MC+ MANAGED CARE ANNUAL EVALUATION

FY 2006

EXECUTIVE SUMMARY

Introduction

MC+ Managed Care serves MC+ Managed Care members in 37 counties of Missouri, which are divided into three regions, Eastern, Central and Western. MC+ Managed Care contracts are competitively bid and are currently awarded to seven MC+ Managed Care health plans. The Division of Medical Services is required to monitor MC+ Managed Care health plans to ensure compliance with the MC+ Managed Care contracts.

The Division of Medical Services (DMS) has conducted an annual evaluation of the MC+ Managed Care program for the fiscal year 2006. The evaluation is divided into seven sections: 1) Population Characteristics; 2) Accessibility of Services; 3) Quality Indicators; 4) Compliance; 5) Systems; 6) Grievance Systems; and 7) Marketing.

Information to conduct the annual evaluation was gathered from DMS internal systems, MC+ Managed Care health plans' reports submitted to DMS, information gathered and provided by the Department of Health and Senior Services (DHSS), information gathered and provided by the Department of Insurance, Financial Institutions, and Professional registration (DIFP), and the 2005 Missouri MC+ Managed Care Program External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Population Characteristics

Legislative Changes

Passage of House Bill 11 and Senate Bill 539 during Missouri's 93rd General Assembly 2005 legislative session resulted in a number of eligibility changes in the MC+ Managed Care Program and the State Children's Health Insurance Program (SCHIP) known as MC+ For Kids.

Effective July 1, 2005, the Medical Assistance for Families (MAF) income limit was reduced from 75% of the Federal Poverty Level (FPL) to the 1996 Aid to Families with Dependent Children (AFDC) income standards. This change only affected eligibility for parents. As a result of this change, approximately 52,118 parents were placed on Transitional Medical Assistance (TMA) effective July 1, 2005. These individuals were only eligible for coverage for an additional 12 months.

Funding for the Extended Transitional Medical Assistance (EMTA) Program was discontinued effective July 1, 2005. This eliminated coverage for up to twelve additional months for uninsured adults. Approximately 1,560 parents lost coverage on July 1, 2005 as a result of this change.

Effective August 28, 2005, parents and guardians of uninsured children with incomes between 151 percent and 300 percent of the FPL who do not have access to affordable employer-sponsored health care insurance or other affordable health care coverage are required to pay a

monthly premium. The total aggregate cost sharing for a family may not exceed five percent of the family's income. No co-payment or other cost sharing is permitted with respect to benefits for well-baby and well-child care, including age-appropriate immunizations. As a result of this change, approximately 50,071 children were required to pay monthly premiums ranging between $12 and $257, based on income and family size.

Also effective August 28, 2005, parents and guardians of children with available incomes between 186 percent and 300 percent of the FPL are no longer responsible for five dollar co-payments or co-payments required in the current Missouri Consolidated Health Care Plan, rounded to the nearest dollar.

The Family Support Division increased case reinvestigations from 70% to 95% by February 2006.

Enrollment

On June 30, 2006, the end of State Fiscal Year 2006 (SFY06), there were 876,736 individuals enrolled in the Missouri Medicaid Program. Of these, 352,438 individuals (40.2%) were enrolled in the MC+ Managed Care Program. There were 189,836 enrollees (53.9%) in the Eastern region, 50,243 enrollees (14.3%) in the Central region, and 112,359 enrollees (31.8%) in the Western region at the end of SFY06. Enrollment in the MC+ Managed Care Program decreased by 58,141 individuals during SFY06.

During SFY06, approximately 49,237 members (13.9%) were auto-assigned to the MC+ Managed Care health plans. Individuals eligible for coverage under the 1915(b) Waiver accounted for 42,081 (85.5%) of the auto-assignments and 7,156 (14.5%) SCHIP members eligible for coverage under the 1115 Demonstration Waiver were auto-assigned to MC+ Managed Care health plans.

There were approximately 80,458 members (22.8%) that selected an MC+ Managed Care health plan during SFY06. Individuals eligible for coverage under the 1915(b) Waiver accounted for 64,573 (80.2%) of the selections and 15,885 SCHIP members (19.8%) eligible for coverage under the 1115 Demonstration Waiver selected their own MC+ Managed Care health plan.

During SFY06, there were 49,380 (14.0%) brand new enrollees (individuals that had never been MC+ eligible before) in the MC+ Managed Care Program. Of these, 22,807 (46.2%) were in the Eastern region, 8,185 (16.6%) were in the Central region, and 18,388 (37.2%) were in the Western region.

Statewide approximately 216,979 MC+ recipients lost eligibility during the period July 2005 through June 2006. MC+ Managed Care closures accounted for 128,028 (59.0%) of the total number of statewide closures. Of the 128,028 members that lost eligibility in the three MC+ Managed Care regions, 44,252 (34.6%) did not reopen under any other category of assistance during the period July 2005 through June 2006. There were 63,004 enrollees in the Eastern region, 19,278 enrollees in the Central region, and 45,746 enrollees in the Western region that lost eligibility and did not reopen under any other category of assistance during SFY06.

Analysis of data from the Family Support Division (FSD) indicated that the top six reasons for closures during SFY06 were:

1. Non-Cooperation,
2. Non-Payment of Premium,
3. No Child in Home,
4. Unable to Locate,
5. Moved Out of State, and
6. Affordable Insurance.

There were 387 MC+ Managed Care enrollees that opted-out of the MC+ Managed Care Program. Of these, 310 enrollees (80.1%) opted-out after enrollment in an MC+ Managed Care health plan and 65 enrollees (16.8%) opted-out prior to enrollment in an MC+ Managed Care health plan.

The top five Opt-Out reasons are:

1. Better Benefits – 112 (28.9%)
2. No Reason Given – 88 (22.7%)
3. Doctor Takes Straight Medicaid – 66 (16.3%)
4. Medical Opt-Outs through RSU – 44 (11.4%)
5. Other – 34 (8.8%)

Statewide during the period July 2005 through May 2006, there was an average of 210,275 (52.7%) Whites, 172,188 (43.2%) Blacks, 3,860 (9.7%) Hispanics, 1,400 (.35%) Asians, and 1,368 (.30%) Multi-Racial enrolled in the MC+ Managed Care Program. There were 6,589 (1.7%) enrollees statewide that Race/Ethnicity was undetermined.

Statewide during the period July 2005 through May 2006, there were an average of 254,922 (63.9%) of MC+ Managed Care enrollees whose primary language was English. There were 140,877 (35.3%) of enrollees who had no primary language listed. Of the languages identified, 1,467 (.4%) enrollees listed Spanish as their primary language.

Enrollment in the MC+ Managed Care Program continues to decrease in all three MC+ Managed Care regions as SFY06 Budget changes are implemented, the Family Support Division (FSD) continues to conduct reinvestigations of cases, and the Division of Medical Services (DMS) continues to close individuals who have moved out of state and individuals who have turned 19 but are still coded as a child in the FSD system.

Accessibility of Services

Access is measured by reviewing Network Adequacy, PCP/Enrollee Ratios, Dentist/Enrollee Ratios, Mental Health Provider/Enrollee Ratios, Average Distance to a Primary Care Provider (PCP), Accessibility (customer services, appointment standards and access to emergent and

urgent care, 24-hour access/after hours availability, open/closed provider panels, cultural competency, and requests to change practitioners), and lead/special needs case management.

The Department of Insurance, Financial Institutions, and Professional Registration (DIFP) evaluates access plans submitted and received annually by the MC+ Managed Care health plans. The DIFP calculates the enrollee access rate for each type of provider in each county the MC+ Managed Care health plan serves to determine if the average enrollee access rate for each county and the average enrollee access rate for all counties are greater than or equal to ninety percent (90%). The entire MC+ Managed Care population is used in the calculation for each MC+ Managed Care health plan. The 2005 Network Analysis completed by the DIFP determined that all but one of the MC+ Managed Care health plans met the 90% standard.

The DMS used information gathered by the DIFP to determine the PCP/enrollee ratios, the dentist/enrollee ratios, the mental health provider/enrollee ratios, and the average distance to PCP. Accessibility and case management information was taken from the MC+ Managed Care health plans' annual evaluations and monthly reporting.

Strengths

- All but one of the MC+ Managed Care health plan exceeded the 90% Network Distance standard as determined by the DIFP.
- Each MC+ Managed Care health plan exceeded the PCP distance standard per state regulation 20 CSR 400-7.095(3)(A)1.B.
- Each MC+ Managed Care health plan's PCP/enrollee ratios were well under benchmark PCP/enrollee ratios found by DMS research.
- Each MC+ Managed Care health plan's dentist/enrollee ratios were within the benchmark ratios found by DMS research.
- Each MC+ Managed Care health plan's mental health provider/enrollee ratios were well under benchmark PCP/enrollee ratios found by DMS research.
- Each MC+ Managed Care health plan monitors providers in regard to MC+ Managed Care contract requirements for access.
- All MC+ Managed Care health plans:
  - Have designated staff responsible for the lead case management program;
  - Have made significant efforts to improve their lead case management program;
  - Are committed to attempting to ensure quality lead case management is provided;
  - Are open to trying new processes; and
  - Use lead data analysis to make decisions to some degree.
- Some MC+ Managed Care health plans report performing focus studies and performance improvement projects regarding lead in 2005.
- Each MC+ Managed Care health plan has designated lead and special needs case management staff.

Areas for Improvement

- While all but one of the MC+ Managed Care health plans met the 90% Network Distance standard, not all the health plans achieved 90% in every provider type category.
- While all MC+ Managed Care dentist/enrollee ratios were within the benchmark ratios found by DMS, the Central Region ratios indicate that enrollees in this region may have more difficulty accessing dental providers.
- While MC+ Managed Care health plans report monitoring of providers regarding access, not all the health plans are monitoring all service accessibility requirements. Therefore, DMS is unable to determine by the health plans' annual evaluations if providers are meeting the service accessibility standards outlined in Section 2.14 of the MC+ Managed Care contract.
- All MC+ Managed Care health plans should have ongoing educational efforts with providers, families and laboratories regarding lead.
- MC+ Managed Care health plans should continue to improve lead case management documentation by utilizing the MOHSAIC system in DHSS.
- MC+ Managed Care health plans should review and revise processes and tools for identifying members with special health care needs to include developing and testing screening tools to better identify those members with special health care needs.
- MC+ Managed Care health plans and DMS should work to improve the monthly case management activity report and processes and documentation so all health plans report consistently and in a timely manner to DMS.
- MC+ Managed Care health plans should work to improve establishing and maintaining communication with all stakeholders i.e.: Department of Health and Senior Services-Bureau of Special Health Care Needs, Schools, Family Support Division, Local Public Health Agencies, PCPs, Department of Mental Health, Court System, etc.
- MC+ Managed Care health plans should monitor utilization review data to ensure preventive services have been provided at the appropriate timeframes to those with special health care needs.

Quality Indicators

Quality indicators were measured by reviewing the Consumer Assessment of Health Plans Survey (CAHPS), Health Plan Employer Data and Information Set (HEDIS) Indicators, Trend Analysis, Provider Surveys and Performance Improvement Projects (PIP). The Provider Surveys and Performance Improvement Projects information was taken from the MC+ Managed Care health plan's annual evaluations.

The DMS and DHSS both gather HEDIS information from the MC+ Managed Care health plans on an annual basis. HEDIS is a standardized set of performance measures designed to enable purchasers and consumers to compare the performance of different MC+ Managed Care health plans. The DHSS publishes their specific HEDIS information and CAHPS information, which measures member satisfaction covering a broad range of issues including

timely and appropriate care, courtesy of provider staff, doctor communications and the health plan's customer service, in an annual MC+ Managed Care Consumer's Guide. The guide provides information on how well MC+ Managed Care health plans are performing in their responsibility to provide high quality health care and customer service to their members.

Strengths

- For the most part, MC+ Managed Care health plans were rated average in each category of the CAHPS survey. (An average rating for a specific plan means the plan scored close to the Statewide Average of MC+ Managed Care health plans.) There were only two instances were a MC+ Managed Care health plan rated below average.
- The statewide average for each HEDIS indicator collected by DHSS increased with the exception of adolescent immunizations and Chlamydia screenings.
- The MC+ Managed Care health plan specific birth trends match the trends of all Medicaid Fee-For-Service births and all non-Medicaid births.
- MC+ Managed Care health plans either conducted a provider survey or took action in 2005 to improve satisfaction among their providers.

Areas for Improvement

- Not all MC+ Managed Care health plans did a comparison of HEDIS measures from year to year in their annual evaluations.
- The MC+ Managed Care health plans should work toward developing and implementing a statewide PIP.

Compliance

Compliance was measured by reviewing Fraud and Abuse, Credentialing and Recredentialing, Subcontractor Oversight Reports and Federal Rule Compliance.

The DMS used information submitted by the MC+ Managed Care health plans to DMS, information from the MC+ Managed Care health plans' annual evaluations and information reported in the 2005 Missouri MC+ Managed Care Program External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Strengths

- The MC+ Managed Care health plans have a Fraud and Abuse Program with designated staff.

- Some MC+ Managed Care health plans have identified and made improvements in their Fraud and Abuse programs based on data analysis.
- All MC+ Managed Care health plans have a process for credentialing and recredentialing providers.
- FirstGuard completed Organizational Provider Quality Reassessment Project with a 100% completion rate.
- FirstGuard custom designed a provider profile which was identified as a best practice by Centene.
- Blue-Advantage Plus was awarded a Certificate of Full Accreditation for compliance with Health Provider Credentialing Standards by URAC.
- MC+ Managed Care health plans use the DMS Subcontractor Oversight Annual Evaluation Report Template to some extent with the exception of one health plan.
- HealthCare USA used the DMS Subcontractor Oversight Annual Evaluation Report Template in completing their report resulting in the report containing all the information necessary for DMS to assess HealthCare USA's monitoring of their subcontractors.
- All MC+ Managed Care health plans Met or Partially Met all applicable federal regulations and related State compliance requirements for MC+ managed care.
- MC+ Managed Care health plans demonstrated strength in compliance with federal regulations for grievance and appeals processes and procedures.
- Across MC+ Managed Care health plans, an investment in the development of programs was observed that often exceeded the strict requirements of the MC+ Managed Care contract.

Areas for Improvement

- MC+ Managed Care health plans should continue to improve systems for an effective MC+ managed care fraud and abuse program for member and provider possible fraudulent situations.
- Initial reports of fraud and abuse should be reported timely to the DMS and if appropriate to other agencies such as the Medicaid Fraud Control Unit.
- Submit quarterly reports timely to DMS.
- Work to improve initial and quarterly reports to include consistent, appropriate, and pertinent follow up information month-to-month and year-to-year.
- Evaluate the fraud and abuse program annually through data analysis making improvements based on data analysis.
- MC+ Managed Care health plans should use the DMS Subcontractor Oversight Annual Evaluation Report Template, which provides the necessary direction on information expected by DMS.
- MC+ Managed Care health plans should monitor, develop, and timely submit policies to ensure compliance with the MC+ Managed Care contract and the federal Managed Care Regulations.
- Continued growth in the utilization of all of the data available to drive healthcare practice and initiatives is required to improve quality and access to care.

Systems

The DMS used system information taken from the MC+ Managed Care health plans annual evaluations and the 2005 Missouri MC+ Managed Care Program External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Strengths

- Two reports, Encounters Submitted and Accepted and Encounter Exception Summary, were developed by DMS and are provided on a monthly basis to DMS staff and MC+ Managed Care health plans to monitor the progress of the health plans regarding submissions of encounter data.
- Implementation of the DMS Encounter Corrective Action Plan (CAP) has improved the encounter overall acceptance rate for all plans from 70.6% to 97.1%.
- The majority of critical fields evaluated for each of the six encounter claim types (Dental, Medical, Pharmacy, Inpatient, Home Health, Outpatient) were accurate, complete, and valid.
- The Dental, Home Health and Pharmacy claim type critical fields contained valid data for analysis of paid encounter claims.
- The EQRO was able to validate 99.01% of diagnosis codes from medical records.

Areas for Improvement

- All of the MC+ Managed Care health plans should strive to reach and maintain an overall encounter acceptance rate of 95%.
- The EQRO was able to validate only 59.97% of procedures codes from medical records.
- Medical records that did not have procedure codes that matched those in the DMS encounter claims database were in error primarily due to missing or illegible data.

Grievance Systems

The DMS used quarterly reports submitted by the MC+ Managed Care health plans regarding member grievances and appeals and provider complaints, grievances and appeals and information taken from the MC+ Managed Care health plans annual evaluations.

Strengths

- All MC+ Managed Care health plans have a member grievance process and a provider complaint, grievance and appeal process in place.
- Member grievances and appeals were less than 1% in calendar year 2005 across all MC+ Managed Care regions.

- Review of the numbers of the provider complaints, grievances, and appeals indicate the MC+ Managed Care health plans are doing a good job in resolving complaints before they become grievances or appeals.

Areas for Improvement

- MC+ Managed Care health plans should work toward consistent and accurate categorization of grievances and appeals for quarterly reporting purposes by utilizing the database created by the DMS.
- More MC+ Managed Care health plan staff education is needed regarding what is a complaint, grievance or appeal.
- MC+ Managed Care health plans should closely follow record keeping and reporting requirements in the MC+ Managed Care contract.

Marketing

Total Health Plan Marketing/Education Submissions for 2005 was 514.
(Total does not include Missouri Primary Association, PSI and Legal Aid of Western Missouri.)

Total Submissions for the Western Region in 2005 was 197.

Total Submissions for the Eastern Region in 2005 was 276.*
(HealthCare USA and Mercy CarePlus are counted in Eastern Region only.)

Total Submissions for the Central Region in 2005 was 41.

Total marketing/education material submitted by health plans in 2004 was 321. We had an additional 193 submissions in 2005 with one additional health plan.

All MC+ Managed Care health plans had an active marketing program geared to educating, retaining, and recruiting new members. In addition, materials submitted for approval included pharmacy and contractually required policy submissions.

Conclusion

While this annual evaluation reveals there are many areas for improvement, it also reveals the commitment of the MC+ Managed Care health plans and the DMS to providing quality health care to MC+ Managed Care members. The DMS, in conjunction with MC+ Managed Care health plans, has developed and implemented standardized reporting processes for member and provider complaints, grievances and appeals; fraud and abuse; and lead reporting. The DMS has begun work to develop standardized reporting to improve the special needs case management

process. The DMS is committed to working with the MC+ Managed Care health plans and all stakeholders in building on the strengths shown in this annual evaluation.

MC+ MANAGED CARE ANNUAL EVALUATION

POPULATION CHARACTERISTICS

ANNUAL ENROLLMENT ANALYSIS
FOR THE MC+ MANAGED CARE HEALTH PLANS

Enrollment

On July 1, 2005, the start of State Fiscal Year 2006 (SFY06), there were 410,579 individuals enrolled in the MC+ Managed Care Program compared to 352,438 individuals enrolled as of June 30, 2006. Enrollment in the MC+ Managed Care Program decreased by 58,141 individuals during SFY06. Statewide there were 876,736 recipients enrolled in the Medicaid Program as of June 30, 2006. MC+ Managed Care enrollees accounted for 40.2% of the total enrollment.

There were 189,836 enrollees (53.9%) in the Eastern region, 50,243 enrollees (14.3%) in the Central region, and 112,359 enrollees (31.8%) in the Western region at the end of SFY06. Individuals eligible for coverage under the 1915(b) Waiver accounted for 318,296 (90.3%) of the enrollees and 34,142 individuals (9.7%) were eligible under the State Childrens' Health Insurance Program.

Enrollment in the MC+ Managed Care Program continues to decrease in all three MC+ Managed Care regions. The Family Support Division (FSD) continues to conduct reinvestigations of cases and close individuals for non-payment of the monthly premium. By February 2006, the FSD increased case reinvestigations from 70% to 95%. The Division of Medical Services (DMS) continues to close individuals who have moved out of state and individuals who have turned 19 but are still coded as a child in the FSD system.

Please refer to Attachment #1 through Attachment #7.

Brand New Enrollees (Never MC+ eligible)

During SFY06, there were 49,380 individuals that had never been MC+ eligible before that enrolled in the MC+ Managed Care Program. The Eastern region gained 22,807 (46.2%) brand new enrollees, the Central region gained 8,185 (16.6%) brand new enrollees, and the Western region gained 18,388 (37.2%) brand new enrollees.

Please refer to Attachment #8 through Attachment #10.

Auto-Assignments

During SFY06, 49,237 enrollees (12.0%) were auto-assigned to the MC+ Managed Care health plans. Of these, 42,081 (85.5%) were eligible for coverage under the 1915(b) Waiver and 7,156 (14.5%) were eligible under SCHIP. There were 22,344 enrollees auto-assigned in the Eastern region, 4,808 in the Central region, and 22,085 in the Western region during the period July 2005 through June 2006. Mercy MC+, Inc. received the majority of the auto-assignments (16.5%) while HealthCare USA in the Central region received the least amount (2.9%).

During statewide open enrollment, May 1, 2006 through June 16, 2006, auto-assignments for new eligibles did not process, resulting in reduced numbers of auto-assignments in May and June.

Please refer to Attachment #11 and Attachment #12.

Member Selection

Statewide approximately 80,458 members selected an MC+ Managed Care health plan during SFY06. Of those members selecting an MC+ Managed Care health plan, 38,059 (47.3%) were in the Eastern region, 13,807 (17.2%) were in the Central region, and 28,592 (35.5%) selections were in the Western region.

Individuals eligible for coverage under the 1915(b) Waiver accounted for 64,573 of the selections and 15,885 SCHIP members selected their own MC+ Managed Care health plan.

The majority of members selected HealthCare USA (22,131) and Family Health Partners (11,052) in the Western region. HealthCare USA in the Western region experienced the lowest number of member selections (2,492).

Please refer to Attachment #13 through Attachment #16.

Transfers

There were 67,432 individuals statewide that transferred between MC+ Managed Care health plans during SFY06. Of these, 56,397 individuals (83.6%) transferred in the Eastern region, 3,228 (4.8%) in the Central region, and 7,807 individuals (11.6%) in the Western region. As a result in the change of ownership of Community Care Plus to include Mercy Health Plans, approximately 39,697 MC+ Managed Care enrollees transferred from Mercy MC+ on June 30, 2006.

During SFY06, there were 42,708 individuals eligible for coverage under the 1915(b) Waiver and 8,486 individuals eligible for coverage under SCHIP that transferred between MC+ Managed Care health plans.

Please refer to Attachment #17 and Attachment #18.

Loss of Eligibility

Statewide approximately 216,979 MC+ recipients lost eligibility during the period July 2005 through June 2006. MC+ Managed Care closures accounted for 128,028 (59.0%) of the total number of statewide closures. Of these, 109,573 (85.6%) were MC+ Managed Care children and 18,455 (14.4%) were MC+ Managed Care parents. Statewide, 81,042 closures were for non-cooperation, 21,732 of the closures were for non-payment of premiums, individuals turning 19 accounted for 21,480 closures, and individuals moving out of state accounted for 19,064 closures.

There were 63,004 MC+ Managed Care enrollees in the Eastern region, 19,278 enrollees in the Central region, and 45,746 enrollees in the Western region that lost eligibility. Of the 128,028 members that lost eligibility in the three MC+ Managed Care regions, 44,252 (34.6%) did not reopen under any other category of assistance during the period July 2005 through June 2006. There were 20,900 enrollees in the Eastern region, 7,551 enrollees in the Central region, and 15,801 enrollees in the Western region that lost eligibility and did not reopen under any other category of assistance during SFY06.

Analysis of data from the Family Support Division (FSD) indicated that the top six reasons for closures during SFY06 were:

1. Non-Cooperation,
2. Non-Payment of Premium
3. No Child in Home,
4. Unable to Locate
5. Moved Out of State, and
6. Affordable Insurance.

Please refer to Attachment #19 through Attachment #25.

Supplemental Security Income (SSI) Opt-Outs

Statewide, during SFY06, there were 387 MC+ Managed Care enrollees that opted-out of the MC+ Managed Care Program. Of these, 343 (88.6%) were processed by Policy Studies, Inc. (PSI) and 44 (11.4%) were processed by the Recipient Services Unit (RSU) at the Division of Medical Services.

There were 224 (57.9%) opt-outs in the Eastern region, 87 (22.5%) in the Central Region, and 76 (19.6%) in the Western region. There were 189 enrollees in the 1915(b) Waiver and 35 enrollees in the 1115 Waiver that opted out in the Eastern region, 78 enrollees in the 1915(b) Waiver and 9 enrollees in the 1115 Waiver that opted out in the Central region, and 55 enrollees in the 1915(b) Waiver and 21 enrollees in the 1115 Waiver that opted out in the Western region.

The top five Opt-Out reasons are:

1. Better Benefits – 112 (28.9%)
2. No Information Provided from PSI – 88 (22.7%)
3. Doctor Takes Straight Medicaid – 66 (16.3%)
4. Medical Opt-Outs through RSU – 44 (11.4%)
5. Other – 34 (8.8%)

There were 310 MC+ Managed Care enrollees (80.1%) that opted-out after enrollment in an MC+ Managed Care health plan and 65 enrollees (16.8%) that opted-out prior to enrollment in an MC+ Managed Care health plan. There were 185 enrollees (47.8%) in the Eastern region,

70 enrollees (18.0%) in the Central region, and 55 enrollees (14.2%) in the Western region that opted-out after enrollment in an MC+ Managed Care health plan.

Of the 387 enrollees that opted out of the MC+ Managed Care Program, 12 reenrolled during SFY06. Six of these enrollees were in the Eastern region, two enrollees were in the Central region, and four enrollees were in the Western region.

Special Health Care Needs

There were 9,076 individuals statewide with special health care needs that were identified and reported to the MC+ Managed Care health plans during SFY06. Of these, 5,015 (55.3%) were in the Eastern Region, 1,316 (14.5%) were in the Central Region, and 2,745 (30.2%) were in the Western Region. There were 2,668 (29.4%) SHCNs individuals identified with HealthCare USA in the Eastern region compared to 351 (3.9%) individuals identified with HealthCare USA in the Western region.

Race *

Statewide during the period July 2005 through May 2006, there were an average of 210,275 (52.7%) Whites, 172,188 (43.2%) Blacks, 3,860 (9.7%) Hispanics, 1,400 (.35%) Asians, and 1,368 (.30%) Multi-Racial enrolled in the MC+ Managed Care Program. There were 6,589 (1.7%) enrollees statewide that Race/Ethnicity was undetermined.

There were 117,740 (54.7%) Black enrollees and 88,926 (41.3%) White enrollees in the Eastern region; 48,366 (82.2%) White enrollees and 8,518 (14.5%) Black enrollees in the Central region; and 72,983 (58.4%) White enrollees and 45,930 (36.8%) Black enrollees in the Western region.

In the Eastern region, Blacks accounted for 80,792 (62.7%) and White accounted for 43,678 (33.9%) of HealthCare USA's total population. In the Central and Western regions, Whites comprised the majority of the population for each of the six MC+ Managed care health plans.

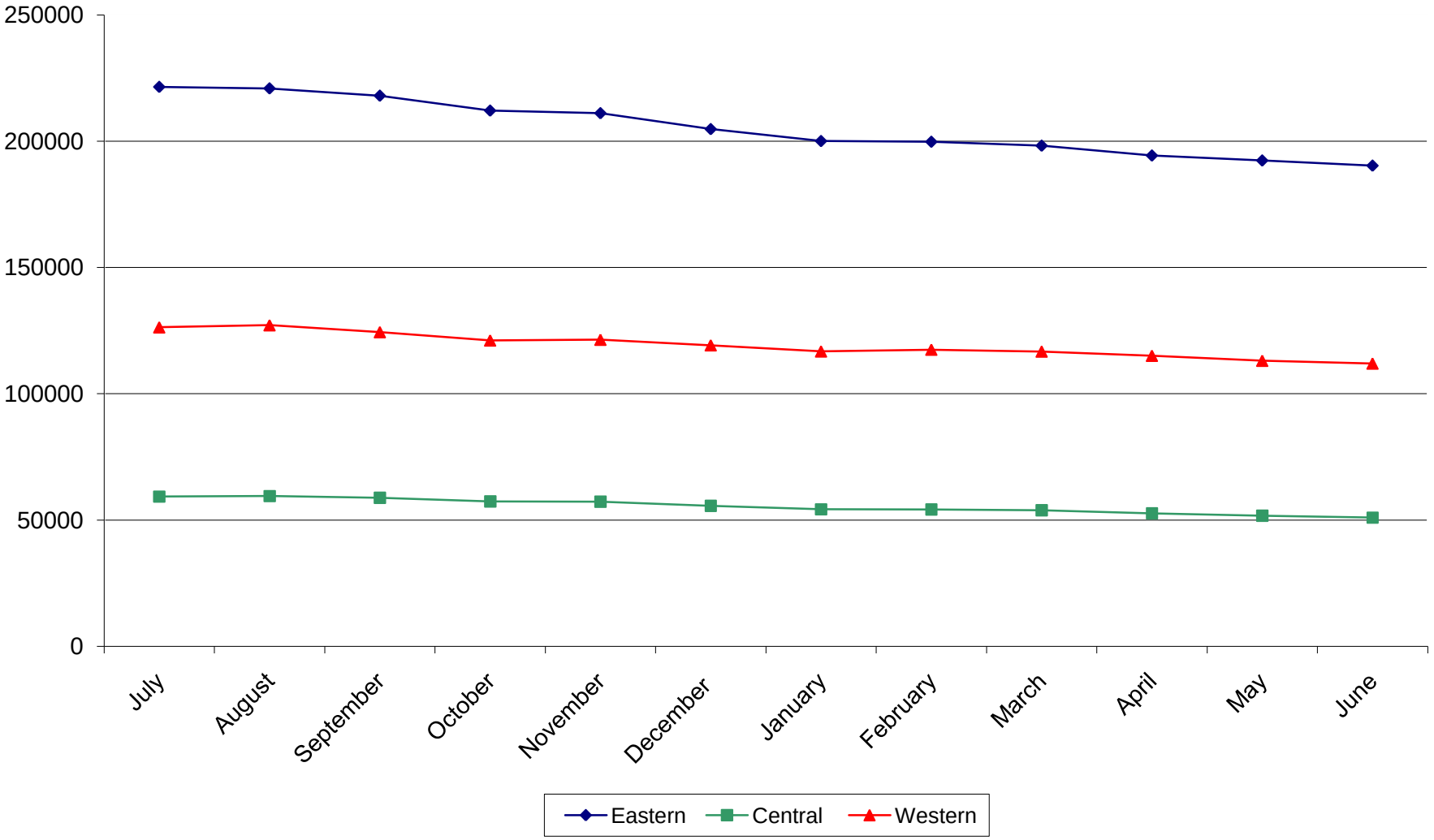
Languages Identified*

Statewide during the period July 2005 through May 2006, there were an average of 254,922 (63.9%) of MC+ Managed Care enrollees whose primary language was English. There were 140,877 (35.3%) of enrollees who had no primary language listed. Of the languages identified, 1,467 (.4%) enrollees listed Spanish as their primary language.

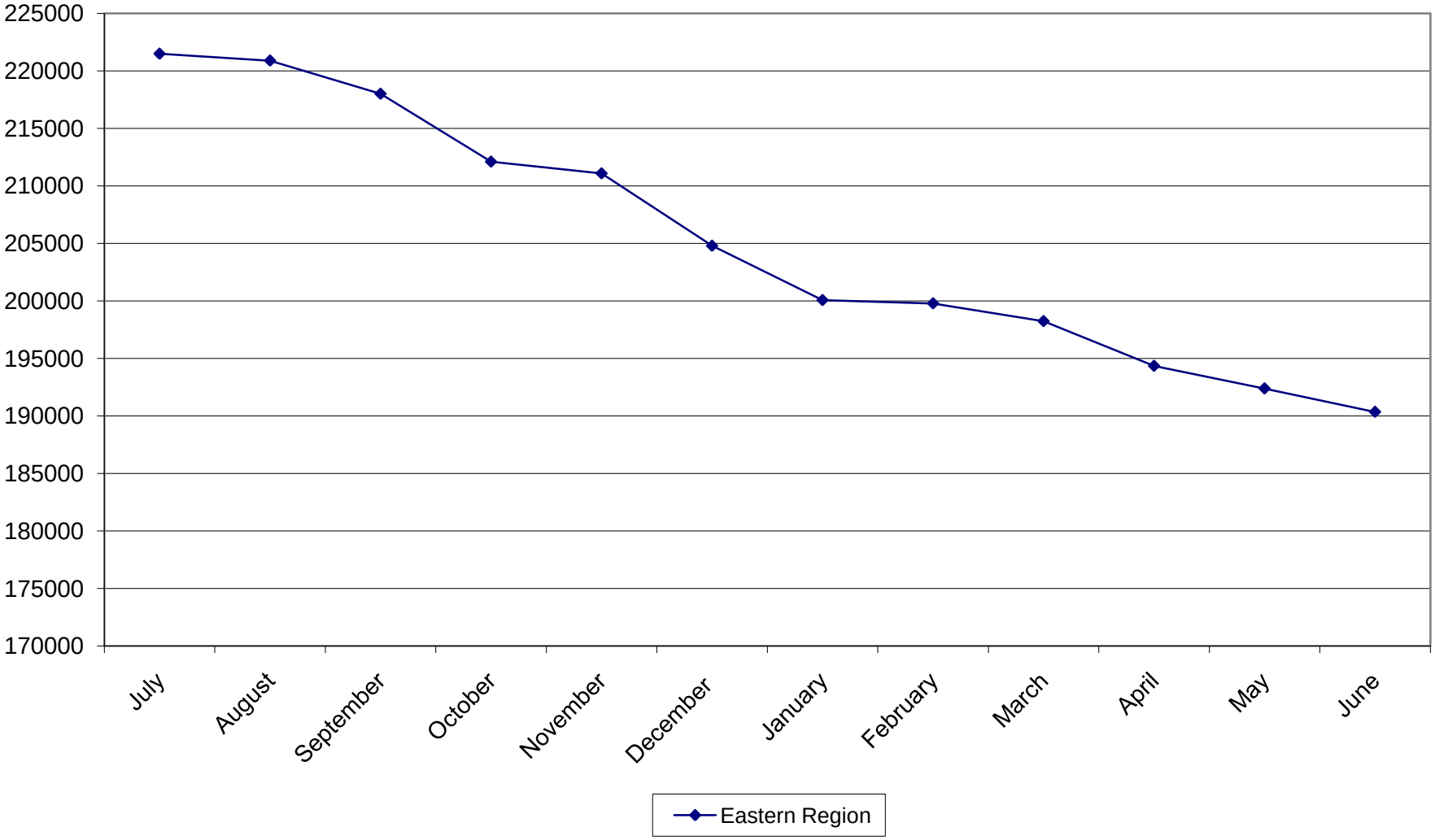
There were 144,372 (81.1%) enrollees in the Eastern region; 37,122 (63.1%) enrollees in the Central Region; and 72,428 (58.0%) of enrollees in the Western region who identified English as their primary language.

* Race and language statistics were computed for the period July 2005 through May 2006 due to the availability of data.

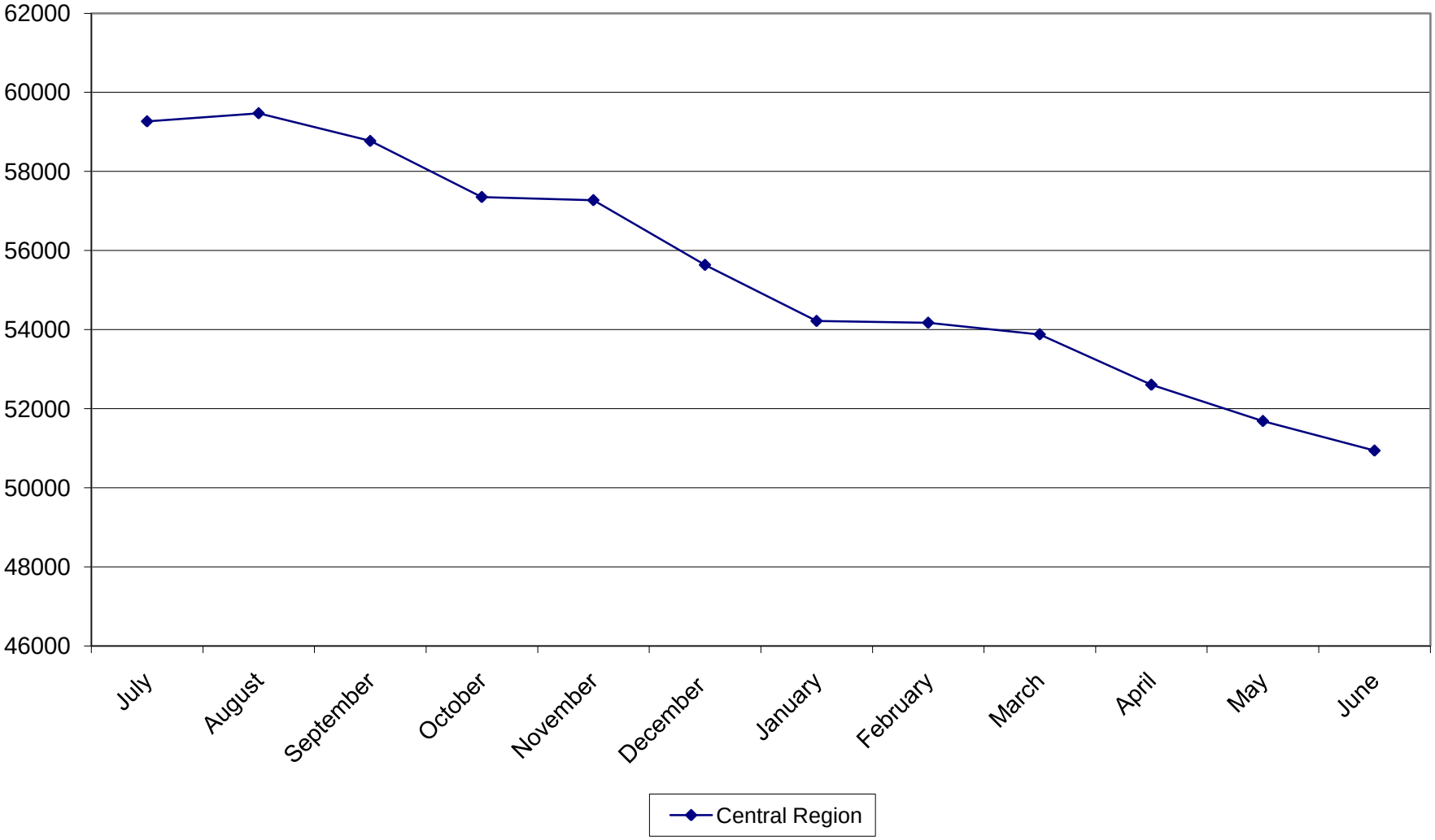
MC+ Managed Care Enrollment by Region
July 2005 - June 2006



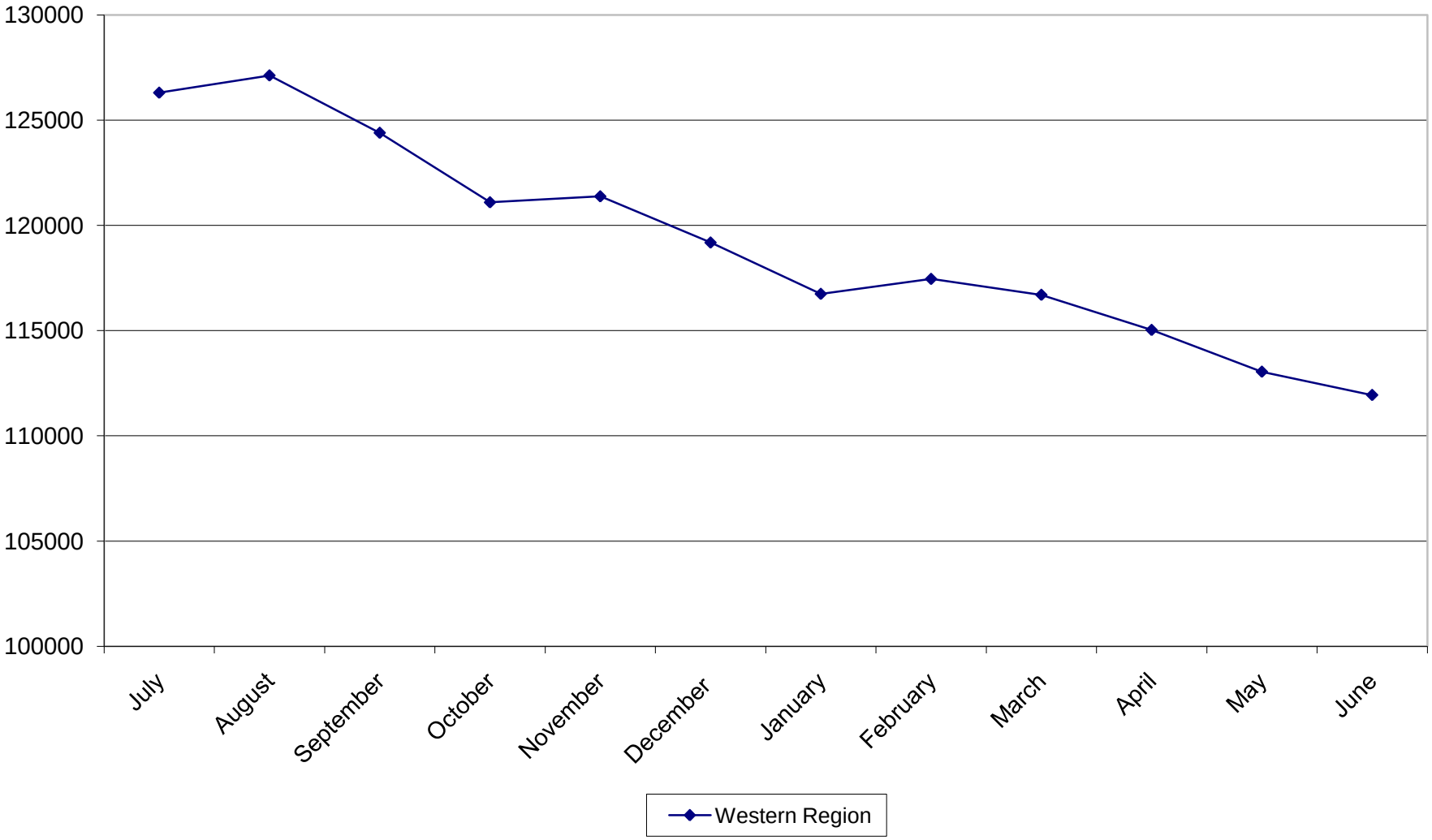
Eastern Region Enrollment
July 2005 - June 2006



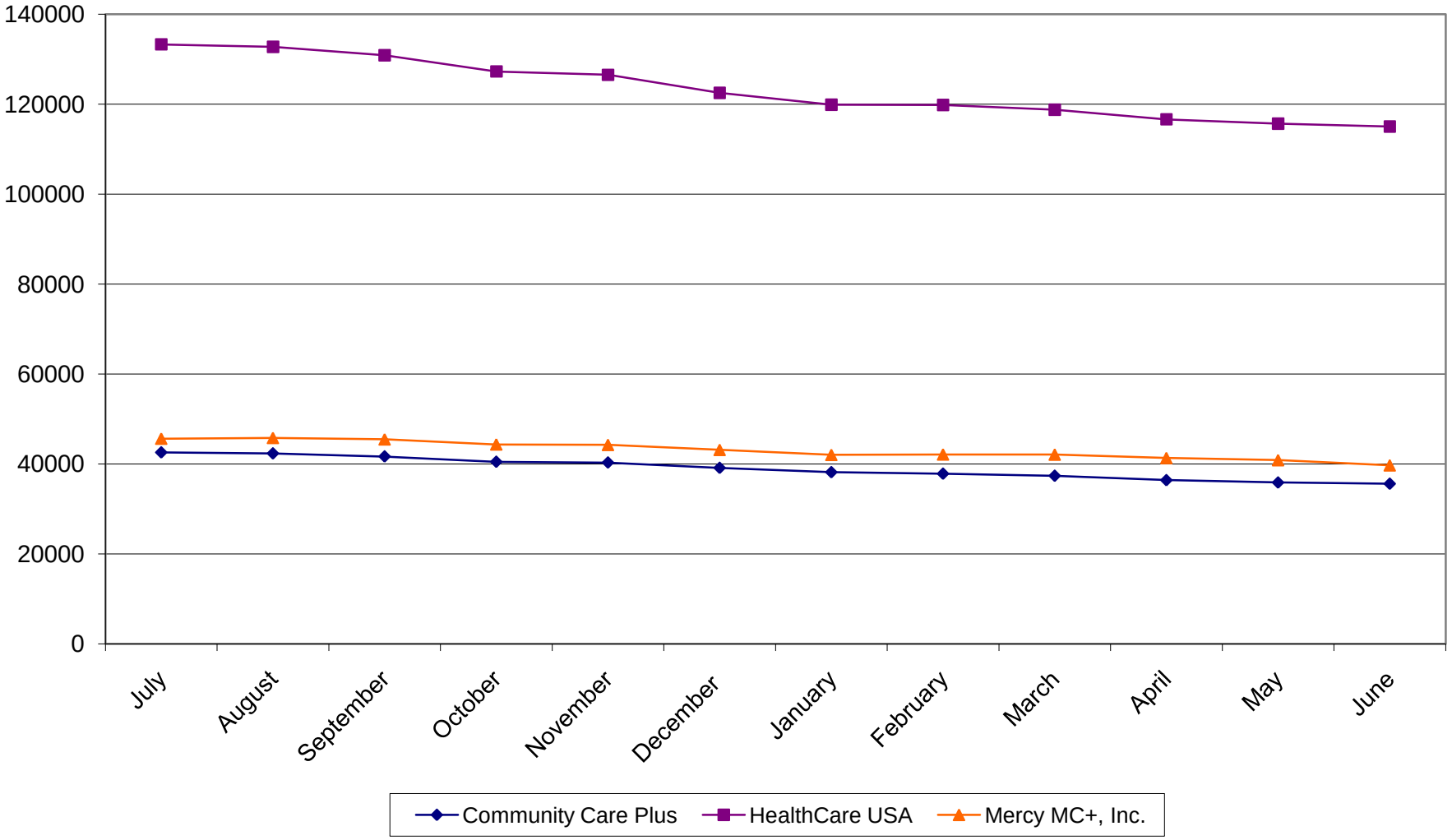
Central Region Enrollment
July 2005 - June 2006



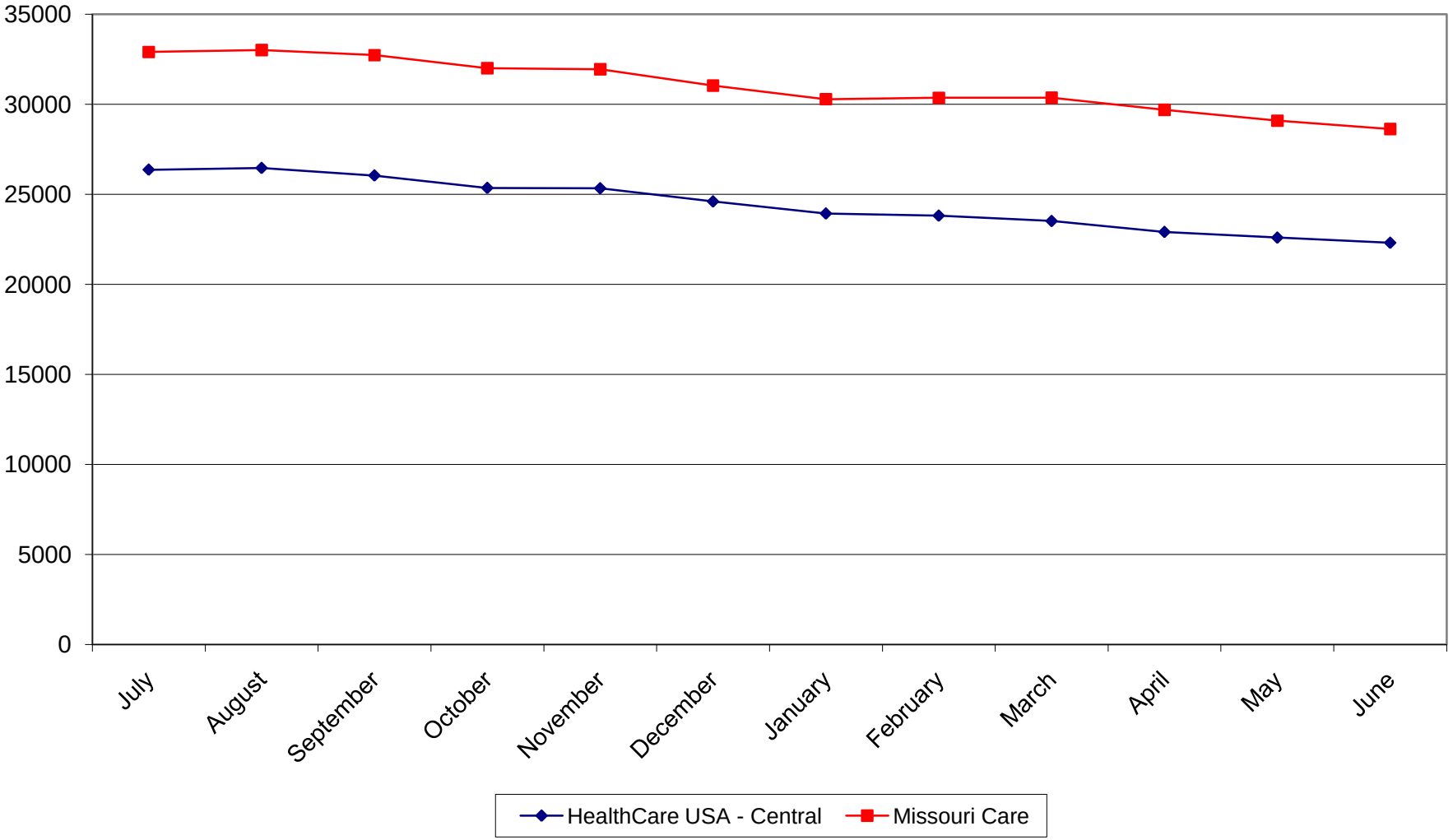
Western Region Enrollment
July 2005 - June 2006



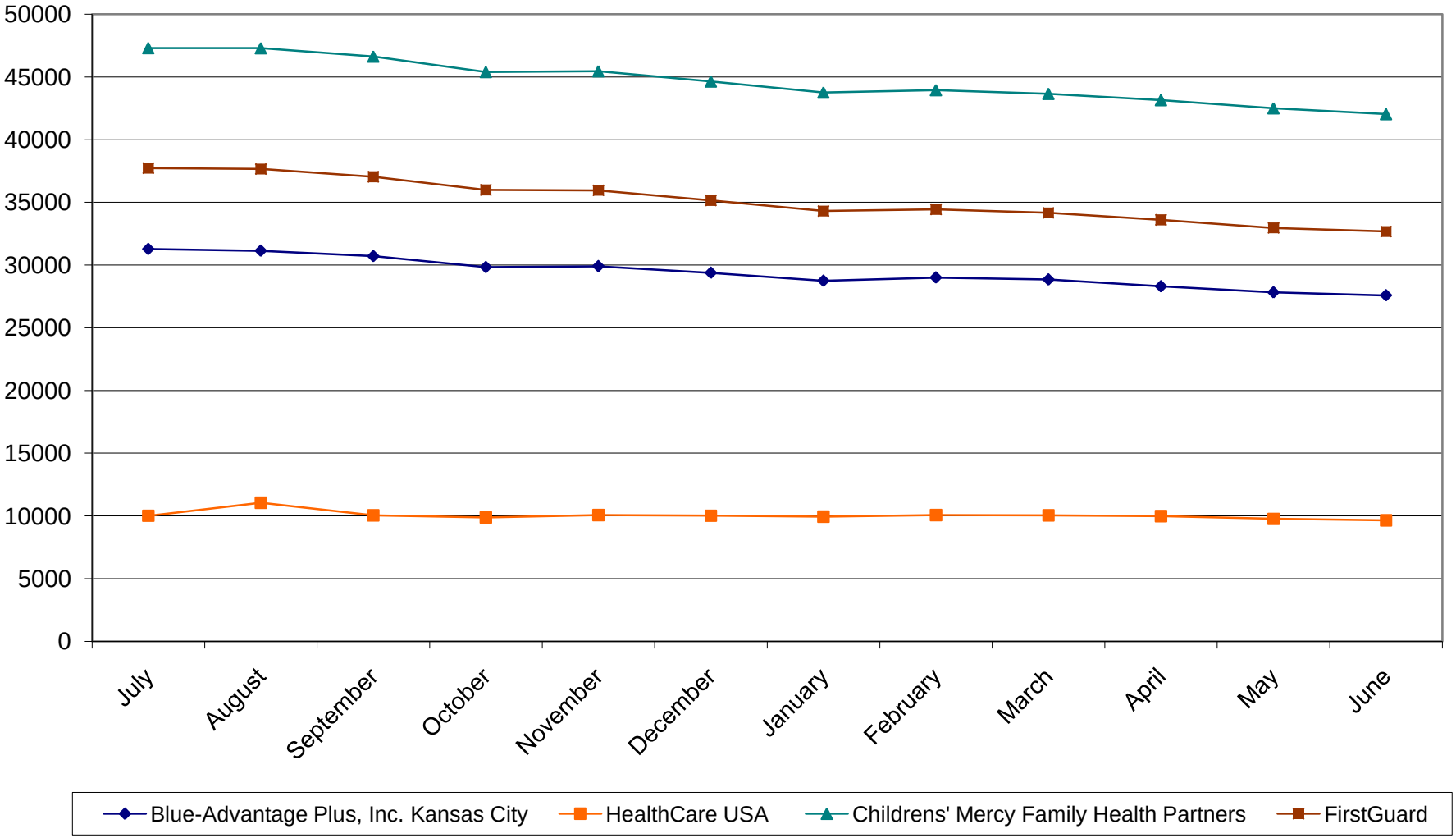
Eastern Region Enrollment by Health Plan
July 2005 - June 2006



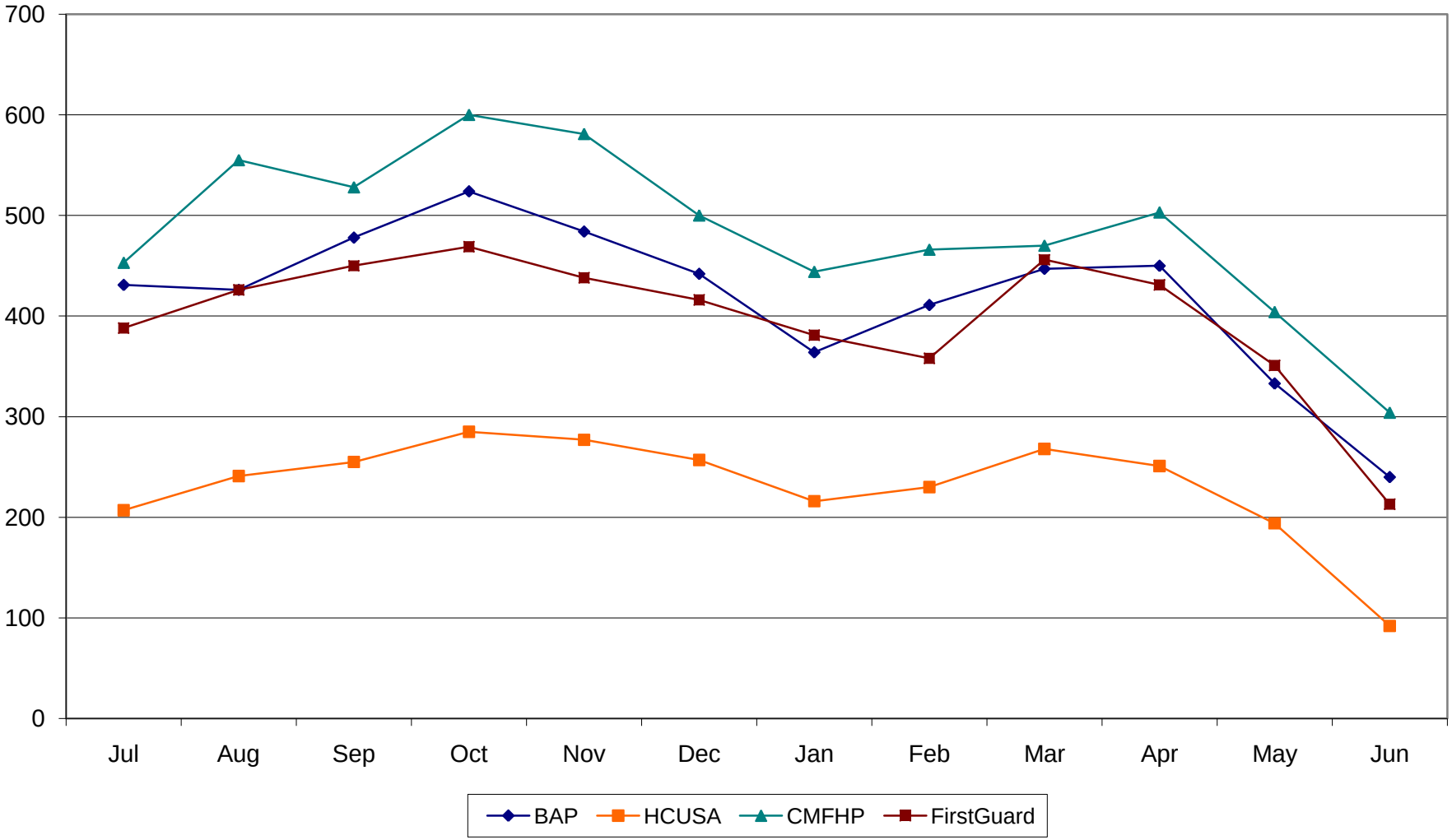
Central Region Enrollment by Health Plan
July 2005 - June 2006



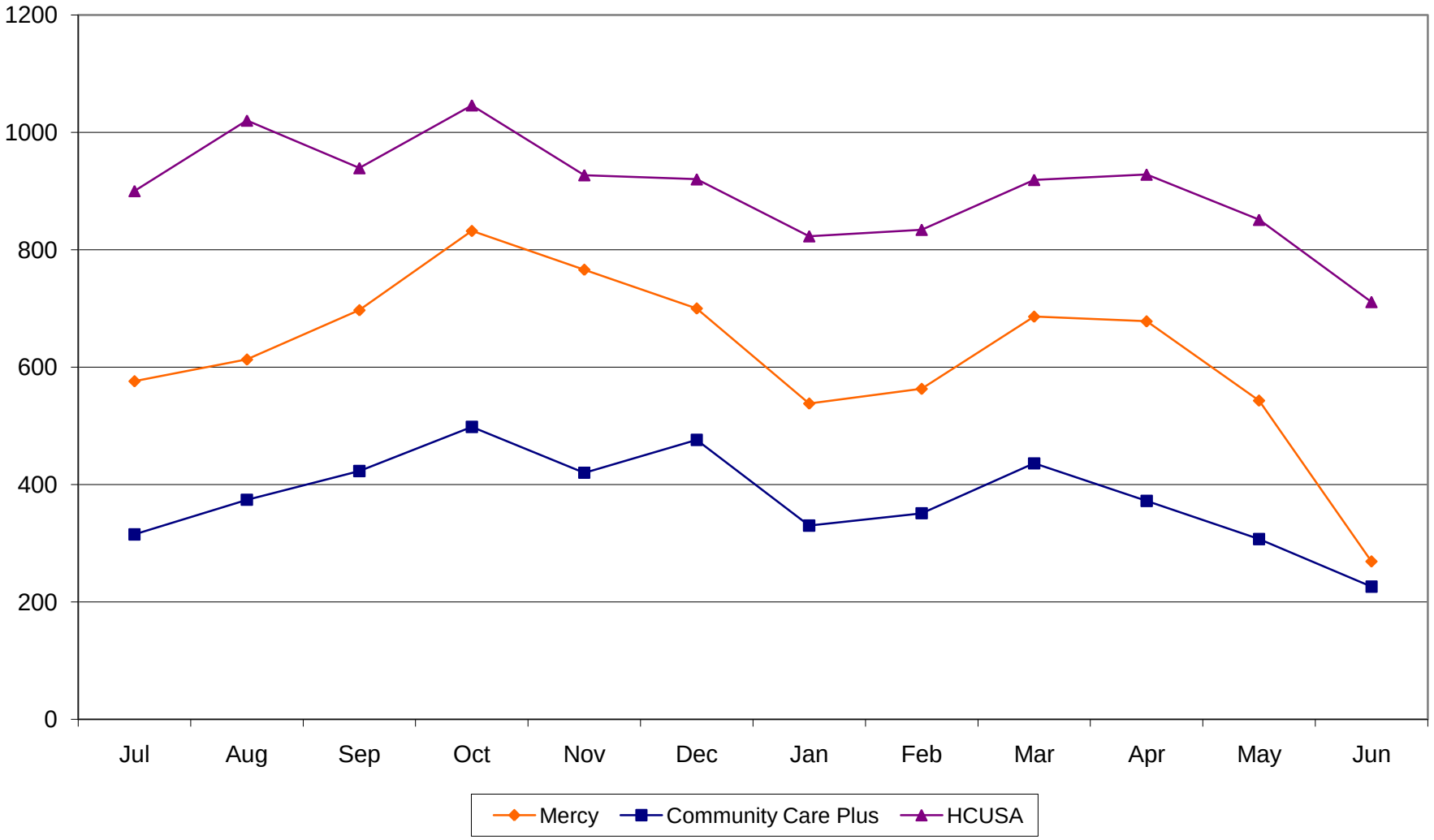
Western Region Enrollment by Health Plan
July 2005 - June 2006



Comparison of New Enrollees - Western Region
July 2005 - June 2006



Comparison of New Enrollees - Eastern Region
July 2005 - June 2006



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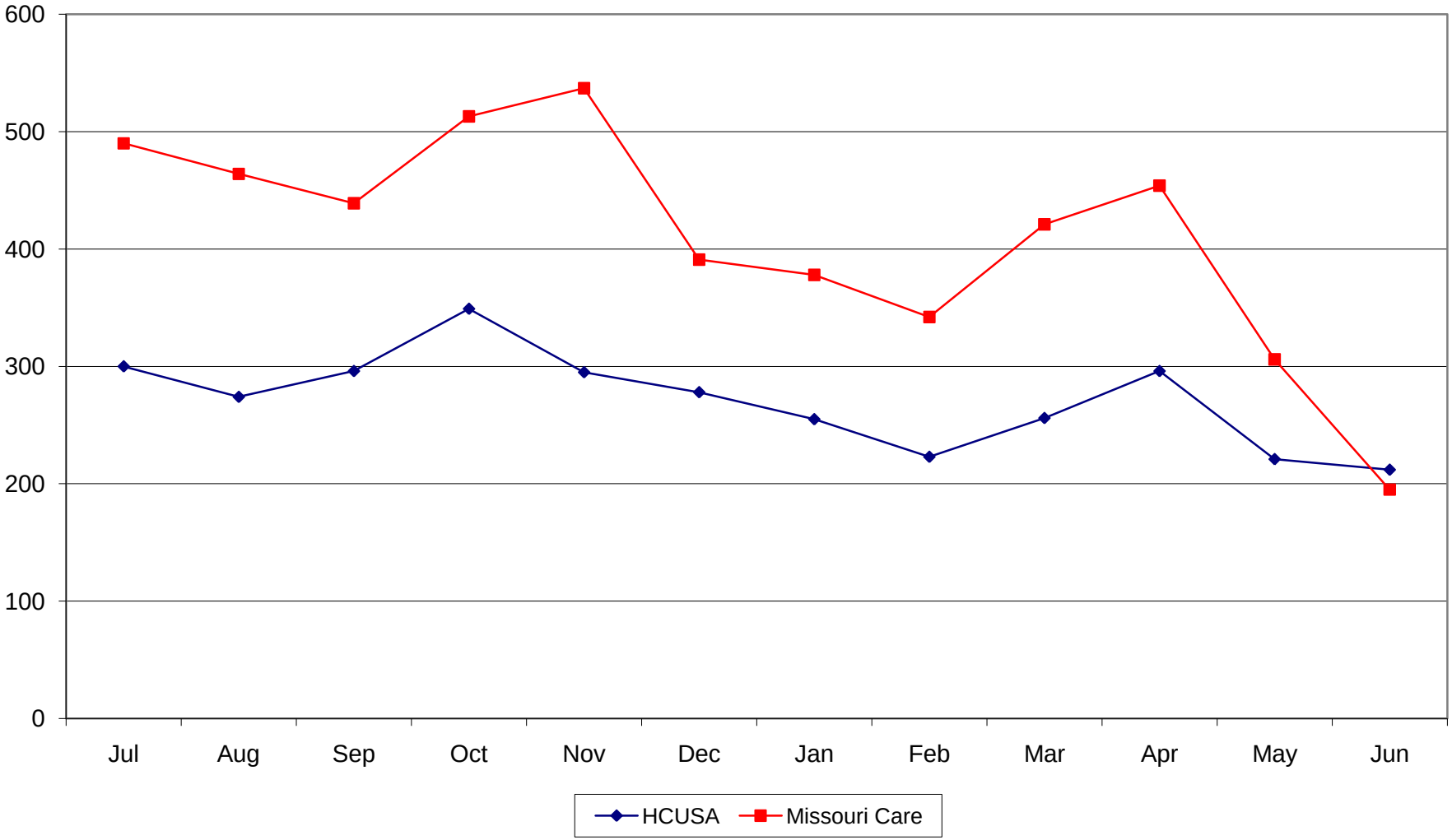
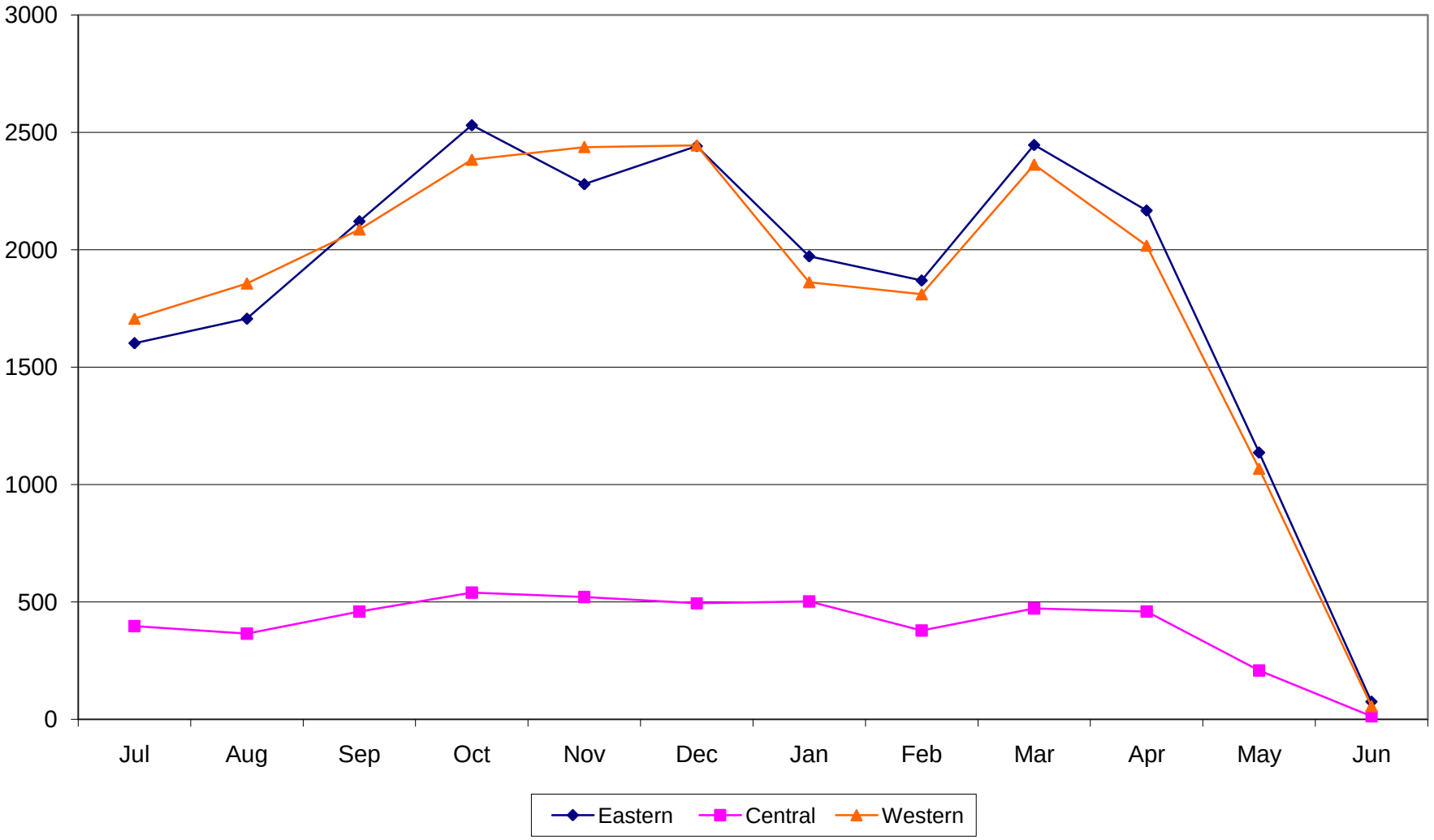
July 2005 - June 2006



Auto-Assignments - Regional Comparison
July 2005 - June 2006



Auto-Assignments by Health Plan
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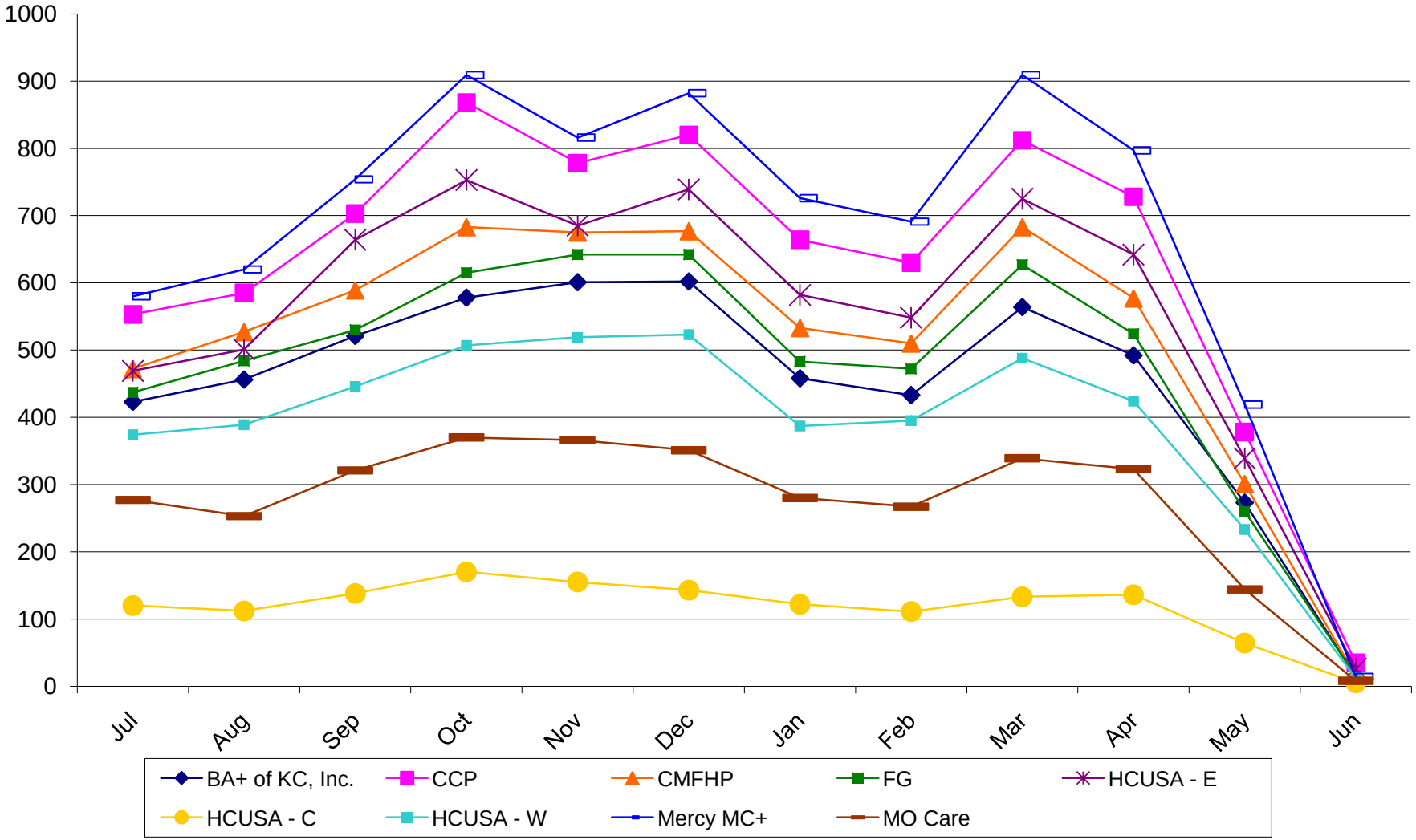
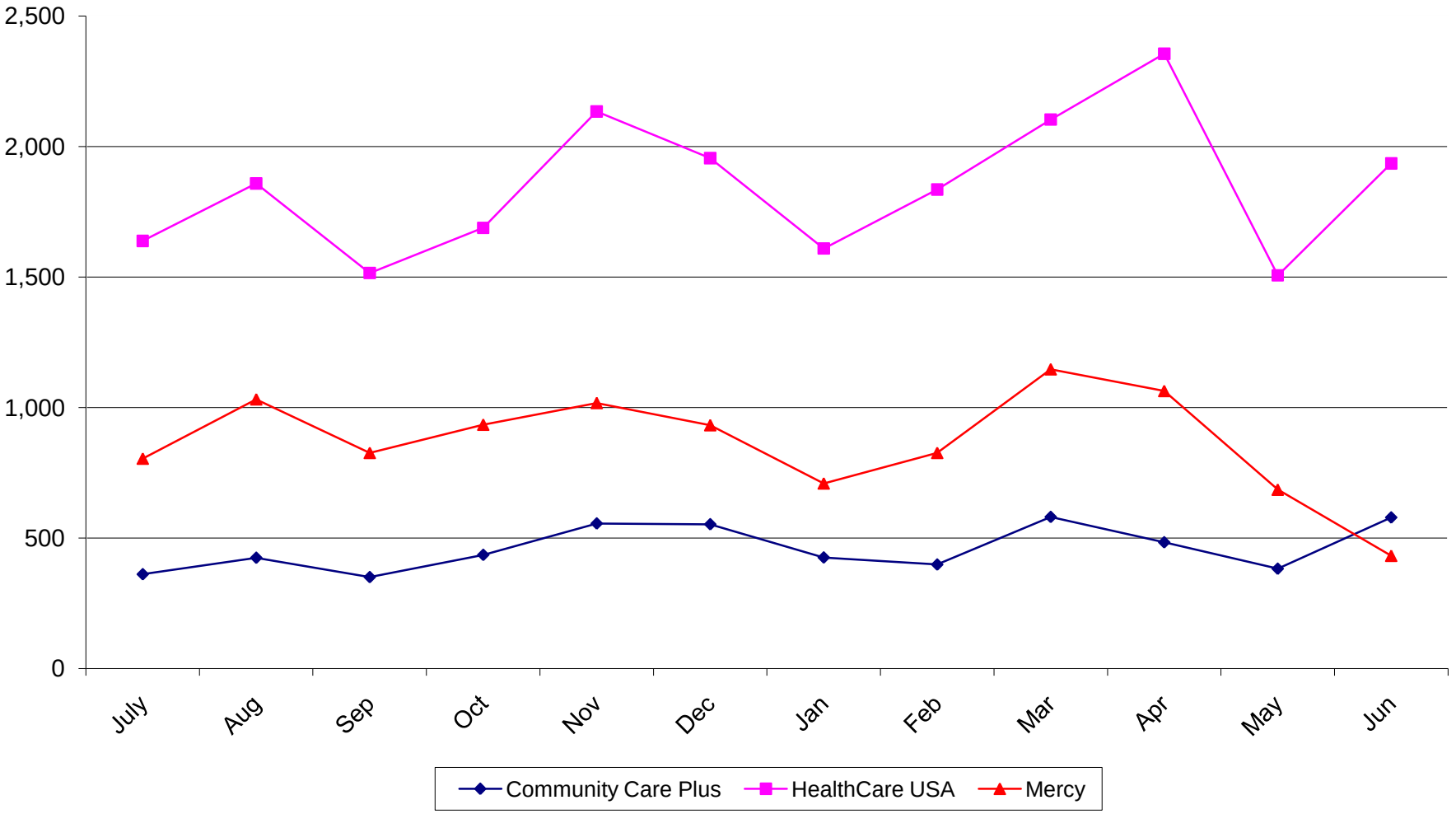
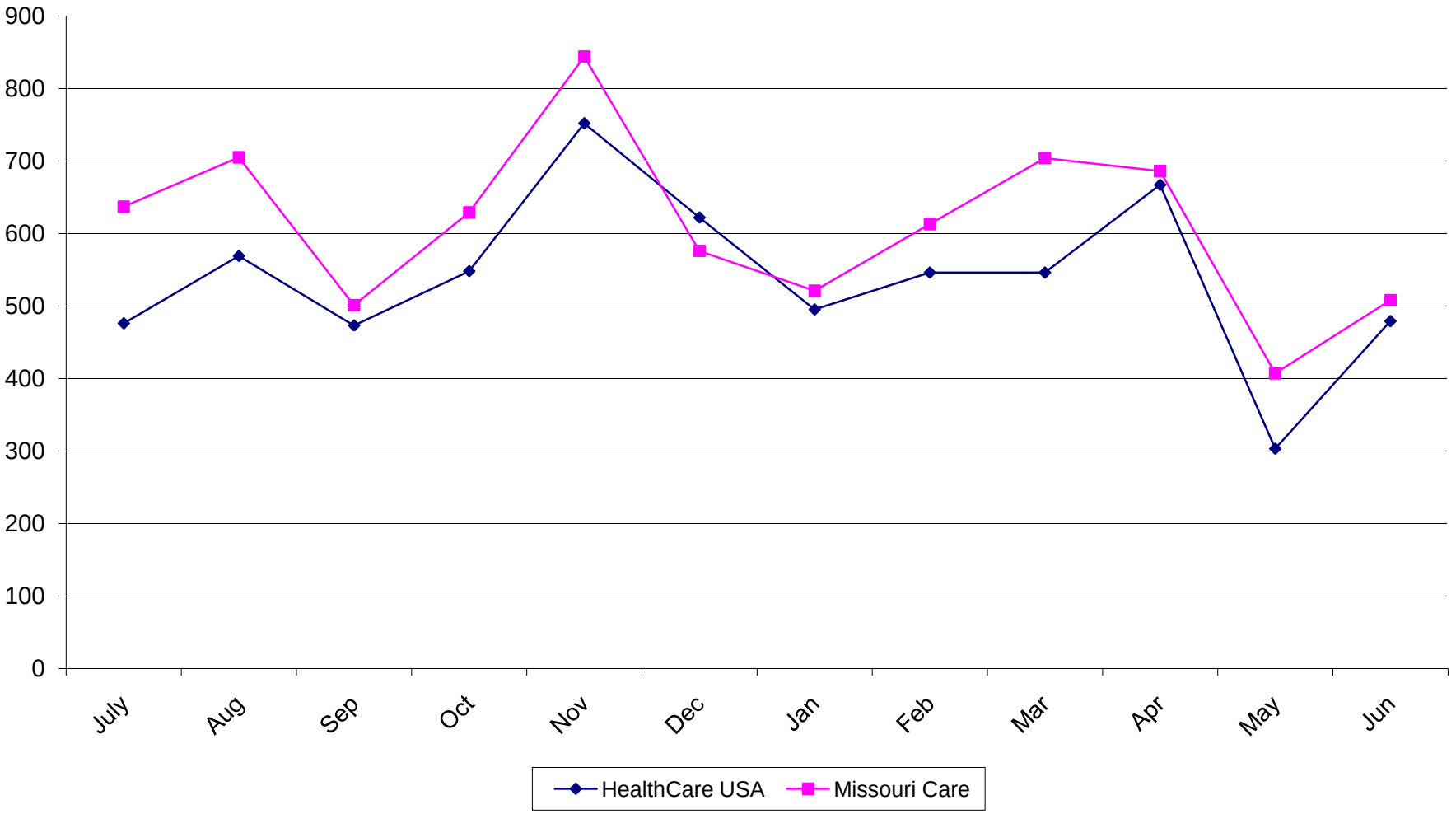


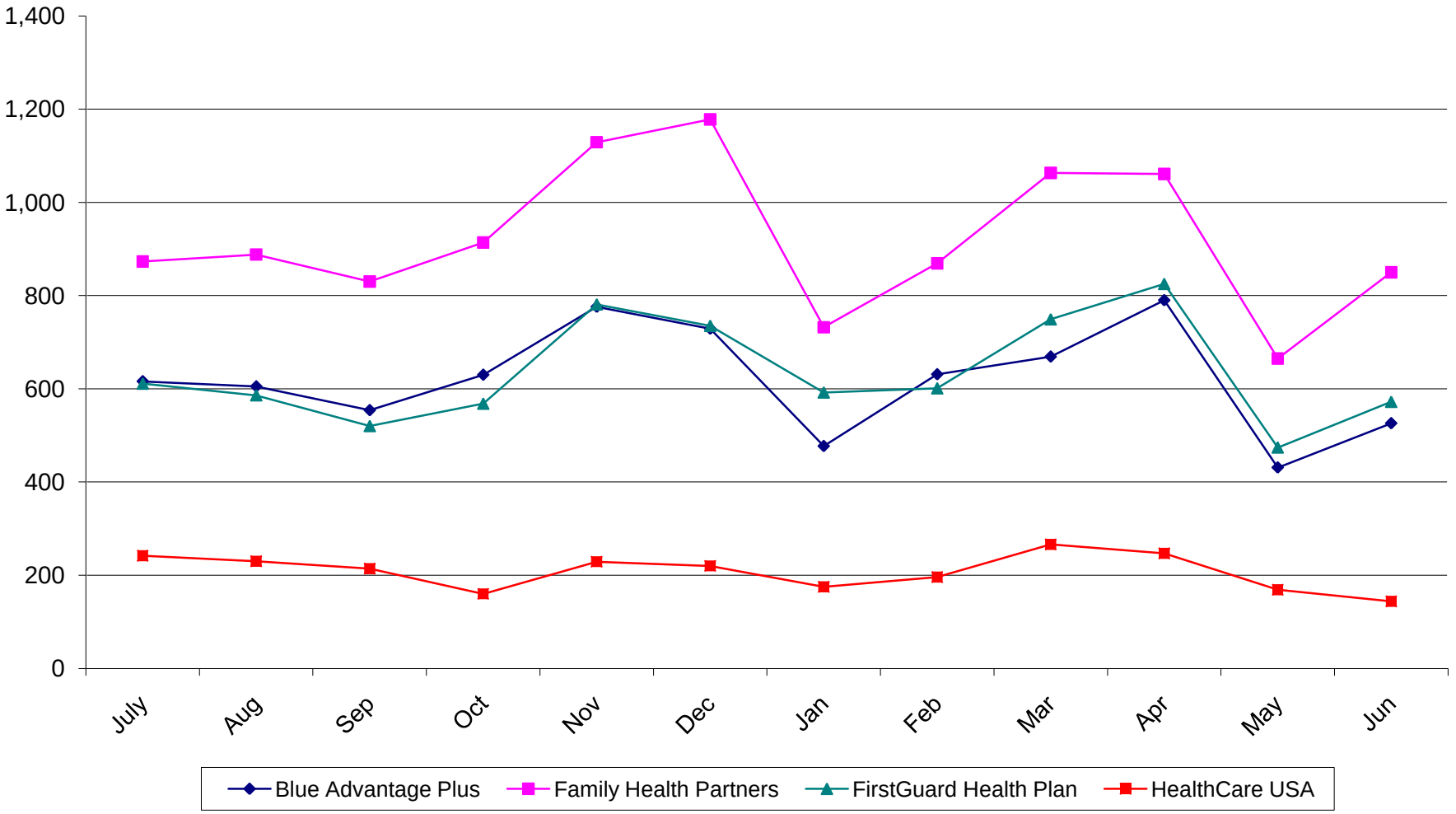
Member Enrollment Selections - All Populations
Eastern Region
July 2005 - June 2006



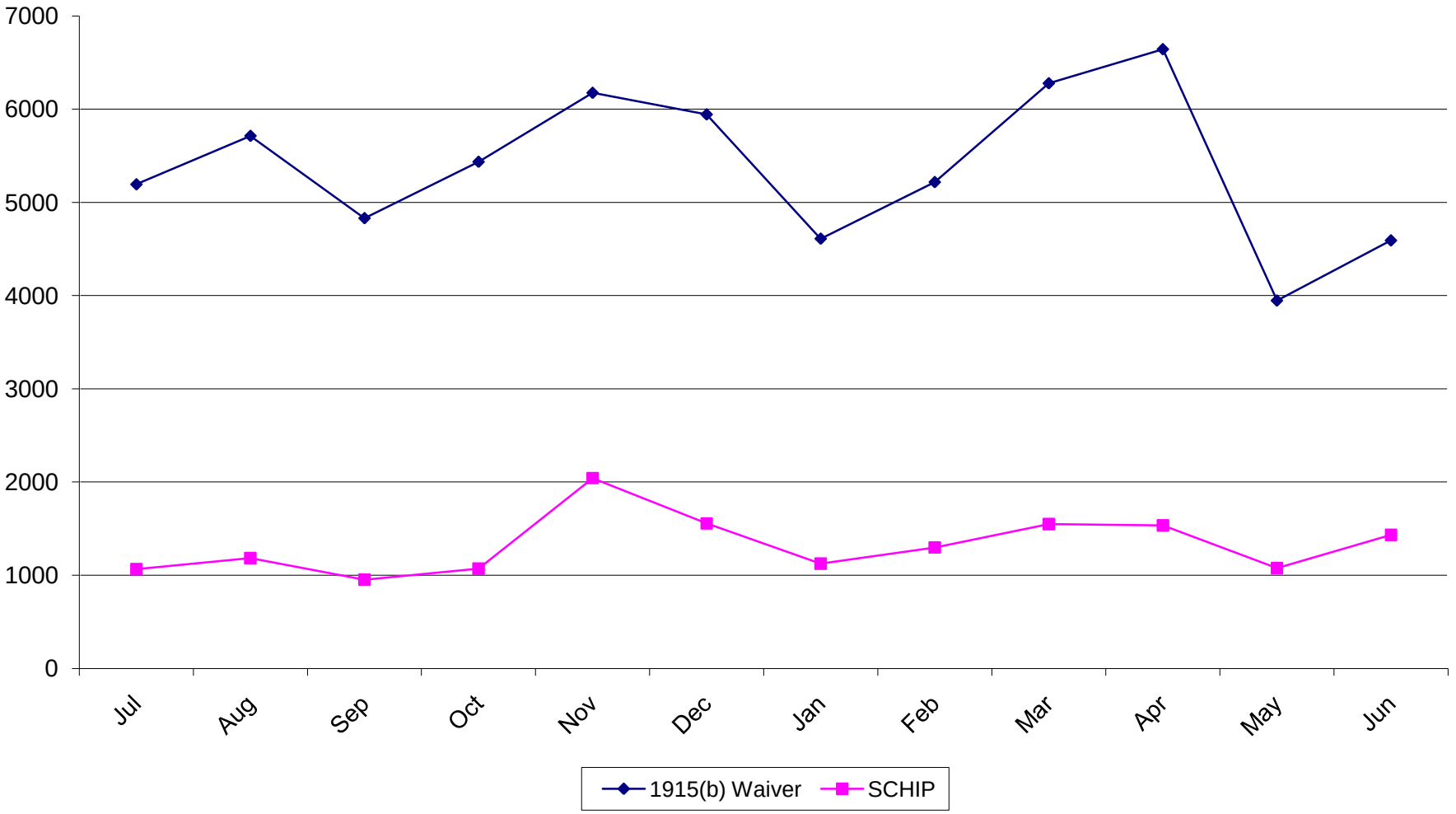
Member Enrollment Selections - All Populations
Central Region
July 2005 - June 2006

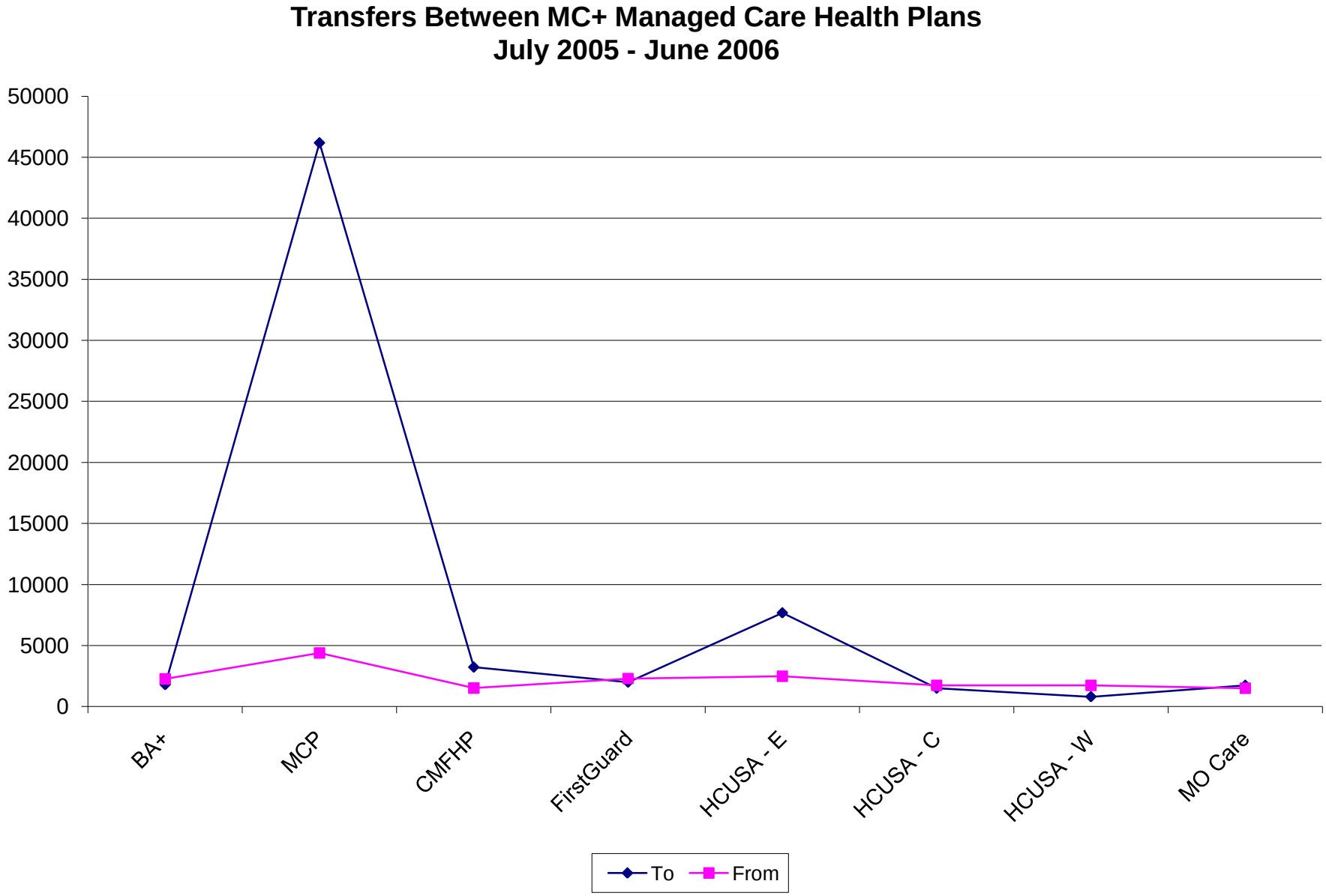


Member Enrollment Selections - All Populations
Western Region
July 2005 - June 2006

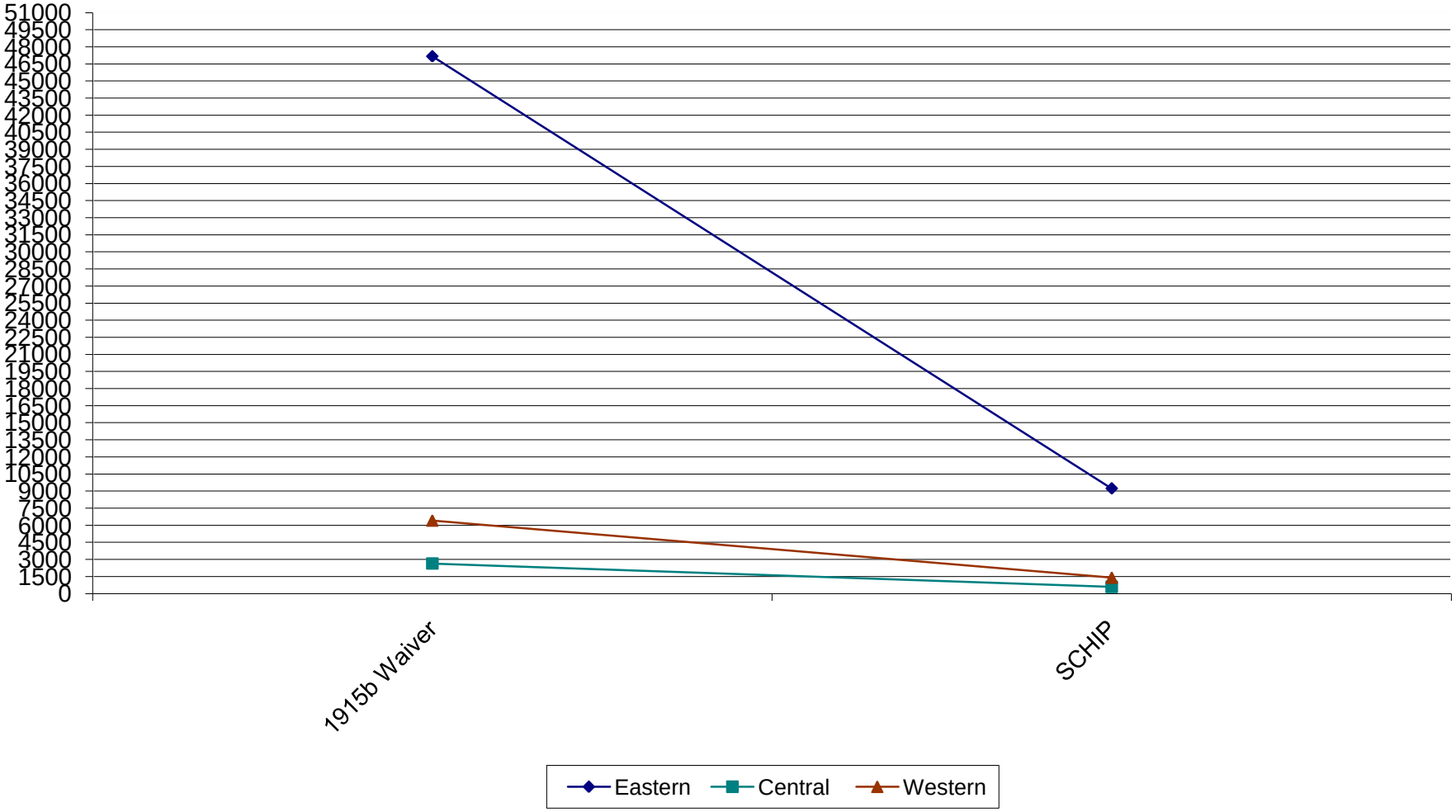


Member Selection by Population
All MC+ Managed Care Regions
July 2005 - June 2006

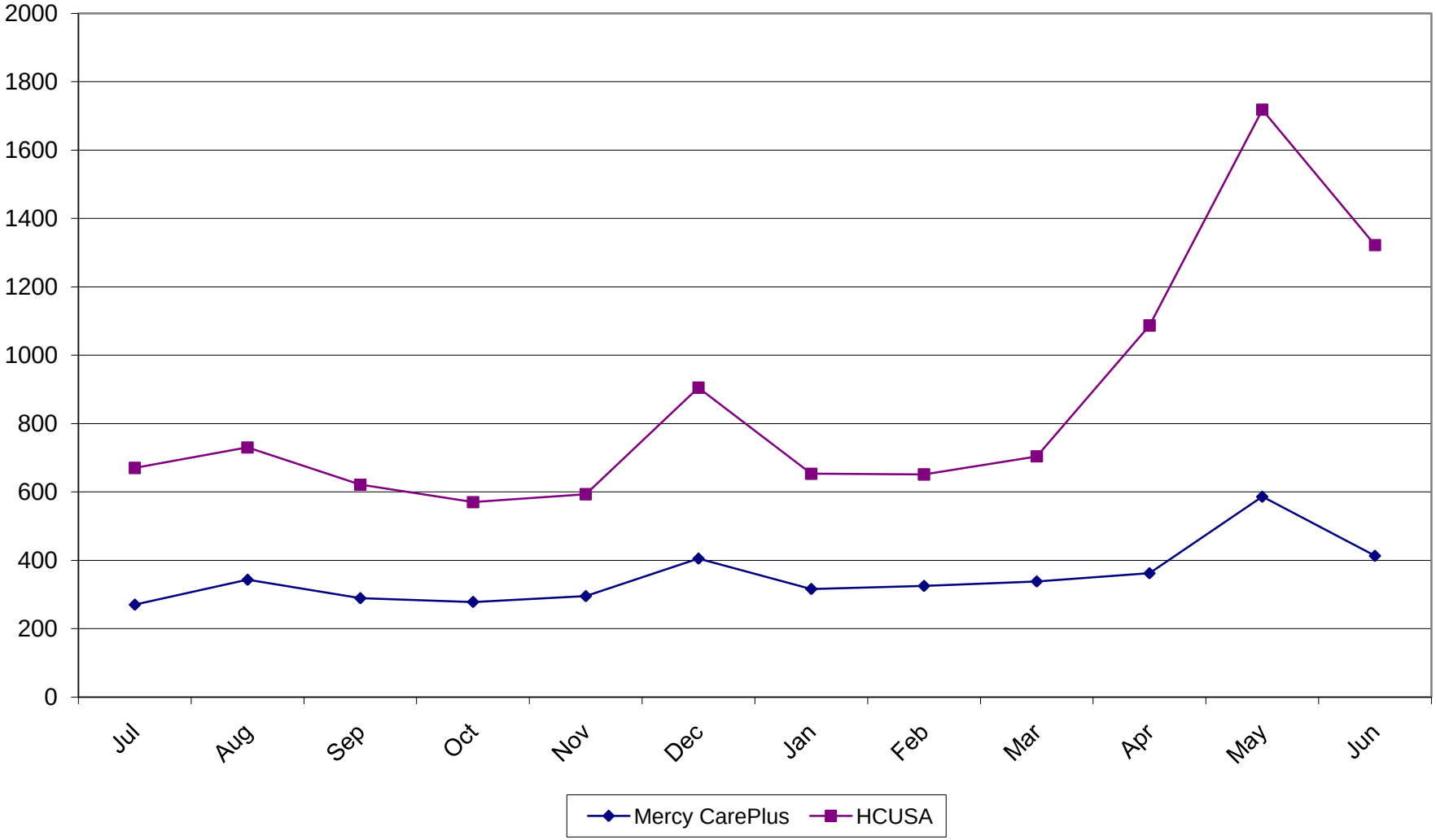



Transfers Between MC+ Managed Care Health Plans
July 2005 - June 2006
50000
45000
40000
35000
30000
25000
20000
15000
10000
5000
0
BA+
MCP
CMFHP
FirstGuard
HCUSA - E
HCUSA - C
HCUSA - W
MO Care
To
From

Transfers Between Health Plans
Regional Comparison
July 2005 - June 2006

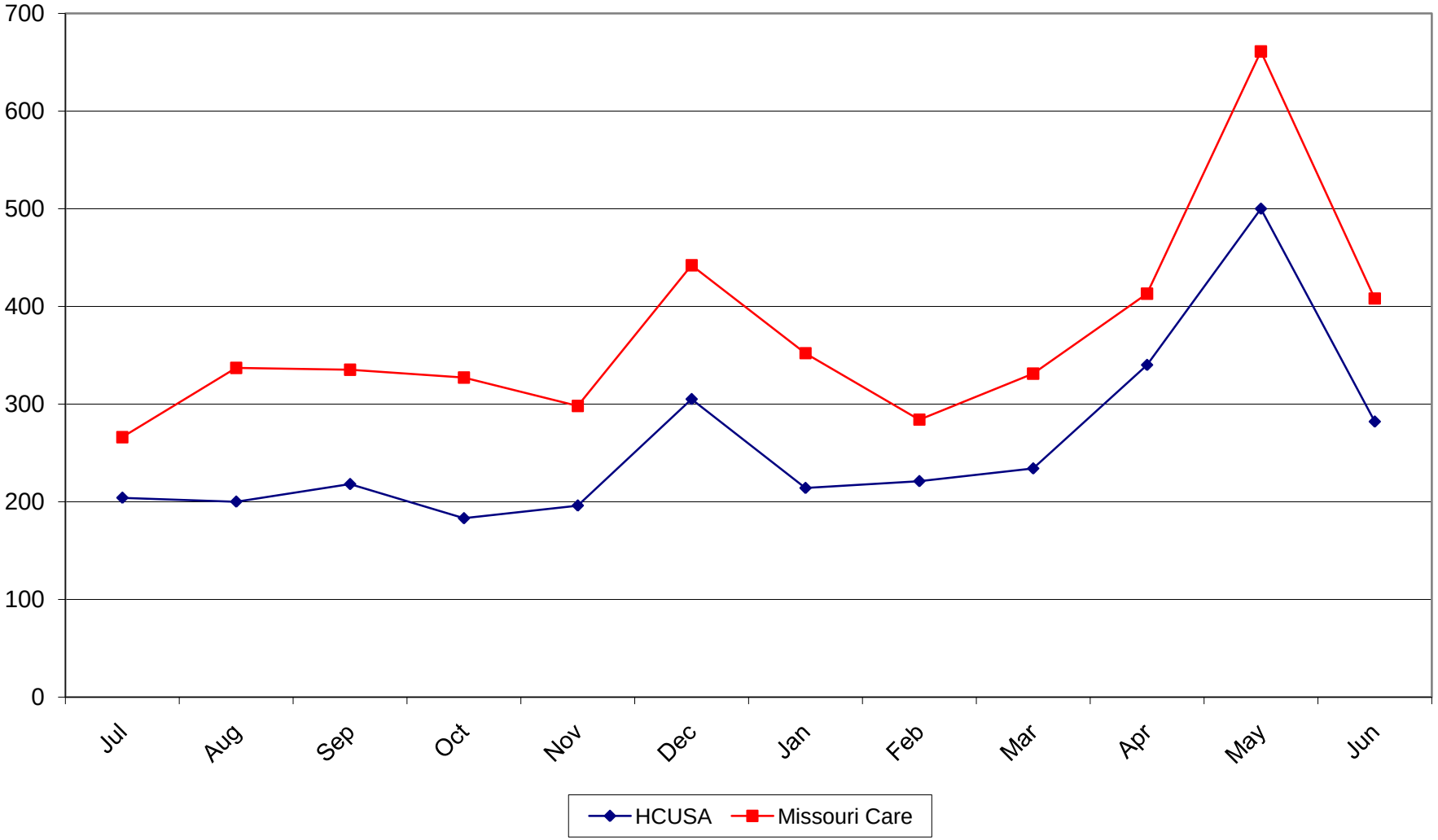


Comparison of True Closures* - Eastern Region
July 2005 - June 2006



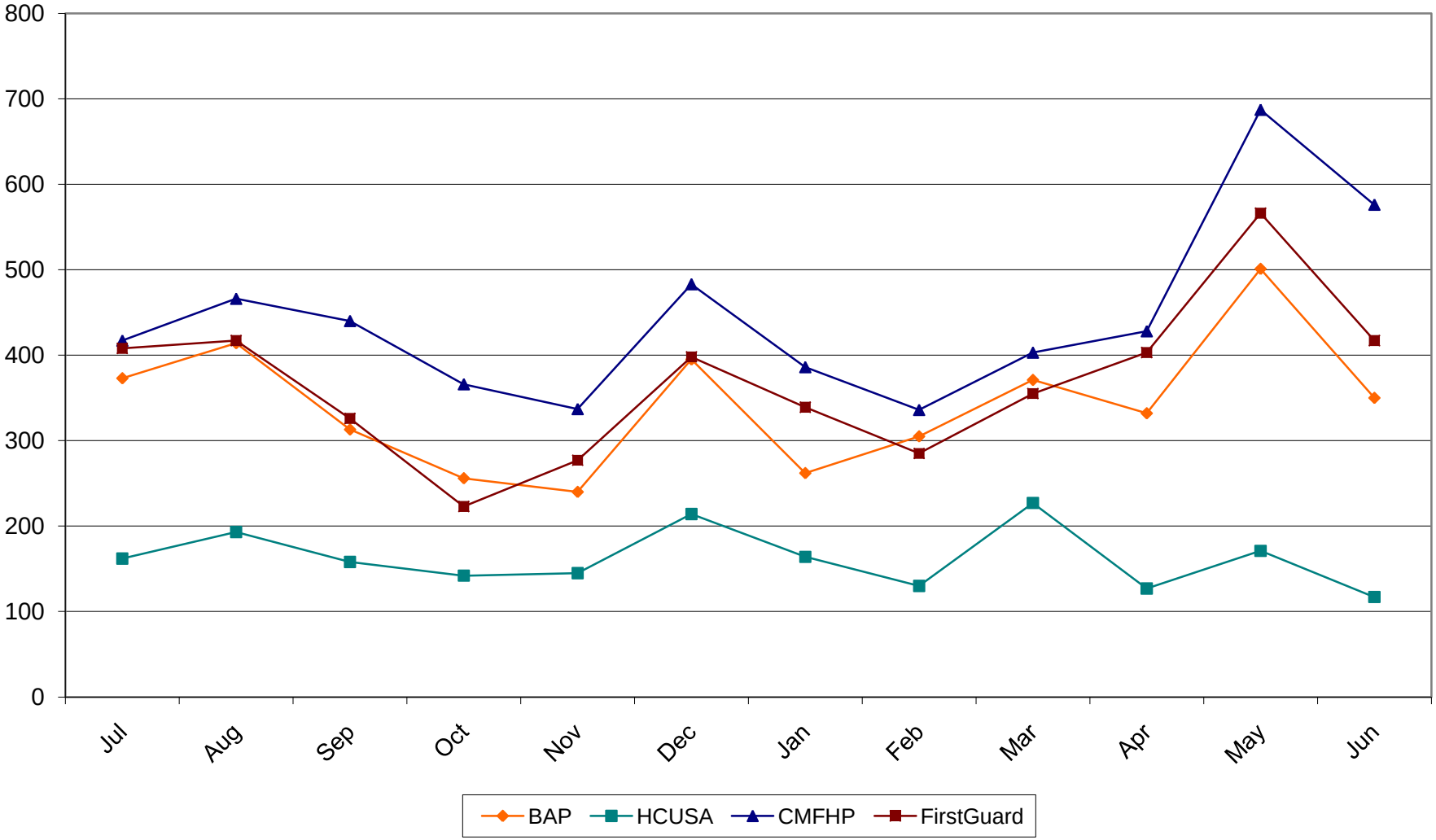
* Did not reopen under any other category of assistance.

Comparison of True Closures* - Central Region
July 2005 - June 2006



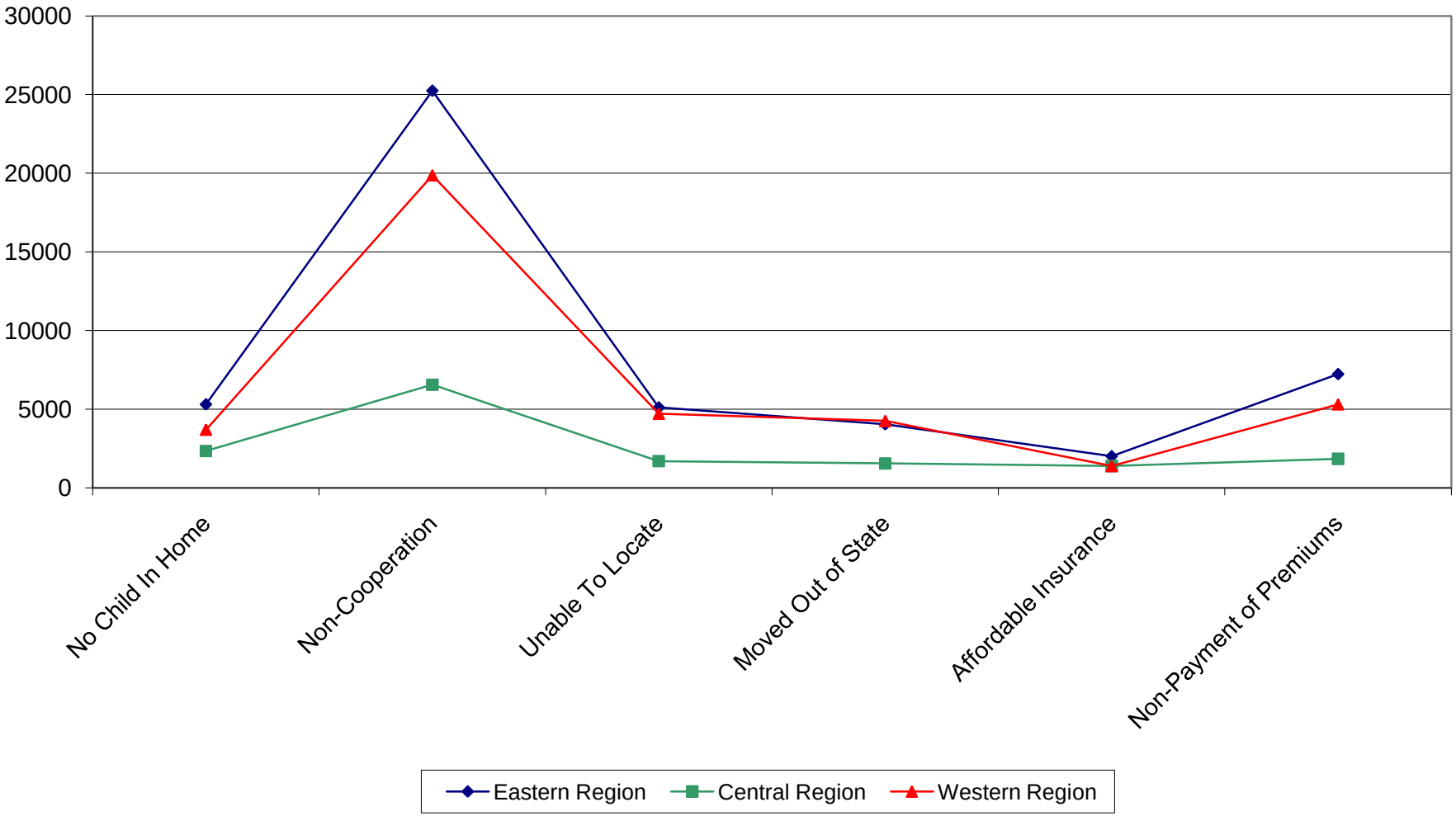
* Did not reopen under any other category of assistance.

Comparison of True Closures* - Western Region
July 2005 - June 2006

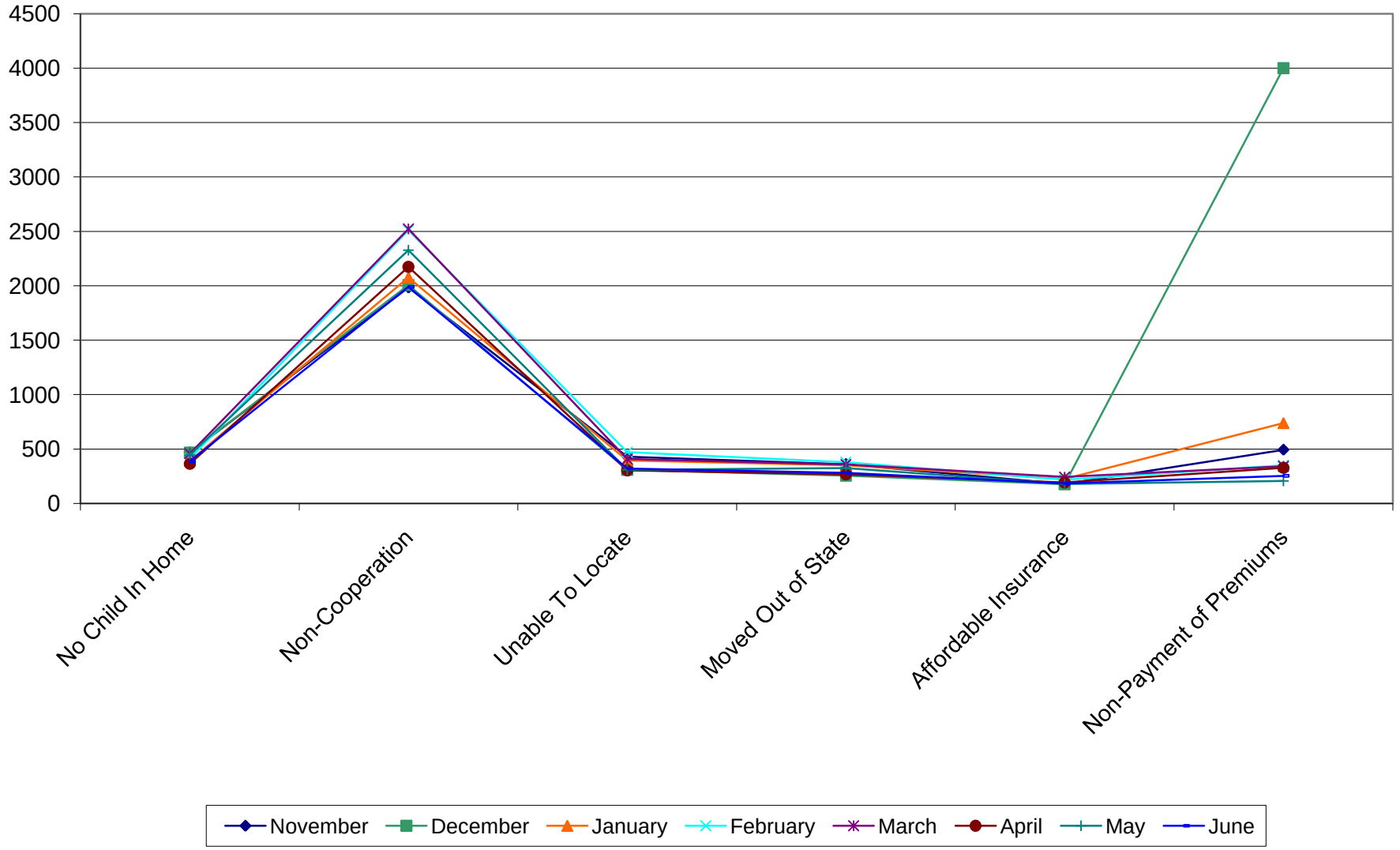


* Did not reopen under any other category of assistance.

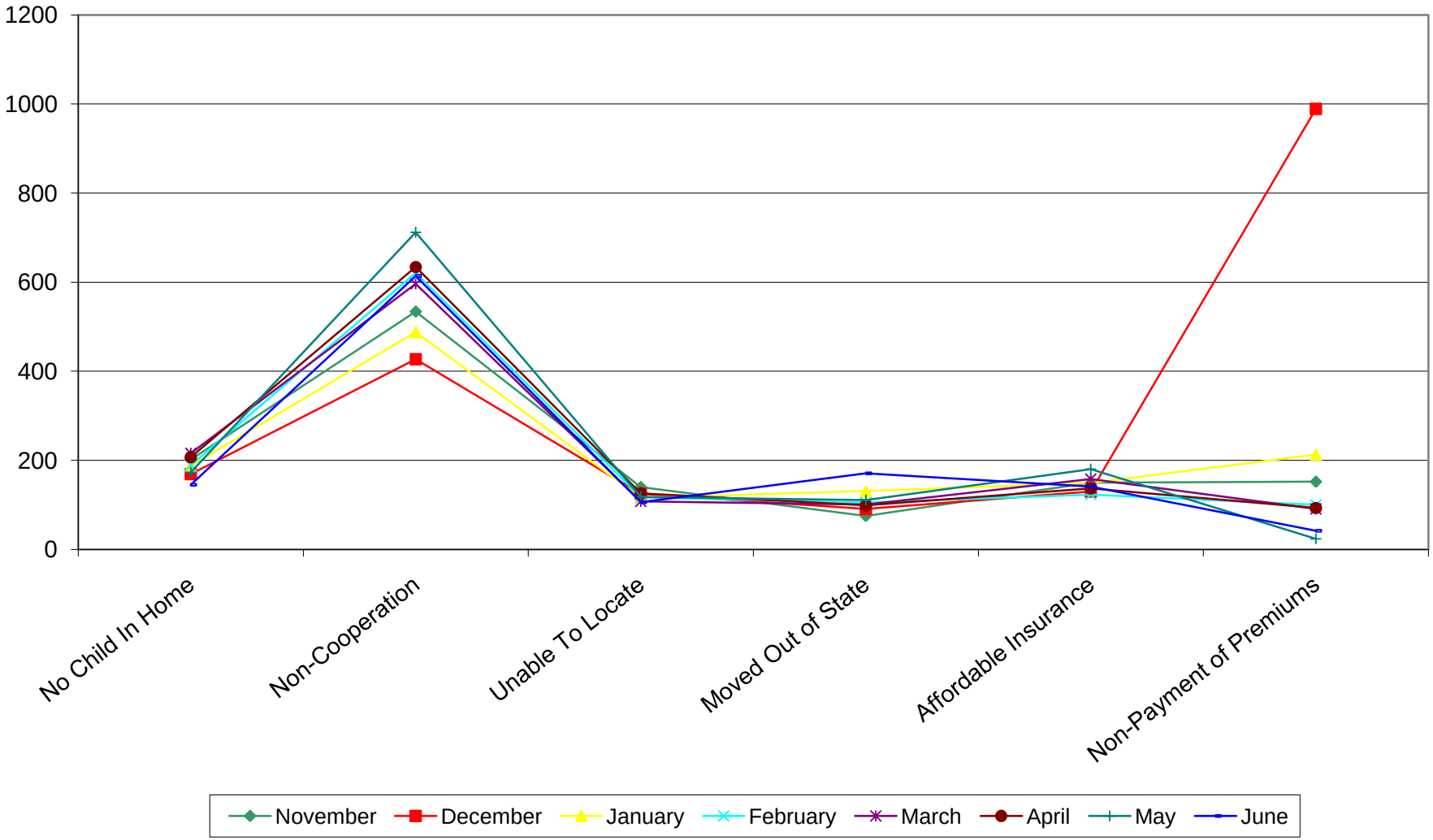
Top 6 Closure Reasons
Regional Comparison
July 2005 - June 2006



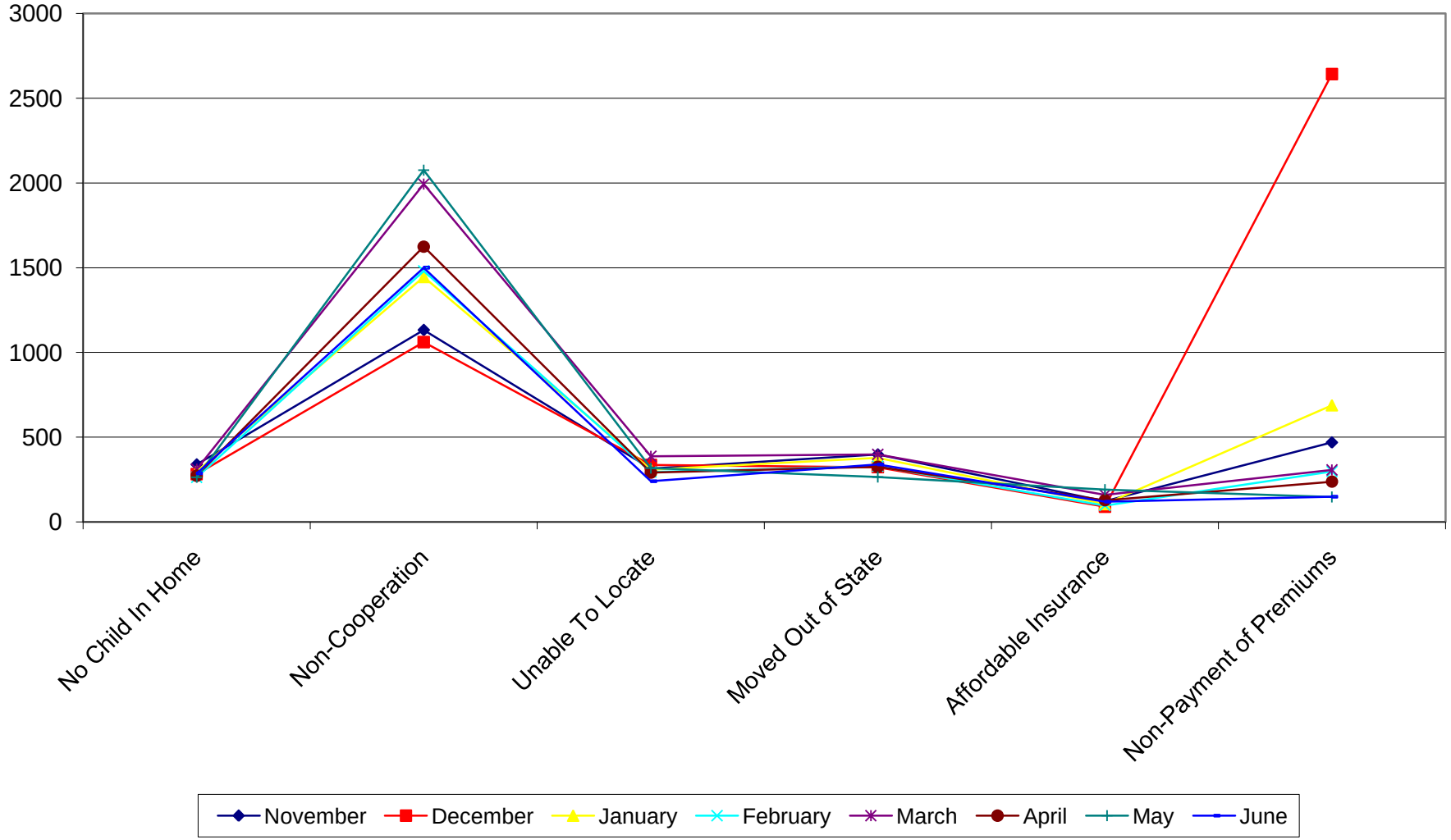
Top 6 Closure Reasons - Eastern Region
July 2005 - June 2006



Top 6 Closure Reasons - Central Region
November 2005 - June 2006



Top 6 Closure Reasons - Western Region
July 2005 - June 2006



MC+ MANAGED CARE ANNUAL EVALUATION

ACCESSIBILITY OF SERVICES

ACCESSIBILITY OF SERVICES

Customer Services

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- During 2005, an average of 4,500 calls were received each month with an average membership of 32,066 for Blue-Advantage Plus (BA+). With the average speed to answer goal of no greater than 30 seconds during 2005, callers waited on average of 9.5 seconds. The goal was met each month in 2005. The goal for abandonment rate is not greater than 5%. In 2005, the abandonment rate was 1.75%. Abandon rate varied between 1.0 and 4.8% by month. The goal was met for every month of 2005.

- Children's Mercy Family Health Partners (CMFHP) has an automatic call distribution system to monitor and track telephone statistics. CMFHP measures on a daily basis and aggregates to a monthly basis telephone statistics for call abandonment rate and average speed of answer rate. CMFHP has been consistent in meeting goals for calls abandoned as well as average speed of answer. In 2005, both measures showed significant improvement as compared to 2004 statistics.

- Community CarePlus (CCP) established ongoing quality monitors to monitor the efficiency of the call center as well as individual representative performance. Individualized quality monitoring is performed to monitor compliance of company policy regarding personal health information and HIPAA as well as call answer rates, abandonment rate, welcome call success rate and average of time on phone lines. Improvement plans are implemented for quality monitors that do not meet the established thresholds. The Customer Service Department received an average of 3,243 calls per month in 2005. The abandon rate average was less than 2%, which falls between CCP' target abandonment rate of 5%.

  Analysis of the 2004 quality monitors resulted in a quality initiative to increase the percent of successful new member welcome calls. In 2004 the new member welcome call success rate was 30%. Processes were revised and implemented to obtain accurate member demographic information. Additional staff training was provided. The welcome call success rate goal was re-established at 60%.

  Analysis of the 2005 Member Service statistics revealed the welcome call success rate had improved from 30% in 2004 to 51% in 2005. Analysis of the 2005 Quality Monitor Logs revealed the new member welcome call success rate increased from 30% in 2004 and 51% IN 2005. CCP' goal for 2006 is 60%.

- FirstGuard continued to monitor abandonment rate in 2005 for Member and Provider Services. As new procedures were introduced, the abandonment rate began to decline and approached the 4% corporate threshold by the end of 2005. Member Services added a new

call measurement in 2005, After Call Wrap-up Time, and is working toward a standard of less than 3 minutes.

- The member services department at HealthCare USA maintained a focus in 2005 to ensure high-quality customer service through ongoing consistent monitoring of several indicators. In 2005, the member services department monitored Call Volume, Average Speed of Answer, Calls Abandonment, Service Level as well as Doc Bear Club Education and Participation, and Language Access.

  Currently, the goals established for each indicator are as follows:
  - ***The Average Speed to Answer (ASA) between 20-30 seconds***
  - ***The Service Level above 75%***
  - ***The abandonment Rate (AR) 3% or less***

Data Analysis

The call volume in 2005 increased by 1.2% when compared to 2004. The overall contributing factor in the fourth quarter is attributed to the changes in the Medicaid program. Calls increased in members seeking to clarify benefits.

The top four call reasons in 2005 were as follows:
- Eligibility
- Benefits
- ID card questions
- PCP change requests

The overall rating for customer service has remained well above the 75% target. The call abandonment rate remained consistent over time, meeting and exceeding the performance goal of <3% for the year.

In 2005, the member services department conducted routine training programs to meet both internal and external needs. These training programs centered on subcontractor information, grievance and appeals, fraud and abuse, Navigator training, quality improvement, and marketing.

The member services department concentrates on member education regarding the Doc Bear Club, EPSDT, lead, immunizations, and benefits. Members were educated on availability of programs and the opportunity to participate in the Boy Scouts and Girl Scouts and certain YMCA programs.

The member services department is committed to continuing efforts in 2006 related to ongoing monitoring, tracking and trending of telephone statistics and implementing interventions as needed. Training programs will continue tin 2006 with additional areas of interest including employee development, phone etiquette, customer service skills, standardizing documentation, typing assessment, and improving the outbound calling functions of the member services department.

- Call Answer Timeliness measurements were included on the performance scorecards as a new indicator in 2004 for Mercy MC+. Telephone reporting enhancements were required to begin calculating phone stats this way; by 2005 all call centers were able to report call timeliness as a percent of calls answered within 30 seconds. Regulatory standards required member service call centers to achieve a 95% threshold of calls answered within 30 seconds.

  Previous standards of call center measurement focus on average speed of answer. This measurement identifies the average length in seconds of all calls until answered by a call center representative. The Plan's Member Call Centers maintained an overall average speed of answer throughout 2005 of 28 seconds. This performance measure met the target of average speed of answer of 30 seconds.

- For Missouri Care, the average answer times in 2005 were as follows:
  - Prior authorization – 12 seconds
  - Behavioral health – 10 seconds
  - Member solutions – 13 seconds

  Departments were well below the industry standard of 30 seconds. Missouri Care has dedicated staff committed to delivering the highest level of service.

  The average abandonment rates in 2005 of 2.49%, 2.68%, and 1.94% for Prior Authorization, Behavioral Health, and Member Solutions Departments, respectively, were well below the industry standard of 5.00%. These rates are reflective of Missouri Care's commitment to service.

Appointment Standards and Access to Emergent and Urgent Care

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- As part of the monitoring process for Blue-Advantage Plus, 480 PCPs that treat adult members and 120 pediatricians were assessed for compliance with urgent appointment access via live pone calls during 2005. Three hundred seventy PCP offices were also called to assess the availability of a physician after normal office hours for urgent care.

  - Members reported receiving routine care within 7 days 86.4% of the time.
  - Members reported receiving urgent care within 24 hours 86.9% of the time.
  - Phone calls yielded that 87% of PCP offices for adult care and 93% for pediatric care had appointments available for urgent care within 24 hours.
  - Two complaints were received from BA+ members regarding urgent care access.
  - 94% of PCP offices provided the member access to a physician after business hours.

  In late 2005, BCBSKC contracted with Take Care Health to provide urgent care services to BA+ members. Nine locations have been established. In 2005, BA+ members accessed emergent care 18,246 times.

- During 2005, CMFHP, as part of the re-credentialing process, routinely reviewed each office's procedures for scheduling appointments. During the review process, no deficiencies were noted. In addition, CMFHP Provider Administrative Manual outlines the appointment standards. Finally, through their Customer Service department, no significant issues were noted with respect to members being unable to access the participating provider network for non-routine appointments.

  CMFHP informs and monitors participating providers' compliance on the guidelines for routine appointments. This is completed through the re-credentialing process, as well as by the Customer Service department, the member grievance system, and the provider compliant, grievance, and appeal process. During 2005, there were no significant issues identified with members being able to access providers for routine appointment needs.

  In general, the CMFHP network of providers is compliant with the access standards for being able to deliver care to their members on a timely and consistent basis.

- CCP includes non-routine needs appointments, routine needs appointments, and access to emergent and urgent care as part of the site visit, but is not trended.

- FirstGuard's Provider Relations staff administered the annual provider access survey between January and March, 2005, to determine appointment availability, in-office waiting time and after-hours coverage consistent with provider contract requirements. Overall compliance for PCP offices was 95.60% and for OB/GYN offices was 94.01%. Provider Relations staff resurveyed offices in November 2005 that did not meet FirstGuard access standards.

- HCUSA recognizes that access and availability monitoring is important to ensuring appropriate health care for members and will continue to monitor in 2006.

  HCUSA subcontracts dental services to Doral Dental. Doral and HCUSA work collaboratively to ensure appropriate access and availability of dentists across all three regions of the network. Doral and HCUSA meet quarterly to discuss key performance indicators, network changes and all other processes as necessary.

  Doral and HCUSA will continue their partnership in 2006.

  HCUSA subcontracts mental health services to MHNET. MHNET and HCUSA work collaboratively to ensure appropriate access and availability of mental health providers across all three regions of the network. MHNET and HCUSA meet quarterly to discuss key performance indicators, network changes and all other processes as necessary.

- A study of routine and urgent access to high-volume PCPs, facilitated by Mercy Health Plan Provider Relation's field representatives was conducted in the first quarter 2004 and again in 2005. Following are the results:

- A sample of Missouri Care providers were surveyed telephonically by Provider Relations staff to monitor the appointment availability of non-routine and routine needs appointments and access to emergent and urgent care. Ninety-six PCPs, 32 primary care obstetricians and 41 primary specialty providers were contacted. The 2005 survey contacts indicated a rate of 100% compliance for PCPs, a rate of compliance between 93-96% for primary specialty providers, and a rate of compliance between 84-100% for primary care obstetricians.

24 Hour Access/After Hours Availability

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- BA+ provides a Nurse Advice Line to members 24 hours per day/7 days per week. The nurse phone line forwards reports on a weekly basis to the BCBSKC Case Management Department for any pregnant caller. These reports are then reviewed by the prenatal nurse coordinator for opportunities to enroll these members in the Little Stars Prenatal Program or refer them for more individualized follow-up by a case manager. The Nurse Advice Line may offer BA+ members the assistance that they need without having to incur an emergency room visit.

- CCP' Provider Relations Department completed the 24-hour access monitor by making calls "after hours" to the offices of high volume practitioners and recording the results for Provider Relations Department review and develop a corrective action plan, if needed.

- The results of the after hours survey for PCPs and OBs are:
  - Is phone # valid? (97% yes, 3% no)
  - Is there an answering machine or is call forwarded to a triage/service line? (69% yes, 31% no)
  - Is there a clear direction of how to reach the physician? (98% yes, 2% no)
  - Is there a phone number to "page" the physician on a beeper? (37% yes, 63% no)
  - Is there an after hours service to relay messages to the physician? (96% yes, 4% no)
  - Is there a nurse triage line to assist the members? (76% yes, 24% no)
  - Are members told to go directly to the ER? (13% yes, 87% no)
  - Are members told to go directly to the ER for life threatening emergencies? (77% yes, 23% no)
  - Is the member told to go to a non-participating ER? (7% yes, 93% no)
  - Is the member told when the office is open for non-emergent appointments? (98% yes, 2% no)

- On an annual basis, the CMFHP' Customer Service department conducts a telephonic survey to determine how their Primary Care Provider (PCP) offices handle their availability after normal hours. Calls were placed after the routine 5 pm office closing time and in the morning from 6a – 8am prior to office opening.

  Of the ninety-six Primary Care offices that were surveyed, all provided adequate after hour availability twenty-four hours a day/7 days a week.

The majority of offices have an answering machine which directed the patient to call "911" if this was a life threatening emergency and if not, a pager number was provided to contact the provider on call for a "nurse advice" line number was given to contact a nurse on call. In addition, some offices had an answering service which paged the physician on call.

CMFHP continuously monitors our members' access to their primary care provider by monitoring customer service complaints, as well as monitoring member grievances related to access. During 2005, there were no significant issues identified with members being able to access providers for there care needs.

- 24 HOUR PROVIDER ACCESS STUDY:

In 2005, the PCP access study included a random sample of primary care providers across all three regions of the network. A sample of 300 primary care providers was selected which is a representative sample of 27% of the PCP network.

Provider Relations conducted random telephonic surveys with PCP providers in all 3 regions to assure and contractually required appointment scheduling standards by all PCPs for routine and urgent requested appointments. In addition, calls were conducted after-hours to PCP providers to assure compliance with after hours availability standards.

Results

Primary Care Appointment Standard:
- PCP's will have urgent appointments for a serious, but not life threatening appointment available at all times.
- PCP's will have urgent, but not life-threatening appointments available the same day.
- PCP's will have urgent care, but not routine appointments available within two days.
- PCP's will have routine care without symptoms appointments within one month.

95% of providers surveyed met these appointment standard

Primary Care After Hours Access Standard:
PCP's are required to ensure that access to care is provided twenty-four hours per day, seven days per week and to maintain phone line coverage after normal business hours.

91% of providers surveyed met this after hours availability access standard

If a provider was identified in this study as not meeting the required standard for access and availability, a HealthCare USA Provider Relations Representative would contact the provider and further educate regarding the standards and the provider's obligation to comply.

For the providers identified as not having after-hours line coverage, follow-up contacts via Provider Relations revealed errors on the provider of the provider's office staff. Some issues

consisted of failure to roll phones over to the correct number, or disconnection issues. In each case, the provider responded to feedback from HealthCare USA and corrected the issue immediately.

Following each survey, Provider Relations also provided feedback to the provider on the results of their assessment.

- Analysis of 24 hour and appointment access:
  - Initial monitor indicated 15% or 57 of 378 physicians surveyed did not meet the requirement; of the 57 that were recalled only 3% or 12 remain out of compliance.
  - Improved overall compliance can be attributed to education of the requirement by the Provider Relations field representatives to physician offices.
  - OB appointment access improved over 2004's baseline measurement; with the exception of Third Trimester; however no complaints or adverse issues related to OB care were reported.

- Missouri Care surveyed a sample of providers telephonically by Provider Relations staff to monitor 24-hour access and after-hours availability. Corrective action was recommended if the clinic did not meet accessibility/availability standards.

  Surveyed providers were found to be 92% compliant:
  - Answering service picks up calls and contacts provider (22, 10%)
  - Service automatically transfers calls to number that will provide access to provider/covering provider (4, 2%)
  - Answering machine directs caller to provider/covering provider at alternative number (168, 81%)
  - No answer (3, 1%)
  - Answering machine plays outgoing messages/directs callers to leave message or call 911 (13, 6%)

Open/Closed Provider Panels

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- Seventy-four percent of BA+ primary care providers have open panels.

- Open/closed provider panels are annually review and reported to the Medical Director at CCP.

- CMFHP tracks open/closed provider panels monthly. However, since State enrollment and eligibility is performed on a daily basis, CMFHP recognizes the need to ensure that the data is current when members are selecting a PCP.

  During 2005, CMFHP had a total of 336 PCP's. Of those providers, 70 had a closed provider panel for a rate of 21% or an open panel rate of 79%. CMFHP did not meet the goal of an

average of at least an 85% open panel rate for 2005. However, of the PCP's that have closed panels, 61 are Internal Medicine or Family Practice. Since their membership is over 75% pediatrics, CMFHP believes their members have adequate access to PCPs, even though they have been unable to attain their overall goal of 85% open panels.

The provider relations staff at CMFHP continues to work with providers to keep as many of their practices open to members, as well as look for opportunities to recruit additional PCPs into the CMFHP network.

CMFHP also tracks member inquiries related to PCP closed panel issues. In 2005, CMFHP documented 294 calls related to a closed panel issue. This represented a decrease of almost 50% of all calls documented regarding closed panels during the past year. CMFHP believes that this decrease may be due to correct information being sent to members by the state concerning what providers are in the CMFHP network. CMFHP spent a great deal of time throughout 2005 reviewing and correcting information that was sent to members concerning our network. The correction of this data may have contributed to this decrease in calls.

In addition to these efforts, CMFHP customer service representatives now have access to the provider data base, which contains the most current information relating to provider panel status. This enables them to provide timely and accurate information to their members concerning provider status.

- Missouri Care monitors providers' panels monthly. Currently, 71% of Missouri Care's PCPs have an open panel.

Cultural Competency

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- CCP currently tracks on a weekly basis, the number and percent of members that have been identified as speaking another language other than English. CCP current membership reports do not reflect a total of 200 or 5% of eligible members that speak a single language other than English. Incorporated into CCP' practitioner orientation program is education on processes to access interpreters for our members.

  CCP enhanced translation services by contracting with two additional vendors for translation services. I.T.S. Translation Service was added in 2005 to enhance translation services for Spanish speaking members. The owner and operator as well as his wife (also a translator) are Hispanic, which also enhances the cultural aspect for the Hispanic members.

  TLC Interpretation Services was also added in 2005 to provide sign language for members that have hearing and speech impairments and or disabilities. CCP also offers the Member Handbook in audio and large print for members that may have difficulty reading. CCP makes available to its members, the Relay for Missouri line to assist members that may have hearing

impairments or disabilities. The Customer Service Annual Training and Ongoing Education Plan also include Cultural Diversity training.

- CMFHP identified the following interventions to address the need for increased awareness and understanding of cultural populations and to ultimately reduce the number of potential racial and ethnic health care delivery disparities:

    - In 2004, CMFHP utilized the services of a part-time bilingual Community Relations representative with the goal of utilizing this staff person to better educate the Spanish speaking community within the Western region about the services of CMFHP. In 2005, they now have a full-time representative that works on outreach efforts to this community.

    - Continued use of communication mechanisms and materials to explain MC+ managed care and CMFHP services. The materials are disseminated to relocated families in the Western region at local public health agencies, regardless of background or physical condition.

    - Continued use of the Cultural Awareness Guide and a local resource guide used by staff and our provider network and community organizations.

    - Communication materials on CMFHP services were disseminated at local public health agencies to immigrant families arriving in the United States.

    - Communication mechanisms and materials were made available for all members, regardless of background or physical condition.

    - Continued use of a Cross-Cultural Health Care Resource Guide was developed to educate staff and providers.

- Mercy Health Plan implemented an enterprise-wide project to improve cultural competency and diversity awareness during 2003; project plans incorporated ongoing assessment and training for cultural and linguistic appropriate service (CLAS). Project goals remained intact and additional training opportunities were identified for employees, physician leaders, and delegated decision-makers.

- Missouri Care efforts comply with applicable federal and state cultural competency requirements and include:
    - Monitoring member demographics to identify the need to provide written materials in a second language
    - Providing members and health-care professionals access to interpretive and sign language services
    - Educating plan personnel who have direct contact with members to promote understanding of and respect for cultural differences and develop services to better meet the needs of diverse populations

- Monitoring the practices of network health professionals and providers as they relate to treatment of a culturally and linguistically diverse membership.

Missouri Care promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (MORE ON PAGE 16???)

Requests to Change Practitioners

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- A new quality monitor was established mid-year in 2005 for CCP.

- In 2004, CMFHP had 10, 671 requests to change PCP's for our members. In 2005, CMFHP has 8,946 requests to change PCPs. This is a 12% reduction in requests to change PCPs. CMFHP believes the reason for the reduction in PCP changes is a result of better member education and PCP stability. CMFHP also thinks this reduction was a result of the State directory clean up that was done by CMFHP for their network. Several discrepancies were noted and sent to the state for correction, resulting in more accurate data being provided to potential and new members.

- During the fiscal year 2005, Mercy Health Plans Member Service teams were not tracking and trending provider change requests.

- During 2005, the Missouri Care Member Solutions staff completed 2,360 PCP changes.

LEAD CASE MANAGEMENT

In 2005, the Department of Social Services, Division of Medical Services (DSS/DMS) in collaboration with the Department of Health and Senior Services (DHSS), finalized a Lead Poisoning Case Management Database. In April 2005, the database and the Lead Case Management Policy and Procedure were presented to the MC+ Managed Care Quality Assessment and Improvement Advisory Group and to the members of the All Plan Group for their input and approval. In June, 2005, the DMS sponsored a training session for the health plan lead case managers regarding the Lead Poisoning Case Management Report Data Base. The training was provided by the Division of Medical Services' staff and the Department of Health and Senior Services' staff. The DMS required the health plans to begin using the report database on July 1, 2005. Since July 1, 2005, the DMS has collected health plan lead case management data. The first annual DMS Regional reports of lead case management are reported below with the corresponding lead case management activity as reported by the health plans for the 2005 Annual Report to DMS as required by the MC+ Improvement Strategy Quality.

EASTERN REGION

Community Care Plus (CCP)

Information Obtained From CCP's 2005 Annual Evaluation

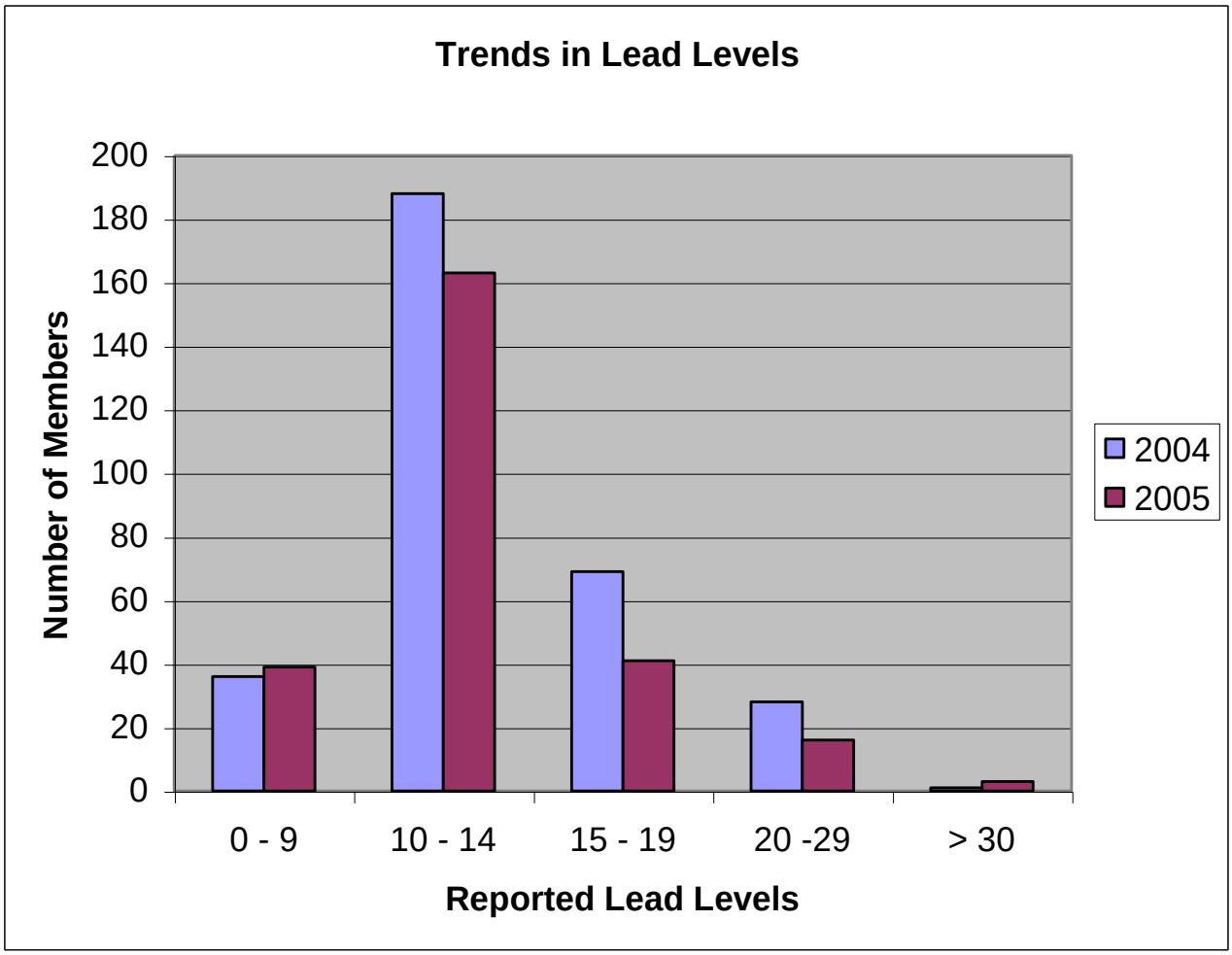
Lead

Case management is provided for members with levels greater than 10mcg/dL. This includes education on nutrition and a healthy environment. Currently Community CarePlus has 264 open cases. An electronic report of elevated lead levels is sent to Community Care Plus monthly from the State. Members identified with levels greater than 10 mcg/dL are entered into case management. Two consecutive levels of 15 and above or one level of 20 or above is entered into the State's Case Management Database.

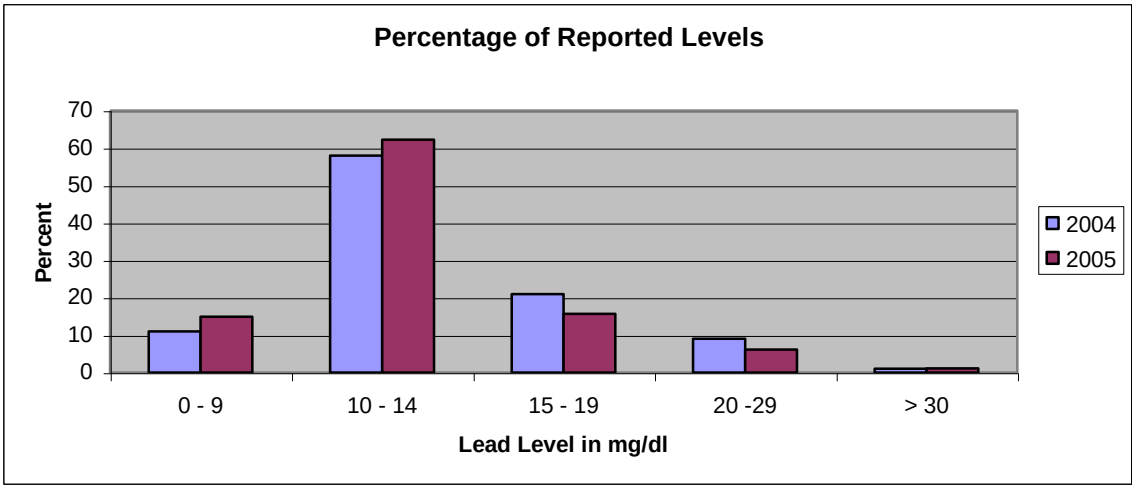
	*2003		2004		2005	
Members w/ levels >9 mcg/dl	302		367		262	
Decreasing Levels	119	39%	166	45%	113	43%
Rising Levels	28	9%	31	8%	22	9%

*Represents only 6 months of data for 2003

There was 28.6% decrease in members identified with levels of 10mcg or greater in 2005 demonstrating that education on lead awareness and environmental hazards are necessary for continued improvement. Children with single lead levels have decreased in the same year by 31.9% indicating that more children are having repeat lead levels due to the efforts of Community CarePlus in sending reminder letters and cards to the physicians and members.



There was a 35% improvement from 2004 to 2005 in members with reported lead levels of 0-9 mg/dl that were in case management. Members with decreasing lead levels increased 16% from 2004 to 2005.



The Lead Case Manager has partnered with Provider Relations to educate Primary Care Providers on the use of Medtox filter papers to facilitate an easier and faster result of lead levels. The focus for 2006 is to trend lead levels in children one to two years of age.

Mercy MC+

Information Obtained From Mercy's 2005 Annual Evaluation

Lead Poisoning Prevention

This is the Plans sixth year of case management support for children ≤ six years of age with high blood lead levels as reported by Missouri State and the County and City Departments of Health. Children with a blood lead level ≥ 10 ug/dl were eligible for Targeted Case Management. In 2005: The number of members in lead prevention case management averaged 122 per month; and MHP assessed approximately 100 refugee members identified by Missouri State for lead testing, immunizations, and well visits.

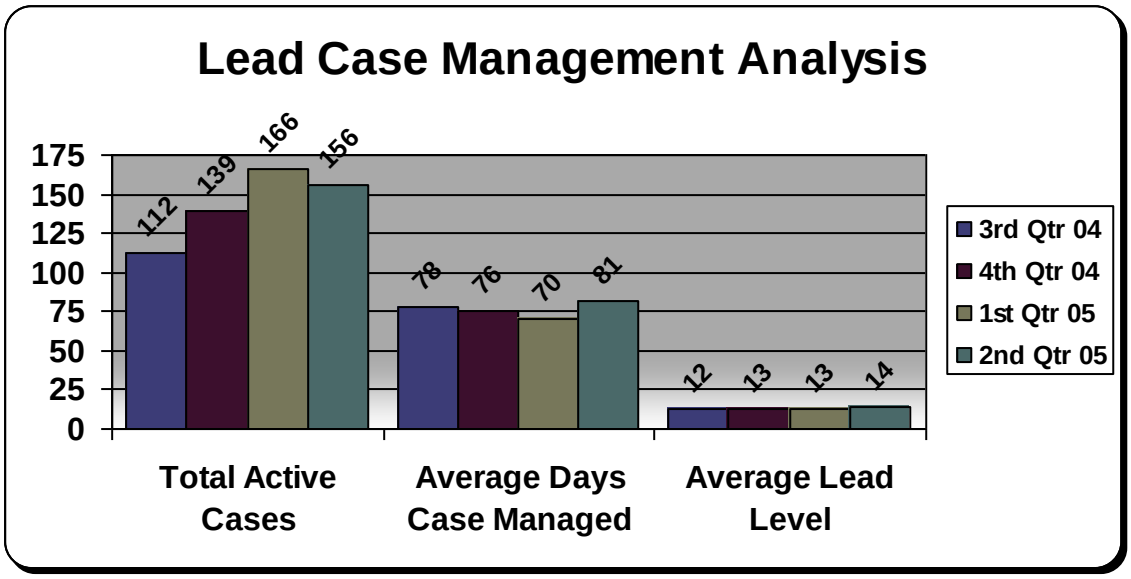
Children with blood lead levels of 10-14 ug/dl are followed for care coordination, which includes notification and monitoring of all lead levels, lead prevention education, and support. Children with blood lead levels ≥ 15 ug/dl are monitored closely, with care coordination and referral to a home health agency for assessment and lead prevention education. In addition, children with blood lead levels of ≥20 ug/dl are referred to appropriate public health agency for home environmental lead risk assessment.

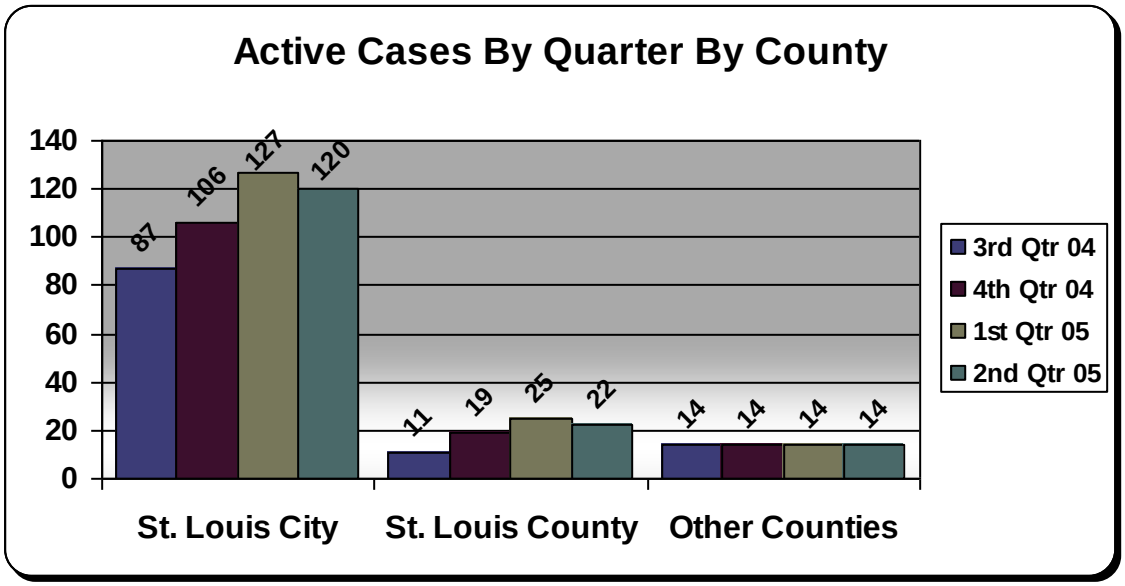
The index formula established to track the effectiveness of the program across all venues of care is: Initial Lead Level over Most Current Lead Level.

Indexes greater than 1.0 indicate progress in the treatment of lead poisoning. The overall program index average was 1.24 as of June 30, 2005 (See attachment "D" – Lead Report 2nd Quarter 2005)

2005 Interventions

- Revised and implemented the CCMS Lead Assessment/Care Plan to reflect changes made to the MC+ Policy Statement of Lead Prevention;
- Upgraded to CCMS 3.1 which included a graph feature to reflect the impact the program has had on each members lead level;
- Implemented the new Missouri State DHSS Access database Lead Poisoning Case Management Report on members with lead levels ≥20;
- Participated in St. Louis City Physician Outreach campaign to increase physician awareness of the need for lead testing;
- Participated in MHP effort to expand community resources with Nurses for Newborns and Catholic Family Services; and
- Participated in Missouri State MC+ Lead Poisoning Prevention campaigns "Protect Your Family" and "Put a Lid on Lead".





Key:

Total Active Cases-Number of members who were case managed at any given time during the reporting Quarter.

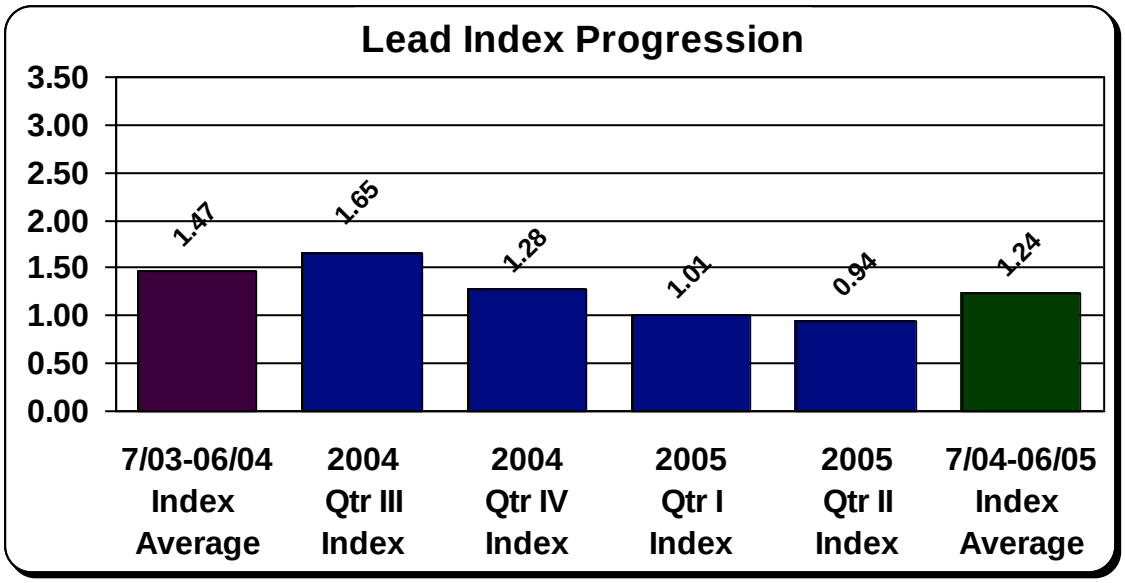
Average Days Case Managed-Average number of days in case management during the quarter

Average Lead Level-Average of Current Lead Levels obtained on active members during the reporting quarter.

Lead Index Progression

Analysis:

Target: Index > 1



Key:

Quarterly Index = *Previous (quarter) Lead Level/Most Current Lead Level*

Index Average = *Sum of all individual quarterly indexes for the rolling year/count of individual indexes for a rolling year.*

Interpretation Key:

<1 is an increase in the lead toxicity level

=1 means no change in lead toxicity level

>1 is a decrease in the lead toxicity level

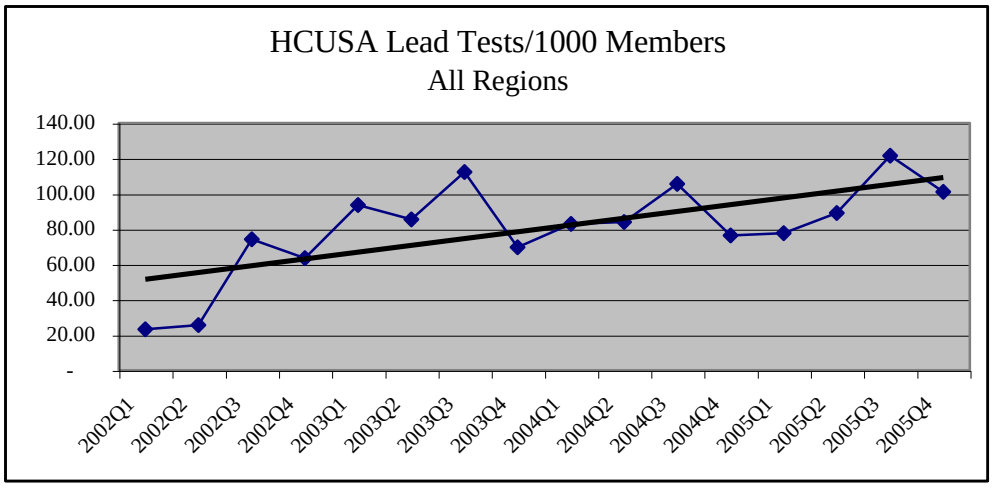
HealthCare USA (HCUSA) In Eastern, Central and Western Regions

Information Obtained From HCUSA's 2005 Annual Evaluation

LEAD:

HealthCare USA recognizes that childhood lead poisoning is the number one environmental hazard facing children in Missouri. The Complex Case Manager for Lead Toxicity coordinates follow-up care for lead screening and educates the family and/or community on the issues and treatment of lead toxicity. In 2005, the average number of members identified and receiving complex case management services for lead was 931. These services have been beneficial in improving the members follow up care related to lead poisoning.

HealthCare USA has been able to demonstrate via claims data that more children are being tested for lead. The graph below shows the marked improvement by HealthCare USA since 2002 in screening its members for lead exposure.



Source: Paid Claims through December 2005

HealthCare USA continues to partner with communities, members and providers to create awareness, improve testing scores and monitor the on-going effectiveness of the program.

Here is one example…
"MW was identified with elevated blood lead levels during her annual HCY/EPSDT visit in May 2005. HealthCare USA's lead case manager initiated personalized outreach and educational activities while providing on-going follow-up in collaboration with the child's PCP. She contacted the St. Louis City Department of Health to conduct a home inspection. The home was determined to be lead-contaminated. HealthCare USA's lead case manager helped the family find alternative housing, and the child's lead levels have declined to an acceptable range."

Missouri Care

Information Obtained From Missouri Care's 2005 Annual Evaluation

Performance Improvement Projects

Clinical - Lead Initiative

Missouri Care expanded its lead outreach program in 2005 in recognition of the dangers of lead poisoning and the importance of lead testing and screening. Missouri Care surveyed PCPs on their current lead testing practices and on their perceived barriers to lead testing in order to better target its lead interventions. The results of the survey indicated that there were no consistent lead testing practices among providers. Additionally, providers noted personal attitudes, parent compliance and lab-testing issues as the top three barriers to blood lead testing. Based on the survey results, a multifaceted intervention was developed to target providers and members.

Provider Interventions

The first part of the intervention was to send a letter to providers reminding them of current state testing guidelines and the dangers of lead poisoning. The letter highlighted a recent case of a member in the Missouri Care network with elevated blood lead levels. The mailing also contained the results of the provider survey and a fact sheet with lead resources for providers. The letters were followed by visits from Missouri Care provider relations representatives, who distributed additional information to providers' office managers. In addition, a provider "toolkit" was created that can be accessed on the Missouri Care Web site. The toolkit provides links to useful information and will display updates on the progress of the lead initiative. Providers were notified of the toolkit during the provider relations representatives' visits and through the Missouri Care provider newsletter.

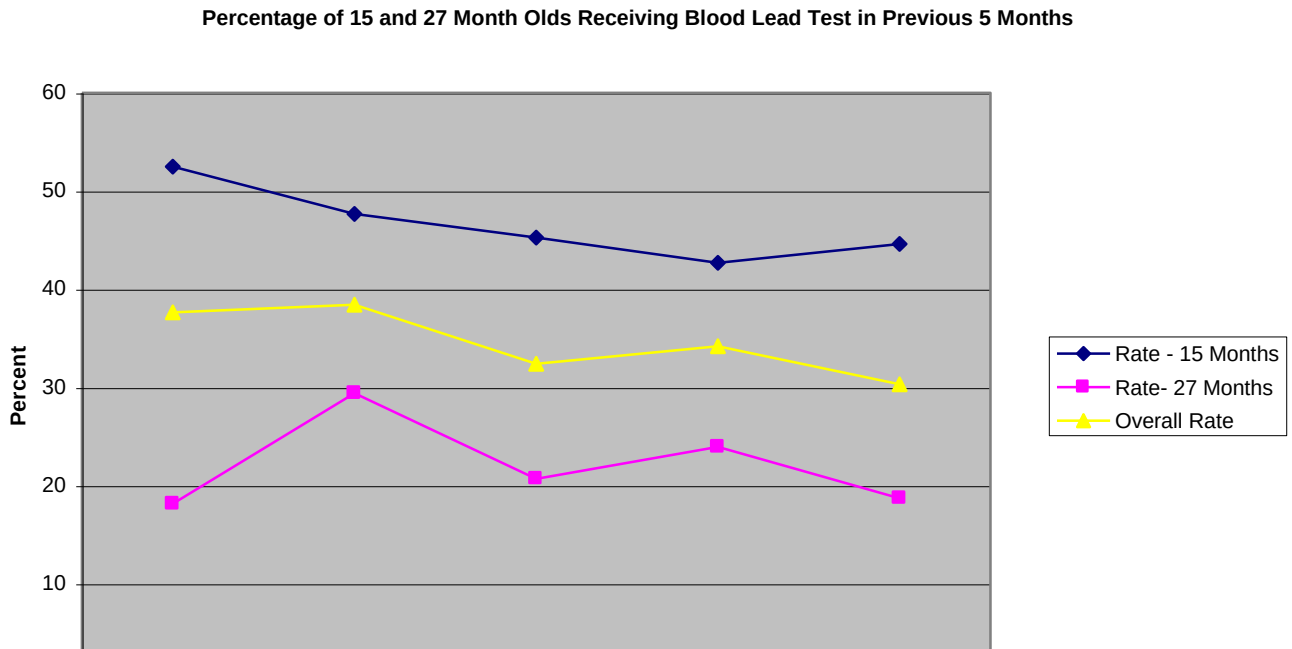
Member Interventions

The intervention also targeted members because one of the barriers identified by providers was parent compliance with testing. Missouri Care strengthened its lead outreach to members by:

- Including a message on the importance of lead testing on the on-hold phone messaging system
- Placing an article on lead in the member newsletter
- Mailing lead information to members who indicated on their state enrollment form that they needed more information on lead
- Distributing lead information at health, back-to-school and maternity fairs

Outcome

Just recently, the State began providing health plans with complete blood lead testing information on their members. This information from calendar year 2005 will be used to evaluate the effectiveness of the above interventions. The study indicator is the percentage of Missouri Care members ages 11 to 15 months and 23 to 27 months receiving blood lead-level testing. As we receive the lead-testing data, we will continually monitor our rates and continue or enhance our lead initiatives as necessary. As of March 2006, data were only available from January through October 2005. Given our age ranges of 11 to 15 and 23 to 27 months, the rates we can produce are limited to a five-month period (see graph below for preliminary rates).



WESTERN REGION

Blue-Advantage Plus of Kansas City, Inc. (BA+)

Information Obtained From BA+'s 2005 Annual Evaluation

Lead – Clinical Performance Improvement Project (PIP)
The BA+ Lead Performance Improvement Project was initiated for the BA+ population in March of 2004. Rationale for initiating this new project included new lead testing guidelines from the State of Missouri, which designated Jackson County as a high risk county, mandated testing for children ages 3 to 6 in the high risk counties and current low lead testing rates overall. In Jackson County, all BA+ members under age 6 are to be tested annually for lead. All 12 and 24 month old children in BA+ in the entire service area are to have a blood lead test. Measures for the initial phase of the project are process measures for testing.

Objectives of the Lead Performance Improvement Project were to:

a. Educate BA+ members on the new lead testing guidelines and the importance of lead testing,
b. Educate BA+ providers on the new lead testing guidelines and the importance of lead testing, and
c. Identify at least two partners outside BCBSKC staff to participate with the lead project.

The Lead Initiative Committee continued to meet on a monthly basis during 2004 and through May of 2005, and have engaged Children's Mercy Health Network and LabOne as participating partners on the project. The project has met all current goals as stated in the initial Work Plan, with member and physician interventions mailed on target dates.

Interventions that were done in 2005:

a. A lead testing promotion to PCPs was completed in 2005. It included the roll out of the dry blood spot filter paper method of capillary blood testing by LabOne. A gift bag of materials was taken to PCPs that contained information on lead testing with this method, notepads for the office to remind of lead testing, a dry erase board with messages about lead testing, picture frame with lead message, lead testing map and risk questionnaire. The packet also included well-child brochures and lead flyers, both in English and Spanish.
b. Distributed educational material on an as needed basis to children in lead case management.
c. Continued care coordination and case management of children with elevated lead levels by Children's Mercy Health Network.
d. Article in provider newsletter to explain new lead testing available from LabOne and procedures to use the new testing system.

e. Educated providers and plan members of higher rates of lead poisoning and the increasing number of risk factors in this population.
f. Informational materials taken to all BA+ PCPs concerning lead testing requirements, Missouri lead testing maps, available lead educational materials, member educational brochure and new testing procedures available from LabOne.
g. Mailing to all BA+ households containing a flyer on lead testing requirements and how to prevent lead poisoning (provided in English and Spanish).
h. Implementation of the LabOne capillary testing method.
i. Educating the local public health departments about the need for lead testing.

The reports indicate:

a. Number of members in each group panel who are under age 7 – report will show each year as an individual group and then will also show a total eligible,
b. Number and percent of those individuals in the eligible group who had on office visit in the time period reviewed (opportunities), and
c. Number and percent of those with an opportunity that received a lead test in the same time period.

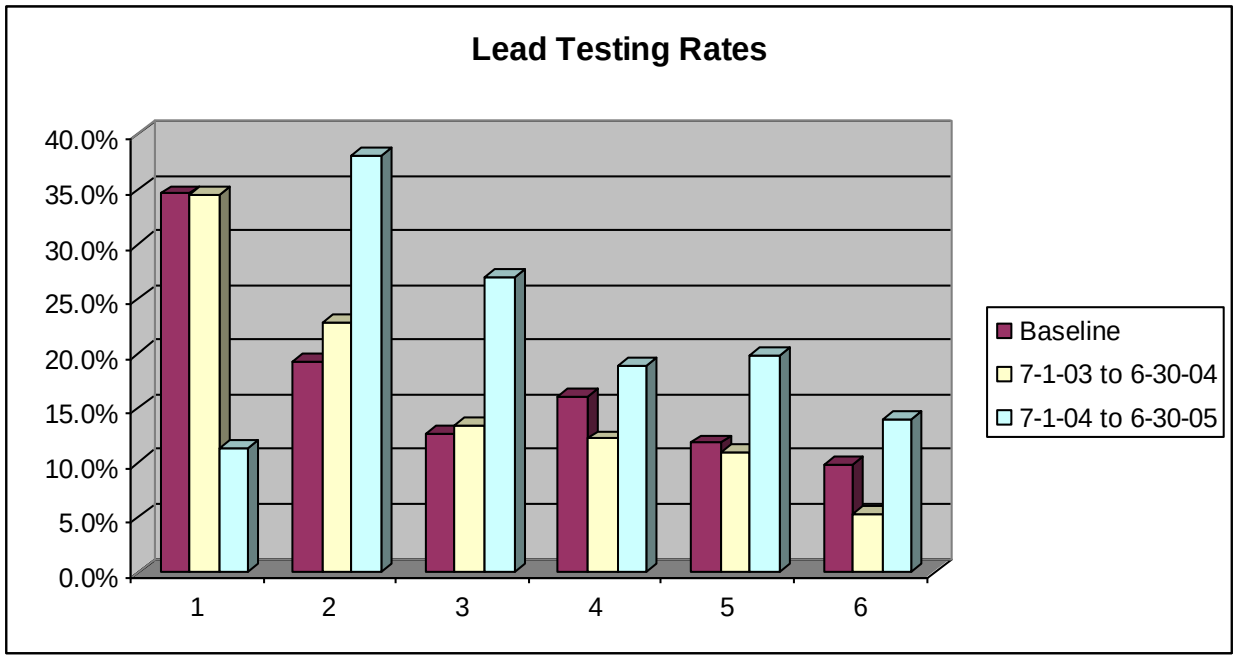
The outcome of this project was a significant improvement in the lead testing rates for all of the BA+ population, as well as the Jackson County population, for the eligible 2-6 year olds.

Total BA+ Population – Member Count by Member Age

	1	2	3	4	5	6	Grand Total
Total # with Lead Test	122	514	283	219	203	156	1497
Total # of Eligible Members	932	823	879	997	938	997	5594
Baseline Percentage	33.4%	18.3%	12.6%	14.7%	12.4%	9.2%	16.8%
6 months percentage	11.6%	38.4%	24.4%	18.0%	17.8%	13.5%	21.2%

Jackson County Population – Member Count by Member Age

	1	2	3	4	5	6	Grand Total
Jackson County with Lead Testing	77	322	204	153	150	110	1016
Jackson County Eligible Members	600	524	553	656	609	673	3615
Baseline Percentage	34.6%	19.2%	12.7%	16.0%	11.8%	9.8%	17.4%
6 months percentage	11.4%	38.1%	26.9%	18.9%	19.8%	14.0%	21.9%



Age	Baseline	7-1-03 to 6-30-04	7-1-04 to 6-30-05
1	34.6%	34.5%	11.4%
2	19.2%	22.8%	38.1%
3	12.7%	13.4%	26.9%
4	16.0%	12.2%	18.9%
5	11.8%	11.0%	19.8%
6	9.8%	5.3%	14.0%

FirstGuard Health Plan

Information Obtained From FirstGuard Health Plan 2005 Annual Evaluation

Lead

FirstGuard continued activities with families of children 0 – 6 years with elevated blood lead levels (a level of 10 or greater) in 2005 for both Missouri and Kansas populations. The goals of the project were twofold: to increase the percentage of successful contacts between FirstGuard and the identified families and to increase the percentage of the children in care management.

FirstGuard continued to collaborate with the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Social and Rehabilitative Services (SRS) to improve

identification of children who have elevated blood lead levels for initiation and stratification of case management.

Children's Mercy Family Health Partners (CMFHP)

Information Obtained From CMFHP 2005 Annual Evaluation

Children's Mercy Family Health Partners
Lead
Performance Improvement Project
2004-2006

Definitions

OAO – Computer system for claims adjudication and authorizations
PCP – Primary Care Physician

Study Topic

Children's Mercy Family Health Partners (CMFHP) has chosen a performance improvement project designed toward improving lead screening rates among members between the ages of 6 months and 3 years. The project plan and design will be done through the CMFHP Special Healthcare Needs (SHCN) Committee members, which include the Director of Health Services, the Manager of Health Services, Pediatric Case Managers, an Adult Case Manager, the Lead/SHCN Case Manager, the SHCN Coordinator, and a Utilization Review Nurse. The CMFHP Utilization Management/Medical Director Committee will have primary oversight of the project, with quarterly reporting to the CMFHP Medical Management Committee.

The project will involve outreach and input from physicians, through the CMFHP Medical Management Committee, and community agencies involved in lead screening for CMFHP members. Interventions to date include general immunization and lead reminders through member and provider newsletters and distribution of well child information through various community events. CMFHP is interested in focusing specific outreach activities at children identified as living in high-risk areas for lead toxicity. All children ages 12 and 24 months in high risk areas should be tested for lead.
The CMFHP Special Healthcare Needs Committee has chosen the topic of lead screening due to its evaluation of current screening rates, as well as recent changes in lead screening requirements (i.e. universal testing areas). Although lead screening rates have continued to increase year after year, there is consensus in the committee that the rates could and should be much higher than they currently are. CMFHP has completed focused studies on lead screening rates since 1999. Data is reviewed annually to determine the percentage of members screened for lead through the CMFHP claims database. This annual analysis was the impetus for the performance improvement project.

Description of Intervention

Interventions:

- *Identification of members eligible with CMFHP as of a determined date, who are between the ages of 6 months and 3 years of age and who have been continuously enrolled since birth:*
  - A report will be run from the CMFHP eligibility system, identifying members meeting the parameters
- *Further identification of those within that specified group who have no lead testing claim in the CMFHP system:*
  - A report will be run identifying those with no lead testing claim in the system from birth to current date
  - Lead testing codes used to identify claims include: G0001LD, G0001RX, G0001PR, G0001UA, 99499LD, 99499UA, 83655, and 83655TC.
- *Interventions to identified members with no lead screening:*
  - Send lead information letter to those identified members ages 6 months to 12 months – educate on the importance of scheduling an EPSDT and lead testing at 12 months of age
  - Identify members from data file ages 12 months to 36 months with no lead testing claim
  - Send educational letter to all members identified as 12 months to 36 months with no lead testing claim
  - Further stratify those members in Jackson County between the 5 highest risk zip codes (64050, 64052, 64053, 64066, and 64088) and all other zip codes in Jackson County
  - Perform phone call outreach to members residing within the 5 highest risk zip codes in Jackson County – track outcome of those calls (i.e. reached, unable to reach, appointment scheduled, etc.)
  - Send PCP's identified from member listing a letter notifying of their member(s) who need lead testing performed
- *Education to the Health Departments in CMFHP's service area regarding appropriate coding and billing for lead screening tests:*
  - Meet with Provider Relations to identify current testing and case management codes
  - Test codes in OAO to ensure accurate adjudication
  - Develop a Quick Reference Guide (QRG) for appropriate codes to take to all Health Departments identified
  - Educate Health Department staff on QRG and accurate coding/billing practices
- *Increase access to lead testing and case management for CMFHP members:*
  - Educate providers and members on lead testing guidelines:
    - Send laminated lead QRG to network PCP offices
    - Add lead information to quarterly member newsletter
    - Add lead information to quarterly provider newsletter
    - Add new brochures to member OB packets
    - Add lead as risk factor to Pregnancy Notification Form (PNF)

- Identify out of network providers for lead filter testing
- Contract with Tamarac for lead filter testing in provider offices
- Review Health Department contracts to ensure lead case management services are included

Hypotheses

Children whose parents receive reminder calls and/or letters containing education about lead toxicity and prevention will be more likely to:

- ✓ Schedule a well child visit
- ✓ Receive a blood lead level test
- ✓ Be identified with lead toxicity; and

Less likely to:

- ✓ Have sick child visits
- ✓ Be hospitalized for chelation therapy

Study Questions

This study is designed to answer the following questions:

1. Do letters and reminder calls to children identified as needing blood lead testing result in increased lead testing for those children?

2. Do letters and reminder calls to children identified as needing blood lead testing result in increased referrals to Case Management for high lead levels (i.e. greater than 10 u/dL)?

Indicators

Rate of blood lead testing per member of the study population. (Goal = 75%) Every 3 months, claims data for the study population will be queried to determine if blood lead level testing has been performed.

Rate of case management cases referred for blood lead level greater than 10 u/dL. Every 3 months, the case management database will be queried to determine if referrals to case management have increased since implementation of the project.

Study Population

The study population included in this project will be children continuously enrolled with CMFHP since birth, who are between the ages of 6 months and 3 years of age.

Sampling Methods

No sampling method will be used. All children who meet the criteria for the study population will be targeted for intervention.

On a semi-annual basis, the eligibility files will be queried to add new members into the study based on established criteria. This is scheduled to occur April 1st and October 1st of each year.

Data Collection

Baseline data on the study population has already been collected, as this study is focusing on members identified with no lead screening claim. Following implementation of the interventions, claims data for the study population will be queried every 3 months in order to evaluate the effectiveness of the interventions. Data will be tracked in excel spreadsheets for ongoing monitoring and reporting of outcomes.

Data Analysis

Data analysis will be performed through the use of control charts, measuring the pre and post intervention effectiveness of both the mailings and the phone interventions. The members who are not able to be contacted will serve as the control group. Analysis will be conducted separately for the 6 month to 1 year old group and the 1 year old to 3 year old group.

Project Implementation

Data will be requested from the CMFHP information system (OAO) to determine the study population and for ongoing claims analysis. Claims for the study population will be analyzed every 3 months following implementation.

The project team will meet monthly through the Special Healthcare Needs Committee for planning and discussing the collection of data, implementation of interventions, and evaluation of the project's progress.

A quarterly summary of the project will be provided to the Medical Management Committee for physician input.

A quarterly update will be provided to the Utilization Management/ Medical Director Committee for internal stakeholder input.

A summary of the project will be provided to the Consumer Advisory Committee for consumer/member input.

Post Intervention Analysis

7/15/05 Study Group 1

The first claims data was reviewed from Study Group I. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. This group received letter intervention educating them about their upcoming

EPSDT visit and the need for a blood lead level test. There were a total of 757 members identified for this study group. Letters were sent to these members on 11/12/04. Claims data was pulled on 6/1/05 to identify at least one blood lead level draw on these members from dates of service 11/12/04-5/31/05. Of the 757 members, 468 (or 62%) had a claim for a blood lead level in that timeframe. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 485 out of 774 continuously enrolled members now have a lead screening claim in the system, which is a 63% lead screening rate.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. This group received letter intervention educating them about the need for blood lead level screenings at 12 and 24 months. There were a total of 3,140 members identified for this study group. Letters were sent to these members on 12/10/04. Claims data was pulled on 6/1/05 to identify at least one blood lead level draw on these members from dates of service 11/12/04-5/31/04. The baseline for this group is zero, as any member with a previous blood lead level claim had been excluded from the study group prior to the intervention. Of the 3,140 members, 1,901 (or 61%) had a claim for a blood lead level in that timeframe. In looking

at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 3,129 out of 4,368 continuously enrolled members now have a lead screening claim in the system, which is a 72% lead screening rate.

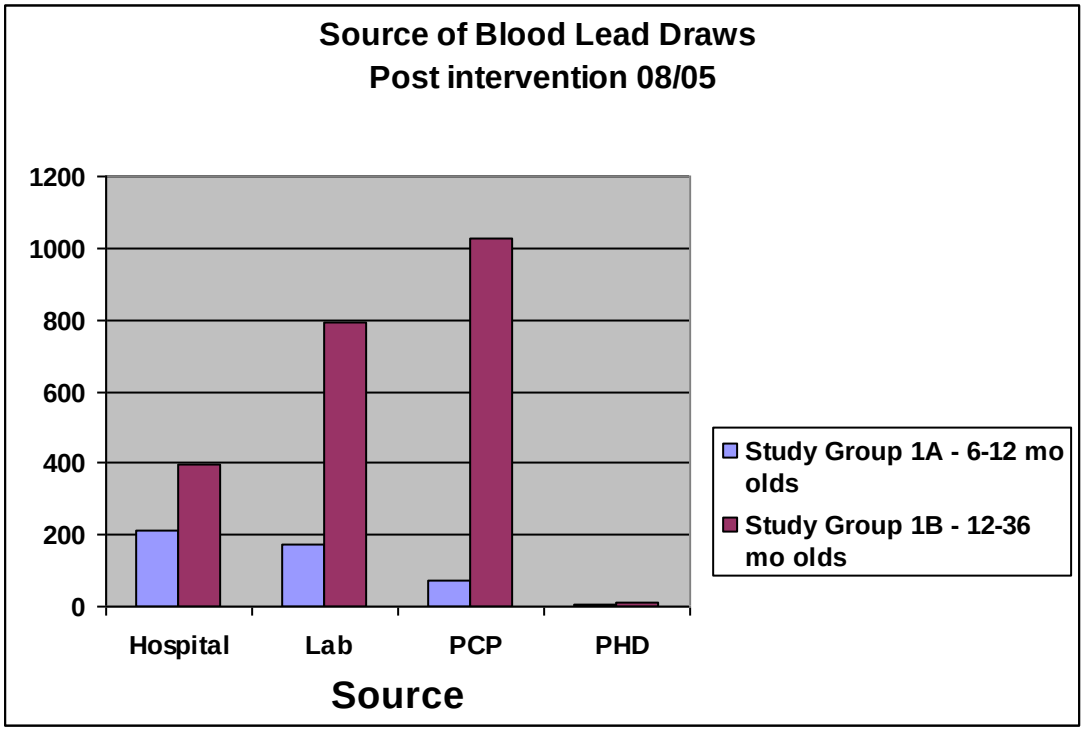
Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. There were 203 members identified for Group 1C. This group received the letter intervention on 12/10/04, as described in the paragraph above, but they also received an additional phone intervention from a Health Services staff member. During the phone intervention to these 203 members, only 67 members (or 33%) were successfully contacted. Claims data was pulled on 6/1/05 to identify at least one blood lead level draw on these members from dates of service 11/12/04-5/31/04. Of the 203 members, 134 (or 66%) had a claim for a blood lead level in that timeframe. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 178 out of 247 continuously enrolled members now have a lead screening claim in the system, which is a 72% lead screening rate.

Lead Case Management referrals were reviewed in the 10 month timeframe since initiation of this project as well. Baseline data of referrals from 3/03 to 8/04 showed an average of 7.6 referrals per month. In the timeframe between 9/04 and 6/05, average referrals were 7.7 per month.

Analysis of Results:
Considering CMFHP's average lead levels for the overall population in 2003 and 2004 were 20-28%, the results of demonstrated blood lead level testing from this initial intervention are significant. Per the study guidelines, claims data will continue to be evaluated on an every 3 month basis. In addition, a second study group was initiated starting in April 2005.

Lead case management referrals have not changed significantly in this initial analysis.

08/16/05 Additional analysis was completed on both Study Groups 1A and 1B concerning the source of blood lead screening for the member's who have now rec'd lead screening. The following table outlines the data collected related to the source of blood lead draw claims.



Post Intervention Analysis

10/15/05 Study Group 1
The second claims data was reviewed from Study Group I. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. Claims data since intervention now demonstrates that 484 out of 757 members have a lead screening claim in the system, which is 64%. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 501 out of 774 continuously enrolled members now have a lead screening claim in the system, which is a 65% lead screening rate.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. Claims data since intervention now demonstrates that 1,953 out of 3,140 members have a lead screening claim in the system, which is 62%. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the

intervention, a total of 3,181 out of 4,368 continuously enrolled members now have a lead screening claim in the system, which is a 73% lead screening rate.

Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. Claims data since intervention now demonstrates that 139 out of 203 members have a lead screening claim in the system, which is 68%. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 183 out of 247 continuously enrolled members now have a lead screening claim in the system, which is a 74% lead screening rate.

Lead Case Management referrals were reviewed in the 14 month timeframe since initiation of this project as well. Baseline data of referrals from 3/03 to 8/04 showed an average of 7.6 referrals per month. In the timeframe between 9/04 and 10/05, average referrals were 8.3 per month. In trending overall lead case management referrals from March 2003 through October 2005, referrals have increased by 57%.

Analysis of Results:
Considering CMFHP's average lead levels for the overall population in 2003 and 2004 were 20-28%, the results of demonstrated blood lead level testing from this initial intervention are significant. Per the study guidelines, claims data will continue to be evaluated on an every 3 month basis. Claims data from Study Group 2 will be analyzed beginning in December 2005. In addition, a third study group was initiated starting in October 2005.

02/21/06 Study Group 1
The third claims data was reviewed from Study Group I in December 2005. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. Claims data since intervention now demonstrates that 486 out of 757 members have a lead screening claim in the system, which is a 64% screening rate for the members in the study.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. Claims data since intervention now demonstrates that 1,974 out of 3,140 members have a lead screening claim in the system, which is a 63% screening rate for the members in the study.

Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. Claims data since intervention now demonstrates that 150 out of 203 members have a lead screening claim in the system, which is a 74% screening rate for the members in the study.

Study Group 2
The initial claims data was reviewed from Study Group 2 in December 2005. In the Study Group, 3 groups were identified and labeled as 2A, 2B, and 2C. Members who were already included in Study Groups 1A, 1B, or 1C were excluded from Study Group 2.

Group 2A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months and not already included in Study Group 1A. This group received letter intervention educating them about their upcoming EPSDT visit and the need for a blood lead level test. There were a total of 706 members identified for this study group. Letters were sent to these members on 6/16/05. Claims data was pulled on 12/1/05 to identify at least one blood lead level draw on these members from dates of service 6/16/05-11/30/05. Of the 706 members, 353 (or 50%) had a claim for a blood lead level in that timeframe.

Group 2B represents all members continuously enrolled since birth between the ages of 12 months and 36 months and not already included in Study Group 1B. This group received letter intervention educating them about the need for blood lead level screenings at 12 and 24 months. There were a total of 330 members identified for this study group. Letters were sent to these members on 6/16/05. Claims data was pulled on 12/1/05 to identify at least one blood lead level draw on these members from dates of service 6/16/05-11/30/05. The baseline for this group is zero, as any member with a previous blood lead level claim had been excluded from the study group prior to the intervention. Of the 330 members, 62 (or 19%) had a claim for a blood lead level in that timeframe.

Group 2C is a subgroup of Group 2B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area and not already included in Study Group 1C. There were 21 members identified for Group 1C. This group received the letter intervention on 6/16/05, as described in the paragraph above, but they also received an additional phone intervention from a Health Services staff member. During the phone interventions to these 21 members, 6 members (or 29%) were successfully contacted. Claims data was pulled on 12/1/05 to identify at least one blood lead level draw on these members from dates of service 6/16/05-11/30/05. Of the 21 members, 4 (or 19%) had a claim for a blood lead level in that timeframe.

Analysis of Results:
Initial results from this study groups 2B and 2C are not as significant as they were for study groups 1B and 1C, however, the study population was smaller and the phone interventions were less successful in this study group. Per the study guidelines, claims data will continue to be evaluated on an every 3 month basis for this study group. Initial results for Study Group 3 will be obtained in June 2006.

CMFHP has decided, based on the initial results from Study Groups 1 and 2, that a process will be established in 2006 to perform these interventions on all CMFHP members between the ages of 6 months and 36 months twice a year, regardless of continuous eligibility status.

03/29/06 Study Group 1
The final claims data was reviewed from Study Group I in March 2006. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. Claims data since intervention now demonstrates that 498 out of 757 members have a lead screening claim in the system, which is a 66% screening rate for the members in the study.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. Claims data since intervention now demonstrates that 2,010 out of 3,140 members have a lead screening claim in the system, which is a 64% screening rate for the members in the study.

Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. Claims data since intervention still demonstrates that 150 out of 203 members have a lead screening claim in the system, which remains at a 74% screening rate for the members in the study.

Study Group 2
The second quarterly claims data was reviewed from Study Group 2 in March 2006. In the Study Group, 3 groups were identified and labeled as 2A, 2B, and 2C.

Group 2A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months and not already included in Study Group 1A. Claims data since intervention now demonstrates that 382 out of 706 members have a lead screening claim in the system, which is a 54% screening rate for the members in the study.

Group 2B represents all members continuously enrolled since birth between the ages of 12 months and 36 months and not already included in Study Group 1B. Claims data since intervention now demonstrates that 78 out of 330 members have a lead screening claim in the system, which is a 24% screening rate for the members in the study.

Group 2C is a subgroup of Group 2B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area and not already included in Study Group 1C. Claims data since intervention now demonstrates that 5 out of 21 members have a lead screening claim in the system, which is a 24% screening rate for the members in the study.

Analysis of Results:
Continue to monitor quarterly results for study groups 2 and 3. Study group 3 will have initial post-intervention results evaluated in June 2006. Study Group 1 has completed a full one year post-intervention analyses, therefore, no further data review on Study Group 1 will be conducted. Due to the success of this intervention, beginning in July 2006, CMFHP will implement this initiative as a semi-annual intervention to all members between the ages of 6 months and 36 months.

Children's Mercy Family Health Partners
2005 Lead Screening Performance Improvement Project
Study Group 1

Study Population:

Study Group	Date of eligibility pull	Total number eligible members	Total number continuously enrolled	Total number with no lead screening claim in the system since birth	Percent of eligible members included in study	Type of intervention	Date intervention completed	% of members reached through intervention
1A 6-11.9 months	08/04	1190	774	757	65%	Mail	11/12/04	96% *based on return mail rate of 4%
1B 12-36 months	08/04	5366	4368	3140	81%	Mail	12/10/04	84% *based on return mail rate of 16%
1C 12-36 months living in 5 high risk Jackson Counties	08/04	N/A – included in above	N/A – included in above	203	N/A – included in above	Phone	1/31/05	33%

Pre-Intervention Data:

Study Group	Average lead screening rates in 2003	Average lead screening rates in 2004	Overall averages for 2 years prior to study intervention
1A	24%	15%	20%
1B	37%	20%	28%
1C	Same as 1B	Same as 1B	Same as 1B

Post-Intervention Data:

Study Group	6/1/05 claims analysis	9/1/05 claims analysis	12/1/05 claims analysis	3/1/06 claims analysis
1A	62%	64%	64%	66%
1B	61%	62%	63%	64%
1C	66%	68%	74%	74%

Children's Mercy Family Health Partners
2005 Lead Screening Performance Improvement Project
Study Group 2

Study Population:

Study Group	Date of eligibility pull	Total number eligible members	Total number continuously enrolled and non-duplicated from SG1	Total number with no lead screening claim in the system since birth	Type of intervention	Date intervention completed	% of members reached through intervention
2A 6-11.9 months	4/1/05	1253	706	706	Mail	6/16/05	Not measured for SG2
2B 12-36 months	4/1/05	5460	1136	330	Mail	6/16/05	Not measured for SG2
2C 12-36 months living in 5 high risk Jackson Counties	4/1/05	N/A – included in above	N/A – included in above	21	Phone	6/30/05	29%

Pre-Intervention Data:

Study Group	Average lead screening rates in 2003	Average lead screening rates in 2004	Overall averages for 2 years prior to study intervention
2A	24%	15%	20%
2B	37%	20%	28%
2C	Same as 2B	Same as 2B	Same as 2B

Post-Intervention Data:

Study Group	12/1/05 claims analysis	3/1/06 claims analysis	6/1/06 claims analysis	9/1/06 claims analysis
2A	50%	54%		
2B	19%	24%		
2C	19%	24%		

Children's Mercy Family Health Partners
2005 Lead Screening Performance Improvement Project
Study Group 3

Study Population:

Study Group	Date of eligibility pull	Total number eligible members	Total number continuously enrolled and non-duplicated from SG1&2	Total number with no lead screening claim in the system since birth	Type of intervention	Date intervention completed	% of members reached through intervention
3A 6-11.9 months	10/1/05	1637	1631	1389	Mail	1/15/06	Not measured for SG3
3B 12-36 months	10/1/05	4783	3462	1717	Mail	1/15/06	Not measured for SG3
3C 12-36 months living in 5 high risk Jackson Counties	10/1/05	N/A – included in above	N/A – included in above	41	Phone	12/31/05	27%

Pre-Intervention Data:

Study Group	Average lead screening rates in 2003	Average lead screening rates in 2004	Overall averages for 2 years prior to study intervention
3A	24%	15%	20%
3B	37%	20%	28%
3C	Same as 3B	Same as 3B	Same as 3B

Post-Intervention Data:

Study Group	6/1/06 claims analysis	9/1/06 claims analysis	12/1/06 claims analysis	3/1/07 claims analysis
3A				
3B				
3C				

CHILDREN WITH SPEACIAL NEEDS CASE MANAGEMENT

EASTERN REGION

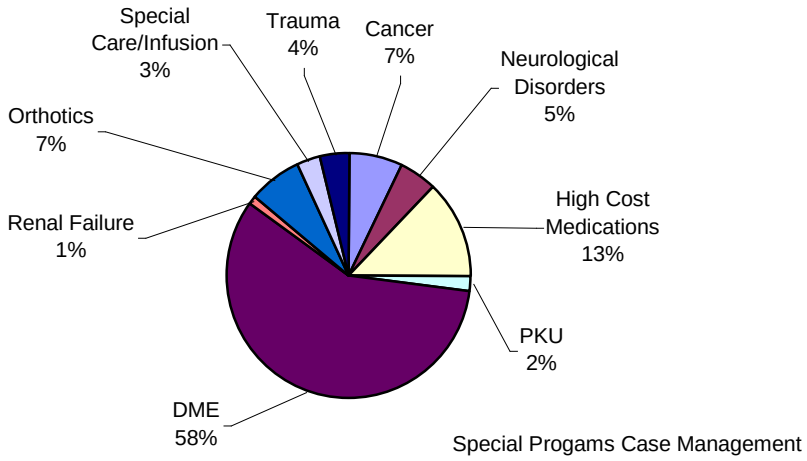
Community Care Plus (CCP)

Information Obtained From CCP's 2005 Annual Evaluation

Children with Special Needs

Community Care Plus (CCP) continues to increase identification and outreach to children with special health care needs. An electronic file of children, with special health care needs, identified by the State Agency is sent monthly to Community Care Plus. The data is divided among three case managers and contact is made to the member or guardian by phone or mail. Children who develop special needs through illness, injury or premature birth are identified by CCP's inpatient certification review staff and referred to the Special Needs/Outreach Coordinator. The intent of this program is to identify members with special needs, coordinate care and initiate case management services. There were a total of 29 special needs cases identified in 2005. Members identified with cancer increased to 18 in 2005 with 19 repeat admissions within 30 days of an inpatient hospitalization due to a carcinoma related diagnosis.

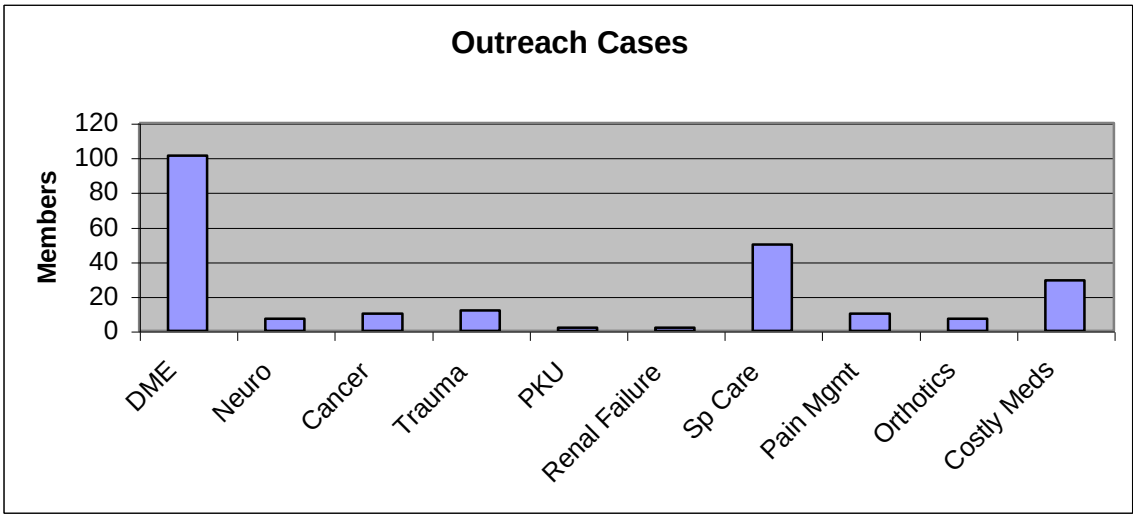
Case management is provided for members with chronic conditions such as Hepatitis C, Inflammatory Bowel Disease, Growth Hormone Deficiency, Bleeding Disorders, etc. Coordination of care and services were provided on an outpatient basis and only 3 members were readmitted within 30 days of an inpatient hospitalization with a related diagnosis.



Special Progams Case Management

The Special Needs/Outreach Coordinator provides case management to the most catastrophic, chronic and at risk members. This involves early identification of complex; long-term cases i.e. trauma, genetic disorders, paralyzed and disabled members, etc. This Registered Nurse provides education on the disease process; assessments of the health care needs and coordinates the health care services. The Special Needs/Outreach Coordinator works collaboratively with the PCP,

specialists and ancillary services to promote optimum outcomes for the members. Monthly phone calls are made to members to follow up, to educate and to evaluate the member's progress. Contact is maintained until the member's health is restored. The readmission rate of members receiving case management was 13% for 2005. A large percentage was members with congenital conditions and chronic diseases such as cancer and fibrosis.



Mercy MC+

Information Obtained From Mercy's 2005 Annual Evaluation

Special Needs

Mercy Health Plans continues to assess members identified for special healthcare needs. These members predominately include children with chronic and catastrophic conditions, mental health and psychosocial needs and those in foster or State care. A social work case manager reviews the MC+ special health care needs monthly report to identify opportunities for case management intervention. Once identified these members are referred for medical and mental health case management. Additionally, MC+ Members Service Representatives may identify a special need through outreach and new member welcome calls.

HealthCare USA (HCUSA)-In Eastern, Central and Western Regions

Information Obtained From HCUSA's 2005 Annual Evaluation

CHILDREN WITH SPECIAL HEALTHCARE NEEDS

The Special Needs Department is comprised of three Licensed Practical Nurses that are responsible for screening those members identified as Special Needs by the State of Missouri, Division of Medical Services during initial enrollment. During the screening process, the coordinator determines whether the member will benefit from Complex Case Management and makes referrals accordingly.

The Special Needs Coordinators (SNC) attempted to reach 1,757 members during the year. The Special Needs Department of HCUSA had a 24%, assessment completion rate with only 3% of those members requiring or wanting intensive follow up or intervention from HCUSA nurses. Members identified as having Special Needs being unreachable by phone or mail in 2005 was10%. HCUSA continues to look for ways to improve connectivity rates.

In 2005 HCUSA worked diligently with the Division of Medical Services to improve the number of dental visits to children in Jackson County in the western region. The Special Needs Coordinator responsible for HCUSA's western region actively participated on the work group and presented information to case workers and other state staff. As a result dental access has been improved in this region.

2006 Goals:

The Special Needs Department will continue to improve the screening rate of special needs children and refer for case management and/or care coordination appropriately.

CENTRAL REGION

Missouri Care

Information Obtained From Missouri Care's 2005 Annual Evaluation

Special Health-Care Needs

Missouri Care receives a monthly file from the Division of Medical Services (DMS) identifying children with special health-care needs. Missouri Care implemented the following interventions in 2005 to meet the intense and diverse care requirements of children with special health-care needs:

- Had a Children with Special Health-Care Needs (CSHCN) Screener to identify children experiencing one or more current functional limitations or service use needs as a result of an on-going physical, emotional, behavioral, developmental or other health condition.
- Developed a specialized provider referral listing designed with the special health care needs of these members in mind, including various specialists and disciplines within the University of Missouri Hospitals and Clinics
- Collaborated with MO-PEDS to help families and primary care providers access comprehensive and coordinated care for children with special needs.

- Provided parents and guardians with a community-based resource directory
- Developed a case management database to automate and track identification, screening, and care coordination services of children with special health care needs

Missouri Care recognizes the challenges that families of children with special health-care needs encounter when navigating the health-care system. Missouri Care can help these members gain access to appropriate services via early identification. Missouri Care, in collaboration with University Hospital and Clinics and MO-PEDS, initiated a team approach to help families find comprehensive and coordinated care for children with special health-care needs.

WESTERN REGION

Blue-Advantage Plus of Kansas City, Inc. (BA+)

Information Obtained From BA+'s 2005 Annual Evaluation

SPECIAL NEEDS

The BA+ Special Programs Coordinator coordinates the flow for referrals made by the Division of Medical Services for members with Special Health Care Needs. BCBSKC has a policy and procedure that outlines the process followed. There are several attempts to reach the members on the list to screen them for potential case management needs. If they meet BCBSKC-BA+ case management criteria, they are further evaluated for case management. Screening tools are included in the policy and procedure. This process is followed by both the BCBSKC-BA+ Case Management department and the subcontracted case managers at Children's Mercy Health Network. Referrals are made as needed to New Directions Behavioral Health, the High Risk Prenatal program and the Asthma Disease State Management program. Three attempts are made to reach members on the list, two by phone and one by letter. If there is not a phone, a letter is sent immediately.

Utilizing the Special Health Care Needs disk to identify members with Special Health Care Needs is a requirement of DMS. BCBSKC reviews claim data to identify other members that might require case management services for Special Health Care Needs. BCBSKC continually reviews the screening tool and makes revisions to questions as deemed necessary. There is ongoing discussion about ways to increase the number of screenings that are done. Barriers that have been identified include incorrect addresses for mailings and lack of phone numbers or working phone numbers.

BA +Special Needs Statistics

	2003	2004	2005
# of Members on Special Needs List	566	623	597
Ages 0-6	234	243	210
Total 0-6 Screened	17	15	19
Number ages 0-6 in case management with Children's Mercy Health Network when disk arrived	32	38	10

Ages 7 and up	327	354	387
Total age 7 and up screened	52	77	58
Number ages 7 and up in case management with BA+ when disk arrived	0	0	1
Number in case management with New Directions when disk arrived	1	0	5
In consent decree case management with Samuel Rodgers or Swope Parkway Health Centers.	77	91	52
Had a phone number listed but could not be contacted	124	180	178
Member had no phone number	189	138	125

FirstGuard Health Plan

Information Obtained From FirstGuard Health Plan's 2005 Annual Evaluation

Special Needs

Clinical studies continued in 2005 to measure and improve case management services for children with special health care needs. The studies measured the enrollment into case management for members identified by the respective State agency as Children with Special Health Care Needs (CSHCN). The study was retired at the end of 2005 following demonstration of consistently high identification of CSHCN and development of treatment plans for members able to be contacted. These remain routine CSHCN processes following completion of study interventions.

Children's Mercy Family Health Partners (CMFHP)

Information Obtained From CMFHP's 2005 Annual Evaluation

Members with Special Health Care Needs

CMFHP has dedicated a full-time Outreach Coordinator to identify and screen our Special Health Care Needs population. In 2005 through monthly disks from the state, CMFHP's Special Health Care Needs Outreach Coordinator identified the following number of individuals within our membership that had special health care needs:

Year	Identified SHCN members	Number of SHCN members already in CM when identified	Number of SHCN members screened	Number in Consent Decree
2005	1164	15	878	271

The Special Health Care Needs Coordinator identifies members who are not already in case management, attempts to screen the member through phone outreach calls, and refers members needing case management services to a CMFHP pediatric Case Manager.

SHCN Needs Reporting 2005

	# of members reported on disc	# of members in cm at HP	# of members enrolled in Consent Decree
January	77	3	14
February	92	1	15
March	90	1	28
April	93	0	11
May	81	0	18
June	88	2	24
July	95	0	30
August	92	0	14
September	135	0	32
October	121	4	22
November	91	2	29
December	109	2	34
	1164	15	271
# screened	878		

EASTERN REGION LEAD REPORT
FY 2006

Member Blood Lead Case Management Information

	MERCY HEALTH PLAN	COMMUNITY CARE PLUS	HEALTHCARE USA - EASTERN REGION
(Duplicated Member Count)	**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**
Member Information Sent to the Health Plan	**392**	**602**	**1,798**
Member Information Received From the Health Plan	**205**	**287**	**393**
Member Information with BLL Results =>10 Not Received Back from the Health Plan	**223**	**428**	**1,280**
(Unduplicated Member Count)			
Member Information Sent to the Health Plan	**258**	**263**	**1,014**
Member Information Received From the Health Plan	**23**	**174**	**219**
Member Information with BLL Results =>10 Not Received Back from the Health Plan	**98**	**91**	**622**
Note: Discrepancy in the total of these figures is a result of health plans returning members identified by the health plan that were not sent by DHSS.			
Case Management Detail (Duplicate Member Count*)			
Members Who Accepted Case Management	173	67	43
Members Who Refused Case Management	12	0	4
Members Who Were Not Offered Case Management	3	1	261
Health Plan Did Not Indicate Case Management Status	17	219	85
Total Members - Case Management Detail	**205**	**287**	**393**
Blood Lead Level [1](BLL) Breakdown of Members in Case Management/Care Coordination (Duplicate Member Count*)			
Members with BLL Less than 10	1	11	7
Members with BLL 10 - 19	113	216	161
Members with BLL 20 - 44	89	57	209
Members with BLL 45 - 69	2	2	15
Members with BLL 70+	0	1	1
Total: BLL Breakdown of Members in Case Management/Care Coordination	**205**	**287**	**393**
Member Age Detail at Most Recent BLL (Duplicate Member Count*)			
Less than One Year of Age	13	7	2
One Year Of Age	63	96	71
Two Years Of Age	52	79	132
Three Years Of Age	32	65	90
Four Years Of Age	38	31	74
Five Years Of Age	6	9	17
Six Years Of Age	0	0	2
Seven Years of Age and Older	1	0	1
Unable to Determine (i.e. test date prior to date of birth)	0	0	4
Total: Member Age Detail at Most Recent BLL	**205**	**287**	**393**

Case Management Discharge Detail

Reasons for Discharge (Duplicate Member Count*)	Year To Date (Based on Quarter Totals)	Year To Date (Based on Quarter Totals)	Year To Date (Based on Quarter Totals)
BLL <15 for at least 6 months	1	2	2
Lead Hazards removed	0	0	0
No New Hazards	0	0	0
Refused Service	0	2	0
Older than 72 months of age	1	4	1
Moved out of the Managed Care Area	5	0	0
Moved out of the State	1	0	0
No Reason Given/Other	1	0	2
Total: Members Discharged from Case Management	**9**	**8**	**5**

Member Information with BLL Results = >10 Sent To But Not Returned by Health Plan

Blood Lead Level (BLL) Detail	Not Returned - Year To Date (Based on Aggregate Total)	Not Returned - Year To Date (Based on Aggregate Total)	Not Returned - Year To Date (Based on Aggregate Total)
Number of Members with BLL 10-14 (Duplicate Member Count)*	105	97	741
Number of Members with BLL =>15 (Duplicate Member Count)*	31	24	204
Number of Members with No BLL Recorded (Duplicate Member Count)*	0	0	0
Total: Number of Members Not Returned (Duplicate Member Count)	**136**	**121**	**945**
Total: Number of Members Not Returned (Unduplicated Member Count)	**98**	**91**	**622**

REFUGEE LEAD (Not included in above calculations)	Total	Total	Total
Refugee Lead Sent May 23, 2006	**59**	**33**	**164**
Refugee Lead Not Returned by June 30, 2006	**58**	**33**	**164**

[1] The Lead Case Management Report from health plans does not indicate whether bll results are venous or capillary however DMS policy dictates when the venous or capillary method is to be used.

* Unduplicated counts are not possible as Case Management Detail, BLL Detail, Age Detail and Case Management Discharge Detail on members are subject to change from month to month.

CENTRAL REGION LEAD REPORT
FY 2006

Member Blood Lead Case Management Information			
		MISSOURI CARE HEALTH PLAN	**HEALTHCARE USA - CENTRAL REGION**
(Duplicated Member Count)		**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**
Member Information Sent to the Health Plan		**322**	**219**
Member Information Received From the Health Plan		**670**	**7**
Member Information with BLL Results =>10 Not Received Back from the Health Plan		**37**	**67**
(Unduplicated Member Count)			
Member Information Sent to the Health Plan		**219**	**178**
Member Information Received From the Health Plan		**200**	**7**
Member Information with BLL Results =>10 Not Received Back from the Health Plan		**5**	**37**
Note: Discrepancy in the total of these figures is a result of health plans returning members identified by the health plan that were not sent by DHSS.			
Case Management Detail (Duplicate Member Count*)			
Members Who Accepted Case Management		130	0
Members Who Refused Case Management		78	0
Members Who Were Not Offered Case Management		0	6
Health Plan Did Not Indicate Case Management Status		462	1
Total Members - Case Management Detail		**670**	**7**
Blood Lead Level [1](BLL) Breakdown of Members in Case Management/Care Coordination (Duplicate Member Count*)			
Members with BLL Less than 10		161	2
Members with BLL 10 - 19		364	3
Members with BLL 20 - 44		133	2
Members with BLL 45 - 69		12	0
Members with BLL 70+		0	0
Total: BLL Breakdown of Members in Case Management/Care Coordination		**670**	**7**
Member Age Detail at Most Recent BLL (Duplicate Member Count*)			
Less than One Year of Age		23	0
One Year Of Age		195	1
Two Years Of Age		158	4
Three Years Of Age		130	0
Four Years Of Age		122	1
Five Years Of Age		25	0
Six Years Of Age		5	1
Seven Years of Age and Older		8	0
Unable to Determine (i.e. test date prior to date of birth)		4	0
Total: Member Age Detail at Most Recent BLL		**670**	**7**

Case Management Discharge Detail

Reasons for Discharge (Duplicate Member Count*)		Year To Date (Based on Quarter Totals)	Year To Date (Based on Quarter Totals)
BLL <15 for at least 6 months		72	0
Lead Hazards removed		0	0
No New Hazards		0	0
Refused Service		2	0
Older than 72 months of age		3	0
Moved out of the Managed Care Area		12	0
Moved out of the State		1	0
No Reason Given/Other		5	1
Total: Members Discharged from Case Management		**95**	**1**

Member Information with BLL Results = >10 Sent To But Not Returned by Health Plan

Blood Lead Level (BLL) Detail		Not Returned - Year To Date (Based on Aggregate Total)	Not Returned - Year To Date (Based on Aggregate Total)
Number of Members with BLL 10-14 (Duplicate Member Count)*		4	46
Number of Members with BLL =>15 (Duplicate Member Count)*		8	13
Number of Members with No BLL Recorded (Duplicate Member Count)*		0	1
Total: Number of Members Not Returned (Duplicate Member Count)		**12**	**60**
Total: Number of Members Not Returned (Unduplicated Member Count)		**5**	**37**

REFUGEE LEAD (Not included in above calculations)		Total	Total
Refugee Lead Sent May 23, 2006		**10**	**6**
Refugee Lead Not Returned by June 30, 2006		**0**	**6**

[1] The Lead Case Management Report from health plans does not indicate whether bll results are venous or capillary however DMS policy dictates when the venous or capillary method is to be used.

* Unduplicated counts are not possible as Case Management Detail, BLL Detail, Age Detail and Case Management Discharge Detail on members are subject to change from month to month.

WESTERN REGION LEAD REPORT
FY 2006

Member Blood Lead Case Management Information					
		BLUE-ADVANTAGE PLUS OF KANSAS CITY	**CHILDREN'S MERCY FAMILY HEALTH PARTNERS**	**FIRSTGUARD HEALTH PLAN**	**HEALTHCARE USA - WESTERN REGION**
(Duplicated Member Count)		**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**
Member Information Sent to the Health Plan		**60**	**159**	**106**	**36**
Member Information Received From the Health Plan		**209**	**206**	**167**	**7**
Member Information with BLL Results =>10 Not Received Back from the Health Plan		**34**	**33**	**29**	**23**
(Unduplicated Member Count)					
Member Information Sent to the Health Plan		**60**	**159**	**106**	**36**
Member Information Received From the Health Plan		**209**	**206**	**167**	**7**
Member Information with BLL Results =>10 Not Received Back from the Health Plan		**10**	**1**	**4**	**13**
Note: Discrepancy in the total of these figures is a result of health plans returning members identified by the health plan that were not sent by DHSS.					
Case Management Detail (Duplicate Member Count*)					
Members Who Accepted Case Management		36	172	104	1
Members Who Refused Case Management		83	3	3	0
Members Who Were Not Offered Case Management		18	24	37	6
Health Plan Did Not Indicate Case Management Status		72	7		0
Total Members - Case Management Detail		**209**	**206**	**167**	**7**
Blood Lead Level [1](BLL) Breakdown of Members in Case Management/Care Coordination (Duplicate Member Count*)					
Members with BLL Less than 10		37	88	27	2
Members with BLL 10 - 19		160	93	118	3
Members with BLL 20 - 44		12	24	21	2
Members with BLL 45 - 69		0	1	1	0
Members with BLL 70+		0	0	0	0
Total: BLL Breakdown of Members in Case Management/Care Coordination		**209**	**206**	**167**	**7**
Member Age Detail at Most Recent BLL (Duplicate Member Count*)					
Less than One Year of Age		9	5	5	0
One Year Of Age		46	47	38	0
Two Years Of Age		95	46	49	2
Three Years Of Age		36	25	26	2
Four Years Of Age		7	31	27	3
Five Years Of Age		4	25	18	0
Six Years Of Age		0	4	4	0
Seven Years of Age and Older		0	10	0	0
Unable to Determine (i.e. test date prior to date of birth)		12	13	0	0
Total: Member Age Detail at Most Recent BLL		**209**	**206**	**167**	**7**

Case Management Discharge Detail					
Reasons for Discharge (Duplicate Member Count*)		**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**	**Year To Date (Based on Quarter Totals)**
BLL <15 for at least 6 months		18	17	1	1
Lead Hazards removed		1	0	2	0
No New Hazards		0	0	1	0
Refused Service		1	0	2	0
Older than 72 months of age		2	2	4	0
Moved out of the Managed Care Area		25	1	0	0
Moved out of the State		0	2	0	0
No Reason Given/Other		2	1	10	0
Total: Members Discharged from Case Management		**48**	**23**	**20**	**1**

Member Information with BLL Results = >10 Sent To But Not Returned by Health Plan					
Blood Lead Level (BLL) Detail		**Not Returned - Year To Date (Based on Aggregate Total)**	**Not Returned - Year To Date (Based on Aggregate Total)**	**Not Returned - Year To Date (Based on Aggregate Total)**	**Not Returned - Year To Date (Based on Aggregate Total)**
Number of Members with BLL 10-14 (Duplicate Member Count)*		7	1	4	14
Number of Members with BLL =>15 (Duplicate Member Count)*		8	0	1	1
Number of Members with No BLL Recorded (Duplicate Member Count)*		0	0	0	0
Total: Number of Members Not Returned (Duplicate Member Count)		**15**	**1**	**5**	**15**
Total: Number of Members Not Returned (Unduplicated Member Count)		**10**	**1**	**4**	**13**

REFUGEE LEAD (Not included in above calculations)		**Total**	**Total**	**Total**	**Total**
Refugee Lead Sent May 23, 2006		**43**	**16**	**15**	**24**
Refugee Lead Not Returned by June 30, 2006		**43**	**0**	**10**	**24**

[1] The Lead Case Management Report from health plans does not indicate whether bll results are venous or capillary however DMS policy dictates when the venous or capillary method is to be used.

* Unduplicated counts are not possible as Case Management Detail, BLL Detail, Age Detail and Case Management Discharge Detail on members are subject to change from month to month.

Network Adequacy

2006 NETWORK ANALYSIS -- RATE OF COMPLIANCE

Health Plan	PCPs	Specialists	Facilities	Ancillary	Overall	Failed to Achieve 90% Compliance
Blue Advantage Plus	100%	100%	99%	94%	98%	Physical Therapy - 87%
Family Health Partners	100%	100%	100%	98%	100%	N/A
FirstGuard	100%	100%	98%	100%	100%	N/A
Healthcare USA (West)	100%	100%	92%	100%	98%	Residential Mental Health - 4%
Healthcare USA (Central)	100%	100%	98%	100%	100%	Residential Mental Health - 86%
Missouri Care	100%	100%	98%	99%	99%	Residential Mental Health - 73%
Community CarePlus	100%	99%	98%	100%	99%	Rheumatology - 85%; Residential Mental Health - 86%
Harmony Health Plan	100%	89%	88%	69%	86%	Allergy - 84%; Endocrinology - 84%; Nephrology - 86%; Neurology - 86%; Obstetrics/Gynecology - 78%; Physical Medicine/Rehab - 84%; Psychiatrist-Adult/General - 78%; Psychiatrist-Child/Adolescent - 85%; Rheumatology - 84%; General Surgery - 85%; Urology - 84%; Psychiatrists/Other Therapy - 59%; Ambulatory Mental Health - 61%; Inpatient Mental Health - 82%; Residential Mental Health - 0%; Audiology - 86%; Occupational Therapy - 51%; Physical Therapy - 37%
Healthcare USA (East)	100%	100%	100%	100%	100%	N/A
Mercy	100%	99%	98%	99%	99%	Psychiatrist-Child/Adolescent - 88%; Residential Mental Health - 80%

2006 PCP/Enrollee Ratios

EAST	PCPs	Enrollees	PCP/Enrollee Ratio
Community CarePlus	527	39,552	1 / 75
Harmony*	381*	1,530*	1 / 4
Healthcare USA(1)	824	123,473	1 / 150
Mercy	940	43,444	1 / 46

(1) **Healthcare USA** submitted one network covering all three regions. EAST PCP count includes all '63xxx' ZIP codes EXCEPT those in Audrain, Macon, Monroe, Ralls, Marion, Montgomery, and Shelby counties. One PCP in Bowling Green, MO and one in Louisisana, MO are counted in both East and Central regions. Two providers in Bourbon, MO (65xxx ZIP) are included in East region.

CENTRAL	PCPs	Enrollees	PCP/Enrollee Ratio
Healthcare USA(2)	298	24,883	1 / 84
Missouri Care	443	31,607	1 / 71

(2) CENTRAL PCP count includes all '65xxx' ZIP codes EXCEPT Bourbon, MO; '63xxx' ZIP codes in Audrain, Macon, Monroe, Ralls, Marion, Montgomery, and Shelby counties; and '64xxx' ZIP codes of Brookfield, Carrollton, and Marceline, MO. One PCP in Bowling Green, MO and one in Louisiana, MO are counted in both East and Central regions. Providers in Carrollton, Cole Camp, Warsaw and Windsor are counted in both Central and West regions.

WEST	PCPs	Enrollees	PCP/Enrollee Ratio
Blue Advantage Plus	369	29,744	1 / 81
Family Health Partners	434	44,912	1 / 103
FirstGuard	459	35,328	1 / 77
Healthcare USA(3)	399	10,122	1 / 25

(3) WEST PCP count includes '64xxx' ZIP codes EXCEPT Brookfield and Marceline, all '66xxx' ZIP codes (KS), and '65xxx' ZIP codes of Cole Camp, Warsaw and Windsor, Missouri. Providers in Carrollton, Cole Camp, Warsaw, and Windsor are counted in both Central and West regions.

SOURCES:

PCPs: Provider data submitted by the MCO's to the Dept of Insurance.
(Provider networks as of January 1, 2006)
* Harmony's network = as of July 1, 2006.

Enrollees: Weekly Summary Report for Total Number of Active Enrollments by Region, County, and Health Plan.
From PSI, January 9, 2006.
* Harmony's enrollment: From PSI, July 10, 2006.

NOTE: PCP/Enrollee ratios in the range of 1/1500 to 1/2500 have been used to represent adequate staffing levels both in federal health programs, and in individual states: http://www.gencmh.org/documents/42CFR.pdf

2006 Dentist/Enrollee Ratios

EAST	Dentists	Enrollees	Dentist/Enrollee Ratio
Community CarePlus	68	39,552	1 / 582
Harmony*	147*	1,530*	1 / 10
Healthcare USA(1)	180	123,473	1 / 686
Mercy	173	43,444	1 / 251

(1) **Healthcare USA** submitted one network covering all three regions. EAST Dentist count includes all '63xxx' ZIP codes.

CENTRAL	Dentists	Enrollees	Dentist/Enrollee Ratio
Healthcare USA(2)	26	24,883	1 / 957
Missouri Care	30	31,607	1 / 1054

(2) CENTRAL Dentist count includes all '65xxx' ZIP codes EXCEPT for three dentists in Springfield, MO.

WEST	Dentists	Enrollees	Dentist/Enrollee Ratio
Blue Advantage Plus	92	29,744	1 / 323
Family Health Partners	89	44,912	1 / 505
FirstGuard	129	35,328	1 / 274
Healthcare USA(3)	101	10,122	1 / 100

(3) WEST Dentist count includes all '64xxx' ZIP codes, all '66xxx' ZIP codes (KS), and three dentists in Springfield, MO.

SOURCES:

Dentists: Provider data submitted by the MCO's to the Dept of Insurance.

(Provider networks as of January 1, 2006)

* Harmony's network = as of July 1, 2006.

Enrollees: Weekly Summary Report for Total Number of Active Enrollments by Region, County, and Health Plan.

From PSI, January 9, 2006.

* Harmony's enrollment: From PSI, July 10, 2006.

One state (New Jersey) requires a dentist/enrollee ratio of no greater than 1/1500.

Five states (Maryland, New York, Oklahoma, Rhode Island, Virginia) require a dentist/enrollee ratio of no greater than 1/2000.

Source:

http://www.gwumc.edu/sphhs/healthpolicy/nnhs4/GSA/Subheads/gsa140.html

2006 Mental Health Provider/Enrollee Ratios

EAST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Community CarePlus	434	39,552	1 / 91
Harmony*	176	1,530	1 / 9
Healthcare USA(1)	1,124	123,473	1 / 110
Mercy	781	43,444	1 / 56
Mercy CarePlus**(1)	1,157	69,260	1 / 60

(1) **Healthcare USA and Mercy CarePlus** each submitted one network covering all three regions.
EAST Provider count includes all MH providers in '62xxx' (Illinois) ZIP codes and most in '63xxx' ZIP codes EXCEPT Kirksville.
MH providers in the cities of Cuba, Hannibal, Kahoka, Louisiana, Monticello, Palmyra, Salem, and Steelville are included in both the East and Central regions.

CENTRAL	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Healthcare USA(2)	291	24,883	1 / 86
Mercy CarePlus**(2)	351	403	1 / 1+
Missouri Care	361	31,607	1 / 88

(2) CENTRAL Provider count includes MH providers in '65xxx' ZIP codes EXCEPT Springfield, MO.
MH providers in the cities of Cuba, Hannibal, Kahoka, Louisiana, Monticello, Palmyra, Salem, and Steelville are included in both the East and Central regions.
MH providers in the cities of Carrollton, Warsaw, and Windsor are included in both the Central and West regions.

WEST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Blue Advantage Plus	704	29,744	1 / 42
Family Health Partners	374	44,912	1 / 120
FirstGuard	217	35,328	1 / 163
Healthcare USA(3)	250	10,122	1 / 40
Mercy CarePlus**(3)	264	1,025	1 / 4

(3) WEST MH Provider count includes '64xxx' ZIP codes.
MH providers in the cities of Carrollton, Warsaw, and Windsor are included in both the Central and West regions.
MH providers in the cities of Joplin, Lamar, Nevada, and Springfield are included in the West region.

SOURCES:
MH Providers: Provider data submitted by the MCO's to the Dept of Insurance.
Includes Adult/General Psyciatrists, Child/Adolescent Psychiatrists, and Psychologists/Other.
(Provider networks as of January 1, 2006)
* Harmony's network = as of July 1, 2006.
**Mercy CarePlus's network = as of September 25, 2006

Enrollees: Weekly Summary Report for Total Number of Active Enrollments by Region, County, and Health Plan.
From PSI, January 9, 2006.
* Harmony's enrollment: From PSI, July 10, 2006.
**Mercy CarePlus's enrollment: From PSI, September 25, 2006

2006 Average Distance to PCP

East Region

			Community CarePlus	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**
Franklin	8,275	20 miles	7	6.9
Jefferson	14,334	20 miles	22	2.6
Lincoln	4,578	30 miles	12	6.5
St. Charles	13,649	10 miles	28	2.1
St. Francois	7,760	20 miles	29	2.9
St. Louis	80,362	10 miles	129	1.3
St. Louis City	70,575	10 miles	259	0.6
Ste. Genevieve	1,294	30 miles	14	2.7
Warren	2,677	30 miles	2	3.0
Washington	4,232	30 miles	17	3.1
Total:	207,736		519	

			Healthcare USA - East	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**
Franklin	8,275	20 miles	56	2.0
Jefferson	14,334	20 miles	19	3.2
Lincoln	4,578	30 miles	14	4.3
St. Charles	13,649	10 miles	82	1.8
St. Francois	7,760	20 miles	35	2.7
St. Louis	80,362	10 miles	316	1.0
St. Louis City	70,575	10 miles	253	0.5
Ste. Genevieve	1,294	30 miles	9	2.4
Warren	2,677	30 miles	11	4.7
Washington	4,232	30 miles	12	3.2
Total:	207,736		807	

			Mercy Health Plan	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**
Franklin	8,275	20 miles	27	3.5
Jefferson	14,334	20 miles	35	2.0
Lincoln	4,578	30 miles	15	6.1
St. Charles	13,649	10 miles	84	1.6
St. Francois	7,760	20 miles	26	2.3
St. Louis	80,362	10 miles	421	1.0
St. Louis City	70,575	10 miles	283	0.5
Ste. Genevieve	1,294	30 miles	0	20.6
Warren	2,677	30 miles	4	4.9
Washington	4,232	30 miles	14	2.4
Total:	207,736		909	

2006 Average Distance to PCP

Central Region			Healthcare USA - Central	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**
Audrain	3,355	30 miles	22	2.0
Boone	12,192	20 miles	55	3.1
Callaway	4,120	30 miles	16	2.3
Camden	3,838	30 miles	14	3.5
Chariton	690	30 miles	7	3.7
Cole	5,903	20 miles	38	3.7
Cooper	1,480	30 miles	4	3.3
Gasconade	1,325	30 miles	6	1.7
Howard	1,202	30 miles	1	5.2
Miller	3,673	30 miles	16	3.1
Moniteau	1,345	30 miles	4	8.3
Monroe	476	30 miles	2	5.8
Montgomery	1,399	30 miles	11	4.7
Morgan	2,648	30 miles	9	4.4
Osage	871	30 miles	9	6.2
Pettis	5,419	30 miles	19	2.5
Randolph	3,257	30 miles	5	2.3
Saline	2,899	30 miles	5	4.1
Totals:	56,092		243	

			Missouri Care	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**
Audrain	3,355	30 miles	26	2.0
Boone	12,192	20 miles	158	2.9
Callaway	4,120	30 miles	24	2.7
Camden	3,838	30 miles	18	3.5
Chariton	690	30 miles	7	2.5
Cole	5,903	20 miles	36	3.9
Cooper	1,480	30 miles	12	4.9
Gasconade	1,325	30 miles	14	2.6
Howard	1,202	30 miles	13	3.8
Miller	3,673	30 miles	16	4.1
Moniteau	1,345	30 miles	4	4.1
Monroe	476	30 miles	3	5.7
Montgomery	1,399	30 miles	7	4.9
Morgan	2,648	30 miles	10	2.7
Osage	871	30 miles	0	13.9
Pettis	5,419	30 miles	20	2.6
Randolph	3,257	30 miles	16	2.0
Saline	2,899	30 miles	16	4.6
Totals:	56,092		400	

2006 Average Distance to PCP

West Region

County	MC+ Eligibles	Distance Standard (for PCP)	Blue Advantage Plus		Family Health Partners	
			PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)
Cass	7,453	20 miles	13	2.7	16	2.5
Clay	13,494	20 miles	24	2.7	36	1.9
Henry	2,700	30 miles	11	6.2	12	3.2
Jackson	83,919	10 miles	198	1.7	309	1.6
Johnson	3,967	30 miles	9	5.3	15	5.5
Lafayette	3,357	30 miles	23	2.3	52	2.0
Platte	3,536	20 miles	16	3.0	15	2.1
Ray	1,902	30 miles	6	3.8	5	3.9
St. Clair	1,121	30 miles	8	4.2	13	3.7
Total:	121,449		308		473	

County	MC+ Eligibles	Distance Standard (for PCP)	FirstGuard		Healthcare USA - West	
			PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)
Cass	7,453	20 miles	12	2.8	20	2.4
Clay	13,494	20 miles	32	2.1	24	2.1
Henry	2,700	30 miles	13	6.3	22	3.2
Jackson	83,919	10 miles	279	1.4	204	1.7
Johnson	3,967	30 miles	4	6.6	12	5.5
Lafayette	3,357	30 miles	27	2.5	66	2.0
Platte	3,536	20 miles	19	1.8	9	4.0
Ray	1,902	30 miles	2	3.8	3	4.2
St. Clair	1,121	30 miles	8	4.0	13	4.5
Total:	121,449		396		373	

MC+ MANAGED CARE ANNUAL EVALUATION

QUALITY INDICATORS

QUALITY INDICATORS

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

PROVIDER SATISFACTION

The input of contracted physicians is vital for evaluating the services which BCBSKC offers to providers and members. HMO Physician Satisfaction Surveys are conducted, analyzed, and reported to the Quality Council and QIC with appropriate recommendations and action plans. The 2005 Physician Satisfaction Survey provided the following feedback:

a. Most of the respondents stated that BCBSKC's overall performance got *Much* or *Somewhat Better* or *Stayed the Same* in the past 12 months.

b. Almost two-thirds of the respondents stated *that BCBSKC is Much* or *Somewhat Better than other managed care organizations in terms of service*.

c. Almost all of the respondents rated *the overall service provided by BCBSKC* as *Excellent, Very Good*, or *Good*.

d. Almost all of he respondents stated they would *Definitely* or *Probably Recommend BCBSKC to colleagues who were considering becoming network providers*.

During 2005, Children's Mercy Family Health Partners completed a formal random sample provider satisfaction survey of participating providers. This survey was sent to 292 providers with the following results:

- CMFHP sent 104 surveys to our primary care providers and 39 were returned, resulting in a 38% return rate.
- There were 128 surveys sent to our specialists with 37 returned for a return rate of 29%.
- Surveys were also sent to our contracted hospitals and ancillary providers. There were 60 surveys sent with 13 returned, resulting in a return rate of 22%.

Responses from the survey were compiled by provider type and the results of the survey were compared with the results from the previous year. The findings were graphed and presented to the Administrative Oversight Committee (AOC) for review. CMFHP continues to see an increase in overall provider satisfaction, which can be attributed to process and system changes resulting in timely claims payment and improved servicing of our providers. The increase in provider visits also appears to have had an impact on provider satisfaction, as well as our increased customer service knowledge.

There were no areas of concerns from any of the provider types and overall the providers indicated that based on the questions answered, CMFHP was above the average when compared with other MC+ plans that they participated with.

Provider Satisfaction – A provider satisfaction survey was not completed in 2005. CCP plans to conduct a satisfaction survey in 2006.
Quality management programs are designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care and services and the processes by which they are delivered to members, through standardized methods such as chart audits, development of preventive care guidelines and sentinel event/target diagnosis review.

The Myers Group administered the Provider Satisfaction Survey to a representative sample of FirstGuard Health Plan network OB/GYN and Primary Care Providers during August and September 2005. The Provider Satisfaction Survey evaluated provider experience with FirstGuard in service areas that included satisfaction with customer service, provider relations, physician network, utilization management, quality management, pharmacy and drug benefits, and finance issues.

FirstGuard is pleased to report an increase in the response rate, from 18.3% in 2004 to 35.5% in 2005. This is largely attributed to a change in survey administration methodology. FirstGuard added a follow up phone call by The Myers Group staff after the two-wave mail procedure. As an additional incentive, FirstGuard offered a lunch to one provider and his/her office staff selected from all survey respondents.

The table below shows the overall results for the areas of service scored by FirstGuard network providers. There is also a comparison to The Myers Group Medicaid provider clients. Notably, FirstGuard providers are determined to be significantly more loyal when compared to the TMG Book of Medicaid business. In addition, overall satisfaction with FirstGuard Health Plan has significantly increased each year for the past two years.

Composites/Ratings	FirstGuard Health Plan - Aggregate 2005 Top Box	All Other Plans 2005 Top Box	FirstGuard Health Plan - Aggregate 2004 Top Box	TMG 2004 Provider B.o.B.
Customer Service	28.6%	22.6%	21.0%	29.2%
Provider Relations	32.7%	21.1%	29.3%	31.8%
Network	33.4%	34.0%	37.0%	38.8%
Utilization Management	26.9%	18.2%	24.4%	25.2%
Quality Management	31.1%	21.4%	26.6%	29.9%
Finance Issues	23.8%	22.4%	19.0%	25.1%
Pharmacy and Drug Benefits	13.7%	14.4%	10.3%	14.6%
Overall				
Willing to recommend to other patients	90.3%	NA	88.1%	80.8%
Willing to recommend to other providers	84.1%	NA	81.3%	78.8%
Overall Satisfaction	**77.0%**	**NA**	**66.1%**	**66.0%**

2005 HCUSA Provider Satisfaction Survey

HCUSA has utilized the Provider Satisfaction with Customer Service survey from DSS Research for the first time in 2005. Coventry has contracted with DSS for two years now to assess the providers' satisfaction with the Customer Service Center. Even though HCUSA has not utilized this survey in the past, historical data is available for the Plan since Corporate Coventry has conducted this survey on our behalf to determine overall satisfaction with all Coventry providers.

Specific objectives for this study include: measure overall satisfaction with Coventry's Customer Service Center, identify reasons for calling customer service, determine overall provider satisfaction with the length of time to provide information and resolve issues, and examine provider satisfaction with specific elements of customer service. DSS designed the survey instrument with input from Coventry Health Care.

Respondents eligible for the survey are the providers having the highest claims volume during 2004. The sample included an equal number of primary care physicians and specialists. A total of 400 providers were included in the mailing. Of those, 179 providers submitted a completed survey. The sampling error is ±7.3% at 95% confidence interval using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate is 47.1%.

HCUSA overall and its customer service overall have both slightly increased since 2004. Both measures are lower than the Coventry average, however customer service is significantly lower than the Coventry average. PCP's and specialists are equally satisfied. The overall rating of HCUSA compared to other Coventry plans has decreased and is significantly below the Coventry average. The rating of HCUSA's Customer Service compared to other Coventry plans decreased significantly and is also significantly below the Coventry average.

Satisfaction with specific plan attributes is mixed, but there were no significant changes from 2004 to 2005 for any plan items. Paper claims submission process and accuracy of claims adjustments are significantly lower than the Coventry average. When compared to other plans, a

decline is seen in most items, except for slight increases in ease of pharmacy authorization process, electronic claims submission process, electronic claims rejection reports and clarity of materials for physicians. The Plan falls below the Coventry average in all other aspects.

HCUSA is below the Coventry average in all areas of the customer service rep scores. Six of these eight areas are significantly lower than the Coventry average. These six areas are: friendliness and courtesy of the representative, ease of understanding explanations given by the representative, knowledge of the representative about the coverage and benefits, ability to reach a representative who could help you, accuracy of the representative's response, and thoroughness and resolution of your issue by the representative.

The top reason for calling Customer Service is to verify member eligibility, the same as in 2004. The second highest reason is to find out about authorizations/pre-certification, followed by to request billing or claim payment information. The top reason for calling related to claims/billing issues is due to claims rejection followed by never received payment or notification of payment.

Reported resolution of issues during the initial call to customer service has increased, yet overall satisfaction decreased. Both of these results fall below the Coventry average. The number of times to call regarding the same issue has increased and is significantly above the Coventry average. The level of satisfaction with the number of times required to call regarding one issue has also decreased and is significantly below the Coventry average.

Seventy-eight percent of providers reported that the telephone was their most frequently used means of contacting customer service. This is in proportion to last years results. The use of the IVR line is decreasing for Coventry overall, but the use of the IVR line by HCUSA providers remains significantly higher than the Coventry average. Providers are most likely to use the Internet and/or Physician Office Management System to check member eligibility or for claims submission. The frequency of need to make a follow-up call after one of these three transactions is higher for HCUSA than the Coventry average.

Overall Improvement Opportunities
The phone is used in most contacts with customer service and satisfaction is inversely linked to the number of calls needed for problem resolution. Increased/improved training for the customer service reps is needed to enable more accurate responses and a thoroughly resolved issue on the first call. These two characteristics drive overall satisfaction with Customer Service and improvements here will generate higher satisfaction levels. Drivers of overall satisfaction with Coventry are claims adjustment timeliness and accuracy. Investment in web technology updates to your system for flexibility and ease of use would help create the impetus for using the web to obtain information which serves two purposes: 1. Reduction in call volume and 2. Quicker availability of claim information. Both concepts should improve the two overall satisfaction measures.

A formal provider survey process was not undertaken during 2005. Anecdotal evidence indicates that wait time improvements would result in higher levels of satisfaction with the prior authorization process. To more effectively meet this goal, additional nurses were approved in early 2005. In addition, the Call Center team implemented a variety of changes during 2005,

many of which took work out of the call queue, but not necessarily out of the system. Additional performance improvement plans are in development.

In addition, a number of high volume facilities indicated a desire to conduct prior authorization activities on-line. Mercy Health Plans intends to offer this opportunity through the CareLink implementation after implementation of QNXT (new primary operating system).

Provider Satisfaction

The Myers Group administers Missouri Care's Provider Satisfaction Survey. A summary of the most positive responses follows:

Composites/ Ratings of Physician Satisfaction	**2004 Scores**	**2005 Scores**	**All Other Plans' Average Top Scores**
Member Service	92.2%	91.4%	79.7%
Provider Relations	84.7%	89.4%	67.9%
Network	80.1%	76.2%	70.6%
Medical Management	76.5%	72.9%	63.4%
Preventive Care	86.1%	86.9%	74.0%
Claims	71.4%	79.1%	74.1%
Recommend to other Patients	93.5%	90.0%	NA
Recommend to other Physicians	93.5%	88.8%	NA

CLINICAL

Lead - The BA+ Lead Performance Improvement Project was initiated for the BA+ population in March of 2004. Rationale for initiating this new project included new lead testing guidelines from the State of Missouri, which designated Jackson County as a high risk county, mandated testing for children ages 3 to 6 in the high risk counties and current low lead testing rates overall. In Jackson County, all BA+ members under age 6 are to be tested annually for lead. All 12 and 24 month old children in BA+ in the entire service area are to have a blood lead test. Measures for the initial phase of the project are process measures for testing.

Objectives of the Lead Performance Improvement Project were to:

a. Educate BA+ members on the new lead testing guidelines and the importance of lead testing,
b. Educate BA+ providers on the new lead testing guidelines and the importance of lead testing, and
c. Identify at least two partners outside BCBSKC staff to participate with the lead project.

The Lead Initiative Committee continued to meet on a monthly basis during 2004 and through May of 2005, and have engaged Children's Mercy Health Network and LabOne as participating partners on the project. The project has met all current goals as stated in the initial Work Plan, with member and physician interventions mailed on target dates.

Interventions that were done in 2005:

a. A lead testing promotion to PCPs was completed in 2005. It included the roll out of the dry blood spot filter paper method of capillary blood testing by LabOne. A gift bag of materials was taken to PCPs that contained information on lead testing with this method, notepads for the office to remind of lead testing, a dry erase board with messages about lead testing, picture frame with lead message, lead testing map and risk questionnaire. The packet also included well-child brochures and lead flyers, both in English and Spanish.
b. Distributed educational material on an as needed basis to children in lead case management.
c. Continued care coordination and case management of children with elevated lead levels by Children's Mercy Health Network.
d. Article in provider newsletter to explain new lead testing available from LabOne and procedures to use the new testing system.
e. Educated providers and plan members of higher rates of lead poisoning and the increasing number of risk factors in this population.
f. Informational materials taken to all BA+ PCPs concerning lead testing requirements, Missouri lead testing maps, available lead educational materials, member educational brochure and new testing procedures available from LabOne.
g. Mailing to all BA+ households containing a flyer on lead testing requirements and how to prevent lead poisoning (provided in English and Spanish).
h. Implementation of the LabOne capillary testing method.
i. Educating the local public health departments about the need for lead testing.

The reports indicate:

a. Number of members in each group panel who are under age 7 – report will show each year as an individual group and then will also show a total eligible,
b. Number and percent of those individuals in the eligible group who had on office visit in the time period reviewed (opportunities), and
c. Number and percent of those with an opportunity that received a lead test in the same time period.

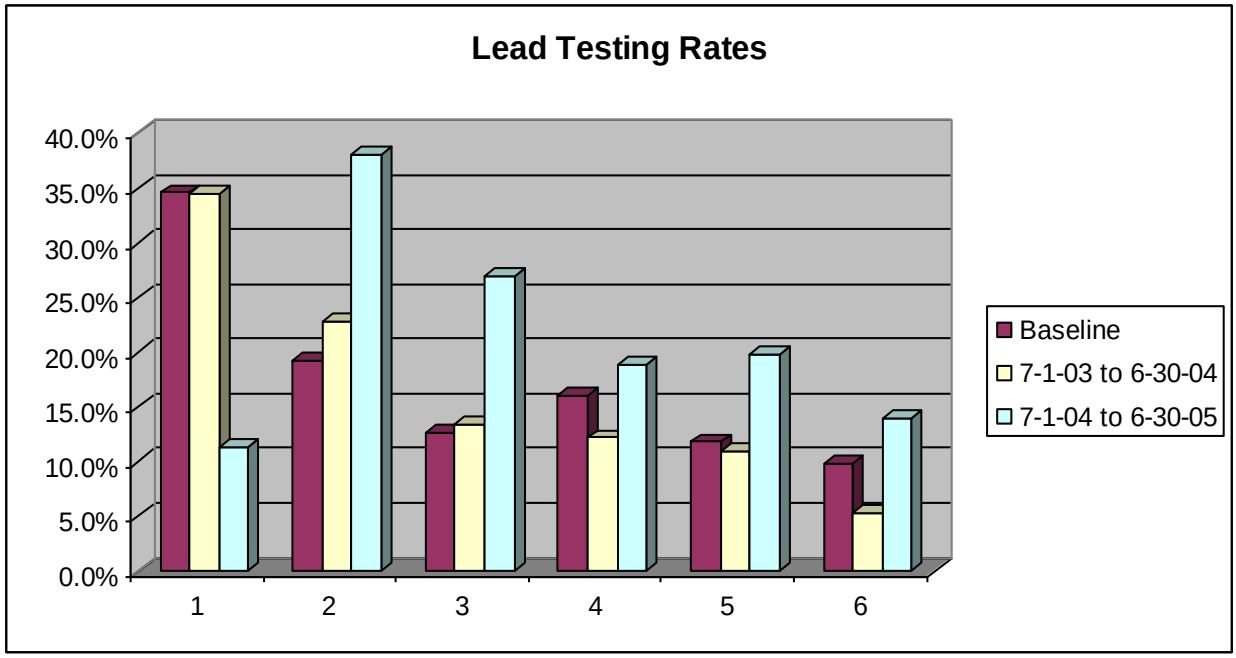
The outcome of this project was a significant improvement in the lead testing rates for all of the BA+ population, as well as the Jackson County population, for the eligible 2-6 year olds.

Total BA+ Population – Member Count by Member Age

	1	2	3	4	5	6	Grand Total
Total # with Lead Test	122	514	283	219	203	156	1497
Total # of Eligible Members	932	823	879	997	938	997	5594
Baseline Percentage	33.4%	18.3%	12.6%	14.7%	12.4%	9.2%	16.8%
6 months percentage	11.6%	38.4%	24.4%	18.0%	17.8%	13.5%	21.2%

Jackson County Population – Member Count by Member Age

	1	2	3	4	5	6	Grand Total
Jackson County with Lead Testing	77	322	204	153	150	110	1016
Jackson County Eligible Members	600	524	553	656	609	673	3615
Baseline Percentage	34.6%	19.2%	12.7%	16.0%	11.8%	9.8%	17.4%
6 months percentage	11.4%	38.1%	26.9%	18.9%	19.8%	14.0%	21.9%



Lead Testing Rates

Age	Baseline	7-1-03 to 6-30-04	7-1-04 to 6-30-05
1	34.6%	34.5%	11.4%

2	19.2%	22.8%	38.1%
3	12.7%	13.4%	26.9%
4	16.0%	12.2%	18.9%
5	11.8%	11.0%	19.8%
6	9.8%	5.3%	14.0%

Asthma Disease State Management Program –The intent of the Healthy Companion disease management program for asthma is to improve the health status of all BA+ members with chronic respiratory conditions such as: asthma and chronic obstructive pulmonary disease (COPD) as evidenced by improvement in quality of life and functional status, and decreases in emergency room (ER) visits and inpatient (IP) admissions.

A related goal is to improve provider compliance with standards of care for asthma as evidenced by improvement in the annual HEDIS® measure for asthma and appropriate utilization of services.

2005 Accomplishments

a. Completed fifth year of interventions for respiratory disease state management program with significant improvement in clinical utilization and functional status outcomes for asthma and COPD;
b. Maintained physician satisfaction with DSM programs. Member satisfaction remains high, exceeding 90% for respiratory program;
c. Promoted appropriate influenza vaccinations to members in Healthy Companion program. Accomplished this by distributing coupons for obtaining the vaccination at selected sites for those over age nine in the DSM programs. Those under nine were sent letters encouraging them to go to their PCPs for the vaccination;
d. Panel-specific PCP profile reporting for the appropriate use of medication for people with asthma was continued. A HEDIS®-based methodology is used for these reports. Report was sent to PCPs and compared PCP performance to plan-wide performance for comparative purposes; and
e. Achieved participation rate above the 50% goal for the asthma program (rate was 53.6% overall and 89% for the ones with good contact information)
f. Significant improvement in the Medicaid population for the number of members who filled prescriptions for greater than 145 day supply of rescue medication in a 12 month period (22% at baseline down to 4.7% in 2005).

Outcomes

a. Programs use an engagement model of eligibility. All eligible members are considered participants of the program unless they actively decline the program by writing a letter or verbally saying "no" to the program.
b. Asthma had an active declination rate of less than 5% for BA+.
c. All programs have measured provider and member satisfaction at least once during the last year.
d. HEDIS® 2005 measure had a slight decline from 2004 but overall has improved significantly for asthma medication use since 2003.

e. Statistically significant improvement in all categories of symptom frequency for adults and children with asthma who participated in the program;
f. Improvement in all quality of life indicators for adults and children participating in the program;
g. 71% and 73% decrease from baseline in ER visits for adults and children, respectively, in the program;
h. 66% and 81% decrease from baseline in inpatient admissions for adults and children, respectively, in the program;
i. For the BA+ total population, inpatient days per 1000 members with asthma, ER visits per 1000 and admissions per 1000 members all decreased significantly from baseline and from previous year;
j. 53% and 33% reduction in missed days of work and school, respectively, for those in the program; there was also a 66% decrease in missed work days for caretaker's due to a child's illness;
k. Overall member satisfaction with the asthma/COPD program exceeded 90% for members responding to the surveys (32% response rate);
l. Provider satisfaction with the Healthy Companion Program was 79%, exceeding the 70% goal and had a response rate of over 15%;
m. Two process measures, "peak flow meter (PFM) use" and "quit smoking rate" for adults with asthma, added to the quarterly clinical outcomes report during 2002, continue to show improvements for 2005. Rates for PFM use went from 5.7% at baseline to 50% for adults. Child peak flow meter use went from 6% to 36%.
n. Of the 24% who said they smoked, there was a smoking quit rate of 21.2% from baseline to re-measure in the adult population.

NON-CLINICAL

In 2005, BA+ did not conduct a non-clinical performance improvement project.

Definitions

OAO – Computer system for claims adjudication and authorizations
PCP – Primary Care Physician

Study Topic

Children's Mercy Family Health Partners (CMFHP) has chosen a performance improvement project designed toward improving lead screening rates among members between the ages of 6 months and 3 years. The project plan and design will be done through the CMFHP Special Healthcare Needs (SHCN) Committee members, which include the Director of Health Services, the Manager of Health Services, Pediatric Case Managers, an Adult Case Manager, the Lead/SHCN Case Manager, the SHCN Coordinator, and a Utilization Review Nurse. The CMFHP Utilization Management/Medical Director Committee will have primary oversight of the project, with quarterly reporting to the CMFHP Medical Management Committee.

The project will involve outreach and input from physicians, through the CMFHP Medical Management Committee, and community agencies involved in lead screening for CMFHP members. Interventions to date include general immunization and lead reminders through member and provider newsletters and distribution of well child information through various community events. CMFHP is interested in focusing specific outreach activities at children identified as living in high-risk areas for lead toxicity. All children ages 12 and 24 months in high risk areas should be tested for lead.

The CMFHP Special Healthcare Needs Committee has chosen the topic of lead screening due to its evaluation of current screening rates, as well as recent changes in lead screening requirements (i.e. universal testing areas). Although lead screening rates have continued to increase year after year, there is consensus in the committee that the rates could and should be much higher than they currently are. CMFHP has completed focused studies on lead screening rates since 1999. Data is reviewed annually to determine the percentage of members screened for lead through the CMFHP claims database. This annual analysis was the impetus for the performance improvement project.

Description of Intervention

Interventions:

- *Identification of members eligible with CMFHP as of a determined date, who are between the ages of 6 months and 3 years of age and who have been continuously enrolled since birth:*
  - A report will be run from the CMFHP eligibility system, identifying members meeting the parameters
- *Further identification of those within that specified group who have no lead testing claim in the CMFHP system:*
  - A report will be run identifying those with no lead testing claim in the system from birth to current date
  - Lead testing codes used to identify claims include: G0001LD, G0001RX, G0001PR, G0001UA, 99499LD, 99499UA, 83655, and 83655TC.
- *Interventions to identified members with no lead screening:*
  - Send lead information letter to those identified members ages 6 months to 12 months – educate on the importance of scheduling an EPSDT and lead testing at 12 months of age
  - Identify members from data file ages 12 months to 36 months with no lead testing claim
  - Send educational letter to all members identified as 12 months to 36 months with no lead testing claim
  - Further stratify those members in Jackson County between the 5 highest risk zip codes (64050, 64052, 64053, 64066, and 64088) and all other zip codes in Jackson County
  - Perform phone call outreach to members residing within the 5 highest risk zip codes in Jackson County – track outcome of those calls (i.e. reached, unable to reach, appointment scheduled, etc.)

- Send PCP's identified from member listing a letter notifying of their member(s) who need lead testing performed

- *Education to the Health Departments in CMFHP's service area regarding appropriate coding and billing for lead screening tests:*
  - Meet with Provider Relations to identify current testing and case management codes
  - Test codes in OAO to ensure accurate adjudication
  - Develop a Quick Reference Guide (QRG) for appropriate codes to take to all Health Departments identified
  - Educate Health Department staff on QRG and accurate coding/billing practices
- *Increase access to lead testing and case management for CMFHP members:*
  - Educate providers and members on lead testing guidelines:
    - Send laminated lead QRG to network PCP offices
    - Add lead information to quarterly member newsletter
    - Add lead information to quarterly provider newsletter
    - Add new brochures to member OB packets
    - Add lead as risk factor to Pregnancy Notification Form (PNF)
  - Identify out of network providers for lead filter testing
  - Contract with Tamarac for lead filter testing in provider offices
  - Review Health Department contracts to ensure lead case management services are included

Hypotheses

Children whose parents receive reminder calls and/or letters containing education about lead toxicity and prevention will be more likely to:

- ✓ Schedule a well child visit
- ✓ Receive a blood lead level test
- ✓ Be identified with lead toxicity; and

Less likely to:

- ✓ Have sick child visits
- ✓ Be hospitalized for chelation therapy

Study Questions

This study is designed to answer the following questions:

1. Do letters and reminder calls to children identified as needing blood lead testing result in increased lead testing for those children?

2. Do letters and reminder calls to children identified as needing blood lead testing result in increased referrals to Case Management for high lead levels (i.e. greater than 10 u/dL)?

Indicators

Rate of blood lead testing per member of the study population. (Goal = 75%) Every 3 months, claims data for the study population will be queried to determine if blood lead level testing has been performed.

Rate of case management cases referred for blood lead level greater than 10 u/dL. Every 3 months, the case management database will be queried to determine if referrals to case management have increased since implementation of the project.

Study Population

The study population included in this project will be children continuously enrolled with CMFHP since birth, who are between the ages of 6 months and 3 years of age.

Sampling Methods

No sampling method will be used. All children who meet the criteria for the study population will be targeted for intervention.

On a semi-annual basis, the eligibility files will be queried to add new members into the study based on established criteria. This is scheduled to occur April 1st and October 1st of each year.

Data Collection

Baseline data on the study population has already been collected, as this study is focusing on members identified with no lead screening claim. Following implementation of the interventions, claims data for the study population will be queried every 3 months in order to evaluate the effectiveness of the interventions. Data will be tracked in excel spreadsheets for ongoing monitoring and reporting of outcomes.

Data Analysis

Data analysis will be performed through the use of control charts, measuring the pre and post intervention effectiveness of both the mailings and the phone interventions. The members who are not able to be contacted will serve as the control group. Analysis will be conducted separately for the 6 month to 1 year old group and the 1 year old to 3 year old group.

Project Implementation

Data will be requested from the CMFHP information system (OAO) to determine the study population and for ongoing claims analysis. Claims for the study population will be analyzed every 3 months following implementation.

The project team will meet monthly through the Special Healthcare Needs Committee for planning and discussing the collection of data, implementation of interventions, and evaluation of the project's progress.

A quarterly summary of the project will be provided to the Medical Management Committee for physician input.

A quarterly update will be provided to the Utilization Management/ Medical Director Committee for internal stakeholder input.

A summary of the project will be provided to the Consumer Advisory Committee for consumer/member input.

Post Intervention Analysis

7/15/05 Study Group 1

The first claims data was reviewed from Study Group I. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. This group received letter intervention educating them about their upcoming EPSDT visit and the need for a blood lead level test. There were a total of 757 members identified for this study group. Letters were sent to these members on 11/12/04. Claims data was pulled on 6/1/05 to identify at least one blood lead level draw on these members from dates of service 11/12/04-5/31/05. Of the 757 members, 468 (or 62%) had a claim for a blood lead level in that timeframe. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 485 out of 774 continuously enrolled members now have a lead screening claim in the system, which is a 63% lead screening rate.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. This group received letter intervention educating them about the need for blood lead level screenings at 12 and 24 months. There were a total of 3,140 members identified for this study group. Letters were sent to these members on 12/10/04. Claims data was pulled on 6/1/05 to identify at least one blood lead level draw on these members from dates of service 11/12/04-5/31/04. The baseline for this group is zero, as any member with a previous blood lead level claim had been excluded from the study group prior to the intervention. Of the 3,140 members, 1,901 (or 61%) had a claim for a blood lead level in that timeframe. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 3,129 out of 4,368 continuously enrolled members now have a lead screening claim in the system, which is a 72% lead screening rate.

Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. There were 203 members identified for Group 1C. This group received the letter intervention on 12/10/04, as described in the paragraph above, but they also received an additional phone intervention from a Health Services staff member. During the phone intervention to these 203 members, only 67 members (or 33%) were successfully contacted. Claims data was pulled on 6/1/05 to identify at least one blood lead level draw on these members from dates of service 11/12/04-5/31/04. Of the 203

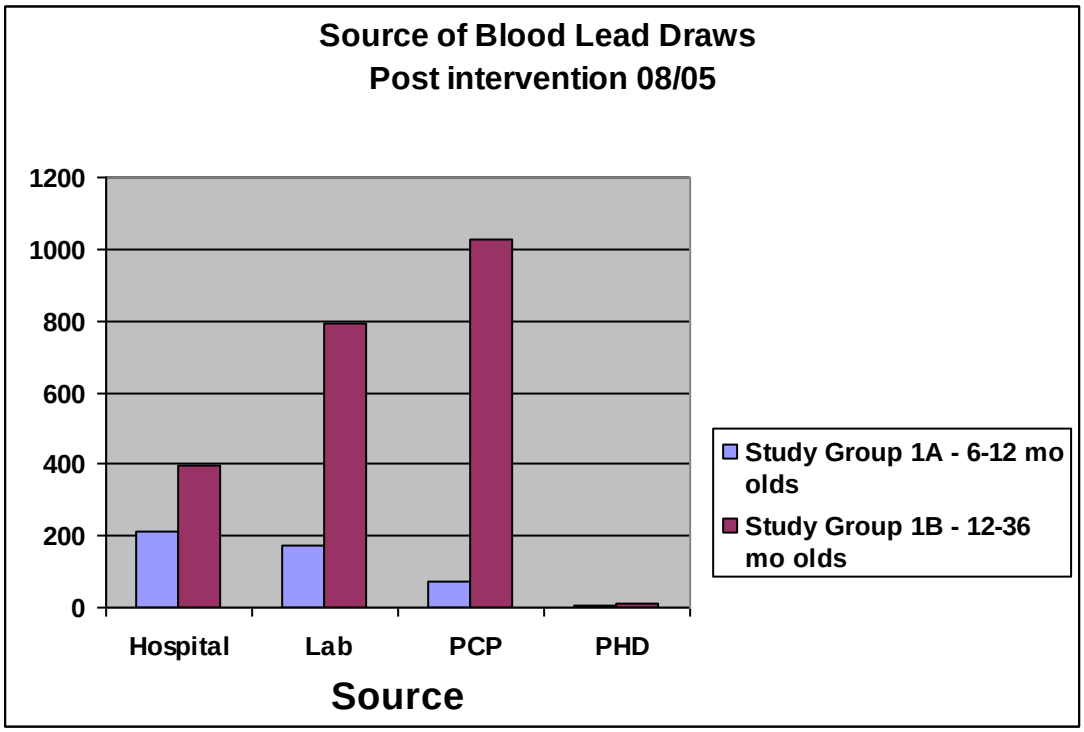
members, 134 (or 66%) had a claim for a blood lead level in that timeframe. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 178 out of 247 continuously enrolled members now have a lead screening claim in the system, which is a 72% lead screening rate.

Lead Case Management referrals were reviewed in the 10 month timeframe since initiation of this project as well. Baseline data of referrals from 3/03 to 8/04 showed an average of 7.6 referrals per month. In the timeframe between 9/04 and 6/05, average referrals were 7.7 per month.

Analysis of Results:
Considering CMFHP's average lead levels for the overall population in 2003 and 2004 were 20-28%, the results of demonstrated blood lead level testing from this initial intervention are significant. Per the study guidelines, claims data will continue to be evaluated on an every 3 month basis. In addition, a second study group was initiated starting in April 2005.

Lead case management referrals have not changed significantly in this initial analysis.

08/16/05 Additional analysis was completed on both Study Groups 1A and 1B concerning the source of blood lead screening for the member's who have now rec'd lead screening. The following table outlines the data collected related to the source of blood lead draw claims.



Post Intervention Analysis

10/15/05 Study Group 1

The second claims data was reviewed from Study Group I. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. Claims data since intervention now demonstrates that 484 out of 757 members have a lead screening claim in the system, which is 64%. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 501 out of 774 continuously enrolled members now have a lead screening claim in the system, which is a 65% lead screening rate.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. Claims data since intervention now demonstrates that 1,953 out of 3,140 members have a lead screening claim in the system, which is 62%. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 3,181 out of 4,368 continuously enrolled members now have a lead screening claim in the system, which is a 73% lead screening rate.

Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. Claims data since intervention now demonstrates that 139 out of 203 members have a lead screening claim in the system, which is 68%. In looking at this age group before removing those who already had a lead screening in CMFHP's system prior to the intervention, a total of 183 out of 247 continuously enrolled members now have a lead screening claim in the system, which is a 74% lead screening rate.

Lead Case Management referrals were reviewed in the 14 month timeframe since initiation of this project as well. Baseline data of referrals from 3/03 to 8/04 showed an average of 7.6 referrals per month. In the timeframe between 9/04 and 10/05, average referrals were 8.3 per month. In trending overall lead case management referrals from March 2003 through October 2005, referrals have increased by 57%.

Analysis of Results:
Considering CMFHP's average lead levels for the overall population in 2003 and 2004 were 20-28%, the results of demonstrated blood lead level testing from this initial intervention are significant. Per the study guidelines, claims data will continue to be evaluated on an every 3 month basis. Claims data from Study Group 2 will be analyzed beginning in December 2005. In addition, a third study group was initiated starting in October 2005.

02/21/06 Study Group 1
The third claims data was reviewed from Study Group I in December 2005. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. Claims data since intervention now demonstrates that 486 out of 757 members have a lead screening claim in the system, which is a 64% screening rate for the members in the study.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. Claims data since intervention now demonstrates that 1,974 out of 3,140 members have a lead screening claim in the system, which is a 63% screening rate for the members in the study.

Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. Claims data since intervention now demonstrates that 150 out of 203 members have a lead screening claim in the system, which is a 74% screening rate for the members in the study.

Study Group 2

The initial claims data was reviewed from Study Group 2 in December 2005. In the Study Group, 3 groups were identified and labeled as 2A, 2B, and 2C. Members who were already included in Study Groups 1A, 1B, or 1C were excluded from Study Group 2.

Group 2A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months and not already included in Study Group 1A. This group received letter intervention educating them about their upcoming EPSDT visit and the need for a blood lead level test. There were a total of 706 members identified for this study group. Letters were sent to these members on 6/16/05. Claims data was pulled on 12/1/05 to identify at least one blood lead level draw on these members from dates of service 6/16/05-11/30/05. Of the 706 members, 353 (or 50%) had a claim for a blood lead level in that timeframe.

Group 2B represents all members continuously enrolled since birth between the ages of 12 months and 36 months and not already included in Study Group 1B. This group received letter intervention educating them about the need for blood lead level screenings at 12 and 24 months. There were a total of 330 members identified for this study group. Letters were sent to these members on 6/16/05. Claims data was pulled on 12/1/05 to identify at least one blood lead level draw on these members from dates of service 6/16/05-11/30/05. The baseline for this group is zero, as any member with a previous blood lead level claim had been excluded from the study group prior to the intervention. Of the 330 members, 62 (or 19%) had a claim for a blood lead level in that timeframe.

Group 2C is a subgroup of Group 2B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area and not already included in Study Group 1C. There were 21 members identified for Group 1C. This group received the letter intervention on 6/16/05, as described in the paragraph above, but they also received an additional phone intervention from a Health Services staff member. During the phone interventions to these 21 members, 6 members (or 29%) were successfully contacted. Claims data was pulled on 12/1/05 to identify at least one blood lead level draw on these members from dates of service 6/16/05-11/30/05. Of the 21 members, 4 (or 19%) had a claim for a blood lead level in that timeframe.

Analysis of Results:

Initial results from this study groups 2B and 2C are not as significant as they were for study groups 1B and 1C, however, the study population was smaller and the phone interventions were less successful in this study group. Per the study guidelines, claims data will continue to be evaluated on an every 3 month basis for this study group. Initial results for Study Group 3 will be obtained in June 2006.

CMFHP has decided, based on the initial results from Study Groups 1 and 2, that a process will be established in 2006 to perform these interventions on all CMFHP members between the ages of 6 months and 36 months twice a year, regardless of continuous eligibility status.

03/29/06 Study Group 1
The final claims data was reviewed from Study Group I in March 2006. In the Study Group, 3 groups were identified and labeled as 1A, 1B, and 1C.

Group 1A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months. Claims data since intervention now demonstrates that 498 out of 757 members have a lead screening claim in the system, which is a 66% screening rate for the members in the study.

Group 1B represents all members continuously enrolled since birth between the ages of 12 months and 36 months. Claims data since intervention now demonstrates that 2,010 out of 3,140 members have a lead screening claim in the system, which is a 64% screening rate for the members in the study.

Group 1C is a subgroup of Group 1B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area. Claims data since intervention still demonstrates that 150 out of 203 members have a lead screening claim in the system, which remains at a 74% screening rate for the members in the study.

Study Group 2
The second quarterly claims data was reviewed from Study Group 2 in March 2006. In the Study Group, 3 groups were identified and labeled as 2A, 2B, and 2C.

Group 2A represents all members continuously enrolled since birth between the ages of 6 months and 11.9 months and not already included in Study Group 1A. Claims data since intervention now demonstrates that 382 out of 706 members have a lead screening claim in the system, which is a 54% screening rate for the members in the study.

Group 2B represents all members continuously enrolled since birth between the ages of 12 months and 36 months and not already included in Study Group 1B. Claims data since intervention now demonstrates that 78 out of 330 members have a lead screening claim in the system, which is a 24% screening rate for the members in the study.

Group 2C is a subgroup of Group 2B. This group represents those members who reside within one of the top five zip codes for lead exposure in the Kansas City area and not already included in Study Group 1C. Claims data since intervention now demonstrates that 5 out of 21 members

have a lead screening claim in the system, which is a 24% screening rate for the members in the study.

Analysis of Results:
Continue to monitor quarterly results for study groups 2 and 3. Study group 3 will have initial post-intervention results evaluated in June 2006. Study Group 1 has completed a full one year post-intervention analyses, therefore, no further data review on Study Group 1 will be conducted. Due to the success of this intervention, beginning in July 2006, CMFHP will implement this initiative as a semi-annual intervention to all members between the ages of 6 months and 36 months.

Definitions

CMH – Children's Mercy Hospital
ED – Emergency Department
ER – Emergency Room
PCP – Primary Care Physician
TMC – Truman Medical Center
CMFHP- Children's Mercy Family Health Partners

Study Topic

Children's Mercy Family Health Partners (CMFHP) recognizes the importance of monitoring member use of emergency services for identification of inappropriate utilization. Inappropriate use of emergency services can lead to non-compliance with preventive services, such as well women screenings, as well as lack of coordination of care between providers and increased cost of services. These concerns regarding decreased quality of care for our members, as well as increasing costs, have brought the issue of emergency services utilization to the forefront of our utilization management initiatives. Children's Mercy Family Health Partners wanted to maintain a balance of educating members on the appropriate use of emergency services, while not limiting their access to the care they need.

In 2004, Children's Mercy Family Health Partners assigned a designated Case Manager to manage members who frequented the ER for non-emergent reasons, as well as send letter outreach to members who were using the ER for dental-related care and using ambulance services for non-emergent transport. The CMFHP Case Manager identified the members in various ways, including:

- Monthly report of all members with more than 2 ED visits in 60 days
- Monthly ED Utilization – all members who visit the ED in the reporting month
- All members who visit the ED at our highest volume facilities (Children's Mercy Hospital and Truman Medical Center) during the current week
- Monthly reports from our Nurse Advice vendors indicating call volumes, types of calls, and triage decisions
- Referrals from Pre-certification or Utilization Review staff

These reports have been used to identify trends in emergency service utilization, as well as whether patients who visited the ED frequently have established a relationship with their Primary Care Physician (PCP).

Identified findings included:

- Approximately 72% of the calls to our Nurse Advice line were for pediatric members, and 28% were for adult members.
- Of those who utilize Nurse Advice, 17 % are sent to the ED based on appropriate triage criteria.
- Of the members who utilized the ED more than twice in 60 days, 90% had never seen their PCP.
- Nurse Advice calls for both adults and pediatrics had been decreasing over time.
- Emergency Room utilization for adults increased in 2002-2003 by approximately 17% for pediatrics and 43% for adults (overall trends for entire 2 year period).

To address the issue of over-utilization of emergency services, Children's Mercy Family Health Partners identified and implemented the following interventions throughout 2004:

- Developed process to call members who utilize the ED for non-emergent services and educate about PCP usage and appropriate access of services.
- Mailed monthly educational letters to adult members identified as using the ED for dental services – including information on dental resources for adults.
- Mailed monthly educational letters to members identified as using the ED for non-emergent diagnoses – including information on Nurse Advice services

In evaluation of our program, at the end of 2004, we determined that the Case Manager was only successful in reaching about 20% of the members she identified. In addition, our ER utilization trends continued to rise. We decided to try something new.

In January 2005, we held a meeting with the Chief Medical Officer and Director of ED Services at Truman Medical Center, our highest volume ER for adult members. After brainstorming issues, the team agreed to pilot a program that would involve our Case Manager spending approximately 4-6 hours per day in the TMC ER seeing CMFHP members who have presented for non-emergent services.

After working with the Compliance and Information Technology teams at TMC, the pilot was implemented in mid January 2005.

Description of Intervention

The Case Management pilot will involve the Case Manager working with the ER staff at TMC 4-6 hours a day. A process will be established to refer CMFHP members to the Case Manager after the member has been triaged and determined to have a non-emergent diagnosis. The Case Manager will meet with the member, either while the member is waiting to be seen by the

physician or after the ER visit concludes, and attempt to determine the reason for the non-emergent visit. The Case Manager's role will be to educate the member on how to access PCP services, assist with choosing a PCP when needed, educate on how to obtain transportation if needed, and educate on the use of Nurse Advice services and other community resources. The Case Manager will also be a resource person for the members seen post intervention and continue to assess needs, referring for more focused disease management as needed. The Case Manager will have access to a laptop and the CMFHP network in order to access the member's PCP status, claims history, and eligibility.

Hypotheses

(1) Members are utilizing Emergency Room services for non-emergent needs, in some cases, in place of utilizing a Primary Care Physician.

(2) Providing direct contact and assistance to the members in accessing a Primary Care Provider or Urgent Care Center for non-emergent services, will decrease ER visits overall and increase access to Primary Care services.

Study Questions

This study is designed to answer the following questions:

3. Does placing a Case Manager in the ER during peak day hours for education of members reduce overall ER utilization in the adult population?

4. Does placing a Case Manager in the ER during peak day hours for education of members increase overall utilization of primary care services for the adult population?

5. Does education of Nurse Advice services during an ER visit increase utilization of those services in the future?

Indicators

Rate of Emergency Room Utilization. Every 3 months, claims data will be queried to determine the rate of ER utilization per 1000 members.

Use of PCP, Urgent Care and ER Visits. In late 2005, CMFH will identify a study population for review of utilization patterns before and after intervention, including ER utilization, Urgent Care utilization, and PCP utilization.

Rate of Nurse Advice Line calls. Every 3 months, call center data will be reviewed to determine the rate of Nurse Advice utilization per 1000 members.

Study Population

The study population for this project is CMFHP members who are identified as having a non-emergent diagnosis and have sought care in the Truman Medical Center ER during the 4-6 hours each day that the CMFHP Case Manager is present. CMFHP members are Medicaid recipients who reside in a nine county area and meet the eligibility requirements for MC+ Managed Care benefits.

Sample Size

The sample size will consist of all members seen by the CMFHP Case Manager during the timeframe of the study, or a minimum of one year.

Data Collection

The ER Case Manager will collect data on each member seen in the ER, such as demographics, reason for visit, education provided, barriers identified, and interventions completed. In addition, the Case Manager will follow the members post intervention and document compliance with the agreed upon plan (i.e. attending a PCP appointment, arranging transportation, etc.).

Data Analysis

Data analysis will be performed through the use of control charts, measuring the pre and post intervention effectiveness of the Case Management interventions. There are many variables assessed in this study. Most common ER complaints, ER, PCP, and UC visits, demographics, and member seasonality are some of the variables to be reviewed when compiling the data.

Project Implementation

Education began in January of 2005, Monday through Friday for a total of 4 hours per day; approximately 80 hrs per month. An ER Database was developed to track members in the study with key indicators for demographic data, reason for visit, PCP history, barriers identified, and interventions.

A laptop was obtained and network capability provided to give the Case Manager access to the CMFHP network for member eligibility, PCP, claims, and authorization history.

Demographic Data Analysis

Below is initial demographic data gathered on the population receiving the intervention from January 2005 through October 2005. There were 215 members seen during this timeframe and used for analyzing demographic trends of members seen in the Truman Medical Center ER.

Disclaimer

There were eight members that duplicated ER services at Truman Medical Center within the period of the 10-month study. Therefore, some of geographical and demographical data consists of duplicated members.

Most Common ER Complaints

Out of the 215 members, there were 180 different ER complaints. Chart 1.1 displays the 11 most common ER complaints that involved 2 or more members from Jan 2005 through Oct. 2005.

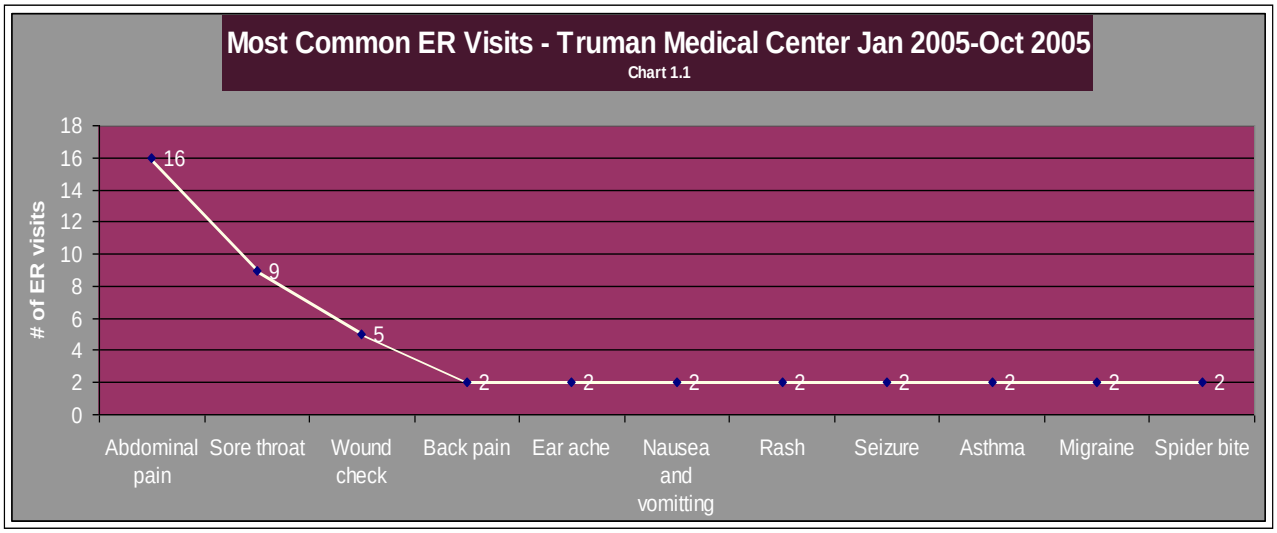


Chart 1.1

Member Seasonality

Specific months were reviewed to determine the most utilized months of the ER. Chart 1.2 displays the member seasonality from Jan 2005 through Oct. 2005.

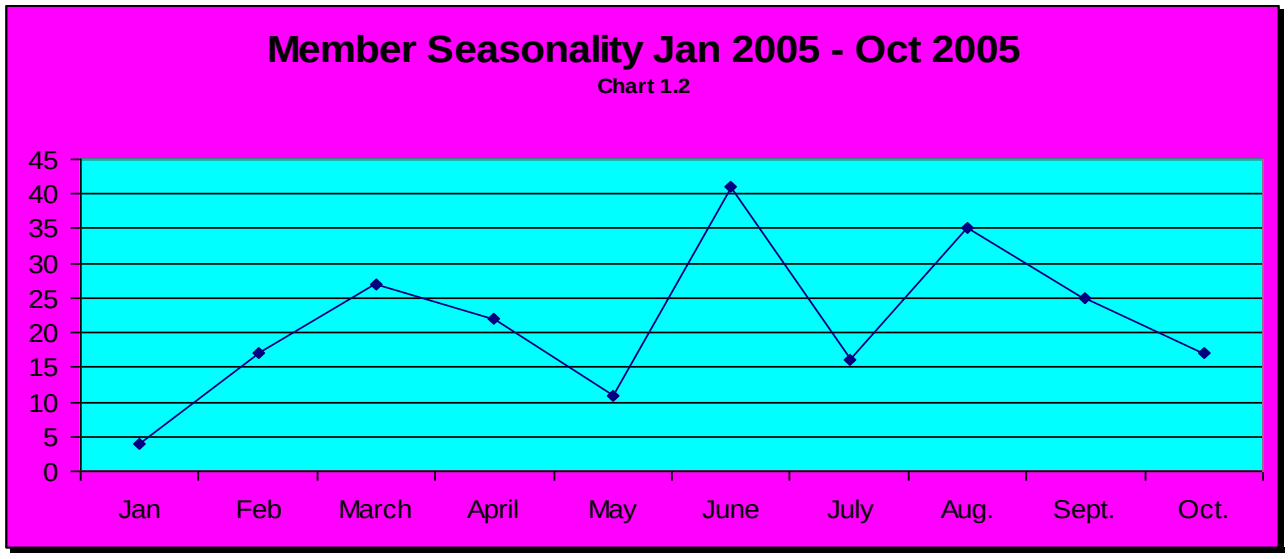


Chart 1.2

ER, PCP, UC Visits

Emergency room, primary care and urgent care visits were compiled for the 215 members from years 2003, 2004, and 2005. Chart 1.3, 1.4 and 1.5 displays the total number of visits among these 215 members from years 2003-2005.

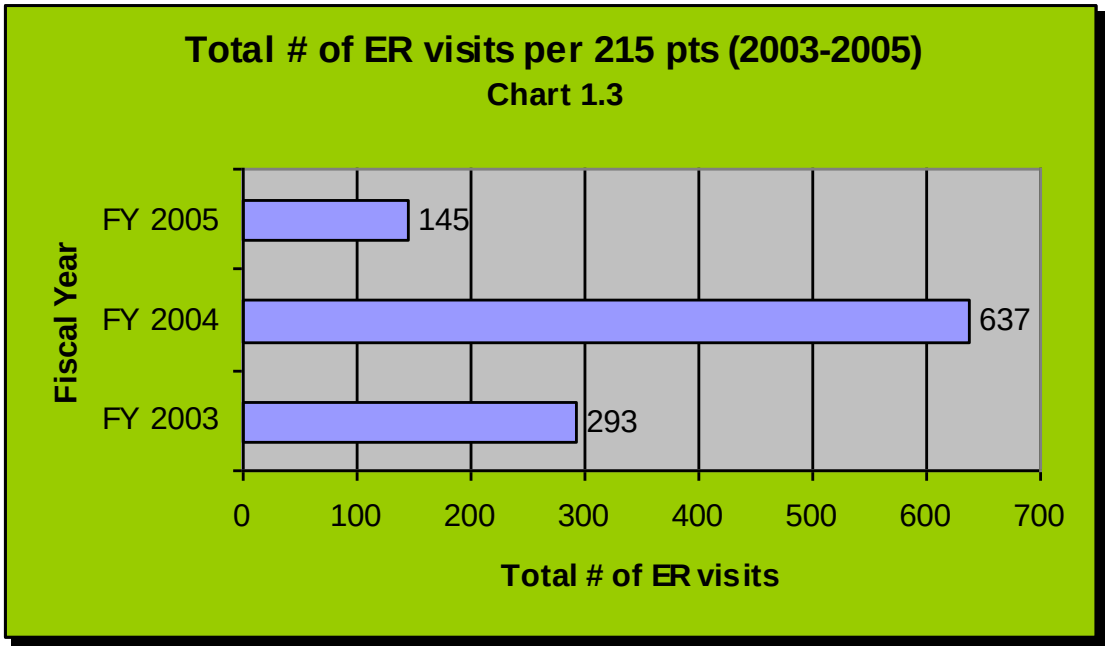


Chart 1.3

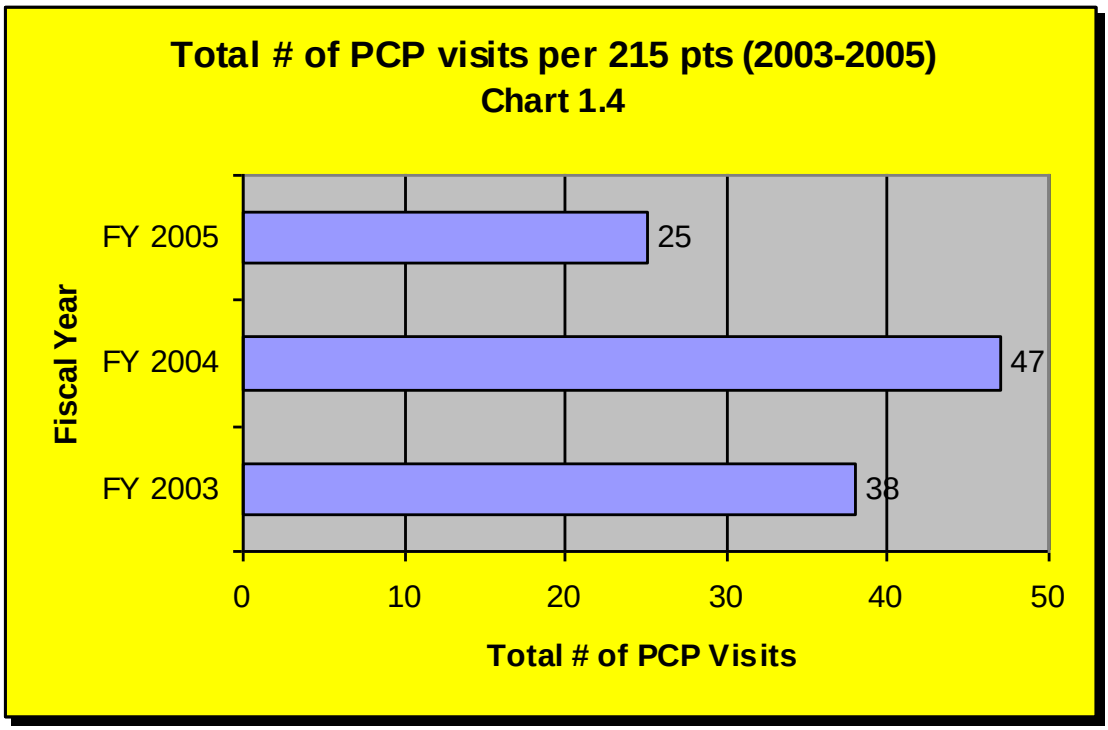


Chart 1.4

Note: Fiscal year represents a calendar year

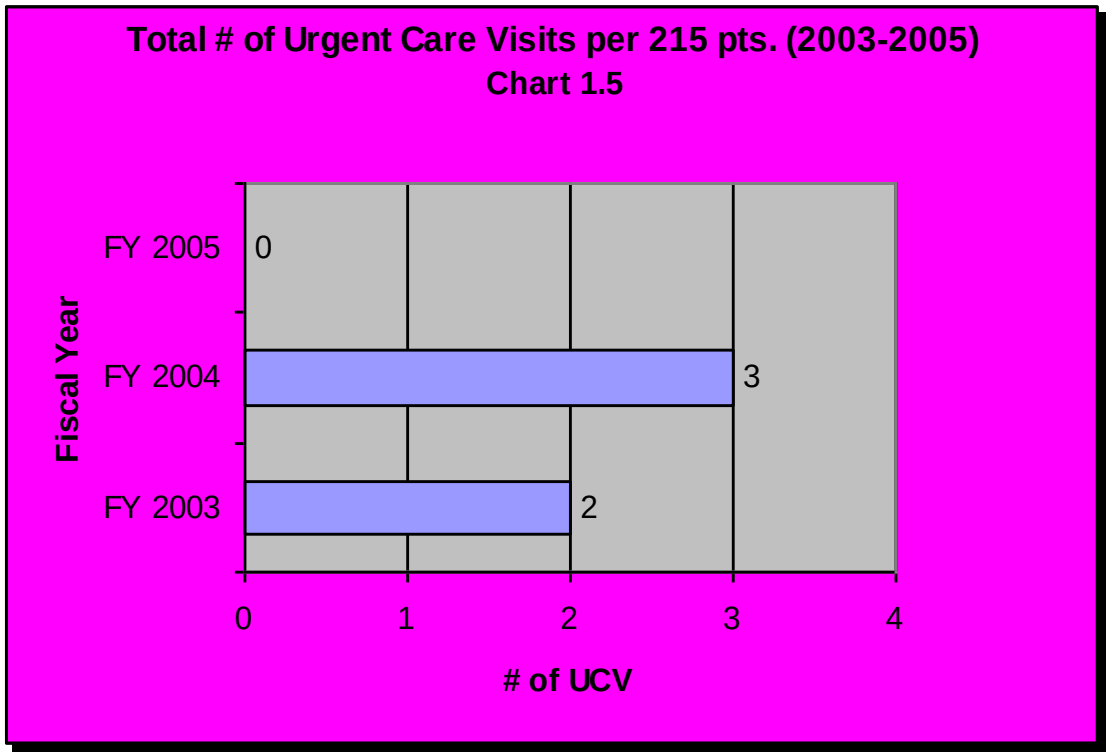


Chart 1.5

Note: Fiscal year represents a calendar year

Demographics

Demographics were analyzed which include gender, most common age groups, and most common patient origins. Charts 1.6 and 1.7 display demographical information for the 215 members from fiscal year 2005. 90% of the members seen during this timeframe were female and the average age was 31 years old.

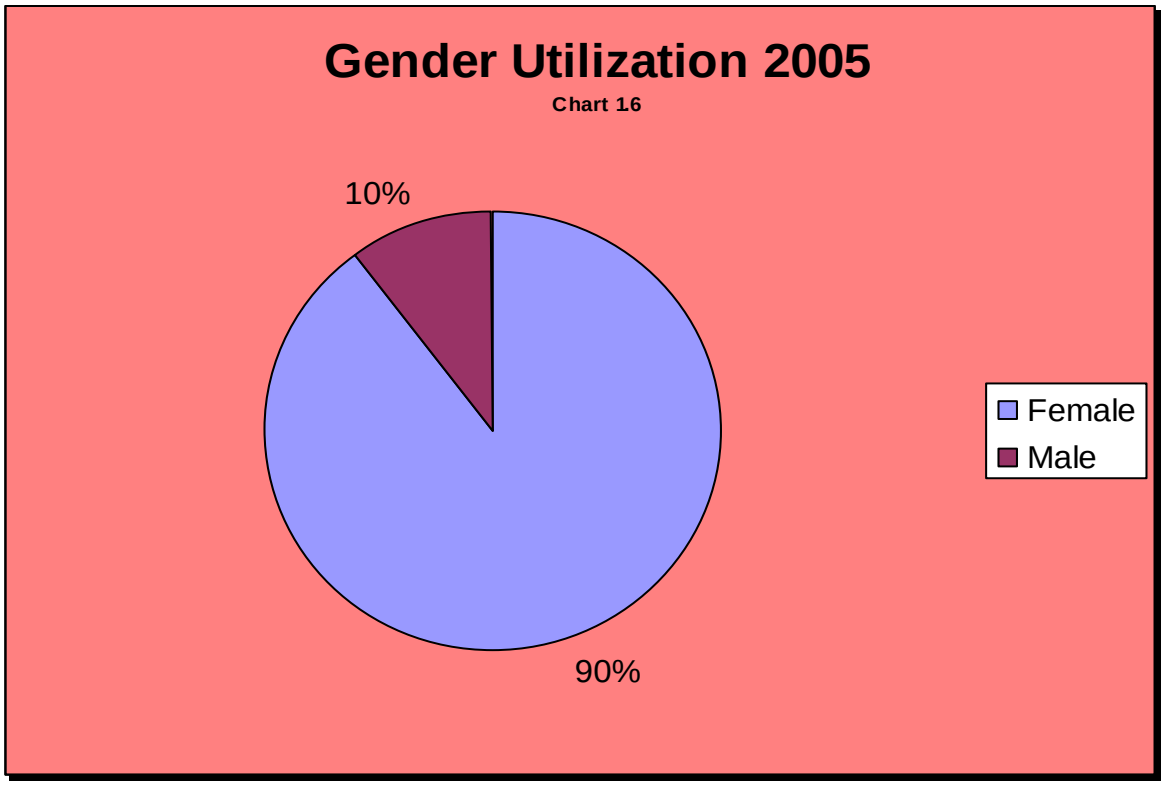
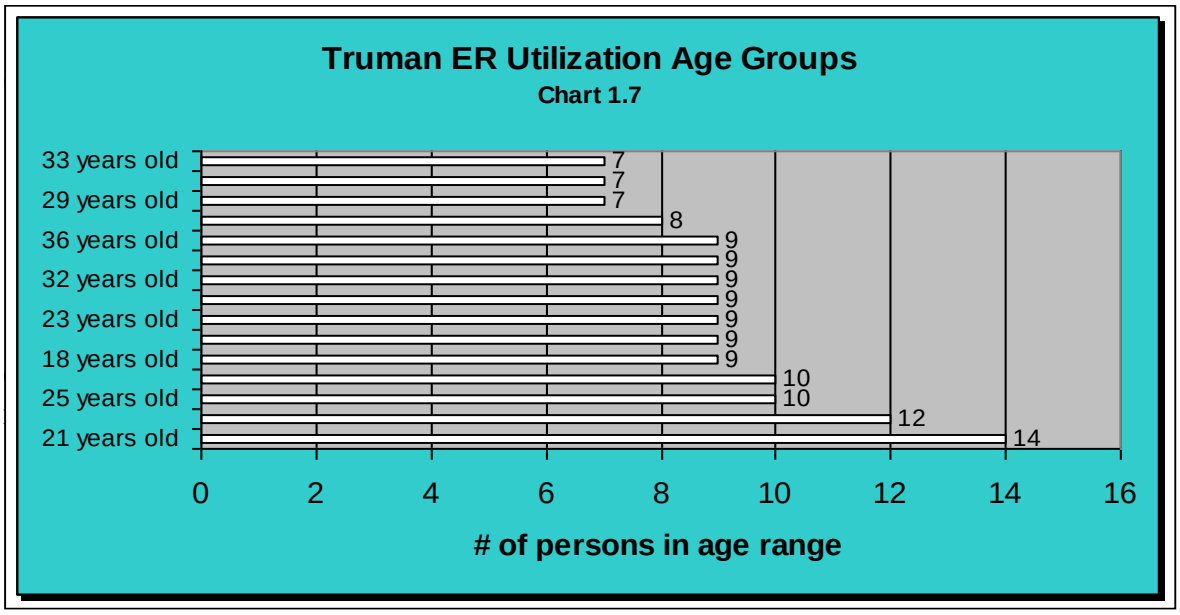

Gender Utilization 2005
Chart 16
10%
90%
Female
Male

Chart 1.6


Truman ER Utilization Age Groups
Chart 1.7
33 years old
29 years old
36 years old
32 years old
23 years old
18 years old
25 years old
21 years old
7
7
7
8
9
9
9
9
9
9
9
10
10
12
14
0
2
4
6
8
10
12
14
16
# of persons in age range

Additional Analysis of the entire CMFHP population

In addition to gathering data for the 215 members who received education in 2005, data was derived from 2002 through 2004 to discover the total number of ER visits per member for all of CMFHP's membership to analyze comparisons between the study population and the entire CMFHP population in the future.

The below chart (1.9) shows ER visits per 1000 members by pediatric and adults from 1st Quarter 2002 through 4th Quarter 2004. In analyzing this data, it was determined that the shift in increased visits noted in 1st Quarter 2004 was a result of urgent care coding changes, therefore, the overall trend is inflated. In order to eliminate the external cause, the next chart (1.10) demonstrates the ER visit per 1000 trend for just 2004 (after the coding changes were implemented).

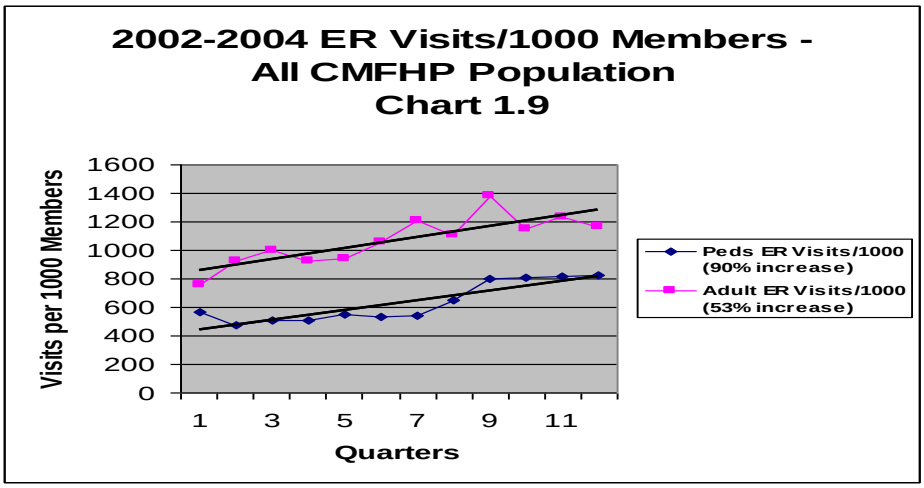


Chart 1.9

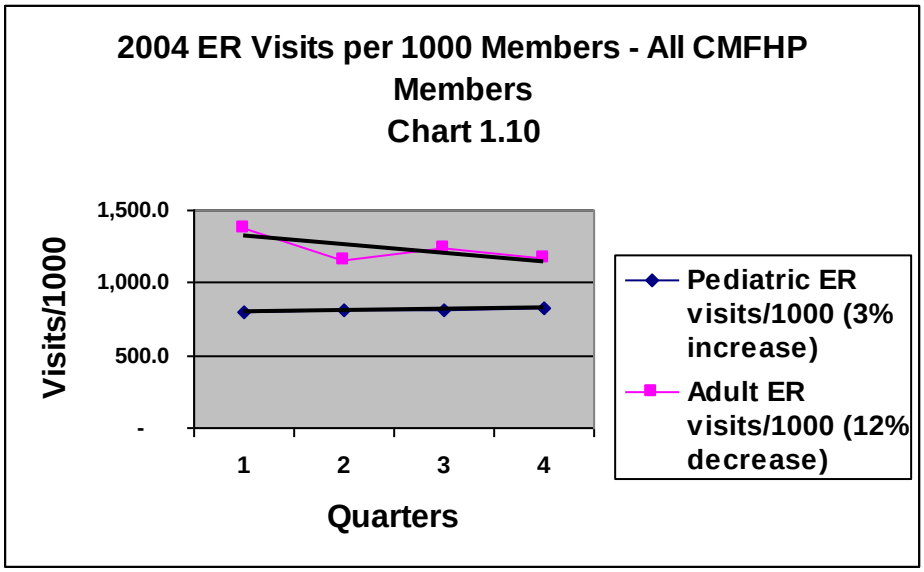
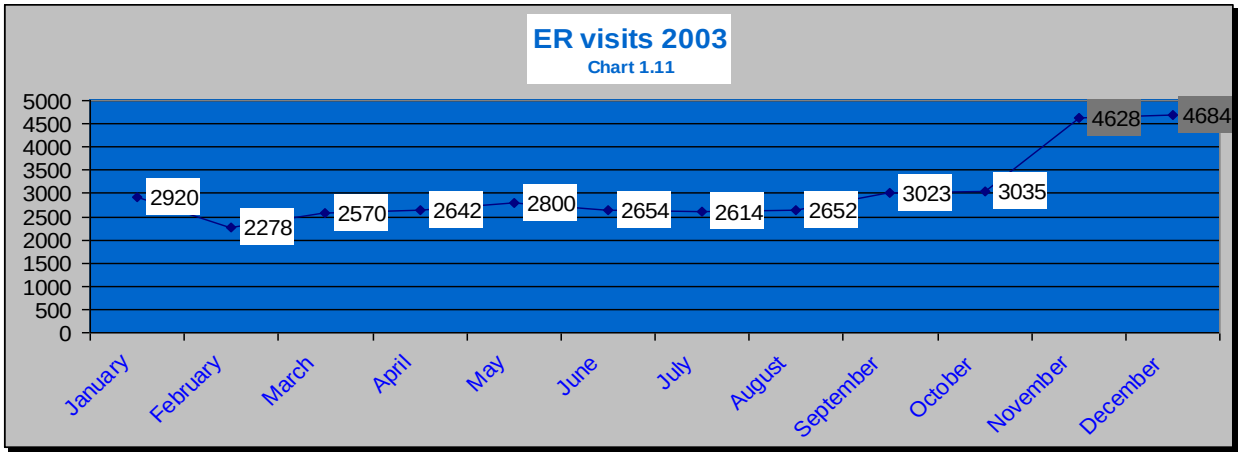
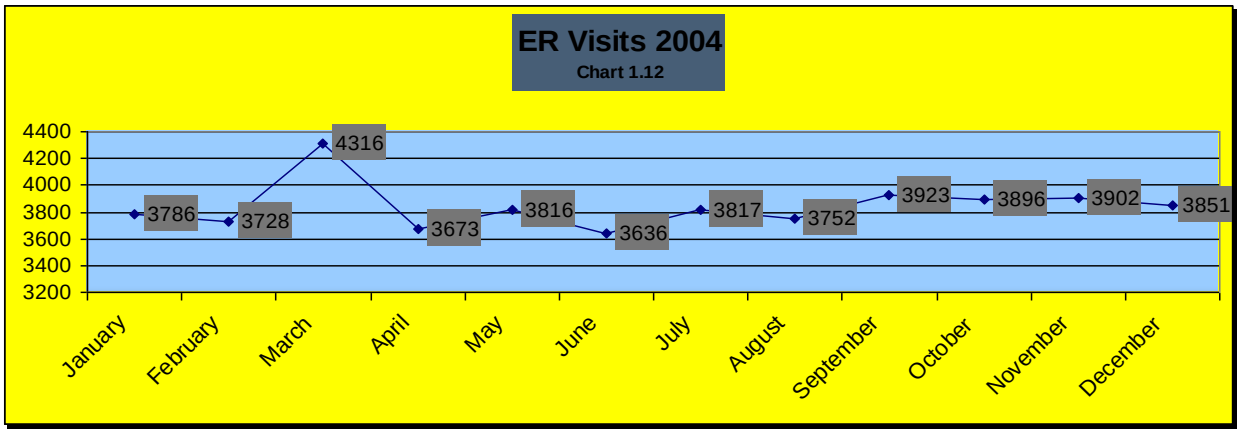
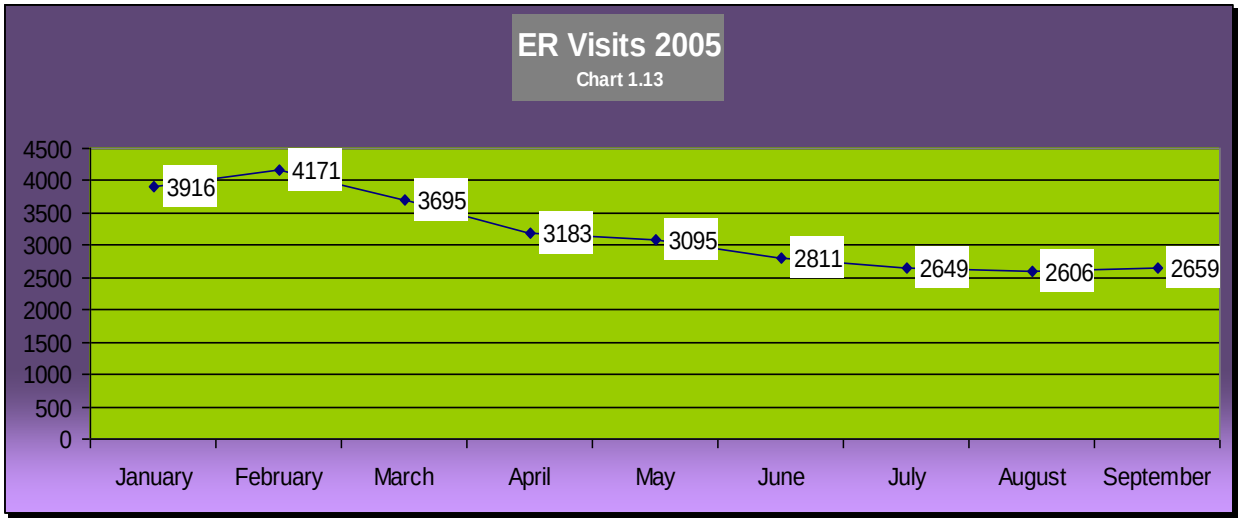


Chart 1.10

Specific information was collected to determine the months most utilized in 2003, 2004 and 2005. Charts 1.11, 1.12, and 1.13 do not show consistent commonality or monthly seasonality from year to year.







Data Analysis Plan

In February 2006, further analysis of the study population was completed with the assistance of a statistician, including collection of eligibility history with CMFHP. Due to changes in adult eligibility criteria in the second half of 2005, many of the original 215 members in the study were no longer eligible. In addition, as pre-intervention data began to be collected, it was determined that for purposes of the study, members with at least 2 years of continuous eligibility and no greater than a 45 day gap in coverage with CMFHP, would be used for pre and post intervention data analysis. Members not meeting these eligibility criteria still received the intervention, but were not used as part of the data analysis going forward. In addition, after collecting the demographic data on the original 215 members, it was decided that all members for the first full year of intervention needed to be included in the study. Therefore, the remaining members seen from October 2005 through January 2006 were added to the data tables for eligibility analysis. The addition of these members increased the population to 238 members before eligibility criteria was applied.

Upon completion of the eligibility analysis, it was determined that 101 members met the criteria for evaluating pre and post intervention data. This study group will be used for analyzing specific utilization patterns (PCP usage, Urgent Care usage, and ER usage) for 2 years prior to the case management intervention and post intervention.

In addition, monitoring of the overall ER, PCP, and UC use for all CMFHP members will be done in conjunction with the study group analysis to determine if the trends differ for the study population in comparison to the overall population.

In January 2006, data began to be collected on a monthly basis for members having a full one year post intervention. However, due to typical three month claim lags, full post intervention analysis of claims data for members seen beginning January 2005 will not start until April 2006.

Future data analysis planned for the study population includes prescription history, total cost of care comparisons, and transportation utilization.

Nurse Advice call center statistics and Emergency Room, Urgent Care, and PCP visit utilization for members in the study will be measured and reported on a quarterly basis. This data will be requested from the CMFHP information system (MC400) based on claims submitted for payment to CMFHP and Nurse Advice center call statistics, as reported by the Call Centers.

This project will be monitored and reported through the semi-monthly Utilization Management/Medical Director Committee.

A quarterly update of the project will be provided to the CMFHP Medical Management Committee.

A summary of the project will be provided to the CMFHP Consumer Advisory Committee for consumer/member input.

CCP conducted two Performance Improvement Projects (PIP) in 2005, Early Intervention in Prenatal Case Management and Its' Relation to Very Low Birth Weight Babies and ER Utilization.

Early Intervention in Prenatal Case Management and Its' Relation to Very Low Birth Weight Babies

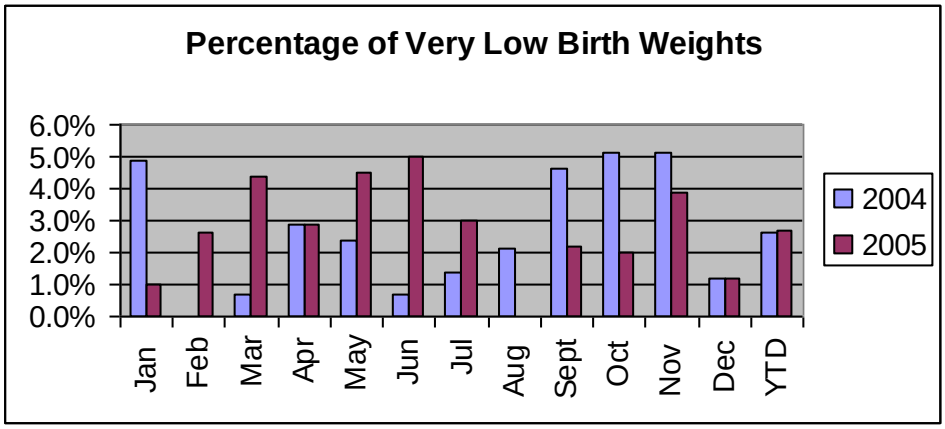
Steps taken by CCP provide early identification and implementation of case management for all pregnant members. It is our goal to increase members' access to prenatal care and implement early case management to reduce the incidence of very low birth weight deliveries. While trends on a national level continue to climb, the goal of the study is to realize a flat trend of very low birth weight deliveries.

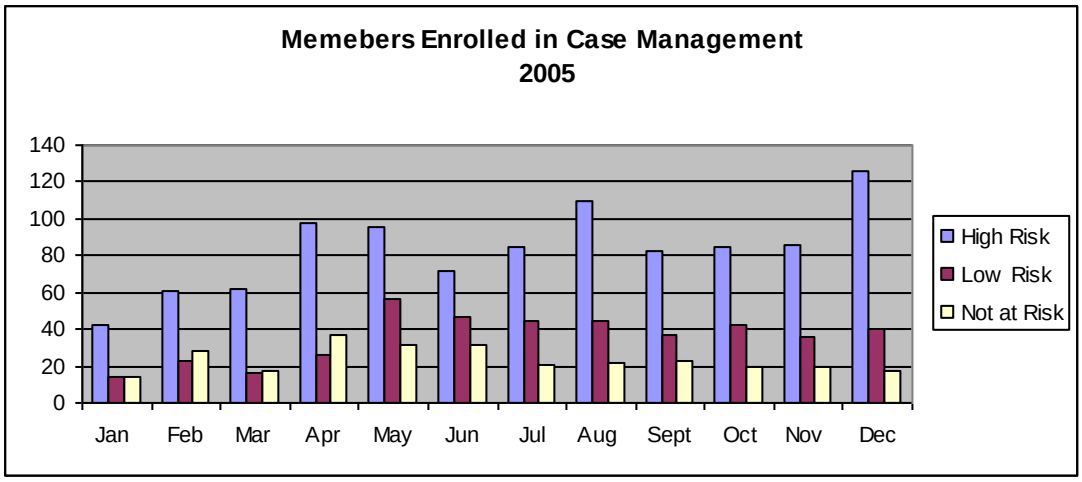
Members are assigned risk levels provided from the Pregnancy Risk Screening forms, telephonic interviews and home assessments. After the risk level has been assigned, case management is implemented. Prior to June 2005 only pregnant women at high risk received case management. Beginning in May 2005, case management was intensified to include all pregnant women.

Total Number Members in Case Management

Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
42	61	62	98	96	151	151	176	142	147	141	183

** June began case managing all pregnancies





In June 2005 began to case manage all pregnancies, not just high-risk pregnancies. The last half of 2005 showed an improvement in very low birth weight births. From August – December 2005 rates were equal to or lower than 2004 rates. 58% of all pregnancies in 2005 were identified as high risk. This is a 20% increase from 2004.

Comparing 2004 rates to 2005 rates, early interventions in Prenatal Case Management are meeting the goal of maintaining a flat trend in very low weight babies. Will continue to track and trend on a quarterly basis.

CCP's membership decreased significantly by 14% from June 3, 2005 - December 31, 2005, but the rate of pregnancies increased from .3% June 3, 2005 to .46% December 31, 2005.

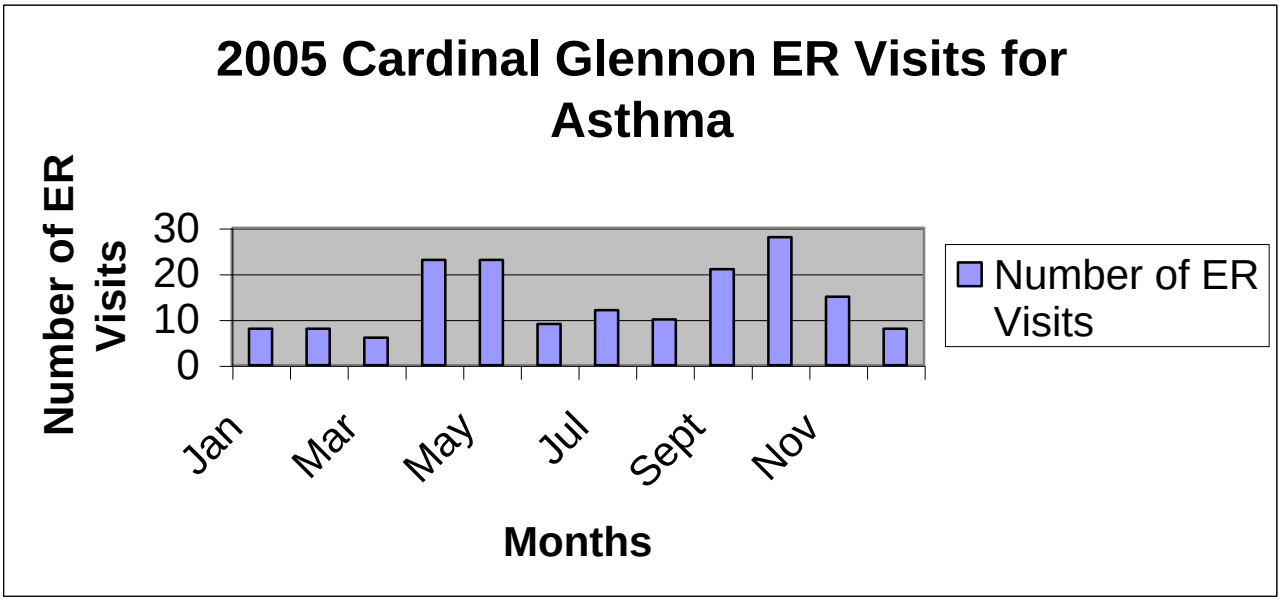
Conclusion: Data analysis for first half 2005 indicated a significant number of very low birth weight babies were products of pregnancies with no identifiable risk factors. In June 2005, CCP began to case manage all pregnancies. Full effect of this intervention will be evaluated through 2006. Two full time nurses are now responsible for case managing all pregnancies. The rate of OB case managed per 1000 members has increased quarter-by-quarter (data not shown). Even though membership has decreased in 2005, the rate of pregnancies increases.

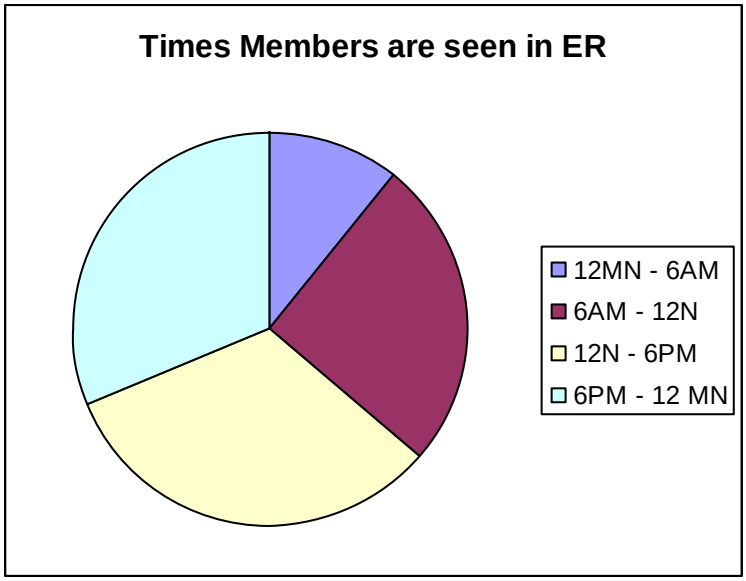
ER Utilization

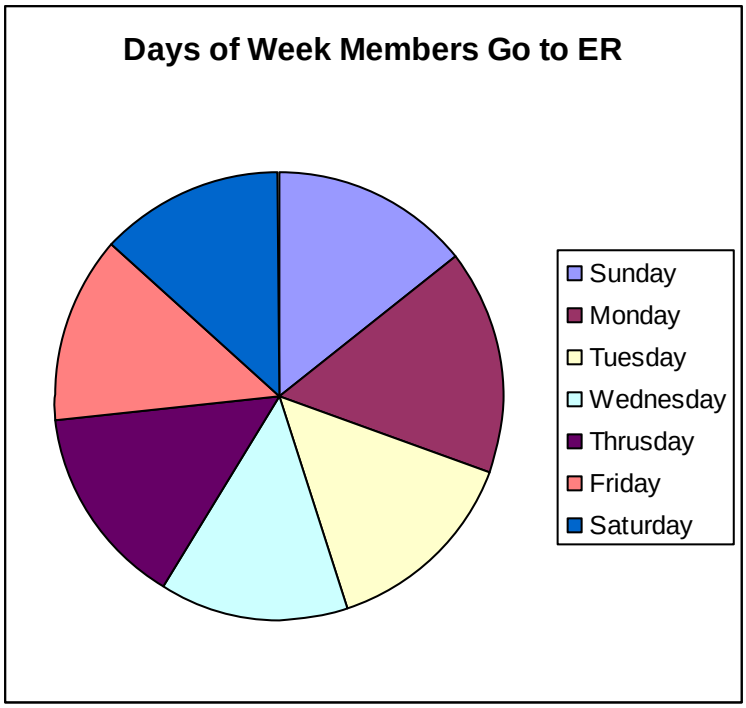
This PIP began as ER utilization for children receiving care at Cardinal Glennon ER.
The total number of ER visits study was reported to the July Quality Improvement Committee (QIC). Because there was no documentation of improvement, the QIC recommended and approved the study be narrowed and the focus would be on asthma related ER visit to Cardinal Glennon Hospital for children 5-18 years of age. This new focus was implemented October 2005.

There were 171 ER visits at Cardinal Glennon Hospital from January 2005 – December 2005 for asthma related complaints for 5-18 year olds. Cardinal Glennon was the focus of the study being the main pediatric hospital where most members seek treatment. October had the largest number

of asthma related visits with 28 visits. March had the lowest number of visits, 6. The average was 14 visits/month.







The study was redirected to focus on asthma related ER visits in October 2005. The data available for this study is insignificant to identify a trend. There is no trend identified for day of the week of ER visits. There is a trend to go to the ER between 12 noon and 12 midnight. Will continue to monitor, track and trend on a quarterly basis. The data will be related to asthma diagnosis only. The "Times Members are seen in ER" will be changed to 9am-5pm, 5pm-1 am and 1am-9 am, which will better map to providers' office hours.

A. Asthma Management: "Improving Asthma Medication Management"

This initiative was continued from the project's start in the 2nd quarter of 2003 to measure the asthma management of FirstGuard members and to educate providers and asthmatic members' families with the intent to improve asthma medication management. The study groups were evaluated after the 4th quarter 2004. The initiative appeared to have had a positive effect, in that the rate of asthmatics with no controller medication (long-acting effect) decreased to a very small percentage. The rate of asthmatics who have controller meds that continued to utilize a high number of short-acting beta agonist medications fell as well.

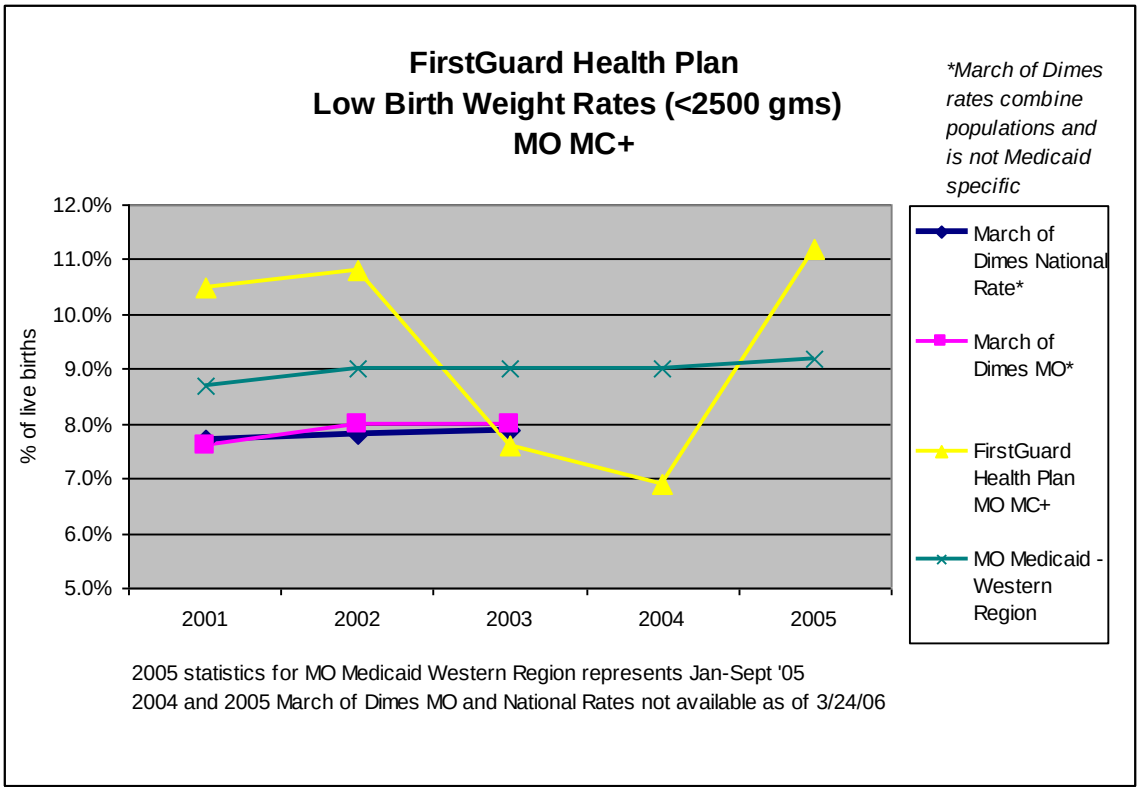
It was agreed to initiate a second cycle of member identification and member and provider interventions in order to determine whether the decrease in outcome rates would be similar after the same timeframe. The following table shows the baseline rates for MC+ and HealthWave. The same intervention with members and providers was completed in 2005. The next evaluation period is 1/1/2006 – 6/30/2006.

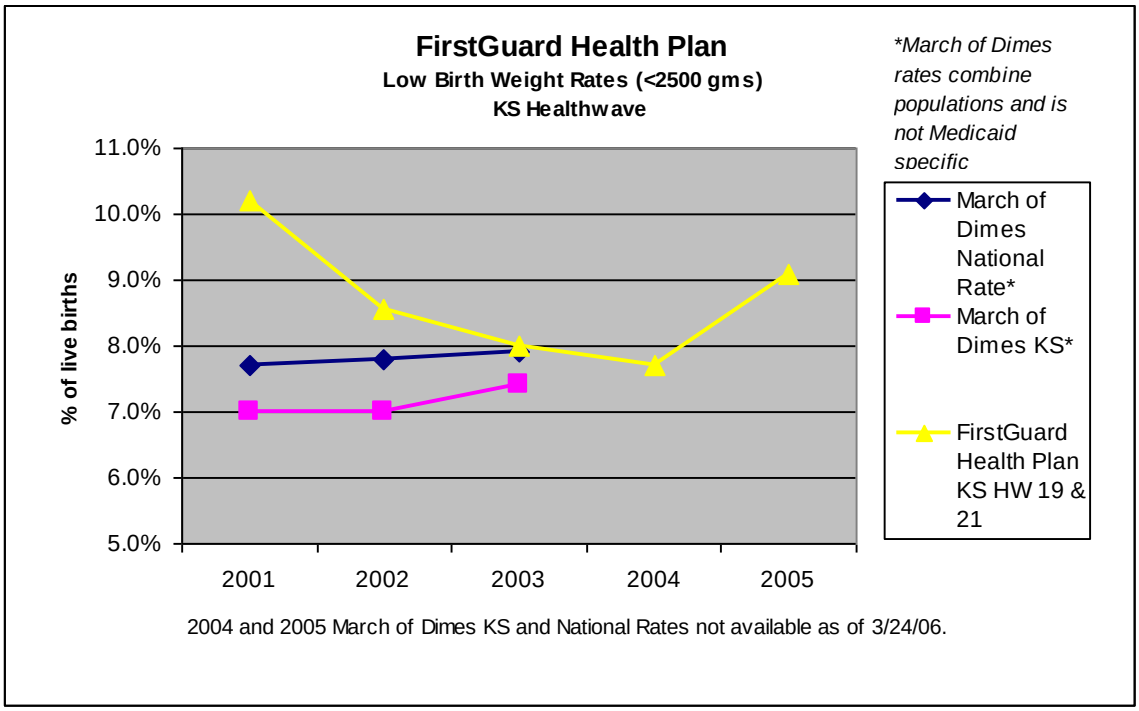
Baseline for Cycle 2 Assessment period- 10/01/2004 – 03/31/2005	Members with no controller and >1 beta agonist scripts	Members with controller and > 4 beta agonist scripts
MC+	2.76%	5.44%
HealthWave 19	2.08%	5.44%
HealthWave 21	2.1%	3.35%

In 2005, Centene Corporation acquired AirLogix, an NCQA-accredited respiratory care management company with offices in the Dallas Ft. Worth area. FirstGuard began contract negotiations with AirLogix to administer their asthma disease management program under the name FirstGuard Healthy Solutions for Life Program. Start date is planned for March 2006. It is anticipated that positive changes to the measures in the asthma medication management improvement project will occur more rapidly once this program is in place.

B. Low Birthweight: "Improving Birthweight Outcomes"

FirstGuard Health Plan developed the Improving Birthweight Outcomes Performance Improvement Project (PIP) in 2004 following the Centers for Medicare and Medicaid Services (CMS) 2002 protocols. The baseline goal is to reduce the incidence of low birthweight infants by 1% per year beginning in 2005. The following table shows FirstGuard member low birth weight rates between 2001 and 2005 for Kansas and Missouri:





The primary objective for the PIP is to address and affect the causes, particularly the psychosocial causes, of early labor and premature delivery of low birthweight babies. The PIP commenced with the collection of information from members and providers

via focus groups (held in November, 2004). FirstGuard Health Plan invited women who delivered a low birthweight baby during the time period between January and June 2004 to attend a focus group, share their experience during the pregnancy, and offer their ideas for improved prenatal support services from FirstGuard Health Plan. FirstGuard Health Plan also asked the members' providers to identify potential areas of assistance from FirstGuard that might have led to improvement in the length of gestation by several weeks. FirstGuard Health Plan utilized external assistance with the focus group presentations to acquire expertise in maternal/child health initiatives.

FirstGuard Health Plan staff reviewed the focus group final report and created a cause and effect diagram, including information obtained from the focus groups and from literature. The diagram displayed causes of low birthweight deliveries. Staff developed potential interventions based on the diagram, then selected, categorized and ranked them. As a result, staff implemented the Community Based Advocate approach as the first intervention. In early 2005 FirstGuard Health Plan launched a workplan to partner with agencies that provide home visits. FirstGuard Health Plan partnered with the following agencies for referrals: in Missouri: Kansas City Healthy Start, Building Blocks and StartRight Teen Moms: in Kansas: Healthy Babies, Inc. and the Kansas Healthy Start Home Visitors Program. FirstGuard Health Plan staff developed a database to capture required fields for the home visit referral process and delivery data. They developed pregnancy fact sheets for educating pregnant members. The quantifiable measure selected for the PIP is the percentage of members who deliver a baby less than 2500 grams (LBW delivery data). The 2004 LBW delivery data served as baseline data; 2005 LBW delivery data would serve as the first measurement for the PIP.

C. Special Needs

Clinical studies continued in 2005 to measure and improve case management services for children with special health care needs. The studies measured the enrollment into case management for members identified by the respective State agency as Children with Special Health Care Needs (CSHCN). The study was retired at the end of 2005 following demonstration of consistently high identification of CSHCN and development of treatment plans for members able to be contacted. These remain routine CSHCN processes following completion of study interventions.

D. Lead

FirstGuard continued activities with families of children 0 – 6 years with elevated blood lead levels (a level of 10 or greater) in 2005 for both Missouri and Kansas populations. The goals of the project were twofold: to increase the percentage of successful contacts between FirstGuard and the identified families and to increase the percentage of the children in care management.

FirstGuard continued to collaborate with the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Social and Rehabilitative

Services (SRS) to improve identification of children who have elevated blood lead levels for initiation and stratification of case management.

Clinical

Clinical indicators were measured according to HEDIS® specifications and tracked over the work plan period. Graphical reports comparing results to prior periods and state averages were reported to and analyzed by the QIC and internal management teams. Member and provider profiles included these measures and facilitated opportunities for outreach and education. Interventions to improve rates were assessed for efficacy and planning begun with an intradepartmental task force to identify interventions to improve rates in 2006.

The following summarizes the results across Plan populations for specific clinical indicators that were reported in 2005 for care that occurred in 2004.

Successes**:**

- Member reminders had positive effect on increasing access to tests,
- Physician Quality Incentive Program initiatives resulted in significant HEDIS® rate increases for Southwest Missouri,
- Exceeded performance targets for Diabetes and Beta Blocker after AMI indicators,
- Hypertension Coaching Program improved rates for controlled HTN, and
- Achieved best practice rates for Asthma Medication Management.

HEDIS® rates for the following indicators did not meet the Plan's performance targets:

- Well care for children and adolescents (Commercial and Medicaid)
- LDL control after acute cardiac events (Commercial and Medicare)
- Breast Cancer screening (Commercial and Medicare)

The Plan's nurse reviewers accomplished medical record review and abstracted data for HEDIS® measurements, as claim data was incomplete or absent. Medical record abstraction produced a high yield for data completeness and dramatically improved the reported results for:

- Childhood /Adolescent Immunizations (All Immunizations)
- Well Child Visits,
- Prenatal/ Post Partum Care Visits, and
- Adolescent Well Visits.

Medical Record Review was unsuccessful to improve reported results for:

- Diabetic Retinal Eye Exams,
- Cervical Cancer Screening, and
- Child Well Visits 3, 4, 5, 6 years of age.

The barriers to data collection for these measures included problems identifying specialists for access to eye exam and maternity care records, and locating data for adolescent care from vendors for school physicals. Many of the assigned PCP's for Medicaid members had never seen the child or had not seen child within the timeframe assessed for care delivery. The Plan was unable to discern medical home for members not seen by the assigned PCP; care may have

been obtained from a public health department clinic that does not provide encounter data to the Plan. (See Attachment "I" – Executive Summary 2005 HEDIS Project Evaluation)

Non-clinical

***Mercy MC+* Encounter Data Project**

MC+ encounter data was a project selected to identify and resolve claims encounter data issues. Mercy Health Plan will submit encounter data for all services provided including those services that are reimbursed by the health plan through a capitated arrangement or other subcontracted arrangement. The goal is to achieve a consistent ≥ 95% acceptance rate in all four encounter data files (institutional, professional, pharmacy, and dental). The accuracy and completeness of the data is critical to the Missouri Division of Medical Services (DMS) assessment of Mercy MC+ care and services delivery and the accurate calculations of the EPSDT participation rates by DMS. A workgroup of subject experts from the information systems department was convened. By improving the encounter claim acceptance rates, contractual penalty will be avoided. The encounter data acceptance rates for the plan are currently:

- Institutional claims: 76%
- Professional claims: 45%
- Pharmacy claims: 95%
- Dental claims: 75%

(See Attachment "J" – QI Project MC+ Encounter Data)

Member Service Quality Call Center Monitoring Project

Member Service Quality Call Center Monitoring was a project selected to improve the quality of the member call encounter and ensure best service is provided to members. The plan has consolidated the call center monitoring function into the Education and Development department, a department within Human Resource, to promote assessment objectivity and eliminate bias. Monitoring of calls will be conducted to each call center staff member who is assigned to receive inbound calls or make outbound calls to members. Call center staff are advised their work may be monitored during the hiring process and periodically thereafter. Call levels have been developed for staff members based on their time in position and proficiency. The lower the average score for the prior three months, the greater the number of calls monitored. The newer the candidate to the position, the greater the number of calls monitored. Scores are available for each section of the call monitoring form: Introduction, Health Insurance Portability and Accountability Act (HIPAA), Excellence, Service, Justice, Dignity, Call Tracking, Transfer Status, and Special Codes. The results of the monitoring are shared monthly through system reports. The goals are to increase the emphasis on the quality service expected in MHP call centers; to gain greater consistency in the call center processes, procedures and metrics; to provide organization-wide statistics; and to facilitate enhancements to the technical training.

The annual CAHPS® survey conducted by Mercy Health Plan demonstrated the rates of customer satisfaction for operations have remained flat or declining. It has been difficult to

determine what the dissatisfiers are. Although for the past three years there has been a significant decrease in the Question "How much of a problem, if any, was it to get the help you needed when you called your health plan's customer service." The results of the monitoring would be utilized by the HR Department to create, maintain, and implement call center representative training programs. We will continue to compare progress in the call center qualitative rates to the customer service rates from the annual CAHPS. Rates will be broken into product line and by individual and group performance to identify opportunities for training, track progress for specific populations and compare to CAHPS. Ongoing training and support for the call center co-workers are required to assure the accuracy and completeness of information provided to members. Average call quality rating is a quantifiable measure being measured. The targeted goal is to achieve an average call rating of $\geq$ 98%. The sum of each month's call rating is divided by the number of months monitored during the time frame. (See Attachment "K" QI Project Quality Monitoring – Service)

Clinical - Lead Initiative

Missouri Care expanded its lead outreach program in 2005 in recognition of the dangers of lead poisoning and the importance of lead testing and screening. Missouri Care surveyed PCPs on their current lead testing practices and on their perceived barriers to lead testing in order to better target its lead interventions. The results of the survey indicated that there were no consistent lead testing practices among providers. Additionally, providers noted personal attitudes, parent compliance and lab-testing issues as the top three barriers to blood lead testing. Based on the survey results, a multifaceted intervention was developed to target providers and members.

Provider Interventions

The first part of the intervention was to send a letter to providers reminding them of current state testing guidelines and the dangers of lead poisoning. The letter highlighted a recent case of a member in the Missouri Care network with elevated blood lead levels. The mailing also contained the results of the provider survey and a fact sheet with lead resources for providers. The letters were followed by visits from Missouri Care provider relations representatives, who distributed additional information to providers' office managers. In addition, a provider "toolkit" was created that can be accessed on the Missouri Care Web site. The toolkit provides links to useful information and will display updates on the progress of the lead initiative. Providers were notified of the toolkit during the provider relations representatives' visits and through the Missouri Care provider newsletter.

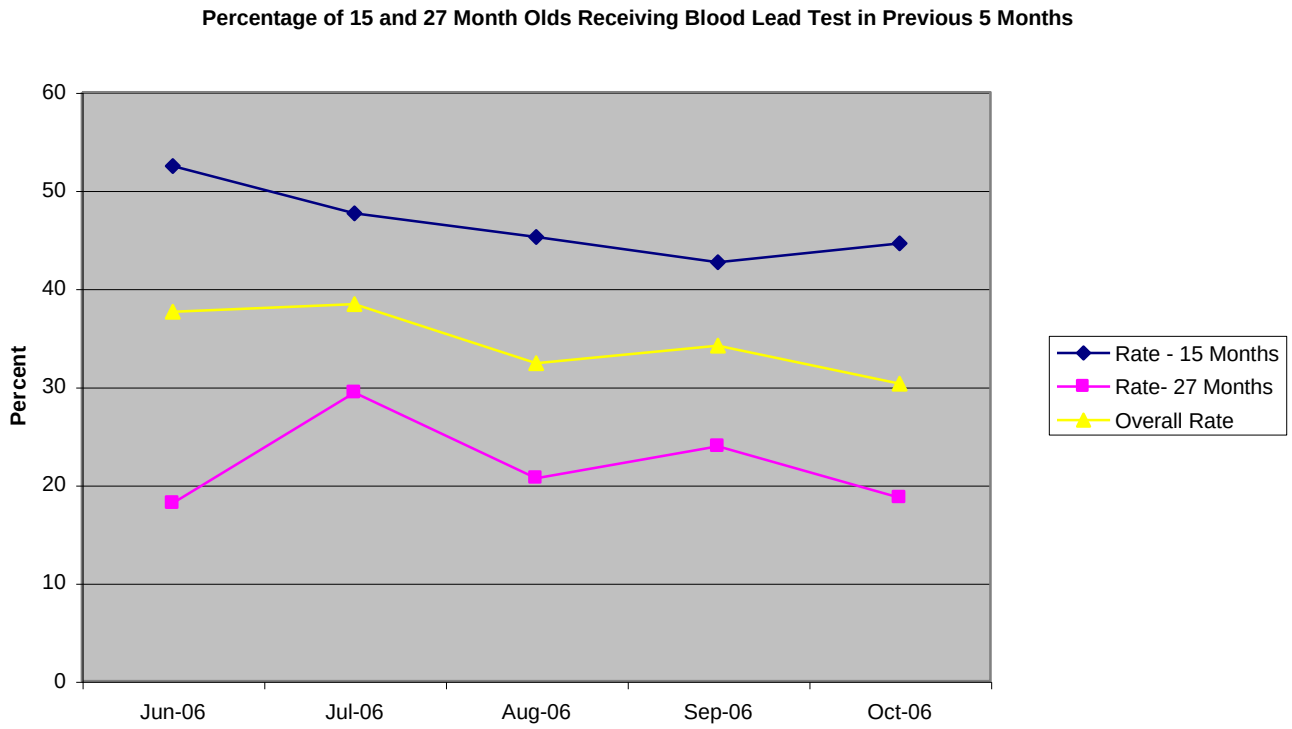
Member Interventions

The intervention also targeted members because one of the barriers identified by providers was parent compliance with testing. Missouri Care strengthened its lead outreach to members by:

- Including a message on the importance of lead testing on the on-hold phone messaging system
- Placing an article on lead in the member newsletter
- Mailing lead information to members who indicated on their state enrollment form that they needed more information on lead
- Distributing lead information at health, back-to-school and maternity fairs

Outcome

Just recently, the State began providing health plans with complete blood lead testing information on their members. This information from calendar year 2005 will be used to evaluate the effectiveness of the above interventions. The study indicator is the percentage of Missouri Care members ages 11 to 15 months and 23 to 27 months receiving blood lead-level testing. As we receive the lead-testing data, we will continually monitor our rates and continue or enhance our lead initiatives as necessary. As of March 2006, data were only available from January through October 2005. Given our age ranges of 11 to 15 and 23 to 27 months, the rates we can produce are limited to a five-month period (see graph below for preliminary rates).



Non-Clinical - Attention Deficit Hyperactivity Disorder (ADHD) Project

A family practice physician first brought forward attention-deficit/hyperactivity disorder (ADHD) as a potential performance improvement project at a Missouri Care's MQM Committee meeting in September 2004. The complex needs of children with ADHD were discussed at the meeting as well as the challenges faced by providers in treating ADHD. The meeting prompted Missouri Care to look at its own members. We found that in 2004, approximately 3,000 members had ICD-9 codes for a diagnosis of ADHD. Of these members, approximately 1,100 had a single diagnosis of ADHD, while nearly 1,900 members with ADHD had other psychiatric comorbidities.

A taskforce was formed to further look at ADHD. The taskforce read recent literature on ADHD and surveyed providers regarding their current practice patterns and challenges faced in the treatment of ADHD. Based on this research the taskforce chose a set of best practices guidelines in which to endorse and develop a toolkit to provide education and resources to providers.

Goal

The task force's main goal is to improve the quality of care for children with ADHD through provider education. Provider education has occurred through the distribution of ADHD toolkits to provider offices, a Web-based provider toolkit and through presentations at continuing medical education conferences.

Outcomes

Since the project is still being rolled out, outcomes have not yet been assessed. The following indicators will be evaluated:

- Is there an increase in the number of members who:
    - Received an EPSDT within one year prior to the initiation of ADHD medications
    - Received a follow up visit within 30 days of ADHD medication
    - Have seen their provider at least quarterly while on ADHD medication after the initial 30-day visit
- Is there a reduction in the number of primary care providers who are writing prescriptions for members with a combination of ADHD and other psychiatric co-morbidities (e.g., more referrals to behavioral health professionals)?
- Do providers feel that they are more effective in:
    - The treatment/management of ADHD
    - Communicating with the children's' schools
    - Setting behavioral goals

2006 Show Me Consumer's Guide:
Medicaid (MC+) Managed Care
Member Satisfaction*
(8/2/06)

Getting Needed Care

XNAICID	Plan Name	% Not Prob	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	84%	2.14	AV
9563631	Children's Mercy Family Health Partners	81%	0.39	AV
9560931	Community Care Plus	80%	-0.34	AV
9536431	FirstGuard Health Plans	84%	2.17	AV
9531832	Healthcare USA of Missouri-Central	82%	1.38	AV
9531831	Healthcare USA of Missouri-Eastern	77%	-1.89	AV
9531833	Healthcare USA of Missouri-western	78%	-1.46	AV
9530931	Mercy MC+	78%	-1.51	AV
9571531	Missouri Care Health Plan	80%	-0.13	AV
999999	**Statewide 2004**	80%		

Getting Care Quickly

XNAICID	Plan Name	%Alwy/Usu	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	79%	-0.80	AV
9563631	Children's Mercy Family Health Partners	79%	-0.31	AV
9560931	Community Care Plus	77%	-2.04	AV
9536431	FirstGuard Health Plans	80%	-0.05	AV
9531832	Healthcare USA of Missouri-Central	84%	3.53	HI
9531831	Healthcare USA of Missouri-Eastern	80%	0.31	AV
9531833	Healthcare USA of Missouri-western	78%	-1.13	AV
9530931	Mercy MC+	81%	0.66	AV
9571531	Missouri Care Health Plan	81%	1.17	AV
999999	**Statewide 2004**	80%		

Courteous & Helpful Staff

XNAICID	Plan Name	%Alwy/Usu	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	91%	-0.72	AV
9563631	Children's Mercy Family Health Partners	89%	-1.76	AV
9560931	Community Care Plus	92%	0.58	AV
9536431	FirstGuard Health Plans	91%	-0.66	AV
9531832	Healthcare USA of Missouri-Central	95%	3.33	HI
9531831	Healthcare USA of Missouri-Eastern	92%	0.69	AV
9531833	Healthcare USA of Missouri-western	91%	-0.27	AV
9530931	Mercy MC+	92%	0.50	AV
9571531	Missouri Care Health Plan	91%	-0.11	AV
999999	**Statewide 2004**	92%		

* Numerators and denominators are not shown since all measures (except Overall Ratings) are composites of multiple questions with varying numerators and denominators.

2006 Show Me Consumer's Guide:
Medicaid (MC+) Managed Care
Member Satisfaction*
(8/2/06)

How Well Doctors Communicate

XNAICID	Plan Name	%Alwy/Usu	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	90%	-1.11	AV
9563631	Children's Mercy Family Health Partners	91%	0.03	AV
9560931	Community Care Plus	91%	-0.15	AV
9536431	FirstGuard Health Plans	91%	0.05	AV
9531832	Healthcare USA of Missouri-Central	93%	2.50	AV
9531831	Healthcare USA of Missouri-Eastern	93%	1.41	AV
9531833	Healthcare USA of Missouri-western	89%	-1.29	AV
9530931	Mercy MC+	90%	-1.17	AV
9571531	Missouri Care Health Plan	92%	1.03	AV
999999	**Statewide 2004**	91%		

Customer Service

XNAICID	Plan Name	% Not Prob	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	77%	0.20	AV
9563631	Children's Mercy Family Health Partners	81%	0.02	AV
9560931	Community Care Plus	73%	0.95	AV
9536431	FirstGuard Health Plans	72%	0.90	AV
9531832	Healthcare USA of Missouri-Central	60%	0.00	LO
9531831	Healthcare USA of Missouri-Eastern	73%	0.84	AV
9531833	Healthcare USA of Missouri-western	71%	0.54	AV
9530931	Mercy MC+	72%	0.82	AV
9571531	Missouri Care Health Plan	76%	0.30	AV
999999	**Statewide 2004**	73%		

Rating of Doctor

XNAICID	Plan Name	% 8,9,10	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	78%	-1.20	AV
9563631	Children's Mercy Family Health Partners	79%	-1.09	AV
9560931	Community Care Plus	80%	-0.55	AV
9536431	FirstGuard Health Plans	79%	-0.98	AV
9531832	Healthcare USA of Missouri-Central	88%	4.66	HI
9531831	Healthcare USA of Missouri-Eastern	82%	0.92	AV
9531833	Healthcare USA of Missouri-western	81%	-0.12	AV
9530931	Mercy MC+	84%	1.91	AV
9571531	Missouri Care Health Plan	78%	-1.63	AV
999999	**Statewide 2004**	81%		

* Numerators and denominators are not shown since all measures (except Overall Ratings) are composites of multiple questions with varying numerators and denominators.

2006 Show Me Consumer's Guide:
Medicaid (MC+) Managed Care
Member Satisfaction*
(8/2/06)

Rating of Specialist

XNAICID	Plan Name	% 8,9,10	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	86%	2.75	AV
9563631	Children's Mercy Family Health Partners	77%	0.66	AV
9560931	Community Care Plus	54%	-4.20	LO
9536431	FirstGuard Health Plans	74%	-0.01	AV
9531832	Healthcare USA of Missouri-Central	77%	0.63	AV
9531831	Healthcare USA of Missouri-Eastern	77%	0.70	AV
9531833	Healthcare USA of Missouri-western	73%	-0.21	AV
9530931	Mercy MC+	76%	0.28	AV
9571531	Missouri Care Health Plan	75%	0.27	AV
999999	**Statewide 2004**	74%		

Rating of Health Care

XNAICID	Plan Name	% 8,9,10	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	76%	-1.64	AV
9563631	Children's Mercy Family Health Partners	81%	0.40	AV
9560931	Community Care Plus	79%	-0.64	AV
9536431	FirstGuard Health Plans	81%	0.51	AV
9531832	Healthcare USA of Missouri-Central	85%	2.71	AV
9531831	Healthcare USA of Missouri-Eastern	82%	0.72	AV
9531833	Healthcare USA of Missouri-western	79%	-0.58	AV
9530931	Mercy MC+	83%	1.25	AV
9571531	Missouri Care Health Plan	77%	-1.60	AV
999999	**Statewide 2004**	80%		

Rating of Plan

XNAICID	Plan Name	% 8,9,10	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	79%	0.15	AV
9563631	Children's Mercy Family Health Partners	78%	-0.15	AV
9560931	Community Care Plus	77%	-0.77	AV
9536431	FirstGuard Health Plans	81%	1.26	AV
9531832	Healthcare USA of Missouri-Central	80%	0.98	AV
9531831	Healthcare USA of Missouri-Eastern	84%	3.62	HI
9531833	Healthcare USA of Missouri-western	75%	-1.46	AV
9530931	Mercy MC+	78%	-0.37	AV
9571531	Missouri Care Health Plan	74%	-2.18	AV
999999	**Statewide 2004**	78%		

* Numerators and denominators are not shown since all measures (except Overall Ratings) are composites of multiple questions with varying numerators and denominators.

2006 MC+ HEDIS REPORT

Table C

(Data Year 2005)

MC+

Well Child Visits in the first 15 Months of Life

0 Visits

	num	den	rate	Test
Healthcare USA of Missouri-Central	16	1074	0.01	LO
Missouri Care Health Plan	7	305	0.02	AV
Mercy MC+ St. Louis	10	411	0.02	AV
Healthcare USA of Missouri-Eastern	132	4765	0.03	AV
Blue-Advantage Plus of Kansas City Inc.	36	1297	0.03	AV
Childrens Mercy's Family Health Partners	49	1751	0.03	AV
Community Care Plus	45	1454	0.03	AV
FirstGuard Health Plans	16	411	0.04	AV
Healthcare USA of Missouri-Western	21	436	0.05	AV
Statewide Avg of 9 MC+ Plans:			2.93%	

MC+

Well Child Visits in the first 15 Months of Life

1 Visit

	num	den	rate	Test
Missouri Care Health Plan	3	305	0.01	LO
Mercy MC+ St. Louis	6	411	0.01	LO
Healthcare USA of Missouri-Central	20	1074	0.02	LO
Healthcare USA of Missouri-Eastern	163	4765	0.03	AV
Community Care Plus	62	1454	0.04	AV
Childrens Mercy's Family Health Partners	76	1751	0.04	AV
FirstGuard Health Plans	19	411	0.05	AV
Blue-Advantage Plus of Kansas City Inc.	60	1297	0.05	AV
Healthcare USA of Missouri-Western	31	436	0.07	HI
Statewide Avg of 9 MC+ Plans:			3.63%	

MC+

Well Child Visits in the first 15 Months of Life

2 Visits

	num	den	rate	Test
Healthcare USA of Missouri-Central	32	1074	0.03	LO
Missouri Care Health Plan	12	305	0.04	AV
FirstGuard Health Plans	17	411	0.04	AV
Mercy MC+ St. Louis	17	411	0.04	AV
Community Care Plus	84	1454	0.06	AV
Blue-Advantage Plus of Kansas City Inc.	76	1297	0.06	AV
Healthcare USA of Missouri-Eastern	299	4765	0.06	AV
Childrens Mercy's Family Health Partners	117	1751	0.07	AV
Healthcare USA of Missouri-Western	32	436	0.07	AV
Statewide Avg of 9 MC+ Plans:			5.24%	

2006 MC+ HEDIS REPORT

Table C

(Data Year 2005)

MC+

Well Child Visits in the first 15 Months of Life

3 Visits

	num	den	rate	Test
Missouri Care Health Plan	12	305	0.04	LO
Healthcare USA of Missouri-Central	60	1074	0.06	LO
Mercy MC+ St. Louis	27	411	0.07	AV
Community Care Plus	127	1454	0.09	AV
Blue-Advantage Plus of Kansas City Inc.	114	1297	0.09	AV
FirstGuard Health Plans	37	411	0.09	AV
Childrens Mercy's Family Health Partners	160	1751	0.09	AV
Healthcare USA of Missouri-Eastern	442	4765	0.09	AV
Healthcare USA of Missouri-Western	46	436	0.11	AV
Statewide Avg of 9 MC+ Plans:			7.95%	

MC+

Well Child Visits in the first 15 Months of Life

4 Visits

	num	den	rate	Test
Missouri Care Health Plan	16	305	0.05	LO
Healthcare USA of Missouri-Central	63	1074	0.06	LO
FirstGuard Health Plans	39	411	0.09	AV
Mercy MC+ St. Louis	47	411	0.11	AV
Community Care Plus	207	1454	0.14	AV
Blue-Advantage Plus of Kansas City Inc.	202	1297	0.16	HI
Healthcare USA of Missouri-Eastern	750	4765	0.16	HI
Childrens Mercy's Family Health Partners	289	1751	0.17	HI
Healthcare USA of Missouri-Western	77	436	0.18	HI
Statewide Avg of 9 MC+ Plans:			12.42%	

MC+

Well Child Visits in the first 15 Months of Life

5 Visits

	num	den	rate	Test
Missouri Care Health Plan	34	305	0.11	LO
FirstGuard Health Plans	52	411	0.13	LO
Healthcare USA of Missouri-Central	147	1074	0.14	LO
Mercy MC+ St. Louis	64	411	0.16	AV
Community Care Plus	274	1454	0.19	AV
Healthcare USA of Missouri-Western	89	436	0.20	AV
Healthcare USA of Missouri-Eastern	1037	4765	0.22	HI
Blue-Advantage Plus of Kansas City Inc.	303	1297	0.23	HI
Childrens Mercy's Family Health Partners	452	1751	0.26	HI
Statewide Avg of 9 MC+ Plans:			18.14%	

2006 MC+ HEDIS REPORT

Table C

(Data Year 2005)

MC+

Well Child Visits in the first 15 Months of Life
6 or More Visits

	num	den	rate	Test
Healthcare USA of Missouri-Western	140	436	0.32	LO
Childrens Mercy's Family Health Partners	608	1751	0.35	LO
Blue-Advantage Plus of Kansas City Inc.	506	1297	0.39	LO
Healthcare USA of Missouri-Eastern	1942	4765	0.41	LO
Community Care Plus	655	1454	0.45	LO
FirstGuard Health Plans	231	411	0.56	HI
Mercy MC+ St. Louis	240	411	0.58	HI
Healthcare USA of Missouri-Central	736	1074	0.69	HI
Missouri Care Health Plan	221	305	0.72	HI
Statewide Avg of 9 MC+ Plans:			49.69%	

MC+

Well Child Visits in the Third, Fourth
and Sixth Year of Life

	num	den	rate	Test
Healthcare USA of Missouri-Western	533	1122	0.48	LO
FirstGuard Health Plans	2856	5601	0.51	LO
Mercy MC+ St. Louis	214	411	0.52	AV
Blue-Advantage Plus of Kansas City Inc.	2375	4264	0.56	LO
Community Care Plus	3100	5555	0.56	LO
Healthcare USA of Missouri-Eastern	12099	20561	0.59	AV
Healthcare USA of Missouri-Central	2376	3858	0.62	HI
Missouri Care Health Plan	256	380	0.67	HI
Childrens Mercy's Family Health Partners	299	411	0.73	HI
Statewide Avg of 9 MC+ Plans:			58.07%	

MC+

Follow-Up After Hospitalization for Mental Illness
Within 7 Days of Discharge

	num	den	rate	Test
Missouri Care Health Plan	24	136	0.18	LO
Healthcare USA of Missouri-Western	10	48	0.21	AV
Community Care Plus	72	285	0.25	AV
Mercy MC+ St. Louis	91	353	0.26	AV
Healthcare USA of Missouri-Eastern	151	534	0.28	AV
Healthcare USA of Missouri-Central	51	147	0.35	AV
FirstGuard Health Plans	94	266	0.35	AV
Childrens Mercy's Family Health Partners	149	330	0.45	HI
Blue-Advantage Plus of Kansas City Inc.	151	301	0.50	HI
Statewide Avg of 9 MC+ Plans:			31.46%	

2006 MC+ HEDIS REPORT

Table C

(Data Year 2005)

MC+

Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge

	num	den	rate	Test
Healthcare USA of Missouri-Western	20	48	0.42	AV
Missouri Care Health Plan	65	136	0.48	AV
Community Care Plus	140	285	0.49	AV
Healthcare USA of Missouri-Eastern	263	534	0.49	LO
Mercy MC+ St. Louis	181	353	0.51	AV
FirstGuard Health Plans	158	266	0.59	AV
Healthcare USA of Missouri-Central	89	147	0.61	AV
Childrens Mercy's Family Health Partners	236	330	0.72	HI
Blue-Advantage Plus of Kansas City Inc.	219	301	0.73	HI
Statewide Avg of 9 MC+ Plans:			55.92%	

MC+

Timeliness of Prenatal Care

	num	den	rate	Test
Blue-Advantage Plus of Kansas City Inc.	561	1404	0.40	LO
Healthcare USA of Missouri-Western	237	584	0.41	LO
Mercy MC+ St. Louis	169	411	0.41	LO
FirstGuard Health Plans	202	411	0.49	LO
Healthcare USA of Missouri-Eastern	2501	4749	0.53	LO
Healthcare USA of Missouri-Central	676	1256	0.54	AV
Community Care Plus	266	411	0.65	HI
Childrens Mercy's Family Health Partners	310	411	0.75	HI
Missouri Care Health Plan	366	411	0.89	HI
Statewide Avg of 9 MC+ Plans:			56.28%	

MC+

Postpartum Care

	num	den	rate	Test
Healthcare USA of Missouri-Western	201	584	0.34	LO
Healthcare USA of Missouri-Eastern	1757	4749	0.37	LO
FirstGuard Health Plans	178	411	0.43	LO
Healthcare USA of Missouri-Central	642	1256	0.51	AV
Community Care Plus	214	411	0.52	AV
Mercy MC+ St. Louis	221	411	0.54	AV
Blue-Advantage Plus of Kansas City Inc.	787	1404	0.56	HI
Childrens Mercy's Family Health Partners	233	411	0.57	HI
Missouri Care Health Plan	275	411	0.67	HI
Statewide Avg of 9 MC+ Plans:			50.15%	

2006 Show Me Consumer's Guide
Managed Care 2005 DY HEDIS Quality Indicators
Medicaid MC+ (8/31/06)

Table B

MC+
Adolescent Immunizations

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	0	928	0.00	LO
9563631	Children's Mercy Family Health Partners	283	411	0.69	HI
9560931	Community Care Plus	106	411	0.26	AV
9536431	FirstGuard Health Plans	70	411	0.17	LO
9531832	Healthcare USA of Missouri-Central	83	432	0.19	LO
9531831	Healthcare USA of Missouri-Eastern	188	432	0.44	HI
9531833	Healthcare USA of Missouri-Western	37	199	0.19	LO
9530931	Mercy MC+	101	411	0.25	AV
9571531	Missouri Care Health Plan	125	411	0.30	AV
999999	**Statewide Avg of 9 MC+ Plans:**			27.55%	

MC+
Adolescent Well-Care Visit

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	1809	5541	0.33	AV
9563631	Children's Mercy Family Health Partners	3095	9354	0.33	AV
9560931	Community Care Plus	2811	9721	0.29	LO
9536431	FirstGuard Health Plans	1981	6918	0.29	LO
9531832	Healthcare USA of Missouri-Central	1817	5021	0.36	HI
9531831	Healthcare USA of Missouri-Eastern	11057	31101	0.36	HI
9531833	Healthcare USA of Missouri-Western	290	1225	0.24	LO
9530931	Mercy MC+	127	411	0.31	AV
9571531	Missouri Care Health Plan	183	411	0.45	HI
999999	**Statewide Avg of 9 MC+ Plans:**			32.68%	

MC+
Annual Dental Visit-2-3

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	299	2237	0.13	HI
9563631	Children's Mercy Family Health Partners	559	3530	0.16	HI
9560931	Community Care Plus	271	2998	0.09	LO
9536431	FirstGuard Health Plans	393	3016	0.13	HI
9531832	Healthcare USA of Missouri-Central	196	2032	0.10	AV
9531831	Healthcare USA of Missouri-Eastern	1006	10062	0.10	AV
9531833	Healthcare USA of Missouri-Western	61	679	0.09	AV
9530931	Mercy MC+	258	3295	0.08	LO
9571531	Missouri Care Health Plan	215	2229	0.10	AV
999999	**Statewide Avg of 9 MC+ Plans:**			10.82%	

MC+
Annual Dental Visit-4-7

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	1162	3217	0.36	HI
9563631	Children's Mercy Family Health Partners	2192	5303	0.41	HI
9560931	Community Care Plus	1307	4119	0.32	AV
9536431	FirstGuard Health Plans	1492	4109	0.36	HI
9531832	Healthcare USA of Missouri-Central	808	2865	0.28	LO
9531831	Healthcare USA of Missouri-Eastern	5378	15461	0.35	HI
9531833	Healthcare USA of Missouri-Western	218	804	0.27	LO
9530931	Mercy MC+	1200	4031	0.30	LO
9571531	Missouri Care Health Plan	922	3196	0.29	LO
999999	**Statewide Avg of 9 MC+ Plans:**			32.69%	

2006 Show Me Consumer's Guide Table B
Managed Care 2005 DY HEDIS Quality Indicators
Medicaid MC+ (8/31/06)

MC+
Annual Dental Visit-7-10

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	1506	3649	0.41	HI
9563631	Children's Mercy Family Health Partners	2824	6224	0.45	HI
9560931	Community Care Plus	2054	5386	0.38	AV
9536431	FirstGuard Health Plans	1796	4285	0.42	HI
9531832	Healthcare USA of Missouri-Central	1068	3328	0.32	LO
9531831	Healthcare USA of Missouri-Eastern	7001	18445	0.38	AV
9531833	Healthcare USA of Missouri-Western	277	873	0.32	LO
9530931	Mercy MC+	1770	4819	0.37	AV
9571531	Missouri Care Health Plan	1140	3617	0.32	LO
999999	**Statewide Avg of 9 MC+ Plans:**			37.41%	

MC+
Annual Dental Visit-11-14

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	1245	3435	0.36	HI
9563631	Children's Mercy Family Health Partners	2316	5670	0.41	HI
9560931	Community Care Plus	1864	5764	0.32	AV
9536431	FirstGuard Health Plans	1438	4005	0.36	HI
9531832	Healthcare USA of Missouri-Central	873	2998	0.29	LO
9531831	Healthcare USA of Missouri-Eastern	6148	19023	0.32	AV
9531833	Healthcare USA of Missouri-Western	189	745	0.25	LO
9530931	Mercy MC+	1531	4752	0.32	AV
9571531	Missouri Care Health Plan	1035	3376	0.31	LO
999999	**Statewide Avg of 9 MC+ Plans:**			32.78%	

MC+
Annual Dental Visit-15-19

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	847	2677	0.32	HI
9563631	Children's Mercy Family Health Partners	1594	4582	0.35	HI
9560931	Community Care Plus	1269	4767	0.27	AV
9536431	FirstGuard Health Plans	1096	3389	0.32	HI
9531832	Healthcare USA of Missouri-Central	529	2455	0.22	LO
9531831	Healthcare USA of Missouri-Eastern	3900	14809	0.26	LO
9531833	Healthcare USA of Missouri-Western	114	566	0.20	LO
9530931	Mercy MC+	1144	4173	0.27	AV
9571531	Missouri Care Health Plan	778	2780	0.28	AV
999999	**Statewide Avg of 9 MC+ Plans:**			27.65%	

MC+
Annual Dental Visit-19-21

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	57	372	0.15	AV
9563631	Children's Mercy Family Health Partners	84	506	0.17	AV
9560931	Community Care Plus	114	618	0.18	AV
9536431	FirstGuard Health Plans	81	510	0.16	AV
9531832	Healthcare USA of Missouri-Central	25	289	0.09	LO
9531831	Healthcare USA of Missouri-Eastern	327	1903	0.17	AV
9531833	Healthcare USA of Missouri-Western	17	110	0.15	AV
9530931	Mercy MC+	113	642	0.18	AV
9571531	Missouri Care Health Plan	72	356	0.20	AV
999999	**Statewide Avg of 9 MC+ Plans:**			16.15%	

2006 Show Me Consumer's Guide Table B
Managed Care 2005 DY HEDIS Quality Indicators
Medicaid MC+ (8/31/06)

MC+
Annual Dental Visit-Combined Rate

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	5116	15587	0.33	HI
9563631	Children's Mercy Family Health Partners	9569	25815	0.37	HI
9560931	Community Care Plus	6879	23652	0.29	AV
9536431	FirstGuard Health Plans	6296	19314	0.33	HI
9531832	Healthcare USA of Missouri-Central	3499	13967	0.25	LO
9531831	Healthcare USA of Missouri-Eastern	23760	79703	0.30	AV
9531833	Healthcare USA of Missouri-Western	876	3777	0.23	LO
9530931	Mercy MC+	6016	21712	0.28	LO
9571531	Missouri Care Health Plan	4162	15554	0.27	LO
999999	**Statewide Avg of 9 MC+ Plans:**			29.34%	

MC+
Asthma Age 5-9

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	172	184	0.93	HI
9563631	Children's Mercy Family Health Partners	272	293	0.93	HI
9560931	Community Care Plus	161	203	0.79	LO
9536431	FirstGuard Health Plans	61	69	0.88	AV
9531832	Healthcare USA of Missouri-Central	91	102	0.89	AV
9531831	Healthcare USA of Missouri-Eastern	935	1057	0.88	AV
9531833	Healthcare USA of Missouri-Western	15	23	NA	NA
9530931	Mercy MC+	178	202	0.88	AV
9571531	Missouri Care Health Plan	164	196	0.84	AV
999999	**Statewide Avg of 9 MC+ Plans:**			87.94%	

MC+
Asthma Age 10-17

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	189	216	0.88	AV
9563631	Children's Mercy Family Health Partners	341	371	0.92	HI
9560931	Community Care Plus	230	274	0.84	AV
9536431	FirstGuard Health Plans	46	48	0.96	HI
9531832	Healthcare USA of Missouri-Central	109	129	0.84	AV
9531831	Healthcare USA of Missouri-Eastern	1069	1246	0.86	AV
9531833	Healthcare USA of Missouri-Western	12	17	NA	NA
9530931	Mercy MC+	177	202	0.88	AV
9571531	Missouri Care Health Plan	166	245	0.68	LO
999999	**Statewide Avg of 9 MC+ Plans:**			85.61%	

MC+
Asthma Age 18-56

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	72	97	0.74	AV
9563631	Children's Mercy Family Health Partners	74	105	0.70	AV
9560931	Community Care Plus	104	157	0.66	AV
9536431	FirstGuard Health Plans	29	34	0.85	AV
9531832	Healthcare USA of Missouri-Central	72	85	0.85	AV
9531831	Healthcare USA of Missouri-Eastern	338	436	0.78	AV
9531833	Healthcare USA of Missouri-Western	10	13	NA	NA
9530931	Mercy MC+	98	116	0.84	HI
9571531	Missouri Care Health Plan	88	147	0.60	LO
999999	**Statewide Avg of 9 MC+ Plans:**			75.35%	

2006 Show Me Consumer's Guide
Managed Care 2005 DY HEDIS Quality Indicators
Medicaid MC+ (8/31/06)

Table B

MC+
Asthma Combined

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	433	497	0.87	AV
9563631	Children's Mercy Family Health Partners	687	769	0.89	HI
9560931	Community Care Plus	495	634	0.78	LO
9536431	FirstGuard Health Plans	136	151	0.90	AV
9531832	Healthcare USA of Missouri-Central	272	316	0.86	AV
9531831	Healthcare USA of Missouri-Eastern	2342	2739	0.86	AV
9531833	Healthcare USA of Missouri-Western	46	53	0.87	AV
9530931	Mercy MC+	453	520	0.87	AV
9571531	Missouri Care Health Plan	418	588	0.71	LO
999999	**Statewide Avg of 9 MC+ Plans:**			84.58%	

MC+
Cervical Cancer Screening

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	1942	2925	0.66	AV
9563631	Children's Mercy Family Health Partners	3266	4897	0.67	AV
9560931	Community Care Plus	3089	5189	0.60	LO
9536431	FirstGuard Health Plans	2669	3960	0.67	AV
9531832	Healthcare USA of Missouri-Central	1776	2525	0.70	HI
9531831	Healthcare USA of Missouri-Eastern	12283	17197	0.71	HI
9531833	Healthcare USA of Missouri-Western	441	788	0.56	LO
9530931	Mercy MC+	271	411	0.66	AV
9571531	Missouri Care Health Plan	272	371	0.73	HI
999999	**Statewide Avg of 9 MC+ Plans:**			66.33%	

MC+
Childhood Immunization-Combo 2

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	607	1274	0.48	LO
9563631	Children's Mercy Family Health Partners	266	403	0.66	HI
9560931	Community Care Plus	252	411	0.61	AV
9536431	FirstGuard Health Plans	204	411	0.50	LO
9531832	Healthcare USA of Missouri-Central	314	432	0.73	HI
9531831	Healthcare USA of Missouri-Eastern	270	431	0.63	AV
9531833	Healthcare USA of Missouri-Western	226	378	0.60	AV
9530931	Mercy MC+	177	411	0.43	LO
9571531	Missouri Care Health Plan	309	411	0.75	HI
999999	**Statewide Avg of 9 MC+ Plans:**			59.77%	

MC+
Chlamydia Screening Age 16-20

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	302	710	0.43	LO
9563631	Children's Mercy Family Health Partners	622	1064	0.58	AV
9560931	Community Care Plus	1138	1368	0.83	HI
9536431	FirstGuard Health Plans	559	922	0.61	HI
9531832	Healthcare USA of Missouri-Central	303	701	0.43	LO
9531831	Healthcare USA of Missouri-Eastern	2599	4256	0.61	HI
9531833	Healthcare USA of Missouri-Western	86	154	0.56	AV
9530931	Mercy MC+	588	1155	0.51	LO
9571531	Missouri Care Health Plan	388	825	0.47	LO
999999	**Statewide Avg of 9 MC+ Plans:**			55.88%	

2006 Show Me Consumer's Guide Table B
Managed Care 2005 DY HEDIS Quality Indicators
Medicaid MC+ (8/31/06)

MC+
Chlamydia Screening Age 21-26

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	320	690	0.46	LO
9563631	Children's Mercy Family Health Partners	501	832	0.60	AV
9560931	Community Care Plus	1002	1130	0.89	HI
9536431	FirstGuard Health Plans	642	1023	0.63	HI
9531832	Healthcare USA of Missouri-Central	302	651	0.46	LO
9531831	Healthcare USA of Missouri-Eastern	2611	4053	0.64	HI
9531833	Healthcare USA of Missouri-Western	120	227	0.53	AV
9530931	Mercy MC+	617	1200	0.51	LO
9571531	Missouri Care Health Plan	367	702	0.52	LO
999999	**Statewide Avg of 9 MC+ Plans:**			58.38%	

MC+
Chlamydia Screening Combined Rate

XNAICID	Plan Name	num	den	rate	Test
9591631	Blue-Advantage Plus of Kansas City, Inc.	622	1400	0.44	LO
9563631	Children's Mercy Family Health Partners	1123	1896	0.59	AV
9560931	Community Care Plus	2140	2498	0.86	HI
9536431	FirstGuard Health Plans	1201	1945	0.62	HI
9531832	Healthcare USA of Missouri-Central	605	1352	0.45	LO
9531831	Healthcare USA of Missouri-Eastern	5210	8309	0.63	HI
9531833	Healthcare USA of Missouri-Western	206	381	0.54	AV
9530931	Mercy MC+	1205	2355	0.51	LO
9571531	Missouri Care Health Plan	755	1527	0.49	LO
999999	**Statewide Avg of 9 MC+ Plans:**			57.02%	

Trends in Missouri Medicaid Quality Indicators:
Eastern Region Medicaid Baseline Vs. Last 57 Months Medicaid MC+

	Before MC+				*After MC+*										
			Baseline												
	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*		*Jan-Sept 2006*		*Significant*
Trimester Prenatal Care Began	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Change****
First	6,343	66.3%	6,177	70.9%	7,311	79.3%	7,809	80.8%	8,273	81.0%	8,816	82.4%	6,659	80.8%	Yes
Second	2,512	26.3%	2,007	23.0%	1,474	16.0%	1,528	15.8%	1,566	15.3%	1,565	14.6%	1,305	15.8%	Yes
Third	360	3.8%	265	3.0%	260	2.8%	214	2.2%	228	2.2%	195	1.8%	185	2.2%	Yes
None	351	3.7%	263	3.0%	172	1.9%	119	1.2%	147	1.4%	120	1.1%	95	1.2%	No
Total	9,566		8,712		9,217		9,670		10,214		10,696		8,244		
Inadequate Prenatal Care	3,055	32.1%	2,412	27.9%	1692	18.9%	1668	17.8%	1680	16.7%	1656	15.8%	1338	16.7%	No
Birth Weight (grams)															
<500	20	0.2%	14	0.2%	34	0.4%	27	0.3%	24	0.2%	26	0.2%	15	0.2%	No
500-1499	143	1.5%	157	1.7%	181	1.9%	188	1.9%	195	1.9%	214	2.0%	147	1.8%	No
1500-1999	200	2.1%	210	2.3%	214	2.2%	208	2.1%	228	2.2%	253	2.3%	166	2.0%	No
2000-2499	710	7.4%	602	6.7%	633	6.6%	648	6.4%	684	6.6%	725	6.7%	546	6.5%	No
2500+	8,556	88.9%	8,045	89.1%	8,498	88.9%	8,978	89.3%	9,302	89.2%	9,662	88.8%	7,494	89.6%	No
Total	9,629		9,028		9,560		10,049		10,433		10,880		8,368		
Low Birth Weight(<2500 grams)	1,073	11.1%	983	10.9%	1,062	11.1%	1,071	10.7%	1,131	10.8%	1,218	11.2%	874	10.4%	No
Method of Delivery															
C-Section	1,650	17.1%	1,476	16.3%	2,315	24.2%	2,681	26.7%	2,989	28.6%	3,261	30.0%	2,501	29.9%	No
VBAC	392	40.5%	314	36.9%	182	17.9%	154	13.9%	132	10.7%	101	7.7%	104	9.5%	No
Repeat C-Section	575	59.5%	537	63.1%	836	82.1%	957	86.1%	1,105	89.3%	1,218	92.3%	996	90.5%	No
Total	9,629		9,030		9,561		10,052		10,435		10,883		8,371		
Smoking During Pregnancy	2,644	27.5%	2,389	26.5%	2,493	26.1%	2,694	26.8%	2,699	25.9%	2,762	25.4%	2,189	26.1%	No
Spacing <18 mos. since last birth	1,267	22.8%	818	16.9%	796	15.7%	739	14.2%	817	14.6%	905	15.8%	688	15.4%	No
Births to mothers <18 years of age	1,065	11.1%	956	10.6%	667	7.0%	677	6.7%	662	6.3%	669	6.1%	503	6.0%	No
Repeat teen births	814	8.5%	656	7.3%	459	4.8%	430	4.3%	433	4.1%	433	4.0%	304	3.6%	No
Fetal Deaths (20+ wks) (1)	65	6.8	75	8.3	93	9.7	98	9.7	73	7.0	88	8.1	52	6.2	No
Total live birth or stillbirth fetuses 500 grams or more (2)	9,675	214.5	9,091	193.6	9,583	127.9	10,086	134.6	10,457	131.3	10,907	149.9	8,393	180.9	Yes
Percent of prenatals on WIC	7,217	75.0%	6,820	75.6%	6,996	73.2%	7,423	73.8%	7,625	73.1%	7,863	72.3%	6,005	71.7%	No
VLBW not delivered in level III hospitals.	26	16.0%	32	18.7%	31	14.4%	25	11.6%	29	13.2%	30	12.5%	17	10.5%	No

Eastern Region Medicaid continued

	Before MC+				*After MC+*									
	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2001*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*
Average maternal length of stay (days) Inpatient admissions	9,474	2.7	8,738	2.6	8,557	2.9	8,967	3.0	9,315	3.0	9,407	3.1	9,873	3.1
Average behavioral health length of stay(days) Inpatient admissions	NA	NA	NA	NA	1,877	7.7	1,908	9.1	1,978	6.7	1,965	6.4	1,966	6.6
Asthma admissions under age 18 Inpatient admissions (2)	1,256	11.1	1,047	8.7	742	4.8	850	5.3	877	5.2	853	5.0	774	4.6
Asthma admissions 4-17 Inpatient admissions (2)	629	8.3	548	6.7	474	4.1	527	4.3	549	4.3	538	4.2	500	4.0
Asthma emergency room visits 4-17	2,333	30.9	2,642	32.2	2,670	28.8	3,155	27.6	3,030	23.7	2,689	21.1	2,934	23.3
Asthma admissions ages 18-64 Inpatient admissions (2)	NA	NA	NA	NA	154	2.7	127	2.3	137	2.2	140	2.2	130	2.4
Emergency room visits under age 18 (2)	91,977	816.5	90,055	748.5	95,491	620.3	96,471	597.1	113,684	673.5	100,833	594.7	109,335	648.8
Emergency room visits ages 18-64 (2)	NA	NA	NA	NA	51,087	908.1	56,956	1009.7	58,831	966.0	59,824	938.3	59,055	1070.4
Hysterectomies (2)	NA	NA	NA	NA	284	6.2	353	7.7	364	7.9	341	6.5	284	6.3
Vaginal hysterectomies	NA	NA	NA	NA	61	21.5%	57	16.1%	102	28.0%	94	27.6%	69	24.3%
Preventable hospitalizations under age 18(2)	3,096	27.5	2,716	22.6	2,150	14.0	2,106	13.0	2,135	12.6	2,098	12.4	2,117	12.6

(1) Rate per 1000 live births
(2) Rate per 1000 population

***Statistically significant change between CY2005 and Jan-Sept 2006 at .05 level of significance using Chi-square test
Source: Missouri Department of Health and Senior Services
12/20/2006

Trends in Missouri Medicaid Quality Indicators:
Eastern Region Non-Medicaid Baseline Vs. Last 57 Months Non-Medicaid MC+

	Before MC+				*After MC+*										
	Baseline														
	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*		*Jan-Sept 2006*		*Significant*
Trimester Prenatal Care Began	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Change****
First	17,246	93.3%	16,974	94.3%	17,037	95.5%	17,178	95.8%	16,895	95.7%	16,426	95.8%	12,895	95.6%	No
Second	922	5.0%	738	4.1%	587	3.3%	556	3.1%	571	3.2%	533	3.1%	457	3.4%	No
Third	134	0.7%	135	0.7%	93	0.5%	97	0.5%	80	0.5%	71	0.4%	59	0.4%	No
None	183	1.0%	157	0.9%	119	0.7%	104	0.6%	104	0.6%	108	0.6%	79	0.6%	No
Total	18,485		18,004		17,836		17,935		17,650		17,138		13,490		
Inadequate Prenatal Care	1,138	6.2%	965	5.4%	682	3.9%	700	3.9%	627	3.6%	591	3.5%	511	3.8%	No
Birth Weight (grams)															
<500	25	0.1%	35	0.2%	44	0.2%	54	0.3%	31	0.2%	51	0.3%	28	0.2%	No
500-1499	192	1.0%	228	1.2%	252	1.4%	245	1.3%	255	1.4%	214	1.2%	180	1.3%	No
1500-1999	223	1.2%	259	1.4%	284	1.6%	260	1.4%	330	1.8%	243	1.4%	220	1.6%	No
2000-2499	729	3.9%	746	4.1%	821	4.5%	748	4.1%	798	4.5%	723	4.2%	641	4.7%	Yes
2500+	17,547	93.8%	17,017	93.1%	16,796	92.3%	16,964	92.8%	16,464	92.1%	16,092	92.9%	12,518	92.1%	Yes
Total	18,716		18,285		18,197		18,271		17,878		17,323		13,587		
Low Birth Weight(<2500 grams)	1,169	6.2%	1,268	6.9%	1,401	7.7%	1,307	7.2%	1,414	7.9%	1,231	7.1%	1,069	7.9%	Yes
Method of Delivery															
C-Section	4,502	24.0%	4,214	23.0%	5,210	28.6%	5,595	30.6%	5,993	33.5%	5,931	34.2%	4,798	35.3%	No
VBAC	684	27.0%	640	27.3%	299	12.4%	249	10.2%	220	9.1%	185	7.3%	140	6.8%	No
Repeat C-Section	1,849	73.0%	1,702	63.1%	2,114	87.6%	2,191	89.8%	2,204	90.9%	2,355	92.7%	1,931	93.2%	No
Total	18,723		18,289		18,201		18,276		17,880		17,326		13,589		
Smoking During Pregnancy	2,432	13.0%	2,208	12.1%	1,367	7.5%	1,334	7.3%	1,285	7.2%	1,090	6.3%	848	6.2%	No
Spacing <18 mos. since last birth	932	8.8%	829	8.1%	754	7.3%	812	8.1%	798	8.2%	823	8.6%	610	8.2%	No
Births to mothers <18 years of age	469	2.5%	447	2.4%	286	1.6%	250	1.4%	261	1.5%	203	1.2%	188	1.4%	No
Repeat teen births	125	0.7%	98	0.5%	90	0.5%	75	0.4%	79	0.4%	53	0.3%	59	0.4%	No
Fetal Deaths (20+ wks) (1)	96	5.1	104	5.7	107	5.9	120	6.6	120	6.7	94	5.4	81	6.0	No
Total live birth or stillbirth fetuses 500 grams or more (2)	18,764	48.1	18,331	47.2	18,226	47.2	18,300	47.3	17,930	47.3	17,339	45.2	13,598	45.9	No
Percent of prenatals on WIC	1,517	8.2%	1,354	7.5%	1,685	9.3%	1,630	8.9%	1,516	8.5%	1,436	8.3%	1,209	8.9%	No
VLBW not delivered in level III hospitals.	55	25.3%	69	26.2%	57	19.5%	44	15.0%	49	17.3%	46	17.8%	39	18.9%	No

Eastern Region Non-Medicaid continued

	Before MC+				*After MC+*									
	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2001*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*
Average maternal length of stay (days) Inpatient admissions	18,353	2.3	18,227	2.1	18,924	3.0	18,127	3.0	18,443	3.0	18,076	3.1	17,723	3.1
Average newborn length of stay (days) Inpatient admissions	18,656	2.6	18,516	2.6	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average behavioral health length of stay(days) Inpatient admissions	NA	NA	NA	NA	20,481	6.9	21,642	6.9	19,814	10.0	20,535	6.7	20,350	6.5
Asthma admissions under age 18 Inpatient admissions (2)	896	2.4	711	1.9	463	1.2	482	1.3	469	1.3	503	1.4	497	1.4
Asthma admissions 4-17 Inpatient admissions (2)	534	1.7	502	1.6	268	0.9	279	0.9	287	1.0	295	1.0	344	1.2
Asthma emergency room visits 4-17	2,106	6.8	2,084	6.8	1,857	6.0	1,884	6.2	1,855	6.2	1,893	6.5	1,901	6.6
Asthma admissions ages 18-64 Inpatient admissions (2)	NA	NA	NA	NA	1,146	0.9	1,166	0.9	1,357	1.1	1,324	1.0	1,410	1.1
Emergency room visits under age 18 (2)	108,146	283.8	104,493	274.2	97,130	250.8	103,222	275.0	104,566	282.8	91,668	254.8	92,199	257.8
Emergency room visits ages 18-64 (2)	NA	NA	NA	NA	354,156	283.4	357,527	282.6	357,862	282.8	335,306	258.7	346,636	265.0
Hysterectomies (2)	NA	NA	NA	NA	5,145	8.2	5,345	8.5	4,828	7.7	4,529	7.0	3,658	5.6
Vaginal hysterectomies	NA	NA	NA	NA	1,802	35.0%	1,871	35.0%	1,657	34.3%	1,582	34.9%	981	26.8%
Preventable hospitalizations under age 18(2)	3,073	8.1	2,565	6.7	2,577	6.7	2,395	6.4	2,330	6.3	2,307	6.4	2,505	7.0

(1) Rate per 1000 live births
(2) Rate per 1000 population

***Statistically significant change between CY2005 and Jan-Sept 2006 at .05 level of significance using Chi-square test
Source: Missouri Department of Health and Senior Services
12/20/2006

Trends in Missouri Medicaid Quality Indicators:
Central Region Medicaid Baseline Vs. Last 57 Months Medicaid MC+

	Before MC+				*After MC+*										
	Baseline														
	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*		*Jan-Sept 2006*		*Significant*
Trimester Prenatal Care Began	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Change****
First	1,717	68.8%	1,794	72.7%	2,145	76.5%	2,241	76.8%	2,437	77.2%	2,484	75.8%	1,911	77.2%	No
Second	628	25.2%	554	22.5%	534	19.0%	563	19.3%	617	19.6%	670	20.4%	483	19.5%	No
Third	132	5.3%	109	4.4%	101	3.6%	85	2.9%	87	2.8%	107	3.3%	62	2.5%	No
None	19	0.8%	10	0.4%	24	0.9%	28	1.0%	15	0.5%	17	0.5%	18	0.7%	No
Total	2,496		2,467		2,804		2,917		3,156		3,278		2,474		
Inadequate Prenatal Care	570	23.2%	498	20.4%	552	20.2%	538	19.4%	556	18.3%	579	18.8%	430	18.4%	No
Birth Weight (grams)															
<500	2	0.1%	5	0.2%	4	0.1%	7	0.2%	5	0.1%	11	0.3%	3	0.1%	No
500-1499	34	1.3%	37	1.5%	51	1.7%	49	1.6%	38	1.1%	41	1.2%	25	0.9%	No
1500-1999	43	1.7%	47	1.8%	56	1.9%	64	2.0%	57	1.7%	69	2.0%	46	1.7%	No
2000-2499	176	6.9%	128	5.0%	155	5.3%	178	5.7%	179	5.2%	198	5.7%	150	5.6%	No
2500+	2,296	90.0%	2,334	91.5%	2,658	90.9%	2,831	90.5%	3,152	91.9%	3,127	90.7%	2,446	91.6%	No
Total	2,551		2,551		2,924		3,129		3,431		3,446		2,670		
Low Birth Weight (<2500 grams)	255	10.0%	217	8.5%	266	9.1%	298	9.5%	279	8.1%	319	9.3%	224	8.4%	No
Method of Delivery															
C-Section	529	20.7%	466	18.3%	774	26.5%	898	28.7%	1,030	30.0%	1,135	32.9%	815	30.5%	No
VBAC	80	29.5%	79	35.0%	46	13.3%	46	12.6%	63	13.7%	46	9.1%	28	7.3%	No
Repeat C-Section	191	70.5%	147	65.0%	300	86.7%	320	87.4%	398	86.3%	459	90.9%	355	92.7%	No
Total	2,551		2,551		2,924		3,129		3,431		3,446		2,671		
Smoking During Pregnancy	1,002	39.3%	937	36.7%	1,099	37.6%	1,141	36.5%	1,266	36.9%	1,212	35.2%	1,021	38.2%	No
Spacing <18 mos. since last birth	231	16.7%	176	13.6%	215	12.7%	240	13.5%	285	15.2%	242	12.8%	250	16.6%	Yes
Births to mothers <18 years of age	237	9.3%	234	9.2%	188	6.4%	165	5.3%	184	5.4%	189	5.5%	153	5.7%	No
Repeat teen births	133	5.2%	131	5.1%	115	3.9%	108	3.5%	128	3.7%	107	3.1%	106	4.0%	No
Fetal Deaths (20+ wks) (1)	10	3.9	9	3.5	15	5.1	18	5.8	14	4.1	14	4.1	19	7.1	No
Total live birth or stillbirth fetuses 500 grams or more (2)	2,559	291.9	2,555	279.9	2,930	149.2	3,137	151.3	3,435	157.1	3,446	172.0	2,682	212.8	Yes
Percent of prenatals on WIC	1,847	72.4%	1,851	72.6%	2,344	80.2%	2,456	78.5%	2,694	78.5%	2,638	76.6%	2,117	79.3%	Yes
VLBW not delivered in level III hospitals	3	8.3%	7	16.7%	6	10.9%	9	15.8%	7	16.3%	14	26.9%	4	14.3%	No

Central Region Medicaid continued

	Before MC +				*After MC+*									
	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2001*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*
Average maternal length of stay (days) Inpatient admissions	2,317	2.7	2,234	2.6	2,574	2.5	2,615	2.4	2,823	2.4	3,045	2.5	3,051	2.5
Average newborn length of stay (days) Inpatient admissions														
Average behavioral health length of stay(days) Inpatient admissions	NA	NA	NA	NA	383	9.6	215	6.7	526	7.5	491	7.0	444	7.9
Asthma admissions under age 18 Inpatient admissions (2)	134	4.9	81	2.9	112	2.9	124	3.0	122	2.7	98	2.0	108	2.2
Asthma admissions 4-17 Inpatient admissions (2)	40	2.2	42	2.2	49	1.9	46	1.5	42	1.3	50	1.4	52	1.5
Asthma emergency room visits 4-17	196	10.9	200	10.4	255	9.9	304	10.0	317	9.7	299	8.4	341	9.6
Asthma admissions ages 18-64 Inpatient admissions (2)	NA	NA	NA	NA	35	2.5	36	2.5	22	1.3	26	1.5	25	1.4
Emergency room visits under age 18 (2)	19,808	731.3	21,042	743.2	26,812	701.8	29,470	707.4	33,330	744.0	31,685	642.6	33,854	686.6
Emergency room visits ages 18-64 (2)	NA	NA	NA	NA	14,986	1071.2	17,219	1185.5	19,745	1180.7	21,798	1259.4	20,792	1201.3
Hysterectomies (2)	NA	NA	NA	NA	123	11.7	146	13.4	155	12.5	143	11.1	128	9.9
Vaginal hysterectomies	NA	NA	NA	NA	52	42.3%	73	50.0%	80	51.6%	62	43.4%	53	41.4%
Preventable hospitalizations under age 18(2)	590	21.8	553	19.5	552	14.4	558	13.4	569	12.7	514	10.4	588	11.9

(1) Rate per 1000 live births
(2) Rate per 1000 population

***Statistically significant change between CY2005 and Jan-Sept 2006 at .05 level of significance using Chi-square test
Source: Missouri Department of Health and Senior Services
12/20/2006

Trends in Missouri Medicaid Quality Indicators:

Central Region Baseline Non-Medicaid Vs. Last 57 Months Non-Medicaid MC+

	Before MC+				*After MC+*										
	Baseline														
	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*		*Jan-Sept 2006*		*Significant*
Trimester Prenatal Care Began	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Change****
First	3,290	88.7%	3,363	89.3%	3,336	88.9%	3,365	90.7%	3,262	90.4%	3,379	90.5%	2,639	91.3%	No
Second	337	9.1%	338	9.0%	327	8.7%	280	7.5%	262	7.3%	278	7.4%	203	7.0%	No
Third	55	1.5%	45	1.2%	59	1.6%	51	1.4%	61	1.7%	56	1.5%	33	1.1%	No
None	28	0.8%	19	0.5%	29	0.8%	16	0.4%	23	0.6%	22	0.6%	14	0.5%	No
Total	3,710		3,765		3,751		3,712		3,608		3,735		2,889		
Inadequate Prenatal Care	256	6.9%	255	6.8%	280	7.6%	255	7.3%	269	8.0%	245	7.2%	189	7.4%	No
Birth Weight (grams)															
<500	4	0.1%	4	0.1%	6	0.2%	6	0.2%	6	0.2%	4	0.1%	6	0.2%	No
500-1499	28	0.7%	18	0.5%	41	1.1%	46	1.2%	32	0.8%	29	0.8%	40	1.3%	Yes
1500-1999	36	1.0%	49	1.3%	50	1.3%	65	1.7%	59	1.5%	42	1.1%	43	1.4%	No
2000-2499	131	3.5%	143	3.8%	158	4.1%	155	4.0%	175	4.5%	177	4.6%	137	4.4%	No
2500+	3,537	94.7%	3,594	94.4%	3,616	93.4%	3,652	93.1%	3,600	93.0%	3,608	93.5%	2,870	92.7%	No
Total	3,736		3,808		3,871		3,924		3,872		3,860		3,096		
Low Birth Weight (<2500 grams)	199	5.3%	214	5.6%	255	6.6%	272	6.9%	272	7.0%	252	6.5%	226	7.3%	No
Method of Delivery															
C-Section	785	21.0%	795	20.9%	1,123	29.0%	1,205	30.7%	1,333	34.4%	1,298	33.6%	1,025	33.1%	No
VBAC	129	29.9%	157	35.5%	68	14.1%	65	13.0%	56	10.3%	59	8.6%	28	6.3%	No
Repeat C-Section	303	70.1%	285	64.5%	413	85.9%	436	87.0%	486	89.7%	627	91.4%	417	93.7%	No
Total	3,736		3,810		3,874		3,924		3,873		3,863		3,099		
Smoking During Pregnancy	461	12.3%	450	11.8%	384	9.9%	351	8.9%	357	9.2%	359	9.3%	282	9.1%	No
Spacing <18 mos. since last birth	154	7.1%	127	5.7%	167	7.4%	149	6.7%	151	6.9%	157	7.2%	117	6.7%	No
Births to mothers <18 years of age	46	1.2%	43	1.1%	35	0.9%	45	1.1%	50	1.3%	45	1.2%	41	1.3%	No
Repeat teen births	20	0.5%	15	0.4%	15	0.4%	10	0.3%	12	0.3%	20	0.5%	17	0.5%	No
Fetal Deaths (20+ wks) (1)	10	2.7	9	2.4	15	3.9	12	3.1	22	5.7	31	8.0	22	7.1	No
Total live birth or stillbirth fetuses 500 grams or more (2)	3,732	35.2	3,806	35.9	3,873	40.1	3,926	40.5	3,884	40.3	3,880	39.1	3,107	40.6	No
Percent of prenatals on WIC	316	8.6%	305	8.1%	391	10.1%	362	9.2%	427	11.0%	427	11.1%	336	10.8%	No
VLBW not delivered in level III hospitals	5	15.6%	1	4.5%	7	14.6%	8	15.4%	4	10.8%	6	18.2%	14	30.4%	No

Central Region Non-Medicaid continued

Before MC+ *After MC+*

	Fiscal Year 1994		*Fiscal Year 1995*		*Calendar Year 2001*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*
Average maternal length of stay (days) Inpatient admissions	3,865	2.2	3,984	2.1	3,932	2.5	3,898	2.6	3,978	2.7	3,989	2.7	3,569	2.6
Average behavioral health length of stay(days) Inpatient admissions	NA	NA	NA	NA	2,775	7.8	2,417	7.0	2,691	6.5	3,004	5.7	2,956	6.0
Asthma admissions under age 18 Inpatient admissions (2)	132	1.4	76	0.8	64	0.7	88	1.0	70	0.8	97	1.2	64	0.8
Asthma admissions 4-17 Inpatient admissions (2)	61	0.8	55	0.7	23	0.3	37	0.5	36	0.5	55	0.9	41	0.7
Asthma emergency room visits 4-17	254	3.2	242	3.1	215	2.8	194	2.7	188	2.7	209	3.3	187	3.0
Asthma admissions ages 18-64 Inpatient admissions (2)	NA	NA	NA	NA	248	0.8	235	0.7	219	0.7	242	0.7	236	0.7
Emergency room visits under age 18 (2)	24,934	269.9	24,322	263.3	23,765	265.0	23,209	273.2	23,182	278.9	23,491	293.3	23,733	296.4
Emergency room visits ages 18-64 (2)	NA	NA	NA	NA	87,804	266.7	88,658	265.8	92,602	278.0	97,006	288.3	105,745	314.3
Hysterectomies (2)	NA	NA	NA	NA	1,201	7.7	1,258	7.9	1,204	7.5	1,164	7.2	1,094	6.8
Vaginal hysterectomies	NA	NA	NA	NA	473	39.4%	457	36.3%	423	35.1%	414	35.6%	320	29.3%
Preventable hospitalizations under age 18(2)	741	8.0	618	6.7	559	6.2	529	6.2	572	6.9	582	7.3	653	8.2

(1) Rate per 1000 live births
(2) Rate per 1000 population

***Statistically significant change between CY2005 and Jan-Sept 2006 at .05 level of significance using Chi-square test
Source: Missouri Department of Health and Senior Services
12/20/2006

Trends in Missouri Medicaid Quality Indicators:
Western Region Medicaid Baseline Vs. Last 57 Months Medicaid MC+

	Before MC+				*After MC+*										
	Baseline												*Provisional*		
Trimester Prenatal Care Began	*Calendar Year 1995*		*Calendar Year 1996*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*		*Jan-Sept 2006*		*Significant*
	Births	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Change****
First	3,849	74.0%	3,825	75.1%	4,883	79.2%	5,321	82.3%	5,756	81.9%	5,862	80.7%	4,212	78.3%	Yes
Second	1,085	20.8%	994	19.5%	1,019	16.5%	960	14.9%	1,040	14.8%	1,148	15.8%	970	18.0%	Yes
Third	183	3.5%	203	4.0%	182	3.0%	127	2.0%	167	2.4%	170	2.3%	154	2.9%	No
None	87	1.7%	69	1.4%	81	1.3%	56	0.9%	69	1.0%	86	1.2%	44	0.8%	Yes
Total	5,204		5,091		6,165		6,464		7,032		7,266		5,380		
Inadequate Prenatal Care	1,131	22.1%	1,094	22.5%	1,061	18.7%	951	16.9%	1,050	16.4%	1,200	17.0%	941	18.3%	No
Birth Weight (grams)															
<500	13	0.2%	13	0.2%	13	0.2%	15	0.2%	16	0.2%	14	0.2%	21	0.4%	No
500-1499	80	1.5%	89	1.7%	102	1.6%	103	1.6%	98	1.4%	125	1.6%	77	1.3%	No
1500-1999	102	1.9%	95	1.8%	121	1.9%	105	1.6%	120	1.7%	135	1.8%	100	1.7%	No
2000-2499	333	6.1%	346	6.5%	344	5.4%	370	5.6%	420	5.8%	455	5.9%	338	5.8%	No
2500+	4,887	90.2%	4,820	89.9%	5,841	91.0%	6,003	91.0%	6,602	91.0%	6,981	90.5%	5,334	90.9%	No
Total	5,415		5,363		6,421		6,596		7,256		7,710		5,870		
Low Birth Weight(<2500 grams)	528	9.8%	543	10.1%	580	9.0%	593	9.0%	654	9.0%	729	9.5%	536	9.1%	No
Method of Delivery															
C-Section	797	14.7%	864	16.1%	1,264	19.7%	1,398	21.2%	1,570	21.6%	1,818	23.6%	1,363	23.2%	No
VBAC	173	39.4%	119	31.2%	89	16.4%	85	13.3%	102	14.3%	68	8.5%	68	12.1%	Yes
Repeat C-Section	266	60.6%	262	68.8%	453	83.6%	555	86.7%	612	85.7%	733	91.5%	493	87.9%	Yes
Total	5,415		5,373		6,423		6,599		7,257		7,715		5,872		
Smoking During Pregnancy	1,728	31.9%	1,626	30.3%	1,644	25.6%	1,710	25.9%	1,892	26.1%	1,987	25.8%	1,500	25.5%	No
Spacing <18 mos. since last birth	430	14.9%	460	15.7%	482	13.6%	533	14.4%	601	14.9%	662	15.1%	557	16.7%	No
Births to mothers <18 years of age	583	10.8%	572	10.6%	459	7.1%	420	6.4%	425	5.9%	439	5.7%	338	5.8%	No
Repeat teen births	358	6.6%	389	7.2%	329	5.1%	316	4.8%	313	4.3%	293	3.8%	204	3.5%	No
Fetal Deaths (20+ wks) (1)	43	7.9	36	6.7	29	4.5	44	6.7	28	3.9	40	5.2	21	3.6	No
Total live birth or stillbirth fetuses 500 grams or more (2)	5,434	209.0	5,386	228.9	6,430	161.8	6,613	155.8	7,259	166.0	7,724	195.3	5,864	197.6	No
Percent of prenatals on WIC	4,254	78.6%	4,207	78.3%	5,051	78.6%	5,182	78.5%	5,778	79.6%	5,993	77.7%	4,584	78.1%	No
VLBW not delivered in level III hospitals	9	9.7%	15	14.7%	14	12.2%	16	13.6%	18	15.8%	13	10.2%	17	17.7%	No

Western Region Medicaid continued

	Before MC+				After MC+									
	Baseline													
	Calendar Year 1995		*Calendar Year 1996*		Calendar Year 2001		Calendar Year 2002		Calendar Year 2003		Calendar Year 2004		Calendar Year 2005	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*
Average maternal length of stay (days) Inpatient admissions	5,138	2.4	5,211	2.4	5,110	2.6	5,214	2.6	5,388	2.7	5,876	2.7	5,920	2.7
Average behavioral health length of stay(days) Inpatient admissions	NA	NA	NA	NA	1,428	12.8	691	22.4	1,668	13.8	1,718	13.4	1,647	12.6
Asthma admissions under age 18 Inpatient admissions (2)	173	2.6	211	3.2	265	3.2	322	3.6	293	3.0	237	2.4	282	2.9
Asthma admissions 4-17 Inpatient admissions (2)	120	2.6	145	3.2	157	2.8	183	2.8	187	2.6	121	1.7	176	2.5
Asthma emergency room visits 4-17	1,320	28.7	1,300	28.8	1,206	21.6	1,380	21.3	1,273	17.9	1,121	16.1	1,140	16.4
Asthma admissions ages 18-64 Inpatient admissions (2)	NA	NA	NA	NA	74	2.7	62	2.2	59	1.8	74	2.2	77	2.3
Emergency room visits under age 18 (2)	54,635	805.9	48,489	741.2	51,508	621.6	51,486	575.7	59,281	605.3	53,738	553.6	54,967	566.3
Emergency room visits ages 18-64 (2)	NA	NA	NA	NA	27,784	1030.6	30,807	1083.1	35,673	1091.6	38,469	1148.7	36,298	1083.9
Hysterectomies (2)	NA	NA	NA	NA	155	7.1	184	8.1	161	7.0	171	6.4	114	4.3
Vaginal hysterectomies	NA	NA	NA	NA	56	36.1%	77	41.8%	59	36.6%	74	43.3%	32	28.1%
Preventable hospitalizations under age 18(2)	695	10.3	637	12.0	944	11.4	1,031	11.5	959	9.8	969	10.0	1,018	10.5

(1) Rate per 1000 live births
(2) Rate per 1000 population

***Statistically significant change between CY2005 and Jan-Sept 2006 at .05 level of significance using Chi-square test
Source: Missouri Department of Health and Senior Services
12/20/2006

Trends in Missouri Medicaid Quality Indicators:
Western Region Non-Medicaid Baseline Vs. Last 57 Months Non-Medicaid MC+

	Before MC+				*After MC+*										
	Baseline														
Trimester Prenatal Care Began	*Calendar Year 1995*		*Calendar Year 1996*		*Calendar Year 2002*		*Calendar Year 2003*		*Calendar Year 2004*		*Calendar Year 2005*		*Jan-Sept 2006*		*Significant*
	Births	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Births*	*Percent*	*Change****
First	8,591	92.4%	8,859	92.5%	9,758	94.1%	9,524	94.8%	9,391	94.3%	9,027	94.0%	6,830	92.5%	Yes
Second	530	5.7%	542	5.7%	447	4.3%	395	3.9%	417	4.2%	432	4.5%	451	6.1%	Yes
Third	97	1.0%	89	0.9%	79	0.8%	63	0.6%	85	0.9%	72	0.7%	52	0.7%	No
None	75	0.8%	85	0.9%	86	0.8%	62	0.6%	70	0.7%	72	0.7%	49	0.7%	No
Total	9,293		9,575		10,370		10,044		9,963		9,603		7,382		
Inadequate Prenatal Care	545	6.0%	563	6.0%	511	5.1%	487	5.0%	496	5.1%	461	4.9%	417	5.7%	Yes
Birth Weight (grams)															
<500	11	0.1%	18	0.2%	10	0.1%	17	0.2%	16	0.2%	10	0.1%	25	0.3%	Yes
500-1499	91	1.0%	101	1.0%	125	1.2%	104	1.0%	143	1.4%	123	1.2%	85	1.1%	No
1500-1999	123	1.3%	126	1.3%	172	1.6%	127	1.3%	158	1.6%	128	1.3%	103	1.3%	No
2000-2499	362	3.8%	379	3.9%	413	3.9%	410	4.1%	437	4.4%	405	4.1%	318	4.2%	No
2500+	8,839	93.8%	9,204	93.7%	9,780	93.1%	9,460	93.5%	9,288	92.5%	9,184	93.2%	7,101	93.0%	No
Total	9,426		9,828		10,500		10,118		10,042		9,850		7,632		
Low Birth Weight(<2500 grams)	587	6.2%	624	6.3%	720	6.9%	658	6.5%	754	7.5%	666	6.8%	531	7.0%	No
Method of Delivery															
C-Section	1,936	20.5%	1,936	19.7%	2,706	25.8%	2,767	27.3%	2,850	28.4%	2,881	29.2%	2,284	29.9%	No
VBAC	369	35.8%	358	36.1%	177	14.9%	143	11.5%	113	9.2%	103	8.7%	74	8.3%	No
Repeat C-Section	662	64.2%	633	63.9%	1,010	85.1%	1,096	88.5%	1,114	90.8%	1,083	91.3%	815	91.7%	No
Total	9,430		9,829		10,501		10,121		10,046		9,853		7,637		
Smoking During Pregnancy	1,122	11.9%	1,162	11.8%	811	7.7%	796	7.9%	772	7.7%	750	7.6%	539	7.1%	No
Spacing <18 mos. since last birth	390	7.5%	818	7.9%	434	7.7%	472	8.3%	452	8.1%	500	8.9%	349	8.3%	No
Births to mothers <18 years of age	244	2.6%	221	2.2%	166	1.6%	173	1.7%	146	1.5%	122	1.2%	139	1.8%	Yes
Repeat teen births	75	0.8%	83	0.8%	58	0.6%	48	0.5%	44	0.4%	53	0.5%	45	0.6%	No
Fetal Deaths (20+ wks) (1)	52	5.5	49	5.0	63	6.0	55	5.4	66	6.6	39	4.0	29	3.8	No
Total live birth or stillbirth fetuses 500 grams or more (2)	9,453	45.9	9,848	47.2	10,539	49.2	10,142	46.7	10,073	48.6	9,867	46.7	7,624	46.8	No
Percent of prenatals on WIC	1,055	11.2%	1,233	12.5%	1,266	12.1%	1,182	11.7%	1,197	11.9%	1,315	13.3%	1,057	13.8%	No
VLBW not delivered in level III hospitals	9	10.0%	20	18.2%	13	11.8%	16	15.4%	17	15.7%	16	17.0%	24	28.6%	No

Western Region Non-Medicaid continued

	Before MC+				After MC+									
	Baseline													
	Calendar Year 1995		*Calendar Year 1996*		Calendar Year 2001		Calendar Year 2002		Calendar Year 2003		Calendar Year 2004		Calendar Year 2005	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*
Average maternal length of stay (days) Inpatient admissions	9,271	1.9	9,312	2.0	9,733	2.6	9,478	2.7	9,818	2.7	9,132	2.7	9,159	2.7
Average behavioral health length of stay(days) Inpatient admissions	NA	NA	NA	NA	9,590	8.4	5,797	8.9	8,182	8.1	7,860	8.0	7,790	7.9
Asthma admissions under age 18 Inpatient admissions (2)	237	1.1	241	1.1	214	1.0	184	0.9	215	1.1	168	0.9	218	1.1
Asthma admissions 4-17 Inpatient admissions (2)	189	1.1	173	1.0	129	0.8	117	0.7	147	0.9	109	0.7	149	1.0
Asthma emergency room visits 4-17	1,142	6.9	1,181	6.8	959	5.6	952	5.7	899	5.5	831	5.0	769	4.6
Asthma admissions ages 18-64 Inpatient admissions (2)	NA	NA	NA	NA	784	1.1	781	1.1	807	1.2	764	1.1	836	1.2
Emergency room visits under age 18 (2)	57,397	277.1	56,568	267.0	64,312	309.8	59,937	297.8	58,771	299.0	54,579	281.7	51,598	266.3
Emergency room visits ages 18-64 (2)	NA	NA	NA	NA	224,973	329.7	224,212	324.4	227,079	329.9	233,358	333.8	241,010	344.8
Hysterectomies (2)	NA	NA	NA	NA	2,614	7.8	2,607	7.6	2,476	7.3	2,097	6.1	1,769	5.1
Vaginal hysterectomies	NA	NA	NA	NA	1,001	38.3%	1,046	40.1%	1,037	41.9%	847	40.4%	590	33.4%
Preventable hospitalizations under age 18(2)	837	4.0	838	4.0	1,148	5.5	1,127	5.6	1,016	5.2	1,017	5.2	1,089	5.6

(1) Rate per 1000 live births
(2) Rate per 1000 population

***Statistically significant change between CY2005 and Jan-Sept 2006 at .05 level of significance using Chi-square test
Source: Missouri Department of Health and Senior Services
12/20/2006

MC+ MANAGED CARE ANNUAL EVALUATION

COMPLIANCE

COMPLIANCE

FRAUD AND ABUSE

Community CarePlus (CCP)
Information Obtained From CCP's 2005 Annual Evaluation

Fraud and Abuse
Prevention and Internal Controls
Community CarePlus provider contracts contain appropriate clauses including but not limited to care and services to be provided for the member, PCP requirements for coordination of care and 24-hour availability, PCP medical documentation requirements, the inspection of medical and financial records upon request, appointment standards, (refer to Policy BD 012, CRE 001, CRE 002)

Within the recredentialing review process, questions and analysis are directed toward the performance and documentation of preventative primary care services. EPSDT screens, immunizations, and cervical cancer screenings are monitored through annual HEDIS evaluation. Community CarePlus' financial accounting policies and processes follow Generally Acceptable Accounting Practices so that internal controls are in place with processes including but not limited to vendor payments and revenue to enrollment reconciliation. (Refer to FN 001) Community CarePlus and NovaSys are audited annually by an independent financial audit agency. Any corrective action recommended by the auditor is addressed.

- Prevention activities include:
- Provider contract requirements
- Oversight of BMOs
- Education of staff, members, providers and subcontractors
- Identification of "debarred" individuals
- Development of corrective initiative as needed
- Reporting to the QIC and the Board for recommendations of corrective initiatives or improvements

Investigation
Community CarePlus believes the key to an anti-fraud and abuse plan is to gather information on a routine basis. When confirmed issues of fraud and abuse are identified, it is the responsibility of the QI Manager to report the findings to the Compliance Committee and to the appropriate State agency. Community CarePlus will collaborate with the State to report all suspected cases of

fraud and abuse as quickly as a potential issue is detected. Employees will be given feedback of the investigation and outcome by their department head.

Training and Education

Providers are educated regarding Fraud and Abuse as part of their orientation. This information is included in the Provider Manual. On an annual basis Community CarePlus provides an article in the provider newsletter regarding the subject of fraud and abuse. Individual provider education regarding fraud and abuse is documented and filed in the provider's file. If a provider is investigated for possible fraud and abuse, he/she is sent a follow up letter stating the outcome of the investigation and the plan of action required to correct the problem.

Members are educated regarding fraud and abuse by way of Member Newsletter. If a member is investigated for the possibility of fraud and abuse, a follow up letter stating the outcome of the investigation is mailed to the member.

Employees are educated at orientation and CCP plans to hold annual education in-services on fraud and abuse for staff.

2005 Cases

A total of seventeen (17) fraud cases were investigated in 2005. Of theses cases, seven (7) were investigated for pharmacy mis-utilization and were put into the "Pharmacy Lock-in" program. The Pharmacy Lock-In limits the member to one pharmacy for all prescriptions, allowing the pharmacy to notify the primary care physician of a member's Schedule II prescription frequency and prevent dispensing of multiple Schedule II medications. Monthly monitoring of the member's detail pharmacy is reviewed and quarterly updates are sent to the state. Currently, 4 remain in the Pharmacy Lock-in Program, 3 of the 7 members have terminated with CCP.

Two (2) investigations regarded the possibility of surrogate pregnancy. Neither case could produce documentation that these allegations were true and both cases were closed. One (1) case involved a claim issue and it was determined that the claim was incorrectly filed. Three (3) involved frequent ER utilization and these members were assigned to case management. Four (4) were miscellaneous investigation and all were closed.

Information reported to DMS by CCP in FY 2006:

	Number/Type		Action/Outcome	
Initial Reports received by DMS from CCP	**Member** 0	**Provider** 0	**Member** NA*	**Provider** NA*
Cases			1-No	NA*

submitted to CCP by DMS	1- Potential Pharmacy Lock In	0	communication after initial fax sent to CCP	
Total	1	0		

- NA= Not Applicable

Mercy MC+

Information Obtained From Mercy MC+ 2005 Annual Evaluation

Fraud and Abuse

Prevention, Detection, Investigation

Mercy Health Plans (the Plan) has established a Special Investigative Unit (SIU) to identify, investigate, and; as appropriate, report to state and federal regulatory agencies suspected irregularities in the provision of services to members. These suspect practices may include, but are not limited to, billing practices, inappropriate provision of services, or misrepresentation of medical information to justify payment and inconsistencies by providers, subcontractors, groups, members, or employees.

Each employee, subcontractor, and/or agent of the Plan has both an ethical and fiduciary obligation to report suspect practices and potential violations of state and federal laws to the Plans' administrative personnel without fear of retribution or adverse consequences. Upon hire and annually thereafter, each of the Plan's employees will receive a copy of the Fraud and Abuse Investigation Policy & Procedure and the Corporate Compliance Program's Code of Conduct and will sign the acknowledgement of receipt. This acknowledgement certifies that he/she has read and understands the policy and that he/she agrees to comply with the policy.

Training and Education

The Plan will conduct education for all employees in order to identify, investigate, and prevent fraud and abuse. Currently in development are plans to provide, through the Intranet, on-line training and review of identified fraud and abuse practices. This type of training will be validated by a comprehension quiz that will record scores and dates of accomplishment.

Currently training is being conducted in a classroom setting and is specific to subject matter of the staff receiving the training and contains examples of fraud or abuse in their particular subject matter. All new employees will receive fraud and abuse training on their start date or within 90 working days of employment. The Plan maintains a training log for all training pertaining to fraud and/or abuse. The log includes the name and title of the trainer, names of all staff attending the training and the date and length of the training.

The Provider Services representatives will provide training to all providers about their responsibilities to report fraud and abuse, and how and where to report. This information is clearly outlined in the Provider Manual, which includes examples of fraudulent activities.

Training updates will continue to be conducted when any changes are made to the policies and procedures. Within the scope of the new training program, update training will be completed within 20 working days of any regulatory or procedural changes made.

Information reported to DMS by Mercy MC+ in FY 2006:

	Number/ Type		Action/Outcome	
Initial Reports received by DMS from Mercy	**Member** 4 - Pharmacy	**Provider** 0	**Member** Member locked in	**Provider** NA*
Cases submitted to Mercy by DMS	1- Pharmacy	0	Follow up information received on Quarterly Report	NA*
Total	5	0		

HealthCare USA (HCUSA) In Eastern, Central and Western Regions
Information Obtained From HCUSA's 2005 Annual Evaluation

COMPLIANCE PROGRAM – FRAUD AND ABUSE:

In 2005, the Fraud and Abuse program underwent several beneficial changes in order to meet state requirements, enhance systems, and help members. HCUSA created a Fraud and Abuse committee to address the program and all its activities. The committee meets quarterly to review any current fraudulent or abusive issues regarding members, providers or subcontractors. The results of these reviews, as well as tracking and trending data are also reported annually to the Quality Management Committee, which implements quality improvement efforts if applicable. A detailed report of the fraud and abuse activities is located later in this report.

Fraud and Abuse

Throughout 2005, HealthCare USA maintained the numerous updates to our fraud and abuse program created and implemented in 2004. The fraud and abuse committee continues to meet quarterly to discuss all reported issues, members and providers, and all applicable topics related to fraud and abuse. While the committee consists of representatives from departments ranging from Pharmacy, Member Services, Provider Relations, Business Reporting, Health Services, Government Programs, Medical Directors and the Special Investigations Unit (SIU), feedback is provided from all perspectives of the company. Many ideas stem from the quarterly meetings, and we will continue to utilize the meetings as a positive resource for the health plan's fraud and abuse program.

In 2005, the health plan continually adhered to the ten (10) policies and procedures created in 2004. The policies encompass the federal and state regulations; internal procedures for monitoring, minimizing and reporting fraud and abuse; the data system utilized for fraud and abuse cases; and procedures for subcontractors. Along with maintaining the previously created policies, the Providers Relations department created a new policy and procedure for provider billing pattern review. The department reviews outpatient Evaluation and Management (E & M) codes and provides results to the providers identified of using a high percentage of E & M codes while asking for an explanation.

The outcomes of the fraud and abuse committee and the updates of the fraud and abuse plan are not only reported to the State continually, but also to HealthCare USA's Quality Management Committee (QMC) annually. Internal employees as well as participating providers on the panel provide feedback. In order to ensure the most beneficial procedures for minimizing fraud and abuse, individual cases, without the use of Personal Health Information, and the overall fraud and abuse plan are presented and discussed.

Among many issues, the lock-in process received positive feedback internally and from the QMC. The health plan has received approvals for all letters associated with the lock-in process. With severe fraudulent or abusive cases, the health plan locks members in to one (1) pharmacy, at which time they are only able to receive medications from that pharmacy. If a member continually commits fraudulent activities after receiving the notification letter, which is sent to all reported members, and the plan decides to place the member in the lock-in process, we send the member a letter allowing them to choose one (1) pharmacy to utilize. If the member does not reply to that letter, the plan will determine a pharmacy for the member after receiving approval from the pharmacy. We then send a letter to the member notifying them of the pharmacy chosen for them and the twelve (12) month lock-in process begins.

When a new member has previously been in the lock-in program with their previous health plan, the State notifies HCUSA and we continually review them to determine if we should place them in the lock-in program also. As well as receiving information that leads to member investigations from the State, the health plan received motive to investigate members from pharmacies, physicians, subcontractors, the SIU and the Office of Inspector General in 2005. After receiving potential fraudulent cases, the health plan immediately initiates the investigation and reports the initial findings to the State. In quarters 1, 2, 3 and 4 respectively, five (5) members, zero (0) members, twelve (12) members and five (5) members were suspected of fraudulent or abusive behaviors and reported to the State. In 2005, the reported cases totaled twenty-two (22) members and twenty-four (24) providers. All but one of the reported providers were flagged because others obtained their information and created a fraudulent P.O. Box. These twenty-three (23) providers did not commit fraudulent activities, yet the flag remains to ensure all claims correlated with the correct address. The other flagged provider was requested by the health plan's Credentialing Committee due to suspected up-coding and misrepresentation of services. The flag for this provider has been removed after reviewing a significant amount of claims submitted by the provider. The statistics in 2005 are similar to 2004, where twenty-nine (29) members and twenty-two (22) providers were flagged and reported.

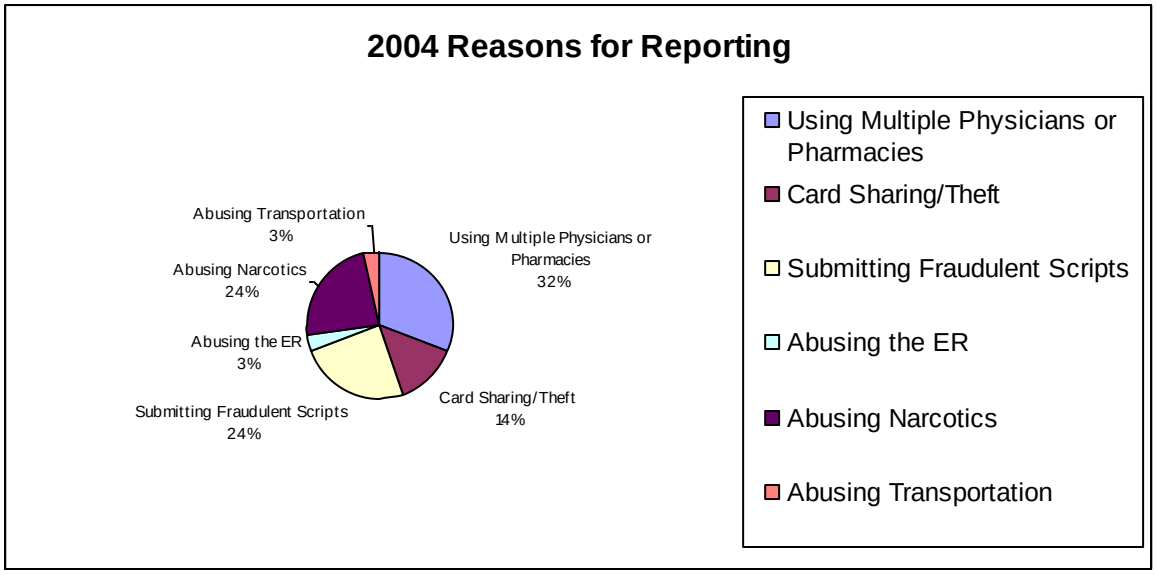
Moving forward, HCUSA will maintain an aggressive approach to curtail fraud and abuse. With the assistance of the plan's fraud and abuse committee and the QMC, we will investigate all fraudulent cases to the fullest and take all appropriate actions. Every idea that stems from these committees will be researched and the outcomes will be presented. Timeliness and accuracy will continue to be a high priority in regards to reporting requirements. Along with maintaining the positive additions to the fraud and abuse program created in the past couple of years, HealthCare USA will continually research new ways to minimize fraudulent and abusive activities.

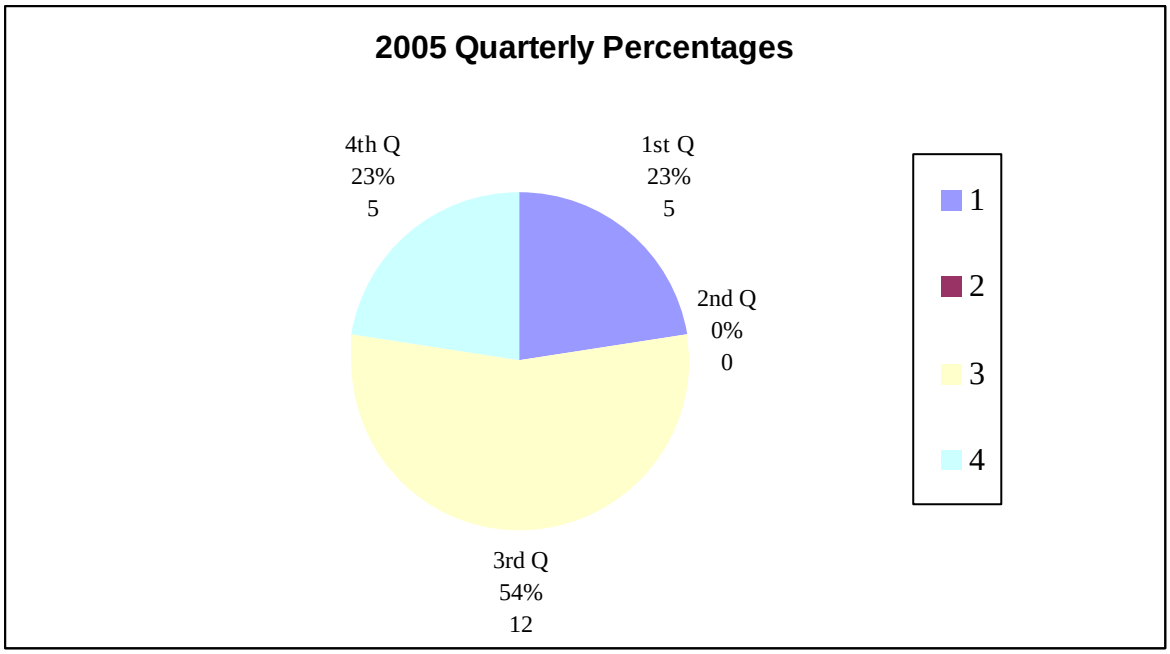
2005 Summary Grid

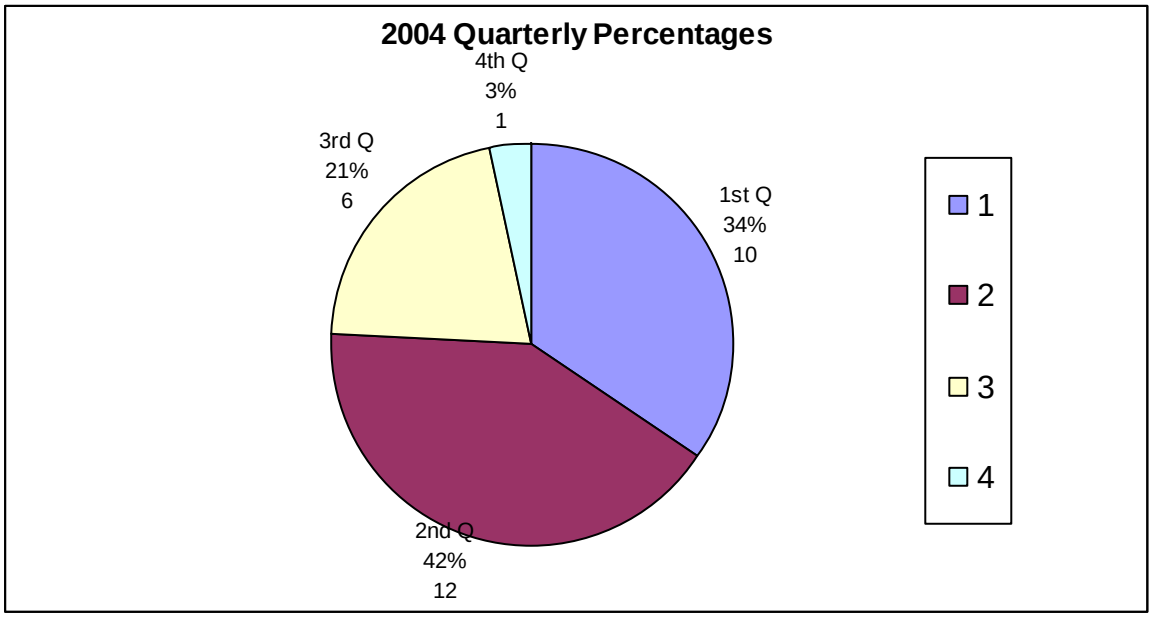
PROPOSAL	PROCESS	OUTCOME
1. Continually meeting quarterly, at minimum, with the fraud and abuse committee.	The committee discusses all reported issues and all applicable topics related to fraud and abuse.	The committee consists of representatives from all applicable departments in order to receive feedback from all aspects of the company. Many ideas generate from the committee and we will continue to utilize the meetings as a positive resource for the health plan's fraud and abuse program.
2. Created a policy and procedure for reviewing billing patterns.	PR reviews outpatient E&M codes and provides results to the providers identified of using a high percentage of E&M codes.	While notifying providers with high E&M code utilization, the provider is asked to provide an explanation. Further steps are taken when necessary.
3. Presented the outcomes and updates of the fraud and abuse program to the State and to QMC.	Annually, the Compliance Officer, or his or her designee, provides outcomes and updates to QMC and quarterly, at minimum, provide outcomes and updates to the State.	The health plan receives feedback from internal employees as well as outside parties in order to create and maintain the most beneficial fraud and abuse program.
4. Obtained all approvals necessary to begin the lock-in program.	With severe fraudulent or abusive cases, the health plan locks member in to one (1) pharmacy. We send the member a letter to choose a pharmacy (the health plan chooses for them if not), notify the pharmacy and obtain approval and begin the lock-in process for 12 months.	All letters associated with the lock-in program were approved by the State in 2005. The program was completely implemented in 2005.

5. Continuing to obtain information leading to minimizing fraudulent and/or abusive activities.	The health plan receives motive to investigate members from the State, pharmacies, providers, subcontractors, the SIU and the OIG.	After receiving the information, the plan immediately begins investigation and provides the State with the initial report as well as the quarterly report to show all outcomes of the investigation. All necessary steps are taken to minimize fraud and abuse.
6. Continuing to minimize fraud and abuse in every possible way.	With the assistance of the State and QMC, investigate all possible fraud and/or abuse and take all steps necessary.	HealthCare USA will maintain all positive additions to the fraud and abuse program implemented thus far and will continue to research new ways to minimize all fraudulent and/or abusive activities.

2005 Graphs Compared to 2004




2005 Quarterly Percentages
4th Q
23%
5
1st Q
23%
5
2nd Q
0%
0
3rd Q
54%
12
1
2
3
4


2004 Quarterly Percentages
4th Q
3%
1
3rd Q
21%
6
1st Q
34%
10
2nd Q
42%
12
1
2
3
4

Information reported to DMS by HCUSA in FY 2006:

	Number/Type		Action/Outcome	
Initial Reports received by DMS from HCUSA	**Member** 18-Pharmacy 3-Eligibility 1-Transportation	**Provider** 1-Inappropriate billing	**Member** All had initial investigations and were re-reported in the Annual Fraud and Abuse Report, March 14, 2005.	**Provider** Initial report was submitted. Doctor was decredentialed. All appropriate actions taken.
Cases submitted to HCUSA by DMS	7-Pharmacy 2-Eligibility	NA*	6-DMS did not receive initial report or any follow up report after reported to HCUSA 3-DMS received initial report and follow up information in the Annual Fraud and Abuse Report, March 14, 2005	NA*
Total	31	1		

CENTRAL REGION

Missouri Care

Information Obtained From Missouri Care's 2005 Annual Evaluation

Fraud and Abuse

Prevention, Detection and Investigation

In 2005 there were 16 fraud and/or abuse issues reported. Each issue can be placed under one of the three categories: provider, member or employee.

Provider

Research into provider fraud and abuse in 2005 included monitoring specific providers for bundling and upcoding on claims. Education was given to providers to help them correct their coding. System changes were also made at Missouri Care to enhance the ability to identify coding irregularities.

Member

There were 13 examples of member fraud and abuse in 2005:

- Misuse of Emergency Room – 1
- High pharmacy utilization – 10, (Falsification of prescriptions – 2, Pharmacy Lock-Ins – 4)
- Member SSN and name used to obtain emergency room services – 1
- Referral from Division of Medical Services re: other insurance for a member – 1
- Missouri Care referral to Medicaid Fraud Investigation Unit for further investigation – 1

Employee

There were no incidents of employee fraud and abuse reported in 2005.

Fraud and Abuse Training and Education

Each employee participates in a Missouri Care Health Plan Compliance Program training seminar conducted once per calendar year.

Training in 2005 included a summary of the types of fraud and abuse that should be reported to the compliance officer. Examples of fraud and abuse were discussed from the previous year and used as training aids.

Information reported to DMS by Missouri Care in FY 2006:

	Number/ Type		Action/Outcome	
Initial Reports received by DMS from Missouri Care	**Member** 4	**Provider** 0	**Member** All researched by Missouri Care and no fraud and abuse found in 3 of the 4 cases. The fourth case is still under	**Provider** NA*

			investigation.	
Cases submitted to Missouri Care by DMS	4- Potential Lock In	0	No further communication on these cases after referral to Missouri Care	NA*
Total	8	0		

*NA= Not Applicable

WESTERN REGION

Blue- Advantage Plus of Kansas City (BA+)

Information Obtained From BA+ 2005 Annual Evaluation

FRAUD AND ABUSE

PREVENTION, DETECTION, INVESTIGATION

The Blue Cross and Blue Shield of Kansas City (BCBSKC) Special Investigations Unit (SIU) was established in 1986 and has been continually in operation since that time. The SIU has multiple goals: to prevent and deter fraud and abuse through acts committed by providers, members, employees and any other BCBSKC business constituent; to deter unnecessary medical services; to demonstrate the company's strong commitment to honest and responsible provider and corporate conduct; to facilitate compliance with state law, federal law, accreditation agency requirements, contractual requirements, and Blue Cross and Blue Shield Association requirements; to prevent processing of fraudulent or abusive claims; to facilitate a more accurate view of risk and exposure relating to fraud and abuse; and to minimize the financial impact of fraud and abuse to BCBSKC and its clients.

The focus of the SIU is to meet the customer expectation that we will reimburse only for services that are appropriate and do not constitute fraudulent or abusive activity, and to comply with Federal and State laws and regulations regarding the detection and reporting of fraud and abuse. We execute this mission through strong inter-departmental processes and communication procedures, supplemented by fraud and abuse detection technology, and supported by appropriate related policies and procedures.

Currently, the SIU has two full time staff members. The SIU Manager is a Licensed Practical Nurse. The Fraud Investigator is currently completing course work for an Associate of Arts degree in Administration of Justice. The SIU also has other resources available on an as-needed basis, including claims auditors, registered nurses, medical directors, pharmacists, quantitative analysts, IS support personnel, and financial analysts.

If required, the SIU also has access to external resources such as investigators and independent review organizations for determination of medical necessity and validity of medical records documentation.

The SIU is housed within the Audit Service and Compliance Division (AS&C) under the management of the Vice President and Chief of Audit, Compliance and Budget; Corporate Compliance Officer. This officer is also the BCBSKC Corporate Compliance Officer and chairs the Compliance Committee meetings. In this capacity he reports directly to the President/CEO and also has a direct line of reporting to the Board of Directors Audit Committee.

Other activities undertaken by the AS&C include: conducting regular reviews and audits of operations to guard against fraud and abuse; assessing and strengthening internal controls to ensure claims are submitted and payments are made properly and that the company's assets are appropriately protected; establishing and maintaining organizational resources to respond to complaints of fraud and abuse; establishing procedures to process fraud and abuse allegations; establishing procedures for reporting information to the state agency and other mandatory reporting requirements; and developing procedures to monitor utilization/service patterns of providers, subcontractors, and beneficiaries.

For the past several years, the SIU has contracted with Ingenix, an external vendor, to provide data mining capabilities to identify patterns of claims submission that may indicate the possibility of fraud or abuse. Beginning in 2006, the SIU has purchased STARSentinel™ software. "STARSentinel is an automated "early warning" system that applies both standard and user-defined rules to identify billing patterns that differ dramatically from a provider's past history of the norms for a given condition or specialty" (2003 ViPS^{SM}). This software will provide us with more timely and accurate in-house data mining capabilities to identify and investigate trends and indicators of fraud and abuse.

The SIU may receive referrals or identify instances of potential fraud and abuse from any of the following sources:

a. Enrollees, providers, other insurers, and the general public
b. Personnel in the BCBSKC claims, customer service, medical management, provider services, audit services, underwriting, and any other BCBSKC departments.
c. BCBSKC employees may also report potential internal fraud. Employees may report improper activity to their supervisors, the General Counsel, the Vice President, Chief of Audit, Compliance and Budget/Corporate Compliance Officer, or a member of the Compliance Committee. The Corporate Compliance Program expressly prohibits retaliation against those who, in good faith, report concerns or participate in the investigation of compliance violations. Employees are allowed to report anonymously.
d. Data studies conducted by BCBSKC and/or contracted external data analysis vendors.
e. The BCBSKC Anti-Fraud Hotlines (816-395-3151 in the Kansas City area, or toll free, 1-800-340-0119).
f. The Federal Employee Program (FEP) Anti-Fraud Unit.

g. The FEP Anti-Fraud Hotline (this 800 number is published in the FEP member handbook).
h. Law and regulatory enforcement agencies such as local police departments, the Missouri Department of Insurance, the FBI, or other such agencies.
i. The Blue Cross and Blue Association Anti-Fraud Unit.
j. Federal Anti-Fraud Task Forces.
k. Local and/or national media sources.

In 2005, the SIU investigated 5 cases of fraud and abuse, four of the cases involved member and one of the cases involved a provider.

As a part of the credentialing/recredentialing process, BCBSKC screens providers against the Office of Inspector General (OIG) debarred providers list as well as the Office of Foreign Asset Control (OFAC) anti-terrorist list in compliance with Executive Order 13224. Likewise, BCBSKC screens new and existing employees against the OFAC lists and conduct background investigations on all new employees. Certain employees (including those involved in government programs) are subject to repeat background checks at five year intervals.

In coordination with the SIU, the Pharmacy Department monitors members' pharmacy claim activity for signs of abuse. The pharmacy also administers the "lock-in" program to prevent members from ongoing abuse of their prescription benefits.

In general, the coordination or departments throughout the organization, the use of technology, the skills and abilities of experienced personnel, and the support of executive management combine to provide a comprehensive approach to the prevention, identification, and investigation of fraud and abuse in the BCBSKC service area.

TRAINING AND EDUCATION

BCBSKC conducts fraud awareness training to highlight the issues of fraud, the red flags that may indicate potential fraud or abuse, and the means to report suspected instances of fraud and abuse. External providers are notified and warned about issues of fraud and abuse in the BCBSKC Provider Guides. As necessary, topics of fraud and abuse will also be communicated via provider newsletters and through provider advisory committees on periodic basis. BCBSKC employees are informed about fraud detection and reporting during the Code of Business Conduct training and through required compliance training sessions. In 2006, BCBSKC is implementing a new on-line training capability that will allow additional training for all employees on this and other compliance topics.

Information reported to DMS by BA+ in FY 2006:

	Number/Type		Action/Outcome	
Initial Reports received by DMS from BA+	**Member** 1-Pharmacy Lock-In 1-Potential ID Fraud	**Provider** 0	**Member** 1-Member lock-in initiated 1-ID Fraud unsubstantiated.	**Provider** 0
Cases submitted to BA+ by DMS	1-Pharmacy -Potential Lock In-member	0	1-No communication after initial fax to BA+	0
Total	3	0		

FirstGuard Health Plan
Information Obtained From FirstGuard's 2005 Annual Evaluation

Evaluation of Fraud and Abuse Activities

FirstGuard maintains fraud and abuse policies and procedures that guide operational activities and internal controls concerning fraud and abuse. These policies and procedures address prevention, detection and investigation and were revised in 2005 to incorporate additional tools and resources available to FirstGuard from its new parent company, Centene.

Prevention Activities

Code Review®, a claims editing software that is used prior to payments being made, is a standard product utilized by the Centene Claim Office. Claims are reviewed against common coding standards established by the AMA, CMS and medical specialty societies. Examples of Code Review® edits are: unbundling of services, mutually exclusive services, maximum frequency per day, incorrect procedures submitted for the patient's age and/or gender. Claims that are identified through these edits are reviewed by the Centene Medical Review Unit (MRU) and payment determinations are made. Consistent provider patterns identified are referred to the SIU. Late in 2005, work began to define the custom set up for Missouri and Kansas business taking into account variations in reimbursement methodologies for providers. Code Review was implemented in the 1st quarter of 2006.

In 2005 FirstGuard began proactively notifying the state agency, DMS, when a member who has an open fraud and abuse case loses eligibility with FirstGuard. The need for this activity was identified during discussions with DMS about specific cases on the quarterly report. DMS

requested that they be notified as early as possible, without having to wait for the quarterly report. By doing this, the state agency could determine if there was reason to alert another health plan of a member's potential misuse of pharmacy benefits.

FirstGuard developed reports to begin reviewing trends in provider and member fraud and abuse cases. To assist us with identifying ways to reduce inappropriate Medicaid dollar expenditures, FirstGuard determined that developing reports that demonstrate problematic areas was a valuable tool in its prevention efforts. The first step in developing the reports was to review and validate that appropriate category codes had been created in the database to capture the reason that a case was referred for review. Then a new data field was added to the database to capture the disposition of the case when it was closed. An appropriate list of category codes to use for this new field was developed. All cases previously entered for 2005 were reviewed and the appropriate code values were applied so that a full year of data would be available for the report. A report of closed cases was developed that provides a review of cases by quarter based on the referral reason and the disposition of the case. The full year 2005 closed case reports for Missouri MC+ and Kansas HealthWave are included in Attachment 3.

The member and provider trend reports were discussed at the Compliance Committee and the Community Board of Trustees meeting in 2005. Feedback from the Community Board of Trustees, which has representation from the provider network and the local community, was positive regarding the value of these reports. The reports also serve to validate that the significant case management activities related to chronic pain management should continue because of the demonstrated results of changing member behavior.

Detection Activities

With the purchase of FirstGuard by Centene in December 2004, additional resources for detection of provider billing errors became available through the Centene Special Investigations Unit (SIU) and the claim office.

In 2005, the Centene SIU began utilizing Patterns Profiler® for FirstGuard claims paid data. This software is designed to detect unusual billing patterns, potential upcoding, irregular trends, high dollar payments for low dollar diagnosis, and overutilization of services. Patterns Profiler® assists in identifying providers that may potentially be causing billing irregularities based on trending, data matching, and statistical activities when compared to other providers and the industry standard.

As part of the standard monthly claim audit process a sample of claims are selected for review against that provider's contract terms. Consistent provider patterns of incorrect billing practices that are identified are referred to the SIU for investigation.

Use of Patterns Profiler® for FirstGuard claims paid data for 2005, direct referrals, and internal overpayment recovery projects resulted in the identification of 10 cases from the MC+ program resulting in potential recoveries of $25,500 and a 12-month cost avoidance savings of $12,750. 10 cases were identified for the HealthWave program resulting in potential recoveries of $2,265 and a 12-month cost avoidance savings of $1,125. The overall experience for all Centene health plans resulted in 116 cases identified with potential recoveries of $3.5 million and a 12-month cost avoidance savings of $2.3 million.

Centene maintains a Waste, Abuse and Fraud Hotline number that was implemented in 2005. An outside company manages this hotline so that reports can be made anonymously if desired. All reports are sent to the Centene SIU for investigation. This new number is being published in member and provider materials.

Investigation Activities

An Access database was developed to track and report member fraud and abuse cases. Samples of the member database screens are included as Attachment 4.

FirstGuard worked closely with its parent company, Centene's SIU in obtaining access to an existing provider database for fraud and abuse cases. The SIU's Access database was made available to FirstGuard compliance staff through a shared drive that allows both FirstGuard and the SIU staff to enter new cases and make updates to open cases. Additionally, this database was enhanced to include some new fields that FirstGuard identified as necessary for state reporting. Samples of the provider database screens are included as Attachment 5.

In 2005 as the Centene SIU applied the new detection methods to FirstGuard claims data it was identified that consistent communication was necessary for management and decision making for provider fraud and abuse cases. To accomplish this a multi-disciplinary team was identified to participate in regular conference calls to review these provider cases. This team consists of representatives from: SIU, compliance, contracting, provider relations, medical management and quality improvement.

FirstGuard continued use of its multi-disciplinary team to manage member fraud and abuse cases. This team includes compliance and medical management staff. The plan pharmacist was added to the team in 2005. Use of a standard agenda format was implemented to allow focus for case review on those cases that are most critical for decisions to be made. Below is the agenda format that is utilized:

- Hot Cases
- New Cases
- Review of Open Cases with Recommendation for Action Other Than Ongoing Monitoring
- Cases Not Discussed for 90 Days
- Closed Case Relapses
- 12-Month MC+ Lock-In Expires in 60 Days or Less

A report from the member fraud and abuse database was developed to provide comprehensive information about each case for review during the regular meetings. Consistent case management activities were implemented and discussion of findings and results of these activities are discussed at the regular meetings.

FirstGuard's case managers developed a process to work closely with the providers who are managing members with an open fraud and abuse case. This includes educational materials as well as prescription medication profiles for their patients. For new cases, the providers are sent a "pain management opioid kit". This kit was developed by a pharmaceutical company and shared with FirstGuard for use with its providers. This kit includes educational materials about chronic

pain management, an initial pain assessment tool and a pain management contract for the member and provider to sign. Additionally, FirstGuard sends the provider a copy of a FirstGuard newsletter that includes an article on pain management. For new cases and on a regular basis, the case manager sends the treating provider a copy of the member's pharmacy profile to aid the provider with their medical treatment plan for that member.

Outcomes

The most significant outcome from the interventions implemented is the success rate in changing member behavior. Results from closed cases from full year 2005 show for MC+ members 12 cases referred for investigation that were classified as "abuse of member and/or pharmacy benefits". Of those 12 cases, it was determined that 7 cases warranted investigation and management; 3 of the 7 cases (43%) were closed with the disposition categorized as "member behavior successfully modified." The remaining 4 cases (57 %) lost eligibility with FirstGuard while under this intensive case management and we expect that some of these cases would have been considered successful behavior modified if they had continued eligibility with FirstGuard. Similar results were identified for Kansas HealthWave members. The base membership population is larger for HealthWave and produced the following results. Results from closed cases from full year 2005 show for HealthWave members 51 cases referred for investigation that were classified as "abuse of member and/or pharmacy benefits". Of those 51 cases, it was determined that 42 cases warranted investigation and management; 19 of the 42 cases (45%) were closed with the disposition categorized as "member behavior successfully modified." FirstGuard initiated disenrollment for 2 of the 42 cases (5%) so that these members could be placed in the State's lock-in program. The remaining 21 cases (50%) lost eligibility with FirstGuard while under this intensive case management and we expect that some of these cases would have been considered successful behavior modified if they had continued eligibility with FirstGuard. The combined MC+ and HealthWave 45% success rate of changing member behavior demonstrates a positive impact on the health outcomes for FirstGuard's members.

Other outcomes include: providers complimented the FirstGuard case managers for their intensive case management actions and indicated that they found the pain management kits and the sharing of the member pharmacy profiles a valuable addition to the management of their patients; and, efficiencies were gained in the collection and review of case information.

Success Story

FirstGuard received a referral from a local hospital reporting that a mother and daughter appeared in their Emergency Department weekly and sometimes twice in the same day requesting drugs. During the investigation, it was also reported by a provider office that FirstGuard should include the entire family in our investigation. FirstGuard reviewed claims history and pharmacy profiles for the 4 family members that were eligible with FirstGuard. Based on the results of this investigation, all 4 members were placed in MC+ pharmacy lock-in for a 12-month period. During that time, a nurse case manager conducted intensive outreach with the mother and the treating providers and positive changes were noted in reduced ER visits and use of controlled substances. For the 17-month period prior to FirstGuard's management, this family of 4 had a combined total of 90 ER visits. For the 17-month period during FirstGuard's management, this family of 4 had a combined total of 20 ER visits and their pharmacy profiles demonstrated compliance with use of controlled substances.

Strengths

1. New resource was made available for detection of potential provider fraud and abuse with the addition of Patterns Profiler®
2. New resources were made available for investigation of fraud and abuse cases with the addition of staff from the Centene Special Investigations Unit (SIU)
3. New resource for reporting potential fraud and abuse cases was made available with the addition of a Waste, Abuse and Fraud Hotline
4. A FirstGuard member fraud and abuse database was developed for tracking and reporting of cases
5. Sharing of the corporate SIU provider fraud and abuse database for tracking and reporting cases by both the SIU and FirstGuard compliance staff
6. Enhancements made to the corporate SIU provider fraud and abuse database to support FirstGuard reporting needs
7. Creation of a multi-disciplinary team for management of provider fraud and abuse cases
8. Continued use of a multi-disciplinary team and the addition of the plan pharmacist to the team for management of member fraud and abuse cases
9. Modifications made to the format of the member fraud and abuse multi-disciplinary meetings to increase focused discussion on critical cases
10. Partnership developed with providers treating members in an active fraud and abuse case, including providing a pain management opioid kit and other educational materials
11. Demonstrated successful member behavior changes resulting from intensive case management of members referred for fraud and abuse
12. Development of initial trend reports for both member and provider fraud and abuse cases
13. Use of the Community Board of Trustees for review and feedback of trend reports

Improvement Opportunities

1. Implementation of Code Review® software in 2006 to achieve savings by preventing some inapproprite provider billing practices
2. Publish the new Waste, Abuse and Fraud Hotline number in the Member Handbook and Provider and Hospital Manuals as they are revised in 2006

Information reported to DMS by FirstGuard in FY 2006:

	Number/Type		Action/Outcome	
Initial Reports received by DMS from FirstGuard	**Member** 13-Pharmacy 4-Eligibility 2-Medical	**Provider** 0	**Member** First Guard submitted initial investigational findings	**Provider** NA*
Cases submitted to FirstGuard	0	0	NA*	NA*

by DMS				
Total	19	0		

*NA=Not Applicable

Children's Mercy Family Health Partners (CMFHP)

Information Obtained From CMFHP 2005 Annual Evaluation

Fraud and Abuse Program Overview

Fraud and Abuse Plan Overview

The Fraud and Abuse Plan requires that fraud and abuse concerns are reported, investigated, resolved and tracked. As part of this process fraud and abuse case data is compiled quarterly with the Compliance Program data and then summarized annually to evaluate the effectiveness of the Program. This information is presented to the Board of Directors. The Chief Executive Officer and the Corporate Compliance Officer provided oversight of the Compliance Program.

Prevention and Detection

Children's Mercy Family Health Partner's (CMFHP) Fraud and Abuse Plan outlines specific methods of prevention and detection of suspected, alleged, potential or actual fraud and abuse. Some of the methods used are (1) claims software that identifies anomalies in provider billings or that do not meet the billing payment requirements, 2) delineation of job responsibilities between departments to ensure checks and balances of processes, 3) routine review of member enrollment and dis-enrollment to ensure accuracy of membership data, 4) strong credentialing and re-credentialing processes that evaluate provider's participation in federal and state programs, 5) strong internal processes such as annual employee conflict of interest review, and 6) ongoing training regarding compliance/fraud and abuse identification and reporting.

Tracking Compliance/Fraud and Abuse Cases and Concerns

In 2003, the Compliance department in conjunction with Children's Mercy Hospital's Compliance department developed on-line database programs to enter, track and report compliance and fraud and abuse cases. Children's Mercy Family Health Partners compliance/fraud and abuse database is maintained separately from Children's Mercy Hospital's (CMH) compliance database. Data access and security for the Children's Mercy Family Health Partners database is limited to the CMFHP Compliance Officer, CMH Corporate Compliance Officer and the database administrator. The database is maintained on a secure server. The data from previous compliance/fraud and abuse cases was uploaded in January 2004. The compliance/fraud and abuse database also links the case narratives to the case file. The case narrative is a summary of the case activity once the case is closed. The information on the log would then be used to create the aggregate quarterly and annual compliance/fraud and abuse case reports.

The development of the database has also provided tools for tracking issues that did not meet the compliance/fraud and abuse case file criteria, but are issues that the Compliance Officer feels should be monitored. The compliance database has a monitoring log that is used in these situations. This provides the Compliance Officer with tracking of recurrent issues that may require additional staff training or education or further operational evaluation.

Fraud and Abuse Case Activity

Starting in 2004 with the use of the database, compliance/fraud and abuse case activity is now available through the reporting function of the compliance/fraud and abuse database. The following represents the fraud and abuse case data for calendar year 2005:

- There were 3 fraud and abuse cases reported in 2005
- Of the 3 cases, all were resolved during 2005 (with the exception of quarterly reporting to DMS for pharmacy lock-in cases)
- All cases were rated as low risk

Training and Education

The database also features a module that can be used to track training and education conducted by the Compliance Officer. This includes annual compliance plan and fraud and abuse plan trainings, employee newsletter articles, provider newsletter articles, etc. The following training and educational activities related to fraud and abuse were completed in 2005:

- New employee orientation (CMFHP specific orientation provides the employee with basic knowledge and expectations related to fraud and abuse identification, detection and reporting)
- Annual Education Fair (employees are required to attend an annual education fair or complete the training on line through the CHEX system. Both of these venues provide information on fraud and abuse identification, detection and reporting).
- Annual Corporate Integrity Plan training (CMFHP employees are required to attend the annual Corporate Integrity Plan training, which occurs each January. The training includes review of the Compliance and Fraud and Abuse Plans)
- Newsletter Articles (employees are required to read the monthly In the Know employee newsletter. Information is routinely submitted from the Compliance department regarding topics related to fraud and abuse).

Pharmacy Fraud and Abuse Detection

In 2004, a process was established to monitor and act upon potential pharmacy fraud and abuse. A quarterly report is produced from pharmacy claims data to identify potential poly-pharmacy issues and narcotic abuse. The report is reviewed by the Senior Case Manager, Director of Health Services, Director of Operations, and Compliance Officer for discussion and determination of follow-up actions. The Senior Case Manager performs specific interventions with identified members and their providers in an attempt to clarify treatment plans and facilitate changes in the member's treatment, if appropriate. Interventions and results of this process are

reported quarterly to the Utilization Management/Medical Director committee, with additional oversight by the Medical Management Committee.

Information reported to DMS by CMFHP in FY 2006:

	Number/Type		Action/Outcome	
Initial Reports received by DMS from FHP	**Member** 0	**Provider** 0	**Member** NA*	**Provider** NA*
Cases submitted to FHP by DMS	1	0	1- FHP investigated and found no inappropriate actions. Did put member on a watch status and if inappropriate actions were seen would proceed with a pharmacy lock-in. No further action noted.	NA*
Total	1	0		

*NA= Not Applicable

Of the seven MC+ Managed Care health plans, five health plans (HCUSA, FirstGuard, BA+, Missouri Care, and Mercy) reported initial fraud and abuse reports to DMS. Of those five plans, DMS received one quarterly report from Missouri Care, three quarterly reports from HCUSA, FirstGuard and BA+ and four quarterly reports were received from Mercy.

The information submitted on the initial and quarterly reports, for the most part, was consistent with the DMS requirement as noted on the DMS Fraud and Abuse policy statement. FirstGuard expanded on the reporting requirement and also submitted PCP disenrollment, pharmacy lock-in and provider terminations due to sanctions on their quarterly reports. HCUSA submitted an accompanying letter with their quarterly repots providing summary detail of actions, analysis and outcomes during the quarter. HCUSA also submitted an annual report that provided a summary of the previous year. HCUSA's 4th Quarter Review and Year-end 2004 Report included a list of the name of providers with zero pended claims. The report was titled, "Flagged Providers with Zero (0) Pended Claims".

CREDENTIALING/RECREDENTIALING

EASTERN REGION

Community CarePlus (CCP)

Information Obtained From CCP's 2005 Annual Evaluation

Credentialing and Recredentialing

Crededentaling and recredentialing process at a minimum includes physicians, (MD and DO), dentists (DDS), podiatrists (DPM), advanced practice nurses (APRN/NP) and physician assistants (PA).

Excluded from this scope are hospital-based physicians (anesthesiologists, radiologist, pathologists and emergency medicine physicians) practicing solely in hospitals unless they also participate in clinic setting.

CCP Credentialed sixty-nine new providers and recredentialed 74 providers in 2005. During quarter 4 2005 CCP performed an internal recredentialing audit and found areas for improvement. An internal credentialing/recredentialing database is an interval function on the new web-base provider listing. The credentialing/recredentialing policy and procedure was revised and approved by the state.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
# New Providers	15	14	6	34
# Family Medicine	1	4	2	4
# Internal Med	2	2	1	19
# OB	6	1	0	1
# Ped	1	1	1	0
# Specialist	3	6	2	10

Mercy MC+

Information Obtained From Mercy MC+ 2005 Annual Evaluation

Credentialing and Re-Credentialing

The Plan continued to delegate credentialing to multiple networks that met its standards. Annual reviews, including process and file evaluations, were completed on an annual basis. All delegates received approval from the MQIC for continued delegation. No corrective action plans were required. A summary of delegated credentialing activities was reported and accepted by the MQIC at the end of the year.

HealthCare USA (HCUSA) In Eastern, Central and Western Regions
Information Obtained From HCUSA's 2005 Annual Evaluation

Credentialing

In 2005, HealthCare USA credentialed 304 practitioners and recredenialed 846 practitioners.

HCUSA completes an annual evaluation of 12 delegated credentialing entities to confirm they are completing the credentialing process using at least the minimum HCUSA credentialing standards. It is HCUSA's requirement that each delegated entity achieve a score at or above 80%, and correct any issues identified during the audit process.

No delegated audited group in 2005 fell below the 80% standard. Some issues and discrepancies were identified with each delegated entity and were communicated to that entity immediately and resolved.

In 2005, 100% of those audited achieved a score of 80% or better. 66% of the entities audited scored 90% or better.

CENTRAL REGION

Missouri Care
Information Obtained From Missouri Care's 2005 Annual Evaluation

Credentialing and Re-Credentialing

The credentialing and re-credentialing processes confirm the qualifications of health-care professionals prior to their participation in and an ongoing basis once part of the Missouri Care provider network.

The objectives of the credentialing process are to:

- Maintain a fair credentialing process
- Obtain application information about a prospective participating health-care professional's practice and background
- Verify applicable credentials with primary sources
- Obtain information from applicable sources about malpractice, sanction activity or felony convictions
- Complete verification of time-sensitive components within specified time frames
- Maintain the confidentiality and security of credentials files
- Include the chief medical officer and appropriate medical committees and oversight bodies in the credentialing process
- Meet the credentialing standards and requirements of applicable state and federal regulators and accreditation agencies

In 2005, Missouri Care approved 102 new providers and re-credentialed 129 providers through the Credentialing and Medical Quality Management Committees as well as provided oversight of

approximately 1,000 providers who are under delegated credentialing agreements. Of the providers seeking credentials in 2005, one was not approved, four were pended for further investigation/discussion and were approved at subsequent meetings and one provider was re-credentialed for only one year instead of the usual three years; all other providers were credentialed or re-credentialed for a three-year period. No large issues were uncovered during the audit processes among Missouri Care's delegated credentialing organizations. In 2005, one organization requested to have their credentialing delegated to them. Missouri Care continues to work with this organization to ensure that their credentialing process is sound before a delegated agreement is put into place.

WESTERN REGION

Blue- Advantage Plus of Kansas City (BA+)

Information Obtained From BA+ 2005 Annual Evaluation

Credentialing and Re-Credentialing

The BCBSKC Corporate Credentials Committee policies ensure that network providers are qualified to provide health services to members. The BCBSKC Credentialing policies and procedures meet the following objectives:

a. To ensure that Medicaid Members who enroll will have their care rendered by appropriately qualified credentialed providers.
b. To ensure that each provider application has equal consideration for eligibility to participate in the Blue-Advantage Plus network in accordance with applicable laws and accreditation standards.
c. To ensure that adequate information pertaining to education, training, licensure, experience, malpractice and other relevant information is reviewed by the appropriate individuals and departments within BCBSKC prior to approval or denial by the Credentials Committee.

All M.D.s, D.O.s, D.P.M.s, D.C.s, D.D.S.s and other licensed independent practitioners who provide covered health care services to members and are or will be listed in the BCBSKC provider directories shall undergo the credentialing and recredentialing process according to the criteria outlined in the Professional Provider Credentialing Policy. Credentialing and recredentialing of HMO primary care practitioners and OB/GYNs includes an on-site assessment of the office environment and medical record-keeping practices in accordance with the Office Site Assessment Policy.

Institutional providers, i.e. Hospitals, Home Health Agencies, Extended Care Facilities, and Ambulatory Care Centers, are credentialed and recredentialed in accordance with the Institutional Credentialing Policy.

URAC awarded BCBSKC-BA+, a Certificate of Full Accreditation for compliance with Health Provider Credentialing Standards, version 3.0 effective March 1, 2005 through March 1, 2008.

FirstGuard Health Plan
Information Obtained From FirstGuard's 2005 Annual Evaluation

A. Credentialing/Recredentialing

FirstGuard continued to review the Office of Inspector General Cumulative Sanction Report and website on a monthly basis to ensure that providers and Health Delivery Organizations in the FirstGuard network are not subject to Medicare/Medicaid exclusion. Results are reported monthly to the Missouri and Kansas QMCs. FirstGuard continues its process of review of new and reappointment applications for network provider status. The following table demonstrates the volume of applications processed and determinations made for 2005.

2005 Credentialing/Recredentialing Summary

	New Providers Credentialed			*Providers Recredentialed*		
	# PCP's	**# Specialists**	**Total**	**# PCP's**	**# Specialists**	**Total**
MO	113	176	289	55	94	149
KS	117	157	274	171	187	358
Combined	230	333	563	226	281	507

There were no Missouri providers terminated from the FirstGuard network due to Medicare/Medicaid sanctions, disciplinary actions by the Board of Healing Arts or quality issues. A total of sixty-five (65) providers withdrew from the network on a voluntary basis. Most providers who elected not to continue participation with FirstGuard had been enrolled for the commercial product which ended in 2002 and declined continued participation with FirstGuard for Medicaid business only.

A total of five (5) Kansas providers were terminated from the FirstGuard network in 2005. Due to State Medicaid action, two (2) providers were termed by FirstGuard network in compliance with contractual requirements. The provider appellate rights regarding the State Medicaid terminations were stayed by the courts and FirstGuard subsequently reinstated the providers according to State Medicaid agency direction pending continuation of provider due process provisions. Activities of the provider have been extensively reviewed and monitored by FirstGuard. Two (2) providers were terminated for disciplinary actions by the Board of Healing Arts, and one (1) provider was terminated for failure to complete and return a recredentialing application. There were forty (40) providers who withdrew from FirstGuard on a voluntary basis.

B. Delegated Credentialing

The Credentialing Staff completed oversight review of organizations with credentialing delegation for both Missouri and Kansas in 2005. The oversight process included random

sample review of provider credentialing/recredentialing files, as well as review of the organization policies/procedures and credentialing committee minutes. During the 2005 on-site oversight reviews, there were no issues identified that required follow-up or Corrective Action Plans.

FirstGuard Missouri

Organization	Review Date
Children's Mercy Professional Group (subdelegated to Children's Mercy Hospital)	5/17/05
Kansas City Physicians Organization	5/19/05
Magellan Behavioral Health	*
VSP (Vision Service Plan)	*
Doral Dental	*

** Refer to separate table for dates of vendor oversight meetings*

C. Reassessment of Organizational Providers

An organizational provider includes, but may not be limited to hospitals, home health/hospice agencies, free-standing surgical centers, and skilled nursing facilities/nursing homes. FirstGuard Health Plan completed the Organizational Provider Quality Reassessment Project in 2005 with a 100% completion rate. The organizational providers reassessed for quality were: Kansas: 244; Missouri: 49; Nebraska: 4; Oklahoma: 1; and Georgia: 1.

FirstGuard Health Plan used the following documents to assess quality:

- current state license;
- current scope of services;
- current accreditation certificate or statement of deficiencies from the most recent CMS or state licensing review;
- current liability coverage, exclusion from Medicare/Medicaid sanction listing;
- current CLIA certificate (if applicable);
- current DEA or BNDD (if applicable), and
- evidence of compliance with Patient Self-Determination Act of 1990 (for hospitals, Skilled Nursing Facilities, Home Health Agencies, Personal Care Service Agencies and Hospice Programs).

For those organizational providers not accredited by an appropriate body, FirstGuard reviewed the organization's Quality Management Program description and evaluation, credentialing process description and criteria for staff membership.

Per NCQA standards FirstGuard Health Plan reassesses organizational providers at least every 3 years.

Credentialing Software

CACTUS credentialing software was implemented at FirstGuard in mid-July, 2004. In the first quarter of 2005, FirstGuard designed a custom provider profile that includes fields to indicate

provider-specific data for substantiated member grievances/quality of care issues for review during the recredentialing process. This has been identified as a best practice among Centene health plans as a model for replication.

In an effort to streamline the efficiency of file review by the Credentialing Committee, profiles are presented for providers with no credentialing/recredentialing concerns, a process which follows current NCQA credentialing standards. Credentialing/recredentialing policies and procedures have been revised to reflect the enhanced process but include a validation process related to uncomplicated or "clean" files presented to the peer review committees for approval.

Children's Mercy Family Health Partners (CMFHP)
Information Obtained From CMFHP 2005 Annual Evaluation

Credentialing and Re-credentialing

Children's Mercy Family Health Partners completes all credentialing and re-credentialing in house, which includes the oversight of all delegated entities through an annual review according to NCQA Standards. The credentialing and re-credentialing process includes review of the application for completeness and any additional information that may be necessary based on responses to specific questions and primary source verification, as well as Medicare/Medicaid sanctions. Children's Mercy Family Health Partners subscribes to the NCQA guidelines for credentialing/recredentialing practices.

Overall in 2005, Children's Mercy Family Health Partners credentialed 234new providers and completed re-credentialing of 169 providers. We also completed the annual review of our delegated entities. Of our five delegated groups, four were at 100 percent compliance with meeting all standards. One provider group had identified deficiencies and a corrective action letter was sent. The provider submitted a corrective action plan for the issues identified and a complete re-audit was done. During the second audit, the provider was found to have corrected all identified deficiencies and was at 100 percent compliance.

Subcontractor Oversight

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- **Blue-Advantage Plus**

  Blue-Advantage Plus can delegate the authority to perform health plan functions on its behalf; however, it cannot and does not delegate the responsibility for insuring that the functions are performed appropriately. To ensure that the quality of care and services provided on behalf of BA+ is maintained, functions will be delegated to only those entities meeting or exceeding BA+ standards. In addition, the State Programs Department has a comprehensive compliance program including requirements for documentation submission. Compliance with contract

requirements is taken very seriously at BA+. Analysis of compliance is completed at least annually and more frequently if required.

The Delegated Oversight Committee Chair, responsible for pre-delegation assessment of potential subcontractors, will notify the Medicaid Plan Administrator of the desire to subcontract with a new entity. The Medicaid Plan Administrator will notify the State of Missouri Division of Medical Services, providing all requested information. The Plan Administrator will notify Delegated Oversight Committee Chair of the decision of the State upon receipt of notification. An implementation plan will be developed, including consideration for transition of care and notification to the members.

BCBSKC and the subcontracting entities have signed agreements before providing services to BA+ members. All agreements provide a description of the services to be fulfilled by the entity. Included in the services that need to be provided to members are State and Federal requirements, and delegation requirements. BCBSKC may choose to delegate specific responsibilities to the entity at BCBSKC's discretion. If delegation is agreed upon, the responsibilities delegated are overseen and audited through the Delegated Oversight Committee at BCBSKC – managed through the Quality Management Department. Delegation agreements are reviewed annually for compliance of expected outcomes.

- **Children's Mercy Family Health Partners**

Bridgeport Dental Services

Children's Mercy Family Health Partners (CMFHP) subcontracts dental services from Bridgeport Dental services. As part of our ongoing relationship with Bridgeport, we work with them to ensure dental access for members as well as to resolve issues that may arise in the areas of access, quality or member benefits.

A quarterly meeting between Bridgeport staff and CMFHP staff is held. During these meetings, a review of the quarter's grievances and appeals is done and issues and/or trends are identified. This integration into CMFHP's quality improvement process helped to identify that there was an issue with orthodontia requests for services and State Fair Hearing appeals. During 2005, we identified an increased number of appeals that were overturned regarding orthodontia requests. Bridgeport completed 179 orthodontia review requests in 2005. The approval rate for orthodontia increased to 32% compared to the 2004 approval rate of 28% of 292 orthodontia review requests. The total number of orthodontia appeals in 2004 was 52 with 2 appeals overturned (3.8% overturn rate). The total number of orthodontia appeals in 2005 was 39 with 5 appeals overturned. After reviewing and discussing these appeals, we identified that there was a difference between how the Dental Director for Bridgeport and the Dental Reviewer for the State were scoring the molds. In addition, there was a specific provider in the dental network that was not making referrals appropriately for orthodontia services. As a result, Bridgeport adopted the State's methodology for scoring of molds, as well as re-educated the dentist who was making inappropriate referrals for orthodontia services.

During 2005, it was also noted that access to primary care services in Henry County were minimal at best. Bridgeport has continued to work with the contracted provider in that county to ensure services are available. However, as we continue to monitor service and access provided to our members, it has become clear that we need to continue to improve access specifically in Henry County as well as a few other counties in the Western region. This has resulted in a collaborative effort to pilot a project initially in Henry County to improve primary dental service access in 2006.

Bridgeport is proactive in identifying issues to CMFHP and has shown true integration with CMFHP and our Quality Management program to ensure that our members receive the best dental services possible in a timely manner.

Commcare Behavioral Health Services

Children's Mercy Family Health Partners (CMFHP) understands that coordinating behavioral health services with the rest of a member's health needs is essential in order to provide effective care. Since 1995, Family Health Partners has contracted with the Community Network for Behavioral Healthcare, Inc. (CommCare) to deliver behavioral health services to CMFHP members. CMFHP and Commcare meet on a quarterly basis to review operational issues, monitor quality and utilization, and develop protocols to integrate medical and mental health services.

In addition to the quarterly oversight meetings, the clinical Manager for Commcare attends case rounds with CMFHP Case Managers monthly to discuss cases where behavioral health issues are involved. This collaboration continues on a daily basis, as needed, to coordinate care for members needing both medical and behavioral health services.

In 2004, CMFHP and Commcare collaborated to develop an educational program for the Community Mental Health Centers, focused on optimal medication prescribing for antidepressant, antipsychotic, and ADHD medications. This program was delivered to all of Commcare's network community mental health centers.

In 2005, Commcare began participating on a quarterly Psych Drug Committee meeting with CMFHP and physicians from Children's Mercy Hospital's behavioral health department. This committee reviews utilization and quality data related to prescribing of antipsychotic, ADHD, and antidepressant drug classes. In addition, the committee is currently overseeing a pilot program for education of Primary Care Providers (PCP's) on diagnosis and treatment of ADHD in the PCP office. Recommendations and actions from this committee are reported to CMFHP's quarterly Pharmacy and Therapeutics Committee for consideration.

Finally, in 2005 CMFHP developed a process to perform annual audits of Commcare's case management records. Following the 2005 audit, improvements were implemented for more comprehensive documentation of discharge planning from inpatient hospitalizations. The 2006 audit is currently underway. Results from these audits are reported to CMFHP's Utilization Management/Medical Director Committee.

MTM Transportation Services

Children's Mercy Family Health Partners (CMFHP) recognizes the importance to members of having available and manageable transportation. CMFHP contracts with Medical Transportation Management, Inc. (MTM) to provide this necessary service to all CMFHP members. CMFHP meets quarterly with MTM to review call center reports, utilization reports, and quality management reports. As a result of this oversight, CMFHP and MTM coordinate a weekly and monthly notification process for member grievances related to transportation. In 2004, CMFHP and MTM identified through the oversight meetings an increased rate of "No Shows" by members (Total CY 2004 = 952 member no shows). As a result, CMFHP and MTM in 2005 implemented a "No Show" program to improve member compliance with transportation to needed health care services and decrease uncompleted transportation trips. The "No Show" program assists members to effectively manage the transportation service and provides an identified CMFHP nurse for coordination of those services. In 2005, these efforts resulted in 17 member referrals to Customer Service for assistance and 29 members were assisted with ongoing transportation needs. The overall outcome was a decrease in member no shows in CY 2005 to a total of 783.

- **Community Care Plus**

The health plan subcontracts the following services: pharmacy, mental health benefit management, vision, dental benefit management and transportation benefit management. All subcontractors adhere to the requirements contained in the State contract with the health plan. Oversight meetings are held quarterly and follow the requirements of the plan's State contract. Any noted deficiencies are addressed by an action plan with the entity and include time frames and objectives. In addition each subcontractor is visited on a yearly basis by the health plan to review delegated policies and procedures. Audit results are presented to the Quality Improvement Committee. The credentialing audit is also presented to the Credentialing Committee.

The following is presented to the Quality Improvement Committee (QIC) for review and discussion:

a) Quality Improvement Program, Work plan and previous year's QI evaluation
b) Utilization Management Program
c) Credentialing criteria
d) Complaints and grievance policy
e) Fraud and abuse program

CCP met on a quarterly basis with subcontractors. Reports regarding provider complaints, grievances and appeals, member grievance and appeals, claims payments, credentialing, fraud and abuse, and utilization data was presented to and reviewed by CCP.

On an annual basis, the subcontracted vendor completes the CCP oversight tool to provide an in-depth review of policies and procedures, as applicable; to assure that the BMO is still meeting all of the contractual obligation.

- **FirstGuard**

FirstGuard consistently conducted quarterly oversight meetings with vendors who provide service to the greatest proportions of our membership for specific services in compliance with contractual requirements. FirstGuard maintained successful relationships with these organizations that have been responsive to FirstGuard requests, queries or concerns. During 2005 there were no issues with subcontracted vendors that required Corrective Action Plans.

FirstGuard subcontracts with the following organizations to whom the indicated services have been delegated and for which FirstGuard conducts quarterly and annual oversight:

Dental Benefit Manager
FirstGuard Health Plan contracts with Doral Dental USA, LLC, a dental benefit manager, to provide covered dental services for MC+ members through a network of participating dentists and oral surgeons. Doral contracts with dentists to provide emergency dental care to members on a 24 hour per day, 7 days per week basis. A 24-hour telephone number is available for members and providers to use for contacting Doral and obtaining access to covered services. Contract effective date: March 1, 1996. Doral Dental is delegated the responsibility to perform credentialing, recredentialing, member appeals and grievances, member and provider services, quality improvement and utilization management. FirstGuard Health Plan holds quarterly oversight meetings with Doral Dental.

Pharmacy Benefit Manager
Express Scripts, Inc. (ESI) contracts with qualified pharmacies to dispense prescribed medications to FirstGuard MC+ and HealthWave members. ESI maintains the network of pharmacies, verifies member eligibility, provides a 24 hour per day, 7 days per week pharmacy "help desk" for pharmacies and members, and pays claims to network pharmacies. Contract effective date: January 1, 1997. ESI is delegated the responsibility to ensure each pharmacy meets participation requirements, including licensure, insurance and provider agreement requirements. FirstGuard Health Plan holds quarterly oversight meetings with ESI.

Vision Benefit Manager
Vision Service Plan Insurance Company (VSP) provides vision services for MC+ members. Contract effective date: January 1, 1997. VSP contracts with optometrists and ophthalmologists, and has delegated responsibilities for claim payments, credentialing, recredentialing, member appeals and grievances, member and provider services, quality improvement and utilization management. FirstGuard Health Plan holds quarterly oversight meetings with VSP via conference call.

Behavioral Health Benefit Manager
FirstGuard Health Plan contracted with Magellan Behavioral Health to provide medically necessary behavioral health and substance abuse treatment services for MC+ members through a network of contracted providers from April, 1996 through September, 2005. Magellan provided a 24-hour telephone number for members and providers to use for obtaining access to covered services. Magellan was delegated the responsibility to perform

credentialing, recredentialing, member and provider services, member appeals and grievances, quality improvement and utilization management. FirstGuard Health Plan held regular oversight meetings with Magellan on a quarterly basis. FirstGuard members with behavioral health needs were successfully transitioned to Cenpatico Behavioral Health on October 1, 2005. Services provided by Cenpatico are identical to those previously provided by Magellan Behavioral Health. Cenpatico will continue to regularly represent FirstGuard at the MC+ Managed Care Health Plan Task Force. The first quarterly oversight meeting with Cenpatico was held on February 9, 2006.

Transportation Service Benefit Manager
FirstGuard Health Plan contracts with Swope Health Services to provide MC+ members non-emergency transportation for routine appointments to clinics, physician offices, outpatient facilities, dental clinics, hospitals, pharmacies and other providers. Non-emergency transportation services are provided by Swope Health Services 24 hours per day, 7 days per week. Contract effective date: January 1, 1997. FirstGuard Health Plan delegates transportation services to Swope Health Services. FirstGuard Health Plan holds quarterly oversight meetings with Swope Health Services.

The following table lists the frequency of oversight meetings for FirstGuard's subcontracted vendors.

Meeting Dates for Each Quarter of 2005

State	Vendor	Q1	Q2	Q3	Q4	CAP*
Missouri & Kansas	Express Scripts (Pharmacy)	2/17/05	5/26/05	8/25/05	11/21/05	N/A
	ParadigmHealth (Neonatal Services) Contract ended 9/30/05	1/20/05	4/21/05	7/21/05	10/13/05	N/A
Missouri	Doral Dental	3/17/05	6/23/05	9/22/05	12/12/05	N/A
	HIMS (Hospitalist group)	1/11/05	6/14/05	9/20/05	12/20/05	N/A
	Magellan Behavioral Health Contract ended 9/30/05	2/10/05	5/19/05	8/11/05	11/10/05	N/A
	McKesson NurseLine (Advice Line) (semi-annual meetings)	2/17/05	Contract ended 1/31/05			N/A
	NurseWise (Advice Line)	Contract began 2/1/05	4/21/05	7/14/05	11/11/05	N/A
	Swope Transportation	1/27/05	---	7/28/05	10/27/05	N/A
	Vision Service Plan	3/10/05	6/9/05	9/29/05	12/7/05	N/A

* CAP=Corrective Action Plan

- **HealthCare USA**

In order to provide a formal mechanism for continuous evaluation and improvement of the care and services provided to members, HCUSA conducts oversight of each health care service subcontractor. During 2005 the Subcontractor Oversight Program included a review and evaluation of these essential components: member education, provider services, health services/utilization management, credentialing, compliance, claims, and quality improvement.

The Subcontractor Oversight Committee, a sub-committee of the Quality Management Committee, is the primary group responsible for conducting oversight of subcontracted

vendors. Each subcontractor met, at least quarterly, with the committee to address key performance indicators, as well as, utilization, member/provider dissatisfaction, and general operational issues. Each subcontractor submitted for review and evaluation: all policies and procedures for delegated areas, provider reference guides, contract templates, and quality documents including work plans and annual evaluations, provider recruitment activities, monthly denial reports, outreach reports, and claims reports. Communication, education and understanding continue to be key components of this successful program. If necessary, ad hoc meetings were scheduled to keep communication channels open and make possible an atmosphere that perpetuated collaboration and education.

Annually, HCUSA submits a summary report to the State of Missouri, which outlines oversight activities for the following year along with corrective actions and interventions. This report is generated and produced in July of each year.

In effect are policies and procedures to review subcontractors for compliance prior to initiating contracts and for ongoing monitoring of compliance and performance. HealthCare USA may delegate care and service management activities to partners who demonstrate the ability to comply with the State requirements and perform each delegated function. During 2005 HealthCare USA had four (4) subcontractors to whom it has delegated contractually-required services that include, but are not limited to, the following:

Subcontractor	**Contractual Services**
Mental Health Network, Inc. (MHNet)	Mental Health and Substance Abuse Services: • Member services • Network management • Utilization management • Care management • Quality improvement • Claims adjudication • Credentialing and re-credentialing • Contracting • Provider complaints
Doral Dental USA	Dental Services: • Provider services • Network management • Utilization management • Claims adjudication • Quality improvement • Credentialing and re-credentialing • Contracting • Provider Complaints
Medical Transportation Management (MTM)	Non-emergent Transportation Services: • Member services • Network management

	• Claims adjudication • Quality improvement
Caremark, Inc.	Pharmacy: • Claims adjudication

HealthCare USA conducts quarterly oversight meetings with MHNet, Doral Dental USA, and MTM. These meetings allow HealthCare USA to monitor and address a range of topics such as:

- problem identification
- opportunities for improvement
- coordination of care and collaborative activities
- process improvements and
- service enhancements

In 2005, HealthCare USA worked with MTM to improve transportation services to members eligible for this benefit by focusing on continuous network development, member grievance analysis, and outcome data monitoring in collaboration with MTM executive and administrative staff.

In preparation for oversight meetings, agendas are set, actions assigned, and during the meeting minutes are taken with follow-up items reviewed at subsequent meetings. Representatives of each internal department at HealthCare USA are present for the meetings. The results of oversight meetings are reported quarterly to the QMC.

HealthCare USA's parent company, Coventry, holds the contract with Caremark to perform claims adjudication of HealthCare USA members' pharmacy claims. Oversight of the Caremark claims adjudication process is monitored by Coventry with full participation from HealthCare USA. During 2005 the health plan pharmacist held weekly phone calls with Caremark to discuss service issues.

HealthCare USA delegates credentialing and re-credentialing to select provider groups who demonstrate the ability to perform such tasks in accordance with State and accreditation standards. Currently, HealthCare USA delegates credentialing and re-credentialing to the following providers:

- BJC Medical Group
- Children's Mercy Health Network
- Family Care Health Center
- Mineral Area Network
- Peoples Health Center
- SSM Health Care
- St. Louis Connect Care
- Truman Medical Center
- Unity Health Services
- Washington University Physician Network
- SLU Care

Delegated audits are performed on the above delegated contractors pertaining to credentialing and re-credentialing prior to contract implementation and annually thereafter.

In 2005, HealthCare USA incorporated the regulatory standards of the Utilization Review Accreditation Commission (URAC), in addition to the MC+ Managed Care Compliance Tool and the National Committee for Quality Assurance (NCQA) standards, for monitoring subcontractors' compliance and performance. Annual audits are performed with each subcontractor to ensure full compliance with each regulatory body. Audits have demonstrated that each subcontractor meets HealthCare USA's standards of care and service, and the QMC has granted them the applicable delegation authority that affirms their ability to meet HealthCare USA's obligations to its members.

In response to recent state concerns of MTM's inability to pay its contracted vendors, HealthCare USA has taken a proactive approach with MTM by initiating closer monitoring of its delegated functions to ensure no disruption of services occurs for HealthCare USA members. HealthCare USA meets with MTM representatives on a frequent basis and reviews performance indicators for "no-show" rates, member grievances and results of access/availability surveys. In addition, HealthCare USA calls businesses on the MTM vendor list to ensure they are still providing satisfactory services to MTM. These monitoring activities will continue in the future to ensure HealthCare USA members are receiving the best transportation services.

Over the course of 2005, HealthCare USA has worked in collaboration with our subcontractors and the Division of Medical Services (DMS) to improve the care and services members receive. We incorporate feedback from several sources such as claims analysis, subcontractor oversight analysis and other internal reports, and rely on our subcontractors' experience when choosing programs and service enhancements. Below are examples of some of the improvement strategies HealthCare USA's subcontractors have implemented.

Activity	**Subcontractor**	**Results**
Developed the "universal consent form" in partnership with DMS and HealthCare USA	MHNet	Allowed for continuity of care between behavioral health providers and PCPs
Educated Family Services Division Fee-for-Service case workers in partnership with DMS.		Case workers were educated regarding MC+ Managed Care services and how to help members navigate through the referral systems.
Participated as a partner with the Mental Health Subgroup of the Quality Assurance & Improvement Committee (QA&I).		New and innovative strategies are developed and implemented to eliminate barriers to care and improve care for the membership

Activity	Subcontractor	Results
Participated in school-based dental programs via dental vans in all three (3) MC+ Managed Care regions	Doral Dental USA	Increases member access to preventive dental services
Implemented extensive quality improvement/performance improvement projects in 2004 regarding annual dental exam HEDIS performance measure: • Expanded the provider network by over twenty-five (25) percent in 2004 and 2005 • Implemented several programs to open access with current providers		HEDIS rates for this indicator improved significantly by six (6) percent in Central Missouri, and gained marked improvement in Eastern and Western Regions.
Participated in the Jackson County Consent Decree project: • Made special arrangements with several clinics, mobile van units and hospitals to set aside certain dates and times for serving these members • Outreach efforts included: ○ Ensuring children's guardians and/or representatives were made aware of the new availability. ○ HealthCare USA developing internal processes that identified children without dental exams in the past six (6) months and notified DMS.		Helped bring Jackson County consent decree children up to date on their dental needs

Activity	Subcontractor	Results
○ Notifying the children's parents/guardians that exams were due and offered assistance with appointment scheduling		
Statewide community events such as Doc Bear Kids Fair, SIDS Urban Outreach Council, National Night Out, Back to School Fair in Jefferson City, and the Family Wellness Fair		Dental screens, preventive dental care and education were provided to members in need of dental services
Through a joint effort between HealthCare USA's Provider Relations Department and MTM's program development staff implemented programs in with Bi-State Development Agency (dba Metro) and the Kansas City transportation department	MTM	Provided improved transportation services to members in St. Louis and Kansas City
Implemented training programs with other subcontractors in 2005		Doral Dental USA and MHNet staff learned more about transportation benefits and how to help members access those benefits

In addition to the above activities, HealthCare USA offers mileage reimbursement to its members who have access to personal transportation.

- **Mercy MC+**

The Plan continued its commitment to delegating quality improvement, utilization/case management, and credentialing functions to organizations that demonstrated the capacity to effectively perform them and achieve quality outcomes. NCQA delegated oversight audit tools were utilized in the delegation review process. Delegates submitted reports at least semi-annually.

- **Missouri Care**

Missouri Care has delegated to designated subcontractors the responsibility for provision of pharmaceutical, dental, vision and medical transportation services to Missouri Care members. These activities meet the policies, procedures and contractual requirements of Missouri Care. These designated subcontractors shall fulfill their own quality assessment and improvement processes to ensure that Missouri Care members receive safe, quality services. They must also work with Missouri Care to provide member service satisfaction through continuous quality improvement. Missouri Care shall retain the oversight function for quality management. Although Missouri Care delegates the authority to perform a function, it does not delegate the responsibility for assuring the function is performed appropriately.

Missouri care monitors four subcontractors:

- Express Scripts, Inc.
- Crown Optical
- Bridgeport Dental
- Medical Transportation Management

Express Scripts, Inc. (ESI)

ESI continues to work on decreasing the price for single-source brand prescriptions. They have also done well in submitting encounters in the new 837 format.

Crown Optical

Crown Optical has begun the expansion of the vision network for Missouri Care. They have recruited providers in the Mexico and Warrenton, Missouri area. In addition, they have upgraded their system to provide automated reports of member complaints as well as prior authorizations/denials.

The encounter submission process continues to be a problem. Despite weekly conference calls with all parties involved, Crown continues to struggle with the submission of past encounters. A corrective action plan has been initiated with Crown beginning in 2006 and their encounter submission remains under close supervision.

Bridgeport Dental (BDS)

BDS submitted testing files and encounters in a timely manner. A project was conducted to improve provider demographic data for dental network. Provider demographic data needed to be improved to accurately show all dental providers that are used by Missouri Care members. Originally, the file only contained providers in the MC+ Central region. However, Missouri Care members may visit providers outside of the MC+ Central region, and we had no demographic data on these providers. This was causing encounters to deny. Network was corrected and currently shows all providers. Ongoing updates have been set up on a monthly basis to compare any additional providers and denied associated denied encounters.

Medical Transportation Management (MTM)

MTM had no problem submitting encounter data in the 837 format. All files were tested and submitted in a timely manner. MTM continues to have issues with member 'no shows'.

Federal Rule Compliance

As part of the federal External Quality Review protocol, the External Quality Review Organization (EQRO) reviewed the MC+ Managed Care health plans for compliance with federal managed care regulations regarding:

- Enrollee Rights and Protections
- Quality Assessment and Performance Improvement
- Grievance Systems

Below is a summary of conclusions the EQRO drew from their 2005 review:

Strengths

- All MC+ Managed Care health plans Met or Partially Met all applicable federal regulations and related State compliance requirements for MC+ managed care.
- MC+ Managed Care health plans demonstrated strength in compliance with federal regulations for grievance and appeals processes and procedures.
- Across MC+ Managed Care health plans, an investment in the development of programs was observed that often exceeded the strict requirements of the MC+ Managed Care contract.

Areas for Improvement

- MC+ Managed Care health plans should monitor, develop, and timely submit policies to ensure compliance with the MC+ Managed Care contract and the federal Managed Care Regulations.
- Continued growth in the utilization of all of the data available to drive healthcare practice and initiatives is required to improve quality and access to care.

MC+ MANAGED CARE ANNUAL EVALUATION

SYSTEMS

SYSTEMS

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

- CLAIMS PROCESSING – TIMELINESS OF CLAIMS PAYMENT

  BCBSKC administers claims processing via policies and programming according to RSMo 376.383 and RSMo 376.384. FACETS is programmed to process claims in accordance with Medicaid requirements. Monitoring is done on a daily basis, measuring inventory levels and quality performance, which ensures claims are being processed correctly and accurately.

  The BA+ Unit reports monthly basis to the BA+ Oversight Committee the claims processing timeliness statistics. The statistics are generated by the Operations Performance Improvement Unit within BCBSKC's Operations Division for all lines of business, including BA+. The BA+ Oversight Committee is managed by the Plan Administrator and Director of State Programs.

  New Directions Behavioral Health processes claims through EPOCH, according to these requirements/Statutes. Their timeliness is monitored by Audit Service and reported for oversight to the Delegated Oversight Committee.

	Claims Accuracy (Goal 97%)	Inquiry Accuracy (Goal 97%)	Claims Processed
Jan-05	NA	NA	31,882
Feb-05	98.4%	98.3%	28,173
Mar-05	99.3%	98.1%	30,558
Apr-05	96.6%	98.1%	28,367
May-05	99.5%	99.1%	37,120
Jun-05	97.4%	98.2%	25,727
Jul-05	99.6%	98.9%	21,464
Aug-05	98.8%	99.5%	30,724
Sep-05	99.5%	100.0%	22,601
Oct-05	100.0%	100.0%	32,860
Nov-05	100.0%	99.7%	23,120
Dec-05	99.6%	99.8%	19,258

- MEMBERSHIP

  Membership is received nightly from the State of Missouri Division of Medical Services and uploaded to Facets. BCBSKC staff use this information to communicate with members. Currently, BA+ has approximately 30,000 members.

- PROVIDERS

  A listing of providers is provided to members at the time of enrollment into BA+. Members may contact BA+ Customer Service and request a copy of the Provider Directory as needed.

  In addition, the listing of BA+ providers is located on the BCBSKC web site (bcbskc.com). Provider information is current in the Facets system.

Changes to the provider network are sent through Infocrossing daily/nightly. The entire file is sent weekly.

Claims Processing - Timeliness of Claims Payment

Children's Mercy Family Health Partners (CMFHP) continues to refine and improve the claims processing system and work flow. In 2005, CMFHP completely implemented scanning and OCR capability for claims, which has allowed us the opportunity to maintain quick and accurate claims processing times for providers.

Imaging and scanning has allowed CMFHP to more accurately and promptly process and pay claims submitted on paper forms. This enhancement allows us to maintain our overall claims inventory at approximately 3,500 claims, which represents approximately a 4 day on hand inventory. This enhancement has also shortened our time to process claims by 50%. Our electronic submissions versus paper submissions have increased during 2005 to seventy-five percent (75%) of claims being received electronically and twenty-five (25%) percent of claims being received on paper.

	Jan-05	Feb-05	Mar-05	Apr-05	May-05	June-05	July-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05
Processed	34,279	44,485	49,158	43,134	42,231	41,110	26,179	43,492	39,531	40,131	49,908	37,174
Accuracy	97.5%	99.81%	97.6%	98.6%	98.7%	99.2%	97.1%	99.67%	99.92%	98.03%	99.03%	97.8%
Days to Pay	9.87	8.13	7.23	6.32	6.04	5.69	5.49	5.6	5.62	5.61	5.1	5.3

Children's Mercy Family Health Partners has continued to enhance the quality review process to ensure that the claims data received from providers is accurately and timely processed for payment. This process looks at the scanning and imaging process and validation as well as the accuracy of system pricing tables and processing by each individual claims analyst.

Lastly, during 2005, Children's Mercy Family Health Partners continued to enhance and expand its coding detection software called Code Review. This software allows for the review of professional claims and instances of unbundling of procedures, as well as services provided during a global surgical period and the appropriate use of multiple surgical procedures and the accurate payment of those services. This continues to be an ongoing refinement process to ensure that we are correctly interpreting coding conventions.

Members

During 2005, Children's Mercy Family Health Partners made no changes in how membership data was received from the State and uploaded into our information management system. The Information Technology department continues to work in conjunction with the Customer Service department to ensure that daily data received from the State is readily available in the membership information/eligibility system. Customer Service staff daily reviews the data received indicating members who did not select a PCP and ensures that a PCP is selected (auto-assigned) to the member so that he/she will receive a member ID card within the specified time frame of five (5) days. Customer Service also continues to track returned mail and updates member addresses and phone numbers in a secondary field to increase the accuracy of mailings and outbound calls to members. The Customer Service staff also communicates with the Division of Medical Services employees when members are identified with mailing addresses outside of our service area. Finally, Customer Service requests language preferences from members and updates the language field in the eligibility software as appropriate.

Providers

Children's Mercy Family Health Partners utilizes Cactus software to maintain the credentialing database of providers. The Cactus database allows for the generation of unique provider ID numbers, maintenance of languages spoken by participating providers, licensure information, educational backgrounds including residency information, and office visit information. In addition, CMFHP is able to produce on a monthly basis, provider directory updates that can be inserted in the Member Handbook/Provider Directory as well as distributed to Customer Service staff to assist members with provider selection or questions related to the provider network.

Children's Mercy Family Health Partners also maintains provider information in the claims system. With consistent communication between Provider Relations and Data Quality, the provider payment/contract information is kept current and accurate. Our

claims payment system contains current Tax ID Numbers, contract arrangements and fee schedules, as well as billing/payment information.

Claims Reimbursement
Analysis of the December 2004 Claim Backlog Report identified areas for process improvement. Goals were established to decrease:

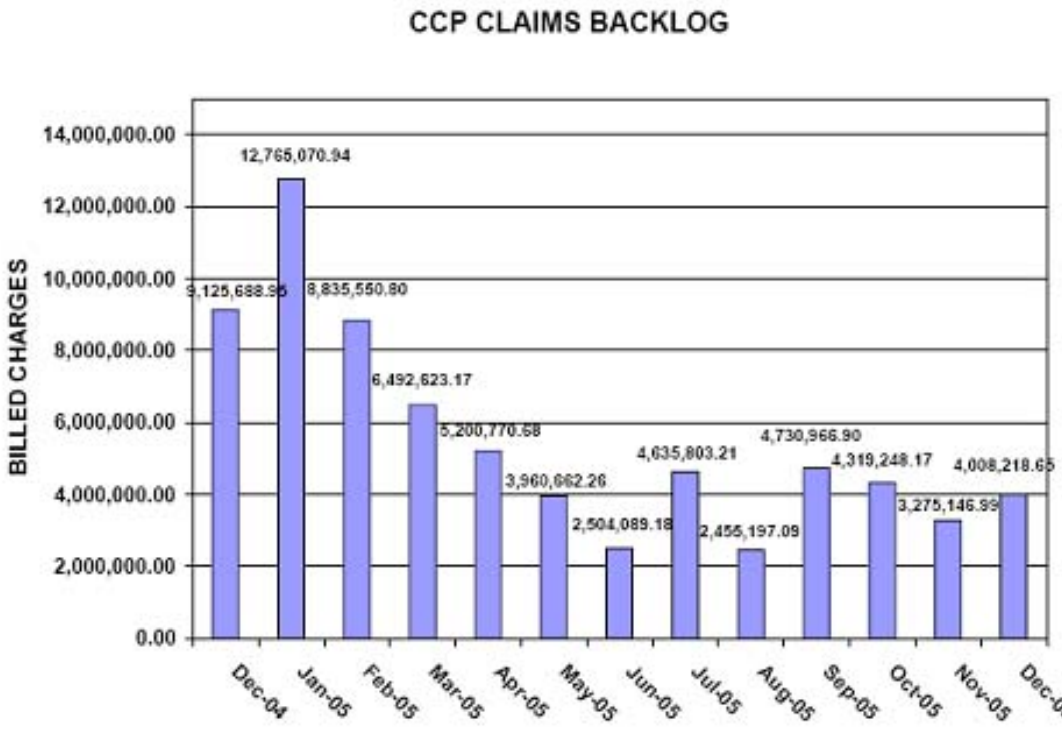
- Number of monthly pended claims to 7,000
- Decrease the average monthly amount of billed charges to 7,000.000.00

Priorities established to obtain the set goals were:

- Processes for consistent phone log reports and staff assignments for working and resolving phone log issues.
- Weekly monitoring of volume of open phone logs related to claim issues
- Process for reviewing and working high dollar (stop loss) pended claims.
- Daily monitoring of high dollar claims.

Analysis of the December 2005 Claim Backlog Report and the monthly Phone Log Report indicates improvement in the volume of open phone logs, pended claims and the pended claim dollar amount.

The percent of claims paid within 10-15 days remain consistent at 95% to 98.7%. The established goal is 95% of all clean claims submitted shall be paid within 10-15 days. The average turn around time for claim adjudication is 6.175 calendar days.



Membership

Membership decreased each quarter, with the largest decrease occurring in quarter 4.

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ending count	46,574	43,513	41,802	38,601

Providers

CCP has a total of 2,978 providers.

One hundred twenty-eight new providers were brought into CCP's Provider Network in 2005.

A. Data Sources

The following health plan data source descriptions remained consistent in 2005:

- Amisys system;
- CACTUS (Credentialing Database);
- Trend Central (Express Scripts pharmacy utilization reporting program);
- Clinical Resource Management System (CRMS) - HEDIS Performance Measurement Application data warehouse, financial, utilization and reporting tool;
- MACESS (Call Tracking Application Software);
- CCMS (Clinical Case Management Software);
- ODS (Data warehouse).

B. Systems Assessment

The Centene IS Department completed revisions to the Information System Capabilities Assessment (ISCA) as required by both state entities (DMS in Missouri, DHPF in Kansas) due to the system conversion in December 2004 from the MC400 to Amisys. The ISCA is a CMS External Quality Review protocol (Appendix Z), which serves as a thorough assessment of information systems.

C. Information Flow

The Key Indicator Variance Report format was consistently used to report the most critical indicators for the various departments on a rotational basis in the QMLT monthly meetings. The variance report, initiated at the beginning of 2000, remained an efficient reporting tool for purposes of leadership monitoring.

The Quality Improvement Activity Summary (QIA) was utilized for clinical quality initiatives in 2005 [Attachment 5].

The Key Indicator Report is a spreadsheet tool that is the foundation for department specific data and allows for the collection of serial data points that can be used to identify data shifts and trends that might signal the need for corrective interventions on a proactive basis [Attachment 5].

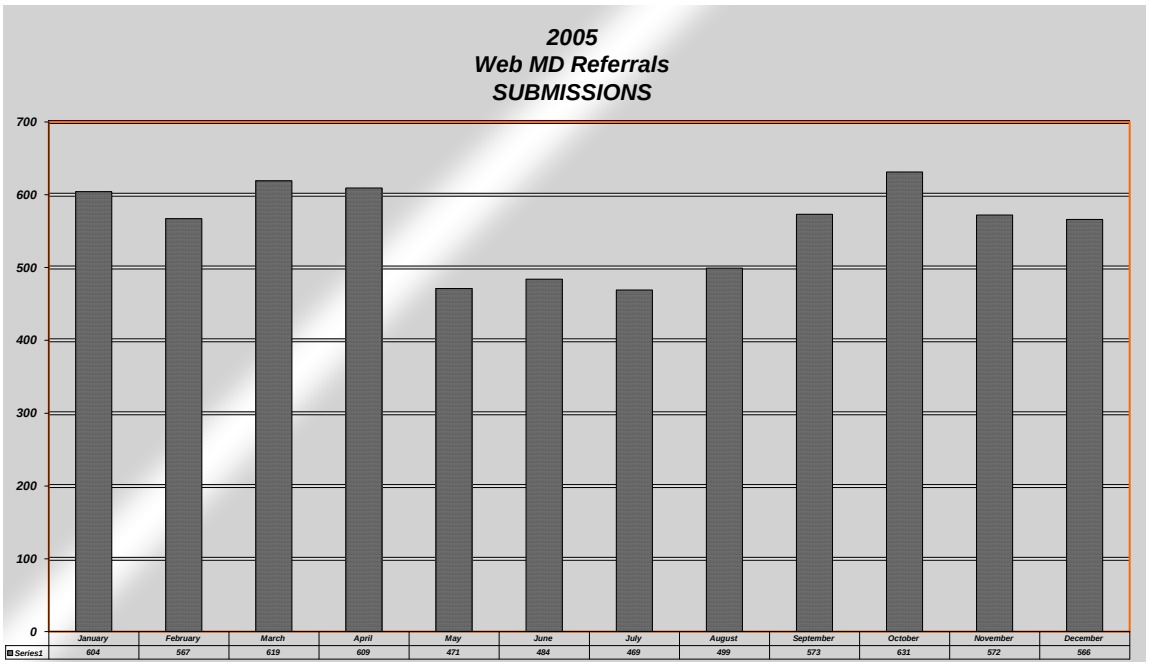
D. Credentialing Software

CACTUS credentialing software was implemented at FirstGuard in mid-July, 2004. In the first quarter of 2005, FirstGuard designed a custom provider profile that includes fields to indicate provider-specific data for substantiated member grievances/quality of care issues for review during the recredentialing process. This has been identified as a best practice among Centene health plans as a model for replication.

In an effort to streamline the efficiency of file review by the Credentialing Committee, profiles are presented for providers with no credentialing/recredentialing concerns, a process which follows current NCQA credentialing standards. Credentialing/recredentialing policies and procedures have been revised to reflect the enhanced process but include a validation process related to uncomplicated or "clean" files presented to the peer review committees for approval.

WEBMD:

HealthCare USA focused efforts in 2004 and 2005 in educating providers and facilities on the benefits of submitting authorization requests via WebMD. The number of online submissions grew significantly in 2005 due to this intervention and was instrumental in reducing call volume for the pre-authorization department. This project produced substantial results in not only reducing call volume, but also improving calls abandoned and service quality. This is lso reflected in the increase in provider satisfaction with the pre-authorization department services.



ENCOUNTERS:

HealthCare USA is required to submit encounter data for all medical, institutional, pharmacy, mental health, and dental encounters to Missouri Medicaid in a timely and accurate fashion.

In October 2003, HealthCare USA was informed by the State of Missouri Department of Social Services, Division of Medical Services (DMS) of the Encounter Data Corrective Action Plan (CAP) for MC+ Managed Care Programs. The CAP states that pursuant to Federal Regulation 42 CFR 438.6 in order to set actuarially sound capitation rates, the State must base utilization and cost data that are derived from Medicaid population, or if not are adjusted to make them comparable to the Medicaid population. As Missouri does not have recent fee for service databases for the regions in which MC+ managed care operates, Missouri will use encounter data as its database on which to base utilization and cost assumptions. The focus of the CAP was to ensure the State of Missouri is receiving complete and accurate encounter data.

In order to partner with the State to obtain the most complete and accurate data, HealthCare USA comprised an Encounter team that specific goal is to focus completely on Encounters. This Encounter team is comprised of the following individuals:

- Business Reporting Manager who is a dual certified professional coder (CPC, CPC-H),
- Senior Information Administrator with a background in UNIX programming (the state transmission system until 2005),
- Claims professional who has 18 years of experience in claims adjudication.
- Eligibility specialist who has 9 years experience in Missouri Medicaid Eligibility.

The Encounter team was charged with increasing HealthCare USA's encounter acceptance rates with a goal in place to reach 95% acceptance by June 2005 and to ensure that the data is complete and accurate. To successfully meet this goal, the encounter team separated the goal into two phases

1. *Acceptance*
2. *Completeness*

Acceptance

Effective 10/2003 DMS made changes to the Health Plan Record Layout for encounters in order to comply with the Health Insurance Portability and Accountability act.

The Senior Information Administrator effectively worked with Coventry's I.S. department to update these changes into HealthCare USA's encounter file. Communication was also established between HealthCare USA and Infocrossing (DMS's Third Party Administrator) to meet all testing deadlines and work through all edits before these changes went to the live system which would have negatively impact HealthCare USA and DMS. Along with managing HealthCare USA's medical and institutional file this person also effectively communicated with HealthCare USA's subcontractor to ensure a smooth transition of our Pharmacy, Mental Health and Dental encounters. As

part of the subcontractor oversight committee, the Senior Information Administrator also communicates all acceptance percentages, rejection rates and updates to these vendors.

The encounter team developed an action plan to review all steps of the encounters such as:

1. Extract file from Healthcare USA's IDX system
2. Claims processing methodologies
3. Paper free processing (allows encounter to be formatted into State required formatted file)
4. Confirmation rejections from InfoCrossing
5. State of Missouri Rejections

This review allowed the team to concentrate on specific issues that suited their experience and background.

HealthCare USA's claims professional found many differences between HealthCare USA's and DMS's claims methodologies. These differences were discussed with the State and changes made to both systems allowed increases in HealthCare USA's acceptance rates.

HealthCare USA's Eligibility Specialist reviewed all eligibility rejects from the State of Missouri. This review not only allowed HealthCare USA to review encounters, but also allowed any discrepancy to be reported to the State's eligibility department and reported to our premium reconciliation team as well.

Completeness of Data

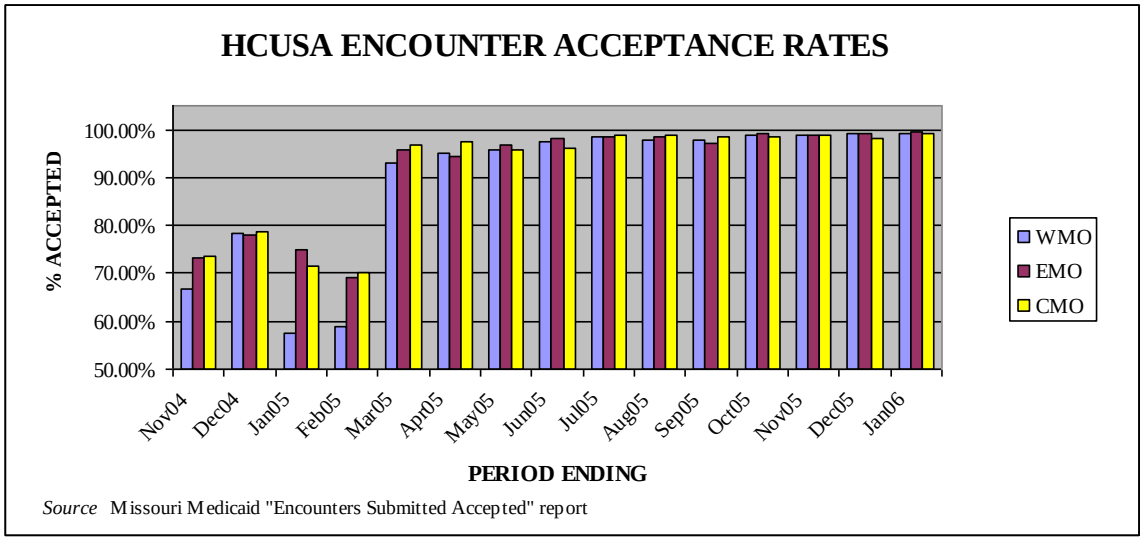
In January 2005, HealthCare USA set a goal to reconcile all approved/paid claims with state accepted encounters (defined by an State ICN number being attached to the claim) in order to ensure that all data sent through the encounter process is as complete as possible. . This process entailed uploading all State rejection numbers and reasons into our data warehouse system and setting up reports to summarize this data by:

- Approved/Paid Claims with ICN numbers assigned
- Approved/Paid claims without ICN numbers assigned
- Total Approved/Paid claims for HealthCare USA

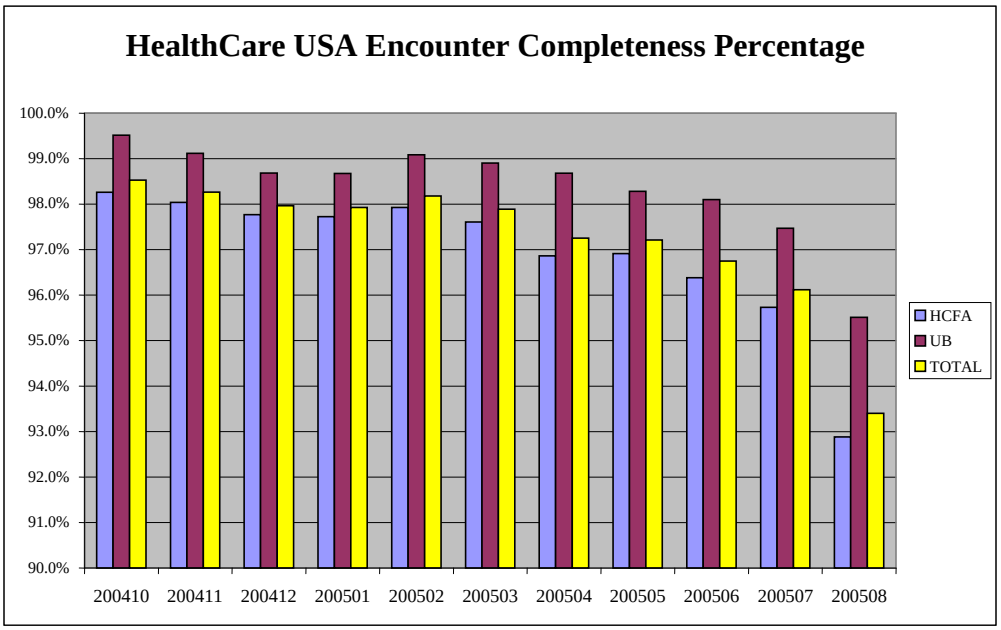
All claims without ICN's are summarized further to denote what rejection code/definition the state assigned to the specific claim. That summary is worked by the encounter team and re-submitted when applicable to the State for acceptance. This allows us to review rejects by # of claims and claim dollars. There have been instances that a claim will not be accepted , in those cases, HealthCare USA has set up an artificial ICN # that we can report by for further review.

Result

This successful endeavor allowed HealthCare USA to bring encounter acceptance percentages to an all time high of 99.3% (combined total of all regions) for the month of December 05. (see below chart)



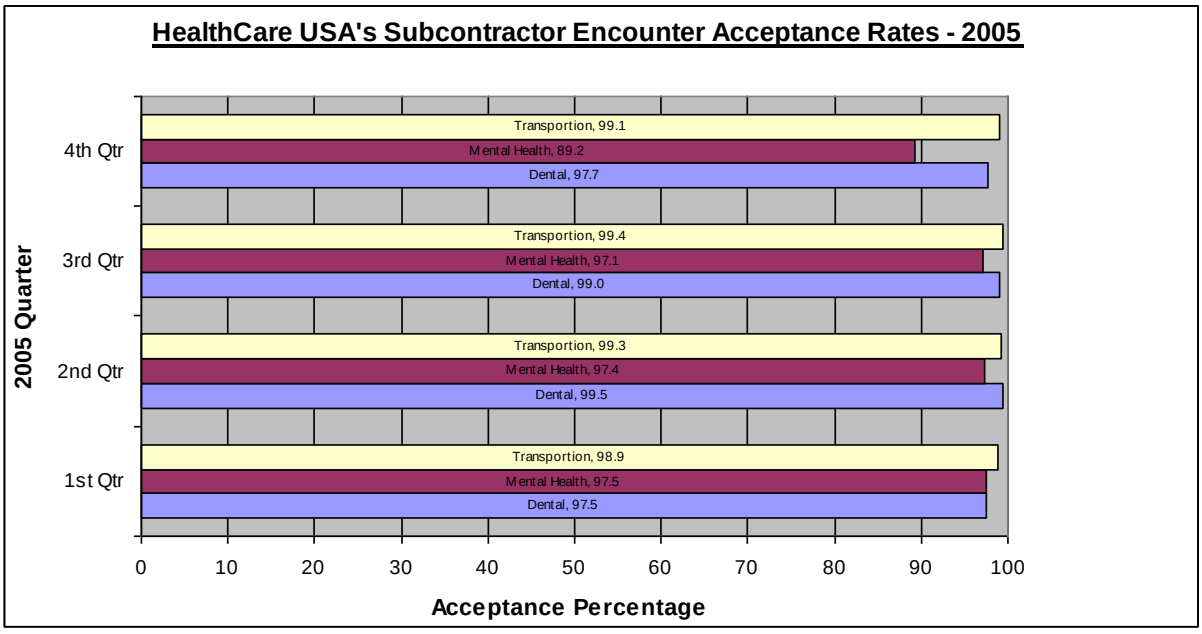
The chart below indicates reconciliation by number of claims through 0805. Reconciliation is performed with a 3 month lag time. The last month reconciled does not show all ICN's due to a timing issue therefore, will always be at a lower percentage.



Source HealthCare USA Reconciliation Report 0805

Subcontractor Encounter Acceptance

Encounter acceptance/rejection rates and issues are now a permanent agenda item in the quarterly subcontractor oversight meetings. This has greatly improved communications, problem solving, and all around awareness of the encounter submission process. As a result of these efforts, the overall subcontractor encounter acceptance rates are now consistently 90% or higher.



2006 Goals

- 99% acceptance rate for 2006.
- 95% completeness rate for 2006

In order to meet the 95 % acceptance goal, the encounter team will concentrate on these specific rejects

- exact duplicates,
- eligibility
- Procedure/modifier rejects.

The completeness 95% goal will be met by utilizing our data warehouse query system to allow ease in reviewing rejections and utilizing our artificial ICN capabilities more when applicable. The Encounter team also is educating all departments within HealthCare USA on the encounter system with hopes of decreasing rejections based on differences between claims methodologies between the health plan .

These goals will be measured by reports from the Acceptance Report sent by the State of Missouri and internal HealthCare USA reporting tools.

Claims Processing – Timeliness of Claims Payment

During 2005 the Claims department received 441,042 claims for our *Mercy MC+* members. Of those claims between 80-85% of were received electronically with 55% of the electronic claims being auto adjudicated upon receipt. Timeliness of payment for 2005 ranged between 98% and 99% paid within 30 days of receipt of the claim.

Membership

The Plan maintained effective information systems for collection, aggregation, and reporting of members and provider information, claims detail, and financial data. Planning and development for several new systems and applications continued throughout 2005 with implementation targets for year-end 2006.

Providers

Provider Relations' ***focus*** in 2005 centered around ways to eliminate inefficient workflows, to develop more simplified reporting tools at an individual and team level, and to implement creative initiatives to assist in achieving customer service excellence.

The creation of the Provider Tactical Portal was MHPs first internet alternative and it allowed providers the opportunity to check claim status allowing a As a result of the changes outlined above, we have been able to refocus our energies on providing accurate statistical data to the Provider Relations Team.

To ensure accountability amongst each representative, a daily team production report (for the day prior) is distributed to the entire team. Comments about production, average call times, etc. are also provided on an individual basis.

Company Initiatives and Their Impact

- Pursuing creative methods to allow individuals the opportunity to attend training sessions, company sponsored seminars, etc. without the negative impact on the team

Team Focus in Summary

Getting Back To Basics

- As a result of the changes outlined above, we have been able to refocus our energies on providing accurate statistical data to the PR Team.
- To ensure accountability amongst each representative, a daily team production report (for the day prior) is distributed to the entire team. Comments about production, average call times, etc. are also provided on an individual basis.

The New Path for Provider Relations

- Through our energized determination to reach our goals…we are eager to experiment with initiatives that will propel our call center, our Company, towards our ultimate goal of offering superior customer service AND excellent customer satisfaction.

Claims Processing

Missouri Care received 420,518 unique claims for calendar year 2005. One of Missouri Care's goals was to improve the EDI claim percentage from 45 percent in 2004 to 55 percent in 2005. Missouri Care exceeded that by posting 68 percent EDI claim submission. Ninety-nine percent of EDI claims were paid within 45 days from submission. Clean claims were paid on average in 16 days from receipt from the provider.

Membership

Missouri Care had 35,301.67 member months in December 2004 and 32,396.19 member months in December 2005. The health plan experienced a contraction in the membership due to state eligibility and benefit changes. Besides legislative mandates Missouri Care's overall membership is stable. Missouri Care recorded market share increases during 2005; although membership had declined.

Providers

Missouri Care Health Plan had 32 PCOs, 315 PCP's and 1,417 specialists in Dec 04. The health plan expanded its provider network in 2005 to 35 PCOs, 343 PCP's and 1,526

specialists. Network expansion occurred because of the health plan's commitment to decrease travel time for members and add new specialties.

MC+ MANAGED CARE ANNUAL EVALUATION

GRIEVANCE SYSTEMS

GRIEVANCE SYSTEMS

The following information was taken from the MC+ Managed Care health plan's annual evaluations:

PROVIDER COMPLAINT, GRIEVANCE AND APPEAL MANAGEMENT

Provider Complaints, Grievances and Appeals and Member Grievances and Appeals are processed in an organized and timely manner in accordance with the Provider Complaints, Grievances, and Appeals and Member Grievance & Appeal Corporate Policies and Procedures. The Polices and Procedures are consistent with the requirements of the Federal Government, State Government, and other regulatory entities. The BA+ Board of Directors reviews and approves this policy annually.

BA+ continues to track and trend Member Grievances and Appeals and Provider Complaints, Grievances and Appeals, in accordance with the State of Missouri contract. Quarterly reports and annual analysis are submitted to the State. These findings and recommendations for action are presented to the BA+ Oversight Committee and Quality Council for evaluation and recommendations.

Provider Complaints, Grievances, and Appeals

a. During 2005, there were 213 provider complaints. These dealt with claims accuracy, timeliness, prior authorization, and medical necessity issues. Out of the 213 provider complaints, 100 were overturned (47%), 6 were partially overturned/upheld (3%), and 107 were upheld (50%).
b. During 2005, there were 28 provider grievances. These dealt with claims accuracy, timeliness, prior authorization and medical necessity issues. Out of the 28 provider grievances, 4 were overturned (14%), 3 were partially overturned/upheld (11%), and 21 were upheld (75%).
c. During 2005, there were 6 provider appeals. All of these dealt with lack of prior authorization and were upheld.

MEMBER GRIEVANCE AND APPEAL MANAGEMENT

The BCBSKC State Programs Department achieved significant improvement in 2004-05 with achieving timeliness requirements with Member Grievances and Appeals & Provider Complaints, Grievances, and Appeals. Through more closely monitoring, tracking, and raising the required response time frames to the awareness of the Corporation, the response times improved significantly.

In an effort to make the Corporation more aware of the requirements, a presentation was developed within the Showcase of Quality – an internal quality improvement program. The presentation was titled the BA+ Complaint Process – The Road to Resolution. Included in the presentation were the problem statement, definitions, the plan to improve,

the steps taken to solve the problem and improve the process, a report on the outcomes, the results, the process on how this is checked/QAed, and the follow up on the action items.

Steps taken to improve the response time included:

a. Development of desk procedures specific to processing Member Grievances and Appeals & Provider Complaints, Grievances, and Appeals;
b. Updated SOPs;
c. Implementation of performance standards and goals;
d. Investigation of every case out-of-compliance – looking for opportunities to improve the process;
e. Implementation of changes as needed; and
f. Training staff on the process and appropriate letter usage.

MEMBER GRIEVANCES AND APPEALS

a. During 2005, there were 96 member grievances. The grievances related to transportation and provider service issues.
b. During 2005, there were 28 member appeals. Seventeen of these appeals were overturned (61%), 2 were partially overturned/upheld (7%), and 9 were upheld (32%). All of the appeals related to the denial of services.

PERFORMANCE MEASURES/ANALYSIS

Performance measures used to track Provider Complaints, Grievances, and Appeals and Member Grievances and Appeals are:

a. Provider and member issues are tracked using the percentage of acknowledgement letters that have been sent within 10 calendar days of receiving the issue in-house.
    1) Goal is 95% compliance
    2) Actual for 2005 94% for member and 99% for provider.

b. The timeframe for resolution of member grievances is 30 calendar days. The timeframe for resolution of member appeals is 45calendar days.
    1) Goal is 95% compliance
    2) In 2005 member grievances were 95% compliant and member appeals were 97% compliant.

c. The timeframe for resolution of provider complaints is 10 calendar days. The timeframe for resolution of provider grievances is 30 calendar days. The timeframe for resolution of provider appeals is 60 calendar days.
    1) Goal is 95% compliance for all categories (provider complaints, grievances and appeals).

In 2005 provider complaints were 85%compliant. Provider grievances were 95% complaint and provider appeals were 100% compliant.

Children's Mercy Family Health Partners (CMFHP) recognizes the importance to providers of having available effective complaint, grievance and appeal mechanisms in the event that they do not agree with a health plan decision. CMFHP offers these mechanisms to address, for example, potential disagreements regarding medical necessity, denials of services, changes in services, claim payments, etc.

Since 1997, CMFHP has coordinated the program's evolving complaint, grievance and appeal service delivery requirements similar to those described in the Request for Proposal.
CMFHP uses analysis of complaints, grievances and appeals as a mechanism to identify areas for improvement. Complaints, grievances and appeals are grouped by category and prioritized. Actions are then developed to reduce complaints, grievances and appeals related to the issue in question.

Since 2000, CMFHP has tracked and trended reasons for complaints, grievances and appeals received. A process change was initiated in third quarter 2005 to ensure compliance of process to our Provider Complaint, Grievance and Appeal Policy. One issue emerged as significant and high volume in 2005: Claims Administrative Denials.

To address these findings, CMFHP implemented the following:

- Unique fields for diagnoses codes and procedure codes were added the CGA Database to provide a tracking matrix for common complaint types
- Provider education was incorporated into Provider Newsletters, visits from Provider Relations Representatives, and Health Services staff to enhance the provider's knowledge of health plan benefits and processes

Outcomes from these specific interventions resulted in continued identification of increased provider complaints related to cosmetic procedures. The health plan reviewed the current claims administrative process for denial of specific diagnoses and procedure codes related to cosmetic and infertility claims. The claims system was updated to remove codes that, upon medical record review, consistently demonstrated medical necessity, resulting in a high overturn rate of cosmetic denials. This update is anticipated to result in a decrease in the number of provider complaints, grievances and appeals in 2006.

Children's Mercy Family Health Partners (CMFHP) recognizes the importance to members of having available effective grievance and appeal mechanisms in the event that they do not agree with a health plan decision rendered on their behalf. CMFHP offers these mechanisms to address, for example, potential disagreements regarding medical necessity, denial of services, change in services, claim payments, etc.

Since 1997, Children's Mercy Family Health Partners has coordinated the program's evolving grievance and appeal service delivery requirements similar to those described in the Request for Proposal.

CMFHP uses analysis of grievances and appeals as a mechanism to identify areas for improvement. Grievances and appeals are grouped by category and prioritized. Actions are then developed to reduce grievances and appeals related to the issue in question.
Since 2000, Family Health Partners has tracked and trended reasons for grievances and appeals received. In 2005, two issues emerged as high volume: member appeals for orthodontic dental care and services identified as cosmetic, which are not a covered benefit.
To address these findings and assess the number of appeals received relating to orthodontic and cosmetic appeals, Children's Mercy Family Health Partners identified the following interventions:

- Tracking and trending the review of orthodontic cases to an objective clinical index: Resulted in a total of 126 members denied for orthodontic service denials, thirty-one (31) member appeals for orthodontic services were received and all appeals were upheld, seven (7) members filed State Fair Hearings related to orthodontics, three (3) have been upheld and four (4) were overturned.

- Tracking and trending of the member appeals for claims identified as cosmetic: Resulted in a process change in third quarter 2005, thirty-nine (39) member appeals related to cosmetic services, thirty-three (33) were overturned and six (6) were upheld.

Since the implementation of these grievance and appeal activities and initiatives, CMFHP has been able to improve various health plan services to the benefit of all members.

- Dental care subcontractor: utilization of a standard objective clinical tool for orthodontic service decisions facilitates consistent clinical decision making and results in improved and supported coordination with the State for delivery of dental services.

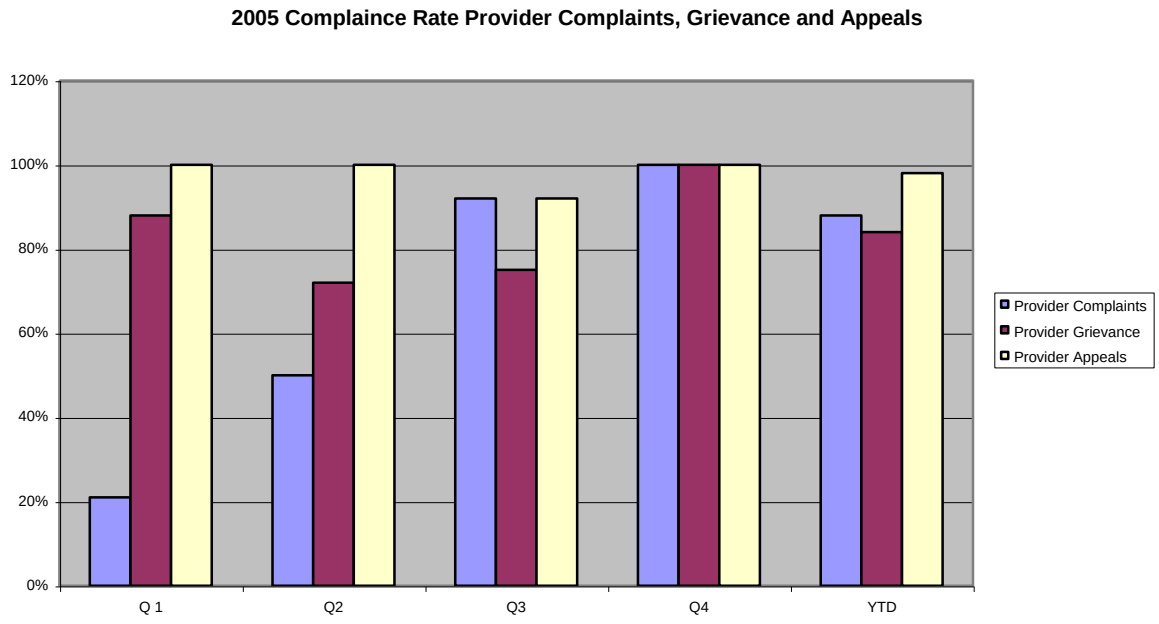
- Tracking and trending of member appeals: identified increased member appeals related to cosmetic with appeal overturns. Claims administration reviewed diagnosis and procedure codes, recommended and implemented changes to the adjudication process. This change is anticipated to decrease member appeals related to medically necessary services.

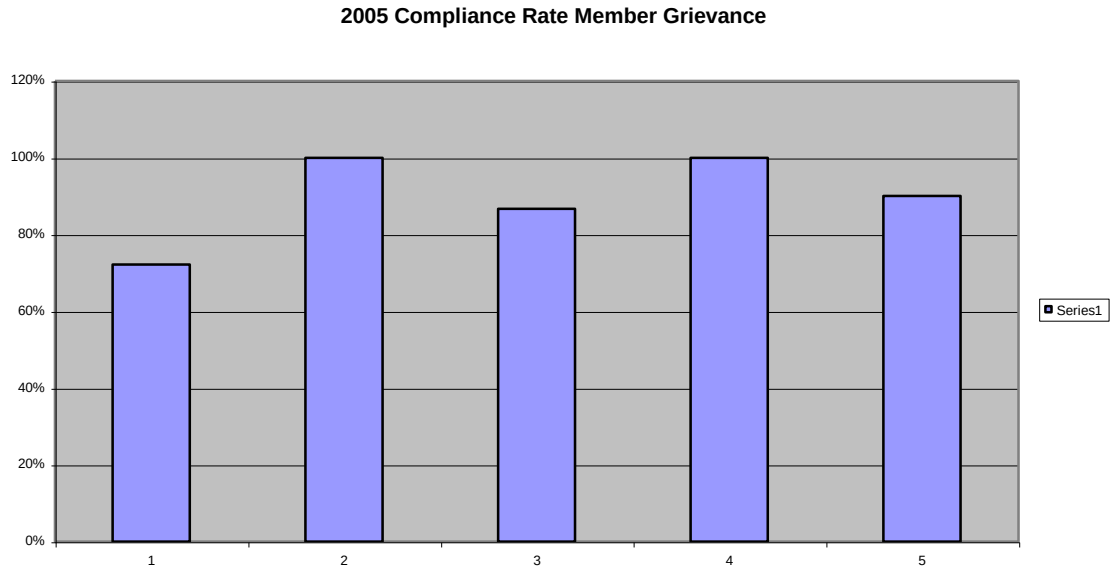
Children's Mercy Family Health Partners continues to monitor the effectiveness of grievance and appeal activities and works to identify additional initiatives that will result in furthering the improvement trends.

Complaints, Grievances and Appeals:
In 2004, a corrective action plan was implemented to better educate CCP staff and providers on the complaint, grievance and appeals (CG&A) processes. CCP created or revised policies and procedures consistent with the guidelines for timely, consistent, and effective adjudication of member and provider complaints, grievances and appeals and submitted to the state for approval in 2005. Both member and provider complaints, grievance and appeals policies were approved by the state in 2005. Internal staff has been educated on the process. CG&A tracking logs are updated monthly to allow for more accurate tracking, analysis and reporting. By instituting these changes, CCP has been able to ensure that members and providers receive a fair and timely

resolution to their concerns and a guarantee that CCP follows all regulatory requirements accuracy of reporting.

Significant improvement was made in the compliance rate of responding to Provider CGA. 100% compliance rate was achieved in quarter 4 for both Provider and Member CGA.





Member Grievances:
A total of 100 member grievances were received in 2005. Seventy-four (74), 97% were administrative grievances. Three (3), 3% were medical grievances. The overall compliance rate for response was 90%.

Provider Complaints:

A total of 1,105 provider complaints were filed in 2005. Of theses, 981, 89%, were administrative complaints and 124, 11% were medical complaints. Complaints upheld were 902, 82% and 203, 18% were overturned.

Provider Grievances

A total of 148 provider grievances were filed in 2005. Of theses, 96, 65%, were administrative grievances and 52, 35% were medical grievances. Grievances upheld were 134, 90% and 14, 10% were overturned.

Provider Appeals

A total of 61 provider appeals were filed in 2005. Of theses, 41, 67%, were administrative appeals and 20, 33% were medical appeals. Appeals upheld were 52, 85% and 9, 15% were overturned.

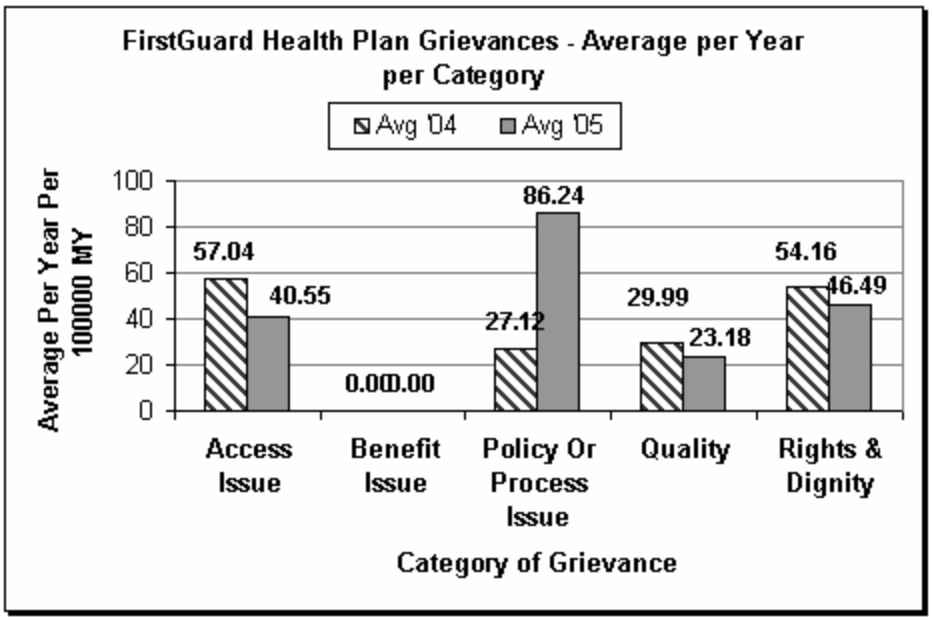
A. Member/Provider Grievance and Appeals Management

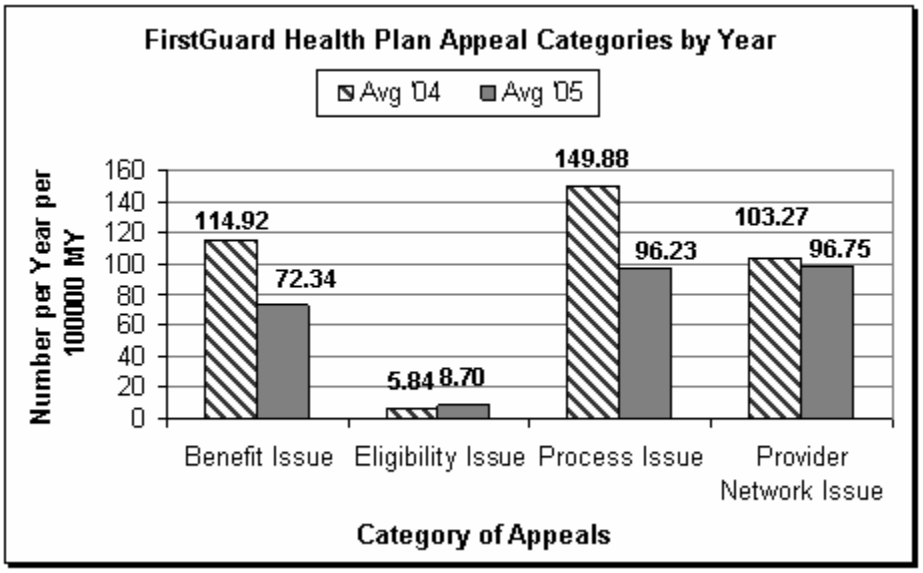
Appeal and Grievance Committee

FirstGuard approaches the member grievance and appeal process as an opportunity to identify areas for improvement in clinical and operational processes in order to impact positively the healthcare and health plan experience of our members. To that end, FirstGuard Health Plan supports an internal high level, multi-disciplinary Appeal and Grievance Committee (AG Committee) that represents all critical health plan service areas and is responsible for disposition of member grievances and resolution of appeals.

The AG Committee routinely reviewed quarterly aggregated reports summarizing the number of cases per 100,000 member years of each category of grievance and appeal. The AG Committee compared current activity with previous periods to evaluate consistency of decisions and to identify root causes and, when evident, made recommendations for improvements with the goal of reducing the number of cases and thus improving outcomes for our members. The AG Improvement Opportunity Log followed by SQI identified internal process improvements not directly the cause of an appeal or grievance. There were five opportunities identified and completed for 2005.

The following tables summarize the Appeal and Grievance Activity for 2005 and compare activity with 2004. Appeal activity in 2005 was similar to that in 2004; grievance activity for 2005 increased significantly for the category Policy or Process Issue. A drill down analysis identified a significant increase for HealthWave 19 under the sub-category of Providers Billing the Member Inappropriately. Appropriate provider education activity was taken by the AG Committee on a case-by-case basis for these grievances.





The data provided has been extrapolated from an internal complaint, grievance, and appeal access database. The information presented represents all three regions (Eastern Central, and Western). The analysis has provided valuable information and allowed for the review of several issues with regard to the eastern region provider complaints.

The number of provider complaints continues to decrease overall. 4th quarter medical complaints were up 6.7% form the 3rd quarter while non-medical complaints decreased 57.7% HCUSA continues to educate providers in the complaint, grievance and appeal process.

All of the medical complaints were overturned due to additional information being submitted. After reviewing these with the Medical Director, it has been determined that when the Medical

Director identifies additional information is being submitted, the complaint will be changed to a "reconsideration".

Overturn rates for non-medical complaints have also decreased by the 4th quarter. The largest number of overturns was due to incorrect payment of the claim accounting for 37.8%, followed by timely filing overturns at 35%.

Timeliness of complaints continues to be problematic. Complaints must be completed within 10 calendar days based upon our contract with the state. 89.14% of medical complaints were resolved with in ten days while 85.54% on non-medical complaints were completed within that time frame. Process changes have been put in place to improve the turn-a-round time for complaints.

Provider Grievances

In 2005 the number of provider grievances had increased by the 4th quarter. This number is much lower than the complaints which is an indication that HCUSA is resolving issues at the complaint level to the provider's satisfaction.

The overturn rate on the grievances has decreased in the last quarter. This signifies that the review done at the complaint level is being done accurately and is being upheld at the grievance level. All of the overturns in the medical grievances were due to additional information. Of the non medical grievances, 19 overturns were due to receiving additional information and 3 were claims processing errors.

Provider Grievances must be resolved within 30 days according to our contract with the state. There was a decrease in the percentage of issues resolved within 30 days in the 4th quarter. Medical grievances were resolved 68.75% within 30 days, while non medical grievances were resolved 65.57% within the appropriate timeframe. Procedures for grievances were changed. We no longer have a Grievance Committee hearing as this was not required by our state contract. There were also some staff issues which are being addressed through an action plan.

Provider Appeals

Medical appeals remain low. These appeals regarded medical criteria not being met. None of the medical appeals were overturned.

Non medical appeals have increased this quarter. 60% of the non medical appeals are from St. Louis Children's hospital. These appeals are due to St. Louis Children's hospital not obtaining authorizations prior to services as well as an ongoing dispute regarding payment of 3D Halograms.

The overturn rate for appeals continues to be low.

Provider appeals must be resolved within 60 days. 100% of the medical appeals were completed in that time frame. For the non medical appeals, 86.57% were completed within 60 days. Again this was due to a staffing issue which is being addressed through an action plan.

Member Appeals

Member Appeals were up from the 3rd quarter . Overturn rate for the 4th quarter was the lowest of the year. Additional physician review procedures were put in place which may account for the drop in the overturn rate. We continue to work with Doral to lower the overturn rate for orthodontia services.

Member Appeals must be resolved within 45 days. 100% of the appeals in the 4th quarter were completed within this time frame. The Member Appeals Committee is now meeting weekly which may account for the successful turnaround time.

Medical criteria not met was the largest category of Member Appeals for the 4th quarter. In addition there were several appeals for non covered benefits due to the change in Medicaid coverage to eliminate physical therapy.

Member Grievances

In 2005 member grievances were down 35% from the 3rd quarter.

Behavioral Health related grievances are at the lowest level this year. Member grievances regarding Dental providers has dropped from the 3rd quarter. There was one additional grievance for access from the last quarter. All other grievance categories for dental have decreased. Quality of Care remains the highest issue for complaint.

Grievances regarding HCUSA decreased in the 4th quarter, as issues with ID cards and the new vendor have improved. There were 19 ID card issues in the 4th quarter as compared to 51 in the 3rd quarter. There was also a significant decrease in the number of grievances regarding access issues, 18 in the 3rd quarter as compared to 8 in the 4th quarter.

Grievances regarding HCUSA medical providers decreased slightly in the 4th quarter overall. However, there was an increase in the category of member billing. Provider Relations continues to work with contracted providers who should not be billing the members. Many of the billing issues involved non contracted providers who are not willing to accept the Medicaid reimbursement rate.

Grievances regarding MTM Transportation services has decreased 54% from the 3rd quarter. These grievances account for 34% of the total grievances received for this quarter, 38% of the total grievances received for the year. HCUSA will continue to monitor the grievances received regarding MTM Transportation to assure that these issues remain under control.

The Provider Relations Appeals, Grievances and Complaints team continued to recognize the need for improving the flow and organization of the information we process in the appeals department. The following issues were identified in the year 2005:

- Triaging incoming documents into correspondence and appeals.
    - Correspondence is then further separated into more specialized categories such as:
        - Correct Coding
        - Corrected Claims
        - Tracers
    - Appeals
        - Contractual
        - Administrative
        - Clinical
- Improving response methods and documentation of issues.
- Tracking of progress including overall volume and days out.
- Reorganization of the Appeals department into contractual and administrative duties with existing staff being trained in each area to further specialize the workload.
- Implemented push days and times to work backlogs of correspondence.

All correspondence including appeals, grievances, and complaints, are logged when received and tracking of days out and resolutions are available. Response letters to written inquiries, appeals, and general correspondence were revised and the entire Provider Relations staff trained on the purpose and use of the letters.

In 2005, the Provider Relations staff identified the need for enhancing the current database. As a result, the database will document and track the progress of appeals, correspondence, inquiries, and grievances.

Member Grievance and Appeal Management

***Mercy MC+* members submitted 79 grievances in 2005 (informal, telephone contacts outlining dissatisfaction with an aspect of the health plans, their benefits, providers, or other issues); this number was 39% lower than 2004.**

Mercy MC+ members (or representatives on their behalf) submitted 20 appeals (request for a reconsideration of a denial issued by Mercy MC+ during either the authorization or the claims process). Over 46% of pre-service appeals were upheld either due to them involving unproven/experimental or cosmetic requests, or not meeting medical necessity criteria.

Provider Complaint, Grievance and Appeal Management

Providers receive information packets at the time of contracting with Missouri Care. The packets contain the complaint, grievance and appeal policies and procedures, specific instructions regarding how to contact the Provider Relations Department and identify the grievance coordinator who receives and processes complaints, grievances and appeals.

During 2005, 1,158 provider complaints were filed with Missouri Care, 668 were medical related and 490 were

non-medical (claim issues and timely filing) complaints. The providers filed 103 grievances and 15 appeals.

Member Grievance and Appeal Management

Missouri Care evaluates and processes grievances and appeals filed by members according to applicable state of Missouri and federal statutes, regulations, contracts and policies. Members can file grievances in regard to any aspect of service including those related to cultural sensitivity or sexual harassment. In no instance will a member be subject to any punitive action, including charges, for utilizing the grievance and appeal process.

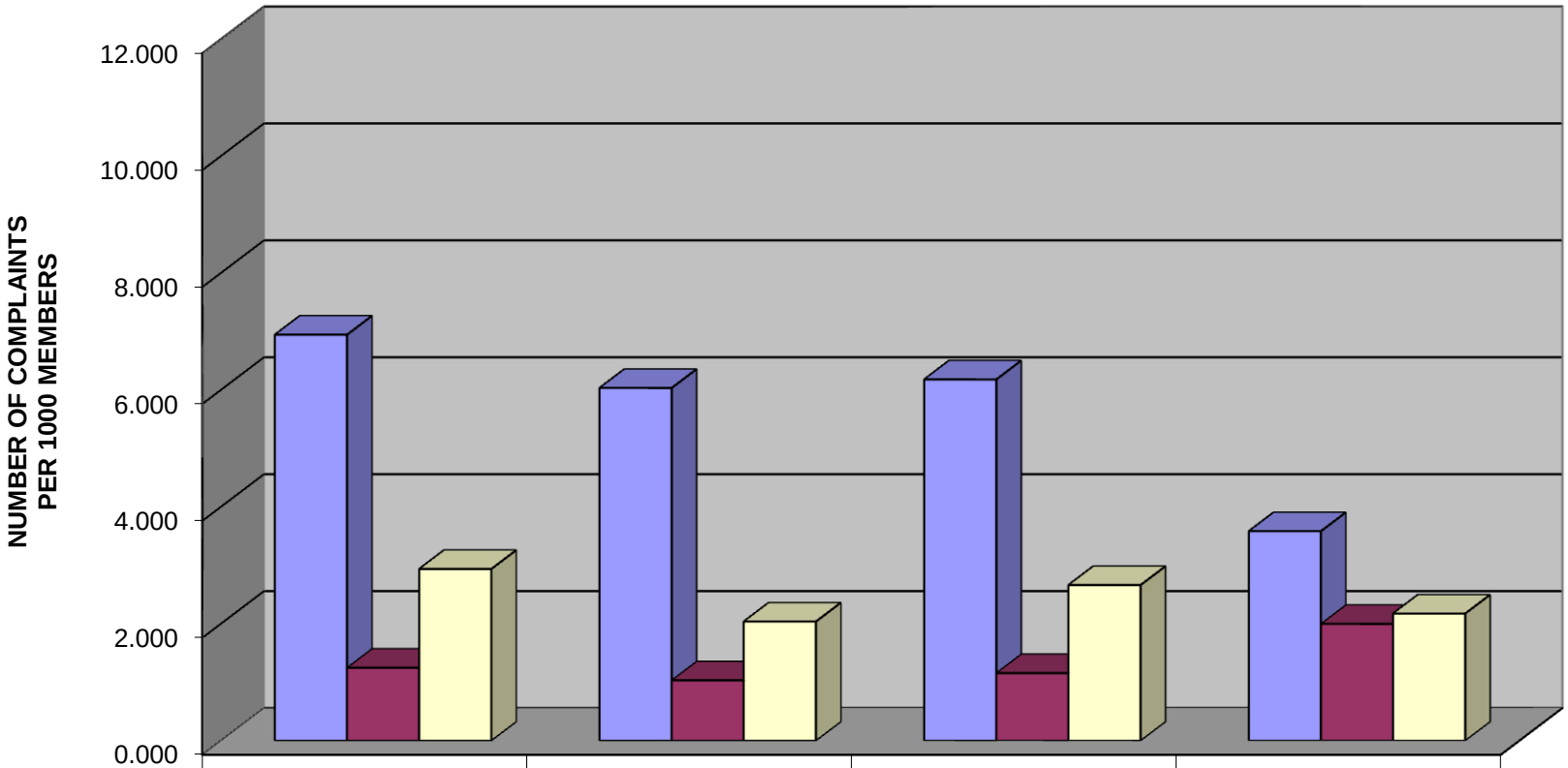
Missouri Care maintains records of grievances and appeals for all MC+ managed care members, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant or appellant, date of the grievance or appeal, date of the decision and the disposition. The SIC conducts a quarterly review of the number of grievances filed by members and by providers to determine if any trends exist. Any identified trends are referred to the appropriate department for review and any necessary education, training or corrective action. All identified trends will also be submitted to QMOC for review. Analyses of grievances are included in provider profiles for review at the time of re-credentialing. Grievances are logged in the QMACS Call Tracking System to identify trends.

Nine appeals and 62 grievances were received from members during 2005.

Provider Complaint, Grievance and Appeals CY 2005 - All Plans
Average Region/Quarterly Enrollment
(Per 1000 Members)

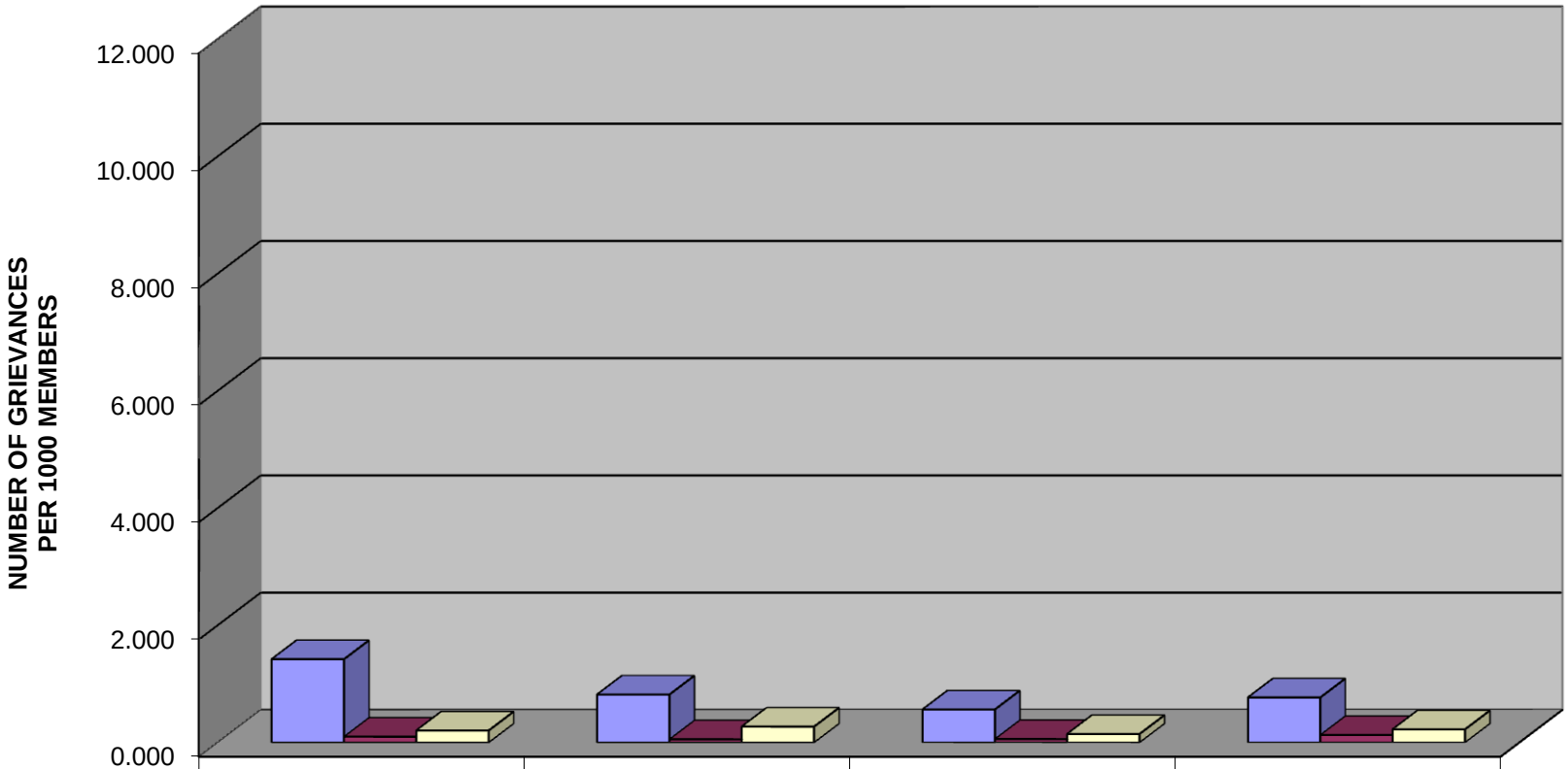
1 Q 05											
East	Comp	Griev	Appeal	West	Comp	Griev	Appeal	Central	Comp	Griev	Appeal
144,267	1,657	172	6	10,497	144	12	0	29,273	407	37	0
46,822	0	160	2	51,423	62	11	2	35,589	295	12	12
47,954	3	8	6	41,390	25	1	0				
				34,291	67	0	1				
239,043	**1,660**	**340**	**14**	**137,601**	**298**	**24**	**3**	**64,862**	**702**	**49**	**12**
Per 1000	**6.944**	**1.422**	**0.059**		**1.247**	**0.100**	**0.013**		**2.937**	**0.205**	**0.050**
2 Q 05											
East	Comp	Griev	Appeal	West	Comp	Griev	Appeal	Central	Comp	Griev	Appeal
141,524	1,048	154	2	10,464	94	6	0	28,249	198	34	1
45,855	354	39	10	50,351	71	3	4	34,908	282	30	2
48,153	19	0	36	40,514	33	0	0				
				33,469	45	4	1				
235,532	**1,421**	**193**	**48**	**134,798**	**243**	**13**	**5**	**63,157**	**480**	**64**	**3**
Per 1000	**6.033**	**0.819**	**0.204**		**1.032**	**0.055**	**0.021**		**2.038**	**0.272**	**0.013**
3 Q 05											
East	Comp	Griev	Appeal	West	Comp	Griev	Appeal	Central	Comp	Griev	Appeal
132,310	999	64	6	9,761	70	2	0	26,289	249	7	0
42,176	347	60	12	47,070	102	2	1	32,881	336	25	5
45,297	12	0	18	37,471	45	0	0				
				29,702	37	9	3				
219,783	**1,358**	**124**	**36**	**124,004**	**254**	**13**	**4**	**59,170**	**585**	**32**	**5**
Per 1000	**6.179**	**0.564**	**0.164**		**1.156**	**0.059**	**0.018**		**2.662**	**0.146**	**0.023**
4 Q 05											
East	Comp	Griev	Appeal	West	Comp	Griev	Appeal	Central	Comp	Griev	Appeal
125,435	466	117	63	9,983	54	12	1	25,097	125	18	6
39,971	281	44	40	45,163	257	10	0	31,657	330	29	4
43,908	3	0	22	35,701	43	0	0				
				29,702	64	5	1				
209,314	**750**	**161**	**125**	**120,549**	**418**	**27**	**2**	**56,754**	**455**	**47**	**10**
Per 1000	**3.583**	**0.769**	**0.597**		**1.997**	**0.129**	**0.010**		**2.174**	**0.225**	**0.048**

MC+ REGION COMPARISON
CY 2005 Provider Complaints
(Per 1000 Members)



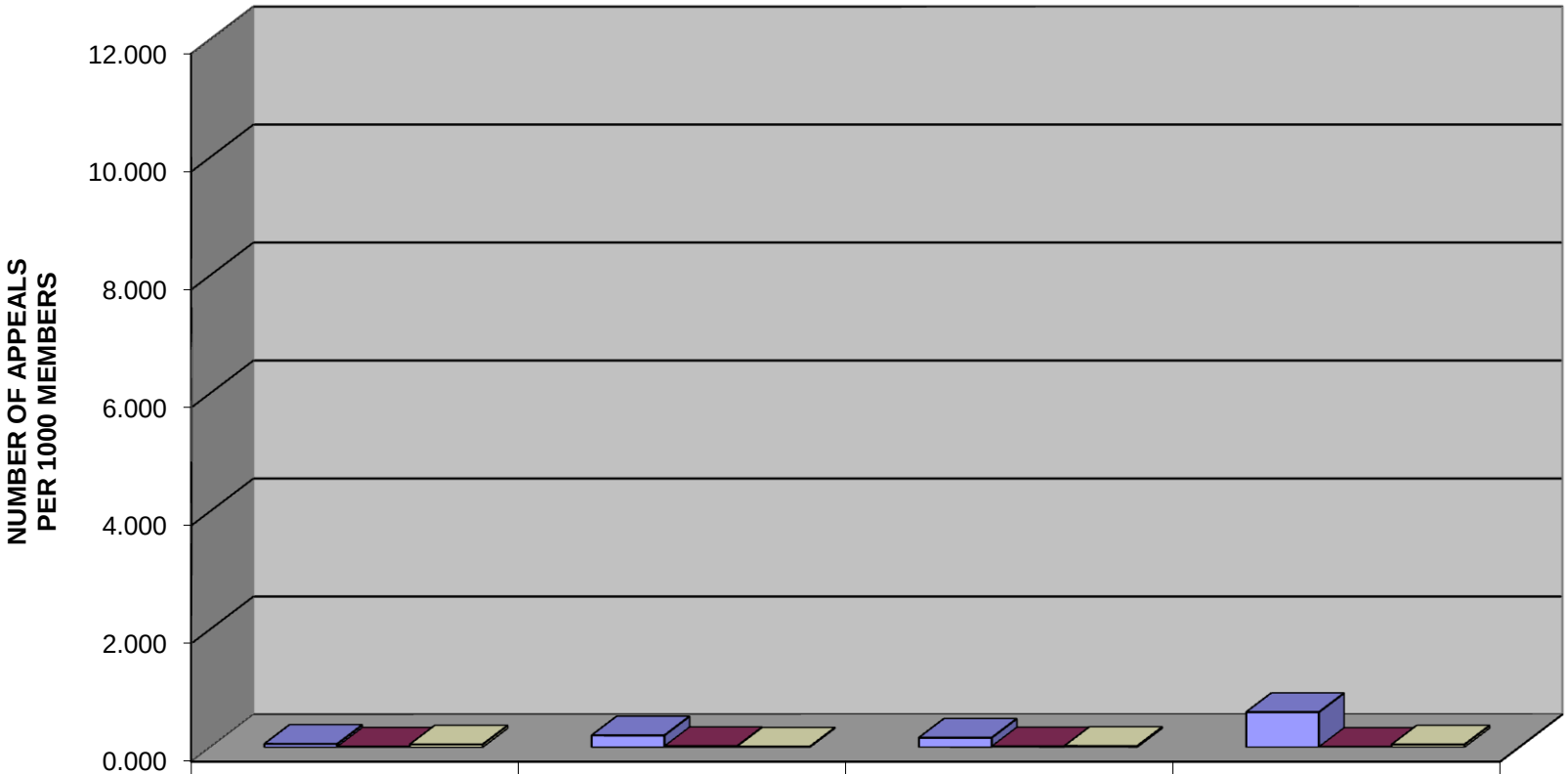
	1 Q 05	2 Q 05	3 Q 05	4 Q 05
Eastern Region	6.944	6.033	6.179	3.583
Western Region	1.247	1.032	1.156	1.997
Central Region	2.937	2.038	2.662	2.174

MC+ REGION COMPARISON
CY 2005 Provider Grievances
(Per 1000 Members)



	1 Q 05	2 Q 05	3 Q 05	4 Q 05
Eastern Region	1.422	0.819	0.564	0.769
Western Region	0.100	0.055	0.059	0.129
Central Region	0.205	0.272	0.146	0.225

MC+ REGION COMPARISON
CY 2005 Provider Appeals
(Per 1000 Members)

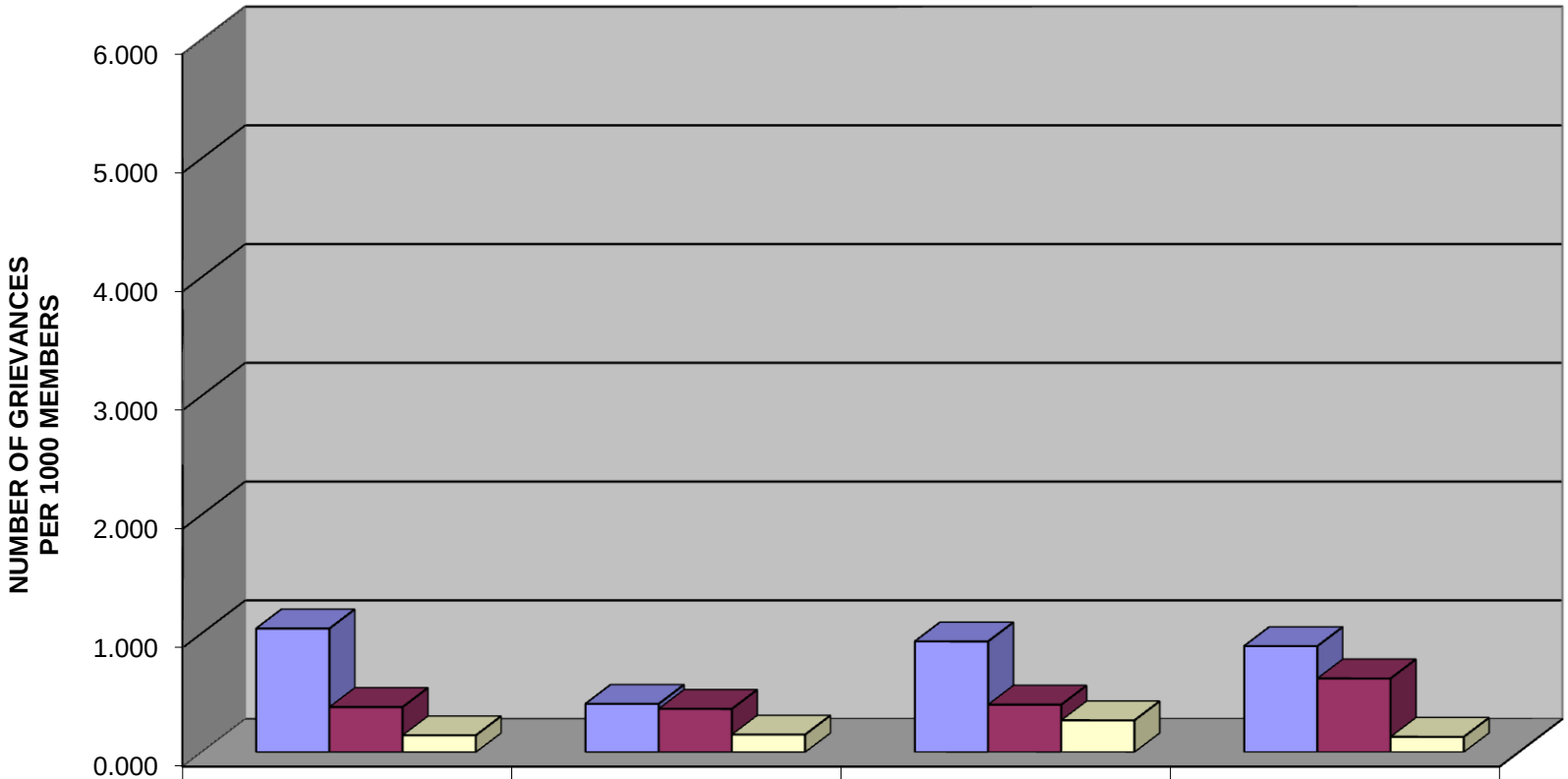


	1 Q 05	2 Q 05	3 Q 05	4 Q 05
Eastern REgion	0.059	0.204	0.164	0.597
Western Region	0.013	0.021	0.018	0.010
Central Region	0.050	0.013	0.023	0.048

Member Grievance and Appeals CY 2005 - All Plans
Average Region/Quarterly Enrollment
(Per 1000 Members)

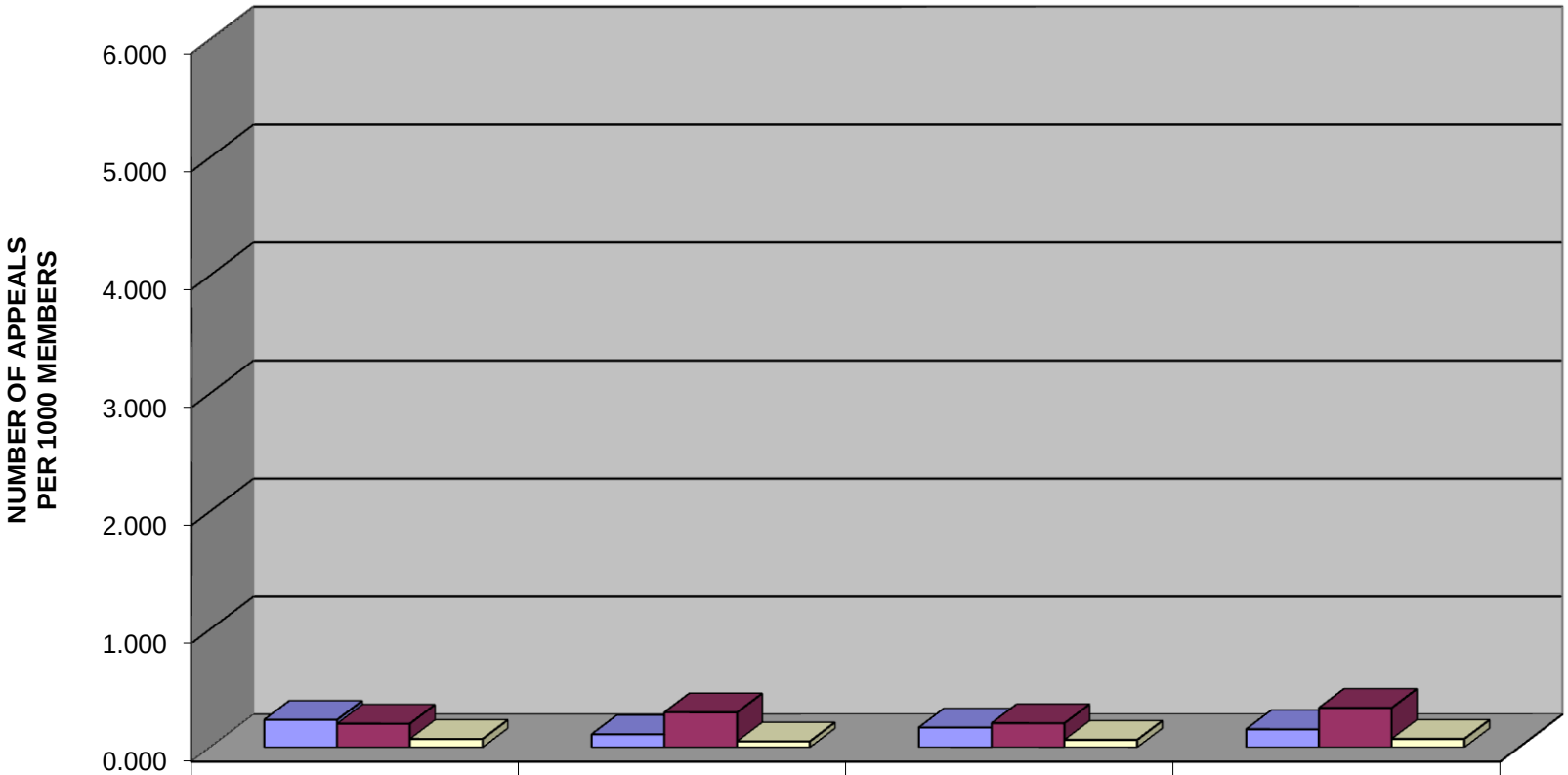
1 Q 05								
East	Griev	Appeal	West	Griev	Appeal	Central	Griev	Appeal
144,267	218	52	10,497	9	3	29,273	15	9
46,822	5	0	51,423	40	34	35,589	19	8
47,954	26	4	41,390	22	4			
			34,291	20	7			
239,043	**249**	**56**	**137,601**	**91**	**48**	**64,862**	**34**	**17**
Per 1000	**1.042**	**0.234**		**0.381**	**0.201**		**0.142**	**0.071**
2 Q 05								
East	Griev	Appeal	West	Griev	Appeal	Central	Griev	Appeal
141,524	61	7	10,464	5	1	28,249	13	2
45,855	18	13	50,351	39	29	34,908	22	10
48,153	17	6	40,514	18	36			
			33,469	24	4			
235,532	**96**	**26**	**134,798**	**86**	**70**	**63,157**	**35**	**12**
Per 1000	**0.408**	**0.110**		**0.365**	**0.297**		**0.149**	**0.051**
3 Q 05								
East	Griev	Appeal	West	Griev	Appeal	Central	Griev	Appeal
132,310	157	24	9,761	20	0	26,289	37	5
42,176	30	6	47,070	36	20	32,881	22	9
45,297	18	7	37,471	9	18			
			29,702	23	7			
219,783	**205**	**37**	**124,004**	**88**	**45**	**59,170**	**59**	**14**
Per 1000	**0.933**	**0.168**		**0.400**	**0.205**		**0.268**	**0.064**
4 Q 05								
East	Griev	Appeal	West	Griev	Appeal	Central	Griev	Appeal
125,435	146	32	9,983	65	4	25,097	19	13
39,971	26	0	45,163	27	17	31,657	8	2
43,908	15	0	35,701	8	37			
			29,702	30	12			
209,314	**187**	**32**	**120,549**	**130**	**70**	**56,754**	**27**	**15**
Per 1000	**0.893**	**0.153**		**0.621**	**0.334**		**0.129**	**0.072**

MC+ REGION COMPARISON
CY 2005 Member Grievances
(Per 1000 Members)



	1 Q 05	2 Q 05	3 Q 05	4 Q 05
Eastern Region	1.042	0.408	0.933	0.893
Western Region	0.381	0.365	0.400	0.621
Central Region	0.142	0.149	0.268	0.129

MC+ REGION COMPARISON
CY 2005 Member Appeals
(Per 1000 Members)



	1 Q 05	2 Q 05	3 Q 05	4 Q 05
Eastern Region	0.234	0.110	0.168	0.153
Western Region	0.201	0.297	0.205	0.334
Central Region	0.071	0.051	0.064	0.072

MC+ MANAGED CARE ANNUAL EVALUATION

MARKETING

MARKETING

The MC+ Managed Care health plans must submits its proposed marketing plan, all marketing materials, and member education materials to the state for written approval prior to use. Below is the total of marketing/education materials for FY2006 (July 2005 through June 2006) for each plan as well as for Policy Studies, Inc., Missouri Primary Association and Legal Aid of Western Missouri.

Blue –Advantage Plus of Kansas City

Total submissions	40
Total approvals	37
Initial approvals	16
Approvals/changes	04
Requested revisions	17
Non-approvals	03

Community Care Plus

Total submissions	71
Total approvals	68
Initial approvals	32
Approvals/changes	00
Requested revisions	36
Non-approvals	03

FirstGuard Health Plan

Total submissions	97
Total approvals	84
Initial approvals	26
Approvals/changes	02
Requested revisions	56
Non-approvals	13

Children's Mercy Family Health Partners

Total submissions	60
Total approvals	47
Initial approvals	14
Approvals/changes	10
Requested revisions	23
Non-approvals	13

HealthCare USA

Total submissions	133
Total approvals	122
Initial approvals	47
Approvals/changes	29

Requested revisions	46
Non-approvals	11

Harmony Health Plan of Missouri

Total submissions	38
Total approvals	27
Initial approvals	07
Approvals/changes	09
Requested revisions	11
Non- approvals	09
Revision status	02

Mercy CarePlus

Total submissions	03
Total approvals	03
Initial approvals	01
Approvals/changes	01
Requested revisions	01
Non-approvals	00

Mercy Health Plan

Total submissions	31
Total approvals	21
Initial approvals	09
Approvals/changes	03
Requested revisions	09
Non-approvals	10

Missouri Care

Total submissions	41
Total approvals	36
Initial approvals	16
Approvals/changes	04
Requested revisions	16
Non-approvals	04
Revisions status	01

Missouri Primary Association

Total submissions	04
Total approvals	04
Initial approvals	02
Approvals/changes	02
Requested revisions	00
Non-approvals	00

Policy Studies, Inc.

Total submissions	12
Total approvals	11
Initial approvals	03
Approvals/changes	01
Requested revisions	07
Non-approvals	01

Legal Aid of Western Missouri

Total submissions	02
Total approvals	02
Initial approvals	01
Approvals/changes	01
Requested revisions	00
Non-approvals	00

The MC+ Managed Care health plans are to correct problems and errors with the marketing plan and/or material as identified by the state. The MC+ Managed Care health plans shall submit written corrected marketing plan or revised material within ten (10) business days following receipt date of the written notice from the state.

The average time taken to approve materials that are sent to the plans with revisions before final approval by the state is less than six days.

Marketing/Education Materials

Some required MC+ Managed Care health plan marketing/education materials shall include: A listing of in-network providers, member's rights and responsibilities, general MC+ eligibility information, member education on how to use a health plan, and how to assert certain rights with their health plan, member benefits, new member orientation, member handbook, and provider directory. Below is a list of marketing/education materials submitted by the MC+ Managed Care health plans, some materials were also submitted in Spanish:

Member Handbooks/Provider Directory
Marketing Plan
Happy Birthday Mailings
Member Newsletters
Well Women Mailings
Member Identification Cards
Open Enrollment Letters, Flyers, Billboards, Mailers
Prenatal Education
Post-Partum Depression
Grievance and Appeals Letters

Pharmacy Lock-In Letters
Lead Education Materials
Immunizations (Shots)
Early Periodic Screening, Diagnosis and Treatment (EPSDT)
Emergency Room Education
Asthma Education
Dental Education
Diabetes Education
Sickle Cell Education
ADHD Information
ADD Information
Smoking Education
MC+ Information Brochures
Case Management Letters
Health Plan Website Information
Pneumonia Education
Flu Education
Obesity Education

Total MC+ Managed Care Health Plan Marketing/Education Submissions for 2005*
514
**Total does not include Missouri Primary Association, PSI and Legal Aid of Western Missouri*.

Total Submissions Western Region 2005
197

Total Submissions Eastern Region 2005*
276
**HealthCare USA and Mercy CarePlus are counted in Eastern Region only*.

Total Submission Central Region 2005
41

Total marketing/education material submitted by MC+ Managed Care health plans in 2004 was 321. We had an additional 193 submissions in 2005 with one additional health plan.

MC+ MANAGED CARE ANNUAL EVALUATION

MISCELLANEOUS INFORMATION

MISCELLANEOUS INFORMATION

Legal Aid of Western Missouri
MC+ Advocacy Project

Reporting Period: January 1, 2006 through June 30, 2006

I. Executive Summary

The past six months for the MC+ Advocacy Project at Legal Aid of Western Missouri has been a period of extensive outreach efforts and work with community health groups, task forces on health issues, and area hospitals. Planning for town hall forums on health care issues, working with the Local Investment Commission on their Health Committee, participating in the MC+ Consumer Task Force, and planning and participating in the Covering the Uninsured Week have been major involvement and contribution areas for the project during this period. Training regarding a number of MC+ coverage issues and changes in Medicaid provisions has been provided to the hospitals serving the largest percentage of the poverty and children population in this region.

Legal Aid of Western Missouri offices on site at Truman Medical Center-Hospital Hill and Truman Medical Center Lakewood have afforded access to clients having questions or issues relating to MC+ coverage and eligibility on a daily basis. As a result, advice and legal assistance with application questions, coverage provisions, or eligibility issues can be provided to a significant number of Medicaid enrollees and applicants. Representation regarding recipient liability in court cases, administrative hearings regarding coverage issues and hearings relating to coverage determinations are ongoing individual representation provided to Medicaid claimants by the MC+ Advocacy Project.

II. Client Data

A. Cases by County:

County	**Number of Cases**
Jackson	74
Clay	11
Platte	6
Cass	1
Johnson	
Ray	
Lafayette	
Henry	
St. Clair	
Total:	92

B. Cases by Health Plan:

Health Plan	**Number of Cases**
Blue Advantage Plus	4
Family Health Partners	7
FirstGuard	13
HealthCare USA	0
MercyCarePlus	0

C. Total Number of Applicants: 19
Total Number of Enrollees: 73

D. Cases by Problem Type:

Mental Health	1
Dental	1
Pharmacy	
Transportation	
Specialty Care	1
Primary Care	
Maternity Care	
Hospital Care	
Ancillary Services	1
Availability of and Access to Providers	2
Eligibility	71
Enrollment	5
Recipient Liability	7
General Questions	3

E. Cases by Resolution:

MC+ Advocacy Project	55
BA+ Complaint Grievance and Appeals	
FHP Complaint Grievance and Appeals	
Healthcare USA Complaint Grievance and Appeals	
FirstGuard Complaint Grievance and Appeals	1
State Fair Hearings	2
FSD	26
DMS Recipient Services	3

Other	
Court settlement/disposition	2
Client withdrew w/o resolution	2
Resolve with provider	2

III. Outreach Activities

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
JANUARY				
01/03/2006	McCoy Elementary Caring Comm.- Parent/Teacher Conferences	Sent materials	Dist. Project and MC+ info.	N/A
01/03/2006	Jackson County Health Dept.	Sent materials	Dist. Project and MC+ info.	N/A
01/04/2006	Cass Co WIC Office	Sent materials	Dist. Project and MC+ info.	N/A
01/04/2006	Holy Family House	Sent materials	Dist. Project & MC+ info.	N/A
01/04/2006	Mo. Baptist Children's Home	Sent materials	Dist. Project & MC+ info.	N/A
01/05/2006	Operation Break-through/Pro-Vote Workshop	Attend Meeting	Dist. MC+ & project info.	15
01/06/2006	Henry County WIC Office	Sent materials	Dist. Project & MC+ info.	N/A
01/06/2006	Ray Co WIC Office	Sent materials	Dist. Project & MC+ info.	N/A
01/09/2006	Woodland Elem. Head Start	Presentation	Dist. Project& MC+ info.	6
01/09/2006	Fairmount Elem. Head Start	Presentation	Dist. Project & MC+ info.	3

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
01/10/2006	Douglass Head Start	Presentation	Dist. Project & MC+ info.	10
01/10/2006	Guadalupe Center	Meeting	Disc. Proj. MC+ info.	1
01/10/2006	Johnson County WIC	Sent materials	Dist. Proj. & MC+ info.	N/A
01/10/2006	Family Health Partners-Member Advisory Comm. Meeting	Meeting	Dist. Project & MC+ info.	10
01/11/2006	Franklin Elem. Head Start	Presentation	Dist. Proj. & MC+ info.	6
01/13/2006	Synergy Services Inc.	Sent materials	Dist. Proj. & MC+ info.	N/A
01/13/2006	Maternal Child Health Coalition	Meeting Town Hall	Planning Mtg. For Town Hall	8
01/16/2006	Coalition of Hispanic Organizations	Meeting	Attended Coalition Meeting	35
01/17/2006	Douglas Head Start	Presentation	Dist. Proj. and MC+ info.	5
01/18/2006	De la Salle Education Center	Presentation	Dist. Proj. and MC+ info.	20
01/18/2006	Moheart/Linwood Community Center	Presentation	Dist. Proj and MC+ info.	8
01/19/2006	Randall Caring Communities Site Meeting	Presentation	Dist. MC+ & project info.	20
01/19/2006	Santa Fe Trail-Winterfest	Information table	Dist. MC+ & project info.	40
01/20/2006	Maternal Child Health Coalition	Information table & Presentation	Dist. MC+ & project info.	60

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
01/23/2006	Mattie Rhodes Counseling Center	Meeting	Dist. MC+ & project info.	1
01/23/2006	Guinotte Head Start	Presentation	Dist. MC+ & project info.	5
01/24/2006	Platte County WIC	Sent materials	Dist. MC+ & project info.	N/A
01/05/2006	Operation Break-through/Pro-Vote Workshop	Attend Meeting	Dist. MC+ & project info.	15
FEBRUARY				
02/03/2006	Coalition of Hispanic Organizations	Meeting & Presentation	Dist. MC+ & project info.	40
02/09/2006	Henry County CHART Meeting	Presentation	Dist. MC+ & project info.	35
02/09/2006	Henry County Housing Authority	Site visit	Dist. MC+ & Project info.	4
02/09/2006	Henry County FSD	Site visit	Dist. MC+ & Project info.	3
02/09/2006	Henry Elementary	Site Visit	Dist. MC+ & Project info.	3
02/09/2006	Henry County Hospital	Site visit	Dist. MC+ & project info.	1
02/13/2006	Division of Workforce Development	Sent materials	Dist. MC+ & project info.	200
2/13/06-2/17/06	Truman Medical Center-Truman Baby Shower Event	Presentation & Information table	Dist. MC+ & project info.	50
02/23/2006	Metropolitan Lutheran Ministries	Sent materials	Dist. matl & info.	N/A

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
02/23/2006	Brushcreek Community Center	Site visit	Dist. matl & project info.	N/A
02/23/2006	YMCA Childcare Center	Site visit	Dist. matl & project info.	N/A
02/23/2006	Crittenton Behavioral Health of Blue Springs	Sent materials	Dist. MC+ & project info.	N/A
02/23/2006	Gillis Center	Sent materials	Dist. MC+ project info.	N/A
02/27/2006	Mexican Consulate Health Event	Information table	Dist. Matl & info.	60
MARCH				
03/01/2006	Missouri Association of Social Welfare Conference	Attend conference	Dist. info & materials	100
03/08/2006	Truman Medical Center HIV+ Women's Support Group	Presentation	Dist. MC+ project materials	4
03/08/2006	El Centro Case Manager Meeting	Presentation	Dist. MC+ & project materials	15
03/08/2006	Grtr KC Chamber of Commerce	Meeting	Disc & matl	1
03/08/06	TMC HIV+ Women's Support Group	Medicaid Legal Issue Present.	Pres. & ?s	4
03/09/2006	Northland Unmet Needs Council	Site visit	Dist. MC+ materials	2
03/13/2006	St. Stephen's Academy	Site Visit	Dist. MC+ materials	N/A
03/14/2006	Child Abuse Prevention Assoc.	Site visit & Presentation	Dist. MC+ & project info.	25
03/14/2006	Robinson School Health Fair	Information booth	Dist. MC+ & project info.	115

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
03/15/2006	Women's issues Forum	Information booth	Dist. MC+ & project info.	10
03/16/2006	Northeast Advisory and Access Group	Attend Meeting	Dist. MC+ & project info.	45
03/17/2006	Community Response Team- Northland Synergy Services	Presentation	Dist. MC+ & project info.	15
03/17/2006	Truman Child Health & Safety	Presentation	Dist. MC+ & project info.	10
03/18/2006	Genesis School FHP Health Event	Presentation	Dist. MC+ & project info.	7
03/23/2006	Dislocated Workers Program- Morning Session	Presentation	Dist. MC+ & project info.	70
03/23/2006	Dislocated Workers Program- Afternoon Session	Presentation	Dist. MC+ & project info.	45
03/28/2006	Panda Place Wellness Center	Letter	Dist. MC+ & project info.	N/A
03/28/2006	Cover the Uninsured Week Cmmttee Meeting	Attend Meeting	Dist. MC+ & project info.	12
03/29/2006	Fire Prairie/Ft. Osage Health Fair	Information booth	Dist. MC+ & project info.	80
03/30/2006	Hawthorne Place FHP Health Event	Information booth	Dist. MC+ & project info.	15
03/31/2006	Douglass Headstart Health Fair	Information booth	Dist. MC+ & project info.	75
03/31/2006	Thornbury Boys and Girls Club	Site visit	Dist. MC+ & project info	N/A
APRIL				
04/06/2006	KCMOSD ESL Program- Thatcher Multicultural Bld	Site visit & Meeting	Dist. MC+ & project info.	2

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
04/06/2006	Clinton Parents as Teachers	Letter	Dist. MC+ & project info.	N/A
04/07/2006	Women's Healthcare Symposium	Information booth	Dist. MC+ & project info.	70
04/10/2006	LINC Health Committee Meeting	Meeting	Dist. MC+ & project info.	25
04/10/2006	Ft. Osage PTA Easter Egg Hunt	Information booth	Dist. MC+ & project info.	100
04/11/2006	Covering the Uninsured Week Meeting	Meeting	Dist. MC+ & project info.	10
04/12/2006	Dislocated Workers Program-Morning Session	Presentation	Dist. MC+ & project info.	75
04/12/2006	Dislocated Workers Program- P.M. Session	Presentation	Dist. MC+ & project info.	30
04/12/2006	Johnson County Human Services Meeting	Presentation & Meeting	Dist. MC+ & project info.	12
04/12/2006	Warrensburg Housing Authority	Site visit	Dist. MC+ & project info.	N/A
04/13/2006	RWJ Statewide MC+ Coalition	Meeting	Dist. MC+ & project info.	40
04/19/2006	Covering the Uninsured Week Meeting	Meeting & Site visit	Site visit & initial plans	N/A
04/21/2006	COHO Health Committee Meeting	Meeting	Dist. MC+ & project info.	10
04/26/2006	Metro. Task Force on Drug Exposed Infants	Presentation	Legal issues & ? session	14
04/27/2006	Truman Medical Ctr. Childcare Class	Presentation	Dist. MC+ & project info.	15

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
04/27/2006	Community Together	Meeting & Information table	Dist. MC+ & project info.	45
04/28/2006	Maternal Child Health Coalition	Meeting & Information table	Dist. MC+ & project info.	35
04/30/2006	Día de los niños @ St. Stephen's Academy	Information booth	Dist. MC+ & project info.	200
MAY				
05/01/2006	Call for Action-Covering the Uninsured Week	Answer phones	Dist. MC+ & project info.	250
05/03/2006	Neighborhood Services Meeting	Presentation & Info. table	Dist. MC+ & project info.	70
05/03/2006	CTUW Health Fair Meeting	Meeting	Discuss Fair logistics	N/A
05/04/2006	Small Business Breakfast-Covering the Uninsured Week	Information table	Dist. MC+ & project info.	30
05/08/2006	Follow up To Call for Action callers	Letters	Application information	8
05/09/2006	Cass County CHART Meeting	Meeting, Presentation & dist. info.	Meeting, dist. Info & answer ?s	15
05/10/2006	Meeting W/First Guard at Gregg Klice Center	Meeting	Visit Fair site and discuss logistics	N/A
05/11/2006	Northeast Middle School ESL Awards Banquet	Information table	Dist. MC+ & project info.	200
05/11/2006	FHP Consumer Health Event	Information table	Project & MC+ info	15

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
05/16/2006	Covering the Uninsured Week	Meeting	Discuss Fair logistics	N/A
05/17/2006	Covering the Uninsured Week Health Fair Mtg.	Meeting	Discuss Fair logistics	N/A
05/17/2006	Mattie Rhodes Counseling Center	Meeting	Disc/ re MC+ & project	1
05/18/2006	Northeast Advisory and Access Group	Meeting	Re health issues and community concerns	30
05/22/2006	Covering the Uninsured Week Health Fair Committee Mtg.	Meeting	Finalize logistics for CTUW health fair	N/A
05/23/2006	Cosby Call Out Event-Penn Valley Community College	Information table	Dist. MC+ & project info.	25
05/24/2006	Chilhowee School	Letter	Dist. MC+ & project info.	N/A
05/25/2006	St. Ann's School	Letter	Dist. MC+ & project info.	N/A
05/26/2006	Truman Medical Ctr. Behavioral Health	Meeting	Meeting re MC+ info and project	2
JUNE				
06/01/2006	First Guard	Meeting	Finalize CTUW health fair plans	N/A
06/02/2006	Gregg Klice	Meeting	Finalize logistics for CTUW fair	N/A
06/03/2006	Covering the Uninsured Week (CTUW)	Information booth	Dist. Project and MC+ info.	200

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
06/07/2006	Missouri Children's Division Resource Fair	Information booth	Dist. Proj. and MC+ info.	300
06/09/2006	Mattie Rhodes-Visions w/Hope	Site visit	Dist. Proj. and MC+ info.	85
06/10/2006	Cabott Westside Clinic	Information booth	Dist. Proj. and MC+ info.	100
06/12/2006	Truman Medical Center-New Mom's support group	Presentation	Dist. Project and MC+ info.	25
06/13/2006	St. Luke's Hospital-Teen Mom's Support Group	Presentation	Dist. Project and MC+ info.	15
06/13/2006	St. Luke's Hospital-Teen Mom's Support Group (Spanish)	Presentation	Dist. Project and MC+ info.	7
06/13/2006	St. Luke's Hospital-Case Management Services	Meeting	Dist. Project and MC+ info.	2
06/13/2006	St. Luke's Hospital- Charity Management	Meeting	Dist. Project and MC+ info.	2
06/14/2006	Truman Medical Center-OB Clinic	Information booth	Dist. Project and MC+ info.	20
06/15/2006	Robert Wood Johnson Statewide MC+ Coalition	Meeting	Dist. Project and MC+ info.	35

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
06/20/2006	St. Luke's Hospital	Letter	Dist. Proj. and MC+ info.	N/A
06/21/2006	MC+ Consumer Advisory Council	Meeting	Dist. Proj. and MC+ info.	30
06/22/2006	Truman Medical Center-Newborn Care Class	Presentation	Dist. Project and MC+ info.	15
06/23/2006	LINC Health Task Force Committee	Meeting	Meeting & dist. MC+ info.	18
06/23/2006	Swope Health Centers	Site visit	Dist. Proj. and MC+ info.	N/A
06/24/2006	Independence Headstart-Citywide Children's Fair	Information booth	Dist. Project and MC+ info.	300
06/27/2006	Coalition of Hispanic Organizations	Letter	Dist. Proj. and MC+ info.	N/A
06/27/2006	St. Luke's Hospital	Letter	Dist. Proj. and MC+ info.	N/A
06/27/2006	Truman Medical Center OB Clinic	Letter	Dist. Project and MC+ info.	N/A
06/28/2006	Excelsior Springs Medical Center	Information booth	Dist. Project and MC+ info.	100
06/29/2006	Binational Health Week Steering Committee	Meeting	Dist. Project and MC+ info.	18

IV. Concerns from Western Missouri

Throughout the last six months, the Project has seen continuing problems with the ex parte review process to be afforded claimants in MC+ cases. Many Eligibility Specialists are not familiar with the requirements for an ex parte review and terminate MC+ recipients with no review of possible eligibility under other Medicaid programs. It is the receipt of Social Security disability benefits which often renders a parent ineligible for continuing Medical Assistance for Families coverage, but many times the Eligibility Specialist fails to review eligibility under the adult Medical Assistance programs before terminating the Medicaid coverage of the parent. It is usually necessary to contact a supervisor with the Family Support Division before these issues are resolved for claimants.

The premium costs for the CHIP group are a continuing concern of claimants contacting Legal Aid of Western Missouri. There are still numerous budgeting errors made by Eligibility Specialists in determining whether a family must pay premiums and the amount of the premiums. It is hoped that the recent changes in premium assessment will alleviate some of the burden on these CHIP households. However, it is also likely that this change will result in additional errors and will require close scrutiny and review of the budgeting in these premium cases.

The accessibility of Eligibility Specialists is a major complaint of claimants. Many applicants and enrollees call our Project after they have tried numerous times to contact their Eligibility Specialists for answers to very basic questions on premium determinations, addition of children to their MC+ case, changes in the household situation that they are trying to report, or to determine the status of their application. Given the large caseloads of most Eligibility Specialists, the new citizenship and strict reinvestigation requirements are going to exacerbate the problem of allocating time to client questions and concerns.

It is anticipated that numerous claimants will experience difficulty with the citizenship verification requirements and that Legal Aid will be assisting and working with the Division in many of these cases to comply with the mandatory provisions on citizenship and identity verification. Our clients in domestic violence shelters and those with very limited income may have great difficulty in obtaining access to the verification required. Lack of Medicaid coverage while citizenship verification is being obtained will be a major problem for many of our clients. We can only hope that some of these requirements may be eased by the federal government. Legal Aid is committed to assisting clients and the Division workers in every way possible to meet these requirements. We will also be reviewing cases very closely to insure that Division staff understands and is properly implementing the citizenship and identity provisions.

Publications

The following information was provided by the MC+ Managed Care health plans regarding participation in publications. Below is a brief summary of each publication. The complete publications are attached.

Children's Mercy Family Health Partners

CMFHP's asthma disease management program was published in CHCS's (Center for Health Care Strategies) Toolkit for Asthma Best Practices.

http://www.chcs.org/usr_doc/AchievingBetterCareforAsthmaToolkit.pdf

Mercy CarePlus (formerly Community Care Plus)

Pediatric Liver Transplant Recipients: Mortality Analysis Over 20 years

Orthotropic liver transplantation (OLT) has become standard and accepted care for pediatric patients with end-stage liver disease. Two large pediatric OLT series are analyzed to determine excess death rates (EDR) over 20 years. The EDR decreases over time and is lower with more recent transplant recipients who have benefited from improved tacrolimus-based immunosuppression and transplant techniques. Fifteen to 20 year EDR is 5 deaths/1000. Biliary atresia is the most common pediatric indication, and these recipients do better than those with other types of liver disease. Most deaths occur in the first post-transplant year, with infection being the largest cause.

The Medical Conversation

When life insurance underwriters are faced with difficult impaired-risk cases, the medical director can be a valuable resource. There must be good communication between the UW and MD for effective exchange of information. The underwriter must explain the applicant's salient familial, social and medical history to the MD in a format that can be followed and analyzed. Medical directors have been trained in the art of case presentation, but this skill is not typically taught to underwriters. Underwriters must be taught how to present cases, and be given adequate practice opportunities with constructive criticism by the MD. The development of an effective case presentation, a medical conversation, allows accurate exchange of information and is central to the education process of the underwriter.

HealthCare USA

17 Alpha-Hydroxyprogesterone Caproate (17P)Usage in a Medicaid Managed Care Plan and Reduction in Neonatal Intensive Care Unit Days

Offerring 17P as a benefit to pregnant women enrollees with a history of preterm delivery can reduce NICU days significantly for a Medicaid plan.

CHCS

Center for
Health Care Strategies, Inc.

Achieving Better Care for Asthma

TOOLKIT

Best Clinical and Administrative Practices for Medicaid Health Plans

CHCS Center for Health Care Strategies, Inc.

Achieving Better Care for Asthma

A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans

About the Center for Health Care Strategies

The Center for Health Care Strategies promotes high quality health care services for low-income populations and people with chronic illnesses and disabilities. We achieve this objective through awarding grants and providing "real world" training and technical assistance to state purchasers of publicly financed health care, health plans, and consumer groups. Our projects aim to improve access to care, increase the use of effective preventive care services, prevent unnecessary hospitalizations and institutionalizations, promote clinical quality by using accepted standards of care, and build organizational capacity to improve managed care services.

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For additional copies

Additional copies can be downloaded or ordered online at www.chcs.org, or by calling 609.895.8101.

Achieving Better Care for Asthma

A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans

November 2002

Table of Contents

Acknowledgements

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Special recognition goes to the members of the *Achieving Better Care for Asthma* workgroup for their generosity, patience, and good humor during the production of this toolkit. Your efforts to improve asthma care for people served by Medicaid and the State Children's Health Insurance Program are inspirational to us all.

Preface

Best Clinical and Administrative Practices (BCAP) is a five-year, $4.4 million initiative of the Center for Health Care Strategies (CHCS) to improve the quality and cost effectiveness of care provided by health plans serving Medicaid and State Children's Health Insurance Program (SCHIP)* enrollees. The program is funded primarily with a major grant by The Robert Wood Johnson Foundation, with additional support from The Commonwealth Fund.

BCAP targets key areas for quality improvement within Medicaid managed care, including birth outcomes, preventive care services for children, achieving better care for asthma, children with special health care needs, adults with chronic illnesses and disabilities, and early child development services. For each topic, BCAP convenes a workgroup of eight to 15 health plan medical directors and other health plan decision makers to develop and pilot best practices. These best practice models are shared with health plans nationwide through workshops and toolkits.

The BCAP *Achieving Better Care for Asthma* workgroup convened 11 health plans that worked collaboratively to develop and pilot best practices for more effective asthma care. In the last decade, a great deal of work has been done to develop and implement programs to improve care for people with asthma. Despite these efforts, however, asthma care for people in low-income families remains a challenge. Systems of care often are fragmented and many providers need the necessary knowledge and support to address the needs of these individuals. Improvements in the medical management of asthma depend on coordinating efforts among providers to address simultaneously the medical needs and personal circumstances that interfere with health outcomes. The move by many states to provide health services to low-income families through managed care arrangements presents an opportunity to improve the management of asthma.

*Activities in this toolkit relate to both Medicaid and State Children's Health Insurance Program enrollees. To simplify text, Medicaid is used throughout the toolkit to represent both populations.

[1] *The Evolution of the Oregon Health Plan: First Interim Report*. Health Care Financing Administration. Springfield, VA, National Technical Information Service, 1999.

[2] Brodsky KL and Baron RJ. "A 'Best Practices' Strategy to Improve Quality in Medicaid Managed Care Plans." *Journal of Urban Health*, December 2000.

Using this Toolkit to Benefit Your Health Plan

This toolkit offers a structured approach for addressing quality improvement and a collection of "lessons learned" by a diverse group of health plans serving Medicaid members. Whether your health plan intends to develop a new asthma management program or is seeking to improve an existing program, this toolkit offers practical, realistic approaches that can help you:

- Recognize common barriers faced by Medicaid plans in achieving better care for members with asthma.
- Develop strategies to overcome these barriers.
- Review clinical and administrative strategies that other health plans have implemented.
- Measure incremental and long-term change.

As reported by the National Asthma Education and Prevention Program (NAEPP) Task Force, most health plan leaders agree that it is important to develop programs supporting better care for asthma because:[3]

- More than 12 million people in the United States suffer from asthma, five million of whom are under the age of 18.
- Asthma disproportionately affects the urban poor.
- Children from low-income populations and certain racial and ethnic groups are more likely to report fair or poor health due to asthma.[4]
- Despite many advances in the treatment of asthma, the rates of asthma-related hospitalizations and emergency department visits have risen steadily.
- In 1990, the health care costs of asthma amounted to $3.4 billion. By 1996, that figure rose to $4.6 billion *just for children with asthma*.[5]

How this Toolkit is Organized

The toolkit begins with a brief discussion of the process improvement model used in BCAP. It then presents the BCAP "Typology for Improvement" developed for the *Achieving Better Care for Asthma* workgroup, followed by a separate chapter covering each typology category. For each typology category, an inventory of change strategies is listed, followed by case studies of innovative pilot projects of this workgroup. The next chapter describes methods to improve provider practices in designing more effective asthma management services. The last chapter outlines effective communication tactics to facilitate change. Finally, the Appendices provide sample tools from BCAP workgroup health plans and other relevant materials.

[3] National Asthma Education and Prevention Program Task Force Report on the Cost-Effectiveness, Quality of Care, and Financing of Asthma Care. *American Journal of Respiratory Critical Care Medicine*, 1996.

[4] Summers LL and Simpson J. *Asthma Care for Children: Financing Issues*. Center for Health Care Strategies, October 2001.

[5] Center on an Aging Society analysis of data from the *1996 Medical Expenditure Panel Survey*.

How this Toolkit was Developed

The contents of this toolkit reflect the experiences of the *Achieving Better Care for Asthma* workgroup, a group of 11 health plans that collaborated to develop and pilot best practices for improving asthma outcomes in their enrollee populations.

The health plans in the *Achieving Better Care for Asthma* workgroup continue to refine their BCAP-related quality improvement strategies and actively participate in the BCAP Network, an alliance of health plans joined by the common goal of furthering the quality and cost-efficiencies of Medicaid managed care.

Throughout this toolkit, you will learn from the projects undertaken by these health plans. Some of them have demonstrated impressive results and chart paths you may want to follow. Some of them provide clear documentation of hypotheses that have yet to realize the intended results. All are works in progress, and they have been selected by the authors because they each have lessons to impart.

Table 1: *Achieving Better Care for Asthma* Workgroup Health Plans

Health Plan	Location	Medical Director Participant	Number of Medicaid Members*
Affinity Health Plan	Bronx, NY	Susan Beane, MD	83,700
AmeriChoice Northeast	New York, NY	Steven Arnold, MD	258,000
CareOregon	Portland, OR	David Labby, MD	88,000
Cimarron Health Plan	Albuquerque, NM	Stephen Ryter, MD	66,330
Community Health Plan of Washington	Seattle, WA	Melicent Whinston, MD	112,858
Health Plus	Brooklyn, NY	Arthur Levin, MD	148,000
University of Oklahoma dba Heartland Health Plan of Oklahoma	Oklahoma City, OK	Kathy Musser, MD**	115,733
Network Health	Cambridge, MA	Allan Kornberg, MD	45,000
Partnership HealthPlan of California	Suisun City, CA	Chris Cammisa, MD	77,000
Passport Health Plan	Louisville, KY	Jacqueline Simmons, MD	118,000
UCare Minnesota	Minneapolis, MN	Craig Christianson, MD	75,000
Total Medicaid Membership			***1,187,621***

*Plan estimates as of August 2002.

** Dr. Musser left the health plan in July 2002.

Measuring for Success: A Process Improvement Strategy

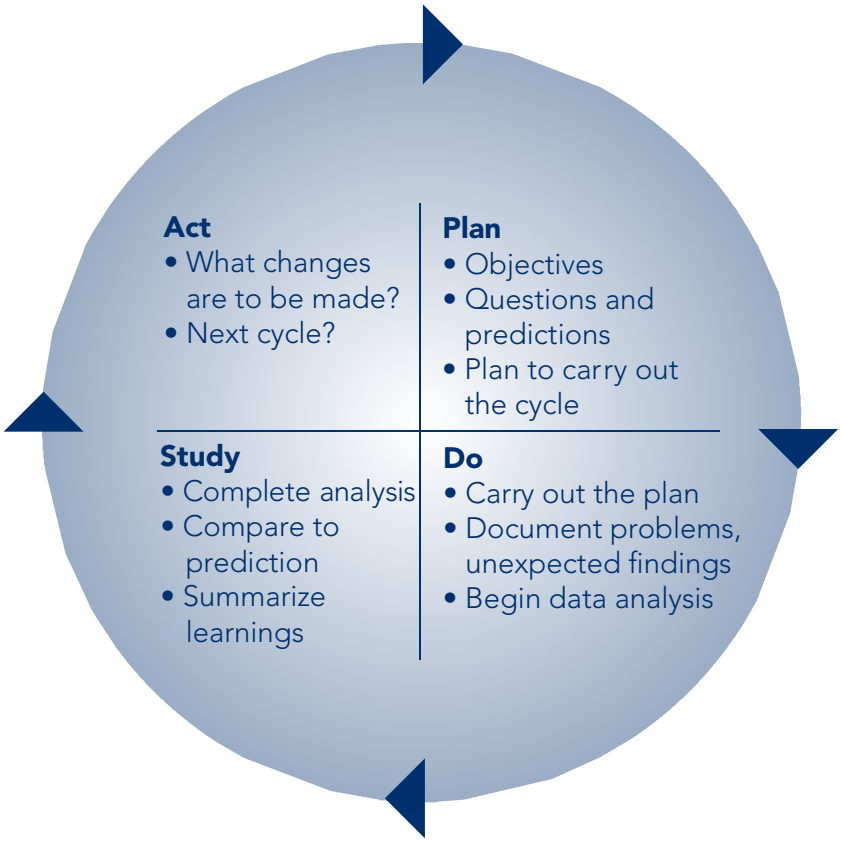
Sustained improvement requires fundamental change in the care-delivery system.[6] Health plans participating in BCAP are encouraged to test changes for long-term viability using a structured model for improvement. Such models provide guidance and focus for health plans implementing change. They also create a common language and approach that facilitates communication and shared learning among the health plans.

A Brief Guide to The Model for Improvement

There are numerous improvement models used in the managed care industry. All offer a systematic guide for identifying problems and making changes. The Model for Improvement[7] used by the *Achieving Better Care for Asthma* workgroup identifies aim, measure, and change strategies by asking three questions:

AIM	What are we trying to accomplish?
MEASURE	How will we know that a change is an improvement?
CHANGE	What changes can we make that will result in improvement?

The framing of these questions is followed by the use of learning cycles to plan and test changes in systems and processes. These are referred to as P-D-S-A (Plan-Do-Study-Act) cycles. The P-D-S-A cycles guide improvement teams through a systematic analysis and improvement process.



[6] Headrick L, Katcher W, Neuhauser D, and McEachern E. "Continuous Quality Improvement and Knowledge for Improvement Applied to Asthma Health Care." *Joint Commission Journal on Quality Improvement*, 1994.

[7] Langley G, Nolan K, Nolan T, Norman C, and Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, 1996.

Step 1: Creating Your Aim Statement

An Aim Statement recognizes a deficiency in an important process or performance measure. It provides a clear goal for your plan's quality improvement team. An effective Aim Statement is clear and specific, and sets "stretch" goals (quantitative targets that are a real reach).

Principles of an Effective Aim Statement

- Write clearly.
- Use specifics.
- Set direction.
- Set numerical goals.
- Set "stretch" or ambitious goals.

Examples of Aim Statements

"Identify 100 percent of health plan members, age two-18 years, who have asthma."

"75 percent of members with asthma will have an asthma action plan."

Step 2: Creating Measures for Improvement

Establishing a "culture of measurement" within health plans is critical to providing quality, cost-effective care. Most health plans have quality improvement departments responsible for creating initiatives to improve the health care and satisfaction of their enrolled members. Where these initiatives often fall short, however, is in measuring the effectiveness of the implemented approach or improvement. The Health Plan Employer Data and Information Set (HEDIS)[8] guidelines establish outcomes that health plans can use to measure improvement, but these measures are collected at lengthy intervals and are mainly useful for analyzing long-term trends.

Measurement for improvement differs substantially from judgment-based measurement in clinical research.[9] Large amounts of data collected over long periods are rarely required to assess the impact of a change. Small repeated samples collected over time will allow you to document progress toward your aim.

Process measures will let you know whether your change is having the expected impact, and in some cases, can highlight the cause of unexpected results. These measures provide short-term feedback to evaluate ongoing improvement efforts. Process measures should be a direct reflection of the Aim Statement.

Creating Process Measures

- Seek usefulness, not perfection.
- Use small, repeated samples.
- Measure over time and over a wide range of conditions.
- Include quantitative and qualitative measures.

Linking Measures to Aims

Aim	Measure
"Contact 90 percent of all members who have asthma."	Numerator: # of successful outreach attempts to members who have asthma Denominator: # of members with asthma

[8] HEDIS is a registered trademark of the National Committee for Quality Assurance.

[9] Solberg LI, Mosser G, and McDonald S. "The Three Faces of Performance Measurement: Improvement, Accountability, and Research." *The Joint Commission Journal on Quality Improvement*, 1997.

Step 3: Identifying, Planning, and Testing a Change

This toolkit inventories the change strategies tested by the plans in the *Achieving Better Care for Asthma* workgroup. The workgroup members selected strategies based on the needs of their own organizations. As you review these, consider which aims most closely reflect those of your organization. Then, review the strategies and barriers listed to determine which are best suited for your health plan. Test selected changes on a small scale, review measures, make adjustments, and measure again. Repeat the cycle until you are satisfied with the results.

As you plan to test a change, specify the "who, what, where, and when," so that all project staff know their roles clearly. Careful planning will foster successful implementation. Be sure to plan for appropriate **training** and **communication** when you "go live" with the change. Use an "Improvement Documentation Form" (Appendix A) to help with planning the change.

Why Test a Change?

- Document magnitude of expected improvement.
- Opportunity for "failure" without having an impact on performance.
- Evaluate "side effects" of change.
- Learn how to adapt the change to your local setting.
- Minimize resistance on full implementation.

Key Principles for Testing a Change

- Start small.
- Use volunteers.
- Don't worry about full buy-in.
- Plan multiple cycles to test and adapt change.

The improvement strategies documented in this toolkit are not "one-size-fits-all." Running testing cycles before full implementation offers a safe way to try something new and make modifications, while minimizing resource use and impact on the organization.

Measuring in Common: Highlighting Trends Over Time

Health plans participating in the *Achieving Better Care for Asthma* workgroup agreed to collect a common set of measures to reflect the progress of the initiative on a broader scale. The common measures included HEDIS measures as well as new measures that the workgroup developed. The purpose of collecting common measures is to document improvement and to show how each plan is improving from its own baseline. These measures provide a common metric for health plans in the BCAP workgroup to track progress.

What Common Measures **Are Not**

Market variations, carve-outs, population differences, physician practice patterns, and plan design may vary significantly among health plans. Common measures are not intended for comparisons of health plan performance, but rather to highlight improvement trends within each health plan.

Collecting BCAP Workgroup Measures

We encourage you to identify measures in Table 2 that will allow you to track the overall success of your improvement initiative, in addition to measuring the effects of individual changes.

Table 2: BCAP Workgroup Common Measures for *Achieving Better Care for Asthma*

Measure	Description
Identification	
1) % of members with diagnosis of asthma	# of members meeting definition of asthma / All members in health plan
Stratification	
1) % of members with asthma stratified	# of members with asthma stratified by plan's criteria / # of members with asthma
2) Validity of stratification	# of members stratified into same category by two methods / # of members with asthma stratified
Outreach	
1) Contact rate	# of members with asthma "successfully" contacted* / # of members with asthma attempted to contact
2) Participation rate	# of members with asthma engaging in program activity / # of members with asthma contacted
	* A successful contact is defined according to the health plan's outreach method (e.g., mailings not returned, completed phone calls, home visits).
Intervention	
1) % of members with asthma hospitalized	# of members with one or more asthma admissions in 12 months / # of members identified with asthma in the same period
2) % of members with asthma who visit the emergency department (ED)	# of members with one or more asthma visits to ED in 12 months / # of members identified with asthma in the same period
3) Average missed work or school days per member with asthma	# of days missed at school or work reported by member / # of members with asthma surveyed
4) % of members with asthma with written asthma management plan	# of members with asthma with a written management plan / # of members with asthma
5) Quality of life	Measure varies according to quality of life tool chosen by plan.
6) Appropriate medication use	HEDIS measure without continuous enrollment criterion.

A Typology for Improvement

CHCS developed a "Typology for Improvement" to classify health plans' activities in designing quality initiatives. The four-step classification system addresses barriers commonly faced by health plans serving Medicaid beneficiaries. The model was developed based on interviews with health plan medical directors and quality improvement directors in 10 states. Participating health plans have found the structure of the typology useful in considering strategies for improvement. It offers a template for approaching quality initiatives that can be customized for a variety of clinical quality improvement projects.

Typology Category	Description
Identification	How do you identify the relevant population?
Stratification	How do you assign risk within that population?
Outreach	How do you reach the target population?
Intervention	What works to improve outcomes?

Applying the Typology to *Achieving Better Care for Asthma*

- **Identification** Identifying members with asthma is the first step toward improving the management of their condition. Useful activities may include:
  - Examining the current method the health plan uses to identify members with asthma.
  - Encouraging providers to assist the health plan in identifying members with asthma.
  - Creating and regularly updating a registry for those members with asthma.

  Health plans that invest in efforts to identify members with asthma are in a better position to offer case management or support services to those most at risk of poor health outcomes.

- **Stratification** Once the health plan has identified its population of members with asthma, how does it determine which members are most at risk of having poor outcomes? Risk factors include:
  - A history of hospitalization for asthma.
  - Emergency department use for asthma.
  - Inappropriate use of asthma medications.
  - Multiple asthma-related absences from school or work.

- **Outreach** Ongoing outreach efforts are critical to ensure that members have access to appropriate services and adhere to asthma management regimens. Health plans must evaluate:
  - How does the health plan reach its members with asthma?
  - Does the health plan make regular calls to members? Does the plan have a home visiting program, or a community presence?
  - Once members with asthma are contacted, how does the health plan encourage ongoing asthma self-management?

- **Intervention** Once the health plan has identified members with asthma, determined their level of risk, successfully contacted them, and encouraged them to participate in asthma management activities, what interventions does the plan offer to meet member needs? Questions to consider include:
  - What programs are available to members with asthma who are at risk for poor outcomes?
  - Are these programs cost effective?
  - Do members use the service?
  - Can the plan document improvements in health outcomes as a result of these programs?

While this typology is useful for organizing tactics into a systematic strategy, there also can be overlap between typology categories. A successful effort to improve identification, for example, can promote activities in stratification, outreach, and intervention. This toolkit is meant as a guide to help organize ideas, but also is designed to allow flexibility for creative planning and design of new initiatives.

Identification

How and when does the health plan find out which of its members has asthma?

By identifying members in need of asthma management services, health plans can address risk factors through outreach and intervention strategies. It also is essential to assess the resources necessary to identify members at risk. Plan data systems and information sources might allow the plan to get basic demographic information, but not provide detailed data that will help the plan more effectively target limited resources.

Here are approaches for identifying members with asthma that can be combined and cross-referenced to identify more members:

- Perform a claims run for ICD-9 493.xx codes.
- Perform pharmacy data analysis on all bronchodilators and inhaled steroids.
- Collaborate with other health plans to build a regional registry.
- Collaborate with schools or school-based health centers to identify children with asthma using standard screening questionnaires.

Additional approaches include:

- Searching durable medical equipment claims for asthma-related devices, e.g., nebulizer, peak flow meter.
- Obtaining information from members, e.g., through new member surveys and a recorded message on the plan's main phone number, such as "Press 6 if you have asthma."
- Searching encounter data.
- Performing chart reviews.
- Enlisting enrollment brokers to identify new members with asthma.
- Screening health risk assessments in new member welcome calls.

All of these strategies may present barriers, such as untimely availability of claims data, asthma-related drugs and durable medical equipment used for conditions other than asthma, incorrect use of the 493.xx diagnostic code for conditions other than asthma, inaccurate recording of asthma on encounter data, and high resource commitment. The 11 health plans in the *Achieving Better Care for Asthma* workgroup piloted a combination of ways to increase identification of members with asthma, measured success rates, frequently measured their impact, selected the most useful methods, and discarded approaches with little yield.

Measuring the appropriate identification rate often presents a challenge for plans. For example, if a plan's aim is to identify 100 percent of members with asthma, how would a plan verify that all members with asthma are identified? There are some benchmarks that can be used, including:

- Comparing plan's identification rate to local prevalence estimates.
- Comparing plan's identification rate to the number of acute episodes already known to the plan by prior identification (e.g., ED visit, hospitalizations).

Developing an Asthma Registry

Four plans in the *Achieving Better Care for Asthma* workgroup developed asthma registries as part of their quality improvement projects. A disease registry is a database that contains information about people diagnosed with a specific type of disease. Registries can be used to support information needs for improvement activities, including member identification, stratification, monitoring, and care management. Details of the asthma registries created by workgroup plans are outlined below.

Table 3: Examples of Asthma Registries

	CareOregon	Network Health	Partnership HealthPlan of California	Community Health Plan of Washington
Purpose of Registry	Identify members and offer a management tool for providers.	Identify and stratify members with asthma to direct outreach to members and providers.	Central repository for members identified with asthma.	Identify and stratify members with asthma to direct outreach to members and providers.
Principal Use	Create detailed reports for clinics and primary care providers.	Identify and stratify members for phone outreach and maintain record of contact.	Identify the population and establish a prevalence rate.	Create reports for clinics to identify members who benefit from outreach.
Is Registry a Stand-Alone Database for Asthma?	Yes. In the future, CareOregon plans to develop one electronic database for disease management.	Yes. Network Health plans to integrate other chronic conditions into the database.	Yes. Partnership manages separate databases for other chronic conditions.	Yes. Separate databases exist for other conditions, such as diabetes.
Registry Initially Populated by	Running Structured Query Language with asthma case definition.	Pharmacy, medical claims, provider, and member databases.	Membership, medical claims/encounter, and pharmacy data.	Medical claims data, including demographic and utilization data, merged with pharmacy claims data.
Registry Updated	By running the code.	Automatically from databases and manually by care manager.	By running programs and updating with eligibility data.	By running programming code.
Frequency of Update	Quarterly.	Monthly.	At least quarterly.	Monthly.
Software	Customized Structured Query Language code and Crystal reports.	Microsoft Access with Visual Basic.	Microsoft Access.	Structured Query Language-Server.
Accessibility	Health plan and reports sent to providers.	Health plan only.	Health plan only.	Health plan only.
Reports	• Patient lists for clinics and primary care providers. • Medication detail report.	• Stratification summary. • Outreach trigger report. • Utilization reports. • Primary therapy. • Pharmacy report. • Rescue pharmacy report. • BCAP contact rate.	None currently. Reports are generated from a previously created database.	• Lists of asthma patients for distribution to primary care clinics. • High-risk status for telephone outreach using inpatient and emergency department use and prescription medication fills.

Data Fields	• Member demographics.
	• Pharmacy utilization.
	• Medical utilization:
	  • Inpatient.
	  • Outpatient.
	  • Emergency department.
	  • Primary care provider/clinic.
	• Performing physician.
		• Member demographics.
		• Primary care provider.
		• Stratification.
		• Missed school/work days.
		• Missed activity.
		• Night waking.
		• Peak flow meter, spacer.
		• Severity history.
		• Outreach history.
		• Medical utilization.
		• Pharmacy utilization.
			• Member demographics.
			• Asthma severity level.
			• Membership eligibility status flag.
				• Member demographics.
				• Primary care clinic.
				• Stratification.
				• Inpatient utilization.
				• Emergency department utilization.
				• Pharmacy utilization.

Health Plan Case Studies

Passport Health Plan: Broadened Asthma Identification Criteria

BACKGROUND: Passport Health Plan is a provider-owned health plan with 118,000 enrollees in Kentucky.

AIM: Identify all members, age two-56, with asthma, estimated at five percent of total plan membership within this same age range.

MEASURE: $\frac{\text{\# of members, age two-56, identified with asthma}}{\text{\# of members, age two-56, in health plan}}$

CHANGE: Passport identified members using the following criteria:

1. Members, age two-56, **and**
2. One pharmacy claim for an asthma drug within the quarter being measured (for a total of at least four pharmacy claims for an asthma medication within the past 12 months — HEDIS), **or**
3. At least one emergency department or inpatient admission within the past 12 months with a 493.xx primary diagnosis, **and**
4. Active with the plan in the last month of the quarter being measured.

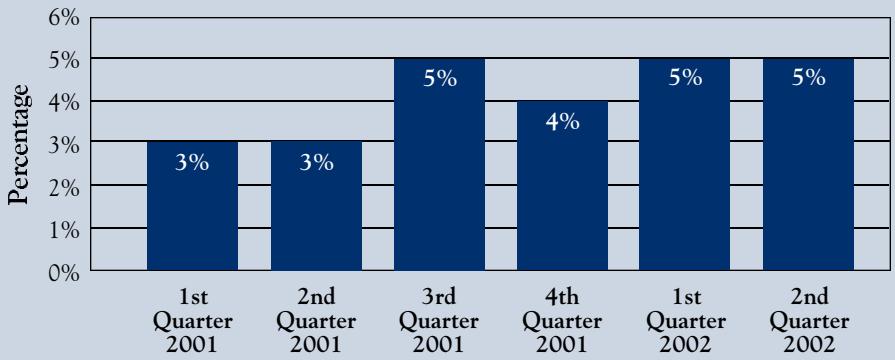
Prior to this new identification criteria, a member was identified as having asthma only if they met all of the above listed criteria for identification. This change was implemented in the third quarter of 2001 and compared to results from the first two quarters of 2001.

RESULTS/LESSONS LEARNED: Passport increased identification of members with asthma from a baseline of three percent in the first two quarters of 2001 to five percent in the third quarter of 2001. Since the first quarter of 2002, Passport has identified five percent of its members with asthma. This satisfies the plan's goal and reflects the American Lung Association of Kentucky's reported asthma prevalence rate of five percent.

The plan believes that using a combination of pharmacy and medical claims helped increase the identification of members with asthma.

NEXT STEPS: Passport Health Plan will visit high-volume practices to educate office staff and providers on NAEPP asthma guidelines in an effort to identify high-risk members with asthma earlier.

Figure 1: Passport Health Plan Members with Asthma – January 2001-April 2002



Affinity Health Plan: Multi-Tiered Approach to Identification

BACKGROUND: Affinity Health Plan is a non-profit managed care organization serving 83,700 Medicaid and SCHIP members in New York City and the five surrounding counties.

AIM: Identify 100 percent of Affinity Health Plan's members with asthma by analyzing claims, pharmacy, utilization management, and self-referral data.

MEASURES:

1. $\frac{\text{\# of members identified with asthma}}{\text{\# of members in health plan}}$

2. $\frac{\text{\# of members with asthma identified from each specific data source}}{\text{\# of members with asthma identified from all data sources}}$

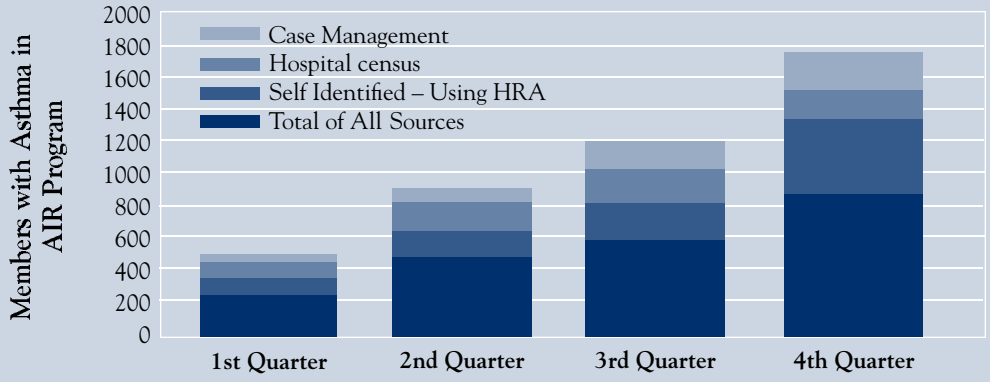
CHANGE: Affinity standardized the process of identifying members with asthma as early as possible by using a variety of sources and enrolling the members into Affinity's asthma disease management program, AIR. Affinity adopted a multi-tiered identification approach that tapped a variety of data sources to increase the rate of timely identification of members with asthma. Beginning with the identification of members with asthma through the new member Health Risk Assessment (see Appendix B) and inpatient utilization data, additional data sources were developed and now include claims (ICD-9 codes 493.00 – 493.92), pharmacy, and a variety of self-referral or physician-referral forms.

RESULTS/LESSONS LEARNED:

1. The new initiative resulted in a four-fold increase in the number of members with asthma identified and enrolled in AIR. The plan increased identification from .7 percent in the first quarter (628 members) to 8.1 percent in the fourth quarter (9,932 members). The source of identification was tracked for members enrolled in the program.
2. Each data source was reviewed to enhance its use as a vehicle for effective identification. For example, the Health Risk Assessment form had a poor rate of return until it was updated and placed more prominently in the Member Handbook. As seen in Figure 2, within the first quarter after the change, the return rate for this form tripled, from 140 in the first quarter to 470 in the fourth quarter.

NEXT STEPS: Affinity is creating an asthma registry, which will be automated to collate all data sources each month and to track all members with asthma by initial source of identification, e.g., Health Risk Assessment form, pharmacy data, etc. Affinity will continue to review the effectiveness of each data source and its role in the early identification of members with asthma.

Figure 2: Affinity Health Plan Members with Asthma in AIR, by Source of Identification



Community Health Plan of Washington: Tapping Utilization and Pharmacy Data to Identify Members with Asthma

BACKGROUND: Community Health Plan of Washington (CHPW) is a non-profit health plan with 112,858 Medicaid and SCHIP members.

AIM: Identify 100 percent of members, age two-14, with asthma.

MEASURE: $\frac{\text{\# of members, age two-14, identified with asthma}}{\text{\# of members, age two-14, enrolled in health plan}}$

CHANGE: CHPW developed criteria to identify members, age two-14, with asthma using utilization and pharmacy data. CHPW identified members with asthma through the following criteria:

- Inpatient, emergency room, or ambulatory claims with ICD-9 code of 493.0-493.9, **or**
- Any member having filled pharmacy claims in the past 12 months for:
  - Two or more fills of an inhaled beta-agonist.
  - One or more fills of an inhaled steroid.
  - One or more fills of a leukotriene modifier.
  - One or more fills of cromolyn or nedocromil.
  - One or more fills of theophylline and age at least six months.

The information is housed in a newly created asthma registry. The plan updates asthma prevalence rates monthly and compares these rates with those of the Washington State American Lung Association that are published annually.

RESULTS/LESSONS LEARNED: As of June 2002, CHPW reported an eight percent prevalence rate for members with asthma, which is comparable to the Washington State American Lung Association's rate of near nine percent. CHPW has integrated the asthma registry into its business operations. For example, case managers receive daily reports listing members who have been admitted for short-stay hospitalization. The asthma coordinator, a registered nurse, uses this information to monitor members who have been recently hospitalized and to tailor outreach to their needs.

CHPW's initial barrier was the limited availability of a data programmer to produce timely reports. Communicating with the plan's information systems team that the success of the asthma project depended on prompt reports brought an agreement to generate reports every month for the asthma project staff.

NEXT STEPS: The CHPW asthma project staff is creating a multi-departmental task force to streamline report requests and increase coordination with the information systems team. Project staff is improving the registry to produce information about asthma medication prescribing patterns based on HEDIS guidelines. This information helps primary care providers increase their use of maintenance medication through face-to-face provider training sessions and provider profiling.

UCare Minnesota: Redefining Diagnosis Codes to Enhance Identification

BACKGROUND: UCare Minnesota serves approximately 75,000 Medicaid and state-subsidized health insurance beneficiaries, of which approximately 53,000 are eligible for the plan's asthma program. UCare uses an outside vendor to conduct its asthma management services.

AIM: Identify 100 percent of people with asthma who are eligible for UCare's asthma program.

MEASURE: $\frac{\text{\# of members identified with asthma}}{\text{\# of members eligible for asthma programs}}$

CHANGE: UCare developed the following criteria to identify members with asthma:

1. One hospital claim, ICD-9 code 493.xx, **or**
2. Two medical (non-hospital) claims, ICD-9 code 493.xx, **or**
3. One medical claim and one asthma drug pharmacy claim, **or**
4. Two asthma drug pharmacy claims, **or**
5. For members between ages two to five, use above claim combinations but add ICD-9 codes 496, 786.09, 786.2, 491, 491.8, and 491.9.

Previously, other ICD-9 codes (491-chronic bronchitis and 786-respiratory symptom codes) were counted as "asthma" and only one pharmacy claim or one medical (non-hospital) claim was used. This resulted in a 12 percent rate of "denies disease." Investigation of this rate showed it to be primarily due to the use of asthma drugs, particularly inhalers and nebulizer drugs, to treat conditions other than asthma. In other instances, an asthma diagnosis code was used for conditions other than asthma. The revised criteria dropped the 491, 496, and 786 codes for members older than five years of age.

RESULTS/LESSONS LEARNED: UCare Minnesota learned to be cautious when using overly-generalized diagnosis codes. The change in definition resulted in a reduction in the "denies disease" rate from 12 percent to five percent. To date, 5,282 members have been identified as having asthma, representing a prevalence rate of 9.8 percent. The estimated prevalence rate for asthma in similar populations is eight to nine percent, and UCare Minnesota is confident it has identified the majority of plan members with asthma.

Health Plan Action Steps for Identification

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of members identified with asthma. For example: *Identify 100 percent of members, age five-18, with asthma.*

_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in bronchodilator use) and develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:

$$\frac{\text{\# of members, age five-18, identified with asthma}}{\text{\# of members, age five-18, in the health plan}}$$

Change:

Evaluate current methods of identification and change strategies that will effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Stratification

How can a plan obtain and use health risk information about members in need of asthma management services?

Stratification is the process by which a plan determines which subpopulations of members are most at risk for not receiving asthma services. How does the health plan determine which members are at risk for poor health outcomes? How does the plan know which members could benefit from enhanced outreach services that will encourage them to seek care? Chart reviews, member welcome calls, and targeted reminders to families can be used to assess members in need of asthma management services.

Steps to Assess Risk of Members with Asthma:

1. Identify specific risk factors (e.g., asthma-related emergency department visits or hospitalizations, smoking, excessive use of bronchodilators, and household pets).
2. Classify the member's level of risk as low, moderate, or high.
3. Determine which risk factors are modifiable (e.g., inappropriate use of asthma medication, smoking, and household pets).

A common challenge in assessing the status of members with asthma is that risk assessment techniques used by health plans and providers may not capture relevant risk information. For example, if household pets or tobacco smoke in the indoor ambient air are important modifiable risk factors, does the risk assessment tool capture them?

Assessing health risks for members with asthma is complicated because persistent asthma may become more severe or less severe over time. Symptom flare-ups may be relatively mild or very severe, regardless of the severity of the member's asthma.

Strategies to Improve Member Stratification

Improve Risk Assessment Information Received from Providers:

- Perform chart reviews in provider practices with a high volume of asthma patients to identify members requiring enhanced asthma services.
- Offer provider incentives for submission of asthma management plans.
- Stratify providers by specialty, practice affiliation, and number of members to evaluate variations in practice patterns and create a profiling system.

Improve Risk Assessment Information Received from Members:

- Provide online or voice-activated risk assessment for members who visit the health plan website or who call the plan.
- Conduct welcome calls to new members and include questions about the presence of asthma.

Improve Risk Assessment Information Received from Other Sources:

- Standardize health risk assessment tools across health plan departments (e.g., member services, case management).
- Standardize health risk assessment tools across health plan providers.
- Standardize health risk assessment tools across health plans.
- Participate in asthma registries in the area.

Get the Most Out of Data in the Health Risk Assessment:

- Use risk assessment forms and claims, encounter, and pharmacy data to stratify members for key factors, including:
  - Medicaid eligibility category.
  - Number and ages of household members with asthma.
  - Ethnicity.
  - Language spoken at home.
  - Smoking among household members.
  - Household pets.
  - Pattern of use of beta-agonists and inhaled steroids.
  - History of asthma-related hospitalizations and emergency department use.
- Designate one department within the health plan for data collection and distribution.
- Establish a process to evaluate data and determine appropriate follow up.
- Develop a decision tool to highlight members with modifiable risk factors.

Assessing Members with Asthma: The Severity/Risk Mix

Many people in the medical and managed care communities use the term asthma severity to mean different things, leading to much confusion. Asthma severity in the biologic sense cannot be assessed directly; rather, it can be inferred by considering the degree to which symptoms are controlled in the context of specific medical management.

Common Ways to Categorize and Monitor

To classify a member's asthma severity, health plans can use national guidelines or their own administrative data, including claims data, patient surveys, and chart reviews. Health plans in the *Achieving Better Care for Asthma* workgroup found a combination of these approaches to be most effective in their stratification efforts.

Table 4: NAEPP Asthma Severity Categorization Criteria

Level of Severity	Day Time Symptoms*	Night Time Symptoms**	Beta-Agonist Use	Lung Function
Mild, intermittent	< or equal to two per week	< or equal to two per month	< or equal to two uses per week	> or equal to 80 percent
Mild, persistent	Three to six per week	> or equal to three to four per month	Three to six uses per week	> or equal to 80 percent
Moderate, persistent	Daily	> or equal to five per month	> zero uses, but < or equal to two uses per day per week	> 60 percent and < 80 percent
Severe, persistent	Continual	Frequent	> two uses per day per week	< or equal to 60 percent

***Day Time Symptoms:** Wheeze, Cough, Chest Tightness, Shortness of Breath
****Night Time Symptoms:** Frequency of Cough, Wheeze, Awakening from Sleep

While the NAEPP asthma guidelines are extremely helpful, there are some disadvantages to keep in mind:

- The NAEPP analysis is designed for patients who have yet to begin treatment; thus, it does not help categorize severity in patients currently on asthma medications, although it does give a good indication of their degree of control.
- A patient may have severe disease, but may have well-controlled asthma with minimal symptoms and relatively normal lung function.
- The information required to use the NAEPP approach must come from patient interviews. While medical records may have such information, it typically is not well recorded.
- Although these criteria are widely accepted, they have not been well validated. In particular, they may not apply well to the care of young children (0-3), who typically have relatively severe exacerbations with viral infections and fewer symptoms in between.

Clearing the Confusion: National Asthma Care Guidelines

A plethora of asthma care guidelines exist from organizations across the country, complicating the task of health plans and providers to identify and follow one standardized set of guidelines for all patients with asthma.

The most widely used national asthma care guidelines were developed by an expert panel of the National Asthma Education and Prevention Program, which is coordinated by the National Heart, Lung and Blood Institute (NHLBI), a part of the National Institutes of Health (NIH). The NAEPP guidelines were established in 1997 and were published in the *Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma*. The guidelines were updated in 2002. These asthma care guidelines are interchangeably referred to as the NAEPP, NHLBI, or the NIH asthma guidelines, or as the NAEPP Expert Panel Report.

The majority of the plans in the BCAP *Achieving Better Care for Asthma* workgroup used the NAEPP Expert Panel Report as a model for developing asthma guidelines. In this toolkit, we refer to them as the NAEPP asthma guidelines.

The NAEPP Expert Panel Report can be found at:
www.nhlbi.nih.gov/guidelines/asthma/index.htm

Administrative Data

Administrative data can provide a tool for determining asthma severity. Indications of poor asthma control include prior hospitalizations for asthma, prior use of oral or systemic steroids, and emergency department visits.

Table 5: Useful Sources of Administrative Data for Classifying Asthma Severity

Medical Facility Usage	Medication Usage
Hospitalizations • There is a 25 percent likelihood that a person hospitalized in one year will be hospitalized in the next year. **Emergency Department Visits** • There is a 15-20 percent likelihood that a person visiting an ED once in a six-month period will visit again within the year. • In evaluating ED use, it is important to consider non-clinical factors such as lack of access to appropriate medical care, hours of operation, day of week, time of day, and cultural and social perspectives. **Outpatient Visits** • Acute and maintenance visits should be evaluated separately. Acute office visits are comparable to ED visits, and likely indicate poor control. Scheduled office visits are likely to be desirable, and associated with better control in some studies.	**Bronchodilators/Albuterol** • If asthma is well controlled, these medications will ideally be used less than twice per week for brief flare-ups. • Increased use of albuterol demonstrates either poor asthma control or poor quality practice. In either event, it is linked to an increase in hospital stays. **Oral Corticosteroids** • Repeated use of oral corticosteroids indicates poor control and is associated with subsequent increase in likelihood of a hospital stay.

Other Sources of Administrative Data: Patient Surveys and Chart Reviews

Health plans use a variety of approaches to assess asthma control, including patient surveys and chart reviews. What are the most effective tools? The following are a variety of techniques and information about reliability:

- The Asthma Therapy Assessment Questionnaire (ATAQ) survey produced by Merck & Co. can be helpful in assessing degree of control. ATAQ measures five asthma management domains: 1) asthma control; 2) knowledge barriers; 3) patient behavior/attitude barriers; 4) self-efficacy (patient beliefs); and 5) patient/provider communication barriers. The asthma control domain measures four indicators of control within seven of its items: 1) patient perception of control; 2) nocturnal symptoms; 3) ability to participate in normal activities; and 4) overuse or increased use of reliever medications.
- HEDIS provides a rough estimate of asthma control in a plan's population. The criteria are designed to capture persistent asthma, but the measures reviewed tend to classify any asthma patient with a sudden flare-up in the persistent category. Care can meet the HEDIS quality criteria if a controller medication is prescribed even once.

- Chart reviews alone are generally not a reliable way to assess asthma severity or to review if patient education was provided. Generally, medical charts lack vital information that is relevant to monitoring the changing status of an asthma patient.
- Asthma action plans are an important tool to facilitate provider-guided patient self-management. The NAEPP guidelines identified the following components of an effective asthma action plan:
  - A summary of treatment goals, such as freedom from symptoms, no lost days from school or work, etc.
  - A summary of daily medications.
  - A summary of daily self-monitoring actions, including:
    - Peak-flow measures.
    - Symptoms.
    - Frequency of use of quick-relief inhaler.
    - Actual use of daily medications.
    - Any restriction of activities.
- An Asthma Registry can provide convenient access to comprehensive data for providers and health plans. It also can track patient outcomes and compliance with treatment plans.

Health Plan Case Studies

CareOregon: Medication Analysis to Predict Moderate/Severe Asthma

BACKGROUND: CareOregon is a non-profit Medicaid health plan with 88,000 enrollees.

AIM: Stratify members with asthma, age five-11, as moderate/severe persistent asthma with at least 95 percent accuracy using claims data.

MEASURE:

$$\frac{\text{\# of members, age five-11, identified by claims and verified by providers as having moderate/severe asthma}}{\text{\# of members, age five-11, initially identified by claims as having moderate/severe asthma}}$$

CHANGE: CareOregon implemented a family intervention program to improve care for children with moderate/severe persistent asthma. To accurately stratify members who are eligible for the program, the plan developed criteria to identify members with moderate/severe asthma using claims and pharmacy data. Lists of members identified with moderate/severe persistent asthma were sent to providers to confirm accuracy of the stratification level. Providers were given referral forms (see Appendix C), including a symptom checklist, to complete for each member identified with moderate/severe persistent asthma. Completed referral forms were entered into a database. To validate the claims-based stratification, members who are ineligible for the program were compared with those found eligible.

RESULTS/LESSONS LEARNED: By June 2002, CareOregon providers verified 48 percent of the 614 children identified. Of the 292 stratified, 33 percent were found to be eligible for the asthma management program (e.g, have moderate to severe persistent asthma according to NAEPP asthma guidelines).

Disappointed by this low accuracy rate, CareOregon analyzed a sample of 203 children identified by claims with completed referral forms. CareOregon examined emergency department visits, outpatient visits, and medication usage, including short-acting beta agonist use and anti-inflammatory use. Hospitalizations were excluded based on low volume.

CareOregon found that having an emergency department visit was not an accurate indicator of severity of asthma, and neither were outpatient visits or high use of Albuterol. The most useful measures for identifying children with moderate/severe asthma using claims are use of an anti-inflammatory medication or a combination indicator that includes either anti-inflammatory medication or six or more Albuterol dispensings in 12 months.. Using only anti-inflammatory dispensings, 74 percent of the children with moderate/severe asthma were identified, compared to 78 percent with the combination indicator.

NEXT STEPS: Care Oregon will continue to use the combination indicator (anti-inflammatory use or six or more Albuterol dispensings) as a stratification method. Providers like the medication analysis report because it provides real-time data (within a month of use) and it effectively identifies members with moderate to severe persistent asthma.

Cimarron Health Plan: Effective Medication Use Can Mask Severity of Asthma

BACKGROUND: Cimarron Health Plan is a for-profit health plan serving approximately 66,000 Medicaid members in New Mexico.

AIM: Stratify 100 percent of members with persistent asthma within one month of identification into mild, moderate, and severe persistent categories using medication.

MEASURES:

1. $\frac{\text{\# of newly-identified members with asthma stratified within one month of identification}}{\text{\# of members newly identified with asthma}}$
2. $\frac{\text{\# of members stratified into mild, moderate, or severe persistent asthma categories}}{\text{\# of newly-identified members stratified within one month of identification}}$

CHANGE: Cimarron stratified members with persistent asthma into three levels of severity based on pharmaceutical usage, numbers of office and emergency department visits, and hospitalizations. Prior to this, members were stratified by case managers using only clinical criteria. A total of 4,638 members were identified as having asthma. Of those, 2,708 were stratified as having persistent asthma within one month of identification.

RESULTS/LESSONS LEARNED: In less than six months, Cimarron Health Plan increased its stratification rate from a baseline of 2.51 percent using only clinical information from case managers to 78.2 percent using the new stratification criteria. Members found to have persistent asthma are stratified into mild, moderate, or severe levels of severity. An important, and unexpected, lesson learned in this activity is that effective medication use can mask severity of asthma.

Table 6: Medication Status of Cimarron's Members with Persistent Asthma

Medication Status	Severe Persistent	Moderate Persistent	Mild Persistent	TOTAL
Medicaid	1,309	121	1,278	2,708
Taking asthma drugs	94.04%	3.31%	61.58%	75%
Not taking asthma drugs	5.96%	96.69%	38.42%	25%
Total	100%	100%	100%	100%

The table indicates that stratification based on clinical criteria alone may incorrectly stratify members with severe asthma who are well controlled as mild. This exercise highlights the importance of using pharmacy data in combination with clinical criteria so that the stratification tool does not mask members with severe or moderate asthma whose condition is effectively controlled by medication.

NEXT STEPS: Cimarron will continue to apply the new stratification tool on a quarterly basis to identify members for its asthma disease management program. It will continue to further refine the tool to separate members with mild persistent asthma from those with more severe asthma under control versus those with truly mild asthma.

Community Health Plan of Washington: Accurate Stratification Using Administrative Data

BACKGROUND: Community Health Plan of Washington (CHPW) is a non-profit health plan with 112,858 Medicaid/SCHIP members.

AIM: Stratify 100 percent of members with asthma, age two-14, as high risk or low risk using the plan's asthma registry. Verify accuracy of stratification method with clinical data obtained from a sample survey of patients with asthma in the high-risk category.

MEASURES:

1. $\frac{\text{\# of members, age two-14, stratified by administrative criteria}}{\text{\# of members, age two-14, identified with asthma}}$
2. $\frac{\text{\# of members, age two-14, with asthma classified as high risk}}{\text{\# of members, age two-14, successfully stratified by administrative criteria}}$
3. $\frac{\text{\# of members, age two-14, classified as high risk by both administrative and clinical data}}{\text{\# of high-risk members, age two-14, as classified by administrative data}}$

CHANGE: CHPW separated its asthma patients into low- and high-risk categories using administrative data from the plan's asthma registry. The plan verified this stratification method by comparing the administrative risk classification with a clinical risk classification in a sample survey of asthma patients who fell into the high-risk category. The clinical risk classification is determined during phone calls with the member.

Administrative criteria for high risk:

- One or more emergency department visits for asthma in last 12 months.
- One or more inpatient admissions for asthma in the last 12 months.
- Four or more prescriptions of an inhaled beta-agonist in the last 12 months (or two or more in the last six months).
- One or more prescriptions of an oral steroid in the last 12 months.
- Four or more clinic visits for asthma in the last 12 months.

Clinical criteria for high risk:

- A member with persistent asthma who is not on a control medication.
- A member with intermittent or persistent asthma who does not recognize symptoms of worsening asthma or know the appropriate steps to take.
- A member with intermittent or persistent asthma who has a history of sudden worsening of symptoms, intubations, or intensive care admissions.
- A member with mild intermittent asthma who uses Albuterol more than twice a week; a member with mild or moderate persistent asthma who uses Albuterol daily or more than three to four times in one day; or a child who uses more than one canister per month.

RESULTS/LESSONS LEARNED: CHPW stratified 100 percent of its members, age two-14, with asthma in the asthma registry. Based on this, 52 percent of the identified asthma population fell into the high-risk category. CHPW then surveyed 79 members who met the criteria for high risk based on the administrative algorithm and found that 100 percent of these members had persistent asthma. Calculation of the proportion of these 79 persons who also meet the criteria for "clinical high risk" currently is underway. At this point, it is known that at least 58 percent of these 79 persons also are "clinically high-risk," because they are not receiving anti-inflammatory medications.

NEXT STEPS: CHPW is pleased with the registry's ability to stratify members into appropriate risk categories. CHPW will continue verifying its registry stratification method by surveying members identified as high risk through the registry.

Network Health: Using Pharmacy and Utilization Data to Build an Asthma Registry

BACKGROUND: Network Health is a provider-sponsored, non-profit Medicaid health plan with approximately 45,000 members in Massachusetts.

AIM: Stratify 100 percent of members with asthma, age two-18, based on pharmacy and utilization data, into categories of low, medium, and high risk of future utilization. Determine whether the members in the medium- or high-risk asthma categories are in or out of control based on the administration of Merck's Asthma Therapy Assessment Questionnaire (ATAQ).

MEASURES:

1. $\frac{\text{\# of members, age two-18, with asthma stratified into low, medium, and high risk of future utilization}}{\text{\# of members, age two-18, with asthma}}$
2. $\frac{\text{\# of medium- and high-risk members, age two-18, "out of control"}}{\text{\# of medium- and high-risk members, age two-18, with asthma completing ATAQ survey}}$

CHANGE: Network Health developed an asthma registry (Appendix D) using pharmacy data, medical claims, and provider and member databases. The registry identifies members with asthma and automatically stratifies them into low, medium, and high risk of future utilization. Members who have had one ED visit, with asthma listed as one of the top four diagnoses, and/or have filled five or more beta-agonist prescriptions in a quarter, are classified as medium risk. If a member has an inpatient admission for asthma or two ED visits in a 12-month period, he or she is stratified as high risk. All other members with asthma are classified into the low-risk category. The registry is updated once a month and the Asthma Program Manager may add a member at any time. Medium- and high-risk members are assessed for asthma control by the Asthma Program Manager via telephone using the ATAQ survey.

RESULTS/LESSONS LEARNED: Network Health successfully stratified 100 percent of members, age two-18, with asthma. Most, 85 percent, were stratified into the low-risk category, with 11 percent in medium-risk and four percent in high-risk. Of the 328 members in the medium- and high-risk categories, the ATAQ survey was administered to 68 members, of which 37, or 55 percent, were found to be "out of control."

The ATAQ survey validates the stratification methodology. At the beginning of the project, Network Health estimated that, based on the survey, 50-75 percent of medium- and high-risk members would be measured as "out of control," and 55 percent of members surveyed have been assessed as "out of control."

NEXT STEPS: The goal is to have an asthma action plan in place for every member whose asthma is "out of control." All high-risk members, and any other member found to be "out of control," are offered home visits by a community agency that can provide further education and home assessment. Home visits also are available to other members with asthma at the discretion of the Asthma Program Manager.

Health Plan Action Steps for Stratification

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
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_____
_____

3. _____
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Aim:

Develop an Aim Statement that focuses on increasing the number of members with asthma stratified by the health plan. For example: *The health plan will receive completed health risk assessments from 80 percent of new members within three months of enrollment to facilitate early referral to asthma management services*.

_____
_____
_____
_____
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_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in number of asthma-related emergency department visits) and develop measures that link directly to your Aim Statement. For example:

# of health risk assessments received from new health plan members within three months of enrollment
# of new health plan members

Change:

Evaluate current methods of stratification and change strategies that will effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Outreach

How does a plan reach members in need of asthma care?

After members have been identified and stratified by risk level, health plans need effective ways to contact members and encourage use of appropriate health services. Outreach to the Medicaid population is particularly challenging. Health plan activities that often are used to reach members in need of asthma care, as well as potential barriers, are listed in Table 7.

Table 7: Common Outreach Strategies – Common Barriers

Strategy	Barriers
Telephone Calls to Members	• Inaccuracy of phone numbers for Medicaid enrollees; lack of a phone in the household.[10] • Cultural competency and language issues.
Mailings to Promote Asthma Services	• More frequent moves among Medicaid members than among commercial members. • Out-of-date mailing addresses. • Literacy issues.
Home Visits by Community Outreach Workers	• Difficulty finding members at home; once found, poor success convincing them to come in for services. • Problems recruiting plan staff willing to conduct visits to inner city or remote rural areas.
Newspaper/Media Ads and Public Service Radio Announcements	• Literacy and language issues. • Too diffuse to reach the specific people targeted for services.

Successful health plan outreach efforts identify what members need or value. Health plans might link outreach services to risk factors identified in the health plan's stratification efforts. An outreach program designed to help members with social service needs (e.g., housing, transportation, child care) may be more effective in getting members with asthma in for care or self-management education than one focusing solely on clinical care improvements.

Strategies to Improve Outreach to Promote Better Care for Asthma

Member Outreach Strategies

- Ask incoming callers if any household members enrolled in the health plan have asthma. If so, remind them about the importance of asthma control.
- Conduct welcome calls to every new plan member that includes a message about asthma care services.
- Develop outreach programs targeted at grandparents and other relatives who may serve a key caretaking role for children with asthma.
- Maintain up to four alternative addresses and telephone numbers (e.g., grandparents, siblings, cousins) for each member to increase the chances of contacting members during outreach efforts.

[10] BCAP workgroup health plans noted phone number inaccuracy in the range of 30-70 percent.

Provider Outreach Strategies

- Offer financial incentives to providers to complete an asthma management plan.
- Reward and recognize providers who prescribe appropriate asthma prevention medications.
- Visit provider offices to educate physicians and staff about teaching patients self-management skills.
- Review performance with high-volume providers.
- Generate reports identifying patient information to providers.

Community or Vendor Outreach Strategies

- Work with churches, synagogues, mosques, and other faith-based organizations to assist with outreach.
- Participate in and/or host health fairs to reach members in need of asthma management services.
- Contract with public health departments to provide outreach.
- Work with school nurses or school-based health centers at schools with high numbers of Medicaid or SCHIP enrollees.
- Contract with enrollment broker to perform initial asthma screening for all new enrollees.

Health Plan Case Studies

CareOregon: Achieving Improvements in Outreach and Enrollment

BACKGROUND: CareOregon is a non-profit Medicaid health plan with 88,000 enrollees.

AIMS:

1. Contact at least 80 percent of eligible children, age five-11, who have moderate or severe persistent asthma. A "contact" is defined by CareOregon as reaching a person by telephone to verify that they have received and understand program materials.
2. Enroll 80 percent of those contacted. Enrollment is defined by CareOregon as successfully completing the assessment tool in a personal interview.

MEASURES:

1. $\frac{\text{\# of children, age five-11, with moderate/severe persistent asthma contacted}}{\text{\# of children, age five-11, eligible}}$
2. $\frac{\text{\# of children, age five-11, contacted who are enrolled}}{\text{\# of children, age five-11, contacted}}$

CHANGE: CareOregon implemented the following changes:

- Added a Spanish-speaking staff member.
- Sent a letter to families upon referral and a follow-up phone call encouraging them to participate.
- Scheduled group sessions in clinics to accommodate family schedules. Reminders are sent by letter and phone calls prior to group sessions.
- Offered incentives for attending group sessions (e.g., phone cards, mattress covers, school supplies, lunch/dinner, childcare services, and peak flow meters).
- Created a database in which unduplicated names of all identified program participants are entered. The plan uses the database to track the percentage of individuals contacted, as well as the percentage enrolled and the percentage retained.

RESULTS/LESSONS LEARNED: In November 2001, CareOregon surpassed its contact aim by reaching 87 percent of eligible children, age five to 11. The plan continues to meet its goal of contacting 80 percent of children verified as eligible. Of those contacted, 64 percent are currently enrolled in the program.

NEXT STEPS: CareOregon will continue to expand its program by working with provider champions in new participating clinics. The health plan is working with the Centers for Disease Control and Prevention to develop a measure for program retention.

Passport Health Plan: Educating Members about Asthma Disease Management

BACKGROUND: Passport Health Plan is a provider-owned health plan with 118,000 enrollees in Kentucky.

AIM: Contact 95 percent of identified members with asthma quarterly, either directly or through their provider.

MEASURE:

$$\frac{\text{\# of members who are contacted quarterly, directly or indirectly, regarding the asthma program}}{\text{\# of members who are newly identified with asthma during the quarter}}$$

CHANGE: Passport identifies members who are eligible for the asthma program each quarter. Members, age two-56, are contacted regarding the asthma program by phone and/or mail. All members identified with asthma are sent mailings. Mailings to members include a welcome letter explaining the benefits of asthma disease management, an annual asthma action plan, an annual flu shot postcard, and information about asthma and self-management of the disease. In addition to mailings, high-risk members receive a phone call from the case manager.

Members with asthma receive an educational mailing at least once a quarter. Members identified as not on appropriate medication are sent a targeted mailing twice a year. Passport Health Plan members also are contacted indirectly through mailings to primary care providers (PCPs). PCPs receive a quarterly listing of members who are not on appropriate medications along with information about their asthma patients' use of services (pharmacy, emergency department, admissions, and specialist). PCPs have responded favorably to this information and requested that future lists be customized, e.g., placing information for only one patient on a page so that it could be inserted in the chart. During a recent HEDIS audit, Passport noticed that PCPs included these reports in patient records.

RESULTS/LESSONS LEARNED: Passport Health Plan exceeded its aim by contacting 100 percent of all identified members with asthma for three quarters in 2001 and the first quarter of 2002. The major obstacle was finding current addresses for members. However, contact information is cross-referenced for members. If an address is incorrect, another contact method (e.g., telephone) is used.

Cimarron Health Plan: Reaching Out to Members to Determine Asthma Knowledge and Level of Control

BACKGROUND: Cimarron Health Plan is a for-profit health plan serving approximately 66,000 Medicaid members in New Mexico.

AIM: Receive information on patient understanding and control of asthma from 60 percent of members identified with persistent asthma (mild, moderate, or severe) through the use of Merck's Asthma Treatment Assessment Questionnaire.

MEASURES:

1. $\frac{\text{\# of members with persistent asthma who returned the baseline ATAQ survey}}{\text{\# of members with persistent asthma sent the baseline ATAQ survey}}$
2. $\frac{\text{\# of members who returned the follow-up ATAQ survey}}{\text{\# of members who returned baseline survey and were sent follow-up ATAQ survey}}$

CHANGE: Cimarron mailed an ATAQ survey to all members identified with mild, moderate, or severe persistent asthma to obtain baseline and six-month follow-up information regarding member's asthma knowledge and the level of asthma control. As an incentive to fill out the survey, consumers who returned the survey received a CD-ROM game, "Air Academy: The Quest for Airtopia," that teaches kids how to control their asthma.

The health plan introduced the baseline ATAQ survey to its members with asthma in three groups:

1. Patients of physicians with 50 or more patients with asthma (April 2002).
2. Patients of physicians with 30-49 patients with asthma (May 2002).
3. Patients of physicians with 29 or fewer patients with asthma (June 2002).

The purpose of the baseline outreach effort was to provide members and their PCPs feedback about which areas would benefit from improvement. The purpose of the six-month follow-up outreach effort was to learn if there had been improvement in level of knowledge and/or level of asthma control, as well as areas where further intervention was needed.

RESULTS/LESSONS LEARNED: To date 1,040 ATAQ surveys have been mailed to 23 adults and 1,017 pediatric members. Only 111 surveys have been completed and entered into the database, representing an 11 percent completion rate. The total numbers of surveys returned as undeliverable was under ten percent.

NEXT STEPS: To address the low completion rate of the ATAQ baseline survey, Cimarron is conducting follow-up calls and distributing letters to members.

Health Plan Action Steps for Outreach

My health plan's challenges:

1. _____
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_____
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2. _____
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_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of members and/or providers the health plan contacts. For example: *Increase the number of outreach visits by health plan staff to provider offices with low prescribing rates for asthma prevention medication from 20 to 50 percent within one year.*

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_____
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_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in asthma-related missed school/work days) and develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:

$$\frac{\text{\# of providers with low prescribing rates visited by health plan staff}}{\text{\# of providers with low prescribing rates}}$$

Change:

Evaluate current outreach methods and evaluate change strategies that will most effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Intervention

What works to improve outcomes of members with asthma?

Clearly, there is evidence that asthma care services, such as the use of inhaled steroids, can prevent acute asthma episodes. Other services, such as self-management education and home environmental assessments, can identify key health issues before they reach a crisis stage.

An assumption of all plans in the *Achieving Better Care for Asthma* workgroup is that there **are** interventions that can make a difference. These tend to focus on improving provider-prescribing patterns; better use of appropriate durable medical equipment, such as peak flow meters; home-based patient education; and increased communication with providers to follow up on asthma-related hospitalizations and ED visits. While this chapter provides examples of some interventions tried by the BCAP plans, many of the activities undertaken in identification, stratification, and outreach also lead to an increase in health plan interventions. For example, the creation of an asthma registry is useful for both identification and stratification of members with asthma, and indicates those members most in need of specific kinds of interventions.

Potential barriers to providing and documenting asthma interventions are listed in Table 8.

Table 8: Common Asthma Interventions and Potential Barriers

Interventions	Barriers
Follow up for members who drop out of routine asthma care.	• Many provider offices that serve primarily Medicaid beneficiaries may function without appointment systems or have no routine procedures for rescheduling missed appointments. • Many primary care offices do not track patient caseload by diagnosis.
Reminder calls for scheduled appointments following asthma-related hospitalization or emergency department visit.	• Incorrect phone numbers or no telephone in the home. • Language and cultural barriers.
Invest in developing provider capacity to "make every visit an asthma education visit."	• Getting providers' attention in a complex market is always challenging.
Provide group self-management education for families affected by asthma.	• Lack of child care services and transportation. • Members may not see the need to attend "classes." • The schedule may be inconvenient, or language/cultural impediments may exist.
Offer incentives to providers to prescribe inhaled steroids for patients with persistent asthma.	• Providers may not accept this as a standard of care. • Patients/parents may not understand the rationale for inhaled steroids and may routinely resist using them when feeling well.

Intervention Strategies to Achieve Better Care for Asthma
Member Strategies
✓ Provide incentives to members with asthma to participate in self-management education, such as a free nebulizer or peak flow meter.
✓ Solicit local businesses and non-profits to provide donations to use for member incentives, e.g., movie tickets, pizza coupons, and bus/subway tokens.
✓ Use a social worker to conduct family interventions to remove the social and psychological barriers to effective asthma management.
✓ Train community-based workers to conduct home assessments and provide guidance on asthma trigger abatement.
Provider Strategies
✓ Link provider compensation to improved delivery of services (e.g., prescribing inhaled anti-inflammatory medications for persistent asthma or documenting an asthma management plan) or to document adoption of plan-sponsored asthma care office systems.
✓ Educate physician office staff on assessing the level of asthma control over a specified time period before the patient sees the physician.
✓ Work with emergency departments to routinely notify primary care physicians when their patients with asthma have been provided emergency asthma-related care.
✓ Assign quality management nurses to monitor high-volume provider offices.
✓ Facilitate coordinated transition between primary care providers and specialists.
✓ Help provider offices implement office tracking systems.

Health Plan Case Studies

Network Health: Using Asthma Action Plans to Improve Member Self-Management

BACKGROUND: Network Health is a provider-sponsored, non-profit Medicaid health plan with approximately 45,000 members in Massachusetts.

AIM: Develop asthma action plans for 80 percent of members with asthma, age two-18, within three months of being identified by pharmacy and utilization data as medium or high utilizers and who are currently in poor control as determined by the plan's assessment tool (ATAQ survey).

MEASURE: $\frac{\text{\# of eligible members with asthma, age two-18, with completed asthma action plans}}{\text{\# of eligible members with asthma, age two-18*}}$

*A member, age two-18, with asthma is eligible for the intervention if he or she is stratified as medium or high risk and is deemed to be "out of control" according to the ATAQ survey.

CHANGE: Network Health hypothesized that the use of asthma action plans increases the likelihood that members will maintain control of their asthma. In order to become eligible for the intervention, members must be stratified as medium to high risk for future utilization and, when assessed by the asthma program manager, are determined to be "not in control" of their asthma based on the ATAQ survey. These members receive a home visit from a qualified asthma educator to develop their asthma action plan. The completed asthma action plan is faxed to the member's provider for approval.

RESULTS/LESSONS LEARNED: As of June 2002, 62.5 percent of eligible Network Health members with asthma had an asthma action plan. Although Network Health was unable to establish a baseline for this activity because asthma action plans were previously not required, the plan is confident that this initial result is an improvement.

Network Health found that it is easier to develop the asthma action plans with members through home visits with an asthma educator, rather than working with the primary care provider. Completed asthma action plans are sent to the member's PCP for signature.

NEXT STEPS: Members will be reassessed one year later using the same survey to determine whether the action plan has helped them remain in control of their asthma as compared to those members eligible for the intervention who did not have a completed asthma action plan.

Health Plus: Focus on Appropriate Pharmacotherapy

BACKGROUND: Health Plus is a non-profit health plan serving 148,000 Medicaid and SCHIP members in the five boroughs of New York City.

AIM: Increase the number of members with persistent asthma who take control medications by 15 percent.

MEASURES:

1. $\frac{\text{\# of members with persistent asthma taking control medications}}{\text{\# of members with persistent asthma taking any asthma medication}}$
2. $\frac{\text{control vs. rescue medication ratio post-intervention}}{\text{control vs. rescue medication ratio pre-intervention}}$

CHANGE: Using a pharmacy database, Health Plus identified members taking asthma medications over a six-month period. The plan identified two groups of members who were good targets for interventions:

- Members with persistent asthma on no control medication.
- Members who are taking a control medication, but are under-medicated (on four or fewer control medications dispensed in the six-month period), based on a diagnosis of persistent asthma.

For both groups, Health Plus developed a physician letter (Appendix E) to report the findings for individual patients. The physician was asked for an update on planned interventions. Health Plus opted to use a baseline of the average control vs. rescue ratio (0.7) for the year prior to the initiation on the intervention.

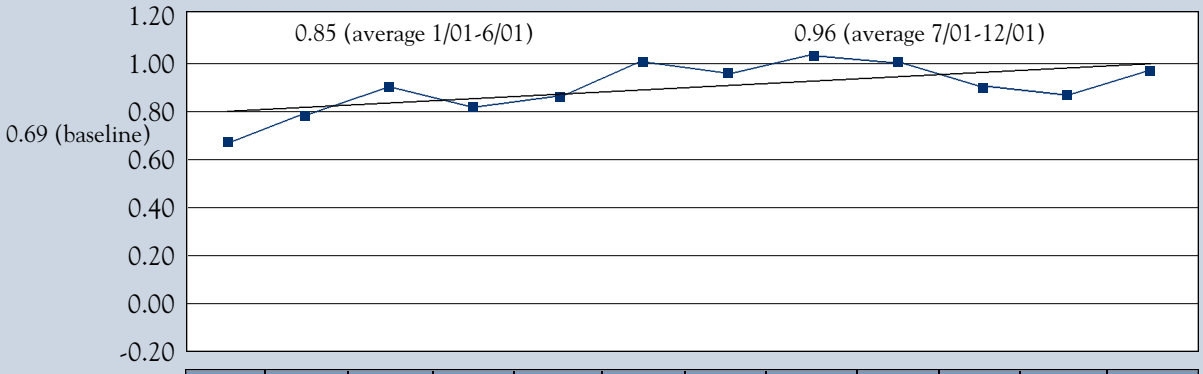
RESULTS/LESSONS LEARNED:

1. From December 2000 to August 2001, the percent of members with persistent asthma on control medications increased from 65 percent to 71 percent.
2. From January to December 2001, the ratio of control vs. rescue medications increased by 39 percent over the baseline ratio, from 0.69 to 0.96 (Figure 3).
3. As of June 2002, Health Plus sent 196 physician letters and received 100 letters in response. The response received indicates that the member had been or would be contacted and medications adjusted. Since the program seems to improve both member health outcomes as well as lead to decreases in ED visits and hospital stays, Health Plus plans to continue to track these members to document improvements.

As a result of the above, admission rates for members with persistent asthma decreased. At baseline, 3.2/1,000 members with asthma were hospitalized. One year later, that number decreased to 2.6/1,000.

NEXT STEPS: Feedback received indicates that providers often are unaware of what medications the member is taking — some members may go to the emergency department to get medication, while others never fill their prescriptions. As a result, the plan has decided to share the information in the pharmacy database with the providers. The plan sends a bimonthly letter that includes the names of all the members in the provider's panel who have filled a prescription for four or more rescue medications without any control medication dispensed during the past six months. The disease management nurse will contact the PCP one month after the letter has been sent to follow up, educate the provider on the program, and assist with contacting the member, if necessary.

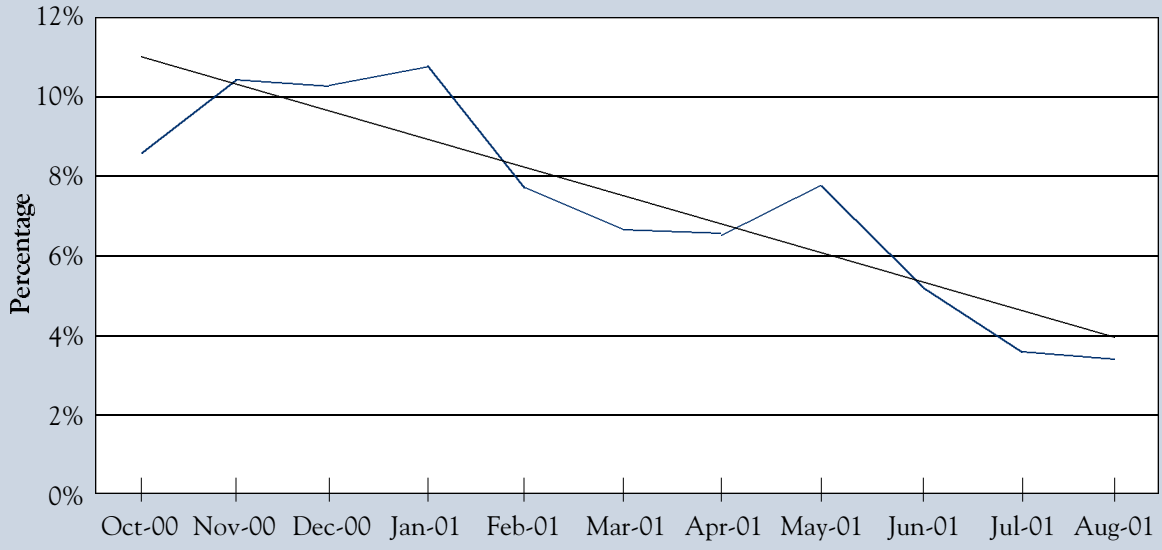
Figure 3: Health Plus Control/Rescue Medication Usage for Members with Asthma



	Jan-01	Feb-01	Mar-01	Apr-01	May-01	Jun-01	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01
Ratio	0.69	0.79	0.90	0.83	0.87	1.03	0.96	1.04	1.01	0.91	0.67	0.96
% change from prior month	0	8%	10%	-5%	3%	16%	-7%	8%	-2%	-10%	-3%	9%

Black line = Trend line Blue line = Actual C/R ratio

Figure 4: Health Plus Percent of Members with Asthma Using Exclusively Rescue Medications



Black line = Trend line Blue line = Percentage of members with asthma using only rescue medications

University of Oklahoma dba Heartland Health Plan: Using a Collaborative Approach to Improving Asthma Care

BACKGROUND: The University of Oklahoma dba Heartland Health Plan of Oklahoma is a Medicaid IPA model plan owned by the University of Oklahoma with 115,733 members.

AIMS:

- Ensure that 100 percent of members with moderate or severe persistent asthma are using appropriate long-acting anti-inflammatory medication per NAEPP asthma guidelines.
- Ensure that 90 percent of members with moderate or severe persistent asthma have a written asthma action plan.
- Increase by 75 percent the use of peak flow meters at home for members with severe or persistent asthma.

MEASURES:

1. $\frac{\text{\# of members with moderate or severe persistent asthma using appropriate long-acting anti-inflammatory medication}}{\text{\# of members with moderate or severe persistent asthma}}$
2. $\frac{\text{\# of members with moderate or severe persistent asthma with a written asthma action plan}}{\text{\# of members with moderate or severe persistent asthma}}$
3. $\frac{\text{\# of members with moderate or severe persistent asthma using peak flow meters at home, post-intervention}}{\text{\# of members with moderate or severe persistent asthma using peak flow meters at home, pre-intervention}}$

CHANGES: Heartland Health Plan, working as part of a collaborative pilot project, including the Oklahoma Health Care Authority and the University of Oklahoma Community and General Pediatrics Clinics, brought about a standardized approach to the care of patients with asthma. The following changes were piloted in one provider clinic:

- Implementation of NAEPP asthma guidelines.
- An assessment and plan of action completed by the medical provider. See Appendix F for Asthma Encounter Form.
- An asthma self-management plan communicated to the patient/guardian. See Appendix G for Breathing Better in Oklahoma Asthma Management Plan.
- Education and instruction regarding triggers and how to monitor asthma status.

RESULTS/LESSONS LEARNED: The results of the measurement period from February 1, 2001 to September 30, 2001 were as follows:

Table 9: Heartland Health Plan of Oklahoma Intervention Results

Measure	Baseline	Goal	Results
Use of long acting anti-inflammatory medications	23.2%	100%	93.5%
Peak flow meter use at home	12.8%	75%	93.8%
Written asthma action plan	3.7%	>90%	100%

Partnership HealthPlan of California: Giving Feedback to Providers to Drive Appropriate Medication Use

BACKGROUND: Partnership HealthPlan of California (PHC) is a non-profit Medicaid health plan in northern California with 77,000 members.

AIM: Ensure that 100 percent of PHC members with asthma are using appropriate prescriptions and that members receive asthma care in the most appropriate location based on severity of their disease.

MEASURES:

1. $\frac{\text{\# of members with persistent asthma with one or more controller prescriptions in the measurement year}}{\text{\# of members with persistent asthma}}$
2. $\frac{\text{\# of members with persistent asthma with eight or less canisters of rescue medication (short-acting beta-agonists) in the measurement year}}{\text{\# of members with persistent asthma}}$
3. $\frac{\text{\# of members with persistent asthma with no emergency department visits in prior year}}{\text{\# of members with persistent asthma}}$
4. $\frac{\text{\# of members with persistent asthma with no inpatient hospital stays in prior year}}{\text{\# of members with persistent asthma}}$

CHANGES: Partnership HealthPlan of California implemented a variety of strategies to assist providers in better monitoring asthma care, including:

- Distributing beta-agonist overuse reports every six months to physician practices (Appendix H). Reports were reviewed at academic detailing visits and practice sites were surveyed regarding usefulness. PHC also proposed to its Physician's Advisory Committee to add the HEDIS asthma measure to the PCP Quality Bonus Incentive criteria for FY 2001/2002. The plan sent full medication profile and a letter to PCPs for members with more than eight canisters of beta-agonist within a one-year period.
- Sponsoring annual physician education updates regarding appropriate management of asthma, training PCP staff in asthma education, and offering enhanced benefits for member asthma education.

RESULTS/LESSONS LEARNED: From 2000 to 2002, PHC achieved the following:

- Increased the percentage of members with asthma using one or more control medications (58.6 percent vs. 67 percent).
- Increased the percentage of members with asthma with eight or less canisters of beta-agonist (83.5 percent vs. 85 percent).
- During this time, PHC also saw the percentage of members with asthma using the emergency room drop from 28.2 percent to 22.5 percent and the members with asthma with no hospital stays remained constant at 97 percent as of first quarter 2002.

Partnership HealthPlan of California found that getting the overuse reports into the practitioners' hands was critical. After reports were mailed in January 2001, follow-up phone calls revealed that more than half of the practice sites had not seen the reports. In response, the plan hand-delivered high beta-agonist reports to 43 practice sites (214 members). The summary report was printed on colored paper and was the first sheet in the report. A follow-up survey showed that practitioners were using the reports appropriately and found them very useful.

Passport Health Plan: A Multi-Layered Strategy to Encourage Appropriate Utilization among Members with Asthma

BACKGROUND: Passport Health Plan is a provider-owned health plan with 118,000 enrollees in Kentucky.

AIMS:

- Increase members with persistent asthma on a control medication from a baseline of 74 percent to 80 percent.
- Decrease current emergency department utilization for uncontrolled asthma from a baseline of 31 percent to 15 percent of total asthma members.
- Decrease current hospital admissions for asthma from a baseline of eight percent to four percent of total asthma members.

MEASURES:

1. $\frac{\text{\# of members with persistent asthma on control medication}}{\text{\# of members identified with persistent asthma}}$
2. $\frac{\text{\# of members with asthma utilizing emergency department}}{\text{\# of members identified with asthma}}$
3. $\frac{\text{\# of members with hospital admission for asthma}}{\text{\# of members identified with asthma}}$

Passport used the definition of control medication adopted by HEDIS 2001. Emergency department and hospital use for asthma were identified as those members having at least one emergency claim and at least one hospital admission claim with the primary diagnosis of asthma (493.xx).

CHANGES: The plan implemented several improvement strategies, including:

- **Provider Report of Members with Asthma:** Lists provider's patients, the number of asthma related emergency department visits and hospitalizations, and pharmacy utilization of rescue and control medications (see Appendix I).
- **Provider Outreach Visits:** Visits to providers by the Asthma Disease Manager to inform them about the Asthma Disease Management Program, program activities (e.g., member educational material, provider asthma member reports), NAEPP asthma guidelines, and services available in managing patients with asthma.
- **Member Education:** Asthma educational materials are sent to members with asthma quarterly to increase member's asthma knowledge.
- **Individual Asthma Disease Management:** The Asthma Disease Manager works with members with asthma who are high utilizers of services. The Asthma Disease Manager contacts members by phone, does a complete asthma assessment, and helps the members and their provider to improve their asthma control and management.
- **PCN (pharmacy vendor) Intervention Letters:** Passport's pharmacy vendor sends letters to providers notifying them of inappropriate use of specific members' medications in relation to their asthma care.

RESULTS/LESSONS LEARNED: As of fourth quarter 2001, Passport increased the percentage of members on control medication from 74 percent to 82 percent (Figure 5). The plan decreased the percentage of members using the emergency department from 31 percent in first quarter 2001 to 18 percent in fourth quarter 2001 (Figure 6). The plan also decreased the percentage of members with hospital admissions for asthma from eight percent in first quarter 2001 to six percent in first quarter 2002.

Figure 5: Percent of Members with Asthma with Appropriate Medication Use

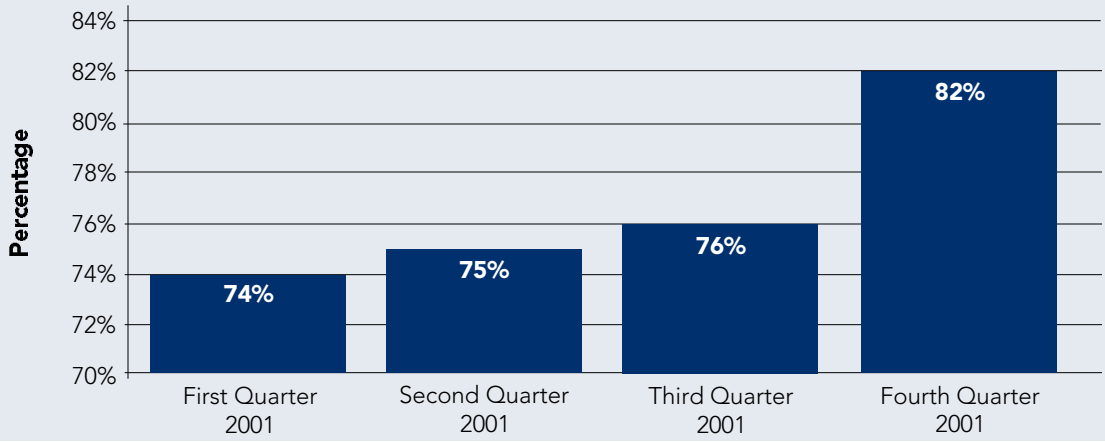
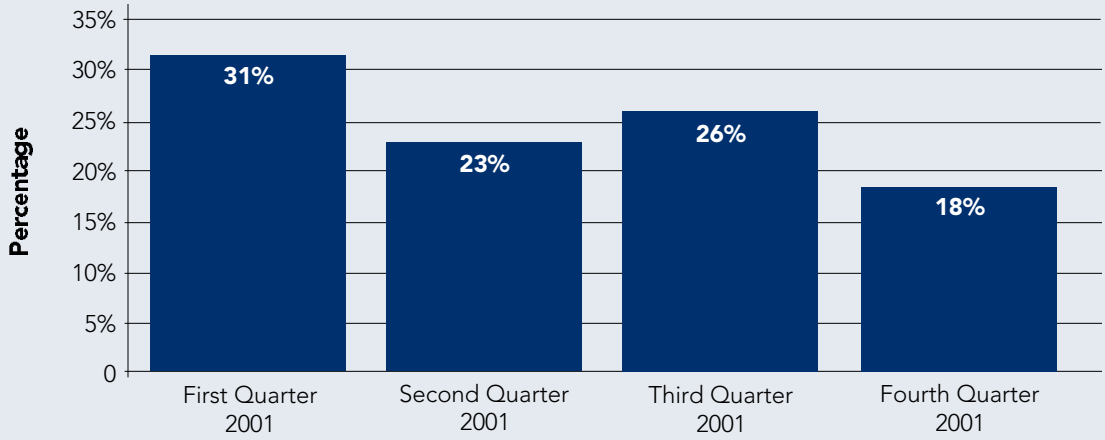


Figure 6: Percent of Members with Asthma Visiting the Emergency Department



INTERVENTION ALTERNATIVES:

Improving Asthma Care for Children, a national program funded by The Robert Wood Johnson Foundation and administered by the Center for Health Care Strategies, is funding five efforts to improve the management of pediatric asthma in high-risk Medicaid and SCHIP beneficiaries. The projects described here offer additional ideas for asthma intervention that can be applied using the BCAP Typology for Improvement.

▶ Affinity Health Plan: Provider Incentive to Participate in Case-Based Training

Affinity Health Plan, based in Bronx, New York, is developing a case-based continuing education program for primary care clinicians to promote adherence to the NAEPP asthma guidelines. The training is performed at pediatric and family practice sites that manage a large number of Affinity members with asthma. Based on provider feedback, one of the changes Affinity implemented is reimbursement for appropriate office-based spirometry and nebulizer treatments. Previously, many practitioners were performing these services as part of their capitation. Once the training program is completed, providers receive four Continuing Medical Education (CME) credits and notification that they may bill for medically necessary spirometry and nebulizer treatments. These services will be paid in addition to capitation.

▶ Contra Costa Health Plan: Use of Asthma Community Advocates

Contra Costa Health Plan, in Martinez, California, is collaborating with the Contra Costa Health Services Department and several community agencies to recruit and train neighborhood residents to provide education about asthma to fellow residents and to provide assessments of environmental triggers for asthma during home visits. The goals of the 36-hour training program are to increase knowledge about asthma and related environmental triggers; to provide the advocate with information to assist a family/child in establishing a medical home; and to demonstrate techniques that will be helpful to the advocate in giving presentations, conducting home assessments, and facilitating group sessions. Each of the trained Community Advocates receives a stipend. Evaluation of the Asthma Community Advocate's work and effectiveness will be monitored by the asthma project team.

▶ Family Health Partners: Provider Incentives for Member Asthma Education

Family Health Partners (FHP), based in Kansas City, Missouri, is developing an education program for provider offices that includes incentives for physicians to conduct member asthma education. Family Health Partners arranged to pay for asthma education by assigning a CPT code that the provider would use when the education has been performed. Since there currently is not a code for asthma education, FHP identified two appropriate surrogate codes: 99402 for a 30-minute education session (initial education) and 99401 for 15 minutes (follow-up education). Providers are not eligible to use these codes to charge for services until they complete the asthma education program. The plan is working with the American Medical Association, through the Joint Council of Allergy, Asthma, and Immunology, to get a new CPT code that is specifically for asthma patient education.

HealthNow: Collaborating with Regional Medicaid Health Plans to Improve Asthma Care

HealthNow is overseeing the collaborative efforts of Community Blue, the health maintenance organization of BlueCross BlueShield of Western New York (a division of HealthNow), Independent Health, and Univera Healthcare to improve asthma care for children, age three to seven, in the Buffalo, New York area. In addition to the three Medicaid health plans, project participants include the American Lung Association, Children's Hospital, and a local business health group. Asthma intervention activities of the project include:

- Conducting asthma educational seminars for day care staff.
- Presenting educational programs for parents of children with asthma.
- Developing common pediatric asthma practice guidelines for network physicians.
- Creating an asthma care kit for families of children with asthma.
- Conducting a CME program for pediatricians who may not routinely follow the practice guidelines.

Monroe Plan for Medical Care: Working in the Community to Manage Pediatric Asthma

Monroe Plan for Medical Care, based in Rochester, New York, is working with Rochester-area school-based and community health centers to decrease asthma-related emergency room visits and hospitalizations. Through Monroe's integrated delivery network partner, ViaHealth, the plan is working to improve asthma care delivered at three urban federally qualified health centers, three school-based health centers, and The Mary Parkes Asthma Center, a ViaHealth Center of Excellence staffed by a multi-disciplinary team of asthma specialists. In partnership with these providers, Monroe Plan is seeking to improve the identification and diagnosis of children with asthma, help patients and their families better manage their disease, and more effectively coordinate care for members with asthma in primary care, specialty, and school settings.

For more information about *Improving Asthma Care for Children*, visit **www.chcs.org.**

Health Plan Action Steps for Intervention

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of members who receive asthma intervention services. For example: *Ensure that 90 percent of members with moderate or severe persistent asthma have a prescription for an inhaled anti-inflammatory medicine*.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:
# of members with moderate/severe persistent asthma with prescription for inhaled anti-inflammatory medication
# of members with moderate or severe persistent asthma

Change:

Evaluate interventions that will most effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Improving Asthma Care at the Provider Level

Physicians and nurses are committed to improving the health and well being of the patients they serve. But why is it that study after study documents that children with asthma fail to receive clinically proven therapies that result in fewer symptoms and improved ability to function? Today's practice delivery system is largely to blame for this disconnect. The system is designed to provide short-term, "transactional" care — the patient comes in with a problem, the clinician makes an assessment and provides the treatment. Simply knowing the science about what treatments work best does not result in changes in the processes of care without broader restructuring of the practice delivery system.

Health plans can play a role in helping physician practices change basic practice patterns to improve the quality of asthma care for members. A complete system for improved care should include policies that support patient-centered, evidence-based care. Health plans can distribute best asthma practice guidelines to physician practices, provide education on adhering to the guidelines, and offer incentives for practices that follow the guidelines. The best source for specific recommendations for asthma care come from evidence-based guidelines, such as those provided by NAEPP. NICHQ summarizes these guidelines as follows:

- Classify severity at every contact.
- Use appropriate anti-inflammatory medication, in appropriate dosage, for all patients with persistent asthma.
- Plan treatment with patients and families and give them a written asthma management plan to document medications and guide actions at home, school, and day care.

NICHQ has found that the first step in designing a system that better meets patient needs and more reliably delivers evidence-based care is to clearly envision what that system would look like.[11,12] Practice systems that meet the needs of patients with asthma have the following characteristics:

- A process for tracking all patients with asthma in the practice and identifying/stratifying patients in need of particular services.
- A method to bring the evidence about best care approaches to the "bedside," i.e., by embedding guidelines in practical tools such as encounter forms and wall charts.
- A team-based approach to care delivery, with each member of the team having a well-defined role and the skills of each profession being best utilized.
- Processes that support the ability of patients and their families to manage their own conditions and enable clinicians to coach patients and families to achieve these goals.
- Close linkages with community resources, such as schools, athletic programs, and day care, to provide a seamless web of care to meet patient needs.

For More Information

This chapter summarizes practice management strategies developed by the National Initiative for Children's Healthcare Quality (NICHQ). The need to promote reorganization of practice systems to improve care and outcomes has led NICHQ to conduct more than half a dozen projects – either on its own or in collaboration with other organizations such as the McColl Institute for Healthcare Innovation, the Institute for Healthcare Improvement, and the Bureau of Primary Care within the United States Health Resources and Services Administration. Visit www.nichq.org for more information.

[11] Wagner EH, Austin BT, and Von Korff M. "Organizing Care for Patients with Chronic Illness." *Milbank Quarterly*, 1996.

[12] Wagner EH. "Chronic Disease Management: What Will it Take to Improve Care for Chronic Illness?" *Effective Clinical Practice*, 1998.

Health plans can provide physician practices with tools to facilitate and accelerate implementation of these system changes. NICHQ developed and tested tools that assist in making the changes required (Appendices J, K, and L).

"Stellar Practice" Case Study

The Problem

How would the current practice delivery system typically care for a child with asthma? Consider Jesse, a six-year-old boy who has been hospitalized for asthma three times in the past two years, with multiple ED and acute office visits. He visits his physician without taking any control medications regularly. His mother reports that Jesse wakes up three times a week with a cough, and he wheezes almost daily. The first grader is unable to participate in sports because he gets short of breath, and cannot keep up with the other children. Jesse is prescribed a quick relief medicine, and a short course of oral corticosteroids. The physician gives the family a brochure about asthma, and tells them to return if Jesse's symptoms do not improve in a week, and otherwise to come in when it is time for his next check up.

A Potential Solution

How would Jesse's experience differ if he were cared for in a practice that had implemented the system changes reviewed here? Jesse's visit would have been prompted by the practice or Jesse's health plan noting an excessive amount of refill requests for his asthma reliever medicine and requesting that Jesse come in for an evaluation. His family would have completed a brief symptom report prior to Jesse being seen by the clinician, and the office staff would have checked his lung function. Using a color-coded wall chart (also reflected in the encounter form), the medical assistant would have indicated the likely asthma severity. The parent report also would indicate potential triggers for Jesse's asthma. During the physician encounter, the physician would communicate the diagnosis and the severity of Jesse's asthma, and discuss treatment goals with the family. The physician would prescribe a maintenance-inhaled corticosteroid, and perhaps additional medicines (such as a long-acting bronchodilator), and link medication usage to addressing patient goals. The office nurse would provide additional education about inhaler and spacer techniques and complete a written asthma management plan. With Jesse's mother's permission, the nurse would share the plan with Jesse's school nurse and his health plan. The school nurse and the practice would have regular calls to review both patient-specific issues and general policies at the school. The front desk staff would schedule a follow-up phone call within three days, and a follow-up visit in three to four weeks. Jesse's mom would be referred to a state-sponsored smoking cessation program.

Health Plan Role

Health plans can facilitate practice-based improvement by coordinating with others in a geographic area to come up with common guidelines and management plans; investing in the creation of registry software that practices can use; providing data about emergency department encounters and pharmaceutical use; and providing adequate access to specialists for patients and primary care clinicians. Plans can assure that durable medical equipment such as nebulizers and peak flow meters are available at limited charge and hassle, and they can support smoking cessation programs for parents of children with asthma. Health plans also can give physicians updated community resources and plan case managers can provide member education and monitoring. Such activities are synergistic with practice-based improvement activities, and together can lead to better care and outcomes for children with asthma.

Results

What would this mean to Jesse and his family? After four months under the care provided in this rejuvenated "Stellar Practice," Jesse reports he wakes up only once a month coughing, and has no wheezing on a regular basis. He uses his Albuterol once every two weeks. He practices soccer daily and plays in his town's soccer league. He loves gym and prefers sports to TV. Jesse has not missed one day of school this term and his mom has not missed a day of work.

Achieving this level of care takes more than just knowledge about good asthma care, and more than a set of reminders, plans, and other tools. Achieving this level of care requires a fundamental change in the practice system that is supported by physicians, health plans, and families.

Communicate to Create Change

Without effective internal and external communication, even the best quality improvement ideas will falter moving from theory to reality. Good communications strategy can solidify buy-in within your organization and, externally, can facilitate collaboration with states, enhance support from providers and their staff, and increase understanding by, and participation of, members.

A good communications strategy is largely common sense:

1. Whom do I need to reach to make this initiative as successful as possible?
2. What does the target audience(s) need to know?
3. How do I reach the audience(s)?

Successful communications hinges on committing time at the beginning of a project to answer these questions and outline a consistent strategy to deliver your message. A written "communication plan," that clearly outlines each of the three components and how they are addressed, is a useful starting point.

Identify Your Audiences

The first step in developing a communications strategy is to define your audience. Internal audiences are essential to building organizational support for your project. Think beyond the team working on your quality improvement project. You might ask, "Whose cooperation do I ultimately need to keep this project moving?" It might be information services contacts whom you rely on for data extraction, front-office staff who answer calls and direct enrollees to case managers, and/or a senior executive whose approval you need for additional staffing support.

Keep your plan's public relations/communications staff aware of your activities. Their support and knowledge of your activities is vital to promoting your accomplishments in established communications vehicles, including internal and/or external plan newsletters, press releases, and media outlets.

Potential Audiences

Internal:
- Health Plan CEO
- Information Services
- Claims Department
- Quality Improvement
- Public Relations/Communications
- Marketing
- Member Services

External:
- Members
- Providers
- State health purchasers
- Other health plans
- Consumer organizations
- Media
- Accrediting bodies

External audiences include anyone outside your plan whose cooperation is necessary to achieve pilot program goals, as well as anyone who would be interested in the successful outcome of the initiative. For example, clear communication with providers and their office staff is critical in successfully identifying members, assessing risk, and implementing interventions. Outreach activities for members require communications tactics geared specifically toward their specific needs and desires.

State Medicaid and SCHIP contacts should not be overlooked as an audience. Keeping states aware of plan quality initiatives and accomplishments will go far in building collaborative partnerships toward a common goal of quality care for Medicaid beneficiaries.

San Francisco Health Plan: Communicating to Build Internal Support

Building the support of colleagues is the first step in getting a new quality initiative off the ground. After attending a BCAP workshop on *Improving Preventive Care Services for Children* in March 2002, Rowena Tarantino, MPH, Manager of Health Education, and Michelle Persha, MPH, Quality Improvement Analyst at San Francisco Health Plan (SFHP), developed a quality improvement strategy to identify overweight child and adolescent members and create provider and member education activities to help these children. After the workshop, the two coordinated brown bag lunch seminars at the plan inviting key colleagues, including representatives from Medical Management, Member Services, Information Systems, and Human Resources, to explain the BCAP process and their proposed quality pilot. Their focus on communication from the onset of the program was worth it.

Working with its Information Systems department, the plan analyzed data over a three-year period and calculated the body mass index for a sample population of children and adolescents. The plan then stratified by age, sex, ethnicity, neighborhood, and clinic site. The analysis revealed a high prevalence of overweight children among the ethnic groups primarily served, specifically Latino, African American, and Asian populations. SFHP identified target clinics in priority neighborhoods and is collaborating with providers to develop tools to assist with screening and assessment, member education materials, as well as to identify community resources for patient referral and care.

"From the beginning, our Health Education, Quality Improvement, and Information Systems departments worked as a team and used the BCAP process to quickly build internal support and a strong foundation for our intervention," says Ms. Tarantino.

Define Your Messages

Once you identify audiences to reach, the next step is crafting a compelling message to reinforce at every opportunity. In most cases, you will start with your overall Aim Statement linked to your quality initiative and reframe it slightly for each audience depending on their perspective. Internally, you may use the same message with different gradations based on your audience. To help revise the message for each audience, answer the following: *Why do they care?* and/or *How will it help them?* The message should be simple and easy to remember. For example:

- **Internal – *Increase identification of members with asthma within ABC Health Plan by 25 percent in 2002.*** This is important for ABC Health Plan because it will potentially improve the health of members with asthma and improve HEDIS scores.
- **Providers – *Submit asthma management plans to ABC Health Plan and receive a $25 incentive.*** This is important for providers because reimbursement will increase and patients will receive more coordinated care.

- **Members –** ***Does asthma keep you or your child from doing what you enjoy?*** Visit your doctor now to keep your asthma in control. This is an important message for members and their parents to hear.
- **State –** ***ABC Health Plan is working to decrease the asthma-related hospitalization rate by identifying members in need of services.*** This is important for the state because these members will ultimately receive higher quality, more responsive, and more cost-effective care.

Partnership HealthPlan of California: Using the Personal Touch to Communicate with Providers

Partnership HealthPlan of California, a member of the *Achieving Better Care for Asthma* workgroup, developed a multi-prong quality improvement strategy to enhance communications with providers to increase the effectiveness of asthma disease management in provider offices. The plan created personalized beta-agonist overuse reports (Appendix H) for physician practices. But after the reports were initially sent out, the plan found that many providers had not even seen the document. For the second distribution of the report, Partnership created a summary sheet that clearly outlined how providers could use the information in the beta-agonist overuse reports. The summary sheet and the first page of the report were printed on brightly colored paper and the reports were hand-delivered to 43 practice sites. A follow-up survey revealed that providers appreciated the reports and were responding to the information. (See the Intervention section for more information about this project.)

Use Communications Tools Creatively

Effective communications need not break the budget, or require intensive time commitment. A successful communications strategy could entail tactics as simple as distributing a clearly written e-mail status report on a monthly basis to important internal contacts. Posting graphics in a public location showing ongoing results of your project provides recognition for team members and can build support and enthusiasm throughout the organization. The key to employing communications tools effectively is consistent use, reinforcement, and gearing tools for specific audiences. Your communications strategy will guide the specific tools or tactics that you use.

Samples of communications tools include:

- Letters, memos.
- Quarterly internal updates.
- Quality improvement status meetings.
- Quality improvement e-mail updates.
- Newsletters (print or e-mail).
- Website.
- Posters, flyers.
- Standardized presentation.
- Press releases.
- List-servs.

Evaluate Effectiveness of Communications

Evaluate the effectiveness of your communications strategy to determine what works and does not work for your target audiences. Define the desired response of your communication up front (e.g., consistent use of a new form, cooperation with a new procedure, referrals, etc.). Then, when you review overall outcomes of your quality initiative, devote time to examine how your communications strategy met the overall goal of the project. If the target audience did not respond appropriately, you may want to rethink your communications strategy to reach them more effectively.

Appendix A

Achieving Better Care for Asthma
Improvement Documentation Form

PLAN NAME: _____

Category: ❑ Identification ❑ Stratification ❑ Outreach ❑ Intervention

Aim Statement:	
Measure(s):	_____
Change:	

Implementation Plan:

Who:	
What:	
When:	
Training:	
Communication:	
Troubleshooting:	

Appendix B

Affinity Health Plan Asthma Health Risk Assessment

Affinity Health Plan
Dedicated to Excellence

Patient's name _____ DOB _____ Age _____
Today's Date _____ Completed By: _____

1. When were you (or your child) diagnosed with asthma? _____
2. How many days have you (or your child) had problems with coughing __, wheezing__, SOB__, or chest tightness?
   __ ≤2xWeek __>2xWeek but <1xWeek __Every day
   __Continuously
3. How often are you (or your child) awakened during the night with symptoms?
   __≤2xMonth __>2xMonth __>1xWeek
   __Frequently
4. How often do you (or your child) have symptoms after exercise, play, or other physical activity?
   __Rarely __May affect activity __Affects activity
   __Limited physical activity
5. Do you (or your child) have a peak flow meter? __Yes __ No Frequency of use_____ Personal Best PEF_____
6. Do you (or your child) use a nebulizer? __Yes __ No Spacer? ___Yes ____ No
7. What medications, if any, do you (or your child) take for your asthma? Frequency?

Steroids:

- ❑ Aerobid (flunisolide)
- ❑ Azmacort (triamcinolone)
- ❑ Beclovent (beclomethasone)
- ❑ Flovent (fluticasone)
- ❑ Pulmicort (budesonide)
- ❑ Vanceril (beclomethasone)
- ❑ Advair (fluticasone propionate 100 mcg / salmeterol 50 mcg inhalation powder)

Nonsteroidal Anti-inflammatory:

- ❑ Tilade (nedocromil)
- ❑ Dexicort Respihaler (budesonide)
- ❑ Crolom(cromolyn)

Beta, adrenergic Agonists:

- ❑ Albuterol inhibitor
- ❑ Maxair (pirbuterol)
- ❑ Proventil (albuterol)
- ❑ Severent (salmeterol)
- ❑ Ventolin (albuterol)
- ❑ Alupent (metaproterenol) inhibitor
- ❑ Isuperol (isoproterenol)
- ❑ Brethine (terbutaline)

Others:

- ☐ Accolare (zafirlukast) – leukotrienne
- ☐ Atrovent (ipratropium) – anticholenergic
- ☐ Epipen (epinephrine) – sympathomimetic
- ☐ Theophylline/dyphylline – bronchodilator
- ☐ Zyflo (zileuton) – leukotrienne inhibitor
- ☐ Singulair (montelukast) – leukotrienne
- ☐ Other _____

8. In the last six months, how often did you (or your child) seek medical care for asthma ?
   Name: _____ Doctor _____ School-based Clinic _____
   ER _____ Hospital _____
9. How many times a week do you (or your child) miss school, play or work due to asthma?
   _____
10. Do you smoke? If yes: How many cigarettes per day? How many packs per week? Are you interested in a smoking cessation program or medication? (Offered? Yes _____ No _____)

Optional for levels one and two, Required for levels three and four: Offer a referral to the appropriate Asthma Specialist.

Offered: Yes ___ No ___ To whom:_____ Accepted: Yes ___No ___

Appendix C

CareOregon Asthma Program Referral Form

CareOregon

CareOregon Asthma Program Referral Form

Hospital/Clinic _____ Date: _____ Attending Physician: _____

Patient Name: _____ Guardian Name: _____

Date of Birth: _____ Patient Phone: _____

Asthma Action Plan? Yes No Insurance: _____

5-11 y/o patient's with asthma, as defined below, should be referred to the intervention program.

NHLBI Definition of Moderate and Severe Persistent Asthma:

Moderate Persistent	Symptoms: • Daily symptoms. • Daily use of inhaled or short acting beta$_2$-agonist. • Exacerbations may affect activity. • Exacerbations ≥ 2 times a week; may last days.	Nighttime Symptoms: >1 time a week	• FEV, or PEF >60% ≤ 80% predicted • PEF variability > 30
Severe Persistent	• Continual symptoms. • Limited physical activity. • Frequent exacerbations.	Frequent	• FEV, or PEF ≤60% predicted • PEF variability > 30%

Please check all applicable:

[ ]Pt has moderate/severe asthma
[ ] Pt is 5 – 11 years old
[ ] Pt on OHP/ no insurance
[ ] Caregivers English or Spanish speakers

Patient not referred because:

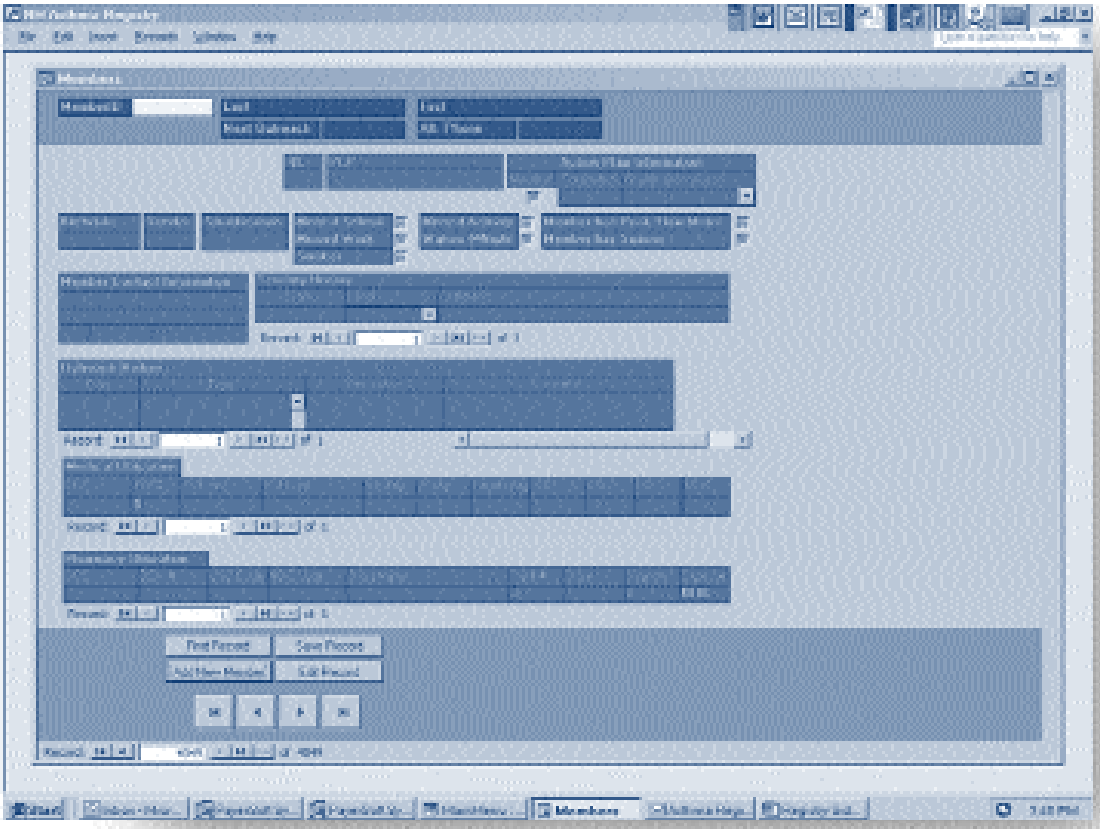
[ ] Pt does not have moderate/severe asthma
[ ] Pt caregivers declined
[ ] Could not locate
[ ] Other _____

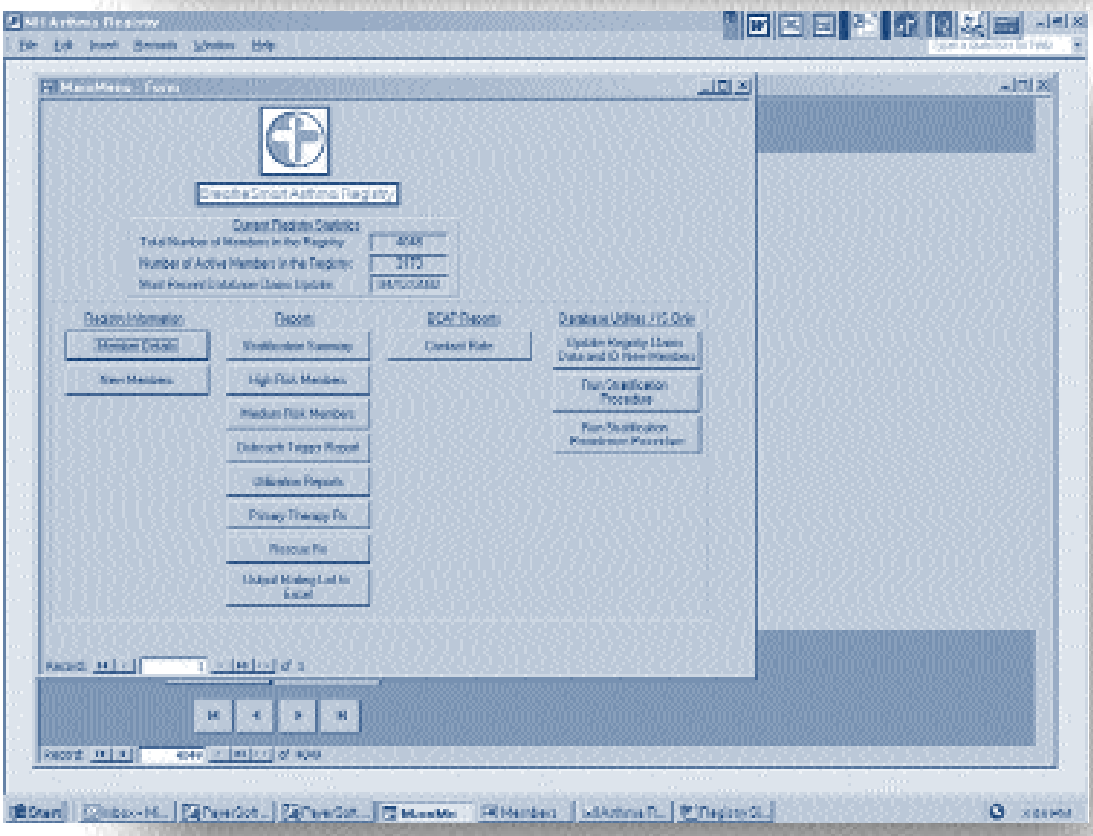
Medications:

☐ Short Acting Beta Agonists (Albuteral, Ventolin,Proventil, Metaproternaol, Alupent, Pirbuterol, Maxair)
☐ Long Acting Beta Agonists (Salmeterol, Serevent)
☐ Inhale Corticosteroids (Beclomethasone, Vanceril, Becloveni, Budesonide, Pulmicort, Flunisolide, Aerobid, Fluticasone, Flovent, Triamcinolone, Azmacort)
☐ Oral Steroids (Prednisone)
☐ Leukotriene Inhibitors (Montelukask, Singulair, Zafirlukast, Accolate, Zileuton, Zyflo)
☐ Methylxanthines (Theophylline, Slo-Phyllin, Elixophyllin, Aminophyline)
☐ Other (Cromolyn, Intal, Ipatropium, Atrovent)

Appendix D

Network Health Asthma Registry Template





Appendix E

Health Plus Asthma Member Medication Usage Letter to Practitioners

John Doe, MD
FAMILY PHYSICIAN HEALTH CENTER
5616 6th Avenue
Brooklyn, NY 11220

Dear Health Plus Participating Physician:

As part of our asthma disease management program, Health Plus identifies members who are taking rescue medications but have no record of receiving control medications. Our goal is to assure that all asthmatics who meet the NIH Expert Panel's guidelines for getting control medications are receiving them. As you may know, these guidelines have recently been revised to include the use of leukotriene modifiers and long-acting bronchodilators. A schematic of the guidelines published by the National Institute for Children's Healthcare Quality (NICHQ) is enclosed. The full description may be found at the web site of the National Asthma Education and Prevention Program at www.nhlbi.nih.gov/ guidelines /asthma/index.htm.

The following attachment lists members of your panel who have been identified as having received more than 34 prescriptions for rescue medications without any control medications, during the past six months.

Please contact these members as soon as possible and evaluate them for the need for control medications. A Health Plus disease management nurse will contact your office within a reasonable period of time to ascertain the results of these evaluations. If you need assistance or wish to enroll a member in the asthma disease management program please contact the program at (718) 630-0123.

We appreciate your help with our asthma disease management effort.

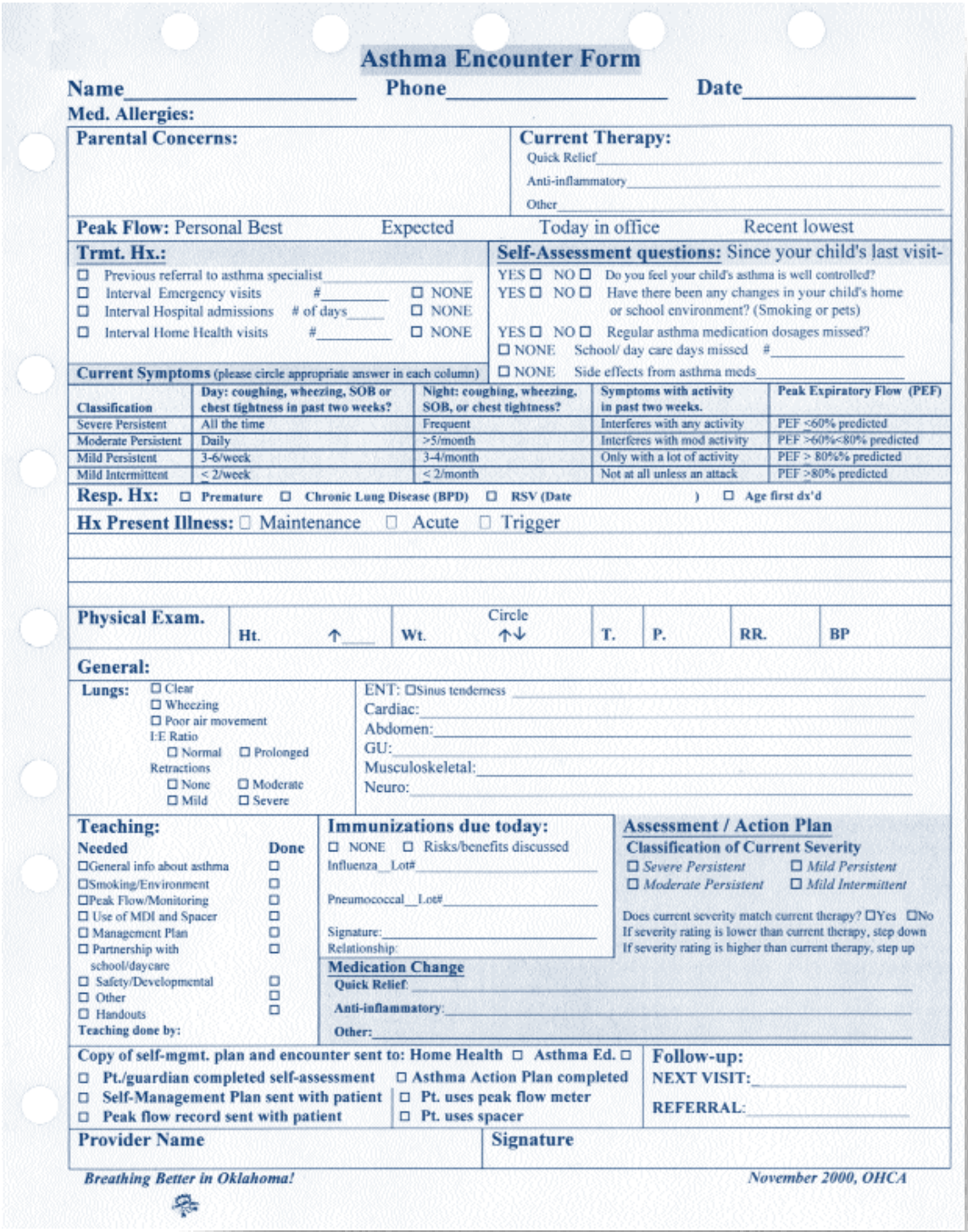
Very truly yours,

Arthur L. Levin, MD
Medical Director

Appendix F

Heartland Health Plan of Oklahoma Asthma Encounter Form

The Asthma Encounter Form is designed as a tool that enables the medical provider to see numerous components involved in the treatment and monitoring of a patient with asthma.



Asthma Encounter Form

Name_____ **Phone**_____ **Date**_____

Med. Allergies:

Parental Concerns:

Current Therapy:
Quick Relief_____
Anti-inflammatory_____
Other_____

Peak Flow: Personal Best Expected Today in office Recent lowest

Trmt. Hx.:
- ☐ Previous referral to asthma specialist_____
- ☐ Interval Emergency visits #_____ ☐ NONE
- ☐ Interval Hospital admissions # of days_____ ☐ NONE
- ☐ Interval Home Health visits #_____ ☐ NONE

Self-Assessment questions: Since your child's last visit-
- YES ☐ NO ☐ Do you feel your child's asthma is well controlled?
- YES ☐ NO ☐ Have there been any changes in your child's home or school environment? (Smoking or pets)
- YES ☐ NO ☐ Regular asthma medication dosages missed?
- ☐ NONE School/ day care days missed #_____
- ☐ NONE Side effects from asthma meds_____

Current Symptoms (please circle appropriate answer in each column)

Classification	Day: coughing, wheezing, SOB or chest tightness in past two weeks?	Night: coughing, wheezing, SOB, or chest tightness?	Symptoms with activity in past two weeks.	Peak Expiratory Flow (PEF)
Severe Persistent	All the time	Frequent	Interferes with any activity	PEF <60% predicted
Moderate Persistent	Daily	>5/month	Interferes with mod activity	PEF >60%<80% predicted
Mild Persistent	3-6/week	3-4/month	Only with a lot of activity	PEF > 80%% predicted
Mild Intermittent	< 2/week	< 2/month	Not at all unless an attack	PEF >80% predicted

Resp. Hx: ☐ Premature ☐ Chronic Lung Disease (BPD) ☐ RSV (Date) ☐ Age first dx'd

Hx Present Illness: ☐ Maintenance ☐ Acute ☐ Trigger

Physical Exam. Ht. ↑____ Wt. Circle ↑↓ T. P. RR. BP

General:

Lungs: ☐ Clear ☐ Wheezing ☐ Poor air movement
I:E Ratio ☐ Normal ☐ Prolonged
Retractions ☐ None ☐ Moderate ☐ Mild ☐ Severe

ENT: ☐Sinus tenderness_____
Cardiac:_____
Abdomen:_____
GU:_____
Musculoskeletal:_____
Neuro:_____

Teaching:

Needed	Done
☐General info about asthma	☐
☐Smoking/Environment	☐
☐Peak Flow/Monitoring	☐
☐ Use of MDI and Spacer	☐
☐ Management Plan	☐
☐ Partnership with school/daycare	☐
☐ Safety/Developmental	☐
☐ Other	☐
☐ Handouts	☐

Teaching done by:

Immunizations due today:
☐ NONE ☐ Risks/benefits discussed
Influenza__Lot#_____
Pneumococcal__Lot#_____
Signature:_____
Relationship:

Assessment / Action Plan
Classification of Current Severity
☐ *Severe Persistent* ☐ *Mild Persistent*
☐ *Moderate Persistent* ☐ *Mild Intermittent*

Does current severity match current therapy? ☐Yes ☐No
If severity rating is lower than current therapy, step down
If severity rating is higher than current therapy, step up

Medication Change
Quick Relief:_____
Anti-inflammatory:_____
Other:_____

Copy of self-mgmt. plan and encounter sent to: Home Health ☐ Asthma Ed. ☐
- ☐ Pt./guardian completed self-assessment
- ☐ Self-Management Plan sent with patient
- ☐ Peak flow record sent with patient
- ☐ Asthma Action Plan completed
- ☐ Pt. uses peak flow meter
- ☐ Pt. uses spacer

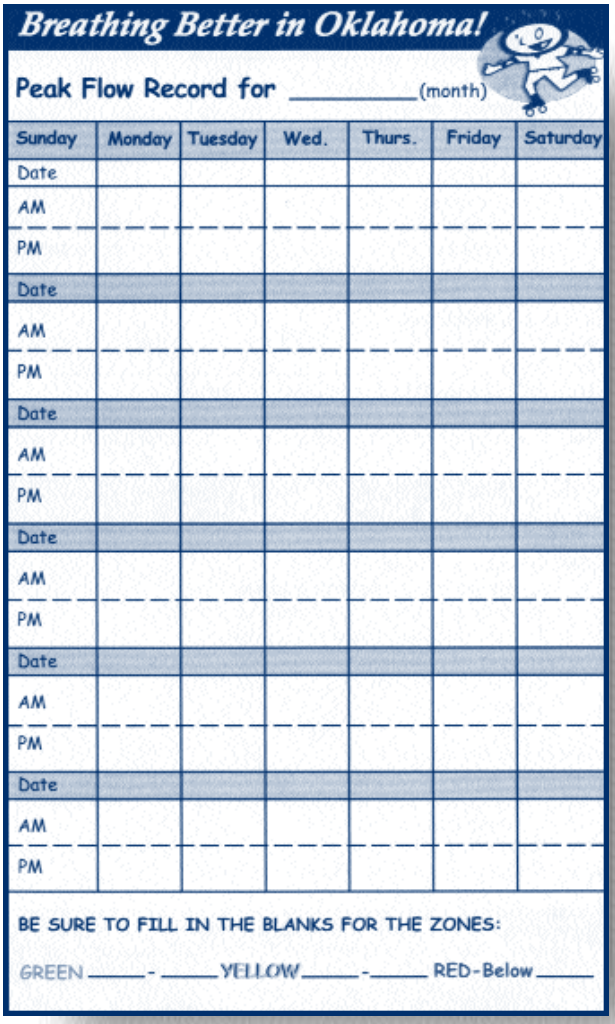
Follow-up:
NEXT VISIT:_____
REFERRAL:_____

Provider Name **Signature**

Breathing Better in Oklahoma! *November 2000, OHCA*

Appendix G

Heartland Health Plan of Oklahoma Asthma Management Plan



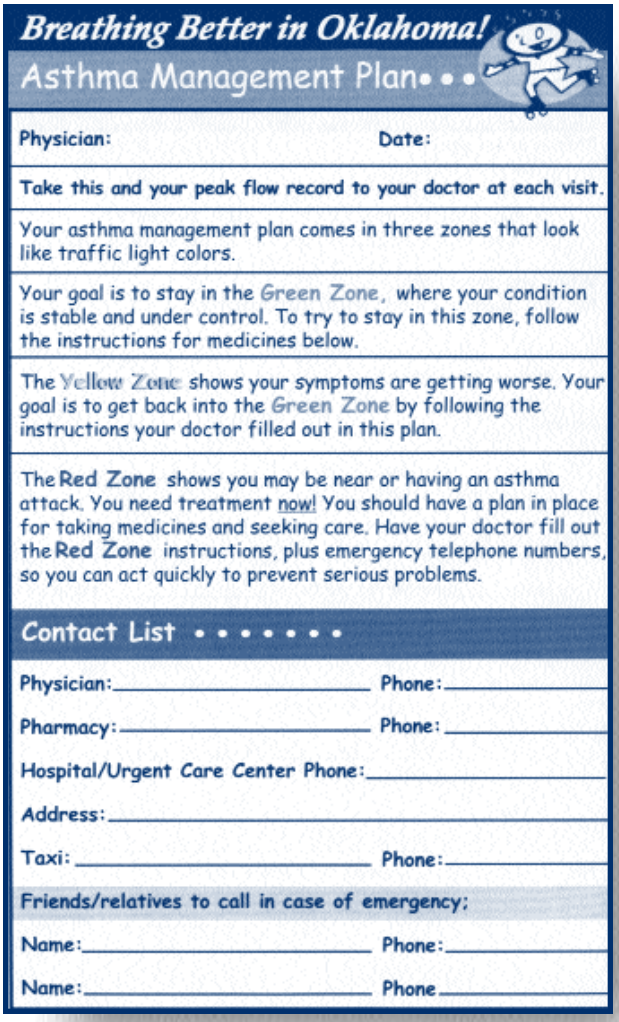
Breathing Better in Oklahoma!

Peak Flow Record for _____(month)

Sunday	Monday	Tuesday	Wed.	Thurs.	Friday	Saturday
Date						
AM						
PM						
Date						
AM						
PM						
Date						
AM						
PM						
Date						
AM						
PM						
Date						
AM						
PM						
Date						
AM						
PM						

BE SURE TO FILL IN THE BLANKS FOR THE ZONES:

GREEN _____-_____ YELLOW_____-_____ RED-Below_____



Breathing Better in Oklahoma!

Asthma Management Plan • • •

Physician: Date:

Take this and your peak flow record to your doctor at each visit.

Your asthma management plan comes in three zones that look like traffic light colors.

Your goal is to stay in the Green Zone, where your condition is stable and under control. To try to stay in this zone, follow the instructions for medicines below.

The Yellow Zone shows your symptoms are getting worse. Your goal is to get back into the Green Zone by following the instructions your doctor filled out in this plan.

The Red Zone shows you may be near or having an asthma attack. You need treatment now! You should have a plan in place for taking medicines and seeking care. Have your doctor fill out the Red Zone instructions, plus emergency telephone numbers, so you can act quickly to prevent serious problems.

Contact List • • • • • • •

Physician:_____ Phone:_____

Pharmacy:_____ Phone:_____

Hospital/Urgent Care Center Phone:_____

Address:_____

Taxi:_____ Phone:_____

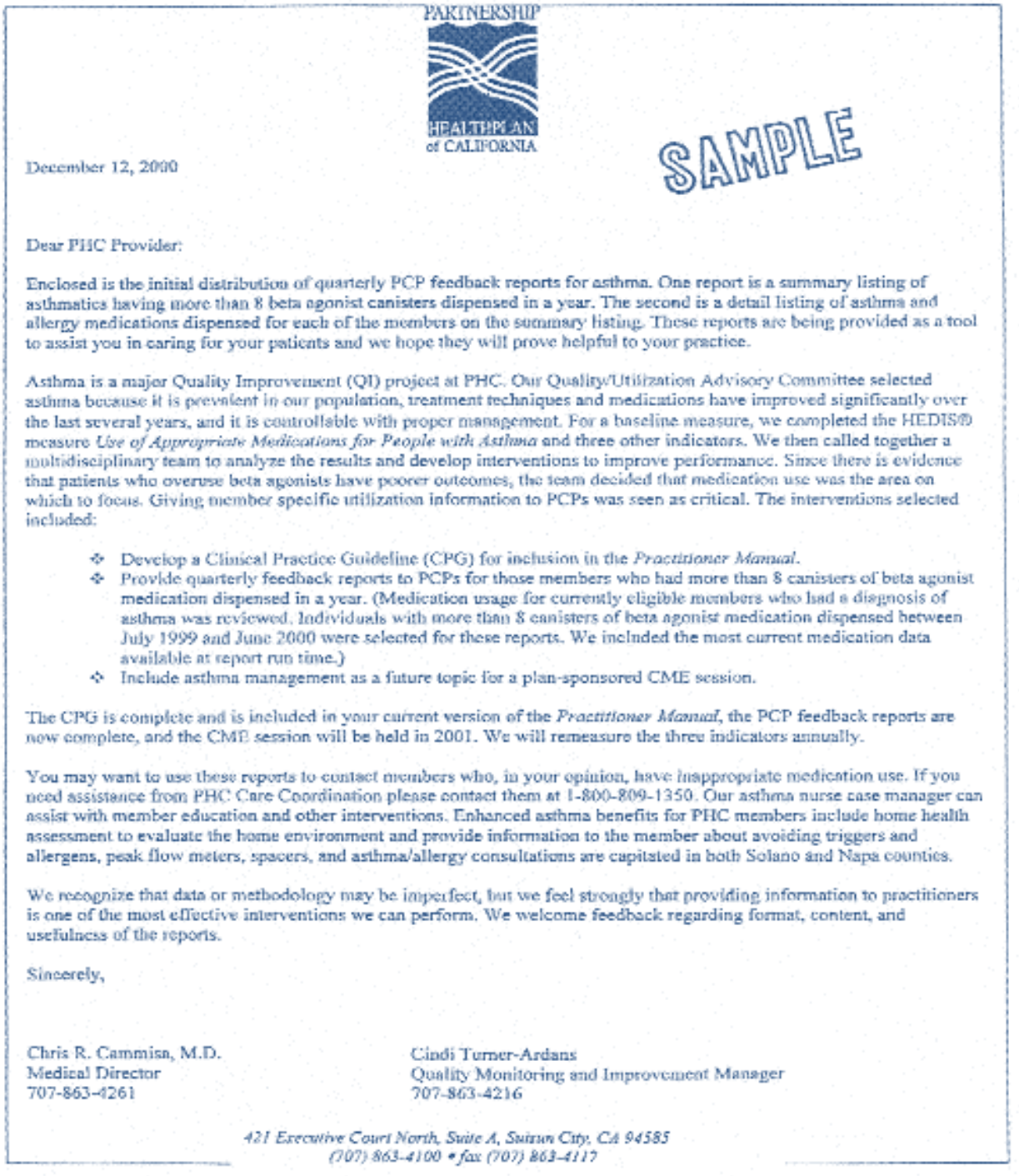
Friends/relatives to call in case of emergency;

Name:_____ Phone:_____

Name:_____ Phone_____

Appendix H

Partnership HealthPlan of California Provider Feedback Letter



PARTNERSHIP HEALTHPLAN of CALIFORNIA

SAMPLE

December 12, 2000

Dear PHC Provider:

Enclosed is the initial distribution of quarterly PCP feedback reports for asthma. One report is a summary listing of asthmatics having more than 8 beta agonist canisters dispensed in a year. The second is a detail listing of asthma and allergy medications dispensed for each of the members on the summary listing. These reports are being provided as a tool to assist you in caring for your patients and we hope they will prove helpful to your practice.

Asthma is a major Quality Improvement (QI) project at PHC. Our Quality/Utilization Advisory Committee selected asthma because it is prevalent in our population, treatment techniques and medications have improved significantly over the last several years, and it is controllable with proper management. For a baseline measure, we completed the HEDIS® measure *Use of Appropriate Medications for People with Asthma* and three other indicators. We then called together a multidisciplinary team to analyze the results and develop interventions to improve performance. Since there is evidence that patients who overuse beta agonists have poorer outcomes, the team decided that medication use was the area on which to focus. Giving member specific utilization information to PCPs was seen as critical. The interventions selected included:

- Develop a Clinical Practice Guideline (CPG) for inclusion in the *Practitioner Manual*.
- Provide quarterly feedback reports to PCPs for those members who had more than 8 canisters of beta agonist medication dispensed in a year. (Medication usage for currently eligible members who had a diagnosis of asthma was reviewed. Individuals with more than 8 canisters of beta agonist medication dispensed between July 1999 and June 2000 were selected for these reports. We included the most current medication data available at report run time.)
- Include asthma management as a future topic for a plan-sponsored CME session.

The CPG is complete and is included in your current version of the *Practitioner Manual*, the PCP feedback reports are now complete, and the CME session will be held in 2001. We will remeasure the three indicators annually.

You may want to use these reports to contact members who, in your opinion, have inappropriate medication use. If you need assistance from PHC Care Coordination please contact them at 1-800-809-1350. Our asthma nurse case manager can assist with member education and other interventions. Enhanced asthma benefits for PHC members include home health assessment to evaluate the home environment and provide information to the member about avoiding triggers and allergens, peak flow meters, spacers, and asthma/allergy consultations are capitated in both Solano and Napa counties.

We recognize that data or methodology may be imperfect, but we feel strongly that providing information to practitioners is one of the most effective interventions we can perform. We welcome feedback regarding format, content, and usefulness of the reports.

Sincerely,

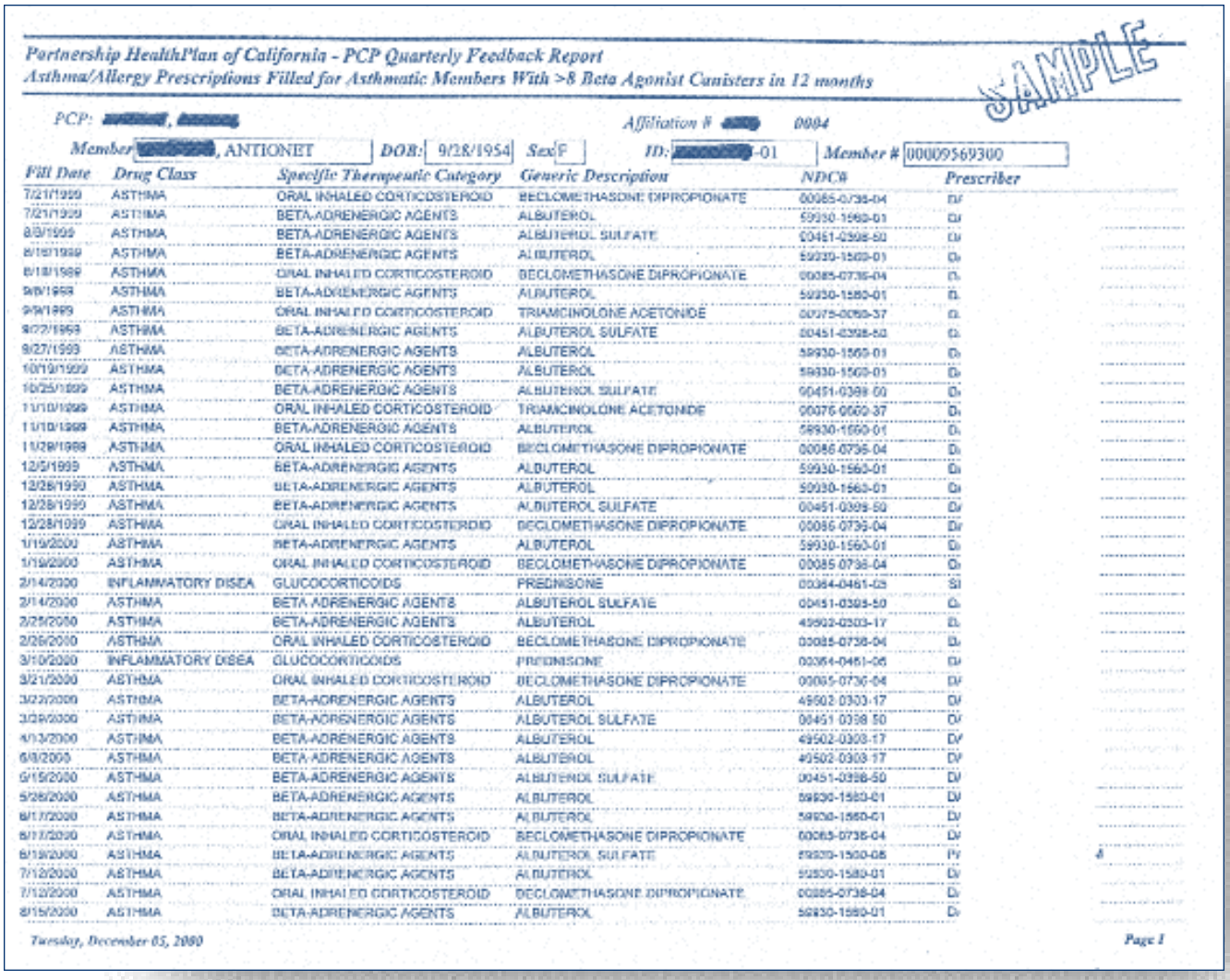
Chris R. Cammisa, M.D.
Medical Director
707-863-4261

Cindi Turner-Ardans
Quality Monitoring and Improvement Manager
707-863-4216

421 Executive Court North, Suite A, Suisun City, CA 94585
(707) 863-4100 • fax (707) 863-4117

Appendix H

Partnership HealthPlan of California Provider Feedback Report



Partnership HealthPlan of California - PCP Quarterly Feedback Report
Asthma/Allergy Prescriptions Filled for Asthmatic Members With >8 Beta Agonist Canisters in 12 months

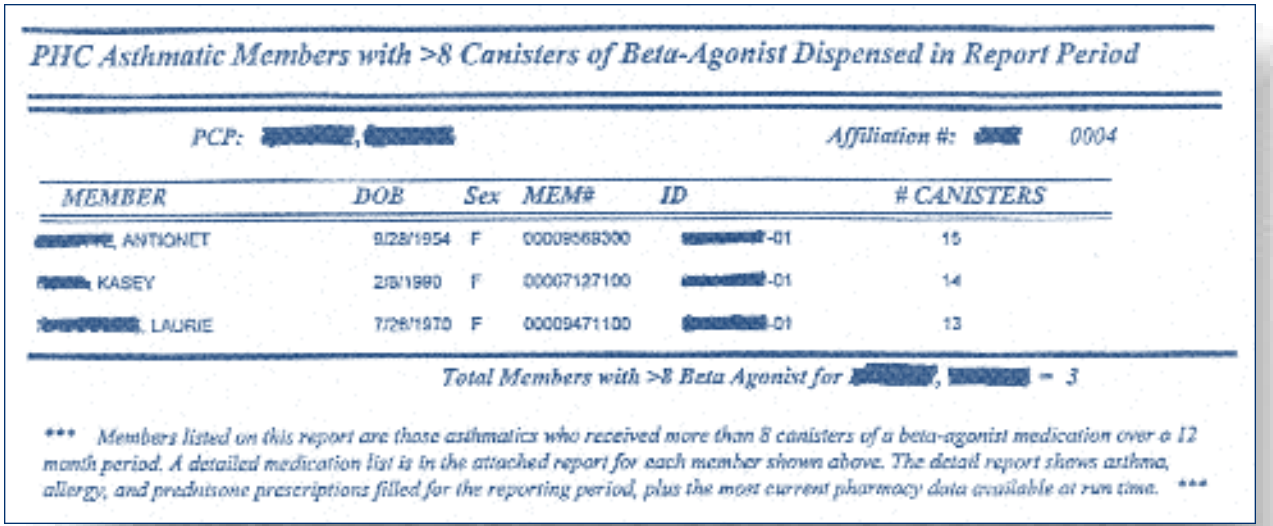
SAMPLE

PCP: [redacted] Affiliation # [redacted] 0004

Member [redacted], ANTIONET DOB: 9/28/1954 Sex: F ID: [redacted]-01 Member #: 00009569300

Fill Date	Drug Class	Specific Therapeutic Category	Generic Description	NDC#	Prescriber
7/21/1999	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
7/21/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
8/3/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	00451-0398-50	DV
8/18/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
8/18/1999	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
9/9/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
9/9/1999	ASTHMA	ORAL INHALED CORTICOSTEROID	TRIAMCINOLONE ACETONIDE	00075-0060-37	DV
9/22/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	00451-0398-50	DV
9/27/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
10/19/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
10/25/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	00451-0398-50	DV
11/10/1999	ASTHMA	ORAL INHALED CORTICOSTEROID	TRIAMCINOLONE ACETONIDE	00075-0060-37	DV
11/10/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
11/28/1999	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
12/9/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
12/28/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
12/28/1999	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	00451-0398-50	DV
12/28/1999	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
1/19/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
1/19/2000	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
2/14/2000	INFLAMMATORY DISEA	GLUCOCORTICOIDS	PREDNISONE	00054-0461-25	SI
2/14/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	00451-0398-50	DV
2/25/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	49502-0303-17	DV
2/25/2000	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
3/10/2000	INFLAMMATORY DISEA	GLUCOCORTICOIDS	PREDNISONE	00054-0461-06	DV
3/21/2000	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
3/23/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	49502-0303-17	DV
3/29/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	00451-0398-50	DV
4/13/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	49502-0303-17	DV
5/9/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	49502-0303-17	DV
5/15/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	00451-0398-50	DV
5/26/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
6/17/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
6/17/2000	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
6/19/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL SULFATE	59930-1560-06	DV
7/12/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV
7/12/2000	ASTHMA	ORAL INHALED CORTICOSTEROID	BECLOMETHASONE DIPROPIONATE	00085-0736-04	DV
8/15/2000	ASTHMA	BETA-ADRENERGIC AGENTS	ALBUTEROL	59930-1560-01	DV

Tuesday, December 05, 2000 *Page 1*



PHC Asthmatic Members with >8 Canisters of Beta-Agonist Dispensed in Report Period

PCP: [redacted] Affiliation #: [redacted] 0004

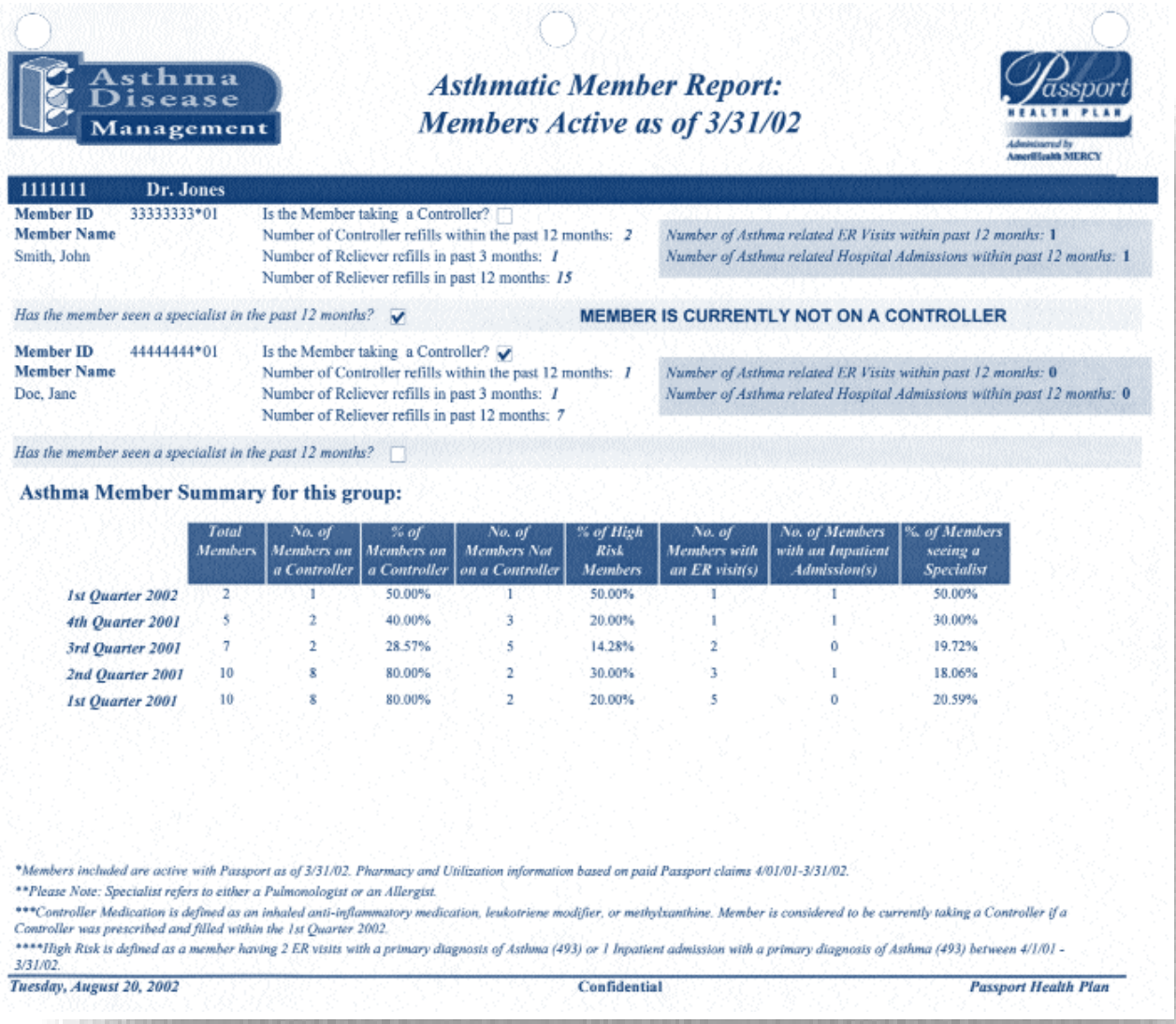
MEMBER	DOB	Sex	MEM#	ID	# CANISTERS
[redacted], ANTIONET	9/28/1954	F	00009569300	[redacted]-01	15
[redacted], KASEY	2/9/1980	F	00007127100	[redacted]-01	14
[redacted], LAURIE	7/28/1970	F	00009471100	[redacted]-01	13

Total Members with >8 Beta Agonist for [redacted] = 3

**** Members listed on this report are those asthmatics who received more than 8 canisters of a beta-agonist medication over a 12 month period. A detailed medication list is in the attached report for each member shown above. The detail report shows asthma, allergy, and prednisone prescriptions filled for the reporting period, plus the most current pharmacy data available at run time. ****

Appendix I

Passport Health Plan Asthma Member Report



Asthma Disease Management

Asthmatic Member Report: Members Active as of 3/31/02

Passport HEALTH PLAN
Administered by AmeriHealth MERCY

1111111 Dr. Jones

Member ID 33333333*01
Member Name
Smith, John

Is the Member taking a Controller? ☐
Number of Controller refills within the past 12 months: *2*
Number of Reliever refills in past 3 months: *1*
Number of Reliever refills in past 12 months: *15*

Number of Asthma related ER Visits within past 12 months: **1**
Number of Asthma related Hospital Admissions within past 12 months: **1**

Has the member seen a specialist in the past 12 months? ☑

MEMBER IS CURRENTLY NOT ON A CONTROLLER

Member ID 44444444*01
Member Name
Doe, Jane

Is the Member taking a Controller? ☑
Number of Controller refills within the past 12 months: *1*
Number of Reliever refills in past 3 months: *1*
Number of Reliever refills in past 12 months: *7*

Number of Asthma related ER Visits within past 12 months: **0**
Number of Asthma related Hospital Admissions within past 12 months: **0**

Has the member seen a specialist in the past 12 months? ☐

Asthma Member Summary for this group:

	Total Members	No. of Members on a Controller	% of Members on a Controller	No. of Members Not on a Controller	% of High Risk Members	No. of Members with an ER visit(s)	No. of Members with an Inpatient Admission(s)	% of Members seeing a Specialist
1st Quarter 2002	2	1	50.00%	1	50.00%	1	1	50.00%
4th Quarter 2001	5	2	40.00%	3	20.00%	1	1	30.00%
3rd Quarter 2001	7	2	28.57%	5	14.28%	2	0	19.72%
2nd Quarter 2001	10	8	80.00%	2	30.00%	3	1	18.06%
1st Quarter 2001	10	8	80.00%	2	20.00%	5	0	20.59%

**Members included are active with Passport as of 3/31/02. Pharmacy and Utilization information based on paid Passport claims 4/01/01-3/31/02.*
***Please Note: Specialist refers to either a Pulmonologist or an Allergist.*
****Controller Medication is defined as an inhaled anti-inflammatory medication, leukotriene modifier, or methylxanthine. Member is considered to be currently taking a Controller if a Controller was prescribed and filled within the 1st Quarter 2002.*
*****High Risk is defined as a member having 2 ER visits with a primary diagnosis of Asthma (493) or 1 Inpatient admission with a primary diagnosis of Asthma (493) between 4/1/01 - 3/31/02.*

Tuesday, August 20, 2002 **Confidential** *Passport Health Plan*

Appendix J

National Initiative for Children's Healthcare Quality Provider Office Strategies for Improving Asthma Care

Desired Characteristic of Practice	Gap to Eliminate or Opportunity to Improve Care Identified	Goal	Tool/Strategy	Tips for Implementation
Track Patients	No system to identify patients with asthma in practice.	90 percent of patients with asthma will be identified.	Database registry.	• Begin with most severe patients and enter information from chart. • Start with patients who come to office for a scheduled visit.
Prompt Appropriate Care	A consistent diagnosis is not used in our practice.	95 percent of children with asthma have a diagnosis in the chart.	*Pediatric Asthma Promoting Best Practice – Guide for Managing Asthma in Children* – section on Diagnosis.	• Have a meeting with clinical staff and discuss the advantages and disadvantages of using the common term "asthma." • Review criteria in guidelines.
	Severity is not classified and documented.	Classify and document asthma severity in chart for 95 percent of patients with asthma.	Living with Asthma Survey.	• Use Living with Asthma form to collect information needed to classify severity.
			Severity chart.	• Remind clinicians that classification of severity is an important first step in prescribing appropriate therapy. • Review link between severity classification and medication dosage.
			Encounter form.	• Implement a flow sheet or encounter form to provide prompt for provider to classify and document severity at every visit.
	Children with persistent asthma are not prescribed appropriate anti-inflammatory medication.	95 percent of children with persistent asthma are prescribed appropriate anti-inflammatory medication.	Medication wall poster or pocket card.	• Review link between severity classification and medication dosage. • Review Executive Summary of the NAEPP Expert Panel Report *Guidelines for the Diagnosis and Management of Asthma – Update on Selective Topics 2002* about long-term management of asthma and evidence about safety of inhaled corticosteroids in children.
			Pharmacy/Formulary Resource list.	• Post list of drugs on formulary or covered by various insurance plans.
Maximize the Efficiency of the Care Team			Living with Asthma Survey.	• Use Living with Asthma form to collect information from patients prior to provider interview. Nurse can review data as patient prepares for visit.

(continued)

Appendix J **(continued)**

Desired Characteristic of Practice	Gap to Eliminate or Opportunity to Improve Care Identified	Goal	Tool/Strategy	Tips for Implementation
Support Patient/Family to Manage Asthma as a Chronic Disease		50 percent of patients will agree to group visit for maintenance planned care and education.	Group visits.	• Offer group visits as alternative design for planned care. • Collaborative team provides care.
	Asthma management plan is not used consistently across providers.	95 percent of patients with persistent asthma have a written asthma management plan in the chart.	Asthma Management Plan – copy to school and daycare.	• First assure severity classification and appropriate use of medications implemented so management plans will include appropriate medications. • Use preprinted forms to facilitate filling in medications and doses – eliminate redundant documentation. • Plan strategy for how to provide access for provider at time of visit.
Develop Linkages With Community Partners	Asthma management plan is not used or is not shared with community partners.	95 percent of patients with persistent asthma have a written asthma management plan; copy is provided to school and/or daycare facility.		• Plan strategy for distribution by provider or parent. • Obtain parent consent for sharing management plan with community partners. • Plan strategy to identify school if direct faxing of forms is planned. • Include office phone/fax to facilitate communication.
Support From the Health Care System	Improved delivery designs are not reimbursed.			• Health plan covers both visit (group and individual) and non-visit (phone and e-mail) care.

Appendix K

National Initiative for Children's Healthcare Quality Classification of Asthma Symptom Severity and Therapy

NICHQ

MEDICATIONS

Inhaled Corticosteroids
Systemic Corticosteroids
Methylprednisolone
Prednisolone
Prednisone

Long-Acting Inhaled Beta2-Agonists
Salmeterol
Formoterol

Combined Medication
Fluticasone/ Salmeterol

Cromolyn and Nedocromil
Cromolyn
Nedocromil

Leukotriene Modifiers
Montelukast
Zafirlukast
Zileuton

Methylxanthines
Theophylline

Classify Severity; Assign Patient to Most Severe Step

SEVERITY	⇨ DAYTIME SYMPTOMS ② NIGHTTIME SYMPTOMS LUNG FUNCTION: PEF is % personal best; FEV_1 is % predicted	LONG TERM CONTROL	
		Older Than 5 Years of Age (see reverse side for drugs and dosages)	Children 5 Years of Age and Younger
Severe Persistent	⇨Continual, Limited physical activity. Frequent exacerbations ② Frequent FEV_1 or PEF ≤ 60% Predicted. PEF variability >30%	*Consider referral to asthma specialist* **Preferred treatment:** • High-dose inhaled corticosteroids **AND** • Long-acting inhaled $beta_2$-agonists	*Refer to asthma specialist* **Preferred treatment:** • High-dose inhaled corticosteroids **AND** • Long-acting inhaled $beta_2$-agonists
		AND, **if needed,** Corticosteroid tablets or syrup 2 mg/kg/day generally not to exceed 60 mg/day (attempt to wean oral med)	AND, if needed, Corticosteroid tablets or syrup 2 mg/kg/day not to exceed 60 mg/day (attempt to wean oral med)
Moderate Persistent	⇨ Daily. Daily use of inhaled short- acting B_2 agonist. Exacerbations affect activity. Exacerbations ≥ 2 times/wk, may last days ② > 1 night/week FEV_1 or PEF >60%-<80% Predicted. PEF variability >30%	*Consider referral to asthma specialist* **Preferred treatments:** • Low-to-medium dose inhaled corticosteroids **AND** • Long-acting inhaled $beta_2$-agonists	*Refer to asthma specialist* **Preferred treatments:** • Low-dose inhaled corticosteroids and long-acting inhaled $beta_2$-agonists, **OR** Medium-dose inhaled corticosteroids
		Alternative treatment: • Increase inhaled corticosteroids within medium-dose range, **OR** Low-to-medium dose inhaled corticosteroids and either leukotriene modifier or theophylline	**Alternative treatment:** • Low-dose inhaled corticosteroids and either leukotriene receptor antagonist or theophylline
		If needed (particularly in patients with recurring severe exacerbations): **Preferred treatment:** • Increase inhaled corticosteroids within medium-dose range and add long-acting inhaled $beta_2$-agonists	If needed (particularly in patients with recurring severe exacerbations): **Preferred treatment:** • Medium-dose inhaled corticosteroids and long-acting inhaled $beta_2$-agonists
		Alternative treatment: • Increase inhaled corticosteroids within medium-dose range and add and either leukotriene modifier or theophylline	**Alternative treatment:** • Medium-dose inhaled corticosteroids and either leukotriene receptor antagonist or theophylline
Mild Persistent	⇨ > 2 times/wk but < 1x/day. Exacerbations may affect activity ② > 2 nights/month FEV_1 or PEF ≥ 80% Predicted. PEF variability 20 - 30%	**Preferred treatment:** • Low-dose inhaled corticosteroids	*Consider referral to asthma specialist* **Preferred treatment:** • Low-dose inhaled corticosteroids
		Alternative treatment: • Cromolyn,leukotriene modifier, nedocromil **OR** sustained release theophylline to serum concentration of 5-15 mcg/mL	**Alternative treatment:** • Cromolyn **OR** leukotriene receptor antagonist
Mild Intermitten	⇨ Symptoms ≤ 2 days/wk. Asymptomatic and normal PEF between exacerbations. Exacerbations brief (hrs-days), variable intensity ② ≤2 nights/month FEV_1 or PEF ≥ 80% predicted. PEF variability <20%	**None**	**None**

GOALS OF THERAPY:
ASTHMA CONTROL

- Minimal or no chronic symptoms day or night
- Minimal or no exacerbations
- No limitations on activities; no school/work missed
- Minimal or no adverse effects from medications
- **Children 5 Years of Age and Younger**: Minimal use of short-acting inhaled $beta_2$-agonist (<1x per day, <1 canister/month)
- **Older Than 5 Years of Age**:Maintain (near) normal pulmonary function (80% personal best (< 1x per day, <1 canister/month)

QUICK RELIEF
Older Than 5 Years of Age

- Short-acting bronchodilator: 2–4 puffs **short-acting inhaled $beta_2$-agonists** as needed for symptoms.
- Intensity of treatment will depend on severity of exacerbation; up to 3 treatments at 20-minute intervals or a single nebulizer treatment as needed. Course of systemic corticosteroids may be needed.
- Use of short-acting $beta_2$-agonists >2 times a week in intermittent asthma (daily, or increasing use in persistent asthma) may indicate the need to initiate (increase) long-term control therapy.

QUICK RELIEF
Children 5 Years of Age and Younger

Bronchodilator as needed for symptoms. Intensity of treatment will depend upon severity of exacerbation.
- Preferred treatment: **Short-acting inhaled $beta_2$-agonists** by nebulizer or face mask and spacer/holding chamber
- Alternative treatment: Oral $beta_2$-agonist

With viral respiratory infection
- Bronchodilator q 4–6 hours up to 24 hours (longer with physician consult); in general, repeat no more than once every 6 wks
- Consider systemic corticosteroid if exacerbation is severe or patient has history of previous severe exacerbations

Use of short-acting $beta_2$-agonists >2 times a week in intermittent asthma (daily, or increasing use in persistent asthma) may indicate the need to initiate (increase) long-term control therapy.

Adapted from NAEPP Expert Panel Report *Guidelines for the Diagnosis and Management of Asthma-Update on Selected Topics 2002*, National Institutes of Health, National Heart, Lung, and Blood Institute.

For infants and children, use MDI with spacer with or w/o mask or nebulizer.

If a patient has seasonal asthma on a predictable basis, daily, long-term anti-inflammatory therapy (inhaled corticosteroids, cromolyn, or nedocromil) should be initiated prior to the anticipated onset of symptoms and continued through the season.

Appendix L

National Initiative for Children's Healthcare Quality Usual Dosages for Long-Term Control Medications

NICHQ

Medication	Dosage Form	Adult Dose	Child Dose*
Inhaled Corticosteroids *(See Estimated Comparative Daily Dosages for Inhaled Corticosteroids.)*			
Systemic Corticosteroids		*(Applies to all three corticosteroids.)*	
Methylprednisolone **Prednisolone** **Prednisone**	2, 4, 8, 16, 32 mg tablets 5 mg tablets, 5 mg/5 cc, 15 mg/5 cc 1, 2.5, 5, 10, 20, 50 mg tablets; 5 mg/cc, 5 mg/5 cc	• 7.5–60 mg daily in a single dose in a.m. or qod as needed for control • Short-course "burst" to achieve control: 40–60 mg per day as single or 2 divided doses for 3–10 days	• 0.25–2 mg/kg daily in single dose in a.m. or qod as needed for control • Short-course "burst": 1–2 mg/kg/day, maximum 60 mg/day for 3–10 days
Long-Acting Inhaled Beta$_2$-Agonists *(Should not be used for symptom relief or for exacerbations. Use with inhaled corticosteroids.)*			
Salmeterol **Formoterol**	MDI 21 mcg/puff DPI 50 mcg/blister DPI 12 mcg/single-use capsule	2 puffs q 12 hours 1 blister q 12 hours 1 capsule q 12 hours	1–2 puffs q 12 hours 1 blister q 12 hours 1 capsule q 12 hours
Combined Medication			
Fluticasone/Salmeterol	DPI 100, 250, or 500 mcg/50 mcg	1 inhalation bid; dose depends on severity of asthma	1 inhalation bid; dose depends on severity of asthma
Cromolyn and Nedocromil			
Cromolyn **Nedocromil**	MDI 1 mg/puff Nebulizer 20 mg/ampule MDI 1.75 mg/puff	2–4 puffs tid-qid 1 ampule tid-qid 2–4 puffs bid-qid	1–2 puffs tid-qid 1 ampule tid-qid 1–2 puffs bid-qid
Leukotriene Modifiers			
Montelukast	4 or 5 mg chewable tablet 10 mg tablet	10 mg qhs	4 mg qhs (2–5 yrs) 5 mg qhs (6–14 yrs) 10 mg qhs (≥ 14 yrs)
Zafirlukast **Zileuton**	10 or 20 mg tablet 300 or 600 mg tablet	40 mg daily (20 mg tablet bid) 2,400 mg daily (give tablets qid)	20 mg daily (7–11 yrs) (10 mg tablet bid)
Methylxanthines *(Serum monitoring is important [serum concentration of 5–15 mcg/mL at steady state]).*			
Theophylline	Liquids, sustained-release tablets, and capsules	Starting dose 10 mg/kg/day up to 300 mg max; usual max 800 mg/day	Starting dose 10 mg/kg/day; usual max: • < 1 year of age: 0.2 (age in weeks) + 5 = mg/kg/day • ≥ 1 year of age: 16 mg/kg/day

Estimated Comparative Daily Dosages for Inhaled Corticosteroids

DRUG	LOW DAILY DOSE		MEDIUM DAILY DOSE		HIGH DAILY DOSE	
	Adult	Child*	Adult	Child*	Adult	Child*
Beclomethasone CFC 42 or 84 mcg/puff	168–504 mcg	84–336 mcg	504–840 mcg	336–672 mcg	> 840 mcg	> 672 mcg
Beclomethasone HFA 40 or 80 mcg/puff	80–240 mcg	80–160 mcg	240–480 mcg	160–320 mcg	> 480 mcg	> 320 mcg
Budesonide DPI 200 mcg/inhalation	200–600 mcg	200–400 mcg	600–1,200 mcg	400–800 mcg	> 1,200 mcg	> 800 mcg
Inhalation suspension for nebulization (child dose)		0.5 mg		1.0 mg		2.0 mg
Flunisolide 250 mcg/puff	500–1,000 mcg	500–750 mcg	1,000–2,000 mcg	1,000–1,250 mcg	> 2,000 mcg	> 1,250 mcg
Fluticasone MDI: 44, 110, or 220 mcg/puff DPI: 50, 100, or 250 mcg/inhalation	88–264 mcg 100–300 mcg	88–176 mcg 100–200 mcg	264–660 mcg 300–600 mcg	176–440 mcg 200–400 mcg	> 660 mcg > 600 mcg	> 440 mcg > 400 mcg
Triamcinolone acetonide 100 mcg/puff	400–1,000 mcg	400–800 mcg	1,000–2,000 mcg	800–1,000 mcg	> 2,000 mcg	> 1,200 mcg

*Children less than 12 years of age.

Adapted from NAEPP Expert Panel Report *Guidelines for the Diagnosis and Management of Asthma-Update on Selected Topics 2002*, National Institutes of Health, National Heart, Lung, and Blood Institute.

Appendix M

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The BCAP Network

The BCAP Network is an alliance of health plans joined by the common goal of furthering the quality and cost-efficiencies of Medicaid and SCHIP managed care. BCAP Network activities include:

- **BCAP Workgroups** – Up to 15 Medicaid/SCHIP health plans collaborate to develop replicable best practice models for targeted clinical and administrative areas.
- **BCAP Workshops** – Hands-on workshops allow attendees to develop quality improvement initiatives for their Medicaid/SCHIP populations.
- **BCAP e-News Update** – Bi-monthly electronic newsletter containing updates on health plan best practice activities. To subscribe, e-mail lm@chcs.org.
- **BCAP Network Exchange Calls** – Lively teleconference discussions about current issues in health care with experts in the field.
- **CHCS Website** – Features current updates on BCAP projects, resources for Medicaid and SCHIP health plans, and CHCS Managed Care Best Practices Publications. **www.chcs.org**
- **Best Practices Grants** – Grants of up to $100,000 are available to Medicaid and SCHIP health plans that want to develop, test, or refine "best practice" programs to improve delivery of managed care in the public sector.

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Pediatric Liver Transplant Recipients: Mortality Analysis Over 20 Years

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Orthotropic liver transplantation (OLT) has become standard and accepted care for pediatric patients with end-stage liver disease. Two large pediatric OLT series are analyzed to determine excess death rates (EDR) over 20 years. The EDR decreases over time and is lower with more recent transplant recipients who have benefited from improved tacrolimus-based immunosuppression and transplant techniques. Fifteen- to 20-year EDR is 5 deaths/1000. Biliary atresia is the most common pediatric indication, and these recipients do better than those with other types of liver disease. Most deaths occur in the first post-transplant year, with infection being the largest cause.

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Key words: Pediatric orthotropic liver transplant, mortality analysis, excess death rates, life insurance.

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Orthotropic liver transplantation (OLT) has become a standard and accepted treatment of pediatric patients with end-stage liver disease. From the two largest pediatric OLT centers in the United States, long-term pediatric OLT survival has been reported for 578 and 808 consecutive patients. With a 5-year survival of only 70% to 80%, OLT recipients would appear to be uninsurable at first glance. Detailed analysis of these studies illustrates that after the first 5 years, patients have a decreasing EDR in post-transplant years 5 through 20. Mortality analysis of data subsets is performed. OLT survival has improved with current transplant techniques and tacrolimus-based immunosuppression, and OLT for biliary atresia, a common pediatric indication, has a better 10-year survival than that of other pediatric liver indications. This analysis, using standard methodology, shows that pediatric OLT recipients may be acceptable life insurance candidates.

STUDY GROUPS

A 2005 study[1] reported patient survival of 3200 consecutive OLT procedures over nearly 20 years (1984 to 2001) at a single center (Dumont-UCLA Liver Transplant Center, Los Angeles, Calif). Of the 2662 patients, 578 were less than 18 years old (average 2, range 0–17), with a male-to-female ratio of 1.1 to 1. Median follow up was 6.7 years (range, 0–20 years). Kaplan-Meier survival curves were created, and survival was reported at 1, 5 and 10 years, with no patients lost in this period. Data was stratified based on age at transplant (0–1 years of age and 1–18 years of age) and indication.

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Profumo

THE MEDICAL CONVERSATION

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Executive Summary: When life insurance underwriters are faced with difficult impaired-risk cases, the medical director can be a valuable resource. There must be good communication between the UW and MD for effective exchange of information. The underwriter must explain the applicant's salient familial, social and medical history to the MD in a format that can be followed and analyzed. Medical directors have been trained in the art of case presentation, but this skill is not typically taught to underwriters. Underwriters must be taught how to present cases, and be given adequate practice opportunities with constructive criticism by the MD. The development of an effective case presentation, a medical conversation, allows accurate exchange of information and is central to the education process of the underwriter.

The underwriter-medical director relationship is critical to evaluation of impaired-risk lives. The importance of establishing excess mortality, teased from clinical research, is published in various newsletters and journals daily. Yet, the clinical picture must be clear for a medical director to help an underwriter place an applicant in the correct mortality category. Underwriters have been taught how to gather relevant information from multiple sources, assimilate it and reach an underwriting decision. On complex impaired-risk lives, underwriters often need guidance and advice from a medical director. Thus, an underwriter must learn how to communicate with the medical director in the language of a concise clinical presentation.

Research on teaching clinical presentation skills is limited and is focused on the training of medical students. Yet, there are many similarities between underwriter and medical student training. While medical students see the clinical presentation as a rigid, "rule-based, data-storage" activity (1), more seasoned physicians see the medical presentation as a method of communication (2, 3, 4). The key to underwriter training, as in medical training, is "the dialogue between physician teachers and their students" (5).

Teachers' criticisms of students' presentations are typically general and vague, often leading to dysfunctional changes. For example, an instruction to "be brief" will lead to a medical student reading his lengthy, fact-filled presentation faster, rather than editing and discussing only the pertinent features of the case (1). Most students eventually make the transition from a rigid regurgitation of facts and findings to a conversation between medical professionals. Since underwriters typically discuss only a small percentage of cases with a medical director, becoming fluent in case presentation may take years, and many bad habits can be ingrained in that time. What follows are suggestions to underwriters and their teachers to help develop the skill of a medical conversation.

It's not an applicant, it's a story.
The best part about medicine, in my opinion, is listening to people's stories. A significant medical history is one of the biggest, most important tales of a person's life, as well as one's most intimate. Tell the applicant's medical history as you would tell about your favorite book. Don't just list the author, characters and publisher, but explain what the story is about. Make it interesting and get the medical director hooked. Medical directors are very interested in a "42-year-old man with coronary artery disease"' with a story that starts this good, he will want to hear more.

How many things appear to be underwriting issues? Let's take them one at a time.
After the MD is hooked, then the story starts. State what you feel are the important issues or impairments. If you are not sure it's relevant, go ahead and mention it. It can be addressed later if need be. Like dealing cards, do it quickly but neatly. After all the cards are on the table, flip each issue up one at a time and discuss in more detail.

Many underwriters present cases chronologically, starting with the latest test results and medicines, but not separating them based on impairment. This may be due to the method of APS review, which starts with the most recent records and goes backward in time. This is data gathering, not interpretation. Underwriters must first organize chronological information into medical issues before they can communicate the story of the applicant to the medical director.

You have to know about the impairment to know what is important.
With each impairment presented, the discussion should paint a clear picture of the clinical situation. This is

17 Alpha-Hydroxyprogesterone Caproate (17P) Usage in a Medicaid Managed Care Plan and Reduction in Neonatal Intensive Care Unit Days

Offering 17P as a benefit to pregnant women enrollees with a history of preterm delivery can reduce NICU days significantly for a Medicaid plan.

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ABSTRACT

Purpose: To evaluate whether providing 17 alpha-hydroxyprogesterone caproate (17P) to high-risk pregnant women who have a history of preterm delivery in a Medicaid managed care population reduces the rate of neonatal intensive care unit (NICU) admissions, NICU length of stay, and associated costs.

Design: A 2004–2005 longitudinal review of birth outcomes in 24 pregnant women with a history of preterm delivery who were treated with 17P versus a control group.

Methodology: Intervention included offering 17P as a benefit to pregnant women who had a history of preterm labor and delivery and who were deemed to be appropriate candidates for this treatment by their physicians. An educational program about 17P was developed that was aimed at physicians, their office staff, and plan members. A process of early identification of potential 17P candidates was also implemented.

Principal findings: NICU admission rates decreased to 14.3 percent in the control group and 8.3 percent in the 17P group. NICU length of stay decreased significantly from 231 days in the control group to 149 days in the 17P group. Overall costs for the control group were $568,462 versus $165, 487 in the treatment group — a significant savings of $402, 975.

Conclusion: Offering 17P as a benefit to pregnant women enrollees with a history of preterm delivery can decrease NICU days significantly for a Medicaid managed care plan.

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INTRODUCTION

Preterm delivery defined as a delivery before 37 weeks, represents a large portion of a managed Medicaid plan's medical expenses, due to high-dollar neonatal intensive care unit (NICU) claims. More than 480,000, or 12 percent, of live births in the United States are preterm births. According to the March of Dimes, in the past decade, there has been an increase in preterm labor and delivery in almost all states. Despite medical and technological advances, the preterm birth rate increased 27 percent from 1982 to 2002 (Martin 2003). The pathophysiological events that trigger preterm delivery are for the most part not known, but a history of spontaneous preterm delivery is one of the strongest risk factors for preterm birth in a subsequent pregnancy (Mercer 1999).

A multicenter, randomized controlled trial by the National Institute of Child Health and Human Development, published in the *New England Journal of Medicine*, showed a significant reduction in preterm labor and delivery for high-risk women with a history of spontaneous preterm delivery. These women received weekly injections of 17 alpha-hydroxyprogesterone caproate (17P) (Meis 2003).

A follow-up study estimated that if 17P therapy was offered to all high-risk women with a history of preterm delivery in 2002, 10,000 spontaneous preterm births would have been prevented, reducing the overall U.S. preterm birth rate by 2 percent (Petrini 2005). This therapy seems to have the same effect among women of diverse backgrounds and offers new hope for helping to slow the rising number of preterm births.

Following the publication of the results from the Meis study, Coventry Health Care began to provide 17P as a benefit to high-risk pregnant enrollees with a history of preterm delivery (Meis 2003). The greatest potential opportunity for 17P to improve birth outcomes within Coventry Health Care is through HealthCare USA of Missouri (HCUSA), the largest managed Medicaid plan in Missouri with 185,000 members throughout the state. Seventy percent of HCUSA's

members are children and pregnant women, and of 7,636 live births in 2004, 8.8 percent of these infants were admitted to the NICU.

Because many of HCUSA's members are from lower socioeconomic groups, much attention is focused on preventing poor birth outcomes and high-cost NICU expenses. Dedicated obstetric (OB) nurse case managers and special needs nurses attempt to identify and provide support for pregnant mothers who are identified as being at high risk for preterm delivery. Yet, despite aggressive efforts, the percentage of NICU admissions and days has remained steady.

The goal of this study was to determine whether weekly injections of 17P could affect the number of NICU admissions, NICU length of stay (LOS), and associated costs in a real Medicaid population.

What is 17P?

A naturally occurring metabolite of progesterone, produced in large quantities during human pregnancy, 17P is used for recurrent miscarriages and various menstrual disorders. This hormone has been indicated for amenorrhea, endometrial carcinoma, and uterine corpus adenocarcinoma.

Attention has been focused on 17P since an article in the *New England Journal of Medicine* reported that a substantially reduced rate of recurrent preterm delivery was associated with its use in high-risk women (Meis 2003). Use of 17P in women who have had a previous premature birth (<37 weeks) has been endorsed by the American College of Obstetrics and Gynecology (2003), but the U.S. Food and Drug Administration does not recognize prevention of preterm delivery for high-risk women as an approved indication for 17P.

How does 17P work?

In animal models, progesterone appears to be responsible primarily for maintaining uterine quiescence during pregnancy. A drop in the progesterone levels normally occurs at the initiation of labor at term. Nevertheless, the physiological mechanism is not the same when considering the initiation of preterm labor, as this is not merely an early initiation of normal labor (ACOG 2003, Katz 1985, Varma 1982, Michaelis 1983, Raman-Wilms 1995, Resseguie 1985).

Substantial evidence suggests that preterm labor and preterm rupture of the membranes result from an inappropriate, inflammatory response. Weekly injections of 250 mg of 17P initiated in the second trimester of pregnancy may suppress this pathological labor (Mercer 1999).

The quantities of 17P produced naturally during pregnancy, predominately by the placenta, far exceed the recommended dose of 250 mg weekly by intramuscular injection during the last half of pregnancy. One would not expect any serious side effects from a nonandrogenic progestin, such as 17P, which is naturally produced in large quantities during pregnancy.

Results from several animal and clinical studies support the safety of 17P in pregnancy. According to information on Reprotox (1997), an online reproductive toxicology database, "There is no available evidence that the administration of this agent [17P] during pregnancy is harmful."

In 2003, Meis and colleagues published the results of their double blind, randomized, placebo-controlled trial involving pregnant women having a documented history of spontaneous preterm delivery. Women were enrolled at 19 clinical centers at 16- to 20-weeks' gestation and randomly assigned by a central data center, in a 2:1 ratio, to receive either weekly injections of 250 mg of 17P or weekly injections of an inert oil placebo; injections were continued until delivery or 36 weeks of gestation.

The primary outcome was preterm delivery prior to 37 weeks of gestation. Analysis was performed according to the intention-to-treat principle. The baseline characteristics were similar for the 310 women who were in the progesterone group and the 153 women in the placebo group. Treatment with 17P significantly reduced the risk of delivery at less than 37 weeks' gestation (incidence, 36.3 percent in the progesterone group vs. 54.9 percent in the placebo group; relative risk, 0.66 [95 percent confidence interval, 0.54 to 0.81]), delivery at less than 35 weeks' gestation (incidence, 20.6 percent vs. 30.7 percent; relative risk, 0.67 [95 percent confidence interval, 0.48 to 0.93]), and delivery at less than 32 weeks' gestation (11.4 percent vs. 19.6 percent; relative risk, 0.58 [95 percent confidence interval, 0.37 to 0.91]).

Infants of women treated with 17P had significantly lower rates of necrotizing enterocolitis, intraventricular hemorrhage, and need for supplemental oxygen. Reasons for exclusion from the trial were multi-fetal gestation, known fetal anomaly, progesterone or heparin treatment during the current pregnancy, current or planned cervical cerclage, hypertension necessitating medication, and seizure disorder (Meis 2003).

METHODS

Availability of benefit

In 2004, 17P was not offered as a benefit in the fee-for-service Medicaid plan or the managed Medicaid plans in Missouri. The fee-for-service Medicaid program is prohibited from paying for any drug product for which a rebate agreement has not been signed. The Missouri Medicaid managed care plans provide coverage on a capitated rate, and therefore, they are not prohibited from paying for 17P. HCUSA's contract with the state of Missouri includes a requirement that any changes to the drug products covered by the health plan first must be submitted to the state for approval.

Only after submission and approval can the products or the criteria around the products be used. Coverage of 17P was submitted through this process, and we received approval to add this product to our prior authorization

process from the Division of Medical Services for the state of Missouri to make the product available as a benefit for our MCO.

Identification of high-risk members

To identify pregnant mothers at risk for preterm delivery and complicated pregnancies, we developed a 7-question risk assessment, which physician offices filled out and submitted with the OB global claim form. If the physician indicates that a member has a history of preterm labor and delivery, an OB nurse case manager reviews the case and a letter is sent to both the member and the physician explaining HCUSA's coverage of 17P (Table 1).

Providing the 17P benefit

If the physician identifies a member who is a suitable candidate for 17P, that member is instructed to call the HCUSA OB nurse case manager. The OB nurse case manager arranges for weekly delivery of 17P to either the physician's office or to the patient's home through a home health care agency. If a member is hospitalized during pregnancy, 17P is sent to the hospital for administration. Every member receiving 17P is assigned an OB case manager who keeps in regular telephonic contact to ensure compliance and to address issues that arise. Our contracted vendor for compounded 17P is Wedgewood Pharmacy, in Swedesboro, N.J.

Educational program

We encourage physicians to follow the guidelines in the aforementioned *New England Journal of Medicine* study (Meis 2003). The guidelines include initiation of 17P at 16- to 21-weeks' gestation and continuation through 36 weeks' gestation or up to delivery. The study's clinical exclusions were women with multi-fetal gestation, known fetal anomaly, progesterone or heparin treatment, current or planned cervical cerclage, hypertension necessitating medication, and seizure disorder (Meis 2003).

TABLE 1 Obstetric risk screening form

Date of first visit	
EDC	
History that may affect current pregnancy (Circle all that apply)	PTL or delivery HTN Asthma Sickle Cell DM Mental illness STD Smoker Alcohol Drugs Other _____
Pregnancy history	
Multiple gestation this pregnancy?	
Enrolled in WIC?	
Lead test on mother?	

DM=diabetes mellitus, EDC=estimated date of confinement, HTN=hypertension, PTL=preterm labor, STD=sexually transmitted disease, WIC=Women, Infants, and Children.

Statistical test

A chi-square analysis (2x2 contingency table) was conducted to determine the significance of reduction in admissions, NICU LOS, and cost savings. This statistical test is used commonly when determining the frequency of an occurrence, such as comparing one year or one group to another.

RESULTS

The measurement of the 17P program's effectiveness is the NICU admission rate and the LOS for babies born to the women enrolled in the program as compared to a control group. The control group consisted of 14 identified members who did not receive 17P treatment during their recent pregnancy and who had a history of preterm delivery within the last 36 months. The members who were selected for the control group also were enrolled in the OB case management program, as they were identified as being at high risk; they received ongoing follow-up services and were monitored for treatment compliance.

Initiation of 17P injections ranged from 15 weeks' gestation to 33 weeks' gestation in the 24 patients. In the intervention group, 15 patients (62.5 percent) started the weekly injections within the treatment initiation window described in the Meis study (2003) of 16- to 21-weeks' gestation. Reasons for delay in initiation of 17P therapy were not identified in this review. Ten patients in the intervention group did not miss any weekly injections of 17P. Five members missed more than 2 doses (Table 2). Reasons for noncompliance were not evaluated for this review (Table 3).

NICU admissions

The control group had 14.3 percent NICU admissions, and the group treated with 17P only had 8.33 percent NICU admissions. This result is not a significant reduction according to the chi-square analysis (Table 4).

NICU length of stay

An analysis of the length of stay is used also to measure successful interventions with improving pregnancy

TABLE 2 Patient compliance with 17P weekly injections

Number of missed doses	Number of patients	Percentage of group
0	10	41.60
1	4	16.70
2	4	16.70
5	3	12.50
6	2	8.33
>6	1	4.17

TABLE 3 Week of initiation of 17P injections

Week of gestation	Number of patients
15	1
16	5
17	2
18	2
19	2
20	2
21	1
22	1
23	1
24	1
28	3
30	1
32	1
33	1

outcomes. The length of treatment for both the intervention group and the control group was analyzed, and a significant reduction in the NICU LOS occurred for members who received the injection versus those members in the control group. Compared to those in the control group who delivered preterm, members in the intervention group who delivered preterm delivered at a later gestational age and remained hospitalized for fewer days. The financial impact resulted in savings of more than $402,975 in inpatient-related costs, which was also statistically significant (Table 5). The financial result is dependent on contracted rates of the facilities accessed by our members, and our members have open access. The savings could vary based on place of service.

Member compliance

Only 1 of 5 NICU/special care nursery deliveries received 100 percent of 17P prescribed treatments. Two patients began 17P treatment after 20 weeks' gestation; two in this group began treatment at 16 weeks' gestation.

Of those 18 patients with well deliveries, 13 (72.2 percent) were at 90 percent or better with compliance with prescribed 17 P treatment. Only five (27.7 percent) patients received less than 90 percent of prescribed treatment. All delivered well babies at full-term. Nine (50 percent) patients started 17P treatment before gestational week 20, nine (50 percent) patients after gestational week 20, and only three patients in this group began treatment at or before 16 weeks. Thirteen women received 17P during the 16- to 20- weeks' gestation window described in the Meis study (2003). Three of these patients were in the group that delivered preterm. Nevertheless, none were less than 32 weeks' estimated gestational age, and they each had a relatively short LOS (5, 5, 10 days). Ten patients received 17P later than 20 weeks' gestation, after the timeframe for initiation of 17P described in Meis et al (2003). Two of these patients delivered preterm, with one delivering twins. The lengths of stay were 66 days, 66 days, and 3 days. The twins were delivered at 30 weeks; the other delivery was at 37 weeks' gestation (Table 6).

Complications

Of 24 women receiving 17P, 1 had an allergic reaction at the injection site after 10 injections, resulting in an abscess. A second patient had an allergic reaction at the injection site after treat-

TABLE 4 NICU admissions: 17P group versus control group

	17P group		Control group		Variance percentage points	Significance
Well delivery	19	79.1%	11	78.6%	-0.50	None
NICU	2	8.3%	2	14.3%	+5.97	None
SCN	3	12.5%	1	7.1%	–5.36	None
Total sample	24	100%	14	100%		

NICU=neonatal intensive care unit, SCN=special care nursery.

TABLE 5 NICU length of stay and financial impact

	17P group	Control group	Variance	Significance
Length of stay	149	231	–21.66 percentage points	*P*<.000 Chi-square = 34.531
Financial impact	$165,486.75	$586,461.78	–56.00 percentage points	*P*=.000 Chi-square = 471,358.9 DF=1

DF=degree of freedom, NICU=neonatal intensive care unit.

TABLE 6 Patient compliance with administration of 17P

EGA treatment began	No. of injections authorized	No. of injections completed	Delivery outcome		No. of days in SCN/NICU	Cost
33	3	3 (100%)	39 weeks	Well	N/A	
21	15	10	37 weeks	SCN	3	$4124.00
19	17	17 (100%)	37 weeks	Well	N/A	
18	18	13 (72%)	32 weeks	SCN	10	$18,041.30
17	19	3 (15%)	38 weeks	Well	N/A	
23	13	1 (7%)	40 weeks	Well	N/A	
28	7	1 (14%)	39 weeks	Well	N/A	
16	21	20 (95%)	38 weeks	Well	N/A	
18	18	18 (100%)	38 weeks	Well	N/A	
32	8	8 (100%)	39 weeks	Well	N/A	
24	12	11 (92%)	35 weeks	Well	N/A	
22	14	14 (100%)	37 weeks	Well	N/A	
20	16	15 (94%)	37 weeks	Well	N/A	
28	9	3 (33%)	37 weeks	Well	N/A	
30	5	5 (100%)	39 weeks	Well	N/A	
19	15	13 (87%)	38 weeks	Well	N/A	
28	8	3 (38%)	30 weeks	SCN	63	$67,647.03
16	20	18 (90%)	35 weeks	NICU	5	$7,086.55
16	20	20 (100%)	38 weeks	Well	N/A	
19	17	17 (100%)	38 weeks	Well	N/A	
17	19	19 (100%)	37 weeks	Well	N/A	
15	20	20 (100%)	37 weeks	Well	N/A	
16	18	18 (100%)	35 weeks	NICU	5	$6,089.00

EGA=estimated gestational age, N/A=not available, NICU=neonatal intensive care unit, SCN=special care nursery.

ment week 3. These complications responded to outpatient treatment. Both patients discontinued 17P injections.

DISCUSSION

Although the intervention group is small, this study shows evidence of a significant reduction in both NICU bed days and cost. Other than offering 17P as a benefit, we are not aware of any external reasons that would have caused decreases in the NICU admission rate and LOS, such as coding changes, changes in NICU admission or discharge criteria, or new interventions that decrease preterm labor.

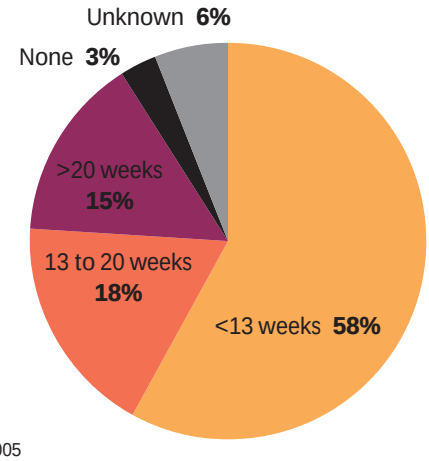
Among this study's strengths are its design, which included patients who would be typical candidates in a managed Medicaid population. Though the sample size and control group are small, the study yielded a statistically significant result for a reduction in the NICU LOS.

A longitudinal review of birth outcomes of 24 pregnant women with a history of preterm delivery prescribed 17P as compared to a control group does have shortcomings. Due to the low number of potential candidates for the control group, demographics could not be taken into consideration when selecting the control group. There is also the potential for risk bias, as the members who are most compliant (at less risk) might be those who agreed to take the weekly injections of 17P. Whether the differences in the birth outcomes of the intervention group versus the control group are attributable to inherent differences between the groups' general approaches to pregnancy or differences in prenatal care was not addressed by this study.

Challenges exist in extending the 17P benefit to a managed Medicaid population. The effects of delaying initiation of 17P and missing weekly injections are neither fully studied nor understood. The *New England Journal of Medicine* study (Meis 2003) initiates the weekly injections between 16 and 21 weeks' gestation. Unfortunately, many obstacles exist that delay the first prenatal visit of Medicaid enrollees, often too late in the second trimester. The process of Medicaid eligibility is complicated. In our Missouri service area, once a woman has a positive pregnancy test, she is immediately eligible for fee-for-service Medicaid. Nonetheless, she must wait for processing to be complete before she is able to choose a managed Medicaid plan. Often, pregnant women signing up for our plan are beyond 20 weeks' gestation. This delay in eligibility and in the start of prenatal care makes it difficult to initiate 17P weekly injections in high-risk women who are suitable candidates for such treatment.

We completed a focus study in 2004

FIGURE Gestational age at start of prenatal care



SOURCE: HCUSA 2005

that analyzed demographic data including the gestational age when prenatal care was initiated. According to the analysis, more than 15 percent of members who become eligible under Medicaid managed care receive prenatal care after 20 weeks' gestation, and more than 15 percent receive prenatal care between 13 and 20 weeks' gestation (Figure).

While only 62.5 percent of the women started 17P injections before gestational week 21, a reduction in NICU bed days still was seen, evidence that 17P can be used successfully in a population that is notorious for late prenatal care.

Once the patient was identified, administration of 17P on a weekly basis was a simple process. Because a physician could arrange to administer the injection in the office or through home health, a high level of compliance with the weekly injection was reported. Frequent contact with our OB nurse case managers most likely contributed to compliance with the weekly injection. The injection was well tolerated, with only two patients discontinuing treatment, due to minor adverse reactions.

To date, there are no widely established treatments to prevent preterm delivery. The reduction in NICU days and cost savings demonstrated in this study by offering 17P as a benefit in a managed Medicaid population is substantial. Use of 17P deserves further investigation, especially for application on a much broader scale.

In conclusion, a 2004 longitudinal review of birth outcomes in 24 pregnant women who had a history of preterm delivery and were prescribed 17P versus a control group showed a significant decrease in NICU LOS for a Medicaid managed care plan. The evidence provided by these results is consistent with those of a double blind, randomized, placebo-controlled trial by Meis and colleagues (2003). The 17P was well tolerated, with only a small abscess and allergic reaction noted at the injection site, both treated on an outpatient basis. The optimal time frame for initiation of 17P treatment as well as the effect of missed weekly injections on outcomes need further study. Use of 17P on a broader scale should be a strong consideration in treating high-risk pregnant women with a history of preterm delivery.

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Legal Aid of Western Missouri
MC+ Advocacy Project

Reporting Period: January 1, 2006 through June 30, 2006

I. Executive Summary

The past six months for the MC+ Advocacy Project at Legal Aid of Western Missouri has been a period of extensive outreach efforts and work with community health groups, task forces on health issues, and area hospitals. Planning for town hall forums on health care issues, working with the Local Investment Commission on their Health Committee, participating in the MC+ Consumer Task Force, and planning and participating in the Covering the Uninsured Week have been major involvement and contribution areas for the project during this period. Training regarding a number of MC+ coverage issues and changes in Medicaid provisions has been provided to the hospitals serving the largest percentage of the poverty and children population in this region.

Legal Aid of Western Missouri offices on site at Truman Medical Center-Hospital Hill and Truman Medical Center Lakewood have afforded access to clients having questions or issues relating to MC+ coverage and eligibility on a daily basis. As a result, advice and legal

assistance with application questions, coverage provisions, or eligibility issues can be provided to a significant number of Medicaid enrollees and applicants. Representation regarding recipient liability in court cases, administrative hearings regarding coverage issues and hearings relating to coverage determinations are ongoing individual representation provided to Medicaid claimants by the MC+ Advocacy Project.

II. Client Data

A. Cases by County:

County	**Number of Cases**
Jackson	74
Clay	11
Platte	6
Cass	1
Johnson	
Ray	
Lafayette	
Henry	
St. Clair	
Total:	92

B. Cases by Health Plan:

Health Plan	**Number of Cases**
Blue Advantage Plus	4
Family Health Partners	7
FirstGuard	13
HealthCare USA	0
MercyCarePlus	0

C. Total Number of Applicants: 19
Total Number of Enrollees: 73

D. Cases by Problem Type:

Mental Health	1
Dental	1
Pharmacy	
Transportation	
Specialty Care	1
Primary Care	
Maternity Care	
Hospital Care	
Ancillary Services	1
Availability of and Access to Providers	2
Eligibility	71
Enrollment	5
Recipient Liability	7
General Questions	3

E. Cases by Resolution:

MC+ Advocacy Project	55
BA+ Complaint Grievance and Appeals	
FHP Complaint Grievance and Appeals	
Healthcare USA Complaint Grievance and Appeals	
FirstGuard Complaint Grievance and Appeals	1
State Fair Hearings	2
FSD	26
DMS Recipient Services	3
Other Court settlement/disposition Client withdrew w/o resolution Resolve with provider	 2 2 2

III. Outreach Activities

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
JANUARY				
01/03/2006	McCoy Elementary Caring Comm.- Parent/Teacher Conferences	Sent materials	Dist. Project and MC+ info.	N/A
01/03/2006	Jackson County Health Dept.	Sent materials	Dist. Project and MC+ info.	N/A
01/04/2006	Cass Co WIC Office	Sent materials	Dist. Project and MC+ info.	N/A
01/04/2006	Holy Family House	Sent materials	Dist. Project & MC+ info.	N/A
01/04/2006	Mo. Baptist Children's Home	Sent materials	Dist. Project & MC+ info.	N/A
01/05/2006	Operation Break-through/Pro-Vote Workshop	Attend Meeting	Dist. MC+ & project info.	15
01/06/2006	Henry County WIC Office	Sent materials	Dist. Project & MC+ info.	N/A
01/06/2006	Ray Co WIC Office	Sent materials	Dist. Project & MC+ info.	N/A
01/09/2006	Woodland Elem. Head Start	Presentation	Dist. Project& MC+ info.	6
01/09/2006	Fairmount Elem. Head Start	Presentation	Dist. Project & MC+ info.	3

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
01/10/2006	Douglass Head Start	Presentation	Dist. Project & MC+ info.	10
01/10/2006	Guadalupe Center	Meeting	Disc. Proj. MC+ info.	1
01/10/2006	Johnson County WIC	Sent materials	Dist. Proj. & MC+ info.	N/A
01/10/2006	Family Health Partners-Member Advisory Comm. Meeting	Meeting	Dist. Project & MC+ info.	10
01/11/2006	Franklin Elem. Head Start	Presentation	Dist. Proj. & MC+ info.	6
01/13/2006	Synergy Services Inc.	Sent materials	Dist. Proj. & MC+ info.	N/A
01/13/2006	Maternal Child Health Coalition	Meeting Town Hall	Planning Mtg. For Town Hall	8
01/16/2006	Coalition of Hispanic Organizations	Meeting	Attended Coalition Meeting	35
01/17/2006	Douglas Head Start	Presentation	Dist. Proj. and MC+ info.	5
01/18/2006	De la Salle Education Center	Presentation	Dist. Proj. and MC+ info.	20
01/18/2006	Moheart/Linwood Community Center	Presentation	Dist. Proj and MC+ info.	8
01/19/2006	Randall Caring Communities Site Meeting	Presentation	Dist. MC+ & project info.	20
01/19/2006	Santa Fe Trail-Winterfest	Information table	Dist. MC+ & project info.	40
01/20/2006	Maternal Child Health Coalition	Information table & Presentation	Dist. MC+ & project info.	60

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
01/23/2006	Mattie Rhodes Counseling Center	Meeting	Dist. MC+ & project info.	1
01/23/2006	Guinotte Head Start	Presentation	Dist. MC+ & project info.	5
01/24/2006	Platte County WIC	Sent materials	Dist. MC+ & project info.	N/A
01/05/2006	Operation Break-through/Pro-Vote Workshop	Attend Meeting	Dist. MC+ & project info.	15
FEBRUARY				
02/03/2006	Coalition of Hispanic Organizations	Meeting & Presentation	Dist. MC+ & project info.	40
02/09/2006	Henry County CHART Meeting	Presentation	Dist. MC+ & project info.	35
02/09/2006	Henry County Housing Authority	Site visit	Dist. MC+ & Project info.	4
02/09/2006	Henry County FSD	Site visit	Dist. MC+ & Project info.	3
02/09/2006	Henry Elementary	Site Visit	Dist. MC+ & Project info.	3
02/09/2006	Henry County Hospital	Site visit	Dist. MC+ & project info.	1
02/13/2006	Division of Workforce Development	Sent materials	Dist. MC+ & project info.	200
2/13/06-2/17/06	Truman Medical Center-Truman Baby Shower Event	Presentation & Information table	Dist. MC+ & project info.	50
02/23/2006	Metropolitan Lutheran Ministries	Sent materials	Dist. matl & info.	N/A

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
02/23/2006	Brushcreek Community Center	Site visit	Dist. matl & project info.	N/A
02/23/2006	YMCA Childcare Center	Site visit	Dist. matl & project info.	N/A
02/23/2006	Crittenton Behavioral Health of Blue Springs	Sent materials	Dist. MC+ & project info.	N/A
02/23/2006	Gillis Center	Sent materials	Dist. MC+ project info.	N/A
02/27/2006	Mexican Consulate Health Event	Information table	Dist. Matl & info.	60
MARCH				
03/01/2006	Missouri Association of Social Welfare Conference	Attend conference	Dist. info & materials	100
03/08/2006	Truman Medical Center HIV+ Women's Support Group	Presentation	Dist. MC+ project materials	4
03/08/2006	El Centro Case Manager Meeting	Presentation	Dist. MC+ & project materials	15
03/08/2006	Grtr KC Chamber of Commerce	Meeting	Disc & matl	1
03/08/06	TMC HIV+ Women's Support Group	Medicaid Legal Issue Present.	Pres. & ?s	4
03/09/2006	Northland Unmet Needs Council	Site visit	Dist. MC+ materials	2
03/13/2006	St. Stephen's Academy	Site Visit	Dist. MC+ materials	N/A
03/14/2006	Child Abuse Prevention Assoc.	Site visit & Presentation	Dist. MC+ & project info.	25
03/14/2006	Robinson School Health Fair	Information booth	Dist. MC+ & project info.	115

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
03/15/2006	Women's issues Forum	Information booth	Dist. MC+ & project info.	10
03/16/2006	Northeast Advisory and Access Group	Attend Meeting	Dist. MC+ & project info.	45
03/17/2006	Community Response Team-Northland Synergy Services	Presentation	Dist. MC+ & project info.	15
03/17/2006	Truman Child Health & Safety	Presentation	Dist. MC+ & project info.	10
03/18/2006	Genesis School FHP Health Event	Presentation	Dist. MC+ & project info.	7
03/23/2006	Dislocated Workers Program-Morning Session	Presentation	Dist. MC+ & project info.	70
03/23/2006	Dislocated Workers Program-Afternoon Session	Presentation	Dist. MC+ & project info.	45
03/28/2006	Panda Place Wellness Center	Letter	Dist. MC+ & project info.	N/A
03/28/2006	Cover the Uninsured Week Cmmttee Meeting	Attend Meeting	Dist. MC+ & project info.	12
03/29/2006	Fire Prairie/Ft. Osage Health Fair	Information booth	Dist. MC+ & project info.	80
03/30/2006	Hawthorne Place FHP Health Event	Information booth	Dist. MC+ & project info.	15
03/31/2006	Douglass Headstart Health Fair	Information booth	Dist. MC+ & project info.	75
03/31/2006	Thornbury Boys and Girls Club	Site visit	Dist. MC+ & project info	N/A
APRIL				
04/06/2006	KCMOSD ESL Program-Thatcher Multicultural Bld	Site visit & Meeting	Dist. MC+ & project info.	2

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
04/06/2006	Clinton Parents as Teachers	Letter	Dist. MC+ & project info.	N/A
04/07/2006	Women's Healthcare Symposium	Information booth	Dist. MC+ & project info.	70
04/10/2006	LINC Health Committee Meeting	Meeting	Dist. MC+ & project info.	25
04/10/2006	Ft. Osage PTA Easter Egg Hunt	Information booth	Dist. MC+ & project info.	100
04/11/2006	Covering the Uninsured Week Meeting	Meeting	Dist. MC+ & project info.	10
04/12/2006	Dislocated Workers Program-Morning Session	Presentation	Dist. MC+ & project info.	75
04/12/2006	Dislocated Workers Program-P.M. Session	Presentation	Dist. MC+ & project info.	30
04/12/2006	Johnson County Human Services Meeting	Presentation & Meeting	Dist. MC+ & project info.	12
04/12/2006	Warrensburg Housing Authority	Site visit	Dist. MC+ & project info.	N/A
04/13/2006	RWJ Statewide MC+ Coalition	Meeting	Dist. MC+ & project info.	40
04/19/2006	Covering the Uninsured Week Meeting	Meeting & Site visit	Site visit & initial plans	N/A
04/21/2006	COHO Health Committee Meeting	Meeting	Dist. MC+ & project info.	10
04/26/2006	Metro. Task Force on Drug Exposed Infants	Presentation	Legal issues & ? session	14
04/27/2006	Truman Medical Ctr. Childcare Class	Presentation	Dist. MC+ & project info.	15

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
04/27/2006	Community Together	Meeting & Information table	Dist. MC+ & project info.	45
04/28/2006	Maternal Child Health Coalition	Meeting & Information table	Dist. MC+ & project info.	35
04/30/2006	Día de los niños @ St. Stephen's Academy	Information booth	Dist. MC+ & project info.	200
MAY				
05/01/2006	Call for Action-Covering the Uninsured Week	Answer phones	Dist. MC+ & project info.	250
05/03/2006	Neighborhood Services Meeting	Presentation & Info. table	Dist. MC+ & project info.	70
05/03/2006	CTUW Health Fair Meeting	Meeting	Discuss Fair logistics	N/A
05/04/2006	Small Business Breakfast-Covering the Uninsured Week	Information table	Dist. MC+ & project info.	30
05/08/2006	Follow up To Call for Action callers	Letters	Application information	8
05/09/2006	Cass County CHART Meeting	Meeting, Presentation & dist. info.	Meeting, dist. Info & answer ?s	15
05/10/2006	Meeting W/First Guard at Gregg Klice Center	Meeting	Visit Fair site and discuss logistics	N/A
05/11/2006	Northeast Middle School ESL Awards Banquet	Information table	Dist. MC+ & project info.	200
05/11/2006	FHP Consumer Health Event	Information table	Project & MC+ info	15

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
05/16/2006	Covering the Uninsured Week	Meeting	Discuss Fair logistics	N/A
05/17/2006	Covering the Uninsured Week Health Fair Mtg.	Meeting	Discuss Fair logistics	N/A
05/17/2006	Mattie Rhodes Counseling Center	Meeting	Disc/ re MC+ & project	1
05/18/2006	Northeast Advisory and Access Group	Meeting	Re health issues and community concerns	30
05/22/2006	Covering the Uninsured Week Health Fair Committee Mtg.	Meeting	Finalize logistics for CTUW health fair	N/A
05/23/2006	Cosby Call Out Event- Penn Valley Community College	Information table	Dist. MC+ & project info.	25
05/24/2006	Chilhowee School	Letter	Dist. MC+ & project info.	N/A
05/25/2006	St. Ann's School	Letter	Dist. MC+ & project info.	N/A
05/26/2006	Truman Medical Ctr. Behavioral Health	Meeting	Meeting re MC+ info and project	2
JUNE				
06/01/2006	First Guard	Meeting	Finalize CTUW health fair plans	N/A
06/02/2006	Gregg Klice	Meeting	Finalize logistics for CTUW fair	N/A
06/03/2006	Covering the Uninsured Week (CTUW)	Information booth	Dist. Project and MC+ info.	200

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
06/07/2006	Missouri Children's Division Resource Fair	Information booth	Dist. Proj. and MC+ info.	300
06/09/2006	Mattie Rhodes-Visions w/Hope	Site visit	Dist. Proj. and MC+ info.	85
06/10/2006	Cabott Westside Clinic	Information booth	Dist. Proj. and MC+ info.	100
06/12/2006	Truman Medical Center-New Mom's support group	Presentation	Dist. Project and MC+ info.	25
06/13/2006	St. Luke's Hospital-Teen Mom's Support Group	Presentation	Dist. Project and MC+ info.	15
06/13/2006	St. Luke's Hospital-Teen Mom's Support Group (Spanish)	Presentation	Dist. Project and MC+ info.	7
06/13/2006	St. Luke's Hospital-Case Management Services	Meeting	Dist. Project and MC+ info.	2
06/13/2006	St. Luke's Hospital-Charity Management	Meeting	Dist. Project and MC+ info.	2
06/14/2006	Truman Medical Center-OB Clinic	Information booth	Dist. Project and MC+ info.	20
06/15/2006	Robert Wood Johnson Statewide MC+ Coalition	Meeting	Dist. Project and MC+ info.	35

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
06/20/2006	St. Luke's Hospital	Letter	Dist. Proj. and MC+ info.	N/A
06/21/2006	MC+ Consumer Advisory Council	Meeting	Dist. Proj. and MC+ info.	30
06/22/2006	Truman Medical Center-Newborn Care Class	Presentation	Dist. Project and MC+ info.	15
06/23/2006	LINC Health Task Force Committee	Meeting	Meeting & dist. MC+ info.	18
06/23/2006	Swope Health Centers	Site visit	Dist. Proj. and MC+ info.	N/A
06/24/2006	Independence Headstart-Citywide Children's Fair	Information booth	Dist. Project and MC+ info.	300
06/27/2006	Coalition of Hispanic Organizations	Letter	Dist. Proj. and MC+ info.	N/A
06/27/2006	St. Luke's Hospital	Letter	Dist. Proj. and MC+ info.	N/A
06/27/2006	Truman Medical Center OB Clinic	Letter	Dist. Project and MC+ info.	N/A
06/28/2006	Excelsior Springs Medical Center	Information booth	Dist. Project and MC+ info.	100
06/29/2006	Binational Health Week Steering Committee	Meeting	Dist. Project and MC+ info.	18

IV. Concerns from Western Missouri

Throughout the last six months, the Project has seen continuing problems with the ex parte review process to be afforded claimants in MC+ cases. Many Eligibility Specialists are not familiar with the requirements for an ex parte review and terminate MC+ recipients with no review of possible eligibility under other Medicaid programs. It is the receipt of Social Security disability benefits which often renders a parent ineligible for continuing Medical Assistance for Families coverage, but many times the Eligibility Specialist fails to review eligibility under the adult Medical Assistance programs before terminating the Medicaid coverage of the parent. It is usually necessary to contact a supervisor with the Family Support Division before these issues are resolved for claimants.

The premium costs for the CHIP group are a continuing concern of claimants contacting Legal Aid of Western Missouri. There are still numerous budgeting errors made by Eligibility Specialists in determining whether a family must pay premiums and the amount of the premiums. It is hoped that the recent changes in premium assessment will alleviate some of the burden on these CHIP households. However, it is also likely that this change will result in

additional errors and will require close scrutiny and review of the budgeting in these premium cases.

The accessibility of Eligibility Specialists is a major complaint of claimants. Many applicants and enrollees call our Project after they have tried numerous times to contact their Eligibility Specialists for answers to very basic questions on premium determinations, addition of children to their MC+ case, changes in the household situation that they are trying to report, or to determine the status of their application. Given the large caseloads of most Eligibility Specialists, the new citizenship and strict reinvestigation requirements are going to exacerbate the problem of allocating time to client questions and concerns.

It is anticipated that numerous claimants will experience difficulty with the citizenship verification requirements and that Legal Aid will be assisting and working with the Division in many of these cases to comply with the mandatory provisions on citizenship and identity verification. Our clients in domestic violence shelters and those with very limited income may have great difficulty in obtaining access to the verification required. Lack of Medicaid coverage while citizenship verification is being obtained will be a major problem for many of our clients.

We can only hope that some of these requirements may be eased by the federal government. Legal Aid is committed to assisting clients and the Division workers in every way possible to meet these requirements. We will also be reviewing cases very closely to insure that Division staff understands and is properly implementing the citizenship and identity provisions.