Primaris
Healthcare Business Solutions

2020 External Quality Review
Compliance

missouricare
A WellCare Company

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MoHealthNet

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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 (SFY) 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. Missouri Care is one of the three MCOs operating in Missouri (MO). MHD works closely with Missouri Care 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).

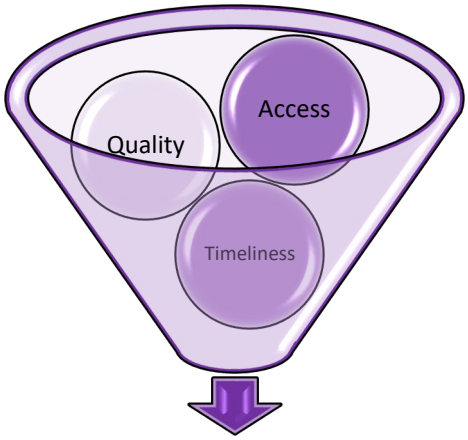
MHD contracts with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to perform an EQR. An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a Managed Care Plan, or its contractors, furnish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

1.2 Compliance with Regulations

Missouri Care 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 Missouri Care 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 Missouri Care's response to previous EQR recommendations.

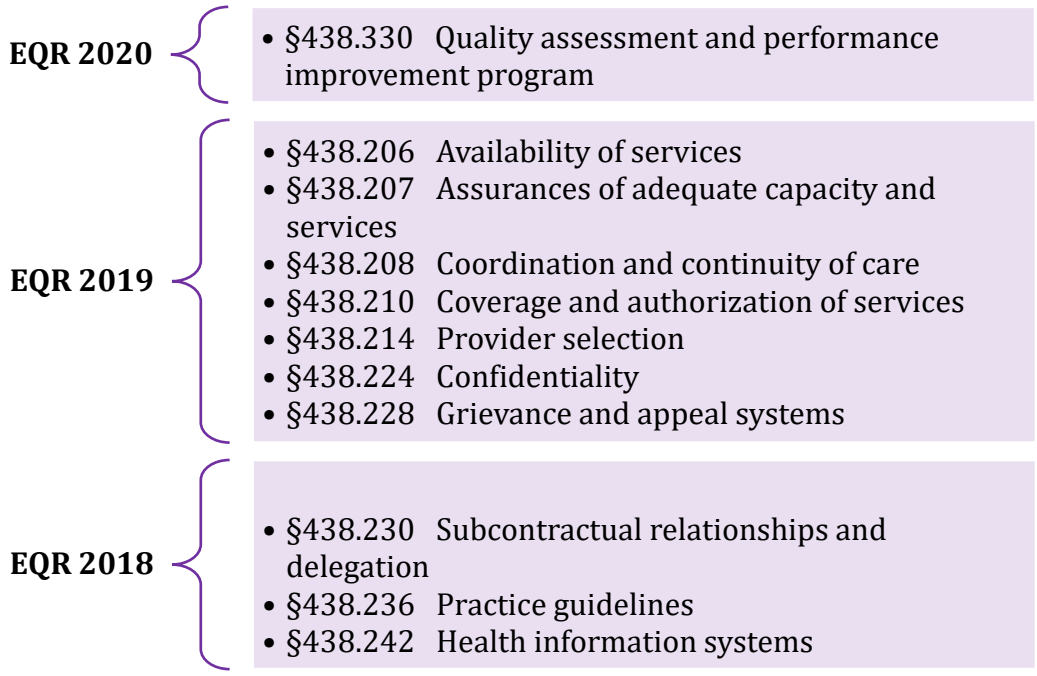


Figure 2. A Three-Year Compliance Review Cycle

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 visit, and interviews (Figure 3). Primaris provided Technical Assistance (TA) during the review period to steer Missouri Care 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). Missouri Care 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:

- ✓ Quality Assessment and Improvement Evaluation Report 2019
- ✓ Quality Improvement Work Plan 2020
- ✓ Program Descriptions: Quality Improvement 2019, Care Management, Utilization Management, Disease Management
- ✓ Quality Improvement-Roles and Responsibilities of Key Personnel
- ✓ Quality Improvement Committee Structure
- ✓ Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey results
- ✓ Minutes of Meeting: Quality Improvement Committee (QIC), Utilization Management Medical Advisory Committee (UMAC)
- ✓ Member and Provider Newsletters
- ✓ Member Advisory Council Description
- ✓ PowerPoint Presentation: Provider Profiling
- ✓ Member HEDIS Care Gap Report
- ✓ Special Healthcare Needs Policy and Mechanism

Onsite Interviews

A virtual meeting with Missouri Care was conducted on May 26, 2020, as travel to onsite office location in St. Louis, Missouri was restricted due to the Covid-19 Pandemic. The following personnel from Missouri Care were available for an interactive session:

- Mark Kapp, Senior Director, Quality Improvement
- Russell Oppenborn, Director, State Regulatory Affairs
- Tanesha Simmons, Field Regulatory and Compliance Specialist
- Erin Dinkel, Manager, Quality Improvement

Compliance Ratings

The information provided by Missouri Care 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

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	32	1	0	65	**98.5**	Year 3 **98.5** EQR 2020
§438.206	Availability of services	11	11	0	0	22	**100**	Year 2 **96.6** EQR 2019
§438.207	Assurances of adequate capacity and services	10	10	0	0	20	**100**	
§438.208	Coordination and continuity of care	17	17	0	0	34	**100**	
§438.210	Coverage and authorization of services	22	22	0	0	44	**100**	
§438.214	Provider selection	12	12	0	0	24	**100**	
§438.224	Confidentiality	19	13	3	3	29	**76**	
§438.228	Grievance and appeal systems	44	44	0	0	88	**100**	
§438.230	Sub Contractual Relationships and Delegation	7	7	0	0	14	**100**	Year 1 100 EQR 2018
§438.236	Practice Guidelines	6	6	0	0	12	**100**	
§438.242	Health Information Systems	7	7	0	0	14	**100**	

Compliance: Missouri Care

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

An assessment was done for one federal regulation in EQR 2020, with Missouri Care achieving a compliance score of 98.5%. Table 2 summarizes findings from EQR 2020 as well as previous reviews within the current three-year review cycle.

3.2 Regulation I-Quality Assessment and Performance Improvement Program

Missouri Care was evaluated for 33 criteria under this regulation and received "Met" for 32 and "Partially Met" for one of them, scoring 98.5% for compliance (Appendix A).

3.2.1 Quality, Timeliness, and Access to Healthcare Services

Strengths

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

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

3. Population Analysis: Missouri Care has a Cultural Competency committee, which addresses cultural and linguistic needs of members. There was no communication/language related grievances in CY 2019. Interpreter services are available

for all members regardless of their native language. Missouri Care employs a variety of strategies to identify members with special health care needs (SHCN) including: MHD Monthly SHCN File; Health Risk Assessments; Member Outreach; and Network Providers. The members are contacted for care management.

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

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

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

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

8. Credentialing: A total of 1,739 new applications were presented to the Missouri

Credentialing Committee, which were processed and turned around in seven days (goal: 15 days turnaround time).

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

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

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

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

Weaknesses

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

2. After-hour Availability: The survey results by Missouri Care's vendor show that after-hour availability for providers (PCPs, Pediatricians, OBGYN, Specialists-high volume, high

impact, BH) was 74.8%, which decreased from last year (80%).

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

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

3.2.2 Areas Requiring Corrective Action

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

4.0 Corrective Action Plan Process

Missouri Care 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; a 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 Missouri Care'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, Missouri Care 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 Missouri Care (EQR 2018 2020)			
42 CFR Regulation	**Key Findings**	**Sections Met/Total**	**Audit Results**
§438.330 Quality assessment and performance improvement program	Concerns identified	32/33	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	Concerns identified, CAP initiated	13/19	Not 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 Missouri Care

Figure 4 depicts the performance of Missouri Care over a three-year review cycle. In EQR 2020 (CY 2019-98.5%), there is an increase of 1.9% points in compliance score from EQR 2019 (CY 2018-96.6%). Missouri Care is not placed on a CAP for this year. During previous EQR, one regulatory standard was scored as “Not Met” and a CAP was initiated. Missouri Care “Met” all the requirements in the CAP. However, there were three sections scored as “Partially Met” for which Missouri Care did not submit any documentation for compliance.

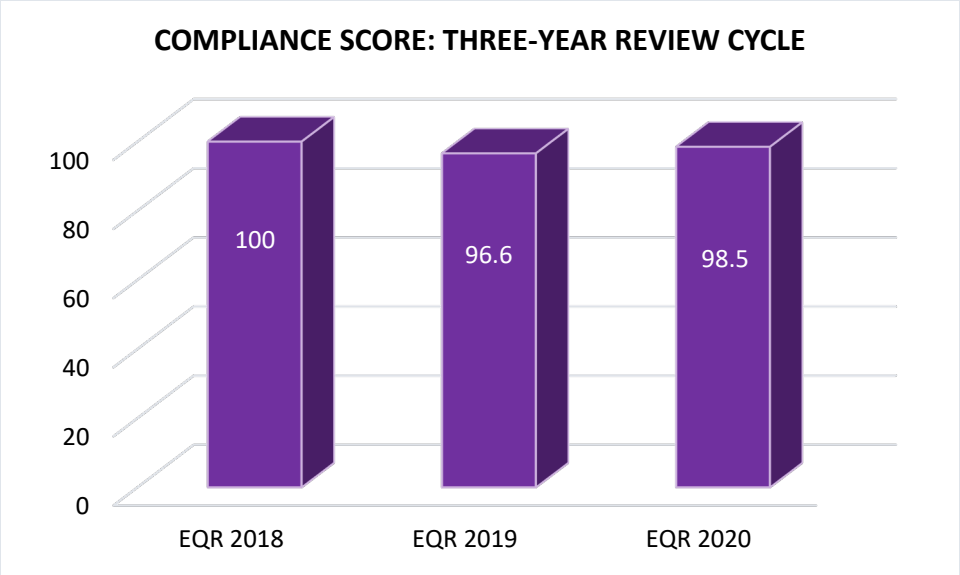


Figure 4. Compliance Score (EQR 2018-EQR 2020)

5.2 Response to Previous Year's Recommendation

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

Table 4. Missouri Care's Response to Previous Recommendations

Recommendations	Action by Missouri Care	Comment by EQRO
EQR 2019 (2nd Year)		
1. Policy update required: Release of PHI to public will be only after prior written consent to the state agency (MHD contract 3.16.1)-Partially Met.	Missouri Care did not submit any documentation to support this requirement. So, the score remains same as in previous EQR 2019.	Partially Met
2. Policy required: If required by the state agency, MCO and any required MCO personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request (MHD contract 3.16.2)-Not Met.	Policy Updated. C13-HIP-01-006-ST HIPAA-Use and Disclosure of PHI Standard-Page 15 of 15 (MHD approval 11.25.19)	Fully Met
3. Policy update required: MCO may use Protected Health Information to report violations of law to	Missouri Care did not submit any documentation to support this	Partially Met

appropriate Federal and State authorities, consistent with 45 CFR 164.502(j) (1) (MHD contract 2.38.2c)-Partially Met.	requirement. So, the score remains same as in previous EQR 2019.	
4. Policy required: If applicable, the MCO may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B) (MHD contract 2.38.2f)-Not Met.	Policy Updated. C13-HIP-01-006-ST HIPAA-Use and Disclosure of PHI Standard-Page 15 of 15 (MHD approval 11.25.19)	Fully Met
5. Policy update required: MCO may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so (MHD contract 2.38.2f)-Partially Met.	Missouri Care did not submit any documentation to support this requirement. So, the score remains same as in previous EQR 2019.	Partially Met
6. MCO shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s) or subcontractor(s) (MHD contract 2.38.3p)-Not Met.	Policy Updated. C13.HIP.01.010 HIPPA-Privacy Policy-Page 4 of 4 (MHD approval 11.25.19)	Fully Met
7. Revisions to policies/documents as a result of technical assistance should be submitted to the MHD for approval.	Missouri Care did not submit this information to EQRO. However, they have provided a written statement that all policies are approved by MHD.	Missouri Care is advised to track all policies that are developed/amended as a result of EQRO TA and send to MHD for approval. EQRO requires information about names of policies and date of approval.

EQR 2018 (1st Year of Cycle)		
3. Missouri Care should update all of their subcontractors' agreements with the "right to audit for 10 years…." as per 42 CFR 438.230(c)(3) (iii), consistently. (Date of applicability: July 1, 2017).	Missouri Care stated: Due to the transition over to Anthem's system effective 1.1.2021, Missouri Care currently is in the process of updating the contracts between Anthem and subcontractors which will be effective 1/1/2021. The standard language in the subcontractor's contracts related to audit/records satisfies 10-year audit timeline.	EQRO will revisit this requirement next year under Anthem, as applicable in EQR 2021.

6.0 Recommendations

6.1 Missouri Care

1. Missouri Care is required to address "Partially Met" criteria as stated in section 3.2.2 and 5.2 (Table 4) including EQRO comments stated in Table 4.
Missouri Care should communicate with MHD if they have issues capturing data for a count of members needing communication accommodations due to hearing impairment or a physical disability. Per MHD this data is provided to the MCOs when the member completes their Health Risk Assessment. Per 42 CFR 438.208 b3, MCO should make best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.

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

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

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

Additional Resources

Missouri Care has analyzed and identified the root causes for the weaknesses stated in section 3.2.1 of this report and have 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 to increasing patients' access to after-hours care.[2]

2. Provider satisfaction:

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

- 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

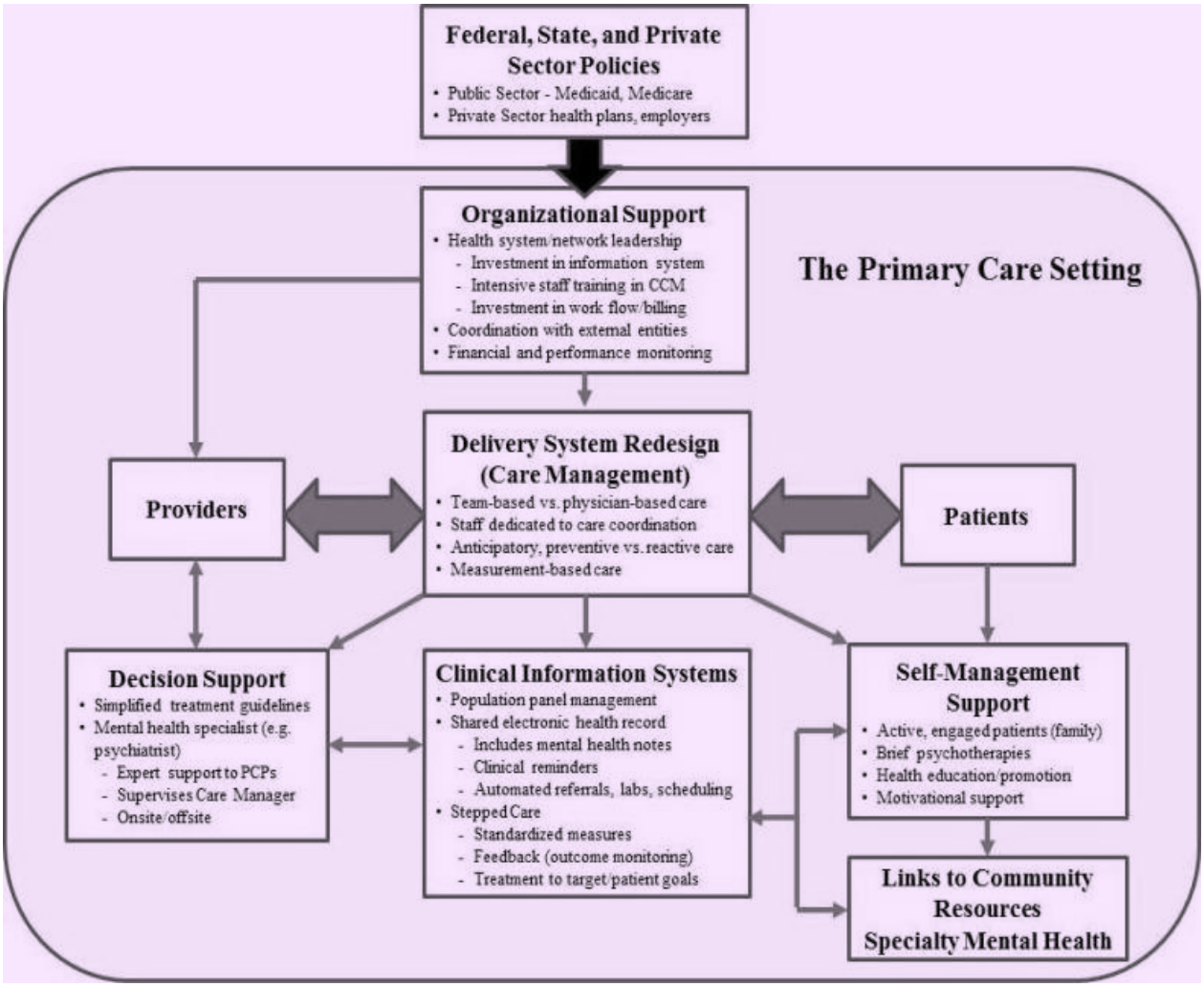


Figure 5. Evidence-based Components of Collaborative Care for Mental Health in Primary Care. Based on the original model articulated in Wagner et al. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986/)

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.

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Appendix A. QAPI Evaluation Tool

Subpart E, 42 CFR 430.330 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).	2019 QA&I Evaluation Report: Pages-7, 8 Supporting Documents: • QIC Minutes • Committee Structure and Charters • UMAC Minutes	Fully Met
Findings: WellCare's (parent company of Missouri Care) Board of Directors has delegated oversight of the Quality Improvement (QI) program to the Quality Improvement Committee (QIC) at the market/regional level. Various subcommittees report to the QIC: Utilization Management Medical Advisory Committee (UMAC), Medical Policy Committee, Credentialing Committee, Delegation Oversight Committee, Service Improvement Committee, Compliance Oversight Committee, Cultural Competency Committee, Community Outreach Advisory Council on Health (COACH). These committees support the QI program in the objective and systematic monitoring of the quality, appropriateness, accessibility, and availability of healthcare and services provided to eligible members. For CY 2019, QIC and its subcommittees reviewed/approved/discussed annual, semi-annual and/or quarterly results as appropriate, including minutes and roll-up reports as noted in subcommittee reports below. Areas reviewed and approved include: HEDIS Reporting; CAHPS Reporting; QI, UM, CM, DM Program Descriptions; EQRO Recommendations; Cultural Competency; CM/DM Performance; QI Work Plan Activities; Service Improvement; Appeals and Grievances Data; COACH; UMAC Activities; Credentialing; Delegation Oversight; Regulatory/Compliance; Access/Availability; Provider Satisfaction; QI/UM Annual Evaluations. **Required Actions:** None.		
ii. Analysis of quality improvement process.	2019 QA&I Evaluation Report: Page 13	Fully Met

	2020 QI Work Plan	
Findings: The Quality Improvement Department is responsible for the overall quality work plan. The Quality Improvement Department, and in collaboration with service matter experts from other departments, annually perform the evaluation of all work plan metrics and compile an annual QI Evaluation document of the findings. Missouri Care also relies on its provider network to evaluate and make recommendations to its quality improvement process through the UMMAC. This evaluation includes trended data (where available) and analyses of impact on clinical care and service delivery. Strengths, weaknesses, barriers and opportunities for improvement are considered during the process to assess the overall effectiveness of the Quality Improvement Program in improving the quality of care and services provided to the membership. Missouri Care develops a work plan each year which includes a quarterly evaluation of activities. The work plan is used to set goals and guide initiatives. It is referenced and updated as needed throughout the year. The work plan is also used at the end of the year to identify quality processes that were successful and processes needed to be changed or replaced in the following year. Goals that have not been reached from the prior year are carried over on the QI work plan to work on in the following year. **Required Actions:** None.		
iii. MCO should have a designated staff (coordinator) with expertise in quality assessment, utilization management, and continuous quality improvement.	QI Program Description-Appendix A (revised) 2019 QI Program Description: Page 6	Fully Met
Findings: WellCare (Missouri Care's parent company) has an integrated model of resources supporting the Missouri Care's QI activities, including behavioral health. These resources include WellCare associates who cross all functional areas of the organization including, but not limited to, the executive team, provider relations staff, quality improvement, case and disease management staff, and data analytics support. Resources supporting QI activities are assessed on an annual basis and modified as necessary. The Sr. Director, Quality Improvement has overall accountability for the day-to-day operations of the QI Program. This individual is responsible for the integration, coordination, compliance, follow-up, and management of the overall QI Program. The Sr. Director of Quality Improvement functions as the QA&I Coordinator to meet the MHD contract requirement. This individual has a CPHQ (Certified Professional in Healthcare Quality) certification, BSN, RN, and MBA with concentration in health management. Additional functions of the Sr. Director, Quality Improvement include, but are not limited to, prioritizing problem areas for resolution, designing strategies for change, implementing improvement activities, and measuring the success of interventions. QI department personnel fall under the leadership of the Sr. Director, Quality Improvement and		

collaborate with QIC and UMAC committees. Personnel in each clinical and administrative department also participate to evaluate quality of care, to identify opportunities, and implement interventions to improve the healthcare and service delivered to members.

Required Actions: None.

2. Evaluation of impact and effectiveness of QAPI: i. Strengths and accomplishments. ii. Opportunities for improvement.	2019 QA&I Evaluation Report: Pages-14 to 18	Fully Met

Findings: Missouri Care evaluated the impact and effectiveness of QAPI and presented its strengths/accomplishments and improvement opportunities. Some of them are as follows:

Strengths and Accomplishments

- Health Plan Engagement: In CY 2019, Missouri Care launched an "I Am Quality" plan-wide training to increase all staff's quality engagement with members and providers.
- Member Engagement: Missouri Care continued its multi-touch approach to impact members' quality care, such as educating members on preventive services and mailing reminders.
- Provider Engagement: Missouri Care expanded its Patient Care Advocate (PCA) program to 2 employees. PCA program included embedding an employee in a provider office to outreach members with HEDIS care gaps to schedule appointments.
- Provider Incentive Program: Missouri Care added a new OB/GYN provider incentive for Prenatal and Postpartum Visits. It also enhanced its PCP and Behavioral Health Provider Incentive Programs.
- Member Incentive Program: Missouri Care continued its Healthy Rewards Program and was successful at surpassing the goal of 10% Participation.
- HEDIS Measures: 15 measures were scored at 50th through 95th percentile.
- Patient Safety: Missouri Care received zero grievances during CY 2019 regarding the quality of practitioners' office sites.

Opportunities for Improvement:

- Explore new opportunities/best practices to improve quality at new corporation, Anthem (WellCare is taken over by Anthem effective Jan 23, 2020).
- Improve dental and medical preventive care, offer mobile medical/dental vans.
- Improve lower rural HEDIS rates in expansion regions.
- Launch "I Am Quality" program in provider offices.
- Increase focus on Statewide HEDIS results, shift from by region to Statewide HEDIS Chart Chase.
- Improve data capture, transfer Electronic Supplemental Data from WellCare to Anthem.
- Improve care gap closure, educate providers on quality during consultations with CMO, Quality Practice Advisors, and Provider Representatives.
- Utilize new materials to increase utilization of healthy rewards program.

- Improve behavioral health provider engagement, offer FUH 30 days Incentive to Clinical Mental Health Counselors (CMHC)/Certified Community Behavioral Health Clinics (CCBHC) and a Statewide Behavioral Health Agency.
- Improve OB specialists' engagement, offer an OB incentive program for prenatal and postpartum visits.
- Improve PCP engagement, through PCP provider incentive program.
- Improve behavioral health care, expand Telehealth and Licensed Clinical Social Worker outreach program.
- Improve Patient Care Advocate calls connected to members and scheduling appointments.
- Decrease non-urgent emergency department utilization by ensuring members are receiving the right care, at the right time, in the right setting.
- Improve coordination of care between medical and behavioral health settings through provider education.

Required Actions: None.

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.	2019 QA&I Evaluation Report: Pages-18 to 21 2019 QA&I Evaluation Report (revised): Page 19	Fully Met

Findings: The greatest number of members by race/ethnicity is Caucasian, at 654 out of 1000 members, followed by African American at 200 out of 1000 members. The race/ethnicity of "Others" is reported for 133 out of every 1000 members. Missouri Care has a Cultural Competency committee, which addresses cultural and linguistic needs of members. Staff, such as Case Managers, address cultural needs on a one-to-one basis. The committee focus is to evaluate how well Missouri Care meets their members' cultural, ethnic, and linguistic needs.

Missouri Care continued to employ a variety of strategies to identify members with special health care needs (SHCN) including: MO HealthNet Monthly SHCN File; Health Risk Assessments; Member Outreach; and Network Providers. The system of care for members with special health care needs involved:

- Having specialists serving as the child's PCP, if acceptable to the member or member's caregivers.
- Active involvement of the member's PCP and specialists in the treatment planning process
- Direct access to a specialist(s).
- Ongoing assessment to identify any special conditions that require a course of treatment or regular monitoring.
- Trauma Informed Care training is provided to staff annually.

The care management team worked to promote the early identification of physical, behavioral and developmental problems; preventive health services; and outreach and education, in accordance with MHD SHCN program requirements. In CY 2019, members referred to CM from State's SHCN file were 771. The State provides language data on enrolled members' language and it is reported as 'Other' for 835 per 1000 members and is blank for 2 out of 1000 members. The data shows that 159 per 1000 members are identified as speaking English and 4 of out of 1000 members are identified as speaking Spanish. Missouri Care does not have the authority to assist members in the input of these identifiers to drill down on the 'Other' category. Missouri Care uses several measures to evaluate the adequacy of their provider network to meet the cultural and linguistic needs of members: • Ratios of providers who speak non-English languages identified by members. • Member grievances related to cultural or language barriers • Member feedback from CAHPS survey regarding provider communication effectiveness and being treated with courtesy and respect. Interpreter services are available for all members regardless of their native language. Written materials are available to members translated into Spanish. Missouri Care had a total of 31 members requesting to opt-out in CY 2019. **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.	2019 QA&I Evaluation Report: Page-31	Not Applicable (N/A)
Findings: Missouri Care stated the current report was unavailable/not provided by DHSS for 2019 Annual Evaluation. Primaris contacted MHD for clarification on this requirement during the preliminary review. MHD provided the indicators to Missouri Care after Primaris brought this issue to their attention. Primaris will mark this section as not applicable (N/A) for EQR 2020.		

Required Actions: Missouri Care 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.	2019 QA&I Evaluation Report: Pages-32, 33	Fully Met
Findings: Missouri Care has reported the specific birth indicators taken from Managed Care Organization Specific Birth Indicators 2018 report which compares the MCOs and FFS rates: Rate of Cesarean Sections; Vaginal birth after Cesareans (VBAC); Adequacy of Prenatal Care; Early Prenatal Care; Low Birth Weight babies <2500 gm.; <2500 gm delivered in level II and III hospitals; Smoking during Pregnancy; Spacing<18 months; Repeat Births to Teen Mothers (< 20 years); Prenatal WIC participants. The data has been analyzed and interventions are planned to improve the outcomes. Managed Care cesarean sections and VBAC rates have been steady for the past three years for the Missouri Care. Adequacy of Prenatal Care has been essentially status quo in the Managed Care population but increased 5% in the FFS population. Contact with Members is initiated within 15 days of notification of their pregnancies and offered Care Management. Benefits and incentives, including the importance of Prenatal and Postpartum Care are discussed with members whether or not they enroll. Members are encouraged to enroll in WIC and linked with Community Supports and physicians. Missouri Care's members continue to be involved with WIC in each region; however, their year over year rate was the same. Missouri Care's care managers and care coordinators continue to focus on encouraging WIC enrollment for every member they outreach. All interventions and program enhancements are geared towards timeliness and frequency of prenatal care focusing on improving birth outcomes. **Required Actions:** None.		
iii. MO HealthNet Managed Care HEDIS Measures.	2019 QA&I Evaluation Report: Pages-21 to 26	Fully Met
Findings: For Effectiveness of Care, Missouri Care reported 38 HEDIS measures. Eight measures have scored above 50th percentile. For Access and Availability of Care, five HEDIS measures are reported. For Utilization and Risk Adjusted Utilization, Missouri Care reported 7 measures. Missouri Care identified barriers to improving these measures and actions/interventions they would take in CY 2020 to improve them. **Required Actions:** None.		
5. Accessibility of Services: An analysis and evaluation of: i. Average Speed of Answer; ii. Call Abandonment Rate;	2019 QA&I Evaluation Report: Pages-34 to 44	Fully Met

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 x. Requests to Change Practitioners.		

Findings: Missouri Care analyzed and evaluated the above requirements of this section:
i. The Average Speed of Answer for member calls during CY 2019 was 15 seconds, which was a slightly higher than CY 2018 and far exceeded the goal of less than or equal to 30 seconds.

ii. The Average Abandonment Rate for member calls during CY 2019 was 0.9%, which was higher than CY 2018 and exceeded the goal metric of less than or equal to 5%.

The CY 2019 rates consistently exceeded goals; therefore, a qualitative analysis was not conducted for i and ii. No barriers were identified.

Missouri Care did not yet have the final CY 2019 results that reflect those providers validated as coming into compliance in the follow-up survey. The CY 2019 initial results are represented for the following sections.

iii. Availability with PCPs for appointments in case of non-symptomatic routine adults was 96%; Pediatric appointments were 97.2%; specialists' availability was 87.5%; OBGYN appointments for 1, 2, and 3 trimesters were 87.7%, 86.9%, and 82.2% respectively. The goal was 90% for all providers.

iv. Appointments for symptomatic routine patients were available with PCPs (96.9%); Pediatricians (98%); OBGYN (92.4%); Oncologists (94.5%); specialists (82.1%). The goal was 90% for all providers.

v. Availability of appointments with PCPs for urgent requirements was 92.5%; Pediatricians' availability was 97.2%; OBGYN was 85.6%; and specialists was 87.1%. The goal was 90%.

Provider Relations (PR) provides ongoing provider education on appointment requirements. These are covered in new provider orientations, included in the provider

manual published on website, and incorporated in provider materials reviewed and distributed at statewide provider conferences, Missouri Care provider workshops, and as part of outreach to providers who fail the survey. In CY 2019, PR also distributed mousepads highlighting our appointment requirements. The mousepads are intended as a reference that a provider's staff can keep near the phone when taking appointment requests.

vi. Missouri Care reported that they consistently met or exceeded the 90% GeoAccess goal for PCPs, behavioral health providers, and specialists statewide, therefore a qualitative analysis was not conducted. The ratio for PCPs overall was 1:42 (goal 1:250); BH providers 1:37 (goal 1:3000); and OBGYN providers 1:88 (1:1000).

vii. The survey results by Missouri Care's vendor show that after-hour availability of providers (PCPs, Pediatricians, OBGYN, Specialists-high volume, high impact, BH) was 74.8% which decreased from last year (80.0%).
The majority of providers utilized answering machines that directed callers to an alternate number providing access to the provider or a covering provider. Some utilized answering services or call forwarding to allow after-hours access to the provider or a covering provider, while others referred members to a contracted 24-hour nurse triage and advice line. Providers who are non-compliant are sent Corrective Action Plan letters. Missouri Care ensures members have evening and weekend access by contracting with a network of urgent care facilities. Members are able to access urgent care centers without referral or prior authorization.

viii. Missouri Care monitors the status of PCP panels on a monthly basis. The proportion of PCPs with open panels was 89.4% as compared to 91.5% for CY 2018. An issue in the auto assignment process caused a PCP in the Children Mercy Pediatric Care Network (CMPCN) to receive a disproportionate amount of member auto assignments. The CMPCN network requested to close all PCP panels until the auto assign issue was resolved and 88 CMPCN PCP panels were closed for this reason in November 2019. Corrections to the auto assignment process are scheduled to be implemented in first quarter 2020 at which time CMPCN will re-open their PCP panels.
One of the Eastern Region provider systems declined to partner with Missouri Care in managing the quality of care provided to their assigned members. Missouri Care closed their 59 PCP panels in August 2019.

ix. A report was run to identify all member grievances closed with subcategories relating to communication/ language barriers, and perceived segregation or discriminatory actions by providers. There was zero (0) communication/language related grievance in CY 2019.

Missouri Care does not require practitioners to identify their race or ethnicity when being considered for inclusion in the network. For this reason, they do not have ethnicity data for providers in the network. However, provider to member ratio (self-identified primary languages of members against the related practitioner counts who have indicated they speak that language in addition to English) are Spanish (1:3); Russian (7:1); Arabic (1:1); Vietnamese (1:2); Chinese (3:1). All language ratios met the goals, and results from the

CAHPS survey identified that the majority of members were satisfied with communication with their doctor. x. In CY 2019, total requests for change of PCP were 20,624 (22,361 in CY 2018). Out of these 73% were due to auto assigned PCP. Missouri Care completed a 100% audit of PCP provider information. They reviewed member claim utilization data to identify if members were receiving care from a PCP other than the one that had been auto assigned to them. Missouri Care updated the member's PCP of record to the PCP who had been providing the member's care. This significantly decreased the need for the member to request Missouri Care to change their PCP of record and reflect the PCP providing their care. Member PCP change requests for reasons other than auto assigned decreased by 30.6% from 7,962 requests in CY 2018 to 5,528 requests in CY 2019. Missouri Care will educate members through welcome calls/packet to choose a PCP upon enrollment. **Required Actions:** None.		
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.	2019 QA&I Evaluation Report: Pages-41 to 44	Partially Met

Findings: i. Number of members who self-identified their primary languages other than English were Spanish-872, Russian-4, Arabic-38, Vietnamese-28, and Chinese-12. All language ratios met the goals, and results from the CAHPS survey identified the majority of members were satisfied with communication with their doctor.

ii. Interpreter services are available for all members regardless of their native language. For in office assistance, Missouri Care offers Sign Language Interpreters, Tactile Interpreters, or Limited English Interpreters, which can be scheduled by the provider, through Care Management, and through the member call center.
In person interpretation requests: Sign Language (2) and Oral (10, 569)
On phone interpretation requests: 3251.

iii. No members requested visual impairment services. A count of members needing communication accommodations due to hearing impairments or a physical disability is not reported by Missouri Care in QAPI. Missouri Care stated they do not capture data on this metric. It is also not available in the state enrollment file.

iv. Members who required hearing impairment services were assisted by Member Service Staff through the toll-free TTY Missouri Relay line. Missouri Care makes the Member Handbook available in CD format or in an easy-to-read form for people with poor eyesight. Missouri Care offers a special phone number for people with poor hearing. Members who use a Telecommunications Device for the Deaf (TTY) can call 711. In addition, the Missouri Care website provides all content in large font.

v. The materials provided in Spanish: Member Handbook; Member Enrollment Brochure; Missouri Care Mini Booklet; Quick Start Guide; Member Enrollment Flyer; Lead Poisoning Education Flyer; Well Child Checkup Education Flyer; Immunization Education Flyer; Women's Education Flyer; Prenatal Education Flyer; Post-Partum Education Flyer; Transportation Education Flyer; Outreach Event Flyer; Annual Pool Party Flyer; Member Welcome Flyer; Dental Flyer; Member Incentive Programs; HEDIS reminders of various services due.
Written materials are available to members translated into Spanish. No other languages required translation services due to less than 200 members identified with Missouri Care's membership.

vi. Missouri Care provides members with large font member material upon request. Missouri Care makes the Member Handbook available in CD format or in an easy-to-read form for people with poor eyesight.

vii. During CY 2019, there were zero (0) grievance related to multilingual issues.

Required Actions: Missouri Care is required to address criterion iii of this section to be fully compliant. Missouri Care should communicate with MHD if they have issues capturing this data.

7. Fraud and Abuse: An analysis and evaluation of the health plan's fraud, waste, and abuse program. (Prevention, Detection, Investigation Training and Education.)	2019 QA&I Evaluation Report: Page-45 2019 QA&I Evaluation Report (revised): Pages-46 to 48	Fully Met
Findings: Missouri Care/WellCare complies with applicable federal and state agency Fraud Waste and Abuse (FWA) related disclosure requirements. The Chief Compliance Officer (CCO) is responsible for overseeing WellCare's compliance with these requirements. WellCare provides mandatory compliance training, including FWA training, to all Associates, Officers and Directors. This training must be completed within 30 days of hire and annually. Associates in reimbursement-related functions also receive supplemental FWA specific training, which must be completed within 30 days of hire and annually. The Special Investigations Unit (SIU) helps develop and maintain the Company's FWA training materials. WellCare conducted periodic assessments to determine how best to focus its FWA efforts. WellCare SIU had overpayment recoveries of $262,305.34 (as of Oct 2019) as compared to $ 92,188.78 in CY 2018. Cost avoidance was $534,136.05 (as of Oct 2019) as compared to $ 696,179.36 in CY 2018. Notice of Adverse Provider Actions (NAPA) were 662 (as of Oct 2019) as compared to 713 in CY 2018. SIU worked to help initiate NAPA process improvements where providers not in Network with no paid claims would bypass the SIU Bucket. This improvement reduced the number of unnecessary NAPA cases worked and resulted in a reduction of the total number of cases worked year over year. Missouri Care has implemented several best practices, e.g., SIU project cases (consisting of multiple proactive investigations with the same or similar allegations of an FWA trend or scheme. The cases are initiated simultaneously, worked as a group and progress together). CY 2020 strategies include: • increase number of SIU projects • Proactive Case Generation • Increase Provider on-sites and Member Visits • Pre-Payment Review • SIU Recommended Provider Terminations • Behavior Health Investigations • Increased Collaboration with the Market • Overpayment Recovery Process **Required Actions:** None.		
8. Information Management: An analysis and evaluation of MCO's claims processing (timeliness, membership, providers) and Management Information System.	2019 QA&I Evaluation Report: Pages-45 to 47	Fully Met

Findings: Claims processing: The goal of 95% of claims processed within 45 days was exceeded throughout the year. CY 2020 process improvement activities include to improve the skill of Missouri Care's team via weekly huddles and monthly team meeting training topics to reduce payment anomalies. Another initiative is to use automatic detection of payment errors with a tool called Prepayment Detect and Correct. Membership: The Customer Service department performs daily, weekly and monthly audits to verify if members' enrollments are correct in the Missouri Care system. The audits compare the State eligibility file to the internal member data platform and then from the platform back to the State eligibility file while capturing discrepancies in either data set. Member Service team initiates necessary changes to the member data platform or works with the State to correct the eligibility file. Member enrollment for 1915 b and CHIP for end of CY 2019 was 219,119. Providers: Missouri Care reported in CY 2019, PCPs increased 56% due to continued recruitment efforts. Provider data affects the member provider directory, claim logic and where payments are deposited. Provider and contract updates can be subject to Sarbanes Oxley (SOX) auditing. Missouri Care has two local departments whose primary or secondary responsibilities are to systematically evaluate provider data and to initiate any changes to the provider's record, if necessary. These local departments work closely with their counterparts who manage updating the technical system so that the provider directory reflects the change requests. Once the system is updated, the online provider directory is refreshed on a nightly basis, exceeding the state's requirements that such updates are made on a monthly basis. **Required Actions:** None.		
9. Quality Management:		
i. Provider Satisfaction.	2019 QA&I Evaluation Report: Pages-47 to 49	Fully Met
Findings: Missouri Care assesses the level of provider satisfaction with the MCO as measured by annual provider satisfaction survey conducted by their vendor, SPH Analytics (SPHA). SPHA uses their entire book of business (surveys for 77 Medicaid plans) as a benchmark to evaluate an individual MCO's findings. Missouri Care's CY 2019 results decreased from prior year in all six composite areas measured by less than 2% from previous year: Call Center Staff; Provider Relations; Network/Coordination of Care; Utilization & Quality Mgt.; Financial Issues; and Net Provider Satisfaction. However, four areas were above the benchmark and the two areas: Call Center Staff and Net Provider Satisfaction were below the benchmark. Net Provider Satisfaction (NPS) decreased from 72.8% in CY 2018 to 72.0% in 2019 – falling short of the 79.0% goal set for this item. The specific items most highly correlated to satisfaction were: • Consistency of reimbursement with contract rates. • Resolution of claims payment problems or disputes.		

- Accuracy of claims processing.
- Overall satisfaction with MCO's call center service.

During CY 2019, Provider Relations (PR) primary focus was to partner with providers to improve provider quality performance. PR will continue to focus on Quality, but the above results reflect a need to incorporate more focus on claims resolution into provider conversations. For CY 2020, PR will:

- Add more focus on claims resolution by provider conversations.
- Continue Provider workshops in each region to capture feedback, address issues, and provide information.
- Improve satisfaction with the call center through regular touchpoints between the market and call center management to share market specific information, trends, and address provider issue resolution.

Required Actions: None.

ii. Member Care Management Services for both Physical and Behavioral Health.	2019 QA&I Evaluation Report: Pages-49 to 56	Fully Met

Findings: The number of identified members who opt out of the care management program rose from 1.25% to 6%, which exceeded Missouri Care's target (2%). While care management received training on techniques for motivational interviewing and scripting for member engagement, scripting related to the centralized PHS may have contributed to the "depersonalization" of the care coordinator interaction. The care coordinators (outside of OB) no longer conduct any screening, thereby decreasing the ability to develop a relationship during the call.

The total enrollment for all members identified for care management is 10% (goal 20%), with 51% unable to contact (down from 58% last year). The most common reason for lack of enrollment remains, by far, inability to reach members. The total members in care management in CY 2019 are 6447 vs 2011 in CY 2018. The new cases in CY 2019 were 3718 (1935 in CY 2018).

Missouri Care explored additional means in locating members by:

- Increasing referrals to Care Managers by Utilization Management nurses during a member's inpatient stay, allowing increased field outreach while the member was still hospitalized. This includes inclusion of Care Managers in Inpatient and Complex inpatient rounds.
- Working with the Missouri Department of Social Services to improve the quality of contact information passed to Missouri Care on eligibility files.
- Evaluating claims and other documents for physician information and contacting provider office for demographic assistance.

For CY 2020, Missouri Care continues to scale up Care Model face-to-face care management program throughout all regions of Missouri. Care Managers and Care Coordinators represent both physical and behavioral health Care Management.

Children's Mercy Pediatric Care Network (PCN) is an integrated pediatric network that coordinates the medical care of pediatric patients. The number of active cases in CY 2019 is 158 (78 in CY 2018). The PCN is an approved MO HealthNet Local Community Care Coordination Program (LCCCP) for Missouri Care. The intent of the LCCCP is for care to be coordinated at the member and provider level in the community which aligns well with the PCN model.

To maximize integration of members' care, an interdisciplinary team consisting of physical health and behavioral health care managers met regularly to discuss the management of members with complex, comorbid physical and behavioral health issues. Missouri Care's CMO and Associate Behavioral Health Medical Director collaborated in managing the interdisciplinary team and in reporting care management results and initiatives to senior leadership as well as to Quality Oversight committees. Grand Rounds, led by Missouri Care's CMO and Associate Behavioral Health Medical Director, is held twice weekly to address complex members that present with dual-diagnoses, complex health needs and challenging psycho-social needs.

Missouri Care's fully integrated management information system enabled case managers to analyze pharmacy and physical and behavioral health information to support treatment decisions. All care managers have access to the same care management data platform and documentation.

The percent of members with a PCP visit with a secondary behavioral health diagnosis who had a behavioral health follow-up visit decreased by 1.02 percentage points to 12.09%. Behavioral health follow-up visit occurred (47.77%) within 30 days of the PCP visit, which was a decrease of 12.08 percentage points from prior year. Neither rate met the goal.

Required Actions: None.

iii. Credentialing and Re-Credentialing.	2019 QA&I Evaluation Report: Pages-64 to 66	Fully Met

Findings: Initial Credentialing: In CY 2019, the target turn-around-time for new application processing was set at 15 calendar days. A total of 1,739 new applicants were presented to the Missouri Credentialing Committee which met the turnaround goal at 7 days. A total of twenty-six (26) files did not meet "clean" file criteria and were presented for in depth review by the Credentialing Committee. Of those, zero (0) providers were denied by the Credentialing Committee in 2019. Quality review indicated less than a 5% error rate.

Re-credentialing: In CY 2019, Missouri Care completed re-credentialing for a total of 2,241 providers. A total of seventeen (17) files did not meet "clean" file criteria and were presented for in depth review by the Credentialing Committee. Of those, three providers were denied by the Credentialing Committee. In 2019, 23 providers were Voluntarily Relinquished due to failing to complete re-credentialing, resulting in a 1.03% Voluntary Relinquishment (VR) rate (goal <5%).

High volume of incorrectly submitted new credentialing applications or applications submitted without complete documentation resulted in the need to conduct outreach and delayed the credentialing process. VR volume is out of Missouri Care's control. These terminations also include providers who do not respond to Re-credentialing requests due to moving, death, or retiring.

Required Actions: None.

iv. Medical Record Review.	2019 QA&I Evaluation Report: Pages-66 to 68 2019 QA&I Evaluation Report (revised): Pages-69 to 71	Fully Met

Findings: In CY 2019, Missouri Care conducted retrospective medical record review focused on documentation of care rendered from January 1, 2018 through December 31, 2018. A random sample of 30 Adult PCPs and 30 Child PCPs with a 20% oversample for both groups with 5 or more members were selected for the adult and child review. The objective was to review PCP's Medical Records to Determine Compliance on:

- Established Documentation Standards.
- Professional Practice Standards.
- Preventive Health Guidelines.
- EPSDT Visit Components.

The goal is 100% PCPs should receive a composite score of 80% or greater for compliance with EPSDT and medical record documentation. Missouri Care documented 100% compliance for medical record documentation standards and 88% score for EPSDT components for all PCPs in sample (100% passed). Missouri Care attributes this score to ongoing education to their providers.

WellCare's Business Performance Management Team reviewed medical records from Missouri Care's contracted behavioral health practitioners for compliance with documentation standards and coordination of care with PCPs. Overall, Missouri Care's behavioral health practitioners obtained consent from members to communicate with their PCP 74% of the time (goal 52%). When consent was obtained, communication occurred 90% of the time (goal 49%). Both of the rates increased from CY 2018 and met the goals. Evidence of communication with the PCP every 90 days or at other significant point in treatment was documented 93% of the time, which was a significant increase of 66 percentage points, and it was 60 percentage points above the goal (33%). Missouri Care's CY 2019 rates were all above the goal; therefore; a qualitative analysis was not conducted.

Required Actions: None.

v. Disease Management: Clinical Practice Guidelines	2019 QA&I Evaluation Report: Pages-60 to 64	Fully Met

Findings: Clinical Practice Guidelines (CPGs) are posted on the Missouri Care website (66 documented in QAPI), in the Provider section, as well as distributed via the quarterly Provider newsletters and the Provider manual. Preventive Health CPGs for adults and pediatric members are reviewed annually in an effort to include the most recent immunization tables (released annually by the CDC). In CY 2019: • 50 existing CPGs were reviewed; there were 9 new CPGs developed. • Six existing Clinical Policy Guiding Documents (CPGD) were reviewed; 2 new CPGDs were developed. • Approximately 800 citations and references were reviewed for new and existing CPGs; this included evidenced based practice guidelines and other publications authored by national healthcare and medical specialty organizations. In Q3 2019, the Medical Policy Governance Team (MPGT) was created and was led by the Clinical Policy Team. The purpose of the MPGT was to: • Expedite and track requests via the newly implemented Clinical Policy Intake System. • Prioritize requests and determine the type of guideline needed. • Minimize the tabling/postponing of guidelines during Medical Policy Committee (MPC) meetings. Care Management Quick Cards are reviewed and approved annually. Quick Cards are based on CPGs and serve as a supplemental tool used by care managers when working with Members both telephonically and in person. The last review and approval was January 2019. **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).	2019 QA&I Evaluation Report: Pages-56 to 60	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: i. Missouri Care uses a proprietary model each month to identify and stratify members for management. Their model has several components including disease status identification, severity, cost, and utilization factors. The model subjects all eligible members to a scoring algorithm that assigns a score based on severity, cost and utilization. In addition to being assigned a score, members are also flagged if they have one or more of the covered chronic conditions (Asthma, Diabetes, CHF, COPD, HTN, and Depression). Members are identified to participate in DM Program by various methods: Algorithm; HRA; referral from Care Management; physician referral; and direct referral by member. Both Care Management and Disease Management are integrated into the LAW algorithm, which is an algorithm that automatically identifies members as eligible for DM and assigns them to a nurse or Care Coordinator for outreach. After initial contact, the member will be transferred to shared services staff or Field Care Managers, as appropriate.

ii. The active participation rate for CY 2019 was 5.96% (goal 0.5%) in comparison to 0.16% in CY 2018.

iii. The number of active members having one or more diagnosis codes was 2248 in comparison to 175 in CY 2018.

iv. The total number of members engaged in the Disease Management program increased in CY 2019 (64,459) by 896.58% from CY 2018 (6,468). The number of actively participating members increased as well, from 0.16% to 5.96%. The number of passively participating members for CY 2019 (94.04%) had a 9.35% increase from CY 2018 (86%). No cases were closed due to noncompliance with treatment plan.
Missouri Care listed their goals and benchmarks are as follows

- DM Active Participation Rate (Defined by NCQA) = 0.5%
- % (Passive) Participating Members of total population = 10%
- % of Total (Active & Passive) Participating Members identified for DM participation = 90%
- Opt-out Rate of DM Members = <10%

- Implement activities to improve HEDIS measures for chronic medical conditions and meet Medicaid HEDIS

In an effort to improve member compliance with the disease management program, members will continue to receive education even after completion of the program. Missouri Care will continue to educate members on chronic care through the Member Newsletter. Also, members will continue to be informed through annual periodicity letters on the importance of seeing their primary care physician for a wellness check-up and chronic care screenings. In an attempt to increase member's level of self-management, Disease Management staff will continue to be trained to address adherence on all chronic care medications on every call with members as well as ongoing staff meetings will be utilized to keep staff informed of the tools to manage chronic conditions, discuss barriers and determine interventions. In addition, refresher training to be provided on an ongoing basis related to current Clinical Practice Guidelines.

In February 2014, Children's Mercy Pediatric Care Network (CMPCN) entered into an agreement for delegated disease management with Missouri Care. The CMPCN Disease Management programs, developed by clinical experts, uses a unique approach to manage chronic disease. Rather than relying exclusively on phone consultations or patient education materials, CMPCN care teams form personal relationships with primary care providers (PCP's) to help them implement comprehensive Disease management in their offices, supporting the patient-provider relationship with the goal of improved patient health and reduced costs. CMPCN uses data to identify members who either have been diagnosed with one of the targeted chronic diseases or who have a condition that is likely to lead to one of those chronic diseases at some time in the future. To do this, CMPCN uses a combination of claims data, hospital encounters, pharmacy utilization and/or lab test data.
The CMPCN active participation rate for CY 2019 is 1.7%. No case was closed due to noncompliance with treatment plan.

Required Actions: None.

11. Rights and Responsibilities. An analysis and evaluation of: i. Member grievances and appeals. ii. Provider complaints and appeals. iii. Confidentiality.	2019 QA&I Evaluation Report: Pages-68 to 72 2019 QA&I Evaluation Report (revised): Pages-76, 77	Fully Met

Findings: i. In CY 2019, 97% of the member grievances were resolved within the timeframe which has decreased by 1% point from previous year (CY 2018, 98%). Standard appeals were resolved in 100% cases and expedited appeals were resolved for 93% of cases which is a decrease of 7% points from previous year (CY 2018, 100%).
Missouri Care resolved a total of 567 member grievances in CY 2019. Of the 567 member grievances filed, 380 were regarding the Attitude/Service category (67%).

Missouri Care received a total of 467 member appeals in 2019. Of those 467 appeals, 205 were voided. The top three types of service for member appeals were: laboratory/radiology/other diagnostic services (204 appeals); dental (116 appeals); and DME/Home Health/Personal Care (51 appeals). ii. Missouri Care has set a goal of ≥95% for standard pre-service and retrospective appeal turnaround time within 30 days of provider appeal. In CY 2019, 97% of the time this standard was met which was a decrease of 2% points from previous year (99%). During CY 2019 there were 7,765 provider appeals filed with Missouri Care. Of those appeals, 702 were voided and 7,063 were reviewed and resolved. The top three categories of service for claim denials were: Outpatient/Primary Care/Specialist Care (3,252 appeals); Inpatient (1,139 appeals); and Laboratory/Radiology/Other Diagnostic Services (583 appeals). The top three types of service for appeals filed regarding service authorizations were Outpatient/Primary Care/Specialist Care (124 appeals), Behavioral Health (87 appeals), and Laboratory/Radiology/Other Diagnostic Services (5 appeals). The only category of Provider Complaints in CY 2019 was Non-Medical. Three of the four complaints were regarding optical services, and other complaint was regarding dental services. Both of these are handled by vendors. iii. WellCare has written policies and procedures to manage the Privacy, Security, and Records and Information management (RIM) compliance requirements. Privacy and Security is managed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as modified by the Health Information Technology for Economic and Clinical Health (HITECH) Act set forth by the United States Department of Health and Human Services (HHS). WellCare promotes the confidentiality of sensitive information including member protected health information (PHI) through the performance of physical walkthroughs. A physical walkthrough consists of verbal inquiry with associates and a visual inspection of an office workspace. The associate who was found noncompliant is provided coaching and/or training on issue detected. The delivery mechanism is either verbal, via email message, or a formal computer-based training. Walkthrough results and findings are reviewed on a quarterly basis at the Market Compliance Officer's quarterly compliance meetings. Walkthrough results for 2019. Total Issues (14): unsecured Laptops (12); PHI on printer/fax machine (1); and unlocked computer screen (1). **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.	2019 QA&I Evaluation Report: Pages-72 to 83 2019 QA&I Evaluation Report (revised): Page-84	Fully Met
Findings: i. The Utilization Management (UM) process influences the continuum of care by evaluating the necessity and efficiency of health care through systematic monitoring of medical necessity and quality and maximizes the cost effectiveness of the care and service provided to members. ii. The scope of the UM Program includes an overview of policies, procedures and operational processes related to the delivery of medical care, behavioral health care, dental care, and pharmaceutical management, including services and physicians who have an impact on the provision of health care. This includes the evaluation of medical necessity and the efficient use of medical and behavioral health services, procedures, facilities, specialty care, inpatient, outpatient, home care, skilled nursing services, and ancillary services. iii. iv. Missouri Care reported discharges (admits)/1000 members for: Medical/Surgical were 39 (same as in CY 2018); NICU were 6.8; Inpatient Rehabilitation were 0.42; births were 48; and under Observation were 19. v. Average Length of Stay for: Medical/Surgical patients was 3.5 days (almost same in CY 2018); NICU was 18.52 days; Inpatient Rehabilitation was 23.8 days; births was 3 days; and under observation was 1.01 days vi. Readmission rate for Medical/Surgical patients was 9.5%. The goal of 14.5% was met.		

vii. Emergency Department Visits per 1000 members (HEDIS AMB-ED measure) was reported 59.79% (statewide aggregate) for CY 2018. CY 2019 results are not finalized yet.

viii. Outpatient visits/1000 members was reported region wise. Primaris calculated statewide aggregate (358.55) for CY 2018. Statewide preliminary rate for CY 2019 was 403.22 (will be finalized on Jun 15, 2020).

ix. During CY 2019, Reports used to identify utilization patterns included quarterly data on admits/1000 members, average length of stay, and 30-day readmission rates. The chief medical officer presented utilization reports to the Utilization Management Medical Advisory Committee and discussed any identified or possible trends with the committee and opportunities for intervention. Missouri Care had various interventions in place during CY 2019 to improve underutilization and encourage members with gaps in care to receive needed care e.g., Member Incentive Program, Provider Incentive Program, Patient Care Advocate Program, HEDIS Care Gaps Reports, HEDIS Provider Tool Kit.

x. The purpose of the inter-rater reliability (IRR) assessment is to establish the consistency of guideline application among the clinical reviewer, both physician and non-physician. Associates scoring less than 85% on an IRR examination are counseled and audited for a period of up to six months. Retesting for compliance with the established criteria can be completed at any time during the six months. The associate is limited to two initial complete assessment attempts to show comprehension and correct application of the established criteria. If the associate does not score at least 85% on the test within two attempts, re-training is given. Ongoing coaching of UM Review Nurses and BH Care Managers occurs during monthly one on one and through Quality Assurance audits. Physical Health licensed clinicians (prior authorization and inpatient care reviewers) IRR score in CY 2019 is reported to be 100%. Missouri Care Behavioral Health UM staff routinely use CALOCUS and LOCUS to assist in determining the appropriate level of care for members receiving behavioral health care services. IRR score for all staff was 100%.

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

Missouri Care has reminders for members in need of EPSDT and preventive services. If a member has not had an EPSDT visit within 120 days, a follow up letter is sent members and PCP's reminding them to schedule a visit. Missouri Care was successful at surpassing the goal of 65% for EPSDT participating ratio in all four regions and successful at improving EPSDT participation in all regions statewide (aggregate 73.5%).

x. Missouri Care met the turnaround time for Physical Health Prior Authorizations (PA) (nonurgent) for 97.7% cases. Behavioral Health PA was compliant in 97.9% cases. In case of urgent PA for Physical Health services, the compliance was 97.6% and for Behavioral Health was 97.4%.

Required Actions: None.		
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.	2019 QA&I Evaluation Report: Pages-83, 84 2019 QA&I Evaluation Report (revised): Pages-89, 90	Fully Met
Findings: Missouri Care conducted clinical and non-clinical State PIPs to improve members' health, including Improving Oral Health and Childhood Immunization Status (CIS). The results and trends of both the PIPs are reported. CIS combo 10 rate in CY 2019 is reported as 27.49% (final rate will be available on Jun 15, 2020). This is same as in CY 2018. The ADV measure in CY 2019 is reported as 58.87% (final rate on Jun 15, 2020) which is an increase of 6.15% 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. (iii) Evaluation of the effectiveness of the interventions based on the performance measures. (iv) Planning and initiation of activities for increasing or sustaining improvement.	2019 QA&I Evaluation Report: Pages-83, 84 2019 QA&I Evaluation Report (revised): Pages-89, 90	Fully Met

Findings: (Note: Detailed evaluation of PIPs will be done by Primaris when Missouri Care 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 HEDIS performance measure indicators were used to assess the PIP for improving childhood immunization status (CIS Combo 10) and for improving oral health PIP (Annual Dental Visit-ADV). ii. Interventions for Childhood Immunization Status include: • Provider Incentive: Missouri Care's provider incentive program, Partnership for Quality, rewards providers with bonus dollars for increasing immunization for members. This Provider incentive increases members' vaccinations by taking every opportunity to educate members on the importance of immunizing members. • Member Incentive: Missouri Care's Healthy Rewards member incentive program includes rewards for members who complete their recommended well-child visits. Intervention for Improving Oral Health: Member Incentive (Members over two years of age who complete their annual dental visit receive a reward). iii., iv. CIS Combo 10 PIP: Missouri Care partnered with two high-volume provider groups to increase the number of members completing HEDIS CIS Combo 10 and increase the CIS Combo 10 provider incentive amount in their Partnership for Quality Provider Incentive Program. Missouri Care has identified a root cause of members not receiving the influenza vaccine and therefore are not compliant with CIS Combo 10. To increase the CIS Combo 10 rate, Missouri Care will develop an intervention to promote the flu shot during flu season. ADV PIP: Missouri Care offered Healthy Rewards program for eligible members completing an annual dental visit. It was considered effective noting that preliminary HEDIS ADV rate improved and Missouri Care had an increase in member participation in the Healthy Rewards Program. To sustain improvement, Missouri Care will continue to offer a member incentive program during CY 2020. Missouri Care has identified an opportunity to work with the Healthy Rewards vendor to identify effective communication methods to further increase member's participation in the program. **Required Actions:** None.		
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.	2019 QA&I Evaluation Report revised: Page-19 2019 QI Program Description: Pages-11, 12 Supporting Documents:	Fully Met

	• C7-CM-MD-4.8 Individuals with Special Health Care Needs: Page 2 • Special Health Care Needs Mechanism	

Findings: Missouri Care identifies members with special health care needs through utilization reports (e.g., diagnosis, claims), provider referrals, member self-referrals, or referrals from other Departments (e.g., Pharmacy, concurrent review), State of Missouri File (received monthly and viewed by Missouri Care's leadership), CyberAccess. Missouri Care reported 771 special health care needs members were referred to CM from State's file during CY 2019.

Missouri Care implements procedures to deliver primary care to and coordinate health care service for all members that:
1. Ensure each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.
2. Coordinate the services furnished to the member with the services the member may receive from another managed care entity during the same period of enrollment.
3. Share with other MCOs serving the member with special health care needs the results of its identification and assessment of that member's needs to prevent duplication of those activities.
4. Ensure the process of coordinating care that each member's privacy is protected in accordance with privacy requirements, to the extent that they are applicable.
5. Ensure that opportunities for improvement are identified through the analysis of information collected from Healthcare Effectiveness Data and Information Set (HEDIS) and utilization patterns.
6. Ensure that an emphasis is placed on, but not limited to, clinical areas relating to women, infants and children, adolescents, young adults, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Missouri Care requires that contracted providers assess the member and develop a plan of care or treatment plan for members. The provider coordinates the treatment plan with the member, family and/or specialist caring for the member. The treatment plan should adhere to community standards for documentation and any applicable Agency quality assurance and utilization review standards.

Missouri Care reported via a separate document that they follow-up with the progress of cases during Complex Case Rounds and/Grand Rounds and Quality Audits.

Required Actions: None. However, Primaris recommends Missouri Care should present complete information in QAPI (evaluation and description) instead of creating separate documents for Primaris only, to meet the requirement of this section.

16. An analysis and evaluation of quality issues and actions identified	2019 QI Program Description: Page-4	Fully Met

through the quality strategy and how these efforts were used to improve systems of care and health outcomes.	2019 QA&I Evaluation Report	
Findings: The annual QI Work Plan identifies specific activities and projects to be undertaken by the Plan and the performance measures to be evaluated throughout the year. Work Plan activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals. The annual QI evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and prior years trending as appropriate. The annual evaluation describes the overall effectiveness of the QI Program by including: • Description of ongoing and completed QI activities and projects • Trended clinical care and service performance measures as well as the desired outcomes and progress toward achieving goals • An analysis and evaluation of the effectiveness of the QI program and its progress toward influencing the quality of clinical care and service • A description of any barriers to accomplishing quality clinical care or achieving desired outcomes • Current opportunities for improvement with recommendations for interventions including tweaks to some interventions, discarding of ineffective interventions, and development of new interventions. **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. The Missouri Care stated that they are not aware of this requirement. Primaris marks this section as N/A for EQR 2020. Missouri Care has not posted any study that they did at their end. **Required Actions:** Primaris recommends Missouri Care to request guidance from MHD on study topic(s) around which the Missouri Care will be required to conduct a focus study and report results in QAPI. Missouri Care 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 Missouri Care'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.	2019 QA&I Evaluation Report: Pages-9 to 12 2019 QI Program Description: Pages-8, 9	Fully Met
Findings: While a function may be delegated to another entity, Missouri Care retains overall accountability for completion of the tasks delegated. The Delegation Oversight Department coordinates and oversees all delegated activities to ensure delegates adhere to contractual, regulatory, and accreditation requirements. Delegation Oversight ensures compliance by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation agreements; completing annual delegation audits; monitoring agencies on corrective action; and monitoring vendor reporting and data submission. The DOC met twelve times in CY 2019, exceeding minimum requirement of nine times per annum. In CY 2019, the objectives for the Delegation Oversight Department were to complete the 2019 audit plan for monitoring and oversight of all delegates to ensure compliance with all federal, state and accreditation standards. Delegation Oversight goals in 2019 were the following: 85% or more of corrective actions plans are completed timely by their due date, and 25% or fewer Corrective Action Plans (CAPs) issued for a repeat deficiency. In CY 2019, 40 delegates were audited for one or more of the following areas: Customer Service, Claims, Credentialing of Practitioners, Credentialing of Facilities, Case Management, Disease Management, Utilization Management, Network Management, Nurse Advice Line, Behavioral Health Crisis Line, Pharmacy Credentialing, Pharmacy Network and Pharmacy Claims, Provider Appeals, and Transportation. The functional audits performed during 2019 were 92 and all were completed timely by the end of CY 2019. There were 18 corrective action plans (CAPs) issued for the Missouri market. CAPs were closed timely 78% of the time. The primary barrier to completing CAPs timely was related to an extended timeframe required for additional file review evidence. Five (5) CAPs remained open and closure expected within the next 60 days. None of the CAPs were issued for repeat issues. **Required Actions:** None.		
19. Work Plan for next year.	2020 QI Work Plan (revised)	Fully Met
Findings: Missouri Care has submitted a detailed work plan for CY 2020. Missouri Care's Quality Improvement work plan outlines and describes the specific clinical and operational performance measures to be monitored and related activities to be conducted during CY 2020 to promote continuous quality improvement throughout the organization. The Work Plan is an adjunct document to the 2020 Quality Improvement Program Description,		

existing to support its goals. It incorporates issues identified through the 2019 Quality Improvement Program Evaluation and also reflects input from community practitioners and organizational physicians. **Required Actions:** None.		
B. The QAPI program is composed of: i. Results, conclusions, team recommendations, and implemented system changes which are reported to 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)	2019 QI Program Description: Pages-2 to 6 Supporting documents: • Provider Profiling Presentation • Member HEDIS Care Gap Report • QIC Minutes • UMAC Minutes • Committee Structure and Charters • Member Advisory Council Description • Newsletters Provider Newsletters Member Newsletters	Fully Met
Findings: i. The QAPI report incorporates outcomes, trends, analysis, actions identified, and evaluation of the quality data and activities as they relate to Missouri Care's Quality Improvement Program. The report identifies strengths, weaknesses, accomplishments, and opportunities for improvement, including improving systems of care and health outcome, and demonstrates QA & I Program is ongoing, continuous, and based on evaluation of past outcomes. Through this annual evaluation, opportunities for improvement are developed and included in the QI Work Plan and QI Program Description for continued improvement and monitoring in the following year. Missouri Care's Quality Improvement (QI) Program: • Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services, as well as provide the essential infrastructure, resources, and processes to impact desired health outcomes. • Identify and implement strategies to improve the quality, appropriateness and accessibility of healthcare provided to members. • Facilitate organization-wide integration of quality management principles. The QI Program goals are primarily identified through: • Ongoing activities that monitor care and service delivery. • Issues identified by tracking and trending data over time. • Issues/outcomes identified in the previous year's QI Program Evaluation.		

• Internal process reviews. • Accreditation, regulatory, and contractual standards. ii. The continuous quality improvement (CQI) is demonstrated in the structure of the QI Program's committees and sub-committees, the QI Program Description, Work Plan and Annual Evaluation. The QAPI involves continuous tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained. Monitoring of quality of care interventions and outcomes are done through nationally recognized quality standards such as HEDIS® performance measures and CAHPS® surveys, and by utilizing current knowledge and clinical experience, feedback from external quality review, periodic medical record reviews, clinical management and quality initiatives. Analyses and QI Program reports are communicated to the QIC and UMAC. Reports are presented to the Board. The QI Program Description and initiative outcomes are available to providers and members upon request. An annual summary of the QI Program Evaluation is presented in the member and provider newsletters. The QIC and UMAC have a responsibility to disseminate information regarding QI Program activities and outcomes internally to staff members. **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; Fraud, waste, and abuse detection and prevention; Access and availability; and Data collection, analysis, and reporting. (MHD contract 2.18.3)	2019 QI Program Description (revised): Page 4, 6, 7, 10 2019 QA&I Evaluation Report Supporting Documents: • UM Program Description • CM Program Description • DM Program Description • QI Work Plan • Committee Structure & Charters • QIC Minutes	Fully Met
Findings: Missouri Care's QAPI includes all the areas listed in this section. These are monitored, evaluated, trended, barriers are identified and improvement initiatives for the next year are recommended.		

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.	2019 QA&I Evaluation Report: Page 7 Committee Structure & Charters: Pages 1 to 18 Supporting Documents: • QIC Minutes • UMAC Minutes	Fully Met
Findings: The QIC met on a quarterly basis during CY 2019. This committee provided a report to the Board of Directors on the QICs activities, findings, and recommendations. Sub-committees, including UMAC monitor each area, and roll-up summary reports to the QIC Committee quarterly. The UMAC includes representatives of the Missouri Care's providers. The CMO chairs the UMAC and QIC Committees. **Required Actions:** None.		
2. Provide for regular utilization management and quality assessment reporting to the management and providers, including profiling of provider utilization patterns.	2019 QI Program Description: Pages-5, 6 Committee Structure and Charters: Pages-10, 11 Supporting Documents: • Provider Profiling Presentation	Fully Met

	• Member HEDIS Care Gap Report	
Findings: The UMAC oversees all clinical QI, UM and behavioral health activities. The UMAC is a vital avenue through which network providers can offer recommendations regarding Missouri Care's practices as well as QI and UM activities. The UMAC comprises practitioner representation from network primary care providers and specialists, with at least one PCP, obstetrician/gynecologist, dentist, and psychiatrist. Analyses and QI Program reports are communicated to the QIC and UMAC. Reports are presented to the Board. The QI Program Description and initiative outcomes are available to providers and members upon request. An annual summary of the QI Program Evaluation is presented in the member and provider newsletters. The QIC and UMAC have a responsibility to disseminate information regarding QI Program activities and outcomes internally to staff members. **Required Actions:** None.		
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.	QIPD Roles and Responsibilities (revised): Pages-1, 2	Fully Met
Findings: WellCare has an integrated model of resources supporting the Missouri Care's QI activities, including behavioral health. These resources include WellCare associates that cross all functional areas of the organization including, but are not limited to, the executive team, provider relations staff, quality improvement, case and disease management staff, and data analytics support. Resources supporting QI activities are assessed on an annual basis and modified as necessary. The Chief Medical Officer (CMO) reports to the State President and is a physician available to oversee the development, implementation, and evaluation of all clinical aspects of the QI Program in each WellCare state of operations. The CMO serves as the clinical leader, guiding activities and consultatively engaging providers in the QI program. The Behavioral Health Medical Director supports and oversees the development, implementation, and evaluation of all behavioral health aspects of the QI Program. The Behavioral Health Medical Director must be a licensed Medical Physician, Clinical PhD, or PsyD. The Senior Director, Quality Improvement has overall accountability for the day-to-day operations of the QI Program. This individual has a CPHQ (Certified Professional in Healthcare Quality) certification, BSN, RN, and MBA with concentration in health management. **Required Actions:** None.		
4. Provide for systematic data collection, analysis, and evaluation of performance and member results.	2019 QA&I Evaluation Report: Page 13	Fully Met

Provide for interpretation of this data to practitioners.	2019 QI Program Description: Pages-5, 6 2020 QI Work Plan (revised)	
Findings: Missouri Care's process of quality improvement is one of constant evaluation. Missouri Care annually reviews its Quality Improvement Program to identify any needed changes to the plan. Changes may include improvements in quality initiatives or follow-though in any instances in which Missouri Care identified opportunity for improvement. Missouri Care develops a work plan each year which includes a quarterly evaluation of activities. The work plan is used to set goals and guide initiatives. It is referenced and updated as needed throughout the year. Missouri Care also relies on its provider network to evaluate and make recommendations to its quality improvement process through the Utilization Management Medical Advisory Committee. **Required Actions:** None.		
5. Provide timelines for correction and assign a specific staff person to be responsible for ensuring compliance and follow-up.	QIPD Roles and Responsibilities (revised): Page-1	Fully Met
Findings: Senior Director, QI, is responsible for the integration, coordination, compliance, follow-up, and management of the overall QI Program. Missouri Care QIC and UMAC Committees meet at least quarterly to ensure compliance, review activities, make recommendations, and follow-up, as needed. In addition, ad-hoc meetings occur with departments to implement improvement opportunities. Additionally, Missouri Care informed Primaris of the following during our interview: Missouri Care has an assigned quality staff person responsible for reviewing each departments Objectives, Goals, Findings, Analysis, Accomplishments, Actions Taken, and Barriers. As a result of this evaluation, opportunities for improvement are identified. Recommendations are made for the upcoming year and reevaluated annually. In addition, quarterly check-ins are monitored throughout the year to identify trends and provide each department SME an opportunity to correct any deficiencies in the QI Work Plan. Both the QI Work Plan and Annual Quality Assessment and Improvement (QA & I) Evaluation Report are reviewed in the QIC and UMAC committees. **Required Actions:** None.		
6. Clearly define the roles, functions, and responsibilities of the quality assessment committee and the Medical Director.	Committee Structure & Charters QIPD Roles, Responsibilities of Key Personnel	Fully Met
Findings: The two documents have details of roles, functions, and responsibilities of Quality Committee and Chief Medical Officer. The QIC promotes the goals and objectives of		

the QI Program through oversight and approval of Plan QI activities. The CMO provides clinical oversight of accreditation efforts and compliance with state and federal regulation. The CMO chairs the UMAC, QIC and Credentialing Committee. Additionally, the CMO is responsible for:

- Overseeing the implementation of the clinical aspects of the QI Program.
- Continuously acting to improve the overall effectiveness of the QI Program.
- Overseeing appropriateness and effectiveness of clinical care provided by Missouri Care.
- Providing final approval or denial of specific healthcare services to Missouri Care's members.
- Overseeing the development of medical policies relative to necessity, access, and availability of service.
- Actively participating in clinical quality improvement committees and review findings.

Required Actions: None.

Compliance Score Quality Assessment and Performance Improvement Program						
Total	Met	=	32	×2	=	64
	Partial Met	=	01	×1	=	01
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	65
Denominator	Total Sections	=	33	×2	=	66
Score %						**98.48**