Primaris
Healthcare Business Solutions

2021 External Quality Review

Annual Technical Report

MoHealth Net

Measurement Period: Calendar Year 2020
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Publish Date: November 1, 2021

Table of Contents

1.0 Executive Summary

1.1 Background

The Department of Social Services, Missouri HealthNet Division (MHD), operates a Health Maintenance Organization (HMO) style managed care program called Missouri (MO) HealthNet Managed Care (hereinafter stated "managed care"). Managed care is extended statewide in four regions: Central, Eastern, Western, and Southwestern to ensure all Missourians receive quality care. Participation in managed care is mandatory for the eligible groups within the regions in operation. The managed care program enables the MHD to provide Medicaid services to section 1931 children and related poverty level populations; section 1931 adults and related poverty level populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. Currently, coverage under CHIP is provided statewide through the managed care delivery system.

The MHD contracts with three Managed Care Organizations (MCOs), also referred to as Managed Care Plans/Health Plans, to provide health care services to its managed care enrollees. Home State Health, Healthy Blue[1], and UnitedHealthcare are the three MCOs operating in Missouri (MO) (Table 1-1). The MHD works closely with the MCOs to monitor quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods, including 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). None of the three MCOs are exempted from the EQR (42 CFR 438.364(a)(7)).

Table 1-1: MCOs Operating under MHD

	Home State Health	Healthy Blue	UnitedHealthcare
*Enrollees	271,381	308,598	228,801
MCO Location	11720 Borman Drive, St. Louis, MO, 63146	1831 Chestnut, St. Louis, MO, 63103	13655 Riverport Dr. Maryland Heights, MO, 63043
Audit Contact	Director, Compliance	Director, State Regulatory Affairs, Compliance Officer	Associate Director, Compliance

*Total 808,780-MHD Data by the end of SFY 2021 (June 25, 2021) for Medicaid and CHIP. The increase in enrollment is 23.01% from the end of SFY 2020. Per the Centers for Medicare & Medicaid Services (CMS) enrollment trends snapshot, the increase in total Medicaid and CHIP enrollment nationwide is largely attributed to the impact of the Covid-19, Public Health Emergency, in particular, enactment of section 6008 of the Families First Coronavirus Response Act (FFCRA).

[1] Previous year's MCO, Missouri Care, was acquired by Anthem, Inc. effective Jan 23, 2020, and is doing business as Healthy Blue in Missouri.

Primaris Holdings, Inc. (Primaris) is the MHD's current External Quality Review Organization (EQRO), started its five-year contract in January 2018. EQR 2021 includes evaluating the MCOs' activities during the calendar year (CY)/measurement year (MY) 2020.

1.2 Overview of External Quality Review

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

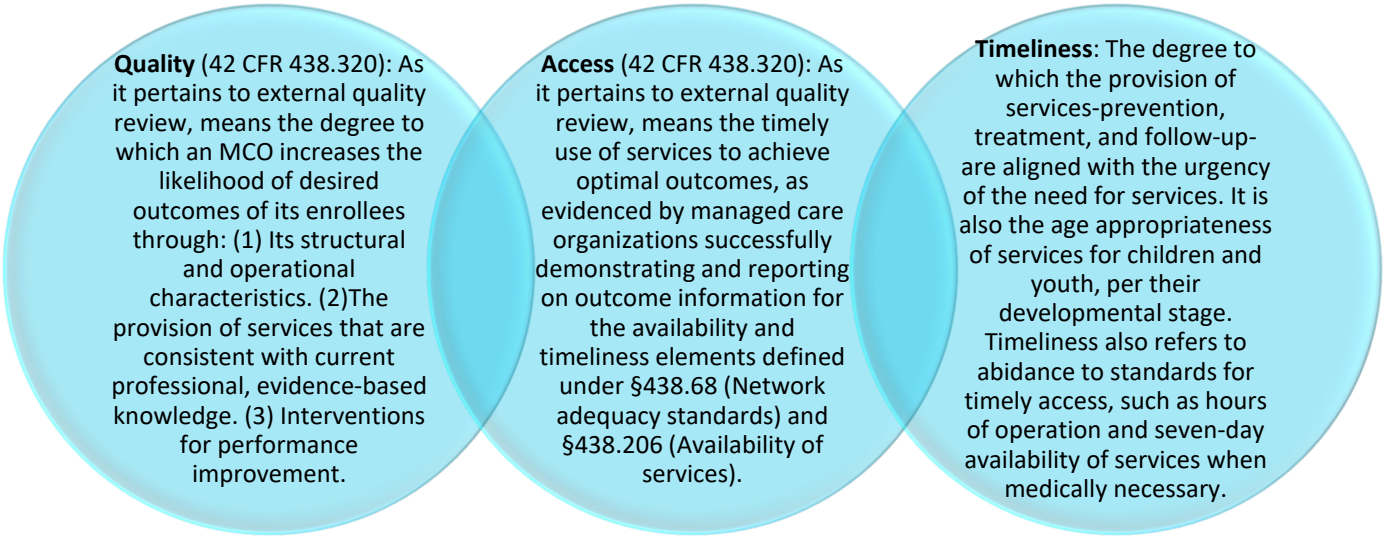


Figure 1-1. External Quality Review-A Federal Requirement

The EQR 2021 began in February and continued through August 2021. The site visits to the MCOs' offices were conducted remotely due to the Covid-19 Pandemic. The evaluation process included creating assessment tools, desk review of policies and procedures, documentations, observations, and interviews during the site meetings. Primaris provided Technical Assistance (TA) during the review period to help the three MCOs towards continuous improvement (Figure 1-2).

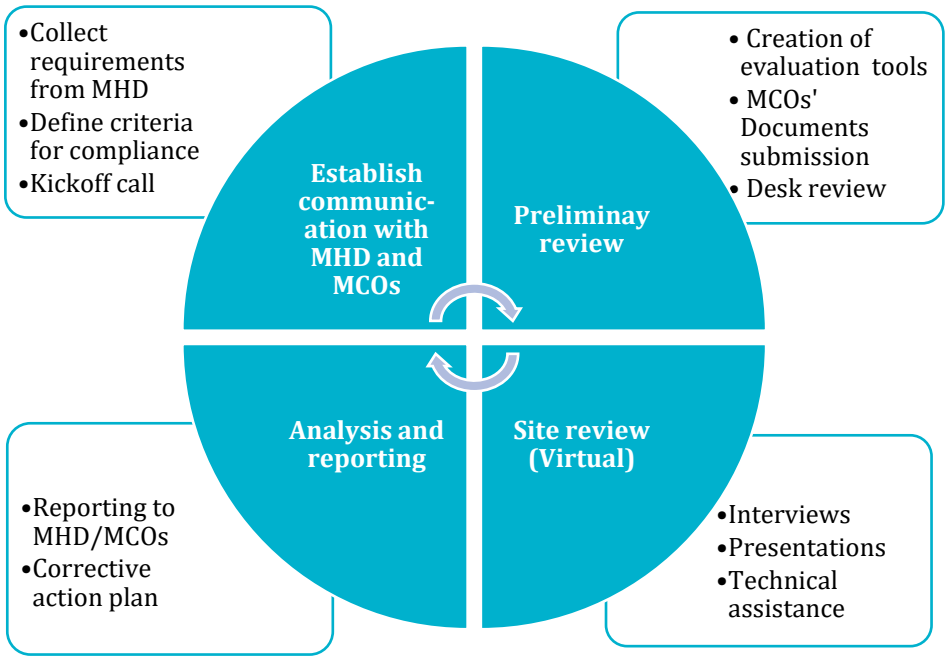


Figure 1-2 EQR Process

To comply with the federal requirements per 42 CFR 438.364, Primaris aggregated and analyzed the performance data for the following activities across the MCOs to prepare an Annual Technical Report.

Mandatory Activities:

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

Optional Activity: None.

1.3 Overall Activities, Comparative Results, and Recommendations

This section presents an overview of all the activities conducted in EQR 2021, comparative results for Home State Health, Healthy Blue, and UnitedHealthcare, and general recommendations. (Refer to sections 2.0 to 4.0 for details.)

1.3.1 Validation of Performance Improvement Projects

Primaris followed the guidelines established in the CMS EQR Protocol 1, version Oct 2019,

to validate the PIPs. For EQR 2021, the MHD required Primaris to validate the following two PIPs (clinical and nonclinical) conducted by Home State Health, Healthy Blue, and UnitedHealthcare during MY 2020. The MHD predetermined the overarching aim for the PIPs. The three MCOs were required to increase the HEDIS® rates by at least 2% points from the previous year (baseline-MY 2019):

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

Comparative Results. Table 1-2 and 1-3 summarize the clinical and the nonclinical PIPs across the three MCOs.

Table 1-2. PIPs Results: MCOs

PIP	MCO	MHD's Aim	Validation Rating	HEDIS® Rate % (MY 2019)	HEDIS® Rate % (MY 2020)	Statistical Significance (P≤0.05)
Improving HEDIS® CIS Combo 10 Rate	Home State Health	🔴	No Confidence	30.17	27.01	No (p=0.31)
	Healthy Blue	🟢	Low confidence	27.49	36.01	Yes (>95% confidence interval)
	UnitedHealthcare	🟢	Low confidence	25.06	36.25	Yes (p=0.0005)
Improving Oral Health (HEDIS® ADV Rate)	Home State Health	🔴	No Confidence	53.24	41.39	Yes (p<0.00001)
	Healthy Blue	🔴	No Confidence	58.87	44.18	Yes (>95% confidence interval)
	UnitedHealthcare	🔴	No Confidence	53.70	41.18	Yes (p=0)

Table 1-3. Summary of Clinical PIPs: MCOs

PIP Title: Improving Childhood Immunization Status-HEDIS® (CIS) Combo 10		
A. PIP Aim Statement		
Home State Health: Increase Home State Health's MY 2019 National Committee for Quality Assurance (NCQA) HEDIS® CIS Combo 10 rate by 2% by December 31, 2020.	**Healthy Blue:** Primary AIM Statement: To increase Healthy Blue's statewide HEDIS® MY 2019 CIS Combo 10 rate of 27.49% (by two percentage points) to 29.49% by HEDIS® MY 2020.	**UnitedHealthcare:** By December 31, 2020, increase the percentage of UnitedHealthcare members aged two and under who are eligible for and receive CIS Combo 10 vaccines from 25.06% to 27.06%.

	Secondary AIM Statement: To increase Mercy East's MY 2019 influenza vaccination rate of 17.86% (by two percentage points) to 19.86% for eligible members with gaps in care after the pilot program with Patient-Centered Care Consultants (PCCCs) and Mercy East by December 31, 2020.	
B. Improvement Strategies or Interventions (Changes tested in PIPs)		
Home State Health: Member-focused. Pacify application (app) vendor was contacted to enhance the robustness of push notifications through the app to remind new moms about the importance of immunizations. MCO-focused. Care managers were re-educated on addressing the importance of immunizations with new moms and offering the members to enroll on the app.	**Healthy Blue:** Provider-focused. Healthy Blue's PCCCs offered a targeted list of members needing influenza vaccines during MY 2020 flu season and reviewed CIS HEDIS® Technical Specifications with providers at Mercy East from October 1, 2020, to December 31, 2020.	**UnitedHealthcare:** Member-focused. The Pfizer Missed Dose Postcard reminder was mailed to the members who were not compliant with Pneumococcal Conjugate Vaccine (PCV13) and were under the age of 2 years old.
Sampling: No	Sampling: No	Sampling: No
C. Was the PIP State-mandated, collaborative, statewide, or plan choice? ☑ State-mandated (State required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☑ Statewide (the PIP was conducted by all MCOs within the State) ☐ Plan choice (State allowed the plan to identify the PIP topic)		
D. Target age group (check one): ☑ Children only (ages 0–17)* Adults only (age 18 and over) Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages (0-2)		
E. Target population description, such as duals, LTSS, or pregnant women (specify):		
Home State Health All members eligible for HEDIS® CIS Combo 10	**Healthy Blue:** The study population included all Healthy Blue	**UnitedHealthcare:** The primary measure study population included all

measure (ages 0-2) were included. A targeted Rapid Cycle improvement initiative for High-Risk pregnant mothers and their newborns was included in the PIP.	members two years of age in MY 2020 and had 12 months of continuous enrollment prior to their 2nd birthday. No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's 2nd birthday was allowed to be considered continuously enrolled. The study population also focused on the members who turned two years of age in MY 2020 and were assigned to PCPs at Mercy East who met the above criteria.	UnitedHealthcare members who were eligible based on the National Committee for Quality Assurance's (NCQA) HEDIS® CIS Combo 10 Technical Specifications. For the secondary measure, the study population consisted of 4,310 members who turned two years old in measurement year (MY) 2020 and were eligible based on NCQA's HEDIS® CIS Pneumococcal Conjugate Vaccine (PCV13) Technical Specifications.
F. Programs: Medicaid (Title XIX) only /CHIP (Title XXI) only/☑ Medicaid and CHIP		
G. PIPs Validation Information		
• PIP submitted for approval • PIPs validated	☑Home State Health ☑Primaris	☑Healthy Blue ☑Primaris	☑UnitedHealthcare ☑Primaris

Table 1-4. Summary of Nonclinical PIPs: MCOs

PIP Title: Improving Oral Health-HEDIS® Annual Dental Visit (ADV)		
A. PIP Aim Statement		
Home State Health: Increase Home State Health's calendar year 2019 NCQA HEDIS® Annual Dental Visit (ADV) rate by 2% by December 31, 2020.	**Healthy Blue:** Primary AIM Statement: To increase the Healthy Blue's statewide HEDIS® MY 2019 Annual Dental Rate (ADV) rate of 58.87% to 60.87% (by two percentage points), by HEDIS® MY 2020. Secondary AIM Statement: To increase Healthy Blue's monthly average of members completing an annual dental visit of 2.01% to 4.01% (by 2% points) in December 2020.	**UnitedHealthcare:** By December 31, 2020, increase the percentage of UnitedHealthcare members between ages 2–20 years old who are eligible for and receive an annual dental visit from 53.70% to 55.70%.

B. Improvement Strategies or Interventions (Changes tested in PIPs)		
Home State Health: Member-focused. Home State Health's vendor, AlphaPointe, outreached to the noncompliant members for the annual dental visit via phone calls. Provider-focused. Home State Health partnered on a member campaign with Affinia, FQHC in the St. Louis area that offered dental care.	**Healthy Blue:** Member-focused. Through a partnership with a dental vendor, DentaQuest, all eligible members in the State of Missouri were assigned a dental home, and a mailing was sent out in October 2020, notifying them of the dental home, educating, and encouraging them to receive dental services by Dec 2020.	**UnitedHealthcare:** Provider-focused. Provide Dental Care Opportunity Report (DCOR) to the top 20 Federally Qualified Healthcare Centers (FQHCs) with the highest volume of non-compliant members for the FQHCs to outreach non-compliant members identified in the report.
Sampling: No	Sampling: No	Sampling: No
C. Was the PIP State-mandated, collaborative, statewide, or plan choice? ☑ State-mandated (State required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☑ Statewide (the PIP was conducted by all MCOs within the State) ☐ Plan choice (State allowed the plan to identify the PIP topic)		
D. Target age group (check one): ☑ Children only (ages 0–17)* Adults only (age 18 and over) Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages (0-2)		
E. Target population description, such as duals, LTSS, or pregnant women (specify):		
Home State Health: The study population included all Home State Health members ages two through twenty who meet the HEDIS® eligibility requirements for the HEDIS® ADV measure. Home State Health also stated that their study population included members, two to nine years old, assigned to Affinia, a large Federally Qualified Health Center (FQHC), as their Primary Care Physician.	**Healthy Blue:** The study population follows NCQA HEDIS® Technical Specification guidelines, which includes all Healthy Blue members 2-20 years of age who had at least one dental visit during the measurement year and are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days. The study population also focuses on members eligible for the HEDIS® ADV Measure who received the DentaQuest Dental Home letter. Letters	**UnitedHealthcare:** The study population for the primary measure consisted of UnitedHealthcare members who were eligible based on NCQA's HEDIS® ADV Technical Specifications. The criteria specify Medicaid members aged 2-20 years as of 12/31/2020 who are continuously enrolled throughout the measurement year with no more than one gap in enrollment as the eligible population. The study population for the secondary measure consisted

	were sent to all eligible Healthy Blue members in the State of Missouri.	of 18,602 members who were attributed to one of the top 20 FQHCs with the highest number of non-compliant members for the ADV measure.
F. Programs: Medicaid (Title XIX) only /CHIP (Title XXI) only/☑ Medicaid and CHIP		
G. PIPs Validation Information		
• PIP submitted for approval • PIPs validated	☑Home State Health ☑Primaris	☑Healthy Blue ☑Primaris	☑UnitedHealthcare ☑Primaris

Recommendations. Home State Health, Healthy Blue, and UnitedHealthcare must refine their skills in developing and implementing approaches to affect change in their PIP methodology. The CMS EQR Protocol 1 and other resources from CMS, e.g., How-to Manual for Health Plans (July 2015)[2] must be used for guidance. The MCOs must clarify on the concepts of target population/project population/PIP variables and clearly define and apply these in the PIP. The PIP should have variables/secondary measures that can assess the performance of the PIP intervention based on Plan-Do-Study Act (PDSA) cycles. The data collection plan should be consistent with the data analysis plan, and intervention should tie to an improvement by correct analysis and interpretation. (Refer to section 2.5 for detailed recommendations for each MCO.)

1.3.2a Validation of Performance Measures

Federal regulations at 42 C.F.R. § 438.330(c) require states to specify standard performance measures for the MCOs to include in their comprehensive quality assessment and performance improvement (QAPI) programs. Primaris was required to determine whether the performance measures calculated by the MCOs were accurate based on the measure specifications and State reporting requirements (42 C.F.R. § 438.330(b)(2)). The MHD provided the list of performance measures to be validated, the specifications for the measures, and the requirements for reporting as identified in Table 1-5 below. Primaris' analysis of the performance measures was based on CMS EQR Protocol 2, version Oct 2019. The measurement period was Jan 1, 2020-Dec 31, 2020, and programs included were Medicaid (Title XIX) and CHIP (Title XXI).

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

Table 1-5. Performance Measures

Performance Measure	Methodology	Specifications Used	Validation Methodology
Inpatient Readmissions-Mental Health (MH), Substance Abuse (SA), and Medical (MED)	Administrative	MHD-Healthcare Quality Data (HQD) Instructions	Primary Source Verification
Well-Child Visits in the First 30 Months of Life (W30)	Administrative	HEDIS®	Primary Source Verification
Chlamydia Screening in Women (CHL)	Administrative	HEDIS®	Primary Source Verification

Comparative Results. Primaris conducted primary source verification using a sample of 45 numerator positive hits for all three measures for each MCO. All measures from the three MCOs were found to be compliant and received a 'Met' designation (Table 1-6).

Table 1-6. Key Review Findings and Audit Results: MCOs

Performance Measure	Sample Size	Key Review Finding (includes ISCA)	Audit Result
Inpatient Readmissions-Mental Health (MH), Substance Abuse (SA), and Medical (MED)	45 administrative numerator positives combined MH, SA, and MED Readmissions	No concerns were identified	Met/Reportable
Well-Child Visits in the First 30 Months of Life (W30)	45 administrative numerator positives	No concerns were identified	Met/Reportable
Chlamydia Screening in Women (CHL)	45 administrative numerator positives	No concerns were identified	Met/Reportable

Inpatient Readmissions-Mental Health (MH), Substance Abuse (SA), and Medical (MED)
The three MCOs provided numerator positive claims for a random sample selected by Primaris. During the virtual onsite review, Primaris validated both the numerator and denominator sets to ensure the original admission and the readmission were for the same or similar diagnosis and within the 30 days of the original admission. Primaris verified that the admissions/readmission met the denominator requirements for age stratifications and service dates. Additionally, Primaris reviewed the member's enrollment history and member months counts to ensure the member was enrolled in the Medicaid product line during both admissions. All three MCOs met the numerator and denominator requirements for inclusion in the three readmission measures. Results are captured in the Table 1-7. There were no significant differences found comparatively. UnitedHealthcare had the least

number of readmissions but also had the lowest membership overall. Home State Health had the most enrollment, followed by Healthy Blue. For this measure, lower counts indicate better performance.

Table 1-7. ***Inpatient Readmissions-Mental Health (MH), Substance Abuse (SA), and Medical (MED)***

Performance Measure: Inpatient Readmissions-Mental Health (MH)			
Definition of Denominator: The total number of Member Months for the designated year for the health plan's Behavioral Health-eligible members aged 0-65+ (HQD Instructions 1.07-1.10).			
Definition of Numerator: Count of readmissions for members aged 0-12 discharged from a mental health inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health or primary substance abuse diagnosis. The diagnosis does not need to be the same for both inpatient stays. Count the total number of readmissions and not the number of members who were readmitted (HQD Instructions 4.13-4.16) (HQD 4.13-4.16).			
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. Claims (99%) were paid within 90 days of receipt. No concerns were identified.			
Data Sources Used: Administrative Mental Health Claims.			
Measure Detail	**Home State Health**	**Healthy Blue**	**UnitedHealthcare**
Age 0-12 – Numerator	82	118	68
Age 0-12 – Denominator	1,568,150	1,519,337	1,225,123
Age 13-17 – Numerator	149	224	111
Age 13-17 – Denominator	481,027	484,999	407,388
Age 18-64 – Numerator	99	104	76
Age 18-64 – Denominator	489,336	474,233	470,909
Age 65+ - Numerator	0	0	0
Age 65+ - Denominator	54	77	52
Total – Numerator	330	446	255
Total - Denominator	2,538,567	2,478,646	2,103,472
Performance Measure: Inpatient Readmissions- Substance Abuse (SA)			
Definition of Denominator: The total number of Member Months for the designated year for the health plan's Behavioral Health-eligible members aged 0-65+ (HQD Instructions 1.07-1.10).			
Definition of Numerator: Count of readmissions for members aged 0-65+ discharged			

from a substance abuse inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health or primary substance abuse diagnosis. The diagnosis does not need to be the same for both inpatient stays. Count the total number of readmissions and not the members who were readmitted. (DQM Instructions 4.17-4.20)**.**
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. Claims (99%) were paid within 90 days of receipt. No concerns were identified.
Data Sources Used: Administrative Substance Abuse Claims.

Measure Detail	Home State Health	Healthy Blue	UnitedHealthcare
Age 0-12 – Numerator	0	0	0
Age 0-12 – Denominator	1,568,150	1,519,337	1,225,123
Age 13-17 – Numerator	4	4	1
Age 13-17 – Denominator	481,027	484,999	407,388
Age 18-64 – Numerator	35	23	8
Age 18-64 – Denominator	489,336	474,233	470,909
Age 65+ - Numerator	0	0	0
Age 65+ - Denominator	54	77	52
Total – Numerator	39	27	9
Total - Denominator	2,538,567	2,478,646	2,103,472

Performance Measure: Inpatient Readmissions-Medical (MED)
Definition of Denominator: The total number of Member Months for the designated year for the health plan's members aged 0-65+ (HDQ Instructions 1.02-1.05).
Definition of Numerator: Count of readmissions for members aged 0-65+ discharged from a medical inpatient stay and readmitted within 30 days with a primary medical diagnosis. The diagnosis does not need to be the same for both inpatient stays. Count the total number of readmissions and not the members who were readmitted (DQM Instructions 4.21-4.24) (HDQ Instructions 4.21-4.24).
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. Claims (99%) were paid within 90 days of receipt. No concerns were identified.
Data Sources Used: Administrative Medical Claims.

Measure Detail	Home State Health	Healthy Blue	UnitedHealthcare
Age 0-12 – Numerator	464	536	380
Age 0-12 – Denominator	1,670,240	1,616,326	1,300,020

Age 13-17 – Numerator	103	111	43
Age 13-17 – Denominator	534,828	533,828	445,268
Age 18-64 – Numerator	671	658	358
Age 18-64 – Denominator	503,938	487,528	481,387
Age 65+ - Numerator	0	0	0
Age 65+ - Denominator	8	77	52
Total – Numerator	1,238	1,305	781
Total - Denominator	2,709,006	2,637,759	2,226,727

Well Child Visits in the First 30 Months of Life (W30)

The three MCOs provided final rates for the W30 measure based on services rendered in MY 2020. Since this is a new HEDIS® measure, the previous year's comparison rates are not available to measure the performance improvement. All three MCOs scored similarly, with Healthy Blue having the highest rate for the first 15 months (51.92%) and 15-30 months (71.49%). Home State Health had the second-highest score for 15 months (47.69%) and 15-30 months (66.43%). UnitedHealthcare had the lowest rate for 15 months (46.55%) and 15-30 months (64.57%). None of the MCOs' rates were significantly different based on the 95% significance test. Numerators, denominators, and rates are presented in Table 1-8 below.

Table 1-8 Well-Child Visits in the First 30 Months of Life (W30)

Performance Measure: Well-Child Visits in the First 30 Months of Life (W30)
Definition of Denominator 1: Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days. **Definition of Denominator 2:** Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Definition of Numerator 1: Six or more well-child visits on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. **Definition of Numerator 2:** Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. Claims (99%) were paid within 90 days of receipt. No concerns were identified.
Data Sources Used: Administrative claims and supplemental data.

Measure Detail	Home State Health	Healthy Blue	UnitedHealthcare
First 15 Months Numerator	3,686	4,238	3,412
First 15 Months Denominator	7,729	8,163	7,330
First 15 Months Rate	**47.69%**	**51.92%**	**46.55%**
15 – 30 Months Numerator	3,806	3,571	2,943
15 – 30 Months Denominator	5,729	4,995	4,558
15 – 30 Months Rate	**66.43%**	**71.49%**	**64.57%**

Chlamydia Screening in Women (CHL).

All three MCOs reported CHL using the administrative methodology. Due to the COVID-19 pandemic, all MCOs were negatively affected by office closures. As a result, routine visits and screenings dropped significantly across the nation. Primaris verified that each MCO was impacted by the office closures and experienced a decline in routine visits over the previous year. Home State Health had the highest rate of 45.92%, followed by UnitedHealthcare (45.27%) and Health Blue (29.43%) (Table 1-9). The difference in rates between Home State Health and UnitedHealthcare was insignificant. However, Healthy Blue's performance continued to be significantly lower than both Home State Health and UnitedHealthcare (greater than 5% points difference in comparison).

Table 1-9 Chlamydia Screening in Women (CHL)

Performance Measure: Chlamydia Screening in Women (CHL)			
Definition of Denominator: Women 16–24 years as of December 31 of the measurement year. Total rate: The total is the sum of the age stratifications (16-20 years, 21-24 years).			
Definition of Numerator: At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.			
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. Claims (99%) were paid within 90 days of receipt. No concerns were identified.			
Data Sources Used: Administrative claims and supplemental data.			
Measure Detail	**Home State Health**	**Healthy Blue**	**UnitedHealthcare**
Numerator	4,314	2,708	3,727
Denominator	9,395	9,195	8,232
Rate	**45.92%**	**29.43%**	**45.27%**

Recommendations. The following general recommendations are provided for Home

State Health, Healthy Blue, and UnitedHealthcare for improving their performances. (Refer to section 3.5 for specific recommendations.)

- The MCOs utilize telehealth services for their members. Telehealth services will eliminate the need for members to travel and perhaps eliminate any fears of being exposed during the Covid-19 pandemic.
- The MCOs send reminders to members with children for well-child visits. The MCOs should assist members with scheduling or rescheduling well-child visits.
- The MCOs discuss chlamydia screening protocol with all primary care providers. Sexually active members should be offered chlamydia screenings at the time of the visit.
- The MCOs utilize all viable supplemental data sources to enhance rates for chlamydia screening and well-child visits.
- The MCOs continue to reduce readmissions for all diagnoses by ensuring transitions of care are coordinated with the primary care providers.

1.3.2b Information System Capabilities Assessment

Primaris conducts ISCA pertaining to the validation of performance measures every year. Any change reported by Home State Health, Healthy Blue, and UnitedHealthcare that could impact information systems and related performance measure outcomes is evaluated each year. Primaris followed CMS EQR protocols, Appendix A-Information Systems Capabilities Assessment, for guidance. Data collection, review, and analysis were conducted for each criterion via the ISCA data collection tools, interview responses, security walk-throughs, and claim/encounter data lifecycle demonstrations.

Comparative Results. None of the MCOs reported having significant changes to their information systems capabilities during the measurement year (Table 1-10). However, minor enhancements were made, which were within the scope of the regular system maintenance schedule. Maintenance items included updates to the medical codes provided quarterly and annually (CPT-4, HCPCs, ICD-10).

Table 1-10. ISCA Findings: MCOs

Criteria	Home State Health	Healthy Blue	UnitedHealthcare
Data Integration	●	●	●
Data Control	●	●	●
Medical Service Data (Claims and Encounters)	●	●	●
Enrollment Data	●	●	●

Provider Data	●	●	●
Supplemental Data	●	●	●

● Met/● Not Met

Operationally, all the MCOs enhanced their remote access to allow staff to work continuously during the Covid-19 pandemic in MY 2019-MY 2020.

All MCOs reported that system backups and recoveries were not compromised during the measurement year. None of the MCOs reported having a disaster that required data restoration or recovery. System backups were done daily and nightly with full backups of data weekly. All MCOs had redundancy systems that would allow restoration of critical data within two hours.

While Healthy Blue acquired Missouri Care in MY 2020, it utilized Missouri Care's information systems and processes. There were no system changes from the previous year. Healthy Blue will fully integrate the former Missouri Care into its systems during MY 2021 and will experience significant changes in the next review.

Recommendations. There were no weaknesses identified. However, Primaris recommends the following for further improvement to all the MCOs:

- All MCOs continue to routinely maintain/enhance system capabilities where efficiencies can be made.
- All MCOs review and enhance their security measures to ensure remote access is not compromised. Regular testing of the security should be conducted throughout the year.
- All MCOs regularly test for disasters and ensure data are secured offsite in case of emergencies.

1.3.3 Review of Compliance with Medicaid and CHIP Managed Care Regulations

The Code of Federal Regulations (CFR) 438.358(b)(iii) requires a review to be conducted within a previous 3-year period to determine the MCO's compliance with standards set forth in subpart D of 42 CFR 438 and subpart E, 438.330. Primaris conducted a review based on the CMS EQR Protocol 3, version Oct 2019. The EQR 2021 was the first year of the current three-year cycle (2021-2023). Six regulations that included 82 criteria/sections were evaluated. Each criterion was scored as Fully Met (2 points), Partially Met (1 point), or Not Met (0 points). Primaris initiated a corrective action plan (CAP) for "Partially Met/Not Met" criteria for all the three MCOs. These will be re-evaluated within 90 days of approval of the CAP by the MHD.

Comparative Results. Table 1-11 describes the compliance score obtained by the three MCOs in the current year (EQR 2021) and the previous two EQRs (2020-2019).

Table 1-11. Compliance Score (EQR 2021-2020-2019): MCOs

42 CFR 438 Medicaid	42 CFR 457 CHIP	Regulation	Home State Health Score %	Healthy Blue Score %	United Health care Score%	Year of Last Review
438.56	457.1212	Disenrollment: Requirements and limitations	94.4	86.1	100	EQR 2021
438.100	457.1220	Enrollee rights	77.8	72.2	86.1	EQR 2021
438.114	457.1228	Emergency and post-stabilization services	100	95.8	95.8	EQR 2021
438.230	457.1233b	Subcontractual relationships and delegation	91.7	91.7	83.3	EQR 2021
438.236	457.1233c	Practice guidelines	100	100	100	EQR 2021
438.242	457.1233d	Health information systems	93.8	65.6	56.3	EQR 2021
438.330	457.1240b	Quality assessment and performance improvement program	87.9	98.5	96.9	EQR 2020
438.206	457.1230a	Availability of services	100	100	100	EQR 2019
438.207	457.1230b	Assurances of adequate capacity and services	100	100	100	EQR 2019
438.208	457.1230c	Coordination and continuity of care	100	100	100	EQR 2019
438.210	457.1230d	Coverage and authorization of services	100	100	95.5	EQR 2019
438.214	457.1233a	Provider selection	100	100	100	EQR 2019
438.224	457.1110	Confidentiality	100	76	100	EQR 2019
438.228	457.1260	Grievance and appeal system	100	100	100	EQR 2019

Compliance Score % = (Total Score x 100)/(Total Sections x 2)

Table 1-12 is a summary of noncompliance status of the three MCOs during EQR 2021 and the previous EQRs.

Table 1-12. Noncompliance Status: MCOs

Current EQR Cycle	Home State Health	Healthy Blue	UnitedHealthcare
EQR 2021	CAP initiated. Partially Met-12 Criteria. Not Met-1 criterion.	CAP initiated. Partially Met-23 Criteria. Not Met-3 criteria.	CAP initiated. Partially Met-18 Criteria. Not Met-3 criteria.
Re-Review	To be reported in the EQR 2022.	To be reported in the EQR 2022.	To be reported in the EQR 2022.
Previous EQR Cycle (2018-2020) Follow Up			
EQR 2020	No CAP. Partially Met-8 criteria.	No CAP. Partially Met-1 criterion.	No CAP. Partially Met-2 criteria.
Re-Review	Followed up in EQR 2021. Five of eight Partially Met criteria were not yet compliant.	Followed up in EQR 2021. The partially Met criterion was not yet compliant.	Followed up in EQR 2021. Both Partially Met criteria were compliant.
EQR 2019 Re-Review	NA. All criteria were complaint	Followed up in EQR 2020. Partially Met-3 criteria are not yet compliant	NA. All criteria were complaint
Follow Up	NA	Again, followed up in EQR 2021. Partially Met criteria-1 of 3 is not yet complaint.	NA

Legends:

Fully Met	Partially Met	Not Met	Not Applicable NA

Recommendations. Home State Health, Healthy Blue, and UnitedHealthcare must submit documentation to comply with all the "Partially Met" and "Not Met" criteria from EQR 2021 and previous EQRs within 90 days of approval of the CAP from the MHD. The MCOs must develop policies and procedures for all the regulations covered for the compliance review proactively. Their documentation should be updated based on the Medicaid and CHIP Final Rule 2020. (Refer to section 4.2 for detailed recommendations for each MCO.)

2.0 Validation of Performance Improvement Projects

2.1 Description, Objective, and Methodology

A PIP is a project conducted by an MCO designed to achieve significant improvement sustained over time in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, or MCO/system level. A statewide performance improvement project (PIP) is defined as a cooperative quality improvement effort by the MCO, the MHD, and the EQRO to address clinical or nonclinical topic areas relevant to the managed care program. (Ref: MHD managed care contract 2.18.8(d)(2)). The PIPs should be completed in a reasonable period to generally allow information on the success of the PIPs in the aggregate to produce new information on the quality of care every year. According to 42 Code of Federal Regulations (CFR) 438.330(d), PIP shall involve the following:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

In EQR 2021, the MHD required Primaris to validate two PIPs conducted by Home State Health, Healthy Blue, and UnitedHealthcare during MY 2020:

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

The MHD Contract, section 2.18.8(d), requires the MCOs to increase HEDIS® CIS Combo 10 and HEDIS® ADV rates each year by at least 2% points in alignment with the Quality Improvement Strategy. The MHD set the overarching aim for the PIPs. Vaccines and recommended doses in HEDIS® CIS Combo 10 include: DTaP (4); IPV (3); MMR (1); HiB (3); HepB (3); VZV (1); PCV (4); HepA (1); RV (2/3); and Flu (2).

Primaris used the MHD managed care contract requirements and confirmed the scope of work with the MHD. Primaris followed guidelines established by the CMS EQR Protocol 1, version Oct 2019: Validation of Performance Improvement Projects. The review period for validation of the PIPs was June-August 2021. Primaris evaluated all steps of PIP activities (Figure 2-1) and reported in the worksheets provided in protocol 1. (Note: Worksheets were submitted to the MHD and are included in the annual technical report.)

Primaris obtained information from Home State Health, Healthy Blue, and UnitedHealthcare through:

Documents submission: Primaris requested the MCOs to submit their PIPs at Primaris' web-based secure file storage site (AWS S3 SOC-2).
Interview: Primaris conducted virtual meetings with Home State Health, Healthy Blue, and UnitedHealthcare officials on July 27, July 28, and July 30, 2021, respectively, to understand their concept, approach/methodology adopted, interventions, and results.
Reference to the CMS' PIPs: A How-To Manual for Health Plans (July 2015)[3], EQR protocol, Institute for Healthcare Improvement's (IHI) Model of Improvement and Plan-Do-Study-Act (PDSA) cycles-as an approach for PIPs was emphasized. Primaris provided feedback/technical assistance on the PIPs for the areas requiring improvement in the future, and submission of additional information, if any, was discussed.

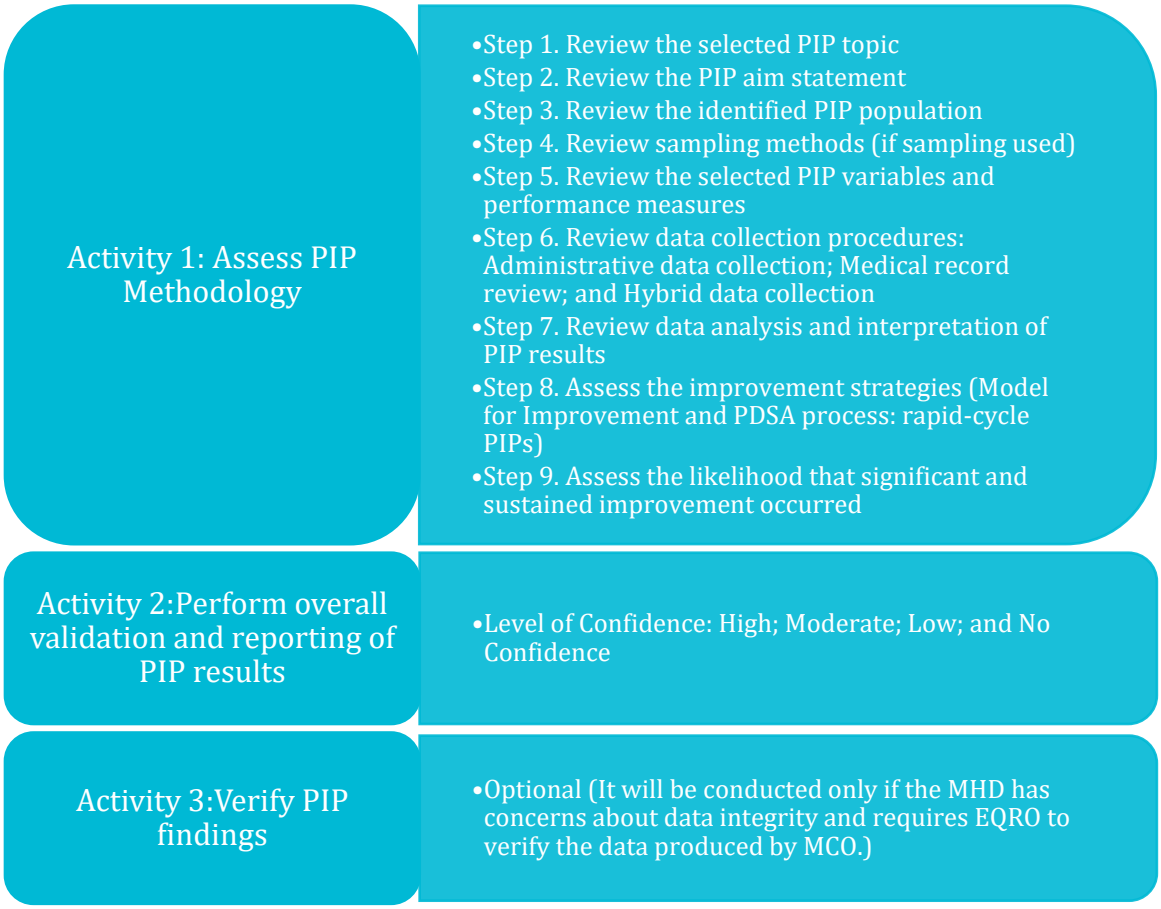


Figure 2-1. PIP Activities

Primaris assessed the overall validity and reliability of the PIP methods and findings to determine whether it has confidence in the results. The validation rating is based on the EQRO's assessment of whether the MCOs adhered to an acceptable methodology for all

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

phases of design and data collection, conducted accurate data analysis and interpretation of the PIP results, and produced significant evidence of improvement (statistically significant change in performance is noted when p-value ≤ 0.05).
The level of confidence is defined as follows:

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

2.2 Findings, Analysis, and Conclusions: Home State Health

(A) Clinical PIP: Improving Childhood Immunization Status

PIP Description from Home State Health

This report section briefly describes the PIP design, intervention(s), and results submitted by Home State Health.
Intervention: Home State Health utilized Pacify app for the pregnant population that started in September 2018. Pacify is a pregnancy support app that members can download on their phones. A member must interact with a care management staff to access the app to obtain an access code. Enrollment in care management is not required. The app provides live support with a Lactation Consultant, a direct line to our care management team, a direct link to the 24 Hour Nurse Advice Line, healthy pregnancy education postings, and push notifications for healthcare reminders, including well-child visits and immunization reminders. The app is available to pregnant members during pregnancy and after delivery up to the child's first birthday.
In Quarter 1-2020, the senior director of care management coordinated her training resources to develop a re-training for the nurses on the importance of educating members about childhood immunization. At the same time, a re-education was provided on offering members the Pacify app and how to enroll members on the app.

Performance Measures/variables: HEDIS® CIS Combo 10 was the performance measure selected for the PIP. The calculations were based on the NCQA HEDIS® Technical Specification definitions for numerator and denominator. Home State Health stated that they focused on sub measures-Measles, Mumps, Rubella (MMR), and Hepatitis A.

Data Collection (Administrative): Data was reported through Home State Health's NCQA certified HEDIS® software, QSI-XL. Input to QSI-XL was from various sources (claims, supplemental data (ShowMeVax portal), charts in the form of paper copies or Electronic Health Records) and provider types (primary care providers, specialty care providers, and ancillary providers).

Findings: The data was divided into four categories:

- New moms who were utilizing the Pacify app and also enrolled in care management.
- New moms who were enrolled in care management but not using the Pacify app.
- New moms who were utilizing the Pacify app but not enrolled in care management.
- New moms who had neither the Pacify app nor were enrolled in care management.

Figures 2-2 and 2-3 show the outcomes from Home State Health's NCQA certified HEDIS® software, QSI-XL.

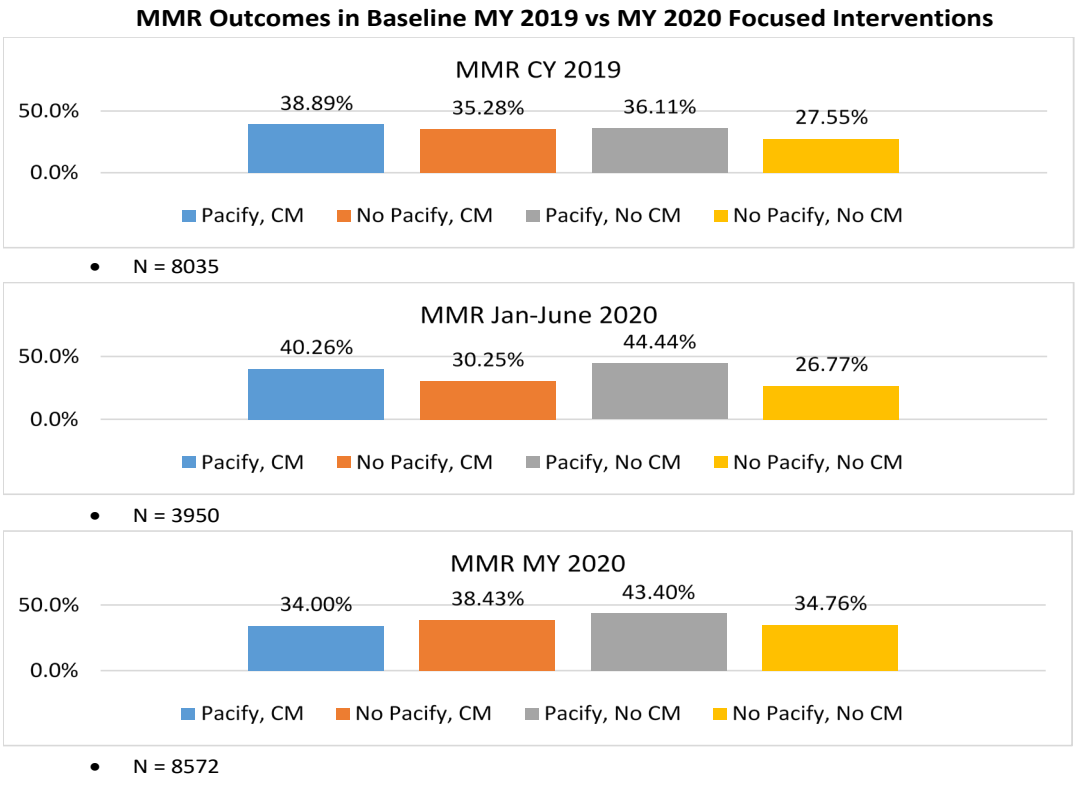
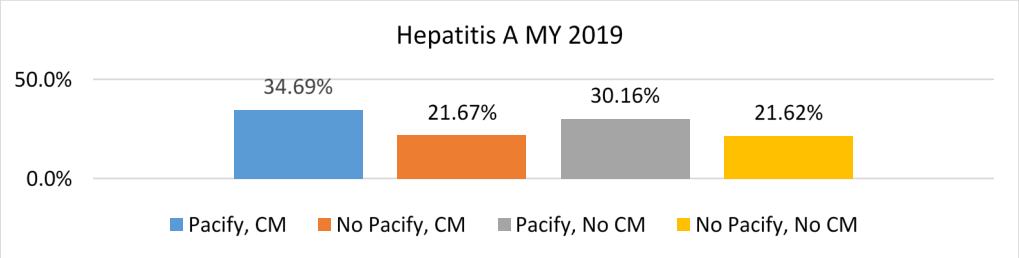
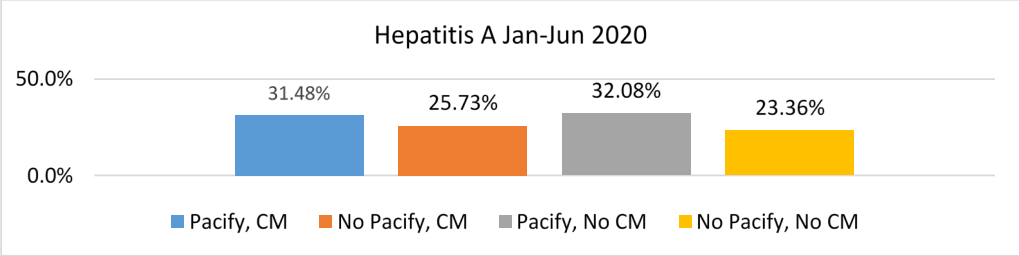


Figure 2-2. MMR Vaccination Rates MY 2019-MY 2020

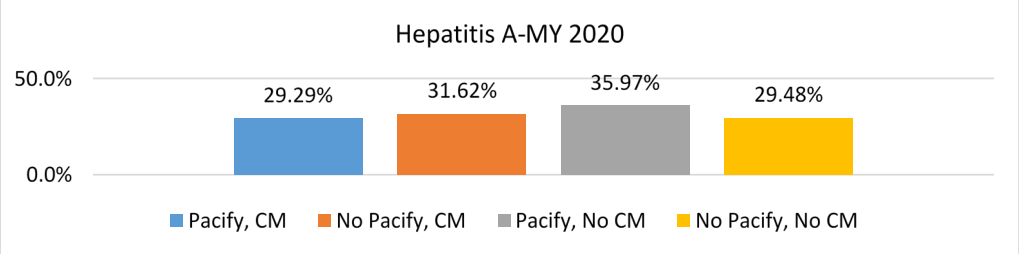
Hepatitis A Vaccination Outcomes in Baseline MY 2019 vs MY 2020 Focused Interventions



- N= 8035



- N = 3950



- N = 8572

Figure 2-3. Hepatitis A Vaccination Rates MY 2019-MY 2020

Table 2-1. Monthly Statewide HEDIS® CIS Combo 10 Rates*

Month	Month Over Month CIS Combo 10 Rates							
	CY2019				CY2020			
	Denom	Numer	Rate	Percentile	Denom	Numer	Rate	Percentile**
January	6981	885	12.68%	<5th	5365	829	15.45%	<5th
February	6902	1008	14.60%	<5th	5419	905	16.70%	<5th
March	6751	1060	15.70%	<5th	5085	939	18.47%	<5th
April	6594	1121	17.00%	<5th	5094	995	19.53%	<5th
May	6460	1203	18.62%	<5th	5093	1031	20.24%	<5th
June	6318	1259	19.93%	5th	5085	1085	21.34%	<5th
July	6266	1274	20.33%	5th	4847	1047	21.60%	<5th
August	6269	1290	20.58%	5th	5051	1122	22.21%	<5th
September	6107	1275	20.88%	5th	5057	1131	22.37%	<5th
October	6068	1271	20.95%	5th	5046	1144	22.67%	<5th
November	6051	1292	21.35%	5th	5044	1147	22.74%	<5th
December	5928	1291	21.78%	5th	5044	1151	22.82%	<5th
Final Admin	5928	1291	21.78%	5th	5044	1161	23.02%	<5th

*These are administrative rates. See Table 2-2 for final hybrid rates.

PIP Result

The aim of the PIP is not met. Home State Health's statewide rate for HEDIS® CIS Combo 10 decreased from 30.17% (MY 2019) to 27.01% (MY 2020), which is a decline of 3.16% points (Table 2-2). However, the decline is not of statistical significance, p value=0.31732 (p≤0.05 is significant).

Table 2-2. Statewide HEDIS® CIS Combo 10 Trend (MY 2018-2020)

Measurement Year (MY)	HEDIS® CIS Combo 10 Rate (%)	NCQA Quality Compass 50th Percentile
MY 2018	21.65	35.28%
MY 2019	30.17	34.79%
MY 2020	27.01	37.47%

(B) Nonclinical PIP: Improving Oral Healthcare

PIP Description from Home State Health

This report section briefly describes the PIP design, intervention(s), and results submitted by Home State Health.
Interventions:
1. Statewide: AlphaPointe is a sheltered workshop in the Kansas City area that performs various outreach campaigns to Home State Health members to understand their benefit, schedule health care appointments, and perform screening. Home State contacted AlphaPointe to request a targeted outbound call campaign for noncompliant members' annual dental visits. AlphaPointe was asked to provide members with information on the member incentive and transportation benefit during any phone call to speak with a member. AlphaPointe began making dental outreach calls in October 2020.

2. In Quarter 3-2020, Home State Health collaborated with Affinia Healthcare, a large FQHC with three locations in the St. Louis area which offers dental care, to focus on dental interventions in the St. Louis area. The goal of this partnership was to increase the rate of compliance on the ADV measure for Home State Health members, 2 to 9 years old, who were assigned to Affinia as their Primary Care Physician.

The following actions were taken:

- Demographic information was exchanged between Affinia and Home State Health to determine the most recent demographic information on file to locate Home State Health members better.
- Home State Health sent dental text reminder/education messages to members

assigned to Affinia as their PCP who were noncompliant with their dental visit.
- Affinia sent dental text reminder/education messages to their assigned members who were noncompliant with their dental visit.
- Affinia provided re-education to their frontline staff and scheduling team to remind them to address dental appointments and benefits information with members.
- Home State supplied additional brochures, including information on member incentives and transportation for the Affinia staff to reference and give to its members.
- Home State Health donated personal protective equipment (PPE) to Affinia for their staff and members.

Performance Measures/variables: HEDIS® ADV was the performance measure selected for the PIP. The calculations were based on the NCQA HEDIS® Technical Specification definitions for numerator and denominator.

Data Collection: Data was reported through Home State Health's NCQA certified HEDIS® software, QSI-XL. Input to QSI-XL was from various sources (claims, supplemental data, charts in paper copies, or Electronic Health Records) and provider types, including dentists and dental practitioners.

Findings: Intervention 1-Home State Health reported that AlphaPointe called 51,007 members and was able to speak with 5,259 (10.31%) members about dental visits and benefits information. Of the 5,259 members they spoke with, 41.41% had dental visits the following month (Table 2-3). This rate is higher than the 10.97% success rate achieved after AlphaPointe performed outreach to members in MY 2019 for well-visits (Table 2-4).

Table 2-3. AlphaPointe 2020 outreach metrics to members for Annual Dental Visit reminders

MY 2020 Month	Members Outreached During Initiative Month	Successful Outreach Rates	Percentage of Successful Outreach Members Who Became Compliant in Following Month
October	20,834	10.00% (2095/20834)	38.52% (807/2095)
November	13,435	9.65% (1297/13435)	44.56% (578/1297)
December	16,738	11.15% (1867/16738)	42.47% (793/1867)
Total	**51,007**	**10.31% (5259/51007)**	**41.41% (2178/5259)**

Table 2-4. AlphaPointe 2019 outreach metrics to members for Annual Dental Visit reminders

MY 2019 Month	Members Outreached During Initiative Month	Successful Outreach Rates	Percentage of Successful Outreach Members Who Became Compliant in Following Month
January	15658	6.07% (950/15658)	7.26% (69/950)
November	12932	9.92% (1283/12932)	13.02% (167/1283)
December	12416	8.06% (1001/12416)	11.89% (119/1001)
Total	**41006**	**7.89% (3234/41006)**	**10.97% (355/3234)**

Intervention 2-The noncompliant member count at the beginning of the initiative was 1045. The collaboration between Affinia and Home State Health resulted in 21% ADV visit compliance (Table 2-5).

Table 2-5. ADV closure rates during Affinia and Home State Health Collaboration

Month-MY 2020	Noncompliant member count
July	947
August	905
September	862
October	825

Home State Health stated that the rates decreased from April 2020 onwards compared to the corresponding month in MY 2019 (Table 2-6). This data indicated the impact of the Covid-19 Pandemic when the multiple facility and organization shut-down began starting in Mid-March 2020. Many dental offices chose to close entirely except for emergency dental needs. During the clinical teams' analysis of the data, it was found that 536 members were compliant with ADV via telehealth. In MY 2020, NCQA updated the ADV Technical Specifications to include telehealth visits in response to the pandemic.

Table 2-6. Monthly Statewide HEDIS® ADV Rates*

Month	MY 2019			MY 2020		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
January	187985	3470	1.85%	167006	2494	1.49%
February	185836	15414	8.29%	168632	16808	9.97%
March	179930	25565	14.21%	157359	24044	15.28%
April	170957	39096	22.87%	157211	29575	18.81%
May	163943	44121	26.91%	156891	30637	19.53%

June	156867	50888	32.44%	156320	32981	21.10%
July	153970	54381	35.32%	150042	37622	25.07%
August	154460	60901	39.43%	155190	43737	28.18%
September	137753	59503	43.20%	154599	47948	31.01%
October	133219	62323	46.78%	153749	48458	31.52%
November	129532	63878	49.31%	153310	54680	35.67%
December	129532	63877	49.31%	152809	59816	39.14%

See Table 2-7 for final administrative rates.

PIP Result

The aim of the PIP was not met. Home State Health's statewide rate for HEDIS® ADV rate decreased from 53.24% (MY 2019) to 41.39% (MY 2020), which is a decline of 11.85% points (Table 2-7). The change in performance is of statistical significance, p value<0.00001 (p≤0.05 is significant).

Table 2-7. Statewide HEDIS® ADV Trend (MY 2018-2020)

Measurement Year (MY)	HEDIS® ADV Rate (%)	NCQA Quality Compass 50th Percentile (%)
MY 2018	47.82	56.60%
MY 2019	53.24	58.03%
MY 2020	41.39	60.15%

2.2.1 Quality, Timeliness, and Access

PIPs Score. Primaris assigned a score of "No Confidence" for both clinical and nonclinical PIPs. The aim of the PIP was not met. The quality improvement process and intervention were poorly executed and could not be linked with the results.
Both the PIPs did not meet all the required guidelines stated in the CFR/MHD contract (42 CFR 438.330(d)(2)/MHD contract, 2.18.8(d)(1) (Table 2-8). Note: Definitions of Met/Partially Met/Not Met are based on the CMS EQR Protocol 3.

Table 2-8. PIPs' Evaluation based on the CFR guidelines

CFR Guidelines	Evaluation
Measurement of performance using objective quality indicators	Partially Met
Implementation of system interventions to achieve improvement in quality	Partially Met

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

Strengths and Weaknesses. Table 2-9 summarizes the strengths and weaknesses identified during the evaluation of the PIPs.

Table 2-9. Strengths and Weaknesses of PIPs

Evaluation Criteria	Strength	Weakness
1. Selection of PIP topic (the MHD provided the topic, hence marked as Not/Applicable-N/A)	N/A	N/A
2. Writing an Aim statement		The aim statement was incomplete. It did not specify the population and the strategy.
3. Identifying the study population		Home State Health lacks clarity on what constitutes the target population and the project population. As a result, multiple statements about the study population were provided.
4. Sampling	N/A	N/A
5. Variables/performance measures (the MHD decided the primary measure)	All charts manually uploaded in the Home State Health's NCQA certified HEDIS® software, QSI-XL, are over-read by team members who have completed and passed Inter-Rater Reliability training for CIS compliance requirements; these charts are also part of random audits to ensure compliance. Results of member satisfaction regarding the utilization of Pacify app were presented in the	The PIP variables were not selected. For the clinical PIP, MMR vaccination rate and Hepatitis A vaccination rate were selected as sub measures even though the intervention was not specific to these measures.

	clinical PIP.	
6. Data collection		The data collection plan did not include all the information about data to be collected as a result of the PIP (primary measure, sub-measure/secondary measure, variable, interventional data) and accurate definitions of data elements. The data collection plan was not linked to the data analysis plan.
7. Data analysis and interpretation of results		A baseline rate before the start of an intervention followed by at least two remeasurements was not presented. PDSA cycles were not implemented.
8. Improvement strategies		The PIP did not provide information on whether the improvement strategies selected for the PIPs were evidence-based and the test of change that would likely lead to the desired improvement in process or outcomes.
9. Significant and sustained improvement		There was no improvement in primary or secondary measures in the clinical PIP. For the nonclinical PIP, the primary measure declined, and insufficient data were reported after the intervention to determine the intervention's effectiveness.

2.2.2 Improvement from previous year

For the MY 2020, the statewide rates for HEDIS® CIS Combo 10 decreased by 3.16% points, and HEDIS® ADV decreased by 11.85% points from the previous year (MY 2019). Table 2-10 shows Home State Health's response to the previous year's (EQR 2020)

recommendations by EQRO and noncompliant items from EQR 2019.

Table 2-10. Home State Health's Response to Previous Year's Recommendations

Previous Recommendation	Action by Home State Health	Comment by EQRO
EQR 2020		
1. While several/ongoing interventions from previous years are very informative, Home State Health should present the interventions applied for the PIPs rather than for statewide or corporate-wide operations.	Home State Health improved to some extent by excluding several ongoing interventions from the previous years and focused on the interventions for the PIPs in MY 2020.	The same recommendation applies to EQR 2021. Home State Health should focus on the steps involved in the PIP methodology.
2. Even though the MHD mandates an overarching goal, Home State Health has the flexibility to select a topic within specified parameters. To ensure a successful PIP, Home State Health should find early and regular opportunities to obtain input from staff, providers, and members on improving care delivery.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
3. Home State Health should translate the aim statement to identify the focus of the PIP and establish the framework for data collection and analysis on a small scale (PDSA cycle). PIP population should be selected from a county, provider office, or a region so that results can be measured during the PDSA cycle and subsequently applied on a larger scale.	There was some improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020. One of the interventions in nonclinical PIP was on a small scale (one FQHC).	The same recommendation applies to EQR 2021.
4. Home State Health should select a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) that could identify Home State Health's performance on the PIPs and track improvement over time. Home State Health can use focus	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.

groups, surveys, and interviews to collect qualitative insights from members, MCO and provider staff, and key external partners. Qualitative measures can serve as secondary or supplement the overall measurement set, providing information to aid PIP planning and implementation.		
5. Home State Health should use variables/secondary measures that should tie an intervention to improvement. Clear and concise definitions of data elements (including numerical definitions and units of measure) should be provided for the data collected after the intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
6. Data collection plan should be linked to the data analysis plan to ensure that appropriate data would be available for the PIP.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
7. A baseline rate should be presented before the start of an intervention followed by at least two remeasurements, and analysis of results should be utilized to plan the next intervention (cycle-PDSA) for future PIP. Additionally, primary and secondary measures/variables should be linked to illustrate the impact of the intervention on a project's performance.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
8. Home State Health should assess whether the PIP resulted in sustained improvement, whether repeated measurements were conducted, and if so, whether a significant change in performance relative to baseline measurement was observed. Repeat measurements	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.

(at least two) in short intervals should be conducted to determine whether significant performance changes relative to baseline measurement were observed.		
9. Effectiveness of the improvement strategy should be determined by measuring a change in performance according to the predefined measures and linking to intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
10. When analyzing multiple data points over time, Home State Health should consider tools such as time series, run chart, control chart, data dashboard, and basic trend analyses.	There was no improvement towards the utilization of such tools in EQR 2021 compared to EQR 2020.	Home State Health should use these tools for the PIPs in the future to show the intervention results.
EQR 2019		
1. Home State Health should follow CMS EQR protocol and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015 for guidance on methodology and approach of PIPs to obtain meaningful results.	There was no improvement in the methodology of PIP in EQR 2021 and EQR 2020.	The same recommendation applies to EQR 2021.
2. Home State Health must refine its skills in the development and implementation of approaches to effect change in the PIPs.	There was no improvement in the methodology of PIP in EQR 2021 and EQR 2020.	The same recommendation applies to EQR 2021.
3. The interventions should be planned specifically for the PIP required by the MHD contract.	Data from operations are reported in the PIP.	The same recommendation applies to EQR 2021.
4. The results should be tied to the interventions.	There was no improvement in the methodology of PIP in EQR 2021 and EQR 2020.	The same recommendation applies to EQR 2021.

2.3 Findings, Analysis, and Conclusions: Healthy Blue

(A) Clinical PIP: Improving Childhood Immunization Status

PIP Description from Healthy Blue

This section of the report briefly describes the PIP design, intervention(s), and results submitted by Healthy Blue.
Intervention: Healthy Blue's PCCC's piloted a program with providers at Mercy East by offering education, as well as a targeted list of members needing influenza vaccine during 2020 flu season starting October 1, 2020, to December 31, 2020.

Performance Measures/variables: HEDIS® CIS Combo 10 statewide was the primary measure. The influenza vaccination rate for Mercy East was used as a secondary measure. Additionally, HEDIS® CIS Combo 10 rate for Mercy East was also tracked to see the impact of the intervention.
The Mercy East's influenza vaccination rate was defined as follows:

Numerator: Members who received an influenza vaccination from October 1, 2020, to December 31, 2020.
Denominator: Members who needed an influenza vaccination on or after October 1, 2020, to December 31, 2020.

The Mercy East's CIS Combo 10 rate was defined as follows:

Numerator: Total number of compliant CIS Combo-10 members assigned to Mercy East providers.
Denominator: Total number of eligible CIS Combo-10 members assigned to Mercy East providers.

Data Collection: Healthy Blue utilized Inovalon, a National Committee for Quality Assurance (NCQA)-certified vendor, to collect the administrative data for HEDIS® CIS measure according to the HEDIS® Technical Specifications. Claims, encounter data, and the State's immunization registry were utilized for data sources. The final statewide HEDIS® rate also includes hybrid data from HEDIS® medical record review. Healthy Blue monitored monthly influenza vaccination rates from claims/encounter data and monthly HEDIS® CIS Combo 10 Rates for Mercy East.

Findings: Figure 2-4 shows monthly influenza vaccination rates for children below two years old during the intervention period. Healthy Blue reported that Mercy East's annual influenza vaccination rate increased from 17.86% (baseline rate-MY 2019) to 21.05% (final rate-MY 2020) by 3.19% points. Furthermore, this large provider group experienced an

increase in their CIS Combo 10 rate by 2.91% points from the prior year (statistically insignificant) (Figure 2-5).

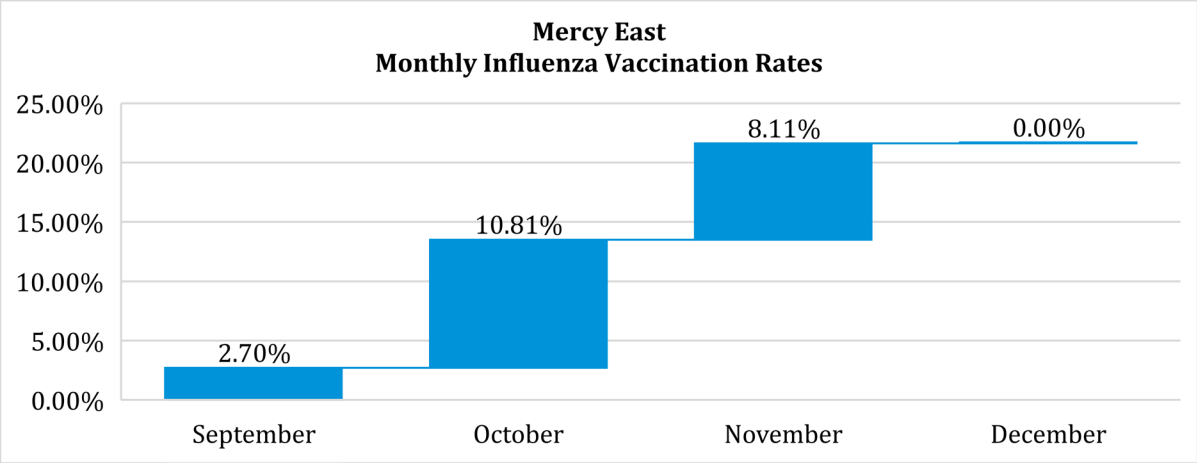


Figure 2-4. Mercy East Influenza Vaccination Rates October-December 2020

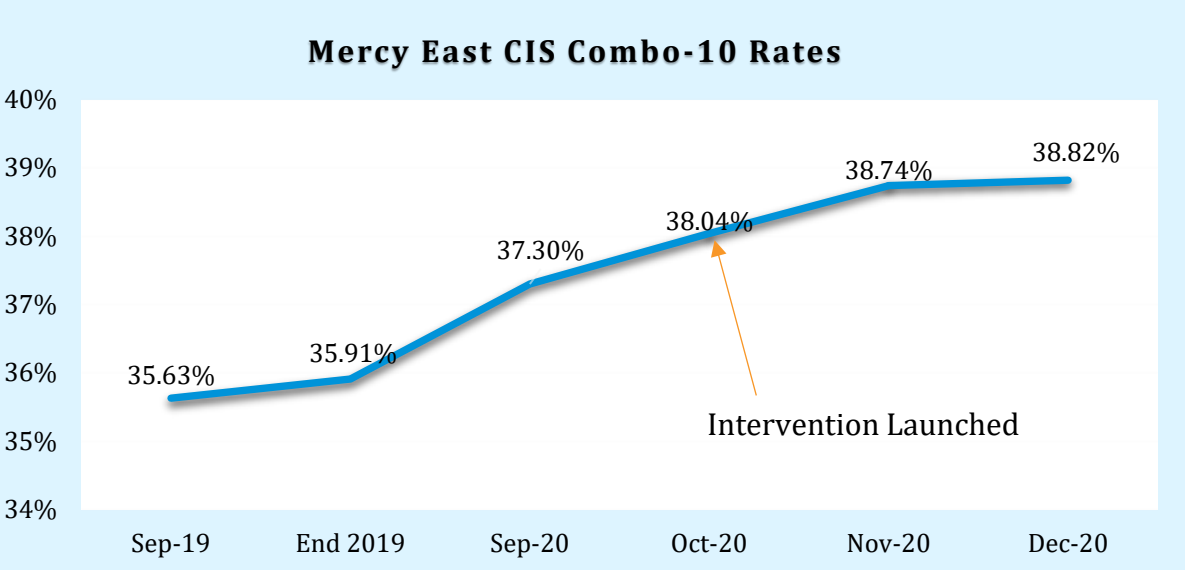


Figure 2-5. Mercy East Combo 10 Rates for baseline and intervention period

Healthy Blue reported a statewide increase in HEDIS® CIS Combo 10, which will exceed the 2% points improvement goal in Table 2-11.

Table 2-11. Statewide HEDIS® CIS Combo 10 Rate (MY 2019-2020)

HEDIS® Quarterly Measurements	HEDIS® MY 2019	HEDIS® MY 2020
Quarter 1	16.76%	20.60%
Quarter 2	21.38%	23.43%
Quarter 3	22.43%	24.59%

Quarter 4	22.81%	24.73%
Final Rate	**27.49%**	**36.01%**

PIP Result

The State goal to increase Healthy Blue's HEDIS® CIS rate by 2% points from the previous year was met. The HEDIS® CIS rate statewide increased from 27.49% to 36.01% (8.52% points), which was statistically significant (> 95% confidence interval, 23.06%-31.93%) (Table 2-12). The aim to increase Mercy East's MY 2019 Influenza vaccination rate of 17.86% by 2% points also was met. The annual Influenza vaccination rate increased from 17.86% to 21.05% (3.19% points) for eligible members with gaps in care, which was not statistically significant.

Table 2-12. Statewide HEDIS® CIS Combo 10 Trend (MY 2018-2020)

Measurement Year (MY)	HEDIS® CIS Combo 10 Rate (%)	NCQA Quality Compass 50th Percentile
MY 2018	27.49%	35.28%
MY 2019	27.49%	34.79%
MY 2020	36.01%	37.47%

(B) Nonclinical PIP: Improving Oral Healthcare

PIP Description from Healthy Blue

This section of the report briefly describes the PIP design, intervention(s), and results submitted by Healthy Blue.
Interventions: Healthy Blue noticed that, on average, only 2.01% of members completed an annual dental visit each month. An opportunity was identified to partner with DentaQuest, to assign members dental homes and mailing out letters identifying the dental homes, and encouraging members to receive annual dental care. Letters were sent to the most of the Healthy Blue's membership in October 2020 (272,062 letters), which identified the member's dental home, the advantages of a dental home, and dental benefits available to the member. The letters included the dentist's name, address, phone number of the dental home, and the customer service number. It also contained the explanation of a dental home, which will see the member every six months and as needed, to provide needed dental care to stay healthy. The impact of the mailing was analyzed in December 2020. A goal was set to increase dental visits by two percentage points by December 2020.

Performance Measures/variables: HEDIS® ADV measure was selected as a primary

measure. The number of members eligible for the HEDIS® ADV Measure who completed an annual dental visit by December 2020, after mailing the DentaQuest dental home letter, was tracked, as well as average monthly compliance rates prior to the mailing.

Numerator: Members compliant with an annual dental visit after the DentaQuest dental home letter was mailed.

Denominator: Members eligible for the HEDIS® ADV Measure who were mailed a DentaQuest dental home letter.

Data Collection: Sources of data used in this study included claims-based software and NCQA-certified software, Inovalon, to collect and calculate the HEDIS® ADV rate. Claims and encounter data were utilized. The statewide HEDIS® ADV rates were tracked quarterly, and ADV compliance rates were tracked prior to the mailing and analyzed again in December 2020.

Findings: Healthy Blue reported that the DentaQuest dental home initiative demonstrated effectiveness in encouraging members to receive preventative dental care, which increased the average monthly rate of dental visits from 2.01% (January–September 2020) to 4.45% (December 2020) (Figure 2-6).

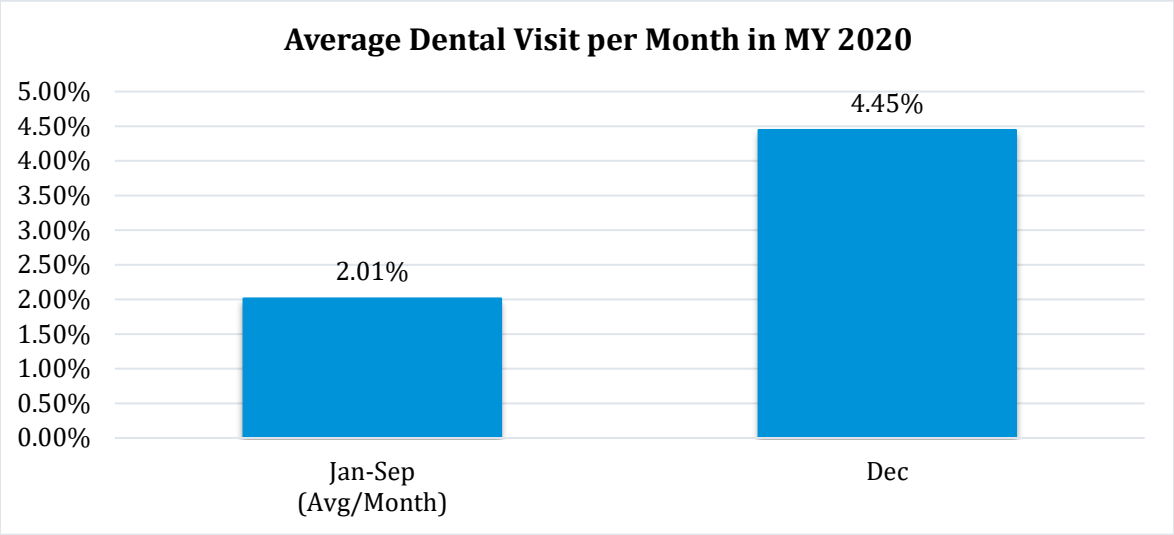


Figure 2-6. Average Dental Visit Before and After Dental Home Letter Intervention

Figure 2-7 and Table 2-13 show statewide HEDIS® ADV rate monthly and quarterly, respectively. Healthy Blue's HEDIS® ADV rate is trending to decline and did not meet its goal of 2% points increase, which Healthy Blue anticipated due to the Covid-19 pandemic.

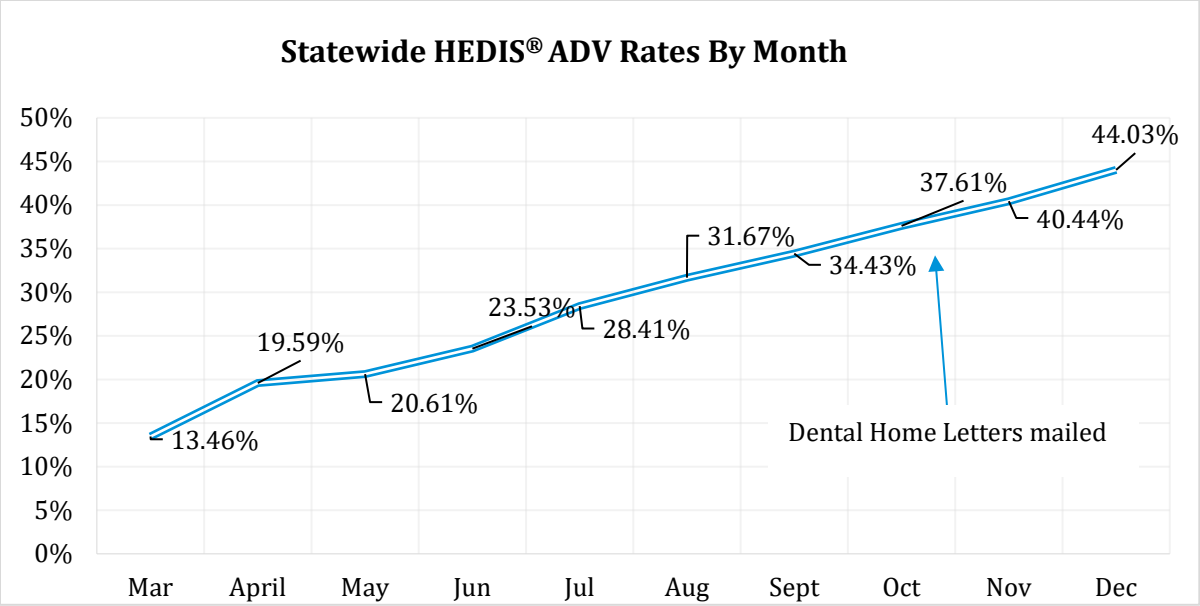


Figure 2-7. Monthly Statewide HEDIS® ADV Rates MY 2020

Table 2-13. Statewide HEDIS® ADV Rate (MY 2019-2020)

HEDIS® Quarterly Measurements	HEDIS® MY 2019	HEDIS® MY 2020
Quarter 1	13.18%	13.46%
Quarter 2	28.86%	23.53%
Quarter 3	39.14%	34.43%
Quarter 4	56.86%	42.67%
Final Rate	**58.87%**	**44.18%**

PIP Result

The State goal to increase the HEDIS® ADV by 2% points from the previous year was not met. Healthy Blue's HEDIS® ADV rate significantly declined (> 95% confidence interval, 58.58%-59.16%) from 58.87% (MY 2019) to 44.18% % (MY 2020) by 14.69% points (Table 2-14). The aim to increase Healthy Blue's monthly average of members completing an annual dental visit of 2.01% by 2% points in December 2020 (4.45%) was met.

Table 2-14. Statewide HEDIS® ADV Trend (MY 2018-2020)

Measurement Year (MY)	HEDIS® ADV Rate (%)	NCQA Quality Compass 50th Percentile
MY 2018	52.72%	56.60%
MY 2019	58.87%	58.03%
MY 2020	44.18%	60.15%

2.3.1 Quality, Timeliness, and Access

PIPs Score.

- Clinical PIP: Improving Childhood Immunization Status

Even though the State goal to increase Healthy Blue's HEDIS® CIS Combo 10 rate by 2% points from the previous year was met, and the HEDIS® CIS Combo 10 rate increased significantly by 8.52% points, the PIP was assigned a score of "Low Confidence." The quality improvement process and intervention were poorly executed and could not be linked to the improvement.

- Nonclinical PIP: Improving Oral Health

The State goal to increase Healthy Blue's HEDIS® ADV by 2% points from the previous year was not met. Instead, the HEDIS® ADV rate significantly declined by 14.69% points. The quality improvement process and intervention were poorly executed and could not be linked to the improvement seen in the secondary rate. Therefore, the PIP is assigned a score of "No Confidence."

Both the PIPs did not meet all the required guidelines stated in the CFR/MHD contract (42 CFR 438.330(d)(2)/MHD contract, 2.18.8(d)(1) (Table 2-15). Note: Definitions of Met/Partially Met/Not Met are based on the CMS EQR Protocol 3.

Table 2-15. PIPs' Evaluation based on the CFR guidelines

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

Strengths and Weaknesses. Table 2-16 summarizes the strengths and weaknesses identified during the evaluation of the PIPs.

Table 2-16. Strengths and Weaknesses of PIPs

Evaluation Criteria	Strength	Weakness
1. Selection of PIP topic (the MHD provided the topic, hence marked as	N/A	N/A

Not/Applicable-N/A)		
2. Writing an Aim statement		Healthy Blue lacks clarity on framing a concise aim statement. Two aim statements were reported (primary and secondary), which did not specify the study population.
3. Identifying the study population		Healthy Blue lacks clarity on what constitutes the target population and the project population.
4. Sampling	N/A	N/A
5. Variables/performance measures (the MHD decided the primary measure)		The PIP variables were not selected. Secondary measures were selected; however, not accurately defined.
6. Data collection	NCQA-certified software (Inovalon) was used to collect data for the PIPs. The data sources were specified. The data collection plan and analysis plan were linked in the clinical PIP.	Data elements to be collected after the intervention were not defined. The data collection plan and analysis plan for the secondary measure was not reported in the nonclinical PIP.
7. Data analysis and interpretation of results		The data after the intervention was presented but not analyzed. The data presented does not link to the intervention.
8. Improvement strategies	The selected strategies for both the PIPs were evidence-based.	The usefulness of the improvement strategies was not tested, and the methodology was not based on the PDSA cycle.
9. Significant and sustained improvement	Clinical PIP: The HEDIS® CIS rate statewide increased significantly. The influenza vaccination rate of Mercy East increased from 17.86% to 21.05% (3.19% points) for eligible members with gaps in care.	Clinical PIP: The influenza vaccination rate fell each month during the intervention from 10.81% (Oct 2020) to 0% (Dec 2020). The reported improvement in Mercy East's influenza vaccination

		rate is not likely to result from the selected intervention. Nonclinical PIP: The HEDIS® ADV rate significantly declined by 14.69% points. The aim to increase Healthy Blue's monthly average of members completing an annual dental visit of 2.01% by 2% points in December 2020 (4.45%) was met. However, it could not be validated due to insufficient/inaccurate data.

2.3.2 Improvement from previous year

For the MY 2020, the statewide rates for HEDIS® CIS Combo 10 increased by 8.52% points, and HEDIS® ADV decreased by 14.69% points from the previous year (MY 2019). Table 2-17 shows Healthy Blue's response to the previous year's (EQR 2020) recommendations by EQRO and noncompliant items from EQR 2019.

Table 2-17. Healthy Blue's Response to Previous Year's Recommendations

Previous Recommendation	Action by Healthy Blue	Comment by EQRO
EQR 2020		
1. Even though the MHD mandates an overarching goal, Healthy Blue can select a topic within specified parameters. To ensure a successful PIP, Healthy Blue should find early and regular opportunities to obtain input from staff, providers, and members, improving care delivery.	There was some improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020, as Healthy Blue stated in their secondary aim.	Healthy Blue should have one concise aim statement. The same recommendation applies to EQR 2021.
3. Healthy Blue should translate the aim statement to identify the focus of the PIP and establish the framework for data collection and analysis on a small scale (PDSA cycle). PIP population should be selected from a county, provider office, or a region so	There was some improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020. Healthy Blue applied the intervention to a small scale for the clinical	The same recommendation applies to EQR 2021.

that results can be measured during the PDSA cycle and subsequently applied on a larger scale.	PIP.	
4. Healthy Blue should select a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) that could identify Healthy Blue's performance on the PIPs and track improvement over time. Healthy Blue can use focus groups, surveys, and interviews to collect qualitative insights from members, MCO and provider staff, and key external partners. Qualitative measures can serve as secondary measures or supplement the overall measurement set, providing information to aid PIP planning and implementation.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
5. Healthy Blue should use variables/secondary measures that should tie an intervention to improvement. Clear and concise definitions of data elements (including numerical definitions and units of measure) should be provided for the data collected after the intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
6. Data collection plan should be linked to the data analysis plan to ensure that appropriate data would be available for the PIP.	There was some improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020. The data collection plan was linked to the data analysis plan for the clinical PIP only.	The same recommendation applies to EQR 2021.
7. A baseline rate should be presented before the start of an intervention followed by at least two remeasurements, and analysis of	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR	The same recommendation applies to EQR 2021.

results should be utilized to plan the next intervention (cycle-PDSA) for future PIP. Additionally, primary and secondary measures/variables should be linked to illustrate the impact of the intervention on a project's performance.	2020.	
9. Effectiveness of the improvement strategy should be determined by measuring a change in performance according to the predefined measures and linking to intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
10. When analyzing multiple data points over time, Healthy Blue should consider tools such as time series, run chart, control chart, data dashboard, and basic trend analyses.	There was some improvement towards the utilization of such tools in EQR 2021 compared to EQR 2020. The clinical PIP had data after the intervention.	The same recommendation applies to EQR 2021.
EQR 2019		
1. Health Blue should follow CMS EQR protocol and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015 for guidance on methodology and approach of PIPs to obtain meaningful results.	There was some improvement in the methodology of PIP in EQR 2021 and EQR 2020.	The same recommendation applies to EQR 2021.
2. Healthy Blue must refine its skills in the development and implementation of approaches to effect change in the PIPs.	There was no improvement in the methodology of PIP in EQR 2021 and EQR 2020.	The same recommendation applies to EQR 2021.
3. The interventions should be planned specifically for the PIP required by the MHD contract.	There was some improvement in EQR 2021. The clinical PIP was designed with an intervention at a small scale and appeared to be new. However, statewide intervention for nonclinical PIP suggests that it was an operational effort reported	The same recommendation applies to EQR 2021.

	in the PIP.	
4. The results should be tied to the interventions.	There was no improvement in the methodology of PIP in EQR 2021 and EQR 2020.	The same recommendation applies to EQR 2021.

2.4 Findings, Analysis, and Conclusions: UnitedHealthcare

(A) Clinical PIP: Improving Childhood Immunization Status

PIP Description from UnitedHealthcare

This section of the report briefly describes the PIP design, intervention(s), and results submitted by UnitedHealthcare.
Intervention: Missed Dose Postcards were mailed out monthly to parents or guardians of children ages 6, 8, and 16 months who missed one or more CIS Combo 10 immunizations. These ages were selected by Pfizer, a manufacturer of the pneumococcal conjugate vaccine (PCV13), one of the CIS Combo 10 vaccines. According to the Centers for Disease Control and Prevention (CDC) immunization periodicity schedule, PCV13 should be administered at months 2, 4, 6, and again between 12 and 18 months of age. Members who receive the postcard are behind on receiving PCV13 and possibly other CIS Combo 10 vaccines. Typically, over 1000 postcards are mailed to UnitedHealthcare members each month.

Performance Measures/variables: The primary and the secondary performance measures selected for the PIP were HEDIS® CIS Combo 10 and PCV13 Vaccine Compliance, respectively. The variable used in the PIP focused on members who turned two years old in MY 2020 and who were non-compliant with the PCV13.

Data Collection (Administrative): UnitedHealthcare used ClaimSphere and Inovalon, HEDIS® -certified software engines to generate the HEDIS® CIS Combo 10 and PCV13 compliance rates. Data for HEDIS® CIS Combo 10 rate were collected quarterly and annually, and the PCV13 compliance rates were collected quarterly. The data for the intervention were collected monthly from the program vendor by the UnitedHealthcare Clinical Program Delivery team and analyzed internally against claims. The data included a list of member names, ages, and member IDs targeted by the intervention in MY 2020. First, UnitedHealthcare contacted their national Clinical Program Delivery team and requested a list of members and member IDs of those mailed a Pfizer Missed Dose Postcard. The date the postcards were mailed and the date range of eight weeks after the mailing were recorded for each month. Next, UnitedHealthcare submitted an internal request (Missouri) to the senior business analyst to compare the member IDs to medical claims within a stated

period, using the specific Current Procedural Terminology (CPT) codes for immunizations. Note: The final HEDIS® CIS Combo 10 rate submitted by UnitedHealthcare was based on the hybrid methodology (medical record review).

Findings: Table 2-18 shows that 18,602 Missed Dose Postcards were mailed to the members during January through November 2020 and the number of members who received one or more CIS Combo 10 vaccines within eight weeks of mailing the postcards.

Table 2-18. Intervention Data for the Clinical PIP

Postcard Date	Number of Missed Dose Postcards Mailed	Missed Dose Reminder Effectiveness Report Timeframe	Received One or More CIS Combo 10 Vaccination(s) Within 8 Weeks*	Response %
1/16/2020	1462	1/16/2020-3/12/2020	147	10.05%
2/18/2020	1462	2/18/2020-4/14/2020	105	7.18%
3/17/2020	1538	3/17/2020-5/12/2020	65	4.22%
4/30/2020	1586	4/30/2020-6/25/2020	82	5.17%
5/27/2020	1702	5/27/2020-7/22/2020	90	5.28%
6/29/2020	1606	6/29/2020-8/24/2020	93	5.79%
7/22/2020	1623	7/22/2020-9/16/2020	86	5.29%
8/27/2020	1801	8/27/2020-10/22/2020	81	4.49%
10/1/2020	1813	10/1/2020-11/26/2020	62	3.41%
11/2/2020	2294	11/2/2020-12/28/2020	73	3.18%
11/23/2020	1715	11/23/2020-12/31/2020	35	2.04%
Total	**18602**		**919**	**4.94%**

*Dates of service through December 31, 2020.
September postcards were not mailed until October 1, 2020, and October postcards were not mailed until November 2, 2020.

Figure 2-8 compares the CIS Combo 10 immunization results for the same intervention during the previous year (MY 2019).

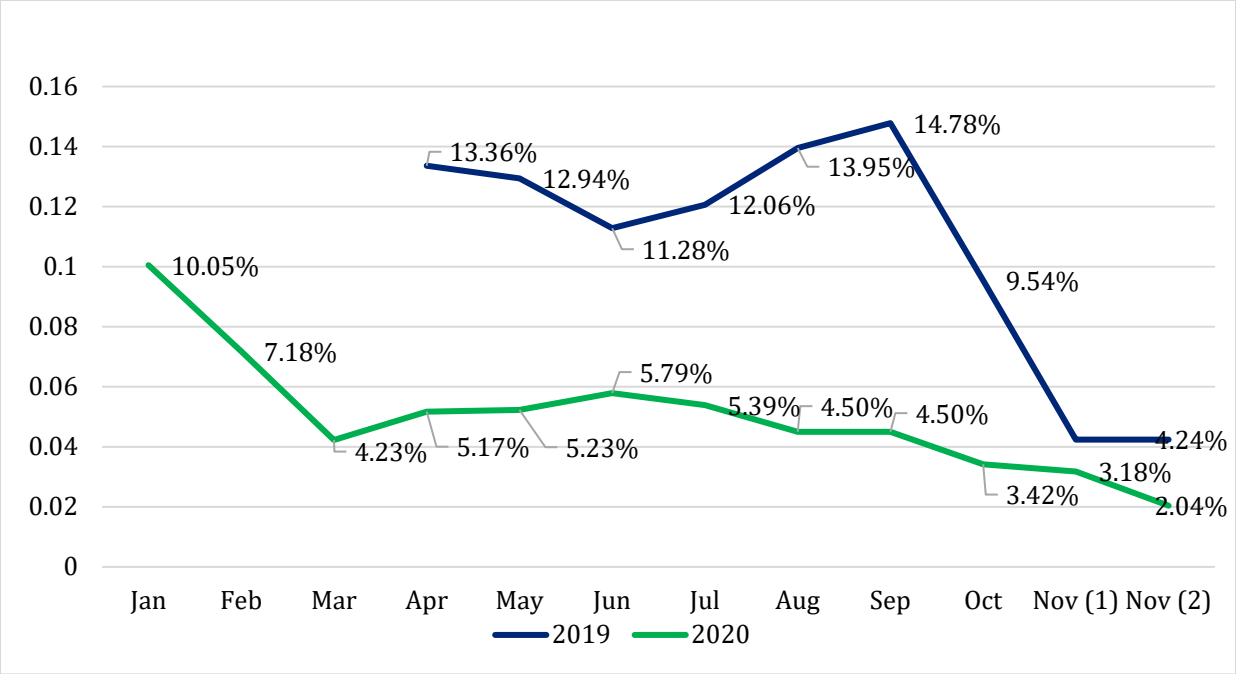


Figure 2-8. MY 2019 and MY 2020 CIS Combo 10 Rates after Pfizer Missed-Dose Post-Cards were mailed.

Table 2-19 and Table 2-20 show the rates for PCV13 (secondary) and HEDIS® Combo 10 (primary) measures and the statistical significance of the changes every quarter.

Table 2-19. Quarterly Compliance Rates-PCV13

MY 2020	Number of Members	Number of Compliant Members	Compliant	Statistical Significance
April (Baseline) Claims as of 3/22/20	4355	1789	41.08%	N/A
July (Remeasurement-RM 1) Claims as of 6/22/20	4354	1877	43.11%	No (Baseline- RM 1)
October (RM-2) Claims as of 9/22/20	4326	1930	44.61%	No (RM1-RM2
December (RM-3) Claims as of 12/7/20*	4318	1955	45.28%	No (RM2-RM3)**

*Claims as of 12/22/20 are not included due to a change in software in the next data cycle.
** The change from the Baseline-RM 3 is reported to be statistically significant (p=0).

Table 2-20. Quarterly Rates-HEDIS® CIS Combo 10

MY 2020	Numerator	Denominator	CIS Combo 10 Rate	Statistical Significance	Goal
April (Baseline) Claims as of 3/22/20	574	4355	13.18%	N/A	27.06%
July (Remeasurement-RM 1) Claims as of 6/22/20	641	4354	14.72%	Yes, P=0.0378 (Baseline-RM1)	27.06%
October (RM-2) Claims as of 9/22/20	667	4326	15.42%	No (RM1-RM2	27.06%
December (RM-3) Claims as of 12/7/20	689	4318	15.96%	No (RM2-RM3)*	27.06%

***The change from the Baseline-RM 3 is reported to be statistically significant (p=0.0002).

PIP Result

The aim of the PIP was met. UnitedHealthcare's statewide rate for HEDIS® CIS Combo 10 increased from 25.06% (MY 2019) to 36.25% (MY 2020), which is an increment of 11.19% points (Table 2-21). The improvement is of statistical significance, p value=0.0005 (p≤0.05 is significant).

Table 2-21. Statewide HEDIS® CIS Combo 10 Trend (MY 2018-2020)

MY	Numerator	Denominator	CIS Combo 10 Rate	NCQA Benchmark (50th Percentile)	Goal
MY 2018	89	411	21.65%	35.28%	N/A
MY 2019	103	411	25.06%	34.79%	23.65%
MY 2020	149	411	36.25%	37.47%	27.06%

(B) Nonclinical PIP: Improving Oral Healthcare

PIP Description from UnitedHealthcare

This section of the report briefly describes the PIP design, intervention(s), and results submitted by UnitedHealthcare.
Intervention: The DCOR is a customized reporting tool that reflects practice level performance data and assists dental providers in identifying member engagement and

educational opportunities related to key dental quality outcome measures. The original plan for the DCOR intervention for the PIP was to be implemented in February, May, and August 2020. Due to the Covid-19 Pandemic, the February and May interventions could not be completed. In July 2020, the Quality Team initiated the first DCOR intervention with the intention of assisting FQHCs in identifying members who needed to be seen for dental care. At this point, it was deemed too late in the year to complete a second intervention for the PIP due to the need for monitoring claims past 12/31/20.

Performance Measures/variables: The primary measure selected for the PIP was HEDIS® ADV and the secondary measure selected was ADV rate for the top 20 FQHCs. The PIP variable selected was defined as UnitedHealthcare members ages 2-20 years who have historically used a FQHC for dental services.

Data Collection: UnitedHealthcare used Inovalon, a HEDIS®-certified software engine, to generate on an annual basis the HEDIS ® ADV measure. Regarding the secondary measure, UnitedHealthcare used ClaimSphere, a HEDIS®-certified software engine, to generate quarterly the ADV measure rates and member-level detail (MLD) reports. The Clinical Quality Consultant used the ADV MLD data to extract the rates for the top 20 FQHCs used in the DCOR intervention. After the distribution of the July DCOR, the reports were run 90 days after the DCOR was distributed to identify members who had no dental visit in the previous 12 months and who had a visit within 90 days after the intervention. The final 90-day results were received and reviewed midway through November. The DCOR and the DCOR Outcome Report data are extracted from claims data received from the dental vendor.

Findings: A total of 4,566 members were included in the DCOR report that was distributed to 20 FQHCs in July 2020. In November 2020, the Quality Team received and reviewed the DCOR Outcome report with the results shown in Table 2-22 below.

Table 2-22. DCOR Intervention

DCOR Outcome Report		Dental Exam (D0120)		Preventive Dental Visit (D1120)		Oral Sealant Applied (D1351)		
Intervention	Number of members with no visit in previous 12 months	Number of members with a dental visit within 90 days	% of members with any dental visit within 90 days	Number of members with preventive service within 90 days	% of members with preventive service within 90 days	Number of members aged 6 to 9 with no visit in previous 12 months	Number of members with sealant applied within 90 days	% of members with sealant applied within 90 days
July 2020	4,566	575	12.59%	510	11.17%	1,115	44	3.95%

UnitedHealthcare presented quarterly ADV rates of 20 FQHCs (Table 2-23) and Statewide

(Table 2-24) as follows:

Table 2-23. Quarterly ADV Rates-20 FQHCs

MY 2020	Numerator	Denominator	ADV Rate	Statistical Significance
July (Baseline) Claims as of 6/22/20	3,535	17,052	20.73%	N/A
September (Remeasurement-RM 1) Claims as of 8/22/20	4,526	16,963	26.68%	Yes, p=0 (Baseline- RM 1)
November (RM 2) Claims as of 9/22/20	5,688	16,737	33.98%	Yes, p=0 (RM1-RM2)*

*The change from the baseline-RM 2 is also reported to be statistically significant (p=0).

Table 2-24. Statewide Quarterly Rates-HEDIS® ADV

MY 2020	Numerator	Denominator	ADV Rate	Statistical Significance	Goal
April (Baseline) Claims as of 3/22/20	19,217	116,832	16.45%	N/A	55.70%
July (Remeasurement-RM 1) Claims as of 6/22/20	24,792	115,988	21.37%	Yes, p=0 (Baseline-RM1)	55.70%
October (RM-2) Claims as of 9/22/20	35,564	114,806	30.98%	Yes, p=0 (RM1-RM2)	55.70%
December (RM-3) Claims as of 12/7/20	42,807	112,630	38.01%	Yes, p=0 (RM2-RM3)*	55.70%

***** The change from the Baseline-RM3 is also reported to be statistically significant (p=0).

PIP Result

The aim of the PIP was not met. UnitedHealthcare's statewide rate for HEDIS® ADV decreased from 53.70% (MY 2019) to 41.18% (MY 2020), which is a decline of 12.52% points (Table 2-25). The change in performance is of statistical significance, p value=0 (p≤0.05 is significant).

Table 2-25. Statewide HEDIS® ADV Rate Trend (MY 2018-2020)

Measurement Period (MY)	Numerator	Denominator	ADV Rate	NCQA Benchmark (50th Percentile)	Goal
MY 2018	44,368	91,969	48.24%	56.60%	N/A

MY 2019	42,772	79,656	53.70%	58.03%	50.24%
MY 2020	46,380	112,635	41.18%	60.15%	55.70%

2.4.1 Quality, Timeliness, and Access

PIPs Score.

- Clinical PIP: Improving Childhood Immunization Status

Even though the aim of the PIP was met, and UnitedHealthcare's HEDIS® CIS rate increased from 25.06% to 36.25% (11.19% points), which is statistically significant (p=0.0005), the PIP was assigned a score of "Low Confidence." The quality improvement process and intervention were poorly executed and could not be linked to the improvement.

- Nonclinical PIP: Improving Oral Health

The aim of the PIP was not met, and UnitedHealthcare's HEDIS® ADV rate significantly declined (p=0) from 53.70% to 41.18% (12.52% points). The quality improvement process and intervention were poorly executed and could not be linked to the improvement seen in the secondary rate. Therefore, the PIP is assigned a score of "No Confidence."

Both the PIPs did not meet all the required guidelines stated in the CFR/MHD contract (42 CFR 438.330(d)(2)/MHD contract, 2.18.8(d)(1) (Table 2-26). Note: Definitions of Met/Partially Met/Not Met are based on the CMS EQR Protocol 3.

Table 2-26. PIPs' Evaluation based on the CFR guidelines

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

Strengths and Weaknesses. Table 2-27 summarizes the strengths and weaknesses identified during the evaluation of the PIPs.

Table 2-27. Strengths and Weaknesses of PIPs

Evaluation Criteria	Strength	Weakness
1. Selection of PIP topic (the MHD provided the	N/A	N/A

topic, hence marked as Not/Applicable-N/A)		
2. Writing an Aim statement	The PIP aim statement defined the improvement strategy, population, and period.	
3. Identifying the study population		UnitedHealthcare lacks clarity on what constitutes the target population and the project population.
4. Sampling	N/A	N/A
5. Variables/performance measures (the MHD decided the primary measure)	UnitedHealthcare's national Quality Solutions Delivery (QSD) team manages all HEDIS®-related activities, including vendor training and State-specific reporting. There is an overread process for all HEDIS® hybrid measures and final validation by an NCQA-certified auditor.	Even though UnitedHealthcare reported using variables in the PIPs, they were incorrectly defined. Furthermore, the intervention was not directed towards those variables. The secondary measures were either inappropriate as the intervention was not directed towards those or not defined.
6. Data collection	The data collection plan and analysis plan were linked. ClaimSphere and Inovalon, HEDIS®-certified software engines were used to collect the data for the primary measures.	Data elements collected after the intervention were not clearly and accurately defined along with units of measure. UnitedHealthcare provided partial information when questioned by Primaris regarding the data sources: if they used data for inpatients, primary care providers, specialty care providers, ancillary service providers, Electronic Health Records (EHR); and if the data collection included encounter/utilization data for all the services provided.
7. Data analysis and interpretation of results		Data collected after the intervention was insufficient and not linked to the change

		in performance of the primary and secondary measures.
8. Improvement strategies	The improvement strategies selected for the PIPs were evidence-based.	The improvement strategy was unsuccessful and not tested using the PDSA cycle even though this methodology is stated in the PIPs. The vaccination rates reported for MY 2020 as a result of postcard intervention was 4.94% as compared to the same intervention in MY 2019 (10.83%). The ADV rate reported as a result of DCOR intervention was less in MY 2020 (12.59%) than the same intervention in MY 2019 (16.20% for 14 FQHCs). (Primaris noted this figure from previous year's PIP).
9. Significant and sustained improvement	HEDIS® CIS Combo 10 rate for MY 2020 increased from 25.06% (MY 2019) to 36.25% (MY 2020). This is an improvement of 11.19% points which is statistically significant (p=0.0005). Quarterly HEDIS® ADV rates and FQHC dental visit rates showed improvement through repeated measurements which were statistically significant.	HEDIS® ADV rate showed a statistically significant (p=0) decline of 12.52% points from 53.70% (MY 2019) to 41.18% (MY 2020). HEDIS® CIS Combo 10 rates measured quarterly showed sustained improvement. However, it was not statistically significant quarter over quarter. The reported improvement is not likely to be a result of the selected intervention for both the PIPs.

2.4.2 Improvement from previous year

For the MY 2020, the statewide rates for HEDIS® CIS Combo 10 increased by 11.19% points, and HEDIS® ADV declined by 12.52% points from the previous year (MY 2019).

Table 2-28 shows UnitedHealthcare's response to the previous year's (EQR 2020) recommendations by EQRO and non-compliant items from EQR 2019.

Table 2-28. UnitedHealthcare's Response to Previous Year's Recommendations

Previous Recommendation	Action by UnitedHealthcare	Comment by EQRO
EQR 2020		
1. Even though the MHD mandates an overarching goal, UnitedHealthcare can select a topic within specified parameters. To ensure a successful PIP, UnitedHealthcare should find early and regular opportunities to obtain input from staff, providers, and members on improving care delivery.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
2. UnitedHealthcare should translate the aim statement to identify the focus of the PIP and establish the framework for data collection and analysis on a small scale (PDSA cycle).	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
3. UnitedHealthcare should select a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) that could identify UnitedHealthcare's performance on the PIPs and track improvement over time. UnitedHealthcare can use focus groups, surveys, and interviews to collect qualitative insights from members, MCO and provider staff, and key external partners. Qualitative measures can serve as secondary measures or supplement the overall measurement set, providing information to aid PIP planning and implementation.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
4. UnitedHealthcare should have	There was no improvement	The same

variables/secondary measures that should tie an intervention to improvement. For example, after sending DCOR reports in ADV PIP, UnitedHealthcare should measure the % of appointments scheduled from the DCOR list and % of members responding by visiting a dentist.	towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	recommendation applies to EQR 2021.
5. Repeat measurements (at least two) in short intervals (unlike 90-day intervals selected in ADV PIP) should be conducted to determine whether significant performance changes relative to baseline measurement were observed.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
6. Effectiveness of the improvement strategy should be determined by measuring a change in performance according to the predefined measures and linking to intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2021 compared to EQR 2020.	The same recommendation applies to EQR 2021.
7. When analyzing multiple data points over time, UnitedHealthcare should consider tools such as time series, run chart, control chart, data dashboard, and basic trend analyses.	UnitedHealthcare presented data for the CIS Combo 10 rates as a result of intervention using run charts.	UnitedHealthcare should use these tools for both the PIPs in the future to show the intervention results.
EQR 2019		
1. UnitedHealthcare must refine its skills in the development and implementation of approaches to effect change in the PIPs.	There was no improvement in the methodology of PIP in EQR 2021 and EQR 2020.	The same recommendation applies to EQR 2021.
2. The interventions should be planned specifically for PIP required by the MHD Contract.	The intervention has been ongoing each month since 2017 for CIS Combo 10 PIP. DCOR intervention is probably ongoing as it included nine FQHCs in the initiation of PIP.	The same intervention continues year over year. This year 20 FQHCs were included. The same recommendation

		applies to EQR 2021.
3. The results should be tied to the interventions.	Analysis of results to link with intervention is not explained.	The same recommendation applies to EQR 2021.

2.5 Recommendations for MCOs

Home State Health, Healthy Blue, and UnitedHealthcare must improve the methodology adopted for their PIPs to meet all the compliance requirements set in the 42 CFR 438.330(d)(2)/MHD contract, section 2.18.8(d)(1). In addition to all the recommendations from the previous years that continue to be applicable for EQR 2021 for each MCO (Table 2-10, 2-17, 2-28), Primaris recommends the following (Table 2-29). (Note: The serial numbers in the Table correspond to the listed recommendations below.)

Table 2-29. Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Healthy Blue	UnitedHealthcare
1.	✓	✓	-
2.	✓	✓	✓
3.	-	-	✓
4.	-	-	✓
5.	✓	✓	✓
6.	✓	✓	✓
7.	✓	-	-
8.	✓	✓	✓

1. Aim Statement: The PIP aim statement should define the improvement strategy, population, and period. It should be clear and concise, measurable, and answerable. Home State Health and Healthy Blue must have one aim statement for their PIP, which can have multiple objectives (if they choose).

2. Study Population: The MCOs should articulate the concepts and clearly define the target population and PIP population. The PIP population should be selected at a small scale (e.g., from a county, provider office, or a region) so that results can be measured during the PDSA cycle and subsequently applied at a larger scale.

3. Variables/secondary measures: Data elements collected by UnitedHealthcare after the intervention should be clearly and accurately defined along with units of measure and correctly utilized to analyze the PIP results.

4. Data Collection: UnitedHealthcare must address the data collection sources and specify if they used data for inpatients, primary care providers, specialty care providers, ancillary service providers, Electronic Health Records (EHR), and if the data collection included encounter/utilization data for all the services provided.

5. PDSA Cycles: The MCOs should adopt PDSA cycles that involve analysis, feedback/lessons learned from the data collected after the intervention, and application of these outcomes to plan another test cycle.

6. Data Analysis and Interpretation of Results: Though conclusive demonstration through controlled studies is not required, the MCOs should compare the results across multiple entities, such as different patient subgroups, provider sites, to ascertain the change brought by the intervention.

7. Improvement Strategies: Home State Health should select improvement strategies that are evidence-based, suggesting that the test of change would likely lead to the desired improvement in processes or outcomes.

8. Sustained improvement: After an intervention is implemented and results are analyzed, the MCOs should identify strategies to create sustained improvement. This allows the MCOs to maintain the positive results of the intervention, correct negative results, and scale the intervention to support longer-term improvements or broader improvement capacity across other health services, populations, and aspects of care. Because PIPs can be resource-intensive, this phase also helps learn how to allocate more efficiently for future projects.

3.0 Validation of Performance Measures

3.1 Description, Objective, and Methodology

Primaris conducted performance measure validation activities for Home State Health, Healthy Blue, and UnitedHealthcare based on the guidelines from the CMS EQR protocol 2, version Oct 2019: Validation of Performance Measures. Information Systems Capabilities Assessment (ISCA) for each MCO was conducted per Appendix A provided in the CMS EQR Protocols. The performance measures selected by the MHD for validation in EQR 2021 (measurement period-MY 2020) were as follows:

- Chlamydia Screening in Women (CHL)
- Well-Child Visits in the First 30 Months of Life (W30)
- Inpatient Readmissions- Mental Health (MH), Substance Abuse (SA), and Medical (MED)

The MHD provided Primaris with the Healthcare Quality Data Instructions for MY 2020, which consisted of requirements and specifications for validation of Inpatient Readmissions. Additionally, the MHD instructed the MCOs to utilize the HEDIS® specifications for the CHL and W30 measures. All the performance measures selected by the MHD were administrative only, which required primary source verification (PSV) from the MCOs' administrative systems (claims and supplemental data).

Primaris validated the performance measures selected by the MHD with the following objectives:

1. Evaluate the accuracy of the performance measures based on the measure specifications and State reporting requirements.
2. Evaluate if the MCOs followed the rules outlined by the MHD for calculating the performance measures (42 C.F.R. § 438.358(b)(ii)).
3. Review Information Systems underlying performance measurement.
4. Assess data integration and control for performance measures calculation.
5. Review performance measure production.
6. Determine the MCOs' ability to process claims, enrollment, provider, and supplemental data accurately.
7. Determine the MCOs' ability to identify numerator and denominator eligible members accurately.
8. Determine if the MCOs have adequate processes in place to ensure data completeness and data quality.

Pre-Audit Process

Primaris prepared a series of electronic communications submitted to the MCOs outlining

the steps in the performance measure validation process based on CMS Performance Measure Validation Protocol 2. The electronic communications included a request for samples, the numerator and denominator files, source code if required, and a completed Information System Capability Assessment (ISCA). Additionally, Primaris requested any supporting documentation required to complete the performance measure validation review. The communications addressed the methodology of selecting a maximum of 45 administrative claims for PSV and the process for sampling and validating the administrative measures during the review process. Primaris provided specific questions to the MCOs during the measure validation process to enhance the understanding of the ISCA responses during the virtual site visit.
Primaris submitted an agenda prior to the virtual visit describing the activities and suggested that subject matter experts attend each session. In addition, Primaris exchanged several pre-onsite communications with the MCOs to discuss expectations, virtual session times and answer any questions that the MCOs' staff may have regarding the overall process.

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

- CMS's ISCA: The MCOs completed and submitted their ISCA's required and relevant portions for Primaris' review. Primaris used responses from the ISCA to complete the onsite and pre-onsite assessment of their information system.
- Source code verification for performance measures: The MCOs contracted with a software vendor to generate and calculate rates for the three administrative performance measures, Inpatient Readmissions (MH, SA, and MED), W30, and CHL. There were no changes to the source code since the previous review in MY 2020, and therefore, no source code review was necessary for any of the measures under review.
- Additional supporting documents: In addition to reviewing the ISCA, Primaris also reviewed the MCOs' file layouts, system flow diagrams, system files, and data collection processes. Primaris reviewed all supporting documentation and identified any issues requiring further clarification.
- Administrative rate verification: Upon receiving the numerator and denominator files for each measure from the three MCOs, Primaris conducted a validation review to determine reasonable accuracy and data integrity.
- Primaris took a sample of 45 administrative claims for each administrative measure, CHL, Inpatient Readmissions (MH-15 samples, SA–15 samples, MED-15 samples), and W30, and conducted primary source verification to validate and assess the MCOs' compliance with the numerator objectives.

Virtual Onsite Activities

Primaris conducted virtual onsite meetings with Healthy Blue on July 13, 2021; Home State Health on July 14, 2021; and UnitedHealthcare on July 15, 2021. The information was collected using several methods, including interviews, system demonstrations, review of data output files, primary source verification, data processing observation, and data reports. The on-site visit activities are described as follows:

- Opening Conference: The meeting introduced the validation team and key MCOs' staff members involved in the performance measure validation activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- Review Information System Underlying Performance Measurement: The evaluation included a review of the information systems, focusing on the processing of claims and encounter data, provider data, patient data, and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the performance measure rates, including accurate numerator and denominator identification and algorithmic compliance, which evaluated whether a) rate calculations were performed correctly, b) data were combined appropriately, and c) numerator events were counted accurately.
- ISCA Review, Interviews, and Documentation: The review included processes used for collecting, storing, validating, and reporting performance measure rates. The review meetings were interactive with the staff members to capture the MCOs' steps taken to generate the performance measure rates. Primaris used these sessions to assess a confidence level in the reporting process and performance measure reporting as well as the documentation process in the ISCA. Primaris conducted interviews to confirm the documentation review findings and ascertain that written policies and procedures were used and followed in daily practice.
- Assess Data Integration and Control Procedures: The data integration sessions comprised system demonstrations of the data integration process and included discussions around data capture and storage, reviewing backup procedures for data integration, and addressing data control and security procedures.
- Complete Detailed Review of Performance Measure Production: Primaris conducted primary source verification to further validate the administrative performance measures.
- Closing Conference/Communicate Preliminary Findings: The closing conference included a summation of preliminary findings based on the review of the ISCA and the site meeting for each MCO.

Validation Process

As part of the performance measure validation process, Primaris reviewed MCOs' data integration, data control, and documentation of performance measure rate calculations.

Several aspects involved in the calculation of the performance measures are crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. Each of the following sections describes the validation processes used and the validation findings. The scores (Table 3-1) are adopted from CMS EQR Protocol 2.

Table 3-1. Scoring Criteria for Performance Measures

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

Data Integration: Data integration is an essential part of the overall performance measurement creation/reporting process. Data integration relies upon various internal systems to capture all data elements required for reporting. Accurate data integration is essential for calculating valid performance measure rates. Primaris reviewed the MCOs' actual results of file consolidations and extracts to determine if they were consistent with those which should have demonstrated results according to documented specifications. The steps used to integrate data sources such as claims and encounter data, eligibility, and provider data require highly skilled staff and carefully controlled processes.
Primaris validated the data integration process used by the three MCOs, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

Data Control: Data control procedures ensure accurate, timely, and complete data integration into the performance measure database by comparing data samples in the repository with transaction files. Good control procedures determine if any members, providers, or services are lost in the process and if the organization has methods to correct lost/missing data. The organization's infrastructure must support all necessary information systems and backup procedures.

Performance Measure Documentation: Sufficient and complete documentation is necessary

to support validation activities. While interviews and system demonstrations provided the necessary information to complete the audit, most of the validation review findings were based on documentation provided by the MCOs in the ISCA. Primaris' Lead Auditor reviewed the computer programming codes, output files, workflow diagrams, primary source verification, and other related documentations.

Performance Measure Specific Findings: Primaris determined validation results for each performance measure based on the definitions listed below. The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "Not Met." Consequently, an error for a single audit element may result in a designation of "Do Not Report (DNR)" because the impact of the error materially biased the reported performance measure. Conversely, it is also possible that several audit element errors may have little impact on the reported rate; thus, the measure is "Reportable (R)." The following is a list of the validation findings and their corresponding definitions:

R = Reportable: Measure was compliant with State specifications.
DNR = Do not report; The MCO's rate was materially biased and should not be reported.
NA = Not applicable; The MCO was not required to report the measure.
NR = Measure was not reported because the MCO did not offer the required benefit.

3.2 Findings, Analysis, and Conclusions: Home State Health

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

Table 3-2. Home State Health Performance Measures Process

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

Data Integration

Home State Health's data integration process did not change from the previous year's review. Home State Health continued to use Inovalon software for performance measures, QSI-XL. Home State Health indicated no significant issues with the migration, and no concerns were identified during on-site primary source verification.

Home State Health consistently reviewed the data quality reports from QSI-XL to ensure all data were captured and data errors were followed up. Home State Health had a two-step validation process that logged records submitted with the file name and record counts. Files with the same name were matched against each other to determine if the record counts matched. The second-tier validation looked to determine error counts and error reasons. Home State Health conducted a full refresh of data rather than doing an incremental data load. This process captured all changes that may have occurred after the initial data were loaded.

Primaris verified hospice members were not included in any data files, as required by HEDIS® specifications. All hospice members were flagged through claims using the HEDIS® code sets for hospice. This flagging was done within Inovalon's software.

Members with duplicate identifiers were mapped to a unique member identifier in AMISYS, and all claims were mapped to the new identifier, ensuring that all claims for a member were captured along with their continuous enrollment segments. Home State Health's corporate team, Centene, ran monthly reports from Inovalon's software to review data on a regular basis. Centene frequently produced month-over-month comparison reports to ensure data were complete and accurate.

Primaris verified each measure's requirements against Home State's applications to determine whether numerators met age, gender, diagnosis, and procedural compliance with the specifications. Primaris did not find any issues during the primary source review. Home State Health backed up data nightly and weekly to ensure no data loss and denied having any significant outages during the year. Home State Health's disaster recovery plan was sufficient to ensure data integrity. Home State Health reported no issues related to COVID-19 in performance measure reporting.

No issues were identified with Home State Health's data integration processes.

Data Control

Primaris validated the data control processes Home State Health used, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Primaris determined that the data control processes in place at Home State Health were acceptable.

Performance Measure Documentation

Primaris' Lead Auditor reviewed the computer programming codes, output files, workflow diagrams, primary source verification, and other related documentations and assigned a "Met" score to Home State Health for this section.

Medical Service Data (Claims and Encounters)

Primaris verified that there were no system or process changes from the previous review of claims and encounters. Home State Health reported no impact from the Covid-19 pandemic on overall claims processing but did indicate a significant drop in claims during the first quarter of the MY 2020. Home State Health's medical services data system has remained unchanged since the previous review. Home State Health used AMISYS as its primary claims processing system, operational for several years. AMISYS captured all relevant fields for performance measure reporting.

During the MY 2020, there were no significant changes to the system other than usual maintenance and minor upgrades limited to provider contract and benefits maintenance. Home State Health continued to capture most of its claims electronically. The small number of paper claims received were either for services that required additional documentation, such as medical records, or services rendered by out-of-network providers. Paper claims were submitted to Home State Health's vendor for scanning. The scanning vendor then transmitted the paper claims back to Home State Health in standard 837 electronic formats for processing in AMISYS. Home State Health continued to have less than 5% manual intervention for claims processing. Most of the manual steps in processing were due to high-dollar claims that required supervisor approval. As in previous audits, Primaris reviewed the coding schemes to determine if nonstandard coding was used. Home State Health did not use any nonstandard coding during the measurement year.

Home State Health's AMISYS system captured primary, secondary, and modifier codes appropriately. Coding updates to the AMISYS system were made annually to ensure the most recent coding schemes were captured. Ninety-nine percent of Home State Health providers continued to be reimbursed based on an FFS payment model, which ensured claims were submitted in a timely manner. As part of the drill-down queries conducted for the audit, Primaris validated that all claims contained appropriate coding and provider payment information. Provider identifiers were reviewed and verified to ensure they were active and credentialed at the time of service on the claim.
Primaris had no concerns with Home State Health's claims and encounter data processes.

Enrollment Data

There were no changes to the enrollment process from the previous year. Home State Health reported an increase in membership during MY 2020. The membership increase can be attributed to Covid-19. The State halted the redetermination process for Medicaid

eligibles in MY 2020 which led to members not being disenrolled. Additionally, Covid-19's forced business shut-downs and layoffs created new Medicaid eligible members. Home State Health denied having any negative impact on enrollment processing due to the increase in membership. There were no concerns with Home State Health's accuracy or significant backlogs of enrollments due to the pandemic.

Home State Health's enrollment data were housed in the AMISYS system, and no changes have been made to the system since the previous year's audit. Enrollment data were still received daily and monthly from the State. New members were processed and entered into AMISYS using electronic methods. Occasionally, enrollment data were added manually upon request by the State. Home State Health's load program contained logic for cross-checking manually entered member information to avoid duplicate records. Home State Health performed monthly reconciliation of enrollment data to ensure all member information was complete and accurate. Additionally, Home State Health submitted enrollment files to its external vendors for processing. The automated process of enrollment at Home State Health included translation and compliance validation of the 834 files and loading of the data into AMISYS. The load program also identified members that were previously entered manually and updated their information, avoiding duplicate entries. Home State Health also processed enrollment changes. Enrollment changes were made primarily via the systematic loads after a change was received in the State files. Change requests submitted via telephone were updated manually by enrollment processors. Home State Health conducted appropriate oversight of the enrollment process through ongoing internal audits and communication with the State enrollment authority.

During the virtual review, Primaris verified that the members captured in the performance measures were the appropriate populations. Primaris selected a sample of members from several administrative numerators and verified that the members were compliant with the measure specifications. Primaris verified age, gender, and enrollment history along with diagnosis and procedure codes. No issues were found during the system review. Primaris had no concerns with Home State Health's ability to capture member information.

Provider Data

There were no changes to the provider process this year. Home State Health continued to utilize two systems for provider processing, Portico, and AMISYS. Provider files were first loaded into Home State Health's Portico system, where the provider began the credentialing process. Once the provider was credentialed, the provider information was loaded into AMISYS. Home State Health had a process to validate provider information daily to ensure both systems contained the same demographic information. Specialties were validated in Portico and then matched with AMISYS.

The two systems used by Home State Health were linked by the unique provider identification number. No significant changes were made to the systems during the measurement year other than provider maintenance. Primaris verified provider specialties and certification status for the W34 measure to ensure they were primary care specialties. The audit team had no concerns upon inspection of the data as both provider systems matched perfectly. Additional verification of the provider specialties looked at the provider credentials to ensure they were appropriately captured in both Portico and AMISYS. The provider credentials review was compliant and matched both systems. Primaris validated that all providers operating in Home State Health's network were licensed to operate under the Medicaid Managed Care contract for the MHD.

AMISYS maintained all relevant information required for performance measure reporting. Both Portico and AMISYS contained unique identifiers and captured identical information as expected. There were no updates or changes to Home State Health's provider data processes, including capturing provider data through its delegated entities.
The final rate review did not reveal any issues with provider mapping for any of the performance measures.

Medical Record Review Validation
Medical record review was not part of the EQR 2021 for MY 2020 as the measures were strictly administrative only and did not include a medical record component.

Supplemental Data
Numerator positive hits through supplemental data sources W30 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record acquisition.

Home State Health Measure Specific Rates
Tables 3-3 to 3-5 show the results of the performance measures in the format adopted from the CMS EQR Protocol 2.

Table 3-3. Home State Health Inpatient Readmissions			
Age Cohort	**Mental Health**	**Substance Abuse**	**Medical**
Age 0-12 – Numerator	82	0	464
Age 0-12 – Denominator	1,568,150	1,568,150	1,670,240
Age 13-17 – Numerator	149	4	103
Age 13-17 – Denominator	481,027	481,027	534,828
Age 18-64 – Numerator	99	35	671
Age 18-64 – Denominator	489,336	489,336	503,938
Age 65+ - Numerator	0	0	0

Age 65+ - Denominator	54	54	8
Total – Numerator	330	39	1,238
Total - Denominator	2,538,567	2,538,567	2,709,006

Table 3-4. Home State Health Well-Child Visits in the First 30 Months of Life (W30)*			
Data Element/MY	**2018**	**2019**	**2020**
First 15 Months Numerator	NA	NA	3,686
First 15 Months Denominator	NA	NA	7,729
First 15 Months Rate	NA	NA	47.69%
15 – 30 Months Numerator	NA	NA	3,806
15 – 30 Months Denominator	NA	NA	5,729
15 – 30 Months Rate	NA	NA	66.43%

*New Measure in MY 2020

Table 3-5. Home State Health Chlamydia Screening in Women All Ages (CHL)			
Data Element/MY	**2018**	**2019**	**2020**
Numerator	3,750	2,972	4,314
Denominator	7,978	6,170	9,395
Rate	47.00%	48.17%	45.92%

3.2.1 Quality, Timeliness, and Access

Strengths.

- Home State Health staff was well prepared for an onsite review and completed all claims and preparation ahead of schedule.
- Home State Health was able to demonstrate and articulate their knowledge and experience of the measures under review.
- Home State Health continues to update the AMISYS systems with the most current diagnoses and procedures as they become available during the year.
- Appropriate services such as laboratory, primary care, and hospital access are readily available in all regions. Admission to hospitalization would require proper authorization. However, participating hospitals are well informed of the process for obtaining authorizations from Home State Health based on conversations with Home State Health's staff.
- Home State Health demonstrated its ability to capture the specific diagnosis codes for each Inpatient Readmission (MH, SA, and MED), CHL, and W30.

- Home State Health continues to monitor and improve upon the data capture in both primary and supplemental data for numerator compliance.

Weakness.
Home State Health's CHL rate in MY 2020 dropped 2.25 percentage points compared to MY 2019. However, it should be noted that this percentage drop in CHL is within the 5% statistically significant threshold.

3.2.2 Improvement from previous year

Some improvement was noted in the Inpatient Readmission measure. Total MH readmissions dropped from 355 in MY 2019 to 330 in MY 2020 (lower the better) (Table 3-6).

Table 3-6. Home State Health Inpatient Mental Health Readmissions MY 2018-2020

Age Cohort	2018	2019	2020
Age 0-12	115	110	82
Age 13-17	193	163	149
Age 18-64	130	82	99
Age 65+	0	0	0
Total	438	355	330

Response to Previous Year's Recommendations. Table 3-7 describes actions taken by Home State Health in response to EQRO recommendations during previous EQR 2020. No weakness/issue was identified in Home State Health's ISCA conducted to validate performance measures during the previous year.

Table 3-7. Home State Health's Response to Previous Year's Recommendations

Recommendation	Action by Home State Health	Comment by EQRO
Home State Health would benefit from implementing strategies to engage members in proper screenings through outreach campaigns once they become aware of a female member becoming sexually active during the ages of 16-24 years. Home State Health should engage providers to immediately begin testing for chlamydia once they have become aware of the member's sexual activity. Additionally, it is advisable that providers discuss the HPV vaccination at	Home State Health continued to address gaps in care for all measures, but no specific activity addressed screenings.	Although this was not a significant drop in the rates, CHL still remains a concern. The total rate dropped from 48.17% to 45.92% from MY 2019. Primaris continues to recommend

the same time if this hasn't already been addressed.		continued outreach to members for screenings.
Medical readmissions should be addressed to determine the primary cause for readmission.	Home State Health utilizes discharge planning following discharges.	The frequency of readmissions should be examined further to prevent any avoidable readmissions.
Primaris recommends Home State Health conduct a further examination into solutions for the continuous readmissions by individual members, especially in the pediatric cohort (ages 0-17).	Home State Health reduced the overall readmissions for MH in the 0-17 category by 42 admissions compared to last year (273 in 2019 to 231 in 2020).	The admissions were part of an overall effort to reduce readmissions for MH.
Primaris continues to recommend Home State Health pursue outpatient mental health engagements following a discharge from a hospital with a diagnosis of mental illness.	Home State Health reduced the overall readmissions for MH in the 0-17 category by 42 admissions compared to last year (273 in 2019 to 231 in 2020).	The admissions were part of an overall effort to reduce readmissions for MH by providing better access to outpatient mental health services.

3.3 Findings, Analysis, and Conclusions: Healthy Blue

Table 3-8 shows the scores achieved by Healthy Blue during the performance measures validation process.

Table 3-8. Healthy Blue Performance Measures Process

Criteria	Met	Not Met	N/A
Data Integration	●		
Data Control	●		
Performance Measure Documentation	●		
Medical Service Data (Claims and Encounters)	●		

Enrollment Data	●		
Provider Data	●		
Medical Record Review Validation			N/A
Supplemental Data	●		

Data Integration

Healthy Blue's data integration process did not change from the previous year's review. Healthy Blue continued to use Inovalon software for performance measures, QSI-XL. Healthy Blue indicated there were no significant issues with the migration, and no concerns were identified during on-site primary source verification.

Healthy Blue's internal data warehouse combined all files for uploading into QSI-XL's certified measures software. The internal data warehouse combined all systems and external data into tables for consolidation prior to loading into QSI-XL file layouts. Most of the information was derived from the Xcelys system, while external data such as supplemental and vendor files were loaded directly into the data warehouse tables. Primaris conducted a review of the HEDIS® data warehouse and found it to be compliant. Healthy Blue had several staff members involved in the process with many years of experience in dealing with data extractions, transformations, and loading. The warehouse continued to be managed well, and access was only granted when required for job duties. Primaris conducted primary source verification and did not encounter any issues during the validation. Member data matched Xcelys as well as the data warehouse and Inovalon numerator events. Primaris also conducted a series of queries during the on-site audit and did not identify any issues. Primaris reviewed Healthy Blue's preliminary rates and did not identify any concerns.

Healthy Blue will be transitioning all provider information from its legacy Missouri Care systems to Healthy Blue systems in MY 2021.

Data Control

Primaris validated the data control processes Healthy Blue used, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Primaris determined that the data control processes in place at Healthy Blue were acceptable.

Performance Measure Documentation

Primaris' Lead Auditor reviewed the computer programming codes, output files, workflow diagrams, primary source verification, and other related documentations and assigned a "Met" score to Healthy Blue for this section.

Medical Service Data (Claims and Encounters)

Even though Anthem, Inc. acquired Missouri Care effective Jan 23, 2020, all claims transactions continued to be processed on Missouri Care's legacy claims system Xcelys during MY 2020. The review focused on the claim system that processed the claims in MY 2020, Xcelys. There were no system or process changes from the previous year's review of the claims and encounters systems for Healthy Blue.

Healthy Blue reported having no negative impact on claims processing due to the Covid-19 pandemic. Healthy Blue did not encounter any significant backlog of claims that they weren't able to resolve in time for performance measure reporting. During the virtual onsite review of the claims completeness and incurred but not received report (IBNR), Primaris did not identify any concerns. Healthy Blue maintained that ninety-five percent (95%) of claims were received in time to be included in the performance measures, having no significant change from the previous year's review.

Primaris reviewed Healthy Blue's claims process using the ISCA tool and during the on-site audit to determine that only standard coding and claim forms were used.
Healthy Blue's Xcelys system captured primary and secondary procedure and diagnosis codes without any issues. The claims system also had the capability to capture as many codes as were billed on a claim. Paper claims transactions were mailed to a Tampa, Florida, mailbox (Change Healthcare-Relay Health), then captured by Imagenet. Imagenet scanned the claims, converted them to an 837 format, and verified that all data were captured. Imagenet's quality control center ensured data were captured appropriately.

Healthy Blue monitored the Imagenet claims daily to ensure all values were captured on the scanned claims. Healthy Blue conducted audits on three percent of all claims submitted. Nearly 100 percent of claims were processed offshore, with exceptions. Approximately 84 percent of all claims were auto adjudicated. In addition to the edits conducted in the pre-processing steps, Healthy Blue used edits within Xcelys to detect provider, member, and payment errors to ensure members existed and payments were accurate. Healthy Blue indicated that it had no issues with providers submitting claims in MY 2020.
Ninety-nine percent of all claims were captured within one day and 100 percent within two days. Healthy Blue also captured encounter data from capitated vendors. Vendor encounters included dental, transportation, and vision. While these encounters were not captured in Xcelys, they underwent edits in Edifecs (XEngine) to verify valid billing codes and member information.
Primaris did not have any concerns with Healthy Blue's claims and encounter data

processing for MY 2020. Healthy Blue is planning on transitioning from Xcelys to Facets during MY 2021.

Enrollment Data

There were no changes to the enrollment process from the previous year. Healthy Blue reported an increase in membership during MY 2020. The membership increase can be attributed to Covid-19. The State halted the redetermination process for Medicaid eligibles in MY 2020 which led to members not being disenrolled. Additionally, Covid-19's forced business shut-downs and layoffs created new Medicaid eligible members. Healthy Blue denied having any negative impact on enrollment processing due to the increase in membership. There were no concerns with Healthy Blue's accuracy or any significant backlogs of enrollments due to the pandemic.

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

Primaris selected a sample of members from several administrative numerators and verified that the members were compliant with the measure specifications. Primaris verified age, gender, and enrollment history along with diagnosis and procedure codes. No issues were found during the system review. Healthy Blue conducted appropriate oversight of the enrollment process through ongoing internal audits and communication with the State enrollment authority.

During the virtual review, Primaris verified that the members captured in the performance measures were the appropriate populations.

Primaris had no concerns with Healthy Blue's ability to capture member information. Healthy Blue will be transitioning all enrollment information from Xcelys to Facets in MY 2021.

Provider Data

Healthy Blue utilized Xcelys to capture its provider data for claims processing. Healthy Blue utilized both direct contracted and delegated entities to enroll providers. Healthy Blue used an internal software tracking mechanism (Omniflow) to manage its provider information. Omniflow was used to send provider data to Healthy Blue's Credentialing department for provider management prior to loading into Xcelys. Once the provider information flowed through Omniflow, the data were then loaded into Xcelys. A unique provider identifier was created along with provider specialties. Healthy Blue's credentialing staff ensured provider specialties were appropriate by validating the provider's education and specialty assignment authorized by the issuing provider board. Primaris verified that the required HEDIS® reporting elements were present in Xcelys, and provider specialties were accurate based on the provider mapping documents submitted with Healthy Blue's ISCA.
All providers were appropriately credentialed in the specialties in which they were practicing. Healthy Blue followed strict credentialing verification to ensure providers did not have any sanctions or criminal activity. In addition, all verification included background checks for each provider prior to committee approval.

Primaris reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. Primaris found Healthy Blue to be compliant with the credentialing and assignment of individual providers at the Federally Qualified Health Centers (FQHCs).
There were no changes to Healthy Blue's provider data processes, including capturing provider data through its delegated entities. Healthy Blue reported no issues related to the Covid-19 pandemic. Healthy Blue will be transitioning all provider information from its legacy Missouri Care systems over to Healthy Blue systems in MY 2021.

Medical Record Review Validation

Medical record review was not part of the EQR 2021 for MY 2020 as the measures were strictly administrative only and did not include a medical record component.

Supplemental Data

Numerator positive hits through supplemental data sources W30 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record acquisition.

Healthy Blue Measure Specific Rates

Tables 3-9 to 3-11 show the results of the performance measures in the format adopted from the CMS EQR Protocol 2.

Worksheet 3-9. Healthy Blue Inpatient Readmissions			
Age Cohort	**Mental Health**	**Substance Abuse**	**Medical**
Age 0-12 – Numerator	118	0	536
Age 0-12 – Denominator	1,519,337	1,519,337	1,616,326
Age 13-17 – Numerator	224	4	111
Age 13-17 – Denominator	484,999	484,999	533,828
Age 18-64 – Numerator	104	23	658
Age 18-64 – Denominator	474,233	474,233	487,528
Age 65+ - Numerator	0	0	0
Age 65+ - Denominator	77	77	77
Total – Numerator	**446**	**27**	**1,305**
Total - Denominator	**2,478,646**	**2,478,646**	**2,637,759**

Table 3-10. Healthy Blue Well-Child Visits in the First 30 Months of Life (W30)*			
Data Element/MY	**2018**	**2019**	**2020**
First 15 Months Numerator	NA	NA	4,238
First 15 Months Denominator	NA	NA	8,163
First 15 Months Rate	NA	NA	**51.92%**
15 – 30 Months Numerator	NA	NA	3,571
15 – 30 Months Denominator	NA	NA	4,995
15 – 30 Months Rate	NA	NA	**71.49%**

*New Measure in MY 2020

Table 3-11. Healthy Blue Chlamydia Screening in Women All Ages (CHL)			
Data Element/MY	**2018**	**2019**	**2020**
Numerator	2,288	1,909	2,708
Denominator	7,402	5,899	9,195
Rate	30.91%	32.36%	29.43%

3.3.1 Quality, Timeliness, and Access

Strengths.

- Healthy Blue staff was well prepared for an onsite review and completed all claims and preparation ahead of schedule.

- Healthy Blue was able to demonstrate and articulate their knowledge and experience of the measures under review.
- Healthy Blue continues to update the Xcelys system with the most current diagnoses and procedures as they become available during the year.
- Healthy Blue did not appear to have any barriers to care services even with the transition to Anthem, Inc.
- Healthy Blue's policies and procedures address quality of care for its members.
- Appropriate services such as laboratory, primary care, and hospital access are readily available in all regions. Admission to hospitalization requires proper authorization, and participating hospitals are well informed of the process for obtaining authorizations from Healthy Blue.
- Healthy Blue demonstrated its ability to capture the specific diagnosis codes for each Inpatient Readmission (MH, SA, and MED), CHL, and W30.
  Healthy Blue continues to monitor and improve upon the data captured in both primary and supplemental data for numerator compliance.

Weakness.
Healthy Blue's CHL rate in MY 2020 dropped 2.93 percentage points compared to MY 2019. However, it should be noted that this percentage drop in CHL is within the 5% statistically significant threshold.

3.3.2 Improvement from previous year

Some improvement was noted in the Inpatient Readmission measure. Total MH readmissions dropped from 514 in MY 2019 to 446 in MY 2020 (lower the better) (Table 3-12).

Table 3-12. Healthy Blue Inpatient Mental Health Readmissions MY 2018-2020

Age Cohort	2018	2019	2020
Age 0-12	204	169	118
Age 13-17	230	233	224
Age 18-64	111	112	104
Age 65+	0	0	0
Total	545	514	446

Response to Previous Year's Recommendations. Table 3-13 describes actions taken by Healthy Blue in response to EQRO recommendations during the previous EQR 2020. No weakness/issue was identified in Healthy Blue's ISCA conducted to validate performance measures during the previous year.

Table 3-13. Healthy Blue's Response to Previous Year's Recommendations		
Recommendation	**Action by Healthy Blue**	**Comment by EQRO**
Although readmissions decreased for the measurement year and effective January 23, 2020, ownership of Missouri Care was changed from WellCare to Anthem, Inc. (dba Healthy Blue). Primaris recommends that Healthy Blue continue to create outreach programs to prevent readmissions within 30 days for the same mental health diagnosis.	Healthy Blue had outreach programs in place to address mental health readmissions overall.	Continue to develop robust outpatient outreach to members to reduce the incidence of readmissions.
Healthy Blue continues to engage members through outreach programs to ensure they are informed of upcoming service requirements. However, there are still concerns with reaching all members. Healthy Blue's chlamydia screening rates are significantly lower in the Central and Southwest Regions. It appears that these two regions would be good candidates for a deeper dive into why compliance is so low.	Minimal interventions were possible due to Covid-19 office closures. This resulted in a lower CHL rate.	It is recommended that Healthy Blue continue to enhance outreach and education to members and providers for future review.
Members should be encouraged to seek outpatient mental health services and follow up once a member is discharged from the hospital following an admission for mental health reasons.	Members were outreached throughout the year and educated to seek outpatient services.	Readmissions decreased for MY 2020. Healthy Blue should continue to use outreach programs/care management to prevent further readmissions for the same diagnosis.

3.4 Findings, Analysis, and Conclusions: UnitedHealthcare

Table 3-14 shows the scores achieved by UnitedHealthcare during the performance measures validation process.

Table 3-14. UnitedHealthcare Performance Measures Process

Criteria	Met	Not Met	N/A
Data Integration	●		

Data Control	●		
Performance Measure Documentation	●		
Medical Service Data (Claims and Encounters)	●		
Enrollment Data	●		
Provider Data	●		
Medical Record Review Validation			N/A
Supplemental Data	●		

Data Integration

UnitedHealthcare used the Inovalon QSI-XL software to produce the performance measure rates under the scope of the review. UnitedHealthcare utilized the CSP Facets system and its relational database/data warehouse to collect and integrate data for reporting.
The Facets production database contained claims, provider, and member data. These data streams were extracted weekly and loaded into the data warehouse, and consumed with vendor data (e.g., laboratory and vision providers). Facets and encounter data were linked using unique identifiers in Facets linking all other identifiers from external sources such as State Medicaid identifiers and social security numbers. All identifiers were tracked and captured in a central data warehouse where they linked members with their encounters and claims transactions.

UnitedHealthcare utilized senior analysts or managers to examine and approve code for quality and validation. Results were compared to prior year's metrics when available or Medicaid benchmarks to determine the reasonableness of results. Per UnitedHealthcare's maintenance cycle, data was reviewed and validated by the assigned analyst and the business owner after requirements were verified and approved. There were no critical errors detected in any of the measures under review.
There were no concerns with UnitedHealthcare's ability to consolidate and report performance measure data.

Data Control

Primaris validated the data control processes UnitedHealthcare used, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Primaris determined that the data control processes in place at UnitedHealthcare were acceptable.

Performance Measure Documentation

Primaris' Lead Auditor reviewed the computer programming codes, output files, workflow diagrams, primary source verification, and other related documentations and assigned a "Met" score to UnitedHealthcare for this section.

Medical Service Data (Claims and Encounters)

There were no system or process changes from the previous year's review of the claims and encounters systems for UnitedHealthcare.

UnitedHealthcare's continued to use the Facets system during MY 2020. UnitedHealthcare only updated the procedure and diagnosis coding along with the regular maintenance of Facets during the MY 2020. These coding updates were done annually. Primaris confirmed that UnitedHealthcare only used standard paper claim forms, CMS-1500 and UB-94, and standard 837P and 837I for electronic submissions. Primaris also confirmed that all vendors used these standard claim forms.

UnitedHealthcare was able to distinguish between the primary and secondary coding schemes. Incomplete claims submitted from providers were promptly rejected and returned for additional information. Incomplete claims were not allowed in the claims system until all required fields were present and valid. UnitedHealthcare's pre-processing edits verified the accuracy of submitted information on all claims and encounters. Claims containing errors such as invalid Current Procedural Terminology (CPT) or diagnosis codes were rejected and returned to the service provider for correction. There were no circumstances where a processor was able to update or change the values on a submitted claim. All medical and behavioral claims were processed using industry-standard paper and electronic means. Medicaid claims were audited regularly for financial and procedural accuracy by randomly selecting thirty-two (32) claims on a weekly basis to validate accuracy and data quality. Quality errors are rectified, and additional training is provided to the claims examiners when issues arise.

Facets provided the claims examiner with specific error messages when a pre-authorization request did not match the service rendered by the provider or when the provider did not request a pre-authorization prior to rendering the service. In either circumstance, the claim required a medical review and was pended for Utilization Management for review. UnitedHealthcare maintained that 99% of all claims were processed within 90 days.

Primaris had no concerns with UnitedHealthcare's claims/encounter processing.

Enrollment Data

There were no changes to the enrollment process from the previous year. UnitedHealthcare reported an increase in membership during MY 2020. The membership increase can be attributed to Covid-19. The State halted the redetermination process for Medicaid eligibles

in MY 2020 which led to members not being disenrolled. Additionally, Covid-19's forced business shut-downs and layoffs created new Medicaid eligible members. UnitedHealthcare denied having any negative impact on enrollment processing due to the increase in membership. There were no concerns with UnitedHealthcare's accuracy or significant backlogs of enrollments due to the pandemic.

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

Medicaid disenrollment and re-enrollment information is entered in the Facets eligibility module. Once UnitedHealthcare received notification of a member's disenrollment, a termination date was entered. If that same member is re-enrolled, the member is reinstated, and a new effective date is created. The member's enrollment spans were captured for reporting and combined to assess continuous enrollment.
There is only one circumstance where a Medicaid member can have multiple identifiers. This occurs when the MHD sends an existing member using different Medicaid identifiers. In this scenario, UnitedHealthcare's enrollment system could potentially create a duplicate entry using that information. Duplicates are resolved by informing the MHD that a potential duplicate exists and then rectifying it manually until a new corrected record is submitted from the MHD and voiding the previous duplicate record.
There were no issues identified with UnitedHealthcare's enrollment data processes as it pertains to performance measurement.
Primaris had no concerns with UnitedHealthcare's ability to capture member information.

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

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

Primaris reviewed the process for mapping provider specialties and verified primary care specialties during the virtual onsite review, primary source verification session. All provider specialties matched the certified provider taxonomy. Primaris also found UnitedHealthcare to be compliant with the credentialing and assignment of individual providers at the Federally Qualified Health Centers (FQHCs).
There were no changes to UnitedHealthcare's provider data processes, including capturing provider data through its delegated entities. UnitedHealthcare did not report any issue related to the Covid-19 pandemic.

Medical Record Review Validation
Medical record review was not part of the EQR 2021 for MY 2020 as the measures were strictly administrative only and did not include a medical record component.

Supplemental Data
Numerator positive hits through supplemental data sources W30 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record acquisition.

UnitedHealthcare Measure Specific Rates
Tables 3-15 to 3-17 show the results of the performance measures in the format adopted from the CMS EQR Protocol 2.

Table 3-15. UnitedHealthcare Inpatient Readmissions			
Age Cohort	**Mental Health**	**Substance Abuse**	**Medical**
Age 0-12 – Numerator	68	0	380
Age 0-12 – Denominator	1,225,123	1,225,123	1,300,020
Age 13-17 – Numerator	111	1	43
Age 13-17 – Denominator	407,388	407,388	445,268
Age 18-64 – Numerator	76	8	358

Age 18-64 – Denominator	470,909	470,909	481,387
Age 65+ - Numerator	0	0	0
Age 65+ - Denominator	52	52	52
Total – Numerator	255	9	781
Total - Denominator	2,103,472	2,103,472	2,226,727

Table 3-16. UnitedHealthcare Well-Child Visits in the First 30 Months of Life (W30)*

Data Element/MY	2018	2019	2020
First 15 Months Numerator	NA	NA	3,412
First 15 Months Denominator	NA	NA	7,330
First 15 Months Rate	NA	NA	46.55%
15 – 30 Months Numerator	NA	NA	2,943
15 – 30 Months Denominator	NA	NA	4,558
15 – 30 Months Rate	NA	NA	64.57%

*New Measure in MY 2020

Table 3-17. UnitedHealthcare Chlamydia Screening in Women All Ages (CHL)

Data Element/MY	2018	2019	2020
Numerator	2,481	2,275	3,727
Denominator	5,514	4,921	8,232
Rate	44.99%	46.23%	45.27%

3.4.1 Quality, Timeliness, and Access

Strengths.

- UnitedHealthcare staff was well prepared for an onsite review and completed all claims and preparation ahead of schedule.
- UnitedHealthcare was able to demonstrate and articulate their knowledge and experience of the measures under review.
- UnitedHealthcare continues to update its systems with the most current diagnoses and procedures as they become available during the year.
- UnitedHealthcare continues to review its source code to ensure it is error-free.
- Appropriate services such as laboratory, primary care, and hospital access are readily available in all regions.
- UnitedHealthcare demonstrated its ability to capture the specific diagnosis codes for Inpatient Readmissions (MH, SA, and MED), CHL, and W30.

Weakness. UnitedHealthcare experienced an increase in readmissions for mental health from the previous year, increasing from 195 readmissions in MY 2019 to 255 readmissions in MY 2020 (lower the better) (Table 3-18).

Table 3-18. UnitedHealthcare Inpatient Mental Health Readmissions MY 2018-2020

Age Cohort	2018	2019	2020
Age 0-12	46	63	68
Age 13-17	83	96	111
Age 18-64	53	36	76
Age 65+	0	0	0
Total	182	195	255

UnitedHealthcare's CHL rate in MY 2020 dropped just under one percentage point compared to MY 2019 (Worksheet 3c above). However, it should be noted that this percentage drop in CHL is within the 5% statistically significant threshold.

3.4.2 Improvement from previous year

Although there were no significant improvements in the CHL or Inpatient Readmissions (MH) this year, much of that may be due to the Covid-19 pandemic and is not data capture related. This information was substantiated by UnitedHealthcare staff that indicated routine screenings were heavily impacted by office closures during the pandemic. It should also be noted that there was also a significant increase in enrollment which likely compounded the negative impact on rates as new members may have been eligible but not seeking services due to Covid-19 office closures.

Response to Previous Year's Recommendations. Table 3-19 describes actions taken by UnitedHealthcare in response to EQRO recommendations during previous EQR 2020. No weakness/issue was identified in UnitedHealthcare's ISCA conducted to validate performance measures during the previous year.

Table 3-19. UnitedHealthcare's Response to Previous Year's Recommendations

Recommendation	Action by UnitedHealthcare	Comment by EQRO
UnitedHealthcare should continue to engage members through outreach programs to ensure they are informed of upcoming service requirements. However, there are still concerns with reaching all members.	UnitedHealthcare continues to send reminders to providers and members. Regional reporting has been	UnitedHealthcare must continue to observe open gaps for measures to ensure members

UnitedHealthcare's chlamydia screening rates are significantly lower in the Central and Southwest Regions. It appears these two regions would be good candidates for a deeper dive into why compliance is lower than other regions.	eliminated for CHL.	are offered every opportunity to get the required care.
Members should be encouraged to seek outpatient mental health services and follow up once a member is discharged from the hospital following an admission for mental health reasons.	UnitedHealthcare staff informed Primaris that they had conducted outreach through HEDIS® programs around the Follow Up after Hospitalization for Mental Illness measure. However, there was no overall reduction in the readmissions for mental illness.	Enhanced care management and outreach are needed to reduce readmissions for mental illness within 30 days of discharge.

3.5 Recommendations for MCOs

Primaris recommends the following for Home State Health, Healthy Blue, and UnitedHealthcare.

- The MCOs pursue outpatient mental health services and educate the members to have a follow-up visit to a doctor within seven days and 30 days of a hospital discharge.
- The MCOs continue to address readmissions for medical services by coordinating care plans with primary care providers to ensure discharge planning is followed up on within 24 hours of a discharge.
- The MCOs should incentivize providers to meet with members for the W30 measure.
- The MCOs continue education and outreach efforts to members and providers to increase Chlamydia screenings.

4.0 Review of Compliance with Medicaid and CHIP Managed Care Regulations

4.1 Description, Objective, and Methodology

Primaris audited Home State Health, Healthy Blue, and UnitedHealthcare to assess compliance with the Medicaid and CHIP Managed Care Regulations; the MHD's QIS; the MHD Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous year's review. EQR 2021 is the first year of the current review cycle (2021-2023). Table 4-1 describes the regulations that will be covered during EQR 2021-2023.

Table 4-1. Regulations for Current Review Cycle (2021-2023)

Year	42 CFR 438 (Medicaid)	42 CFR 457 (CHIP)	Standard Name
EQR 2021 (1-year)	438.56	457.1212	Disenrollment: Requirements and limitations
	438.100	457.1220	Enrollee rights
	438.114	457.1228	Emergency and post-stabilization services
	438.230	457.1233(b)	Subcontractual relationships and delegation
	438.236	457.1233(c)	Practice guidelines
	438.242	457.1233(d)	Health information systems
EQR 2022 (2-year)	438.206	457.1230(a)	Availability of services
	438.207	457.1230(b)	Assurances of adequate capacity and services
	438.208	457.1230(c)	Coordination and continuity of care
	438.210	457.1230(d)	Coverage and authorization of services
	438.214	457.1233(a)	Provider selection
	438.224	457.1110	Confidentiality
	438.228	457.1260	Grievance and appeal systems
EQR 2023 (3-year)	438.330	457.1240(b)	Quality assessment and performance improvement program

Note: In the assessment of 42 CFR 438.242 (457.1233d) Health Information System, Primaris marked one criterion as Not Applicable (N/A) during EQR 2021: Application Programming Interface (API) as specified in 42 CFR 431.60 and 431.70. API was required to be implemented by January 1, 2021. However, per CMS's letter dated August 14, 2020, due to the COVID-19 public health emergency, CMS exercises enforcement discretion and does not expect to enforce this requirement prior to July 1, 2021. Therefore, Primaris will evaluate this criterion as a follow up item during the next EQR 2022 for all the MCOs.

Primaris utilized CMS EQR Protocol 3, version Oct 2019: Review of Compliance with

Medicaid and CHIP Managed Care Regulations, to conduct a compliance review in February-May 2021. The evaluation process included the following steps:
Collaboration: Primaris collaborated with the MHD and the three MCOs:

- To determine the scope of the review, scoring methodology, and data collection methods.
- To finalize the site review (virtual meeting) agenda.
- To collect and review data/documents before, during, and after the site meeting.
- To analyze the data and identify strengths and weaknesses.
- To prepare a report related to the findings of the current year.
- To review the MCOs' response to previous EQR recommendations.

Evaluation Tools: Primaris created evaluation tools based on the CFR, EQR protocol, the MHD Managed Care contract, and the QIS (Appendices A-F).

Technical Assistance (TA): Primaris provided TA to the MCOs pre-and post-site meeting. Before the preliminary review, the evaluation tools were sent to the MCOs to set up the documents' submission expectations.

Documents' Submission: The three MCOs submitted their documents via Amazon Web Services-simple storage services (AWS S3) to enable a complete and in-depth analysis of its compliance with regulations. These documents included policies, procedures, spreadsheets, PowerPoint presentations, reports, newsletters, mailers, and screenshots.

Site Interviews: Primaris conducted virtual site meetings with Home State Health, Healthy Blue, and UnitedHealthcare from April 6-9, 2021, due to travel restrictions to the onsite office in Missouri during the Covid-19 Pandemic. The purpose of the interview was to collect data to supplement and verify the learnings through the preliminary document review.

Compliance Ratings

The information provided by the MCOs was analyzed and assigned an overall compliance score. Two points were assigned for each criterion/section evaluated in a regulation (denominator) and scored as Fully Met (2 points), Partially Met (1 point), or Not Met (0 points)(Numerator). Primaris utilized the compliance rating system (Table 4-2) from EQR Protocol 3.

Table 4-2. 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–provides 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 points): No documentation is present, and MCO staff have little to no knowledge of processes or issues that comply with regulatory provisions; or No documentation is present, and MCO staff have little to no knowledge of processes or issues that comply with key components (as identified by the State) of a multi-component provision, regardless of compliance determinations for remaining non-key components of the provision.

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

Corrective Action Process

Primaris initiated a corrective action plan (CAP) after submitting the final report to the MHD. The MCOs were required to identify for Partially Met/Not Met criteria, the interventions it planned to implement to comply with the regulations, including how the MCOs will measure the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. The MCOs submitted the CAP to the MHD within 10 days of its initiation. When deemed sufficient, the MHD, in consultation with Primaris, approves the CAPs. Within 90 days of approval of the CAPs, the MCOs must submit their documentation to close the identified noncompliant criteria. Primaris will evaluate the submissions and report in the next year (EQR 2022).

4.2 Findings, Analysis, Conclusions, and Recommendations: Home State Health

EQR 2021 involved assessing six federal regulations, with Home State Health achieving a compliance score of 91.5%. The score and audit result for each regulation are presented in Table 4-3.

Table 4-3. Home State Health Compliance Summary-EQR 2021 (1-Year)

Medicaid	CHIP		Number of Sections/Criteria						
42 CFR 438	42 CFR 457	Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %	Audit Result
438.56	457.1212	Disenrollment: Requirements and limitations	18	16	2	0	34	94.4	●

438.100	457.1220	Enrollee rights	18	11	6	1	28	77.8	
438.114	457.1228	Emergency and post-stabilization services	12	12	0	0	24	100	
438.230	457.1233b	Subcontractual relationships and delegation	12	10	2	0	22	91.7	
438.236	457.1233c	Practice guidelines	06	06	0	0	12	100	
438.242	457.1233d	Health information systems	16	14	2	0	30	93.8	
Total			**82**				**150**	**91.5**	

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

4.2.1 Quality, Timeliness, and Access

Primaris evaluated the following federal regulations and determined strengths and weaknesses (including corrective actions) with respect to the quality, timeliness, and access to health care services furnished by Home State Health to its managed care enrollees. Recommendations pertaining to specific regulations for improving the identified weaknesses are also included in this report section.

Regulation I-Disenrollment: Requirements and Limitations.

Strengths. Home State Health staff is knowledgeable about the Disenrollment requirements and limitations per the CFR and the MHD contract. Home State Health has policies and procedures for initiating a disenrollment for the reasons: member not following the prescribed treatment; missing appointments without notification; fraudulently misusing the MHD Managed Care program; indulging in misconduct; or requesting a home birth service. Home State Health shall cite at least one good cause before requesting the MHD to disenroll a member. Home State Health does not initiate disenrollment because of a medical diagnosis of a member, pre-existing medical conditions, high-cost bills, disruptive behaviors arising from members' special needs, race, color, national origin, gender, gender identity, or sexual disorientation. Until the member is disenrolled by the Department of Social Services (DSS), Home State Health continues to provide all core benefits and services to its member.

At Home State Health, a member can request disenrollment without a cause during open enrollment; within 90 days of initial enrollment; when misses the annual disenrollment opportunity in case of temporary loss of Medicaid eligibility followed by auto-enrollment; and when the MHD imposes intermediate sanctions. Home State Health acknowledged that a member could request for disenrollment for a just cause: if the transfer is a resolution to grievance or appeal; if the member's Primary Care Physician or specialist does not

participate with Home State Health; due to cultural sensitivity issues; due to services not covered; for correction of an enrollment error made by the broker; bringing all family members under one MCO; and due to sanctions imposed by the MHD. Home State Health allows automatic and unlimited changes in the MCO choice as often as circumstances necessitate the children in State care and custody and adoption subsidy. Home State Health does not require its members to go through an appeal process before asking for disenrollment, but they have an option to do so.

Except for newborns, Home State Health does not assume financial responsibility for members of other MCOs hospitalized in an acute setting on the effective date of coverage with Home State Health until an appropriate acute inpatient hospital discharge.

A member is considered a Home State Health member until receiving the 834-enrollment files from Wipro (MHD's Fiscal agent), indicating disenrollment. Home State Health does not disenroll any member. The disenrollment shall be no later than the first day of the second month following the month in which the enrollee or Home State Health files the request. The disenrollment request is deemed approved if the State fails to make the disenrollment determination within the specified timeframes. On each business day, Home State Health process the daily HIPAA 834 enrollment files obtained from Wipro for any edits and disenrollment and loads them into its claims adjudication system. Home State Health processes daily 834 files and ensures that all discrepancies are resolved within five business days from the receipt of the 834 enrollment files.

Weaknesses. Primaris identified areas of concern, so corrective action is required. The following criteria were "Partially Met":

- Disenrollment is requested by a member for a just cause, at any time, if the MCO does not cover services the member seeks because of moral or religious objections. Home State Health did not submit documentation on this requirement.
- Hospitalization at the time of enrollment or disenrollment: Home State Health did not address that Fee-For-Service members will continue to remain in Fee-For-Service until an appropriate acute inpatient hospital discharge.

Recommendations. Primaris recommends:

- Home State Health updates its policy, MO.ELIG.02 Disenrollment, and implement the member's right to request disenrollment if Home State Health does not cover services the member seeks because of moral or religious objections.
- Home State Health should specify in their policy, MO.ELIG.01 Eligibility Guidelines that Fee-For-Service members will continue to remain in Fee-For-Service until an appropriate acute inpatient hospital discharge.

Regulation II-Enrollee Rights.

Strengths. Home State Health has a policy of providing each member the following rights: to be treated with dignity; privacy; receive information on all available treatment options; participate in decisions of their healthcare including refusal of treatment; be free from restraint or seclusion; obtain a copy of medical records free of cost.

Home State Health provides notice about the termination of a contracted provider to each enrollee who received primary care by the terminated provider. The notice is provided 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later. Home State Health provides its members a member handbook and other written materials with information on how to access services within 10 business days of being notified by the MHD of their future enrollment with Home State Health. Home State Health maintains an updated web-based provider search tool. Online data is continually available for Data Quality Checks. Home State Health shall have printed hard copies of the provider directory mailed within 48 hours of a member's request. The enrollees are informed via the member handbook that the information provided on Home State Health's website is mailed in a paper form without charge within five business days upon request. Home State Health notifies its members about the non-discrimination policy in the member handbook.

Weaknesses. Primaris identified areas of concern, so corrective action is required. The following criteria were "Partially Met":

- Enrollees should receive information in accordance with 42 CFR 438.10. Home State Health does not have documentation that meets all the requirements such as:
    - MCO will have written materials critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service area.
    - Auxiliary aids and services must be made available upon request of the potential enrollee or enrollee at no cost.
    - Language assistance will be provided to enrollees who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English.
    - MCO shall make available general services and materials, such as MCO's member handbook, in the 15 languages identified by the MHD that is spoken by individuals with limited English proficiency for the State of Missouri. The MCO shall include statements in those languages that tell members that translated documents are available and how to obtain them on all materials.
- On an annual basis, MCO shall review the member handbook, revise as necessary,

and document that such review occurred. Even though Home State Health revises its member handbook annually, Home State Health's policy, MO.MBRS.06 Member Handbook and ID Cards miss three sections that must be included in the member handbook based on the MHD contract, section 2.12.16. These are as follows:

  - In the case of a counseling or referral service that MCO does not cover because of moral or religious objections, MCO must inform members that MCO does not cover the service; and MCO must inform members how they can obtain information from the State agency about how to access the services.
  - Information on how to access auxiliary aids and services, including additional information in alternative formats or languages.
  - Information on how and where members can access any benefits the State provides, including how transportation is provided.

- The information about tort, product liability, or medical malpractice lawsuits is not stated in the policy or member handbook.
- The member handbook is deficient in its contents per the instructions provided in the MHD contract, section 2.12.16 (48 items). Home State Health fully complied with 40 of 48 items, partially complied with seven items, and was deficient in one item.
- The provider directory (for all regions) submitted by Home State Health does not include all the information for all the providers and hospitals: name of providers, group affiliations, board certification status, address, telephone number, website URL, specialty, panel status, cultural and linguistic abilities, including American Sign Language or skilled medical interpreter, accommodations for people with disabilities.

  The policy, MO.PRVR.19 Provider Directory Updates, submitted post-site meeting does not include the information on website URL; accommodations for people with physical disabilities including offices, exam rooms, and equipment; American Sign Language or skilled medical interpreter availability at provider's office.
- Provider directories must be made available on the MCO's website in a machine-readable file and format specified by the Secretary (42 CFR 438.10(h)(4)). Primaris visited Home State Health's website in March 2021, and a provider directory was not found. Instead, Home State Health has a web-based search tool that allows members to search for a provider/practitioner or a health center, clinic, hospital, ancillary services-vision or dental.

Primaris identified the following criterion that was "Not Met":
MCO must give each enrollee notice of any change that MHD defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change (42 CFR 438.10(g)(4)). Home State Health did not submit a policy/procedure/documentary evidence of notifying their enrollees of any significant change in the member handbook. Home State Health submitted an email written to the

State about the changes and requested approval.

Recommendations.

- During the interview, Home State Health stated that they do not monitor whether their providers explain various treatment options to the members. Primaris recommends Home State Health educate their providers on explaining the provision in the CFR about providing treatment options to their members. Additionally, Home State Health can conduct member surveys internally to seek information from the members regarding various treatment options offered by the treating doctor.
- Home State Health must have a policy based on 42 CFR 438.10 for disseminating member information. There is no requirement for taglines in font size 18, per CFR effective December 14, 2020. Home State Health should update their policy to reflect this change after discussing with the MHD for amending their contract.
- Home State Health updates its policy, MO.MBRS.06 Member Handbook and ID Cards based on the MHD contract section 2.12.16.
- Home State Health should have a policy/procedure of notifying their enrollees of any significant change in the member handbook at least 30 days before the intended effective date of the change. Supporting evidence (mail letters, newsletters) should be submitted.
- Home State Health is recommended to update its member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16, even though the MHD provides a template.
- Home State Health is recommended to update their policy, MO.PRVR.19 Provider Directory Updates, to include all the requirements about their network providers listed under this section of the evaluation tool. The provider directory (PDF version) submitted to Primaris should be updated to consistently reflect all the criteria for every provider and hospital in the network per 42 CFR 438.10(h) and the MHD contract, section 2.12.17. Home State Health should educate its providers about the contractual requirement for submitting their information to Home State Health.
- Home State Health is recommended to upload their provider directory on their website in a machine-readable format (computer/mobile readable). Thus, the members will access them once downloaded on their computer or mobile, even without internet accessibility/availability.

Regulation III-Emergency and Post-stabilization Services.

Strengths. Home State Health has policies and procedures in place and the staff is knowledgeable about the requirements for Emergency and Post-stabilization Services: covers and pays for the emergency services regardless of whether the provider that

furnishes the services has a contract with Home State Health (in-network or out-of-network); have an agreement with the providers on payment for services; does not deny payment for treatment obtained for an emergency medical condition and post-stabilization care services within or outside of the network even though not pre-approved under certain circumstances, administered to maintain, improve, or resolve the member's stabilized condition; does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or Home State Health of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services; and does not hold an enrollee with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize him/her.

Weaknesses. There are no areas of concern, so corrective action is not required. However, Primaris noted a weakness in the document, Participating Provider Agreement for Medicaid, that states medical records retention period of 7 years from the last date of the professional service provided. The duration for the record retention does not comply with the requirement stated in 42 CFR 438.230. The records should be retained for 10 years from the last day of the contract period or from the date of completion of any audit, whichever is later.

Recommendations.

- Home State Health is recommended to update their Participating Provider Agreement for Medicaid with medical records retention to 10 years from the last date of the contract period or from the date of completion of any audit, whichever is later (ref. 42 CFR 438.230).

Regulation IV-Subcontractual Relationships and Delegation.

Strengths. Home State Health submitted one subcontract, The TurningPoint Healthcare Solutions, for review. Primaris determined that Home State Health has acknowledged that their subcontractor will not knowingly employ, hire for employment, or continue to employ an unauthorized worker to perform work within the State of Missouri. The subcontractor agreed to perform the delegated activities and reporting responsibilities specified in the contractual obligations. The contract provides for revocation of the delegation of activities or obligations or specifies other remedies when the MHD or Home State Health determines that the subcontractors did not perform satisfactorily.

The MHD contract, section 3.9.6, requires Home State Health to specify the delegated activities or obligations, and related reporting responsibilities, in the subcontract or written agreement. The subcontract incorporates all the 19 items mandated by the MHD.

The subcontractor agreed to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, agreeing that the State, CMS, the Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect at any time, any books, records, contracts, computer or other electronic systems, physical facilities, and premises of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under Home State Health's contract with the State. The right to audit exists 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

The subcontract includes appropriate provisions and contractual obligations to ensure that the MHD is indemnified, saved, and held harmless from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract. All disputes between Home State Health and any subcontractor shall be solely between such subcontractor and Home State Health.

Weaknesses. Primaris identified areas of concern, so corrective action is required. Primaris noted weakness for a criterion that is assigned a score of "Fully Met."
The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Home State Health's policy, MO.COMP.21 Oversight of Delegated Vendor states that each health care provider maintains comprehensive medical records for a minimum of seven (7) years.

Primaris identified the following criteria that were "Partially Met":

- The TurningPoint Healthcare Solutions subcontract does not incorporate the responsibility/accountability of Home State Health for all legal and financial responsibilities related to the execution of a subcontract. However, Home State Health has a policy that assumes Home State Health's responsibility for the actions of its subcontractors.
- Home State Health did not submit a policy or procedure for establishing new subcontracting arrangements or changing subcontractors, including seeking approval from the MHD before the subcontract was effective for the MHD Managed Care members. Primaris noted that the Addendum 8 of the Master Service Agreement between Home State Health (as applicable to the MHD Managed Care Contract) was effective August 21, 2019, and the MHD approved it later on August 30, 2019.

Recommendations.

- Home State Health includes a language regarding "legal and financial aspects" of

their responsibility/accountability in their policy explicitly. Also, Home State Health must incorporate it in the subcontract with TurningPoint Healthcare Solutions and all other subcontracted vendors.

- Home State Health has a policy/procedure regarding establishing new subcontracting arrangements or changing subcontractors. The MHD's approval is required before any subcontract is effective.
- Home State Health updates its policy, MO.COMP.21 Oversight of Delegated Vendor, to require its providers to maintain the records for a minimum of 10 years duration from the final date of the contract period or from the date of completion of any audit, whichever is later.

Regulation V-Practice Guidelines.

Strengths. Home State Health has practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals. Home State Health's corporate Clinical Policy Committee is responsible for researching evidence-based guidelines. These are adopted in consultation with the network providers and reviewed and updated annually and upon significant change to evidence-based guidelines. Practice Guidelines are based on the population's health needs and opportunities for improvement as identified through the Quality Assessment and Performance Improvement (QAPI) Program. New or updated guidelines are disseminated to providers via Home State Health's website as soon as possible. A listing of adopted clinical practice and preventive health guidelines is maintained in the provider manual, with the links to the full guidelines or a notation that the links and full guidelines are available on the website or a hard copy upon request. These are also provided to the enrollees and potential enrollees upon request.

Home State Health ensures that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines through process audits and Inter-Rater Reliability. At least annually, the chief medical director and vice president of medical management (VPMM) assess the consistency with which medical directors and other UM staff making clinical decisions apply UM criteria in decision-making.

Weaknesses. There are no areas of concern, so corrective action is not required. However, weakness was noted when Primaris visited Home State Health's website on April 13, 2021. The immunization schedule uploaded on the website is an old version from May 2017.

Recommendations.

- Home State Health updates the immunization schedule posted on their website with

the most current version.

- Home State Health follows what it has stated in its policy regarding informing its members about the practice guidelines. The information about practice guidelines and the members' right to request these may be disseminated via member handbooks, newsletters, mailers, website, or other ways available at Home State Health. Currently, the care managers at Home State Health inform the members enrolled in the care management program about the availability of these guidelines.

Regulation VI-Health Information Systems.

Strengths. Home State Health maintains a health information system (HIS) to collect, integrate, track, analyze, and report data. The HIS provides information on but is not limited to, Utilization, Claims, Grievance and Appeals, and Disenrollment other than loss of eligibility. Home State Health reports an expanded set of data elements for electronic transmission of claims data consistent with the Medicaid Statistical Information System to detect fraud and abuse necessary for program integrity, program oversight, and administration. Thus, Home State Health is compliant with section 6504a of the Affordable Care Act and section 1903(r)(1)(F) of the Act. Home State Health has in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically, except claims that require written documentation to justify the payment. Home State Health has a mechanism to ensure that data received from providers are accurate and complete. The encounters are submitted to the MHD within 30 days of payment of the claim. Home State Health maintains a ninety-eight percent (98%) acceptance rate on encounters submissions monthly. Sufficient enrollee encounter data is collected and maintained to identify the provider who delivers any item(s) or service(s) to enrollees. The provider identifiers required in the transactions are National Provider Identifiers (NPI), the billing provider primary identifier, the rendering provider, atypical provider. The Companion Guide provides Centene (Home State Health's parent company) trading partners with guidelines for submitting 5010 version of 837 Professional and Institutional Claims.

Home State Health's toll-free member hotline is staffed with Member/Provider Services Representatives (MSRs/PSRs) during regular business hours (8:00 am to 5:00 pm Monday through Friday excluding State holidays). After-hour member/provider hotline calls are answered by an automated attendant that furnishes the member/provider with information on office hours and confirms member enrollment. The callers will have the option to talk with Nursewise, Home State Health's 24-hour nurse information and triage line, for prior authorizations and confirmation of covered services. In the event of a major disaster, Home State Health's claims processing system shall be back online within 36 hours of the failure's or disaster's occurrence. Medicaid customer services, including

enrollment and claims information, will be back in less than four hours.

Weaknesses. There are areas of concern, so corrective action is required. Primaris identified the following criteria that were "Partially Met":

- Adherence to Key Transaction Standards: MCO shall adhere to "…electronic transactions standards, federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18, 455.19, and RSMo 376.383 and 376.384".
  Primaris noted that Home State Health did not address signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. Additionally, Primaris noted that RSMo 376.383 states, "if the health carrier has not paid the claimant on or before the forty-fifth processing day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day." However, Home State Health's Provider Billing and Claims Filling Instructions State that Home State Health will process 99% of clean claims within 90 business days of receipt.
- Submission of all enrollee encounter data, including the allowed amount and the paid amount that the State is required to report to CMS under § 438.818.
  Home State Health has not submitted information that complies with the "allowed amount" requirement for the services by the providers.

Recommendations.

- Home State Health must address signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. Also, Primaris suggests Home State Health align its claims processing deadlines per RSMo 376.383.
- Submit information on the "allowed amount" in the encounter data submitted to the MHD and Primaris for evaluation.
- Home State Health must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. Primaris will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.

4.2.2 Improvement from previous year

Table 4-4 describes Home State Health’s response to recommendations from EQR 2020.

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

Recommendations From EQR 2020	Action by Home State Health	Comment by EQRO
1. Home State Health did not report on several measures provided by the Department of Health and Senior Services (DHSS): Adequacy of Prenatal Care, Early (1st Trimester) Prenatal Care, Low Birth Weight (LBW Less than 2500G), LBW (<2500G) Delivered in Level II/III Hospital, VLBW (<1500G) Delivered in Level III Hospital, Smoking During Pregnancy, Spacing Less Than 18 Months, Birth Mothers Less than 18 Years, Repeat Births to Teen Mothers (<20 Years), Prenatal WIC Participants. (Scored as Partially Met.)	QAPI 2020: Pages-85 to 95 QAPI 2020 includes analysis, evaluation of the DHSS measures for CY 2020 and Home State Health's actions for further improvement	Fully Met
2. Home State Heath reported rates for 16 HEDIS® measures for CY 2019 along with trends in the previous two years. However, Home State Health did not evaluate or analyze their performance measures. (Scored as Partially Met.)	QAPI 2020: Pages-77 to 82 QAPI 2020 includes analysis, evaluation of the HEDIS® measures for CY 2020 and Home State Health's actions for further improvement.	Fully Met
3. Home State Health should present analysis, evaluation, trends, and recommendations for the future year regarding information related to cultural competence and requests to change practitioners. (Scored as Partially Met.)	QAPI 2020: Pages-18, 19, 20, 104 QAPI included data for CY 2020, analysis, future actions planned by Home State Health for cultural competence, and requests to change Primary Care Practitioners (PCPs).	Partially Met QAPI 2020 did not include the trends related to cultural competence and change requests for PCPs.
4. Home State Health is required to provide analysis and evaluation of a summary of services provided to members with visual or hearing impairments or members who are physically disabled (e.g., Braille, large print, cassette, sign interpreters); an inventory of member materials available in alternative formats. (Scored as Partially Met.)	QAPI 2020: Pages- 22-27 Members identified as having visual impairment were 0.03%, and mobility impairment was 0.13%. In CY 2020, no requests were received for the Alternative Format request. A catalog of documents available in	Partially Met QAPI Evaluation requires data from the review and previous years to show the trend, followed by evaluation, analysis, and future action for improvement.

	Spanish and Alternative Formats is provided. There is no data for trends and analysis.	
5. Information Management: Analysis and evaluation of Information Systems in relation to membership and providers is not provided in QAPI. (Scored as Partially Met.)	QAPI 2020: Pages-17,143, 144 Description of Information System is provided. Data on membership is provided for CY 2020. There is no data to show the trend and analyses for members and providers.	Partially Met QAPI Evaluation requires data from the review and previous years to show the trend, followed by evaluation and analysis.
6. Integrated Care Management (CM) Services for Physical and Behavioral Health. Home State Health should evaluate and analyze data regarding integrated physical and behavioral health CM. (Scored Partially Met.)	QAPI 2020: Pages-136, 137, 138 Information about the pregnancy with substance use disorder (SUD) program, data on enrollment and outreach in CY 2019 and CY 2020 is presented. The decrease in 11.3% points in enrollment is attributed to the Covid-19 Pandemic.	Partially Met Home State Health should evaluate and analyze data regarding integrated physical and behavioral health CM of pregnancy/SUD program and other members who are not pregnant and are in CM program for behavioral and physical health issues.
7. Home State Health has not provided analysis and evaluation of Average Length of Stay (ALOS); Readmissions/1000 members; Emergency Department Utilization (EDU)/1000 members; Outpatient Visits (OPV)/1000 members; Inter-Rater Reliability; Timeliness of Prior Authorization/Certification Decision Making. (Scored as Partially Met.)	QAPI 2020: Pages-157, 158, 159, 162, 163 ALOS, EDU/OPV measures have a data comparison and some analysis; other measures are reported for CY 2020 without data comparison and analysis.	Partially Met QAPI Evaluation must include data trends, evaluation, and analysis to determine the cause and actions that Home State Health will take towards improvement.
8. Home State Health should submit an evaluation and analysis of provider profiling regarding utilization of services and outcomes for CY 2019. (Scored as Partially Met.)	QAPI 2020: Pages-164 Data on utilization of services and spend rates, comparison with data from the previous year, analysis, and their plan to	Fully Met

	continue to evaluate and access utilization to identify engagement and network accessibility is provided.	

4.3 Findings, Analysis, Conclusions, and Recommendations: Healthy Blue

Primaris assessed six federal regulations, with Healthy Blue achieving a compliance score of 82.3%. The score and audit result for each regulation are presented in Table 4-5.

Table 4-5. Healthy Blue Compliance Summary-EQR 2021 (1-Year)

Medicaid	CHIP		Number of Sections						
42 CFR 438	42 CFR 457	Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %	**Audit Result**
438.56	457.1212	Disenrollment: Requirements and limitations	18	14	3	1	31	**86.1**	
438.100	457.1220	Enrollee rights	18	8	10	0	26	**72.2**	
438.114	457.1228	Emergency and post-stabilization services	12	11	1	0	23	**95.8**	
438.230	457.1233b	Subcontractual relationships and delegation	12	10	2	0	22	**91.7**	
438.236	457.1233c	Practice guidelines	6	6	0	0	12	**100**	
438.242	457.1233d	Health information systems	16	7	7	2	21	**65.6**	
Total			**82**				**135**	**82.3**	

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

4.3.1 Quality, Timeliness, and Access

Primaris evaluated the following federal regulations and determined strengths and weaknesses (includes corrective actions) with respect to the quality, timeliness, and access to health care services furnished by Healthy Blue to its managed care enrollees. Recommendations pertaining to specific regulations for improving the identified weaknesses are also included in this report section.

Regulation I-Disenrollment: Requirements and Limitations.

Strengths. Healthy Blue staff is knowledgeable about the Disenrollment requirements and limitations per the CFR and the MHD contract. Healthy Blue has policies for initiating a disenrollment for the reasons: member not following the prescribed treatment; missing appointments without notification; fraudulently misusing the MHD Managed Care program; indulging in misconduct; or requesting a home birth service. Healthy Blue shall cite at least

one good cause before requesting the MHD to disenroll a member. Healthy Blue does not initiate disenrollment because of a medical diagnosis of a member, pre-existing medical conditions, high-cost bills, disruptive behaviors arising from members' special needs, race, color, national origin, gender, gender identity, or sexual disorientation.

At Healthy Blue, a member can request disenrollment without a cause during open enrollment; within 90 days of initial enrollment; and when the MHD imposes intermediate sanctions. Healthy Blue acknowledged that a member could request for disenrollment for a just cause: if the transfer is a resolution to grievance or appeal; member's Primary Care Physician or specialist does not participate with Health Blue; due to cultural sensitivity issues; services not covered; correction of an enrollment error made by the broker; bringing all family members under one MCO; and sanctions imposed by the MHD. Healthy Blue allows automatic and unlimited changes in the MCO choice as often as circumstances necessitate for the children in care and custody and adoption subsidy. Healthy Blue does not require its members to go through an appeal process before asking for disenrollment, but they have an option to do so.

Except for newborns, Healthy Blue does not assume financial responsibility for members of other MCOs and Fee-For-Service program hospitalized in an acute setting on the effective date of coverage with Healthy Blue until an appropriate acute inpatient hospital discharge.

Weaknesses. Primaris identified areas of concern, so corrective action is required. The following criteria were "Partially Met":

- Disenrollment can be requested by a member without cause. Healthy Blue did not incorporate in their policy MO29-OP-CS-003 Member Disenrollment, a reason for disenrollment without cause. Disenrollment can happen upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.
- Disenrollment can be requested by a member for a just cause, at any time, if the MCO does not cover services the member seeks because of moral or religious objections. Healthy Blue did not submit documentation on this requirement.
- MCO shall have written policies and procedures for complying with the MHD's disenrollment orders. Though Healthy Blue stated that its Enrollment and Billing Department will process all 834 disenrollment within 24 hours of receipt from the MHD in accordance with the contract, the procedure for complying with the MHD's disenrollment orders was not submitted for review.

The following criterion was "Not Met":
MCO shall implement written policies and procedures to receive updates on enrollment and disenrollment and incorporate them in MCO and MCO's subcontractors' management

information system each day. MCO shall reconcile this membership list against the MCO's internal records within 30 business days of receipt and shall notify the State agency of any discrepancies. Healthy Blue did not submit a procedure for receiving, incorporating, and reconciling membership as stated in its policy.

Recommendations. Primaris recommends:

- Healthy Blue incorporates in their policy on Member Disenrollment, to request disenrollment upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.
- Healthy Blue incorporates in their policy on Member Disenrollment and implements the member's right to request disenrollment if Healthy Blue does not cover services the member seeks because of moral or religious objections.
- Healthy Blue must have a written procedure for complying with the MHD's disenrollment orders.
- Healthy Blue should have a documented procedure for receiving enrollment and disenrollment updates and incorporating them in Healthy Blue and the subcontractor management system daily. Healthy Blue should also list the procedure for weekly reconciliation of membership with the MHD's 834 files.

Regulation II-Enrollee Rights.

Strengths. Healthy Blue has a policy of providing each member the following rights: to be treated with dignity; privacy; receive information on all available treatment options; participate in decisions of their healthcare including refusal of treatment; be free from restraint or seclusion; obtain a copy of medical records free of cost.

Healthy Blue updates its provider and hospital data with changes within 30 days of receipt from the providers. Validation of directory listings occurs on an annual basis through provider and hospital audits. A provider-finding tool containing the entire network is made available on the Healthy Blue website. The website tool is updated through the normal daily interact file available on the web portal. Healthy Blue departments have access to daily updated electronic copies on the Healthy Blue website. Healthy Blue informs its members via the member handbook that a paper form of provider directory will be mailed to their members within 48 hours of the request. During the interview, Healthy Blue informed Primaris that the members would be communicated via Member Portal messaging and a Blog regarding the member's right to obtain a provider directory on an annual basis, starting July 1, 2021. Healthy Blue has informed its enrollees via the member handbook that the information provided on Healthy Blue's website is made available in a paper form without charge within five business days upon request.

Weaknesses. There are areas of concern, so corrective action is required. Primaris identified the following criteria that were "Partially Met":

- Enrollees should receive information in accordance with 42 CFR 438.10. Healthy Blue did not submit its policy on member materials as per 42 CFR 430.10. The Welcome Quick Guide-flier meets all but the following two requirements, as applicable:
  - MCO shall make available general services and materials, such as MCO's member handbook, in the 15 languages identified by the MHD that individuals speak with limited English proficiency for the State of Missouri. The MCO shall include statements in those languages that tell members that translated documents are available and how to obtain them on all materials.
  - All written materials shall be worded such that the materials are understandable to a member who reads at the sixth (6th) grade reading level. Primaris assessed the readability statistics-Flesch Kincaid Grade level-of Welcome Quick Guide to be 10.4, which is not per the MHD contract, section 2.14.6.
- Notice to the enrollee must be provided 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice. Healthy Blue did not address the requirement to notify 15 calendar days after receipt or issuance of the termination notice.
- MCO shall provide a member handbook and other written materials with information on accessing services to all members within 10 business days of being notified of their future enrollment with the MCO.
  Healthy Blue has not submitted a policy/guideline which meets the requirements of this section. However, Healthy Blue submitted a flier to Primaris, which provides information to its members about accessing the member handbook on their website.
- On an annual basis, MCO shall review the member handbook, revise as necessary, and document that such review occurred. Healthy Blue has not submitted its revision history or any documentation that confirms this requirement.
- MCO must give each enrollee notice of any change that the MHD defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change (42 CFR 438.10(g)(4)). No documentation was submitted for Primaris to ascertain that the members were notified about the change. One such example of a change provided by Healthy Blue was on immunization information.
- The member handbook is deficient in its contents per the instructions provided in the MHD contract, section 2.12.16 (48 items). Healthy Blue fully complied with 40 of 48 items, partially complied with six, and was deficient in two items.
- The provider directory (southwest region) submitted by Healthy Blue does not include all the information required for providers and hospitals: name of providers,

group affiliations, board certification status, address, telephone number, website URL, specialty, panel status, cultural and linguistic abilities, including American Sign Language or skilled medical interpreter, accommodations for people with disabilities. Healthy Blue submitted a policy, Provider Listing Updates (Draft version), that does not address the requirement on website URL, American Sign Language or skilled medical interpreter availability, and accommodations for people with disabilities. Primaris noted that the information on panel status and accommodation is inconsistently reported for the providers in the directory.

- Provider directories must be made available on the MCO's website in a machine-readable file and format specified by the Secretary (42 CFR 438.10(h)(4)). Primaris visited Healthy Blue's website in March 2021, and a provider directory was not found. Instead, Healthy Blue has a web-based search tool that allows members to search for a provider/practitioner or health center, clinic, hospital, ancillary services-vision, or dental.
- MCO must comply with any applicable federal and State laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights, including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 regarding education programs and activities; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act. Even though Healthy Blue has notified its members about the non-discrimination policy in the member handbook, the references are not quoted in the policy, Member Rights and Responsibilities-MO. Thus, Primaris cannot ascertain with confidence that Healthy Blue is fully compliant with the requirement.

Recommendations.

- Healthy Blue must address the requirement to notify its members 15 calendar days after receipt or issuance of the termination notice to any provider.
- Healthy Blue must have a policy about providing a member handbook and other written materials with information on how to access services to all members within 10 business days of being notified by the MHD of their future enrollment with Healthy Blue.
- Healthy Blue updates their policy, Development of Marketing and Member Communications, and align it with the MHD contract, section 12.13.2. Per the MHD contract, the marketing materials are not deemed approved if there is no response from the State within 30 days.
- Healthy Blue is required to maintain a log with the changes they made each year to

its member handbook along with the date of approval by the MHD.

- Healthy Blue is recommended to update its member handbook to meet all the 48 criteria listed in the MHD contract, section 2.12.16, even though the MHD provides a template.
- Healthy Blue should consider revising the documentation in Providers Resource on their website on "encouraging members to receive family planning services within the network." Per 42 CFR 441.20, for beneficiaries eligible under the plan for family planning services, the plan must provide that each beneficiary is free from coercion or mental pressure and free to choose the method of family planning to be used. Healthy Blue member handbook states that the members are allowed to a Healthy Blue provider or any MHD Fee-for-Service approved provider to get family planning services without a referral. However, per the website, the providers should encourage members to avail family planning services within the network. This is contradictory to what is stated in the member handbook and the CFR.
- Healthy Blue must notify its enrollees of any change that the MHD defines as significant in the enrollee handbook at least 30 days before the intended effective date of the change.
- Healthy Blue consistently reports all the provider directory requirements for its providers, including hospitals in the network per the 42 CFR 438.10(h) and the MHD contract, section 2.12.17. Healthy Blue should educate its providers about the contractual requirement for submitting their information to Healthy Blue. Healthy Blue should update their policy, Provider Listing Updates, with the missing information about the requirements and submit it to the MHD for approval.
- Healthy Blue must upload their provider directory on their website in a machine-readable format (computer/mobile readable). Thus, the members will access them once downloaded on their computer or mobile, even without internet accessibility/availability.
- Healthy Blue should quote the references from federal regulations in its policy, Member Rights and Responsibilities-MO, that expresses Healthy Blue's commitment to comply with all the regulations on observing and protecting enrollee rights.

Regulation III-Emergency and Post-stabilization Services.

Strengths. Healthy Blue has policies and procedures in place and the staff is knowledgeable about the requirements for Emergency and Post-stabilization Services: covers and pays for the emergency services regardless of whether the provider that furnishes the services has a contract with Healthy Blue (in-network or out-of-network); does not deny payment for treatment obtained for an emergency medical condition and post-stabilization care services within or outside of the network even though not pre-

approved under certain circumstances, administered to maintain, improve, or resolve the member's stabilized condition; does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or Healthy Blue of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services; and does not hold an enrollee with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize him/her.

Weaknesses. There is an area of concern, so corrective action is required. Primaris identified the following criterion that was "Partially Met":
MCO must cover and pay for emergency services regardless of whether the provider furnishes the services has a contract with the MCO (in-network or out-of-network). MCO and providers to reach an agreement on payment for services. (MHD contract, section 2.6.12(a, b)). In the post-site meeting, Healthy Blue submitted "Single Case Agreement: Process –Missouri Medicaid," which is neither approved by their organization nor by the MHD. This document does not meet the requirement of this section.

Recommendations. Healthy Blue must submit documentation to show that Healthy Blue and providers have an agreement on payment for the emergency and post-stabilization services.

Regulation IV-Subcontractual Relationships and Delegation.

Strengths. Healthy Blue submitted three subcontracts: Ancillary Services Agreement (Dental); MTM Inc.; and March Vision Care Group, Inc. for review. Primaris determined that Healthy Blue has acknowledged that their subcontractors will not knowingly employ, hire for employment, or continue to employ an unauthorized worker to perform work within the State of Missouri. The subcontractors agreed to perform the delegated activities and reporting responsibilities specified in the contractual obligations. The contracts provide revocation of the delegation of activities or obligations or specify other remedies when the MHD or Healthy Blue determines that the subcontractors did not perform satisfactorily.

The subcontractors agreed to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, agreeing that the State, CMS, the Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect at any time, any books, records, contracts, computer or other electronic systems, physical facilities, and premises of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under Healthy Blue's contract with the State. The right to audit exists 10 years

from the final date of the contract period or from the date of completion of any audit, whichever is later.

Weaknesses. There are areas of concern, so corrective action is required. Primaris identified the following criteria that were "Partially Met":

- The MHD contract, section 3.9.6 requires Healthy Blue to specify the delegated activities or obligations, and related reporting responsibilities, in the subcontract or written agreement.
  Two of the three subcontracts, March Vision Care Group, Inc. and MTM Inc., did not incorporate all the 19 items required by the MHD.
- "All disputes between the MCO and any subcontractors shall be solely between subcontractors and the MCO. The MCO shall indemnify, defend, save, and hold harmless the State of Missouri, the Department of Social Services and its officers, employees, and agents, and enrolled, managed care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature…." The March Vision Care Group, Inc. Service Agreement does not mention State indemnification in a dispute between Healthy Blue and the subcontracted providers. However, there is a clause for indemnifying each other.

Recommendations.

- Healthy Blue updates its contract with March Vision Care Group, Inc. and MTM Inc. with the requirements set under the MHD contract, section 3.9.6.
- Healthy Blue updates its agreement with the March Vision Care Group, Inc. to indemnify the State in case of a dispute between Healthy Blue and the subcontracted providers.

Regulation V-Practice Guidelines.

Strengths. Healthy Blue has practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals. The practice guidelines are adopted in consultation with the network providers and reviewed and updated annually and upon significant change to evidence-based guidelines throughout the year. Practice Guidelines are based on enrollee's health needs obtained from care management and disease management services, Medical Advisory Committee, National guidelines, current literature. Prospective guidelines are evaluated in several areas, such as a condition's prevalence within communities (e.g., Opioid Crisis) and complexity of a disease course (e.g., Diabetes or Schizophrenia). Information about the availability of the guidelines is included in the provider manual, provider newsletters, bulletins, and committees. These are placed on the provider website and include links to the guidelines themselves. These are also provided to the enrollees and potential enrollees upon request.

Healthy Blue ensures that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines through Inter-Rater Reliability (IRR). Mechanisms, such as hypothetical Utilization Management (UM) test cases or a sample of UM determination files using a National Committee for Quality Assurance (NCQA)-approved auditing method, are utilized to evaluate the consistency of application of criteria.

Weaknesses. There are no areas of concern, so corrective action is not required. However, inconsistent information regarding updating practice guidelines was noted between the policy, QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring, and during the interview. Per the policy, the CPGs are updated at least biennially (every two years) or when changes are made to national guidelines. During the interview, Healthy Blue stated that the guidelines are updated annually or earlier in case of significant changes.

Recommendations.

- Healthy Blue staffs' knowledge and policies must be consistent with each other.
- Primaris recommends Healthy Blue inform its members about the existence and availability of practice guidelines via member handbooks, newsletters, or mailers and how to request these documents.

Regulation VI- Health Information Systems.

Strengths. Healthy Blue maintains a health information system (HIS) sufficient to support collecting, integrating, tracking, analyzing, and reporting data. The HIS provides information on but is not limited to, Utilization, Claims, and Disenrollment other than loss of eligibility. Sufficient enrollee encounter data is collected and maintained to identify the provider who delivers any item(s) or service(s) to enrollees. Healthy Blue's MIS is 5010 compliant and currently accepts data in the HIPAA standard X12 format. Additionally, Healthy Blue supports Health Level 7 (HL7) and several State-specific formats through a file transfer process.

Weaknesses. There are areas of concern, so corrective action is required. Primaris identified the following criteria that were "Partially Met":

- Healthy Blue did not provide an explanation/description of their process as to how Healthy Blue's HIS provides information on the Grievances and Appeals. However, Healthy Blue has submitted a flow chart of HIS that includes Grievances and Appeals.
- MCO should comply with Section 6504(a) of the Affordable Care Act, which requires claims processing and retrieval systems to collect data elements necessary to enable

the mechanized claims processing and information retrieval systems in operation to meet the requirements of section 1903(r)(1)(F) of the Act.
Even though Healthy Blue has documented evidence that their information system with claims management tool offers a high degree of automation and data capture, there is no documentation to ascertain its compliance with section 6504(a) of the Affordable Care Act and 1903(r)(1)(F) of the Act. These sections have a requirement to report an expanded set of data elements under the Medicaid Management Information System to detect fraud and abuse. The automated data system should meet the requirement for program integrity, program oversight, and administration.

- As part of this electronic claims management (ECM) function, the MCO shall provide online and phone-based capabilities to obtain claims processing status information. Primaris reviewed the claims processing flow diagram, which shows that providers can submit their claims electronically, in paper format, or online. However, the phone-based capabilities to obtain claims processing status information was not presented.
- Adherence to Key Transaction Standards: MCO shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18, 455.19, and RSMo 376.383 and 376.384. Healthy Blue has not addressed the federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. The requirements stated in RSMo 376.383 and 376.384 are also not addressed in the documents received by Primaris.
- MCO must have a mechanism to ensure that data received from providers are accurate and complete. Healthy Blue did not submit policies and procedures to ascertain that data received from providers are consistent and timely reported.
- MCO shall maintain at least a ninety-eight percent (98%) acceptance rate on encounters submissions monthly (MHD contact 2.26.5(c)). Healthy Blue did not submit their policy/supporting documentation on the frequency and acceptance rate of enrollee encounter data to the State.
- MCO shall ensure that critical member and provider Internet and telephone-based functions and information, including but not limited to electronic claims management and self-service customer service functions, are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the State agency and the MCO. MCO's core eligibility/enrollment and claims processing systems shall be back online within 72 hours of the declared major failure or disaster's

occurrence.
Healthy Blue's Enterprise Business Continuity Program Guidance does not address the requirement that core eligibility/enrollment, and claims processing systems shall be restored within 72 hours of declared major failure or a disaster. Primaris noted that Healthy Blue had not submitted any evidence suggestive of compliance with the requirement that the critical member and provider Internet and telephone-based functions and information, including but not limited to critical provider Internet and telephone-based functions, electronic claims management are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week.

Primaris identified the following criteria were "Not Met":

- Submission of all enrollee encounter data, including the allowed amount and the paid amount that the State is required to report to CMS under § 438.818. Healthy Blue has not submitted documentation in support of this requirement.
- Encounters must be submitted within 30 days of the day the MCO pays the claim and must be received no later than two (2) years from the last date of service (MHD contract, 2.26.5(h)).

Recommendations.

- Healthy Blue should explain/describe their process as to how Healthy Blue's health information system provides information on the Grievances and Appeals.
- Healthy Blue must submit documentation to show that their claims processing system is capable of detecting fraud, waste, and abuse in compliance with section 6504(a) of the Affordable Care Act and 1903(r)(1)(F) of the Act.
- Healthy Blue must provide documentation supporting its phone-based capabilities to obtain claims processing status information and provide documentation supporting this requirement.
- Healthy Blue must address the federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. The requirements stated in RSMo 376.383 and 376.384 also need to be addressed, and supporting documents must be submitted.
- Healthy Blue must have policies and procedures to verify the consistency and timeliness of reported data, including data from network providers Healthy Blue compensates based on capitation payments.
- Healthy Blue annotates its policy that all data collected will be submitted to CMS and other State agencies if requested.
- Healthy Blue must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. Primaris will

evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.

- Healthy Blue develop a policy and supporting documentation on submitting all enrollee data, including allowed and paid amounts.
- Healthy Blue develop a policy/procedure and evidence to show compliance with the timeframe for submitting encounters to the MHD.
- Healthy Blue addresses the requirements, both in their policies and in practice, related to the availability of information systems during normal operations and in the event of a declared major failure or disaster.

4.3.2 Improvement from previous year

Table 4-6 describes Healthy Blue's response to recommendations from previous EQRs: 2020, 2019 and 2018.

Table 4-6. Healthy Blue's Response to the Previous Year's Recommendations

Recommendations	Action by Healthy Blue	Comment by EQRO
EQR 2020		
1. Multilingual Services: An analysis and evaluation of the multilingual services provided, to include: A count of members needing communication accommodations due to hearing impairments or a physical disability. This was not reported by Missouri Care (currently dba Healthy Blue) in QAPI. (Scored as Partially Met.) Missouri Care had stated that they do not capture data on this metric, and it was not available in the State enrollment file. Primaris recommended that Missouri Care communicate with the MHD if they have issues capturing data for a count of members needing communication accommodations due to hearing impairment or a physical disability. Per information provided by the MHD to Primaris, this data is provided to the MCO when they complete their Health Risk Assessment (HRA).	Healthy Blue responded by stating that the MHD does not ask for this information on the HRA provided by the MHD to the MCO. Healthy Blue sends out its own HRA requesting this additional information. However, due to the low volume of actual returned completed HRAs, Healthy Blue suggests that the MHD modifies their HRA to include this information related to the "hearing impairments or a physical disability" at the time of enrollment. This would ensure that the required information is captured.	Partially Met Healthy Blue did not contact the MHD to discuss the issue and make their suggestions. Thus, this criterion remains Partially Met. Primaris finds a disconnect between the information provided by the MHD and Healthy Blue. Healthy Blue must contact the MHD to find a solution to capture the number of members needing communication accommodations due to hearing impairments or a physical disability.

2. Grievances and Appeals: Healthy Blue has reported Member Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. Primaris finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. Primaris recommends that Healthy Blue seek written clarification on expectations from the MHD. Healthy Blue should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting.	Healthy Blue did not submit a response.	The issue remains open. Healthy Blue must contact the MHD for clarification and resolution.
EQR 2019		
1. Policy update required: Release of PHI to the public will be only after prior written consent to the State agency (MHD contract 3.16.1). (Scored as Partially Met).	Healthy Blue submitted the following policies: • CPP509 Disclosure with Authorization: Page 1 • CPP1401 Verification and Authentication: Page 5	Partially Met Healthy Blue has rules for releasing PHI to public officials and any other requesters. However, the release of PHI only after written consent from the State agency is not mentioned. Healthy Blue must incorporate this requirement in its policies.
2. Policy update required: MCO may use Protected Health Information to report violations of law to appropriate federal and State authorities, consistent with 45 CFR 164.502(j)(1)/(MHD contract 2.38.2(c). (Scored as Partially Met).	Healthy Blue submitted the following policy: CPP204 Non-Retaliation: Page	Fully Met
3. 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 2.38.2(f)). (Scored as Partially Met.)	Healthy Blue submitted the following policy: CPP102 De-Identification: Page 7	Fully Met The policy submitted meets the requirement, but it applies to Iowa Medicaid Plans. Healthy Blue must

		update it to apply for Missouri Medicaid as well.
EQR 2018		
Missouri Care (currently dba Healthy Blue) 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).	Healthy Blue submitted three subcontracts with updated information.	No further action is required.

4.4 Findings, Analysis, Conclusions, and Recommendations: UnitedHealthcare

Primaris assessed six federal regulations, with UnitedHealthcare achieving a compliance score of 85.4%. The score and audit result for each regulation are presented in Table 4-7.

Table 4-7. UnitedHealthcare Compliance Summary-EQR 2021 (1-Year)

Medicaid	CHIP		Number of Sections						
42 CFR 438	42 CFR 457	Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %	Audit Result
438.56	457.1212	Disenrollment: Requirements and limitations	18	18	0	0	36	**100**	
438.100	457.1220	Enrollee rights	18	13	05	0	31	**86.1**	
438.114	457.1228	Emergency and post-stabilization services	12	11	01	0	23	**95.8**	
438.230	457.1233b	Subcontractual relationships and delegation	12	08	04	0	20	**83.3**	
438.236	457.1233c	Practice guidelines	06	06	0	0	12	**100**	
438.242	457.1233d	Health information systems	16	05	08	3	18	**56.3**	
Total			**82**				**140**	**85.4**	

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

4.4.1 Quality, Timeliness, and Access

Primaris evaluated the following federal regulations and determined strengths and weaknesses (includes corrective actions) with respect to the quality, timeliness, and access to health care services furnished by UnitedHealthcare to its managed care enrollees. Recommendations pertaining to specific regulations for improving the identified weaknesses are also included in this report section.

Regulation I-Disenrollment: Requirements and Limitations.

Strengths. UnitedHealthcare has policies and procedures compliant with the Disenrollment Requirements and Limitations, and the staff is knowledgeable per the CFR and the MHD contract. UnitedHealthcare is aware of initiating a disenrollment for the reasons: member not following the prescribed treatment; missing appointments without notification; fraudulently misusing the MHD Managed Care program; indulging in misconduct; or requesting a home birth service. UnitedHealthcare shall cite at least one good cause before requesting the MHD to disenroll a member. UnitedHealthcare does not initiate disenrollment because of a medical diagnosis of a member, pre-existing medical conditions, high-cost bills, disruptive behaviors arising from members' special needs, race, color, national origin, gender, gender identity, or sexual disorientation.

At UnitedHealthcare, a member can request disenrollment without a cause during open enrollment; within 90 days of initial enrollment; when misses the annual disenrollment opportunity in case of temporary loss of Medicaid eligibility followed by auto-enrollment; and when the MHD imposes intermediate sanctions. UnitedHealthcare acknowledges that a member can request for disenrollment for a just cause: if the transfer is a resolution to grievance or appeal; member's Primary Care Physician or specialist does not participate with UnitedHealthcare; due to cultural sensitivity issues; services not covered by UnitedHealthcare due to moral or religious objections; services not covered; correction of an enrollment error made by the broker; bringing all family members under one MCO; and sanctions imposed by the MHD. UnitedHealthcare allows automatic and unlimited changes in the MCO choice as often as circumstances necessitate for the children in care and custody and adoption subsidy. UnitedHealthcare does not require its members to go through an appeal process before asking for disenrollment, but they have an option to do so.

Except for newborns, UnitedHealthcare does not assume financial responsibility for members of other MCOs or the MHD Fee-For-Service hospitalized in an acute setting on the effective date of coverage with UnitedHealthcare until an appropriate acute inpatient hospital discharge.

UnitedHealthcare receives updates from the MHD on newly enrolled or disenrolled members with UnitedHealthcare daily and incorporates them in their and the subcontractors' management information system each day. UnitedHealthcare sends weekly, via electronic media, a listing of current members. UnitedHealthcare reconciles this membership list against their internal records within 30 business days of receipt notifies the MHD of any discrepancies.

Weaknesses. There are no areas of concern, so corrective action is not required. However, Primaris noted a weakness in the Disenrollment Standard Operating Procedure

(SOP). This document does not list all the reasons when a member can request disenrollment without a cause. Thus, it is inconsistent with UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates.

Recommendations. Primaris recommends that UnitedHealthcare update its Disenrollment SOP by incorporating all the reasons a member can request disenrollment without cause.

Regulation II-Enrollee Rights.

Strengths. UnitedHealthcare has a policy in place that guarantees each member the following rights: to be treated with dignity; privacy; receive information on all available treatment options; participate in decisions of their healthcare including refusal of treatment; be free from restraint or seclusion; and obtain a copy of medical records free of cost.

UnitedHealthcare provides notice about the termination of a contracted provider to each enrollee who receives primary care by the terminated provider. The notice is provided 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later. UnitedHealthcare provides its members a member handbook and other written materials with information on how to access services within 10 business days of being notified by the MHD of their future enrollment with UnitedHealthcare. The member handbook is reviewed annually and submitted to the MHD for approval prior to distribution to its members. Provider directories are available on the MCO's website in a machine-readable file. The automated PDF directories are maintained weekly. UnitedHealthcare shall have printed hard copies of the provider directory mailed within 48 hours of a member's request. The enrollees are informed via the member handbook that the information provided on UnitedHealthcare's website is made available in a paper form without charge within five business days upon request. UnitedHealthcare notifies its members about the non-discrimination policy in the member handbook.

Weaknesses. There are areas of concern, so corrective action is required. Primaris noted the following weaknesses for the sections that are assigned a score of "Fully Met":

- The policy, MR-001 UHC MO Member Rights, does not describe how UnitedHealthcare ensures Enrollee Rights. However, the team responded they were in compliance during the interview.
- Provider Directory Creation and Distribution policy states that the request for a paper form of provider directory is processed within 48 hours. The requirement is that the directory should be mailed within 48 hours of the enrollee's request.

Primaris identified the following criteria that were "Partially Met":

- Enrollees should receive information in accordance with 42 CFR 438.10: All written materials shall be worded such that the materials are understandable to a member who reads at the sixth-grade reading level.
  Primaris visited UnitedHealthcare's website on April 23, 2021, and found a newsletter for members (Spring 2021 Health Talk-Take Care). The readability statistics-Flesch-Kincaid Grade Level-was 8.4.
- MCO must give each enrollee notice of any change that the MHD defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change (42 CFR 438.10(g)(4)).
  During the interview, UnitedHealthcare informed Primaris that letters are mailed to the enrollees whenever there is a change in the provider network. UnitedHealthcare did not provide evidence in support of this statement. For other changes, the member handbook is updated, but the members are not informed.
- The member handbook is deficient in its contents per the instructions provided in the MHD contract, section 2.12.16 (48 items). UnitedHealthcare fully complied with 36 of 48 items, partially complied with nine, and was deficient in three items.
- Provider Directory does not include all the information for all the providers and hospitals: name of providers, group affiliations, board certification status, address, telephone number, website URL, specialty, panel status, cultural and linguistic abilities, including American Sign Language or skilled medical interpreter, accommodations for people with disabilities.

Recommendations.

- UnitedHealthcare should update its policy, MR-001 UHC MO Member Rights, to describe how UnitedHealthcare ensures Enrollee Rights. Primaris suggests UnitedHealthcare survey members for the areas not addressed in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess the extent to which the Enrollee's Rights are met. The providers should also be educated at regular intervals on the State and federal requirements.
- UnitedHealthcare should post the member rights and responsibilities on their website under member resources so that members are aware of these even without reading the member handbook.
- UnitedHealthcare must update its policy, MO-MK001 Marketing Guidelines, with the font size requirement to "conspicuously visible size" of the taglines instead of "18 font size." UnitedHealthcare member materials should be readable at the sixth-grade level. The medical diagnoses and tests/healthcare industry words should be explained in simple language.
- UnitedHealthcare must explore different ways to notify changes impacting members

at least 30 days before the effective day of change and implement them.

- UnitedHealthcare must update its member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16, even though the MHD provides a template.
- UnitedHealthcare must update its policy, Rally-Online Directory, to include all the requirements about their network providers listed under this section of the evaluation tool. The provider directory (PDF version) submitted to Primaris should be updated to consistently reflect all the criteria for every provider in the network per the 42 CFR 438.10(h) and the MHD contract, section 2.12.17. UnitedHealthcare should educate its providers about the contractual requirement for submitting their information to UnitedHealthcare.
- UnitedHealthcare should update its policy, Provider Directory Creation and Distribution, to clearly state what they mean by "processing the request within 48 hours." UnitedHealthcare is required to mail the directories to the members within 48 hours of their requests.
- UnitedHealthcare should consider providing a notification for their members on the website about requesting a paper directory.
- Currently, the only means of disseminating information to the members regarding Enrollee Rights, per 42 CFR 438.10, is via a member handbook. UnitedHealthcare should consider using its website to disseminate information about access to member-related information in a paper format. Newsletters and flyers, blogs are some suggested ways of communicating information on Enrollee Rights.

Regulation III-Emergency and Post-stabilization Services.

Strengths. UnitedHealthcare has policies and procedures for not denying payment for treatment obtained for an emergency medical condition and post-stabilization care services within or outside the network even though not pre-approved under certain circumstances, administered to maintain, improve, or resolve the member's stabilized condition. UnitedHealthcare does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or UnitedHealthcare of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. An enrollee with an emergency medical condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize him/her.

Weaknesses. There is an area of concern, so corrective action is required. Primaris noted weakness for a criterion that is assigned a score of "Fully Met." The definitions of an emergency medical condition and emergency services are not consistent and accurate in one of their policies and the member handbook.

Primaris identified the following criterion that was "Partially Met":
MCO must cover and pay for emergency services regardless of whether the provider furnishes the services has a contract with the MCO (in-network or out-of-network). MCO and providers to reach an agreement on payment for services. (MHD contract, section 2.6.12(a)(b).

- UnitedHealthcare did not submit documentation to show an agreement with providers on payment for services.
- UnitedHealthcare must update the other supporting documents.
  - Provider Manual states, "After the member has received emergency care; the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable." The duration should be updated to 30 minutes instead of one hour.
  - UB-04, 2020F7012C Reimbursement Policy does not incorporate payment agreement for services between UnitedHealthcare and the providers.

Recommendations.

- UnitedHealthcare must consistently update definitions of an emergency medical condition, emergency services, and post-stabilization services in all its documents. UnitedHealthcare should update the policy, 2020F7012C Reimbursement, on the definition of an emergency medical condition. Also, update the definition of "emergency services" in the member handbook.
- UnitedHealthcare must update the Provider Manual that states, "After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable." The duration for approval must be updated to 30 minutes instead of one hour.
- UnitedHealthcare must provide documentation on the payment agreement with its providers on emergency and post-stabilization services.

Regulation IV-Subcontractual Relationships and Delegation.

Strengths. UnitedHealthcare has a policy and procedure in place to establish any new or change subcontracting arrangements. Primaris reviewed six subcontracts submitted by UnitedHealthcare. UnitedHealthcare acknowledged that they or their subcontractors should not knowingly employ, hire for employment, or continue to employ an unauthorized worker to perform work within the State of Missouri. All the subcontractors agreed to perform the delegated activities and reporting responsibilities specified in UnitedHealthcare's contract obligations. The contracts or written arrangements provide for revocation of the delegation of activities or obligations or specify other remedies when the MHD or UnitedHealthcare determine that the subcontractors did not perform satisfactorily.

The subcontractors agreed to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, agreeing that the State, CMS, the Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect at any time, any books, records, contracts, computer or other electronic systems, physical facilities, and premises of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under UnitedHealth's contract with the State. The right to audit exists 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Weaknesses. There are areas of concern, so corrective action is required. Primaris noted weaknesses for criteria that are assigned a score of "Fully Met."

- Rose International, Inc. Master Services Agreement (Exhibit G) is for Medicare Advantage subcontractors, not Medicaid, that complies with the criterion, "the subcontractor will make available, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees." This agreement does not specify its applicability to Missouri Medicaid.
- The duration of record retention for 10 years is inaccurate and inconsistent in Rose International, Inc. and CareCore National, LLC.

Primaris identified the following criteria that were "Partially Met":

- MCO shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract. Primaris reviewed six contracts/agreements submitted by UnitedHealthcare for their subcontracted services. All the contracts had a similar language, as applicable, to the services. Even though the language implied that UnitedHealthcare was accountable, the contract did not explicitly State: "MCO shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract." UnitedHealthcare did not submit a policy/procedure or a Master Service Agreement that meets this criterion.
- The MHD contract, section 3.9.6 requires UnitedHealthcare to specify the delegated activities or obligations, and related reporting responsibilities, in the subcontractor written agreement.
  Except for one of the six subcontracts (Dental Benefit Providers), the subcontracts did not incorporate all the 19 items required by the MHD.
- All subcontracts must include appropriate provisions and contractual obligations to ensure that the MHD is indemnified, saved, and held harmless from and against any

and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract.
Four of the six subcontracts have Fully Met this requirement, March Vision Care Group, Inc. is inconsistent with the requirement, and Rose International, Inc. does not indemnify the MHD.

- All disputes between the MCO and any subcontractors shall be solely between such subcontractors and the MCO. The MCO shall indemnify, defend, save, and hold harmless the State of Missouri, the Department of Social Services, its officers, employees, agents, and enrolled, Managed Care members….
  Primaris noted that two of the six contracts, namely, Rose International, Inc. and CareCore National, LLC, do not meet the requirement in their entirety.

Recommendations.

- UnitedHealthcare explicitly and consistently includes in all the subcontracts that UnitedHealthcare shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract. UnitedHealthcare must have a policy or guidelines or Master Service Agreement that meets this criterion.
- UnitedHealthcare should update all their contracts other than the Dental Benefit Providers' contract, with the requirements set under the MHD contract, section 3.9.6.
- UnitedHealthcare should update its contract with Rose International, Inc. and include Missouri Medicaid on the "right to audit."
- UnitedHealthcare should update the duration of record retention for 10 years consistently at all places in all the subcontracts.
- UnitedHealthcare should update the Rose International, Inc. Master Services Agreement and March Vision Care Group, Inc., contract to consistently ensure the MHD is indemnified, saved, and held harmless from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract.
- UnitedHealthcare should update its subcontract with Rose International, Inc. to indemnify the State in any dispute between UnitedHealthcare and its providers. CareCore National, LLC's contract should be updated to include that the State will not be involved in any dispute between UnitedHealthcare and the subcontractor.

Regulation V-Practice Guidelines.

Strengths. UnitedHealthcare has practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals. These are adopted in consultation with the network providers and reviewed and updated annually or often as indicated by the newly published evidence. The enrollee needs are considered for developing the

practice guidelines. The Member Advisory Committee (MAC), chaired by UnitedHealthcare's Director of Provider Operations and Member Engagement, is a forum for members to provide feedback and insights about services and experiences, including but not limited to cultural and linguistic needs. Furthermore, UnitedHealthcare applies Population Health Management Strategy to explore the enrollee's needs. UnitedHealthcare disseminates the guidelines to all affected providers through the company websites. On an annual basis, practitioners are notified via mail, fax, or email about the availability of these guidelines on the website. These are provided to the enrollees and potential enrollees upon request.

UnitedHealthcare ensures that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines through process audits; Inter-Rater-Reliability (IRR) assessments; conducting member surveys by an external vendor; and development of targeted, relevant action plans for continuous process improvement activities.

Weaknesses. There are no areas of concern, so corrective action is not required.

Recommendations. Primaris recommends that UnitedHealthcare inform its members via any medium, e.g., member handbook, mailers, newsletters, about the availability and access of evidence-based practice guidelines.

Regulation VI- Health Information Systems.

Strengths. UnitedHealthcare maintains a health information system that supports collecting, integrating, tracking, analyzing, and reporting data. The encounters are submitted to the MHD within 30 days of payment of the claim. UnitedHealthcare maintains at least a ninety-eight percent (98%) acceptance rate on encounters submissions monthly.

Weaknesses. There are areas of concern, and corrective action is required. Primaris identified the following criteria that were "Partially Met":

- MCO must provide information on utilization, grievance and appeals, and disenrollment for other than loss of eligibility. Primaris noted that UnitedHealthcare submitted only the flow charts showing their IT architecture. UnitedHealthcare did not provide an explanation/description of their process as to how the health information system provides information on Utilization Management (UM), claims, grievances and appeals, and disenrollment.
- MCO should comply with Section 6504(a) of the Affordable Care Act, which requires claims processing and retrieval systems to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation to

meet the requirements of section 1903(r)(1)(F) of the Act.
Primaris noted that UnitedHealthcare has a policy stating its Management Information System (MIS) complies with all the Missouri Medicaid Program requirements, including Section 6405 of the Affordable Care Act. However, no documentation was provided to assess that data elements for electronic transmission of claims are consistent with the Medicaid Statistical Information System MMIS to detect fraud and abuse necessary for program integrity, program oversight, and administration. (Note: UnitedHealthcare did not have electronic transmission of claims during the review period. They did not submit data integrity requirements for processing the paper claims.)

- Adherence to Key Transaction Standards: MCO shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18, 455.19, and RSMo 376.383 and 376.384.
  Primaris noted that policy and procedure on HIPAA standards related to claims processing, electronic transaction standards are not submitted by UnitedHealthcare. However, they have introduced a flow chart for claims showing HIPAA Strategic National Implementation Process (SNIP) validations. (Primaris noted that UnitedHealthcare did not have Electronic Claims Management during the review period).
- MCO must have a mechanism to ensure that data received from providers are accurate and complete.
  UnitedHealthcare did not submit how they verify the provider data's timeliness and data collection from providers in standardized formats, including secure information exchanges and technologies utilized for the MHD's quality improvement and care coordination efforts.
- MCO must collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.
  UnitedHealthcare did not submit a description, and the process followed for collection and maintenance of sufficient enrollee encounter data that identifies providers who deliver the services or items.
- MCO shall ensure that critical member and provider Internet and telephone-based functions and information, including but not limited to electronic claims management and self-service customer service functions, are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the State agency and the MCO.
  The provider's Internet and telephone-based functions and information, including

but not limited to electronic claims management, were not seen on the website in March-April 2021 when Primaris conducted a desk audit/preliminary review. UnitedHealthcare had launched this functionality later in April 2021 and then submitted the screenshots, which Primaris validated on May 6, 2021.

Primaris identified the following criteria that were "Not Met":

- MCO has an electronic claims management (ECM) capability that accepts and processes claims submitted electronically.
  Primaris noted that during the review period, UnitedHealthcare did not have ECM functionality. UnitedHealthcare informed Primaris about its plan to launch the initiative to replace paper checks with electronic payment on April 23, 2021. During the post-site review (May 6, 2021), Primaris visited UHCprovider.com and found that UHC has launched its ECM functionality and is rolling out its electronic payment solutions.
- Submission of all enrollee encounter data, including the allowed amount and the paid amount that the State is required to report to CMS under § 438.818.
  UnitedHealthcare has not submitted any documentation in support of this requirement.
- Specifications for submitting encounter data to the State in standardized Accredited Standards Committee (ASC) X12N 837.
  UnitedHealthcare submitted a policy post-site meeting with a statement that they submit encounters to the State of Missouri in ANSI Standard X12 837 format. No details are mentioned on which Primaris can ascertain UnitedHealthcare's compliance with this criterion.

Recommendations.

- UnitedHealthcare must have documentation regarding the data elements for electronic transmission of claims consistent with the Medicaid Statistical Information System to detect fraud and abuse necessary for program integrity, program oversight, and administration.
- UnitedHealthcare must have policies in place for ECM and provide phone-based capabilities to obtain claims processing status information.
- UnitedHealthcare must have policies and procedures to address HIPAA standards related to claims processing, electronic transaction standards.
- UnitedHealthcare must have policies and detailed process/procedures describing their HIS System flow charts' functional/operational aspects. Also, they must address how they verify the timeliness of the reported provider data and collect data from providers in standardized formats, including secure information exchanges and technologies utilized for the MHD quality improvement and care

coordination efforts.

- UnitedHealthcare must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. Primaris will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.
- UnitedHealthcare must have a detailed description of its process and data elements captured to identify the providers delivering services or items to enrollees.
- UnitedHealthcare should have a policy and submit evidence to show that their encounter data submitted to the MHD includes the allowed and paid amounts per 42 CFR 438.818.
- UnitedHealthcare must submit sufficient documentation to show that encounter data submitted to the MHD comply with standardized Accredited Standards Committee (ASC) X12N 837 and has implemented version 5010 transaction set.

4.4.2 Improvement from previous year

Table 4-8 describes UnitedHealthcare's response to recommendations from EQR 2020.

Table 4-8. UnitedHealthcare's Response to the Previous Year's Recommendations

Recommendations	Action by UnitedHealthcare	Comment by EQRO
1. An analysis and evaluation of disease management program: The active participation rate (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility) was not reported by UnitedHealthcare. (Scored as Partially Met.) UnitedHealthcare had stated that they did not write these rates due to the technology upgradation requirement for such reporting. Primaris recommended that UnitedHealthcare provide these rates in QAPI and should communicate its difficulties to the MHD.	UnitedHealthcare provided the active participant rate for its disease management program in the most current QAPI 2020. The rate range was 95%-99% for asthma, hypertension, obesity, diabetes, depression, and attention deficit hyperactivity disorder-disease management.	Fully Met There is no data from the previous year to compare and provide an analysis and evaluation. No further action is required for this year. However, UnitedHealthcare must analyze and evaluate its data in QAPI instead of only presenting the figures in the future.
2. UnitedHealthcare should report data and analysis on the availability of appointments for routine symptomatic	UnitedHealthcare reported its data in the current QAPI 2020. Appointment	Fully Met There is no data

patients per the MHD contractual requirements. (Scored as Partially Met.)	availability for routine symptomatic patients within one week of seeking an appointment was 80%.	from the previous year to compare and provide an analysis and evaluation. No further action is required for this year. However, UnitedHealthcare must analyze and evaluate its data in QAPI instead of only presenting the figures in the future.
3. Grievances and Appeals: UnitedHealthcare reported Member Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. Primaris finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. Primaris recommends that UnitedHealthcare seek written clarification on expectations from the MHD. UnitedHealthcare should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting.	UnitedHealthcare acted on this issue by reaching out to the MHD after the post-site meeting. No changes are made in the current QAPI 2020. The MHD will inform UnitedHealthcare of their decision.	The issue remains open until the MHD provides a clarification and the decision is implemented by UnitedHealthcare.

Suggestion to MCOs for Improving Emergency Services

Recommendations pertaining to each regulation are already described in sections 4.2.1, 4.3.1, and 4.4.1 for Home State Health, Healthy Blue, and UnitedHealthcare, respectively. Primaris provided suggestions to all the MCOs to improve Emergency Services as follows: During the interview, Home State Health, Healthy Blue, and UnitedHealthcare informed Primaris that their Medicaid and CHIP enrollees utilize 61%, 24%, 50% of the emergency room (ER) care for non-urgent conditions, respectively. A report to Congress by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, on March 2, 2021,[4] is a useful resource for decreasing ER utilization. Additionally, Primaris suggests other resources and methods referenced below that the

[4] https://aspe.hhs.gov/system/files/pdf/265086/ED-report-to-Congress.pdf

MCOs may implement to reduce the load and cost of ER services:

- Proactive member education and engagement.
- Post-ER follow-up.
- Help members in provider selection and appointment scheduling.
- Telehealthcare promotion and coordination.[5]
- Making referrals to community resources to help eliminate barriers such as transportation to doctor's appointments, prescription assistance programs, and financial assistance programs.
- Make referrals to population health programs that may benefit members: Lifestyle/wellness coaching (e.g., tobacco cessation, weight management); chronic condition coaching; acute medical case management; and behavioral health coaching.[6]
- Extended work hours at providers' offices, including weekend appointment availability.
- Accept walk-in members at providers' offices.

During the interview, Primaris inquired about the average wait time for enrollees who seek emergency services. Home State Health responded that they do not measure the average wait time and they have not received any complaints from the members. UnitedHealthcare responded that the health coach contacts the members after an emergency room visit but does not capture the wait time. Healthy Blue reported 183 minutes (around 3 hours). Healthy Blue members who left ER before they were attended to was 2%. Patients who presented with stroke symptoms were attended to within the first 45 minutes in 72% of cases. Primaris suggested that the Home State Health and UnitedHealthcare should contact the members receiving emergency services and capture the wait time information. All three MCOs can analyze this data, compare it with the national average wait time, and utilize it to improve emergency services[7].

[5] https://carenethealthcare.com/how_to_improve_health_plan_er_diversion_strategy/
[6] https://www.bluechoicesc.com/great-expectations/ERCG
[7] https://www.cdc.gov/nchs/about/factsheets/factsheet_nhcs.htm

5.0 Quality Strategy: Recommendations for MHD

Per 42 CFR 438.364(a)(4), Primaris is required to provide recommendations to the MHD on achieving their target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. Table 5-1 presents the State quality strategy elements per the CFR 438.340, the MHD's QIS goals, and the EQR activities required to be conducted per the EQRO contract. The quality strategy elements listed in the 42 CFR 438.340 and the MHD's QIS goals that were not included in the current EQRO contract for a review are marked as "Not Applicable-N/A."

Table 5-1. Quality Strategy Goals under EQRO contract

Quality Strategy Elements under 42 CFR 438.340	MHD's QIS Goals	EQRO Contract
Network adequacy and availability of service standards.		N/A
Examples of clinical practice guidelines.		It is covered under compliance activity in EQR 2018, further due in EQR 2022.
State's goals and objectives for continuous quality improvement.	Goal 1-Ensure appropriate access to care. Goal 2-Promote wellness and prevention. Goal 3-Ensure cost-effective utilization of services. Goal 4-Promote member satisfaction with the experience of care.	Goal 1-Access to care is covered in a separate activity, "secret shopper survey," which is not a part of the Annual Technical Report. The survey was not conducted in CY 2020 due to the Covid-19 Pandemic. Goal 2-CHL and W30 measures are addressed in this report that is part of promoting wellness and prevention. Goal 3-N/A Goal 4-N/A
Performance measures.		Covered in EQR 2021
Performance improvement projects.		Covered in EQR 2021
Transition to care policy.		N/A

Evaluation of health disparities.		N/A
Intermediate sanctions for MCOs for 42 CFR 438 Subpart I.		N/A
State's assessment of performance and quality outcomes achieved by PCCM entity.		N/A
Identification of persons who need LTSS or special healthcare needs.		N/A
Nonduplication of EQR activities.		N/A
Definition of significant change.		N/A

Primaris provided the following recommendations to the MHD for the activities conducted per the EQRO contract. The recommendations are not provided for the activities listed in the MHD's QIS, which are outside the scope of the EQRO contract.

5.1 Performance Improvement Projects

1. The PIPs' assessments, information gathered during the interview sessions, followed by questions raised by Home State Health and UnitedHealthcare demanding an explanation on Primaris' evaluation, revealed that the MCOs have extensive gaps in knowledge about the PIP manuals/protocol and their approach in conducting a PIP. A formal one-on-one technical assistance would help in alleviating the MCOs' questions and providing clarifications. An improved training, assistance, and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research reviews.

2. The MHD should require the MCOs to develop a specific PIP plan, including a timeline, SMART aim statement, names, and credentials of team members conducting the PIP, key driver diagram, performance indicators (primary and secondary measures, variables), interventions planned, data collection plan by the first quarter of a given MY, for approval.

5.2 Performance Measures

1. The MHD should consider including other Medicaid measures from CMS Adult Core Set, Child Core Set, and Behavioral Health Core Set in addition to the measures required by HEDIS® reporting.

2. The MHD should work with the MCOs to track, monitor, and measure the interventions taken to improve performance of Inpatient Readmissions, W30, and CHL and measures.

5.3 Compliance with Medicaid and CHIP Managed Care Regulations

Primaris reviewed the MHD communication and the contract with Home State Health, Healthy Blue, and UnitedHealthcare. The following recommendations identify issues needing clarification or program enhancements that would improve the EQR process and findings:

1. The MHD revise the Managed Care contract with the MCOs to include policies and procedures for all the regulations covered under compliance review for the Medicaid and CHIP Managed Care Regulations regarding EQR.
2. The MHD brainstorm with Primaris and the MCOs on ways to increase the value of the EQR process.
3. The MHD includes Primaris in all quality-related meetings with the MCOs and include EQR as a standing agenda item.
4. The MHD require the MCOs focus on adopting documented and measurable ways to "ensure" that its providers and staff follow the regulations per the MHD contract and the 42 CFR 438 instead of tracking the member complaint system for issues and training/educating the staff/providers, e.g., conducting member surveys, provider surveys in addition to CAHPS.
5. Identify additional ways the EQRO can assist the MCOs in meeting quality requirements, e.g., TA with quality improvement measures and models.
6. Enrollee rights
    - Revise the MHD contract, section 2.14.6(b), which states, "written materials must include taglines in the prevalent non-English languages in the State, as well as large print (font size no smaller than 18 points)…." Per the Managed Care Final Rule 2020, effective December 14, 2020, the requirement of the font size 18 is replaced by "conspicuously visible size" for the taglines.
    - Primaris has not evaluated one of the criteria listed under Enrollee Rights from the MHD contract section (2.12.16(c)(22)). This section is related to the member handbook in the context of information on the Grievance and Appeals. The MCOs were required to address "the specific regulations that support or the change in federal or State law that requires the action." The MCOs did not address this requirement due to a lack of clarity. Primaris recommends that the MHD provides a clarification/expectation on this requirement.
7. Emergency and post-stabilization services
   The MHD should revise its MHD contract, section 2.6.12(i), "MCO's financial responsibility for post-stabilization care services which the MCO has not pre-approved ends when:

- An MCO physician with privileges at the treating hospital assumes responsibility for the member's care.
- An MCO physician assumes responsibility for the member's care through transfer.
- An MCO representative and the treating physician reach an agreement concerning the member's care.
- The member is discharged (MHD contract, section 2.6.12(i)).”

In reference to the 42 CFR 422.113(c)(3), Primaris recommends the MHD update the statement in the MHD contract for the first two bullet points above to read as follows:

- Member's MCO physician with privileges at the treating hospital assumes responsibility for the member's care.
- Member's MCO physician assumes responsibility for the member's care through transfer.

8. The MHD must work with the MCOs to address the EQRO recommendations and monitor the CAP.