Primaris
Healthcare Business Solutions

2020 External Quality Review
Annual Technical Report

MoHealth Net

Measurement Period: Calendar Year 2019
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1.0 Executive Summary

1.1 Background

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 "Managed Care"). To ensure all Missourians receive quality care, Managed Care is extended statewide in four regions: Central, Eastern, Western, and Southwestern. The goal is to improve access to needed services and quality of healthcare services in the Managed Care and state aid eligible populations, while controlling the program's cost. Participation in Managed Care is mandatory for certain eligibility groups within the regions in operation.

MHD contracts with three Managed Care Organizations (MCOs), also referred to as Managed Care Plans, to provide health care services to its Managed Care enrollees. Home State Health, Missouri Care, and UnitedHealthcare are the three MCOs operating in Missouri (MO) effective May 01, 2017 (Figure 1-1). MHD works closely with these MCOs to monitor services 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 (EQR).

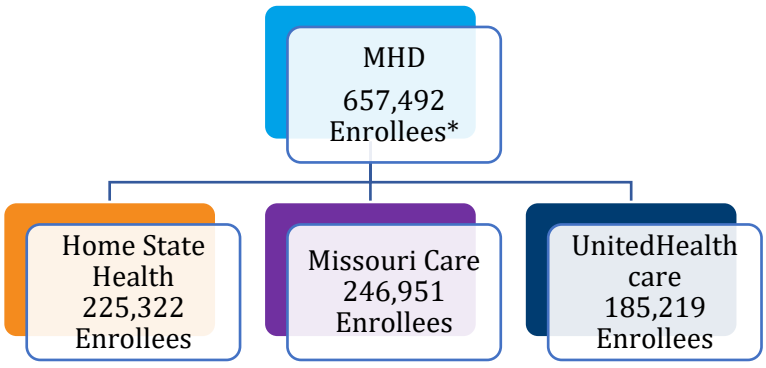


Figure 1-1. MCOs under MHD

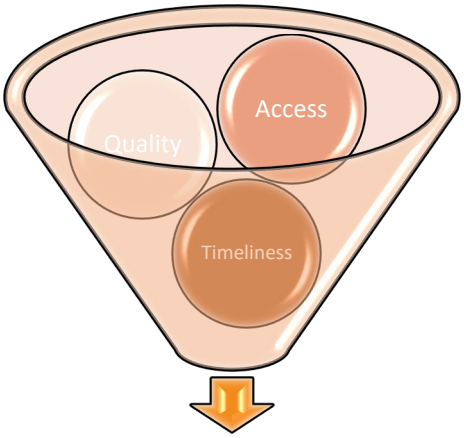
*Data by end of SFY 2020 (Jun 30, 2020) for Medicaid and CHIP combined. This is an increase of 10.2% from the end of SFY 2019).

The MHD contracts with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to perform an External Quality Review (EQR). EQR 2020 includes evaluation of activities of the MCOs during calendar year (CY) 2019.

1.2 Overview of External Quality Review

An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a Managed Care Plan, or its contractors, furnish to Medicaid beneficiaries (Figure 1-2).
Primaris conducted an EQR 2020 for the three MCOs: Home State Health, Missouri Care, and UnitedHealthcare. The information used to carry out the EQR was obtained from the Code of Federal Regulations (CFR), 42 CFR 438.358; the protocols established by Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 438.352 (Protocols 1, 2, 3, Appendices A and B, version Oct 2019); the MHD Managed Care Contract; and the MHD Quality Improvement Strategy (QIS).

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



Access (42 CFR 438.320): As it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care organizations successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).

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

Figure 1-2. EQR-A Federal Requirement

The EQR 2020 activities began in February and continued through Nov 2020. The site visits to MCOs' offices were conducted remotely due to the Covid-19 Pandemic. These visits/meetings were delayed until May 2020 per the MHD's instructions due to the impact of the Covid-19 on the MCOs' priorities and lockdown.
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 1-3). 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, evaluation, and recommendations for the following "mandatory" and "optional" activities.

Mandatory Activities:

1. Validation of Performance Improvement Projects (PIPs).
2. A. Validation of Performance Measures (PMs).
   B. Information Systems Capabilities Assessment (ISCA).
3. Review of Compliance with Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations.

Optional Activity: Review of Care Management (CM) Program.

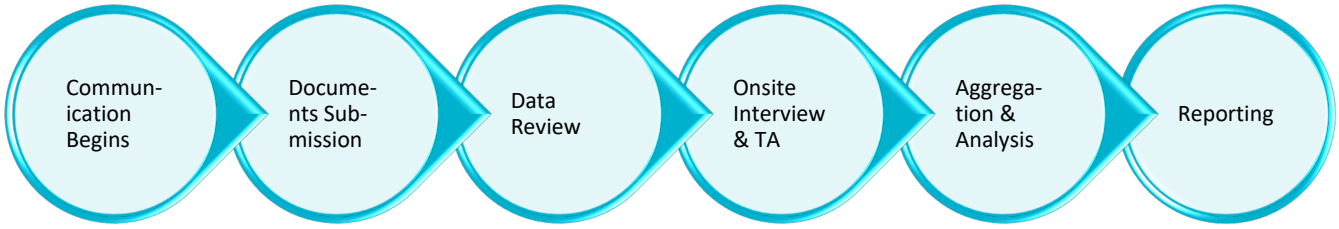


Figure 1-3. Evaluation Process

1.3 Overall Activities, Comparative Results, and Recommendations

This section presents a high-level overview of all the activities conducted in EQR 2020. Comparative results for Home State Health, Missouri Care, and UnitedHealthcare are presented followed by strengths, weaknesses, and general recommendations for all MCOs. (Refer to sections 2.0 to 5.0 for detailed information.)

1.3.1 Validation of Performance Improvement Projects

The 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 (MHD-Managed Care Contract 2.18.8d). For EQR 2020, MHD required Primaris to validate the following two PIPs (clinical and nonclinical) conducted by Home State Health, Missouri Care, and UnitedHealthcare during CY 2019. The aim was predetermined by the MHD. The MCOs were required to increase the HEDIS® rates by at least 2% points from the previous

year (baseline-CY 2018):

- Clinical PIP: Improving Immunization-Childhood Immunization Status (HEDIS® CIS Combo 10).
- Nonclinical PIP: Improving Oral Health-Annual Dental Visit (HEDIS® ADV).

Primaris followed guidelines established in the CMS EQR Protocol 1, version Oct 2019: Validating Performance Improvement Projects. The following activities were conducted for PIPs Validation:

- Activity 1: Assess PIP methodology.
- Activity 2: Perform Overall validation and reporting of PIP results.

The findings were reported in terms of "level of confidence-high confidence, moderate confidence, low confidence, no confidence (definitions are provided in section 2.1)".

Comparative Results.

Tables 1-1, 1-2, and 1-3 summarize the results and provide a high-level overview of the clinical and the nonclinical PIPs across the three MCOs.

Table 1-1. PIPs Results: MCOs

PIP	MCO	MHD's Aim*	Validation Rating	HEDIS® Rate % (CY 2018)	HEDIS® Rate % (CY 2019)	Statistical Significance (P≤0.5)
Improving HEDIS® CIS Combo 10 Rate	Home State Health	Met	Low confidence	21.65	30.17	Yes (p=0.005)
	Missouri Care	Not Met*	Low confidence	27.49	27.49**	Not applicable
	UnitedHealth care	Met	Low confidence	21.65	25.06	No (p=0.24)
Improving Oral Health (HEDIS® ADV Rate)	Home State Health	Met	Low confidence	47.82	53.24	Yes (p<0.00)
	Missouri Care	Met	Low confidence	52.72	58.87	Yes (>95% confidence interval)
	UnitedHealth care	Met	Low confidence	48.24	53.70	Yes (p=0)

*Missouri Care met the aim set by their organization on a small scale where they had applied intervention but did not meet the overarching aim set by MHD.
**Reported CY 2018 rate as chart chase was affected by the Covid-19 Pandemic and administrative rates for the CY 2019 were lower than the final CY 2018 rate.

Table 1-2. Summary of Clinical PIPs: MCOs

PIP Title: Improving Childhood Immunization Status-HEDIS® (CIS) Combo 10		
A. PIP Aim Statement		
Home State Health: To increase the rate of CIS Combo-10 immunizations for members who turn two during CY 2019, from 21.65% to 23.65% or above, by Dec 31, 2019.	Missouri Care: Increase the percentage of eligible members who turned two in CY 2019, assigned to Jordan Valley and Cox Health, and received CIS Combo-10 immunizations from 17% to 19% (Jordan Valley) and from 18% to 20% (Cox Health) by December 31, 2019.	UnitedHealthcare: By Dec 31, 2019, increase the percentage of UnitedHealthcare members aged two and under who are eligible for and receive CIS Combo 10 vaccines, from 21.65% to 23.65%.
B. Improvement Strategies or Interventions (Changes tested in PIPs)		
Home State Health: Provider-focused. A provider group (a system of community health centers) was contracted to provide supplemental data on immunizations.	Missouri Care: Provider-focused. Provider Partnership with Jordan Valley and Cox Health.	UnitedHealthcare: Member-focused. Pfizer Missed Dose Postcard reminders (mailed monthly Apr-Dec 2019) to noncompliant members of age 6, 8, and 18 months.
Sampling: No	Sampling: No	Sampling: No
C. Was the PIP state-mandated, collaborative, statewide, or plan choice? ☑ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☑ Statewide (the PIP was conducted by all MCOs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)		
D. Target age group (check one): ☑ Children only (ages 0–17)* Adults only (age 18 and over) Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages (0-2)		
E. Target population description, such as duals, LTSS or pregnant women (specify): All members eligible for HEDIS® CIS Combo 10 measure (ages 0-2).		
F. Programs: Medicaid (Title XIX) only /CHIP (Title XXI) only/☑ Medicaid and CHIP		
G. PIPs Validation Information		
• PIP submitted for approval • PIPs validated	☑Home State Health ☑Primaris	☑Missouri Care ☑Primaris	☑UnitedHealthcare ☑Primaris

Table 1-3. Summary of Nonclinical PIPs: MCOs

PIP Title: Improving Oral Health- HEDIS® ADV Rate		
A. PIP Aim Statement		
Home State Health: To increase the rate of dental visits for members age 2 through 20 from 47.82% to 49.82% or above by end of Dec 31, 2019.	Missouri Care: Increase the percentage of all eligible members ages 2-20 years old in CY 2019 who completed an annual dental visit from 52.72% to 54.72% by December 31, 2019.	UnitedHealthcare: By December 31, 2019, increase the percentage of UnitedHealthcare members between ages 2–20 years old who are eligible for and receive an annual dental visit, from 48.24% to 50.24%.
B. Improvement Strategies or Interventions (Changes tested in PIPs)		
Home State Health: Member-focused. Outreaches by AlphaPointe (vendor) via phone call and text messages to noncompliant members (parents/guardians).	Missouri Care: Member-focused. Members were motivated to complete an annual dental visit by offering an incentive of $30.00 through the Healthy Rewards program. The period of intervention was Jan 1-Dec 31, 2019.	UnitedHealthcare: Provider-focused. Provide Dental Care Opportunity Report (DCOR) to the Federally Qualified Healthcare Centers (FQHCs) with the highest volume of non-compliant members for the FQHCs to outreach non-compliant members identified in the report.
Sampling: No	Sampling: No	Sampling: No
C. Was the PIP state-mandated, collaborative, statewide, or plan choice? ☑ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☑ Statewide (the PIP was conducted by all MCOs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)		
D. Target age group (check one): ☑ Children only (ages 0–17)* Adults only (age 18 and over) Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages (2-20)		
E. Target population description, such as duals, LTSS or pregnant women (specify): All members eligible for HEDIS® ADV measure (ages 2-20) including, but not limited to, members with special needs and physical or behavioral health conditions.		
F. Programs: Medicaid (Title XIX) only /CHIP (Title XXI) only/☑ Medicaid and CHIP		
G. PIPs Validation Information		
• PIP submitted for approval • PIPs validated	☑Home State Health ☑Primaris	☑Missouri Care ☑Primaris	☑UnitedHealthcare ☑Primaris

Strengths.

The MCOs have met the aim determined by MHD to increase the HEDIS® CIS Combo 10 rate (except Missouri Care) and HEDIS® ADV rate (all MCOs) by 2% points from the previous year (CY 2018).

MCOs' have responded to technical assistance provided by Primaris for the past two years.

The transition to rapid cycle PIPs (PDSA-Plan-Do-Study-Act) has begun. UnitedHealthcare attempted to test the intervention in the first cycle involving 9 FQHCs and thereafter adopted the cycle by widening the scope (included 14 FQHCs). They reported results of secondary measures and the primary measure by test of significance (p value). Missouri Care implemented intervention for the clinical PIP (improving immunization) on two health providers.

Weaknesses.

A measure/variable that would help in tracking actual performance of the PIP was not selected. Clear and concise definitions of data elements (including numerical definitions and units of measure) were not provided. A link between the intervention and the performance measure is not explained accurately. Though primary measures have increased from baseline year, data does not suggest the improvement to be the result of intervention.

Recommendations.

Home State Health, Missouri Care, and UnitedHealthcare must continue to refine their skills in the development and implementation of approaches to affect change in their PIP methodology. They must use CMS EQR Protocol 1 and other resources from CMS, e.g., How-to Manual for Health Plans.

MCOs should use variables/secondary measures with clear and concise definitions of data elements (including numerical definitions and units of measure) that would be collected after intervention. Data collection around a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) should be such that intervention can be directly linked to the projected improvement in primary/secondary measures. The data collection plan should be consistent with the data analysis plan and an intervention should tie to an improvement by correct analysis and interpretation. (Refer to section 2.5 for detailed recommendations for each MCO.)

1.3.2 (A) Validation of Performance Measures

Validation of performance measures is one of four mandatory EQR activities, as set forth in 42 CFR §438.358, which generates data and information for the annual technical report.

Federal regulations at 42 C.F.R. § 438.330(c) require states to specify standard performance measures for MCOs to include in their comprehensive quality assessment and performance improvement (QAPI) programs. Each year, the MCOs must: (1) measure and report to the state the standard performance measures specified by the state; (2) submit specified data to the state which enables the state to calculate the standard performance measures; or (3) a combination of these approaches. Primaris was utilized to determine whether the performance measures calculated by the MCOs were accurate based on the measure specifications and state reporting requirements (42 C.F.R. § 438.330(b)(2)). MHD provided the list of performance measures to be validated, the specifications for the measures, and the requirements for reporting as identified in Table 1-4 below.

Table 1-4. 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 or Primary Source Verification
Chlamydia Screening in Women (CHL)	Admin	HEDIS®	Primary Source Verification
Inpatient Mental Health Readmissions	Admin	MHD	Primary Source Verification

*Due to Covid-19 Pandemic impacting medical records chase, MHD/NCQA allowed MCOs to opt for reporting this measure administratively.

Primaris' analysis of the performance measures was based on CMS EQR Protocol 2, version Oct 2019, and included document reviews, staff interviews and onsite examination of information systems, processes and medical record 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. Primaris 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 systems' capabilities and data integration strategies.
- Policies and procedures surrounding systems capabilities and data management were collected and reviewed to determine if the MCOs' objectives were consistent with the 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.

Comparative Results.

Primaris conducted primary source verification using a sample of 45 numerator positive hits for CHL and Inpatient Mental Health Readmissions for all three MCOs. For the W34 measure, Primaris validated 14 medical records hits for Home State Health and UnitedHealthcare and 45 numerator positive hits for Missouri Care to verify the accuracy of the three measures under review.

(Note: Missouri Care opted to report W34 using the administrative-only methodology, citing concerns over gaining access to providers' offices due to the Covid-19 Pandemic. MHD authorized this method of measure reporting as it was supported by NCQA and CMS.)

All measures from the three MCOs were found to be compliant and received a 'Met' designation (Table 1-5).

Table 1-5. Key Review Findings and Audit Results: MCOs

Performance Measure	Sample Size	Key Review Finding	Audit Result
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	45 (numerator positives for Missouri Care) 14 (medical records hits for Home State Health and UnitedHealthcare)	No concerns were identified	Met
Chlamydia Screening in Women (CHL)	45 (numerator positives)	No concerns were identified	Met
Inpatient Mental Health Readmissions	45 (numerator positives)	No concerns were identified	Met

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

The three MCOs provided final rates for the W34 measure based on services rendered in CY 2019. All three MCOs scored significantly below the national average (72.08%), with Home State Health scoring 60.51% and UnitedHealthcare scoring 60.58% (Table 1-6). Missouri Care (65.76%) scored the highest which was likely due to their decision to report

administrative-only. For this measure, the higher rate indicates better performance.

Table 1-6. Performance Measures CY 2019 (W34 and CHL): MCOs

Data Element/MCO	Home State Health	Missouri Care	United Healthcare	National Medicaid Average
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)				
Rate	60.51%	65.76%	60.58%	72.08%
Chlamydia Screening in Women (CHL)				
Rate	48.17%	30.91%	46.23%	58.12%

Chlamydia Screening in Women (CHL).

All three MCOs reported CHL using the administrative methodology. All three MCOs fell significantly below the national average (58.12%). Home State Health had the highest statewide, weighted average (48.17%), followed by UnitedHealthcare (46.23%) and Missouri Care (30.91%) (Table 1-6). 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% points difference in comparison). For this measure, the higher rate indicates better performance.

Inpatient Mental Health Readmissions.

Claims data were used to report readmission for mental health diagnoses. All three MCOs were subjected to a review of a sample of claims to determine compliance with the specifications and to ensure the claims being counted were for mental health diagnoses. 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 (514) during CY 2019, followed by Home State Health (395) and UnitedHealthcare (195) (Table 1-7). For this measure, the lower number indicates better performance.

Table 1-7. Inpatient Mental Health Readmissions CY 2019: MCOs

All Regions	Home State Health	Missouri Care	UnitedHealthcare
Age 0-12	110	169	63
Age 13-17	163	233	96
Age 18-64	82	112	36
Age 65+	0	0	0
Total	355	514	195

Strengths.

All three MCOs were able to demonstrate and articulate their knowledge and experience of the measures under review. 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. All MCOs have higher readmissions rates for individuals in the pediatric cohorts, 0-17 years old.

Recommendations.

Primaris recommends all three MCOs pursue outpatient mental health engagements following a discharge from a hospital with a diagnosis of mental illness, especially in the 0-17 age cohort.

1.3.2 (B) Information System Capabilities Assessment

The MHD requires Primaris to conduct a complete Information Systems Capabilities Assessment (ISCA) for each MCO, once every three years. Additionally, Primaris conducts a ISCA pertaining to validation of performance measures every year. Any change reported by an MCO that could impact information systems and related performance measure outcomes is also evaluated each year. Primaris followed CMS EQR protocols, Appendix A-Information Systems Capabilities Assessment, for guidance. 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.
A full ISCA was not in the scope of work for EQR 2020. Primaris evaluated the changes in information systems from previous year.

Comparative Results.

Table 1-8 depicts information on timings of full ISCA, its score, findings from this year's review and recommendations to MCOs.

Table 1-8. ISCA Findings and Recommendations: MCOs

MCO	Full ISCA (Year)	Score	Changes from previous year reviewed in EQR 2020	Findings	EQR 2020 Score	Recommendations
Home State Health	EQR 2018	Fully Met	Reported one significant change to their information systems, updates to their Provider Portal. This change had no major impact upon Home State Health's information systems.	Reactive process to maintain provider demographic information published in the provider directory. Citation: 42 CFR 438.242, 438.608, Section 2.12.17, 2.18.8 MHD Contract	Partially Met	Home State Health in concurrence with MHD, may decide on a time frame that is maintainable for both Home State Health and the providers. A suggestion is to outreach to any provider with data that has not been updated in a set time frame and run a query in the provider database to pull all provider rows without change in the 4-6-month (or desired) time frame.
Missouri Care	EQR 2018	Fully Met	Reported one significant change to their information systems, Virtual Health Launch – a CareCentral update. This change had no major impact upon Missouri Care's information systems.	Reactive process to maintain provider demographic information published in the provider directory. Citation: 42 CFR 438.242, 438.608, Section 2.12.17, 2.18.8 MHD Contract	Partially Met	Missouri Care in concurrence with MHD, may decide on a time frame that is maintainable for both Missouri Care and the providers. A suggestion is to outreach to any provider with data that has not been updated in a set time frame and run a query in the provider database to pull all provider rows without change in the 4-6-month (or desired) time frame.
United Health care	EQR 2019	Fully Met	Reported three changes to their information systems: updates to the suspend process; CSP Facets upgrade; and Independent processor reviews. These changes did not have major impact upon UnitedHealthcare's information systems	Reactive process to maintain provider demographic information published in the provider directory. Citation: 42 CFR 438.242, 438.608, Section 2.12.17, 2.18.8 MHD Contract	Partially Met	UnitedHealthcare in concurrence with MHD, may decide on a time frame that is maintainable for both UnitedHealthcare and the providers. A suggestion is to outreach to any provider with data that has not been updated in a set time frame and run a query in the provider database to pull all provider rows without change in the 4-6-month (or desired) time frame.

Strengths.

All MCOs showed strong testing processes and development methodologies that met and exceeded industry standards. Each MCO's internal team(s) process change requests in-house with strict guidelines, managed by their current staff members (a large knowledgebase). Consistent communication regarding upcoming changes keep each MCO's staff well informed and creates a cohesiveness. Lastly, all MCOs have very robust and well documented processes for encounter data. MCOs do not modify the data at any point, always communicating back to the source for correction.

Weaknesses.

All MCOs displayed documented processes for verifying provider directory data. However, while checking the provider directories in-depth, Primaris discovered many discrepancies and unclear data points. The current processes in place are not effectively verifying large data sets.

1.3.3 Review of Compliance with Medicaid and CHIP Managed Care Regulations

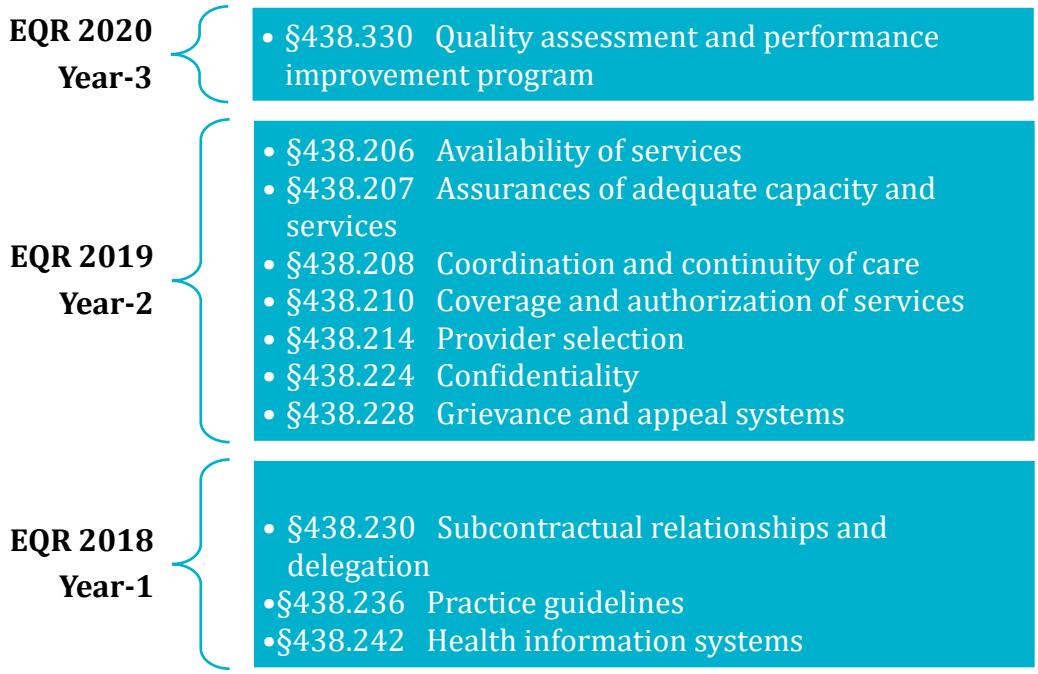


Figure 1-4. A Three-Year Compliance Review Cycle

The Code of Federal Regulations (CFR) 438.358(b) (iii) requires a review to be conducted within a previous 3-year period to determine the MCO's compliance with standards set forth in subpart D of 42 CFR 438 and subpart E, 438.330. Primaris conducted a review

based on Centers for Medicare and Medicaid Services (CMS), EQR Protocol 3, version Oct 2019: Review of Compliance with Medicaid and CHIP Managed Care Regulations. Figure 1-4 enumerates the regulations evaluated during a three-year cycle (EQR 2018-EQR 2020). (Note: First year of review cycle (EQR 2018) included Home State Health and Missouri Care only. UnitedHealthcare was not included 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 EQR 2018) were reviewed in EQR 2019 for UnitedHealthcare.)

The regulation evaluated in EQR 2020 was 42 CFR 438, Subpart E, 438.330: Quality assessment and performance improvement (QAPI) program. An evaluation tool was created based on MHD instructions and the template for QAPI, the Managed Care Contract, and 42CFR 438.330 QAPI. A total of 33 criteria were evaluated. Each criterion was scored as Fully Met (2 points); Partially Met (1 point); or Not Met (0 point) according to the Compliance Rating System per CMS EQR Protocol 3. Primaris initiates a corrective action plan (CAP) for "Not Met" criteria only. These are re-evaluated within a time frame decided by MHD. The "Partially Met" criteria are reviewed during the next EQR.

Comparative Results.

Table 1-9 shows aggregate scores achieved by the three MCOs for the current review cycle.

Table 1-9. Compliance Score (aggregate %) 3-Year Cycle: MCOs

Standard	Standard Name	Home State Health	Missouri Care	UnitedHealth care
§438.330	Quality assessment and performance improvement program	87.9%	98.5%	96.9%
§438.206	Availability of services	100%	96.6%	99.4%
§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	100%	100%	
§438.236	Practice Guidelines			
§438.242	Health Information Systems			

Home State Health was compliant with 25 of 33 criteria, Missouri Care complied with 32 of 33 criteria, and UnitedHealth was compliant with 31 of 33 criteria. The remaining criteria were scored as "Partially Met." None of the MCOs were placed on a CAP in EQR 2020. Table 1-10 identifies the EQR audit findings for all MCOs in a three-year cycle.

Table 1-10. EQR Audit Findings for All MCOs (EQR 2018-EQR 2020)

3-Year Cycle	Home State Health	Missouri Care	UnitedHealthcare
EQR 2020	No CAP/Partially Met-8 criteria	No CAP/Partially Met-1 criterion	No CAP/Partially Met-2 criteria
Re-Review EQR 2020	Due for next year EQR 2021	Due for next year EQR 2021	Due for next year EQR 2021
EQR 2019	No CAP/No concerns identified	CAP/Not Met-3 criteria/Partially Met-3 criteria	No CAP/Partially Met-2 criteria
Re-Review EQR 2019	NA	Not Met-nil/ Partially Met-3 criteria	Partially Met-nil
EQR 2018	No CAP/ No concerns identified	No CAP/No concerns identified	Not included in review
Re-Review EQR 2018	NA	NA	NA

Legends: Fully Met | Partially Met | Not Met | Not Applicable NA

Strengths.

Table 1-11 identifies strengths at a highlevel in QAPI of the three MCOs. Details on individual MCOs performance is provided in section 4.0 of this report.

Table 1-11. High Performance Categories in QAPI: MCOs

Home State Health	Missouri Care	UnitedHealthcare
QAPI Structure and Management	QAPI Structure and Management	QAPI Structure and Management
	QAPI Evaluation and Reporting	
Population Analysis	Population Analysis	Population Analysis
Accessibility of Services	Accessibility of Services	Accessibility of Services
Network Adequacy	Network Adequacy	Network Adequacy
Fraud, Waste, and Abuse Program	Fraud, Waste, and Abuse Program	Fraud, Waste, and Abuse Program

Use of Clinical Practice Guidelines	Use of Clinical Practice Guidelines	Use of Clinical Practice Guidelines
Claims Management	Information Management (Claims)	Information Management (claims processing-timeliness, membership, providers)
Improvement in HEDIS® rates included in PIPs		Improvement in HEDIS® rates included in PIPs
Credentialing/Recredentialing	Credentialing	Credentialing/Recredentialing
	Medical Record Review	Medical Record Review
	Grievance and Appeals	Grievance and Appeals: Providers
	Utilization Management	Utilization Management
		Subcontractors and Vendor management

Weaknesses.

The following areas/categories were identified which require attention for improvement (Table 1-12).

Table 1-12. Opportunities for Improvement

Home State Health	Missouri Care	UnitedHealthcare
QAPI Reporting		
Provider Satisfaction	Provider Satisfaction	Provider Satisfaction
Grievance and Appeals: Members		Grievance and Appeals: Members
		Confidentiality
After-hours Access	After-hours Availability	After-hours Care Access
	HEDIS® Measures	
	CM: Opt-out members/BH follow up visits/Integrated Physical and BH services	
Medical Record Review		
Disease Management		

Recommendations.

All the MCOs must work on the deficiencies identified as "Partially Met" criteria and submit information to MHD in the QAPI evaluation report for the review period (CY 2019). They must incorporate all instructions/guidelines from MHD and recommendations from Primaris (per details in section 4.5) for reporting of QAPI in subsequent years.

1.3.4 Review of Care Management Program

Primaris utilized guidelines provided under the MHD Managed Care contract, section 2.11, for evaluation of the MCOs' CM Program. The aim of review was to identify contributing issues and key drivers. For EQR 2020, Primaris evaluated three focus areas as required by MHD:

- Asthma (members in age group of 5-18 years only).
- Opioid /substance use disorder (SUD).
- Behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

Evaluation of the MCOs' CM program was conducted under the headings in Figure 1-4 and results are presented in Table 1-13:

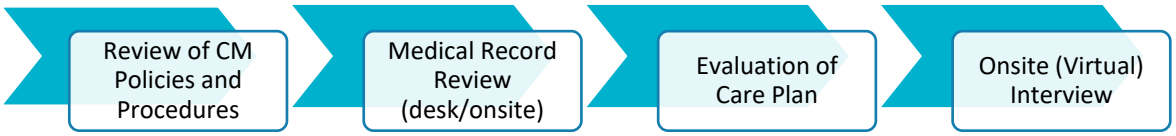


Figure 1-4. CM Evaluation Process

Comparative Results.

Table 1-13. Compliance with CM requirements (Aggregate score %): MCOs

Heads (Sections)	Home State Health	Missouri Care	UnitedHealthcare
Review of CM Policies and Procedures	100%	100%	100%
Medical Record Review (MRR)*	90%	87%	87%
Specific BH CM criteria: The MCO assesses members for CM within (5) business days of admission to a psychiatric hospital or residential substance use Tx program.	45%	16%	60%
Review of Care Plan	Each MCO utilized policies and procedures based on contractual guidelines for care plan. However, the care plan per se was member driven and did not always include all components listed under MHD contract, section 2.11.1e.		

*Note: Twenty medical records were required to be reviewed for evaluation of each focus area. All criteria listed in the MHD contract for CM were assessed. Due to the variation in sample size submitted by the MCOs for Opioid/SUD focus area, these aggregate results are not comparable. Hence, CM evaluation score for individual focus area across MCOs is provided in Table 1-14.

Table 1-14. Medical Records Compliance with CM Criteria: MCOs

MCO	Asthma	Opioid/SUD	BH
Home State Heath	92%	93%#	85%
Missouri Care	88%	85%##	89%
UnitedHealthcare	91%	90%##	81%

Mostly Obstetric cases (sample size: 20)
Other cases (not obstetric)/sample size: 5-6

Strengths.

The three MCOs have policies and procedures in place for a CM program. They have achieved an aggregate score of 80% and above for the three focus areas as evidenced during MRR. All of them have skilled clinical staff (licensed) for BH CM (includes Opioid/SUD CM), provide education to providers on asthma action plans and to members on utilization of services: emergency; urgent care; and Primary Care Providers (PCPs). Monitoring of medication adherence for asthma cases is at 95% across the three MCOs.

Weakness.

The MCOs have not been able to offer CM within five business days of admission to psychiatric hospital or substance use treatment program for all of their eligible members. Discharge plans and follow up for members enrolled in CM for the three focus areas was an issue as well. The main reasons were either the members could not be contacted (UTC-unable to reach), lost eligibility, or they declined CM.

Recommendations.

Engaging members in the CM program; before closing a case for UTC, at least three (3) different types of attempts be made prior to closure for this reason; auditing providers to determine the use of asthma action plan in treating members with asthma; following MHD guidelines and including all points as stated in the contract while creating a care plan for members; sharing a care plan with PCPs for members in BH CM are the recommendations for all MCOs operating under MHD.

2.0 Validation of Performance Improvement Projects

2.1 Description, Objective, and Methodology

A Performance Improvement Project (PIP) is a project conducted by an MCO that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MCO/system level. A statewide PIP is defined as a cooperative quality improvement effort by the MCO, MHD, and the EQRO to address clinical or non-clinical topic areas relevant to the Managed Care Program (MHD Managed Care Contract 2.18.8 (d) 2). Completion of PIPs should be in a reasonable period to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.

For EQR 2020, MHD required Primaris to validate the following two PIPs (clinical and nonclinical) conducted by Home State Health, Missouri Care, and UnitedHealthcare during CY 2019. The baseline year for the PIPs was CY 2018.

- Clinical PIP: Improving Immunization-Childhood Immunization Status (HEDIS® CIS Combo 10).
- Nonclinical PIP: Improving Oral Health-Annual Dental Visit (HEDIS® ADV).

Primaris followed guidelines established by CMS EQR Protocol 1, version Oct 2019: Validation of Performance Improvement Projects. Protocol 1 specifies procedures to be used in assessing the validity and reliability of a PIP per 42 C.F.R. § 438.358(b)(i), (Figure 2-1). This new version of EQR protocol was published in Feb 2020, whereas the PIPs were conducted in CY 2019, so introduction of new criteria or new worksheets for evaluation were marked as "Not applicable (N/A)" by Primaris in EQR 2020. Credit was also given if an MCO followed guidelines from the older version. Technical Assistance was provided to MCOs on Apr 3, 2020 to conduct their PIPs (in CY 2020) based on the new version of the protocol.

The MHD Contract, section 1.18.8d requires the MCOs to increase HEDIS® CIS Combo 10 and HEDIS® ADV rates each year by at least 2% points in alignment with the Quality Improvement Strategy. This was the overarching goal/aim set for the PIPs by the MHD. Vaccines and recommended doses in HEDIS® CIS Combo 10 include: DTaP (4); IPV (3); MMR (1); HiB (3); HepB (3); VZV (1); PCV (4); HepA (1); RV (2/3); and Flu (2).

The review period for validation of PIPs was in Aug-Sept 2019. Primaris evaluated all steps of PIP activities and reported in worksheets as per protocol 1. (Note: Worksheets were submitted to MHD and are not included in this report.)

Primaris obtained information from each MCO through:

- Documents submission: MCOs were requested to submit their PIPs at Primaris' web-based secure file storage site.
- Interview: Virtual meetings with Missouri Care, Home State Health, and UnitedHealthcare officials were conducted on Aug 18, Aug 19, and Aug 20, 2020 respectively to understand their concept, approach, methodology adopted, implementation and results of the PIP intervention. Additionally, areas requiring improvement, correction, and submission of additional information were discussed during the interviews.

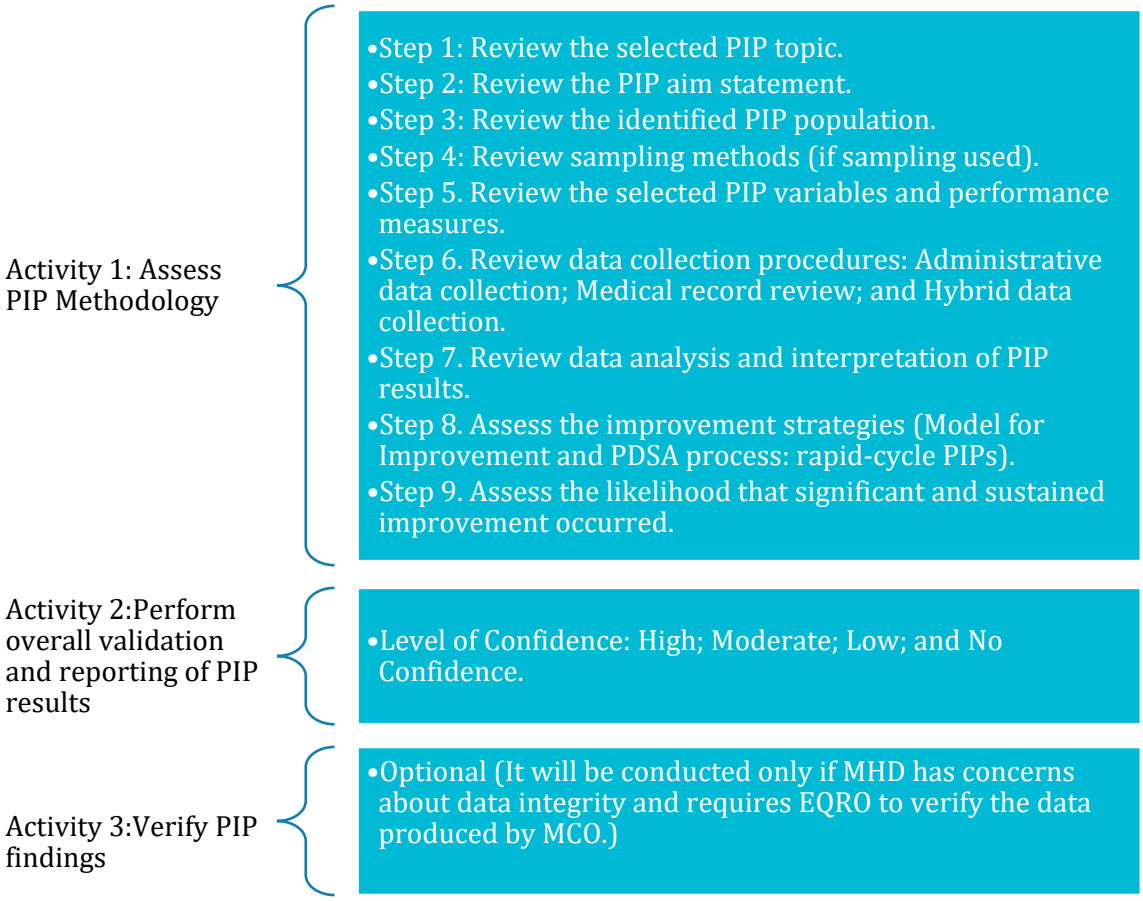


Figure 2-1. PIP Activities

Primaris assessed the overall validity and reliability of the PIP methods and findings to determine whether or not it has confidence in the results. The validation rating is based on the EQRO's assessment of whether the MCO adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
The level of confidence is defined as follows:

- High Confidence = the PIP was methodologically sound, achieved the SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- Moderate Confidence = the PIP was methodologically sound, achieved the SMART Aim, 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 was not achieved; or (B) the SMART Aim was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- No Confidence = The PIP methodology was not an acceptable/approved methodology for all phases of design.

2.2 Findings and Conclusions: Home State Health

(A) Improving Childhood Immunization Status (HEDIS® CIS Combo 10)

Description of Data Obtained from Home State Health

This section presents information regarding intervention(s) and results submitted by Home State Health.
Target population: All Home State Health members who turn two years of age during the measurement year who meet the HEDIS® eligibility requirements for CIS Combo 10 measure. The member must have been continuously enrolled in Medicaid in the 12 months prior to their second birthday with no more than a one-month gap in coverage.

PIP Population: Intervention was applied to all eligible members ages zero through two at the time of intervention. No sampling was done.

Intervention: The Supplemental Data System (SuDS) project was selected as an intervention utilized to improve the CY 2019 HEDIS® CIS Combo 10 rate. A provider group (a system of community health centers) was contracted to provide supplemental data on immunizations. The SuDS project would increase access to member medical data to obtain records of compliancy with the measure.

Performance Measures: Primary Measure-HEDIS® CIS Combo 10 rate.

Numerator: Home State Health members in the denominator who met the measure specification requirements for CIS Combo 10 as defined by the HEDIS® Technical Specifications.[1]
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 with no more than a one-month gap in enrollment.
Secondary Measure/variable-None.

Data Collection Plan: HEDIS® CIS Combo 10 rate was determined using administrative claims and non-claims clinical data. Additionally, HSH retrieved medical records from a variety of providers in order to capture documentation of immunizations administered which might not have been submitted to the Missouri Department of Health and Senior Services' ShowMeVax immunization registry. These medical records were accounted for through the HEDIS® Hybrid Technical Specifications. Home State Health monitored this study indicator throughout the year to evaluate the effectiveness of the intervention and to determine if additional interventions are needed.
The contracted provider group received a monthly roster of Home State Health's members. The provider group then pulled information within the electronic medical record system and reviewed the information for quality measure compliance, including the CIS measure. This compiled information was then submitted via secure data transfer to Centene where the data was reviewed for accuracy. Information was then processed through Centene's Enterprise Data Warehouse (EDW) and Quality Spectrum Insight (QSI) to measure compliance with HEDIS® CIS Combo 10 measure.

Data, Analysis, and Interpretation: In the monthly review of the CIS measure, Home State Health reported that HEDIS® CIS Combo 10 rate increased each month (Table 2-1). Additionally, the rate for CY 2019 was consistently above the CIS rate for the same month in CY 2018. As a result, no changes to the intervention mid-year were required.

Table 2-1. Home State Health Monthly HEDIS® CIS Combo 10 Rate (%)

CY	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Final Hybrid Rate
2018				11.02	11.02	11.99	10.27	11.46	11.58	11.70	11.72	10.96	21.65
2019	12.68	14.60	15.70	17.00	18.62	19.93	20.33	20.58	20.88	20.95	21.35	21.78	30.17

[1] National Committee for Quality Assurance (NCQA) HEDIS 2020: Healthcare Effectiveness Data and Information Set. Vol.2, Technical Specifications.

The progress of SuDS intervention was monitored on a quarterly basis (Table 2-2). In CY 2019, the provider group was able to provide supplemental data to convert 359 members from non-compliant to compliant with CIS Combo 10 vaccines, as opposed to converting 54 members in CY 2018.

Table 2-2. Members Compliant for Combo 10 Vaccines via SuDS

Quarter	CY 2018	CY 2019
Q1	39	89
Q2	1	171
Q3	14	33
Q4	0	66
Total	**54**	**359**

Table 2-3 presents the records (in %) provided by the SuDS provider group (Compliant Hits) to substantiate that immunization was provided to Home State Health members.

Table 2-3. CIS Combo 10 Compliance with Provider Group

CIS Immunization	Percentage of Compliant Hits by SuDS Providers	
	CY 2018	CY 2019
DTaP	7%	10%
Influenza	8%	9%
Hepatitis B	7%	10%
Hepatitis A	8%	10%
H Influenza Type B	8%	9%
MMR	8%	10%
Pneumococcal Conjugate	4%	7%
OPV/IPV	5%	9%
Rotavirus	8%	8%
Chicken Pox	7%	10%

PIP Result

The statewide rate for HEDIS® CIS Combo 10 for the baseline year (CY 2018) was 21.65%. It has increased to 30.17% during the measurement year (CY 2019), which is an improvement of 8.52% points (Table 2-4). This increase is statistically significant with p=0.005 (p≤0.05 is significant). The aim of the PIP is met.

Table 2-4. Home State Health Statewide HEDIS® CIS Rate

Measurement Year	HEDIS® CIS Combo 10 Rate (%)	NCQA Quality Compass 33rd Percentile (%)
CY 2017	27.01	Not Reported
CY 2018	21.65	30.9
CY 2019	30.17	30.17

(B) Improving Oral Healthcare-Annual Dental Visit (HEDIS® ADV)

Description of Data Obtained from Home State Health

This section presents information regarding intervention(s) implemented and results submitted by Home State Health.

Target Population and PIP Population: Population for this project includes all Home State Health members ages two through twenty who meet the eligibility requirements for HEDIS® ADV measure. Interventions are applied to all eligible members ages two through twenty at the time of intervention. Sampling was not done.

Interventions:
1. Outbound Call: Home State Health contracted with AlphaPointe, a sheltered workshop in Missouri, to call members regarding care gaps (this campaign was effective August 18, 2017). Members identified as not receiving their annual dental visit were contacted telephonically by AlphaPointe, a contracted vendor, to remind them of their dental benefit and, if applicable, of their benefit to receive transportation to and from their dental visits. Additionally, AlphaPointe would text members that they would receive an incentive payment on their rewards card for attending a dental visit.
2. Texting: Home State Health utilized an interactive text to outreach guardians of members who were not compliant with the ADV measure.

Performance Measures: Primary Measure-Primary Measure-HEDIS® ADV rate.

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

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

Secondary Measure/Variable-None.

Data Collection Plan: HEDIS® ADV rate is measured by administrative method that does not allow information to be gathered using direct chart review, but instead uses claims and enrollment information as data sources. Administrative claims processing utilizes the ADA Current Dental Terminology (CDT) and the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes as well as non-claims administrative data. These supplemental data files are loaded into Centene's Enterprise Data Warehouse (EDW). 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 EDW into Quality Spectrum Insight XL (QSI XL) on a monthly basis. Home State Health calculates the ADV rates by using data obtained from (QSI XL). QSI XL is Home State Health's certified HEDIS® software that is used to calculate the rates of this study indicator. Home State Health's Outcome Analyst then extracts the monthly preliminary HEDIS® results to monitor the effectiveness of interventions based on changes in HEDIS® ADV rate. Monitoring occurs at a minimum on a quarterly basis but typically occurs monthly.

Data, Analysis, and Interpretation:
During CY 2019, the Home State Health HEDIS® ADV rate continued to rise throughout the year. When compared to the same month in the previous year, the CY 2019 HEDIS® ADV rate was more than 2% points above the HEDIS® ADV rate for CY 2018. As a result of monitoring these rates month over month, it was determined that no mid-year adjustments needed to be made for the ADV PIP (Table 2-5).

Table 2-5. Home State Health Monthly HEDIS® ADV rate (%)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Final
CY2018				16.77	16.77	24.43	30.18	33.71	37.55	40.60	43.39	43.66	47.82
CY2019	1.85	8.29	14.21	22.87	26.91	32.44	35.32	39.43	43.20%	46.78	49.31	49.31	53.24

Outbound Call: In January, November, and December 2019, AlphaPointe was provided with a list of members who were not compliant with the HEDIS® ADV measure. They attempted to place calls to 41,006 members to remind them of their dental benefit. The results of these outreaches are listed in Table 2-6.

Table 2-6. AlphaPointe Results CY 2019

Call Result	Count	% Total
No Answer	10,134	24.71%
Hang Up	7,887	19.23%

Left VM Message	7,310	17.83%
Answering Machine	4,223	10.30%
Disconnected Number	3,771	9.20%
Message Delivered	3,172	7.74%
Wrong Number	1,295	3.16%
Automated Refusal	1,271	3.10%
Do Not Call	914	2.23%
Not Available	784	1.91%
Refused Validation	129	0.31%
Member Will Contact	53	0.13%
Fax/Modem	49	0.12%
Successful Transfer	9	0.02%
Language Barrier	5	0.01%
TOTAL	41,006	100%

AlphaPointe conducted calls for Home State Health in the past. Data from the previous year's outreaches (CY 2018) are compared to CY 2019 call outreaches: number of messages delivered decreased from 8.52% to 7.74%; members agreed to schedule an appointment decreased from 0.26% to 0.13%; and successful transfer decreased from 0.08% to 0.02%. However, Home State Health reports this intervention as valuable.
Prior to outreach by AlphaPointe, none of the 41,006 members were compliant with dental visits. Table 2-7 details the results of the successful outreach attempts.

Table 2-7. Member compliance after outreach

Month	Members Outreached During Initiative Month	Successful Outreach Rates	Percentage of Successful Outreach Members Who Became Compliant in Following Month
Jan	15658	6.07% (950/15658)	7.26% (69/950)
Nov	12932	9.92% (1283/12932)	13.02% (167/1283)
Dec	12416	8.06% (1001/12416)	11.89% (119/1001)
Total	41006	7.89% (3234/41006)	10.97% (355/3234)

Texting: In Quarter 4 (Q4), on October 31, 2019, Home State Health sent out text reminders to members who were noncompliant with the HEDIS® ADV measure. If the member did not have a phone number in their record, had opted out of text messaging, or had already received five texts per month limit, they were excluded. Also, if there was more than one child in a family who was noncompliant with HEDIS® ADV measure, only one text was sent to the parent/guardian. As a result, of the 78,250 noncompliant members, 11,180 texts were sent. After texting, 2,056 of the texted members became compliant. This represents

18.39% of the texted members converting to a compliant status (Table 2-8). Prior to texting, the 11,180 members identified for texting were all noncompliant with ADV measure and Home State Health's compliance rate at the end of Q3 in CY 2019 was 43.20%. At the end of Q4 in CY 2019, the compliance rate had risen to 49.31%.

Table 2-8. Changes in Compliancy after Texting

Region	Sent Text	Compliant After Text	% Change
Central	2355	448	19.02%
Eastern	4874	915	18.77%
Southwestern	1832	388	21.18%
Western	1706	299	17.53%
Unknown	413	6	1.45%
Total	11180	2056	18.39%

PIP Result

The statewide rate for HEDIS® ADV for the baseline year (CY 2018) was 47.82%. It has increased to 53.24% during the measurement year (CY 2019), which is an improvement of 5.42% points (Table 2-9). This increase is statistically significant with $p<0.00001$ ($p\leq0.05$ is significant). The aim of the PIP is met.

Table 2-9. Home State Health Statewide HEDIS® ADV Rate

Measurement Year	HEDIS® ADV Rate (%)	NCQA Quality Compass 33rd Percentile (%)
CY 2017	41.65	Not Reported
CY 2018	47.82	51.51
CY 2019	53.24	52.71

2.2.1 Quality, Timeliness, and Access

PIPs Score.

Primaris assigns a score of Low Confidence for both PIPs for the reasons explained below. However, Home State Health has achieved the aim set by MHD for both PIPs.

The PIP for improving Childhood Immunization Status: Even though there is an indication that intervention has contributed to some improvement (2% points) in HEDIS® CIS Combo 10 rate, the quality improvement process, intervention, and data collection and analysis were poorly executed and could not be linked to the overall improvement.

The PIP for improving oral health: HEDIS® ADV rate increased each month but was not related to outbound call intervention. The texting intervention did show a positive response; this was a one-time intervention with no remeasurement data. Thus, even though the aim was achieved, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

The PIPs did not meet all the required guidelines stated in the CFR/MHD contract (Table 2-10). (Ref: 42 Code of federal Regulations (CFR) 438.330 (d)/MHD contract 2.18.8 d 1). Note: Definitions of Met/Partially Met/Not Met are utilized from CMS EQRO Protocol 3.

Table 2-10. Home State Health's PIPs 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	Not Met
Planning and initiation of activities for increasing or sustaining improvement	Met

Strengths.

- Improving Childhood Immunization Status:

1. Improvement Strategy: Home State Health reported that the State of Missouri does not require providers who do not participate in the Vaccines for Children (VFC) program to submit immunization records to the ShowMeVax immunization registry. Home State Health identified an opportunity to improve the ability to locate member medical records for compliant visits/immunizations from provider groups contributing to improved HEDIS® CIS rate.

2. Follow up activity: Provider education on claims submission or other alternative methods of obtaining immunization records may be a potential intervention for the future.

- Improving Oral Health

1. Home State Health conducted a barrier analysis for the future PIP. It was determined that Home State Health would partner with the Federally Qualified Health Center (FQHC) to increase the rate of compliance on the HEDIS® ADV measure for Home State Health members aged 2 to 9 years old who were assigned to the FQHC as their Primary Care

Physician. Home State Health and the FQHC plan to share demographics on the members to enhance the ability to communicate with members.

2. Home State Health provided a possible explanation for improved data generated as a result of texting intervention compared to outbound call intervention. Home State Health is in possession of accurate cell phone data for more members than was suggested by the AlphaPointe response. An alternative explanation is that members respond to texting but do not answer a phone call, as many of the calls from AlphaPointe were not answered.

Weaknesses.

- Improving Childhood Immunization Status:

1. PIP variable or secondary measure: A measure/variable that would help in tracking actual performance of the PIP was not selected. However, Home State Health has submitted some data related to intervention. Clear and concise definitions of data elements (including numerical definitions and units of measure) were not provided.

2. Incorrect reporting of provider group activities: Home State Health reported that supplemental data accounted for a 7 to 10%-points increase in compliance for each of the individual types of immunizations. This calculation is incorrect.
Primaris calculated the overall contribution of SuDS intervention towards compliance of CIS Combo 10 vaccines was 7% in CY 2018 and 9% in CY 2019, which is an improvement by 2% points.

3. Inconsistence in data reporting: HEDIS® CIS rate is reported monthly in %; data from intervention is reported in numbers (numerator only, no denominator) quarterly; Compliance Hits (% of immunization data received as a result of SuDS intervention out of total Medicaid compliance Hits) is presented annually.

4. Linking of intervention to improvement: The link between the intervention and the performance measure is not explained accurately by Home State Health. The secondary data submitted as a result of ongoing intervention on a quarterly basis does not show improvement each quarter, whereas the primary measure has shown improvement month over month in CY 2019.

5. Statistical significance: Statistically significant improvement in the HEDIS® CIS Combo 10 rate is reported. However, statistical significance of results of the intervention is not tested.

- Improving Oral Health

1. PIP variable/secondary measure: Data elements, their definitions, unit of measurement to be collected as a result of intervention was not specified. Data reported is inconsistent. Home State Health has submitted data related to intervention as "change in compliance in %" but the baseline rate prior to intervention was not reported.
2. Selected improvement strategy: There is no information or evidence presented (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes.

3. Sustained improvement: Data presented for the intervention of outbound calls did not show any improvement. Other intervention of texting showed some positive response but cannot be relied on as it was measured only once.

4. Analysis error: Based on the data submitted by Home State Health in Table 2-5: Monthly HEDIS® ADV Rates, Primaris differs with the analysis provided by Home State Health. The HEDIS® ADV rate by end of Oct 2019 (intervention began on the last day of Oct 2019) was 46.78% and rate by end of Q4 was 49.31% as opposed to Home State Health's comparison of end of Q3 rate (43.20%) with end of Q4 rate.

5. Ongoing interventions: Home State Health has presented several ongoing interventions from past years undertaken to improve the HEDIS® ADV measure. The link between the specific interventions used for the purpose of this PIP and the increase in HEDIS® ADV measure is not established.

2.2.2 Improvement from previous year

The statewide CIS Combo 10 rate has increased by 8.52% points and the statewide rate for HEDIS® ADV increased by 5.42% points. Table 2-11 shows Home State Health's compliance with previous year's recommendations by EQRO.

Table 2-11. Home State Health's Response to Previous EQR's Recommendations

Recommendations	Action by Home State Health	Comment by EQRO
Primaris recommends: 1. Home State Health to follow CMS EQRO protocol and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health	There is some improvement by Home State Health in writing the aim statement, baseline year, measurement year, and interventions. Improvement is required in the manner the	Partially Met

Plans, July 2015[2], for guidance on methodology and approach of PIPs to obtain meaningful results.	interventions should be conducted and data to be collected and reported.	
2. Home State Health must continue to refine their skills in the development and implementation of approaches to affect change in their PIP.	There is not much improvement. Same interventions have been continued this year. Data presentation about intervention has improved over previous year.	Partially Met
3. The aim and study question(s) should be stated clearly in writing (baseline rate, % increase to achieve in a defined period).	Achieved.	Met
4. 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.	Achieved.	Met
5. The interventions should be planned specifically for the purpose of PIP required by MHD Contract.	The interventions are continued from previous year and would continue in the future as stated by Home State Health.	Not Met
6. The results should be tied to the interventions.	Analysis of results of the intervention is not linked with the outcome.	Not Met
7. Instead of repeating interventions that were not effective, evaluate new interventions for their potential to produce desired results before investing time and money.	Interventions were repeated which did not have positive impact in CY 2018 and CY 2019 (Oral Health PIP). Home State Health has decided to continue the same in the future.	Not Met
8. A request for technical assistance from EQRO would be beneficial.	Achieved.	Met

[4]https://www.medicaid.gov/medicaid/benefits/downloads/pip-manual-for-health-plans.pdf

Improved training, assistance and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.		
9. Home State Health must utilize the PIP's process as part of organizational development to maintain compliance with the state contract and the federal protocol.	The interventions are already in use for organization development; however, they were not tested for effectiveness in the PIPs.	Partially Met

2.3 Findings and Conclusions: Missouri Care

(A) Improving Childhood Immunization Status (HEDIS® CIS Combo 10)

Description of Data Obtained from Missouri Care

This section presents information regarding intervention(s) implemented and results submitted by Missouri Care.

Intervention: Missouri Care identified an opportunity to improve the HEDIS® CIS Combo 10 rate in CY 2019 (HEDIS® 2020) by partnering with two large provider groups (Jordan Valley and Cox Health), meeting routinely (6-8 weeks) with their quality improvement teams. This intervention took place from Jan 1, 2019 to Dec 31, 2019. Topics reviewed during meetings: HEDIS® Care Gaps, HEDIS® Technical Specifications, HEDIS® Toolkits, and update on Partnership for Quality Provider Incentive Program performance. As part of the provider partnership, Missouri Care monitored quarterly CIS Combo 10 rates of Jordan Valley and Cox Health and reported the findings to the provider groups.

PIP Population: The PIP considered all Missouri Care members two years of age who were assigned PCPs at Jordan Valley or Cox Health including, but not limited to members with special needs and physical or behavioral health conditions, and who had no more than one gap in enrollment of up to 45 days during 12 months prior to child's second birthday.

Sampling Method: Sampling was not used. The entire population of Missouri Care members two years of age in the measurement year who were assigned to Jordan Valley or Cox Health are measured from an administrative standpoint and rates are calculated using HEDIS® Technical Specifications and NCQA-certified software.

Performance Measures:
Primary Measure-HEDIS® CIS Combo 10 rate. According to HEDIS® 2020 (CY 2019) NCQA Technical Specifications, this measure captures the following:

Numerator-Must include:

- 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 2019) 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.

Secondary Measure/variable: None.

Data Collection Plan: HEDIS® CIS Combo 10 rates at Jordon Valley and Cox Health were measured from an administrative standpoint (claims/encounter data) using HEDIS® Technical Specifications and NCQA-certified software and monitored quarterly.

Data, Analysis, and Interpretation: Table 2-12 shows progress in the HEDIS® CIS Combo rate measured bimonthly for Jordan Valley and Cox Health's. Jordan Valley improved from 17% (CY 2018) to 31% (CY 2019) and Cox Health improved from 18% (CY 2018) to 23% (CY 2019) (Table 2-13) and met the aim of 2% points improvement.

Table 2-12 Missouri Care HEDIS® CIS Combo 10 Bimonthly Rate CY 2019

Bimonthly Measurement	Jordon Valley	Cox Health
January	17.24%	18%
March	24.78%	19%
May	27.03%	19%
July	28.18%	21%
Sept	29.35%	21%

Nov	29.35%	22%
Final Result	**31.00%**	**23%**

Table 2-13. Missouri Care HEDIS® CIS Combo 10 Rate (Quarterly)

Quarterly Measurement	Jordon Valley		Cox Health	
	CY 2018	CY 2019	CY 2018	CY 2019
Quarter 1	16.44%	24.78%	10.81%	18.85%
Quarter 2	17.54%	28.18%	17.43%	20.27%
Quarter 3	19.54%	30.00%	17.79%	21.33%
Quarter 4	17.00%	31.00%	18.00%	23.00%

Table 2-14 shows statewide improvement in the HEDIS® CIS Combo 10 rate greater than 2% points in all 4 quarters over the prior year. However, since the COVID-19 impacted chart chase for medical record review and the final hybrid rate, Missouri Care reported their prior year's HEDIS® rate (27.49%) from CY 2018 in CY 2019 (permitted by National Committee for Quality Assurance guidelines due to Covid-19).

Table 2-14. Missouri Care Statewide CIS Combo-10 Rate

Quarterly and Final Rate	CY 2018	CY 2019
Quarter 1	13.37%	17.80%
Quarter 2	15.82%	21.38%
Quarter 3	16.49%	22.43%
Quarter 4	17.21%	22.86%
Final Rate	27.49%	27.49%

PIP Result

The statewide rate for HEDIS® CIS Combo 10 for the baseline year (CY 2018) and measurement year (CY 2019) was reported as 27.49%. The state goal for the PIP is not met. However, aim of the PIP is met: HEDIS® CIS Combo 10 rate for Jordan Valley increased from 17% to 31% (14% points increase which is statistically significant) and for Cox Health the rate increased from 18% to 23% (5% points increase which is not statistically significant).

(B) Improving Oral Healthcare-Annual Dental Visit (HEDIS® ADV)

Description of Data Obtained from Missouri Care

This section presents information regarding intervention(s) implemented and results

submitted by Missouri Care.
Intervention: Members were motivated to complete an annual dental visit by offering an incentive of $30.00 through the Healthy Rewards program. The duration of this intervention was from Jan 1-Dec 31, 2019.

Target Population/PIP Population: All Missouri Care members 2 through 20 years of age who had at least 1 dental visit during the measurement year and were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.

Sampling Method: This was not used in the PIP.

Performance Measures:
Primary Measure-HEDIS® ADV rate. According to HEDIS® 2020 (CY 2019) NCQA Technical Specifications, this measure 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 2019).
Denominator: Members 2 through 20 years of age who are continuously enrolled during the measurement year (CY 2019) with no more than one gap in enrollment of up to 45 days.

Secondary Measure/variable-None.

Data Collection Plan: The data collected included the entire eligible population of ADV claims/encounter according to HEDIS® Technical Specifications within the measurement year (CY 2019). Sources of data used in this study include claims-based software and NCQA Certified Software (Inovalon) to calculate the HEDIS® ADV rate and monitored quarterly.

Data, Analysis, and Interpretation: Missouri Care reported 4% of members attested to completing an annual dental visit as opposed to 1.12% in CY 2019. Table 2-15 shows the HEDIS® ADV rate for CY 2018 and CY 2019 on a quarterly basis.

Table 2-15. Missouri Care Statewide HEDIS® ADV Rate

HEDIS Quarterly Measurements	CY 2018	CY 2019
Quarter 1	17.57%	13.18%
Quarter 2	32.07%	28.86%
Quarter 3	41.58%	39.14%

Quarter 4	51.79%	56.86%
Final HEDIS® ADV Rate	**52.72%**	**58.87%**

PIP Result

The statewide rate for the HEDIS® ADV rate in the baseline year (CY 2018) was 52.72%. It increased to 58.87% during the measurement year (CY 2019), which is an improvement of 6.15% points. This increase is statistically significant with confidence level > 95%. The aim of the PIP and state goal is met.

2.3.1 Quality, Timeliness, and Access

PIPs Score.

Primaris assigns a score of Low Confidence for both PIPs. The MHD's goal/aim was achieved for one PIP, namely, Improving Oral Health. PIP for improving Childhood immunization Status did not meet the state goal of 2% points increase in CIS Combo 10 rate from the prior year; however, Missouri Care met the aim set for their PIP. The quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

PIPs did not meet all the required guidelines stated in the CFR/MHD contract (Table 2-16). (Ref: 42 Code of federal Regulations (CFR) 438.330 (d)/MHD contract 2.18.8 d 1). Note: Definitions of Met/Partially Met/Not Met are utilized from CMS EQRO Protocol 3.

Table 2-16. Missouri Care's PIPs 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	Not Met
Planning and initiation of activities for increasing or sustaining improvement	Met

Strengths.

- Improving Childhood Immunization Status:

1. Improvement Strategy: The selected strategy was evidence-based. The Managed Healthcare Executive's article, "Simplify Gaps in Care and Improve Member Compliance,"

states, “It’s important to determine how we can partner with our providers to give them gaps in care reports so that when they have a patient in their office, they can try to close some of those gaps.”[3]

2. Root Cause Analysis: Missouri Care has identified a root cause for not being fully compliant for HEDIS® CIS Combo 10. Providers typically administer immunizations during well-child visits but are not scheduling follow-up visits during the fall to administer the flu vaccine. Missouri Care has identified an opportunity for next year’s PIP (CY 2020) to educate providers on the importance of administering the flu vaccine, which will result in more members becoming compliant for HEDIS® CIS Combo-10.

- Improving Oral Health

Improvement Strategy: The selected strategy was evidence-based. According to the Center on Budget and Policy Priorities, research has shown that offering Medicaid beneficiaries immediate rewards, such as gift cards, for engaging in healthy behaviors can be successful in increasing behaviors[4].

Weaknesses.

- Improving Childhood Immunization Status:

1. PIP variable or secondary measure: A measure/variable that would help in tracking actual performance of the PIP was not selected. Only the primary measure, HEDIS® CIS Combo 10 rate, for Jordon Valley and Cox Health was selected.

2. Linking of intervention to improvement: The data submitted as a result of intervention on a bimonthly/quarterly basis does show improvement; however, that the improvement is a result of the intervention is not evident.

- Improving Oral Health:

1. A secondary measure/variable related to the member incentive program to track performance of the PIP over time was not selected/reported at regular intervals.

2. The PIP is not designed to show that the improvement projected in the HEDIS® ADV

[3] https://www.managedhealthcareexecutive.com/care-compliance/simplify-gaps-care-and-improve-member-compliance May2020
[4] https://www.cbpp.org/research/health/restrictions-on-access-to-care-don’t-improve-medicaid-beneficiaries-health May 2020

measure is a result of intervention.

3. Data generated over time as a result of the intervention (member incentives) is not presented. Only one measurement for CY 2018 and CY 2019 is presented.

2.3.2 Improvement from previous year

The statewide HEDIS® CIS Combo 10 rate was 27.49% for both CY 2018 and CY 2019 and HEDIS® ADV increased by 6.15% points from prior year. Table 2-17 shows Missouri Care's compliance with previous year's recommendations by EQRO.

Table 2-17. Missouri Care's Response to Previous EQR's Recommendations

Recommendations	Action by Missouri Care	Comment by EQRO
Primaris recommends: 1. Missouri Care to follow CMS EQRO protocol and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015[5], for guidance on methodology and approach of PIPs to obtain meaningful results.	Missouri Care has followed the steps to some extent as mentioned in CMS EQRO PIPs Protocol.	Partially Met
2. Missouri Care must continue to refine their skills in the development and implementation of approaches to affect change in their PIP.	Some improvement is noticed in CIS Combo 10 PIP whereas no improvement is seen in approaches for ADV PIP.	Partially Met
3. The aim and study question(s) should be stated clearly in writing (baseline rate, % increase to achieve in a defined period).	Achieved.	Met
4. 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	Achieved.	Met

[4]https://www.medicaid.gov/medicaid/benefits/downloads/pip-manual-for-health-plans.pdf

information on quality of care every year.		
5. The interventions should be planned specifically for the purpose of PIP required by MHD Contract.	Intervention for Childhood Immunization PIP appears to be new, but the Oral Health PIP intervention is from previous year without evidence of its effectiveness seen last year or this year. Missouri Care intends to continue this intervention in future.	Partially Met
6. The results should be tied to the interventions.	Analysis of results of intervention is not linked with the outcome.	Not Met
7. Instead of repeating interventions that were not effective, evaluate new interventions for their potential to produce desired results before investing time and money.	Intervention was repeated which did not have positive impact in CY 2018 and CY 2019 (Oral Health PIP). However, new intervention is reported for Childhood Immunization PIP.	Partially Met
8. 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.	Achieved.	Met
9. Missouri Care must utilize the PIP's process as part of organizational development to maintain compliance with the state contract and the federal protocol.	The interventions are already in use for organization development; however, they were not tested for effectiveness in the PIPs.	Partially Met

2.4 Findings and Conclusions: UnitedHealthcare

(A) Improving Childhood Immunization Status (HEDIS® CIS Combo 10)

Description of Data Obtained from UnitedHealthcare

This section presents information regarding intervention(s) and results submitted by UnitedHealthcare.

PIP Intervention: A total of 13,126 Pfizer Missed Dose Postcard reminders were mailed from April to Dec 2019. Over 1000 postcards were mailed on a monthly basis to parents and/or guardians of children ages 6, 8, and 16 months who missed one or more CIS Combo 10 immunizations.

PIP Population: The study population consisted of 2,705 members who turned 2 years old in CY 2019 and were identified to be non-compliant with CIS Combo 10 vaccinations.

Performance Measures: Primary Measure is HEDIS® CIS Combo 10 rate.
The Secondary Measure is the number of members who received one or more CIS Combo 10 vaccinations after a missed dose postcard was sent by UnitedHealthcare.

Data Collection (Administrative): The HEDIS® CIS Combo 10 rate is based on HEDIS® Technical Specifications and generated by using Inovalon, a HEDIS®-certified software engine. For the purpose of PIP monitoring, this rate is administratively collected. However, the final rate is reported based on Hybrid methodology (includes medical record review). For the secondary measure: first, UnitedHealthcare contacted the National UHC Clinical Program Delivery team and requested a list of members and member ID of those who had been mailed a Pfizer Missed Dose Postcard. Next, UnitedHealthcare submitted an internal request (at a local level in MO) to the Senior Business Analyst who compared member IDs to medical claims within a stated period (8 weeks of sending postcard reminders), using the specific CPT codes for immunizations.

Data, Analysis, and Interpretation: Out of 13,126 members who received a postcard, 1422 (10.83%) received one or more CIS Combo 10 vaccinations within 8 weeks of receiving the postcard (Table 2-18).

Table 2-18. Intervention Data for Immunization PIP

Month	No. of Missed Dose Postcards Mailed	Received One or More CIS Combo 10 Vaccination(s) Within 8 Weeks
Apr	1482	198
May	1461	189

Jun	1498	169
Jul	1368	165
Aug	1434	200
Sep	1935	286
Oct	1384	132
Nov*	1321	56
Dec*	1243	27
Total	**13126**	**1422**

(*Accepting claims through Dec 31, 2019)

Table 2-19 shows immunization compliance rates for members ages 6 months, 8 months and 16 months. Figure 2-2 shows quarterly administrative HEDIS® CIS Combo 10 rates for CY 2019.

Table 2-19. Immunization Compliance

Month	Number of Members at 6 Months, 8 Months, & 16 Months of age	Number of Compliant Members	Compliant %
April (Baseline)	2495	1013	40.60%
July (Remeasurement 1)	2464	1096	44.48%
October (Remeasurement 2)	2360	988	41.86%
December (Remeasurement 3)	2345	1102	46.99%

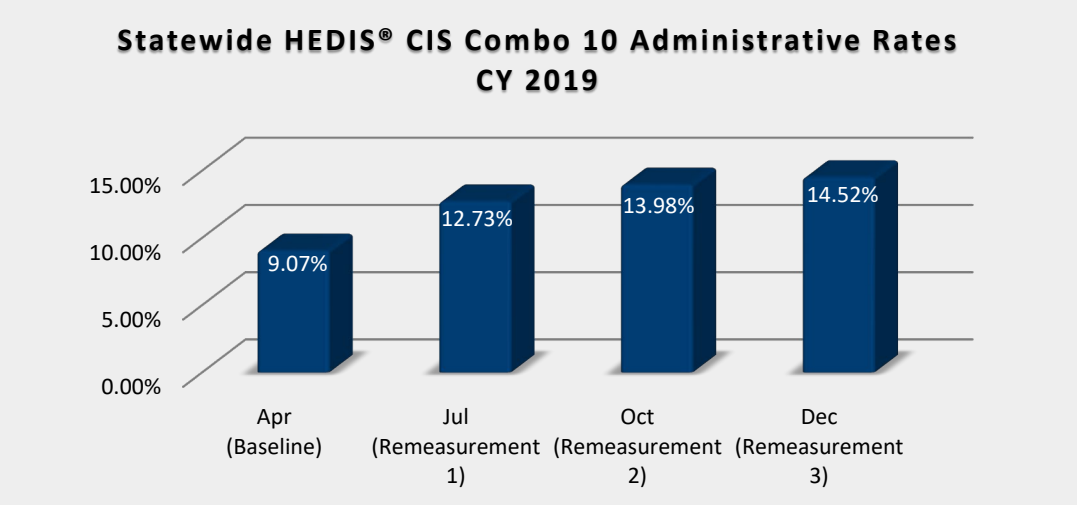


Figure 2-2. UnitedHealthcare HEDIS® CIS Combo 10 rate

PIP Result

The statewide rate for HEDIS® CIS Combo 10 for the baseline year (CY 2018) was 21.65%. It has increased to 25.06% during the measurement year (CY 2019), which is an improvement of 3.41% points (Figure 2-3). This is not of a statistical significance as p value is 0.24 (P≤0.05 is significant). However, aim of the PIP is met.

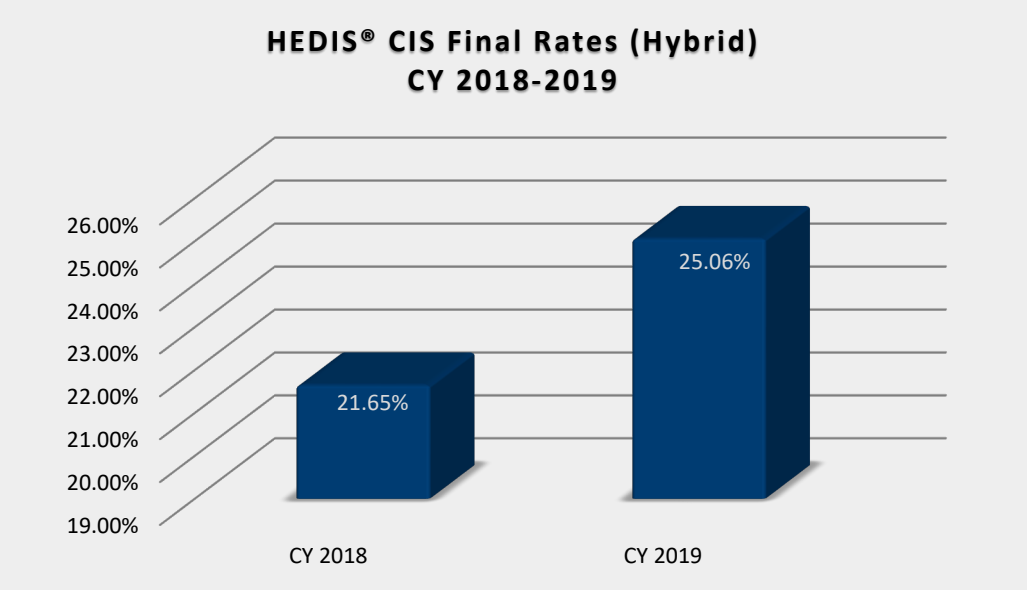


Figure 2-3. UnitedHealthcare HEDIS® CIS Combo 10 Rate

(B) Improving Oral Healthcare-Annual Dental Visit (HEDIS® ADV)

Description of Data Obtained from UnitedHealthcare

This section presents information regarding intervention(s) implemented and results submitted by UnitedHealthcare.

PIP Population: All non-compliant members in nine FQHCs (cycle 1 of intervention-3,198 members) and 14 FQHCs (cycle 2 of intervention-2,655 members) were included in the study. Total number of unique members were 4,757 (Table 2-20).

Performance Measures: Primary Measure is HEDIS® ADV rate (measured per HEDIS® Technical Specifications). Secondary Measures: UnitedHealthcare selected three secondary measures as follows.

- Dental Exam.

  Numerator-Members who had a dental visit (D0120) within 90 days of DCOR delivery.

  Denominator-Members aged 2-20 years old as of December 31 of the measurement

year who had no dental visits during the previous 12 months.

- Preventive Dental Visit.

Numerator-Members who had a preventive dental visit (D1120) within 90 days of DCOR delivery.

Denominator-Members aged 2-20 years old as of December 31 of the measurement year who had no dental visits during the previous 12 months.

- Oral Sealant Applied.

Numerator-Members who had an oral sealant applied (D1351) within 90 days of DCOR delivery.

Denominator-Members aged 6-9 years old as of December 31 of the measurement year who had no dental visits during the previous 12 months.

Data Collection: Primary Measure was reported using HEDIS® Technical Specifications (administrative methodology). Data collection for the secondary measure was based upon the DCOR outcome report. The DCOR outcome report is generated by the UnitedHealthcare Dental team 90 days after the DCORs are distributed to providers. Both reports, the DCOR and the DCOR outcome report, are generated based on claims data received by the dental vendor. The DCOR is run on a Tax ID Number (TIN)-specific basis to identify members who are non-compliant for the secondary measures.

Data, Analysis and Interpretation: Nine FQHCs were identified for distribution of DCORs in May 2019 (Intervention-Cycle 1). A total of 903 members out of 4,026 (22%) had a dental visit within 90 days after May DCOR-intervention-cycle 1 (Table 2-20, 2-21). ADV rates specific to the nine FQHCs improved 16.06% points by August 2019 and 25.04% points by October 2019 compared to the baseline rate in May (Figure 2-4). UnitedHealthcare decided to broaden the scope and include fourteen FQHCs in October 2019 (intervention-cycle 2). A total of 802 members out of 3,293 (24%) were seen within 90 days after cycle 2. Only one measurement was available due to the PIP period ending December 31, 2019. The rate improved by 7.76% points from the October baseline to the January remeasurement (looking at claims processed as of 12/7/2019) (Figure 2-5). Statistical significance testing of these rates shows that the baseline and remeasurement rates for both interventions were statistically significant with a p value of less than 0.05.

Table 2-20. Intervention Timeline

DCOR Date	Date(s) DCOR Distributed to FQHCs	Number of FQHCs Targeted	Number of Members Targeted	DCOR Outcome Report Timeframe
5/14/2019	5/31/2019 – 6/7/2019	9	4,026	6/20/2019 – 9/18/2019

9/27/2019	10/11/2019	14	3,292	10/31/2019 – 1/29/2020*

*Allows for claims runout after 12/31/2019.

Table 2-21. DCOR Intervention

		Dental Exam (D0120)		Preventive Dental Visit (D1120)		Oral Sealant Applied (D1351)		
Intervention	**Number of members with no visit in previous 12 months**	**Number of members with dental visit within 90 days**	**% of members with dental visit within 90 days**	**Number of members with preventive service within 90 days**	**% of members with preventive service within 90 days**	**Number of members age 6 to 9 with no visit in previous 12 months**	**Number of members with sealant applied within 90 days**	**% of members with sealant applied within 90 days**
May 2019	3,198	472	14.76%	387	12.10%	828	44	5.31%
Oct 2019	2,655	430	16.20%	341	12.84%	637	31	4.87%

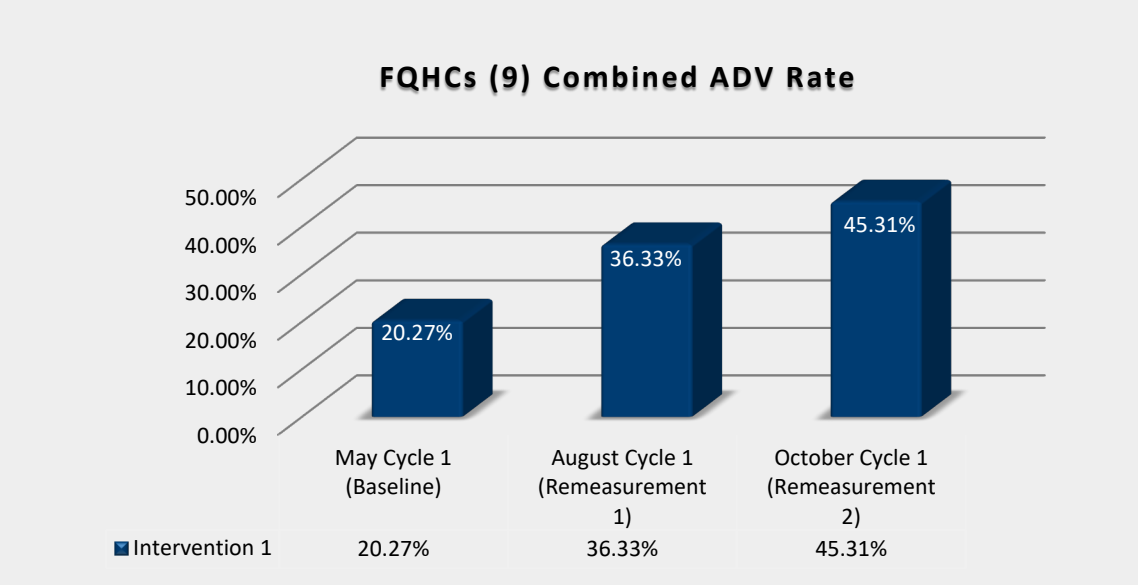


Figure 2-4. Intervention (Cycle 1-May 2019 DCOR Delivery)

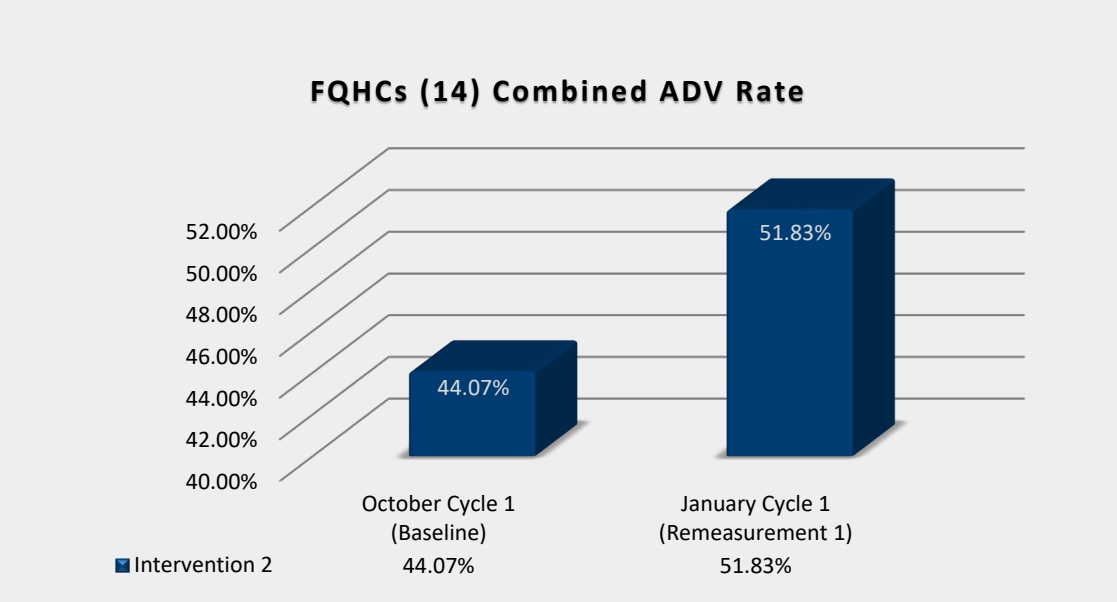


Figure 2-5. Intervention (Cycle 2-October 2019 DCOR Delivery)

Quarterly HEDIS® rates (Figure 2-6) shows the rate improved consistently over the course of the year and was statistically significant (p≤0.5).

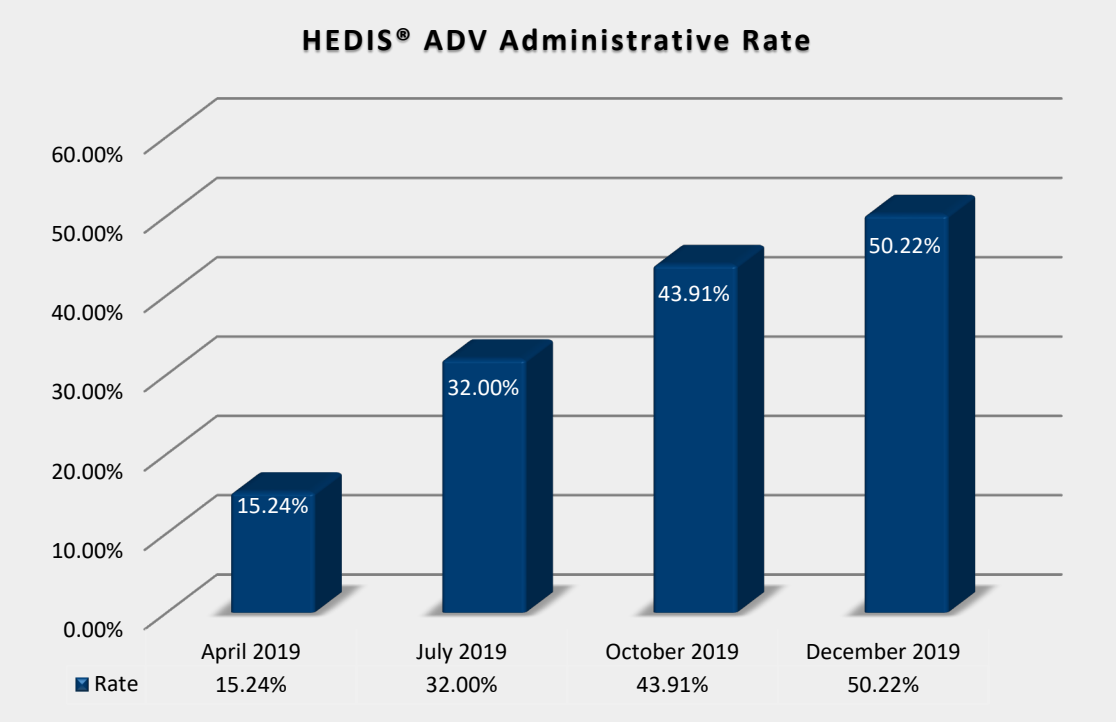


Figure 2-6. UnitedHealthcare HEDIS® ADV Rate (CY 2019-Quarterly)

PIP Result

The statewide rate for HEDIS® ADV for the baseline year (CY 2018) was 48.24.%. It increased to 53.70% during the measurement year (CY 2019), which is an improvement of 5.46% points (Figure 2-7). This increase is of a statistical significance as p value is 0.0 (P≤0.05 is significant). The aim of the PIP is met.

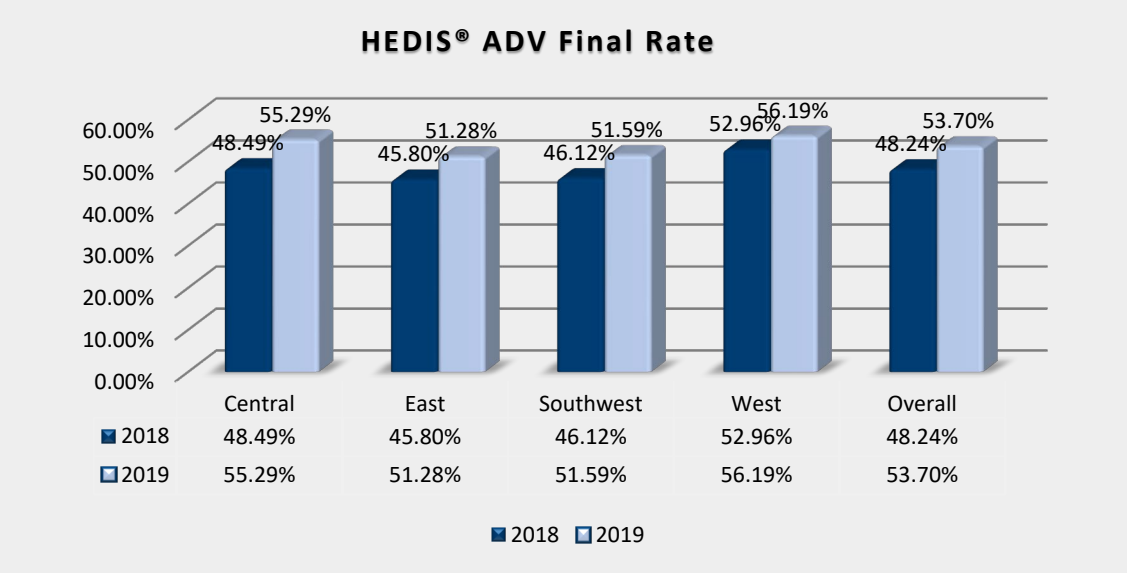


Figure 2-7. UnitedHealthcare HEDIS® ADV Rate (CY 2018-2019)

2.4.1 Quality, Timeliness, and Access

PIPs Score.

Primaris assigns a score of Low Confidence for both PIPs. The aim was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

The PIPs did not meet all the required guidelines stated in the CFR/MHD contract (Table 2-22). (Ref: 42 Code of federal Regulations (CFR) 438.330 (d)/MHD contract 2.18.8 d 1). Note: Definitions of Met/Partially Met/Not Met are utilized from CMS EQRO Protocol 3.

Table 2-22. UnitedHealthcare's PIPs Evaluation based on CFR guidelines

CFR Guidelines	Evaluation
Measurement of performance using objective quality indicators	Met
Implementation of system interventions to achieve improvement in quality	Not Met

Evaluation of the effectiveness of the interventions	Not Met
Planning and initiation of activities for increasing or sustaining improvement	Met

Strengths.

Improving Oral Health PIP: UnitedHealthcare initiated Plan-Do-Study-Act (PDSA) cycles to test the improvement (involved 9 FQHCs) and thereafter adopted the cycle by widening the scope (included 14 FQHCs). They reported results of secondary measures and the primary measure by test of significance (p value).

Weaknesses.

- Improving Childhood Immunization Status:

1. A link between member response to intervention (average CIS Combo 10 rate 10.83%) and changes in the CIS Combo 10 rate is not explained. CIS Combo 10 rates for members at ages 6, 8, 18 months in Apr was 40.40% (baseline), increased to 44.48% in July, decreased to 41.86% in Oct and again increased to 46.99%.

2. Even though the postcards were sent to children who were noncompliant at 6, 8, 18 months, the rationale for projecting CIS Combo 10 rates for only these age groups as an evidence to show improvement is not clear.

3. The overall HEDIS® CIS Combo 10 rate (administrative) for Apr is 9.07% (baseline-beginning of intervention) which increased to 12.73% in Jul, 13.98% in Oct, and 14.52% in Dec 2019. Thus, the increase from the baseline rate (beginning of intervention) in Apr to Dec (end of intervention) is 60% (5.45% points) which is much higher than the postcard response.

4. UnitedHealthcare stated, "Pfizer Missed Dose Postcard operates in 26 states within UnitedHealthcare Medicaid plans since 2017, to include Missouri." It is clear that the baseline projected in this PIP already was a part of ongoing intervention.

- Improving Oral Health PIP:

1. An assumption is made that distribution of DCOR reports to FQHCs have resulted in increased dental visits. There is no data to show if an action was taken by FQHCs (e.g., number of appointments scheduled for members appearing in the report) and how many members responded to those appointments. The member response rate of 22% (cycle 1) and 24% (cycle 2) could be due to members' own initiatives. There was an increase in

dental visit from Aug (36.33%) to Oct 2019 (45.31%) by 8.98% points even when the intervention was not in place.

2. The data does not suggest that the increase in HEDIS® ADV rate (primary measure) could be the result of intervention. The statewide HEDIS® ADV rate increased significantly from 15.24% (in Apr 2019) to 32.00% (in July 2019) by 16.76% points (Figure 5) at the beginning of the cycle-1 of intervention (DCOR distribution 5.31.2019-6.7.19). This indicated there are many other factors influencing HEDIS® ADV rate.

3. The secondary measures are reported as: dental exam 14.76%; preventive dental visit 12.10%; and oral sealant applied 5.31%, after May DCOR cycle-1 intervention. Baseline values and repeat measurements for these secondary measures are not reported.

2.4.2 Improvement from previous year

The statewide CIS Combo 10 rate has increased by 3.41% points and statewide rate for HEDIS® ADV has increased by 5.46% points. Table 2-23 shows UnitedHealthcare's compliance with the previous year's recommendations by EQRO.

Table 2-23. UnitedHealthcare's Response to Previous EQR's Recommendations

Recommendations	Action by UnitedHealthcare	Comment by EQRO
Primaris recommends: 1. UnitedHealthcare to follow CMS EQRO protocol and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015[6], for guidance on methodology and approach of PIPs to obtain meaningful results.	UnitedHealthcare has followed the steps mentioned in CMS EQRO PIPs Protocol.	Met
2. UnitedHealthcare must refine their skills in the development and implementation of approaches to effect change in their PIP.	UnitedHealthcare has shown some improvement.	Partially Met
3. The aim and study question(s) should be stated clearly in writing	Achieved.	Met

[4]https://www.medicaid.gov/medicaid/benefits/downloads/pip-manual-for-health-plans.pdf

(baseline rate, % increase to achieve in a defined period).		
4. 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.	Achieved.	Met
5. The interventions should be planned specifically for the purpose of PIP required by MHD Contract.	Intervention is ongoing each month since 2017, for CIS Combo 10 PIP. DCOR intervention seems to be ongoing as it included nine FQHCs in the initiation of the PIP.	Partially Met
6. The results should be tied to the interventions.	Analysis of results to link with intervention is not explained.	Not Met

2.5 Recommendations for MCOs

Table 2-24 displays recommendations (with numbers corresponding to the listed items) as applicable to Home State Health/Missouri Care/UnitedHealthcare.

Table 2-24 Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Missouri Care	UnitedHealthcare
1.	✓		
2.	✓	✓	✓
3.	✓	✓	✓
4.	✓	✓	✓
5.	✓	✓	✓
6.	✓	✓	
7.	✓	✓	✓
8.	✓	✓	
9.	✓	✓	
10.	✓	✓	✓
11.	✓	✓	✓
12.	✓		
13.			✓

14.			✓
Suggested Resources	✓	✓	✓

1. While several/ongoing interventions from previous years are very informative, Home State Health should present the interventions applied for the PIPs rather than for statewide or corporate wide operations.

2. Even though the overarching goal is mandated by MHD, MCOs have the flexibility to select a topic within specified parameters. To ensure a successful PIP, Home State Health should find early and regular opportunities to obtain input from staff, providers, and members on how to improve care delivery.

3. MCOs should translate the aim statement to identify the focus of the PIP and establish the framework for data collection and analysis on a small scale (Plan-Do-Study-Act Cycle-PDSA). The PIP populations should be selected from a county, provider office, or a region so that results can be measured during a PDSA cycle and subsequently applied on a larger scale.

4. MCOs should select a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) that could identify their performance on the PIPs and track improvement over time.
MCOs can use focus groups, surveys, and interviews to collect qualitative insights from members, MCO and provider staff, and key external partners. Qualitative measures can serve as the secondary measures and/or supplement the overall measurement set, providing information that will aid PIP planning and implementation.

5. MCOs should use variables/secondary measures that should tie an intervention to improvement.

6. Home State Health and Missouri Care should provide clear and concise definitions of data elements (including numerical definitions and units of measure) that would be collected after intervention.

7. MCOs should link their data collection plan to the data analysis plan to ensure that appropriate data would be available for the PIP.

8. Home State Health and Missouri Care should assess whether the PIP resulted in sustained improvement, whether repeated measurements were conducted, and if so,

whether significant change in performance relative to baseline measurement was observed. Repeat measurements (at least two) in short intervals should be conducted to determine whether significant change in performance relative to baseline measurement was observed.

9. Home State Health and Missouri Care should have a baseline rate presented before start of an intervention followed by at least two remeasurements, and analysis of results should be utilized for planning the next intervention (cycle-PDSA) for the future PIP. Additionally, primary and secondary measure/variable should be linked to illustrate an impact of the intervention on the performance of a project.

10. Effectiveness of the improvement strategy should be determined by measuring change in performance according to the predefined measures and linking to intervention.

11. When analyzing multiple data points over time, Home State Health can consider tools such as: time series; run and control chart; data dashboard; and basic trend analyses.

12. Home State Health is advised to follow the steps in CMS EQR Protocol 1 in chronological order.

13. UnitedHealthcare should conduct repeat measurements (at least two) in short intervals (unlike 90-day intervals selected in ADV PIP) to determine whether significant changes in performance relative to baseline measurements are observed.

14. UnitedHealthcare should determine the effectiveness of the improvement strategy by measuring change in performance according to the predefined measures and linking to intervention.

Suggested Resources
https://health.mo.gov/data/InterventionMICA/OralHealth/index_5.html
https://www.chcs.org/media/OHLC-Webinar-Slides_12.18.14.pdf

3.0 Validation of Performance Measures

3.1 Description, Objective, and Methodology

Primaris conducted performance measure validation activities for Home State Health, Missouri Care, and UnitedHealthcare as described in the CMS EQR protocol 2, version Oct 2019: Validation of Performance Measures. The performance measures selected by MHD for validation in EQR 2020 (measurement period CY 2019) were as following (also in Table 1-4 under section 1.3.2)

- Chlamydia Screening in Women (CHL)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)[7]
- Inpatient Mental Health Readmissions

MHD provided Primaris with the Healthcare Quality Data Instructions for CY 2019, which consisted of requirements and specifications for validation of Inpatient Mental Health Readmissions. Additionally, MHD instructed the MCOs to utilize the HEDIS® specifications for the CHL and W34 measures. Out of the three performance measures, 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 were administrative measures, which required primary source verification from each MCO's claim and/or encounter system.

For the hybrid measure, W34, Primaris requested either 45 or all (in case of less than 45) medical records for hybrid review. Primaris conducted over-reads of the 14 available medical records for Home State Health and UnitedHealthcare to validate compliance with both the specifications and abstraction process. Missouri Care opted to report the W34 measure administratively. Therefore, all measures were subjected to primary source verification from Missouri Care's claim and/or encounter system.

Since the Inpatient Readmissions for Mental Health measure was not considered a certified measure from NCQA, the MCOs had an 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

[7] Due to the Covid-19 pandemic an MCO was allowed to opt to report the W34 measure administratively for CY 2019 per MHD/NCQA guidelines.

verification 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 CMS 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 performance measures validation review. The communications addressed the medical record review methodology of selecting a maximum of 45 records for over read and the process for sampling and validating the administrative measure during the review process. Primaris provided specific questions to MCOs during the measure validation process to enhance the understanding of the ISCA responses during the virtual site visit.

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

Data Collection and Analysis

The following points describe components and the methodology used by Primaris to conduct its analysis and review:

- CMS's ISCA: All three 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 Home State Health and UnitedHealthcare, Primaris requested these two MCOs secure a maximum sample of 45 medical records (or all medical records if <45) for the W34 measure. Home State Health and UnitedHealthcare had a high rate of administrative claims capture for W34, therefore only 14 records were collected during their medical record abstraction process. Primaris used those 14 medical records to determine the validity of the positive results. As Missouri Care opted to report the W34 administratively, medical record review was not conducted.
- Source code verification for performance measures: The three MCOs contracted with a software vendor to generate and calculate rates for the two administrative performance measures, Inpatient Mental Health Readmissions and CHL. Primaris reviewed these source codes to determine whether there were no changes since the previous review in EQR 2019.

- 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 administrative claims for each administrative measure, Chlamydia Screening in Women and Inpatient Mental Health Readmissions, in order to conduct primary source verification to validate and assess MCOs' compliance with the numerator objectives.

Virtual Onsite Activities

Primaris conducted virtual onsite meetings with Home State Health on July 27; Missouri Care on July 28; and UnitedHealthcare on July 30, 2020. 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 on-site visit activities are described as follows:

- Opening Conference: The opening meeting included an introduction of the validation team and key MCOs' staff members involved in the performance measure validation activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- Review Information System Underlying Performance Measurement: 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 a) rate calculations were performed correctly, b) data were combined appropriately, and c) 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. These sessions were used by Primaris to assess confidence in 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.

- Assess Data Integration and Control Procedures: The data integration sessions comprised of system demonstrations of the data integration process and included discussions around data capture and storage, reviewing backup procedures for data integration, and addressing data control and security procedures.
- Complete Detailed Review of Performance Measure Production: Primaris conducted primary source verification to further validate the administrative performance measures.
- Assess Sampling Procedures for Hybrid Measures: Primaris verified that the three MCOs utilized appropriate sampling methodology using certified vendor software, Inovalon.
- Closing conference/Communicate Preliminary Findings: The closing conference included a summation of preliminary findings based on the review of the ISCA and the on-site meeting for each MCO.

Validation Process

As part of the performance measure validation process, Primaris reviewed MCOs' data integration, data control, and documentation of performance measure rate calculations. The scoring criteria used in validation process are described in Table 3-1.

Table 3-1. Scoring Criteria

Score	Definition
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 fully compliant with State specifications. This designation should be used for any validation component that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All components with this designation must include explanation of the deviation in the comments section.
N/A	The validation component was not applicable.

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. Primaris reviewed MCOs' actual results of file consolidations and extracts to determine if they were consistent with those which should have demonstrated results 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 the MCOs, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

Data Control: 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 with 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' Lead Auditor and Information Technology Analyst reviewed the computer programming codes, output files, workflow diagrams, primary source verification and other related documentations.

Performance Measure Specific Findings: Primaris determined validation results for each performance measure rate based on the definitions listed below. 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 an error for a single audit element may result in a designation of "Do Not Report (DNR)" because the impact of the error materially biased the reported performance measure. Conversely, it is also possible several audit element errors may have little impact on the reported rate, thus the measure is "Reportable (R)." The following is a list of the validation findings and their corresponding definitions:
R = Reportable: Measure was compliant with State specifications.
DNR = Do not report; MCO's rate was materially biased and should not be reported.
NA = Not applicable; MCO was not required to report the measure.
NR = Measure was not reported because MCO did not offer the benefit required by the measure.

3.2 Findings and Conclusions: Home State Health

Table 3-2 shows the scores achieved by Home State Health during the performance measures validation process.

Table 3-2. Home State Health Performance Measures Process

Criteria	Met	Not Met	N/A
Data Integration	●		
Data Control	●		
Performance Measure Documentation	●		
Medical Service Data (Claims and Encounters)	●		
Enrollment Data	●		
Provider Data	●		
Medical Record Review Validation	●		
Supplemental Data	●		

Data Integration

Home State Health's data integration process did not change from the previous year's review. Home State Health continued to use Inovalon software for performance measure production but migrated to the new version of Inovalon's QSI product called QSI Excel. Home State Health indicated there were no significant issues with the migration and no concerns were identified during on-site primary source verification. Home State Health consistently reviewed the data quality reports from QSI to ensure all data were captured and data errors were followed up on. Home State Health had a two-step validation process that logged records submitted with the file name and record counts. Files with the same name were matched against each other to determine if the record counts matched. The second-tier validation looked to determine error counts and error reasons. Home State Health conducted a full refresh of data rather than doing an incremental data load. This process captured all changes that may have occurred after the initial data were loaded.

Primaris verified 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 verified each measure's requirements against Home State's applications 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 the year. Home State Health's disaster recovery plan was sufficient to ensure data integrity. Home State Health reported no issues related to Covid-19 Pandemic in performance measure reporting.
No issues were identified with Home State Health's data integration processes.

Data Control
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.

Performance Measure Documentation
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 ISCA. Home State Health "Met" the requirements for this section.

Medical Service Data (Claims and Encounters)
Primaris verified with Home State Health there were no system or process changes from the previous review of claims and encounters. Home State Health reported no impact from Covid-19 Pandemic on its claims processing. Home State Health's medical services data system remained unchanged since the previous review. Home State Health used AMISYS as its primary claims processing system, which has been operational for several years. AMISYS captured all relevant fields for performance measure reporting. During the measurement year, there were no significant changes to the system other than usual maintenance and minor upgrades limited to provider contract and benefit maintenance. Home State Health continued to capture most of its claims electronically. The small number 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 continued to have very little manual intervention for claims processing. Most of the manual steps in processing were due to high-dollar claims that required

supervisor approval. As in previous audits, 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. Ninety-nine percent of Home State Health providers continued to be reimbursed based on an FFS payment model, which ensured claims were submitted in a timely manner. As part of the drilldown queries conducted for the audit, Primaris validated all claims contained appropriate coding and provider payment information. Provider identifiers were reviewed and verified to ensure they were active and credentialed at the time of service on the claim.
Primaris had no concerns with Home State Health's claims and encounter data processes.

Enrollment Data
There were no changes to the enrollment process from the previous year. Home State Health reported no impact from Covid-19 Pandemic on its ability to capture members' enrollment accurately. There were no reported backlogs of enrollments due to the pandemic.
Home State Health's enrollment data were housed in the AMISYS system, and no changes were made to the system 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 using electronic methods. 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 system. The automated process of enrollment at Home State Health included translation and compliance validation of the 834 file and loading of the data into AMISYS. The load program also identified members that were previously entered manually and updated their information, avoiding duplicate entries.

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 members from several administrative numerators and verified the members were compliant with the measure specifications. Primaris verified

age, gender, and enrollment history along with diagnosis and procedure codes. No issues were found during the system review.

Home State Health conducted appropriate oversight of the enrollment process through ongoing internal audits and communication with the State enrollment authority.
During the virtual review, Primaris verified the members captured in the performance measures were the appropriate populations.
Primaris had no concerns with Home State Health's ability to capture member information.

Provider Data

There were no changes to the provider process this 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 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 not significantly impacted from the Covid-19 Pandemic closures. The W34 measures numerator hits are primarily generated from administrative claims and

only a small number of numerator hits are generated from the medical record. Home State Health was fully compliant with the MRR reporting requirements. Home State Health abstracted records in accordance with the standard specifications for each measure. Home State Health conducted initial and ongoing training for each abstractor and regularly monitored the accuracy through inter-rate reliability checks. Home State Health provided adequate oversight of its vendor and Primaris had no concerns.

Primaris selected all 14 numerator positive records that were abstracted by Home State Health 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. No issues were detected in the sample of 14 medical records selected during the validation process.

Supplemental Data

Numerator positive hits through supplemental data sources W34 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record acquisition.

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

Table 3-3. Home State Health Key Review Findings and Audit Results

Performance Measure	Key Review Finding	Audit Result
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Reportable
Chlamydia Screening in Women (CHL)	No concerns identified	Reportable
Inpatient Mental Health Readmissions	No concerns identified	Reportable

Home State Health Measure Specific Rates (CY 2017-2019) (Tables 3-4, 3-5).

Table 3-4. Home State Health Rates (W34 and CHL)

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)			
Data Element/CY	2017	2018	2019
Numerator	270	225	239
Denominator	407	371	395
Rate	66.34%	60.65%	60.51%

Chlamydia Screening in Women All Ages (CHL)			
Numerator	1,733	3,750	2,972
Denominator	3,321	7,978	6,170
Rate	52.18%	47.00%	48.17%

Table 3-5. Home State Health Inpatient Mental Health Readmissions

Age Cohort	2017	2018	2019
Age 0-12	66	115	110
Age 13-17	123	193	163
Age 18-64	107	130	82
Age 65+	0	0	0
Total	296	438	355

Lower the better

3.2.1 Quality, Timeliness, and Access

Strengths.

- Home State Health staff was well prepared for an onsite review and had all claims and preparation completed ahead of schedule.
- Home State Health was able to demonstrate and articulate their knowledge and experience of the measures under review.
- Home State Health continues to update the AMISYS systems with most current diagnoses and procedures as they become available during the year.
- Home State Health did not appear to have any barriers to care services.
- Home State Health's policies and procedures address quality of care for its members.
- 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 of 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.
- Home State Health continues to monitor and improve upon the data capture in both primary and supplementary data for numerator compliance.

Weakness.

None to report at this time.

3.2.2 Improvement from previous year

Significant improvements were noted in the Inpatient Readmission measure (admissions dropped from 438 in 2018 to 355 in CY 2019). Minimal improvements were noted in the CHL measure (rate changed <5% as from 47.00% to 48.17%).

Response to Previous Year's Recommendations.

Table 3-6 describes actions taken by Home State Health in response to EQRO recommendations during previous EQR 2019.

Table 3-6 Home State Health's Response to Previous Year's Recommendations

Recommendation	Action by Home State Health	Comment by EQRO
1. Home State Health 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. Home State Health 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 has not already been addressed.	Home State Health continued to address gaps in care for all measures, but no specific activity addressed screenings.	Some improvement was noted in the CHL measure from 47% to 48.17%. Primaris recommends continued outreach to members for screenings.
2. Home State Health should consider looking at members in the Eastern region as it 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.	Regional reporting was not required for CY 2019 by MHD and therefore no specific regional efforts were noted by Home State Health. However, the regional rates submitted to Primaris show the Eastern region did experience a drop in readmission in 2019.	Overall, admissions decreased and Primaris is satisfied with the results.
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.	Home State Health staff advised they have conducted outreach through HEDIS® programs around the	Readmissions decreased in CY 2019.

	Follow Up after admissions for mental health diagnoses.	
4. Home State Health should continue incentivizing providers to meet with members for the W34 measure. They have included this measure in their P4P (Pay for Performance) in Jan 2018. This may positively impact the rates for future years.	Home State Health continues to communicate with their providers to improve the W34 measures.	Numerator-positive compliance for W34 did increase year over year from 225 to 239.

3.3 Findings and Conclusions: Missouri Care

Table 3-7 shows the scores achieved by Missouri Care during the performance measures validation process.

Table 3-7. Missouri Care Performance Measures Process

Criteria	Met	Not Met	N/A
Data Integration	●		
Data Control	●		
Performance Measure Documentation	●		
Medical Service Data (Claims and Encounters)	●		
Enrollment Data	●		
Provider Data	●		
Medical Record Review Validation	●		
Supplemental Data	●		

Data Integration

Missouri Care continued to use its internal data warehouse to combine all files for uploading to the Inovalon certified measures software. The internal data warehouse combined all systems and external data into tables for consolidation prior to loading into Inovalon's file layouts. The majority of information was derived from the Xcelys system while external data such as supplemental and vendor files were loaded directly into the data warehouse tables. Primaris conducted a review of the HEDIS® data warehouse and found it to be compliant. Missouri Care had several staff members involved in the process with many years of experience in dealing with data extractions, transformations, and loading. The warehouse was managed well, and access was only granted when required for

job duties.
Primaris conducted primary source verification and did not encounter any issues during the validation. Member data matched Xcelys as well as the data warehouse and Inovalon numerator events. Primaris also conducted a series of queries during the on-site audit and did not identify any issues. Primaris reviewed Missouri Care's preliminary rates and did not identify any concerns. There were no changes to Missouri Care's systems or data integration processes since the previous year's HEDIS® review.

Data Control
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.

Performance Measure Documentation
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.

Medical Service Data (Claims and Encounters)
There were no system or process changes from the previous review of claims and encounters for Missouri Care. Missouri Care reported no negative impact in claims processing due to the Covid-19 Pandemic. Missouri Care reported no backlog of claims that were not resolved in time to report the performance measures. During the virtual onsite review of the claims incurred but not received report (IBNR), no concerns were identified with claims not being captured on time for reporting. Over ninety-five percent (95%) of claims were received in time to be included in the performance measures. Missouri Care was also acquired by Centene in 2019; however, all claims were processed on the Missouri Care claims/encounter system. Therefore, there were no changes for measurement reporting in 2020 for CY 2019 data.

All claims were processed through Xcelys. Primaris reviewed Missouri Care's claims process during the on-site audit and determined no significant changes occurred in Xcelys or in the overall claims process since the prior year. Documentation provided in the Roadmap tables was reviewed in Xcelys. Missouri Care staff members indicated there were no processing changes during the measurement year. Missouri Care's Xcelys system captured primary and secondary procedure and diagnosis codes without any issues. The

claims system also had the capability to capture as many codes as were billed on a claim. Paper claims transactions were mailed to a Tampa, Florida, mailbox (Change Healthcare [Relay Health]), where they were then captured by Imagenet. Imagenet scanned the claims, converted them to an 837 format, and verified all data were captured. Imagenet's quality control center ensured data were captured appropriately.

Missouri Care monitored the Imagenet claims daily to ensure all values were captured on the scanned claims. Audits were conducted on 3 percent of all claims submitted. Nearly 100 percent of claims were processed offshore, with exceptions. Approximately 84 percent of all claims were auto adjudicated. In addition to the edits conducted in the pre-processing steps, Missouri Care used edits within Xcelys to detect provider, member, and payment errors to ensure members existed and payments were accurate. Missouri Care indicated that it had no issues with claims processing in 2019. Ninety-nine percent of all claims were captured within one day and 100 percent within two days. Missouri Care also captured encounter data from capitated vendors. Vendor encounters included dental, transportation, and vision. While these encounters were not captured in Xcelys, they underwent edits in Edifecs (XEngine) to verify valid billing codes and member information.
Primaris did not have any concerns with Missouri Care's claims and encounter data processing.

Enrollment Data
Missouri Care received daily enrollment files from the State via a process that has been in place over the last several years. Missouri Care received the daily enrollment files in a standard Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 834 electronic format and loaded the files directly into Xcelys. Missouri Care reconciled the daily files with a monthly file, also provided by the State, to ensure data were accurate prior to enrolling the member. Primaris reviewed the Xcelys system during the on-site audit and confirmed each enrollment span was captured. Additionally, Primaris reviewed several enrollment records to ensure that all HEDIS®-required data elements were present and accurate. Primaris conducted on-site drill downs that looked at the enrollment process and enrollment spans for all Missouri Care members. Additional queries looked at the length of enrollment for all members. The average length of time a member was continuously enrolled was 11 months or more, which was no different than the last review Primaris conducted. Missouri Care denied having issues with the enrollment process during the measurement year.
Missouri Care conducted appropriate oversight of the enrollment process through ongoing internal audits and communication with the State enrollment authority. Primaris confirmed there were no changes to Missouri Care's enrollment data process since the

previous year's review.
Missouri Care reported no issues with managing the enrollment process due to Covid-19 or for any other reason in 2019.

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 the required HEDIS® reporting elements were present in Xcelys and provider specialties were accurate based on the provider mapping documents submitted with Missouri Care's ISCA. All providers were appropriately credentialed in the specialties in which they were practicing. 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. Missouri Care also denied having any issues related to the Covid-19 Pandemic.

Medical Record Review Validation (MRRV)

Missouri Care stated they were significantly impacted by the COVID-19 pandemic and therefore opted to report administratively. This resulted in a selection of 45 administrative claims for primary source verification review. No issues were detected in the sample of 45 administrative claims during the validation process.

Supplemental Data

Numerator positive hits through supplemental data sources W34 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record acquisition.

Table 3-8 shows the key review findings and final audit results for Missouri Care for each performance measure rate.

Table 3-8. Missouri Care Key Review Findings and Audit Results

Performance Measure	Key Review Finding	Audit Result
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Reportable
Chlamydia Screening in Women (CHL)	No concerns identified	Reportable
Inpatient Mental Health Readmissions	No concerns identified	Reportable

Missouri Care Measure Specific Rates (CY 2017-2019) (Tables 3-9, 3-10)

Table 3-9. Missouri Care Rates (W34 and CHL)

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)			
Data Element/CY	**2017**	**2018**	**2019**
Numerator	263	22,099	18,709
Denominator	411	35,940	28,450
Rate	63.99%	61.49%	65.76%
Chlamydia Screening in Women All Ages (CHL)			
Numerator	1,458	2,288	1,909
Denominator	3,534	7,402	5,899
Rate	41.26%	30.91%	32.36%

Table 3-10. Missouri Care Inpatient Mental Health Readmissions

Age Cohort	2017	2018	2019
Age 0-12	137	204	169
Age 13-17	158	230	233
Age 18-64	130	111	112
Age 65+	0	0	0
Total	425	545	514

Lower the better

3.3.1 Quality, Timeliness, and Access

Strengths.

- Missouri Care staff was well prepared for an onsite review and had all claims and preparation completed ahead of schedule.
- Missouri Care was able to demonstrate and articulate their knowledge and experience of the measures under review.
- Missouri Care continues to update the Xcelys system with the most current diagnoses and procedures as they become available during the year.
- Missouri Care did not appear to have any barriers to care services even considering the merger with Centene and thereafter with Anthem.
- Missouri Care's policies and procedures address quality of care for its members.
- 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 of 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 continues to monitor and improve upon the data captured in both primary and supplementary data for numerator compliance.

Weakness.

During the virtual on-site review, there were no immediate weaknesses detected.

3.3.2 Improvement from previous year

- Minimal improvements were noted in the Inpatient Readmission measure (admissions dropped from 545 in CY 2018 to 514 in CY 2019).
- Minimal improvements were noted in the CHL measure (rate changed <5%, from 30.91% to 32.36%).
- Minimal improvements were noted in the W34 measure (rate change <5%, from 61.49% to 65.76%).

Response to Previous Year's Recommendations.

Table 3-11 describes actions taken by Missouri Care in response to EQRO recommendations during previous EQR 2019.

Table 3-11. Missouri Care's Response to Previous Year's Recommendations

Recommendation	Action by Missouri Care	Comment by EQRO
1. 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.	Regional reporting was not required this year. Missouri Care continued to engage members of any care requirements.	Minor improvements were noted for CHL. It is recommended that Missouri Care continue to enhance outreach to members and providers for the future review.
2. Missouri Care was 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.	Regional reporting was not required this year.	Minor improvements were noted for the readmission measure.
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.	Members are engaged throughout the year to seek outpatient services.	Readmissions decreased for CY 2019. Missouri Care should continue to create outreach programs/care management to prevent further readmissions for the same diagnosis.
4. Missouri Care should consider incentivizing providers to meet with members for the W34 measure. This may positively impact the rates for future years.	Missouri Care continues to communicate with their providers to improve the W34 measure.	Minor improvements were noted for W34. This measure was retired by NCQA in Measurement Year 2020 and therefore will no longer be part of the performance measurement. No further action is required.

3.4 Findings and Conclusions: UnitedHealthcare

Table 3-12 shows the scores achieved by UnitedHealthcare during the performance measures validation process.

Table 3-12. UnitedHealthcare Performance Measures Process

Criteria	Met	Not Met	N/A
Data Integration	●		
Data Control	●		
Performance Measure Documentation	●		
Medical Service Data (Claims and Encounters)	●		
Enrollment Data	●		
Provider Data	●		
Medical Record Review Validation	●		
Supplemental Data	●		

Data Integration

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 codes 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. In the previous year's review, a critical error was found in the Inpatient Mental Health Readmission measure (i.e., the numerator contained members that

were not in the Medicaid population). 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 such errors detected in this year's review and UnitedHealthcare was able to report the measure without incident.
There were no other concerns with UnitedHealthcare's ability to consolidate and report data.

Data Control
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.

Performance Measure Documentation
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.

Medical Service Data (Claims and Encounters)
UnitedHealthcare's FACETs system underwent an upgrade during the measurement year. The upgrade did not materially affect the processing of claims other than to streamline real-time work distribution and improve auto-adjudication rates by efficiently correcting repetitive errors. Coding updates to the FACETs system were made annually. UnitedHealthcare only 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 and returned for additional information. 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 containing errors such as invalid Current Procedural Terminology (CPT) or diagnosis codes were rejected and returned 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 by randomly selecting thirty-two (32) claims on a weekly basis to validate accuracy and data quality. Quality errors were rectified, and additional training was

provided to the claims examiners when issues arise. FACETS provided the claims examiner with specific error messages when a pre-authorization request did not match the service rendered by the provider or when the provider did not request a pre-authorization prior to rendering the service. In either circumstance, the claim required medical review and was pended for 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.

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 members 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 were evaluated under the ISCA report.
There were no issues identified with UnitedHealthcare's enrollment data processes as it pertains to 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 receive 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 providers' specialties are not synchronized with providers' education and board certifications.
Primaris reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification and 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 selected all 14 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. No issues were detected in the sample of 14 medical records selected during the validation process.

Supplemental Data
Numerator positive hits through supplemental data sources W34 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record acquisition.

Table 3-13 shows the key review findings and final audit results for UnitedHealthcare for

each performance measure rate.

Table 3-13. UnitedHealthcare Key Review Findings and Audit Results

Performance Measure	Key Review Finding	Audit Result
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Reportable
Chlamydia Screening in Women (CHL)	No concerns identified	Reportable
Inpatient Mental Health Readmissions	No concerns identified	Reportable

UnitedHealthcare Measure Specific Rates (CY 2017-2019) (Tables 3-14, 3-15).

Table 3-14. UnitedHealthcare Rates (W34 and CHL)

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)		
Data Element/CY	**2018**	**2019**
Numerator	220	249
Denominator	411	411
Rate	53.53%	60.58%
Chlamydia Screening in Women All Ages (CHL)		
Numerator	2,481	2,275
Denominator	5,514	4,921
Rate	44.99%	46.23%

Table 3-15. UnitedHealthcare Inpatient Mental Health Readmissions

Age Cohort All Regions	2018	2019
Age 0-12	46	63
Age 13-17	83	96
Age 18-64	53	36
Age 65+	0	0
Total	182	195

Lower the better

3.4.1 Quality, Timeliness, and Access

Strengths.

- UnitedHealthcare staff was well prepared for an onsite review 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.
- UnitedHealthcare updated their source code and implemented additional quality assurance steps in place to ensure the correct population is being reported. This addressed the concerns found in the previous year's review where Medicare members were counted in the Inpatient Mental Health Readmission measure.
- UnitedHealthcare did not appear to have any barriers to care services.
- UnitedHealthcare's policies and procedures address quality of care for its members.
- 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 of 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.

Weakness.

UnitedHealthcare experienced an increase in readmissions for mental illness from the previous year, mainly in the pediatric cohort (0-17 years of age). Program development in this area may be necessary to avoid readmissions for the same diagnosis.

3.4.2 Improvement from previous year

- UnitedHealthcare implemented safeguards in place to ensure accurate reporting of the Medicaid population. This addressed the concerns found in the previous year's review where Medicare members were counted in the Inpatient Mental Health Readmission measure.
- Significant improvements were noted in the W34 measure (rate changed >5% from 53.35% to 60.58%).
- Minimal improvements were noted in the CHL measure (rate changed <5% as from 44.99% to 46.23%).

Response to Previous Year's Recommendations.

Table 3-16 describes actions taken by UnitedHealthcare in response to EQRO recommendations during previous EQR 2019.

Table 3-16. UnitedHealthcare's Response to Previous Year's Recommendations

Recommendation	Action by UnitedHealthcare	Comment by EQRO
1. UnitedHealthcare should examine 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.	UnitedHealthcare corrected the coding error that allowed DSNP members into the Inpatient Readmissions measure.	Issue corrected and no concerns.
2. UnitedHealthcare should continue 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 these two regions would be good candidates for deeper dives into why compliance is lower than other regions.	UnitedHealthcare continues to send reminders to providers and members. Regional reporting has been eliminated for these two measures.	Continue to observe open gaps for measures to ensure member are offered every opportunity to get the required care.
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.	UnitedHealthcare staff advised Primaris that they have conducted outreach through HEDIS® programs around the Follow Up after Hospitalization for Mental Illness measure. There was no overall reduction in the readmissions for mental illness.	Enhanced care management and outreach is needed to reduce readmissions for mental illness within 30 days of discharge.

3.5 Recommendations for MCOs

Table 3-17 displays recommendations (with numbers corresponding to the listed items) as applicable to Home State Health/Missouri Care/UnitedHealthcare.

1. Primaris recommends Home State Health continue reaching out to members and providers to increase Chlamydia screenings. Home State Health 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. Home State Health 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 has not already been addressed.

2. Primaris continues to recommend Home State Health pursue outpatient mental health engagements following a discharge from a hospital with a diagnosis of mental illness.

3. While it was not noted as a weakness for Home State Health and Missouri Care, but noted as a weakness for UnitedHealthcare, many readmissions at all MCOs were from individual members with severe mental illness being readmitted multiple times. Primaris recommends MCOs conduct further examination into solutions for the continuous readmissions by individual members, especially in the pediatric cohort (ages 0-17).

4. Although readmissions decreased for the measurement year and effective January 23, 2020, ownership of Missouri Care was changed from WellCare to Anthem, Inc., Primaris recommends that Anthem continue to create outreach programs to prevent readmissions within 30 days for the same mental health diagnosis.

Table 3-17 Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Missouri Care	UnitedHealthcare
1.	✓		
2.	✓		
3.	✓	✓	✓
4.		✓	

3.6 Information Systems Capabilities Assessment

3.6.1 Description and Methodology

MHD requires Primaris to perform a detailed ISCA once in every three years. However, Primaris performs ISCA each year, relevant to the mandatory activity: Validation of Performance Measures. Additionally, Primaris analyzes any major change that occurred from previous year that would affect MCO information systems and related performance measures outcomes. In EQR 2020, MHD contract and communications specified additional validation of the two points below.

- All network providers must be enrolled with MHD as a Medicaid provider as of

January 1, 2018 per 42 Code of Federal Regulations (CFR) 438.602(b) and 438.608(b) (MHD contract 2.18.8c).

- MCO shall have one integrated information system platform for care management and utilization management that provides both physical health and behavioral health information, including but not limited to claims data, notes, and prior authorizations. MCO shall have one integrated information system platform implemented by June 30, 2019 (MHD contract 2.26.10).

Primaris bases their methodology directly on the Centers for Medicare and Medicaid Services (CMS) EQR protocol, Appendix A-Information Systems Capabilities Assessment including Tool for Assessing MCO Information Systems, Information System Review Worksheet and Interview Guide. Data collection, review, and analysis were conducted via the ISCA data collection tools, interview responses, security walk-throughs, and claim/encounter data lifecycle demonstrations.

A full ISCA was conducted for Home State Health and Missouri Care in EQR 2018 and for UnitedHealthcare in EQR 2019. The section(s) rescored for ISCA in EQR 2020, are those where change occurred or concern for data integrity was raised. Thus, if there was no change reported or detected, the section was not rescored.

A complete ISCA is conducted under seven sections.

- A – Information Systems
- B – IT Infrastructure
- C – Information Security
- D – Encounter Data Management
- E – Eligibility Data Management
- F – Provider Data Management
- G – Performance Measures and Reporting

The ISCA change review process consists of four phases, focused and applied to areas of change.

Phase 1. Change notification: Primaris sends the official ISCA change notification request to the MCO with a deadline to be completed and returned electronically to Primaris prior to the scheduled onsite (virtual) review activities. Each MCO is asked to proactively report any change throughout the year to Primaris. The official notice serves as a final chance to report changes prior to the live interviews and demonstrations.

Phase 2. Change review: Primaris reviews change reports and supporting documentation. All submitted documentation is thoroughly reviewed, flagging answers that seem incomplete or indicating an inadequate process for follow-up. The follow-up questions and review take place during the onsite activities.

Phase 3. Onsite activities: Primaris conducts interviews with the MCO's staff to review any proprietary material, live system demonstrations and security walk-throughs. Open interviews with other members of staff related to their information systems management presentation(s) are expected.

Phase 4. Analysis: Primaris compares and scores the findings against industry standards and contract requirements, determining if any major system changes have occurred. If a change was reported or detected during analysis, then the coordinating ISCA subsection(s) will be rescored and reported. Scoring standards are described in Table 3-19.

ISCA Scoring Key and Standards.

Each section of the ISCA is awarded one of the three scoring options: Fully Met, Partially Met, or Not Met. In the event a Partially Met or Not Met score is awarded, recommendations will be provided to MCOs by Primaris. Scores for the ISCA align with other EQR protocols Not Met criteria. Table 3-18 presents the scoring key used and descriptions.

Table 3-18. Scoring Key

Scoring Key	Description
Fully Met	All necessary requirements were proven to be satisfied with supporting documentations, system demonstrations, and staff interviews.
Partially Met	Some supporting evidence and/or positive results that meet some of the requirements and industry standards.
Not Met	No supporting evidence or positive results to meet requirements and industry standards.

Scoring Standards.

Scoring Standards Table 3-19 presents the detailed Federal regulations, MHD Managed Care contract requirements, and industry standards against which Home State Health was evaluated.

Table 3-19. 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 HealthNet Division (MHD)	Claims Processing and Management Information Systems section.
Section 2.18.8c MHD Contract	Missouri HealthNet Division (MHD)	All network providers must be enrolled with MO HealthNet as a Medicaid provider as of January 1, 2018.
NIST	National Institute of Standards and Technology	"The Information Systems Group develops and validates novel computational methods, data/knowledge mining tools, and semantic services using systems-based approaches, to advance measurement science and standards in areas such as complex biological systems, translational medicine, materials discovery, and voting, thus improving the transparency and efficacy of decision support systems" **
ANSI ASC X 12	American National Standards Institute, the Accredited Standards Committee	"The American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for inter-industry electronic exchange of business transactions, namely electronic data interchange." ***

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

3.6.2 Findings and Conclusions: Home State Health

Reported Change Review: Provider Portal.

Home State Health reported one significant change to their information systems since the last ISCA, in EQR 2018. Upon review of the change and related documentation it is determined there is no major impact to Home State Health's information systems or performance measure outcomes. The reported change enhances Home State Health's provider data management capabilities and aligns with requirements of MHD contract 2.26.10: One Integrated Information System Platform and 2.18.8c: Networked Providers Enrollment. Impact of change is determined by comparing the change-related documentation to the key scoring components in the corresponding ISCA section. Specific details and score of the change to Home State Health's information systems are documented as follows:

ISCA section(s) affected: A–Information Systems, D–Encounter Data Management, F–Provider Data Management.
ISCA section(s) not affected: B–IT Infrastructure, C–Information Security, E–Eligibility Data Management, G–Performance Measures and Reporting.

Score: Met

Home State Health demonstrated their own Provider Portal to the Primaris team on July 27, 2020. Implementing the full capabilities of this system has been in development and released this year at no additional cost for providers. The Provider Portal allows providers to check eligibility, submit, correct, and check claim status, submit and view prior authorizations, view patient care gaps and more. The portal is online and available 24/7, truly enhancing communication efforts. The portal does not house any of the information accessed, it merely displays information from Home State Health's back-end systems. Empowering providers with access to real-time information is a great effort in data accuracy maintenance. Primaris determines this change has no adverse effect on calculation of performance measures or systems integration. The Provider Portal serves as a new documented strength for Home State Health's ISCA.

Additional Validations from MHD Contract.

Network Providers Enrollment.

Primaris also queried the provider data leadership and staff while viewing virtual walk-throughs of Home State Health's provider data management system. Home State Health was able to show data samples and provide documentation per requirements of MHD contract 2.18.8c: All network providers must be enrolled with MO HealthNet as a Medicaid provider as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b). Primaris found

opportunity for improvement on maintaining accurate provider data, specific details on data accuracy and scoring are as follows:

ISCA section(s) affected: F–Provider Data Management.
ISCA section(s) not affected: A-Information Systems, B-IT Infrastructure, C-Information Security, D- Encounter Data Management, E-Eligibility Data Management, G-Performance Measures and Reporting.

- **Score: Partially Met**

Home State Health attested all networked providers are enrolled with MHD as Medicaid providers. During live demonstrations on July 27, 2020, Home State Health staff displayed documents and explained their provider credentialing process and provider enrollment process. Home State Health has a robust system for processing and storing data proactively sent from providers and/or rosters. Primaris addressed the question of provider data accuracy: "Once a provider has been enrolled how does Home State Health ensure the accuracy of data published into the provider directory over time?" Home State Health responded with highlighting the provider portal. Though the portal opens the line of communication between Home State Health and the provider, the initial notification or request for change must still be initiated by the provider. This process does not address unreported changes in specialty, phone number, address, hours, etc. Primaris questioned Home State Health's thoughts on a more proactive approach, such as regular outreach to the providers. Home State Health responded by expressing concern about causing additional time and burden on the providers and office staff, especially currently with added pandemic stress. Home State Health also assured there is validation checking performed by the provider data management team but is focused on data type accuracy (street validation, date) versus accuracy of published provider data (services offered). The setback is the risk of having undetected, incorrect data published in the provider directory. There is an opportunity for collaboration to help reduce the burden while lessening the chance of incorrect data being stored and published. The goal is to provide members with the most accurate data possible to increase quality and timeliness of care.
This finding results in a Partially Met score rating. Though Home State Health utilizes very strong systems (i.e., Provider Portal) and processes, simple efforts to improve this metric will result in positive impact on the quality of services offered to members. Please see the recommendation in section 3.6.4 for suggestion on how to improve this rating.

One Integrated Information System Platform.

Primaris verified Home State Health has one integrated systems platform for care management and utilization management that provides both physical health and behavioral health information. During interviews, Primaris asked Home State Health staff

to demonstrate data integration mapping and processing by walking through a series of data collection, update, and validation exercises. Home State Health was able to satisfy the requirements of MHD contract 2.26.10: One Integrated Information System Platform. Details and scoring are as follows:
ISCA section(s) affected: A–Information Systems.
ISCA section(s) not affected: B-IT Infrastructure, C-Information Security, D- Encounter Data Management, E-Eligibility Data Management, F-Provider Data Management, G-Performance Measures and Reporting.

Score: Met

Primaris requested Home State Health staff to demonstrate data integration mapping and processing by walking through a series of data collection, update, and validation exercises during onsite activities July 27, 2020. Home State Health was able to provide several samples of thorough data integration between all systems into one unified platform. Data was input or updated in several different fields of the front-end collection systems and then followed the exact data field through processing to verify updates at the storage level. Integration walk throughs for various data elements were verified in direct conversation with leadership staff and additionally reviewed on each performance measure member sample review.

Quality, Timeliness, and Access.

Home State Health's change affected three of seven scoring sections within the ISCA protocol: A–Information Systems, D–Encounter Data Management and F–Provider Data Management.
Additional review points from MHD's contract affected one of the seven scoring sections within the ISCA protocol: F–Provider Data Management.
Rescored results (Tables 3-20 to 3-22) for the affected sections and subsections are below.

Table 3-20. Home State Health Information Systems (A) Rescore Results

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

EDI	None	Met		45 CFR 164.312, ANSI, Section 2.26.5 MHD Contract
TOTAL SCORE		**Met**		

Table 3-21. Home State Health Encounter Data Management (D) Rescore Results

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

Table 3-22. Home State Health Provider Data Management (F) Rescore Results

Sub-section	Issues	Score		Citation/Standard
Provider Directory Management	Reactive process to maintain provider demographic information published in the provider directory.	Partially Met		42 CFR 438.242, 438.608, Section 2.12.17, 2.18.8 MHD Contract
Payment Reconciliation	None	Met		42 CFR 438.242, 438.608
TOTAL SCORE		**Partially Met –**		

Strengths.

- Strong platform for provider communication with Home State Health's Provider Portal.
- Policies, procedures, and robust training documentation readily available to all necessary staff.

- Testing processes and development methodologies meet and exceed industry standards.
- Change requests processed in-house with strict guidelines and managed by current staff members.
- Implemented adequate validation edits in its data processes.
- Encounter data is not altered by Home State Health but sent back to source for correction.
- Consistent communication regarding upcoming changes.

Weaknesses.

- Risk of publishing incorrect provider information in the provider directory.

3.6.3 Findings and Conclusions: Missouri Care

Reported Change Review: Virtual Health Launch.

Missouri Care reported one change to their information systems since the last ISCA, in EQR 2018. Upon review of the change and related documentation it is determined there is no major impact to Missouri Care's information systems or performance measure outcomes. The reported change enhances Missouri Care's care management capabilities and aligns with requirements of MHD contract 2.26.10: One Integrated Information System Platform. Impact of the change is determined by comparing the change-related documentation to the key scoring components in the corresponding ISCA section. Specific details and score of the change to Missouri Care's information systems are documented as follows:

ISCA section(s) affected: A–Information Systems, D–Encounter Data Management.
ISCA section(s) not affected: B–IT Infrastructure, C–Information Security, E–Eligibility Data Management, F– Provider Data Management, G–Performance Measures and Reporting.

Score: Met

Summary: As part of Missouri Care's continuing enhancements of CareCentral, the Case Management component was launched powered by Virtual Health®. This new component was available for Missouri membership beginning June 1, 2019. The platform provides automated capabilities to manage all aspects of care and program monitoring for members. The system allows care managers to follow members from pre-enrollment to program completion in a systematic process. It also supports the use of data-driven algorithms to determine urgency and prioritization of assignment and outreach. Care Managers then use a proprietary Comprehensive Needs Assessment (CNA) that auto-populates information from medical and pharmacy claims and Health Risk Assessment (HRA) data. Members'

unique responses to the CNA auto generate an individualized and customizable set of problems, goals and interventions. Additionally, there are offline capabilities for field staff to complete assessments and care plans with an auto synchronization upon upload. The system is designed to be member-centric, allowing all assessments and care plan information to be utilized across programs and managed holistically by multiple care team members. Primaris determines this change has no adverse effect on calculation of performance measures or systems integration.

Additional Validations from MHD Contract.

Network Providers Enrollment.

Primaris also queried the provider data leadership and staff while viewing virtual walk-throughs of Missouri Care's provider data management system. Missouri Care was able to show data samples and provide documentation per requirements of MHD contract 2.18.8c: All network providers must be enrolled with MO HealthNet as a Medicaid provider as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b). Primaris found opportunity for improvement on maintaining accurate provider data, specific details on data accuracy and scoring are as follows:

ISCA section(s) affected: F–Provider Data Management.
ISCA section(s) not affected: A-Information Systems, B-IT Infrastructure, C-Information Security, D- Encounter Data Management, E-Eligibility Data Management, G-Performance Measures and Reporting.

Score: Partially Met

Missouri Care attested all networked providers are enrolled with MHD as Medicaid providers. During live demonstrations on July 28, 2020, Missouri Care staff displayed documents and explained their provider credentialing process and provider enrollment process. Missouri Care has a robust system for processing and storing data proactively sent from providers and/or rosters. Primaris addressed the question of provider data accuracy: "Once a provider has been enrolled how does Missouri Care ensure the accuracy of data published into the provider directory over time?" Missouri Care relies on the providers to fill out the appropriate form to notify Missouri Care. The form begins an automated change management request and log that is cleared daily/weekly by the provider data team. This process does not address unreported changes in specialty, phone number, address, hours, etc. Primaris questioned Missouri Care on a more proactive approach, such as regular outreach to the providers. Missouri Care responded by expressing concern about causing additional time and burden on the providers and office staff, especially currently with added pandemic stress. Missouri Care also assured that there is validation checking performed by the provider data management team but is focused on data type accuracy

(street validation, date) versus accuracy of published provider data (services offered). The setback is the risk of having undetected, incorrect data published in the provider directory. There is an opportunity for collaboration to help reduce the burden while lessening the chance of incorrect data being stored and published. The goal is to provide members with the most accurate data possible to increase quality and timeliness of care.
This finding results in a Partially Met score. Though Missouri Care utilizes very strong systems and processes, simple efforts to improve this metric will result in positive impact on the quality of services offered to members. Please see the recommendation in section 3.6.4 for suggestion on how to improve this rating.

One Integrated Information System Platform.

Primaris verified Missouri Care has one integrated systems platform for care management and utilization management that provides both physical health and behavioral health information. During interviews, Primaris asked Missouri Care staff to demonstrate data integration mapping and processing by walking through a series of data collection, update, and validation exercises. Missouri Care was able to satisfy the requirements of MHD contract 2.26.10 One Integrated Information System Platform. Details and scoring are as follows:

ISCA section(s) affected: A–Information Systems
ISCA section(s) not affected: B-IT Infrastructure, C-Information Security, D- Encounter Data Management, E-Eligibility Data Management, F-Provider Data Management, G-Performance Measures and Reporting

Score: Met

Primaris requested Missouri Care staff to demonstrate data integration mapping and processing by walking through a series of data collection, update, and validation exercises during onsite activities July 28, 2020. Missouri Care was able to provide several samples of thorough data integration between all systems into one unified platform. Data was input or updated in several different fields of the front-end collection systems and then followed the exact data field through processing to verify updates at the storage level. Integration walk throughs for various data elements were verified in direct conversation with leadership staff and additionally reviewed on each performance measure member sample review.

Quality, Timeliness, and Access.

Missouri Care's change affected a total two of seven scoring sections within the ISCA protocol, A–Information Systems and D–Encounter Data Management.
Additional review points from MHD's contract affect one of the seven scoring sections within the ISCA protocol, F–Provider Data Management.

Rescored results (Tables 3-23 to 3-25) for the affected sections and subsections are below.

Table 3-23. Missouri Care Information Systems (A) Rescore Results

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

Table 3-24. Missouri Care Encounter Data Management (D) Rescore Results

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

Table 3-25. Missouri Care Provider Data Management (F) Rescore Results

Sub-section	Issues	Score		Citation/Standard
Provider Directory Management	Reactive process to maintain provider demographic information published in the provider directory.	Partially Met		42 CFR 438.242, 438.608, Section 2.12.17, 2.18.8 MHD Contract

Payment Reconciliation	None	Met		42 CFR 438.242, 438.608
TOTAL SCORE		**Partially Met**		

Strengths.

- Policies, procedures, and robust training documentation readily available to all necessary staff.
- Experienced IT staff.
- Testing processes and development methodologies meet and exceed industry standards.
- Change requests processed in-house with strict guidelines and managed by current staff members.
- Implemented adequate validation edits in its data processes.
- Encounter data is not altered by Missouri Care, but sent back to source for correction.
- Consistent communication regarding upcoming changes.
- Frequent internal audits.

Weaknesses.

- Risk of publishing incorrect provider information in the provider directory.

3.6.3 Findings and Conclusions: UnitedHealthcare

UnitedHealthcare reported three changes to their information systems since the last ISCA in EQR 2019. Upon review of the changes and related documentation, it is determined that the changes do not have major impact to UnitedHealthcare's information systems or performance measure outcomes. All changes reported proved to enhance UnitedHealthcare's use of their current infrastructure and data management. Impact of each change is determined by comparing the change-related documentation to the key scoring components in the corresponding ISCA section. Specific details and score of each change to UnitedHealthcare's information systems are documented as follows:

Reported Change Review.

1. Claim and Encounter Suspend Process.

ISCA section(s) affected: D–Encounter Data Management, F–Provider Data Management

ISCA section(s) not affected: A–Information Systems, B–IT Infrastructure, C–Information Security, E–Eligibility Data Management, G–Performance Measures and Reporting.

Score: Met

UnitedHealthcare reported a change to the Medicaid claims/encounter suspend ("pend") process including timeliness of reconciling pended services. A provider outreach program was implemented on August 14, 2019 for coordination of benefits-related denials including missing or invalid explanation of benefits. In this process a trained examiner/processor reaches out to a provider to obtain required information to allow claims payment rather than sending the provider a denial. UnitedHealthcare reports this reduces rework and prevents unnecessary provider abrasion. For this program, claims are pended internally, and external outreach is completed by trained processors to obtain necessary information for claim adjudication.

UnitedHealthcare walked Primaris through the interface of this change and demonstrated the new processes for comparison to the previous during onsite (virtual) activities on July 30, 2020. The change proved to be minor in relation to UnitedHealthcare's information systems and capability to produce accurate data for performance measures. Primaris was able to verify UnitedHealthcare's 2020 Operation Scorecard, showing claims processing times improving from 7.15 days to 4.76 days in a span of six months.

2. Community & State Strategic Platform (CSP) Facets.

ISCA section(s) affected: A–Information Systems, D–Encounter Data Management, F–Provider Data Management.

ISCA sections (s) not affected: B–IT Infrastructure, C–Information Security, E–Eligibility Data Management, G–Performance Measures and Reporting.

Score: Met

UnitedHealthcare reported an upgrade to their claims processing system, CSP Facets. The CSP Facets 5.5 R4 release was put into production environment on February 23, 2019. UnitedHealthcare is now utilizing the most current release available of the CSP Facets platform, avoiding extended maintenance costs of being on an unsupported version of the software. The CSP Facets 5.5 R4 update contained several feature upgrades to modules such as Accumulators and the Benefit Management Application as well as defect fixes for all functional areas of Facets. In addition, the CSP Facets 5.6 R2 release was introduced in UnitedHealthcare's production environment on August 17, 2019. Features for this release included implementing CMS's Medicare Fall 2018 changes as well as updating Facets Batch and Open access to run as 64-bit processes.

Primaris reviewed the specific updated interfaces during interviews on July 30, 2020. All statements made by UnitedHealthcare were supported by documentation and demonstrations of the upgraded features in CSP Facets. Primaris determines this change

has no major effect on UnitedHealthcare's information systems, provider data management, or encounter data management capabilities. This change has no adverse effect on calculation of performance measures.

3. Independent Processor Reviews.

ISCA section(s) affected: D–Encounter Data Management.
ISCA section(s) not affected: A-Information Systems, B–IT Infrastructure, C–Information Security, E–Eligibility Data Management, F–Provider Data Management, G–Performance Measures and Reporting

Score: Met

UnitedHealthcare reported a change to Independent Processor Reviews. Prior to June 2019, Independent Processor Reviews were post-disbursement reviews completed by QuEST Quality. Effective June 2019, independent processor reviews transitioned to claim operations. Claim operations has shifted focus to pre-disbursement quality audits to ensure claim processing accuracy. UnitedHealthcare reports this allows for immediate identification and correction of potential claim payment inaccuracies prior to payment. Utilizing pre-payment resources now allows for real-time coaching and developmental feedback.
Primaris reviewed the new process documentation and participated in a virtual demonstration of the production system for independent processor reviews on July 30, 2020. UnitedHealthcare also shared operation statistics for claims processed prior to the change versus after the change, and there is significant improvement. Primaris was made aware of this change during onsite activities in June of EQR 2019, and confirmed no major change affecting the information system(s) capabilities, interoperability, or performance measure calculation.

Additional Validations from MHD Contract.

Network Providers Enrollment.

Primaris also queried the provider data leadership and staff while viewing virtual walk throughs of UnitedHealthcare's provider data management system. UnitedHealthcare was able to show data samples and provide documentation per requirements of MHD contract 2.18.8c: All network providers must be enrolled with MO HealthNet as a Medicaid provider as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b). Primaris found opportunity for improvement on maintaining accurate provider data, specific details on data accuracy and scoring are as follows:

ISCA section(s) affected: F–Provider Data Management.
ISCA section(s) not affected: A-Information Systems, B-IT Infrastructure, C-Information

Security, D- Encounter Data Management, E-Eligibility Data Management, G-Performance Measures and Reporting.

Score: Partially Met

UnitedHealthcare attested all network providers are enrolled with MHD as Medicaid providers. During live demonstrations on July 30, 2020, UnitedHealthcare staff displayed documents and explained their provider credentialing process and provider enrollment process. UnitedHealthcare has a robust system for processing and storing data proactively sent from providers and/or rosters. Primaris addressed the question of provider data accuracy: "Once a provider has been enrolled how does UnitedHealthcare ensure the accuracy of data published into the provider directory over time?" UnitedHealthcare's process for this portion of maintenance is to rely on the provider to fill out the appropriate form to notify the MCO. The form begins an automated change management request and log that is cleared daily/weekly by the provider data team. This process does not address unreported changes in specialty, phone number, address, hours, etc. Primaris questioned UnitedHealthcare's thoughts on a more proactive approach, such as regular outreach to the providers. MCO responded by expressing concern about causing additional time and burden on the providers and office staff, especially currently with added pandemic stress. The setback is the risk of having undetected, incorrect data published in the provider directory. There is an opportunity for collaboration to help reduce the burden while lessening the chance of incorrect data being stored and published. The goal is to provide members with the most accurate data possible to increase quality and timeliness of care. This finding results in a Partially Met score. Though UnitedHealthcare utilizes very strong systems and processes, simple efforts to improve this metric will result in positive impact on the quality of services offered to members. Please see the recommendation in section 3.6.4 for suggestion on how to improve this rating.

One Integrated Information System Platform.

Primaris verified UnitedHealthcare has one integrated systems platform for care management and utilization management that provides both physical health and behavioral health information. During interviews, Primaris asked UnitedHealthcare staff to demonstrate data integration mapping and processing by walking through a series of data collection, update, and validation exercises. UnitedHealthcare was able to satisfy the requirements of MHD contract 2.26.10 One Integrated Information System Platform. Details and scoring are as follows:

ISCA section(s) affected: A–Information Systems.

ISCA section(s) not affected: B-IT Infrastructure, C-Information Security, D- Encounter Data Management, E-Eligibility Data Management, F-Provider Data Management, G-Performance Measures and Reporting.

Score: Met

Primaris requested UnitedHealthcare staff to demonstrate data integration mapping and processing by walking through a series of data collection, update, and validation exercises during onsite activities July 30, 2020. UnitedHealthcare was able to provide several samples of thorough data integration between all systems into one unified platform. Data was input or updated in several different fields of the front-end collection systems (i.e., CSP Facets or CommunityCare) and then followed the exact data field through processing to verify updates at the storage level. Integration walk throughs for various data elements were verified in direct conversation with leadership staff and additionally reviewed on each performance measure member sample review.

Quality, Timeliness, and Access.

UnitedHealthcare's changes affected a total three of seven scoring sections within the ISCA protocol, A–Information Systems, D–Encounter Data Management, and F–Provider Data Management.

Additional review points from MHD's contract affect one of the seven scoring sections within the ISCA protocol, F–Provider Data Management.

Rescored results (Tables 3-26 to 3-28) for the affected sections and subsections are below.

Table 3-26. UnitedHealthcare Information Systems (A) Rescore Results

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

Table 3-27. UnitedHealthcare Encounter Data Management (D) Rescore Results

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

Table 3-28. UnitedHealthcare Provider Data Management (F) Rescore Results

Sub-section	Issues	Score		Citation/Standard
Provider Directory Management	Reactive process to maintain provider demographic information published in the provider directory.	Partially Met		42 CFR 438.242, 438.608, Section 2.12.17, 2.18.8 MHD Contract
Payment Reconciliation	None	Met		42 CFR 438.242, 438.608
TOTAL SCORE		**Partially Met**		

Strengths.

- Policies and procedures readily available to staff on a need-to-know basis.
- Availability of thorough and accurate information system mapping documents.
- A clear training and continued education program for staff.
- Testing processes and development methodologies meet and exceed industry standards.
- Change requests processed in-house with strict guidelines and managed by current staff members.
- Implementation of adequate validation edits in data processes.
- Encounter data not altered by UnitedHealthcare but sent back to source for correction.

- Well managed system upgrade processes.

Weaknesses

- Risk of publishing incorrect provider information in the provider directory.

3.6.4 Recommendations for MCOs

All MCOs should develop a proactive approach for maintaining accurate provider data published in the provider directory. Currently, the providers must initiate the process to notify for change of specialty, new patient appointments, hours, phone number(s), etc. As a result, provider service and contact information are published without detection of inaccuracies.

Primaris suggests a proactive outreach to the providers to ensure accuracy. MCOs in concurrence with MHD, may decide on a time frame that is maintainable for both Home State Health and the providers. A suggestion is to identify any provider with data that has not been updated in a set time frame and run a query in the provider database to pull all provider rows without change in the 4-6-month (or desired) time frame. Notification or outreach to the providers can utilize the robust Provider Portal demonstrated to reduce burden on providers who are enrolled with the service. This solution will begin to offer statistics needed to track provider data accurately.

4.0 Review of Compliance with Medicaid and CHIP Managed Care Regulations

4.1 Description, Objective, and Methodology

Primaris audited Home State Health, Missouri Care, and UnitedHealthcare to assess compliance with the Medicaid and CHIP Managed Care Regulations; the MHD's Quality Improvement Strategy; the MHD Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous year's review. 42 CFR 438.358(b) (iii) requires a review to be conducted within a previous 3-year period to determine the MCOs' compliance with standards set forth in subpart D of 42 CFR 438 and subpart E, 438.330. EQR 2020 is the third year of current review cycle. Table 4-1 describes the regulations covered in three years during EQR 2018-2020.

Table 4-1. Regulations in Review Cycle

Year	CFR	Regulations	MCO
EQR 2020 (Year-3)	42 CFR 438, Subpart E	§438.330: Quality assessment and performance improvement (QAPI) program	Home State Health Missouri Care UnitedHealthcare
EQR 2019 (Year-2)	42 CFR 438, Subpart D	§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	Home State Health Missouri Care UnitedHealthcare*
EQR 2018 (Year-1)	42 CFR 438, Subpart D	§438.230 Subcontractual relationships and delegation §438.236 Practice guidelines §438.242 Health information systems	Home State Health Missouri Care

*All regulations due in EQR 2018 were covered in EQR 2019 for UnitedHealthcare as it was not included in EQR 2018 (newly contracted with MHD effective May 1, 2017).

Primaris collaborated with MHD and the three MCOs 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 on-site review.
- Identify key issues through analyzing the data collected.

- Prepare a report for each MCO related to the findings of current year and a summary of findings from all previous reviews within the current three-year review cycle.
- Review MCOs' response to previous EQR recommendations.

Primaris utilized CMS EQR Protocol 3, version Oct 2019: Review of Compliance with Medicaid and CHIP Managed Care Regulations, to conduct compliance review in May-July 2020. The evaluation process included requesting and analyzing documentations pre- and post-virtual onsite, and interviews (May 26-28, 2020). Technical Assistance was provided during the review period to help MCOs achieve excellence (details were presented to MHD on Jun 11, 2020). An evaluation tool was created based on MHD instructions and template for QAPI, Managed Care Contract, and 42CFR 438.330 QAPI.
Home State Health, Missouri Care, and UnitedHealthcare submitted their documents electronically via Primaris' secure file storage service to enable a complete and in-depth analysis of their compliance with regulations. These included policies, procedures, logs, PowerPoint presentations, reports, and print-screens as follows:

Table 4-2. MCOs' Documents for Compliance Review

MCO	Documents Reviewed
Home State Health	Annual Quality Program Evaluation 2019; Work Plan 2020; MO.QI.01.02 Quality Program Description; and Utilization Management UM1: Annual Evaluation.
Missouri Care	Quality Assessment and Improvement Evaluation Report 2019; Quality Improvement Work Plan 2020; Program Descriptions: Quality Improvement 2019, Care Management, Utilization Management, Disease Management; Quality Improvement-Roles and Responsibilities of Key Personnel; Quality Improvement Committee Structure; Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey results; Minutes of Meeting: Quality Improvement Committee (QIC), Utilization Management Medical Advisory Committee (UMAC); Member and Provider Newsletters; Member Advisory Council Description; PowerPoint Presentation-Provider Profiling; Member HEDIS® Care Gap Report; and Special Healthcare Needs Policy and Mechanism.
UnitedHealthcare	Quality Improvement Program Description; 2019 Annual State Quality Improvement Program Evaluation; Quality Improvement Work Plan 2020; 2019 Annual Population Health Management Assessment and Evaluation; Population Health Management Strategy; Inventory by Language of Member Materials Translated; Whole Person Care Program Description; Special Healthcare Needs (SHCN) Narrative; UnitedHealthcare–Missouri Architecture; 2019

	Patient Care Opportunity Report (PCOR); Systemic Data Correction Narrative; Hybrid Resample; All Access Metrics; LAMP Metrics (languages); QA003-POL.2413020-Provider Profiling and Monitoring of Over and Underutilization; PowerPoint Presentation-QAPI; 2019 Annual Collaborative Analysis Continuity and Coordination between Behavioral Health and Medical Care; Compliance Committee Report; Annual Fraud, Waste, and Abuse (FWA) Training; 2019 Interpreter Reports; Care Provider Demographic Information Update; and Minutes of Meetings- Compliance Oversight Committee (COC), Healthcare Quality & Utilization Management (HQUM), Physician Advisory Committee (PAC), Quality Improvement Committee (QIC).

Compliance Ratings

The information provided by MCOs was analyzed and an overall compliance score in percentage was given. Each section of an evaluation tool was assigned 2 points (denominator) and was scored as: Fully Met (2 points), Partially Met (1 point), or Not Met (0 point). Primaris utilized a compliance rating system as defined in Table 4-3 (Source: EQR Protocol 3). 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 4-3. Compliance Scoring System

●	**Fully 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.

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

Corrective Action Plan (CAP) Process

MCOs must identify for each "Not Met" criteria, a corrective action which should include: the interventions it plans to implement to achieve compliance with the requirement; way to 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 adequately addresses the interventions needed to bring performance into compliance with the requirements. Primaris does not generate a CAP for "Partially Met" sections. However, MCOs are required to resolve these issues which would be evaluated during next EQR.

4.2 Findings and Conclusions: Home State Health

Table 4-4. Home State Health Compliance (3-Year Cycle)

		Number of Sections Evaluated						
42 CFR Code	Regulation	Total	Met	Partially Met	Not Met	Score	Score %	Aggregate Score% (3 Years)
§438.330	Quality assessment and performance improvement program	33	25	8	0	58	**87.9**	Year 3-**87.9** EQR 2020
§438.206	Availability of services	11	11	0	0	22	**100**	Year 2-**100** EQR 2019
§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**	
§438.230	Sub Contractual Relationships and Delegation	7	7	0	0	14	**100**	Year 1-**100** EQR 2018
§438.236	Practice Guidelines	6	6	0	0	12	**100**	
§438.242	Health Information Systems	7	7	0	0	14	**100**	

An assessment was done for one federal regulation (42 CFR 438.330) in EQR 2020. Home State Health was evaluated for 33 criteria under this regulation and received "Met" for 25,

and “Partially Met” for eight of them, scoring 87.9% for compliance. Table 4-4 summarizes findings from EQR 2020 as well as previous reviews within the current three-year review cycle.

4.2.1 Quality, Timeliness, and Access

Strengths.

1. Structure: Home State Health Board of Directors (BOD), President and Chief Executive Officer (CEO), Chief Medical Director (CMD), and the senior management team provide oversight of Home State Health’s quality, utilization, and operational quality improvement (QI) functions. The BOD delegates the daily oversight and operating authority of the QAPI Program to the Quality Improvement Committee (QIC). In order to integrate feedback from stakeholders into the Quality Program Description, participating network physicians are members of the QIC, the Utilization Management Committee (UMC), The Credentialing Committee (CC), and the Peer Review Committee (PRC). QAPI Program Description, QI Work Plan, and QAPI Program Evaluation are integrated. The Director of Quality, reports to identified executive leadership, is responsible for directing the activities of Home State Health’s quality management staff in maintaining compliance with the MHD Managed Care contract, National Committee for Quality Assurance (NCQA) Standards, monitoring and auditing Home State Health’s health care delivery system, including but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality.

2. Population Analysis: Home State Health regularly examines population demographics and characteristics to ensure that there are services in place to meet the members’ needs. English is the primary language spoken in 93% of households in Missouri according to the information derived from the CY 2019 CAHPS Child Medicaid 5.0H Summary Report. The second most common language is Spanish (2%). Language services requested are evaluated and analyzed at QIC twice per year. Home State Health has made it a priority to hire Customer Service Representatives who are Spanish bilingual. The number of children and adolescents identified with disabilities is 21,836/204,474 (11%) of the population. The number of disabled adults is 1,050/204,475 (0.5%). Those individuals meeting the criteria of having a disability are limited to two service types (members that require oxygen supplies and members that require enteral and parenteral supplies). Utilizing the claims data, Home State Health determined there were 38,278/204,474 (19%) unique child and adolescent members identified as having a Severe Mental Illness (SMI). Unique adult members with SMI were 15,749/204,474 (8%). Home State Health utilized this data to assess the potential need for case management.

3. Accessibility of Services: Percentage of calls (in English) to Home State Health answered within 30 sec (goal 90%) is 94.60% for physical health services and 93.8% for behavioral health services. The call abandonment rates for physical and behavioral health services are 1.7% and 2.6% respectively (goal<5%). Home State Health reported 100% (goal 90%) of surveyed PCPs/Hematologists/Oncologists had availability for non-symptomatic routine care appointment within 30 days and for symptomatic routine care appointment within 1 week. All the surveyed OBGYNs (100%) had availability for first or second trimester appointments within 7 days and third trimester appointments within 3 days of request. PCPs meeting urgent care appointments (within 24 hours) were 99% (goal 90%). These results were obtained from surveys conducted by SPH Analytics (vendor) and CAHPS 5.0 reports.

4. Network Adequacy: Provider-to-member ratio is 1:2.5. All geographic availability requirements and standards were met for all Primary Care Practitioners, High Volume Specialists (OBGYN), and High Impact Specialists except for Rural Pediatricians. All practitioner-to-member ratios for each type of practitioner met standards and goals. Home State Health has evaluated the Rural Pediatric availability per county and has met 90% availability standard. Home State Health provided data on practitioners accepting new patients, with results ranging from 84% to 100% availability of appointments (goal by MHD is 80%).

5. Fraud, Waste, and Abuse (FWA) Program: In CY 2019, approximately $7.5M was identified in savings due to the payment policy edits, and approximately $7.6M in savings for CY 2018. Home State Health uses a clinical policy requiring a prior authorization for genetic testing services. Due to these controls, Home State Health had a low volume of claims and related payments when a genetic testing fraud scheme was identified within Missouri in early CY 2019.

6. Clinical Practice Guidelines: Home State Health has adopted specific clinical practice guidelines which are evidence-based and adopted from recognized sources e.g., Centers for Disease Control and Prevention (CDC), U.S. Preventive Services Task Force (USPSTF), U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI). These guidelines facilitate preventive health services and enhance the plan's Coordinated Care Programs. Guidelines are reviewed/revised at least every two years as per NCQA guidelines. The guidelines are incorporated in the disease management program and work synergistically with Home State Health's disease management provider, Envolve People Care (vendor).

7. Claims Management: In CY 2019, the percentage of claims that Home State Health paid within 15 days was 94.5%, meeting their goal of > 90%. They fell short of their goal for claims paid within 30 days (98%, with a goal of 99%). Primaris commends these strict internal goals established by Home State Health. These are higher than those in section 2.26 of the MHD, which requires the MCO to follow timeframes listed under RSMo 376.383 and 376.384 (2014) and permits a processing time of up to 45 days from the date of receipt of the claim.

8. Home State Health conducted performance improvement projects (PIPs) to improve Childhood Immunization Status (HEDIS® CIS combo 10) and Annual Dental Visit (HEDIS® ADV) rate in CY 2019. The CIS combo 10 rate in CY 2019 is reported as 24.09%, which is an increase of 2.4% points from CY 2018. The ADV rate in CY 2019 is reported as 53.16% which is an increase of 5.34% points from CY 2018. (Note: QAPI was submitted in Apr 30, 2020 and HEDIS results are finalized in mid-Jun 2020.)

9. Credentialing/Recredentialing: Home State Health recredentialed 1,055 practitioners and 424 providers (99.9-100% of these were within the timeframes per NCQA guidelines/MHD contract section 2.18.8c which requires MCO to follow to RSMo 354.442.1 (15) and 20 CSR 400.7.180). They credentialed 2,423 practitioners and 216 providers in compliance with MHD contract 2.18.8c.

Weaknesses.

1. QAPI Report: Several areas lack reporting requirements on analysis and evaluation of data (details are provided under heading “CAP” below). Detailed information on PIPs, Substance Use and Lead care management program was posted in QAPI which suggests that Home State Health lacks understanding of MHD instructions and requirements for QAPI reporting.

2. Access: PCP offices that have after-hours access was 94% (goal 100%).

3. Provider Satisfaction: Home State Heath conducted a survey for provider satisfaction and assessed the score for overall satisfaction to be 54.5% in CY 2019 which decreased from CY 2018 (64.7%). The benchmark set is 66.6% (SPH Analytics Medicaid Book of Business-vendor for survey).

4. Medical Record Review: To assist with monitoring care provided by network practitioners, Home State Health reviews network practitioner medical records at least every 3 years. Medical records are identified for review, in part, by identification of

concerns regarding provider performance. In CY 2018, there were 347 potential issues identified (total medical records reviewed were 839). Of 839 medical records, 53 reviews resulted in corrective action plan. In CY 2019, there were 230 potential issues (total medical records reviewed were 250). Out of 250, 16 resulted in corrective action plan.

5. Disease Management: The number of cases closed in CY 2019 due to noncompliance with a disease management treatment plan was 1,825 for Asthma, 304 for Diabetes, and 1,437 for Depression. An average of 58% of members were unable to be contacted due to incorrect demographic information or a non-response to outreach efforts. Asthma-active participation rates in the DM program decreased from CY 2018 (18.57%) to CY 2019 (14.47%). Diabetes-active participation rates decreased from CY 2018 (16.21%) to CY 2019 (12.26%).

6. Member Grievances and Appeals: In CY 2019, the largest proportion (46%) of member grievances was in the Access category. The second largest proportion (31%) of member grievances was in the Attitude/Service category. Major contributing factor for grievance was related to member transportation. The overall rate of member grievances increased from 0.96 per 1,000 members in CY 2018 to 1.62 per 1,000 members in CY 2019 but continued to meet the goal of fewer than 2.0 grievances per 1,000 members.

Corrective Action.

A CAP was not recommended. However, Home State Health is required to resolve all issues associated with eight criteria that are assigned a score of "Partially Met" listed below:

1. Home State Health did not report on several measures provided by Department of Health and Senior Services (DHSS) namely, Adequacy of Prenatal Care, early (1st Trimester) Prenatal Care, Low Birth Weight (LBW Less than 2500G), LBW (<2500G) Delivered in Level II/III Hospital, VLBW (<1500G) Delivered in Level III Hospital, Smoking During Pregnancy, Spacing Less Than 18 Months, Birth Mothers Less than 18 Years, Repeat Births to Teen Mothers (<20 Years), Prenatal WIC Participants.

2. Home State Heath reported rates for 16 HEDIS® measures for CY 2019 (finalized in Jun 2019) along with trends in previous two years. However, the Home State Health did not evaluate or analyze their performance measures.

3. Home State Health should present analysis, evaluation, trends, and recommendations for future year regarding information requested for "cultural competence" and "requests to change practitioners" per evaluation tool.

4. Home State Health is required to provide analysis and evaluation of: A summary of services provided to members with visual or hearing impairments or members who are physically disabled (Braille, large print, cassette, sign interpreters, etc.); an inventory of member materials available in alternative formats.

5. Information Management: Analysis and evaluation of Information System in relation to membership and providers is not provided in QAPI.

6. Integrated Care Management Services for Physical and Behavioral Health. Home State Health should evaluate and analyze data regarding integrated physical and behavioral health CM.

7. Home State Health has not provided analysis and evaluation of: Average Length of Stay; Readmissions/1000 members; Emergency Department Utilization/1000 members; Outpatient Visits/1000 members; Inter-Rater Reliability; Timeliness of Prior Authorization/Certification Decision Making.

8. Home State Health should submit evaluation and analysis of provider profiling regarding utilization of services and outcomes for CY 2019.

4.2.2 Improvement from previous year

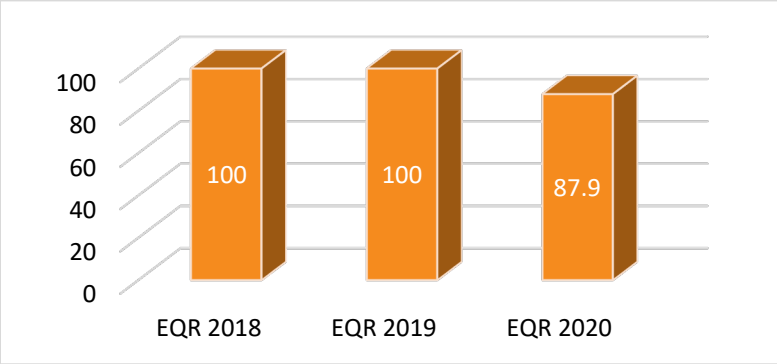


Figure 4-1 Home State Health Compliance (%)

Figure 4-1 depicts the performance of Home State Health over a three-year review cycle. In EQR 2020 (87.9%), there was a decrease of 12.1% points in compliance score from EQR 2019 (100%). During two previous EQRs the Home State Health was not placed on a CAP.

Response to Previous Year's Recommendations.

Home State Health's response to recommendations from prior two years of current cycle are as follows (Table 4-5):

Table 4-5. Home State Health's Response to Previous Recommendations

Recommendations	Action by Home State Health	Comment by EQRO
EQR 2019 (2nd Year of Cycle)		
Revisions to policies/documents as a result of technical assistance should be submitted to the MHD for approval.	Home State Health updated the following policies and received an approval from MHD. • MO.UM.01 UM Program (MHD approval 4.29.19) • MO.QI.11 Member Grievance and Appeal System Description (MHD approval 6.29.19) • MO.UM.01.01 Covered Benefits and Services (MHD approval 8.8.19)	No further action required-Item closed.
EQR 2018 1st Year of Cycle		
Revisions related to 42 CFR 438.230 b, c (Sub Contractual Relationships and Delegation) were recommended.	Home State Health updated their policies in CY 2019.	No further action required. Items closed in EQR 2019.

4.3 Findings and Conclusions: Missouri Care

An assessment was done for one federal regulation (42 CFR 438.330) in EQR 2020. Missouri Care was evaluated for 33 criteria under this regulation and received "Met" for 32, and "Partially Met" for one of them, scoring 98.5% for compliance. Table 4-6 summarizes findings from EQR 2020 as well as previous reviews within the current three-year review cycle.

Table 4-6. Missouri Care Compliance (3-Year Cycle)

		Number of Sections						
42 CFR Code	**Regulation**	**Total**	**Met**	**Partially Met**	**Not Met**	**Score**	**Score %**	**Aggregate Score% (3 Years)**
§438.330	Quality assessment and performance improvement program	33	32	1	0	65	**98.5**	Year 3-**98.5** EQR 2020

§438.206	Availability of services	11	11	0	0	22	**100**	Year 2-**96.6** EQR 2019
§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**	
§438.230	Sub Contractual Relationships and Delegation	7	7	0	0	14	**100**	Year 1-**100** EQR 2018
§438.236	Practice Guidelines	6	6	0	0	12	**100**	
§438.242	Health Information Systems	7	7	0	0	14	**100**	

4.3.1 Quality, Timeliness, and Access

Strengths.

1. Structure: Board of Directors, WellCare Health Plans, Inc. (parent company of Missouri Care) has delegated oversight of the Quality Improvement (QI) program to the Quality Improvement Committee (QIC). The State President ensures the continual assessment of opportunities and challenges within her/his assigned geographic segment. The Chief Medical Officer (CMO) reports to the State President and is a physician available to oversee the development, implementation, and evaluation of all clinical aspects of the QI Program. The Sr. Director, Quality Improvement, is a Certified Professional in Healthcare Quality (by National Association for Healthcare Quality) and has overall accountability for the day-to-day operations of the QI Program.

2. QAPI Report: Missouri Care has a detailed annual QI Work Plan which identifies specific activities and projects to be undertaken by the Missouri Care and the performance measures to be evaluated throughout the year. Work Plan activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals. The QAPI report incorporates outcomes, trends, analysis, and evaluation of the quality data and activities as they relate to Missouri Care's QAPI Program. The report identifies strengths, weaknesses, accomplishments, barriers and opportunities for improvement, including improving systems of care and health outcome, and demonstrates the QA & I Program is ongoing, continuous, and based on evaluation of past outcomes.

3. Population Analysis: Missouri Care has a Cultural Competency committee, which

addresses cultural and linguistic needs of members. In CY 2019, there were no communication/language related grievances. Interpreter services were available for all members regardless of their native language. Missouri Care employed a variety of strategies to identify members with special health care needs (SHCN) including: MHD Monthly SHCN File; Health Risk Assessments; Member Outreach; and Network Providers. The members are contacted for care management.

4. Accessibility of Services: Missouri Care met or exceeded the goals for criteria set by MHD for accessibility of services. Average speed of answering the member calls was 15 secs (goal: 30 secs), average abandonment rate for member calls was 0.9% (goal 5% or less), availability of appointments for non-symptomatic routine patients within 30 days: for PCPs was 96%; pediatric appointments (97.2%); and specialists (87.5%). OBGYN providers in first, second (within 7 days), and third trimester of pregnancy (within 3 days) was 87.7%, 86.9%, and 82.2% respectively. Missouri Care has met the MHD's goal of 80%, though did not meet their internal goal of 90%. Appointments for symptomatic routine patients (within one week) were available with: PCPs (96.9%); Pediatricians (98%); OBGYN (92.4%); Oncologists (94.5%; and specialists (82.1%). The goal was 90% for all providers. Missouri Care monitored the status of PCP panels on a monthly basis. The proportion of PCPs with open panels was 89.4% as compared to 91.5% for CY 2018. Though decreased, it still met the MHD's goal of 80% appointment availability for new patients. Missouri Care has identified the cause and would implement intervention in first quarter of 2020.

5. Network Adequacy: Missouri Care reported they consistently met or exceeded the 90% GeoAccess (Percentage of Members with Identified Specialty within Distance Requirements) goal for PCPs, behavioral health providers, and specialists statewide. The ratio of providers to members for: PCPs was 1:42 (goal 1:250); BH providers 1:37 (goal 1:3000); and OBGYN providers 1:88 (1:1000).

6. Fraud, Waste, and Abuse (FWA) Program: Missouri Care provides mandatory compliance training, including FWA training, to all Associates, Officers and Directors. This training must be completed within 30 days of hire and annually. Missouri Care's Special Investigations Unit (SIU) had overpayment recoveries of $262,305.34 (as of Oct 2019) as compared to $92,188.78 in CY 2018. Cost avoidance was $534,136.05 (as of Oct 2019) as compared to $696,179.36 in CY 2018. Notice of Adverse Provider Actions (NAPA) were 662 (as of Oct 2019) as compared to 713 in CY 2018.

7. Information Management (Claims): The goal of 95% of claims processed within 45 days was exceeded throughout the year.

8. Credentialing: A total of 1,739 new applications were presented to the Missouri Credentialing Committee, which were processed and turned around in seven days (goal: 15 days turnaround time).

9. Medical Record Review: Missouri Care documented 100% compliance for medical record documentation standards and 88% score for EPSDT components for all PCPs in sample (100% passed). The goal is 100% PCPs should receive a composite score of 80% or greater for compliance with EPSDT and medical record documentation.

10. Disease Management: Missouri Care utilizes evidence-based clinical practice guidelines that have been formally adopted by Missouri Care's QIC or other clinical committees, and member empowerment strategies to support the provider-member relationship and the plan of care. The active participation rate in disease management program for CY 2019 was 5.96% (goal 0.5%) in comparison to 0.16% in CY 2018.

11. Grievances and Appeals: In CY 2019, 97% of the member grievances were resolved within the timeframe (≤30 days) which has decreased by 1% point from previous year (CY 2018, 98%). Standard appeals (≤30 days) were resolved in 100% cases and expedited appeals (≤72 hours) were resolved for 93% of cases, which is a decrease of 7% points from previous year (CY 2018, 100%). (Goal set by Missouri Care is to resolve 95% of appeals and grievances within compliance and accreditation timeframes)

12. Utilization Management: Missouri Care met the turnaround time for Physical Health Prior Authorizations (PA) (nonurgent) for 97.7% cases. Behavioral Health PA was compliant in 97.9% cases. In case of urgent PA for Physical Health services, the compliance was 97.6% and Behavioral Health, 97.4%. (Goal set by Missouri Care is to meet turn-around-time ≥ 95% of cases.)

Weaknesses.

1. Effectiveness of Care: Missouri Care reported 38 HEDIS® measures. Only eight measures have scored above 50th percentile. Missouri Care identified barriers to improving these measures and actions/interventions they would take in CY 2020 to improve them. PIP has been conducted to improve the HEDIS® Childhood Immunization Status (CIS) Combo 10 measure. There was no increase in the measure in CY 2019. (Note: NCQA allowed Missouri Care to report their 2018 rate for this measure due to complications in obtaining medical records from providers due to Covid-19.)

2. After-hour Availability: The survey results by Missouri Care's vendor show that after-

hour availability for providers (PCPs, Pediatricians, OBGYN, Specialists-high volume, high impact, BH) was 74.8%, which decreased from last year (80%).

3. Provider Satisfaction: Annual provider satisfaction survey of Missouri Care conducted by Missouri Care's vendor, SPH Analytics (SPHA) in CY 2019, showed decreased results in all six composite areas measured from previous year (by less than 2%): Call Center Staff (31.3%); Provider Relations (estimated 36%); Network/Coordination of Care (30%); Utilization & Quality Mgt. (estimated 31%); Financial Issues (29.8%); and Net Provider Satisfaction (NPS) (72.0%).

4. Care Management: Number of identified members to opt out of the care management program rose from 1.25% to 6%, which exceeded Missouri Care's target (2%). Regarding integrated care management services for both Physical and Behavioral Health, the percent of members attending a PCP with a secondary behavioral health diagnosis who had a behavioral health follow-up visit decreased by 1.02 percentage points to 12.09%. Behavioral health follow-up visit within 30 days of the PCP visit was 47.77%. This was a decrease of 12.08% points from prior year.

Corrective Action.

A CAP was not recommended. However, Missouri Care is required to resolve an issue associated with one criterion that is assigned a score of "Partially Met." A count of members needing communication accommodations due to hearing impairments or a physical disability is not reported by Missouri Care in QAPI. Missouri Care stated that they do not capture data on this metric, and it is not available in the state enrollment file.

4.3.2 Improvement from previous year

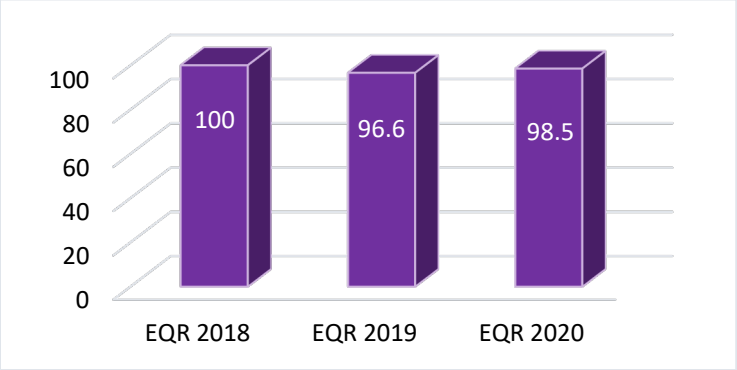


Figure 4-2. Missouri Care Compliance (%) EQR 2018-2020

Figure 4-2 depicts the performance of Missouri Care over a three-year review cycle. In EQR 2020 (98.5%), there is an increase of 1.9% points in compliance score from EQR 2019 (96.6%). Missouri Care is not placed on a CAP for this year. During the previous EQR, one regulatory standard was scored as "Not Met" and a CAP was initiated. Missouri Care "Met" all the requirements in the CAP. However, there were three sections scored as "Partially Met" for which Missouri Care did not submit any documentation for compliance.

Response to Previous Year's Recommendations.

Missouri Care was required to submit documentation to support all Not Met/Partially Met criteria from last year's review and provide their response to other recommendations (Table 4-7).

Table 4-7. Missouri Care's Response to Previous Recommendations

Recommendations	Action by Missouri Care	Comment by EQRO
EQR 2019 (2nd Year)		
1. Policy update required: Release of PHI to public will be only after prior written consent to the state agency (MHD contract 3.16.1)-Partially Met.	Missouri Care did not submit any documentation to support this requirement. So, the score remains the same as in previous EQR 2019.	Partially Met
2. Policy required: 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.	Policy Updated. C13-HIP-01-006-ST HIPAA-Use and Disclosure of PHI Standard-Page 15 of 15 (MHD approval 11.25.19)	Fully Met
3. Policy update required: 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.	Missouri Care did not submit any documentation to support this requirement. So, the score remains the same as in previous EQR 2019.	Partially Met
4. Policy required: 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.	Policy Updated. C13-HIP-01-006-ST HIPAA-Use and Disclosure of PHI Standard-Page 15 of 15 (MHD approval 11.25.19)	Fully Met

5. Policy update required: 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.	Missouri Care did not submit any documentation to support this requirement. So, the score remains the same as in previous EQR 2019.	Partially Met
6. 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.	Policy Updated. C13.HIP.01.010 HIPPA-Privacy Policy-Page 4 of 4 (MHD approval 11.25.19)	Fully Met
7. Revisions to policies/documents as a result of technical assistance should be submitted to the MHD for approval.	Missouri Care did not submit this information to EQRO. However, they have provided a written statement that all policies are approved by MHD.	Missouri Care is advised to track all policies that are developed/amended as a result of EQRO TA and send to MHD for approval. EQRO requires information about names of policies and date of approval.
EQR 2018 (1st Year of Cycle)		
3. Missouri Care should update all of their subcontractors' agreements with the "right to audit for 10 years…." as per 42 CFR 438.230(c)(3) (iii), consistently. (Date of applicability: July 1, 2017).	Missouri Care stated: Due to the transition over to Anthem's system effective 1.1.2021, Missouri Care currently is in the process of updating the contracts between Anthem and subcontractors which will be effective 1/1/2021. The standard language in the subcontractor's contracts related to audit/records satisfies 10-year audit timeline.	EQRO will revisit this requirement next year under Anthem, as applicable in EQR 2021.

4.4 Findings and Conclusions: UnitedHealthcare

An assessment was done for one federal regulation (42 CFR 438.330) in EQR 2020. UnitedHealthcare was evaluated for 33 criteria under this regulation and received "Met" for 31, and "Partially Met" for two of them, scoring 96.9% for compliance. Table 4-8 summarizes findings from EQR 2020 as well as previous reviews within the current three-year review cycle.

Table 4-8. UnitedHealthcare Compliance (3-Year Cycle)

		Number of Sections						
42 CFR Code	**Regulation**	**Total**	**Met**	**Partially Met**	**Not Met**	**Score**	**Score %**	**Aggregate Score% (3 Years)**
§438.330	Quality assessment and performance improvement program	33	31	2	0	64	**96.9**	Year 3-**96.9** EQR 2020
§438.206	Availability of services	11	11	0	0	22	**100**	Year 2-**99.4** EQR 2019
§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**	
	Exempted. UnitedHealthcare was not operational for one full year (new contract)							Year 1-**N/A** EQR 2018

4.4.1 Quality, Timeliness, and Access

Strengths.

1. QAPI Program: The National Quality Oversight Committee (NQOC) directs quality programs for UnitedHealthcare at the national level. The Governing Board of Directors (BOD) delegates oversight of the QAPI program to the State level Quality Management Committee (QMC). QMC is the decision-making body that is ultimately responsible for the

implementation, coordination, and integration of all QAPI activities for UnitedHealthcare in MO. QMC meets at least quarterly and reports to the BOD at least annually. The Chief Executive Officer (CEO) is responsible for oversight of the QAPI Program and chairs or designates the chair for the QMC.
UnitedHealthcare's QAPI program procedures are developed and implemented by experienced professionals in quality assessment, utilization management, and continuous improvement processes. The Chief Medical Officer is a Missouri licensed physician who is responsible for implementation of the QAPI Program. The Associate Director, Clinical Quality, is responsible for coordination of all QAPI activities. The coordinator is a Certified Professional in Healthcare Quality (CPHQ) designated by the National Association of Healthcare Quality (NAHQ).

2. Population Analysis: UnitedHealthcare has a Population Health Management Strategy that analyzes and evaluates information population characteristics: race, ethnicity, languages, and special needs to segment members into categories (e.g., selected age or gender bands, common diagnoses, identified social determinants, disability categories, and utilization patterns). Within these segments, members may be determined to be at low or high risk and interventions are directed accordingly. Low risk members are primarily focused on prevention. High-risk, medically fragile members are targeted for the Intensive Opportunity Complex Case Management Program. UnitedHealthcare analyzes, evaluates, and provides Culturally and Linguistically Appropriate Services (CLAS) to its members.

3. Accessibility of Services: Access to urgent care services (within 24 hours) was 98.01% in CY 2019 (CAHPS survey) as compared to 91.98% in CY 2018 (member survey by UnitedHealthcare). The goal of 80% was met. Non-symptomatic routine appointments (within 30 days) availability with PCPs was 95.54% in CY 2019 (CAHPS survey) as compared to 88.73% in CY 2018 (member survey). The appointment availability for specialty care was at 89.02% in CY 2019 (CAHPS survey) as compared to 78.87% in CY 2018 (member survey conducted by the UnitedHealthcare). The goal of 80% was met in CY 2019.

4. Network Adequacy: The number of PCPs-to-enrollees ratio in CY 2019 was 1:6 (goal 1:1000, ratio targets are set based on analysis of published literature and trend performance for the UnitedHealthcare network). Ratio of Pediatricians to enrollees was 1:15 (goal 1:1000). Ratio of High Impact providers (Cardiologists and Oncologists) to enrollees was 1:10 (goal 1:2000) and 1:22 (goal 1:4000) respectively. Analysis of the network indicates the plan has a robust network of practitioners to meet members' needs.

5. Performance Measures: UnitedHealthcare reported 14 HEDIS® measures. Of these, 10 measures showed improvement from previous year. Performance Improvement Projects are done around two HEDIS® measures: Childhood Immunization Status (CIS combo 10) rate in CY 2019 (25.06%) showed an increase by 3.41% points from CY 2018 and Annual Dental Visit (ADV) measure (53.70%) increased by 5.46% points from CY 2018 (interim rates as on 5.4.20). UnitedHealthcare monitors concurrent (prospective) HEDIS® reports to identify any areas of concern or opportunities for improvement. The Patient Care Opportunity Report (PCOR) is a preventive health care information report run by the provider's Tax ID Number (TIN) that includes a list of attributed members based on claims data and their compliancy with certain HEDIS® measures. The PCOR is updated on a monthly basis and is available on UnitedHealthcare's provider portal. In addition, UnitedHealthcare's Clinical Practice Consultants (CPCs) deliver the PCOR monthly to providers who participate in the Community Plan–Primary Care Practitioner Incentive (CP-PCPi) program and discuss the open care opportunities and quality improvement practices related to incentive/Pay for Performance (P4P) HEDIS® measures.

6. Fraud, waste, and abuse (FWA) program: UnitedHealthcare has a prospective claim review process. Claims are identified by pre-pay flags as being potential FWA. During CY 2019, UnitedHealthcare reviewed approximately 4,036 MO Medicaid claims. Following medical record review by certified coders, about 53% claims were paid, 25% were denied. About 2.8% (117 out of 4036) were hard denials for reasons such as previous investigations or sanctions. As a part of these campaigns a potential billing issue is chosen and then analytics are run to identify providers requiring education on a large scale across all identified states.

7. Information Management (claims processing-timeliness, membership, providers): UnitedHealthcare processed 99.98% to 100% clean claims within the turnaround time of 30 days each month (1.59 million clean claims for Medicaid in CY 2019). Primaris commends these strict internal goals established by UnitedHealthcare. These are higher than those in MHD contract section 2.26 which requires the MCO to follow timeframes listed under RSMo 376.383 and 376.384 (2014) and permits a processing time of up to 45 days from the date of receipt of the claim.

8. Credentialing/Recredentialing: UnitedHealthcare met 99% of the goal of 60 days set by State for credentialing practitioners and facilities. Recredentialing was completed within 3 years for 99.6% of providers.

9. Medical Record Review: UnitedHealthcare carried out a medical record review to

determine whether a provider is following the policies and procedures related to advance directives (required per MHD contract as a part of recredentialing). PCPs (33) were randomly selected from claims data from 9.1.18 to 9.30.19. All providers were compliant in CY 2019.

10. Clinical Practice Guidelines: UnitedHealthcare utilizes evidence-based clinical practice guidelines that are formally adopted by UnitedHealthcare's National Quality Oversight Committee (NQOC), which oversees the implementation and compliance of the clinical program/care management content with the guidelines.

11. The grievance and appeal department did not receive any provider complaints in CY 2019. Providers have many options for resolving issues before filing a provider complaint, such as working with the provider advocates.

12. Utilization Management: UnitedHealthcare has systems and processes in place to monitor under and overuse of services and to communicate information on member utilization using provider profiles to PCPs. Provider profiles were generated and shared with PCPs having 200 or more members bi-annually. UnitedHealthcare's Chief Medical Officer (CMO) and quality staff utilize the data to build relationships with network providers and educate them about expectations relative to utilization and the quality of care. The report includes provider- or group-specific data for key utilization measures with a peer comparison percentile ranking.

13. Quality Evaluation: The evaluation process of quality issues and actions identified through the quality strategy includes a review of all aspects of the QI Program, emphasizing demonstrated improvements in the quality and safety of care and quality of service provided to members as well as opportunities for improvement. For all goals that are not met, a root cause or barrier analysis is conducted to identify the underlying reason. This information is utilized to determine changes or restructuring of the QI Program as necessary.

14. Subcontractors: Vendors for Dental, Vision, Transportation, and Call Center services are evaluated for Fraud, Waste, and Abuse (FWA); Encounter data; Prior Authorization Denials; Timely payment; PIPs and HEDIS® measures (Dental Vendor); and Customer Satisfaction and Member Experience (Transportation Vendor). Transportation vendor reported 19 cases of FWA in CY 2019 which have decreased from 25 cases in CY 2018 and 36 cases in CY 2017. UnitedHealthcare stated that all vendors have a good relationship with UnitedHealthcare and met established performance requirements related to quality.

Weaknesses.

1. Provider Satisfaction: Response to a provider satisfaction survey conducted by UnitedHealthcare (Sept 9-Oct 31, 2019 with sample size 2,027) was very low (3%). The satisfaction result for claims processing was approximately 38%, care coordination was < 38%, and communications < 36%.

2. UnitedHealthcare formed a collaborative work group in June 2018 and continued to meet throughout CY 2019 on a Bi-monthly/frequent basis. Data and work group activities reviewed were related to exchange information between medical and behavioral health practitioners. The results of clinical satisfaction survey showed UnitedHealthcare has met their goal of 5% increase in usefulness of information provided by PCPs to Behavioral Health providers in CY 2019 in comparison to CY 2018, but the rate is still very low (45% for usefulness of information). The goal for timeliness of information exchange was not met (36%).

3. Grievances and Appeals: The number of member grievances increased from 2.39 (SFY 2018) to 3.09 (SFY 2019) per 1000 members which is an increase of 29.28%. The number of member appeals increased from 1.2 (SFY 2018) to 1.7 (SFY 2019) per 1000 members which is an increase of 41.66%. The increase in grievances and appeals were in the areas of Access, Attitude/Service, and Billing/Financial.

4. Confidentiality: In CY 2019, there were two instances of a breach of confidentiality (misdirected mail and misdirected manual fax) affecting two members though they were of a low impact.

5. Access: After-hours care access decreased to 78.66% in CY 2019 as compared to 93.10% in CY 2018. This was a decrease of 14.44 percentage points from the previous year's member survey (goal 80%).

Corrective Action.

A Corrective Action Plan (CAP) was not recommended. However, UnitedHealthcare is required to resolve issues associated with two criteria that are assigned a score of "Partially Met" listed below:

1. UnitedHealthcare should report data and analysis on availability of appointments for routine symptomatic patients per MHD contractual requirements.

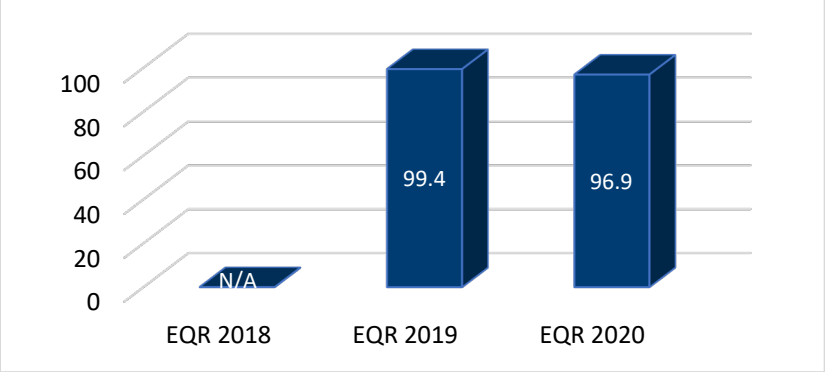
2. An analysis and evaluation of disease management program: The active participation

rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility). UnitedHealthcare has not reported on NCQA participation rate (section A 10 ii)-Partially Met.

4.4.2 Improvement from previous year

Figure 4-3 depicts the performance of UnitedHealthcare over a three-year review cycle. In EQR 2018, UnitedHealthcare was exempted from EQR and a TA session was provided by Primaris. In EQR 2020 (96.9%), there is a decline of 2.5% points in compliance score from EQR 2019 (99.4%). None of the regulatory standards scored "Not Met" in two EQRs.

Figure 4-3 UnitedHealthcare Compliance (%) EQR 2018-2020



Response to Previous Year's Recommendations.

UnitedHealthcare is required to submit documentation to support all "Partially Met" criteria from last year's review including response to recommendations (Table 4-9).

Table 4-9. UnitedHealthcare's Response to Previous Recommendations

Recommendations	Action by UnitedHealthcare	Comment by EQRO
1. Member handbook/policies did 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	UnitedHealthcare has updated the required language in Member handbook (page 59).	Fully Met
MCO is responsible for payment of custom items (e.g. custom or power wheelchairs, eyeglasses, hearing aids,	UnitedHealthcare has a policy in place: CL-001 Payment of Custom Items	Fully Met

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		
3. UnitedHealthcare should update all of their subcontractors' agreements with the "right to audit for 10 years..." as per 42 CFR 438.230(c) (3) (iii), consistently. (Date of applicability: July 1, 2017).	UnitedHealthcare has submitted in writing that they have updated all subcontractors' agreements per their Master Agreement: Missouri State Program(S) Regulatory Requirements Appendix.	No further action required. Item closed.
4. Revisions to policies/documents as a result of technical assistance should be submitted to the MHD for approval.	UnitedHealthcare updated the following policies and received an approval from MHD. • Payment of Custom Items PP20 UHC024 (MHD approval 8.2.19) • UHC State notification of provider termination policy PP19 UHC033 (MHD approval 5.21.19) • MO Privacy and Confidentiality PP19-UHC032 (MHD approval 5.29.19) • MO Medicaid Member Appeal and Grievance Policy PP19-UHC031 (MHD approval 6.12.19) • Subcontractor Oversight PP21 UHC005 (MHD approval 7.15.20) • UCSMM.06.10 Clinical review criteria PP21-UHC024 (MHD approval 7.15.20)	No further action required. Item closed.

4.5 Recommendations for MCOs

Table 4-10 displays recommendations (with numbers corresponding to the listed items) as applicable to Home State Health/Missouri Care/UnitedHealthcare.

Table 4-10 Recommendations applicable (✓) for MCOs

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

1. Home State Health is required to address eight "Partially Met" criteria as stated earlier in section 4.2.1.

2. Home State Health must follow instructions/reporting requirements for QAPI Evaluation provided by MHD. Only relevant information related to data, analysis, evaluation, recommendation, is required to be presented in QAPI Evaluation report.

3. Performance Improvement Projects: Primaris recommends that Home State Health test evidence-based interventions for improvement. One of the interventions for improving oral health (Alpha pointe) did not show any improvement. Such interventions should be abandoned or restructured for future projects instead of using them year after year without improvement. Also, Primaris recommends that Home State Health presents relevant information which pertains to PIPs interventions and analysis for the year under review. Details about other interventions which are not part of these PIPs need not be included in QAPI.

4. Missouri Care is required to address "Partially Met" criteria as stated earlier in section 4.3.1 and 4.3.2 (Table 4-7) including EQRO comments stated in the Table 4-7. Missouri Care should communicate with MHD if they have issues capturing data for a count of members needing communication accommodations due to hearing impairment or a physical

disability. Per MHD this data is provided to the MCOs when the member completes their Health Risk Assessment. Per 42 CFR 438.208 b3, MCO should make best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.

5. Missouri Care has reported Member Appeals under categories adopted from NCQA accreditation standards such as: Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. Primaris finds these categories not in alignment with the definition of adverse benefit determination & appeals per 42 CFR 438.400. Primaris recommends Missouri Care to seek written clarification on expectations from MHD. Missouri Care should update data in 2019 QAPI report as well as comply with MHD's instructions for future reporting. (Suggestion: Missouri Care may report criteria from all authorities such as NCQA, MHD contract, and incorporate adjacent columns to indicate applicable/not applicable, goals met/not met, in the data tables presented in QAPI report.)

6. Missouri Care has set internal goals for many criteria in QAPI, e.g., number (%) of resolution of member appeals and grievances within the timeframe, number of prior authorizations that meet turnaround time. Missouri Care should contact MHD for clarification on setting goals for these standards. (Note: MHD/CFR has set standards for these criteria and do not indicate percentage of members (goal) required to meet a particular criterion. MHD contract section 2.1.2 states that an MCO shall adhere to all applicable local, State and Federal requirements regarding operation of the MHD Managed Care Program.)

7. Performance Improvement Projects: Missouri Care should select strategies that should be evidence-based, that is, there should be existing evidence (published or unpublished) suggesting the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the variables). For the CIS Combo 10 PIP the intervention did not contribute to the increase in CIS Combo 10 rate.

8. UnitedHealthcare is required to address two "Partially Met" criteria as detailed in section 4.4.1 of this report. Disease Management-Active Participation Rate (as defined by NCQA): UnitedHealthcare stated that they did not report these rates due to technology upgradation requirement for such reporting. Primaris recommends UnitedHealthcare to provide these rates in QAPI. Any difficulties in the process should be communicated to MHD.

9. Grievances and Appeals: UnitedHealthcare has reported Member Appeals under

categories adopted from NCQA accreditation standards such as: Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. Primaris finds these categories not in alignment with the definition of adverse benefit determination & appeals per 42 CFR 438.400. Primaris recommends UnitedHealthcare to seek written clarification on expectations from MHD. UnitedHealthcare should update data in 2019 QAPI report as well as comply with MHD's instructions for future reporting.
(Suggestion: UnitedHealthcare may report criteria from all authorities such as NCQA, MHD contract, and incorporate adjacent columns to indicate applicable/not applicable, goals met/not met, in the data tables presented in QAPI report.)

Suggested Resources for All MCOs:

A. Improving Access to Care, After-hour appointments.

- Appointments scheduled at these times (5 p.m.-8 a.m., Monday-Friday, any time on weekends, holidays) may be billed using the appropriate after-hours CPT code for an additional reimbursement.
- PCPs may provide coverage via telemedicine, video conferencing, phone, in person, by email or combination of these means of communication.[8]
- After-hours care may be coordinated with a patient's usual primary care provider and facilitated by consideration of patient demand, provider capacity, a shared electronic health record, systematic notification procedures and a broader practice approach to improving primary care access and continuity. Also, payer support is important to increasing patients' access to after-hours care.[9]

B. Provider satisfaction:

- Increase Physician Satisfaction with the Right EHR: https://emds.com/increase-physician-satisfaction/
- Significant opportunity exists to improve physician satisfaction with health plans, specifically in pharmacy/formulary management: https://www.ajmc.com/journals/issue/2019/2019-vol25-n7/physician-satisfaction-with-health-plans-results-from-a-national-survey

C. Care Management-Collaboration between PCPs and Behavioral Health Providers.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986/
- https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_

[8] https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0494
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3475839/

to_building_collaborative_mental_health_care_partnerships.pdf

D. Ways to improve low response to satisfaction surveys:

- https://www.ajmc.com/journals/issue/2019/2019-vol25-n7/physician-satisfaction-with-health-plans-results-from-a-national-survey
- https://www.nap.edu/read/18293/chapter/6
- https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-015-0016-z

5.0 Review of Care Management Program

5.1 Description, Objective, and Methodology

Review of care management (CM) program is one of the activities mandated in MHD-EQRO contract. For EQR 2020, MHD required Primaris to evaluate three focus areas for Home State Health, Missouri Care and UnitedHealthcare:

- Asthma (members in age group of 5-18 years only).
- Opioid dependence/substance use disorder (SUD).
- Behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

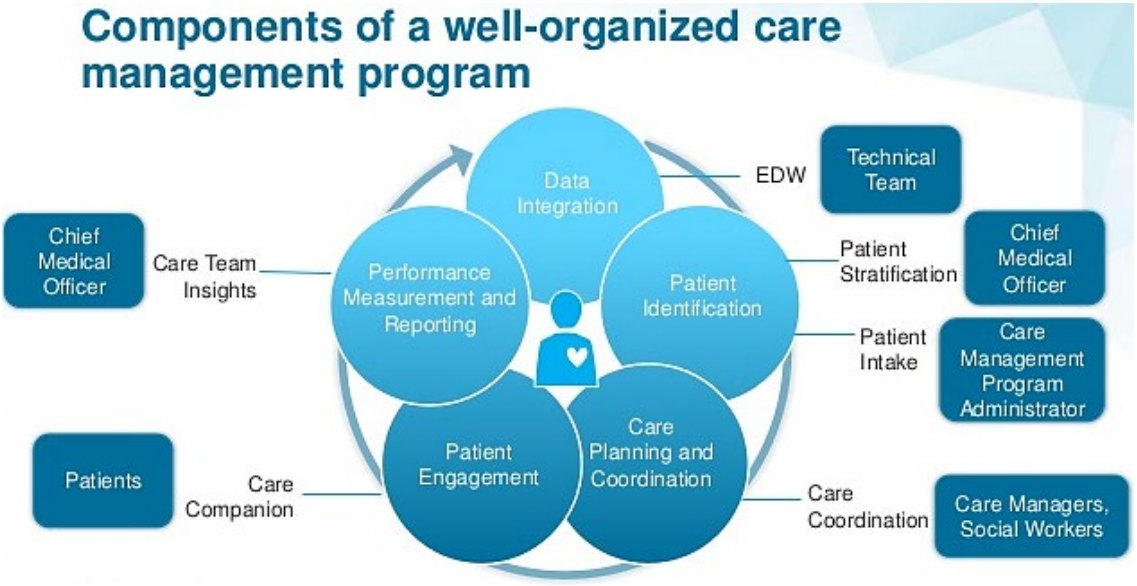


Figure 5-1. Care Management Components (Source: Healthcatalyst.com, Acronym EDW-Enterprise Data Warehouse)

CM is a promising team-based, patient-centered approach "designed to assist patients and their support systems in managing medical conditions more effectively."[10] It also encompasses those care coordination activities needed to help manage chronic illness (Figure 5-1). Three key strategies to enhance existing or emerging CM programs: (1) identify population(s) with modifiable risks; (2) align CM services to the needs of the population(s); and (3) identify, prepare, and integrate appropriate personnel to deliver the needed services. CM is organized around the precept that appropriate interventions for

[10] http://www.chcs.org/resource/care-management-definition-and-framework/

individuals within a given population will reduce health risks and decrease the cost of care[11].

MHD contract, section 2.11, was followed as a standard for evaluation for the CM program. The evaluation was conducted under the following heads:

1. Review of CM Policies and Procedures: In reference to MHD contract section 2.11.1c 5, MCOs must have policies and procedures in place for CM program. Primaris reviewed all the documents submitted by the three MCOs and assigned them a score of "Fully Met" (Table 5-1).

Table 5-1. MCOs' CM Documents

Policies and Procedures reviewed by EQRO per MHD 2.11.1c5		
Home State Health	**Missouri Care**	**UnitedHealthcare**
1. A description of the system for identifying, screening, and selecting members for CM services.		
MO.CM.01 Case Management Program Description.	C7-CM-MD-012 Care Management Program Description; and C7-CM-MD-1.2 Care Management Program Description.	Community and State WPC Program Description FY 2020; MCM 0012 Risk Stratification Process; and MCM 001 Identification of High-Risk Members for Case Management.
2. Provider and member profiling activities.		
MO.CM.01 Case Management Program Description; Annual Quality Assessment and performance Improvement Program Evaluation; and Monitoring utilization MO.UM.01.03.	MO29-HS-UM-021 Physician Profiling/Over and Under-Utilization; C7-UM-012 Under and Over-Utilization of Services Policy; C7-UM-012-PR-001 Under and Over-Utilization of Services; and C7-CM-MD-1.2 Care Management Program Description.	Community and State WPC Program Description FY 2020; MCM 011 Cultural Proficiency; MCM 001 Identification of High-Risk Members for Case Management; and NCM 002 Rider-MO_01 Hi Risk Case Management Process.
3. Procedures for conducting provider education on CM.		

[11] https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html#ref3

Home State Provider Orientation (5.7.19).	C7-CM-MD-012 Care Management Program Description; and Medicaid Provider Manual 2019.	MCM 007 Informing and Educating Providers; and MCM 11 Cultural Proficiency.
4. A description of how claims analysis will be used.		
MO.CM.01 Case Management Program Description.	C7-CM-MD-012 Care Management Program Description.	MCM 001 Identification of High-Risk Members for Case Management.
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.		
MO.CM.01 Case Management Program Description.	C7-CM-MD-012 Care Management Program Description; and C7-CM-MD-1.2 Care Management Program Description.	MCM002 CM Process Community and State WPC Program Description FY 2020.
6. A process to ensure integration and communication between physical and behavioral health.		
MO.CM.01 Case Management Program Description.	C7-CM-MD-012 Care Management Program Description.	MCM 006 Integration of Physical and Behavioral Health; and MO CM-01 Missouri Case Rounds.
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.		
MO.CM.01 Case Management Program Description.	C7-CM-MD-1.2 Care Management Program Description.	MO CM-01 Missouri Case Rounds; and NCM 002 Rider-MO_01 Hi Risk Case Management Process.
8. A process to ensure that care plans are maintained and updated, as necessary.		
MO.CM.01 Case Management Program Description.	C7-CM-MD-012 Care Management Program Description.	MCM 002 Care Management Process; and NCM 002 Rider-MO_01 High-Risk Case Management Process.
9. A description of the methodology for assigning and monitoring CM caseloads that ensures adequate staffing to meet CM requirements.		
Case Guide Visual.	C7-CM-MD-012-PR-006 Care Management Program Description Process-Telephone Care Manager	NCM 002 Rider-MO_01 High-Risk Case Management Process.

	Caseload Procedure.	
10. Timeframes for reevaluation and criteria for CM closure.		
MO.CM.01 Case Management Program Description.	C7-CM-MD-012 Care Management Program Description.	MCM 002 Care Management Process.
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.		
Home State Provider Orientation (5.7.19).	C7-CM-MD-012 Care Management Program Description; and C7-QI-026-PR-001 Provider Clinical Practice Guidelines Procedure.	Community and State WPC Program Description FY 2020; and NCM 030 Clinical Practice Guidelines.
Additional information.		
Care Management User Guide (123-127); CM Audit Tool; Provider Quick Reference Guide; Training Transcript; and MM Training Plan.	C7-CM-MD-6.0-PR-001 Decrease in Emergency Room Overuse Procedure; C7-CM-MD-012-PR-008 Care Management Program Description Process-Health Risk Assessment Procedure; C7-CM-MD-032 Decrease in Emergency Room Overuse; and C7-CM-MD-032-PR-001 Decrease in Emergency Room Overuse Procedure.	UHC Privacy Policy P15, NCM 010 Case Manager Orientation and Performance Management

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 focus areas.
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 include 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.

Primaris' Observation: All MCOs

Upon interviewing officials of Home State Health, Missouri Care, and UnitedHealthcare and conducting MRR for all three CM focus areas, Primaris concluded MCOs utilize policies and procedures based on contractual guidelines for care plan. However, the care plan per se, is member driven and may not include all the components as listed above. The care managers work with the members and create goals based on the care gaps or requirements projected by the members. Interventions are planned to address those requirements before a case is closed. If a member is not willing to address a care gap/issue, it is not included in care plan.

3. Onsite Interviews: The MCOs' officials were interviewed during onsite (virtual) meetings on Oct 26, Oct 27, and Oct 29, 2020 to assess:

- The knowledge of MHD contract and requirements for CM. The guiding principle for CM is that the resources should be focused on 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 Records' Review (MRR). Primaris assessed MCOs' ability to make available any and all pertinent medical records for review. A list of members care managed in CY 2019

for the three focus areas was submitted by each MCO. Primaris selected a sample of 30 medical records (required sample size of 20 plus 50% oversample for exclusions and exceptions) for each focus area by using systemic random sampling methodology based on Appendix B of CMS protocols for EQR, Oct 2019 version. MCOs were requested to upload all 30 medical records for each focus area, at Primaris' secure web-based file upload site. Desk review of policies, procedures, and medical records was conducted in Feb-Apr 2020. Clarifications/additional information were requested during onsite session. (Note: Due to Covid-19 Pandemic, the onsite visit scheduled for Mar 2020 was cancelled per MHD's instructions and rescheduled in Oct 2020 virtually.)

An evaluation tool (Excel workbook) was created to capture information from medical records which included, at a minimum: referrals; assessment; medical history; psychiatric history; developmental history; medical conditions; psychosocial issues; legal issues; care planning; lab testing; progress/contact notes; discharge plans; aftercare; transfers; coordination/linking of services; monitoring of services and care; and follow-up. (Note: MCOs submits CM Logs to MHD each quarter. Review of these logs was outside the scope of EQR.)

Inter Rater Reliability: 10% of the MR from each focus area were reviewed by a different auditor to assess the degree of agreement in assigning a score for compliance in the evaluation tool. Primaris' aim is to achieve 95% score for IRR. Primaris scored 100%.

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

- Asthma CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Asthma (ICD-10-CM code J45.xxx)
Anchor date: Members should be enrolled in CM in CY 2019
Age: Members in age group 5-18 years during the measurement year (CY2019).

- Opioid/SUD CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Opioid Dependence (ICD-10-CM code F11.xxx).
Anchor date: Members must be enrolled in CM in CY 2019.
Age: N/A

- BH CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.

Event/Dx: Must not have been in care management in CY 2018 (unless a new diagnosis made in CY 2019). Members should be hospitalized in a psychiatric hospital or be receiving residential treatment for substance use disorder in CY 2019.
Anchor date: Members should be enrolled in CM in CY 2019.
Age: 6 years or older during the measurement year (CY 2019).

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.

5.2 Findings and Conclusions: Home State Health

Home State Health: CM Data

Medicaid Managed Care members enrolled in CY 2019 = 205,395
Members enrolled in CM (each focus area) = Asthma:122, SUD: 136; BH: 235
CM staff available = 83 (clinical/nonclinical), Care Managers: 28
Average case load = 62 active cases
Maximum members who can receive CM = Home State Health will ensure sufficient staffing is available to meet the contractual obligations for providing CM to all members who need these services.

This section provides information on CM program obtained from Home State Health, followed by findings and conclusions of MRR conducted by Primaris for each focus area.

Care Management Functions at Home State Health include:

- Early identification of members who have special needs.
- Assessing member's risk factors.
- Developing an individualized plan of care in concert with the member and/or member's family, Primary Care Provider (PCP), and managing providers.
- Identifying barriers to meeting goals included in the care plan.
- Applying appropriate interventions to remove barriers to meeting goals included in the care plan.
- Referring and assisting to ensure timely access to providers.
- Coordinating of care linking members to providers, medical services, residential, social, and other support services where needed.

- Ongoing monitoring and revision of care plan as required by the member's changing condition and the rationale for implementing CM services.
- Supporting continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/CM activities.
- Addressing the member's right to decline participation in the CM program or dis-enroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all CM procedures in compliance with HIPAA and state law.
- Planning and conducting provider education on CM.
- Improving member care and health outcomes.
- Investigating members' complaints about care delivery.
- Identifying the rationale for implementing CM services.
- Determining circumstances under which information will be disclosed to third parties.
- Reducing of inappropriate inpatient hospitalizations or utilization of emergent services and lowering total costs through better-educated providers and members.
- Ensuring the member handbook informs members that they may request case management services at any time.

Population Identification

Sources utilized for assessment of the entire member population include:

- Data provided by the state agency (includes information such as age, especially for children/adolescents and elderly, sex, ethnicity, race, primary language, and benefit category).
- Diagnostic and utilization data (e.g., overall claims received, inpatient admissions and ED visits, and pharmacy data, authorizations).

The population assessment specifically addresses the needs of children and adolescents, individuals with disabilities, and members with serious and persistent mental illness (SPMI). Results of the population assessment are analyzed and subsequent enhancements are made to the CM Program if opportunities for improvement or gaps in CM services are identified such as: staffing ratio/caseloads; types of CM activities assigned to specific members; implementation of targeted training related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff; and identification of appropriate community or other resources for members and staff.

Members with asthma are stratified (High, Medium, and Low Risk) based on criteria

followed by Home State Health. Asthma CM provides telephonic outreach, education, and support services to promote adherence to asthma treatment guidelines, prevent exacerbations and optimize functional status. Enhanced Asthma Care Management program (Waves Program) was designed in early CY 2019 and launched in mid-CY 2019 with a goal to reduce the medical costs through prevention of inappropriate emergency room (ER) admissions and inpatient hospitalizations (IP) due to medication issues.

Findings of MRR

Table 5-2 shows number of medical records included in the study for each CM focus area.

Table 5-2. Home State Health CM Medical Records

	Asthma CM	Opioid/SUD CM	Behavioral Health CM
Sample size/oversample	20	21	27
Number of medical records excluded from review	None	1	7
Number of medical records included in study	20	20*	20
Cases closed-goals met	4	5	4
Cases open-in progress	4	8	3

*Obstetrics cases mostly

Table 5-3 identifies compliance (%) of medical records with various criteria per MHD contract, applicable to all three CM focus areas.

Table 5-3. Home State Health Compliance (%) with CM Criteria

Evaluation Criteria	Asthma CM	Opioid/SUD CM	BH CM
Diagnosis	100	100	100
Risk stratification	100	Not applicable (N/A)	N/A
Enrollment date CM	100	100	100
Case closure date	100	100	100
Referral date	100	100	100
Offer CM (Assessment) within 30 days (new patient or new diagnosis). For OB cases-within 15 days.	100	85	N/A
Offer CM (Assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program	N/A	N/A	45
Assessment	100	100	100

Medical history	100	100	100
Psychiatric history	100	100	100
Developmental history	100	100	100
Psychosocial issues	100	100	100
Legal issues	100	90	80
Care plan	100	100	100
Participation by member in care plan/reasons for non-participation	100	N/A	N/A
Care plan updated	100	100	100
Progress notes	100	100	100
Lab tests	100	100	100
Transfer	100	100	100
Monitoring medication adherence	95	N/A	N/A
Monitoring services and care	95	100	100
Coordination and linking of services	100	100	100
Discharge plan	19	33	24
Follow up	19	33	24
PCP notification of case closure*	88	100	20
Aggregate Score	**92**	**93**	**85**

*Applicable for children only (age through 18 years)

Red highlighted figures (score < 80%) indicate areas for improvement.

Note: Per MHD's instructions, Criterion-Provider Treatment Plan-is not evaluated in EQR 2020 due to change in contract requirements effecting this criterion.

5.2.1 Quality, Timeliness, and Access

Home State Health scored 80% to 100% in: 22 of 24 criteria evaluated for Asthma CM; 19 of 21 criteria for Opioid/SUD CM; and 17 of 21 criteria for BH CM (Table 5-3). Table 5-4 reports some of the HEDIS® measures related to the three focus areas. Improvement in some of the rates can be attributed to Home State Health's CM Program.

Table 5-4. Home State Health HEDIS® Measures: CM Focus Areas

CM	HEDIS® Measures	CY 2018	CY 2019	National Average (Medicaid)
Asthma	Medication Management for People with Asthma (age 5-64 years)-50% covered	61.66%	65.95%*	61.52%

	Medication Management for People with Asthma (age 5-64 years)-75% covered	40.45%	40.28%*	37.76%
	Asthma Medication Ratio (age 5-64 years)	62.82%	63.65%*	62.99%
Opioid	Use of Opioids from Multiple Providers (Prescribers)	20.66%	16.43%*	23.20%
	Use of Opioids from Multiple Providers (Pharmacies)	14.29%	10.36%	8.29%
	Use of Opioids from Multiple Providers (Prescribers and Pharmacies)	7.72%	4.95%	4.83%
BH	Follow Up After Hospitalization for Mental Illness-within 7 days	31.54%	29.47%	35.80%
	Follow Up After Hospitalization for Mental Illness-within 30 days	52.74%	53.87%	56.78%

*Exceeds the national average for Medicaid-HMO

Strengths.

The following strengths/key drivers were identified during MRR and Home State Health's staff interview (Table 5-5).

Table 5-5. Home State Health Key Drivers

Asthma CM
• Education to providers on using asthma action plan. • Education to members on cessation of smoking, identification, and avoidance of environmental triggers. • Environmental evaluation of risk factors-partner with Asthma Bridge Program for home assessment. • Checking for immunization status for influenza vaccine. • Monitoring for medication adherence (CyberAccess℠).* • Providing nutritional and physical activity counselling resources. • Nursewise (nursing advice services round the clock, 24 x 7). • Transportation services-Utilizing LYFT for transportation to decrease member complaints and missed appointments (for all CM focus areas). • Providing information about PCPs/Urgent Care/ED utilization.
Opioid/SUD CM
• Skilled clinical staff (licensed) is assigned to all aspects of the screening and assessment process, including initial telephone contacts. • Education to pregnant members on risks with smoking marijuana, quitting strategies. Offering Smoking Cessation Program. • 24 hours Nurse Advice Line. • Providing information about psychiatrists and counsellors.

• Substance Awareness Traffic Offender Program (SATOP). Members are referred for legal issues regarding DUI (driving under the influence). • Provision of Aunt Bertha community resource platform. • Referral to Bridgeway (offers options for detoxification from drug or alcohol dependence with an individualized treatment plan tailored to members' needs).
BH CM
• Engagement of care managers with the members during hospitalization. • Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital. • Training of care managers regarding linguistic and cultural competency. • Provider engagement. • Linking to community resources. • Medication adherence monitoring. • Intensive Outpatient Program (IOP).

* CyberAccess[sm] is a web-based, HIPAA-compliant tool that allows the MCO to view drug utilization information in near real time.

Weaknesses.

1. CM Criterion: Offer CM (need assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program.
Home State Health scored 45% for this criterion in EQR 2020. Even though this is an improvement from EQR 2019 (13%); low score remains an issue.

2. Repeat CM Assessment: A need assessment for CM is not done each time a member is enrolled in BH CM.
Members may be hospitalized several times while remaining enrolled in CM or a member may be reenrolled in CM after a previous case closure. Home State Health stated that they reassess a member as appropriate-on a six month or annual basis and review previous assessment after each hospital discharge.
Primaris noticed ambiguity in this regard during MRR. There are no guidelines in MHD contract on this issue.

3. CM Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for new member with diagnosis/new diagnosis of existing member (for Asthma CM and Opioid/SUD CM).
Home State Health lacks clarity on what constitutes a "new diagnosis" or a "new member." A member may have multiple enrollment dates in a given year.
Since these terms are not specifically defined in MHD contract, Primaris evaluated this criterion as: Offer CM (date of need assessment) within 30 calendar days of notification/referral (by any source: member services/case managers/utilization

management alerts/internal reports generated by using claims data and authorizations).

4. Care Plan: As stated earlier in section 5.1 (2), the care plan addresses areas based on members' projected needs and does not include all points listed in MHD contract.
A member in Asthma CM refused to address asthma in care plan and wanted help in management for obesity only. Five members in Opioid/SUD CM did not want to address SUD issues in the care plan.

5. Discharge plan and follow up: Low compliance scores for these criteria are noted across all CM focus areas.
Asthma CM: Cases were lost due to unable to contact (UTC-9 cases); declined CM (1 case); loss of eligibility (1 case).
Opioid/SUD CM: UTC (5 cases); loss of eligibility (2 cases).
BH CM: UTC (5 cases); loss of eligibility (7 cases); declined CM (1 case).

6. Pharmacy: Home State Health reported difficulties they had faced on some occasions in gathering member information from MHD's Pharmacy unit. On further enquiry by Primaris, Home State Health agreed that they do not maintain a log or a tracking mechanism related to issues faced and actions taken to resolve those issues.

7. Notification of case closure to PCPs in case of BH members was an issue. Home State Health attributed it to inaction on part of one BH care manager.

5.2.2 Improvement from previous year

Table 5-6 shows results of medical records' compliance with CM criteria listed under MHD contract, for three years (EQR 2018-EQR 2020). (Note: The overall score for these years is not comparable due to exclusion of one of the low scoring areas from previous years, "Provider Treatment Plan" in EQR 2020.

Table 5-6. Home State Health MRR-Compliance with CM Criteria (EQR 2018-EQR 2020)

Year	OB*	EBLLs*	BH	Asthma	Opioid/SUD	Average Score**
EQR 2020	N/A	N/A	85%	92%	93%	90%
EQR 2019	92%	82%	83%	N/A	N/A	86%
EQR 2018	86%	75%	98%	N/A	N/A	86%

*Acronyms: OB-Obstetric, EBLLs-Elevated blood lead levels / **Not comparable

Response to Previous Year's Recommendations.

Table 5-7 shows previous year's recommendations applicable to overall CM program and Home State Health's response to them. (Note: The Table does not address previous recommendations specific to focus areas which were not reviewed in EQR 2020).

Table 5-7. Home State Health's Response to Previous EQR's Recommendations

Recommendation	Action by Home State Health	Comment by EQRO
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 denoting "case start date."	Same observation during EQR 2020: case start date is different from enrollment date. However, Home State Health explained their new definition of enrollment. They consider a member to be enrolled in CM on the day a care plan is created.	Fully Met Home State Health should consistently apply their definition of enrollment to all focus areas in CM.
2. 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 the 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).	Home State Health does make calls/sends letters before closing a case in most instances.	Partially Met Home State Health should also consider visiting a family's home and checking with the PCP, other providers, and programs before closing a case as UTC.
3. CM Assessment within 5 days of admission in psychiatric	Home State Health has improved score from 13% to 45%.	Partially Met

hospital/residential treatment program:		Most of the referrals for BH CM occur during concurrent review. Home State Health should work with the hospital authorities to secure permission for the care managers to visit patients during hospital stays so that they can engage with the member for a CM assessment during hospitalization.
4. Care managers should obtain written consent from the members in BH CM so that their care plan can be shared with PCPs. This is important for integration of BH and physical health. (Care managers must also recognize 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.)	Home State Health shared care plans with PCPs for less than 50% cases reviewed during MRR. They stated during an interview that BH-sensitive information was removed before sharing the care plan with PCP.	Partially Met BH care plan should be shared with PCPs after obtaining written consent from members according to instructions in 42 CFR Part 2,* as applicable.
5. The care plan submitted to the providers should receive an acknowledgement/approval from providers.	This criterion was not evaluated in EQR 2020 per MHD's instructions.	Partially Met MHD and Home State Health are working on a process to address this issue.
6. Engaging members in CM program. Deploying the right team member at the right time has a significant impact on a patient's interest in participation. Tailor messaging to different patient populations to address any unique barriers to enrollment for each.	Home State Health has made some progress in this regard. The number of BH cases closed due to "goals met" have increased from 3 to 4 in comparison to previous EQR. The	Partially Met

	number of cases closed due to "UTC" (5) and "declined CM" (1) remains the same in EQR 2020 as compared to previous year.	

*42 Code of Federal Regulations Part 2: Confidentiality of SUD Patient Records

5.3 Findings and Conclusions: Missouri Care

Missouri Care: CM Data

Medicaid Managed Care members enrolled in CY 2019 = 219,119
Members enrolled in CM (each focus area) = Asthma: 499, Opioid/SUD and BH: 742
CM staff available = Care Managers-Field: 5, Telephonic: 8, Obstetrics: 5, BH: 9
Care coordinators-12
Average case load = Corporate benchmark-300 cases per nurse per year: telephonic (tele). Missouri Care load is 60-80 cases (medical), 50 cases (BH).
Maximum members who can receive CM = 2400 medical cases per year.
BH care managers open both field and telephonic cases, either 8 new field cases or 10 new cases (at least 2 tele) or 12 new tele cases each month. Thus, 850-1100 cases total annually (depending on the mix of field and tele).

This section provides brief information on CM program obtained from Missouri Care, followed by findings and conclusions of MRR conducted by Primaris for each focus area.

The mission of the WellCare Care (parent company of Missouri Care, ownership changed to Anthem, Inc. on Jan 23, 2020) Management 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.
The CM team consists of registered nurses, licensed clinical social workers, social workers, and care coordinators, working in a collaborative, deeply integrated model. The integrated CM model covers the full range of physical health, behavioral health, social and community-based support of a member in a coordinated and member-centered manner. The care

manager may use a combination of face-to-face and telephonic outreach during the relationship with the member. This high touch, community-based approach to CM focuses on addressing the needs of the most vulnerable members.

Sources of Population Identification for CM

- Health Risk Assessment (HRA) completed by care coordinators.
- Self-referral by members using CM hotline.
- Inpatient nurses who review admissions.
- Provider or community sources.
- Other care managers managing a member for another condition.
- Claims.
- Special needs list that is provided by the state monthly.

Asthma CM

Enrollment Process

- Review claims through Missouri Care's authorization system, decision point, cyber access to verify member has a diagnosis of asthma.
- Obtain phone number for member/parent from information on file or reach out to Primary Care Provider's (PCP) office on file.
- Complete Comprehensive Need Assessment (CAN).
- Education as necessary for triggers, medications, controlling exacerbations.
- Discuss need for pulmonologist if member does not already have one.
- Review Durable Medical Equipment, peak flow meter (for ages 6 and above), hypoallergenic mattress covers/pillow covers, HEPA (High Efficiency Particulate Air) filter vacuum.
- Inform parent/member about the community Asthma Bridge Program and the home assessment provided for their completion to aid in the decrease of asthma exacerbations by acknowledging triggers.
- Make a care plan with items discussed with parent/member, making member goals which are obtainable, send care plan to member/parent as well as PCP.

Missouri Care does not:

- Call providers to discuss care plans or send out care plans to members who do not engage in CM.
- Educational material is not mailed out to opt out/unable to contact (UTC) members.
- Engage with providers on regular basis to inform or educate providers regarding clinical practice guidelines. They have methods in place for informing and educating

providers regarding the clinical practice guidelines.

BH CM

BH CM is integrated in the overall Care Model. This population may require additional services and attention which may lead to the development of special arrangements and procedures with our provider networks to arrange for and provide certain services. For example, some members require coordination of services after discharge from acute care facilities to transition back into the community. This includes coordination to implement or access services with network behavioral health providers or community mental health clinics (CMHCs) also called Community Service Boards (CSB).

Missouri Care's BH CM program employs comprehensive and integrated services to members, including outreach to all members admitted for acute behavioral health treatment, provider and community referrals, consultation about additional resources, including education and vocational support, Department of Mental Health and Community Support waiver guidance, and care gap monitoring. Field CM is available to members living near Kansas City, Springfield, Columbia, and St. Louis. Additionally, many of the care managers visit members while they are in the hospital. Members with a severe and persistent mental illness may receive intense or targeted CM services by community mental health providers or integrated care from a Behavioral Health Home (BHH).

Findings of MRR

Table 5-8 shows number of medical records included in the study for each CM focus area.

Table 5-8. Missouri Care CM Medical Records

	Asthma CM	Opioid/SUD CM	BH CM
Sample size/oversample	21	6	44 (exceeded maximum limit)
Medical records excluded from review	1	1	25
Medical records reviewed	20	5	19
Cases closed-goals met	11	1	15
Cases open-in progress	None	1	None

Table 5-9 identifies compliance (%) of medical records with various criteria per MHD contract, applicable to all three CM focus areas.

Table 5-9. Missouri Care Compliance (%) with CM Criteria

Evaluation Criteria	Asthma CM	Opioid/SUD CM	BH CM
Diagnosis	90	100	100
Risk stratification	95	Not applicable (N/A)	N/A
Enrollment date CM	100	100	100
Case closure date	100	100	100
Referral date	95	100	100
Offer CM (Assessment) within 30 days (new patient or new diagnosis)	70	100	N/A
Offer CM (Assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program	N/A	N/A	16
Assessment	90	100	100
Medical history	95	100	100
Psychiatric history	90	100	100
Developmental history	95	80	100
Psychosocial issues	100	80	100
Legal issues	85	80	100
Care plan	95	100	100
Participation by member in care plan/reasons for non-participation	95	N/A	N/A
Care plan updated	95	100	100
Progress notes	90	100	100
Lab tests	100	100	100
Transfer	100	100	100
Monitoring medication adherence	95	N/A	N/A
Monitoring services and care	100	100	95
Coordination and linking of services	90	100	100
Discharge plan	60	25	68
Follow up	60	25	68
PCP notification of case closure*	35	0	19
Aggregate Score	88	85	89

*Applicable for children only (age through 18 years).

Red highlighted figures (score < 80%) indicate areas for improvement.
Note: Per MHD's instructions, Criterion-Provider Treatment Plan-is not evaluated in EQR 2020 due to change in contract requirements effecting this criterion.

5.3.1 Quality, Timeliness, and Access

Missouri Care scored 80% to 100% in: 20 of 24 criteria evaluated for Asthma CM; 18 of 21 criteria for Opioid/SUD CM; and 17 of 21 criteria for BH CM (Table 5-9). Table 5-10 reports some of the HEDIS® measures related to the three focus areas. Improvement in some of the rates can be attributed to Missouri Care's CM Program. Table 5-11 shows cost outcomes of BH CM.

Table 5-10. Missouri Care HEDIS® Measures: CM Focus Areas

CM	HEDIS® Measures	CY 2018	CY 2019	National Average (Medicaid)
Asthma	Medication Management for People with Asthma (age 5-64 years)-50% covered	54.31%	62.52%*	61.52%
	Medication Management for People with Asthma (age 5-64 years)-75% covered	31.55%	38.59%*	37.76%
	Asthma Medication Ratio (age 5-64 years)	47.16%	63.61%*	62.99%
Opioid	Use of Opioids from Multiple Providers (Prescribers)	42.89%	22.00%*	23.20%
	Use of Opioids from Multiple Providers (Pharmacies)	12.77%	10.87%	8.29%
	Use of Opioids from Multiple Providers (Prescribers and Pharmacies)	9.81%	7.13%	4.83%
BH	Follow Up After Hospitalization for Mental Illness-within 7 days	29.28%	34.17%	35.80%
	Follow Up After Hospitalization for Mental Illness-within 30 days	54.14%	59.62%*	56.78%

*Exceeds the national average for Medicaid-HMO

Table 5-11. Missouri Care BH CM Cost Outcomes Summary 2019

	Inpatient			Emergency Room		
	Count	Billed	Paid	Count	Billed	Paid
Pre-Program	1186	$1,758,203.79	$461,759.56	1423	$510,431.18	$107,459.60
Post-Program	104	$49,310.08	$15,090.43	411	$84,456.40	$22,381.59
Improvement	91.2%	97.2%	96.7%	71.1%	83.5%	79.2%

Strengths.

The following strengths/key drivers were identified during MRR and Missouri Care's staff interview (Table 5-12).

Table 5-12. Missouri Care Key Drivers

Asthma CM
• Education to members on identification and avoidance of environmental triggers, use of inhalers, asthma action plan. • Referrals for all members to Asthma Bridge Program (home visit/education). • Providing DME. • Checking for immunization status for influenza vaccine. • Monitoring for medication adherence (CyberAccess℠)*. • Providing nutritional and physical activity counselling resources. • Nurse line (nursing advice services round the clock, 24 x 7). • Transportation services. • Providing information about PCPs/pulmonologists.
Opioid/SUD CM
• Skilled clinical staff assigned to all aspects of the screening and assessment process, including initial telephone contacts for all CM areas (same for BH CM). • Providing information about psychiatrists and counsellors, behavioral therapy. • Monitoring medication adherence. • Nurse line services.
BH CM
• Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital. • Intensive family intervention services-Crisis Stabilization. • Crisis line services. • Linking to community resources/BH support services/therapists. • Medication adherence monitoring. • Monitoring compliance with doctor's appointments.

* CyberAccess℠ is a web-based, HIPAA-compliant tool that allows the MCO to view drug utilization information in near real time.

Weaknesses.

1. CM Criterion: Offer CM (need assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program.
Missouri Care scored 16% for this criterion in EQR 2020. This is a further decrease from EQR 2019 (25%); low score remains an issue.

2. CM Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for new member with diagnosis/new diagnosis of existing member (for Asthma

CM and Opioid/SUD CM).
Missouri Care lacks clarity on what constitutes a "new diagnosis" or a "new member." A member may have multiple enrollment dates in a given year. The date of diagnosis of asthma is noted to be the same as the date of referral/notification in Asthma CM.
Since these terms are not specifically defined in MHD contract, Primaris evaluated this criterion as: Offer CM (date of need assessment) within 30 calendar days of notification/referral (by any source: member services/case managers/utilization management alerts/internal reports generated by using claims data and authorizations).

3. Care Plan: As stated earlier in section 5.1 (2), the care plan addresses areas based on members' projected needs and does not include all points listed in MHD contract. One case in Asthma CM was closed as "goals met" within 10 days.

4. Discharge plan and follow up: Low compliance scores for these criteria are noted across all CM focus areas.
Asthma CM: Cases were lost due to unable to contact (UTC-9 cases).
Opioid/SUD CM: UTC (3 cases).
BH CM: UTC (4 cases).

5. Notification of case closure to PCPs in all focus areas was an issue. Missouri Care attributed it to an automation process of their new CM Medical Record System (Virtual Health-Care Compass) where notifications were not sent. They informed Primaris about another transition when Missouri Care will adopt Anthem's CM Medical Record System effective Jan 1, 2021 (ownership of Missouri Care has changed from WellCare to Anthem, Inc.)

5.3.2 Improvement from previous year

Table 5-13. Missouri Care MRR-Compliance with CM Criteria (EQR 2018-EQR 2020)

Missouri Care	OB*	EBLLs*	BH	Asthma	Opioid/SUD	Average Score**
EQR 2020	N/A	N/A	89%	88%	85%	87%
EQR 2019	94%	82%	88%	N/A	N/A	88%
EQR 2018	91%	62%	97%	N/A	N/A	83%

*Acronyms: OB-Obstetric, EBLLs-Elevated blood lead levels / **Not comparable

Table 5-13 shows results of medical records' compliance with CM criteria listed under MHD contract, for three years (EQR 2018-EQR 2020). (Note: The overall score for these years is

not comparable due to exclusion of one of the low scoring areas from previous year, "Provider Treatment Plan" in EQR 2020.)

Response to Previous Year's Recommendations.

Table 5-14 shows previous year's recommendations applicable to overall CM program and Missouri Care's response to them. (Note: The Table does not address previous recommendations specific to focus areas which were not reviewed in EQR 2020).

Table 5-14. Missouri Care's Response to Previous EQR's Recommendations

Recommendation	Action by Missouri Care	Comment by EQRO
1. 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 the 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).	Missouri Care makes calls/sends letters before closing a case in most instances. However, an issue was noted during MRR for Asthma CM: A member was contacted three times in three days and a case was closed as UTC.	Partially Met Missouri Care should also consider visiting a family's home and checking with the PCP, other providers, and programs before closing a case as UTC.
2. CM Assessment within 5 days of admission in psychiatric hospital/residential treatment program:	Missouri Care's performance has decreased from 25% (EQR 2019) to 16% (EQR 2020).	Partially Met Missouri Care should continue to work with the hospital authorities to secure permission for the care managers to visit patients

		during hospital stay so that they can engage with the member for a CM assessment during hospitalization.
3. Care managers should obtain written consent from the members in BH CM so that their care plan can be shared with PCPs. This is important for integration of BH and physical health. (Care managers must also recognize 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.)	Most of the medical records show that a consent was taken from patients and care plan was shared with PCPs. BH-sensitive information was also removed prior to sharing.	Partially Met BH care plan should be shared with PCPs after obtaining written consent from members. Missouri Care informed Primaris about their progress on implementing instructions per 42 CFR Part 2* regarding sharing of BH insensitive information with PCPs.
4. The care plan submitted to the providers should receive an acknowledgement/approval from providers.	This criterion was not evaluated in EQR 2020 per MHD's instructions.	Partially Met MHD and Missouri Care are working on a process to address this issue.
5. Engaging members in CM program. Deploying the right team member at the right time has a significant impact on a patient's interest in participation. Tailor messaging to different patient populations to address any unique barriers to enrollment for each.	Missouri Care has made progress in this regard: The number of BH cases closed due to "goals met" have increased from 9 to 15 in comparison to previous EQR. Cases closed due to "UTC" have decreased from 7 to 4. None of the members declined CM.	Partially Met

*42 Code of Federal Regulations Part 2: Confidentiality of SUD Patient Records

5.4 Findings and Conclusions: UnitedHealthcare

UnitedHealthcare: CM Data

Medicaid Managed Care members enrolled in CY 2019 = 156,969
Members enrolled in CM (each focus area) = Asthma: 31, SUD: 7; BH: 68
CM staff available = 47 care managers
Average case load = 250
Maximum members who can receive CM = 11,750 in varying levels of stratification with specialized level of outreach for each level of intensity. The caseloads are flexed in order to meet the needs of all members.

This section provides brief information on the CM program obtained from UnitedHealthcare, followed by findings and conclusions of an MRR conducted by Primaris for each focus area.

1. The Care Managers complete the initial comprehensive assessment as expeditiously as the member's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the member as appropriate for high-risk CM and is completed within 60 days of identification.

2. Member reassessments will be completed annually, or to document significant change in condition or per contractual requirements.

3. If the member's case is closed due to loss of eligibility, the CM will educate the member regarding the existence of community-based organizations or alternate resources for receiving care.

Figure 5-2 represents sources of notification/referral to CM program. Figures 5-3 and 5-4 represent overall CM/SUD/BH process.

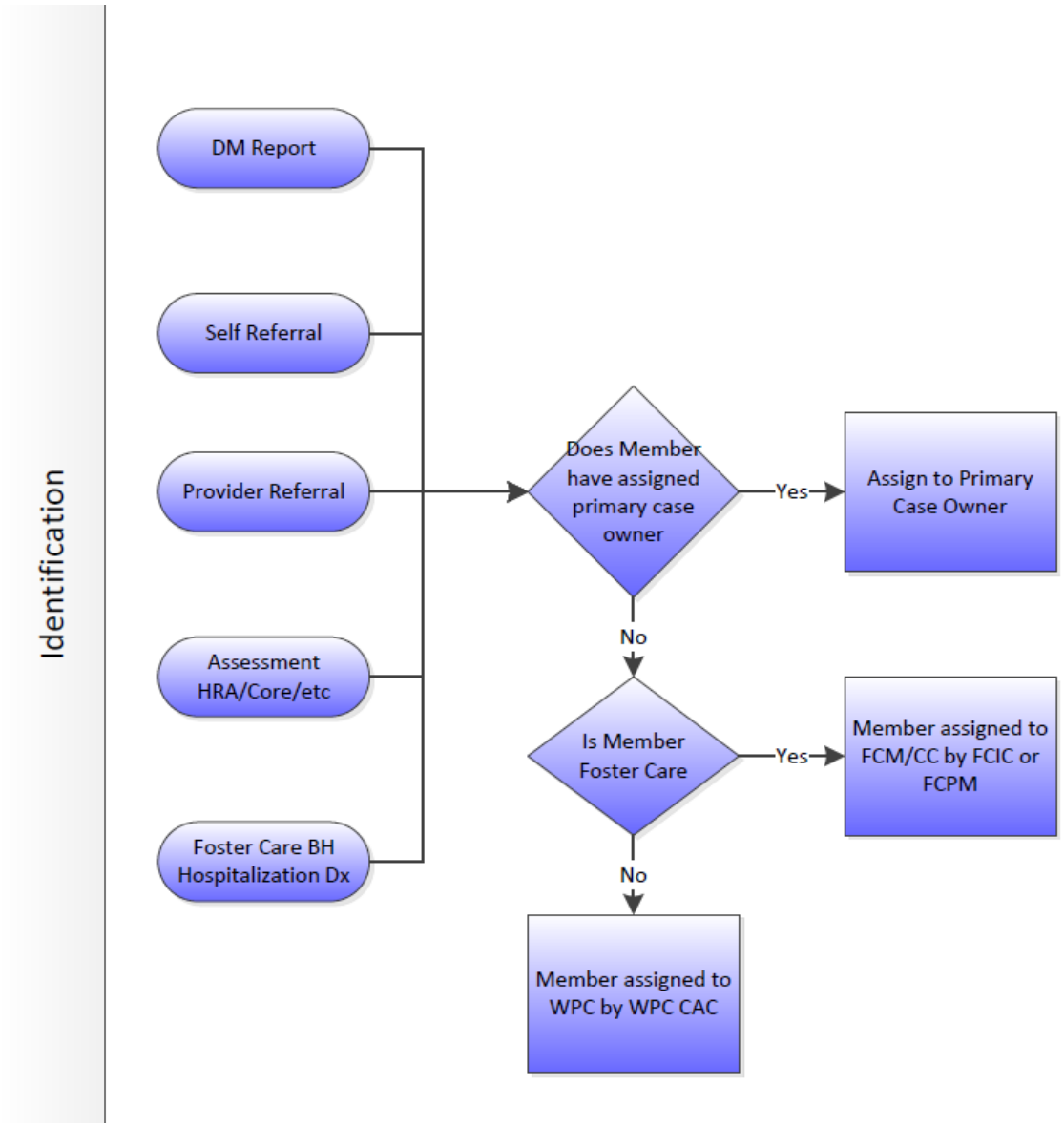


Figure 5-2. Population Identification for CM

(Source: UnitedHealthcare, Acronyms used: CC-care coordinator; FC/JJ-foster care/juvenile justice; FCIC-foster care intake coordinator; FCPM-foster care program manager; CANS-assessment for foster kids, WPC-whole person care management program; CAC-clinical administrative coordinator; HRA-high risk assessment)

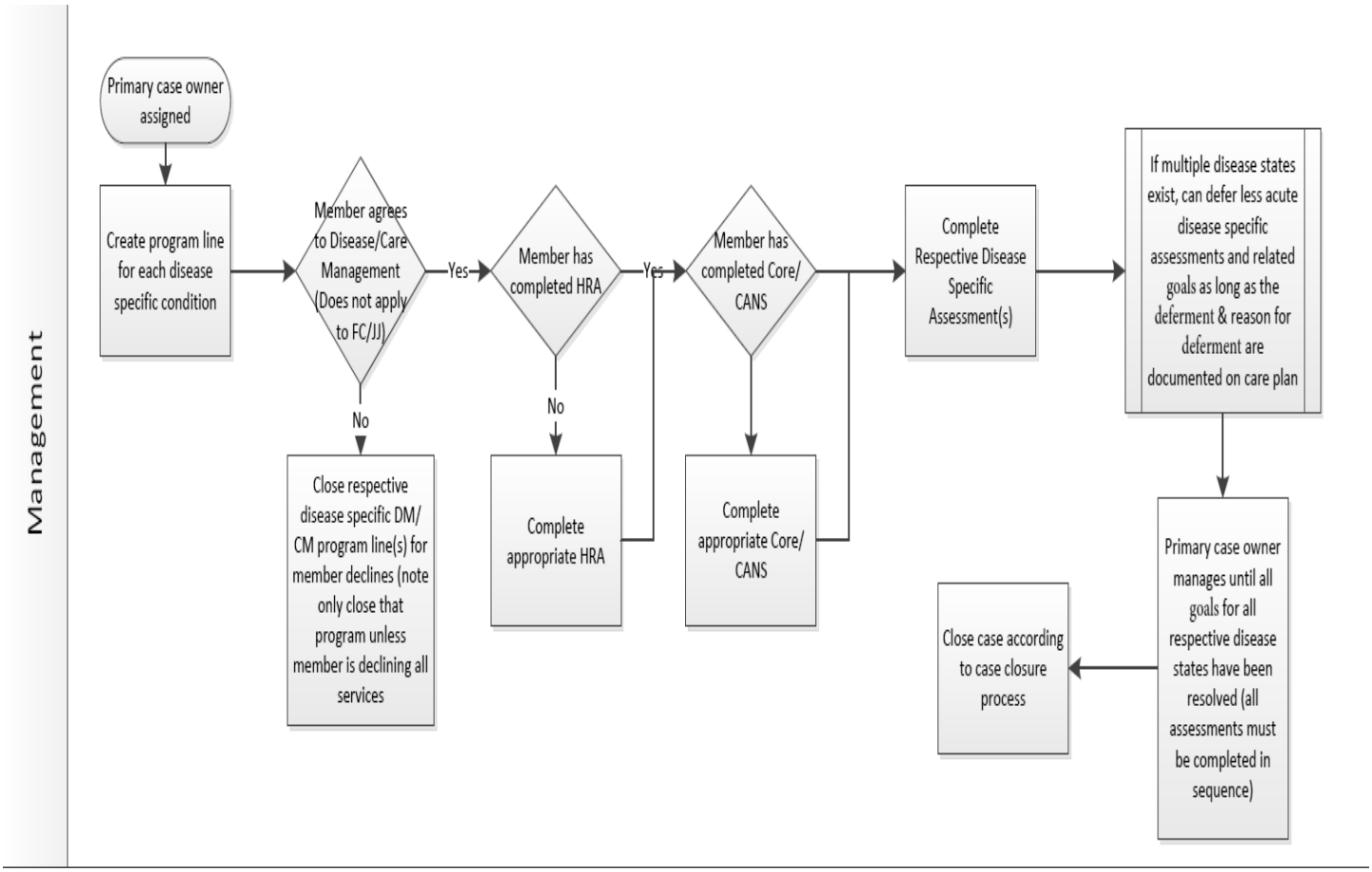


Figure 5-3. Overall CM Process (Source: UnitedHealthcare)

Whole Person Care (WPC) Program

Behavioral health care management is provided by UnitedHealthcare's 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 National Committee for Quality Assurance (NCQA) case management.

Interventions:

- The BH CM team collaborates with UM partners via daily rounds and multiple internal teams via interdisciplinary rounds to foster integrative and efficient member support.
- The BH CM team maintains relationships with facilities, outreaching upon member admission, either telephonically or in the field.
- The BH CM team identifies admissions proactively, via census reporting, to promptly assess for member needs, facilitate FUH appointments and assist with discharge-planning.

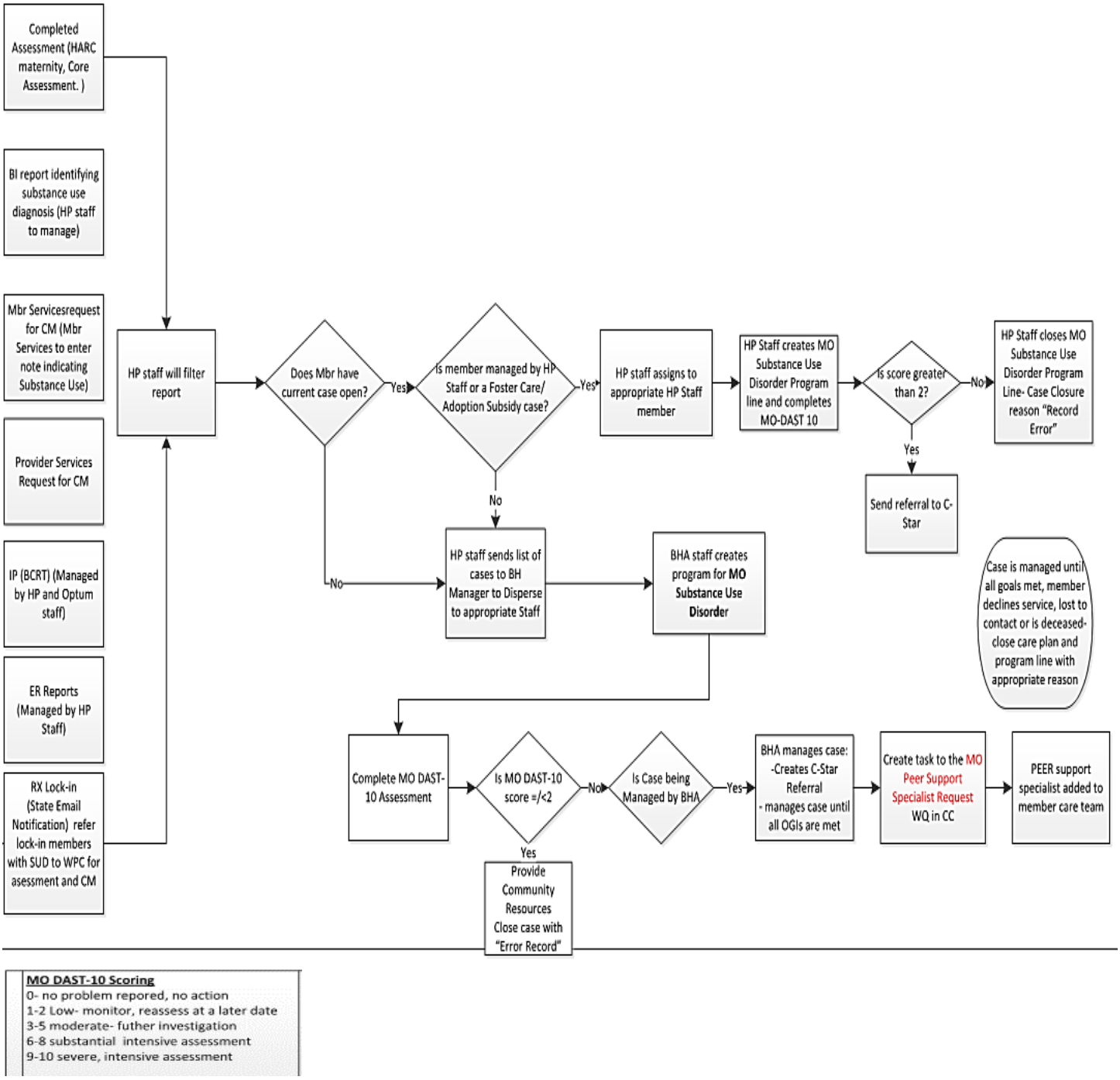


Figure 5-4. Substance Use CM Process (Source: UnitedHealthcare, Acronym: DAST-drug abuse screening test)

Findings of MRR

Table 5-15 shows number of medical records included in the study for each CM focus area.

Table 5-15. UnitedHealthcare CM Medical Records

	Asthma CM	Opioid/SUD CM	BH CM
Sample size/oversample	20	6	20
Number of medical records excluded from review	None	None	None
Number of medical records included in study	20	6	20
Cases closed-goals met	4	1	8
Cases open-in progress	9	2	1

Table 5-16 identifies compliance (%) of medical records with various criteria per MHD contract, applicable to all three CM focus areas.

Table 5-16. UnitedHealthcare Compliance (%) with CM Criteria

Evaluation Criteria	Asthma CM	Opioid/SUD CM	BH CM
Diagnosis	100	100	90
Risk stratification	90	Not applicable (N/A)	N/A
Enrollment date CM	100	100	100
Case closure date	100	100	100
Referral date	100	100	100
Offer CM (Assessment) within 30 days (new patient or new diagnosis).	70	100	N/A
Offer CM (Assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program	N/A	N/A	60
Assessment	100	100	70
Medical history	100	50	65
Psychiatric history	95	100	70
Developmental history	95	100	75
Psychosocial issues	100	100	75
Legal issues	85	83	55
Care plan	100	100	95
Participation by member in care plan/reasons for non-participation	100	N/A	N/A
Care plan updated	100	100	95
Progress notes	100	100	100
Lab tests	100	100	95

Transfer	100		100
Monitoring medication adherence	95	N/A	N/A
Monitoring services and care	95	100	90
Coordination and linking of services	100	100	95
Discharge plan	27	25	47
Follow up	27	25	47
PCP notification of case closure*	100	100	94
Aggregate Score	**91**	**90**	**81**

*Applicable for children only (age through 18 years).

Red highlighted figures (score < 80%) indicate areas for improvement.

Note: Per MHD's instructions, Criterion-Provider Treatment Plan-is not evaluated in EQR 2020 due to change in contract requirements effecting this criterion.

5.4.1 Quality, Timeliness, and Access

UnitedHealthcare scored 80% to 100% in: 21 of 24 criteria evaluated for Asthma CM; 18 of 21 criteria for Opioid/SUD CM; and 12 of 21 criteria for BH CM (Table 5-16). Table 5-17 reports some of the HEDIS® measures related to the three focus areas. Improvement in some of the rates can be attributed to UnitedHealthcare's CM Program.

Table 5-17. UnitedHealthcare HEDIS® Measures

CM	HEDIS® Measures	CY 2018	CY 2019	National Average (Medicaid)
Asthma	Medication Management for People with Asthma (age 5-64 years)-50% covered	70.95%	65.81%*	61.52%
	Medication Management for People with Asthma (age 5-64 years)-75% covered	46.62%	41.99%*	37.76%
	Asthma Medication Ratio (age 5-64 years)	71.60%	61.94%	62.99%
Opioid	Use of Opioids from Multiple Providers (Prescribers)	21.87%	BR**	23.20%
	Use of Opioids from Multiple Providers (Pharmacies)	12.40%	BR**	8.29%
	Use of Opioids from Multiple Providers (Prescribers and Pharmacies)	7.20%	BR**	4.83%

BH	Follow Up After Hospitalization for Mental Illness-within 7 days	17.88%	26.15%	35.80%
	Follow Up After Hospitalization for Mental Illness-within 30 days	37.41%	47.81%	56.78%

*Exceeds the national average for Medicaid-HMO, **BR: UnitedHealthcare reported as biased rate.

The following data is provided by UnitedHealthcare in support of timeliness of care for BH CM (Table 5-18).

Table 5-18. UnitedHealthcare BH: Transition of Care (TOC)

Criteria	Score (%)
Discharge Outreach	
• Within 1 Day of Discharge Alert	99.5%
• Beyond 1 Day of Discharge Alert	0.5%
Post-Hospitalization Assessment (PHA)	
• PHA Within 3 Days	73.8 %
• PHA Beyond 3 Days	26.2%

Strengths.

The following strengths/key drivers were identified during MRR and UnitedHealthcare's staff interview (Table 5-19).

Table 5-19. UnitedHealthcare Key Drivers

Asthma CM
• Education to providers on using asthma action plan. • Education to members on cessation of smoking, identification and avoidance of environmental triggers-Asthma Education Program. • Checking for immunization status for influenza vaccine. • Monitoring for medication adherence (CyberAccess^{sm}).* • Providing nutritional and physical activity counselling resources. • Nurse line (nursing advice services round the clock, 24 x 7). • Transportation services (for all CM focus areas) • Providing information about PCPs/Urgent Care/ED utilization.
Opioid/SUD CM
• Skilled clinical staff (licensed social workers, counsellors) are assigned to all aspects of the screening and assessment process, including initial telephone contacts. • Providing information about psychiatrists and counsellors, behavioral therapy (ReDiscover/ PEEPS recovery program).

• Provider portal-providers have access to care plan and information about written patient consent for sharing care plan with PCPs. • Educating members on medication adherence, self-management, post hospitalization appointments. • Nurse line services
BH CM
• Skilled clinical staff (licensed social workers, counsellors) are assigned to all aspects of the screening and assessment process, including initial telephone contacts. • Engagement of care managers with the members during hospitalization. • Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital. • Linking to community resources/BH support services/therapists. • Medication adherence monitoring. • Monitoring compliance with doctors' appointments. • Crisis line services

* CyberAccess℠ is a web-based, HIPAA-compliant tool that allows the MCO to view drug utilization information in near real time.

Weaknesses.

1. CM Need Assessment: UnitedHealthcare did not include medical, psychiatric, developmental, psychosocial, and legal history in a single questionnaire. They elicited members' history in their notes which they refer to as "Functional Domain." Several questions pertaining to these areas/histories were missed by care managers. In BH CM, these areas scored between 55-75%, and in Opioid/SUD CM, score was between 50-100% (Table 5-16).

2. The questionnaire used for assessment included a few issues. For example: i. advance directives (addressed in care plan) should not be included for all children. They should be based on State guidelines; ii. a question on military service should not be included in assessment for children; iii. a question on breast feeding should not be included in assessment for older children.

3. Repeat CM Assessment: A need assessment for CM is not conducted each time a member is enrolled in BH CM.
Members may be hospitalized several times while remaining enrolled in CM or a member may be reenrolled in CM after a previous case closure. UnitedHealthcare stated they reassess a case on a six month/annual basis or in case of three or more ER visits, inpatient admissions (Transition of Care assessment).
Primaris noticed ambiguity in this regard during MRR. There are no guidelines in MHD contract on this issue.

4. CM Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for a new member with a diagnosis/new diagnosis of an existing member (for Asthma CM and Opioid/SUD CM).
UnitedHealthcare lacks clarity on what constitutes a "new diagnosis" or a "new member." A member may have multiple enrollment dates in a given year. However, they use the "special healthcare needs" file sent to them from MHD on a monthly basis and begin to outreach members for CM need assessment.
Since these terms are not specifically defined in the MHD contract, Primaris evaluated this criterion as: Offer CM (date of need assessment) within 30 calendar days of notification/referral (by any source: member services/case managers/utilization management alerts/internal reports generated by using claims data and authorizations).

5. Policy: One of the policies submitted by UnitedHealthcare: Case Management Process number NCM 002, states, "the care managers complete the initial comprehensive assessment as expeditiously as the member's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the member as appropriate for high-risk CM and is completed within 60 days of identification."
Per MHD contract the requirement is to screen new enrollees within 30 days and not within 60 days.

5. CM Criterion: Offer CM (need assessment) within 5 business days of admission to psychiatric hospital or a substance use treatment program.
UnitedHealthcare scored 60% for this criterion in EQR 2020. Even though this is a noteworthy improvement from EQR 2019 (20%); low score remains an issue.

6. Care Plan: As stated earlier in section 5.1(2), the care plan addresses areas based on members' projected needs and does not include all points listed in the MHD contract.
A case in BH CM was closed as "goals met" even though a CM assessment was not conducted. #One of the six cases that was UTC in Asthma CM was closed as "goals met" even though there was no discharge plan/follow up.
During interview, UnitedHealthcare informed Primaris that short-term goals are created as members allow and case is closed once those goals are achieved.

7. Discharge plan and follow up: Low compliance scores for these criteria are noted across all CM focus areas.
Asthma CM: Cases were lost due to unable to contact (UTC-6 cases#); loss of eligibility (2 case); reason not specified (1 case).

Opioid/SUD CM: UTC (2 cases); loss of eligibility (1 cases).
BH CM: UTC (7cases); loss of eligibility (4 cases).

8. Pharmacy: UnitedHealthcare reported difficulties they had faced on some occasions in gathering member information from MHD's Pharmacy unit. On further enquiry by Primaris, UnitedHealthcare agreed that they do not maintain a log or a tracking mechanism related to issues faced and actions taken to resolve those issues.

5.4.2 Improvement from previous year

Table 5-20 shows results of medical records' compliance with CM criteria listed under MHD contract, for two years (EQR 2019-EQR 2020). (Note: The overall score for these years is not comparable due to exclusion of one of the low scoring areas from previous year, "Provider Treatment Plan" in EQR 2020.)

Table 5-20. UnitedHealthcare-MRR Compliance with CM Criteria (EQR 2018-EQR 2020)

Year	OB*	EBLLs*	BH	Asthma	Opioid/SUD	Average Score**
EQR 2020	N/A	N/A	81%	91%	90%	87%
EQR 2019	71%	62%	66%	N/A	N/A	66%

*Acronyms: OB-Obstetric, EBLLs-Elevated blood lead levels / **Not comparable

Response to Previous Year's Recommendations.

Table 5-21 shows previous year's recommendations applicable to overall CM program and UnitedHealthcare's response to them. (Note: The Table does not address previous recommendations specific to focus areas which were not reviewed in EQR 2020).

Table 5-21. UnitedHealthcare's Response to Previous EQR's Recommendations

Recommendation	Action by UnitedHealthcare	Comment by EQRO
1. 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.	They have not created a comprehensive assessment to include several areas in history. However, UnitedHealthcare elicits history in their notes which they refer to as Functional Domain.	Partially Met

2. 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 the 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).	UnitedHealthcare does make calls/sends letters before closing a case in most instances.	Partially Met UnitedHealthcare should also consider visiting a family's home and checking with the PCP, other providers and programs before closing a case as UTC.
3. CM Assessment within 5 days of admission in psychiatric hospital/residential treatment program:	UnitedHealthcare has improved their score from 20% (EQR 2019) to 60% (EQR 2020).	Partially Met Most of the referrals for BH CM occur during concurrent review. UnitedHealthcare should continue to work with the hospital authorities to secure permission for the care managers to visit patients during hospital stay so that they can engage with the member for a CM assessment during hospitalization.
4. UnitedHealthcare should consider enrolling a member in CM program	Same comment as above.	Partially Met

and completing "Access to Care-assessment" when they have an opportunity to interact with a member post-discharge for completing their "TOC-assessment."		
5. Care managers should obtain written consent from the members in BH CM so that their care plan can be shared with PCPs. This is important for integration of BH and physical health. (Care managers must also recognize 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.)	Some of the medical records show that a consent was taken from patients and care plan was shared with the PCPs.	Partially Met BH care plans should be shared with PCPs after obtaining written consent from members according to instructions in 42 CFR Part 2,* as applicable.
6. The care plan submitted to the providers should receive an acknowledgement/approval from providers.	This criterion was not evaluated in EQR 2020 per MHD's instructions.	Partially Met MHD and UnitedHealthcare are working on a process to address this issue.
7. Engaging members in CM program. Deploying the right team member at the right time has a significant impact on a patient's interest in participation. Tailor messaging to different patient populations to address any unique barriers to enrollment for each.	UnitedHealthcare has made progress in this regard. The number of BH cases closed due to "goals met" have increased from 5 to 8 in comparison to previous EQR; cases closed due to "UTC" have decreased from 10 to 7. None of the members declined CM once they were enrolled in CM.	Partially Met
8. MHD contract section 2.11.1 e 5 requires a documentation of member/family notification of discharge from CM. Primaris recommends UnitedHealthcare notify members by sending a member	UnitedHealthcare has complied with the requirement. They scored 100% in Asthma and Opioid/SUD CM; and 94% in BH CM.	Met

closure letter as opposed to a verbal notification.		

*42 Code of Federal Regulations Part 2: Confidentiality of SUD Patient Records

5.5 Recommendations for MCOs

Table 5-22 displays recommendations (with numbers corresponding to the listed items) as applicable to Home State Health/Missouri Care/UnitedHealthcare.

Table 5-22 Recommendations applicable (✓) for MCOs

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

1. PCPs should be notified about case closure per instructions in MHD contract section 2.11.1f. If there are issues due to automation of their New CM Medical Record System, Missouri Care should manually send a written notification to PCPs.

2. UnitedHealthcare's CM Assessment should include population specific questions (adults/children of different age groups).

3. UnitedHealthcare's policy on Case Management Process number: NCM 002, requires a revision to reflect the correct time requirement of screening of new enrollees for health needs.

4. Primaris recommends Home State Health and UnitedHealthcare initiate a process that tracks all the issues related to MHD's Pharmacy unit, from start to finish, including but not limited to: date/time of encounter; who spoke to whom (with titles/roles); name and Medicaid ID of the member for whom the communication/contact was made; issue discussed; and the specific outcome.

The MCOs must use supporting documentation (e.g., fax, letters); collaborate with provider services to support improving communication with the MHD Pharmacy unit; and utilize the demographic reports sent by the MHD, the providers (of record) to locate the member for CM services.

5. All the MCOs should continue to work on the previous EQR's recommendations scored as "Partially Met" in Table 5-7 (Home State Health); Table 5-14 (Missouri Care); and Table 5-21 (UnitedHealthcare).

6. Members in BH CM are neither assessed each time a case is reopened nor when a member is discharged from hospital multiple times, while being enrolled in CM. Primaris recommends MCOs should refer to MHD contact, section 2.11.1d5 as applicable for BH CM and contact MHD for additional clarifications on the frequency of CM assessment for existing patients who have recurring episodes of behavioral issues.

7. The MCOs informed Primaris about educating their providers regarding use of asthma action plan[12] for their members in Asthma CM. Primaris recommends MCOs audit providers' medical records at planned intervals to determine whether providers are using asthma action plan (recommended by Centers of Disease Control and Prevention (CDC)/or tailored) in managing asthma. Also, to check whether providers have adopted prescribing practices consistent with clinical practice guidelines.

8. The MCOs should address all points listed under MHD contract, section 2.11.1.e while developing a care plan for each member.

Suggested Resources for All MCOs

1. Engaging Stakeholders in a Care Management Program. https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm2.html.

2. Patient Engagement. https://www.healthcatalyst.com/three-must-haves-of-an-effective-care-management-system.

3. A guide for an overview of case management for substance use disorder treatment providers. https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215. It discusses models, program evaluation,

[12] https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/asthma-action-plan

managed care issues, referral and service coordination requirements, and clients with special needs.

6.0 Recommendations for MHD

This section includes Primaris' recommendations to MHD in order to help MHD target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
(Note: Primaris advises MHD to make amendments to their Managed Care contract according to "2020 Medicaid & CHIP Managed Care final rule" effective Dec 14, 2020 (except for the additions of 42 CFR 438.4(c) and 438.6(d)(6) and amendments to 438.340 and 438.364 which are effective Jul 1, 2021) so that MCOs are current in their policies and procedures which would be due for evaluation in EQR 2021.)

6.1 Validation of Performance Improvement Projects

Technical assistance from EQRO would be beneficial for each MCO individually, throughout their course of conducting PIPs. Improved training, assistance and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.

6.2 Validation of Performance Measures

1. The MHD is advised that W34 measure has been retired by NCQA for CY 2020. A new measure should be selected for review in future. MHD should consider including other Medicaid measures from CMS Adult Core Set, Child Core Set, and Behavioral Health Core Set measures.

2. The MHD should set standardized benchmarks for all the performance measures that are required to be reported by the MCOs. This applies also to those performance measures which are not included in the Performance Withhold Program. The benchmark needs to be the same for all MCOs.

Information Systems Capabilities Assessment

The MHD should support the MCOs in efforts to implement a process similar to or accomplishing the objective towards improving provider data accuracy. Currently, there is concern expressed for the burden this may add, again more so during a pandemic, to providers.
This effort will be more successful and less burdensome to all, if done as a unified task,

coordinated with MHD's support and other MCOs. To meet industry standards, ideally there should be a single source provider database. The MCOs and the MHD should have the ability to update and access this database. Having one source reduces redundancy and coordinates efforts performed by all, while increasing productivity and decreasing the risk of storing inaccurate data undetected. All stakeholders working to maintain one data source is a highly effective way to reduce burden.

Primaris recommends MHD consider a similar approach to maintain member contact information regarding improving quality of care management. There is continued conversation and reports of receiving inaccurate data on the 834 files from MHD. Data such as member contact information (phone, address, etc.) is sometimes out of date or missing. MCOs often have the correct information presented to them through contact with a member. Since MCOs cannot update the member's information globally, the data is updated internally, and each member is directed back to the state to update data again. The probability of a member contacting their MCO and the MHD with every contact/demographic update is considered low as a consensus. Giving the MCOs an opportunity to update one database shared with the state eliminates the need of sending members back to the state. It is recommended that MHD should have a process in place where an MCO is enabled to update members' most recent, accurate demographic information so that it is corrected in State's database in real time. The MHD should decide the validation process MCO should follow when collecting updated contact information (e.g., voice recording between MCO and member). This effort shares the responsibility of creating state-wide interoperability amongst members, MCOs, and the MHD as an operational team.

6.3 Review of Compliance with Medicaid and CHIP Managed Care Regulations

During EQR 2020, Primaris noted a few criteria under the QAPI Program evaluation for which there were either no instructions provided to the MCOs or there was ambiguity regarding expectations from the MCOs. For this reason, two sections out of 35 were marked as "Not Applicable" (N/A) in the evaluation tool. Table 6-1 lists criteria for which MHD is required to set expectations for MCOs.

Table 6-1. Recommendations for QAPI

Requirements and References	Recommendation for MHD
1. Population Characteristics: An analysis and evaluation of how MCO incorporates its population characteristics into its quality	MHD should clarify what information is expected from MCOs to present in QAPI regarding "opt outs." **Suggestion:**

strategy: race, ethnicity, languages, special needs, and opt outs.	opt out of CM program opt out of MCO opt out of Managed Care to Fee-for-Service
2. Quality Indicators	
Trends in Missouri Medicaid Quality Indicators provided by the Department of Health and Senior Services (DHSS).	MHD should consult DHSS and provide indicators to MCOs. These should be clarified in QAPI instructions.
MO HealthNet Managed Care HEDIS® Measures.	In addition to HEDIS® measures, MHD to consider if MCOs should include custom measures from Quality Data Instructions in QAPI.
3. Quality Management: Medical Record Review.	MHD should specify the provider groups (PCP/Specialty) and criteria for auditing medical records. **Suggestion:** MHD contract 2.28.5; 2.18.8c2; EPSDT; Use of clinical practice guidelines by providers for Asthma, Hypertension.
4. The MCO must include the following in their QAPI program: Timeliness of Care Delivery	MHD should provide indicators to MCOs for reporting. **Suggestion:** Timeliness of Prenatal care/postpartum care; EPSDT screening in foster care; and care management in foster care. Additionally, Agency for Healthcare Research and Quality (AHRQ) is a great resource. The access standards already established by the MHD can also be used to guide MCO on this criterion.
5. Trends identified for focused study; results of focused studies; corrective action taken; evaluation of the effectiveness of the actions and outcomes; description of how the results of the focused studies will impact the health plan's Quality Improvement Program during the upcoming year.	MHD should provide guidance on topic(s) around which the MCO should conduct focus studies. This should be incorporated in the contract as well as instruction guidelines regarding QAPI. MCOs may be allowed to identify trends for their focus studies even if a topic or statewide trend is not identified by MHD. Sometimes these trends are within the MCOs' population, based on how they conduct business or is a physician/provider specific.

6.4 Review of Care Management Program

1. Care Plan: The MHD mandate MCOs to create a checklist with all the requirements listed under MHD contract section 2.11.1e while developing a care plan for each member.

2. Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for a new member with a diagnosis/new diagnosis of an existing member. Criterion needs to be modified so that the contract requirement of "an MCO is required to conduct a risk assessment/need assessment within 30 days of notification of enrollment by the MHD" can be assessed accurately. Clear definitions of "new member" "new diagnosis" should be provided.

3. Criterion: CM Assessment within 5 days of admission in psychiatric hospital/residential treatment program.
Primaris recommends a change in the criteria by replacing "admission" with "discharge" and "business days" with "calendar days." Many members may not be in a proper mental state to engage with care managers within five days of admission. The MCOs may have several holidays/non-business days which may delay members' care.

4. Case Closure Notification: The MHD contract, section 2.11.1f states that a PCP must be notified in writing of all instances of children discharged from CM and the reason for discharge. MHD should provide clarification as to whether PCP notification requirement is limited to children (age limit) only and not applicable for adults.

5. The MHD should provide a minimum duration for which a CM outreach should be tried by MCOs before case closure for "UTC" occurs.

6. The MHD should consider setting benchmarks and incentives for critical criteria in the CM program which can serve as a driving force for the MCOs to improve their efforts towards member outcomes.