Primaris
Healthcare Business Solutions

2020 External Quality Review
Compliance

home state health

Measurement Period: Calendar Year 2019
Validation Period: May-July 2020
Publish Date: September 10, 2020

MoHealthNet

Table of Contents

1.0 Purpose and Overview

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. Total number of Managed Care (Medicaid and CHIP combined) enrollees by end of State Fiscal Year 2020 was 657,492 representing an increase of 10.20% as compared to end of SFY 2019.

MHD contracts with Managed Care Organizations (MCOs), also referred to as Managed Care Plans, to provide health care services to its Managed Care enrollees. Home State Health is one of the three MCOs operating in Missouri (MO). MHD works closely with Home State Health 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).

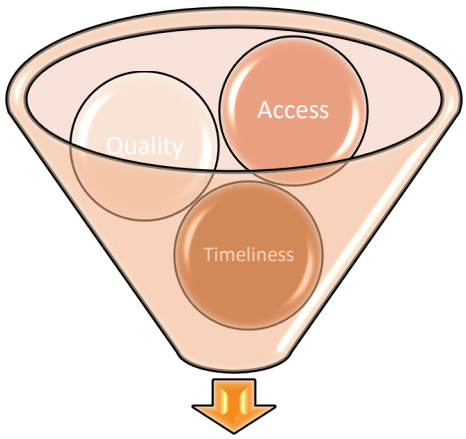
MHD contracts with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to perform an EQR. An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a Managed Care Plan, or its contractors, furnish to Medicaid beneficiaries (Figure 1). EQR 2020 evaluates activities of Home State Health during calendar year (CY) 2019.

1.2 Compliance with Regulations

Home State Health is audited annually to assess compliance with the Federal Medicaid Managed Care and Children's Health Insurance Program (CHIP) Regulations; State Quality Strategy; MHD Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous year's review. A review is conducted based on Centers for Medicare and Medicaid Services (CMS), Oct 2019 EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, to

meet the requirements of Code of Federal Regulations (CFR) 438.358(b) (iii). This section of the CFR requires a review to be conducted within 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.

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



EQR of Managed Care Services

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. EQR-A Federal Requirement

2.0 Methodology

Regulation due for review in EQR 2020 (third year of cycle) was 42 CFR 438, Subpart E, 438.330: Quality assessment and performance improvement (QAPI) program (Figure 2). Primaris collaborated with MHD and Home State Health 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 related to the findings of current year and a summary of findings from all previous reviews within the current three-year review cycle.
- Review Home State Health's response to previous EQR recommendations.

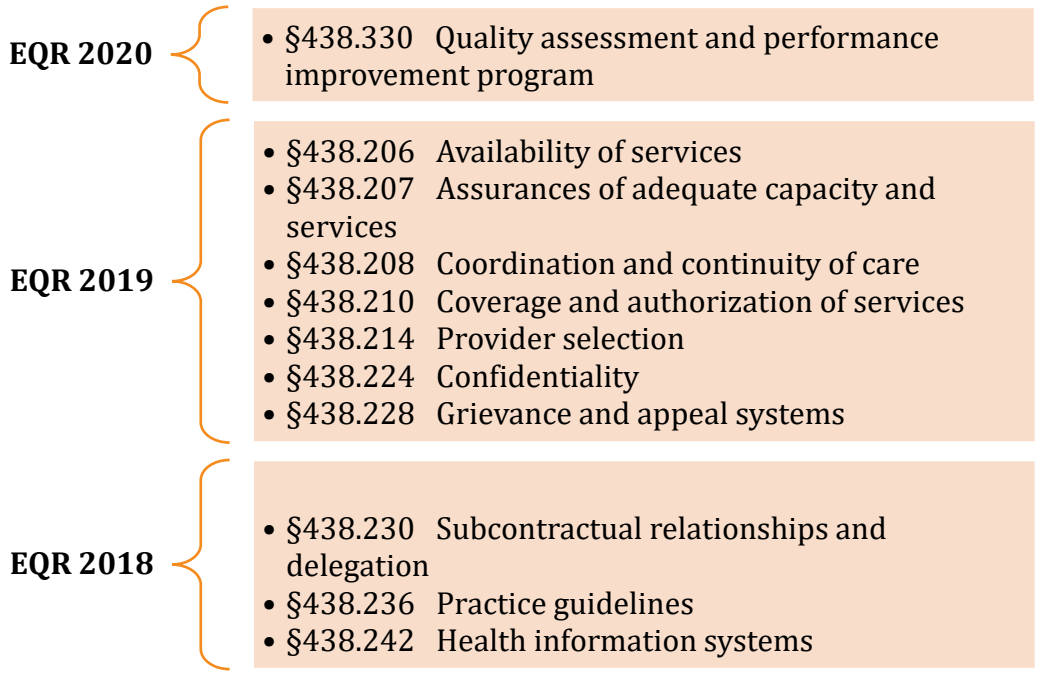


Figure 2. A Three-Year Compliance Review Cycle

Figure 3. Process of Compliance Evaluation

Primaris conducted compliance review in May-July 2020. The evaluation process included requesting and analyzing documentations pre- and post-virtual onsite, and interviews (Figure 3). Primaris provided Technical Assistance (TA) during the review period to steer Home State Health towards excellence. The details of the technical assistance provided 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 (Appendix A). Home State Health submitted their documents via Primaris' secure website 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:

- ✓ Annual Quality Program Evaluation 2019
- ✓ Work Plan 2020
- ✓ MO.QI.01.02 Quality Program Description
- ✓ Utilization Management UM1: Annual Evaluation

Onsite Interviews

A virtual meeting with Home State Health was conducted on May 28, 2020, as travel to onsite office location in St. Louis, Missouri was restricted due to the Covid-19 Pandemic. The following personnel from Home State Health were available for an interactive session:

- Megan Barton, Senior Vice President, Medical Management
- Bob Lampe, Vice President, Compliance
- Lucian Nevatt, Director, Quality Improvement
- Lupe Ponce, Accreditation Specialist
- Susan Nay, Senior Quality Management Specialist
- Kelley Peters, Director, Case Management
- Corina Bohrer, Director, Utilization Management

Compliance Ratings

The information provided by Home State Health 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 will utilize a compliance rating system as defined in Table 1 (Source: EQR Protocol 3).

Table 1. 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.

3.0 Performance Strengths and Areas Requiring Corrective Action

3.1 Overall Summary of Findings

An assessment was done for one federal regulation in EQR 2020, with Home State Health achieving a compliance score of 87.9%. Table 2 summarizes findings from EQR 2020 as well as previous reviews within the current three-year review cycle.

Table 2. Summary of 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	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**	

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

3.2 Regulation I-Quality Assessment and Performance Improvement Program

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 (Appendix A).

3.2.1 Quality, Timeliness, and Access to Healthcare Services

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). Home State Health uses a Continuous Quality Improvement (CQI) cycle approach to assess, monitor and improve the overall quality of care and service to its members and stakeholders. 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 this 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 in section 3.2.2). 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 having 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). (Details in Appendix A section A9i.)

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.

3.2.2 Areas Requiring Corrective Action

A corrective Action Plan (CAP) is not recommended. However, Home State Health is required to resolve all issues associated with eight criteria that are assigned a score of “Partially Met” (details in appendix A).

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 (appendix A-section A 4 ii)-Partially Met.

2. Home State Heath reported rates for 16 HEDIS measures for CY 2019 (will be finalized in Jun 2019) along with trends in previous two years. However, the Home State Health did not

evaluate or analyze their performance measures (section A 4 iii)-Partially Met.

3. Home State Health should present analysis, evaluation, trends, and recommendations for future year regarding information presented in (ix) cultural competence and (x) requests to change practitioners (section A 5)-Partially Met.

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.) (section 6 iv); an inventory of member materials available in alternative formats (section 6vi)-Partially Met.

5. Information Management: Analysis and evaluation of Information System in relation to membership and providers is not provided in QAPI (section A 8)-Partially Met.

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 (section 9 ii)-Partially Met.

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 (section A 12 v, vi, vii, viii, x, xii)-Partially Met.

8. Home State Health should submit evaluation and analysis of provider profiling regarding utilization of services and outcomes for CY 2019 (section D 2)-Partially Met.

4.0 Corrective Action Plan Process

Home State Health 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 Home State Health's 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, Home State Health is required to resolve these issues which would be evaluated during next year's review. Table 3 is inclusive of all deficiencies noted during a three-year review cycle (EQR 2018-2020).

Table 3. Audit Results for Home State Health (EQR 2018 2020)			
42 CFR Regulation	**Key Findings**	**Sections Met/Total**	**Audit Results**
§438.330 Quality assessment and performance improvement program	Concerns identified	25/33	Partially Met
438.206 Availability of services	No concerns identified	11/11	Met
438.207 Assurances of adequate capacity and services	No concerns identified	10/10	Met
438.208 Coordination and continuity of care	No concerns identified	17/17	Met
438.210 Coverage and authorization of services	No concerns identified	22/22	Met
438.214 Provider selection	No concerns identified	12/12	Met
438.224 Confidentiality	No Concerns identified	19/19	Met
438.228 Grievance and appeal systems	No concerns identified	44/44	Met
§438.230 Sub Contractual Relationships and Delegation	No concerns identified	7/7	Met
§438.236 Practice Guidelines	No concerns identified	6/6	Met
§438.242 Health Information Systems	No concerns identified	7/7	Met

5.0 Conclusion

5.1 Improvement by Home State Health

Figure 4 depicts the performance of Home State Health over a three-year review cycle. In EQR 2020 (CY 2019-87.9%), there is a decrease of 12.1% points in compliance score from EQR 2019 (CY 2018-100%). During two previous EQRs the Home State Health was not placed on a CAP.

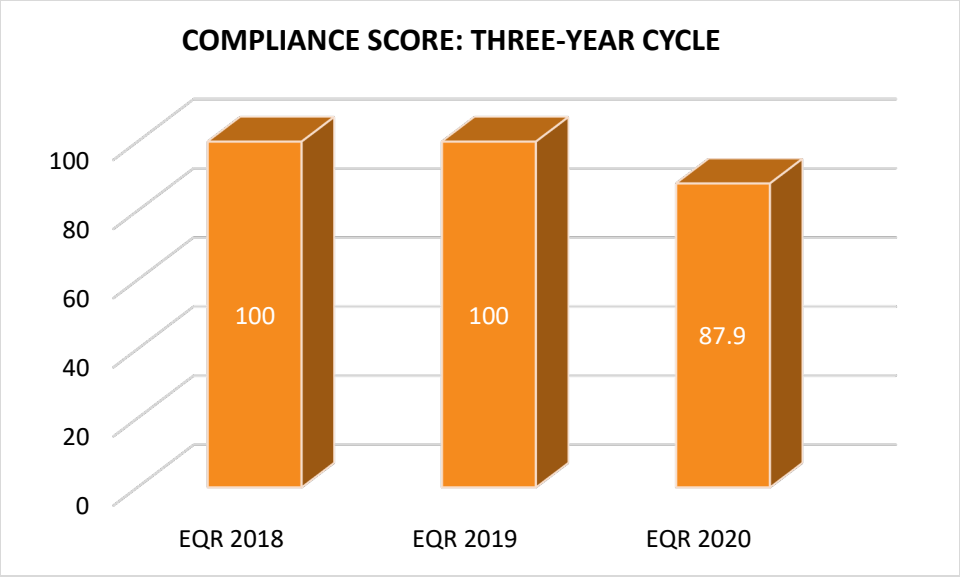


Figure 4. Compliance Score (EQR 2018-EQR 2020)

5.2 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):

Table 4. 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 were recommended.	Home State Health updated their policies in the previous year.	All items closed in EQR 2019.

6.0 Recommendations

6.1 Home State Health

1. Home State Health is required to address eight "Partially Met" criteria stated in section 3.2.2 of this report .

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 tests 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.

Additional Resources

Home State Health has analyzed and identified the root causes for the weaknesses stated in section 3.2.1 of this report and developed interventions for implementation in CY 2020. Primaris provides additional resources/suggestions that may be helpful in improving the outcomes:

1. 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.[1]
- 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 towards increasing patients' access to after-hours care.[2]

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

2. 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

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

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986/ (Figure 5)
- https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf.

(This space is left blank intentionally.)

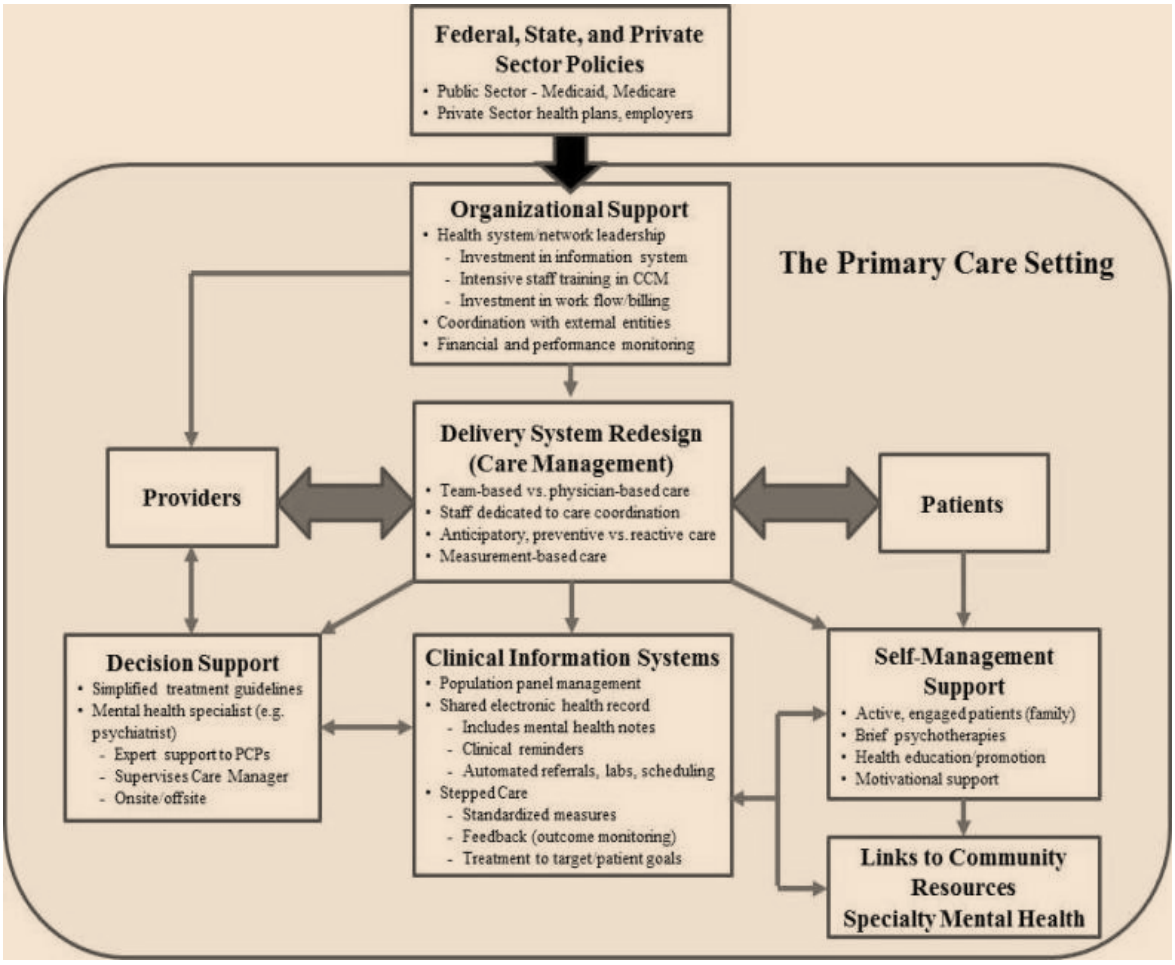


Figure 5. Evidence-based Components of Collaborative Care for Mental Health in Primary Care. Based on the original model articulated in Wagner et al. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986/)

6.2 MHD

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 MCOs. For this reason, two sections out of 35 were marked as "Not Applicable" (N/A) in the evaluation tool (ref. to appendix A). Table 5 lists criteria for which MHD is required to set expectations for MCOs.

Table 5. Recommendations for MHD

Requirements and References	Recommendation for MHD
3. Population Characteristics: An analysis and evaluation of how MCO incorporates its population characteristics into its quality strategy: race, ethnicity, languages, special needs, and opt outs.	MHD should clarify what information is expected from MCOs to present in QAPI regarding "opt outs." **Suggestion:** opt out of CM program opt out of MCO opt out of Managed Care to Fee-for-Service
4. Quality Indicators	
i. 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.
iii. 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.
9. iv. 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 CPGs by providers for Asthma, Hypertension.
12. The MCO must include the following in their QAPI program: xi. Timeliness of Care Delivery	MHD should clarify indicator expected from MCO. **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 state can also be used to guide MCO on this criterion.
17. 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. MCO 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 MCO's population, based on how they conduct business or is a physician/provider specific.

(This space is left blank intentionally)

Appendix A. QAPI Evaluation Tool

Subpart E, 42 CFR 438.330 Quality Assessment and Performance Improvement (QAPI) Program		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes the elements identified in this section (MHD QA & I instructions).		
1. Development, approval, and monitoring of QAPI: i. Quality and Compliance Committee. An analysis and evaluation of action items documented in the meeting minutes of MCO's quality and compliance committee(s).	Annual Quality Program Evaluation: Pages: 1 to 6 Quality Program Description: Pages-11, 12 Supporting Documents: • QIC Meeting Minutes • UMC Meeting Minutes • BOD Meeting Minutes (redacted version)	Fully Met
Findings: 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 the health plan's quality, utilization, and operational quality improvement (QI) functions. The annual Program Description, Program Evaluation and Work Plan are reviewed and approved by the Quality Improvement Committee (QIC) prior to the BOD final review and approval. These entities serve as the foundation for making recommendations based upon identified opportunities for improvement, implementing interventions, and ensuring follow-up for effectiveness of adopted recommendations. The BOD delegates the daily oversight and operating authority of the QAPI Program to the QIC. The QIC and subcommittees reporting to it are comprised of members from multiple departments to enhance communication through the plan. 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). A designated Compliance Officer and a Compliance Committee is charged with the responsibility of developing and implementing Home State Health's compliance program in collaboration and involvement of the company's leadership. The Compliance Officer also reports compliance program activities and evaluation of its effectives to the company's leadership and Board of Directors. **Required Actions:** None.		

ii. Analysis of quality improvement process.	Annual Quality Program Evaluation: Page-2 Quality Program Description: Pages-6 to 8	Fully Met
Findings: The QAPI Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, barrier/root cause analysis, identification of opportunities, implementation of interventions as indicated, and evaluation. Home State Health uses a Continuous Quality Improvement (CQI) cycle approach to assess, monitor and improve the overall quality of care and service to its members and stakeholders. The year-end Quality Program Description Evaluation identifies barriers, opportunities for improvement, results and recommended interventions. The Evaluation is then used to make modifications to the coming year's Quality Program Description and to create the key metrics of the QI Work Plan. Centene Corporate Quality Improvement and Accreditation Departments provide oversight and support throughout the Quality Program. **Required Actions:** None.		
iii. MCO should have a designated staff (coordinator) with expertise in quality assessment, utilization management, and continuous quality improvement.	Annual Quality Program Evaluation: Page-9	Fully Met
Findings: Quality Coordinators/Specialists are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management. At least one of the Home State Health's Quality Coordinators/Specialists is a Missouri registered nurse. The Quality Coordinator/Specialist collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through health plan's quality improvement activities and quality of care reviews. **Required Actions:** None		
2. Evaluation of impact and effectiveness of QAPI: i. Strengths and accomplishments. ii. Opportunities for improvement.	Annual Quality Program Evaluation: Pages-9, 10	Fully Met
Findings: Home State Health identified strengths and accomplishments. Some of them are listed as follows: • Participation in various workgroups with MHD to enhance reports and develop associated specifications such as: Complaints, Grievances and Appeals Quarterly Report Automation. • Participation in workgroups with MHD to enhance processes such as: Follow-Up After Hospitalization for Mental Illness (FUH), ADV. • Expansion and development of Health Plan Data Analytics Dashboards.		

- Use of Healthcare Quality Data Measures created with Inovalon as MHD custom measures.
- Collaboration with Delegated Vendors to provide coordination of care and drive HEDIS result.
- Completion of Annual Compliance Training by all Home State Health employees.
- Completion of Quarterly Cultural Competency Trainings.
- Continuation of Primary Care Dental Home Assignments for all eligible members.
- All UM Nurses compliantly passed Inter-rater reliability testing for InterQual.
- CM made outreach to members upon notification of pregnancy in a timely manner in 96.6% cases.
- Claims Financial Accuracy averaged 98.8%.
- Claims Payment Accuracy 95.7%.
- Participated in multiple community events across Missouri including health fairs, baby showers and other outreach activities.
- Increased number of P4P Provider agreements.
- Conducted Texting Programs aimed at increasing member engagement.
- Improved auditing process for Member Services Department resulting in a significant increase in staff feedback.
- Increased member response to post call surveys for the Member Services Department by 114%.
- Increased collaboration between Network and Medical Management with regards to provider feedback.
- Year-round data collection from provider documentation for HEDIS.
- State approval of providing Mom's Meals for members.
- Developed Rapid Response Team to respond to state or other entity emergent inquiries
- Successful Fluvention program, resulting in an increase of 4.65% inoculation rate.
- Use of alternative transportation service (LYFT) implemented.

Some of the opportunities for improvement identified by Home State Health are as follows:

- Increasing member inclusion in Care Management plans of care including: Face-to-face requirement for Lead Program requirement of 100%; optimize the coordination of care of members with medical and behavioral health diagnoses; and improve ongoing outreach to members with readmissions.
- Increase HEDIS rates to meet or exceed the 50th percentile.
- Improve CAHPS scores with particular focus on Customer Service, Rating of Health Care and Rating of Home State Health.
- Improve Complex Care Management Satisfaction Survey Methodology and increase response rate.
- Decrease statewide Emergency Room Utilization to <1,887 claims per 1,000 per month.
- Continue to refine Performance Improvement Projects to better align with CMS Tools; focusing on measurements of success.
- Increase number of Electronic Supplemental Data Exchanges with Large Provider Systems.
- Reduce Med/Surg Length of Stay.

- Reduce Neonate Length of Stay.
- Reduce Neonate rate.
- Continue to encourage member participation in the federal Safelink Phone Program

Required Actions: None. However, it is advised that Home State Health should be objective/specific in stating their accomplishments and improvement areas.

3. Population Characteristics: An analysis and evaluation of how MCO incorporates its population characteristics into its quality strategy: race, ethnicity, languages, special needs, and opt outs.	Annual Quality Program Evaluation: Pages-11 to 13 Annual Quality Program Evaluation (revised): Pages-16, 20, 21, 24	Fully Met

Findings: Home State Health regularly examines population demographics and characteristics to ensure that there are services in place to meet the members' needs.

Age analysis: The vast majority of Home State Health's membership is children ages 2 to 19. Also, there are a significant number of pregnant women (approximately 5%). As a result of population distribution, quality improvement activities are targeted towards improving the health of pediatric and maternity populations.

Home State Health reviews race and ethnicity information to determine if there are cultural needs specific to the membership: non-Hispanic White (52.73%); White (7.83%); Non-Hispanic Black (19.56%); Black (5.42%); all others include Hispanics, Asians, Unknown.

Primary language spoken in households in Missouri according to the information derived from the CY 2019 CAHPS Child Medicaid 5.0H Summary Report for Home State Health is English (93%). The second most common language is Spanish (2%). Remaining 5 % (total) of the members speak Arabic, Vietnamese, Nepali, and other languages. Data does not reveal any other specific linguistic or cultural needs of the Home State Health membership. 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 & adolescents identified with disabilities is 21,836/204,474 (11%) of the population. The number of disabilities for adult population of Home State Health members is 1,050/204,475 or 0.5%. Those that meet 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.

From Jul to Dec 2019, 21,736 members were identified for care management outreaches. Of these members, 3,347 refused this offer (15.4%). Care management staff are trained in Motivational Interviewing skills and are provided with talking points and engagement strategies to attempt to engage members in care management. Additionally, members are offered incentives to engage in care management. **Required Actions:** None.		
4. Quality Indicators: An analysis and evaluation of all MHD Managed Care quality indicators including the following and how MCO will incorporate the results from this analysis and evaluation into MCO's QAPI and implementation of PIPs, MCO initiatives, member/provider incentives, additional benefits, etc. during the upcoming year.		
i. Trends in Missouri Medicaid Quality Indicators provided by the Department of Health and Senior Services.		Not Applicable (N/A)
Findings: Home State Health did not present this information in the QAPI. Home State Health stated that they were not aware of quality indicators provided by Department of Health and Senior Services (DHSS) for evaluation, analysis, and reporting in QAPI. Primaris contacted MHD for clarification on this requirement during the preliminary review. MHD provided the indicators to Home State Health after Primaris brought this issue to their attention. Primaris will mark this section as not applicable (N/A) for EQR 2020. **Required Actions:** Home State Health is required to submit the information requested in this section to MHD in a given time period. Primaris will evaluate this section and report the score in next year's compliance report as a follow up activity.		
ii. HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births provided by the Department of Health and Senior Services.	Annual Quality Program Evaluation (revised): Page-68	Partially Met
Findings: Home State Health monitors the rate of live births. This information is received from MHD on an annual basis and is retrospective. The most recent report received from MHD is from CY 2018. This information is reviewed to determine Home State Health's performance in comparison to other MCOs and Fee-for-service Medicaid. Cesarean Section births: Home State Health reported that rates did not significantly vary from the other MCOs. Compared to fee-for-service (MHD), Home State Health was		

significantly below the MHD in the Western region (lower the better). There was no difference in other regions. Vaginal Birth after Cesarean Sections (VBAC): Home State Health rate did not vary from the fee-for-service rates but was lower than the other MCOs for the Central region. This report is reviewed to determine the care management needs and information that may be shared with members in newsletters. In CY 2019, Home State Health created scorecards and dashboards to show the provider groups their individual Cesarean Section rates. The intent is for providers to review if they are an outlier and whether or not there are any measures, they can take to fall in an appropriate range for the population they serve. Home State Health did not report on 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. **Required Actions:** Primaris recommends Home State Health to evaluate, analyze, and report on the measures that are not reported.		
iii. MO HealthNet Managed Care HEDIS Measures.	Annual Quality Program Evaluation: Pages-22, 23	Partially Met
Findings: Home State Heath reported rates for 16 HEDIS measures for CY 2019 (will be finalized in Jun 2019) along with trends in previous two years. However, the Home State Health did not evaluate or analyze their performance measures. **Required Actions:** Primaris recommends analysis and evaluation of HEDIS performance measures in QAPI.		
5. Accessibility of Services: An analysis and evaluation of: i. Average Speed of Answer; ii. Call Abandonment Rate; iii. Non-Symptomatic-Routine Needs Appointments; iv. Symptomatic-Routine Needs Appointments; v. Access to Emergent and Urgent Care; vi. Network Adequacy-Provider/Enrollee Ratios; vii. 24 Hour Access/After Hours Availability; viii. Open/Closed Panels; ix. Cultural Competency; and	Annual Quality Program Evaluation: Pages-25 to 42 Annual Quality Program Evaluation (revised): Pages-10, 73 to 79	Partially Met

x. Requests to Change Practitioners.		

Findings: i. Percentage of calls (English) answered within 30 sec (goal 90%) is 94.60% for physical health services and 93.8% for behavioral health services.

ii. The call abandonment rates for physical and behavioral health services are 1.7% and 2.6% respectively (goal<5%).

iii. & iv. 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.

v. PCPs meeting urgent care appointments (within 24 hours) were 99% (goal 90%).

vi. There are 82,015 providers in the Home State Health network. In CY 2019, there were 209,845 members. 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 Pediatrics. 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 this 90% availability standard.

vii. PCP offices after-hours access mechanisms meeting Home State Health's standards were 94% (goal 100%). There have been no appeals about physical health access for appointments in CY 2019. Access complaints were 0.0273 per 1000 members (goal <0.5 per 1000 members).

viii. Home State Health provided data on practitioners accepting new patients, the results ranged from 84% to 100% availability of accepting new patients and making appointments. The providers are required to inform Home State Health when they reach 85% of their capacity.

ix. Home State Health stated that based on CY 2019 data on network adequacy and cultural and linguistic needs, there were no network cultural or linguistic deficiencies identified. However, the Home State Health did not share data in support of above statement.
Home State Health also discusses culturally and linguistically appropriate services in the member handbook, lists provider languages on the Find-A-Provider (FAP) tool and includes language blocks and translation of letters, upon a member's request.

x. Home State Health monitors member requests to change their PCP. This is accomplished through the member portal or by phone. There were 22,037 phone requests and 3,834 requests via member portal to change their PCP. The Home State Health educates members

about how to change practitioners independently via member portal. Analysis and evaluation of reasons for change requests, trends are not reported. **Required Actions:** Home State Health should present analysis, evaluation, trends, and recommendations for future year regarding information presented in (ix) and (x) of this section.		
6. Multilingual Services: An analysis and evaluation of the multilingual services provided, to include, at a minimum: i. A count by language of how many members declared a language other than English as their primary language; ii. A summary by language of translation services provided to members (oral and in-person); iii. A count of members identified as needing communication accommodations due to visual or hearing impairments or a physical disability; iv. 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.); v. An inventory by language of member material translated; vi. An inventory of member materials available in alternative formats; and vii A summarization of grievances regarding multilingual issues and dispositions.	Annual Quality Program Evaluation (revised): Pages-10, 17, 18	Partially Met
Findings: i. Home State Health provided counts about member population speaking other languages than English (93%): Spanish (2%); Arabic (2%), Vietnamese, Nepali, and other (1%). ii. In CY 2019, there were a total of 8,860 face-to-face interpreter services requests fulfilled by a vendor at Home State Health. The Home State Health reviews requests for language translation services for incoming calls. During the assessment period, the most requested language translation by a large margin was Spanish (69.89%). The second largest requested language was Arabic (6.87%). This was followed by Swahili (4.41%), Somali (2.92%), and Nepali (2.05%).		

iii. There were 50 Home State Health members identified as potentially needing communication accommodations due to visual disabilities. Of these, 44 were children. There were 1,135 members who were deaf or had hearing impairment. Majority of these members (1,041) were children.
iv. This section is not reported by Home State Health in QAPI, though Home State Health stated that additional communication accommodations, e.g., translation into Braille and American Sign Language are provided to members, if needed.

v. Home State Health has the following documents available in Spanish:

- Home State Health Member Booklet.
- Short and long version of Non-Discrimination Notice and language taglines.
- New Member Packet (Home State Health Member Booklet, Benefit Booklet, Directory Insert, ID).
- Welcome Letter, New Member Packet Envelope, and New Member Welcome Magnet.
- Taking Care Booklets, examples (Taking Care of Your Cancer Book and Taking Care of Your MS Book).
- Survey/Assessments/Newsletters/Flyers, examples: CAHPS MO Child Survey, Home State Health Risk Assessment, all Quarterly Newsletters, all Educational materials, Fluvention Flyer, Lead Poisoning Flyer, My Health Pays Flyer, Home State Health Emergency Room Brochure, PCP Change Form, and HIPAA/Authorization Forms).

vi. This section is not reported by Home State Health in QAPI.

vii. Home State Health monitors complaints and grievances on a monthly basis and reports all grievances received to MHD. In CY 2019, Home State Health had zero (0) grievances concerning multilingual issues and dispositions.

Required Actions: Home State Health is required to provide analysis and evaluation of iv, vi, of this section.

7. Fraud and Abuse: An analysis and evaluation of the health plan's fraud, waste, and abuse program. (Prevention, Detection, Investigation Training and Education.)	Annual Quality Program Evaluation (revised): Pages-8 to 10	Fully Met

Findings: Home State Health's Compliance and Ethics Program established and maintains an effective compliance program to prevent, detect, and correct fraud, waste and abuse; ethical concerns; and non-compliance with federal, state and contractual requirements and accreditation standards.

Prevention: Prepayment editing. In CY 2018, approximately $7.6M was identified in savings due to the payment policy edits and $7.5M in CY 2019. Home State Health has 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.

Detection and Investigation: In CY 2019, the volume of current opened cases at the end of 2019 was 33 (increase from 25 at the end of CY 2018). Eighteen of the opened cases in CY 2019 were internally generated through data mining and analytics. The results of many of these investigations resulted in educating the provider of billing errors and were not identified as fraud or abuse; however, Centene Special Investigations Unit (SIU) is currently investigating or planning to review the previously educated providers to verify if their billing practices are corrected. If the provider is found to continue the inaccurate billing, this would support fraud and abuse allegations. Due to the education and because many of these providers were investigated through the prepayment review process, fewer retrospective investigations were performed and therefore less recoupment was initiated in CY 2019 ($52,017 vs $189,227 in CY 2018).

The specialized training that specifically covered fraud, waste and abuse was attended by 150 personnel in CY 2019.

Required Actions: None.

8. Information Management: An analysis and evaluation of MCO's claims processing (timeliness, membership, providers) and Management Information System.	Quality Program Description: Pages-28 to 30 Annual Quality Program Evaluation (revised): Pages-121 to 126	Partially Met

Findings: Home State Health has the technology infrastructure and data analytics capabilities to support goals for quality management and value. Home State Health's health information systems collect, analyze, integrate, and report encounter data and other types of data to support utilization, complaints/grievances and appeals, care management/coordination, and all quality activities.

At Home State Health, the claims processing is monitored on a monthly basis for timeliness. If a provider contacts the Home State Health about failure to be paid, check dates are validated, copies of cashed checks are obtained, and electronic funds transfers are confirmed. If this information is not able to be obtained, an investigation is launched with the finance department and other teams.

In CY 2019, Home State Health paid claims in 15 days (94.5% vs goal of > 90%) but missed their goal (> 99%) for claims paid in 30 days (98%) by 1% point. There was an increase of 1.1% for claims paid in 15 days in comparison to CY 2018 (93.5%) and a decrease of claims paid in 30 days by 1.2% compared to CY 2018 (99.2%). In CY 2019, the operations department hired a new Vice President and they have worked to determine process improvements and efficiencies. Home State Health will continue to monitor claims timeliness on a monthly basis in 2020 and look for continued process improvements.

Analysis and evaluation of Information System in relation to membership and providers is not provided in QAPI. **Required Actions:** Home State Health is required to present information on analysis and evaluation of Information System in relation to membership and providers.		
9. Quality Management:		
i. Provider Satisfaction.	Annual Quality Program Evaluation (revised): Pages-106 to 108	Fully Met
Findings: 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). Recommendation of Home State Health to other providers was scored at 37%, satisfaction with provider relations was scored at 23.9% (almost same in CY 2018), satisfaction with call center staff reduced in CY 2019 (22.0% vs 26.2% in CY 2018), network/coordination of care decreased (17.5% vs 23.2% in CY 2018). Home State Health developed a work plan related to these results: • Identified target areas for each department for improvement related to provider relations. • Leadership from each department meets monthly to discuss initiatives in progress. • Initiatives and progress are being tracked with target dates for completion. • Created a Provider Advisory Committee. • Created the Member and Provider Satisfaction Workgroup. **Required Actions:** None.		
ii. Member Care Management Services for both Physical and Behavioral Health.	Annual Quality Program Evaluation: Pages-54, 56 Annual Quality Program Evaluation (revised): Pages-30, 31 Pages-118 to 120	Partially Met
Findings: When Home State Health staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff ensures that he/she manages both conditions. Home State Health assesses the following areas of collaboration between medical and behavioral healthcare: • Exchange of information between behavioral health care and primary care practitioners and other relevant medical delivery system practitioners or providers. • Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care. • Management of treatment access and follow-up for patients with coexisting medical and behavioral disorders.		

• Primary or secondary preventive behavioral healthcare program implementation. • Special needs of members with severe and persistent mental illness. Home State Health provided information about their member satisfaction survey for CM, complaints and grievances, and reduced admissions rate but did not provide analysis and evaluation of Care Management Services for both Physical and Behavioral Health. However, information presented about pregnancy/Substance Use Disorder Program as their "focused study," is suggestive of their integration efforts for both physical and BH CM. **Required Actions:** Home State Health should fully comply with the requirements of this section by providing evaluation and analysis of data regarding integrated physical and behavioral health CM as per MHD contract, section 2.11.1a.		
iii. Credentialing and Re-Credentialing.	Annual Quality Program Evaluation: Pages-55, 56	Fully Met
Findings: Home State Health's credentialing and recredentialing are functions which are completed by their parent organization, Centene Corporation. There were a total of 20 delegated entities for credentialing. Centene Credentialing conducts annual audits of their delegates. The results are taken monthly to the Home State Health Credentialing Committee for approval for continued participation. Home State Health's Credentialing Committee meets monthly and reviews cases for potential adverse determinations. As of December 31, 2019, Home State Health had 827,015 in-network practitioners. This number includes providers to which credentialing has been delegated. Home State Health credentialed 2,423 practitioners (excludes delegated) and recredentialed 1,055 practitioners (100% within the timeframe). Six practitioners were denied credentialing based on adverse findings presented to the committee. Three practitioners were terminated for cause. Home State Health's contract with the MHD, states that as a part of recredentialing, the Home State Health shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives. Home State Health is working with the Corporate Credentialing staff on this recredentialing audit process. **Required Actions:** None.		
iv. Medical Record Review.	Annual Quality Program Evaluation: Page 58 Annual Quality Program Evaluation (revised): Pages-148 to 149	Fully Met
Findings: To assist with monitoring care provided by network practitioners, Home State Health reviews network practitioner medical records at least every 3 years. In accordance with MO HealthNet program requirements and Home State Health credentialing and participation policies, all adult Home State Health members, age 18 and older, must receive information regarding advance directives that explains the definition and purpose of		

advance directives as well as the right of patients to execute such advance directives. This notification must be documented in each adult patient's medical record. Home State Health Quality Improvement team audits a sample of provider documentation each year, in conjunction with the 3-year accreditation cycle, to ensure compliance with this requirement. The overall CY 2017 Chart Audit scores were 95% (664/698) in compliance with Home State Health documentation standards. 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). Out of 839, 53 medical records 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. **Required Actions:** None.		
v. Disease Management: Clinical Practice Guidelines	Annual Quality Program Evaluation: Pages-49 to 54	Fully Met
Findings: Home State Health analyzes membership data to determine the number of at-risk members and inform programs that will facilitate better health outcomes. To address the needs of this at-risk population, Home State Health has adopted specific clinical practice guidelines. Home State Health believes clinical practice guidelines help practitioners and members make decisions about appropriate care for specific clinical circumstances. 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. They are evidence-based and adopted from recognized sources. The guidelines are incorporated in disease management programs, and work synergistically with disease management provider, Envolve People Care. **Required Actions:** None.		
10. An analysis and evaluation of the disease management programs to include the following information for each disease management program:		
i. A narrative description of the eligibility criteria and the method used to identify and enroll eligible members. ii. 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).	Annual Quality Program Evaluation (revised): Pages-108 to 111	Fully Met

iii. The total number of active members having one or more of the diagnosis codes (ICD-10 Codes) relating to each of the disease management programs. iv. Information on the programs' activities, benchmarks, and goals; the number of disease management cases closed due to non-compliance with treatment plans; and a description of activities aimed at engaging members and reducing non-compliance rates.		

Findings: Home State Health collaborates with Envolve People Care (EPC), an NCQA-certified Disease Management (DM) vendor, for the DM services provided to members with chronic conditions such as asthma, diabetes, back pain, weight management, tobacco cessation, and puff-free pregnancy. EPC has staff on-site and participates closely with Home State Health staff in developing and providing care to members.

i. EPC identifies members with disease management conditions through claims and referrals from Home State Health. EPC performs telephonic and mail outreach to the members in efforts to engage them in the Disease Management program. For Home State Health Depression DM, members are also identified through claims via a claims-based report using a predictive modeling software (Impact Pro). Members may also be identified through health risk assessment results, data collected by utilization managers or case managers, inpatient census reports, member self-referral, referral by physician, or referral through new member welcome calls. Depression DM is available for members aged 12 and above. To participate in these programs, a member needs to be identified as having the condition or in need of disease management services. Members may be excluded from the program if he/she declines the program, if the member's provider requests exclusion, if the member is not capable of participating due to a behavioral health or physical health issue. Once referred to a Disease Management program, the member is assessed to determine risk behaviors, clinical needs, and readiness to change. The member is then assigned to the most appropriate program intensity level to meet his/her needs.

ii. In CY 2019, 12.69% of eligible members participated in active Disease Management for Asthma was 12.69%, Diabetes was 10.78%, and Depression was 28.44%.

iii. Total number of new members enrolled in active DM for Asthma is 607 and for Diabetes in 61. The average monthly member count in active program (including members from previous years) for Asthma is 430 and for Diabetes is 154.

iv. The number of cases closed in CY 2019 due to noncompliance with DM 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.
The outcome measure for the Depression DM program includes the AMM measure (Antidepressant Medication Management-both the Effective Acute and Effective Continuation measures). For H2020/CY2019, the Acute AMM measure resulted in 54.98% compliance which is above the 66.67th NCQA Quality Compass rate. For the Continuation AMM measure, Home State Health members were 36.89% compliant which is above the 50th NCQA Quality Compass rate.
EPC's goal for active participation rates is to have 100% member participation for DM Program. EPC monitors these rates for all Centene Health Plans and reports this as a composite rate. The 2019 active participation rates reflect the following:

- Asthma-active participation rates decreased by 22.1% from 2018 (18.57%) to 2019 (14.47%).
- Diabetes-active participation rates decreased by 24.4% from 2018 (16.21%) to 2019 (12.26%).

At Home State Health, DM staff for DM-Depression are trained in Motivational Interviewing to improve member engagement and reduce non-compliance rates. Additionally, staff are encouraged to send written materials to members from Krames (patient education material) to help to educate members about their disease. For EPC, Health Coaches and CSRs (Customer Service Representatives) received Engagement Trainings in CY 2019 which were aimed at engaging members and reducing non-compliance rates.

Required Actions: Home State Health should check the information presented in section ii and iv above, regarding active participation rate for Asthma and Diabetes in CY 2019.

11. Rights and Responsibilities. An analysis and evaluation of: i. Member grievances and appeals. ii. Provider complaints and appeals. iii. Confidentiality.	Annual Quality Program Evaluation (revised): Pages-102 to 106, 147 Quality Program Description: Pages 9, 10	Fully Met

Findings: i. In CY 2019, largest proportion (46%) of member grievances was in the Access issue category (appointment availability and network adequacy). The second largest proportion (31%) of member grievances was in the Attitude/Service issue category. Major contribution 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.
Home State Health and its transportation vendor in particular continue to collaborate and reaffirm all aspects of the delegation agreement are clear and revised when applicable. In CY 2019 Home State Health implemented a pilot using LYFT to alleviate issues with transportation.

Home State Health's annual goal is to receive less than one (1) appeal per 1,000 members. The number of member appeals Home State Health received decreased from 166 in CY

2018 (goal 237.8) to 136 in CY 2019 (goal 209.8). Because the membership decreased from CY 2018 to CY 2019, the number of authorizations and denials could have decreased resulting in a decrease of appeals. For both years, Home State Health met their goal. Home State Health reviews Member Appeal data quarterly at QIC meetings as well as at HEC (HEDIS, EPSDT, CAHPS) and Performance Improvement Team (PIT) workgroups, with the intent to identify potential areas for action and process improvement. In CY 2019, the Appeals staff was moved to the Utilization Management department. This allowed staff creating authorizations and processing appeals to be better aligned. In CY 2020, it is expected that there will be increased focus on auditing the appeals process to ensure appropriate MHD and NCQA standards are followed. ii. In CY 2019, Home State Health received 0.11 provider grievances per 1000 providers. This is an increase from 0.08/1000 provider grievances received in CY 2018. Provider grievances are to be resolved within 30 days. In CY 2019, 96% of the grievances were resolved timely in comparison to 100% timely resolution in CY 2018. In CY 2019, Empathy Training was provided to the Provider Experience Team and Grievance Team. In early CY 2020, the Grievance Team was moved to the Operations Team with the intent to better identify and rectify process improvement opportunities to decrease the amount of grievances received. Rate of provider appeals increased from CY 2018 (1.04 per 1000 providers) to 1.52 per 1000 providers in CY 2019. Timely resolution (<30 days) was done for 85% providers in CY 2018 and 67% providers in CY 2019. In October 2019 it was identified that workflow in the UM department was creating barriers to proper payments resulting in provider appeals. Due to this, the appeals team was moved under the UM department to work together on identifying workflows and removing barriers to initial proper payment. Home State Health anticipates provider appeal volume to decrease in CY 2020. iii. The Compliance Team monitors the number and types of unauthorized disclosures. In CY 2019, there were a total of 21 incidents and 2 breaches. Trends included sending information to the wrong fax number or wrong facility. The majority of these confidentiality issues resulted in staff education, but one staff was terminated as a result of a confidentiality incident. Per the contract, the appropriate information was reported to the state Security Officer. **Required Actions:** None.		
12. An analysis and evaluation of utilization and clinical performance data that supports use of evidenced based practice. There should be mechanisms to detect both underutilization and overutilization of services.		

The MCO must include the following areas in their QAPI program: i. Utilization Improvement Program; ii. Scope; iii. Discharges Per Year/1000 members; iv. Inpatient Visits/1000 members; v. Average Length of Stay; vi. Re-Admissions/1000 members; vii. Emergency Department Utilization/1000 members; viii. Outpatient Visits/1000 members; ix. Over/Under Utilization; x. Inter-Rater Reliability; xi. Timeliness of Care Delivery; and xii. Timeliness of Prior Authorization/Certification Decision Making	Utilization Management Annual Evaluation: Pages-5, 34 Annual Quality Program Evaluation (revised): Pages-125, 126, 128, 131-137, 141-143	Partially Met

Findings: i. ii. The Utilization Management Program seeks to advocate the appropriate utilization of resources, using the following program components: 24-hr nurse triage, prior authorization/precertification, second opinion, concurrent review, ambulatory review, and retrospective review for health care services, care management, maternity management, preventive care management and discharge planning activities. Additional program components implemented to achieve the program's goals include tracking utilization of services to guard against over and under-utilization of services, focus on patient safety, and interactive relationships with practitioners to promote appropriate practice standards. Referrals to hospital discharge planners and dialogue with the primary care provider (PCP) regarding long-term needs are initiated promptly. The PCP is responsible for assuring appropriate utilization of services along the continuum of care.

iii. and iv. In CY 2019, the number of physical health inpatient admits/1000 was higher than for CY 2018. This was the pattern for every month (the number of discharges is the same as the number of visits). Inpatient admits ranged from 99 (in June 2019) to 115 (in Dec 2019) per 1000 members. Behavioral health inpatient admits ranged from 12.2 (Jul 2019) to 19 (Apr 2019) per 1000 members (goal set is below 16.1 admits/1000 members). This information is shared with the care management team to assist them with planning for interventions with the members.

v. Medicaid physical health inpatient length of stay utilization for CY 2019 increased by 5.71%. Graphical representation of data for CY 2018 and CY 2019 was presented. No analysis/evaluation was reported in QAPI.

vi. Home State Health provided Readmission percentage by month for physical health (average 13.9% in CY 2019 with goal set at < 15.7%) and for behavioral health (13.30% in CY 2019). No analysis/evaluation/trend is provided.

vii. Home State Health presented graph displaying data for CY 2018 and CY 2019 regarding ER visits per 1000 members for Medical reasons. However, the Home State Health did not provide analyses/evaluation of data.

In CY 2019, Home State Health began a texting program for Emergency Department education. Every member who has had an Emergency Department visit who has not opted out of texting receives a reminder that Home State Health is available to help with their medical needs. Home State Health also has a CM Super utilizer program for members with 3 or more Emergency Department visits in 90 days. Home State Health provides these members with education and information on utilization of Outpatient services.

viii. Home State Health presented data about outpatient visits/1000 members for each month. It ranged from 17.66 outpatient visits/1000 members (in Nov 2019) to 25.06/1000 members (in Oct 2019). However, Home State Health did not report on trends, evaluation, and analysis.

ix. In CY 2019, there was no evidence of under-utilization. Home State Health reported on "Length of Stay" for overutilization.

x. New UM staff is required to successfully complete inter-rater reliability (IRR) testing prior to being released from training oversight. A passing score of 80% is required with a goal of 100% of co-workers passing. In CY 2019, all staff and leaders who perform UM or have oversite of UM took IRR testing and passed. Home State Health did not provide data in support of this criteria.

xi. Since there is no definite instruction from MHD on timeliness of delivery care, Primaris is evaluating the Home State Health based on the information presented in QAPI for this criterion.

Home State Health also reported about prior authorizations (PA) for timeliness of delivery care (see section xii below).
In CY 2019, Home State Health was 85% compliant with timeliness for member appeals with a 51% overturn rate and 67% compliant with timeliness for provider appeals with a 44% overturn rate. Home State Health has identified internal process issues resulting in receiving appeal information outside of required timeframes and has been meeting with various internal departments to resolve issues. In CY 2019, an automated report to track timeliness and overturn rates is being developed for Medicaid and Marketplace appeal metrics.

xii. In CY2019, Home State Health created a turnaround time report for prior authorizations (PA). This report shows compliance for state contract and NCQA timelines requirements. Home State Health presented data regarding turnaround time for IP, OP, Urgent OP and IP.

Individual staff members are audited on a monthly basis to ensure compliance with timeliness, documentation requirements, proper application of clinical criteria and adherence to internal workflows. Individuals must receive scores of 90% or greater on an ongoing basis. Audit scores are communicated with the staff at the time of audit completion and also reviewed during monthly one-on-ones with their direct supervisor. The data for denials for PA are presented for the entire year on a monthly basis. However, analysis and evaluation is not presented for PA or denials. **Required Actions:** Subsections v, vi, vii, viii, x, and xii have no information related to analysis and evaluation. Home State Heath should provide complete information to fully meet this section.		
13. MCOs should conduct performance improvement projects (PIPs), including any performance improvement projects required by CMS, that focus on both clinical and nonclinical areas. Each MCO must report the status and results of each project conducted per State as requested, but not less than once per year. The outcomes and trended results of each PIP should be reported.	Annual Quality Program Evaluation: Pages-16 to 21	Fully Met
Findings: Home State Health initiated two PIPs mandated by MHD: Clinical-aimed at increasing the number of two (2) year old immunized (CIS combo 10 measure); and Non Clinical-aimed at improving oral health (Annual Dental Visit-ADV measure). The results and trends of both the PIPs are reported. CIS combo 10 rate in CY 2019 is reported as 24.09% (can change slightly when results finalize towards end of June 2020) This is an increase of 2.4% points from CY 2018. The ADV measure in CY 2019 is reported as 53.16% which is an increase of 5.34% points from CY 2018. **Required Actions:** None.		
14. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: (i) Measurement of performance using objective quality indicators. (ii) Implementation of interventions to achieve improvement in the access to and quality of care.	Annual Quality Program Evaluation (revised): Pages-31 to 65	Fully Met

(iii) Evaluation of the effectiveness of the interventions based on the performance measures. (iv) Planning and initiation of activities for increasing or sustaining improvement.		

Findings: (Note: Detailed evaluation of PIPs will be done by Primaris when Home State Health submits PIPs for CY 2019 by end of June 2020. The score assigned here only indicates that the criteria listed above were addressed in QAPI.)

i. The indicator used to evaluate performance of PIP was HEDIS CIS Combo 10 rate for CIS PIP and HEDIS ADV rate for Improving Oral Health PIP in CY 2019.

ii. Interventions: CIS PIP- Allow inclusion of corrective data submitted through the Supplemental Data System (SuDS) by Missouri Health Plus (MH+) (a group of federally qualified health centers-FQHC).

ADV PIP

- Automated text messages were sent to all members identified as not having an annual dental visit in the past 365 days. Opt-out methodology was approved by the state in May 2019. By Q3 CY 2019, texts were sent to all members instead of only members who have opted in to receive texts.
- 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 (implemented on Oct 31, 2019).

iii. The intervention tested was the same as last year's (CY 2018) for CIS PIP. It showed improvement of 2-3% in individual vaccination rates used in Combo 10.
The first intervention (Alpha pointe) did not show any improvement from previous year (same intervention was used in previous year). The success rate for dental visits after outreach was negligible (0.02%). The second intervention (texting) helped in increasing ADV rate by 18.39% in two months (Nov 2019 and Dec 2019).

iv. In early CY 2020, Home State Health began participating in the Missouri Immunization Task Force. They conducted CIS barrier analysis. Home State Health will continue to provide a number of long-term projects designed to educate and incentivize members, empower providers with the ability to offer immunizations to their patients, and more efficiently capture and analyze immunization data. Home State Health has performed barrier analysis for improving ADV rate. The Medical Director reached out to partner with a local FQHC in developing an intervention for the Home State Health members who were a part of the FQHC in order to further increase the ADV measure.

Required Actions: None at this time. However, Primaris recommends Home State Health to 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 for future projects instead of using them year after year leading to no improvement. Also, Primaris recommends Home State Health not to present entire PIPs (all steps per CMS EQR protocol 1) in QAPI. Only summarized information including four points listed in this section is required. Additionally, they should present relevant information which pertains to interventions and analysis for the year under review. Details about other interventions which are not part of these PIPs in CY 2019, should not be included in QAPI.		
15. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under §438.340.	Annual Quality Program Evaluation: Page 1 Annual Quality Program Evaluation (revised): Pages-20 to 24	Fully Met
Findings: Home State Health's QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special health care needs. This systematic approach to QI provides a continuous cycle for assessing the quality of care and service among Home State Health initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. Determining disease prevalence allows Home State Health's Medical Management department to assess the needs and care coordination approach of the population. Internal data was sourced from Impact Pro and Enterprise Data Warehouse, which are primarily based on claims data. Utilizing the claims data, Home State Health determined there were 38,278/204,474 (19%) unique members identified as having a Severe Mental Illness (SMI) for the Child and Adolescent membership and 15,749/204,474 (8%) for Adult membership. Home State Health utilized this data of identified members to determine the disease prevalence of members with a SMI to assess the potential need for care management. **Required Actions:** None.		
16. An analysis and evaluation of quality issues and actions identified through the quality strategy and how these efforts were used to improve systems of care and health outcomes.	Quality Work Plan (revised) Annual Quality Program Evaluation (revised): Page-3 Quality Program Description (MHD approved): Pages-31 to 33	Fully Met
Findings: QAPI Program Description, QI Work Plan, and QAPI Program Evaluation are integrated. The QI Department has established annual reporting of activities, initiatives, and		

results by completing the QAPI Program Evaluation based upon a calendar year (January to December) reporting period. The year-end Quality Program Description Evaluation identifies barriers, opportunities for improvement, results and recommended interventions. The Evaluation is then used to make modifications to the coming year's Quality Program Description and to create the key metrics of the QI Work Plan. Centene Corporate Quality Improvement and Accreditation Departments provide oversight and support throughout the Quality Program. Policy and procedure development, organizational best practices and new technology provided by Centene provide the foundation for the success of the Home State Health Quality Program Description. **Required Actions:** None.		
17. 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.		N/A
Findings: MHD did not set an expectation or requirement for this section. Home State Health stated that they are not aware of this requirement. Primaris marks this section as N/A for EQR 2020. Primaris acknowledges that Home State Health has posted information about the Lead CM program and Substance Use in Pregnancy CM program. However, this does not meet the requirement of this section. **Required Actions:** Primaris recommends Home State Health to request guidance from MHD on study topic (s) around which the Home State Health will be required to conduct a focus study and report results in QAPI. Home State Health can identify trends for their focus studies even if a topic or statewide trend is not identified by MHD. These trends may be within the Home State Health's population, based on how they conduct business or is a physician/provider specific.		
18. An analysis and evaluation of subcontractor relationships that addresses integration with MCO's QAPI program. This analysis and evaluation is not a replication of the Subcontractor Oversight Annual Evaluation report.	Annual Quality Program Evaluation (revised): Pages-149 to 153	Fully Met
Findings: An Oversight of Home State Health's delegated vendors is conducted within the Joint Operations Committees (JOC) which are active sub-committees of the PIT. These quarterly meetings serve to provide oversight of the operations affecting the scope of functions of delegated vendors, review periodic activity reports from delegated vendors,		

ensure compliance with all NCQA standards and regulations related to the delegation relationship, ensure compliance with MHD Managed Care contract Section 3.9 and recommend actions to address any identified opportunities for improvement in delegated services.

Home State Health contracts with Envolve Dental, a Centene subsidiary, to provide the dental network and administers the dental benefit for members. Envolve Dental successfully met the provider call center requirements (Service Level, Average Hold Time, Abandonment Rate), claims processing requirements, provider appeals and grievances acknowledgement and resolution timeframes, utilization management decision turnaround timeframes, and network adequacy standards. The credentialing turnaround time requirement (i.e., credential decision in 60 days) was not met in March and April 2019 due to volume of providers added. This resulted in an overall delay of the credentialed providers. The credentialing group again met starting in May and continued compliance continued through remaining CY 2019.

Home State Health contracted with Cenpatico Behavioral Health, a Centene subsidiary, to provide behavioral health utilization management services in Q1 2019. Starting on April 1, 2019, the utilization management services were performed by Centene. The Centene teams work on improving the FUH measure as well as working with Medical Management to providing optimal integration of services to members. Overall contract requirement performance continues to be monitored and reported through monthly meetings with the Centene teams and reported through the QIC committee meetings.

Envolve Vision, a Centene subsidiary, is the Home State Health's vision care vendor. Quarterly JOCs are held where the parties review topics such as performance metrics, interventions for care gaps, and complaint trends. Envolve Vision continues to conduct retrospective claims review and appointment setting for Diabetic members to ensure retinal exams were offered to all applicable members. Quarterly JOC meetings were held to monitor performance with no material issues identified. Envolve Vision successfully met the provider call center requirements (Service Level, Average Hold Time, Abandonment Rate), claims processing requirements, provider appeals and grievances acknowledgement and resolution timeframes, utilization management decision turnaround timeframes, credentialing standards and network adequacy standards. In relation to encounter accuracy, the requirements were met; however, an encounter field change in CY 2015 and CY 2017 was not implemented. To correct the encounters, Home State Health and Envolve Vision, in collaboration with the state, voided and resubmitted the applicable encounters. The final encounters were successfully submitted and accepted in Q1 2020. The current process that communicates new requirements to applicable vendors was not in place for part of CY 2019.

MTM (Medical Transportation Management, Inc.) is the Home State Health's transportation vendor. For CY 2019, in the first quarter, the call center service level was below expectation. MTM reported higher than normal call volumes in January that impacted service levels. By the end of February, MTM had added staff and call service levels returned to compliant

levels. MTM successfully met the Call Center requirements (Service Level, Average Hold Time, Abandonment Rate) during Q2, Q3, and Q4 2019. Transportation related member complaints/grievances were the highest category of complaints for Home State Health with many related to transportation not available, especially when the request was received the same day of the trip. To mitigate these risks, Home State Health worked with MTM to allow the use of Lyft when other transportation options were not available. This began in May of 2019. Home State Health and MTM will continue to monitor the benefits of the Lyft pilot program. Overall, MTM did not meet the required service level during Q1 2019; however, consistently met the State requirements during the remainder of CY 2019. NIA (National Imaging Associates) is the radiology benefits management vendor for Home State Health. NIA successfully met the Call Center requirements (Service Level, Average Hold Time, Abandonment Rate) during 2019. NIA did not have any issues regarding Authorization requirements and Appeals acknowledgement and resolution requirements during 2019. During 2019, NIA initiated provider education and outreach programs for providers with high denial rates for imaging services. Envolve PeopleCare (EPC), a Centene subsidiary, performs the following services for Home State Health members: Nurse Advice Line (triage health conditions and health questions including identification and treatment of health issues), Disease Management programs for members who have Asthma or Diabetes and a Behavioral Health Crisis Line. EPC successfully met the Call Center requirements for most of CY 2019 with the exception of the Service Level during Q3 2019. The Q3 Service Level of 89% (goal 90%). This performance metric was closely monitored and EPC and performance was above the 90% requirement during Q4 2019. **Required Actions:** None.		
19. Work Plan for next year.	2020 Quality Work plan (revised) Utilization Management Annual Evaluation: Pages-45, 46	Fully Met
Findings: Home State Health has a detailed workplan. The Home State Health evaluates the Quality Program Description and Quality Work Plan annually to assess whether program objectives were met and recommend adjustments when necessary. The Utilization Management team continues to identify opportunities for improvement while remaining focused on compliance and quality. **Required Actions:** None.		
B. The QAPI program is composed of: i. Results, conclusions, team recommendations, and implemented system changes which are reported to	Quality Program Description: Pages-31 to 33	Fully Met

the MCO's governing body at least quarterly. ii. Reports that are evaluated, recommendations that are implemented when indicated, and feedback provided to providers and members (MHD contract 2.18.2)	Annual Quality Program Evaluation (revised): Page-3	
Findings: i. The Quality Program Evaluation includes an annual summary of all quality activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Program Evaluation outlines the completed and ongoing activities of the previous year for all departments of Home State Health, including activities regarding provider services, member services, utilization management, care management, complex case management, condition management, and safety of clinical care. The Chief Medical Director and Quality VP/Director are responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the QIC and Board of Directors for approval annually. ii. Home State Health provides general information about the Quality Program to members and providers on the website or member/provider materials such as the member handbook or provider manual. If required, communication includes how to request specific information about Quality Program goals, processes, and outcomes as they relate to member care and services and may include results of performance measurement and improvement projects. Information available to members and providers may include full copies of the Quality Program Description and/or Quality Program Evaluation, or summary documents. **Required Actions:** None.		
C. MCO shall implement a Quality Improvement strategy that includes components to monitor, evaluate, and implement the contract standards and processes to improve the following: Quality management; Utilization management; Records management; Information management; Care management; Member services; Provider services; Organizational structure; Credentialing; Network performance;	Quality Program Description: Pages-33 to 41 Quality Program Description (MHD approved): Page-6	Fully Met

Fraud, waste, and abuse detection and prevention; Access and availability; and Data collection, analysis, and reporting. (MHD contract 2.18.3)		
Findings: All the above criteria are addressed by Home State Health in Program Description. The scope of the Quality Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to Home State Health members including medical, behavioral health, dental, and vision care as applicable to Home State Health's benefit package. Home State Health incorporates all demographic groups, benefit packages, care settings, and services in its quality management and improvement activities. Areas addressed by the Quality Program include preventive health; emergency care; acute and chronic care; population health management; health disparity reduction; behavioral health; episodic care; long-term services and supports; ancillary services; continuity and coordination of care; patient safety; social determinants of health; and administrative, member, and network services as applicable. **Required Actions:** None.		
D. MCO shall have written quality assessment and improvement program procedures. The procedures shall include monitoring, assessment, evaluation, and improvement of the quality of care for all clinical and health service delivery areas (MHD Contract 2.18.8a):		
1. Ensure that the utilization management and quality assessment committees have established operating parameters. The committees shall meet at least quarterly, on a regular schedule. Committee members must be clearly identified and representative of the MCO's providers. The committee shall be accountable to the Medical Director and governing body. The committees must maintain appropriate documentation of the committees' activities, findings, recommendations, actions, and follow-up.	Annual Quality Program Evaluation: Pages-3 to 5 Utilization Management Annual Evaluation: Page-6, 7 Supporting Documents: • QIC Meeting Minutes • UMC Meeting Minutes	Fully Met
Findings: The QIC is the senior leadership committee, accountable to the Board of Directors that reviews and monitors all clinical quality and service functions of the health plan and		

<table>
<tr><td colspan="3">provides oversight of all subcommittees. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered, and to continuously enhance and improve the quality of care and services provided to members through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes using the quality process. QIC meets quarterly, with additional meetings scheduled per Home State Health's need basis.
Daily oversight and operating authority of utilization management activities are delegated to the UMC, which reports to QIC and ultimately to BOD. The UMC is responsible for the review and approval of medical necessity criteria, policies, and department policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual under- or over-utilization, which may impact health care services, coordination of care and appropriate use of services and resources as well as member and practitioner satisfaction with the UM process.

Required Actions: None.</td></tr>
<tr><td>2. Provide for regular utilization management and quality assessment reporting to the management and providers, including profiling of provider utilization patterns.</td><td>Quality Program Description: Pages-7, 11

Annual Quality Program Evaluation (revised): Page-141</td><td>Partially Met</td></tr>
<tr><td colspan="3">Findings: Home State Health encourages providers to participate in quality initiatives and gives support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines.

Home State Health stated that provider utilization patterns are monitored by the Utilization Management, Care Management, Finance, Quality, and Provider Relations Departments. Home State Health also uses HEDIS measures to identify potential over/under utilization as well as set thresholds. Rates/data are reviewed at least quarterly and compared against thresholds to detect under/over utilization trends, as well as the need to modify initiatives to improve outcomes. However, data was submitted for one indicator "Length of Stay" only. No information on provider profiling of utilization was submitted.

Required Actions: Primaris recommends Home State Health to submit evaluation and analysis of provider profiling in regard to utilization of services and outcomes for CY 2019.</td></tr>
<tr><td>3. Be developed and implemented by professionals with adequate and appropriate experience in quality assessment and improvement: quality assessment, utilization management, and continuous improvement processes.</td><td>Quality Program Description: Pages-25 to 27</td><td>Fully Met</td></tr>
</table>

Findings: The Quality Department staffing model is determined by membership, products offered, and (when applicable) state and/or federal contract requirements and includes the following positions: Chief Medical Director/Medical Directors; Quality VP, Quality Manager, Quality Coordinator/specialist, Outcomes Analyst, Accreditation Manager, Accreditation Specialist. **Required Actions:** None.		
4. Provide for systematic data collection, analysis, and evaluation of performance and member results. Provide for interpretation of this data to practitioners.	Quality Program Description: Page-41	Fully Met
Findings: Home State Health offers a quality, cost and utilization tool designed to support providers who participate in a value-based program in order to identify provider performance opportunities and assist with population health management initiatives. Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts in order to optimize pay-for-performance (P4P) payouts, which may include: Key performance indicators; cost and utilization data; emergency room cost, utilization, and trending data; pharmacy comparisons of brand vs. generic; and/or Value-Based Contracting performance summaries. Through these supporting platforms, Home State Health works to keep providers engaged in the delivery of value-based care by promoting wellness and incentivizing the prudent maintenance of chronic conditions. This engagement helps providers identify performance insights as well as identify opportunities for improvement. Interventions may be discussed with the practitioner to address practitioners' performance that is out of range from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices and/or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not implemented. **Required Actions:** None.		
5. Provide timelines for correction and assign a specific staff person to be responsible for ensuring compliance and follow-up.	Annual Quality Program Evaluation (revised): Page-12 2020 Quality Work plan (revised)	Fully Met
Findings: The Director of Quality reports to identified executive leadership and is responsible for directing the activities of the quality staff in 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. The Director of Quality assists the senior executive staff, both clinical and non-clinical, in overseeing the activities of the operations to meet the goal of providing health care services that improve		

the health status and health outcomes of its members. Additionally, the Director coordinates the QIC proceedings in conjunction with the Chief Medical Director, supports corporate initiatives through participation on committees and projects as requested, reviews statistical analysis of clinical, service and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable. The Director of Quality will provide all required tasks of the QA&I as required in the MHD Contract. The Director is responsible for directing the activities of Home State Health's quality management staff in maintaining compliance with the MHD Managed Care contract and 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. The designated staff would also set the timeline for any needed correction or follow-up. Home State Health has provided the timeline for completion of various activities in the Work Plan. **Required Actions:** None.		
6. Clearly define the roles, functions, and responsibilities of the quality assessment committee and the Medical Director.	Quality Program Description: Pages-12 to 25	Fully Met
Findings: The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated the authority and responsibility for the development and implementation of the Quality Program to the Quality Improvement Committee. The Quality Improvement Committee is the senior management lead committee accountable directly to the Board of Directors and reports Quality Program activities, findings, recommendations, actions, and results to the Board of Directors no less than annually. Population Health and Clinical Outcomes Committee, Performance Improvement Committee, Peer Review Committee, and Credentialing Committee are subcommittees of QIC (ref. page 13 of Quality Program Description). **Required Actions:** None.		

Compliance Score Quality Assessment and Performance Improvement Program						
Total	Met	=	25	×2	=	50
	Partial Met	=	08	×1	=	08
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	58
Denominator	Total Sections	=	33	×2	=	66
Score%						**87.87**