ADV Rates CY 2015-CY 2018

The statewide HEDIS® ADV rate increased from 41.65% in CY 2017 (H2018) to 47.82% in CY 2018 (H2019) which is an increase by 6.17 percentage points (Figure 5-2). This increase is not statistically significant (p value=0.94). However, the aim of the PIP is met.
There has been a rise in statewide HEDIS® ADV rate (Figure 3) as well as in central, eastern and western regions over the 2 years. However, southwest region which was newly formed in May 2017, shows a decline by 3 percentage points from CY 2017. Home State Health is currently at NCQA 25th percentile (47.48%).

Score and Summary PIPs

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.

PIP CIS Combo 10

The aim of the PIP was not met. Only one intervention was tested and analyzed, namely, to allow the inclusion of corrective data submitted through the Supplemental Data System (SuDS) by Missouri Health Plus (MH+) which did have a positive impact on compliance hits (an increase by 4-8%) but failed to increase the HEDIS® CIS Combo 10. The statewide rate dropped by 5.36 percentage points from the previous year which is a statistically significant drop.

PIP Improving Access to Oral Healthcare

The aim of the PIP was met and the HEDIS® ADV rate increased by 6.17% points. The intervention namely, telephonic outreach campaign with AlphaPointe had a very insignificant impact on the outcome (0.34%) and could not be tied to the result. The other interventions were not tested and analyzed by Home State Health.

Strengths

- Home State Health expressed their willingness to learn the correct methodology for PIP during a Technical Assistance session. They responded by providing updates/additional information/corrections and tried to align with the expectations of EQRO.
- Home State Health has committed to a number of long-term projects designed to empower providers with the ability to offer immunizations/dental services to their patients as well as a more robust and efficient method of capturing and analyzing data. The plan for future interventions is created in order to achieve set goals for CY 2019 PIPs.

Weaknesses

- 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 2.18.8d1), (Table 5-6).
- Annual evaluation of HEDIS® measures were used as quality indicators. The indicators were not specifically chosen to measure the impact of interventions.

Table 5-6 Evaluation based on CFR guidelines

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	Partially Met
Planning and initiation of activities for increasing or sustaining improvement	Met

- Interventions could not be linked to the measured quality indicators. The Missouri Health plus intervention showed some positive impact on the CIS compliance but the annual HEDIS® CIS Combo 10 rate decreased by 5.36 percentage points. On the other hand, AlphaPointe intervention showed minimal impact (0.34%), but the annual HEDIS® ADV rate increased by 6.17 percentage points.
- Analysis about the impact of each intervention is not done.
- Some interventions are ongoing from previous years, without evaluation of their usefulness/impact on the quality indicators.
- PIPs result: The CIS combo 10 rate has decreased by 5.36 percentage points from the previous year in spite of interventions.

Quality, Timeliness and Access to HealthCare Services

Home State Health executed a plan to collaborate with Missouri Health Connection (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 allows Home State Health to collect additional HEDIS® data, including immunizations, and enable reporting through supplemental data.

Home State Health is committed to a number of long-term projects including:

- Continue to work with their dental vendor, Envolve Dental, to inform members of their benefits.
- Family household approach to outreach.
- Emphasis of transportation and incentive benefits
- Disseminating information through schools via take-home flyers to children (if allowed by state).
- Exploring opportunities at Head-Start programs-deploying dental vans.

Improvement by Home State Health

- Some improvement in the documentation/presentation (e.g., aim statement, identifying proper baseline and measurement year, and analysis of interventions) is noted after a Technical Assistance session was conducted by EQRO.

- The statewide HEDIS® ADV rate has increased from 41.65% to 47.82% which is an increase by 6.17 percentage points from the previous year, though this increase is not statistically significant.

5.3 Findings and Analysis Missouri Care

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

Description of Data Obtained from Missouri Care

Aim: To increase the number of eligible children receiving CIS Combo10 by their 2nd birthday by 3 percentage points from CY 2017 to CY 2018.

Study Question: "Will providing the proposed list of interventions to eligible members increase the number of children receiving Combo-10 by their 2nd birthday by 3 percentage points in CY 2018?"

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

Sampling: There was no sampling for the PIP and interventions were applied to the entire eligible population. However, the final CIS Combo 10 rate was measured as per the 2019 HEDIS® Technical Specifications (hybrid measure).

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.

Baseline Data: CY 2017 is the baseline year with HEDIS® CIS rate as 26.52%.

Methodology: Sources of data used in this study included claims-based software and NCQA Certified Software (Inovalon) to calculate HEDIS® CIS-Combo 10 rate. The data collected includes the entire eligible population of CIS claims/encounter data according to HEDIS® Technical Specifications by members' second birthday (CY 2018). As part of its systematic method of collecting valid and reliable data, claims data for the study were queried from the claims-based software and put into NCQA-certified software (Inovalon).
According to HEDIS® 2019 NCQA Technical Specifications, the study indicator data pulled from the HEDIS® CIS rate captures:

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.

Denominator: All children 2 years of age in the measurement year (CY 2018) 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.

Annually, Missouri Care collects medical records to supplement the administrative claims data. This is known as a hybrid review or medical record review, which uses a set of members for the denominator. Missouri Care follows NCQA requirements for this hybrid measure, which includes a sample of 411 members plus a 5% oversample (432 members) for each region, if appropriate. Missouri Care used NCQA Certified HEDIS® Software vendor (Inovalon) and CHANGE Health vendor for medical record review.
Additionally, Missouri Care tracked quarterly HEDIS® CIS Combo-10 rates so data trends could be identified early.

Interventions and Impact on PIP: Missouri Care utilized interventions to ensure rates sustain or improve through member engagement (Table 5-7).

Table 5-7 Intervention List	Year
CIS Provider Incentive: Missouri Care's provider incentive program, Partnership for Quality, rewards providers with bonus dollars for increasing immunization status for members.	Jan 1-Dec 31, 2018
Member Incentive: Missouri Care's Healthy Rewards member incentive program includes rewards for members who complete their recommended well-child visits.	Jan 1-Dec 31, 2018

1. Table 5-8 illustrates the number of eligible members for the EPSDT/Wellness visits, which includes completing immunizations in first 15 months of life (W15). There is a decrease (3.01% points) in member participation during CY 2018 with the Healthy Rewards Member Incentive Program. Thus, the intervention did not have a positive impact on Missouri Care's Statewide HEDIS® CIS rate.

Table 5-8 Healthy Rewards Member Incentive Program for Well Child Visit

Well-Child Visits in First 15 Months of Life (W15)	Eligible Members	Attested Activities	% Attested	Yr. Over Yr. Comparison
CY 2017	3,560	351	9.86%	Baseline
CY 2018	4,710	323	6.85%	↓

2. Table 5-9 illustrates the number of closed CIS-Combo 10 gaps in care after implementing the Provider Incentive Program. There is a decrease of 3.5% points in CY 2018. Thus, the intervention did not have a positive impact on Missouri Care's Statewide HEDIS® CIS rate.

Table 5-9 Partnership for Quality Provider Incentive Program

HEDIS® CIS Combo 10	CIS Eligible Gaps	Number of CIS Gaps Closed	% CIS Gaps Closed	Yr. Over Yr. Comparison
CY 2017	2605	482	18.5%	Baseline
CY 2018	5218	788	15%	↓

PIP Results

Missouri Care's HEDIS® CIS Combo 10 rate statewide for the CY 2018 (HEDIS® 2019) is 27.49% which is an increase from the CY 2017 (26.52%) by 0.97% point (Table 5-10). This increase is not statistically significant. The aim of the PIP is not met. Figure 5-3 represents HEDIS® Combo 10 rates for CY 2016 (HEDIS® 2017)-CY 2018 (HEDIS® 2019). There is no statistically significant improvement seen statewide over the last two years.

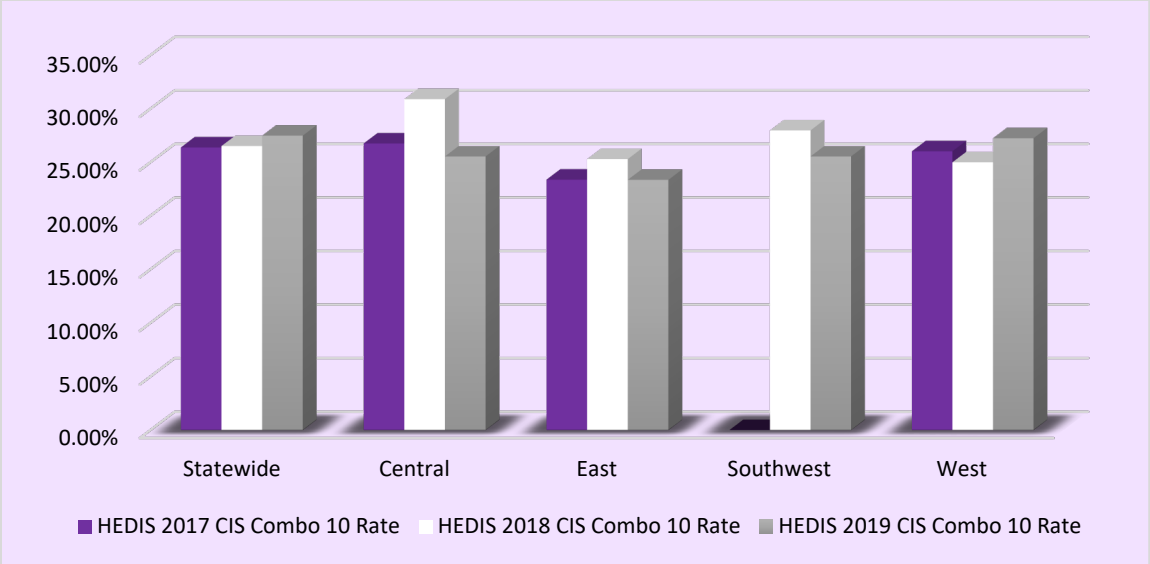


Figure 5-3 HEDIS® CIS Combo 10 Rates H2017-H2019

Table 5-10 HEDIS® CIS Combo 10 Rate Statewide

HEDIS® Quarterly Measurements	HEDIS® 2018	HEDIS® 2019
Quarter 1	13.44%	13.37%
Quarter 2	19.35%	15.82%
Quarter 3	17.81%	16.49%
Quarter 4	20.76%	17.21%
Final HEDIS® Rate	26.52%	27.49%

(B) PIP Nonclinical: Improving Access to Oral Healthcare

Description of Data Obtained from Missouri Care

Aim: To increase the annual dental visits of children ages 2 through 20 years old by 3 percentage points from CY 2017 to CY 2018.

Study Question: "Will providing the proposed interventions to eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3 percentage points in CY 2018?"

Study Indicator: HEDIS® Annual Dental Visit (ADV) Rate. From the current HEDIS® Technical Specification, NCQA recommends that eligible members have at least one dental visit during the measurement year. For ADV, the period of time measured includes a full calendar year (2018).

Study population: 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.

Sampling: No sampling techniques are used in this PIP. The study includes all members 2 through 20 years of age (as per HEDIS® Specifications).

Baseline Data: CY 2017 is the baseline year with HEDIS® ADV rate as 48.42%.
Methodology: Sources of data used in this study include claims-based software and NCQA Certified Software (Inovalon) to calculate the HEDIS® ADV rate. According to HEDIS® 2019 Technical Specifications, the HEDIS® ADV rate captures:

Numerator: Members 2 through 20 years of age identified as having one or more dental visits with a dental practitioner during the measurement year (CY 2018).
Denominator: Members 2 through 20 years of age who are continuously enrolled during the measurement year (CY 2018) with no more than one gap in enrollment of up to 45 days.

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).

Intervention and Impact on PIP: The barrier addressed in this PIP is, "lack of motivation to complete annual dental visit" and the intervention implemented is follows:
ADV Member Incentive: To help motivate members to complete an annual dental visit, the members receive an incentive through Healthy Rewards program. CY 2018 is the first full-year for Missouri Care to have the ADV Member Incentive in place.
Table 5-11 illustrates the number of eligible members for the ADV Healthy Rewards incentive and those who attested to completing the service. There is a negligible increase (0.45 percentage point) in member participation during CY 2018 with the Healthy Rewards Program. It is evident that the intervention did not have an impact on HEDIS® ADV rate.

PIP Results

HEDIS® ADV rate statewide for the CY 2018 (HEDIS® 2019) is 52.72% which is an increase from the CY 2017 (48.42%) by 4.3 percentage points (Table 5-12). The aim of the PIP is

met. Figure 5-4 represents HEDIS® ADV rates for CY 2016 (HEDIS® 2017)-CY 2018 (HEDIS® 2019). There is an evidence of a statistically significant statewide improvement.

Table 5-11 Healthy Rewards Member Incentive Program for ADV

Annual Dental Visit	Eligible Members	Attested Activities	% Attested	Yr. Over Yr. Comparison
CY2017	62,893	422	0.67%	Baseline
CY2018	142,398	1,592	1.12%	↑

Table 5-12: HEDIS® ADV Rates Statewide

HEDIS® Quarterly Measurements	HEDIS® 2018	HEDIS® 2019
Quarter 1	13.27%	17.57%
Quarter 2	29.57%	32.07%
Quarter 3	38.50%	41.58%
Quarter 4	47.38%	51.79%
Final HEDIS® Rate	48.42%	52.72%

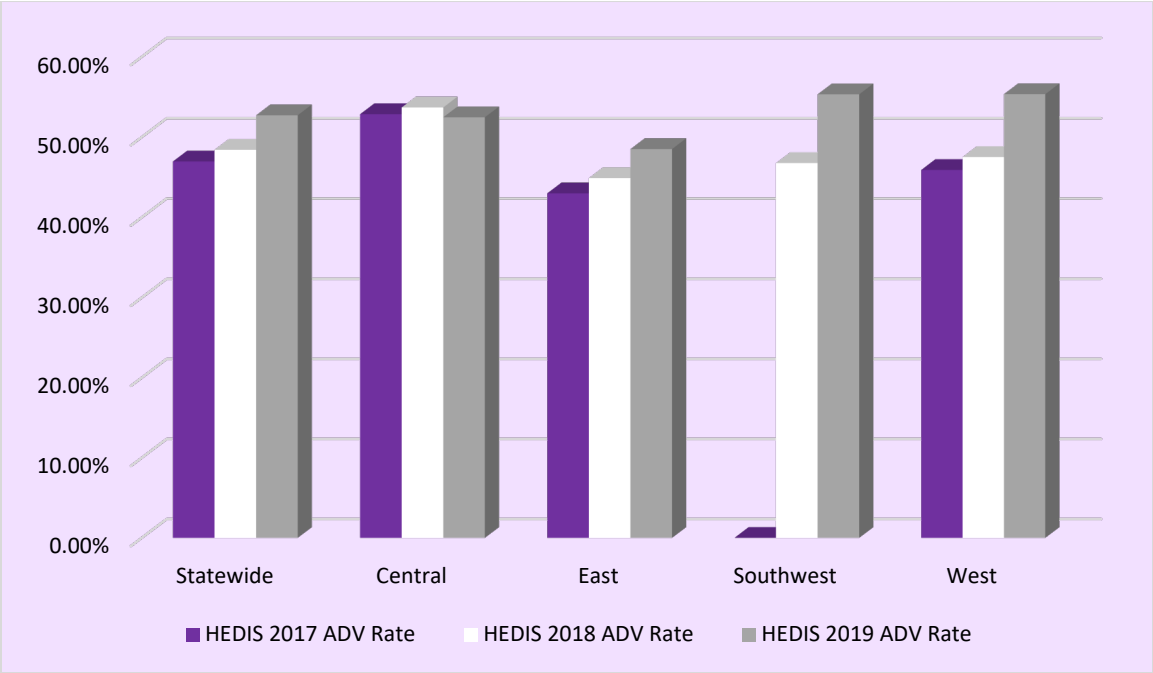


Figure 5-4 HEDIS® ADV Rates (H2017-H2019)

Score and Summary PIPs

Primaris assigned the following score to both the PIPs: 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.

PIP CIS Combo 10

The aim of the PIP was not met. The two interventions, namely Healthy Rewards Member Incentive Program and Provider Incentive Program failed to have any positive impact on the outcomes. The annual HEDIS® CIS Combo 10 increased by 0.97 percentage point which had no statistical significance.

PIP Improving Access to Oral Healthcare

The aim of the PIP was met and the HEDIS® ADV rate has significantly increased by 4.3 percentage points. The intervention had a very small impact (0.45 percentage point) on the outcome and it could not be tied to the result.

Strength

Missouri Care expressed their willingness to learn the correct methodology for PIP during a Technical Assistance session. They responded by providing updates/additional information/corrections and tried to align with the expectations of EQRO.

Weaknesses

- The PIPs did not meet all the required guidelines stated in CFR/MHD contract (Ref: 42 Code of federal Regulations CFR438.330 (d)/MHD contract 2.18.8 d 1), (Table 5-13).

Table 5-13 Evaluation based on CFR guidelines

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

- Annual evaluation of HEDIS® measures were used as quality indicators. The indicators were not specifically chosen to measure the impact of interventions.
- Interventions could not be linked to the measured quality indicators. The member incentive program or the provider incentive program had no impact on the wellness visits of children in first 15 months of life or the HEDIS® CIS combo 10 rate. The member incentive program implemented to improve the ADV rate showed a small increase of 0.45 percentage point, though the annual HEDIS® ADV rate increased by 4.3 percentage points.
- PIPs result: The CIS combo 10 rate has increased by 0.97 percentage points from the previous year which is not statistically significant.

Quality, Timeliness and Access to HealthCare Services

Member Incentive Program (for ADV and Wellness visits): In July 2017, Missouri Care launched the newly revised Healthy Rewards Program, which included a new ADV incentive, a new wellness incentive, and a new vendor with additional opportunities at various retail stores. Missouri Care members were notified of the new program through various means such as New Member Welcome Packet, Mailers, and Care Management. Besides a more holistic approach to incentive measures, the new program allows members to attest services that were completed 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. CY 2018 was the first full year when this intervention was implemented.

In CY 2019, the MCO has added Walmart as a vendor to the Healthy Rewards program and also increased the incentive amount from $20 to $30, which should help to increase participation.

Additionally, in CY 2017, Missouri Care launched a revised Provider Incentive Program, Partnership for Quality, which included all eligible Primary Care Providers within their network. In order to impact CIS-Combo 10, providers were incentivized to provide all needed childhood immunizations. Providers were notified of the program through Missouri Care's Quality Practice Advisors, Provider Relations representatives, mailed packets, and on the provider portal.

Improvement by Missouri Care

- Some improvement/clarity in reporting the study question, baseline year, measurement year, evaluation of interventions is seen.
- The statewide HEDIS® ADV rate has increased from 48.42% to 52.72%.

5.4 Findings and Analysis UnitedHealthcare

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

Description of Data Obtained from UnitedHealthcare

Aim: By Dec 31, 2018, increase children ages two (2) and under, receiving CIS (Combo 10) vaccines by 3 percentage points from the baseline year (CY 2017).

Study Question: Will implementing the interventions for UnitedHealthcare eligible members increase the number of children ages two (2) and under receiving CIS (Combo 10) vaccines by 3 percentage points?

Study Indicator: The percentage of children 2 years of age who had four Diphtheria, Tetanus and acellular Pertussis (DTaP); three Polio (IPV); one Measles, Mumps and Rubella (MMR); three Hemophilus 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 on or by their second birthday.

Sampling: There will be no sampling; the entire eligible population is measured as per the 2018 HEDIS® Technical Specifications.

Baseline Data: Since UnitedHealthcare's contract with MHD went into effect on May 01, 2017, the baseline year includes only a period of 8 months of administrative data (May 01-Dec 31, 2017) for the eligible members. UnitedHealthcare has reported this as "interim," which has been accepted as baseline by Primaris for the purpose of validation of the PIP.

Methodology: UnitedHealthcare used ClaimSphere, HEDIS®-certified software to generate the CIS (Combo 10) measure rates. The study uses the 2018 HEDIS® Technical Specifications for CIS (Combo 10) measure coinciding with the appropriate measurement year, as described below.

Denominator: All UnitedHealthcare's Managed Care eligible members meeting the following specifications are included:

- Children who turn 2 years of age during the measurement year.
- Continuous enrollment 12 months prior to the child's second birthday.
- No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
- Enrolled on the child's second birthday.

Numerator: The members who meet the eligibility requirements above and receive the combination of immunizations in the measurement period.

Interventions and Impact on PIP: The interventions implemented by UnitedHealthcare are listed in Table 5-14 that address at least one of the following three barriers:

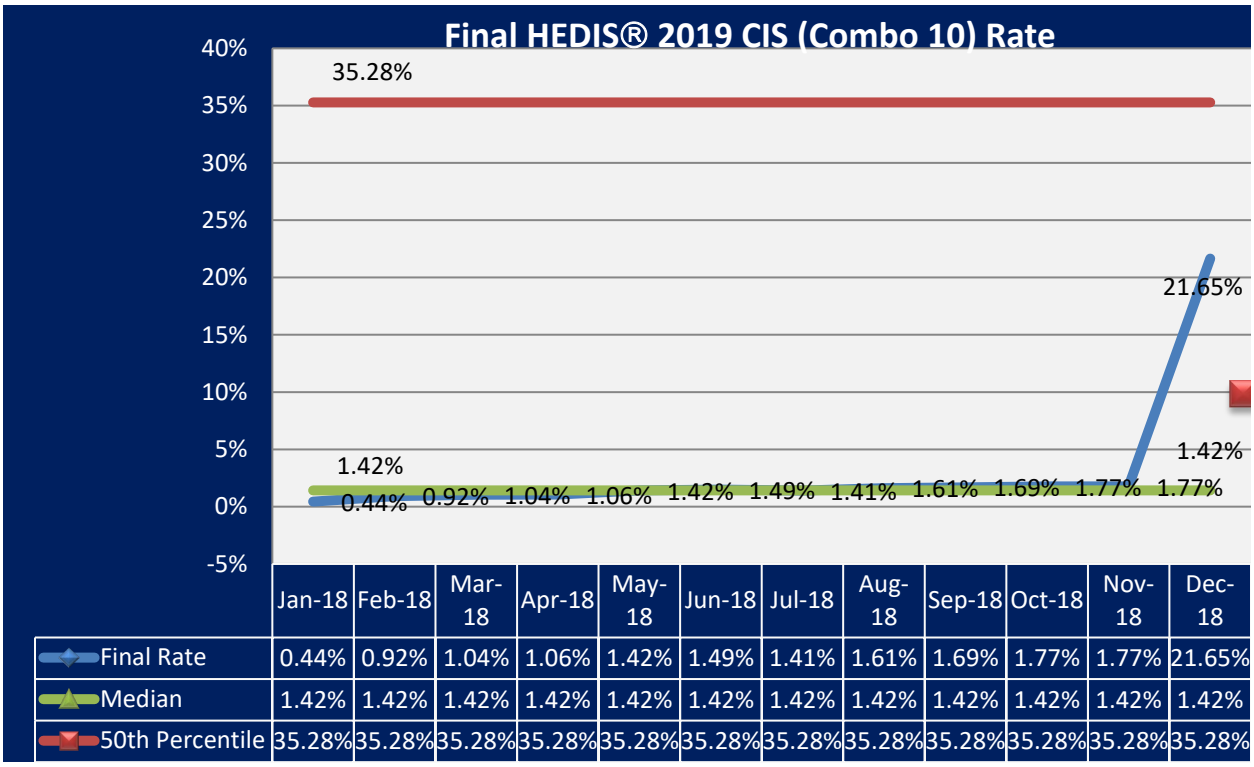
1. A lack of knowledge about the importance of preventive services, including recommended vaccine schedules
2. A lack of knowledge about provider-specific immunization practices: Provider Barrier
3. A lack of access to immunization data: System Barrier

Table 5-14 Interventions for CIS Combo 10 PIP

Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
1. Health First Steps Program	1			May 2017– December 2018
2. Baby Blocks Program	1			May 2017– December 2018
3. Custom EPSDT Reporting and Analysis			3	July 2017– December 2018
4. EPSDT Member Outreach Calls	1			Mid-July 2017
5. EPSDT Billing & Coding Guide for Providers		2		Developed September 2017, Reviewed with Providers September 2017– December 2018
6. Review of PCOR Data with Providers		2		November 2017– December 2018
7. Rose International (Call Center) Member Outreach Calls	1			May 2018– December 2018
8. EPSDT Provider Education – Quality Department "Push"		2		May 2018–June 2018
9. Jordan Valley Mission Distinction Program (Grant Award)	1			Month of May 2018
10. EPSDT West IVR Calls	1			July 2018– December 2018
11. UHCCP MO Participation in State-wide Back to School Events	1			July 2018–August 2018
12. CIS/IMA Pre-season Data Collection Project		3		July 2018–August 2018

Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
13. Immunization Data "Deep Dive" Analysis			3	August 2018
14. CPC Provider Engagement Assessment		2		August 2018– December 2018
15. Annual Preventive Services Mailing	1			September 2018
16. Request to state – ShowMeVax			3	August 2018
17. Request to State – Historical Immunization Data			3	August 2018
18. CPC Collaboration with and Attendance at DHSS Bureau of Immunization Trainings/Events	1	2		CY 2018

None of the interventions were tested individually to measure their impact on the PIP. However, a run chart (Figure 5-5) tracked the progress of HEDIS® CIS Combo 10 rate with all the interventions applied throughout CY 2018.

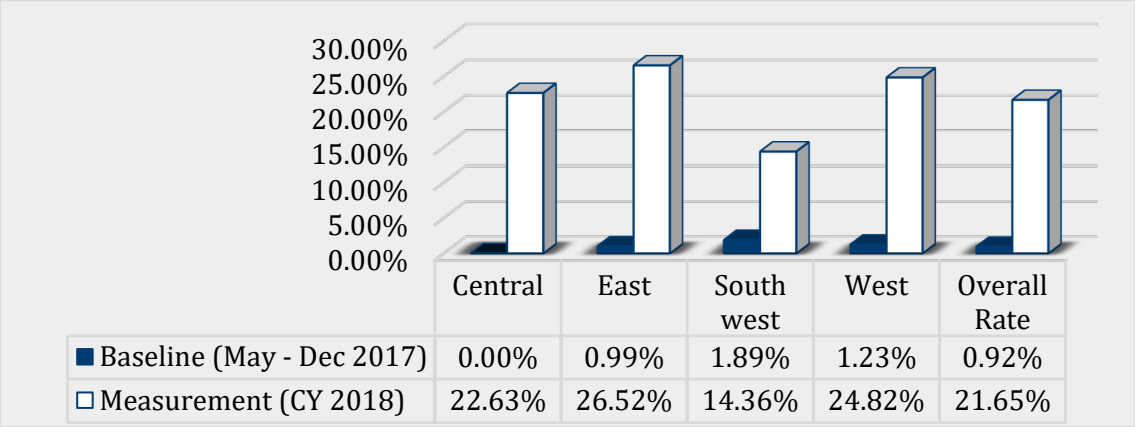


	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Final Rate	0.44%	0.92%	1.04%	1.06%	1.42%	1.49%	1.41%	1.61%	1.69%	1.77%	1.77%	21.65%
Median	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%
50th Percentile	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%

Figure 5-5 Run Chart-HEDIS® CIS Combo 10 rate

PIP Results

The statewide rate for CIS Combo 10 during the baseline year (May-Dec 2017) was 0.92%. It has increased to 21.65% during the measurement year (CY 2018) which is a rise by 20.73 percentage points. Due to the maturity of the UnitedHealthcare in MO and the technical specifications for this measure (children who turn 2 years of age during the measurement year and are continuously enrolled for 12 months prior to their 2nd birthday) data is limited for the baseline year and reflects a significantly low rate. Primaris will not comment on the performance of the PIP as UnitedHealthcare did not operate for an entire year in MO during CY 2017. (Figure 5-6).



	Central	East	South west	West	Overall Rate
Baseline (May - Dec 2017)	0.00%	0.99%	1.89%	1.23%	0.92%
Measurement (CY 2018)	22.63%	26.52%	14.36%	24.82%	21.65%

Figure 5-6 HEDIS® CIS Combo 10 Rates

(B) PIP Nonclinical: Improving Access to Oral Healthcare

Description of Data Obtained from UnitedHealthcare

Aim: By December 31, 2018, increase the percentage of preventive oral health services in members 2–20 years of age by 3 percentage points (ADV), 1-20 years of age by 3.33 percentage points (CMS 416 Preventive Services), and 6-9 years of age by 3.33 percentage points (CMS 416 Oral Sealants).

Study Questions:

1. Will implementing the list of interventions for UnitedHealthcare MHD eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3 percentage points for the measurement year?
2. Will implementing the list of interventions for UnitedHealthcare MHD eligible members from the ages of 1 through 20 years of age increase the number of children who receive an annual dental visit for a preventive service by 3.33 percentage points per year from CY 2018 (HEDIS® Year 2019) through Data Year 2022 (HEDIS® Year 2023)?
3. Will implementing the list of interventions for UnitedHealthcare MHD eligible members from the ages of 6 through 9 years of age increase the number of children who receive

the application of an oral sealant to at least one permanent molar by 3.33 percentage points per year from Data Year 2018 (HEDIS® Year 2019) through Data Year 2022 (HEDIS® Year 2023)?

Study Indicators:

1. The rate of eligible members from the ages of 2 through 20 who have had at least one dental visit as measured by the HEDIS® 2019 (data from CY 2018) Annual Dental Visit (ADV) total rate through the administrative method of measurement.
2. The rate of eligible members from the ages of 1 through 20 who have had at least one preventive dental service as measured in the Centers for Medicare and Medicaid Services (CMS) 416 report for the HEDIS® Year 2019 (data from CY 2018).
3. The rate of eligible members from the ages of 6 through 9 who have had an application of an oral sealant to at least one permanent molar as measured in the CMS 416 report for the HEDIS® Year 2019 (data from CY 2018).

Study Population: All UnitedHealthcare MHD eligible members from the ages of 1 through 20 in the measurement year.

Sampling: There is no sampling. The entire eligible population is measured as per the HEDIS® 2018 Technical Specifications and applicable CMS 416 methodology.

Baseline Data: Since UnitedHealthcare's contract with MHD commenced on May 01, 2017, the baseline includes only a period of 8 months of administrative data (May 01-Dec 31, 2017) for the eligible members (Table 5-15).

Table 5-15 Baseline Rates (May 01-Dec 31, 2017)

Study Indicators	Rates (%)	Benchmark (%)
HEDIS® ADV	35.10	59.43 (NCQA 50th percentile)
CMS 416 Preventive services	26.47	32.66 (2016 CMS 416 report)
Members receiving sealants	9.53	13.51 (2016 CMS 416 report)

Methodology: UnitedHealthcare used ClaimSphere, a HEDIS® -certified software engine to generate the HEDIS® ADV measure rates. The study uses the HEDIS® 2018 Technical Specifications for the Annual Dental Visit (ADV) measure coinciding with the appropriate measurement year, and the applicable CMS 416 methodology for the Preventive Service and Oral Sealant measures, as described below:

Denominator

1. HEDIS® ADV Rate–all UnitedHealthcare MHD eligible members from the ages of 2 through 20 as of December 31 of the measurement year.
2. Preventive Service–all UnitedHealthcare MHD eligible members from the ages of 1 through 20 as of December 31 of the measurement year.
3. Oral Sealant Application–all UnitedHealthcare MHD eligible members from the ages of 6 through 9 as of December 31 of the measurement year.

Numerator

1. HEDIS® ADV Rate–all UnitedHealthcare MHD eligible members from the ages of two 2 through 20 who have had at least one dental visit in the measurement year.
2. Preventive Services–all UnitedHealthcare MHD eligible members from the ages of 1 through 20 who have received at least one preventive service in the measurement year.
3. Oral Sealant Application–all UnitedHealthcare MHD eligible members from the ages of 6 through 9 who have had an application of an oral sealant to at least one permanent molar in the measurement year.

Interventions and Impact on PIP: The interventions implemented by UnitedHealthcare (Table 5-17) address at least 1 of the following barriers identified:

1. A lack of knowledge by the membership of the need for dental care: Member Barrier
2. A lack of knowledge by the membership of dental care access: Member Barrier
3. A lack of information flow to the dental and medical providers: Provider Barrier
4. A lack of outreach activities related to dental care for the membership: System Barrier

Table 5-16 Interventions for Oral Health PIP

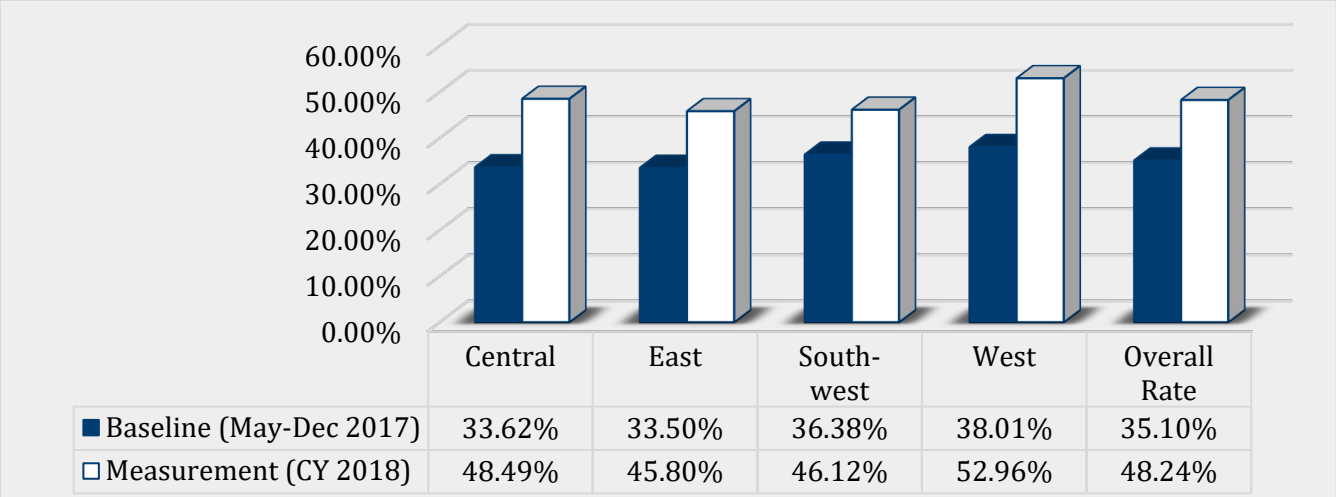
Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
1. National Children's Dental Health Month Events	1, 2	3		February 2018
2. Provider Feedback - Barriers to Preventive Dental Services		3		February 2018
3. Health Talk Newsletter – "Smile. sealants prevent cavities."	1, 4			Spring 2018 Edition
4. Practice Matters Newsletter – "Get Updated Clinical Practice Guidelines" (Preventive Pediatric Health Care Screening)		3		Spring 2018 Edition

Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
5. Jordan Valley Mission Distinction Program (Grant Award)			1, 2, 3	May 2018
6. Letter of Support for MO DHSS and ODH			3	June 4, 2018
7. Dental Interactive Voice Recording (IVR) Calls	4			March, May, August, October 2018
8. ADV Reminder Added to EPSDT Member Outreach Calls	4			March 2018 – December 2018
9. Rose International (Call Center) – EPSDT Gaps in Care Addressed	4			March 2018– December 2018
10. UHCCP MO Participation in State-wide Back to School Events	1, 2			July 2018–August 2018
11. HealthTalk Newsletter – "Toothache?"	1, 4			Summer 2018 Edition
12. Practice Matters Newsletter– "Reducing Missed EPSDT Appointments"		3		Summer 2018 Edition
13. ADV Member Mailing	1, 4			October 2018
14. ADV Member Rewards Program	2, 4			October 2018 – December 2018
15. Monthly Clinical Collaboration with Dental Vendor (SkyGen)			1, 2, 3, 4	CY 2018
16. Health Plan Participation on State Dental Task Force			3	Began December 2018

PIP Results

1. HEDIS® ADV rates

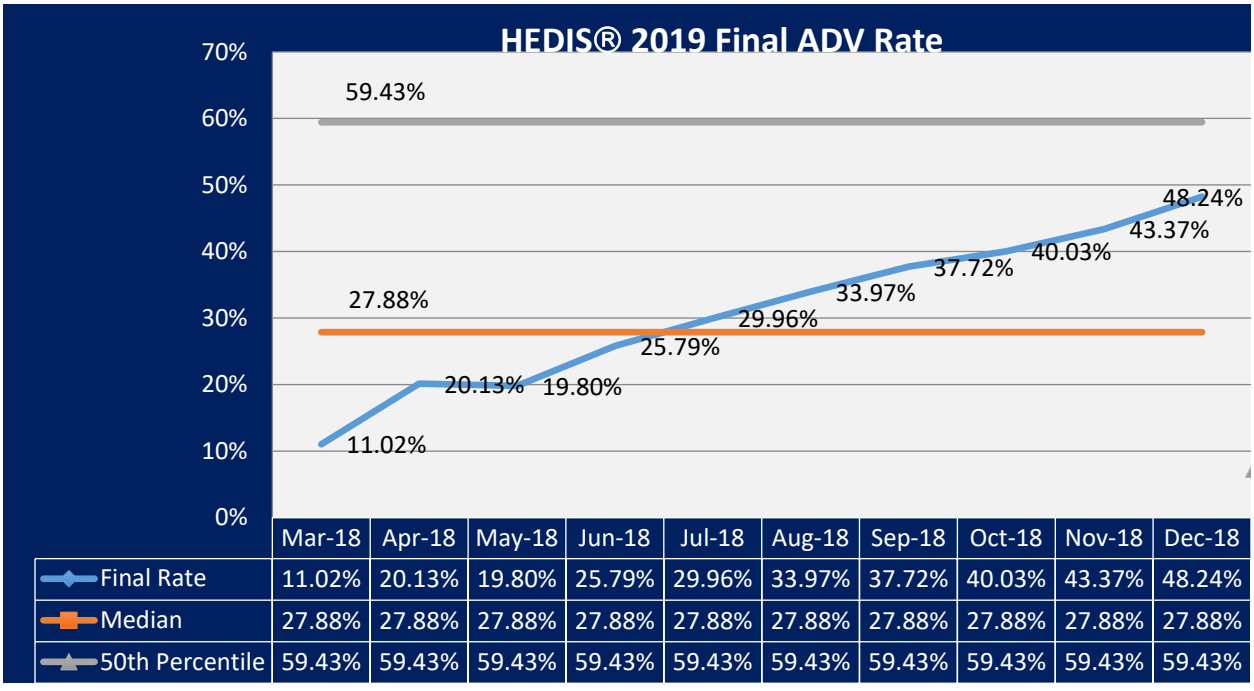
There is an increase in ADV rates for all the four regions (Figure 5-7). The statewide ADV rate has increased from 35.10% (CY 2017) to 48.24% (CY 2018), which is an increase by 13.14% points. The significance could not be stated because of lack of data for the entire baseline CY 2017.



	Central	East	South-west	West	Overall Rate
Baseline (May-Dec 2017)	33.62%	33.50%	36.38%	38.01%	35.10%
Measurement (CY 2018)	48.49%	45.80%	46.12%	52.96%	48.24%

Figure 5-7 HEDIS® ADV Rates

Figure 5-8 is the run chart to show the progress in HEDIS ADV rate throughout the year with multiple interventions in place in CY 2018. (Note: the interventions were not tested individually, and the impact was not measured.)



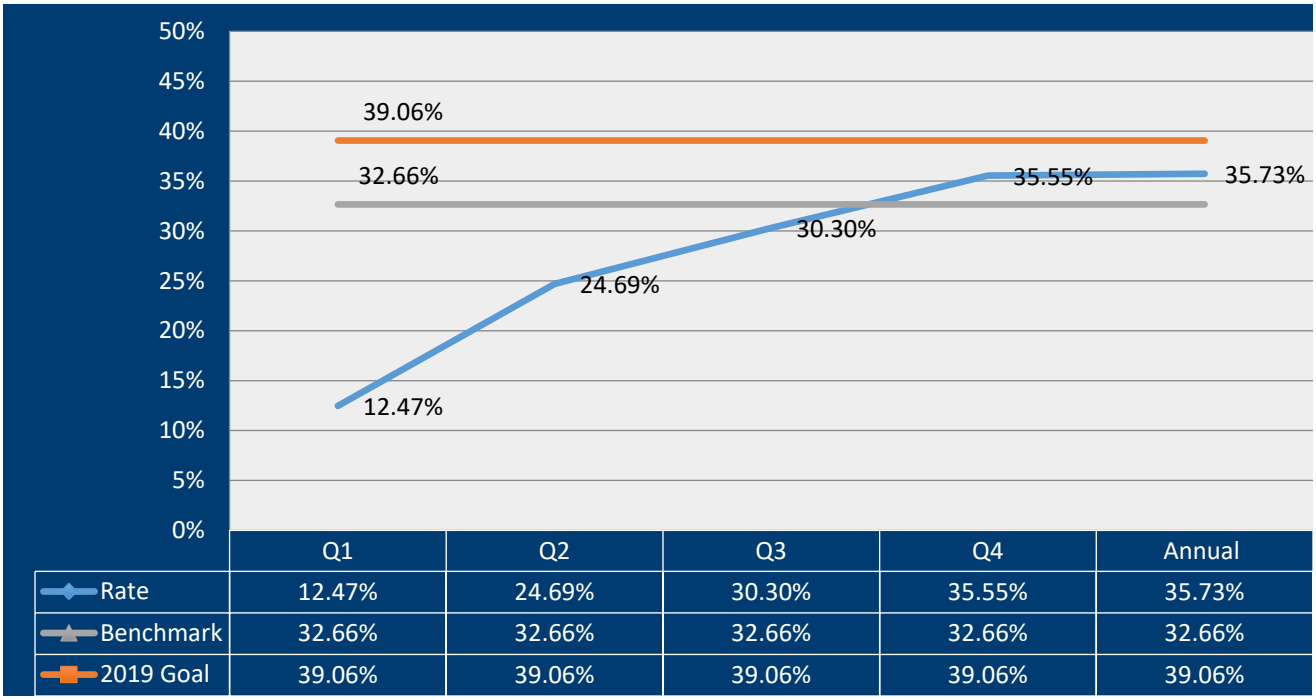
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Final Rate	11.02%	20.13%	19.80%	25.79%	29.96%	33.97%	37.72%	40.03%	43.37%	48.24%
Median	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%
50th Percentile	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%

Figure 5-8 Run Chart-HEDIS® ADV Rate

2. CMS 416 Preventive Services

A significant improvement (23.26% points) in the rate of members who met the eligibility requirements and received at least one preventive service in the measurement year is noted between Q1 2018 (12.47%) and by end of measurement year (overall rate 35.73%).

This exceeds the 2016 MO CMS 416 Annual Report benchmark of 32.66% (Figure 5-9). The overall rate of members who received CMS 416 preventive services in CY 2018 (35.73%) compared to the rate in baseline year (26.47%) shows an increase by 9.26 percent points. This is an improvement, but significance could not be stated because of lack of data for the entire baseline CY 2017.

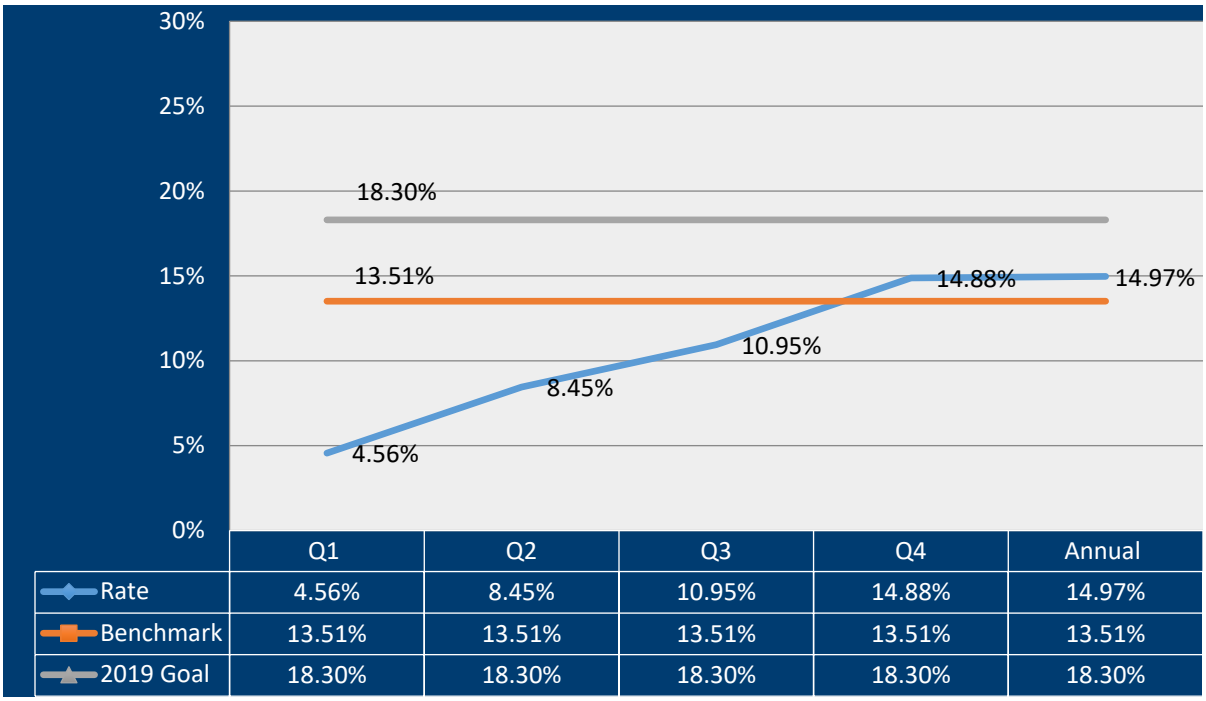


	Q1	Q2	Q3	Q4	Annual
Rate	12.47%	24.69%	30.30%	35.55%	35.73%
Benchmark	32.66%	32.66%	32.66%	32.66%	32.66%
2019 Goal	39.06%	39.06%	39.06%	39.06%	39.06%

Figure 5-9 Run Chart 2018 CMS 416 Preventive Service Rate

3. CMS 416 Oral Sealant

A significant improvement (10.41 percent points) in the rate of members who met the eligibility requirements and had an oral sealant applied in the measurement year is noted between Q1 2018 (4.56%) and by end of the measurement year (overall rate 14.97%) exceeding the 2016 MO Annual CMS 416 Report benchmark of 13.51% (Figure 5-10). The overall rate of members who received CMS 416 oral sealant in CY 2018 (14.97%) compared to the overall rate in the baseline year (9.53%) shows an increase of 5.44 percent points. This shows an improvement, but significance could not be stated because of lack of data for the entire baseline CY 2017.



	Q1	Q2	Q3	Q4	Annual
Rate	4.56%	8.45%	10.95%	14.88%	14.97%
Benchmark	13.51%	13.51%	13.51%	13.51%	13.51%
2019 Goal	18.30%	18.30%	18.30%	18.30%	18.30%

Figure 5-10 2018 CMS 416 Oral Sealant Rate

Score and Summary PIPs

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

Reported PIP results were not credible = The PIP methodology was not executed as approved, or for reasons beyond control of MCO.

The decision was made on the basis that UnitedHealthcare did not have data for the full year which could have served as the baseline for the measurement year. Therefore, the data is incompatible for a meaningful comparison of baseline data of 8 months (May-Dec 2017) with measurement data of 12 months (CY 2018).

PIP CIS Combo 10

The aim of CIS Combo PIP was met. The increase in the CIS Combo 10 rate was by 20.73 % points exceeding the set aim of 3 percentage points, from the baseline year (CY 2017). The significance of this increase could not be determined due to lack of data for the entire baseline year for comparison. The methodology adopted for the PIP was not sound. Multiple interventions were implemented throughout the measurement year. Impact of interventions and its usefulness was not evaluated by UnitedHealthcare.

PIP Improving Access to Oral Healthcare

The aim of the Oral Health improvement PIP was met. All three indicators: HEDIS® ADV rate; CMS 416 preventive services; and CMS 416 sealant application, used to measure the

improvement in oral health showed an increase by more than 3.33 percentage points (which is the set aim/goal), from the baseline year (CY 2017). However, the methodology was not sound. Multiple interventions are implemented throughout the measurement year. Impact of interventions and its usefulness was not evaluated by UnitedHealthcare.

Strengths

- UnitedHealthcare expressed their willingness to learn the correct methodology for PIP during the Technical Assistance session. They responded by providing updates/additional information/corrections and tried to align with the expectations of EQRO.
- HEDIS®/CMS 416 quality indicators are measured on a monthly/quarterly basis and the data is depicted in the run charts. This is suggestive of regular monitoring/progress of the results.
- Barrier analysis was done around the three categories-Member, Provider, and System. The interventions were designed to address at least one of these barriers.

Weaknesses

- 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 5-17):

Table 5-17 Evaluation based on CFR guidelines

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	Met

- Annual evaluation of HEDIS® measures were used as quality indicators. The indicators were not specifically chosen to measure the impact of interventions.
- Interventions could not be linked to the measured quality indicators. Multiple interventions were implemented throughout the CY 2018 and the impact of any individual intervention could not be judged. Thus, UnitedHealthcare would not be

able to decide the follow up activities/interventions for next year based on these results.

Quality, Timeliness and Access to HealthCare Services

Improving CIS

UnitedHealthcare worked in accordance with the Missouri HealthNet Childhood Immunization Initiative to increase vaccination coverage of children 2 years of age and older, improve vaccine delivery, and increase vaccination accessibility.

In July and August 2018, the Clinical Practice Consultants (CPCs) conducted pre-season data collection for the CIS/IMA (Immunizations for Adolescents) measures in anticipation of the HEDIS® 2019 Hybrid season. A sample of medical records was requested from each CPCs assigned providers based upon the applicable HEDIS® Technical Specifications to assess compliance with documentation practices (evidence of gap closure). The CPCs engaged providers and their staff during this process to assess the culture of immunization within their practices, as well as provide further education and identify opportunities for improvement ("10 Ways to Create a Culture of Immunization Within Your Pediatric Practice", CDC 2017).

UnitedHealthcare conducted an immunization "deep dive" in July and August 2018 to validate immunization data quality and flow and the following was noted:

- Rates were being calculated correctly based on available data and the current 2018 technical specifications.
- Validation of combo vaccines are being attributed correctly (i.e., Pediarix)
- Current data from the state is available in SMART (UnitedHealthcare's data warehouse) and being ingested into ClaimSphere.
- Rates are trending similarly to other new MCOs.
- Historical immunization data (CY 2016) was not received from the state until February 2019.
- Incorrect and/or invalid CPT codes were identified in the immunization registry.

Improving Oral Health

- UnitedHealthcare provided comprehensive dental care as a part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. All dental services are covered, including diagnostic care, as well as all necessary treatment and follow-up care with no limits on services or costs. Dental benefits are covered for all members from birth through age 20 and for all pregnant women. Non-pregnant members who are 21 or older do not have any dental benefits unless there are chronic conditions related to oral health (e.g., cancer, trauma related to oral health, diabetes).

- UnitedHealthcare sponsored a series of community outreach events in support of National Children's Dental Health Month in February 2018. UnitedHealthcare's quality team engaged providers (i.e., FQHCs, PCPs, Dentists, staff) in discussions about barriers they believe impact UHCCP MO HealthNet members receiving preventive dental services.

Improvement by UnitedHealthcare

- UnitedHealthcare conducted PIPs for the first time under MHD contract. Therefore, Primaris cannot comment on any improvement related to methodology or the process adopted for these PIPs.
- Although the baseline for the entire CY 2017 is not available, leading to inability to measure statistical significance, an increase in the quality indicators from the previous year has been identified:
  - The CIS Combo 10 has increased from 0.92% to 21.65% (NCQA 25th percentile 27.75%).
  - The statewide ADV rates have increased from 35.10% to 48.24% (NCQA 50th percentile 59.43%).
  - The overall rate for CMS 416 preventive services increased from 26.47% to 35.73% (2016 CMS 416 annual report benchmark 32.66%).
  - The overall rate for CMS 416 oral sealant increased from 9.53% to14.97% (2016 CMS 416 annual report benchmark 13.51%).

5.5 Recommendations for MCOs

Table 5-18 Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Missouri Care	UnitedHealthcare
1.	✓	✓	✓
2.	✓	✓	✓
3.	✓	✓	✓

1. **PIPs Approach**
   - Primaris recommends the MCOs to follow CMS EQRO protocol 3[1] and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015[2], for guidance on methodology and approach of PIPs to obtain meaningful results.

[1] https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf
[2] https://www.medicaid.gov/medicaid/benefits/downloads/pip-manual-for-health-plans.pdf

- The MCOs must continue to refine their skills in the development and implementation of approaches to effect change in their PIP.
- The aim should be stated clearly in writing (it should include baseline rate, % increase to achieve in a defined period). Baseline year, measurement year should be correctly written.
- 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.
- The results and impact should be measured on a regular basis (monthly/quarterly) and a run chart should be submitted. UnitedHealthcare had submitted run charts for both PIPs.
- The results should be tied to the interventions.
- Instead of repeating interventions that were not effective, evaluate new interventions for their potential to produce desired results, before investing time and money.
- 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.
- The MCOs must utilize the PIPs process as part of organizational development to maintain compliance with the state contract and the federal protocol.

2. **Improvement in CIS rate**

According to the CDC, some children might be unvaccinated because of choices made by parents, whereas for others, lack of access to health care or health insurance might be factors. They may face hurdles, such as not having a health care professional nearby, not having time to get their children to a doctor, and/or thinking they cannot afford vaccines.

CDC recommends healthcare professionals to make a strong vaccine recommendation to their patients at every visit and make sure parents understand how important it is for their children to get all their recommended vaccinations on time. The Vaccines for Children (VFC) program helps reduce financial hurdles parents face when trying to get their children vaccinated and protected from

vaccine-preventable diseases.[3] Home State Health has plans to utilize this opportunity in future.

3. **Improvement in Oral Healthcare**
   - Dental caries-risk assessment, based on a child's age, biological factors, protective factors, and clinical findings, should be a routine component of new and periodic examinations by oral health and medical providers (American Academy of Pediatric Dentistry).[4]
   - Promote school-based sealant programs aligned with the Centers for Disease Control's expert work group recommendations for school-based sealant programs.[5]
   - Interprofessional Collaboration: Incorporate oral health improvement strategies across healthcare professions (such as medicine, nursing, social work, and pharmacy) and systems to improve oral health knowledge and patient care.[5]
   - Work Force: Develop health professional policies and programs which better serve the dental needs of underserved populations[5].

[3] https://ivaccinate.org/states-with-the-worst-vaccination-rates/

[4] https://www.aapd.org/globalassets/media/policies_guidelines/bp_cariesriskassessment.pdf).

[5]https://sboh.wa.gov/Portals/7/Doc/OralHealth/WSBOH-OH-Strategies-2013.pdf?ver=2013-11-19-094100-000

6.0 Care Management Review

6.1 Description and Methodology

For EQR 2019, MHD required Primaris to evaluate Care Management (CM) Program of Home State Health, Missouri Care, and UnitedHealthcare. The three focus areas under evaluation were:

- Pregnant (Obstetrics) members (OB).
- Children with elevated blood lead levels (EBLLs).
- Behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

CM is an umbrella term that encompasses services such as, but not limited to:

- Comprehensive CM applying clinical knowledge to the member's condition
- Care coordination
- Health promotion services
- Comprehensive transitional care
- Individual and family support activities
- Disease management
- Referrals to community and social supports

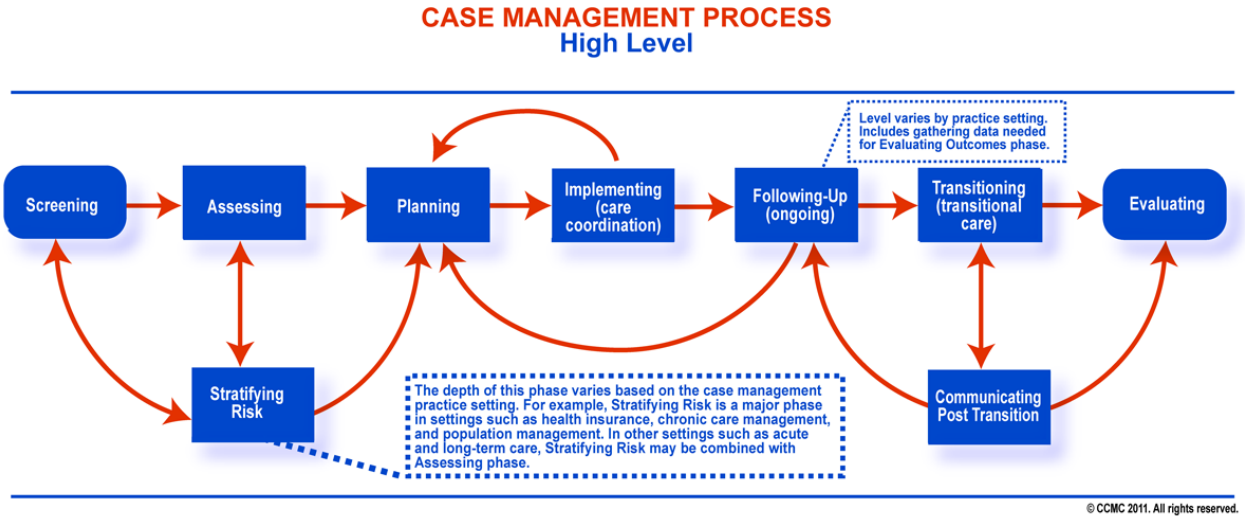


Figure 6-1 Care Management Process
(https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge)

Figure 6-1 explains the CM process which involves 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, and cost-effective outcomes.
MHD contract section 2.11 was followed as a standard for evaluation for the CM program. The evaluation was carried out under the following headings:

1. Review of Care Management Policies and Procedures

In reference to MHD contract section 2.11.1c 5, MCO should have policies and procedures for CM program. Primaris reviewed all the documents submitted by the three MCOs and reported the results in Tables 6-1, 6-9, 6-20 for each of the MCOs.

2. Evaluation of Care Plan

MHD contract 2.11.1e provides guidelines for the "care plan" as listed below. Primaris followed these guidelines to evaluate the care plan for each of the members included in the samples for medical record review for all three CM programs.
Care plan for ALL eligibles: The MCO shall use the initial assessment to identify the issues necessary to formulate the care plan. All care plans shall have the following components:

- Use of clinical practice guidelines (including the use of CyberAccess to monitor and improve medication adherence and prescribing practices consistent with practice guidelines).
- Use of transportation, community resources, and natural supports.
- Specialized physician and other practitioner care targeted to meet member's needs.
- Member education on accessing services and assistance in making informed decisions about care.
- Prioritized goals based on the assessment of the member's needs that are measurable and achievable.
- Emphasis on prevention, continuity of care, and coordination of care. The system shall advocate for and link members to services as necessary across providers and settings.
- Reviews to promote achievement of CM goals and use of the information for quality management.

Care plan for pregnant women: In addition to the requirements listed above, the MCO shall include the following in the care plans for pregnant women:

- A risk appraisal form must be a part of the member's record.
- Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women under MHD Managed Care.

- Referrals to prenatal care (if not already enrolled), within 2 weeks of enrollment in CM.
- Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on missed appointments shall be made within 1 week of the appointment.
- Methods to ensure that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screens are current if the member is under age 21.
- Referrals to Women, Infants, and Children (WIC) (if not already enrolled), within 2 weeks of enrollment in CM.
- Assistance in making delivery arrangements by the 24th week of gestation
- Assistance in making transportation arrangements for prenatal care, delivery, and post-partum care.
- Referrals to prenatal or childbirth education where available.
- Assistance in planning for alternative living arrangements which are accessible within 24 hours for those who are subject to abuse or abandonment.
- Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT services) including provision of referral/assistance with MHD application for the child, if needed.
- Assistance in identifying and selecting a medical care provider for both the mother and the child.
- Identification of feeding method for the child.
- Notifications to current health care providers when care management services are discontinued.
- Referrals for family planning services if requested.
- Directions to start taking folic acid vitamin before the next pregnancy.

3. Onsite Interviews

The MCOs' officials were interviewed during onsite visit from Jun 24, 2019 to Jun 27, 2019 to assess:

- The knowledge of MHD contract and requirements for CM. The guiding principle for CM is that the resources should be focused towards people receiving the services they need, not necessarily because the service is available.
- The focus of CM 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.

4. Medical Record Review (MRR)

Primaris assessed MCOs' ability to make available any and all pertinent medical records for the review. A list of members care managed in CY 2018 for the three focus areas was submitted by the three MCOs. Primaris selected a sample of 30 medical records (maximum limit: required sample size of 20, plus 50% oversample for exclusions and exceptions) by using stratified random sampling method based on Appendix II of 2012, CMS protocols for EQR).

The MCOs were requested to upload all the 30 medical records electronically at Primaris' secure file upload site. The medical records were reviewed during onsite visits at MCOs' offices in MO. Evaluation tools (excel spreadsheets) were created to ensure that the medical records included, at a minimum, the following : referrals; assessment; 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 are reviewed by different auditors to assess the degree of agreement in assigning a score for compliance in the evaluation tool.

The following criteria were used for inclusions/exceptions/exclusions of medical records in the study sample. The MCOs were informed of these criteria beforehand:
Inclusion Criteria

- OB CM
  Anchor date: Members must be enrolled in CY 2018 (at a minimum of 1 full quarter). May include enrolled pregnant members in last month of CY 2017.
  Age: N/A
  Continuously enrolled: No break in enrollment for more than 45 days with the MCO.
  Event/Diagnosis: Pregnancy.
- EBLLs CM
  Anchor date: Should be enrolled in CY 2018 (at a minimum of 1 full quarter.)
  Age: Children who are at least 1 during the measurement year and up.
  Continuously enrolled: No break in enrollment for more than 45 days with the MCO.
  Event/Diagnosis: A venous lead level of 10 µg/dL.

- BH CM
  Anchor date: Members should be enrolled in CY 2018 (at a minimum of 1 full quarter).
  Age: 6 years or older during the measurement year/CY 2018.
  Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
  Event/Dx: Must not have been in CM in CY 2017 (unless a new diagnosis made in 2018). Members should be hospitalized in a psychiatric hospital or be receiving residential treatment for substance use disorder in CY 2018.

Exclusion Criteria: Failure of initial contact with the member in spite of exhausting all means to contact a member-as listed in MHD contract 2.11. There is no exclusion/exception for patient refusal to CM.
Exceptions: The member does not require CM on medical grounds.

6.2 Findings and Analysis Home State Health

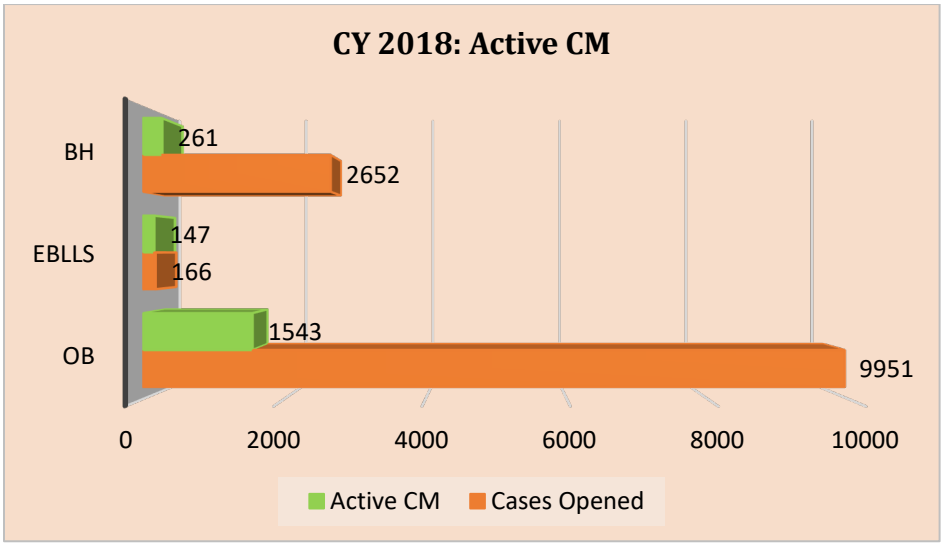


Figure 6-2 Active Members in CM during CY 2018

Figure 6-2 demonstrates the total number of cases opened/identified for CM (OB: 9,951; EBLLs: 166; and BH: 2652) and members actively care managed CY 2018 (OB: 1,543; EBLLs: 147; and BH: 261). (Note: Cases active in CY 2018 could reflect cases opened in a prior year.)

Review of Policies and Procedures
The following policies and procedures were submitted by Home State Health (Table 6-1).

Upon review, Primaris concluded that Home State Health was 100% compliant with all the requirements mandated by MHD contract.

Table 6-1 Care Management Policy Review Home State Health

Policies and Procedures shall include (MHD 2.11.1c5):	Document Name(s)
1. A description of the system for identifying, screening, and selecting members for CM services.	CM Program Description 2019.
2. Provider and member profiling activities.	Home State Provider Manual 2018, 2019 Quality Assurance Performance Improvement Program Evaluation.
3. Procedures for conducting provider education on CM.	CM Program Description 2019, Provider Quick Reference Guide, Home State Provider Orientation.
4. A description of how claims analysis will be used.	Provider Quick Reference Guide, Home State Provider Orientation.
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.	CM Program Description 2019.
6. A process to ensure integration and communication between physical and behavioral health.	CM Program Description 2019.
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	CM Program Description 2019, Medical Management Training Plan, Complex Rounds Criteria, Training Transcript.
8. A process to ensure that care plans are maintained and updated as necessary.	CM Program Description 2019.
9. A description of the methodology for assigning and monitoring CM caseloads that ensures adequate staffing to meet CM requirements.	Case Guide Visual, Case Load Population.
10. Timeframes for reevaluation and criteria for CM closure.	CM Program Description 2019, CM Audit Tool (based on MHD Contract.
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	CM Program Description 2019, CM Audit Tool, Home State Provider Orientation.
12. Additional information.	Complex Rounds Criteria, MM Training Plan, Training Transcript.

Evaluation of Care Plan

Upon interviewing Home State Health officials and reviewing the medical records for all three CM focus areas, Primaris concluded that Home State Health had policies and procedures based on contractual guidelines for "care plan," and members were managed according to those guidelines. However, the "care plan" per se did not include all the components listed in the MHD contract 2.11.1e. The care managers worked with the members and created goals based on the care gaps. Interventions were planned to close those gaps. The care plan was updated once a month.

A. Obstetric (OB) Care Management

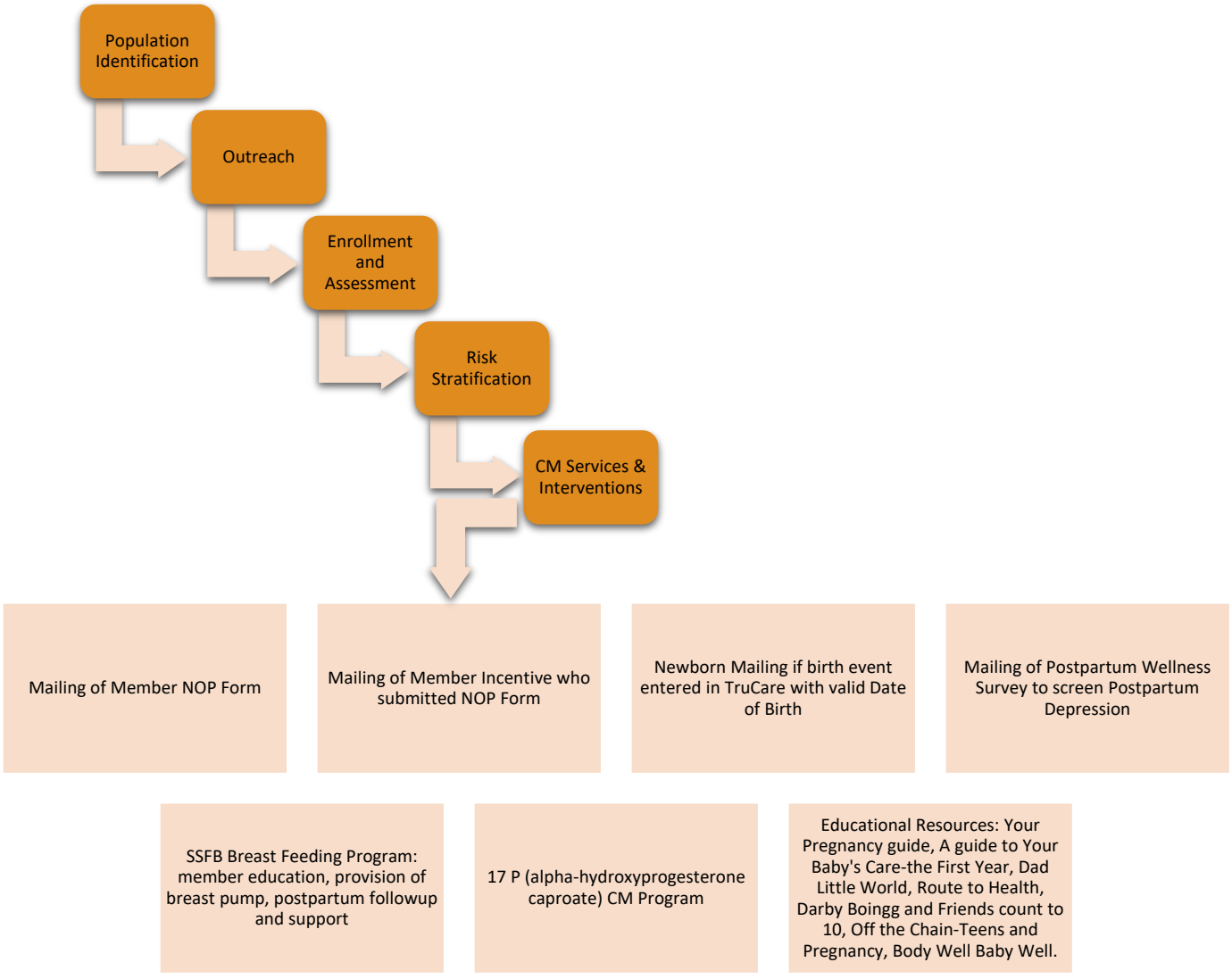


Figure 6-3 Work Flow of OB CM

Home State Health's OB CM techniques are designed to extend the gestational period and reduce the risks of pregnancy, premature delivery, and infant disease. The Start Smart for Your Baby® (SSFB) is an award winning program which incorporates the concepts of CM, care coordination, and disease management in an effort to improve the health of mothers and their newborns. The program's multi-faceted approach to improving prenatal and postpartum care includes enhanced member outreach and incentives, wellness materials, intensive CM, provider incentives, and support of the appropriate use of medical resources.

During an onsite interview, Home State Health described the workflow for OB CM (Figure 6-3). Once OB members are identified and their risk factors collected in the Notification Of Pregnancy (NOP-a screening assessment), members are stratified into low, medium, and high risk groups. Higher risk members are prioritized for outreach by Home State Health staff. Particular attention is paid to members with a history of prior preterm delivery. Home State Health begins OB CM (field and/or telephonic) within 15 business days of notification of pregnancy. For members who are not reachable on MHD provided phone numbers, Home State Health attempts to find them by: outreaching to the OB offices; making calls to pharmacy; home visits at last known address; and missed appointment outreach (from claims data). Some other ways to engage members in OB CM include:

- Denying office visit payments to OB providers who do not submit a NOP form.
- Free diapers to members who enroll in our Substance Use Field Case Management.
- Free applications which offers 24 hour access to a face-to-face (Skype) visit with a dietician or lactation consultant.
- Pre-loaded debit card for members who attend OB appointments.

Medical Record Review

An oversample of 30 medical records was reviewed. Out of those, only 17 medical records were included for evaluation. There were 13 exclusions as the members were not under the CM program for at least a full quarter.

Primaris reported the MRR compliance (%) under the following headings (Figure 6-4):

a. Diagnosis: 100% compliance.
   The medical records had a documentation of diagnosis for all the 17 cases.
b. First enrollment/Last enrollment date: 100% compliance.
   Upon notification of pregnancy, a case was opened for CM. This was marked as "case start date" in all the medical records. Attempts to outreach an OB member began and on being successfully contacted, an assessment was completed. An issue was detected during IRR of medical records regarding the enrollment date/case start date (details

are provided under "Issues" later in this section). The case closure/last enrolled date was documented in all medical records.

c. Offer CM within 15 business days of notification of pregnancy: 82% compliance.
Home State Health assessed the needs of their members within the timeframe for 14 of 17 cases.

d. Referrals: 100% compliance.
Referrals were through NOP (11); member-referred (2); state notification (1); eligibility (1); provider (1); and report (1).

e. Assessment: 100% compliance.
All the required components per MHD contract were included in the assessment questionnaire, namely medical history, psychiatric history, developmental history, psychosocial issues, and legal issues. An assessment was seen in all the medical records.

f. Updated care plans: 100% compliance.
Updated care plans were present all 17 cases.

g. Risk appraisal: 100% compliance.
Risk appraisal (screening) was done for all the 17 cases.

h. Provider treatment plans: Zero compliance.
The care plans were mailed to the providers and their treatment plan was requested for a better care coordination. It was also made available via Home State Health's website. However, the providers did not respond to the care plan unless the care managers called them as needed. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.

i. Lab tests: 100% compliance.
These were documented in all 17 cases.

j. Progress notes: 100% compliance.
The medical records were updated with the progress of the care given to the members and notes were available for every call/interaction with the members.

k. Discharge plan: 79% compliance
Discharge planning was done in 11 of 14 cases (N/A for 3 cases as they were open for CM).

l. Aftercare: 82% compliance.
Aftercare was provided in 14 of 17 cases.

m. Transfers: 100% compliance.
This was addressed in all 17 cases. There were no transfers to/from another MCO.

n. Coordination, linking, and monitoring of services: 100% compliance.
Medical records revealed that all 17 cases were linked to community resources and the care had been monitored.

o. Follow up (case closure no sooner than 60 days post-partum): 71% compliance.

Even though post-partum follow-up care was given to all 14 closed cases, 4 cases were closed earlier than 60 days post-partum for Goals Met (1), UTC (2), loss of eligibility (1). This had resulted in a reduced compliance score of 71%.

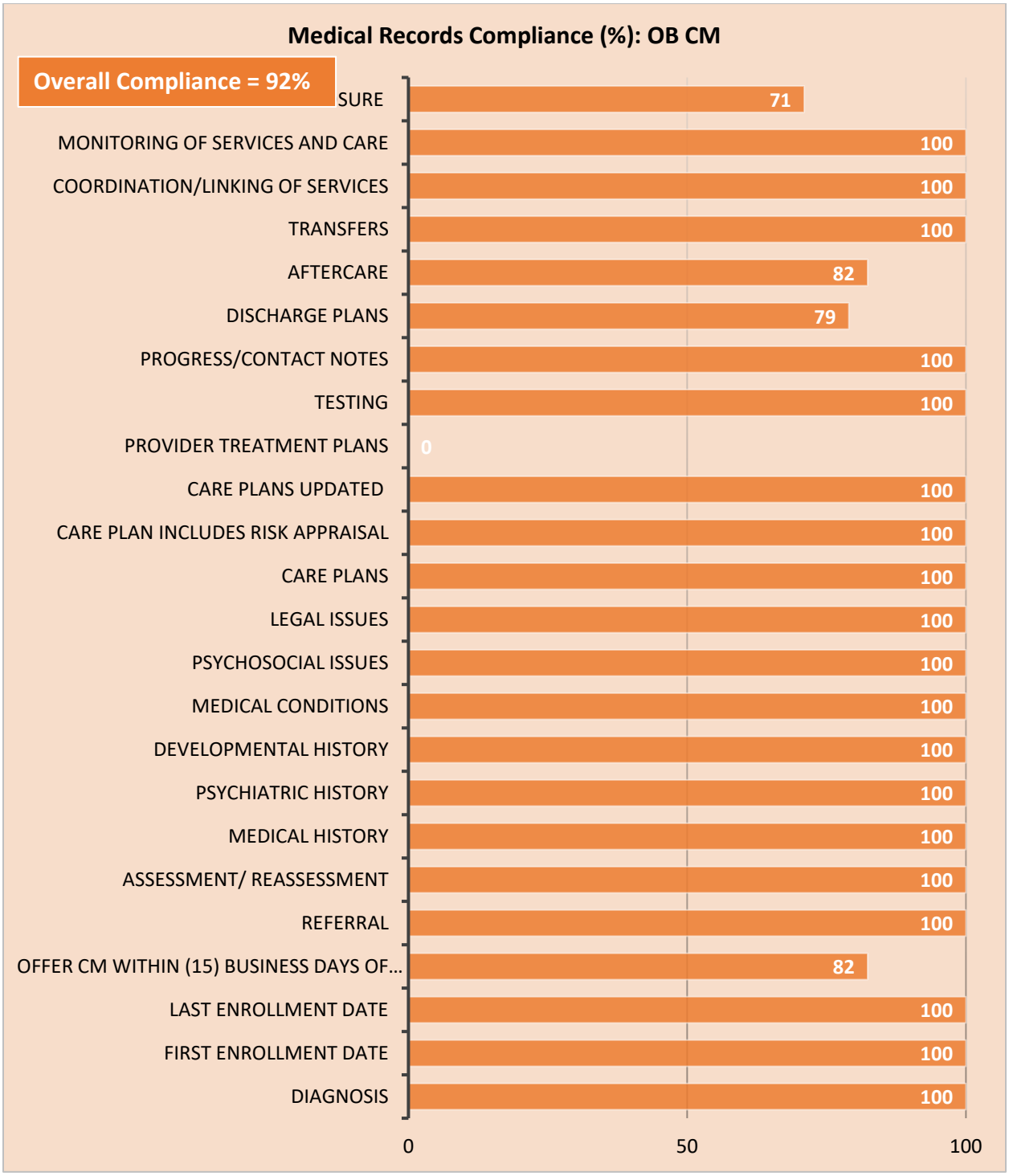


Figure 6-4 Medical Record Review OB CM

Overall Conclusion

Oversample of medical records: 30 (Exclusions: 13)

MRR sample: 17 cases. Out of these 17 cases, 3 remained open for CM in CY 2019 and 14 were closed due to: goals met (10); unable to contact (UTC) (3); and loss of eligibility (1).

Issues

- During the IRR an issue regarding date of enrollment of members in the CM program surfaced. The medical records had a "case start date" which did not correspond to the "enrollment date" provided during an onsite review. On enquiry, Home State Health stated that they opened a case at the time of notification of pregnancy and record it as "case start date." Member was considered as "enrolled" when a care manager successfully contacted a member and completed their assessment. However, this date was not identified or stated in the medical records as "enrollment date." One had to assume the date of "assessment" was an "enrollment date." This led to inconsistencies in documentation of enrollment dates by different auditors.
- The engagement of providers with the care plan was nil (0%). The care plan was available to the providers through mail/Home State Health's website. However, there was no feedback/acknowledgement received from the provider.
- Care mangers were not able to assess the needs of OB members within 15 days of notification of pregnancy in 3 of 17 cases due to UTC. Only telephonic attempts were made to contact a member.
- Some cases were closed before 60 days post-partum (4 of 14).
- Discharge planning and aftercare was not done in 3 cases due to UTC.

Key Drivers

- Member engagement, motivation.
- Supporting patient's self-management goals.
- Care manager's training and education.
- Use of evidence-based care.
- Holistic, comprehensive, culturally competent approach with awareness and respect for diversity.
- Accurate contact addresses and telephone numbers of primary, secondary, and emergency contacts.
- Providers' involvement with care.
- Elaborate assessment of needs of the members.
- User friendly interface for Electronic Medical Records.
- Team work and coordinated care with care managers, members, providers, community resources.

- Aligning resources with the population needs.

Quality, Timeliness, Access to Health Care and Services

- The overall compliance of OB CM MRR was 92%. Home State Health was able to outreach their OB members to offer CM and complete assessment within 15 business days of notification of pregnancy in 82% cases.
- Home State Health reported their outreach rate to OB members within 15 days of notification of pregnancy as 97.7%.

Improvement by Home State Health

Table 6-2 Score (%) OB CM MRR for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	100	100
First Enrollment Date	100	100
Last Enrollment Date	100	100
Offer CM within (15) business days of notification of pregnancy	100	82
Referral	100	100
Assessment/ Reassessment	95	100
Medical History	95	100
Psychiatric History	95	100
Developmental History	100	100
Medical Conditions	100	100
Psychosocial Issues	100	100
Legal Issues	100	100
Care Plans	95	100
Care Plan Includes Risk Appraisal	95	100
Care Plans updated	95	100
Provider Treatment Plans	0	0
Testing	100	100
Progress/Contact Notes	95	100
Discharge Plans	60	79
Aftercare	60	82
Transfers	70	100
Coordination/Linking of Services	70	100
Monitoring of Services and Care	70	100
Follow-Up: case closure	70	71

A comparison with previous year (CY 2017) was made to determine the extent to which Home State Health effectively addressed the recommendations for quality improvement made by the EQRO (Table 6-2).
An improvement (highlighted green) was noticed in: assessment, medical history, psychiatric history, updated care plans, risk appraisal, progress notes (5% points each); discharge plans (19% points); aftercare (22% points); transfers, coordination/linking, and monitoring of services (30% points each); and follow up care (1% point).
There was a decline (highlighted red) of 18% points in offering CM within 15 business days of notification of pregnancy.

B. Children with Elevated Blood Levels (EBLLs) Care Management

Home State Health's EBLLs CM Program:

- Identifies all pediatric members who have unsafe blood lead levels.
- Educate parents and/or member's representative and providers on the importance of lead screening and treatment.
- Facilitates appropriate screening, testing, treatment, repeat testing, and follow-up.
- Help parents/member's representative towards increased self-management of lead values by increasing their knowledge base and comfort level.

Screening and Identification of members for EBLLs:

- Any child under the age of 6 years who resides or spends more than ten hours a week in an area identified as high risk by the Department of Health and Senior Services (DHSS) shall be tested annually for lead poisoning.
- All eligible children will be blood tested for lead at age 12 months and 24 months of age.
- Members are eligible for the EBLLs CM Program when a positive blood lead test is equal to or greater than 10 µg/dL.

Home State Health follows the time frames listed in MHD contract section 2.11 for the EBLLs CM activities: An outreach to offer CM services ; coordination with PCP for an initial confirmation of capillary tests using venous blood; guidelines for a retest and follow up home visits.
Figure 6-4 describes the workflow for EBLLs CM at Home State Health

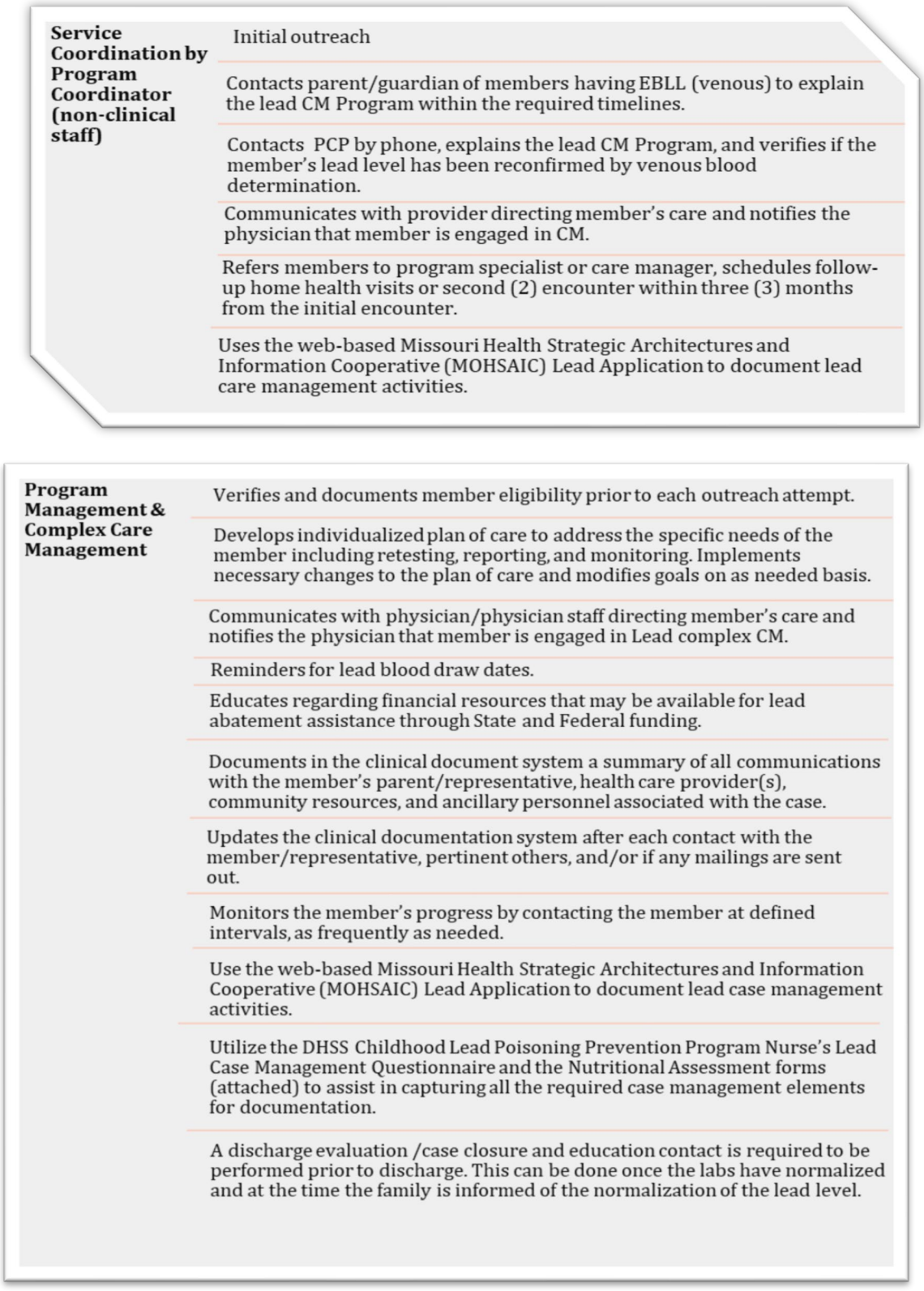


Figure 6-4 Work Flow of EBLLs CM

Medical Record Review

An oversample of 30 medical records was reviewed. Out of those, only 18 medical records were included for evaluation. There were 12 exclusions: CM not done for at least a full quarter (4); and CM not done in CY 2018 (8).

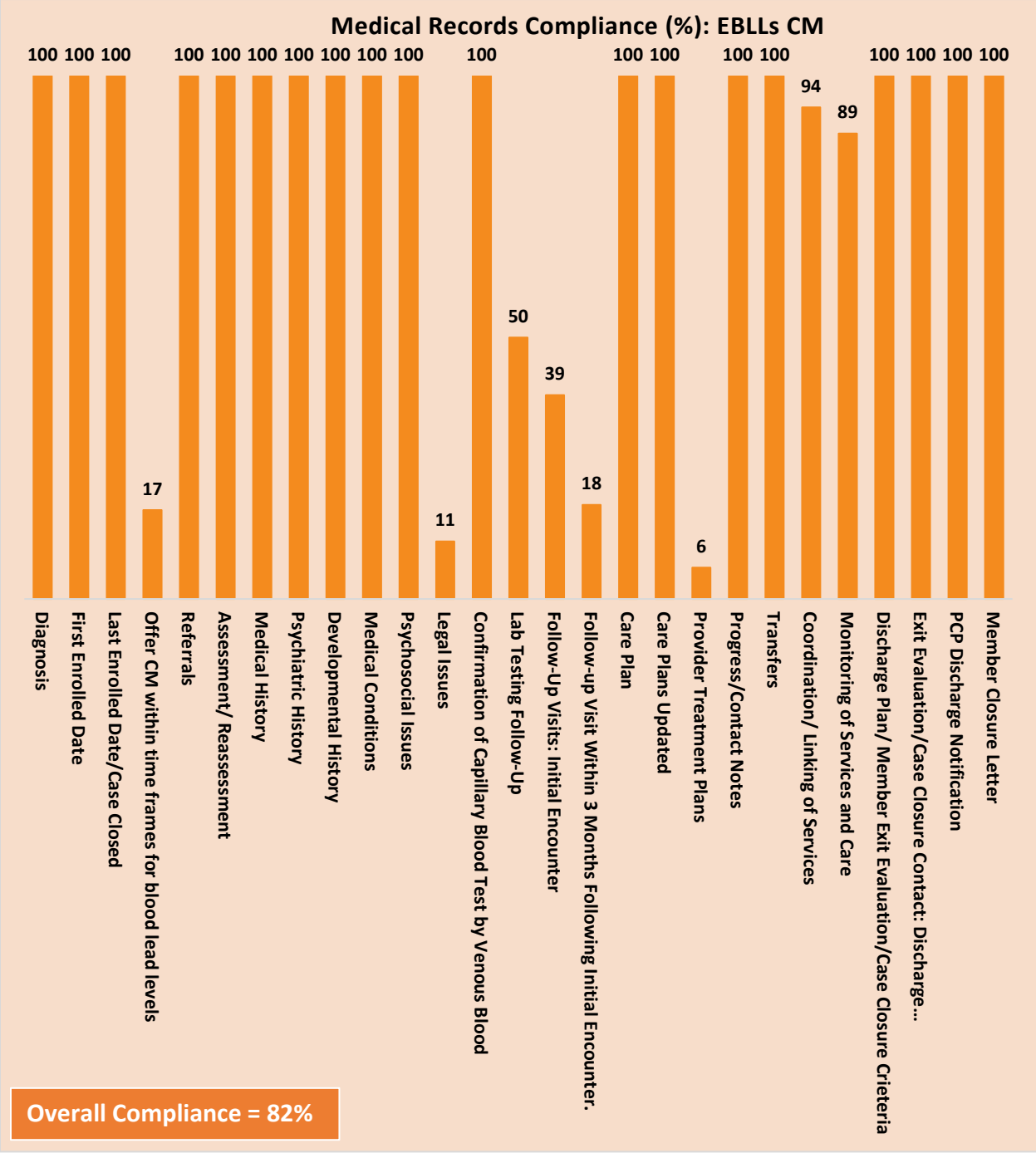


Figure 6-5 Medical Record Review for EBLLs CM

Primaris reported the MRR compliance (%) under the following headings (Figure 6-5):

a. Diagnosis: 100% compliance.
   There was a documented evidence of diagnosis in all cases.
b. First enrollment date: 100% compliance.
   Case start date was the same as the date of notification even though the member with EBLL had not been contacted. This is an issue which is discussed later in the report.
c. Last enrollment date: 100% compliance.
   There were 12 closed cases and 6 were still open for CM in CY 2019.
d. Offer CM within time frames for EBLLs: 17% compliance.
   Care Mangers attempted to outreach a member within 24 hours of notification from the state most of the time. The members were not available for an assessment or did not answer the phone. That resulted in a delay in assessing the members within the contractual time frame.
e. Referrals: 100% compliance.
   Home State Health had received referrals from the state in all 18 cases.
f. Assessment: 100% compliance.
   The lead assessment was complete in all cases. An assessment included medical history, psychiatric history, developmental history, psychosocial and legal issues. The compliance of all these elements was 100% except for legal issues (11% compliance). Home State Health stated that the advanced directives/legal issues were not addressed in the medical records due to the age of member/child (minor).
g. Confirmation of capillary blood test by venous test within the time frame per MHD guidelines: 100% compliance.
   In 16 of 18 cases, venous blood lead levels were available at the time of state's notification to the MCO. For the remaining 2 of 18 cases, Home State Health complied with the requirement.
h. Follow up on EBLLs within the time frame per MHD guidelines: 50% compliance.
   This was evident in 9 of 18 cases. For the remaining cases: 6 cases had a follow up lab test done outside of the given timeframe; and 3 cases did not have a repeat lab test.
i. Home visits: 39% compliance for first visit, 18% compliance for second visit.
   Home State Health contracted with home health agencies for various home services including lead assessment and subsequent visits.
j. Care plan with updates/progress notes: 100% compliance.
   An updated care plan was found in all 18 cases. Detailed notes on every contact with the member were present in all medical records.
k. Provider treatment plan: 6% compliance.
   The engagement of providers with the care managers in developing a care plan was nil. Home State Health mailed the care plans to the providers. These were also made

available via Home State Health's website. However, the care managers did not receive any feedback from them. Care managers contacted the providers when there was an issue with the member's care (e.g., missed appointments for blood lead levels). There was 1 of 18 cases in which a provider had corresponded with Home State Health regarding authorization of services. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.

l. Transfer: 100% compliance.
This was addressed in all the medical records. Only 1 case was transferred to Local Public Health Agency (LPHA) due to loss of eligibility with Home State Health.

m. Coordination and linking of services: 94% compliance.
In 17 of 18 cases, the members were linked to PCPs, community resources, home health services, home remediation services, LPHAs.

n. Monitoring of services: 89% compliance.
Well visits, immunizations, appointments, services by LPHAs were monitored in 16 of 18 cases. In 2 cases the monitoring was not done due to UTC followed by loss of eligibility.

o. Discharge plan and exit evaluation/case closure contact: 100% compliance.
Education on prevention of re-exposure to lead, nutrition, and environmental maintenance was discussed over phone or during face-to-face encounters. Discharge planning and exit evaluation were done in 11 cases. Out of remaining 7 cases: this was N/A for 6 cases as they were open for CM in CY 2019; and 1 case lost eligibility.

p. Notification to providers/members: 100% compliance.
In 12 of 12 cases, the providers and members were sent a written notification about child's condition and case closure (N/A for 6 open cases).

Overall Conclusion

Oversample of medical records: 30 (Exclusions: 12)

MRR sample: 18 cases. Out of 18 cases, 6 remained open for EBLLs CM in CY 2019 and 12 were closed due to goals met (8) and loss of eligibility (4).

Issues

- As stated earlier for the OB CM Program, same issue related to case start date/enrollment date was detected for EBLLs CM program as well. Medical records had a "case start date" which did not correspond to the "enrollment date" provided during an onsite review.
- The CM was offered within the time frames based on the EBLLs in 17% cases (3 of 18 cases). In 83% cases (15 of 18 cases) CM was offered but outside of the

mandated time frame. Unsuccessful contact with a member was the main cause of delay.

- The timely follow up of repeat blood lead levels was done in 50% cases (9 of 18). For the remaining 9 of 18 non-compliant cases: 6 cases had a follow up blood test but outside of the mandated timeframe; 3 cases did not have a repeat blood test done (refusal by PCP in 1 case). Provider's knowledge about the retesting blood lead levels per Centers for Medicare and Medicaid Services (CDC)/MHD guidelines appeared to be an issue.
- Initial home visit was made in 39% cases (7 of 18) within the timeframe and in 16% cases (3 of 18) outside of the time frame. Second home visit was made in 18% cases (3 of 17). The MCO made several attempts to contact the members. The members did not respond to the calls/not keep their appointments. There seemed to be a lack of understanding about the impact of lead on the health of their child.
- Provider engagement with the care plan was negligible.

Key Drivers

- Education of parents/guardians of children about harmful effects of lead, preventive measures, importance of timely BLL testing, and usefulness of CM services.
- Maintaining high motivation of clients throughout their CM.
- Education, skills, knowledge, competencies, and experience of care managers.
- Coordination between providers, care managers, and environmental risk assessors, home remediation service agencies, and local health agencies.
- Feedback from the member/guardian about CM services.
- Updated contact information.
- Creating proactive care plan with self-management goals.
- Providers' education about CDC guidelines for EBLLs CM.

Quality, Timeliness, and Access to Health Care Services

- The overall compliance of EBLLs CM MRR was 82%. Home State Health scored: 100% in documentation of diagnosis, enrollment and case closure dates, referrals, assessment (including medical history, psychiatric history, developmental history, psychosocial issues), a confirmation of capillary BLL level with venous BLL within the time frame, updated care plans, progress notes, transfers, discharge plan, exit evaluation, PCP and member discharge notifications; 94% for coordination and linking of services; 89% for monitoring of services and care.
- Initiative was taken by care managers to call the providers for confirming appointments of their members and to follow up with their blood lead levels. The

care managers also educated the providers about the CDC/MHD recommended timeframes for retesting EBLLs.

- Home State Health measured EBLLs CM Program effectiveness by the percent of eligible members screened (Table 6-3): 100% of members with venous blood lead levels 10 µgm/dl or greater need to be assessed and referred for lead abatement, or documentation must be on file that the necessity for lead abatement procedures has been assessed and/or that the remediation has occurred.

Table 6-3 Eligible Members Screened for Lead in CY 2018

Metric	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of members with EBLLs ≥10 µgm/dl	30	54	75	36
% of Timely outreach to members	100	100	100	100

- Additionally, Home State Health evaluated CM program by using HEDIS measures for Lead Screening in Children (LSC) (Table 6-4). The rate had increased from 60.74% (CY 2017) to 61.26% (CY 2018) which an increase of 0.52% point.

Table 6-4 Lead Screening Rates from H 2017-H 2019

HEDIS Year (HY)	Lead Screening In Children (LSC) Rate	NCQA Quality Compass 25th Percentile	NCQA Quality Compass 50th Percentile	Year over Year % Points Change
H2017/ CY 2016	56.30%	59.65%	71.38%	
H2018/ CY 2017	60.74%	62.53%	73.13%	4.44
H2019/ CY 2018	61.26%	Pending	Pending	0.52

Improvement by Home State Health

A comparison with previous year (CY 2017) was made to determine the extent to which Home State Health effectively addressed the recommendations for quality improvement made by the EQRO (Table 6-5).

An improvement (highlighted green) was noticed in: assessment including medical history, medical conditions, psychosocial issues, psychiatric history, developmental history (5% points each); confirmation of capillary blood test by venous blood test within the time frames (5% points); follow up home visits-Initial encounter (4% points), updated care plan

(10% points); discharge plan, exit evaluation and discharge documentation (84% points each); PCP discharge notification (34% points).
There was a decline (highlighted red) noticed in: offer CM within timeframes for blood lead levels (33% points); addressing legal issues in assessment (84% points); Lab testing follow up (45% points); second home visit (2% points); provider treatment plans (94% points); coordination and linking of services (6% points); monitoring of services (11% points).

Table 6-5 Score (%) EBLLs CM MRR for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	100	100
First Enrolled Date	100	100
Last Enrolled Date/Case Closed	100	100
Offer CM within Time Frames for BLLs	50	17
Referrals	100	100
Assessment/Reassessment	95	100
Medical History	95	100
Psychiatric History	95	100
Developmental History	95	100
Medical Conditions	95	100
Psychosocial Issues	95	100
Legal Issues	95	11
Confirmation of Capillary Blood Test by Venous Blood within Timeframe	95	100
Lab Testing Follow Up	95	50
Follow-Up Visits: Initial Encounter	35	39
Follow-up Visit within 3 Months Following Initial Encounter.	20	18
Care Plan	90	100
Care Plans Updated	90	100
Provider Treatment Plans	90	6
Progress/Contact Notes	100	100
Transfers	100	100
Coordination/Linking of Services	100	94
Monitoring of Services and Care	100	89
Discharge Plan/Member Exit Evaluation/Case Closure Criteria	16	100
Exit Evaluation/Case Closure Contact: Discharge Documentation	16	100
PCP Discharge Notification	66	100

Member Closure Letter	100	100

C. Behavioral Health (BH) Care Management

Home State Health provides both episodic and complex CM, based on member needs and the intensity of service required. CM program manages comorbidities and addresses the whole person, not simply the primary condition (Figure 6-6).

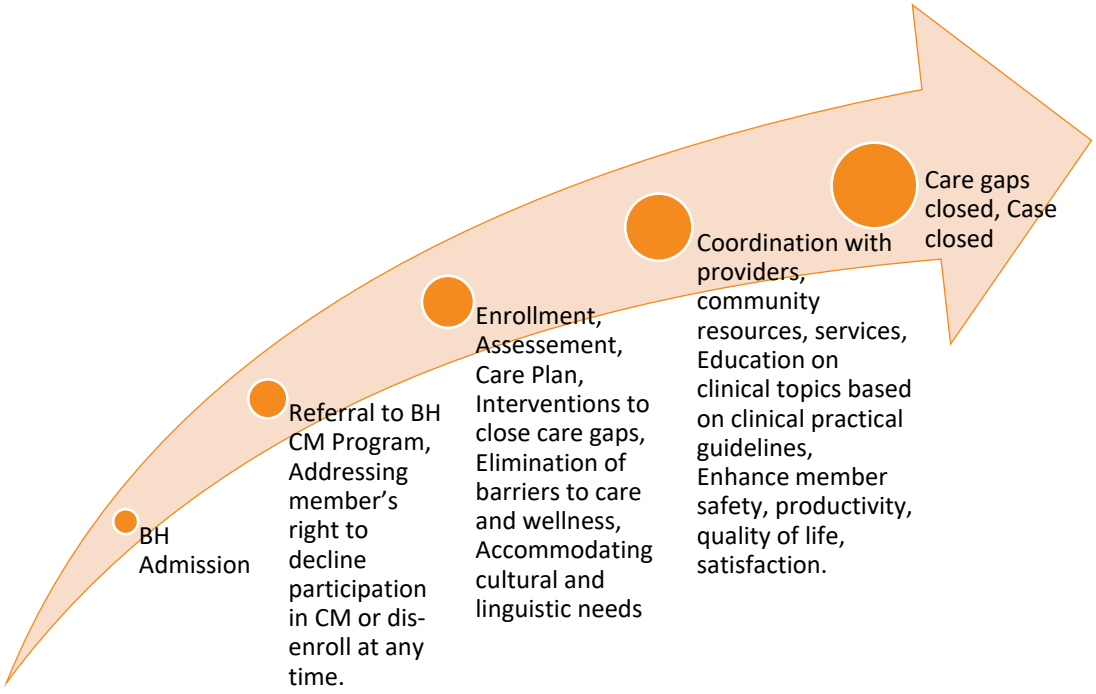


Figure 6-6 Work Flow of BH CM

Medical Record Review

An oversample of 30 medical records was reviewed. Only 15 of them were included in the sample to assess the CM of members with BH diagnosis leading to hospitalization (including residential treatment program for substance use disorder). The remaining 15 cases were excluded: no CM for at least a full quarter (7 cases); and no Inpatient (IP) admissions (8 cases).

Primaris reported the MRR compliance (%) under the following headings (Figure 6-8):

a. Diagnosis: 100% compliance.
   There was a documentation of diagnosis in all 15 cases. Major depression was the admitting diagnosis in 7 of 15 cases. The other reasons for hospital admissions were disruptive mood disregulation disorder (4), schizophrenia (1), suicide attempt (1), generalized anxiety disorder with pregnancy (1), substance use disorder (1).
b. First enrollment date: 100% compliance.

The case start date was when the care managers were notified of admission by UM system.

c. Last enrollment date: 100% compliance.
   All closed cases (11 of 15) had a documented case closure date. Remaining 4 cases were open for CM in CY 2019.
d. Assessment of the members for CM within 5 business days of admission to a psychiatric hospital or residential treatment program: 13% compliance (Figure 6-7).
   MHD has mandated Primaris to focus on this section. Various reasons attributable for low compliance as explained by the MCO:
   - The care manager is not permitted to meet the patient during hospital stay.
   - Patient's condition does not warrant a conversation with care manager for an assessment.
   - The care manager is not able to successfully contact the patient in spite of several attempts. Efforts to outreach begin within 24 hours of discharge of a patient from the hospital.

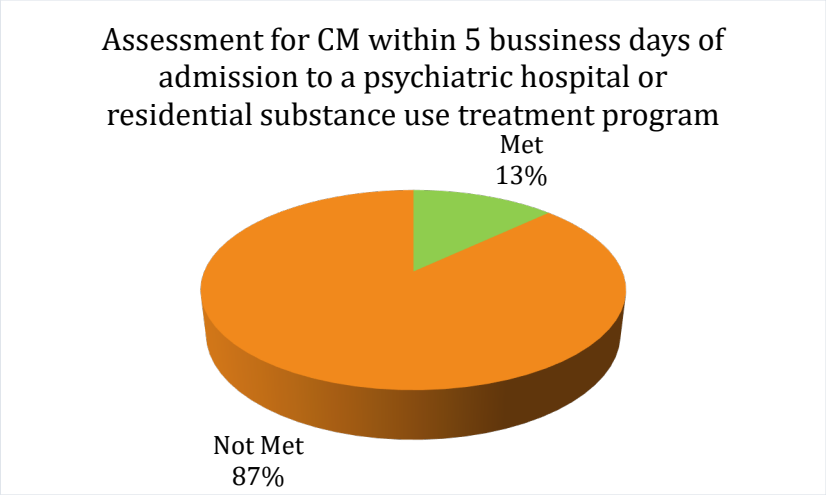


Figure 6-7 Assessment for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program

e. Referrals: 100% compliance.
   All cases included in the study were referred by UM system. Some other sources of referral were BH crisis line, member self-referrals, and reports.
f. Assessment: 100% compliance.
   All the cases had an assessment which included medical history, psychiatric history, developmental history, psychosocial issues (each 100% compliance) and legal issues (60% compliance).
g. Care plan with updates/progress notes: 100% compliance.

A care manager discussed the needs with the member and developed a care plan with interventions directed at closing those care gaps. The providers were contacted, if necessary. The care plan is updated on a monthly basis and progress notes were maintained for each member.

h. Risk appraisal: 100% compliance.
   High risk assessment was available for all 15 cases.
i. Provider treatment plan: Zero compliance.
   Care plan was sent to PCP in 47% cases (7 of 15). It was not sent to PCP in 53% cases (8 of 15). No response was received from providers unless a care manager called the provider when needed and hence the compliance for this category was scored zero. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.
j. Testing: N/A
   Home State Health informed Primaris that BH patients were recommended for lab tests only in a few cases, e.g., patients on mood stabilizing drugs (lithium) where the therapeutic levels were required to be monitored. There were no cases with a recommendation for a drug test. Hence, this section was considered N/A.
k. Transfer: 100% compliance.
   This section was addressed in all the medical records.
l. Coordination and linking of services: 100% compliance.
   Care managers coordinated with PCPs, BH providers, therapists, social workers, transportation, interdisciplinary care team, counseling services to ensure full support and a complete recovery of their patients.
m. Monitoring of services and care: 87% compliance
   Care managers monitored services and care received by the members regarding preventive health visits, dental services, medications, immunizations for 13 of 15 cases (UTC-2 of 15 cases).
n. Discharge plan and Follow up: 36% compliance, 27% compliance respectively.
   Discharge planning was done in 4 of 11 cases. The remaining 7 cases did not have a discharge plan due to UTC (4), refusal to CM (1), and loss of eligibility (2).
o. Follow up: 27% compliance.
   This was done in 3 of 11 cases. Remaining 8 cases could not be followed up due to UTC (5), refusal to CM (1), loss of eligibility (2).

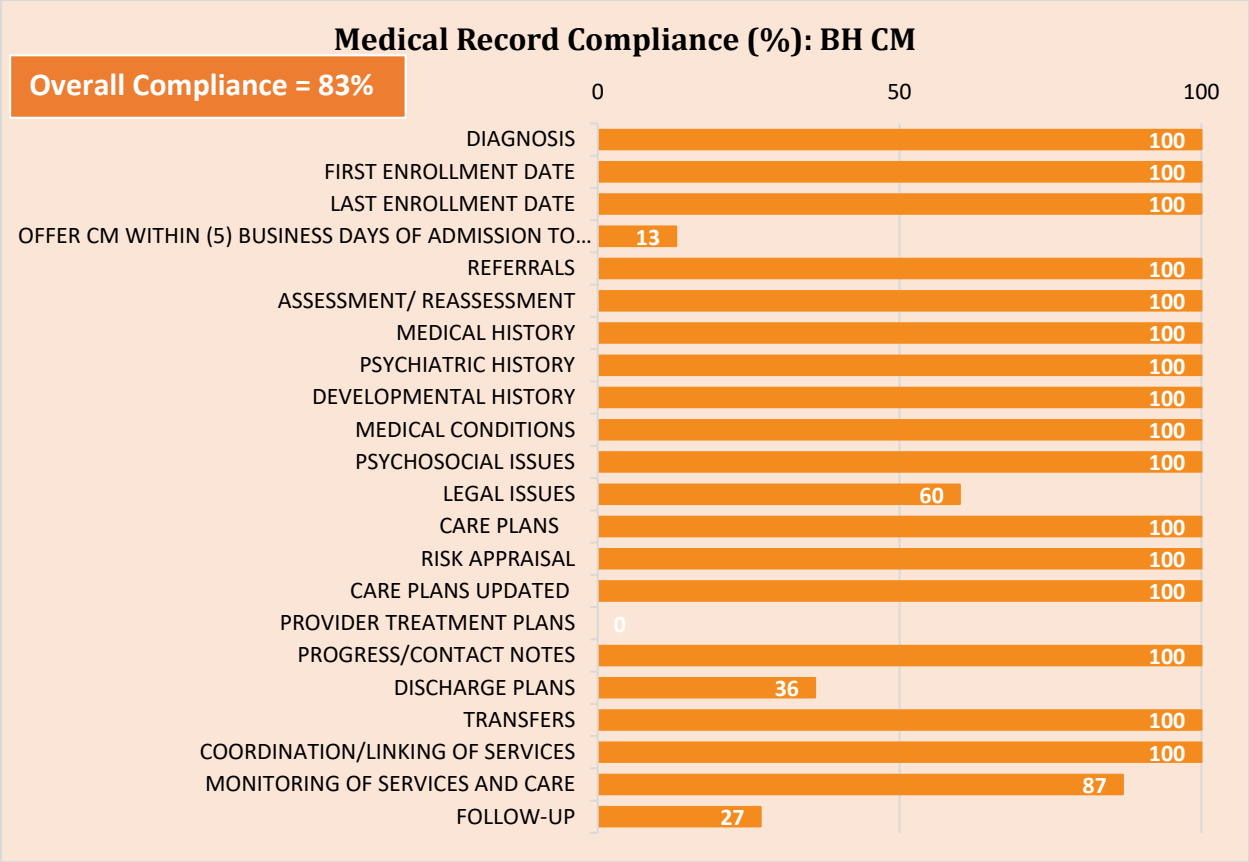


Figure 6-8 Medical Record Review for BH CM

Overall Conclusion

Oversample of medical records: 30 (Exclusions: 15)

MRR sample: 15 cases. Of these 15 cases, 4 remained open for CM in CY 2019 and 11 were closed under BH CM program due to the following reasons (Table 6-6):

Table 6-6 Case Closure	11
Goals met	3
Lost eligibility	2
Unable to contact (UTC)	5
Declined CM	1

Issues

- The success rate of the MCO to initiate CM assessment of their members within 5 business days of admission to a psychiatric hospital/residential treatment program

was only 13%. Several post-discharge outreach attempts were made before a care manager was able to enroll a member in CM program and begin an assessment. Most common reason noted for this delay in assessment was "UTC-phone call not answered."

- Providers were not engaged in the care plan. However, when care managers called provider offices to confirm compliance of the members with their scheduled appointments, they received a feedback/response.
- The ability to stay in contact over a long term is a challenge in tracking member's care. Sometimes, the members become overwhelmed with too many people involved in their care. They lack the understanding of their roles and opt out of care management. Consequently, Refusal to CM after enrollment was 7% (1 of 15 cases) and 33% cases were closed because of UTC (5 of 15). Members did not respond to the calls by the care managers. This led to decreased discharge planning (36% compliance) and Follow up (27% compliance).
- Follow-Up After Hospitalization for Mental Illness (HEDIS Measure): 7-Day Follow-Up rate in CY 2018 was 31.54% versus 37.78% in CY 2017 (a decrease of 6.24% points). Similarly, 30-Day Follow-Up in CY 2018 was 52.74% versus 55.93% in CY 2017 (a decrease of 3.19% points).

Key Drivers

- Early engagement of care manager with the members.
- Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital.
- Educating members and providers about the significance of CM program.
- Training care managers/linguistic and cultural competency.
- Supporting patient's self-management goals.
- Provider engagement.
- Linking to community resources.
- Medication management.

Quality, Timeliness, and Access to Health Care Services

- The overall compliance for BH CM MRR was 83%. Home State Health scored 100% in documenting their medical records with diagnosis, enrollment and case closure dates, referrals, assessments, updated care plans, progress notes, and coordination and linking of services.
- Readmission Rates: BH Readmission Rates within 30 days were consistent around 15% and Readmission Rates within 90 days were maintained around 25%

throughout the CY 2018 (Figure 6-9). The readmission rates within 30 days in CY 2017 varied from 9-19% throughout the year.

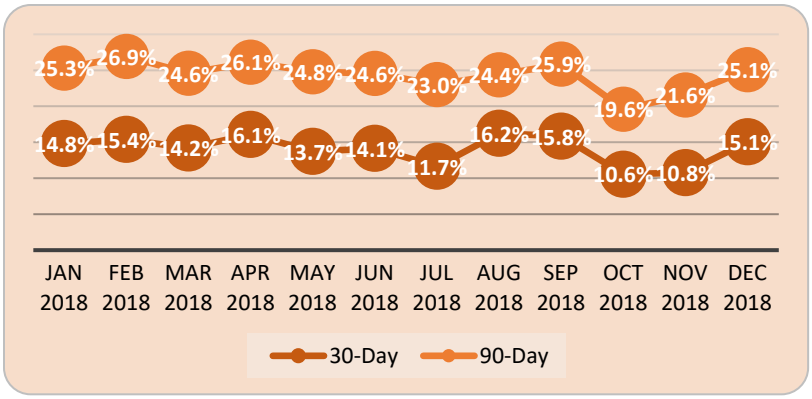


Figure 6-9 BH (Medicaid) Readmission Rates CY 2018

Improvement by Home State Health

Table 6-7 Score (%) BH CM MRR for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	100	100
First Enrollment Date	100	100
Last Enrollment Date	100	100
MCO assesses members for CM within 5 business days of admission to a psychiatric hospital or residential substance use Tx program	100	13
Referrals	100	100
Assessment/ Reassessment	100	100
Medical History	100	100
Psychiatric History	100	100
Developmental History	100	100
Medical Conditions	100	100
Psychosocial Issues	100	100
Legal Issues	100	60
Care Plans	100	100
Care Plan Includes Risk Appraisal	100	100
Care Plans updated as indicated or w/in 90 days of discharge from inpatient stay or ED Visit	100	100
Provider Treatment Plans	95	0
Progress/Contact Notes	100	100
Discharge Plans	95	36
Transfers	95	100

Coordination/Linking of Services	95	100
Monitoring of Services and Care	100	87
Follow-Up	90	27

A comparison with previous year (CY 2017) was made to determine the extent to which Home State Health had effectively addressed the recommendations for quality improvement made by the EQRO (Table 6-7).
(**Note**: For CY 2017 the focus was on CM offered to patients with a diagnosis of serious mental illness and for CY 2018 the focus was on CM offered to members post-psychiatric hospitalization/residential substance use treatment program. Common/relevant criteria applicable to both these focus areas have been included in the Table.)

There was an increase (highlighted in green) of 5% points for compliance in medical records addressing: transfers; and coordination and linking of services.
There was a decrease % compliance (highlighted in red) noted in: assessment of members for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program (87% points); information on legal issues (40% points); provider treatment plans (95% points); discharge plans (59% points); monitoring of services and care (13% points); and follow up (63% points).

6.3 Findings and Analysis Missouri Care

Members enrolled in all CM programs: 2,281 (OB-551; EBLLs-82; BH-702)

Review of Policies and Procedures
The following policies and procedures were submitted by Missouri Care (Table 6-8). Upon review, Primaris concluded that Missouri Care was 100% compliant with all the requirements mandated by MHD contract.

Table 6-8 Care Management Policy Review Missouri Care

Policies and Procedures shall include (MHD 2.11.1c5):	Document Name(s)
1. A description of the system for identifying, screening, and selecting members for CM services.	2019 CM Program Description, C7 CM-MD-1.2 CM Program Description, C7-CM-017-PR-014 Health Risk Assessment (HRA) for Member Outreach, MO29-HS-CM-003 Care Management.
2. Provider and member profiling activities.	2018 Annual Evaluation, MO29-HS-UM-021 Physician Profiling/Over and Under-Utilization, MO29-HS-CM-003 Care Management.

3. Procedures for conducting provider education on CM.	2019 CM Program Description, C7 CM-MD-1.2 CM Program Description, Missouri Care Provider Orientation Presentation -2019, 2018 Missouri Medicaid Provider Manual.
4. A description of how claims analysis will be used.	2018 Annual Evaluation, C7-CM-MD-6.0-PR-001 Decrease in Emergency Room Overuse Procedure, C7 CM-MD-1.2 CM Program Description, Missouri Care Provider Orientation Presentation -2019, 2018 Missouri Medicaid Provider Manual.
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.	2019 CM Program Description, C7 CM-MD-1.2 CM Program Description.
6. A process to ensure integration and communication between physical and behavioral health.	2018 Annual Evaluation, 2019 CM Program Description, C7 CM-MD-1.2 CM Program Description, MO29-HS-CM-003 Care Management
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	2019 CM Program Description, C7 CM-MD-1.2 CM Program Description.
8. A process to ensure that care plans are maintained and updated as necessary.	2019 CM Program Description, MO29-HS-CM-003 Care Management.
9. A description of the methodology for assigning and monitoring CM caseloads that ensures adequate staffing to meet CM requirements.	C7-CM-MD-1.2-PR-006 CM Program Description Process (Telephone Care Manager Caseload).
10. Timeframes for reevaluation and criteria for CM closure.	MO29-HS-CM-003 Care Management, MO29-HS-CM-002 Perinatal Case Management, MO29-HS-CM-00I Lead Case Management.
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	2018 Annual Evaluation, C7-QI-026 Provider Clinical Practice Guidelines Policy, C7-QI-026-PR-001 Provider Clinical Practice Guidelines Procedure, C7 CM-MD-1.2 CM Program Description
12. Additional information.	QI Work Plan.

Evaluation of Care Plan

Upon interviewing Missouri Care officials and reviewing the medical records for all three CM focus areas, Primaris concluded that Missouri Care had policies and procedures based on contractual guidelines for "care plan," and members were managed according to those guidelines. However, the "care plan" per se did not include all the components listed in the MHD contract 2.1.1e. The care managers worked with the members and created goals based on the care gaps. Interventions were planned to close those gaps. The care plan was updated once a month.

A. Obstetric (OB) Care Management

The Obstetrics CM program of Missouri Care is an integrated program offered to all identified pregnant women with a goal for the pregnant member to have an uncomplicated pregnancy and deliver a healthy term infant. Missouri Care employs dedicated and specially-trained OB care managers, supported by care coordinators to outreach all pregnant members, conduct assessments, and offer CM. This may be in-person or telephonic outreach, depending on the member's individual needs. Figure 6-10 shows the work flow of OB CM.

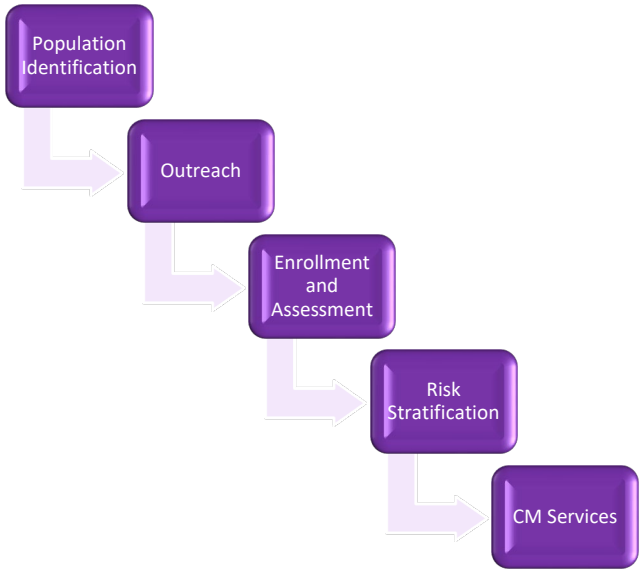


Figure 6-10 Work Flow of OB CM

Medical Record Review

An oversample of 23 medical records was reviewed. Out of these, 20 medical records were evaluated. There were 3 exclusions: unable to contact (UTC)-1 case; and enrolled in CM for less than a quarter-2 cases.

Primaris reported the MRR compliance (%) under the following headings (Figure 6-11):

a. Diagnosis: 100% compliance.
   Medical records had a documentation of a diagnosis of pregnancy (high risk/low risk) in all the 20 cases.
b. First enrollment/Last enrollment date: 100% compliance.
   All cases were enrolled within 24 hours of notification of a member's pregnancy and outreach to a member was initiated. First enrollment and last enrollment dates were documented in all medical records.
c. Offer CM within 15 business days of notification of pregnancy: 100% compliance.
   Missouri Care had contacted their OB members within the time frame to assess their needs.
d. Referrals: 100% compliance.
   All the referrals were received through state notifications.
e. Assessment: 100% compliance.
   All the required components per MHD contract were included in the assessment questionnaire, namely medical history, psychiatric history, developmental history, psychosocial issues, and legal issues. An assessment was seen in all the medical records.
f. Updated care plans: 100% compliance.
   Updated care plans were present all 20 cases.
g. Risk appraisal: 100% compliance.
   This was present in 20 of 20 cases.
h. Provider treatment plans: Zero compliance.
   The care plans were mailed/faxed to the providers. However, the providers did not respond to the care plan/treatment plan unless the care managers called them as needed. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.
i. Lab tests: 100% compliance.
   These were documented in all 20 cases.
j. Progress notes: 100% compliance.
   The medical records were updated with the progress of the care given to the members and notes were available for every call/interaction with the members.
k. Discharge plan, Aftercare: 95% compliance.
   Discharge plan and aftercare was provided in 19 of 20 cases. This was missing in 1 case because of UTC.
l. Transfers: 100% compliance.
   This was addressed in all 20 cases. There were no transfers to/from another MCO.
m. Coordination, linking, and monitoring of services: 100% compliance.

Medical records revealed that all 20 cases were linked to community resources and the care had been monitored.

n. Follow up (case closure no sooner than 60 days post-partum): 80% compliance.
A post-partum follow up care was seen in all 20 cases. However, 4 cases were closed within 55-59 days post-partum period for "Goals Met." This resulted in a reduced compliance score of 80%.

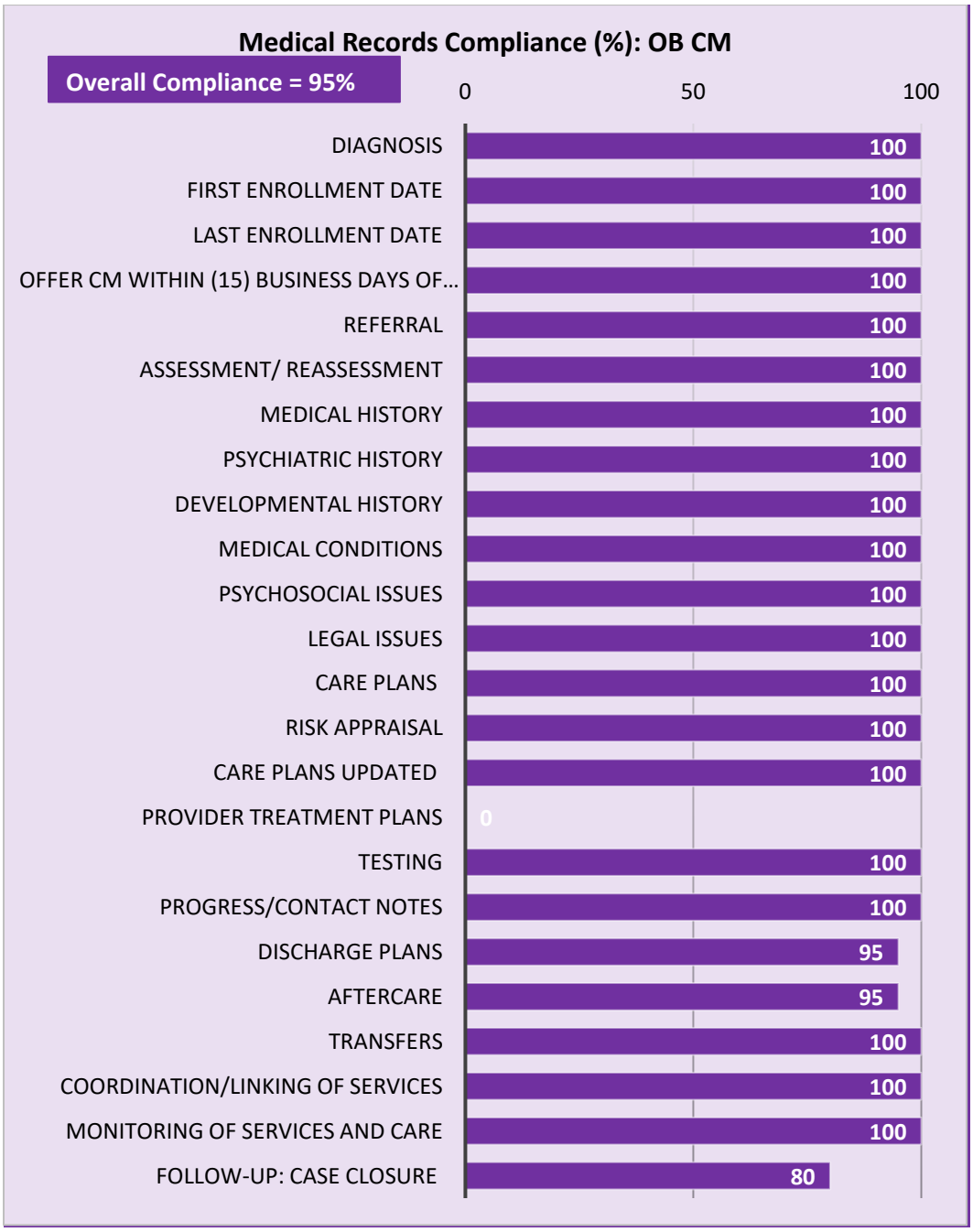


Figure 6-11 Medical Record Review for OB CM

Overall Conclusion

Oversample of medical records: 23 (Exclusions: 3)

MRR sample: 20 cases. These cases were closed for Goals met (19) and UTC (1).

Issues

- The engagement of providers with the care plan was nil (0%). The care plan was available to the providers either through fax/mail/Missouri Care's website. However, there was no feedback/acknowledgement received from the provider.
- Some of the cases were closed (4 of 20) before 60 days post-partum.
- Prenatal and Postpartum Care (PPC) HEDIS Measure
  Timelines of Prenatal Care: Missouri Care achieved a rate of 75.67% in CY 2018 (H2019). This was a decline of 5.84% points from the previous year (Table 6-9).
  Postpartum Care: Missouri Care achieved a rate of 56.45% in CY 2018 (HEDIS 2019). This was a decline of 0.73% point from the previous year (Table 6-10).

Table 6-9 Timeliness of Prenatal Care

HEDIS Year	Timeliness of Prenatal Care %	NCQA Quality Compass 25th Percentile	Annual %point change
2017	77.05	77.66	-0.46
2018	81.51	76.89	4.46
2019	75.67		-5.84

Table 6-10 Postpartum Care

HEDIS Year	Postpartum care %	NCQA Quality Compass 25th Percentile	Annual % point change
2017	51.45	59.59	-10.27
2018	57.18	59.61	5.73
2019	56.45		-0.73

Key Drivers

- Member engagement, motivation.
- Supporting patient's self-management goals.
- Care manger's training and education.
- Use of evidence-based care.

- Holistic, comprehensive, culturally competent approach with awareness and respect for diversity.
- Accurate contact addresses and telephone numbers of primary, secondary, and emergency contacts.
- Providers' involvement with care.
- Elaborate assessment of needs of the members.
- User friendly interface for Electronic Medical Records.
- Team work and coordinated care with care managers, members, providers, community resources.
- Aligning resources with the population needs.

Quality, Timeliness, Access to Health Care and Services

- The overall compliance of OB CM MRR was 94%. Missouri Care was able to outreach their OB members to offer CM and complete assessment within 15 business days of notification of pregnancy in 100% cases. Referrals to the CM program were 100% through state notifications. The medical records had a documentation of: diagnosis; enrollment date; closure date; assessment inclusive of medical history, psychiatric history, developmental history, psychosocial issues and legal issues; updated care plans; lab testing; progress notes; transfers; coordination, linking, and monitoring of services in 100% of cases. Discharge plan and aftercare was provided in 95% cases. High risk assessment (risk appraisal) was available for 90% cases.
- Missouri Care monitored the effectiveness of the maternity program by monthly CM chart audits, OB outreach rate, HEDIS (Healthcare Effectiveness Data and Information Set) metrics, and Utilization metrics. The following information was reported:
  - OB Outreach in CY 2018 was 94% in Q1 (Jan-Apr); 95% in Q2-Q3 (May-Sept); and 94.5% in Q4 (Oct-Dec).
  - Delivery (Birth) PA
    Missouri Care approved 42.44/1000 PAs for delivery in CY 2018, which exceeded the benchmark (21.20). This was suggestive of access of care to the members (Table 6-12).

Table 6-11 Delivery (Birth) PA

Birth PA	HEDIS 2017	HEDIS 2018	HEDIS 2019
Approved PA/1000	47.88	35.23	42.44
PA benchmark		37.03	21.20
Approved Days/1000	153.44	135.00	129.52

Day benchmark		113.68	64.80

Improvement* by *Missouri Care

A comparison with previous year (CY 2017) was made to determine the extent to which Missouri Care had effectively addressed the recommendations for quality improvement made by the EQRO (Table 6-12).

An improvement (highlighted green) was noticed in: documentation of appropriate diagnosis (10% points); offering CM within 15 business days of notification of pregnancy (40% points); discharge plans and aftercare (25% points).

There was a decline (highlighted red) of 20% points for post-partum follow-up for 60 days.

Table 6-12 Score (%) OB CM MRR for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	90	100
First Enrollment Date	100	100
Last Enrollment Date	100	100
Offer CM within (15) business days of notification of pregnancy	60	100
Referral	100	100
Assessment/ Reassessment	100	100
Medical History	100	100
Psychiatric History	100	100
Developmental History	100	100
Medical Conditions	100	100
Psychosocial Issues	100	100
Legal Issues	100	100
Care Plans	100	100
Risk Appraisal	100	100
Care Plans updated	100	100

Provider Treatment Plans	0	0
Testing	100	100
Progress/Contact Notes	100	100
Discharge Plans	70	95
Aftercare	70	95
Transfers	100	100
Coordination/Linking of Services	100	100
Monitoring of Services and Care	100	100
Follow-Up: case closure	100	80

B. Children with Elevated Blood Levels (EBLLs) Care Management

Missouri Care's CM for EBLLs include all members with identified blood lead levels of 10 µg/dl or greater. The care team involves a care manager, primary care providers (PCP), Department of Health and Senior Services (DHSS), Home Health Agencies (HHA) and/or the Local Public Health Agencies (LPHA). An outreach, confirmation of capillary tests using venous blood, guidelines for a retest and follow up home visits are based on MHD's contractual guidelines per section 2.11 of Managed Care contract. All communications and interventions are documented in the member's record in Missouri Care's Enterprise Medical Management Automation (EMMA) CM platform including initial visit, follow-up visits, contact with the child's PCP, and the exit visit. Missouri Care reported that all aspects of CM for EBLLs are documented in the state's web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application database (not validated by EQRO). Figure 6-12 depicts the work flow of Missouri Care's EBLLs CM.

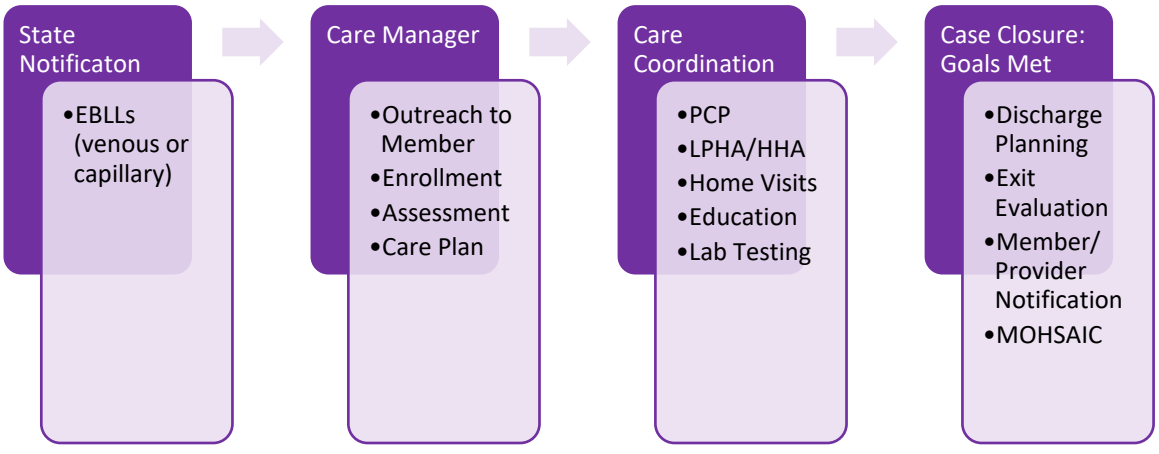


Figure 6-12 Work Flow of EBLLs CM

Medical Record Review

An oversample of 23 medical records was reviewed in order to obtain the required sample size of 20 medical records. Exclusions were 3 (no CM done in CY 2018).

Primaris reported the MRR compliance (%) under the following headings (Figure 6-13):

a. Diagnosis: 100% compliance.
   There was a documented evidence of diagnosis in all cases.
b. First enrollment date: 100% compliance.
   Cases were enrolled in CM on the day care manager was able to contact a member and was able to complete an assessment.
c. Last enrollment date: 100% compliance.
   There were 12 closed cases and 8 were open for CM in CY 2019.
d. Offer CM within time frames for EBLLs: 55% compliance.
   Care Mangers attempted to outreach a member within 24 hours of notification from the state most of the time. The members were not available for an assessment or did not answer the phone. That resulted in a delay in assessing the members within the contractual time frame.
e. Referrals: 100% compliance.
   Missouri Care received referrals from state in all the 20 cases.
f. Assessment: 95% compliance.
   The lead assessment was complete in 19 of 20 cases. An assessment included medical history, psychiatric history, developmental history, psychosocial and legal issues. The compliance of all these elements was 95% except for legal issues (55% compliance). Missouri Care documented that the advanced directives/legal issues were not addressed in the medical records due to the age of member/child (minor).
g. Confirmation of capillary blood test by venous test within the time frame per MHD guidelines: 90% compliance.
   In 18 of 20 cases, confirmation of venous blood lead levels was available within the timeframe. Most of these cases (17 of 18) were reported with venous blood lead levels at the time of notification to the MCO by the state.
h. Follow up on EBLLs within the time frame per MHD guidelines: 83% compliance.
   This was evident in 15 of 18 cases. For 2 cases, it was N/A as these were closed due to low venous level (l.0-4.0 µgm/dl) reported at the time of confirmation of capillary lead levels.
i. Home visits: 47% compliance for first visit, 25% compliance for second visit.
   Missouri Care contracted with home health companies for various home services including lead assessment and subsequent visits.

j. Care plan with updates: 95% compliance.
   An updated care plan was seen in 19 of 20 cases.
k. Progress notes: 100% compliance.
   Detailed notes on every contact with the member were present in 20 medical records.
l. Provider treatment plan: Zero compliance.
   The engagement of providers with the care managers in developing a care plan was nil (0). Missouri Care sent care plan to the providers and did not receive any feedback from them. Care managers contacted providers when there was an issue with the member's care (e.g., missed appointments for blood lead levels). As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.
m. Transfer: 100% compliance.
   This section was addressed in all the medical records. There were no transfers to another state or another MCO. However, 1 member was termed with the MCO.
n. Coordination and linking of services: 95% compliance.
   In 19 of 20 cases, the members were linked to dental services, PCPs, Interdisciplinary care team (ICT), therapy services, HHA, home remediation services, LPHAs.
o. Monitoring of services: 90% compliance.
   Services (well visits, immunizations, home visits, remediation services, appointments) were monitored in 18 of 20 cases.
p. Discharge plan: 67% compliance
   All cases were mailed an "education package" on prevention of re-exposure to lead, nutrition, and environmental maintenance. These were discussed over the phone or during face-to-face encounters. Discharge plan was seen in 8 of 12 cases. Some cases (8) were marked as N/A as they were still open for CM in CY 2019.
q. Exit evaluation/case closure contact: 67% compliance.
   Exit evaluation was done in 8 of 12 cases. It was marked as N/A for 8 cases as they were still open for CM.
r. Notification to providers/members: 100% compliance for provider notification/92% compliance for member notification.
   In 12 of 12 cases, the providers were sent a written notification about child's condition and case closure. Most members (11 of 12) were notified in writing about case closure. (N/A for 8 open cases).

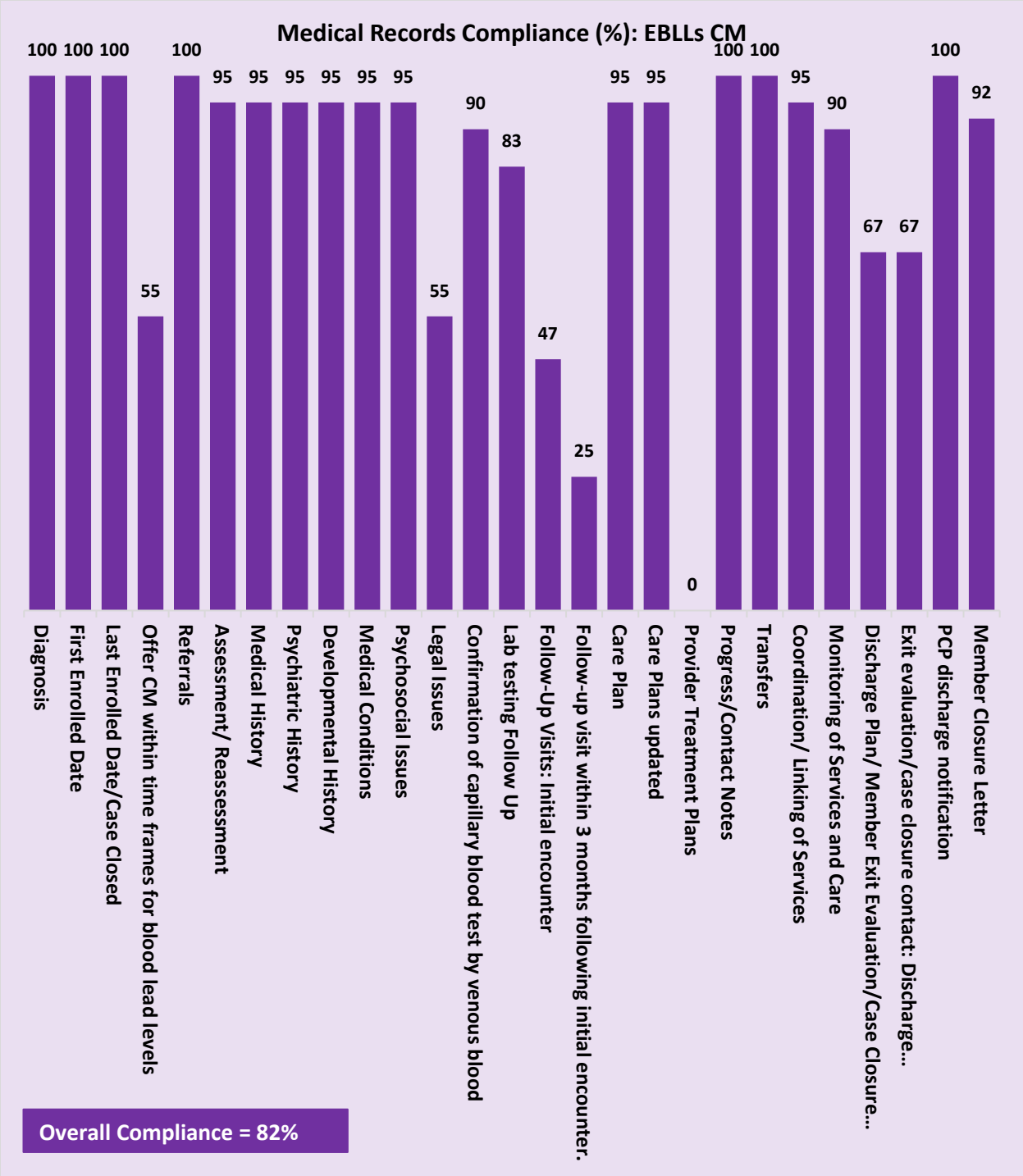


Figure 6-13 Medical Record Review for EBLLs CM

Overall Conclusion

Oversample of medical records: 23 (Exclusions: 3)

MRR sample: 20 cases. Out of 20 cases, 8 remained open for EBLLs CM in CY 2019 and12 were closed due to: goals met/low blood lead levels (9); loss of eligibility (2); and UTC (1)

Issues

- The CM was offered within the time frames based on the EBLLs in 55% of cases (11 of 20 cases). In 40% cases (8 of 20 cases) CM was offered but outside of the mandated time frame. Unsuccessful contact with a member was the main cause of delay. Remaining 5% noncompliance (1 of 20 cases) is because of UTC.
- The timely follow up of repeat blood lead levels was done in 83% of cases (15 of 18), initial home visit was done in 47% cases (9 of 19), and a second visit was done in 25% cases (4 of 16). The MCO made several attempts to contact the members. The members did not respond to the calls/not keep their appointments. There seems to be a lack of understanding about the impact of lead on the health of their child.
- Provider engagement with the care plan was zero. The care plan is sent to the providers, but no response/advice is received.
- Discharge plan and exit evaluation were done in 67% (8 of 12) of cases. For the remaining cases, the care managers were not able to contact the members.
- Out of the 2 members who lost eligibility with the MCO, 1 member was not notified about case closure.

Key Drivers

- Education of parents/guardians of children about harmful effects of lead, preventive measures, importance of timely BLL testing, and usefulness of CM services.
- Maintaining high motivation of clients throughout their CM.
- Education, skills, knowledge, competencies, and experience of care managers.
- Coordination between providers, care managers, and environmental risk assessors, home remediation service agencies, and local health agencies.
- Feedback from the member/guardian about CM services.
- Updated contact information.
- Creating proactive care plan with self-management goals.
- Providers' education about CDC guidelines for EBLLs CM.

Quality, Timeliness, and Access to Health Care Services

- The overall compliance of EBLLs CM MRR was 82%. Missouri Care scored: 100% in documentation of diagnosis, enrollment and case closure dates, referrals, transfers, and PCP discharge notifications; 95% of cases had an assessment, an updated care plan, progress notes, coordination and linking of services; 90-92% cases had a confirmation of capillary EBLL level with venous EBLL within the time frame, monitoring of services, member notification of case closure; and 83% cases had followed up lab tests on blood lead levels.

- Initiative was taken by care managers to call the providers for confirming appointments of their members and to follow up with their blood lead levels. The care managers also educated the providers about the CDC/MHD recommended timeframes for retesting EBLLs.
- Missouri Care stated that they measured the effectiveness of the EBLLs CM by chart audits for compliance as well as HEDIS metrics. Lead screening, as a HEDIS care gap, was discussed with primary care providers during Quality Practice Advisor (program) care gap meetings as well as during CM/PCP communications. Table 6-13 indicates an improvement of 2.75% points in lead screening in children in HY 2019/CY 2018 (59.20%) as compared HY 2018/CY 2017 (56.45%).

Table 6-13 Lead Screening Rates from H 2017-H 2019

HEDIS Year (HY)	Missouri Care Lead Screening In Children (LSC) Rate	NCQA Quality Compass 25th Percentile	NCQA Quality Compass 50th Percentile	Year over Year Percentage Point Change
2017	56.94%	59.65%	71.38%	
2018	56.45%	62.53%	73.13%	-0.49%
2019	59.20%			2.75%

Improvement by Missouri Care

A comparison with previous year (CY 2017) was made to determine the extent to which Missouri Care has effectively addressed the recommendations for quality improvement made by the EQRO (Table 6-14).

An improvement (highlighted green) was noticed in: offer CM within 15 business days of notification of pregnancy (5% points); assessment including medical history, medical conditions, psychosocial issues (40% points); psychiatric history, developmental history (35% points); confirmation of capillary blood test by venous blood test within the time frames (5% points); follow up home visits-first visit (25% points), second home visit (8% points); updated care plan (55% points); and discharge plan, exit evaluation and discharge documentation (12% points).

There was a decline (highlighted red) noticed in: Lab testing follow up (2% points); provider treatment plans (40% points); coordination and linking of services (5% points); monitoring of services (90% points); member closure letter (8% points).

Table 6-14 Score (%) EBLLs CM MRR for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	100	100
First Enrolled Date	100	100
Last Enrolled Date/Case Closed	100	100
Offer CM within time frames for blood lead levels	50	55
Referrals	100	100
Assessment/Reassessment	55	95
Medical History	55	95
Psychiatric History	60	95
Developmental History	60	95
Medical Conditions	55	95
Psychosocial Issues	55	95
Legal Issues	55	55
Confirmation of Capillary Blood Test by Venous Blood within Timeframe	85	90
Lab Testing Follow Up	85	83
Follow-Up Visits: Initial Encounter	22	47
Follow-up Visit Within 3 Months Following Initial Encounter.	17	25
Care Plan	40	95
Care Plans Updated	40	95
Provider Treatment Plans	40	0
Progress/Contact Notes	100	100
Transfers	100	100
Coordination/Linking of Services	100	95
Monitoring of Services and Care	100	90
Discharge Plan/Member Exit Evaluation/Case Closure Criteria	55	67
Exit Evaluation/Case Closure Contact: Discharge Documentation	55	67
PCP Discharge Notification	100	100
Member Closure Letter	100	92

C. Behavioral Health (BH) Care Management

The mission of the Missouri Care's CM Model is to support members in receiving the "Right Care at the Right Time in the Right Setting." The goal of CM is to decrease fragmentation of healthcare service delivery, facilitate appropriate utilization of available resources, and

optimize member outcomes through education, care coordination and advocacy services for the medical and/or behavioral health compromised populations served. CM strives to meet the needs of the medically compromised population with a model that focuses on a full range of physical health, behavioral health, social and community based support of a member in a coordinated and member-centered manner. BH CM is integrated in the overall Care Model. The goals and objectives of the behavioral health activities are congruent with the Health model and are incorporated into the overall care management model program description. Case review conferences with care managers and medical directors from both behavioral health and physical health occur on as needed basis. Figure 6-14 shows the work flow of BH CM at Missouri Care.

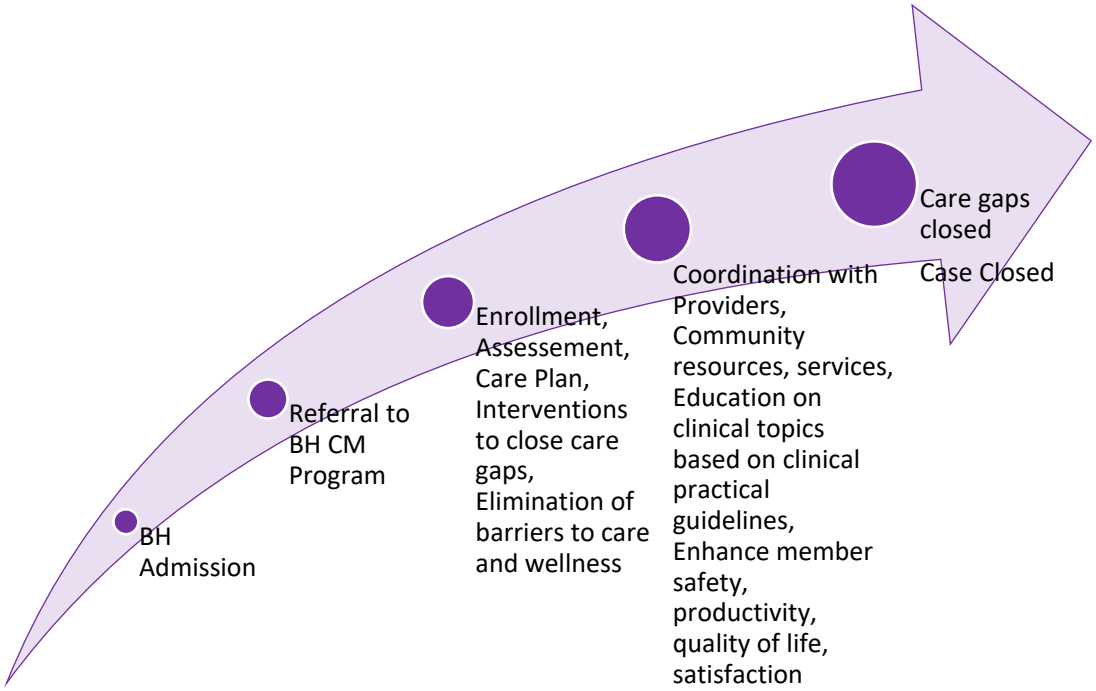


Figure 6-14 Work Flow of BH CM

Medical Record Review

A sample size of 20 medical records was reviewed to assess the CM of members with BH diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

Primaris reported the MRR compliance (%) under the following headings (Figure 6-16):

a. Diagnosis: 100% compliance.
   There was a documentation of diagnosis in all the 20 cases. Major depressive disorder was the admitting diagnosis in 6 of 20 cases. The other reasons for hospital admissions were disruptive mood disregulation disorder, bipolar disorder, post-traumatic stress

disorder, attention deficit hyperactivity disorder, and stimulant use disorder. These conditions co-occurred with each other.

b. First enrollment date: 100% compliance.
   The cases were enrolled on the first day of successful outreach with the patient. The care managers were able to contact the patients at various times: during the hospital stay; immediately after discharge; or much later after the discharge.
c. Last enrollment date: 100% compliance.
   All the 20 cases were closed.
d. Assessment of the members for CM within 5 business days of admission to a psychiatric hospital or residential treatment program: 25% compliance (Figure 6-15).
   MHD has mandated Primaris to focus on this section. Various reasons attributable for low compliance as explained by the MCO:
   - The care manager is not permitted to meet the patient during hospital stay.
   - Patient's condition does not warrant a conversation with care manager for an assessment.
   - The care manager is not able to successfully contact the patient in spite of several attempts. Efforts to outreach begin within 24 hours of discharge of a patient from the hospital.

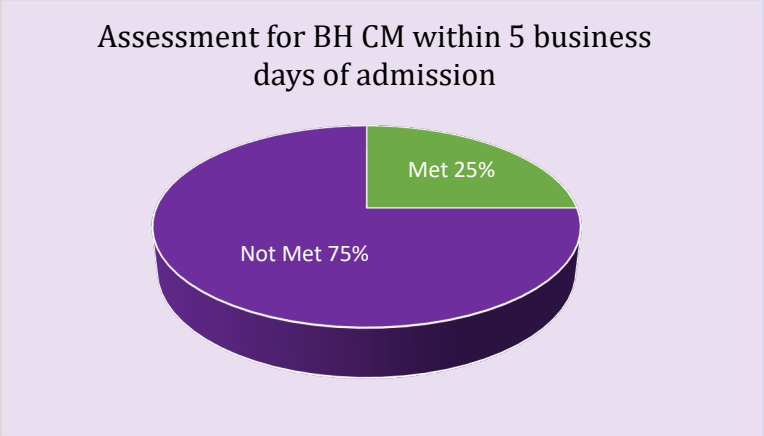


Figure 6-15 Assessment for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program

e. Referrals: 100% compliance.
   Most of the cases (16 of 20) were referred during concurrent review, some cases were self-referred (3 of 20) and one was detected from Law (algorithm).
f. Assessment: 100% compliance.
   All the cases had an assessment which included medical history, psychiatric history, developmental history, psychosocial and legal issues.

g. Care plan with updates/progress notes: 100% compliance.
   The care manager discussed the needs with the member and developed a care plan with interventions directed at closing those care gaps. The providers were contacted, if necessary. The care plan was updated on a monthly basis and progress notes were maintained for each member.
h. Risk appraisal: 100% compliance.
   High risk assessment was available for all 20 cases.
i. Provider treatment plan: Zero compliance.
   Care plan was sent to PCP in 25% cases (5 of 20). It was not sent to PCP in 75% cases (15 of 20) because either there was no medical diagnosis or there was no written consent of member to share the BH details. There was no response received from providers unless a care manager called the provider when needed and hence the compliance for this category was scored zero. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.
j. Testing: N/A
   Missouri Care informed Primaris that BH patients were recommended for lab tests only in a few cases, e.g., patients on mood stabilizing drugs (lithium) where the therapeutic levels were required to be monitored. There were no cases with a recommendation for a drug test. Hence, this section is considered N/A.
k. Transfer: 100% compliance.
   This section was addressed in all the medical records.
l. Coordination and linking of services/monitoring of services: 100% compliance.
   Care managers coordinated with PCPs, BH providers, therapists, social workers, transportation, interdisciplinary care team to ensure full support and a complete recovery of their patients.
m. Discharge plan and Follow up: 50% compliance.
   This was done in 10 of 20 cases. The remaining 10 cases did not have a discharge plan and follow-up because of UTC (7), refusal to CM (1), and loss of eligibility (2).

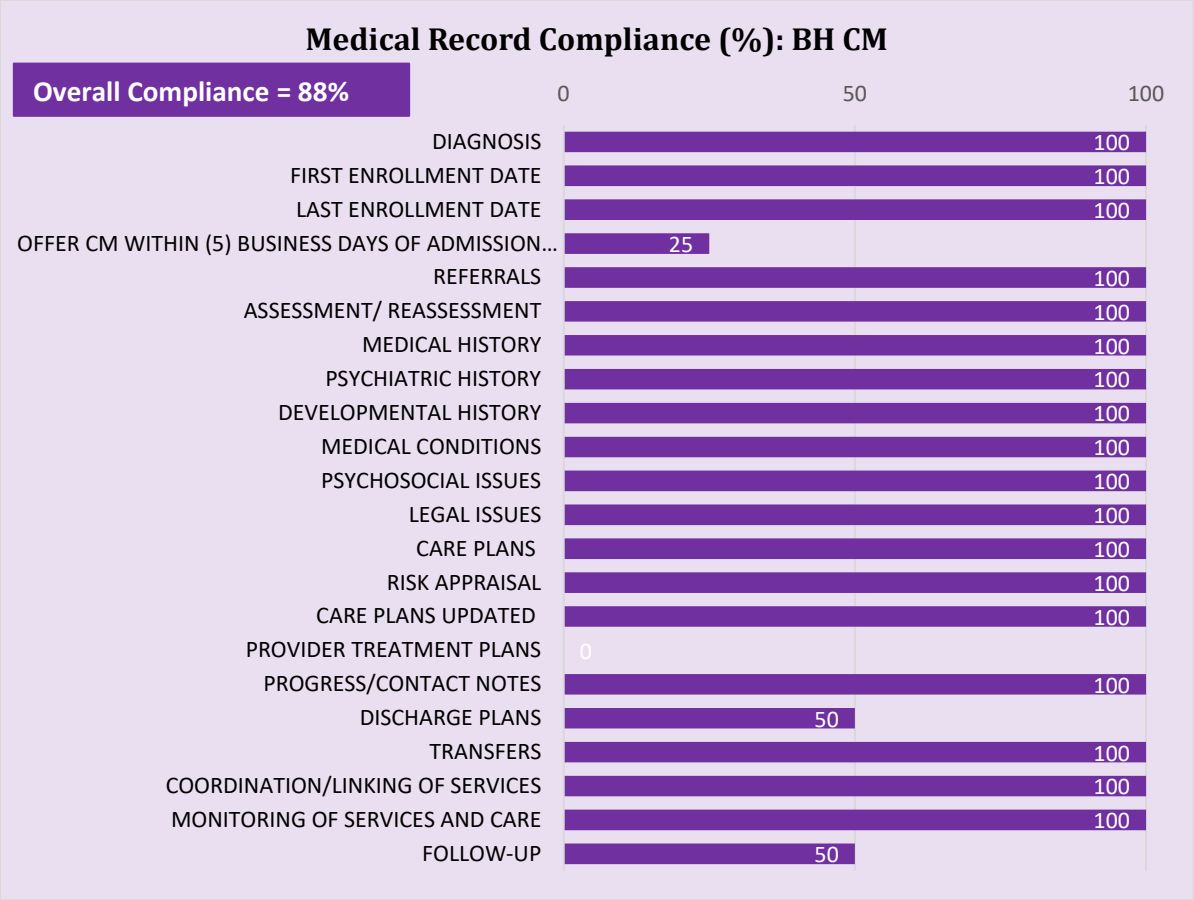


Figure 6-16 Medical Record Review for BH CM

Overall Conclusion

Oversample of medical records: Nil.

MRR sample: 20 cases. All cases were closed under BH CM program due to the following reasons (Table 6-15):

Table 6-15 Case Closure	20
Goals met	9
Lost eligibility	2
Unable to contact (UTC)	7
Declined CM	2

Issues

- The success rate of the MCO to initiate CM assessment of their members within 5 business days of admission to a psychiatric hospital/residential treatment program was only 25%. Several post-discharge outreach attempts were made before a care manager was able to enroll a member in CM program and begin an assessment.

Most common reason noted for this delay in assessment was "UTC-phone call not answered."

- Providers were not engaged in the care plan. The care plan was not sent to the PCPs if there were BH issues, as a written consent was not obtained from the member. However, when care managers called provider offices to confirm compliance of the members with their scheduled appointments, they received a feedback/response.
- The ability to stay in contact over a long term is a challenge in tracking member's care. Sometimes, the members become overwhelmed with too many people involved in their care. They lack the understanding of their roles and opt out of care management. Refusal to CM after enrollment was 15% (2 of 20 cases) and 35% cases were closed because of UTC (7 of 20). Members did not respond to the calls by the care managers.
- Follow-Up After Hospitalization for Mental Illness (HEDIS Measure): 7-Day Follow-Up rate in CY 2018 was 29.28% versus 31.45% in CY 2017 (a decrease of 2.17% points). Similarly, 30-Day Follow-Up in CY 2018 was 54.14% versus 56.81% in CY 2017 (a decrease of 2.67% points).
- Antidepressant Medication Management (HEDIS Measure): Though there was an increase of 3.02% points in effective acute phase treatment in CY 2018 (48.03%) as opposed to CY 2017(45.01%), there was a decrease of 2.01% points in effective continuation phase treatment in CY 2018 (30.11%) as opposed to CY 2017 (32.12%).

Key Drivers

- Early engagement of care manager with the members.
- Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital.
- Educating members and providers about the significance of CM program.
- Training care managers/linguistic and cultural competency.
- Supporting patient's self-management goals.
- Provider engagement.
- Linking to community resources.
- Medication management.

Quality, Timeliness, and Access to Health Care Services

- The overall compliance for BH CM MRR was 88%. Missouri Care scored 100% in documenting their medical records with diagnosis, enrollment and case closure dates, referrals, assessments, updated care plans, progress notes, coordination, linking, and monitoring of community care services.

- Missouri Care had the following BH Inpatient CM outcomes (Table 6-16):

Table 6-16 BH Inpatient Outcomes			
	Count	Billed ($)	Paid ($)
Pre Program	646	8,852,380	2,348,576
Post Program	128	1,859,709	487,025
Improvement	80.2%	79.0%	79.3%

Improvement by Missouri Care

A comparison with previous year (CY 2017) was made to determine the extent to which Missouri Care had effectively addressed the recommendations for quality improvement made by the EQRO (Table 16).

(**Note**: For CY 2017 the focus was on CM offered to patients with a diagnosis of serious mental illness and for CY 2018 the focus was on CM offered to members post-psychiatric hospitalization/residential substance use treatment program. Common/relevant criteria applicable to both these focus areas have been included in the table.)

There was a decrease % compliance (highlighted in red) noted in: assessment of members for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program (75% points); provider treatment plans (95% points); discharge plans (35%); and follow up (39%).

Table 6-16 Score (%) BH CM MRR for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	100	100
First Enrollment Date	100	100
Last Enrollment Date	100	100
MCO assess members for CM within 5 business days of admission to a psychiatric hospital or residential substance use Tx program	100	25
Referrals	100	100
Assessment/ Reassessment	100	100
Medical History	100	100
Psychiatric History	100	100
Developmental History	100	100
Medical Conditions	100	100
Psychosocial Issues	100	100
Legal Issues	100	100

Care Plans	100	100
Care Plan Includes Risk Appraisal	100	100
Care Plans updated as indicated or w/in 90 days of discharge from inpatient stay or ED Visit	100	100
Provider Treatment Plans	95	0
Progress/Contact Notes	100	100
Discharge Plans	85	50
Transfers	84	100
Coordination/Linking of Services	100	100
Monitoring of Services and Care	100	100
Follow-Up	89	50

6.4 Findings and Analysis UnitedHealthcare

Members identified for CM programs: 51,057
Members enrolled in all CM programs: 21,165
Figure 6-17 demonstrates the volume of identified members (293) for OB CM, the number managed (109 members with an assessment and a care plan) and the volume that declined/lost contact (184).

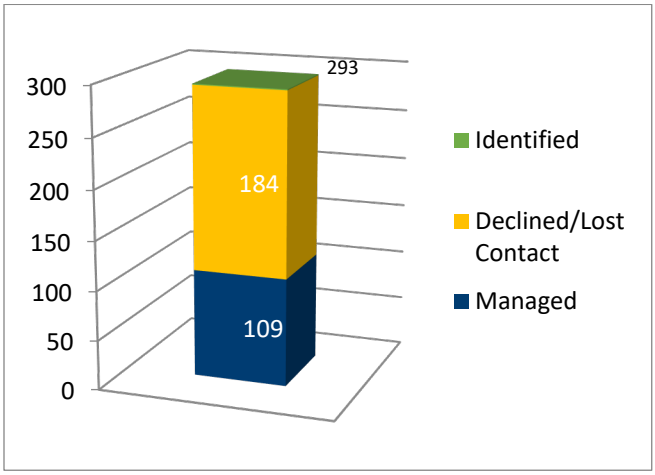


Figure 6-17 CY 2018 OB CM Members

Figure 6-18 demonstrates the volume of identified members for Lead (74), the number managed (57) and the volume that declined/lost contact (17).

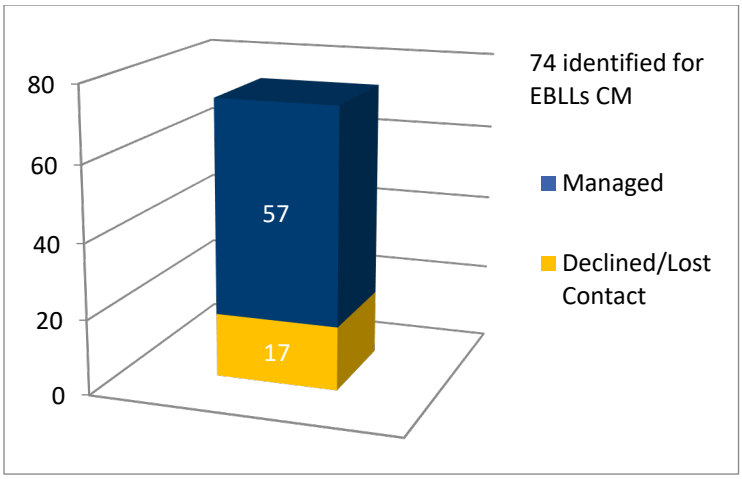


Figure 6-18 CY 2018 EBLLs CM Members

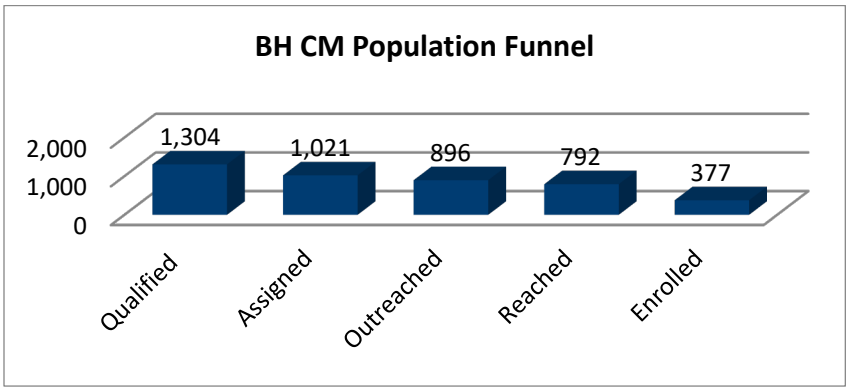


Figure 6-19 BH CM Members

Figure 6-19 demonstrates the total number of eligible members (1,304) for BH CM in CY 2018. Only 377 could be successfully enrolled.

Review of Policies and Procedures

The following policies and procedures are submitted by UnitedHealthcare (Table 6-17). Upon review, Primaris concluded that UnitedHealthcare is 100% compliant with all the requirements mandated by MHD contract.

Table 6-17 Care Management Policy Review UnitedHealthcare

Policies and Procedures shall include (MHD 2.11.1c5):	Document Name(s)
1 A description of the system for identifying, screening, and selecting members for Care Management services.	NCM 001 Identification of High Risk Members for CM, NCM 012 Risk Stratification Process, NCM 020 Delegated CM/Care Coordination,

		Whole Person Centered Care Model (WPC) 2019.
2	Provider and member profiling activities.	NCM 012 Risk Stratification Process.
3	Procedures for conducting provider education on CM.	WPC 2019, NCM 007 Informing and Educating Providers, MO CM 01 Missouri Case Rounds.
4	A description of how claims analysis will be used.	WPC 2019, NCM 012 Risk Stratification Process, MO MCH-01 Missouri Maternity Program, NCM 001 Identification of High Risk Members for CM.
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.	WPC 2019, NCM 020 Delegated CM/Care Coordination.
6	A process to ensure integration and communication between physical and behavioral health.	WPC 2019, NCM 020 Delegated CM/Care Coordination.
7	A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	WPC 2019, NCM 020 Delegated CM/Care Coordination.
8	A process to ensure that care plans are maintained and updated as necessary.	WPC 2019, NCM 001 Identification of High Risk Members for CM, NCM 002 High Risk CM Process, NCM 020 Delegated CM/Care Coordination.
9	A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet Care Management requirements.	WPC 2019.

10	Timeframes for reevaluation and criteria for Care Management closure.	WPC 2019, NCM 001 Identification of High Risk Members for CM, NCM 002 High risk CM Process, NCM 020 Delegated CM/Care Coordination MO 01 Elevated Lead Level Program.
11	Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	WPC 2019, NCM 020 Delegated CM/Care Coordination.

Evaluation of Care Plan

Upon interviewing UnitedHealthcare officials and reviewing the medical records for all three CM focus areas, Primaris concluded that UnitedHealthcare had policies and procedures based on contractual guidelines for "care plan," and members were managed according to those guidelines. However, the "care plan" per se did not include all the components listed in the MHD contract 2.11.1e. The care managers worked with the members and created goals based on the care gaps. Interventions were planned to close those gaps. The care plan was updated once a month.

A. Obstetric (OB) Care Management

Healthy First Steps® (HFS) is a special voluntary program for UnitedHealthcare pregnant members and their babies. It is designed specifically to address the needs of this vulnerable population through an integrated, holistic approach across the continuum of care. The HFS program aims to identify pregnant members early on by leveraging sophisticated identification and stratification algorithms; and engaging them as early as possible to ensure that members receive the care and services necessary to promote a healthy pregnancy and achieve better health outcomes for infants and children. The HFS program focuses on the importance of prenatal and postpartum care in addition to the social determinants of health. UnitedHealthcare's locally-based nurse coordinators not only serve as the single point of contact for their highest risk, complex needs members, but they are also integral in providing education, coordination, and consultation with obstetric and pediatric practitioners to optimize the health of their members. Figure 6-20 shows the work flow of OB CM.

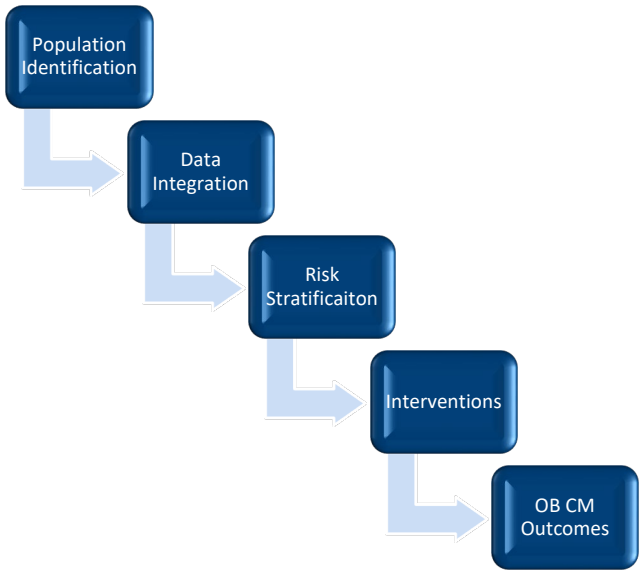


Figure 6-20 Work Flow of OB CM

Medical Record Review

An oversample of 30 medical records was reviewed. Only 17 were included for evaluation of OB CM as 13 medical records had to be excluded (3 cases-enrolled in last quarter for CM; 4 cases-unable to contact (UTC); 3 cases-incorrect diagnosis; 2 cases-declined CM; and 1 case-ineligibility).

Primaris reported the MRR compliance (%) under the following headings (Figure 6-21):

a. Diagnosis: 100% compliance.
   Medical records had a diagnosis of pregnancy (high risk/low risk) in all the 17 medical records.
b. First enrollment: 100% compliance.
   All cases were enrolled within 24 hours of notification of a member's pregnancy and outreach to a member was initiated.
c. Last enrollment: 100% compliance.
   A case was closed at 60 days post-partum. When a case manager was unable to reach a member, the case was closed after third outreach attempt.
d. Offer CM within 15 business days of notification of pregnancy: 100% compliance.
   UnitedHealthcare contacted their OB members within the time frame to assess their needs.
e. Referrals: 100% compliance.
   The referrals were received through claims, eligibility, or enrollment data.
f. Assessment: 100% compliance.

All cases had an assessment. However, there were three different types of assessment questionnaires followed by the care managers. All the required components per MHD contract were not included in those different questionnaires. Thus, medical history was assessed in 100% cases; psychiatric history, developmental history, and psychosocial issues were assessed in 88% cases; and legal issues were addressed in 24% cases.

g. Updated care plans: 76% compliance.
   Updated care plans were present in 13 of 17 cases. Out of 4 cases that did not have a care plan-2 declined CM, 1 case was UTC and 1 case-notes suggested that the goals were met, but care plan was missing from the medical record.
h. Risk appraisal: 94% compliance.
   This was present in 16 of 17 cases. One case was closed as UTC.
i. Provider treatment plans: Zero compliance.
j. Providers had access to the care plan via UnitedHealthcare's website. However, they were not involved with the care plan/treatment plan unless the care managers called them as needed. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.Lab tests: 35% compliance.
   These were documented in 6 of 17 cases.
k. Progress notes: 88% compliance.
   These were found in 15 of 17 cases. One case declined CM, and one case-UTC.
l. Discharge plan, Aftercare: 29% compliance.
   Discharge plan and aftercare notes were present in 5 of 17 cases. For the remaining 12 cases: 3 cases declined CM; 7 cases are UTC; and in 2 cases there was no documentation about an outreach effort by the care managers.
m. Transfers: 100% compliance.
   This was addressed in all 17 cases. There were no transfers to/from another MCO.
n. Coordination and linking of services: 76% compliance.
   Medical records show that 13 of 17 cases were linked to community resources. In the remaining 4 cases: 3 cases declined CM, and one was UTC.
o. Monitoring of services: 65% compliance.
   Services were monitored in 11 of 17 cases. The reasons for noncompliance in 6 cases were due to decline for CM (3 cases), UTC (2 cases), no efforts made by care manager per medical records (1 case).
p. Follow up (case closure no sooner than 60 days post-partum): 59% compliance.
   A post-partum follow up care was seen in 10 of 17 cases. 7 cases did not have a follow up as 3 declined CM and 4 were reported as UTC.

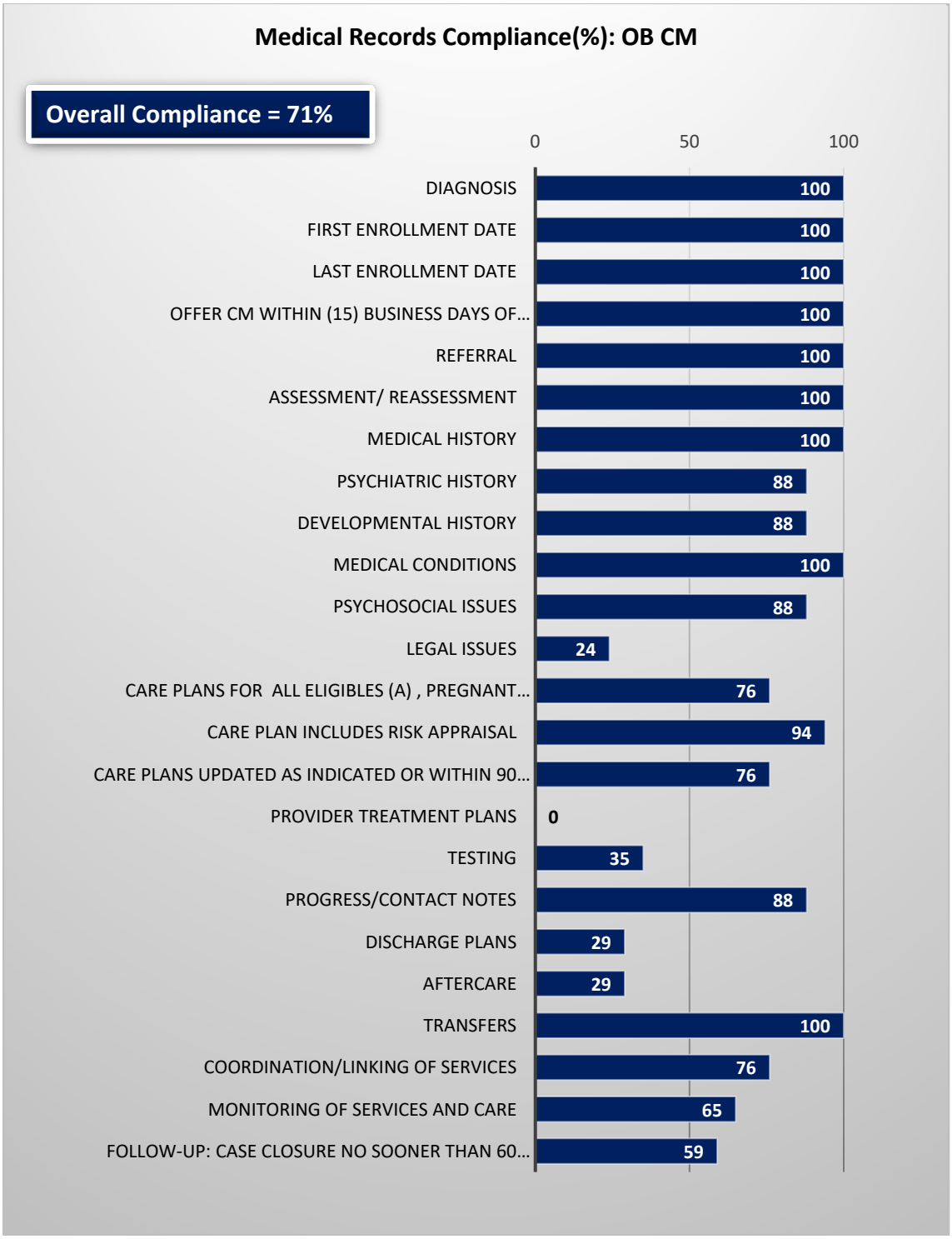


Figure 6-21 Medical Record Review for OB CM

Overall Conclusion

Oversample of medical records: 30 (Exclusions: 13)

MRR sample: 17 cases. These cases were closed due to: goals met (6); incomplete CM (1); UTC (7); and decline CM (3)

Issues

- Only 35% pregnant members (6 of 17) were managed successfully with all the "goals met." The MCO was not able to contact 41% (7 of 17) of members, and 18% (3 of 17) declined CM at the time of being active in OB CM program. It appeared that there was a lack of member engagement in the CM. This explained the low compliance for discharge planning (29%), after-care (29%), and post-partum case closure (59%). In 6% of cases (1 of 17), there was a lack of documentation about the outreach attempts for post-partum care.
- The care workers used 3 different assessment questionnaires for members. All the required information, namely, medical history, psychiatric history, developmental history, psychosocial issues, and legal issues for each pregnant member were not captured in every assessment. The compliance rate ranges from 24%-100% for various requirements listed above.
- An updated care plan was available in 76% cases. The common reasons for non-compliance were: member declined CM, or UTC. Incomplete documentation also appeared to be an issue (1 case).
- The engagement of providers with the care plan was nil (0%). The care plan was posted on the website and the providers had access to it. No acknowledgement or feedback was received from the providers.
- Lab tests were documented in 35% cases. All the pregnant women require blood/urine tests/Ultrasonography at regular intervals. These were not documented in the medical records or linked to claims system which could serve as an evidence.

Key Drivers

- Member engagement, motivation.
- Supporting patient's self-management goals.
- Care manager's training and education.
- Use of evidence-based care.
- Holistic, comprehensive, culturally competent approach with awareness and respect for diversity.
- Accurate contact addresses and telephone numbers of primary, secondary, and emergency contacts.
- Providers' involvement with care.
- Elaborate assessment of needs of the members.
- User friendly interface for Electronic Medical Records.

- Team work and coordinated care with care managers, members, providers, community resources.
- Aligning resources with the population needs.

Quality, Timeliness, Access to Health Care and Services

- The overall compliance of OB CM MRR was 71%. UnitedHealthcare was able to outreach their OB members to offer CM and complete assessment within 15 business days of notification of pregnancy in 100% cases. Referrals to the CM program were 100% either through enrollment, claims, or eligibility system. High risk assessment (risk appraisal) was available in 94% cases. Coordination and linking to services are evident in 76% cases.
- UnitedHealthcare implemented multifaceted identification and stratification methodologies that addressed the comprehensive and holistic needs of pregnant members to include medical, social, and behavioral risk factors and conditions.
- UnitedHealthcare stated they provide support through clinical and nonclinical staff as well as network providers and practitioners for women at risk for complications during or throughout their pregnancies and deliveries, including but not limited to: behavioral health support; outreach and coordination for babies in the neonatal intensive care unit; 17 alpha-hydroxyprogesterone caproate treatment program (17P), and coordination with community resources and programs.

Improvement by UnitedHealthcare

UnitedHealthcare's contract with MHD went in effect on May 01, 2017. Since data for the entire CY 2017 was not available, UnitedHealthcare was not included in EQR 2018. Thus, there were no recommendations from last year's EQR which could serve as basis for assessing improvement in EQR 2019.

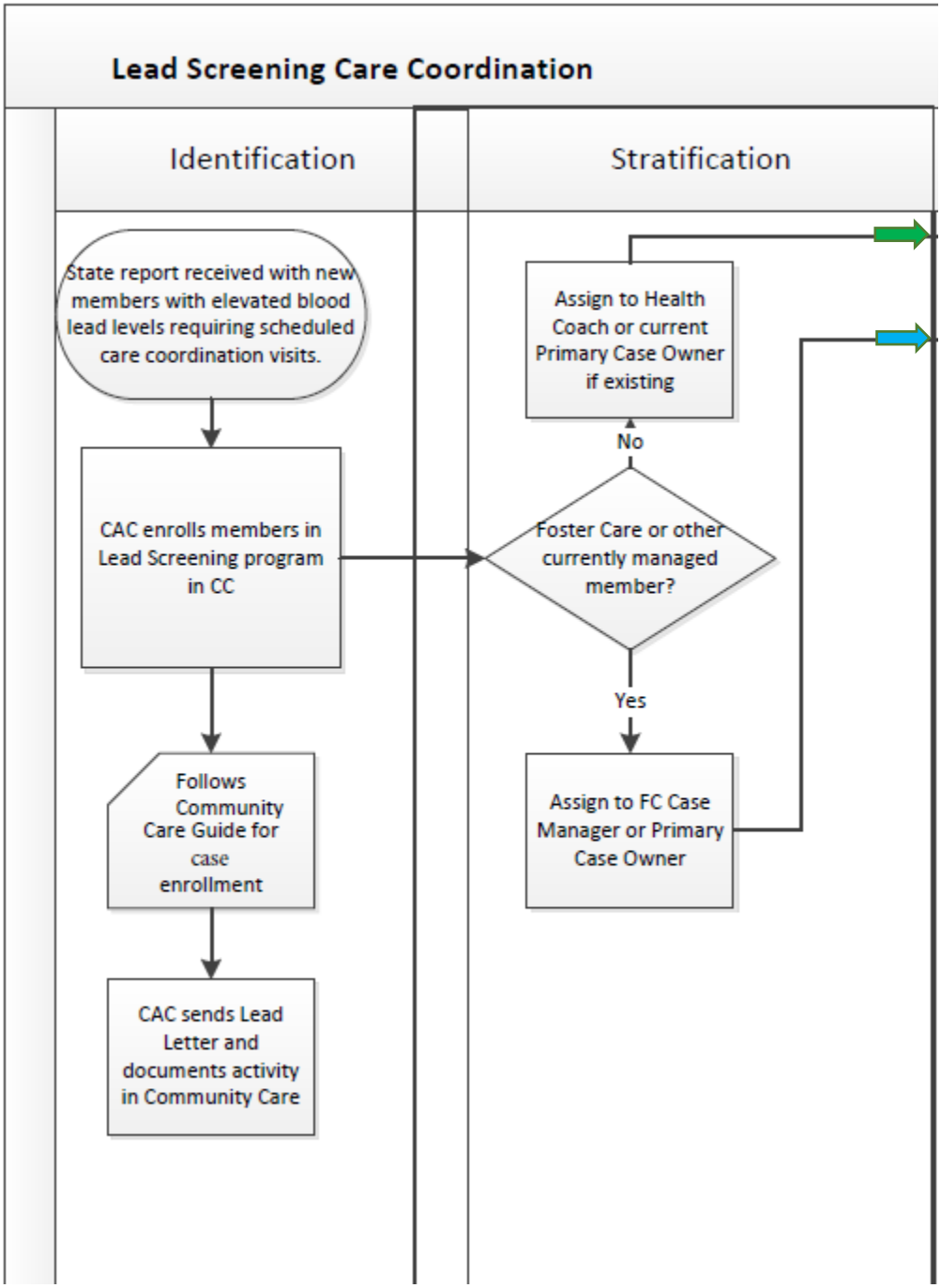
B. Children with Elevated Blood Levels (EBLLs) Care Management

CM services at UnitedHealthcare are offered to all eligible members with a blood lead level (BLL) of 10 ug/dL or greater in accordance with MHD guidelines. BLL testing is mandatory at 12 and 24 months of age for all MO HealthNet children or annually for all children 6 months to 72 months of age, if the children are residing in an area designated as "high risk" for lead poisoning in Missouri, as defined by DHSS. UnitedHealthcare reported that all aspects of CM for EBLLs are documented in the state's web-based MOHSAIC Lead Application database (not validated by EQRO).

UnitedHealthcare uses the DHSS childhood lead poisoning prevention program nurse's lead CM questionnaire and the nutritional assessment forms to capture all the required CM

elements for documentation. An internal lead assessment is also completed in the community care (CC) clinical documentation system.

Figure 6-22 describes the work flow of EBLLs CM at UnitedHealthcare. In addition to sending a monthly report to the MCO, DHSS contacts their care managers by telephone to notify about EBLL of their members.



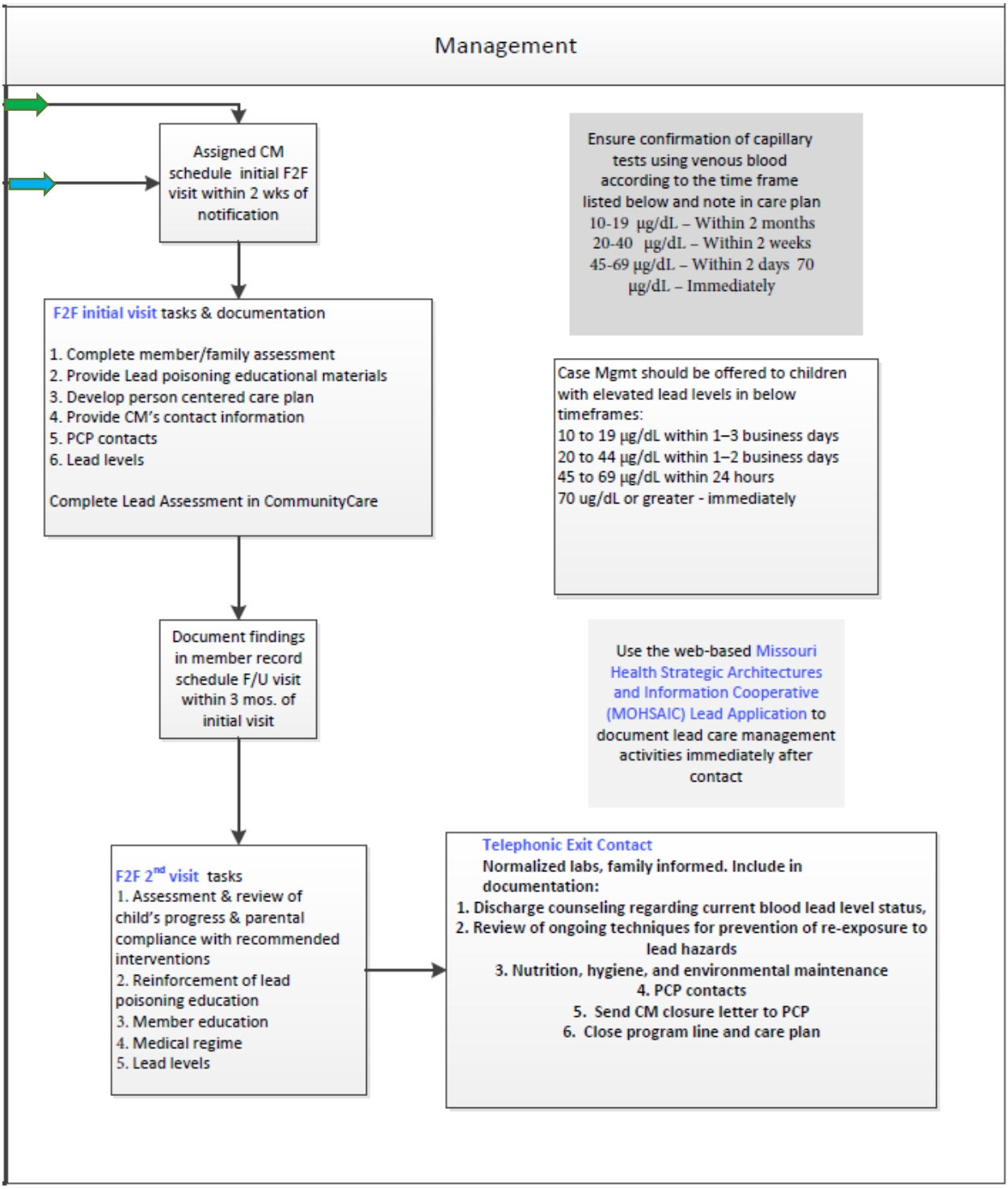


Figure 6-22 Work Flow of EBLLs CM

Medical Record Review

An oversample of 27 medical records was reviewed in order to obtain the required sample size of 20 medical records. Exclusions were 7 (5 cases: No CM in CY 2018 and 2 cases: UTC).

Primaris reported the MRR compliance (%) under the following headings (Figure 6-23):

a. Diagnosis: 100% compliance.
   There was a documented evidence of diagnosis in all cases. However, cases managed by Pediatric Care Network (PCN-subcontractor of UnitedHealthcare offering CM in Western region of Missouri) mentioned "high lead" in their notes/assessment as opposed to clearly stating in the medical record.
b. First enrollment date: 100% compliance.
   Most of the cases (18 of 20) were enrolled for CM on the same day of notification from the state. 2 cases have a different enrollment date (managed by PCN).
c. Last enrollment date: 100% compliance.
   Cases were closed due to goals met (6), loss of eligibility (2), unable of contact (UTC-1), refusal for CM (6). One of the 6 members who refused CM, was in contact with local public health agency and did not want to be engaged with UnitedHealthcare. 5 cases are still open for CM in CY 2019.
d. Offer CM within time frames for EBLLs: 30% compliance.
   The attempt to outreach a member began within 24 hours of notification from the state. The members were not available for an assessment or did not answer the phone or refuse CM. The review showed that 6 of 20 cases had assessment within timeframe, 8 of 20 cases had assessment outside of time frame and 6 of 20 cases did not have an assessment.
e. Referrals: 100% compliance.
   UnitedHealthcare received referrals from state (100%), PCPs, or the members.
f. Assessment: 75% compliance.
   The lead assessment was complete in 15 of 20 cases. However, an assessment did not include medical history, psychiatric history, developmental history, psychosocial and legal issues. The compliance of these elements was 20% only. The CM done by PCN included all the components of assessment per MHD contract.
g. Confirmation of capillary blood test by venous test within the time frame per MHD guidelines: 95% compliance.
   In 19 of 20 cases, confirmation of venous blood lead levels were available within the timeframe. Most of these cases (15 of 19) were reported with venous blood lead levels at the time of notification to the MCO by State. One case did not have a confirmation by venous blood as mother refused CM.
h. Follow up on EBLLs within the time frame per MHD guidelines: 68.4% compliance.
   A follow up BLL within the time frame was done in 13 of 19 cases. This requirement is marked as not applicable (N/A) for 1 case as venous level was low (l.0 µgm/dl).

i. Home visits: 68.4% compliance for first visit, 10.5% compliance for second visit. If a home visit was done by LPHA for an environmental risk assessment, UnitedHealthcare did not make a home visit (first follow up) at member's residence.
j. Care plan with updates: 75% compliance.
   An updated care plan was found in 15 of 20 cases.
k. Progress notes: 85% compliance.
   Detailed notes on every contact with the member were present in 17 of 20 cases.
l. Provider treatment plan: 26.3% compliance.
   The engagement of providers with the care managers in developing a care plan was low (5 of 19 cases, N/A in one case).The care plan was posted on the website which was accessible to the providers. Care managers contacted the providers when there was an issue with the member's care (e.g., missed appointments for blood lead levels). As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.
m. Transfer: 100% compliance.
   This section was addressed in all the medical records. There were no transfers to another state or another MCO.
n. Coordination and linking of services: 90% compliance.
   In 18 of 20 cases, the members were linked to dental services, vision services, PCPs, local public health department, DHSS, home remediation services.
o. Monitoring of services: 75% compliance.
   Services were monitored in 15 of 20 cases.
p. Discharge plan: 100% compliance
   All cases were mailed an "education package" on prevention of re-exposure to lead, nutrition, and environmental maintenance. These were discussed over the phone or during face- to-face encounters. There were 5 cases marked as N/A as they were still open for CM.
q. Exit evaluation/case closure contact: 60% compliance.
   Only 9 of 15 cases had an exit evaluation. This was not applicable for 5 cases as they were still open for CM.
r. Notification to providers/members: 93.3% compliance for provider notification/13.3% compliance for member notification.
   In 14 of 15 cases, the providers have been sent a written notification about child's condition and case closure. Only 2 of 15 members were notified in writing about case closure. The case managed by PCN had a member-closure letter. UnitedHealthcare did not send a member closure letter. The members were verbally notified. (N/A for 5 open cases).

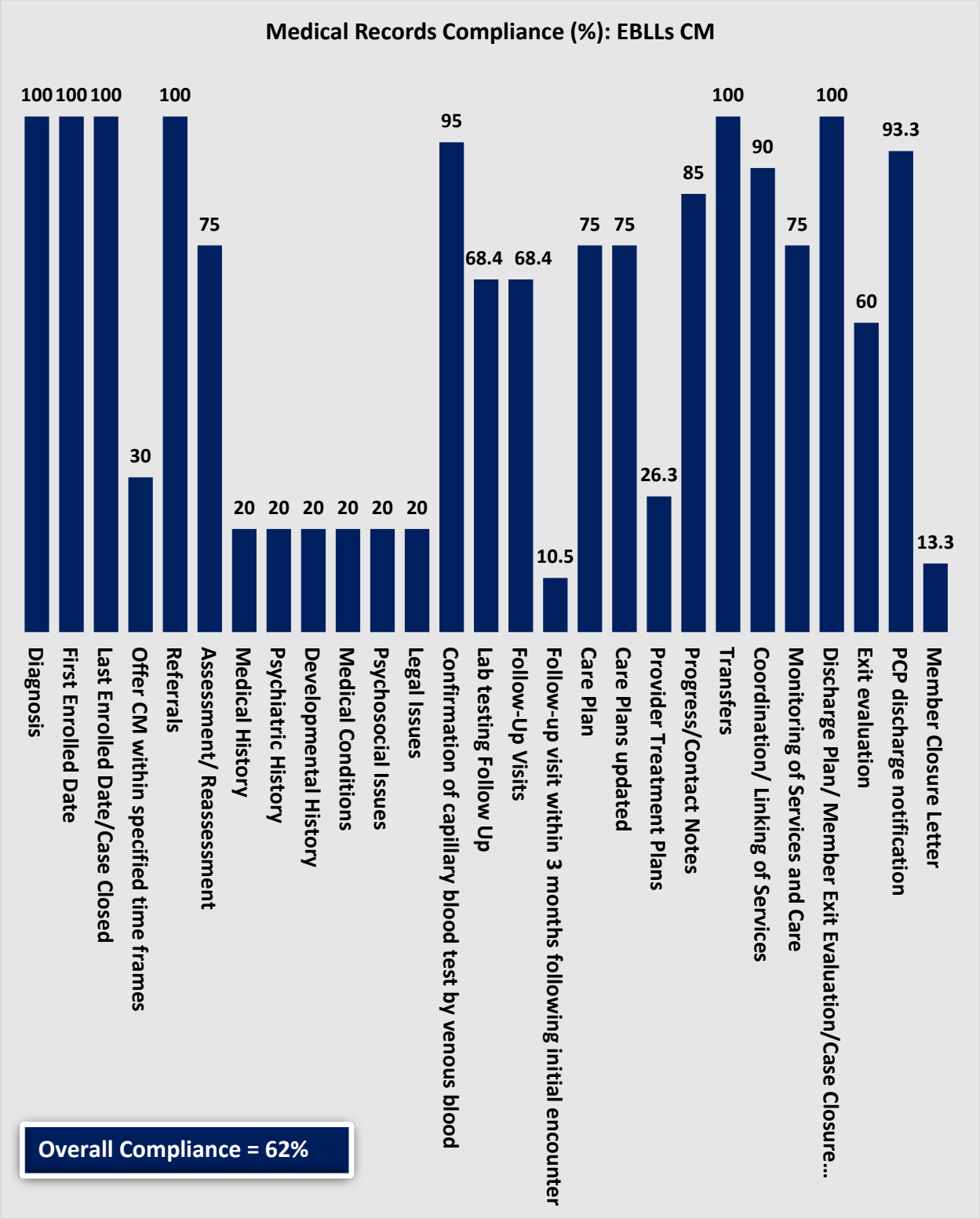


Figure 6-23 Medical Record Review for EBLLs CM

Overall Conclusion

Oversample of medical records: 27 (Exclusions: 7)

MRR sample: 20 cases. 5 cases remained open for EBLLs CM in CY 2019. 15 of 20 cases were closed for EBLLs CM due to following reasons. (Table 6-18):

Table 6-18 Case Closure	15
Goals met/low blood lead levels	6
Lost eligibility	2
Unable to contact (UTC)	1
Declined CM	6

Issues

- The CM was offered within the time frames based on the EBLLs in 30% cases (6 of 20 cases). In 40% cases (8 of 20 cases) CM was offered but outside of the mandated time frame. Unsuccessful contact with a member is the main cause of delay. Another 30% (6 of 20 cases) refused CM.
- UnitedHealthcare did not assess their members based on the criteria required by MHD. They followed a questionnaire with a focus on lead exposure. A detailed assessment of a member which should include medical, psychiatric, developmental, psychosocial and legal history was not present in most of the medical records. Only 20% of the cases had a detailed assessment which were managed by PCN.
- Refusal to CM was the main issue for compliance. The timely follow up of repeat blood levels was done in 68.4% cases (13 of 19), initial home visit was done in 68.9% (13 of 19), and a second visit was done in 10.5% cases (2 of 19).
- Provider engagement with the care plan was only in 26.3% of cases.
- UnitedHealthcare did not notify their members in writing about the case closure.

Key Drivers

- Education of parents/guardians of children about harmful effects of lead, preventive measures, importance of timely BLL testing, and usefulness of CM services.
- Maintaining high motivation of clients throughout their CM.
- Education, skills, knowledge, competencies, and experience of care managers.
- Coordination between providers, care managers, and environmental risk assessors, home remediation service agencies, and local health agencies.
- Feedback from the member/guardian about CM services.
- Updated contact information.
- Creating proactive care plan with self-management goals.
- Providers' education about CDC guidelines for EBLLs CM.

- Auto-referral UM system alerts to care managers when a member is hospitalized or discharged.

Quality*, *Timeliness*, and *Access* to *Health Care Services

- The overall compliance of Elevated BLL CM MRR is 62%. UnitedHealthcare had scored 100% in maintaining their medical records with diagnosis, enrollment and case closure dates, referrals, transfers, and discharge plan. An education package was mailed even if a member refused CM or UTC. 95% of cases had a confirmation of capillary BLL level with venous BLL within the time frame. Coordination and linking of community resources was seen in 90% cases. A written notification was sent to the providers at the time of case closure in 93.3% cases. Updated care plan was available in 75% cases.
- Initiative was taken by care managers to call the providers and notify them about the care plan and confirm appointments of their members. This has resulted in providers' engagement in 26.3% cases. The care managers also educated the providers about the CDC/MHD recommended timeframes for retesting EBLLs.
- UnitedHealthcare participated in Lead education via DHSS training (Aug 17, 2018).

Improvement by UnitedHealthcare

As stated earlier, since UnitedHealthcare was not included in EQR 2018, there were no recommendations from last year's EQR which could serve as basis for assessing improvement in EQR 2019.

C. Behavioral Health (BH) Care Management

Whole Person Care (WPC) Program

UnitedHealthcare provides BH CM by its WPC program. This program provides care coordination within an integrated, multi-disciplinary and geographically local team. The Whole Person Care (WPC) Management program is designed to address both the management of acute events as well as the reduction of future risk for a member through integrated medical and behavioral care management/care coordination to Medicaid members. The WPC program focuses on the clinical and psychosocial needs to optimize the health status of individuals with complex and/or chronic health conditions. The program is accredited by NCQA CM.

The primary features of the WPC model:

- Primary point of contact for engaged member.
- Evidence-based proprietary identification and stratification.
- Comprehensive assessment and care plan.

- Telephonic and face-to-face member engagement.
- Locally based interdisciplinary team.

Figure 6-24 shows the work flow of BH CM at UnitedHealthcare

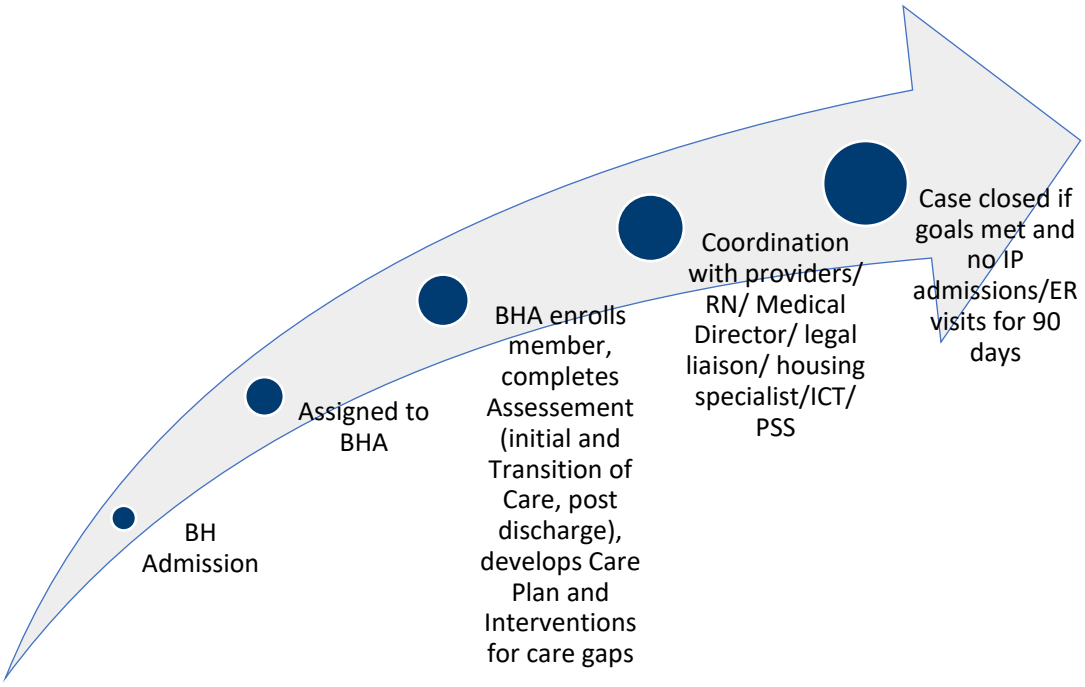


Figure 6-24 Workflow of BH CM

Medical Record Review

CM of members with BH diagnosis leading to hospitalization (including residential treatment program for substance use disorder) was assessed. An oversample of 27 medical records was reviewed in order to obtain the required sample size of 20 medical records for evaluation. There were 7 exclusions (5 cases: No CM in CY 2018 and 2 cases: UTC). Primaris reported the MRR compliance (%) under the following headings (Figure 6-26):

a. Diagnosis: 100% compliance.
   There was a documentation of diagnosis in all the 20 cases. Major depressive disorder was the admitting diagnosis in 12 of 20 cases. The second common reason for admission was disruptive mood dysregulation disorder (3 cases). The remaining 5 cases were unspecified psychosis (1), bipolar disorder (1), adjustment disorder (1), mental disorder (1), and attention deficit hyperactivity disorder (1).
b. First enrollment date: 100% compliance.
   The cases were enrolled on the first day of successful outreach with the patient. However, all cases were enrolled after the discharge date from hospital/residential care.
c. Last enrollment date: 100% compliance.

Cases were closed due to goals met (5), loss of eligibility (2), unable of contact (UTC-10), refusal of CM (3).

d. Assessment of the members for CM within 5 business days of admission to a psychiatric hospital or residential treatment program: MHD has mandated Primaris to focus on this section. Compliance is 20% (Figure 6-25). Various reasons attributable for low compliance as explained by the MCO:
    - The care manager is not permitted to meet the patient during hospital stay.
    - Patient's condition does not warrant a conversation with care manager for an assessment.
    - The care manager is not able to successfully contact the patient in spite of several attempts. Efforts to outreach begin within 24 hours of discharge of a patient from the hospital.

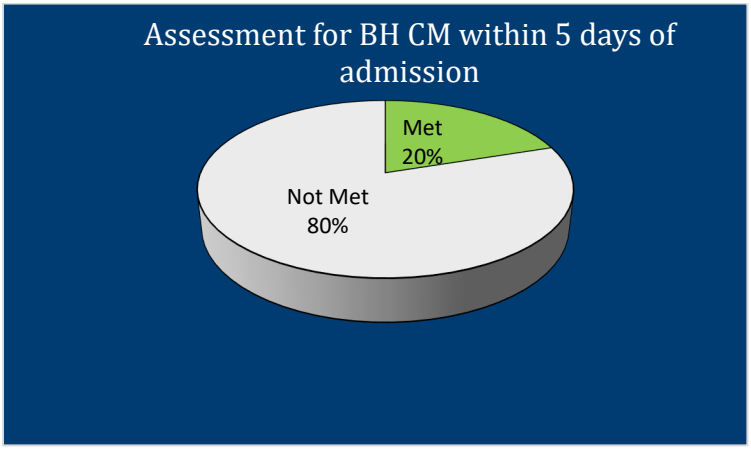


Figure 6-25 Assessment for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program

e. Referrals: 100% compliance.
Utilization Management system (UM) at UnitedHealthcare generated an auto-referral alert as a member was hospitalized or discharged from the hospital, and thus the care managers were notified.

f. Assessment: 45% compliance.
There were two forms used for assessing a member's condition. One was "Access to Care" and other was "Transition of Care." Detailed assessment which should include medical, psychiatric, developmental, psychosocial history, was missing in 9 of 20 cases. However, legal issues were discussed in 19 of 20 cases (95% compliance).

g. Care plan with updates/progress notes: 100% compliance.
Care managers discussed the needs with the members and developed a care plan with interventions directed at closing those care gaps. The providers were contacted, if

necessary. The care plan was updated on a monthly basis and progress notes were maintained for each member.

h. Risk appraisal: 45% compliance.
   High risk assessment was available for 9 of 20 cases only.
i. Provider treatment plan: 70% compliance.
   Care manager contacted a provider (psychiatrist, BH therapist, inpatient department, pharmacy) to verify the member's compliance with their scheduled appointments and also checked for medication refills. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.
j. Testing: N/A
   UnitedHealthcare informed Primaris that BH patients were recommended for lab tests only in a few cases, e.g., patients on mood stabilizing drugs (lithium) where the therapeutic levels were required to be monitored. There were no cases with a recommendation for a drug test by a provider. Hence, this section was considered N/A.
k. Transfer: 100% compliance.
   This section was addressed in all the medical records. One case was transferred to another state and thus lost eligibility with the MCO.
l. Coordination and linking of services/monitoring of services: 90% compliance.
   Care managers coordinated with pharmacy, PCP, community resources, PSS, housing facilities, BH providers, transportation services, RNs, school counselling services, financial services to ensure full support and a complete recovery of their patients. Out of the 20 cases, 2 did not receive these benefits as the members could not be contacted, even after several attempts (more than 3).
m. Discharge plan: 25% compliance.
   This was available for 5 of 20 cases. The remaining 15 cases did not have a discharge plan because of UTC (10 cases), loss of eligibility/transfer to another state (2 cases), refusal to CM (3 cases).
n. Follow up: 35% compliance.
   This was done in 7 of 20 cases. The remaining cases did not have a follow-up because of UTC (9), refusal to CM (3), and loss of eligibility (1).

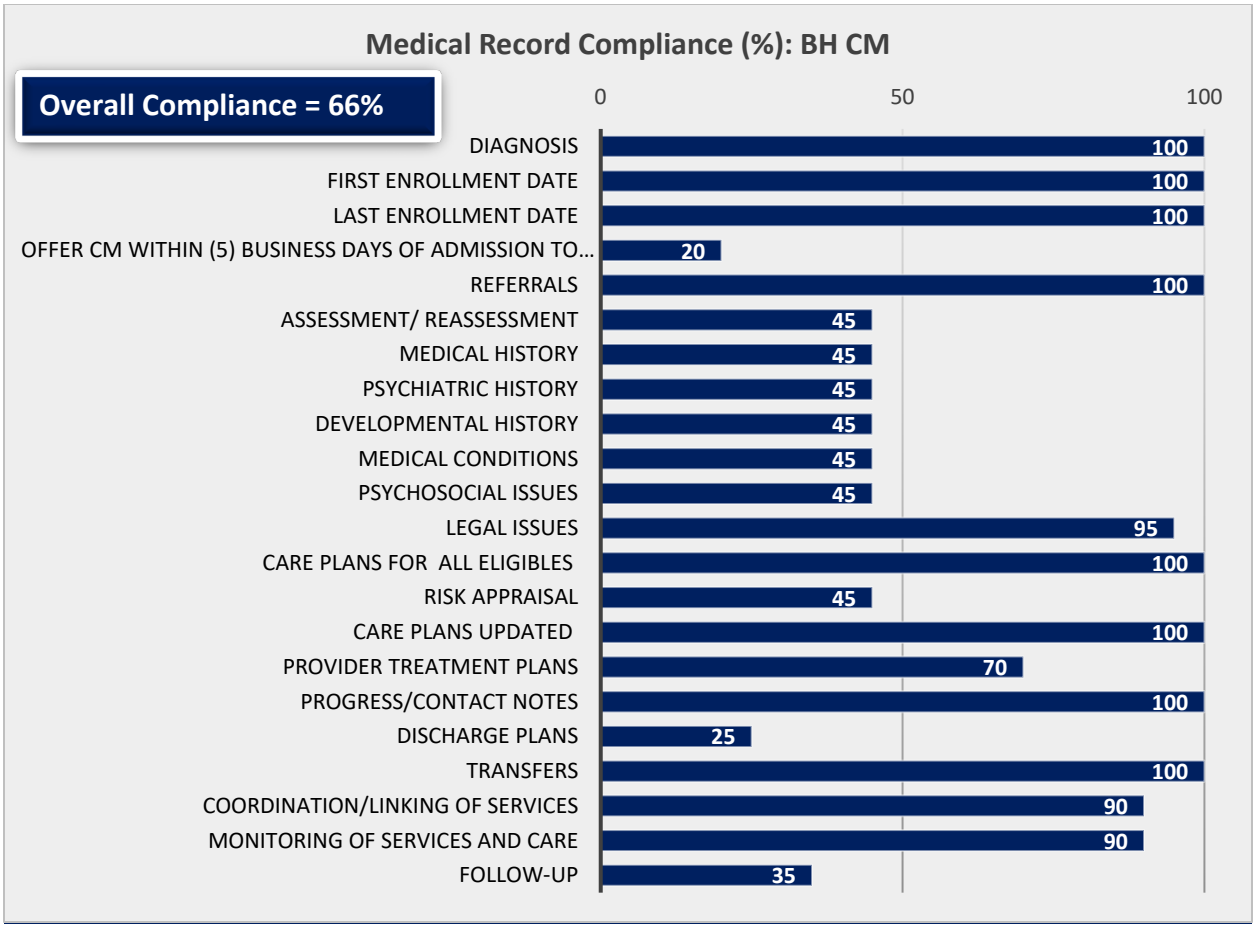


Figure 6-26 Medical Record Review for BH CM

Overall Conclusion

Oversample of medical records: 27 (Exclusions: 7)

MRR sample: 20 cases. All cases are closed under BH CM program due to the following reasons (Table 6-19):

Table 6-19 Case Closure	20
Goals met	5
Lost eligibility	2
Unable to contact (UTC)	10
Declined CM	3

Issues

- The success rate of the MCO to initiate CM assessment of their members within 5 business days of admission to a psychiatric hospital/residential treatment program was only 20%. Several post-discharge outreach attempts were made before a care manager was able to enroll a member in CM program and begin an assessment.

Most common reason noted for this delay in assessment was "UTC-phone call not answered."

- The detailed CM assessment (called as Access to Care Assessment) was conducted only in 45% of the cases (9 of 20).
- Providers were not engaged in the care plan. However, when care managers called the providers' offices to confirm compliance of their members with their scheduled appointments, they received a feedback/response.
- UnitedHealthcare informed Primaris about a correspondence between them and their providers: A concern was expressed by providers that in the interest of confidentiality, patient information was not being released to UnitedHealthcare's clinical staff requesting it for care coordination and management. This concern was shared by care managers. Information about a BH patient was not shared with a provider as care managers did not have a written consent/permission by the patient. This led to lack of coordination between providers and care managers to effectively implement a care plan.
- During the MRR, UnitedHealthcare officials stated that a care manager was not able to verify the provider of a given member in 44.5% cases (Figure 6-27).
- The ability to stay in contact over a long term is a challenge in tracking member's care. Sometimes, the members become overwhelmed with too many people involved in their care. They lack the understanding of their roles and opt out of care management. Consequently, the cases (3 of 20) (15%) refused CM after being enrolled. 50% of the cases (10 of 20) did not get the entire benefit of care plan. The cases were closed because of UTC-members did not respond to the calls by the care managers.

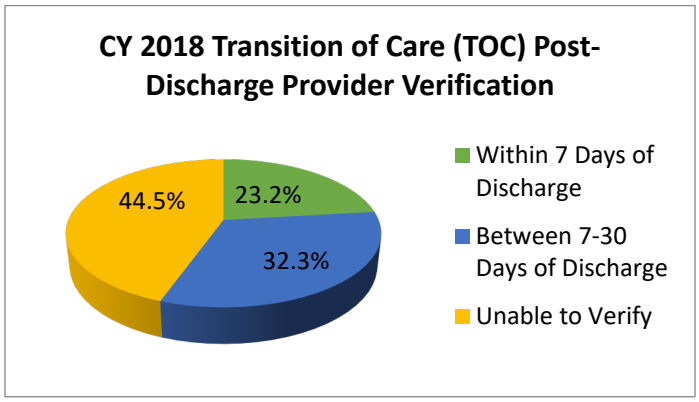


Figure 6-27 Post-Discharge Provider Verification

Key Drivers

- Early engagement of care manager with the members.

- Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital.
- Educating members and providers about the significance of CM program.
- Training care managers/linguistic and cultural competency.
- Detailed "need assessment" for a care plan with member's self-management goals.
- Provider engagement.
- Linking to community resources.
- Medication management.

Quality, Timeliness, and Access to Health Care Services

- The overall compliance for BH CM MRR was 66%. UnitedHealthcare scored 100% in maintaining their medical records with diagnosis, enrollment and case closure dates, referrals, updated care plans, progress notes. Coordination, linking, and monitoring of community care services were seen in 90% cases.
- UnitedHealthcare stated that in CY 2018 the program model for Whole Person Care was redesigned to create regionally based CM teams and to maximize opportunities for clinical oversight and direction of cases. As a result of the program redesign, the number of licensed behavioral health clinicians for MO WPC more than doubled.
- UnitedHealthcare engaged 20 behavioral health facilities to discuss policies and procedures related to behavioral health advocates (BHAs) gaining onsite access to members while they were still inpatient. The goal of this intervention was to engage more members at the hospital to facilitate follow up treatment post-discharge and prevent future readmissions. This intervention, along with the model redesign, helped contribute to an 82% increase in member visits by BHAs at inpatient facilities (as on April 19, 2019).
- UnitedHealthcare submitted that they completed "Transition of Care-Assessment (TOC)," within 3 days of hospital discharge in 87.5% cases (Figure 6-28).

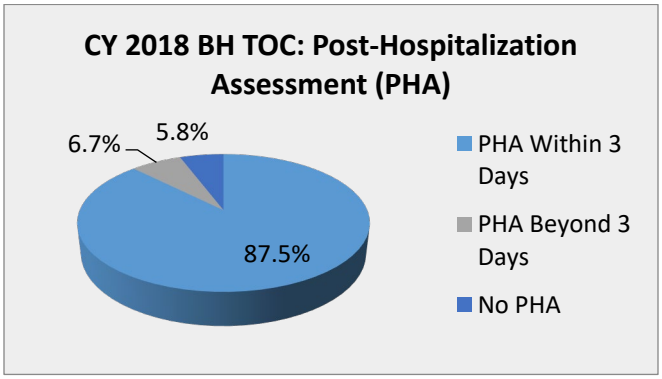


Figure 6-28 Transition of Care (TOC) Assessment-Post Discharge

Improvement by UnitedHealthcare

Since UnitedHealthcare was not included in EQR 2018, there were no recommendations from last year's EQR which could serve as basis for assessing improvement in EQR 2019.

6.5 Recommendations for MCOs

Table 6-20 Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Missouri Care	UnitedHealthcare
OB CM			
1.	✓		
2.			✓
3.			✓
4.	✓	✓	✓
5.	✓	✓	✓
6.	✓	✓	✓
EBLLs CM			
1.	✓		
2.			✓
3.			✓
4.			✓
5.	✓	✓	✓
6.	✓	✓	✓
7.	✓	✓	✓
8.	✓	✓	✓
9.	✓	✓	✓
BH CM			
1.	✓	✓	✓
2.			✓
3.			✓
4.			✓
5.	✓	✓	✓
6.	✓	✓	✓
7.	✓	✓	✓
8.	✓	✓	✓
9.	✓	✓	✓
10.	✓	✓	✓
11.	✓	✓	✓
All CM			
1.	✓	✓	✓

OB CM

1 Enrollment date should be clearly stated in medical records. It is recommended that a member should be considered as "enrolled" when a care manager makes an assessment of the need of the member and this marks the "case start date." The date of notification of pregnancy is not the "case start date." There should not be two different dates for "case start date" and "enrollment date". As per MHD Managed Care Contract, the initial CM and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.

2 UnitedHealthcare should include all the information pertaining to medical, psychiatric, developmental, psychosocial, and legal history in a single questionnaire which should be used for assessing a member's needs.

3 UnitedHealthcare should have a documentation about outreach and its outcomes in progress notes and care plan should be updated.

4 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.
   - Sending letters with an address correction request. (Post Offices can be contacted for information on change of address).

5 Engaging members in CM program: Successful CM programs require a seamless patient enrollment process. Deploying the right team member at the right time has a significant impact on a patient's interest in participation. First, consider designating enrollment responsibilities to staff with a mindset and competencies similar to that of a salesperson. Staff must be able to persuade patient candidates that the program is worth their time and effort. Second, target outreach to all available care settings and patient touch points, allowing patients to be reached at times when they may be more receptive to CM services. Leveraging existing relationships in other care settings, such as in the hospital or a specialist's office, can help encourage patient participation. Finally, tailor messaging to different patient populations to address any unique barriers to enrollment for each. Messaging should account for the health care experience of the members and any potential privacy concerns[6].

6 Collaboration with the Prenatal Care Provider: CM services must be delivered in close collaboration with the patient's prenatal care provider and when reinforcing and

[6] https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2015/02/enroll-patients-in-care-management

supporting the clinical care plan. OB care managers must communicate regularly with the prenatal care provider about patient progress toward goals, as well as current needs and issues that may impact clinical care. Care managers are a part of the patient's prenatal care team and should regularly visit the Pregnancy Medical Home practices to which they are assigned. They must develop effective practice-specific communication strategies to ensure coordination of care[7].

EBLLs CM

1 Enrollment date should be clearly stated in the medical records. It is recommended that a member should be considered as "enrolled" when a care manager makes an assessment of the need of the member and this marks the "case start date." The date of notification of EBLL is not the "case start date." There should not be two different dates for "case start date" and "enrollment date". As per MHD Managed Care Contract, the initial CM and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.

2 UnitedHealthcare's CM Assessment should include medical, psychiatric, developmental, psychosocial, and legal history in addition to lead specific questions. The diagnosis should be conspicuous.

3 Home Visits: Follow up home visits (2) after receiving a confirmatory venous BLL should be made by UnitedHealthcare's care managers. A home visit by the county/local public health department for environmental assessment should not be considered in lieu of a follow up home visit. If the MCO wants to use local public health agencies to provide services, the MCO shall enter into written contracts with the local public health agencies (MHD Contract 2.11.1 e 4). Member/guardian should receive an explanation about the significance of home visits by the care managers and how this would help in tailoring their care plan.

4 MHD contract section 2.11.1 e 5 requires a documentation of member/family notification of discharge from the care management. Primaris recommends UnitedHealthcare to notify members in writing (a closure letter) as opposed to a verbal notification.

5 Contact Guardian/Member: Different modes of outreach should be used at different times of the day and different days of the week to increase opportunities of actually reaching the member/guardian to initiate the CM process. The number of days for which a case will remain open even after UTC should be decided. Language barriers may present obstacles for the initial contact of the member/guardian. Local

[7] https://whb.ncpublichealth.com/provpart/docs/pregCareManual/PregnancyCareManagementStandardizedPlan-Revised2012-11-13.pdf

community-based resources may be necessary to facilitate initial contact and confirm effective follow-up (Table 6-21).

Table 6-21 Methods to Contact Members

Methods Used for Contact Information	Methods to Verify/Update Contact Information
Phone 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 Call member/guardian at differing times and days	Inquire WIC contact Inquire economic assistance contact Inquire Child Protection contact Inquire Primary Care Provider Inquire US Postal Service for forwarding the recent address Inquire contact person/guardian listed at admission

6 Member engagement: The member/guardian should be explained about the significance of home visits by the care managers and how this would help in tailoring the care plan.

7 Lead Poisoning Education: In addition to mailing educational materials to the parents/guardians, they should receive explanations about risks; how children are exposed to lead; products containing lead; preventive measures; healthy diets; effects of lead on children, adults, and pregnant women; testing and reporting guidelines; methods of testing; and treatment. This may help in generating member awareness about significance of their involvement in CM program.
Providers should be educated regarding a follow up on venous BLLs within the time frame as per Centers for Disease Control and Prevention (CDC) guidelines/MHD contract guidelines.

8 Provider engagement: The MCO should have a point of contact at every provider's office to discuss and share the care plan.

9 Ref to https://www.cdc.gov/nceh/lead/casemanagement/managingEBLLs.pdf for additional information management of EBLLs.

BH CM

1 CM Assessment within 5 days of psychiatric hospital/residential treatment program: Most of the referrals for BH CM are during concurrent review. It is best to engage with the member for an assessment during hospitalization. The MCOs should work with the hospital authorities for permission for the care managers to visit patients during hospital stay.

UnitedHealthcare has already begun to channelize their efforts in this direction through Hospital Care Transition (HCT) program. Primaris recommends expanding it to all the behavioral health facilities since UnitedHealthcare has already witnessed improvement through their HCT program.

2 UnitedHealthcare should consider enrolling a member in CM program and completing "Access to Care-assessment" when they have an opportunity to interact with a member post-discharge for completing their "TOC-assessment."

3 Detailed Assessment: Primaris recommends UnitedHealthcare create an assessment which should include medical, psychiatric, developmental, psychosocial, and legal history. These requirements are listed in MHD contract.

4 MHD contract section 2.11.1 e 5 requires a documentation of member/family notification of discharge from the care management. Primaris recommends UnitedHealthcare to notify members by sending a member closure letter as opposed to a verbal notification.

5 Engagement of providers: There is a need to educate providers about the role of care managers in management of the BH members. These care managers are capable of providing holistic care which can reduce inpatient readmission rates, emergency room utilization, increase the rates: follow-up after hospitalization for mental illness; and follow-up after emergency department visit for mental illness. This would improve the member outcomes of care and lead to significant cost savings. This savings could be used for incentivizing providers-a step towards engagement.

6 BH providers (psychiatrists, psychologists, psychiatric nurses, clinical social workers, mental health counselors, and other professionals) who provide treatment to patients with a mental health condition may share protected health information (PHI), including mental health information, in order to treat patients and prevent them from harming themselves or others. Health Insurance Portability and Accountability Act of 1996 (HIPAA) helps mental health professionals by allowing them to make decisions about when to share mental health information based on their professional judgment about what is in the best interests of the patient or what is needed to prevent or lessen a risk of harm.[8] Under HIPAA, both the MCO and providers are defined as covered entities.[9] Covered Entities are not required to obtain individual consent or authorization for the use and disclosure of regular Protected Health Information (PHI) for purposes of treatment, payment and health care operations where there is an existing relationship

[8] https://www.hhs.gov/sites/default/files/hipaa-helps-prevent-harm.pdf

[9] *See* 45 CFR 160.103 which states "Covered Entity means (1) a health plan (2) a healthcare clearing house (3) a healthcare provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter."

between the member, the MCO, and the provider. [10] However, the care managers can obtain a written consent from the member so that a care plan can be shared with the provider (BH/PCP). Additionally, care managers must also recognize when some patients with severe mental illness may not have the capacity to make decisions regarding the sharing of their information, as in the case of intoxication or temporary psychosis.[11]

7 Appropriate discontinuation of service[6]: Care management is a service with an ultimate goal that, at some point, the client will no longer need the help of his or her care manager. Care continued beyond this point often wastes valuable time-both the patient's and the care manager's-and limited community resources. Instead, the client should be counseled on his or her possible "graduation" from behavioral health care management.

8 All the BH care plans should be shared with the PCP even if there is no medical diagnosis. This is an important step in integration of BH and general health.

9 Medication management errors and adherence issues are known causes of frequent ED use, hospitalization and readmissions. Network pharmacists and pharmacy techs are critical members of the care team in the performance of medication reconciliation, comprehensive medication reviews, resolution of drug therapy problems, closing the gaps on adherence issues, and other medication-related interventions. Primaris recommends care managers to work with their pharmacy for a better member outcome.

10 Strength-Based Approach: A care manager should focus on resolving problems through the cultivation of the positive aspects of a client's life that promote mental well-being rather than on specific pathology. Points of focus should include the client's personal strengths and talents, positive interpersonal relationships in the client's life, identifying realistic goals and discussing possible ways of achieving them[11].

11 Average case load[12]: According to CMSA there are many factors that determine the case load capacity and care load calculation of a care manager. Because of the multiple factors and complexity of determining the appropriate caseload, CMSA has created a Case Load Capacity Calculator Tool. Missouri Care can utilize this online tool to optimize their staff load for any CM program and improve member outcomes.

---

[10] *See* 45 CFR 164.506. "A Covered Entity may disclose PHI to another Covered Entity for purposes of health care operations activities of the entity that receives the information, if each entity has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship and the disclosure is… for a purpose listed in paragraph (1) or (2) of the definition of healthcare operations."

[11] https://www.socialsolutions.com/blog/3-behavioral-health-case-management-best-practices/

[12] https://casemanagementstudyguide.com/ccm-knowledge-domains/case-management-concepts/case-load-calculation/

All CM

1 In regards to low compliance with Provider Treatment Plans, it is recommended that MCOs add an acknowledgement clause with the submission of the care plan to the provider which confirms their support of the care plan unless they reach out to the MCO within 30 days to express concerns or offer changes. By including this statement on every treatment plan, the MCO will be closing the loop and rates for provider treatment plan can greatly improve. Discussions with the MHD reveal clarifications on this topic must also be made in the managed care contract. Currently, the managed care contract does not clearly define "provider treatment plans." The MHD confirms it will clarify this expectation through the next contract amendment which will allow for a clearer path to contract compliance.

7.0 Comparative Performance Managed Care Organizations

This section provides a comparison of performance of Home State Health, Missouri Care, and UnitedHealthcare for each Mandatory and Optional activity conducted during EQR 2019.

7.1 Compliance with Medicaid Managed Care Regulations

Table 7-1 Compliance Score (%) MCOs

Standard	Standard Name	Home State Health	Missouri Care	United Health care
§438.206	Availability of services	100%	100%	100%
§438.207	Assurances of adequate capacity and services	100%	100%	100%
§438.208	Coordination and continuity of care	100%	100%	100%
§438.210	Coverage and authorization of services	100%	100%	95.5%
§438.214	Provider selection	100%	100%	100%
§438.224	Confidentiality	100%	76%	100%
§438.228	Grievance and appeal systems	100%	100%	100%
§438.230	Sub Contractual Relationships and Delegation	N/A	N/A	100%
§438.236	Practice Guidelines	N/A	N/A	100%
§438.242	Health Information Systems	N/A	N/A	100%
Score %	**Total**	**100**	**96.6**	**99.4**

N/A (Not Applicable): These standards were evaluated during EQR 2018, thus marked as N/A for EQR 2019.

Table 7-1 shows the score of the three MCOs for the above standards from 42 CFR 438: Medicaid Managed Care Regulations. An average score for overall standards was calculated. Home State Health was 100% compliant, followed by UnitedHealthcare at 99.4% and Missouri Care at 96.6%.

7.2 Validation of Performance Measures

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents. Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood. Well-care visits provide an opportunity for providers to influence health and development. They are a critical opportunity for screening and counseling. For W34 measure, the best performing regions included the East and West. Home State Health performed best in the East Region (66.39%) and was lowest in the Central Region (51.82%). Missouri Care performed best in the East Region (64.58%) and was lowest in the Central Region (57.90%). UnitedHealthcare performed best in the West Region (61.56%) and was lowest in the Southwest Region (46.71%). Missouri Care was significantly better than the other two MCOs in the Central and Southwest Regions (+5% points or higher). In the West Region, UnitedHealthcare performed significantly better than Home State Health with +6.06% points higher score (Figure 7-2).

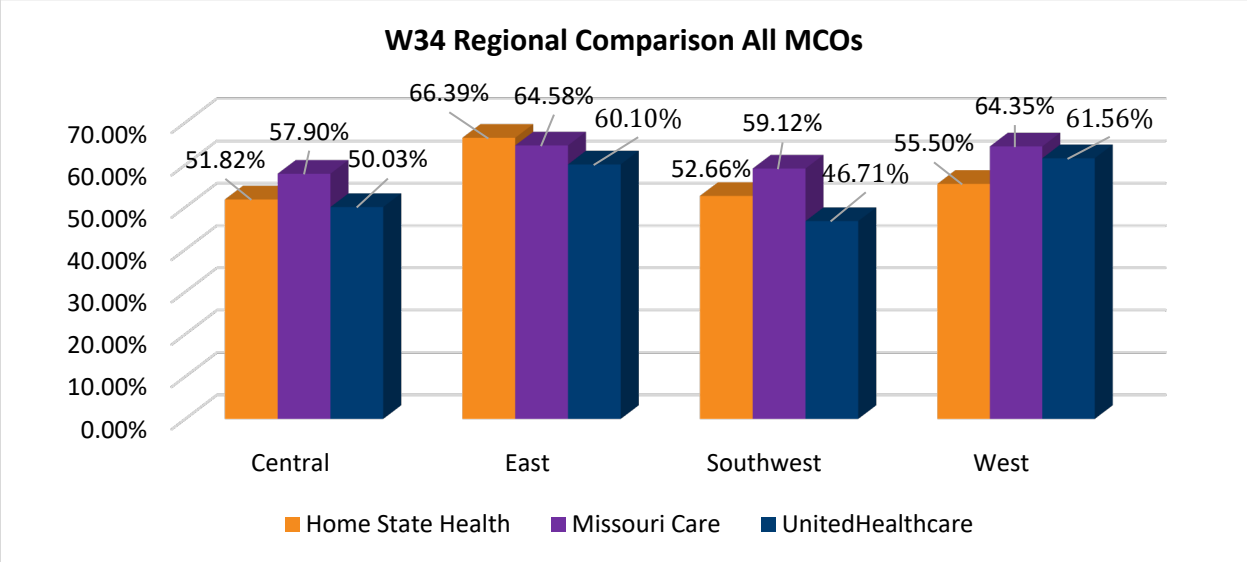


Figure 7-2 Comparison of W34 Regional Rates *(National Medicaid average CY 2018: 73.0 %)*

Chlamydia Screening in Women (CHL)

Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes

pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV. Screening is important, as approximately 75% of chlamydia infections in women are asymptomatic. The Chlamydia screening in Women looks at the percentage of 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. All three MCOs were required to report their rates by region for CY 2018. Home State Health (55.12%) and UnitedHealthcare (56.77%) performed best in East Region, while Missouri Care performed best in the West Region (45.66%). Home State Health and UnitedHealthcare outperformed Missouri Care in all but the West Region where Missouri Care (45.66%) inched out UnitedHealthcare (44.54%) by just under 1% point, an insignificant difference. Home State Health (51.64%) significantly outperformed Missouri Care and UnitedHealthcare in the West Region. The Southwest Region had the worst performance overall for all three MCOs with the Central Regions coming in second (Figure 7-3).

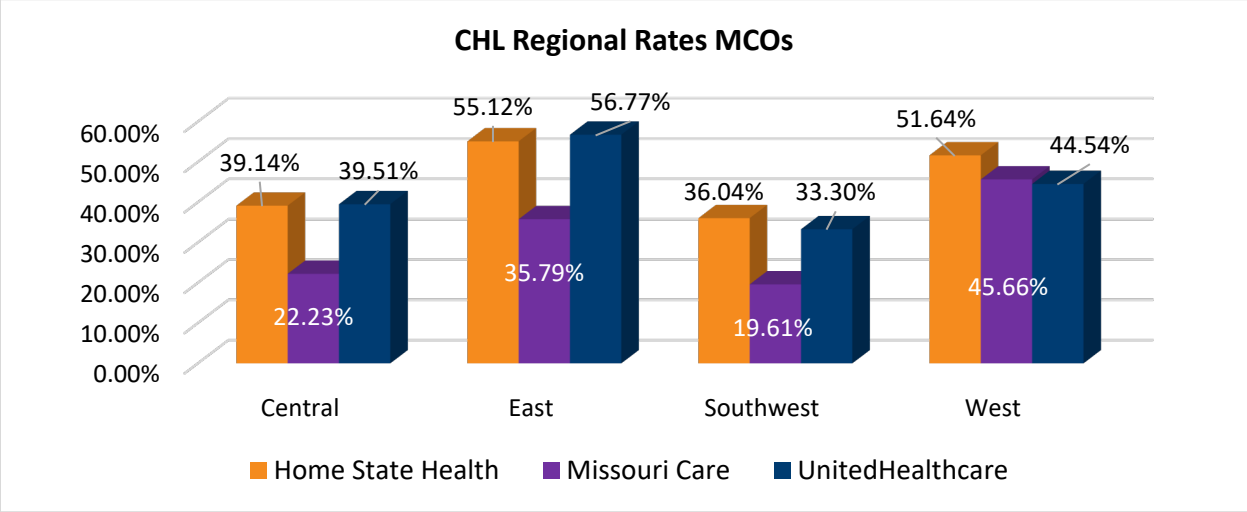


Figure 7-3 Comparison of CHL Regional Rates *(National Medicaid average CY 2018 57.6%)*

Inpatient Mental Health Readmissions

CMS defines a hospital readmission as "an admission to an acute care hospital within 30 days of discharge from the same or another acute care hospital." A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.

Table 7-2 Mental Health Readmissions for CY 2018

Region	Age	Home State Health	Missouri Care	UnitedHealthcare	Comparison Graphs
Central	Age 0-12	28	72	10	
Central	Age 13-17	50	77	26	
Central	Age 18-64	18	32	11	
Central	Age 65+	0	0	0	
Central	Total	96	181	47	
East	Age 0-12	43	30	13	
East	Age 13-17	89	44	23	
East	Age 18-64	74	29	24	
East	Age 65+	0	0	0	
East	Total	206	103	60	
Southwest	Age 0-12	27	30	14	
Southwest	Age 13-17	28	31	11	
Southwest	Age 18-64	19	31	13	
Southwest	Age 65+	0	0	0	
Southwest	Total	74	92	38	
West	Age 0-12	17	72	9	
West	Age 13-17	26	78	23	
West	Age 18-64	19	19	5	
West	Age 65+	0	0	0	
West	Total	62	169	37	
For this measure lower count indicates better performance					

Comparing the readmission counts for the three MCOs in CY 2018 shows that Missouri Care had the highest readmissions for Central (181) and West (169) regions compared to

UnitedHealthcare Central (47) and West (37)and Home State Health Central (96) and West (62). Missouri Care had the most readmission overall (545) for all regions and age cohorts combined. UnitedHealthcare had the least counts of readmissions overall (182), however, they did not have a full year of experience in Missouri. The East Region had the most readmissions combined for all three MCOs (369) followed by Central (324), West (268) and finally Southwest (204) (Table 7-2).

7.3 Validating Performance Improvement Projects

Table 7-3 Comparison of PIPs Results

PIP	MCO	Aim	Score	HEDIS® Rate %
Improving HEDIS® CIS Combo 10 Rate	Home State Health	Not Met	Low confidence	21.65
	Missouri Care	Not Met	Low confidence	27.49
	UnitedHealthcare	Met	Results not credible	21.65
Improving Oral Healthcare (HEDIS® ADV Rate)	Home State Health	Met	Low confidence	47.82
	Missouri Care	Met	Low confidence	52.72
	UnitedHealthcare	Met	Results not credible	48.24

Table 7-3 shows that the aim of PIP for CIS Combo 10 PIP was Not Met by Home State Health and Missouri Care. They both received a score of "Low confidence." Even though UnitedHealthcare Met the aim of PIP, they were scored as "Results not credible." This was due to insufficient data for CY 2017 (baseline year) as the MCO did not operate under MHD for the entire CY 2017.
Missouri Care had the highest rate for HEDIS® CIS Combo 10 measure (27.49%) followed by Home State Health and UnitedHealthcare. They both were at 21.65% (Figure 7-4).

All the three MCOs Met the aim of the PIP for Improving Oral Healthcare (HEDIS® ADV rate). However, Home State Health and Missouri Care scored "Low confidence" and UnitedHealthcare scored "Results not credible" for the same reasons as explained above. Missouri Care had highest rate for HEDIS® ADV measure (52.72%) followed by UnitedHealthcare at 48.24% and Home State Health at 47.82% (Figure 7-4).

Note: UnitedHealthcare had two additional indicators for measuring improvement in Oral Healthcare PIP. The MCO had attained the CMS benchmark for the two measures stated

below. The other two MCOs did not use these indicators for their PIP related to improving Oral Healthcare:

CMS 416 Oral Sealant Rate = Annual 14.97% (CMS benchmark 13.51%)

CMS 416 Preventive Services = Annual 35.73% (CMS benchmark 32.66%)

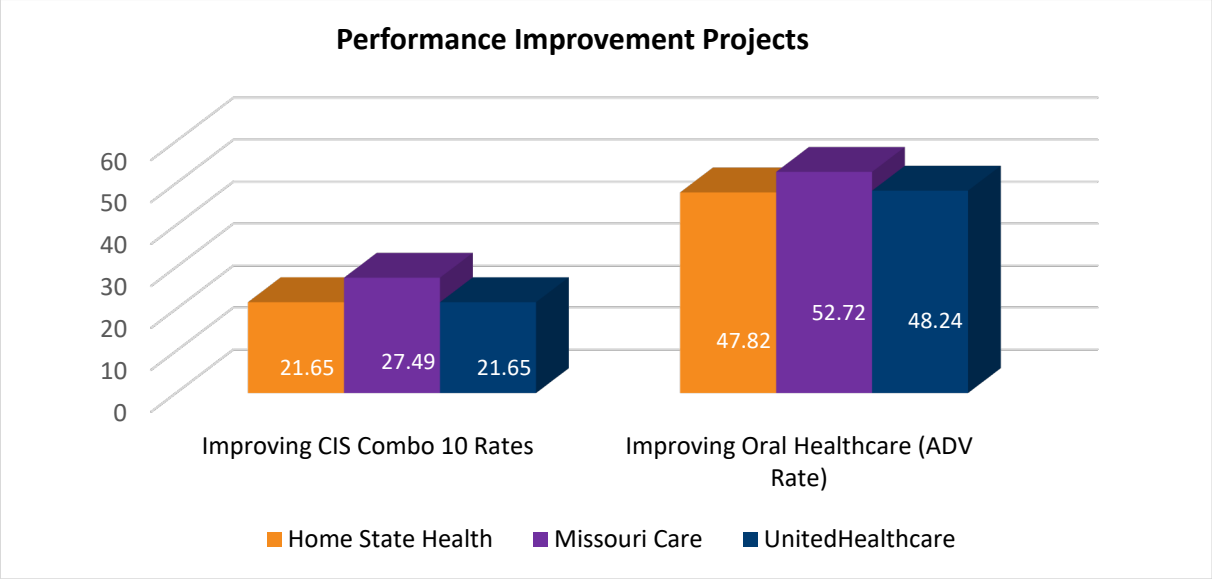


Figure 7-4 Comparison of HEDIS® CIS Combo 10 and HEDIS® ADV rates CY 2018

7.4 Care Management Review

Figure 7-5 show a comparative score for the three CM focus areas (OB, EBLLs, and BH) obtained from medical record reviews of the MCOs.

For OB CM, Missouri Care had achieved the highest score of 94%, followed by Home State Health at 92% and UnitedHealthcare at 71%.

For EBLLs CM, both Missouri Care and Home State Health scored 82%, whereas UnitedHealthcare was at 62%.

For BH CM, Missouri Care scored highest at 88% followed by Home State Health at 83% and UnitedHealthcare at 66%. MHD required Primaris to evaluate an important criterion from BH CM: Offering CM within (5) business days of admission to a psychiatric hospital or residential substance use Tx program. Missouri Care scored 25% followed by UnitedHealthcare at 20% and Home State Health at 13%.

Missouri Care took the lead for the overall CM program by achieving 88% followed by Home State Health at 86% and UnitedHealthcare at 66%.

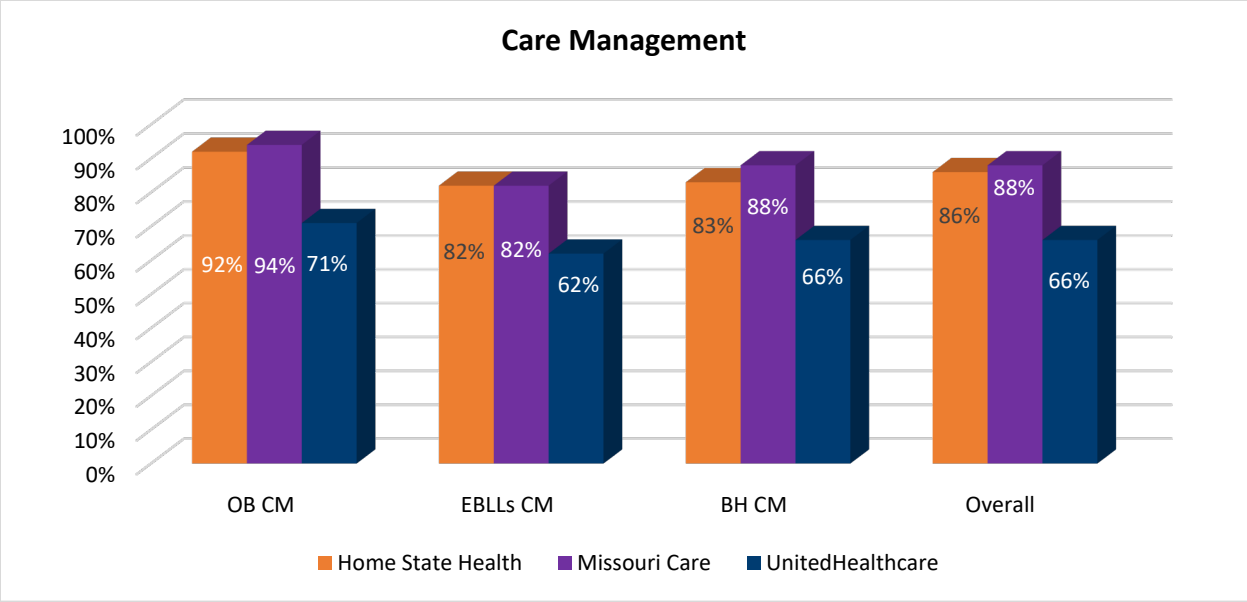


Figure 7-5 Comparison of CM Program

8.0 Recommendations for MO HealthNet

This section includes recommendations provided by Primaris to MHD in order to align the MHD contract guidelines with the CFR and also have improved member outcomes as a result of activities conducted by MCOs towards quality, timeliness and access to healthcare services.

8.1 Compliance with Medicaid Managed Care Regulations

- The definition of "adverse benefit determination" in the MHD contract section 2.15.1 a5 states that "the failure of the MCO to act within the time frames provided at Section 2.12.16. c. 22 of the contract regarding the standard resolution of grievances and appeals." Though Home State Health follows the definition given in the MHD contract, section 2.12.16 c 22 of the MHD contract does not mention the time frames for standard resolution of grievances and appeals.
  Primaris recommends that MHD replaces section 2.12.16 c 22 by section 2.15.5 e and 2.15.6 m of MHD contract, which states the time frames for resolution of grievances and appeals per 42 CFR 438.408(b) (1) and (2).
- MHD contract 2.15.5 e states that "The health plan shall resolve each grievance and provide written notice of the resolution of the grievance, as expeditiously as the member's health condition requires but shall not exceed 30 calendar days of the filing date." The CFR states that "standard resolution of grievances may not exceed 90 calendar days from the day the MCO receives the grievance."
  Primaris recommends MHD to specify an action that would be taken by them if any MCO is not able to resolve a grievance in 30 days but has resolved within 90 days. Same would be applicable for "standard authorization" decisions where the time frame specified by the MHD contract is more restrictive than the CFR.
- As a follow up from the previous year (EQR 2018), 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 438.230(c) (3) (iii))."
  Primaris recommends MHD to make an amendment to their MHD Managed Care Contract "section 3.9 Subcontractors," to reflect the duration of "right to audit" for 10 years as opposed to 5 years in the subcontractor's section.

8.2 Performance Measures Validation

MHD is advised to consider including more of state custom measures, CMS coreset measures apart from HEDIS measures for validation purpose, so as to diagnose any inaccuracies in the results that are reported and submitted by the MCOs to MHD/CMS.

Information System Capabilities Assessment

Primaris recommends that MHD develops a better system to capture accurate member demographic data in 834 file. It should allow the MCOs to update the most recent member information so that 834 file is current and useful. This would allow the MCOs to reach out to their members in a timely manner to extend CM services.

8.3 Performance Improvement Projects

MHD and EQRO should work together to set clear expectations for the PIPs which would be beneficial for sustained and improved member outcomes. EQRO should be allowed to engage with MCOs for one-on-one technical assistance (TA) sessions on a regular basis. Improved training, assistance and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.

8.4 Care Management Review

- MHD may mandate the MCOs to create a checklist with all the requirements listed in MHD contract section 2.11.1e while developing a "care plan" for each member.
- MHD is currently required to follow the DHSS State Regulation 19 CSR 20-8.030 for EBLLs CM guidelines. Primaris recommends MHD to work with the DHSS to consider the facts below for amending their guidelines for EBLL CM program.
  References:
  https://www.cdc.gov/nceh/lead/acclpp/lead_levels_in_children_fact_sheet.pdf
  https://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
  https://www.cdc.gov/nceh/lead/acclpp/actions_blls.html
  New Recommendations to Define Elevated Blood Lead Levels:
  "In January 2012, a committee of experts recommended that the CDC change its "blood lead level of concern." The recommendation was based on a growing number of scientific studies that show that even low blood lead levels can cause lifelong health effects. The committee recommended that CDC link lead levels to data from the National Health and Nutritional Examination Survey (NHANES) to identify children living or staying for long periods in environments that expose them to lead hazards. This new level is based on the population of children aged 1-5 years in the U.S. who are in the top 2.5% of children when tested for lead in their blood. Currently, that is 5 micrograms per deciliter of lead in blood. CDC's "blood lead level

of concern" has been 10 micrograms per deciliter. The new value means that more children will be identified as having lead exposure earlier and parents, doctors, public health officials, and communities can take action earlier. The committee also said, as CDC has long said, that the best way to protect children is to prevent lead exposure in the first place."

Appendix A: Evaluation Performance Improvement Projects MCOs

A.1 Home State Health

Date of evaluation: May 30, 2019

MCO Name or ID:	Home State Health
Name of Performance Improvement Projects:	Childhood Immunization Status- Combo 10 (CIS) Improving Access to Oral Healthcare
Dates in Study Period:	Jan 1, 2018-Dec 31, 2018
Demographic Information:	Number of Medicaid/CHIP enrollees in MCO: 235,918 Medicaid/CHIP members included in PIP (CIS Combo 10): 8,528 Medicaid/CHIP members included in PIP (Improving Oral Healthcare): 156,353

Score: Met (M) /Not Met (NM) / Partially Met (PM) /Not Applicable (N/A)

Table 5-6 shows score for various parameters which served as a basis for Primaris' evaluation of both the PIPs for Home State Health.

Table 5-6 PIPs Score Home State Health

Component/Standard	Score CIS Combo 10	Score Improving Oral Healthcare
Activity 1: Assess the study methodology		
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	M	M
1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M	M
1.3. Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	M
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	M

1.5. Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	M
Step 2: Review the Study Question(s)		
2.1. Was/were the study question(s) measurable and stated clearly in writing? It should be stated in a way that supports the ability to determine whether the intervention has a measurable impact for a clearly defined population.	M	M
Step 3: Review the Identified Study Populations		
3.1. Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	M
3.2. If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	M
Step 4: Review Selected Study Indicator(s)		
4.1. Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	M
4.2. Did the indicators track performance over a specified period?	M	M
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 A primary measure is used as an indicator. Primaris recommends that the MCO should have specific secondary indicators which could measure the impact of each intervention implemented.	PM A primary measure is used as an indicator. Primaris recommends that the MCO should have specific secondary indicators which could measure the impact of each intervention implemented.
Step 5: Review Sampling Methods		
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	N/A (No sampling was done for PIPs. However, the final rates provided for PIPs were based on HEDIS® hybrid methodology.)	N/A (No sampling was done.)

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)	N/A (No sampling was done.)
5.3. Did the sample contain a sufficient number of enrollees?	N/A ((same comment as above)	N/A (No sampling was done.)
Step 6: Review Data Collection Procedures		
6.1. Did the study design clearly specify the data to be collected?	M	M
6.2. Did the study design clearly specify the sources of data?	M	M
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	M
6.4. Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	M
6.5. Did the study design prospectively specify a data analysis plan?	M	M
6.6. Were qualified staff and personnel used to collect the data?	M	M
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1. Was an analysis of the findings performed according to the data analysis plan?	M	M
7.2. Were numerical PIP results and findings accurately and clearly presented?	M	M
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	M
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	M
Step 8: Assess Improvement Strategies		
8.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	M	M

8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	M	M
8.3 Are the interventions culturally and linguistically appropriate?	M	M
Step 9: Assess Whether Improvement is "Real" Improvement		
9.1. Was the same methodology as the baseline measurement used when measurement was repeated?	M	M
9.2. Was there any documented, quantitative improvement in processes or outcomes of care?	NM The HEDIS® CIS Combo 10 rate shows a decline of 5.36 percentage points from the previous year and this is statistically significant drop.	PM The ADV rate increased by 6.17 percentage points in CY 2018, but this was not of statistical significance.
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 Analysis of one intervention showed some improvement but that did not improve the overall CIS Combo 10 rate. The analysis of other interventions was not done.	NM The success rate of one intervention tested in the PIP showed an increase of dental visit by 0.34% only. The overall increase in ADV rate does not appear to be the result of this planned intervention.
9.4. Is there any statistical evidence that any observed performance improvement is true improvement?	NM The final CIS Combo 10 rate has declined significantly.	NM The improvement seen is not of statistical significance.
Step 10: Assess Sustained Improvement		
10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?	NM Although there has been a repeated measurements, sustained improvement is not demonstrated.	M The annual ADV rates have increased for last two years.

Activity 2: Verifying study findings (optional)	Not done by EQRO	Not done by EQRO
Activity 3: Evaluate overall validity and reliability of study results.	**"Low confidence"**	**"Low confidence"**

A.2 Missouri Care

Date of evaluation: May 16, 2019

MCO Name or ID:	Missouri Care
Name of Performance Improvement Project:	Improving Oral Health
Dates in Study Period:	Jan 1, 2018-Dec 31, 2018
Demographic Information:	Number of Medicaid/CHIP enrollees in MCO:250,263 Medicaid/CHIP members included in PIP (CIS Combo 10): 6,612 Medicaid/CHIP members included in PIP (Improving Oral Healthcare): 142,397

Score: Met (M) /Not Met (NM) /Partially Met (PM) /Not Applicable (N/A)

Table 5-13 shows score for various parameters which served as a basis for Primaris' evaluation of both the PIPs for Missouri Care.

Table 5-13 PIPs Score Missouri Care

Component/Standard	Score CIS Combo 10	Score Improving Oral Healthcare
Activity 1: Assess the study methodology		
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	M	M
1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M	M
1.3. Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	M

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	M
1.5. Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	M
Step 2: Review the Study Question(s)		
2.1. Was/were the study question(s) measurable and stated clearly in writing? It should be stated in a way that supports the ability to determine whether the intervention has a measurable impact for a clearly defined population.	M	M
Step 3: Review the Identified Study Populations		
3.1. Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	M
3.2. If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	M
Step 4: Review Selected Study Indicator(s)		
4.1. Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	M
4.2. Did the indicators track performance over a specified period?	M	M
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 Missouri Care used the HEDIS® CIS-Combo 10 rate as an indicator. Primaris recommends that the MCO should have specific indicators which could measure the impact of each intervention implemented.	PM A primary measure is used as an indicator. Primaris recommends that the MCO should have specific secondary indicators which could measure the impact of each intervention implemented.
Step 5: Review Sampling Methods		

5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	N/A (No sampling was done for PIPs. However, the final rates provided for PIPs were based on HEDIS® hybrid methodology.)	N/A (No sampling was done.)
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)	N/A (No sampling was done.)
5.3. Did the sample contain a sufficient number of enrollees?	N/A ((same comment as above)	N/A (No sampling was done.)
Step 6: Review Data Collection Procedures		
6.1. Did the study design clearly specify the data to be collected?	M	M
6.2. Did the study design clearly specify the sources of data?	M	M
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	M
6.4. Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	M
6.5. Did the study design prospectively specify a data analysis plan?	M	M
6.6. Were qualified staff and personnel used to collect the data?	M	M
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1. Was an analysis of the findings performed according to the data analysis plan?	M	M
7.2. Were numerical PIP results and findings accurately and clearly presented?	M	M
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	M

7.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	NM The PIP was not successful. Missouri Care intends to modify the interventions in the upcoming year while developing new interventions to continually improve members' CIS rate.	M The PIP was successful even though the intervention had a meagre (0.45% point) positive impact on the outcomes. The follow up plan for activities were discussed.
Step 8: Assess Improvement Strategies		
8.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	M	M
8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	M	M
8.3 Are the interventions culturally and linguistically appropriate?	M	M
Step 9: Assess Whether Improvement is "Real" Improvement		
9.1. Was the same methodology as the baseline measurement used when measurement was repeated?	M	
9.2. Was there any documented, quantitative improvement in processes or outcomes of care?	NM The CIS Combo 10 rate has increased by 0.97 % point over the previous year. This is neither of any statistical significance nor a result of planned interventions.	M HEDIS® ADV rate statewide for the CY 2018 is 52.72% which is an increase from the CY 2017 by 4.3% points.
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 did not have any positive result in increasing the quality indicator.	NM Overall HEDIS® ADV rate increased, but the increase was not the result of the planned intervention. The intervention had 0.45 percentage point increase on the outcome.

9.4. Is there any statistical evidence that any observed performance improvement is true improvement?	NM The 0.97% point increase in the final HEDIS®CIS Combo 10 rate, does not appear to be the result of the planned quality improvement intervention. There is no statistical significance of this improvement.	M The annual HEDIS® ADV rate has increased by 4.3 percentage points which is statistically significant.
Step 10: Assess Sustained Improvement		
10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?	PM Although there has been improvement in CIS rates over last two years, it is not of any statistical significance.	M There is an improvement seen over the comparable time periods (quarter over quarter). The HEDIS® ADV rates over last 2 years have increased which is of statistically significance.
Activity 2: Verifying study findings (optional)	Not done by EQRO	Not done by EQRO
Activity 3: Evaluate overall validity and reliability of study results.	**"Low confidence"**	**"Low confidence"**

A.3 UnitedHealthcare

Date of evaluation: May 09, 2019

MCO Name or ID:	UnitedHealthcare
Name of Performance Improvement Project:	Improving Oral Health
Dates in Study Period:	Jan 01, 2018-Dec 31, 2018
Demographic Information:	Number of Medicaid/CHIP enrollees in MCO: 154,192 Medicaid/CHIP members included in PIP (CIS Combo 10): 3,206

	Medicaid/CHIP members included in PIP (Improving Oral Healthcare): 117,108

Score: Met (M) /Not Met (NM) /Partially Met (PM) /Not Applicable (N/A)

Table 5-18 shows score for various parameters which served as a basis for Primaris' evaluation of both the PIPs for UnitedHealthcare.

Table 5-18 PIPs Score UnitedHealthcare

Component/Standard	Score CIS Combo 10	Score Improving Oral Healthcare
Activity 1: Assess the study methodology		
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	M	M
1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M	M
1.3. Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	M
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	M
1.5. Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	M
Step 2: Review the Study Question(s)		
2.1. Was/were the study question(s) measurable and stated clearly in writing? It should be stated in a way that supports the ability to determine whether the intervention has a measurable impact for a clearly defined population.	M	M
Step 3: Review the Identified Study Populations		
3.1. Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	M

3.2. If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	M
Step 4: Review Selected Study Indicator(s)		
4.1. Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	M
4.2. Did the indicators track performance over a specified period?	M	M
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 Indicators used in the PIP is a primary measure and the study questions are directly based on them. Primaris recommends that the PIPs should be designed such that the MCO has secondary measures as their focus/aim and interventions should be around those secondary measures, so that the impact of the interventions can be clearly assessed.	PM Indicators used in the PIP is primary measure and the study questions are directly based on them. Primaris recommends that the PIPs should be designed such that the MCO has secondary measures as their focus/aim and interventions should be around those secondary measures, so that the impact of the interventions can be clearly assessed.
Step 5: Review Sampling Methods		
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	N/A There was no sampling; the entire eligible population is included as defined by the HEDIS® 2018 technical specifications and CMS 416 methodology.	N/A There was no sampling; the entire eligible population is included as defined by the HEDIS® 2018 technical specifications and CMS 416 methodology.

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)	N/A (same comment as above)
5.3. Did the sample contain a sufficient number of enrollees?	N/A ((same comment as above)	N/A (same comment as above)
Step 6: Review Data Collection Procedures		
6.1. Did the study design clearly specify the data to be collected?	M	M
6.2. Did the study design clearly specify the sources of data?	M	M
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	M
6.4. Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	M
6.5. Did the study design prospectively specify a data analysis plan?	M	M
6.6. Were qualified staff and personnel used to collect the data?	M	M
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1. Was an analysis of the findings performed according to the data analysis plan?	M	M
7.2. Were numerical PIP results and findings accurately and clearly presented?	M	M
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	M
7.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	NM There was no interpretation of the extent to which the interventions were successful. The information about follow up activities is	NM There was no interpretation of the extent to which the interventions were successful. The information about follow up activities is

	not submitted. Primaris recommends including an analysis of each interventions potential impact on the specific indicator being measured.	not submitted. Primaris recommends including an analysis of each interventions potential impact on the specific indicator being measured.
Step 8: Assess Improvement Strategies		
8.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	M	M
8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	M	M
8.3 Are the interventions culturally and linguistically appropriate?	M	M
Step 9: Assess Whether Improvement is "Real" Improvement		
9.1. Was the same methodology as the baseline measurement used when measurement was repeated?	M	
9.2. Was there any documented, quantitative improvement in processes or outcomes of care?	M Quantitative improvement has been reported for all the three indicators, but its significance could not be assessed due to non-availability of data for the entire baseline year.	M HEDIS® ADV rate statewide for the CY 2018 is 52.72% which is an increase from the CY 2017 by 4.3% points.
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.	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?	N/A Primaris considered CY 2017 results as a baseline year and data was available only for 8 months. It was not	N/A Primaris considered CY 2017 results as a baseline year and data was available only for 8 months. It was not

	reasonable to compare to CY 2018 data of 12 months.	reasonable to compare to CY 2018 data of 12 months.
Step 10: Assess Sustained Improvement		
10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?	N/A It is early in the life of the PIP to remark on sustained improvement.	N/A It is early in the life of the PIP to remark on sustained improvement.
Activity 2: Verifying study findings (optional)	Not done by EQRO	Not done by EQRO
Activity 3: Evaluate overall validity and reliability of study results.	**"Not Credible"**	**"Not Credible"**