Quality Improvement Strategy - 2022
State of Missouri
MO HealthNet Division

Prepared by
The Missouri Department of Social Services
MO HealthNet Division (Missouri Medicaid)
October 2022

Initial QIS: 6/28/2021
Current Revision: 10/2022

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History and Description of MO HealthNet 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, children in state care, and non-disabled adults ages 19-64 with income up to 138% of the Federal Poverty Level (FPL). The Missouri Medicaid program is jointly financed by the federal government and State of Missouri, 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. These adults began receiving services through the managed care system October 1, 2021 under Section 1932(a). For additional background on the operation of Managed Care in Missouri, please visit https://dss.mo.gov/mhd/mc/pages/overview.htm. The MO HealthNet 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 that have received approval from the Department of Health and Human Services 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 up to 300% of the Federal Poverty Level (FPL). Currently, coverage is provided statewide through the Managed Care delivery system.

Women's Health Services Program

MO HealthNet offers Women's Health Services to women ages 18 through 55 that have family income at or below 185% of the Federal Poverty Level (FPL) and are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services. There is no cost sharing for this coverage and services are obtained through the MO HealthNet fee-for-service program.

Former Foster Care Youth (FFCY)

Effective July 1, 2021 MO HealthNet implemented the FFCY Section 1115 Demonstration to provide MO HealthNet coverage to Missouri residents who are former foster care youth under age 26, who were in foster care under the responsibility of another state for at least six months and as of the date they turned age 18, and who were enrolled in Medicaid while they were in foster care. Missouri will maintain MO HealthNet coverage for this population of former foster care youth, increase and strengthen overall coverage of former foster care youth in Missouri, and improve health outcomes for these youth.

Show-Me Healthy Babies

Starting on January 1, 2016, Missouri added coverage to the state's separate CHIP to include targeted 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.

MO HealthNet Managed Care Specialty Plan

MO HealthNet awarded a Specialty Plan contract to Home State Health Plan called Show Me Healthy Kids. Effective July 1, 2022 all children in the care and custody of the state, children receiving adoption subsidy and Former Foster Care Youth were moved to the specialty plan. 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. Show Me Healthy Kids was established to provide a trauma-informed comprehensive and integrated Behavioral Health/Physical Health delivery system allowing these children and youth to grow into healthy adults and live full and satisfying lives.
This plan will focus on ensuring these children and youth receive all comprehensive services, wrap around services and care management. To further integrate care, behavioral health services, previously carved out of Managed Care, have been incorporated into the Show Me Healthy Kids benefit package.

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.

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, moving to or from Fee-For-Service, or moving to or from the Specialty Plan 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 members in their third trimester of pregnancy to continue to receive services from their prenatal care provider (in-network or out-of-network) without any form or prior authorization, through the postpartum period (defined as 60 calendar days from date of birth.
- 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. They are required to submit a report on Adult and Child Core Set measures that reflect results stratified by age, race, ethnicity, and region (urban/rural). 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 federal government, state government, the MCOs, and their providers. Federal regulations, 42 CFR 438.340(b) lay the groundwork for the development and maintenance of a quality strategy to assess and improve the quality of managed care services offered within a state. This quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measureable goals and targets for improvement. 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.

Administrative activities, such as handling member grievances and provider appeals are carried out by the customer service and provider relations divisions within the MCOs with oversight by the State. The MCOs are accountable for improving the well-being of members. Customer service and care management functions provided by the MCOs 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 Managed Care Quality Oversight Unit conducts planning meetings to prepare for each public forum. The QA&I is facilitated by a chairperson designated by MHD. 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 semiannually in the spring and fall.

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.

Quality Improvement Strategy 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, tribal consultation, 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 information is considered when planning modifications to the QIS. After undergoing review by the Missouri Department of Social Services, a draft is distributed to key stakeholders and posted to MHD's website for a thirty (30) day public comment period. The State of Missouri will also consult with the federally recognized Indian tribe Kansas City Indian Center in accordance with the State's Tribal consultation policy and 42 CFR 438.340 (c)(ii). All feedback is reviewed by MHD and enhancements are incorporated into the Quality Strategy.

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", and Information Systems Capabilities Assessment (ISCA) conducted by the EQRO. Network adequacy is assessed by 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 Quality Data Review Committee that regularly reviews MCO reports that are contractually required on items such as member complaints and appeals, care management, disease management, provider complaints and grievances, and prior authorizations. Data are submitted by each MCO to the Managed Care Policy, Contracts and Compliance Unit which is responsible for the collection and monitoring of the data. 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. Data summaries are presented annually at QA&I Advisory Group meetings.

2018 Quality Improvement Strategy - Evaluation of Effectiveness

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.

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. HEDIS information by MCO for performance years 2018 thru 2021 are available at the following link: https://dss.mo.gov/mhd/mc/pages/dashboard.htm

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 was implemented in 2021.

QIS Goals, Objectives and Measures

The MO HealthNet QIS is designed to communicate, assess, and evaluate the Managed Care Program's progress toward meeting its goals, objectives, and target measures. This is 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 provides 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.

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 2022 QIS aligns the goals and objectives and specific metrics to measures as outlined in Appendix 1.

The 2022 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 2023, 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 2022 QIS measures align with HEDIS measures in the SFY23 Performance Withhold Program that begins July 1, 2022. 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.

Quality Assessment and Performance Improvement Strategy 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 2022 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 2022 QIS, which is a blueprint for the Managed Care Program as a whole, each health plan is required to implement a Quality Assessment and Performance Improvement Strategy, compliant with CFR 438.330 Quality assessment and performance improvement (QAPI) program. 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 performance improvement, quality management, care management, access and availability, and data collection, analysis, and reporting, mechanism to detect under and over utilization and mechanism to assess quality and appropriateness for beneficiaries with special health needs.

Performance Improvement Projects

A Performance Improvement Project (PIP) is a project conducted by the 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, and/or MCO/system level. PIP topics should target improvement in relevant areas of clinical and non-clinical services.

The MCOs are all required to participate in three statewide PIPs that have been selected by MHD to align with specific agency goals and priority areas. MHD selected PIPs that focus on better care for members and improved health outcomes. These statewide PIPs are evaluated by the EQRO each year. PIPs are targeted at improving quality measures such as HEDIS, Adult and Child Core Set and/or CAHPS data, published by the NCQA. The three statewide PIPs and their key performance measures are:

- Improving member satisfaction (non-clinical)
  - ✓ The health plan shall set a goal for improving member satisfaction for a combination of up to three defined measures submitted in the PIP plan, each year by at least five percentage points or sustain $\geq$ 75th national percentile. Measures should be chosen from the CAHPS Patient Experience Health Plan Rating Measures, specifying adult or child survey.

- Improving maternal/infant health (clinical-medical)
  - ✓ The health plan shall set a goal to improve the plan-specific Child Core Set Measure Living Birth, less than 2,500 grams each year by at least one percentage point with a focus on reducing racial disparities.

- Improving the rate of follow up visits after a hospitalization for a mental illness (clinical-behavioral)
  - ✓ The health plan shall set a goal to improve the plan-specific HEDIS Follow-up after Hospitalization for Mental Illness 30 calendar days each year by at least two percentage points in alignment with the Quality Improvement Strategy.

The PIP for improving the rate of follow up visits after hospitalization for a mental illness was introduced in July 2020. The MCOs and MHD collaborated through a workgroup, focused on improving performance before transitioning this measure into an official PIP beginning in calendar year 2023.

MO HealthNet interventions for these PIPs include program support starting with review/approval of PIP plans, quarterly check-points to discuss progress, success of interventions, review of PDSA cycles and ultimately analysis of performance at the end of each calendar year. A collaboration of MHD staff, MCOs (including subcontractors), clinical professionals and multiple medical associations throughout the state focus on improving quality measures through improving access, quality and timeliness of care.

External Quality Reviews

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. Pro Team Management, LLC (PTM) currently holds the contract for EQR activities. PTM 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. EQR reports are available on the Department of Social Services, MO HealthNet Division website: http://dss.mo.gov/mhd/mc/pages/eqro.htm

Accreditation

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

NCQA Health Plan 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
UnitedHealthcare	Accredited	4/18/2025

Source: https://reportcards.ncqa.org/health-plans

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 2022 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.

Care Management

Care management is a process of identification, assessment, enrollment and discharge. 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. MCOs are 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 within thirty (30) calendar days of a member's new diagnosis. Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

Special populations require more intensive care management. MCOs are required to offer care management within five (5) business days of admission to a psychiatric hospital or residential substance-use treatment program. MCOs are required to offer care management within fifteen (15) 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 μg/dL within one to three (1-3) business days;
- ✓ 20 to 44 μg/dL within one to two (1-2) business days;
- ✓ 45 to 69 μg/dL within twenty four (24) hours; and
- ✓ 70 μg/dL or greater – immediately.

MHD recognizes that these lead levels are behind those endorsed by the CDC. DHSS is currently working on a state regulation that will align with national guidelines. The Managed Care contract will be updated to require care management for elevated blood lead levels, within specified timeframes, as defined by regulatory changes.

MO HealthNet Primary Care Health Homes Program

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, and
- 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 Program

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 Health Home if they have:

- Serious and persistent 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 five 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 Accountability and Transparency, which focuses on health plan Fraud and Abuse activities and Operational Data Reporting requirements. Value-Based Purchasing is another incentive in which the state agency may require the health plans to participate in a state-selected Value-Based Purchasing Model and/or Purchasing Strategy during any period of the contract. These strategies seek to improve overall health and well-being of members and reduce cost. Lastly, the delivery 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 selected PCP
- Care is provided by a physician-directed team that collectively cares for the member
- Care is coordinated and integrated across all aspects of health care
- Care is informed by continuous quality improvement strategies and aligned with the state agency's Quality Strategy
- Member Care Management includes comprehensive care management, care coordination, health promotion services, comprehensive transitional care, individual and family support activities, disease management, and referrals to local social support resources.
- Care includes recognition of and referral to necessary community and social support options.

LCCCP Program

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 MHD to realize a number of improvements that could be made through transformation efforts. MHD has been actively working to implement some of these improvements.

- Managed care members now have day one enrollment
- MHD l implemented a new hospital outpatient and inpatient payment method on July 1, 2021,
- A revised care management evaluation is being developed,
- A single-MCO model with specialized capabilities for our children in state care and custody population began July 1, 2022, which includes behavioral health services being covered through managed care for this population.

- MHD is preparing to procure a contract compliance tool to electronically evaluate much of the quality data received from our contracted MCOs.

Performance Withhold Program

A performance withhold program was started with the MCOs in 2015 to improve performance on selected quality 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 HEDIS Medicaid 50th percentile for each HEDIS measure. HEDIS information by MCO is available at the following link: https://dss.mo.gov/mhd/mc/pages/dashboard.htm.

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 for SFY21 which included three tasks.

- Conduct a focused study on a quality improvement project that 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 received 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 evaluated on 15 HEDIS measures and 5 report-only 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
- Prevention and Screening

The State Fiscal year 2023 Performance Withhold model will mirror the HEDIS measures and percentage point improvement targets in the SFY22 Technical Specifications. The MHD will consider increasing performance year targets as impact of the COVID-19 pandemic subsides.

Quality Rating System

In the coming years, MHD will develop a Quality Rating System (QRS) for its MCOs. CAHPS and health outcome measures that reflect member experience and access to quality health care will be used for the QRS. 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. Adult and Child corset measures will likely be a component of the QRS, therefore, MHD included reporting requirements in the Managed Care contract effective July 1, 2022. Calendar year 2023 will be the first year of data available for Adult and Child corset measures, reported to MHD by November 30th, 2024.

The MHD is preparing to procure a contract 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 tool will be used to monitor MCO compliance with reporting requirements in the Managed Care contract. The use of this tool will allow 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 MHD to automate quality ratings for our MCOs based on data they remit. MHD intends to publish quality ratings on our website once this tool is fully implemented.

MO HealthNet Managed Care Standards

In accordance with 42 CFR 438.66, 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, 2022-June 30, 2023 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.

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
	2.5 Health Plan Provider Networks
	2.6 Service Accessibility Standards
	2.9 Second Opinion
	2.13.16 Member Handbook
	2.19.9 Credentialing
438.207 Assurances of Adequate Capacity and Services	2.5 Health Plan Provider Networks
438.208 Coordination and Continuity of Care	2.5 Health Plan Provider Networks
	2.6.9 Direct Access and Standing Referrals
	2.12.13 Transition of Care
	2.12 Member Care Management and Disease Management
	2.19 Quality Assessment and Improvement
438.210 Coverage and Authorization of Services	2.6.5 Prior Authorizations
	2.16.2f Grievance and Appeal System
	2.19 Quality Assessment - Utilization Management
438.214 Provider Selection	2.2.8 Non-Discrimination in Hiring and Provision of Services
	2.19 Quality Assessment and Improvement
	2.19.9c Provider Credentialing
438.224 Confidentiality	2.39 Business Associate Provisions
	4.20 Confidentiality
438.56 Disenrollment requirements and limitations	2.13 Eligibility, Enrollment, and Disenrollment
438.100 Enrollee Rights	2.13 Eligibility, Enrollment, and Disenrollment
438.114 Emergency and Post-Stabilization Services	2.7.14 Payment for Emergency Services and Post-Stabilization Care Services
438.228 Grievance systems	2.16 Member Grievance System
438.230 Sub contractual Relationships and Delegation	2.23.13 Subcontractor Oversight Reports
	4.11 Subcontractors
438.236 Practice Guidelines	2.19.5 Practice Guidelines
438.330** Quality Assessment and Performance Improvement Program	2.19 Quality Assessment and Improvement
438.242 Health Information Systems	2.27 Claims Processing and Management Information Systems.
***Formerly located in Section 438.240.*	

Special Health Care Needs

Individuals with special health care needs including those individuals, who, without services such as private duty nursing, home health, durable medical equipment/supplies, or CM may require hospitalization or institutionalization. The following groups of individuals are at high risk of having special health care needs:

- ✓ Individuals with Autism Spectrum Disorder;
- ✓ Individuals with serious mental illness including, at a minimum: schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, major depression, reactive attachment disorder of childhood, disruptive mood dysregulation disorder, oppositional defiant disorder, separation anxiety disorder of childhood and moderate to severe substance use disorder.

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. 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.

Monitoring and Compliance

In accordance with 42 CFR 438.66, 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/docs/reporting-schedule-SFY23-202207.pdf 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.go/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
- Critical Incident Activities
- Disease Management Activities
- Fraud, Waste, and Abuse
- Improvement Plan Activities

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

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.

Care Management Review

MHD's strategy for ongoing monitoring and continuous quality improvement of MCO Care Management (CM), includes tools to identify progress or lack of progress on CM structure, process and outcome measures. The reporting system allows MHD to identify early signs and problem areas through regular reporting on CM Program measures. The retrospective analysis provides a targeted review to drill down on identified CM priority and problem areas.

Reporting system:
The reporting system provides data for monitoring and oversight of the program and consists of reviewing MCO self-reported data. The goal of all monitoring and oversight is to be able to quickly identify variances from expectations and take rapid action to investigate before issues become more significant. Examples of specific reports and monitoring forums include:

- Quarterly CM Report
- Quarterly MCO CM Meetings
- Annual CM Member survey
- Annual Review of QAPI and Care Management Program Description and Evaluation
- CM new policy review
- Review of documentation and progress for the PIP "Improving the rate of follow up visits after a hospitalization for a mental illness"

Responsibility:
The Quality Data Review Committee is responsible for monthly, quarterly and annual review and analysis of data, feedback and dialogue with MCOs. Results are discussed with individual MCOs and the QA&I.

Retrospective Analysis:
The retrospective analysis is typically comprised of audit results and performance measurement that looks backward to evaluate if appropriate care and services were received, assess compliance with federal and state regulations and contract standards, and examines whether specific interventions have succeeded in meeting established contract requirements, goals and performance thresholds.

Annual Care Management Audit - Domains include:

- Utilization Review
- Denials and Appeals
- CM Outreach
- CM Engagement
- CM Assessment
- Care Planning
- Care Management Activities
- Pregnancy Care Management
- Lead Care Management
- Disease Management

Sampling Approach: A 10/30 methodology is utilized which is designed from a NCQA model. A sample of 30 files is pulled, and if the first ten show no deficits, the review is complete. If any of the initial ten charts show deficiencies, the remaining 30 are reviewed.

Responsibility:
The Clinical Unit is responsible for completing audits and analysis of data, feedback and dialogue with MCOs. Results are presented to the QA&I annually.

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 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 clinicians, 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.

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, 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. MHD will also monitor network access through network development and management plan reports submitted by each MCO.

MCOs are required to meet certain Provider Directory accuracy and panel 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.

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, 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. MHD shares this data with MMAC to assist them in their audit and compliance activities. 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 Part 438, Subpart I.

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	2.30.10 Basis for Imposing Intermediate Sanctions
438.702 Types of Intermediate Sanctions	2.30.11 Types of Intermediate Sanctions
438.706 Special rules for temporary management	2.30.12 Special Rules for Temporary Management
438.708 Termination of an MCO entity contract	2.30.15 Termination of a Health Plan Contract
438.710 Notice of Sanction and pre-termination hearing	2.30.15 c. Termination of a Health Plan Contract
438.730 Sanctions by CMS	2.30.14 Federal Sanctions

The Managed Care contract addresses sanctions in Section 2.30. 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 Managed Care 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 Physician Incentive Plans.
- 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.

Information Systems Capabilities

MCO technical infrastructure has implications for all of the activities lined out within the 2022 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 (TMSIS) because it has met CMS production readiness criteria. CMS recognized Missouri for its commitment to improve data and data analytic capability. The TMSIS solution is sourced from the Business Intelligence Solution Enterprise Data Warehouse (BIS-EDW). IBM-Watson Health was awarded the contract and implemented the BIS-EDW with the MHD in March 2022. 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 Managed Care contract includes a requirement that the MCOs must maintain encounter data completeness and accuracy each month. Each MCO must meet a 98% encounter data acceptance rate for each health plan. 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.

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 inconsistences 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.

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.

MHD 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. MHD received the audit results in August of 2021 and are continuously working on identified areas of improvement. A summary of results is located at the following link: https://dss.mo.gov/mhd/mc/pages/quality-oversight.htm

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
- Forwards verified Third Party Liability (TPL) data for coordination of benefits.
- Performs choice counselor functionality assisting members with questions by phone 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 Automated Health Systems (AHS) to implement a new Beneficiary Support and Premium Collection Solution and Services Center, which will have the following additional functionality, through a phased in approach, beginning in 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 continues to support MHD and AHS with implementation of 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 2022 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. In addition, eligibility was extended to an Adult Expansion group who began enrolling in October 2021. New Managed Care contracts were awarded effective July 1, 2022 that include significant program changes with the implementation of the Managed Care Specialty Plan.

Staffing

Within the MHD, the EBDSU 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 four Research Data Analysts to work on the Performance Withhold Program, network adequacy, EQRO activities, and quality improvement processes. A Registered Nurse was also added to the Quality Oversight Unit 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.

In an effort to improve transparency and accountability of the MO HealthNet Managed Care program MHD has developed public facing dashboards to display performance data received by the plans through reporting requirements. The dashboards are located at the following link and are continuously evolving to provide additional information: https://dss.mo.gov/mhd/mc/pages/dashboard.htm.

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, Pro Team Management, LLC will continue to complete EQR activities required by CMS, and, the MHD plans to utilize PTM for special projects designed to improve quality at the agency and MCO level. The MHD may enlist PTM to provide technical assistance on special topics that arise during implementation of the QIS. PTM 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 public meetings and continually monitor this feedback for opportunities for improvement.

Summary

The MHD intends to use the 2022 QIS to help drive quality improvement at many different levels. The MHD is optimistic that the measures included in the 2022 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 2022 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 2022
Goals, Objectives, and Measures

Goals	Objectives	Measures
Goal 1 Ensure appropriate access to care.	Ensure timely access to care	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.
	Ensure an adequate healthcare network	Percentage of primary care physician offices that meet mandated access standards.
		Percentage of specialist offices that meet mandated access standards.
Goal 2 Promote wellness and prevention.	Promote Child Health	Well-Child Visits in First 30 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, and have completed the human papillomavirus (HPV) vaccine series 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.*
	Promote Chronic Disease Management	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.*

Quality Strategy State Fiscal Year 2022
Goals, Objectives, and Measures

Appendix 1

Goals	Objectives	Measures
Goal 2 cont. Promote Wellness and Prevention	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 2022 or reach the national median (where national benchmarks are available). Future years will require a larger percentage point increase.*

Performance Withhold State Fiscal Year 2023
HEDIS Measures

Appendix 2

HEDIS Abbreviation	HEDIS Measure	Withhold Amount
	Access to Care for Children	
W30	**Well-Child Visits in the First 30 Months of Life (0-15 months):** Percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits.	0.167%
	Well-Child Visits in the First 30 Months of Life (15-30 Months): Percentage of members who turned 30 months old during the measurement year and who had two or more well-child visits.	0.167%
WCV	**Child & Adolescent Well-Care Visits (3-11 yrs):** 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 (12-17 yrs): 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 (18-21 yrs): Percentage of members age 18-21 years old who had at least one comprehensive well-care visit with a PCP or anOB/GYN practitioner during the measurement year.	0.167%
ADV	**Annual Dental Visits (Total):** Percentage of members 2–20 years of age who had atleast one dental visit during the measurement year.	0.167%
	Screening & Immunizations for Children	
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 typeB (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 2):** Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and a cellular pertussis (TdaP), and have completed the human papillomavirus (HPV) vaccine series 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	
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 medication of 0.50 or greater during the measurement year.	0.10%
	Chronic Disease Management -Adults	
HBD	**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	
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 orbetween 7 and 84 days after delivery.	0.15%
CHL	**Chlamydia Screening in Women:** 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	
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%

Report-Only Measures		
Behavioral Health		0.10%
UOP	**Use of Opioids from Multiple Providers:** This measure assesses the rate of healthplan members 18 years and older who receive opioids from multiple prescribers and multiple pharmacies (to monitor for possible inclusion in future years).	
PCR	**Plan All-Cause Readmission:** 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.	
CBP	**Controlling High Blood Pressure:** Percentage of members 18-85 years 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 cancer cytology performedwith 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) contesting within the last 5 years.	
BCS	**Breast Cancer Screening:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	
Electronic Clinical Data Systems		
PDS-E	Postpartum Depression Screening and Follow-up The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.	0.00%
	Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	0.00%
Total Performance Withhold		2.5%