



**Quality Improvement Strategy - 2021
State of Missouri
MO HealthNet Division**

**Prepared by
The Missouri Department of Social Services
MO HealthNet Division (Missouri Medicaid)
July 2021**

History of Medicaid and Managed Care

The Medicaid Program, authorized by federal legislation in 1965, provides health care access to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children. Since that time, legislative options and mandates have expanded the categories of eligibility to include Medicaid coverage for children and pregnant women in poverty, and children in state care. The Missouri Medicaid program is jointly financed by the federal government and Missouri State Government, and is administered by the State of Missouri. The agency charged with administration of the Medicaid program is the MO HealthNet Division (MHD), within the Department of Social Services.

A 1915(b) Waiver enables Missouri to use the managed care system to provide Medicaid services to Section 1931 children and related poverty level populations; Section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. Effective May 1, 2017, Managed Care was extended statewide in Missouri. Previously, Managed Care was only available in certain regions. A constitutional amendment was passed in August 2020 requiring the state to offer services to adults ages 19-64 with income up to 138% of the Federal Poverty Level. When implemented, these adults will receive their services through the managed care system. For additional background on the operation of Managed Care in Missouri, please visit <https://dss.mo.gov/mhd/mc/pages/overview.htm>. The Fee-for-Service Program serves the aged, blind, and disabled population.

MO HealthNet Waiver Programs

In 1981, Congress enacted Section 2176 of Public Law 97-35 of the Social Security Act, entitled the Omnibus Budget Reconciliation Act. Through this enactment, certain statutory limitations have been waived in order to provide states who have received approval from the Department of Health and Human Services with the opportunity for innovation in delivering home and community based services to eligible persons who would otherwise require institutionalization in a nursing facility, hospital or intermediate care facility for the developmentally disabled (ICF/DD). Approved Missouri waivers to provide services are listed at the following webpage: <https://dss.mo.gov/mhd/waivers/>.

Children's Health Insurance Program (CHIP)

Missouri's Children's Health Insurance Program (CHIP) was a Medicaid expansion implemented on September 1, 1998 through a waiver under Section 1115 of the Social Security Act, and subsequently through a Title XXI State Plan that covered children under the age of 19 in families with a gross income of 300% of the Federal Poverty Level (FPL). Currently, coverage is provided statewide through the Managed Care delivery system. Uninsured women losing their MHD eligibility sixty (60) days after the birth of their child are covered for women's health services for an additional year, regardless of their income level. This population receives services through the MHD Fee-For-Service Program.

Show-Me Healthy Babies

Starting on January 1, 2016, Missouri added coverage to the state's separate CHIP to include pregnant women and unborn children from conception to birth. Eligible women have a household income up to 300% of the FPL when the mother is not eligible for Medicaid, CHIP or affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. Targeted women and unborn children receive a benefit package of essential, medically necessary health services identical to the MO HealthNet for Pregnant Women benefit package. The purpose is to provide pregnant women with access to prenatal care and an opportunity to connect individuals to longer-term coverage options.

Managed Care Specialty Plan

Currently, Children in the Care and Custody of the State or Receiving Adoption Subsidy receive most of their services through the general Managed Care Program. Effective July 1, 2022, this population will be moved to a single plan known as the Specialty Plan. This plan will focus on ensuring these children and youth receive all comprehensive services, wrap around services and care management.

Transition of Care

The MO HealthNet, Managed Care, Transition of Care policy is publicly available in the Managed Care Contract located at <https://dss.mo.gov/business-processes/managed-care/>. The policy requires newly enrolled members and members transitioning from one health plan to another to receive, at a minimum, the following services:

- Transfer of relevant member information including medical records and other pertinent materials to ensure a smooth transition.
- Provide care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans.
- Work with out-of-network providers to affect a smooth transfer of care to appropriate in-network providers.
- Facilitate continuity of care for medically necessary covered services.
- Ensure that any member entering the health plan is held harmless by the provider for the costs of medically necessary covered services except for applicable MO HealthNet cost sharing.

- Allow non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior authorization and without regard to whether such services are being provided by in-network or out-of-network providers, for the lesser of sixty (60) calendar days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment.
- Allow pregnant members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.
- Ensure that inpatient and residential treatment days are not prior authorized during transition of care.

Anticipated Benefits of the Managed Care Program

The goal of the Managed Care Program is to furnish high quality health care services resulting in measurable improvements in population health to members while providing the State with significant cost efficiencies. The State recognizes that the keys to a successful Managed Care Program include the provision of effective high quality services, the satisfaction of members, and the involvement of stakeholders. Managed Care is an opportunity to deliver high quality, patient-centered evidence-based care in a way that also stabilizes costs and gains budget predictability by making payments on a predetermined, per-member-per-month basis while establishing specific expectations for quality outcomes. It also provides a more accountable, coordinated system of care for beneficiaries, with an emphasis on preventive and primary care services in addition to chronic disease services. Specifically, Managed Care provides:

- Integrated Care - Care coordination is a fundamental underlying principle of managed care. Care management focuses on enhancing and coordinating a member's care across an episode or continuum of care; obtaining and coordinating services and resources needed by members and their families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative impact; and creating opportunities and systems to enhance outcomes. Thus, Managed Care Organization (MCO) care managers emphasize health promotion through preventive care such as screenings, vaccinations, and evaluation of the home environment. Comprehensive transitional care includes follow-up from inpatient and other settings. When needed, referrals to community and support services are made. The care management requirements include qualifications for care managers, frequency of contact with beneficiaries, screening and preventative services, and outcome standards.
- Quality - MCOs are held to rigid quality metrics and performance measurements. Missouri requires participating MCOs to be accredited by the National Committee for Quality Assurance (NCQA) at a level of accredited or better. An External Quality Review Organization (EQRO) evaluates MCOs annually, as well.

- Access - One of the benefits of utilizing managed care is the requirement that each MCO provides members with access to health care services. MCOs are required to ensure that their provider networks consist of the right types and sufficient numbers of providers and specialists for their members. The Code of State Regulations 20 CSR 400-7.095 contains strict network adequacy standards that ensure all members have access to care, including specialty care that they need.
- Cost-Savings - MCOs place emphasis on preventive care services, and ensure coordination of care across the healthcare spectrum through an effectively managed provider network, allowing MCOs to provide cost-saving measures for MO HealthNet beneficiaries without compromising quality or access.

Overview of Managed Care Quality Management Structure

Under Managed Care, oversight responsibility is shared among the State, the MCOs, and their providers. The State has direct oversight of its contracted MCOs and establishes payment rates for these entities as well as the parameters governing the amount, duration, and scope of benefits covered in these contracts. The MCOs establish standards dictated by the State for medical care, prior authorizations, and initial referral policies, determine payment methods, and rates for MCO providers.

The focus of administrative activities, such as member grievances and provider appeals shifts from direct contact with the State to customer service and provider relations divisions within the MCO. The MCOs are accountable for improving the well-being of members. Customer service and care management functions provided by the MCO contribute to improved member involvement and better health outcomes and provide an opportunity to improve the quality of care being furnished.

The Quality Assessment & Improvement (QA&I) Advisory Group was created with the inception of Managed Care. The purpose of the QA&I Advisory Group is to impact service utilization and quality through collaborative monitoring and continuous quality improvement activities. The QA&I Advisory Group and its task forces assist in maintaining an open forum for collaboration and communication among MCOs, other stakeholders (e.g., advocates, consumers, and providers), and state agencies (the Departments of Mental Health; Social Services; Commerce and Insurance; Elementary and Secondary Education; and Health and Senior Services). The QA&I Advisory Group conducts public meetings at least twice annually.

The QA&I Advisory Group designates task forces as necessary to work on specific performance improvement initiatives. The initiative activities may include, but are not limited to, identification of indicators, trends, evaluation of outcomes, and development of recommendations for intervention strategies. The task forces exist for a specific designated period and are terminated when the desired outcome is reached. Reports of task force meetings, actions and outcomes are regularly presented to the QA&I Advisory Group. Task force members include MCO quality staff, other stakeholders, and state agency staff.

The QA&I Advisory Group task forces that have been convened include, but are not limited to: Maternal Child Health, Dental, Behavioral Health, Encounter Data, and Follow Up After Hospitalization for Mental Illness. The task force leader/facilitator works directly with and is accountable to the chair of the QA&I Advisory Group. The chair of the QA&I Advisory Group works directly with state agency staff.

Development, Review, and Revisions

Missouri's Quality Improvement Strategy (QIS) is a comprehensive plan incorporating monitoring, evaluation, and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to participants in the Managed Care Program. The QIS provides a framework to communicate the State's vision, goals, objectives, and measures that address access to care, wellness and prevention, chronic disease care, cost effective utilization of services, and customer satisfaction. This comprehensive plan incorporates the processes of monitoring, assessment, and improvement.

The QIS is developed through collaborative partnerships with members, stakeholders, other state agencies, MCOs, and community groups. This process is undertaken to ensure that:

- Quality health care services are provided to Managed Care members;
- Established benchmarks for outcomes are being met;
- MCOs are in compliance with Federal, State, and contract requirements; and,
- A collaborative process is maintained to collegially work with the MCOs to improve care.

Development of the QIS is a multi-step process. A review of the prior QIS is conducted, and findings are discussed among MHD administrative, program, and quality staff. Input is solicited from key stakeholders, and all this information is considered when planning modifications to the QIS. After undergoing Departmental review, a draft is distributed to key stakeholders and the public for comment. The State of Missouri does not currently have any Federally recognized Indian tribes to consult.

The QIS will be reviewed at least annually. The Missouri EQRO will conduct a systematic review of progress made toward identified goals, objectives, and measures. The added benefit of having the EQRO's contribution to this review is they can provide technical assistance and recommendations based on their expertise in the quality arena. The MHD will also assess progress made at the individual plan level and for Managed Care as a whole.

There are two categories of data used for these systematic reviews. First are the primary data sources that align with our established measures such as findings from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Reviews will also utilize data from the annual "Secret Shopper Survey", conducted by the EQRO. Network adequacy is assessed by the MHD's analysis of network access plans submitted by the MCOs annually. A number of measures that assess

the cost effectiveness of healthcare services are provided to the MHD via a partnership with another cabinet-level agency, the Department of Health and Senior Services (DHSS).

The MHD has a structure to review other data regularly reported by the MCOs on items such as member complaints and appeals, care management, disease management, provider complaints and grievances, and prior authorizations. These data measurements are important to view along with the primary data sources because they are often reported monthly and/or quarterly, which provides an opportunity to monitor trends, gaps, and successes on an ongoing basis. These supporting data can also contribute to the annual evaluation.

Results of these annual evaluations are reviewed and discussed with the MCOs and stakeholders at QA&I and other meetings where quality and outcomes are discussed. The QA&I and other meetings can be used to discuss the root causes of why each strategy and intervention is or is not effective. The public is invited to participate in these discussions at the QA&I meetings.

Results will be used internally to guide program planning and development. This may lead to changes in proposed activities and interventions, methods of analysis, or revision of the measures themselves. The MHD may also enlist the EQRO to provide technical assistance to one or more MCOs related to their performance.

The QIS will be revised at least every three years, as required by CMS. Significant changes to the operation or scope of MHD's Managed Care Program (defined as anything that impacts quality operations) will also result in a revision of the QIS. An example would be changes in carve-in or carve-out services or changes to models of care.

2018 Quality Improvement Strategy - Evaluation of Effectiveness

The previous QIS, titled "MO HealthNet Quality Improvement Strategy –2018" can be found at <https://dss.mo.gov/mhd/mc/pages/quality-oversight.htm>. A formal evaluation of the 2018 QIS is found in "Evaluation of the 2018 State of Missouri, MO HealthNet Division Quality Improvement Strategy". This document is a systematic evaluation of MCO progress toward meeting goals and objectives outlined in the 2018 QIS.

In creating the evaluation of the 2018 QIS, we found that the measures selected demonstrated significant improvement when they were included in the MHD's Performance Withhold Program. The State determined many HEDIS rates were declining in areas of care that affected our very vulnerable managed care population. Implementing a redesigned Performance Withhold Program in State Fiscal Year 2020 allowed our MCOs to develop strategic provider and member incentive programs to drive quality improvement on these measures.

The MHD did experience some setbacks. A Secret Shopper Survey was planned to gain insight into the accuracy of MCOs' provider directories and appointment standards, but methodological challenges resulted in its abandonment for 2020. In its place the MHD monitored member grievance and appeals related to provider directory and appointment

concerns and addressed them with our MCOs when necessary. A revised methodology for the Secret Shopper Survey is being finalized and will be implemented in 2021.

2018 QIS Goals, Objectives and Measures

The MO HealthNet 2018 QIS was designed to communicate, assess, and evaluate the Managed Care Program’s progress toward meeting its goals, objectives, and target measures. This was an intended roadmap for the Managed Care Program as a whole, with the understanding that individual MCO performance may vary from year to year for each measure. The QIS provided a framework to address access to care, wellness and prevention, outcomes, cost-effective utilization of services, and customer satisfaction. All of this has supported the Department’s mission.

Mission
Empower Missourians to live safe, healthy, and productive lives.

Furthermore, the MHD’s vision statement specifies that *“Together we will build a **best in class** Medicaid program that addresses the needs of **Missouri’s most vulnerable** in a way that is **financially sustainable**.”* Therefore, the MHD’s mission for the 2021 QIS aligns the goals and objectives and specific metrics to measures as outlined in Appendix 1.

The 2021 QIS is divided into four goals. Included within each one of these goals are objectives and specific metrics that will be used to measure progress on a yearly and longer-term basis. The target for all measures outlined in Appendix 1 is to improve by one percentage point each year. The MHD previously set a goal of improvement by two percentage points each year, however, the Coronavirus pandemic impacted many of these measures and in State Fiscal Year 2022, improvement is unlikely to be feasible. As the pandemic subsides, the MHD intends to increase the objectives to seek higher percentage point improvements year over year. Alternatively, where national benchmarks are available, the target is for the measure to reach or exceed the national median when possible. Please refer to Appendix 1 for the full QIS Table of Goals, Objectives, and Measures.

The 2021 QIS measures align with the HEDIS measures that will be incorporated into the Performance Withhold Program on July 1, 2021. Two of these HEDIS measures (well-child visits and chlamydia screening) are also Performance Measures evaluated by the EQRO each year, providing an extra layer of monitoring and assessment.

Missouri 2021 QIS – 4 Goals



Activities

The following is a discussion of several activities that occur at the MCO and Managed Care Program level that will contribute to the ability of the MCOs to achieve the goals, objectives, and measures outlined in the 2021 QIS. For each measure, it may take several different interventions and activities working together to drive change. Development, implementation, and assessment must occur along the way to ensure planned and novel strategies are effective in creating meaningful change. In addition to the 2021 QIS, which is a blueprint for the Managed Care Program as a whole, each health plan is required to implement a Quality Assessment and Improvement Strategy. According to the Managed Care contract, this includes components to monitor, evaluate, and implement the contract standards and processes to improve quality in different areas. These areas include quality management, care management, access and availability, and data collection, analysis, and reporting.

Performance Improvement Projects

Each health plan must conduct Performance Improvement Projects (PIPs) aimed at improving clinical and nonclinical care of their members. The state agency requires that the MCOs measure performance using objective quality indicators (typically, they use HEDIS measures), implement interventions designed to achieve improvement in quality, evaluate the effectiveness of their interventions, and make plans to sustain or increase improvement over time. PIPs are typically aimed at showing improvement within each contract year.

The MCOs are all required to participate in three statewide PIPs that have been selected by the MHD to align with specific agency goals and priority areas. These statewide PIPs are discussed during QA&I meetings and are evaluated by the EQRO each year. The three statewide PIPs are all measured using HEDIS:

- Improving Oral Health, based on guidance from CMS’s Oral Health Initiative <https://www.medicaid.gov/medicaid/benefits/dental/index.html>.
- Improving the rate of immunizations for members by their second birthday.
- Improving the rate of follow up visits after a hospitalization for a mental illness

The PIP for improving the rate of follow up visits after a hospitalization for a mental illness is new and the MCOs are actively working with the MHD on a pilot project. Once the pilot project is complete, the focus will transition into an official PIP evaluation.

MO HealthNet interventions for these PIPs include facilitating the Dental Task Force and a Follow Up after Hospitalization workgroup. A collaboration of MHD staff, MCOs (including subcontractors), clinical professionals and multiple medical associations throughout the state focus on improving HEDIS measures through improving access, quality and timeliness of care. These PIPs are also included in MO HealthNet’s Performance Withhold Program.

Accreditation

The MHD requires the MCOs to obtain and maintain accreditation from NCQA. The accreditation status of the three current MCOs is included in the table below.

NCQA Accreditation Status for Current Missouri MCOs		
MCO Name	Status	Expiration Date
Home State Health	Accredited	8/3/2023
Missouri Care (dba Healthy Blue)	Accredited	8/24/2023
United Healthcare	Accredited	5/21/2022

Source: <https://reportcards.ncqa.org/#/health-plans/list>

Community Health Initiatives

All MCOs are required to participate in community health improvement initiatives in collaboration with the DHSS and local public health agencies. These initiatives must align with the Maternal and Child Health Program and DHSS strategic priorities and include topics such as increasing immunization rates, chronic disease prevention and management, and oral health promotion. Many of these topic areas also align with objectives and measures included in the 2021 QIS. Mandatory activities include participation in regional or community Maternal and Child Health coalitions, planning and implementing health improvement programs, and providing feedback about the effectiveness of initiatives and plans.

External Quality Reviews

Primaris Holdings, Inc. is the MHD's current EQRO, and started their five-year contract in January 2018. The EQRO performs all federally mandated activities, as well as optional activities requested by MHD, such as the annual Secret Shopper Survey. Their findings and recommendations are presented at an annual conference with MCO administrative and clinical management staff, at the QA&I meetings, and in a written Annual Technical Report. EQR reports are available on the Department of Social Services, MO HealthNet Division website: <http://dss.mo.gov/mhd/mc/pages/eqro.htm>.

Care Management

The care management requirements are comprehensive and have evolved over time as newer data from MHD program evaluations have emerged to inform these requirements. Part of that evolution is the incorporation of the principles used in the MHD Section 2703 Health Home Program (see below). In addition to incorporating those principles within the Managed Care contract, MCOs are historically required to assess members for care management within a specified number of days after enrollment or diagnosis with specific conditions and/or risk factors. Care management is a process of identification, assessment, enrollment and discharge. MCOs were required to report this activity on a care management log each quarter. The required timeframe for offering care management for chronic diseases such as diabetes and asthma and for special healthcare needs, is thirty calendar days. Special populations require more intensive care management. MCOs are required to offer care management within five business days of admission to a psychiatric hospital or residential substance use program. MCOs are required to offer care management within fifteen business days of notification of pregnancy. Children with elevated blood lead levels must be assessed for care management within these timeframes, depending on the degree of elevation:

- 10 to 19 micrograms per deciliter (ug/dL) within one to three business days
- 20 to 44 ug/dL within one to two business days
- 45 to 69 ug/dL within twenty-four hours
- 70 ug/dL or greater – immediately

MHD recognizes that these lead levels are behind those endorsed by the CDC and will be requiring care management when an elevated blood lead level is at 5 micrograms per deciliter when managed care contracts are rebid in 2021-2022. The DHSS is currently working on a state regulation that will align with national guidelines.

Care management for pregnancy and for children younger than the age of two with elevated blood lead levels are included in the current Performance Withhold Program. This allows the MHD to emphasize the importance of timely care management for these critically important conditions.

In addition, MCOs are required to ensure collaboration with the MHD Section 2703 Health Homes Program for their members. MO HealthNet's Primary Care Health Home (PCHH) Program strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population through providing clinical care and wrap around services. One aspect of the program includes the implementation and evaluation of the Patient Centered Medical Home model as a means to:

- Achieve accessible, high quality primary care
- Demonstrate cost-effectiveness in order to validate and support the sustainability and spread of the model
- Support primary care practices by increasing available resources and improving care coordination thus improving the quality of clinician work life and patient outcomes

The PCHH initiative offers comprehensive care management services for Medicaid participants who have two or more chronic health conditions including asthma/COPD, developmental disabilities, diabetes, cardiovascular disease, overweight/obesity, substance use disorder, depression, anxiety, and tobacco use. The program also emphasizes the integration of primary care and behavioral health care in order to achieve improved health outcomes.

Behavioral Healthcare Homes recognized by the Missouri Department of Mental Health under Section 2703 serve to assist individuals in accessing needed health, behavioral health, social services and supports; managing their mental illness and other chronic conditions; improving their general health; coordination with primary care; and developing and maintaining healthy lifestyles.

Individuals covered by MO HealthNet are eligible to be served by a Behavioral Healthcare Home if they have:

- A serious mental illness
- Other mental health conditions
- A substance use disorder, and
- A chronic physical condition listed in the PCHH section above when they are co-occurring in individuals who have serious mental illness, other mental health conditions, and/or substance use disorder.

Show-Me ECHO

Show-Me ECHO (Extension for Community Healthcare Outcomes) is part of the University of Missouri's Telehealth Network. Show-Me ECHO uses videoconferencing technology to connect a team of interdisciplinary experts with primary care providers. The discussions with, and mentoring from, specialists help equip primary care providers to give their patients the right care, in the right place, at the right time.

The MHD has required all MCOs to participate in this initiative since January 2018. The MCOs collaborate with the MHD to develop the focus of the project, create evidence-based goals and

expected outcomes, and develop metrics to measure health outcomes and anticipated reduced health care costs. This may include activities such as attending meetings and engaging with existing projects.

The Show Me ECHO projects selected for MCO participation align with MHD concerns and priorities. These include the management of high-risk obstetrics cases, the reduction in the occurrence of neonatal abstinence syndrome, the management of opioid use disorder and the management of chronic pain.

The MCOs collaborate with the University of Missouri and the MHD to promote Show-Me ECHO to the health care providers in Missouri, focusing on health care providers in the MCOs' contracted networks.

Medicaid Transformation

One of the guiding principles in the Managed Care Program is the Medicaid Reform and Transformation Program. This principle is supported through contract provisions that require the MCOs participate in three different types of initiatives. First are member incentive programs that encourage personal responsibility related to health behaviors and outcomes. The second are provider incentive programs. Provider incentive programs involve financial rewards for achieving established goals such as reaching a target number of qualifying patient visits or other quality benchmarks. The third is the creation of a Local Community Care Coordination Program (LCCCP), which is another evidence-based patient-centered concept that incorporates MHD's Health Homes Program principles, thus providing a unified paradigm across the Division and its programs. LCCCPs have the following components:

- Every member has a PCP
- Care is provided by a physician-directed team that collectively cares for the member
- Care is coordinated across all aspects of health care
- Member Care Management includes care coordination, health promotion, transitional care, individual and family support activities, disease management, and referrals to local social support resources.

In February 2019, the Missouri Department of Social Services worked with a contractor to conduct a Rapid Response Review and Assessment of Missouri's Medicaid Program. This review allowed the MHD to realize a number of improvements that could be made through transformation efforts. The MHD has been actively working to implement some of these improvements. Managed care members now have day one enrollment, the MHD will implement a new hospital outpatient and inpatient payment method on July 1, 2021, a revised care management patient journey evaluation is being introduced, a single-MCO model with specialized capabilities for our state care and custody population will begin July 1, 2022, which includes behavioral health services being covered through managed care for this population. The MHD is currently exploring procurement of a contract compliance tool to electronically evaluate much of the quality data received from our stakeholders.

Performance Withhold Program

A performance withhold program was started with the MCOs in 2015 to improve performance on selected metrics. The MHD has consistently collaborated with the MCOs to promote continuous improvement and implement measures that will drive improvements to improve care and quality within Missouri's managed care program.

In State Fiscal Year 2020, the MHD introduced a new Performance Withhold Program using HEDIS measures calculated and reported by the MCOs' certified HEDIS vendors. Prior year baseline data was utilized to determine the percentage point improvement of 14 different measures. In addition to percentage point improvements, the MHD analyzed the program to determine how Missouri's MCOs compared to national rates in the NCQA's Quality Compass. The MHD and the MCOs established a program goal to reach the 50th percentile for each HEDIS measure. Although some measures continue to be below the 50th percentile, significant improvements have been made due to the implementation of this revised model. HEDIS information by MCO for performance years 2018 and 2019 are shown in Appendix 3.

The Coronavirus pandemic introduced some unforeseen concerns to HEDIS rates and consequently impacted the ability to operate a Performance Withhold Program developed around many measures that required an office visit. The MHD and MCOs quickly collaborated to implement a temporary alternative model which included three tasks.

- Conduct a focused study on a quality improvement project which can be improved upon or studied in-depth to improve the health outcomes of managed care participants.
- Report a set of MHD approved HEDIS measures and include enhanced data analysis for race/ethnicity, county, and gender.
- Develop a report describing the effects of COVID-19 on performance measures, utilization, and incentive programs.

The MHD will receive the deliverables from the State Fiscal Year 2021 timeframe in August 2021. The information gained from this model will help in the development of future quality initiatives to our program and gain some better insight on the impact COVID-19 has had on the managed care population in Missouri.

The State Fiscal year 2022 Performance Withhold Program (see Appendix 2) will be based on 15 HEDIS measures focusing on the following categories:

- Access to Care for Children
- Screening and Immunizations for Children
- Chronic Disease Management – Children
- Chronic Disease Management - Adults
- Women's Health
- Behavioral Health

This will reintroduce the State Fiscal Year 2020 model that was deemed such a success in its first year of operation. Due to COVID-19 continuing to have an impact on Missourians in 2021, year-over-year percentage point improvement targets have been reduced. In 2022, the MHD will consider increasing these targets.

Quality Rating System

In the coming years, the MHD will be developing a Quality Rating System (QRS) for its MCOs. The plan is for the QRS to use CAHPS and health outcome measures that reflect member experience and access to quality health care. MCOs will be incentivized to improve their quality related to customer satisfaction and health outcomes because the QRS will be presented for members to consider when selecting a health plan.

The MHD is exploring the procurement of a compliance tool which will automate many of the manual processes for analyzing quality data reports submitted by the MCOs on a monthly, quarterly, and annual basis. The use of this tool will allow the MHD to focus efforts on quickly identifying areas of improvement and implementing plans of action instead of the manual process that exists today. A compliance tool will also allow the MHD to automate quality ratings for our MCOs based on data they remit. The MHD intends to publish quality ratings on our website once this tool is fully implemented.

MO HealthNet Managed Care Specialty Plan

In 2022, the MHD will select a single Managed Care “Specialty Plan” to serve the population of children in state care which includes foster children and those receiving adoption subsidy. The specialty plan will collaborate with the state agency to implement requirements to comply with the Family First Prevention Services Act of 2018 (PL115-123) and other programs impacting specialty plan members. The specialty plan benefit package will include an array of physical and behavioral health services designed to support the unique and complex needs of specialty plan members. The specialty plan will be encouraged to provide additional health benefits that include social determinants of health needs, considering the special and unique needs of the plan population.

MO HealthNet Managed Care Standards

In accordance with 42 CFR 438.204, all state quality strategies must provide documentation of Managed Care contract provisions that incorporate the standards of Part 438, Subpart D. Table 1 provides a section-by-section comparison between Subpart D and the July 1, 2020-June 30, 2021 MO HealthNet Managed Care contract. Table 1 shows that the Managed Care contract’s standards related to access to care, structure, operations, and quality measurement and improvement are all at least as stringent as the standards in Part 438, Subpart D. Below is a discussion about standards of particular importance to CMS, the MHD, and its members.

Special Health Care Needs

The Special Health Care Needs (SHCNs) population in the contract includes members with Autism Spectrum Disorder. Individuals with special health care needs are those individuals who may require hospitalization or institutionalization if they do not receive services such as private duty nursing, home health, durable medical equipment/ supplies, and/or care management.

The following groups of individuals are at high risk of having a special health care need:

- Individuals with Autism Spectrum Disorder.
- Individuals eligible for Supplemental Security Income (SSI).
- Individuals receiving foster care or adoption subsidy or other out-of-home placement.
- Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.

To identify persons with SHCN, the choice counselor at the beneficiary support center administers the Managed Care Health Risk Assessment (HRA) to the member during initial and annual open enrollment periods. The choice counselor includes an HRA form for eligible members in each household in the enrollment packet. The choice counselor also administers the HRA via telephone at the time of a telephone change or transfer request. If the mail-in enrollment information does not include a completed HRA, the choice counselor must make an attempt to contact the individual by telephone for the information. There should be a health risk assessment for each eligible person in the household. The completed HRAs are provided nightly to the MCOs as they are collected. The MCO is required by contract to make their best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful. The MHD allows Managed Care enrollment to be completed by telephone, mail, or online at the following location:

<https://dss.mo.gov/mhd/participants/mc/how-to-enroll.htm>.

The HRA provides the MCO with important information about the health risks of new members. This provides opportunities for early identification of members who can be referred to care management or disease management. Members with identified health risks have or need one or more of the following:

- Pregnancy
- Special Health Care Needs
- Chronic conditions (asthma, diabetes, high blood pressure)
- Behavioral health treatment or counseling
- Substance use treatment or counseling
- Physical, speech, or occupational therapy
- Special equipment to help with moving, walking, talking, hearing, breathing, feeding, personal care, etc.

The MCOs have developed condition-specific detailed assessment forms. Based upon assessment results and in partnership with the member, a more detailed care plan may be developed or the appropriate frequency of follow-up outreach identified. Follow-up care may include, specialist referrals, accessing durable medical equipment, medical supplies, and home health services. Where appropriate, care managers provide coordination and continuity of services to members. MCOs are required to complete a treatment plan for all members meeting the requirements of persons with special health care needs as defined above. All treatment plans must comply with 42 CFR 438.208 and include requirements for direct access to specialists.

Race, Ethnicity, Primary Language, and Data Collection

Missouri updated its procedures for collecting racial and ethnic data consistent with the Office of Management and Budget (OMB) revised standards via Administrative Notice (A-14-2003) on September 11, 2003. Missouri follows the guidance presented in the OMB Administrative Notice for obtaining information when individuals fail to self-identify themselves. The two ethnic categories are: Hispanic or Latino, and Non-Hispanic or Latino. The five racial categories are: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, Multi-Racial and White. During the application process, the applicant identifies race, ethnicity, and primary spoken language.

The Managed Care contract includes language requirements compliant with Federal regulations. The MCOs are notified of member enrollment/disenrollment information via a nightly enrollment file and a weekly enrollment reconciliation file. To facilitate care delivery appropriate to member needs, the enrollment file also includes race, primary language spoken, and selective health information. The MCOs utilize information on language to provide interpretive services, develop educational materials for employee training, and facilitate member needs in the context of their language requirements.

With the revised Performance Withhold Program, MCOs are now including race/ethnicity, gender, and county in their measurement data. This additional detail will allow the MHD and MCOs to improve efforts to reduce disparities within our managed care populations and evaluate the need for programs focusing on social determinants of health.

Table 1

Managed Care Contract Provisions that Incorporate the Standards of 42 CFR Part 438, Subpart D - Quality Assessment and Performance Improvement	
Federal Rule Section	Managed Care Contract Section
438.206 Availability of Services	2.3 Cultural Competency
	2.4 Health Plan Provider Networks
	2.5 Service Accessibility Standards
	2.8 Second Opinion
	2.12.16 Member Handbook
	2.18.8 Credentialing
438.207 Assurances of Adequate Capacity and Services	2.4 Health Plan Provider Networks
438.208 Coordination and Continuity of Care	2.4 Health Plan Provider Networks
	2.5.8 Direct Access and Standing Referrals
	2.5.9 Transition of Care
	2.11 Member Care Management and Disease Management
	2.18 Quality Assessment and Improvement
438.210 Coverage and Authorization of Services	2.5.5 Prior Authorizations
	2.15.2f Grievance and Appeal System
	2.18 Quality Assessment - Utilization Management
438.214 Provider Selection	2.27 Non-Discrimination in Hiring and Provision of Services
	2.18 Quality Assessment and Improvement
	2.18.8c Provider Credentialing
438.224 Confidentiality	2.38 Business Associate Provisions
	3.16 Confidentiality
438.226* Enrollment and Disenrollment	2.12 Eligibility, Enrollment, and Disenrollment
438.228 Grievance systems	2.15 Member Grievance System
438.23 Subcontractual Relationships and Delegation	2.22.12 Subcontractor Oversight Reports
	3.9 Subcontractors
438.236 Practice Guidelines	2.18.5 Practice Guidelines
438.330** Quality Assessment and Performance Improvement Program	2.18 Quality Assessment and Improvement
438.242 Health Information Systems	2.26 Claims Processing and Management Information Systems.
<i>*This item may be removed from Subpart D in the Final Rule.</i>	
<i>**Formerly located in Section 438.240.</i>	

Monitoring and Compliance

In accordance with 42 CFR 438.204, all state quality strategies must provide documentation of procedures that regularly monitor and evaluate Managed Care plan compliance with standards of Part 438, Subpart D.

The State's monitoring program consists of a variety of tools, activities, and reports. Visit <https://dss.mo.gov/business-processes/managed-care/> for a complete list of current MCO reporting requirements.

The Managed Care contract also requires the MCOs to have internal quality assurance programs that the MHD regularly monitors. The MCOs, in turn, are responsible for communicating established standards to their network providers and subcontracted benefit management organizations. They monitor provider compliance, and enforce corrective actions as needed.

Within MHD, the Evidence-Based Decision Support Unit (EBDSU) evaluates process measures, clinical outcomes, and service utilization rates. Measures consist of nationally defined standards as well as locally developed metrics. In addition, the EBDSU houses the Behavioral Health Program, which conducts reviews of behavioral health services within Managed Care, covering a variety of indicators addressing network adequacy, utilization, timely service availability, and hospitalization follow-up, among others. The resulting data from these efforts drive program and policy decisions. MCO Annual Data reports are posted on the MHD website at <https://dss.mo.gov/mhd/mc/pages/quality-oversight.htm>, these reports contain quality metrics and results MHD uses to measure health plan performance and improvement.

The EBDSU works closely with the Managed Care Policy, Contracts, and Compliance Unit (MCPCCU) and the Quality Oversight Unit. These units act as liaisons with the MCOs regarding required reporting and take necessary steps to ensure compliance. The Performance Withhold Program is housed within the Quality Oversight Unit, which works closely with EBDSU to compile data that are used to evaluate MCO performance.

Structure and Operations

The MCOs provide MHD with monthly operational data on:

- Institution of Mental Disease (IMD) Services
- Member Grievance and Appeals
- Health Plan Hospital Services Reporting

▪ The MCOs provide MHD with quarterly operational data on:

- Call Center Services
- Care Management Services
- Disease Management Activities
- Foster Care Members
- Fraud, Waste, and Abuse

- Overpayments Due to Fraud Activities
- Prior Authorizations and Denials
- Third Party Savings
- Timeliness of Claims Adjudication

The MHD analyzes the data for trends and areas of concern, which are discussed during monthly Quality Data Review Committee meetings. As MHD evaluates performance, it identifies areas of opportunity or weakness and works with the MCOs to improve performance. Quarterly meetings are conducted with all the MCOs to address any data concerns and provide additional guidance when necessary. In addition, MHD uses corrective action plans to address deficiencies identified through evaluation of the MCOs. Additional follow-up with internal MHD staff and MCOs occurs when noncompliance or inconsistencies are discovered.

Quality Measurement and Improvement

DHSS compiles the *Maternal and Child Health Indicators and Trends Report* from publicly reported vital health statistics and hospital discharge data sets each year. Aggregate data from the Managed Care Program baseline (1995 to the present) are available for nine maternal/infant and four child health indicators. This is presented at a QA&I meeting annually.

The Maternal and Child Health (MCH) Indicators are also used to examine the impact of the Managed Care Program on maternal/infant and child health and to compare this progress with Non-Medicaid and MO HealthNet Fee-for-Service participant groups.

The QA&I Advisory Group monitors and reviews behavioral health metrics that are reported to the State on an annual basis. In addition, the State collaborates with the DMH to conduct annual Behavioral Health Reviews of each MCO and their behavioral health contractor. These consist of surveys and comprehensive on-site behavioral health operational reviews designed to monitor areas of particular concern such as care management, behavioral health provider availability, and other issues identified through routine monitoring activities. The reviews address the following areas:

- Adequacy of quality monitoring systems including oversight of staff performance; caseloads; network access; provider practice patterns; utilization; denial and complaint trends; and, other quality data.
- Involvement of the Medical Director in utilization and quality management.
- Effectiveness of executive management and MCO oversight and reports.
- Performance on a number of key metrics including telephone response, staff turnover, network access, and utilization and complaint rates.

Quality Data Review

The Quality Data Review (QDR) committee provides a consistently scheduled opportunity for managers and administrators to review the variety of quality data that are received, primarily in the monthly and quarterly data feeds, from the MCOs. The committee was formed to ensure reports based on these data were reviewed and acted upon in a timely manner.

These reports are also disseminated to MHD staff designated to review and intervene in the various programs monitored by these data, including member grievances and appeals, member call center activity, claims adjudication, prior authorizations, fraud/waste/abuse, care management, and disease management. The QDC meets monthly to review 3-4 of these reports each meeting, with the goal of reviewing all reports generated from the MCOs' monthly and quarterly data submissions over the course of that quarter. This allows for review of trends, formulation of questions/follow-up for the MCOs, and development of interventions to address problematic or recalcitrant findings. Additionally, review of data from the annual reporting cycle has been incorporated into the QDR Committee as well.

Access to Care

MCOs must comply with travel distance standards as set forth by the Department of Commerce and Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 (<https://s1.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c400-7.pdf>) as amended. MCOs submit network files as part of the annual access plan required by DIFP, the State uses these plans to calculate member access rates by county and statewide to determine if the provider network is capable of meeting the needs of MCO members.

MCOs are required to meet certain Provider Panel Directory standards. The EQRO conducts a Secret Shopper Survey to assess MCO compliance with this requirement.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT is a comprehensive preventive and primary health program for Medicaid-eligible children. In Missouri, EPSDT is also known as the Healthy Children and Youth (HCY) Program. EPSDT/HCY is included in the Managed Care contract as a deliverable. The target measure for EPSDT/HCY performance in the contract is based on the participant ratio, which measures the extent to which members are receiving initial and periodic screening services throughout the year. MCOs are required to achieve a 65% participant ratio on EPSDT for newborns (infants less than one year old) and children ages one through less than six. Additionally, MCOs must meet the CMS requirement of an 80% participant ratio for members under the age of 21.

MCOs submit annual EPSDT data to the MHD reporting their participant ratios.

External Quality Review

The MHD has arranged for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract. Primaris, Inc currently holds the contract for EQR activities. Primaris conducts an annual, EQR of the MCOs utilizing the EQR protocols (<https://dss.mo.gov/mhd/mc/managed-care-health-plans.htm>) in accordance with federal requirements 42 CFR 358 and 42 CFR 438.330, and as designated by the MHD's Quality Strategy.

Oral Health Initiative

The MHD has increased its emphasis on improving oral health care in pregnant women beginning in December 2019. A pilot was conducted to encourage pregnant women in Cole County, Missouri to seek a dental visit. The pilot program resulted in 41% of pregnant women receiving a dental visit. This was significant considering preliminary data only showed a statewide rate of 18 percent of pregnant members sought a dental visit in 2018. With the success of the pilot program, the state agency has encouraged the MCO's to participate in a community health initiative on a statewide level to all pregnant members enrolled in their plan. The MHD and MCOs will continue to monitor this effort on a quarterly basis to determine if there is success.

Fraud, Waste, Abuse and Program Integrity

The MHD and the Missouri Medicaid Audit and Compliance (MMAC), conducts individual quarterly meetings with each MCO to discuss fraud, waste and abuse trends and activities, and provides program integrity training. The MCOs implement internal controls, policies, and procedures designed to prevent, detect, review, report, and assist in the prosecution of fraud, waste, and abuse activities by providers, subcontractors, and members. Policies and procedures articulate the MCO's commitment to comply with all applicable Federal and State standards.

In 2020, the MHD implemented an Overpayments Due to Fraud process in which the MCOs report payments that are in the process of being recouped from providers due to fraudulent activity. The MHD shares this data with MMAC to assist them in their audit and compliance activities. The MHD also shares this data with our actuary, Mercer Government Human Services Consulting (Mercer), for utilization in rate setting processes.

Sanctions

In accordance with the 42 CFR 438.204, all state quality strategies must provide documentation of Managed Care contract provisions that incorporate the standards of Part 438, Subpart I related to the appropriate use of intermediate sanctions. Table 2 shows that the current Managed Care contract meets the requirements of subpart I of this Part 438.

Table 2

MO HealthNet Managed Care Contract Provisions that Incorporate the Standards of 42 CFR Part 438, Subpart I - Sanctions	
Federal Rule Section	Managed Care Contract Section
438.700 Basis for Imposition of Sanctions	2.29.9 Basis for Imposing Intermediate Sanctions
438.702 Types of Intermediate Sanctions	2.29.10 Types of Intermediate Sanctions
438.730 Sanctions by CMS	2.29.13 Federal Sanctions

The Managed Care contract addresses sanctions in Section 2.29. For each working day that a report or deliverable is late, incorrect, or deficient, the MCO shall be liable to the state agency for liquidated damages as specified in the contract.

In the event the state agency determines the MCO failed substantially to provide one or more medically necessary covered services as required in the Managed Care contract, the state agency shall direct the MCO to provide such service. If the MCO continues to refuse to provide the covered service(s), the state agency shall authorize the members to obtain the covered service from another source and shall notify the MCO in writing that the MCO shall be charged (at the state agency's discretion) either the actual amount of the cost of such service or \$500 per occurrence. In such event, the charges to the MCO shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the MCO. With such deductions, the state agency shall provide a list of the members with respect to whom payments were deducted, the nature of the service(s) that the MCO failed to provide, and payments the state agency made or will make to provide the medically necessary covered services.

Use of the remedy under this section shall not foreclose the state agency from imposing any other applicable remedy listed herein. The failure to provide a covered service timely (i.e., in accordance with the timeframes specified herein, or when not specified herein, with reasonable promptness) shall be considered a violation resulting in either the actual amount of the cost of the service or \$500 per occurrence.

In the event of any failure by the MCO to provide any services under the contract (including both covered services and administrative services), the state agency may, in addition to any other applicable remedies, require the MCO to submit and follow a corrective action plan in order to ensure that the MCO corrects the error or resumes providing the service.

Basis for Imposing Intermediate Sanctions

In addition to the above, the state agency may impose intermediate sanctions when a MCO acts or fails to act as specified below. Before imposing intermediate sanctions, the state agency shall give the MCO timely written notice that identifies the violation and explains the basis and nature of the sanction. A MCO is subject to intermediate sanctions if it:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the contract, to a member covered under the contract.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the MO HealthNet program.
- Acts to discriminate among members on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the state agency.
- Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
- Fails to comply with the requirements for PIPs.
- Distributes directly or indirectly through any agent or independent subcontractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.
- Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Types of Intermediate Sanctions

The types of intermediate sanctions that the state agency may impose upon the MCO include:

- Civil monetary penalties
- Appointment of temporary management for a MCO as provided in 42 CFR 438.706.
- Special Rules for Temporary Management

Information Systems Capabilities

MCO technical infrastructure has implications for all of the activities lined out within the 2021 QIS as well as the ability to measure whether these activities will be able to meet the strategies goals and objectives. The EQRO conducts an Information Systems Capabilities Assessment every three years. They will conduct a “mini-review” the following year if an MCO does not obtain a “Met” rating during the prior year’s review or if the MCO underwent system changes since the last review. Additionally, the EQRO evaluates encounter data related to performance measures.

Missouri Medicaid Information System

The Missouri Medicaid Information System (MMIS) supports the initial and ongoing operation and review of the Missouri QIS. In March 2018, CMS notified MO HealthNet that Missouri meets the criteria for a Transformed Medicaid Statistical Information System because it has met CMS production readiness criteria. CMS recognized Missouri for its commitment to improve data and data analytic capability. The MHD is in the process of procuring a new MMIS which will provide the opportunity for even more improvement in this area.

Encounter data are used by the State for rate setting and quality improvement evaluation, and the State conducts a complex process for assuring validity of encounter claims submitted by the MCOs. This involves using software algorithms as well as conducting a review of medical records for a random sample of claims in order to assure completeness and accuracy of submitted data. Complete and accurate encounter data are important to ensure quality measures such as HEDIS and EPSDT are calculated, reported, and assessed correctly and fairly.

The MHD maintains a contract requirement that the MCOs must maintain encounter data completeness and accuracy each quarter. Each MCO must meet a 98% encounter data acceptance rate for each health plan region. In 2020, the MHD strengthened contract language to prohibit encounter claims from being held without the MHD's prior approval in an attempt to maintain a 98% encounter data acceptance rate. This is often necessary when system issues occur or unique programs are implemented and efforts are required to ensure accurate data is received.

The MHD operates an Encounter Data Workgroup (EDWG) consisting of MHD and MCO experts as well as our actuary, Mercer. The EDWG was formed due to inconsistencies that prohibited Mercer from using 100% of encounter data when developing rates. Through the success of this group, 100% of encounter data is now used in rate setting processes. The EDWG meets regularly with internal stakeholders and quarterly with MCO personnel. Topics typically include system edits that result in encounters denying. The EDWG will discuss system requirements, education, and work towards system upgrades when necessary.

The MHD also provides an encounter data liaison to the MCOs which can be contacted to work one-on-one to find resolutions to any ongoing problems they may have.

The MHD has also enlisted the assistance of Mercer to conduct a complete audit of health plan encounter data in accordance with 42 CFR 438.602(e) of the Managed Care Final Rule. The MHD is looking forward to the results of this audit and capitalizing on any areas of improvement that are identified.

Enrollment Broker

Missouri currently uses a Beneficiary Support Services Center to provide the following enrollment broker functionality:

- Creates and sends enrollment packets and letters to members
- Assigns members into Managed Care health plans
- Forwards data from Health Risk Assessments received by members to MMIS (to compile) who then forwards info to health plans
- Performs choice counselor functionality assisting members with questions byphone regarding plan choices and enrollment into a Managed Care health plan
- Process changing health plans, opt-out, opt-in, and just-cause transfers initiated by members

- The MHD recently awarded a contract to a new Beneficiary Support and Premium Collection Solution and Services Center, which will have the following additional functionality by spring 2022:
 - Web Portal to assist members in enrolling with a health plan, transfers, opt-in/out, and mailings to be printed or imported by members.
 - Provider directory in the web portal for members to locate PCPs or pharmacies located near them.
 - Auto assignment into health plans with an algorithm approved by the MHD.
 - Premium collections module to assist with premium payments for CHIP, Spenddown, and Ticket to Work

The DSS Family Support Division is responsible for determining MO HealthNet eligibility and will be an important partner with the MHD on the new Beneficiary Support and Premium Collections Solution and Services Center.

Conclusion

The MHD and its EQRO will conduct a systematic annual review of the QIS to document progress toward meeting goals, objectives, and measures outlined in Appendix 1. During this process, it will be important to consider the fact that the 2021 QIS is being implemented during a time of great change for Managed Care in Missouri. Managed Care was expanded statewide on May 1, 2017 after being operated regionally since its inception in Missouri.

Staffing

Within the MHD, the EBDU and MCPCCU each play an important role in quality improvement on an ongoing and annual basis. To underscore the MHD's commitment to quality improvement, it has created a Quality Oversight Unit consisting of a Quality Manager and three Data Analysts to work on the Performance Withhold Program, network adequacy, EQRO activities, and quality improvement processes.

A Registered Nurse was added to the MCPCCU to provide clinical expertise in policy development, quality and compliance arenas.

The EBDSU has improved the review and validation process subsequent to data submission to allow our MCOs to examine their data within the context of all three plans. By presenting side-by-side graphs, the MCOs can easily spot outlier performance and determine whether it reflects actual performance differences or is, rather, an error in calculation. We also provide similar tables showing the year-to-year change in values, so that the MCOs can easily target and inspect suspiciously large differences. Similarly, our quarterly data reporting process has seen significant improvements in validation processes, and while this often results in rejection of datasets from the MCOs, the quality of the data, once it passes all validation checks, is vastly improved.

Partnerships

The QA&I group continues to make recommendations to ensure the focus remains on developing meaningful quality improvement ideas. Meetings take place twice per year to review quality data analysis and evaluation activities to determine if improvements or new opportunities need to be explored. In order to generate greater discussion surrounding quality improvement processes by the plans, and expectations by MHD, agendas are modified to keep the group innovative. The QA&I group will continue to establish separate task forces if specific areas of improvement are identified. The QA&I has been helpful in developing strategies that the MHD can implement to drive quality improvement.

The MHD's EQRO vendor, Primaris Holdings, Inc. will continue to complete EQR activities required by CMS, and, the MHD plans to utilize Primaris for special projects designed to improve quality at the agency and MCO level. The MHD may enlist Primaris to provide technical assistance on special topics that arise during implementation of the QIS. Primaris will be involved with the QA&I as well.

A major area of strength has been the ongoing partnerships with the DMH to improve health outcomes for those accessing behavioral health services through community mental health centers and/or certified community behavioral health organizations. Another initiative underway involves collaboration among inpatient behavioral health facilities, MCOs, and community providers in order to improve communication, coordination, and collaboration among all partners following inpatients admissions. Collaborations with DHSS have been helpful to improve health outcomes for the Maternal and Child population. Additionally, we solicit input through our Consumer Advisory Committee (CAC) and other public meetings and continually monitor this feedback for opportunities for improvement.

Summary

The MHD intends to use the 2021 QIS to help drive quality improvement at many different levels. The MHD is optimistic that the measures included in the 2021 QIS and Performance Withhold Program will guide the MCOs as they plan and implement activities such as PIPs, care management, provider incentives, member incentives, and LCCCP participation.

The effort to align quality improvement activities with the goals, objectives, and measures featured in the 2021 QIS will be most effective if it is a collaborative process among the MHD, MCOs and stakeholders. The ultimate goal among the MHD and its partners is to improve members' appropriate access to care, wellness and prevention, cost-effective utilization of services, and satisfaction with experience of care.

The MHD is committed to continuous quality improvement designed to help achieve the Department's mission, to empower Missourians to live safe, healthy, and productive lives.



Quality Strategy State Fiscal Year 2021 Goals, Objectives, and Measures

Goals	Objectives	Measures
<p style="text-align: center;">Goal 1</p> <p>Ensure appropriate access to care.</p>	<p>Ensure timely access to care</p>	Percentage of Primary Care Provider offices that met the urgent appointment standard (24 hours for illness or injury requiring immediate care).
		Percentage of Primary Care Provider offices that met the routine appointment standard (30 days for routine care without symptoms).
		Percentage of psychiatrist offices that met the two-week appointment standard for routine behavioral health and substance use services without symptoms.
	<p>Ensure an adequate healthcare network</p>	Percentage of primary care physician offices that meet mandated access standards.
		Percentage of specialist offices that meet mandated access standards.
<p style="text-align: center;">Goal 2</p> <p>Promote wellness and prevention.</p>	<p>Promote Child Health</p>	Well-Child Visits in First 15 Months of Life (0-15 Months): Percentage of children who turned 15 months old during the measurement year and had six or more well-child visits.*
		Well-Child Visits in First 30 Months of Life (15-30 Months): Percentage of children who turned 30 months old during the measurement year and had two or more well-child visits.*
		Child & Adolescent Well-Care Visits (3-11yrs): Percentage of members age 3-11 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.*
		Child & Adolescent Well-Care Visits (12-17yrs): Percentage of members age 12-17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.*
		Child & Adolescent Well-Care Visits (18-21yrs): Percentage of members age 18-21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.*
		Annual Dental Visits (Total): Percentage of members 2–20 years of age who had at least one dental visit during the measurement year.*
		Childhood Immunization Status (Combo 10): Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.*
		Immunizations for Adolescents (Combo 1): Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (DTaP) vaccine by their 13th birthday.*
	Lead Screening in Children: Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.*	
	<p>Promote Chronic Disease Management</p>	<p>Asthma Medication Ratio (Total): Percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.*</p>



Quality Strategy State Fiscal Year 2021 Goals, Objectives, and Measures

Goals	Objectives	Measures
Goal 2 cont. Ensure cost-effective utilization of services.	Promote Chronic Disease Management	Comprehensive Diabetes Care: Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c Control (<8.0%).*
	Promote Women’s Health	Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.*
		Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.*
		Chlamydia Screening in Women (Total): Percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.*
Improve management of behavioral health and substance use disorder	Follow-Up After Hospitalization for Mental Illness (30 Days): Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.*	
Goal 3 Ensure cost-effective utilization of services	Decrease readmission rates	Rate of behavioral health inpatient readmissions.
	Decrease use of emergency rooms	Rate of emergency room (ER) visits due to asthma among children younger than 4 years of age.
		Rate of emergency room (ER) visits due to asthma among children 4 to 17 years of age.
		Rate of emergency room (ER) visits among children younger than 18 years of age.
		Rate of emergency room (ER) visits among members 18 to 64 years of age.
	Decrease preventable hospitalizations	Rate of preventable hospitalizations among children younger than 18 years of age.
Rate of preventable hospitalizations due to asthma among children younger than 18 years of age.		
Goal 4 Promote member satisfaction with experience of care.	Promote access to care	Rate of always or usually getting needed care as soon as needed within the last six months.
		Rate of always or usually getting care quickly within the last six months.
	Promote rating of healthcare	Increase member healthcare satisfaction ratings to score an 8, 9, or 10 within the last six months.

**Due to COVID-19, the target is to improve by one percentage point during measurement year 2021 or reach the national median (where national benchmarks are available). Future years will require a larger percentage point increase.*



Performance Withhold State Fiscal Year 2022 HEDIS Measures

Appendix 2

Category	Portion of Total Withhold per Category	Acronym	Healthcare Effectiveness Data and Information Set (HEDIS) Measure	Portion of Total Withhold Per HEDIS Measure
Access to Care for Children	1.00% (Note: W30, WCV, and ADV measures include trailing decimal to equal a total of 1.00%)	W30	Well-Child Visits in First 15 Months of Life (0-15 Months): Percentage of children who turned 15 months old during the measurement year and had six or more well-child visits.	0.167%
			Well-Child Visits in First 30 Months of Life (15-30 Months): Percentage of children who turned 30 months old during the measurement year and had two or more well-child visits.	0.167%
		WCV	Child & Adolescent Well-Care Visits (3-11yrs): Percentage of members age 3-11 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	0.167%
			Child & Adolescent Well-Care Visits (12-17yrs): Percentage of members age 12-17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	0.167%
			Child & Adolescent Well-Care Visits (18-21yrs): Percentage of members age 18-21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	0.167%
ADV	Annual Dental Visits (Total): Percentage of members 2–20 years of age who had at least one dental visit during the measurement year.	0.167%		
Screening & Immunizations for Children	0.55%	CIS	Childhood Immunization Status (Combo 10): Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	0.20%
		IMA	Immunizations for Adolescents (Combo 1): Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (DTaP) vaccine by their 13th birthday.	0.20%
		LSC	Lead Screening in Children: Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	0.15%
Chronic Disease Management - Children	0.10%	AMR	Asthma Medication Ratio (Total): Percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	0.10%
Chronic Disease Management - Adults	0.10%	CDC	Comprehensive Diabetes Care: Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c Control (<8.0%).	0.10%
Women's Health	0.40%	PPC	Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	0.15%
			Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	0.15%
		CHL	Chlamydia Screening in Women (Total): Percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	0.10%
Behavioral Health	0.25%	FUH	Follow-Up After Hospitalization for Mental Illness (30 Days): Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.	0.25%

The following measures are report-only measures. Health plans will receive 0.10% of the Performance Withhold by reporting the HEDIS rates. These rates will be utilized as a baseline for consideration in SFY2023. No evaluation will be done on these measures in SFY2022.

Category	Portion of Total Withhold per Category	Acronym	Healthcare Effectiveness Data and Information Set (HEDIS) Measure	Portion of Total Withhold Per HEDIS Measure
Behavioral Health		UOP	Use of Opioids from Multiple Providers. This measure assesses the rate of health plan members 18 years and older who receive opioids from multiple prescribers and multiple pharmacies (to monitor for possible inclusion in future years).	0.10%
Risk Adjusted Utilization		PCR	Plan All-Cause Readmissions: For Medicaid members 18-64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	
Cardiovascular Conditions		CBP	Controlling High Blood Pressure: Percentage of members 18-85 of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	
Prevention and Screening		CCS	Cervical Cancer Screening: Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: * Women 21-64 years of age who had cervical cytology performed with the last 3 years * Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years * Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years	
Prevention and Screening		BCS	Breast Cancer Screening: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	

HEDIS Measure Results 2018-2019

Measure Name		Missouri Care 2018		Home State Health 2018		Missouri Care 2019		Home State Health 2019		UnitedHealthcare 2019	
		% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)
W15	Well-Child Visits in the First 15 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.*	-1.7	25	-9.76	33.33	7.59	25	2.63	10	10.47	10.00
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: Assesses children 3–6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.*	-2.5	10	-5.69	10.00	4.27	10	-0.14	5	7.05	5.00
AWC	Adolescent Well-Care Visits: Assesses adolescents and young adults 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.*	5.83	33.33	6.33	10.00	4.24	50	2.43	25	-1.22	33.33
ADV	Assesses Medicaid members 2-20 years of age with dental benefits, who had at least one dental visit during the year.*	4.3	25	6.19	10.00	6.15	33.33	5.42	25	5.46	25.00
LSC	Assesses children 2 years of age who had one or more blood tests for lead poisoning by their second birthday.*	2.75	10	0.52	10.00	4.55	25	1.12	10	8.52	10.00
CIS	Assesses children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.*	0.97	10	-5.36	10.00	0	10	8.52	25	3.41	5.00
IMA	Assesses adolescents 13 years of age who had one dose of meningococcal vaccine and one Tdap vaccine series by their 13th birthday.*	3.4	10	0	0	1.46	5	4.63	0	3.4	0
CHL	Assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.*	-10.35	10	-5.18	25.00	1.45	0	1.17	10	1.24	10.00
PPC	Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.**	-5.84	33.33	-3	10.00	15.57	50	8.91	75	-8.24	10.00
PPC	Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.**	-0.73	10	-8.78	95.00	20.44	50	11.46	50	8.89	25.00
CDC	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had controlled HbA1c.*	-2.92	10	-4.87	10.00	3.17	10	3.41	10	6.33	25.00
MMA	Medication Management for People With Asthma: Assesses children 5-11 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period.*	4	33.33	9.51	50.00	9.29	75	-0.93	75	-8.73	75.00
MMA	Medication Management for People With Asthma: Assesses children 12–18 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period.*	1.45	50	8.04	50.00	4.49	66.67	0.56	75	-3.75	90.00
FUH	Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 30 days of discharge.*	-2.67	33.33	-3.19	33.33	5.48	50	1.13	33.33	10.40	10.00