MO HealthNet Managed Care
Annual Evaluation

SFY 2007

MC+ Managed Care Annual Evaluation

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Executive Summary

EXECUTIVE SUMMARY

Introduction

MC+ Managed Care serves 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 six 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 state fiscal year 2007. The evaluation is divided into ten (10) sections: Development, Approval and Monitoring of the Quality Improvement (QI) Program, Population Characteristics, Quality Indicators, Accessibility of Services, Fraud and Abuse, Information Management, Quality Management, Rights and Responsibilities, Utilization Management and Performance Improvement Projects (PIPs). The MC+ Managed Care health plans also submitted work plans for SFY2008.

Information to conduct the annual evaluation was gathered from the DMS internal systems, MC+ Managed Care health plan reports submitted to the 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 2006 Missouri MC+ Managed Care Program External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Legislative Changes

Effective July 1, 2006 the following changes to the MC+ Managed Care program occurred as a result of passage of House Bill 1011 during Missouri's 93rd General Assembly 2006 legislative session:

- ❖ Optometric services for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61) were limited to eye examinations and one pair of eyeglasses following cataract surgery.

- ❖ Durable medical equipment (DME) was limited to prosthetic devices; respiratory equipment and oxygen, with the exception of CPAP, BiPAP, and nebulizers; wheelchairs (including batteries and accessories); diabetic supplies and equipment; and ostomy supplies for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61). Regardless of age, participants with a home health plan of care receive DME services for the duration of their home health plan of care.

Development, Approval and Monitoring of the QI Program

Development, Approval and Monitoring of the QI Program was measured by reviewing the health plan's quality and compliance committees, the analysis of their quality improvement process and the overall effectiveness of their quality improvement program including strengths

and accomplishments as well as opportunities for improvement. This information was taken from the MC+ Managed Care health plans' Annual Evaluation for SFY2007.

Strengths and Accomplishments
- ❖ All MC+ Managed Care health plans have a variety of oversight committees to develop and approve as well as monitor their QI program.
- ❖ Utilization Review Accreditation Commission (URAC) accreditation obtained.
- ❖ National Committee for Quality Assurance (NCQA) accreditation of disease management program.
- ❖ Improvement in Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
- ❖ Oversight committees formed to address QI areas.
- ❖ Implemented comprehensive and integrated care management models.
- ❖ Implemented a Healthy Lifestyles Program (HeLP).

Opportunities for Improvement
- ❖ Continue efforts to increase HEDIS and CAHPS scores.
- ❖ Continue collaboration between the areas within QI and health plan management to ensure interventions to improve service and clinical care is ongoing.
- ❖ Decrease emergency department utilization.
- ❖ Continue to improve lead testing rates.

Population Characteristics
Population Characteristics were measured by reviewing the health plan's race/ethnicity, special needs, identified languages, and opt-outs from the MC+ Managed Care health plans' Annual Evaluation for SFY2007. Additionally, the DMS performed region wide analysis measuring the same population characteristics.

Across all MC+ Managed Care health plans during SFY 2007 the race of enrollees consisted of 54.3% white, 41.16% black, 0.94% Hispanic, .69% Asian, 0.50% multi-racial and .13% 'other'. There were also 2.28% of enrollees in which race/ethnicity was undetermined.

Eastern region enrollees consisted of 52.8% black and 43.35% white; Central region enrollees consisted of 14.89% black and 81.19% white; and Western region enrollees consisted of 35.96% black and 58.36% white.

During SFY 2007 there were 11,359 unique individuals that were identified with special health care needs and were reported to the appropriate MC+ Managed Care health plan. Of these 6,585 (57.97%) were in the Eastern Region, 1,124 (9.90%) were in the Central Region, and 3,650 (32.13%) were in the Western Region.

In all MC+ Managed Care health plans during SFY 2007 there were 62.34% of MC+ Managed Care enrollees whose primary language was English. Additionally, 0.31% enrollees listed Spanish as their primary language, 0.30% other languages and 37.05% of enrollees had no primary language listed. The highest percentage of enrollees in each region who identified having a primary language identified English as their primary language with Spanish being a distant second. 65.44% of enrollees in the Eastern region identified English as their primary

language, 60.74% of enrollees in the Central region identified English as their primary language and 58.14% of enrollees in the Western region identified English as their primary language. .17% of enrollees in the Eastern region identified Spanish as their primary language, .19% in the Central region identified Spanish as their primary language and .60% Western region enrollees identified Spanish as their primary language.

In all MC+ Managed Care health plans during SFY 2007 there were 328 MC+ Managed Care enrollees that opted-out of the MC+ Managed Care program. Of these 91.16% were processed by Policy Studies, Inc. (PSI) and 8.84% were processed by the participant services unit at DMS. Regionally, of all the opt-outs 58.54% were in the Eastern region, 16.77% were in the Central region and 24.70% were in the Western region. There were 294 enrollees in the 1915(b) Waiver and 34 enrollees in the 1115 Waiver in the total opt-out group.

The top five opt-out reasons are:
1. Better Benefits – 54.57%
2. No Information Provided from PSI – 19.21%
3. Doctor Takes Straight Medicaid – 13.72%
4. Other – 9.15%
5. Too Many Referrals – 1.22%

Of the 328 enrollees that chose to opt out 80.79% opted-out after enrollment in an MC+ Managed Care health plan and 14.02% opted-out prior to enrollment in an MC+ Managed Care health plan, 2.44% re-enrolled, 2.13% had their request for opt-out denied and 0.61% indicated 'other'.

Quality Indicators

Quality Indicators were measured by reviewing the health plans' performance measures, trends in MC+ Medicaid quality indicators and HEDIS indicators by MC+ Managed Care Health Plans Within Regions, Live Births. This information was taken from the MC+ Managed Care health plans' Annual Evaluation for SFY2007.

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 the DMS Managed Care health plans. The DHSS publishes their specific HEDIS information and CAHPS information, which measures member satisfaction coving 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 the health plans are performing in their responsibility to provide high quality health care and consumer service to their members. The HEDIS measures collected by the DMS is compiled into a statewide report to provide information back to the health plans. This enables the health plans to compare their performance to the other health plans and to see how their performance ranks against the statewide average.

Strengths and Accomplishments
   ❖ Identified trends and established corrective action plans.
   ❖ Created focus studies and PIP's to further improve quality.

❖ Showed an increase in measured results for most measures.

Opportunities for Improvement
❖ Not all health plans performed a year-to-year comparison for HEDIS measures
❖ Continue to utilize focus studies and PIPs as tools to improve services to members

Accessibility of Services

Accessibility of Services were measured by reviewing the health plan's average speed of answer, call abandonment rate, non-routine and routine needs appointments, access to emergent and urgent care, network adequacy and provider/enrollee ratios, 24 hour access and after hours availability, open and closed panels, cultural competency and requests to change practitioners. This information was taken from the MC+ Managed Care health plans' Annual Evaluation for SFY2007.

Strengths and Accomplishments
❖ Use of automated call tracking system to monitor and track telephone statistics for average speed of answer and call abandonment rate. Health plan monitoring indicates adequate response.
❖ Random provider telephone surveys to assure compliance with contract standards for appointments and after-hours access to emergent and urgent care. Health plan monitoring indicates adequate access.
❖ Provides diversity/cultural competency training for providers and health plan employees

Opportunities for Improvement
❖ Authorize out-of-network access to accommodate cultural/ethnic diversity issues.
❖ Monitor PCP change request reasons for quality of care issues and investigate accordingly.
❖ Keep provider directory up-to-date to assure members are advised of PCPs with closed panels.
❖ Monitor grievance and appeals for accessibility of services issues.

Additionally, the Missouri 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 and the MC+ Managed Care health plans serve to determine if the average enrollee access rates 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.

Strengths and Accomplishments
❖ 2006 Network Analysis completed by the DIFP determined that all but one of the MC+ Managed Care health plans met the 90% standard with the rest achieving 98% and greater.
❖ All health plans exceeded the PCP distance standard per state regulation 20 CSR 400-7.095(3)(A)1.B.

❖ All health plan PCP/enrollee ratios were well under benchmark PCP/enrollee ratios found by the DMS research.
❖ All health plan dentist/enrollee ratios were within the benchmark dentist/enrollee ratios found by the DMS research.
❖ All health plan mental health provider/enroll ratios were well under benchmark mental health provider/enrollee ratios found by the DMS research.

Opportunities for Improvement
❖ While all but one of the MC+ Managed Care health plans met the 90% network distance standard, not all health plans achieved 90% in every provider type category.

Fraud and Abuse

Fraud and Abuse was measured by reviewing the health plan's prevention, detection and investigation practices as well as training and education. This information was taken from the MC+ Managed Care health plans' Annual Evaluation for SFY2007.

Effective beginning in SFY 2006 the MC+ Managed Care health plans began using a uniform reporting system for their quarterly reports to the DMS. When appropriate the MC+ Managed Care health plans report to and cooperate with the Medicaid Fraud Control Unit (MFCU), the Attorney General's Office and other agencies that conduct investigations for the purpose of exchanging information and strategies for addressing fraud and abuse, as well as allowing access to documents and other available information related to program violations.

Strengths and Accomplishments
❖ Special Investigation Units and special committees focused on fraud and abuse.
❖ Review of fraud and abuse policies annually and update as needed.
❖ Staff training and education is ongoing for fraud and abuse.
❖ Initiate and monitor lock-in on members when warranted to reduce fraudulent use of pharmacy benefits and other services.
❖ Claim processing edits to better identify coding irregularities that may indicate fraud and abuse.

Opportunities for Improvement
❖ Continue to monitor claim submissions and implement additional edits to better identify potential fraud and abuse.
❖ Continue health plan staff, provider and member training in fraud and abuse prevention and detection.
❖ Initial reports of fraud and abuse should be reported timely to the DMS and if appropriate to other agencies.
❖ Monitor member and provider grievance and appeals for trends that may indicate fraud and abuse.

Information Management

Information Management was measured by reviewing the health plans' claims processing/timeliness of claims payment, membership and providers. For this section the DMS

used information from the 2006 External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Encounter claims data are used by the State Medicaid Agency (SMA) to conduct rate setting and quality improvement evaluation. Before the SMA encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields (e.g., diagnosis and procedure codes, units and dates of service, member and provider identifiers) are complete (each field contains information), accurate (the information contained in each field is of the right size and type), and valid (the information represents actual dates or procedure and diagnosis codes). Several critical fields for each of six claim types (Medical, Dental, Home Health, Inpatient, Outpatient, Hospital, and Pharmacy) were identified by the SMA and examined by the EQRO for completeness, accuracy, and validity using an extract file from the SMA paid encounter claims. To examine the extent to which the SMA encounter claims database was complete (the extent to which the SMA encounter claims database represents all claims paid by MC+ MCOs); the level and consistency of services was evaluated by examining the rate of each of six claim types. Additionally, the representativeness (or completeness) of the SMA encounter claims database was examined by comparing data in the SMA encounter claims database to the medical records of members. A random sample of medical records was used to compare the diagnosis codes, procedure codes, drug name dispensed, and drug quantity dispensed in the SMA encounter claims database with documentation in MC+ member medical records. The findings of these comparisons were used to determine the completeness of the SMA encounter claims database in regards to the medical records of members. The completeness of the SMA paid encounter claims was then compared with MC+ MCO records of paid and unpaid claims. This proved to be a difficult task, as all of the MC+ MCO data submissions did not include unique claim identifiers that could be used to accomplish this comparison. Although all five MC+ MCOs provided data in the format necessary to make the comparisons; the data did not include a unique identifier that could be utilized to match claims. The results obtained are detailed in the results of the Aggregate Encounter Data Validation section of this report.

Strengths
  ❖ MC+ members are receiving more services than their fee-for-services counterparts. The claims data presented above details a much higher rate of claims per 1,000 members for MC+ members. This is likely due to a greater availability of needed services, more access points to care, and the timeliness in which those services are delivered.

  ❖ All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MC+ MCOs. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.

  ❖ For all MC+ MCOs, the first Outpatient Diagnosis Code field was 100.0% complete, accurate and valid.

  ❖ All MC+ MCOs submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.

❖ The examination of the level, volume, and consistency of services found significant variability between MC+ MCOs in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), with no patterns of variation noted by MC+ Managed Care region or type of MC+ MCO.

❖ There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all MC+ MCOs.

❖ Unpaid claims represent less than .02% of all claims submitted to the SMA.

Areas for Improvement
❖ For all MC+ MCOs, all unmatched encounters were due to missing internal control numbers (ICN), which are required to match the encounter to that of the SMA.

❖ For the Medical claim type, there were invalid values for the First Diagnosis Code fields, including blank fields.

❖ The Procedure Code field in the Outpatient Home Health and Outpatient Hospital claim types included some invalid information. Most of this was due to blank fields.

❖ The Inpatient claim type fields contained incomplete, invalid, and inaccurate fields.

❖ The match rates between the SMA database and MC+ MCO medical records for claim type procedures were 76.63%, this is however a significant improvement over last year's match rate of 52.0%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or illegible information.

❖ The match rates between the SMA database and MC+ MCO medical records for claim type procedures were 72.86%, this is significantly lower than last year's match rate of 99.01%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or illegible information.

Quality Management

Quality Management was measured by reviewing the MC+ health plans' provider satisfaction, care coordination, case management, disease management program, mental health care management including case management, clinical practice guidelines, credentialing and re-credentialing, medical record review and subcontractor monitoring. This information was taken from the MC+ Managed Care health plans' Annual Evaluation for SFY2007.

Strengths
❖ Health plans have either completed a provider satisfaction survey during SFY 2007 or have plans to conduct one.

❖ Extensive care coordination and case management processes are in place to identify members in need of this specialized care.

- ❖ Disease management and mental health care management programs are designed to ensure members in need are identified and are followed by health plan staff to ensure appropriate services are received by the member.

- ❖ Clinical practice guidelines utilize nationally based criteria to promote the consistent application of available benefits based on the individual circumstances and/or condition of the member. Health plans have policies on the adoption and distribution of these guidelines.

- ❖ Processes are in place for credentialing and recredentialing providers. Not all health plans specified the specific criteria used however some noted they utilize nationalized standards such as NCQA and URAC.

- ❖ On-site medical record reviews are conducted to ensure providers maintain adequate, detailed and comprehensive medical records on members.

- ❖ Subcontractor monitoring is performed on a continuous bases to insure quality of care and services provided on behalf of the health plan as well as compliance with all requirements of their contract with the DMS.

Areas for Improvement
- ❖ Health plans should make great effort to locate/contact members who are identified with complex or chronic clinical conditions in order to provide case management services to them.

Rights and Responsibilities

Rights and Responsibilities were measured by reviewing the health plan's member grievance and appeal, and provider complaint, grievance, and appeal management, as well member confidentiality practices.

The DMS used quarterly reports submitted by the MC+ Managed Care health plans regarding member grievances and appeals, and provider complaints, grievances and appeals, as well as information taken from the MC+ Managed Care health plans' Annual Evaluations. Beginning January 1, 2006 all health plans were required to use a standardized database for reporting member grievances and appeals, and provider complaint, grievances, and appeals.

Strengths
- ❖ All MC+ Managed Care health plans are reporting member grievances and appeals and provider complaints, grievances, and appeals via the required database on a quarterly basis.

- ❖ Member grievances and appeals were less than 1 per 1000 members in SFY2007 across all health plans.

❖ Provider grievances and appeals were less than 1 per 1000 members in SFY2007 across all health plans. Provider complaints were less than 4 per 1000 members in SFY2007, with the majority of complaints related to claim denials.

❖ Health plans have written policies and procedures regarding member rights which comply with State and Federal regulations.

Areas for Improvement
❖ Ensure all member grievances and appeals, and provider complaints, grievances, and appeals are recorded and submitted to the DMS.

❖ Provide continued staff education to ensure consistent and accurate categorization of complaints, grievances, and appeals.

Utilization management

Utilization Management was measured by reviewing the MC+ health plans' Utilization Improvement Program scope including discharges, inpatient visits, average length of stay, re-admissions, emergency department utilization, outpatient visits, over/under utilization, inter-rater reliability, timeliness of care delivery and timeliness of prior authorization/certification decision making. This information was taken from the MC+ health plans' Annual Evaluation for SFY2007.

Strengths
❖ A large scope of utilization management processes continuously monitor discharges, inpatient visits, average length of stay, re-admissions, emergency department utilization, outpatient visits, over/under utilization, inter-rater reliability, timeliness of care delivery, and timeliness of prior authorization/certification decision making.

Areas for Improvement
❖ Continue to monitor utilization patterns and implement processes as warranted by the patterns identified.

Performance Improvement Projects (PIPs)

Performance Improvement Projects were measured by reviewing clinical and non-clinical PIPs, as well as on-going interventions and improvements. For this section the DMS used information from the 2006 External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs for each MCO that were underway during the previous 12 month period at each MC+ MCO, for a total of 10 PIPs validated. Eligible PIPs for validation were identified by the MC+ MCOs, SMA, and the EQRO. The final selection of the PIPs for the 2006 validation process was made by the SMA in December 2006. PIPs are aimed at studying the effectiveness of clinical or non-clinical interventions, and should improve processes highly associated with healthcare outcomes, and/or healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued

improvement; or 3) stability in improvement as a result of an intervention. Under the State contract for Medicaid Managed Care, MC+ MCOs are required to have two active PIPs, one of which is clinical in nature and one non-clinical. Specific feedback and technical assistance was provided to each MC+ MCO by the EQRO during the site visits for improving study methods, data collection, and analysis.

Access to Care
Access to care was an important theme addressed throughout all the PIP submissions reviewed. Specific PIPs attempted to impact the access to primary care providers (PCPs)for members who used the emergency room as the means of obtaining medical services (Mercy CarePlus and Children's Mercy Family Health Partners (CMFHP)). Two MC+ MCOs focused on education and support to obtain appropriate medications for the treatment of asthma (Mercy CarePlus and Missouri Care). All the projects reviewed used the format of the PIP to improve access to care for members. Three of the projects clearly focused on ensuring that members had adequate and timely access to services after being hospitalized for mental health related issues (HealthCare USA, Missouri Care, BA+). The on-site discussions with MC+ MCO staff indicate that they realize that improving access to care is an ongoing aspect of all projects that are developed.

Quality of Care
Topic identification was an area that provided evidence of the attention to providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. All PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MC+ MCO, or in the direct provision of services delivered. The corresponding interventions that address barriers to quality care and health outcomes were clearly evident in the narratives submitted, as well as in the discussions with MC+ MCOs during the on-site review. These interventions addressed key aspects of enrollee care and services, such as medication and treatment management; risk identification and stratification for various levels of care; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

Timeliness of Care
Timeliness of care was the major focus of a number of the PIPs reviewed. Three projects identified the need for timely aftercare for members who required inpatient hospitalization for mental illness (HealthCare USA, Missouri Care, and BA+). The remaining projects focused on subjects such as timely encounter data acceptance (HealthCare USA), appropriate medications and treatment for asthma (Mercy CarePlus, Missouri Care), improved access to primary care (CMFHP), and improved access to well-child visits in the first 15 months of life. All addressed the need for timely access to preventive and primary health care services. The MC+ MCOs all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness in that they addressed internal processes and direct service improvement.

Recommendations
   1. It is recommended that MC+ MCOs continue to refine their skills in the development and implementation of the PIPs. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available. One MC+

MCO (CMFHP) utilized the services of a statistician from a local university to ensure valid and reliable findings.

2. In the design of PIPs, MC+ MCOs need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, "Conducting Performance Improvement Projects" were recommended by the EQRO at each MC+ MCO as a guideline to frame the development, reporting and analysis of the PIP.

3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions.

4. PIPs that are not yet complete should include narrative reflecting next steps and the plan for how the PIP will be maintained and enhanced for future years.

5. It continues to be recommended that a statewide PIP be initiated by the SMA and the MC+ QA & I Group for planning and implementation one year prior to the planned implementation.

6. It appears that many MC+ MCOs conduct PIPs on an ongoing basis as part of their quality improvement program, continuing to utilize these PIPs as tools to improve the organization's ability to serve members will be beneficial.

Conclusion

Review of the SFY 2007 Annual Evaluation submitted by the MC+ Managed Care health plans reveals there continue to be many areas for improvement as well as many areas in which improvement is evident.

The MC+ Managed Care health plans have submitted detailed work plans for the next year which outline their continued efforts in providing quality health care in tandem with maintaining compliance with their contract with the DMS and with applicable State and Federal regulations.

The commitment of the MC+ Managed Care health plans and the DMS to provide quality health care to MC+ members is evident through the findings in this report.

ANNUAL
ENROLLMENT
ANALYSIS

ANNUAL ENROLLMENT ANALYSIS
FOR THE MC+ MANAGED CARE HEALTH PLANS

Enrollment

On July 1, 2006, the start of State Fiscal Year 2007 (SFY07), there were 352,099 individuals enrolled in the MC+ Managed Care Program compared to 344,829 individuals enrolled as of June 30, 2007. Enrollment in the MC+ Managed Care Program decreased by 7,270 individuals during SFY07. Statewide there were 822,685 participants enrolled in the Medicaid Program as of June 30, 2007. MC+ Managed Care enrollees accounted for 41.9% of the total enrollment.

There were 187,393 enrollees (54.3%) in the Eastern region, 48,196 enrollees (14.0%) in the Central region, and 109,240 enrollees (31.7%) in the Western region at the end of SFY07. Individuals eligible for coverage under the 1915(b) Waiver accounted for 311,242 (90.3%) of the enrollees and 33,587 individuals (9.7%) were eligible under the State Children's Health Insurance Program (SCHIP).

Enrollment in the MC+ Managed Care Program decreased in all three MC+ Managed Care regions during SFY07. The Family Support Division (FSD) continues to conduct reinvestigations annually on all cases and is 99.5% current on completing these. FSD stopped closing eligibility for non-payment of premium for children in families with gross incomes between 150% FPL and 225% FPL in May 2006, but their coverage stops until they pay the premium. Cases continue to close for non-payment of premium for children in families with gross incomes over 225% FPL. The Division of Medical Services (DMS) continues to disenroll 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 AEA 1 through Attachment AEA 7.

Auto-Assignments

During SFY07, 34,827 enrollees (10.6%) were auto-assigned to the MC+ Managed Care health plans. Of these, 28,971 (83.2%) were eligible for coverage under the 1915(b) Waiver and 5,856 (16.8%) were eligible under SCHIP. There were 15,249 enrollees auto-assigned in the Eastern region, 6,467 in the Central region, and 13,111 in the Western region during SFY 2007. HealthCare USA in the Eastern region received the majority of the auto-assignments (18.7%) while HealthCare USA in the Central region received the least amount (1.5%).

Please refer to Attachment AEA 8 through Attachment AEA 10.

Member Selection

Statewide approximately 103,628 members selected a MC+ Managed Care health plan during SFY07. Of those members selecting an MC+ Managed Care health plan, 49,581 (47.9%) were in the Eastern region, 16,153 (15.6%) were in the Central region, and 37,894 (36.6%) selections were in the Western region.

Individuals eligible for coverage under the 1915(b) Waiver accounted for 79,556 of the selections and 24,072 SCHIP members selected their own MC+ Managed Care health plan.

The majority of members selected HealthCare USA (33,222) in the Eastern region, Missouri Care (7,897) in the Central region, and Children's Mercy Family Health Partners (16,422) in the Western region. Mercy CarePlus in the Central region experienced the lowest number of member selections (415).

Please refer to Attachment AEA 8 through Attachment AEA 11.

Transfers
There were 59,304 individuals statewide that transferred between MC+ Managed Care health plans during SFY07. Of these, 9,842 individuals (16.6%) transferred in the Eastern region, 3,316 (5.6%) in the Central region, and 46,146 individuals (77.8%) in the Western region. As a result of HealthCare USA purchasing FirstGuard Health Plan, 29,407 MC+ Managed Care enrollees transferred from FirstGuard on January 31, 2007.

During SFY07, there were 48,534 individuals eligible for coverage under the 1915(b) Waiver and 10,770 individuals eligible for coverage under SCHIP that transferred between MC+ Managed Care health plans.

Please refer to Attachment AEA 12 and Attachment AEA 13.

Supplemental Security Income (SSI) Opt-Outs
In all MC+ Managed Care health plans during SFY 2007 there were 328 MC+ Managed Care enrollees that opted-out of the MC+ Managed Care program. Of these 91.16% were processed by Policy Studies, Inc. (PSI) and 8.84% were processed by the participant services unit at DMS.

Regionally, of all the opt-outs 58.54% were in the Eastern region, 16.77% were in the Central region and 24.70% were in the Western region. There were 294 enrollees in the 1915(b) Waiver and 34 enrollees in the 1115 Waiver in the total opt-out group.

The top five opt-out reasons are:
1. Better Benefits – 54.57%
2. No Information Provided from PSI – 19.21%
3. Doctor Takes Straight Medicaid – 13.72%
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5. Too Many Referrals – 1.22%

Of the 328 enrollees that chose to opt out 80.79% opted-out after enrollment in an MC+ Managed Care health plan and 14.02% opted-out prior to enrollment in an MC+ Managed Care health plan, 2.44% re-enrolled, 2.13% had their request for opt-out denied and 0.61% indicated 'other'.

Please refer to Attachment AEA 14.

Special Health Care Needs
During SFY 2007 there were 11,359 unique individuals were identified with special health care needs and reported to the appropriate MC+ Managed Care health plan. Of these 6,585

(57.97%) were in the Eastern Region, 1,124 (9.90%) were in the Central Region, and 3,650 (32.13%) were in the Western Region.

Please refer to Attachment AEA 15.

Race
Across all MC+ Managed Care health plans during SFY 2007, the race of enrollees consisted of 54.3% white, 41.16% black, 0.94% Hispanic, 0.69% Asian, 0.50% multi-racial and 0.13% 'other'. There were also 2.28% of enrollees in which race/ethnicity was undetermined.

Eastern region enrollees consisted of 52.8% black and 43.35% white; Central region consisted of 14.89% black and 81.19% white; and Western region consisted of 35.96% black and 58.36% white.

With the exception of HealthCare USA in the Eastern Region, where blacks accounted for 60.23% and whites accounted for 36.34% of enrollees, the majority of all other MC+ Managed Care health plan enrollees were white.

Please refer to Attachment AEA 16.

Languages Identified
In all MC+ Managed Care health plans during SFY 2007 there were 62.34% of MC+ Managed Care enrollees whose primary language was English. Additionally, 0.31% enrollees listed Spanish as their primary language and 37.05% of enrollees had no primary language listed.

Regionally, enrollees who identified English as their primary language were at 65.44% in the Eastern region; 60.74% in the Central Region; and 58.14% in the Western region. Enrollees who identified Spanish as their primary language were at 0.17% in the Eastern region, 0.19% in the Central region; and 0.60% Western region. Enrollees who did not identify a primary language were at 34.02% in the Eastern region, 38.86% in the Central region; and 41.04% Western Region.

Please refer to Attachment AEA 17.

1915b WEEKLY MC+ HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
EASTERN REGION
STATE FISCAL YEAR 07 (1 JULY 2006 - 30 JUNE 2007)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Harmony Health Plan of Missouri		HealthCareUSA		Mercy CarePlus	
		enrollment	% of total	enrollment	% of total	enrollment	% of total
7-Jul	173,211	1,377	1%	106,590	62%	65,244	38%
14-Jul	173,458	1,524	1%	106,864	62%	65,070	38%
21-Jul	173,588	1,603	1%	106,997	62%	64,988	37%
28-Jul	172,785	1,742	1%	106,655	62%	64,388	37%
4-Aug	172,878	1,774	1%	107,422	62%	63,682	37%
11-Aug	173,011	1,803	1%	107,569	62%	63,639	37%
18-Aug	173,359	1,880	1%	107,821	62%	63,658	37%
25-Aug	173,575	1,988	1%	108,020	62%	63,567	37%
1-Sep	172,300	2,066	1%	107,594	62%	62,640	36%
7-Sep	172,575	2,183	1%	107,693	62%	62,699	36%
15-Sep	172,713	2,320	1%	107,818	62%	62,575	36%
22-Sep	172,861	2,403	1%	107,919	62%	62,539	36%
29-Sep	171,791	2,533	1%	107,417	63%	61,841	36%
6-Oct	171,887	2,659	2%	107,433	63%	61,795	36%
13-Oct	172,430	2,774	2%	107,751	62%	61,905	36%
20-Oct	172,679	2,835	2%	107,951	63%	61,893	36%
27-Oct	171,469	2,869	2%	107,323	63%	61,277	36%
3-Nov	171,341	2,965	2%	107,279	63%	61,097	36%
9-Nov	171,500	3,026	2%	107,396	63%	61,078	36%
17-Nov	172,108	3,139	2%	107,721	63%	61,248	36%
27-Nov	171,120	3,201	2%	107,223	63%	60,696	35%
4-Dec	171,258	3,320	2%	107,212	63%	60,726	35%
8-Dec	171,656	3,387	2%	107,489	63%	60,780	35%
15-Dec	171,848	3,415	2%	107,639	63%	60,794	35%
22-Dec	172,191	3,537	2%	107,844	63%	60,810	35%
29-Dec	171,230	3,610	2%	107,295	63%	60,325	35%
5-Jan	171,441	3,696	2%	107,403	63%	60,342	35%
12-Jan	171,595	3,692	2%	107,526	63%	60,377	35%
19-Jan	171,814	3,735	2%	107,693	63%	60,386	35%
26-Jan	172,156	3,835	2%	107,837	63%	60,484	35%
2-Feb	170,773	3,862	2%	107,098	63%	59,813	35%
9-Feb	171,174	3,958	2%	107,321	63%	59,895	35%
16-Feb	171,440	4,015	2%	107,514	63%	59,911	35%
23-Feb	171,754	4,094	2%	107,740	63%	59,920	35%
2-Mar	170,122	4,095	2%	106,747	63%	59,280	35%
9-Mar	169,938	4,036	2%	106,811	63%	59,091	35%
16-Mar	170,598	4,232	2%	107,148	63%	59,218	35%
23-Mar	170,940	4,306	3%	107,391	63%	59,243	35%
30-Mar	171,212	4,352	3%	107,539	63%	59,321	35%
6-Apr	171,025	4,422	3%	107,443	63%	59,160	35%
13-Apr	171,229	4,494	3%	107,583	63%	59,152	35%
20-Apr	171,576	4,718	3%	107,954	63%	58,904	34%
26-Apr	170,623	4,704	3%	107,446	63%	58,473	34%
4-May	170,526	4,825	3%	107,328	63%	58,373	34%
11-May	170,897	4,915	3%	107,535	63%	58,447	34%
18-May	171,301	5,025	3%	107,701	63%	58,575	34%
25-May	171,495	5,051	3%	107,834	63%	58,610	34%
1-Jun	170,186	5,054	3%	107,009	63%	58,123	34%
8-Jun	170,465	5,117	3%	107,199	63%	58,149	34%
15-Jun	170,748	5,185	3%	107,371	63%	58,192	34%
22-Jun	171,167	5,255	3%	108,058	63%	57,854	34%
29-Jun	170,317	5,281	3%	107,490	63%	57,546	34%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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1915b WEEKLY MC+ HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
CENTRAL REGION
STATE FISCAL YEAR 07 (1 JULY 2006 - 30 JUNE 2007)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	HealthCareUSA		Mercy CarePlus		Missouri Care	
		enrollment	% of total	enrollment	% of total	enrollment	% of total
7-Jul	44,657	18,920	42%	186	0%	25,551	57%
14-Jul	44,700	18,873	42%	219	0%	25,608	57%
21-Jul	44,715	18,852	42%	234	1%	25,629	57%
28-Jul	44,320	18,677	42%	259	1%	25,384	57%
4-Aug	44,428	18,748	42%	267	1%	25,413	57%
11-Aug	44,374	18,678	42%	290	1%	25,406	57%
18-Aug	44,507	18,699	42%	318	1%	25,490	57%
25-Aug	44,508	18,669	42%	345	1%	25,494	57%
1-Sep	44,086	18,470	42%	353	1%	25,263	57%
7-Sep	44,159	18,467	42%	373	1%	25,319	57%
15-Sep	44,221	18,501	42%	380	1%	25,340	57%
22-Sep	44,214	18,461	42%	380	1%	25,373	57%
29-Sep	43,709	18,193	42%	379	1%	25,137	58%
6-Oct	43,832	18,243	42%	387	1%	25,202	57%
13-Oct	43,957	18,233	41%	419	1%	25,305	58%
20-Oct	44,000	18,235	41%	433	1%	25,332	58%
27-Oct	43,498	18,039	41%	429	1%	25,030	58%
3-Nov	43,518	18,055	41%	439	1%	25,024	58%
9-Nov	43,550	18,058	41%	440	1%	25,052	58%
17-Nov	43,704	18,092	41%	467	1%	25,145	58%
27-Nov	43,287	17,854	41%	478	1%	24,955	58%
4-Dec	43,265	17,795	41%	486	1%	24,984	58%
8-Dec	43,366	17,816	41%	510	1%	25,040	58%
15-Dec	43,361	17,810	41%	517	1%	25,034	58%
22-Dec	43,533	17,858	41%	528	1%	25,147	58%
29-Dec	43,190	17,700	41%	548	1%	24,942	58%
5-Jan	43,230	17,678	41%	540	1%	25,012	58%
12-Jan	43,238	17,661	41%	535	1%	25,042	58%
19-Jan	43,347	17,698	41%	553	1%	25,096	58%
26-Jan	43,436	17,695	41%	563	1%	25,178	58%
2-Feb	43,029	17,543	41%	579	1%	24,907	58%
9-Feb	43,148	17,541	41%	597	1%	25,010	58%
16-Feb	43,202	17,576	41%	603	1%	25,023	58%
23-Feb	43,293	17,597	41%	624	1%	25,072	58%
2-Mar	42,735	17,382	41%	618	1%	24,735	58%
9-Mar	42,611	17,394	41%	613	1%	24,604	58%
16-Mar	42,864	17,456	41%	632	1%	24,776	58%
23-Mar	42,989	17,513	41%	654	2%	24,822	58%
30-Mar	43,187	17,630	41%	659	2%	24,898	58%
6-Apr	43,261	17,617	41%	669	2%	24,975	58%
13-Apr	43,473	17,689	41%	694	2%	25,090	58%
20-Apr	43,575	17,765	41%	738	2%	25,072	58%
26-Apr	43,258	17,669	41%	746	2%	24,843	57%
4-May	43,221	17,623	41%	748	2%	24,850	57%
11-May	43,304	17,615	41%	751	2%	24,938	58%
18-May	43,189	17,557	41%	754	2%	24,878	58%
25-May	43,290	17,594	41%	771	2%	24,925	58%
1-Jun	43,089	17,498	41%	766	2%	24,825	58%
8-Jun	43,234	17,486	40%	769	2%	24,979	58%
15-Jun	43,121	17,471	41%	768	2%	24,882	58%
22-Jun	43,095	17,426	40%	767	2%	24,902	58%
29-Jun	42,780	17,285	40%	772	2%	24,723	58%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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1915b WEEKLY MC+ HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
WESTERN REGION
STATE FISCAL YEAR 07 (1 JULY 2006 - 30 JUNE 2007)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Blue-Advantage Plus of Kansas City		Children's Mercy Family Health Partners		FirstGuard Health Plan		HealthCare USA		Mercy CarePlus	
		enrollment	% of total	enrollment	% of total	enrollment	% of total	enrollment	% of total	enrollment	% of total
7-Jul	100,802	24,676	24%	37,266	37%	29,119	29%	9,243	9.17%	498	0.49%
14-Jul	100,858	24,697	24%	37,222	37%	29,111	29%	9,268	9.19%	560	0.56%
21-Jul	100,883	24,705	24%	37,216	37%	29,101	29%	9,258	9.18%	603	0.60%
28-Jul	100,338	24,527	24%	37,060	37%	28,882	29%	9,212	9.18%	657	0.65%
4-Aug	100,234	24,492	24%	36,996	37%	28,906	29%	9,170	9.15%	670	0.67%
11-Aug	100,477	24,539	24%	37,106	37%	28,893	29%	9,221	9%	718	1%
18-Aug	100,570	24,486	24%	37,120	37%	28,946	29%	9,272	9%	746	1%
25-Aug	100,780	24,528	24%	37,127	37%	29,027	29%	9,315	9.24%	783	0.78%
1-Sep	99,731	24,202	24%	36,743	37%	28,750	29%	9,237	9%	799	1%
7-Sep	99,999	24,291	24%	36,753	37%	28,804	29%	9,312	9%	839	1%
15-Sep	100,252	24,338	24%	36,781	37%	28,889	29%	9,345	9%	899	1%
22-Sep	100,399	24,366	24%	36,794	37%	28,907	29%	9,392	9%	940	1%
29-Sep	99,476	24,086	24%	36,471	37%	28,576	29%	9,363	9.41%	980	0.99%
6-Oct	99,433	24,010	24%	36,384	37%	28,579	29%	9,435	9%	1,025	1%
13-Oct	99,709	24,075	24%	36,447	37%	28,575	29%	9,545	10%	1,067	1%
20-Oct	99,885	24,095	24%	36,503	37%	28,581	29%	9,602	10%	1,104	1%
27-Oct	99,156	23,845	24%	36,344	37%	28,331	29%	9,525	9.61%	1,111	1.12%
3-Nov	99,111	23,820	24%	36,266	37%	28,322	29%	9,541	10%	1,162	1%
9-Nov	99,225	23,814	24%	36,260	37%	28,358	29%	9,594	10%	1,199	1%
17-Nov	99,481	23,880	24%	36,284	36%	28,437	29%	9,633	10%	1,247	1%
27-Nov	98,737	23,690	24%	36,030	36%	28,220	29%	9,519	9.64%	1,278	1.29%
4-Dec	98,652	23,668	24%	35,944	36%	28,179	29%	9,546	10%	1,315	1%
8-Dec	98,962	23,757	24%	36,011	36%	28,242	29%	9,612	10%	1,340	1%
15-Dec	99,013	23,764	24%	36,029	36%	28,195	28%	9,663	10%	1,362	1%
22-Dec	99,217	23,810	24%	36,028	36%	28,210	28%	9,753	10%	1,416	1%
29-Dec	98,533	23,598	24%	35,771	36%	27,945	28%	9,760	9.91%	1,459	1.48%
5-Jan	98,442	23,574	24%	35,771	36%	27,756	28%	9,829	10%	1,512	2%
12-Jan	98,552	23,593	24%	35,915	36%	27,576	28%	9,921	10%	1,547	2%
19-Jan	99,070	23,826	24%	36,504	37%	0	0%	37,136	37%	1,604	2%
26-Jan	99,267	23,971	24%	36,625	37%	0	0%	37,013	37.29%	1,658	1.67%
2-Feb	98,283	23,766	24%	36,422	37%	0	0%	36,421	37%	1,674	2%
9-Feb	98,531	23,877	24%	36,653	37%	0	0%	36,260	37%	1,741	2%
16-Feb	98,602	23,910	24%	36,968	37%	0	0%	35,953	36%	1,771	2%
23-Feb	98,788	23,959	24%	37,134	38%	0	0%	35,856	36.30%	1,839	1.86%
2-Mar	97,741	23,705	24%	36,783	38%	0	0%	35,382	36%	1,871	2%
9-Mar	97,500	23,954	25%	37,080	38%	0	0%	34,625	36%	1,841	2%
16-Mar	98,148	24,108	25%	37,321	38%	0	0%	34,747	35%	1,972	2%
23-Mar	98,305	24,164	25%	37,413	38%	0	0%	34,720	35%	2,008	2%
30-Mar	98,759	24,211	25%	37,631	38%	0	0%	34,831	35.27%	2,086	2.11%
6-Apr	98,695	24,284	25%	37,768	38%	0	0%	34,518	35%	2,125	2%
13-Apr	98,990	24,369	25%	37,871	38%	0	0%	34,549	35%	2,201	2%
20-Apr	99,180	24,240	24%	37,934	38%	0	0%	34,730	35%	2,276	2%
26-Apr	98,526	24,014	24%	37,779	38%	0	0%	34,421	34.94%	2,312	2.35%
4-May	98,499	24,109	24%	37,922	38%	0	0%	34,072	35%	2,396	2%
11-May	98,738	24,192	25%	38,001	38%	0	0%	34,085	35%	2,460	2%
18-May	98,737	24,159	24%	38,037	39%	0	0%	34,058	34%	2,483	3%
25-May	98,768	24,153	24%	38,080	39%	0	0%	34,027	34.45%	2,508	2.54%
1-Jun	98,211	23,966	24%	37,962	39%	0	0%	33,733	34%	2,550	3%
8-Jun	98,425	24,036	24%	38,071	39%	0	0%	33,728	34%	2,590	3%
15-Jun	98,545	24,035	24%	38,172	39%	0	0%	33,737	34%	2,601	3%
22-Jun	98,714	24,045	24%	38,297	39%	0	0%	33,729	34%	2,643	3%
29-Jun	98,145	23,871	24%	38,136	39%	0	0%	33,452	34.08%	2,686	2.74%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

Effective February 1, 2007, HealthCare USA purchased FirstGuard Health Plan

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MC+ FOR KIDS WEEKLY MC+ HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
EASTERN REGION
STATE FISCAL YEAR 07 (1 JULY 2006 - 30 JUNE 2007)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Harmony Health Plan of Missouri		HealthCareUSA		Mercy CarePlus	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
7-Jul	16,458	121	1%	9,848	60%	6,489	39%
14-Jul	16,725	149	1%	10,008	60%	6,568	39%
21-Jul	16,904	159	1%	10,166	60%	6,579	39%
28-Jul	16,957	170	1%	10,198	60%	6,589	39%
4-Aug	17,018	184	1%	10,302	61%	6,532	38%
11-Aug	17,113	188	1%	10,355	61%	6,570	38%
18-Aug	17,072	181	1%	10,308	60%	6,583	39%
25-Aug	17,033	183	1%	10,302	60%	6,548	38%
1-Sep	17,186	177	1%	10,448	61%	6,561	38%
7-Sep	16,980	180	1%	10,312	61%	6,488	38%
15-Sep	17,286	196	1%	10,529	61%	6,561	38%
22-Sep	17,465	208	1%	10,644	61%	6,613	38%
29-Sep	17,628	211	1%	10,769	61%	6,648	38%
6-Oct	17,620	217	1%	10,777	61%	6,626	38%
13-Oct	17,779	222	1%	10,911	61%	6,646	37%
20-Oct	17,879	228	1%	11,007	62%	6,644	37%
27-Oct	17,963	222	1%	11,076	62%	6,665	37%
3-Nov	17,984	230	1%	11,087	62%	6,667	37%
9-Nov	17,977	233	1%	11,070	62%	6,674	37%
17-Nov	18,087	245	1%	11,136	62%	6,706	37%
27-Nov	18,181	254	1%	11,159	61%	6,768	37%
4-Dec	18,202	265	1%	11,176	61%	6,761	37%
8-Dec	18,098	276	2%	11,132	62%	6,690	37%
15-Dec	18,181	279	2%	11,183	62%	6,719	37%
22-Dec	18,195	281	2%	11,186	61%	6,728	37%
29-Dec	18,206	290	2%	11,195	61%	6,721	37%
5-Jan	17,992	285	2%	11,073	62%	6,634	37%
12-Jan	18,076	285	2%	11,147	62%	6,644	37%
19-Jan	18,127	278	2%	11,188	62%	6,661	37%
26-Jan	18,224	299	2%	11,223	62%	6,702	37%
2-Feb	18,203	298	2%	11,246	62%	6,659	37%
9-Feb	18,292	306	2%	11,299	62%	6,687	37%
16-Feb	18,359	317	2%	11,320	62%	6,722	37%
23-Feb	18,383	322	2%	11,361	62%	6,700	36%
2-Mar	18,338	322	2%	11,323	62%	6,693	36%
9-Mar	18,302	321	2%	11,317	62%	6,664	36%
16-Mar	18,419	328	2%	11,358	62%	6,733	37%
23-Mar	18,456	327	2%	11,371	62%	6,758	37%
30-Mar	17,306	305	2%	10,695	62%	6,306	36%
6-Apr	17,195	312	2%	10,620	62%	6,263	36%
13-Apr	17,186	321	2%	10,602	62%	6,263	36%
20-Apr	17,217	324	2%	10,621	62%	6,272	36%
26-Apr	17,254	324	2%	10,649	62%	6,281	36%
4-May	17,224	326	2%	10,616	62%	6,282	36%
11-May	17,300	333	2%	10,669	62%	6,298	36%
18-May	17,344	347	2%	10,667	62%	6,330	36%
25-May	17,332	347	2%	10,665	62%	6,320	36%
1-Jun	17,219	348	2%	10,611	62%	6,260	36%
8-Jun	17,193	351	2%	10,616	62%	6,226	36%
15-Jun	17,175	348	2%	10,631	62%	6,196	36%
22-Jun	17,144	342	2%	10,661	62%	6,141	36%
29-Jun	17,076	355	2%	10,584	62%	6,137	36%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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MC+ FOR KIDS WEEKLY MC+ HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
CENTRAL REGION
STATE FISCAL YEAR 07 (1 JULY 2006 - 30 JUNE 2007)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	HealthCareUSA		Mercy CarePlus		Missouri Care	
		enrollment	% of total	enrollment	% of total	enrollment	% of total
7-Jul	5,646	2,660	47%	11	0%	2,975	53%
14-Jul	5,653	2,683	47%	12	0%	2,958	52%
21-Jul	5,700	2,703	47%	12	0%	2,985	52%
28-Jul	**5,803**	**2,743**	**47%**	**16**	**0%**	**3,044**	**52%**
4-Aug	5,808	2,761	48%	18	0%	3,029	52%
11-Aug	5,828	2,774	48%	18	0%	3,036	52%
18-Aug	5,783	2,733	47%	19	0%	3,031	52%
25-Aug	**5,768**	**2,738**	**47%**	**21**	**0%**	**3,009**	**52%**
1-Sep	5,792	2,754	48%	22	0%	3,016	52%
7-Sep	5,694	2,710	48%	21	0%	2,963	52%
15-Sep	5,751	2,736	48%	21	0%	2,994	52%
22-Sep	5,855	2,788	48%	21	0%	3,046	52%
29-Sep	**5,949**	**2,848**	**48%**	**23**	**0%**	**3,078**	**52%**
6-Oct	5,931	2,831	48%	24	0%	3,076	52%
13-Oct	5,917	2,816	48%	22	0%	3,079	52%
20-Oct	5,957	2,833	48%	22	0%	3,102	52%
27-Oct	**5,974**	**2,828**	**47%**	**30**	**1%**	**3,116**	**52%**
3-Nov	5,991	2,839	47%	28	0%	3,124	52%
9-Nov	5,956	2,804	47%	30	1%	3,122	52%
17-Nov	5,984	2,823	47%	31	1%	3,130	52%
27-Nov	**6,018**	**2,825**	**47%**	**31**	**1%**	**3,162**	**53%**
4-Dec	6,038	2,818	47%	35	1%	3,185	53%
8-Dec	5,987	2,814	47%	35	1%	3,138	52%
15-Dec	6,037	2,811	47%	32	1%	3,194	53%
22-Dec	6,049	2,801	46%	32	1%	3,216	53%
29-Dec	**6,055**	**2,799**	**46%**	**33**	**1%**	**3,223**	**53%**
5-Jan	5,969	2,759	46%	35	1%	3,175	53%
12-Jan	6,007	2,789	46%	33	1%	3,185	53%
19-Jan	6,029	2,796	46%	35	1%	3,198	53%
26-Jan	**6,059**	**2,811**	**46%**	**39**	**1%**	**3,209**	**53%**
2-Feb	6,046	2,809	46%	37	1%	3,200	53%
9-Feb	6,032	2,779	46%	37	1%	3,216	53%
16-Feb	6,049	2,776	46%	39	1%	3,234	53%
23-Feb	**6,001**	**2,770**	**46%**	**41**	**1%**	**3,190**	**53%**
2-Mar	6,037	2,773	46%	42	1%	3,222	53%
9-Mar	6,010	2,771	46%	42	1%	3,197	53%
16-Mar	6,079	2,796	46%	51	1%	3,232	53%
23-Mar	6,078	2,787	46%	52	1%	3,239	53%
30-Mar	**5,660**	**2,590**	**46%**	**53**	**1%**	**3,017**	**53%**
6-Apr	5,625	2,580	46%	53	1%	2,992	53%
13-Apr	5,628	2,589	46%	57	1%	2,982	53%
20-Apr	5,646	2,601	46%	63	1%	2,982	53%
26-Apr	**5,643**	**2,597**	**46%**	**64**	**1%**	**2,982**	**53%**
4-May	5,676	2,595	46%	67	1%	3,014	53%
11-May	5,640	2,564	45%	62	1%	3,014	53%
18-May	5,655	2,579	46%	68	1%	3,008	53%
25-May	**5,573**	**2,551**	**46%**	**61**	**1%**	**2,961**	**53%**
1-Jun	5,524	2,516	46%	64	1%	2,944	53%
8-Jun	5,500	2,514	46%	68	1%	2,918	53%
15-Jun	5,528	2,512	45%	63	1%	2,953	53%
22-Jun	5,562	2,516	45%	68	1%	2,978	54%
29-Jun	**5,416**	**2,470**	**46%**	**61**	**1%**	**2,885**	**53%**

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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MC+ FOR KIDS WEEKLY MC+ HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
WESTERN REGION
STATE FISCAL YEAR 07 (1 JULY 2006 - 30 JUNE 2007)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Blue-Advantage Plus of Kansas City		Children's Mercy Family Health Partners		FirstGuard Health Plan		HealthCare USA		Mercy CarePlus	
		enrollment	% of total	enrollment	% of total	enrollment	% of total	enrollment	% of total	enrollment	% of total
7-Jul	11,325	2,713	24%	4,643	41%	3,147	28%	774	6.83%	48	0.42%
14-Jul	11,444	2,736	24%	4,700	41%	3,170	28%	784	6.85%	54	0.47%
21-Jul	11,554	2,764	24%	4,749	41%	3,192	28%	793	6.86%	56	0.48%
28-Jul	11,592	2,780	24%	4,760	41%	3,187	27%	804	6.94%	61	0.53%
4-Aug	11,559	2,773	24%	4,776	41%	3,148	27%	804	6.96%	58	0.50%
11-Aug	11,611	2,782	24%	4,804	41%	3,148	27%	812	6.99%	65	0.56%
18-Aug	11,588	2,782	24%	4,777	41%	3,160	27%	802	6.92%	67	0.58%
25-Aug	11,517	2,741	24%	4,753	41%	3,151	27%	808	7.02%	64	0.56%
1-Sep	11,550	2,739	24%	4,780	41%	3,158	27%	816	7.06%	57	0.49%
7-Sep	11,383	2,687	24%	4,680	41%	3,125	27%	825	7.25%	66	0.58%
15-Sep	11,610	2,736	24%	4,777	41%	3,194	28%	834	7.18%	69	0.59%
22-Sep	11,738	2,747	23%	4,821	41%	3,250	28%	848	7.22%	72	0.61%
29-Sep	11,801	2,784	24%	4,815	41%	3,268	28%	855	7.25%	79	0.67%
6-Oct	11,816	2,780	24%	4,852	41%	3,247	27%	850	7.19%	87	0.74%
13-Oct	11,916	2,786	23%	4,892	41%	3,288	28%	861	7.23%	89	0.75%
20-Oct	11,913	2,785	23%	4,874	41%	3,316	28%	856	7.19%	82	0.69%
27-Oct	11,942	2,798	23%	4,867	41%	3,334	28%	856	7.17%	87	0.73%
3-Nov	11,890	2,779	23%	4,823	41%	3,342	28%	860	7.23%	86	0.72%
9-Nov	11,880	2,767	23%	4,826	41%	3,339	28%	864	7.27%	84	0.71%
17-Nov	11,972	2,785	23%	4,880	41%	3,345	28%	871	7.28%	91	0.76%
27-Nov	12,019	2,781	23%	4,924	41%	3,342	28%	875	7.28%	97	0.81%
4-Dec	12,058	2,789	23%	4,936	41%	3,343	28%	878	7.28%	112	0.93%
8-Dec	12,026	2,761	23%	4,943	41%	3,334	28%	877	7.29%	111	0.92%
15-Dec	12,142	2,778	23%	4,999	41%	3,358	28%	887	7.31%	120	0.99%
22-Dec	12,090	2,764	23%	4,966	41%	3,352	28%	884	7.31%	124	1.03%
29-Dec	12,121	2,760	23%	5,006	41%	3,340	28%	893	7.37%	122	1.01%
5-Jan	12,005	2,750	23%	4,952	41%	3,279	27%	900	7.50%	124	1.03%
12-Jan	12,070	2,792	23%	4,954	41%	3,274	27%	922	7.64%	128	1.06%
19-Jan	12,129	2,819	23%	5,138	42%	0	0%	4,043	33.33%	129	1.06%
26-Jan	12,200	2,855	23%	5,166	42%	0	0%	4,042	33.13%	137	1.12%
2-Feb	12,185	2,861	23%	5,185	43%	0	0%	3,989	32.74%	150	1.23%
9-Feb	12,213	2,892	24%	5,206	43%	0	0%	3,961	32.43%	154	1.26%
16-Feb	12,204	2,901	24%	5,268	43%	0	0%	3,885	31.83%	150	1.23%
23-Feb	12,227	2,914	24%	5,301	43%	0	0%	3,861	31.58%	151	1.23%
2-Mar	12,212	2,906	24%	5,303	43%	0	0%	3,846	31.49%	157	1.29%
9-Mar	12,200	2,931	24%	5,353	44%	0	0%	3,762	30.84%	154	1.26%
16-Mar	12,248	2,935	24%	5,379	44%	0	0%	3,772	30.80%	162	1.32%
23-Mar	12,270	2,939	24%	5,394	44%	0	0%	3,771	30.73%	166	1.35%
30-Mar	11,426	2,765	24%	5,033	44%	0	0%	3,470	30.37%	158	1.38%
6-Apr	11,265	2,740	24%	5,007	44%	0	0%	3,355	29.78%	163	1.45%
13-Apr	11,327	2,780	25%	5,019	44%	0	0%	3,353	29.60%	175	1.54%
20-Apr	11,404	2,780	24%	5,062	44%	0	0%	3,377	29.61%	185	1.62%
26-Apr	11,385	2,757	24%	5,069	45%	0	0%	3,370	29.60%	189	1.66%
4-May	11,367	2,732	24%	5,096	45%	0	0%	3,340	29.38%	199	1.75%
11-May	11,357	2,722	24%	5,095	45%	0	0%	3,340	29.41%	200	1.76%
18-May	11,361	2,740	24%	5,103	45%	0	0%	3,320	29.22%	198	1.74%
25-May	11,343	2,735	24%	5,102	45%	0	0%	3,305	29.14%	201	1.77%
1-Jun	11,236	2,696	24%	5,078	45%	0	0%	3,263	29.04%	199	1.77%
8-Jun	11,253	2,682	24%	5,074	45%	0	0%	3,284	29.18%	213	1.89%
15-Jun	11,214	2,674	24%	5,074	45%	0	0%	3,247	28.95%	219	1.95%
22-Jun	11,196	2,645	24%	5,086	45%	0	0%	3,235	28.89%	230	2.05%
29-Jun	11,095	2,624	24%	5,018	45%	0	0%	3,222	29.04%	231	2.08%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

Effective February 1, 2007, HealthCare USA purchased FirstGuard Health Plan

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TABLE 23
MISSOURI MEDICAID RECIPIENTS AND PAYMENTS - GRAND TOTAL
JULY 2007

ELIGIBILITY CATEGORY: ALL CATEGORIES
NUMBER OF ELIGIBLES ENROLLED ON 6/30/07:   822,685
NUMBER OF ELIGIBLES ENROLLED DURING JULY 2007:   848,039

CAPITATION ENROLLMENT: 390,161

	EXPENDITURES	RECIPIENTS	COST PER RECIPIENT	UNITS OF SERVICE	UNITS PER RECIPIENT	COST PER SERVICE
NURSING FACILITIES	$63,525,623	23,989 *	$2,847.91	913,500	33.9	$78.10
HOSPITALS	$71,058,262	86,477 *	$831.31	745,494	9.7	$95.32
INPATIENT	$40,811,963	8,202	$4,976.75	24,332	3.0	$1,677.26
OUTPATIENT	$30,247,068	81,777	$369.87	721,162	8.8	$41.94
DENTAL SERVICES	$814,428	5,903 *	$137.9	24,968	4.2	$32.62
PHARMACY	$44,952,459	179,562 *	$250.34	848,541	4.7	$53.00
PART D - COPAYS	$391,600	61,577 *	$6.31	364,432	5.9	$1.07
PHYSICIAN RELATED	$24,932,717	184,004 *	$135.50	2,041,636	11.1	$12.21
PHYSICIAN	$1,684,127	23,943	$70.34	58,159	2.4	$28.96
CLINIC	$13,457,137	115,748	$116.33	1,688,302	14.6	$7.98
FAMILY PLANNING	$883,576	10,461	$84.30	25,604	2.4	$34.51
X-RAY AND LAB	$1,710,395	29,239	$58.50	111,667	3.8	$15.29
NURSE PRACTITIONER	$25,919	546	$47.47	868	1.6	$29.63
PODIATRY	$132,454	5,512	$24.03	9,157	1.7	$14.46
CRNA SERVICES	$423	14	$30.23	295	21.1	$1.43
RURAL HEALTH CLINICS	$3,692,744	40,624	$90.90	60,290	1.5	$61.25
CASE MANAGEMENT	$30,166	1,112	$34.32	1,183	1.1	$32.26
FED QUALIFIED HEALTH CARE	$2,676,792	12,705	$210.67	67,681	5.3	$39.55
PSYCHOLOGIST SERVICES	$620,963	4,498	$138.36	18,570	4.1	$33.80
IN-HOME SERVICES	$29,540,537	36,812 *	$761.99	6,974,950	182.1	$4.06
HOME HEALTH SERVICES	$352,758	720	$490.88	54,941	76.3	$6.55
ADULT DAY HEALTH CARE	$1,063,260	1,152	$922.97	18,262	15.9	$58.22
AGED AND DISABLED WAIVER	$6,921,369	14,184	$487.97	1,762,637	124.3	$3.93
PERSONAL CARE	$16,496,089	32,492	$569.90	4,582,260	153.4	$3.91
AIDS WAIVER	$36,794	22	$1,672.45	9,381	426.4	$3.92
PHYSICAL DISABLED WAIVER	$364,279	46	$7,919.11	54,871	1,192.9	$6.64
INDEPENDENT LIVING WAIVER	$305,279	132	$2,267.51	91,571	869.2	$3.37
REHAB AND SPECIALTY SERVICES	$12,152,965	445,584 *	$27.30	1,868,746	4.2	$6.44
AUDIOLOGY SERVICES	$18,933	248	$76.96	1,250	5.0	$15.40
OPTOMETRIC SERVICES	$511,890	9,204	$55.62	21,464	2.3	$23.84
DURABLE MEDICAL EQUIPMENT	$3,842,524	25,111	$153.06	1,077,419	42.9	$3.57
AMBULANCE SERVICES	$1,078,679	6,420	$168.02	132,133	20.6	$8.16
REHABILITATION CENTER	$29,825	175	$170.63	4,239	24.2	$7.04
HOSPICE	$4,393,177	1,521	$2,886.35	51,713	34.0	$84.95
NON-EMERGENCY TRANS	$2,267,723	441,738	$5.18	600,183	1.4	$3.81
NON-PARTICIPATING PROV	$13,155	211	$62.35	804	3.8	$16.36
COMPREHENSIVE DAY REHAB	$0	0	$0.00	0	0.0	$0.00
DISEASE MANAGEMENT	-$13,847	12	-$1,182.26	-450	-37.8	-$30.79
BUY-IN PREMIUMS	$11,513,017	115,014 **	$98.36			
PART-A	$414,339	1,002	$413.51			
PART-B	$10,898,678	114,012	$95.59			
MENTAL HEALTH SERVICES	$31,415,462	9,142 *	$3,436.50	1,752,458	191.7	$17.93
PRIVATE HOME ICF/MR	$395,180	74	$5,353.86	2,293	31.0	$172.76
MR/DD WAIVER	$29,462,894	6,850	$4,301.15	1,476,521	215.6	$19.95
PSYCH REHAB-PRIVATE	-$27	0	$0.00	-14	0.0	-$1.52
CSTAR - PRIVATE	$0	0	$0.00	0	0.0	$0.00
TARGETED CASE MANAGEMENT	$877,455	2,537	$345.86	121,527	47.9	$7.22
COMMUNITY SUPPORT WAIVER	$679,982	684	$994.13	152,131	222.4	$4.47
STATE INSTITUTIONS	$22,906,282	31,401 *	$719.82	1,157,543	36.6	$19.53
ICF/MENTALLY RETARDED	$4,309,348	467	$9,228.45	14,637	31.3	$293.90
MENTAL HOSPITAL	$15,132	2	$8,565.87	18	9.0	$729.54
PSYCH CARE UNDER AGE 22	$553,677	61	$9,161.51	1,108	18.1	$506.31
PSYCH REHAB-PUBLIC	$7,853,165	13,381	$588.68	622,764	46.5	$12.61
CSTAR - PUBLIC	$2,396,790	3,058	$784.43	227,863	74.5	$10.53
TARGETED CASE MANAGEMENT	$3,104,422	16,138	$192.37	289,461	17.9	$10.72
DFS CASE MANAGEMENT	$4,377,587	1,681	$2,604.90	1,681	1.0	$2,604.10
EPSDT SERVICES	$6,658,804	61,634 *	$167.06	1,157,644	22.4	$6.35
EPSDT SCREENINGS	$486,311	6,788	$66.75	5,866	1.0	$49.57
EPSDT REFERRAL SERVICES	$6,100,702	40,096	$185.36	1,149,317	23.4	$7.90
EPSDT TARGETED CASE MGMT	$93,351	851	$109.70	841	1.0	$111.00
MANAGED CARE PREMIUMS	$74,375,093	390,951 *	$190.63			
TOTAL	$395,744,549	855,661 *	$462.49			

* Unduplicated total
** Recipients are not added to the total
Note: Total expenditures do not include $3,979.38
The number of eligibles enrolled during the month include everyone eligible as of the last day of the month plus anyone who closed during the month.
The number of eligibles enrolled on the last day of the month is a point in time count of eligibles active on that date.

1915b MC+ ASSIGNMENTS
ALL MC+ REGIONS - STATEWIDE
STATE FISCAL YEAR 2007 (1 JULY 2006 - 30 JUNE 2007)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Recipient Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	4,885	839	4,882	10,606	994	9,658	10,955	21,607	32,213
AUGUST	2,007	347	2,065	4,419	1,212	6,926	6,827	14,965	19,384
SEPTEMBER	2,566	394	2,552	5,512	1,114	7,621	6,721	15,456	20,968
OCTOBER	2,316	361	2,431	5,108	1,203	6,841	6,234	14,278	19,386
NOVEMBER	2,174	300	2,137	4,611	1,039	6,829	5,952	13,820	18,431
DECEMBER	2,226	314	2,181	4,721	1,002	6,135	5,096	12,233	16,954
JANUARY	2,168	313	1,864	4,345	1,078	6,141	4,685	11,904	16,249
FEBRUARY	2,193	308	2,092	4,593	925	5,786	6,955	13,666	18,259
MARCH	2,197	334	2,147	4,678	1,086	7,122	6,997	15,205	19,883
APRIL	2,152	317	2,105	4,574	957	10,239	5,393	16,589	21,163
MAY	2,202	353	2,200	4,755	978	7,171	8,102	16,251	21,006
JUNE	1,885	276	1,963	4,124	1,070	8,007	5,639	14,716	18,840
TOTAL ASSIGNMENTS	28,971	4,456	28,619	62,046	12,658	88,476	79,556	180,690	242,736
*TYPE CODE ASSIGN	12%	2%	12%	26%	5%	36%	33%	74%	100.00%

*total number of each code divided by total of all codes   Source: Verizon Reports   Revised: 07/09/07

Note: The increase in reassigns starting in Sept. is being researched through a SPAR.   j:\reports\asgntype excel\1915b\2007\assigns all regions fy07ytdY.xls
The projection is the increase could be due to changes performed by FSD through more frequent review of cases.

As a result of a merger between Mercy MC+ and Community Care Plus (becoming Mercy CarePlus) as well as an open enrollment period, assignment counts for the month of July 2006, are higher than norm

MC+ for Kids (Title XXI) ASSIGNMENTS
ALL MC+ REGIONS - STATEWIDE
STATE FISCAL YEAR 2007 (1 JULY 2006 - 30 JUNE 2007)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Recipient Selectio S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	1,012	119	879	2,010	0	9,852	2,946	12,798	14,808
AUGUST	393	47	339	779	0	3,234	1,885	5,119	5,898
SEPTEMBER	516	47	453	1,016	0	3,786	2,162	5,948	6,964
OCTOBER	449	40	415	904	0	3,243	1,809	5,052	5,956
NOVEMBER	457	34	418	909	0	3,130	1,982	5,112	6,021
DECEMBER	455	54	416	925	0	3,008	1,727	4,735	5,660
JANUARY	402	38	356	796	0	3,054	1,557	4,611	5,407
FEBRUARY	432	40	375	847	0	2,666	2,236	4,902	5,749
MARCH	446	56	434	936	0	3,371	2,143	5,514	6,450
APRIL	448	44	384	876	0	6,850	1,624	8,474	9,350
MAY	451	56	399	906	0	3,256	2,289	5,545	6,451
JUNE	395	38	419	852	0	4,025	1,712	5,737	6,589
TOTAL ASSIGN	5,856	613	5,287	11,756	0	49,475	24,072	73,547	85,303
*TYPE CODE A	7%	1%	6%	14%	0%	58%	28%	86%	100.00%

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*total number of each code divided by total of all codes   Source: Verizon Reports   Revised: 07/09/07

As a result of a merger between Mercy MC+ and Community Care Plus (becoming Mercy CarePlus) as well as an open enrollment period, assignment counts for the month of July 2007, are higher than norn

ASSIGNMENT TYPES - ALL WAIVERS
ALL MC+ REGIONS - STATEWIDE
STATE FISCAL YEAR 2007 (1 JULY 2006 - 30 JUNE 2007)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Recipient Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	5,897	958	5,761	12,616	994	19,510	13,901	34,405	47,021
AUGUST	2,400	394	2,404	5,198	1,212	10,160	8,712	20,084	25,282
SEPTEMBER	3,082	441	3,005	6,528	1,114	11,407	8,883	21,404	27,932
OCTOBER	2,765	401	2,846	6,012	1,203	10,084	8,043	19,330	25,342
NOVEMBER	2,631	334	2,555	5,520	1,039	9,959	7,934	18,932	24,452
DECEMBER	2,681	368	2,597	5,646	1,002	9,143	6,823	16,968	22,614
JANUARY	2,570	351	2,220	5,141	1,078	9,195	6,242	16,515	21,656
FEBRUARY	2,625	348	2,467	5,440	925	8,452	9,191	18,568	24,008
MARCH	2,643	390	2,581	5,614	1,086	10,493	9,140	20,719	26,333
APRIL	2,600	361	2,489	5,450	957	17,089	7,017	25,063	30,513
MAY	2,653	409	2,599	5,661	978	10,427	10,391	21,796	27,457
JUNE	2,280	314	2,382	4,976	1,070	12,032	7,351	20,453	25,429
TOTAL ASSIGNMENTS:	34,827	5,069	33,906	73,802	12,658	137,951	103,628	254,237	328,039
***TYPE CODE ASSIGNMENT RATE:**	11%	2%	10%	22%	4%	42%	32%	78%	100.00%

*total number of each code divided by total of all codes   Source: Various Ad Revised   09-Jul-07

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Attachment AEA 11

Recipient Enrollment Selections (Non-Assigned)
All MC+ Health Plans
All Waivers - FY07

	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL
Eastern Region													
Harmony Health Plan of Missouri	134	56	67	53	61	38	41	51	62	71	248	170	1,052
HealthCare USA	6,111	3,337	3,085	2,637	2,411	2,143	1,944	2,057	2,484	2,031	2,867	2,115	33,222
Mercy CarePlus	1,648	1,256	1,330	1,270	1,291	1,177	992	1,229	1,245	1,060	1,608	1,182	15,288
Central Region													
HealthCare USA	857	628	686	643	689	548	542	602	598	545	955	545	7,838
Mercy CarePlus	21	31	23	23	23	30	24	28	34	49	76	53	415
Missouri Care	873	647	745	705	667	576	524	559	607	526	817	651	7,897
Western Region													
Blue Advantage Plus of Kansas City	1,116	677	749	661	671	565	611	1,067	1,156	746	687	582	9,490
Children's Mercy Family Health Partners	1,590	1,071	1,000	914	1,049	783	895	2,744	2,143	1,232	1,778	1,223	16,422
FirstGuard Health Plan	1,035	682	842	757	759	671	216	0	0	0	0	0	4,962
HealthCare USA	481	285	321	352	268	226	404	801	753	711	1,044	755	6,401
Mercy CarePlus	35	37	18	28	45	66	49	33	55	46	131	75	619
MONTHLY TOTAL	13,901	8,707	8,866	8,043	7,934	6,823	6,242	9,191	9,140	7,017	10,391	7,351	103,606

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Revised: Auto Update

1915b MC+ TRANSFERS BETWEEN HEALTH PLANS
ALL MC+ REGIONS STATEWIDE
STATE FISCAL YEAR 2007 (1 JULY 2006 - 30 JUNE 2007)

	Eastern Region -------------	Central Region -------------	Western Region -------------	Total -------------
July				
# of Transfers:	398	72	147	617
% of Total MC+ Transfers:	64.51%	11.67%	23.82%	100.00%
August				
# of Transfers:	1,315	200	446	1,961
% of Total MC+ Transfers:	67.06%	10.20%	22.74%	100.00%
September				
# of Transfers:	779	208	433	1,420
% of Total MC+ Transfers:	54.86%	14.65%	30.49%	100.00%
October				
# of Transfers:	707	232	390	1,329
% of Total MC+ Transfers:	53.20%	17.46%	29.35%	100.00%
November				
# of Transfers:	566	204	428	1,198
% of Total MC+ Transfers:	47.25%	17.03%	35.73%	100.00%
December				
# of Transfers:	473	144	339	956
% of Total MC+ Transfers:	49.48%	15.06%	35.46%	100.00%
January				
# of Transfers:	554	177	30,714	31,445
% of Total MC+ Transfers:	1.76%	0.56%	97.68%	100.00%
February				
# of Transfers:	476	157	890	1,523
% of Total MC+ Transfers:	31.25%	10.31%	58.44%	100.00%
March				
# of Transfers:	496	147	1,274	1,917
% of Total MC+ Transfers:	25.87%	7.67%	66.46%	100.00%
April				
# of Transfers:	1,537	603	1,300	3,440
% of Total MC+ Transfers:	44.68%	17.53%	37.79%	100.00%
May				
# of Transfers:	461	270	652	1,383
% of Total MC+ Transfers:	33.33%	19.52%	47.14%	100.00%
June				
# of Transfers:	533	272	540	1,345
% of Total MC+ Transfers:	39.63%	20.22%	40.15%	100.00%
Total Transfer TO:	8295	2686	37553	48534

This summary information is from the monthly report, Transfers Between Health Plans.
Source: IFOX   Revised 07/17/07

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Note: FirstGuard discontinued services 1/31/07.
Effective 2/1/07, Healthcare USA purchased FirstGuard Health Plan.

MC+ For Kids (Title XXI) TRANSFERS BETWEEN HEALTH PLANS
ALL MC+ REGIONS STATEWIDE
STATE FISCAL YEAR 2007 (1 JULY 2006 - 30 JUNE 2007)

	Eastern Region	Central Region	Western Region	Total
July				
# of Transfers:	87	11	31	129
% of Total MC+ Transfers:	67.44%	8.53%	24.03%	100.00%
August				
# of Transfers:	250	39	109	398
% of Total MC+ Transfers:	62.81%	9.80%	27.39%	100.00%
September				
# of Transfers:	161	39	103	303
% of Total MC+ Transfers:	53.14%	12.87%	33.99%	100.00%
October				
# of Transfers:	149	43	68	260
% of Total MC+ Transfers:	57.31%	16.54%	26.15%	100.00%
November				
# of Transfers:	107	53	97	257
% of Total MC+ Transfers:	41.63%	20.62%	37.74%	100.00%
December				
# of Transfers:	70	37	69	176
% of Total MC+ Transfers:	39.77%	21.02%	39.20%	100.00%
January				
# of Transfers:	115	45	6,991	7,151
% of Total MC+ Transfers:	1.61%	0.63%	97.76%	100.00%
February				
# of Transfers:	78	39	218	335
% of Total MC+ Transfers:	23.28%	11.64%	65.07%	100.00%
March				
# of Transfers:	104	37	328	469
% of Total MC+ Transfers:	22.17%	7.89%	69.94%	100.00%
April				
# of Transfers:	241	142	309	692
% of Total MC+ Transfers:	34.83%	20.52%	44.65%	100.00%
May				
# of Transfers:	77	65	153	295
% of Total MC+ Transfers:	26.10%	22.03%	51.86%	100.00%
June				
# of Transfers:	108	80	117	305
% of Total MC+ Transfers:	35.41%	26.23%	38.36%	100.00%
Total Transfer TO:	1,547	630	8,593	10,770

This summary information is from the monthly report, Transfers Between Health Plans.
Source: IFOX   Revised 07/18/07

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Note: FirstGuard discontinued services 1/31/07.
Effective 2/1/07, HealthCare USA purchased FirstGuard Health Plan.

Supplemental Security Income (SSI) Opt-Outs
State Fiscal Year 2007

PROCESSED BY	#	Percent
Quality Services	0	0.00%
PSI	299	91.16%
RSU	29	8.84%
TOTAL	328	100.00%

REGION	#	Percent
Eastern	192	58.54%
Central	55	16.77%
Western	81	24.70%
TOTAL	328	100.00%

1115 Members	#	Percent
Eastern Region (1)	23	67.65%
Western Region (2)	9	26.47%
Central Region (3)	2	5.88%
TOTAL	34	100.00%

WAIVER	#	Percent
1915(b)	294	89.63%
1115	34	10.37%
TOTAL	328	100.00%

REASONS	#	Percent
Better Benefits	179	54.57%
No Information Provided by PSI	63	19.21%
Doctor Takes Straight Medicaid	45	13.72%
Did Not Meet Opt Out Criteria	3	0.91%
Other	30	9.15%
Too Many Referrals	4	1.22%
Caseworker Suggested	3	0.91%
Too Many Doctors	1	0.30%
TOTAL	328	100.00%

STATUS	#	Percent
Disenrollment from a Plan	265	80.79%
Disenrollment prior to Enrollment	46	14.02%
Re-enrollment	8	2.44%
Opt Out Denied	7	2.13%
Other	2	0.61%
TOTAL	328	100.00%

MO HealthNet Managed Care Special Health Care Needs
State Fiscal Year 2007

	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL
East													
Harmony	67	31	52	41	32	55	53	42	45	39	36	53	**546**
HCUSA	429	233	268	206	217	205	223	205	174	216	264	246	**2,886**
MCP	*2,271	108	128	137	144	129	118	144	108	118	138	133	**3,676**
Central													
MoCare	71	62	98	71	69	49	78	64	51	57	76	66	**812**
HCUSA	43	31	42	34	44	40	35	44	23	45	45	16	**442**
MCP	11	0	6	2	4	3	6	3	5	3	13	0	**56**
West													
BA+	39	39	65	47	50	35	49	62	51	54	53	53	**597**
CMFHP	103	100	101	90	81	69	84	163	94	91	123	82	**1,181**
HCUSA	29	29	31	31	21	31	33	**1,460	54	64	56	53	**1,892**
FG	70	37	64	62	61	45	36	0	0	0	0	0	**375**
MCP	28	14	15	13	20	18	26	19	10	21	22	15	**221**
TOTAL	**3,161**	**684**	**870**	**734**	**743**	**679**	**741**	**2,206**	**615**	**708**	**826**	**717**	**12,684**

* Transfer of Mercy enrollees

**Transfer of FirstGuard enrollees

Unduplicated Members	#	Percent
Central Region	1,124	9.90%
Eastern Region	6,585	57.97%
Western Region	3,650	32.13%
TOTAL	*11,359	100.00%

*110 members transferred between regions, however are only counted once.
 Therefore, regional percentages may be off by no more than 1%

MO HealthNet Managed Care Race Analysis
State Fiscal Year 2007

	HCUSA West	MCP West	CMFHP	BA+	FG		
Time Period	FY 2007	FY 2007	FY 2007	FY 2007	FY 2007	Total	
Race	Members	Members	Members	Members	Members	Western	Percentage
Asian	547	56	586	414	455	2,058	1.06%
Black	19,529	1,519	19,060	13,426	16,156	69,690	35.96%
Hispanic	588	56	640	447	439	2,170	1.12%
Multi-Racial	384	28	445	314	284	1,455	0.75%
Other	142	28	140	123	89	522	0.27%
Unable to determine	1,419	202	1,516	933	750	4,820	2.49%
White	26,975	2,916	37,805	24,581	20,827	113,104	58.36%
TOTAL	**49,584**	**4,805**	**60,192**	**40,238**	**39,000**	**193,819**	**100.00%**

	MCP Central	CUSA Central	Mo Care		
Time Period	FY 2007	FY 2007	FY 2007	Total	
Race	Members	Members	Members	Central	Percentage
Asian	14	166	248	428	0.58%
Black	247	4,109	6,685	11,041	14.89%
Hispanic	11	139	311	461	0.62%
Multi-Racial	9	216	315	540	0.73%
Other	3	29	39	71	0.10%
Unable to determine	29	525	851	1,405	1.90%
White	1,473	24,943	33,772	60,188	81.19%
TOTAL	**1,786**	**30,127**	**42,221**	**74,134**	**100.00%**

	Harmony	MCP East	HCUSA East		
Time Period	FY 2007	FY 2007	FY 2007	Total	
Race	Members	Members	Members	Eastern	Percentage
Asian	43	454	611	1,108	0.44%
Black	4,305	38,174	91,621	134,100	52.80%
Hispanic	96	914	1,259	2,269	0.89%
Multi-Racial	28	243	323	594	0.23%
Other	10	56	44	110	0.04%
Unable to determine	268	2,447	2,984	5,699	2.24%
White	4,918	49,892	55,288	110,098	43.35%
TOTAL	**9,668**	**92,180**	**152,130**	**253,978**	**100.00%**

STATEWIDE					
Time Period FY2007	Total	Total	Total		
Race	Central	Western	Eastern	TOTAL	Percentage
Asian	428	2,058	1,108	3,594	0.69%
Black	11,041	69,690	134,100	214,831	41.16%
Hispanic	461	2,170	2,269	4,900	0.94%
Multi-Racial	540	1,455	594	2,589	0.50%
Other	71	522	110	703	0.13%
Unable to determine	1,405	4,820	5,699	11,924	2.28%
White	60,188	113,104	110,098	283,390	54.30%
TOTAL	**74,134**	**193,819**	**253,978**	**521,931**	**100.00%**

LANGUAGE ANALYSIS OF MO HEALTHNET HEALTH PLANS   SFY 2007

FY 2007	Central Region Plans	Western Region Plans	Eastern Region Plans	Total	Percent
Language	Members	Members	Members		
ASL	0	0	2	2	0.00%
Arabic	1	45	92	138	0.03%
Cambodian	2	3	3	8	0.00%
Chinese	4	8	44	56	0.01%
English	43,057	89,045	159,650	291,752	62.34%
Haitian	0	1	6	7	0.00%
Japanese	1	0	0	1	0.00%
Laotian	0	0	2	2	0.00%
Other	75	204	556	835	0.18%
Polish	0	1	6	7	0.00%
Romanian	0	0	6	6	0.00%
Russian	58	3	32	93	0.02%
Spanish	133	920	407	1,460	0.31%
Tagalog	0	0	5	5	0.00%
Vietnamese	7	67	154	228	0.05%
~ Missing	27,546	62,852	83,000	173,398	37.05%
	70,884	153,149	243,965	467,998	100.00%

FY 2007	Central Region Plans		Western Region Plans		Eastern Region Plans	
Language	Members	Percentage	Members	Percentage	Members	Percentage
ASL	0	0.00%	0	0.00%	2	0.00%
Arabic	1	0.00%	45	0.03%	92	0.04%
Cambodian	2	0.00%	3	0.00%	3	0.00%
Chinese	4	0.01%	8	0.01%	44	0.02%
English	43,057	60.74%	89,045	58.14%	159,650	65.44%
Haitian	0	0.00%	1	0.00%	6	0.00%
Japanese	1	0.00%	0	0.00%	0	0.00%
Laotian	0	0.00%	0	0.00%	2	0.00%
Other	75	0.11%	204	0.13%	556	0.23%
Polish	0	0.00%	1	0.00%	6	0.00%
Romanian	0	0.00%	0	0.00%	6	0.00%
Russian	58	0.08%	3	0.00%	32	0.01%
Spanish	133	0.19%	920	0.60%	407	0.17%
Tagalog	0	0.00%	0	0.00%	5	0.00%
Vietnamese	7	0.01%	67	0.04%	154	0.06%
~ Missing	27,546	38.86%	62,852	41.04%	83,000	34.02%
TOTAL	**70,884**	**100.00%**	**153,149**	**100.00%**	243,965	100.00%

DEVELOPMENT, APPROVAL AND MONITORING OF THE QUALITY IMPROVEMENT PROGRAM

Development, Approval and Monitoring of the Quality Improvement Program

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Quality and Compliance Committee

Quality Management Committee (QMC)
The QMC is delegated by the governing body and administration to prioritize and coordinate all organization wide quality and utilization/performance improvement activities in accordance with the approved Quality Improvement Program Strategy. In addition to the Board of Managers, a review of and recommendations related to quality improvement activities are received from the Executive Quality Committee, the Physician Advisory Council and other departments and committees of HealthCare USA.

The QMC is comprised of HealthCare USA leaders, the Medical Director, and at least five community physicians, credentialed by either HealthCare USA or a delegated entity. The Medical Director, Vice President of Health Services, provider relations and other physicians recommend physicians from the community for participation on the committee. The Medical Director, serving as the chairperson, makes final selection decisions.

The QMC meets at least quarterly, or more often at the call of the Chair. Business is conducted by written agenda, which is maintained on file with the minutes of each meeting.

The QMC oversees the quality and utilization/performance improvement function organization wide, as well as all key processes associated with successful implementation and outcomes. Specifically, the QMC shall:

- Develop, modify, and approve the Quality Improvement Program Strategy prior to approval by the Board of Managers.

- Approve strategic quality and utilization management initiatives based on strategic plan goals.

- Prioritize quality and utilization management initiatives and other quality improvement projects based on actual or potential impact on outcomes of care and service and, as available, review of data, as well as organization objectives.

- Oversee and support cross-functional, interdisciplinary teams; facilitate the involvement of settings/departments/services in support of team activities.

- Plan and design organizational mechanisms and methodologies to support cross-functional, interdisciplinary quality and utilization management/performance improvement activities.

- Review aggregated data/information feedback from customer satisfaction surveys, utilization management processes, adverse/sentinel events and other data/information impacting organizational performance.

- Review periodic data/outcome summaries from quality and utilization performance improvement initiatives.

- Oversee a confidential peer review policy whereby all practitioner specific issues are referred to the appropriate peer review committee or manager.

- Determine and support the education and training needs of the organization related to quality and utilization performance improvement.

- Evaluate the effectiveness of the quality and utilization/performance improvement activities of the departments.

- Provide timely summary information concerning improvements in organization performance to all involved.

Compliance Management Committee
Regulatory Compliance staff report all activities, policies, and compliance updates/issues to the Compliance Management Committee (CMC). The Director of Policy and Compliance, who also serves as HealthCare USA's Compliance Officer, chairs the CMC and is responsible for the plan's overall compliance with applicable Federal, State, and regulatory bodies' standards and regulations. The Regulatory Compliance Analysts co-chairs the CMC and acts as the plan's key contact for monitoring and maintaining policies and procedures and marketing distributions, tracking annual approval of these documents, as well as state submissions of applicable policies and procedures and all member marketing communications.

Within these positions, maintaining and monitoring Health Insurance Portability and Accountability Act (HIPAA) compliance and managing business associate agreements with physician consultants, other subcontractors, and vendors is administered. Regulatory Compliance staff monitor and maintain the Medicaid fraud and abuse program as described in the fraud and abuse policies and procedures. All fraud and abuse cases, as well as coordination, prevention and detection activities, are reported quarterly to the CMC and annually to the State agency. All functions within the Regulatory Compliance department are incorporated into the health plan's Compliance Plan. This Plan adheres to the seven elements of a Compliance Plan, consistent with the Office of Inspector General (OIG) compliance elements.

Education for all compliance standards is provided to employees, members and providers via a variety of different avenues in order to ensure understanding. Education is key to administering compliance and lessening deficiencies. Regulatory Compliance staff conduct internal audits to ensure compliance with all applicable regulations and requirements, including but not limited to the code of federal regulations (CFRs), the code of state regulations (CSRs), HIPAA requirements and the deficit reduction act (DRA). All findings are presented to the CMC to aid in setting compliance standards, the identification of vulnerable areas and associating risk (low, medium, or high) and to monitor ongoing compliance accordingly. The CMC is responsible for initiating corrective action plans as deficiencies are detected.

The CMC reports summary activities at least quarterly to the Quality Management Committee, the Executive Quality Committee, and at least annually to the Board of Managers. Annually, the CMC evaluates the impact of the Compliance Plan using audit results and oversight information.

This information is presented to and approved by the Quality Management Committee (QMC), as delegated by the Board of Managers.

Executive Quality Committee & Physician Advisory Council
HealthCare USA developed an Executive Quality Committee and a Physician Advisory Council (PAC) in 2007. The Executive Quality Committee reviews, makes recommendations, and approves the activities of the Quality Management Committee, the Credentialing Committee, Peer Review Committee, Complaints, Grievances and Appeals Committee, and the Compliance Management Committee, including non-clinical issues related to regulatory compliance, corporate compliance and fraud and abuse. The Committee meets at least quarterly and includes members of senior leadership and the Senior Executive. The committee is responsible for reviewing the activities and providing feedback to the individual Committees.

The purpose of the PAC is to provide advice and guidance in areas such as physician services, plan activities affecting physician providers in the community, medical and pharmacy management and specialty programs. The Medical Director(s) appoints at least eleven (11) community physician members to reflect a balance of viewpoints, education and experience representing physician practice in rural areas, underserved and urban areas. The PAC meets at least bi-annually and reports to the QMC.

Analysis of Quality Improvement Process
HealthCare USA implemented, in 2007, the rapid cycle methodology to identify, prioritize and accelerate the improvement process and keep focused on targeted improvements. This methodology identifies, implements and measures change to processes. An overall goal is set with improvements occurring through small rapid PDSA (Plan, Do, Study & Act) cycles or tests of change.

The PDSA cycle of change involves four steps. A plan for a test of change is set based on theory and best practice. Do, on a small scale, a test to determine effectiveness without wasting resources. Study the outcomes of the small scale implementation and Act by applying the change to a larger population, stopping the change or revising the change. Outcomes of small tests of change can be seen in real time or a nearly immediate basis, which allows numerous cycles of tests of change to occur in a short period of time. There are often several PDSA cycles for each improvement project implemented.

The Center for Healthcare Strategies BCAP (Best Clinical and Administrative Practices) excel workbook format has been adopted as a mechanism to document initial quality project design and to evaluate on-going progress. The workbook incorporates several tools including documentation of the project work plan and progress, data collection and self-assessment. For many measures, the tool can be used to automatically create graphs of measures to illustrate progress and help "tell the story" of the quality improvement efforts.

These changes in the quality improvement process have allowed HealthCare USA to more efficiently manage, evaluate and track quality improvement projects. The on-going evolution of the program helps HealthCare USA improve and maintain best practices consistent with evidenced based clinical practice guidelines and national quality improvement standards.

Overall Effectiveness of the Quality Improvement Program

HealthCare USA's Quality Improvement Programs have been effective in meeting and exceeding many of the goals set for individual quality projects. Through the analysis and evaluation of past outcomes and current data, the plan has been able to implement multiple improvement projects, workgroups and task forces to improve outcomes of care and service across all three (3) regions of Missouri.

HealthCare USA continued to meet the needs of our diverse membership, provided expanded services and established strong partnerships with agencies and organizations dedicated to improving the lives of minority cultures and disparate populations in Missouri. HealthCare USA also strengthened partnerships in rural communities to help prevent avoidable out-migration of care and provide the best services for this population.

The EPSDT workgroup was expanded to include HEDIS measures in 2006. The expansion of this multi-disciplinary team resulted in many interventions and an overall improvement in HEDIS measures from calendar year 2005. The most significant improvements were seen in immunizations, prenatal and postpartum care, and chlamydia screening. The rise in chlamydia testing is an outcome of the performance improvement project that was developed in 2006. HealthCare USA will continue this approach to further improve HEDIS rates for 2007.

The results of the CAHPS member satisfaction survey showed varying satisfaction rates in 2007. The rating of Health Plan overall improved in both Central and Western Missouri, but decreased slightly in Eastern Missouri. However, satisfaction measures continue to be higher than the Medicaid average in each of the three regions. HealthCare USA will continue to strive to meet and exceed the needs of the membership and improve satisfaction with the Plan.

The HealthCare USA provider network has remained appropriate for the membership. HealthCare USA received a score of 100% for network adequacy in Eastern and Western Missouri and 99% in Central Missouri. The access and availability study revealed appropriate access and opportunities for improvement. The results were used by the Provider Relations Department to educate providers identifies as not being in compliance with the standards.

HealthCare USA continues to support a robust Fraud and Abuse Program. An enhanced staff education program improved internal communication and reporting of suspected fraud or abuse. There was an increase in fraud and abuse cases identified in this timeframe as a result of the increased staff awareness.

HealthCare USA maintains a focus on ensuring efficient processing of data in the claims, membership, and provider software systems. Statistics for each of these areas continue to meet or exceed company standards. HealthCare USA continues to assess processes to identify opportunities and implement activities to make the information systems work as efficiently as possible. The Plan has also continued the encounter data submission performance improvement project to meet the State and Plan's need for complete and accurate encounter data.

Overall provider satisfaction with HealthCare USA and the Customer Service Department has steadily increased over the past few years. HealthCare USA conducted provider Seminars in

2006 and 2007, to improve communication and collaboration with providers in each region. A Physician Management Advisory Council was also developed to help raise the awareness of HealthCare USA with the management staff at provider practices in all three regions.

HealthCare USA made several changes in the Health Services Department to improve processes related to member medical management. The special needs staff continue to asses the needs of members identified by the state health risk assessment and refer to appropriate services within the Plan. Care Management staff and resources were divided to better address the differences between Case Management and Disease Management. The Case Management staff continue to manage the complex and acute member cases. The Disease Management staff focus on diagnosis specific high volume and/or high cost populations with specific diagnoses such as asthma, diabetes and those identified as high risk OB. The change allows the Plan to stratify our member population and better meet the needs of those who have the greatest risk for morbidity and mortality as a result of the acuity of their disease and psychosocial factors.

MHNet continued to focus improvement efforts on ambulatory care and family therapy for children and adolescents. MHNet has an ongoing ambulatory follow-up performance improvement project to address the needs of patients following discharge for a mental health illness. They also have developed several strategies to encourage and improve coordination of care between the PCP and mental health providers for members receiving family therapy for children and adolescents.

The Quality Management Committee has reviewed and approved nineteen (19) evidence based clinical practice guidelines in 2006 and 2007. Links to these guidelines are all available on the HealthCare USA website where providers can access them and utilize in their practice.

HealthCare USA continues to effectively manage the credentialing and recredentialing needs of the provider network. New providers continue to be added to the network and existing providers are recredentialed every three years. The credentialing department has efficiently managed the files while guaranteeing the credentials of each provider accepted to the network. The eleven (11) delegated credentialing entities have continued to meet required State regulations and NCQA standards to maintain this function.

The Quality Improvement department has increased the volume of on-site medical record reviews. Medical record and claims for Primary Care Providers are now reviewed at a minimum of every three years according to their recredentialing cycle. The chart audit tool has been enhanced to not only asssess for EPSDT and HEDIS measures and general documentation guidelines, but to also review for evidence of compliance with evidence based clinical practice guidelines for several conditions including asthma and diabetes.

HealthCare USA has continued to maintain and improve collaborative efforts with subcontractors and other providers. Improving coordination of care has been a significant focus in 2006 and 2007. Mental health services are contracted to MHNet, dental services to Doral Dental, transportation services to MTM and pharmacy adjudication to Caremark Pharmaceuticals. In addition to participation on the QMC, routine case management and grand rounds have been established. MHNet participates routinely in rounds with UM staff. MTM and

Doral Dental participate in rounds on an ad hoc basis. Routine care management rounds have also been established with a high volume FQHC.

Provider complaints, grievances and appeals and member grievances and appeals have been an area of focused improvement in 2007. A multi-disciplinary, interdepartmental team focuses efforts on decreasing the rate of complaints, grievances and appeals received. The team also monitors overturn rates and timeliness on an on-going basis. This improvement project has shown promising results in 3rd quarter 2007.

The Medical Management departments continue to monitor utilization of services including appropriateness and quality of care and service received by members. With the rising trend in admissions per thousand and increasing lengths of stay, HealthCare USA is striving to assure the safest, most effective and efficient care possible. A continued focus on over and under utilization has led to several quality projects in areas such as emergency department utilization, hospital readmissions, and pharmacy abuse. Resources were also focused on improving inter-rater reliability through participation in InterQual education programs and implementation of a revised process for nursing and physician routine inter-rater reliability testing and case discussion.

Strengths and Accomplishments

In 2006 and 2007, HealthCare USA continued to collaborate and share best practices with national resources and subject matter experts, and partnered with local community based stakeholders to most efficiently and effectively implement programs to continue to improve clinical, functional, cost, satisfaction and safety related outcomes of care and service.

In addition to programs focused on member and provider services and assuring on-going contract compliance, HealthCare USA sought and achieved full URAC accreditation in 2007. "URAC is a not-for-profit organization that promotes continuous improvement and efficiency of health care management through process of accreditation, education and measurement." (URAC, 2007) The accreditation process evaluates quality procedures, operations and accountability for health care organizations through nationally recognized, publicly available standards, thus increasing transparency for consumers, providers and regulators.

As a result of our commitments and efforts, in addition to URAC accreditation, the following are some of the accomplishments achieved since 2005:

- Achieved full compliance with contractual requirements.
- Implementation of the Rapid Cycle Improvement methodology and use of the CHCS BCAP workbook elements for establishing, implementing and tracking Quality Projects.
- Establishment of a Balanced Scorecard for on-going tracking of key clinical, operational, safety and satisfaction measures and for early identification of opportunities for improvement and successes achieved.
- Enhancement of employee knowledge including:

- o the State contract, Fraud and abuse, HIPAA and National URAC standards throughout the Plan.
  - o InterQual train the trainer program
  - o Patient-centered interviewing

- Improved collaboration and information sharing with providers and subcontractors through:
  - o Continued PCP education in areas such as: documentation, communicable disease reporting, mental health access, medical record management, access standards, 24-hour availability requirements, HEDIS and HealthCare USA requirements.
  - o Establishment of the Provider Management Advisory Council
  - o Establishment of routine case and grand rounds

- Improvement in EPSDT participation ratios and HEDIS Measures through:
  - o On-going provider education and successful implementation of a provider incentive program for completion of claims code modifier for the post partum visit
  - o Successful deployment of member incentive programs for compliance with prenatal and post partum visits, adolescent immunizations.
  - o Successful process for medical record reviews at provider locations
  - o Deployment of a combined EPSDT/HEDIS multi-disciplinary team
  - o Implementation of a report for statistical comparisons on rates from year to year for HEDIS

- Continuation of expansion of interdepartmental, multi-disciplinary teams to address over and under utilization including:
  - o Non-urgent/avoidable emergency ED project
  - o Hospital readmissions
  - o Pilot hyperemesis program

- Continued evaluation and improvements in the special needs process.

- Developed strategic community partnerships in all regions with a focus on addressing equitability as evidenced by:
  - o Successful community health fairs providing physicals, dental screenings and other services in the local communities of all three regions
  - o Successful implementation of rural dental fairs.
  - o Successful pilot of a student nurse internship program

- Improved processes to assess member and provider satisfaction and to identify needs and gain subject matter expertise by:
  - o Developed and implemented a Member Advisory Council, Physician Advisory Council, and Physician Management Advisory Council
  - o Revised the member program specific satisfaction surveys and developing provider program specific satisfaction surveys.

HealthCare USA believes the following have been key to our success:

- Support of an organizational framework for quality improvement that encourages on-going active learning, knowledge sharing, team work and open communication

- Development and enhancement of technologies to identify opportunities and track, trend and report care and service metrics.

- Commitment to collaborate with stakeholders and other organizations in providing quality improvement focused on improving outcomes of care, service and safety to maximize timeliness, efficiency, effectiveness, patient-centeredness and equitability.

- Commitment to continuously improving organizational and administrative capacity to assure that enrollee's protection remains our focus.

Opportunities for Improvement

- Continue efforts to maintain a network of appropriate providers, particularly specialists, that is sufficient to provide adequate access to all services covered under the contract including implementation of the expansion counties.

- Continue efforts to improve monitoring mechanisms that support the ongoing evaluation of the provider network and ensure that all services covered are available and accessible to members while avoiding unnecessary out-migration of services.

- Continue to improve member outcomes by increasing the number of members screened and actively participating in case management and disease management services.

- Continue to improve member adherence to treatment and prevention services, as evidenced by improved EPSDT participation ratios and HEDIS measures, through on-going education and implementation of member self-management plans.

- Continue to collaborate with the State regarding the screening data on Children with Special Health Care Needs.

- Continue to refine the member outreach educational activities and mechanisms to determine the effectiveness of the outreach activities.

- Continue efforts to maintain and/or improve the EPSDT and HEDIS measures in populations or geographic areas that are lagging.

- Continue to monitor and improve information management through on-going on-site medical record reviews and the provider feedback processes.

- Continue to improve the process and tools utilized to conduct medical record review.

- Continue to identify alternative languages spoken by providers and office staff.

- Increase education to parents regarding well child visits, immunizations, lead and dental.

- Continue to improve working relationships with providers by seeking input and feedback to align incentives and improve outcomes of care and service.

- Continue to seek input and feedback from and collaborate with members to reduce barriers to care and services and continue to improve member satisfaction.

<center>**Mercy CarePlus**</center>

Quality and Compliance Committee
MCP's Quality Improvement Committee ("QIC") is responsible for the overall CQI program. The QIC members include MCP's senior management, quality improvement staff and designated network providers. The purpose of the QIC is the following:
- Strategic quality planning to determine the goals and objectives for quality improvement to meet the needs of customers
- Provide proactive leadership for systemic quality improvement in care and service
- Evaluate the provision of resources to meet goals and objectives
- Monitor performance in meeting the goals and objectives
- Integrate and coordinate quality improvement activities
- Review and approve all quality improvement activity reports

Analysis of Quality Improvement Process
MCP's quality improvement program has proven its effectiveness through the achievement of HEDIS scores that were within the 95% confidence interval, the results of the Performance Improvement Projects and the measurement of performance indicators. The QIC continues to play a positive role in guiding the focus of the quality improvement program to effectively measure the quality of care and services provided to members.

Overall Effectiveness of the Quality Improvement Program
   Strengths and Accomplishments
- Completion of multiple Performance Improvement Projects
- Continued improvement of HEDIS scores

   Opportunities for Improvement
- Continue to monitor performance measures
- Continue efforts to increase HEDIS and CAHPS® scores
- Develop a non-clinical Performance Improvement Project

<center>**Harmony**</center>

Quality and Compliance Committee
- Quality Improvement Committee (minutes were submitted with the annual report) including review of the following:
  - Credentialing/Re - credentialing Summary
  - Medical Advisory Committee
  - Customer Service Quality Improvement Workgroup
  - Delegation Oversight Committee
  - Appeals & Grievances
  - Encounters
  - Compliance & Regulatory Affairs

<center>9</center>

Analysis of Quality Improvement Process
Overall Effectiveness of the Quality Improvement Program
    Strengths and Accomplishments
    Opportunities for Improvement
See Attachment Dev 1

Missouri Care

Quality and Compliance Committees
Several committees oversee the Missouri Care Quality Improvement Program. The structure of the committees is presented below. All quality committees report up through the Quality Management Oversight Committee (QMOC) to the Operating Board, which has ultimate accountability for the quality management program. The following is a description of each of the quality committees, their roles and key issues identified through these committees in SFY07.
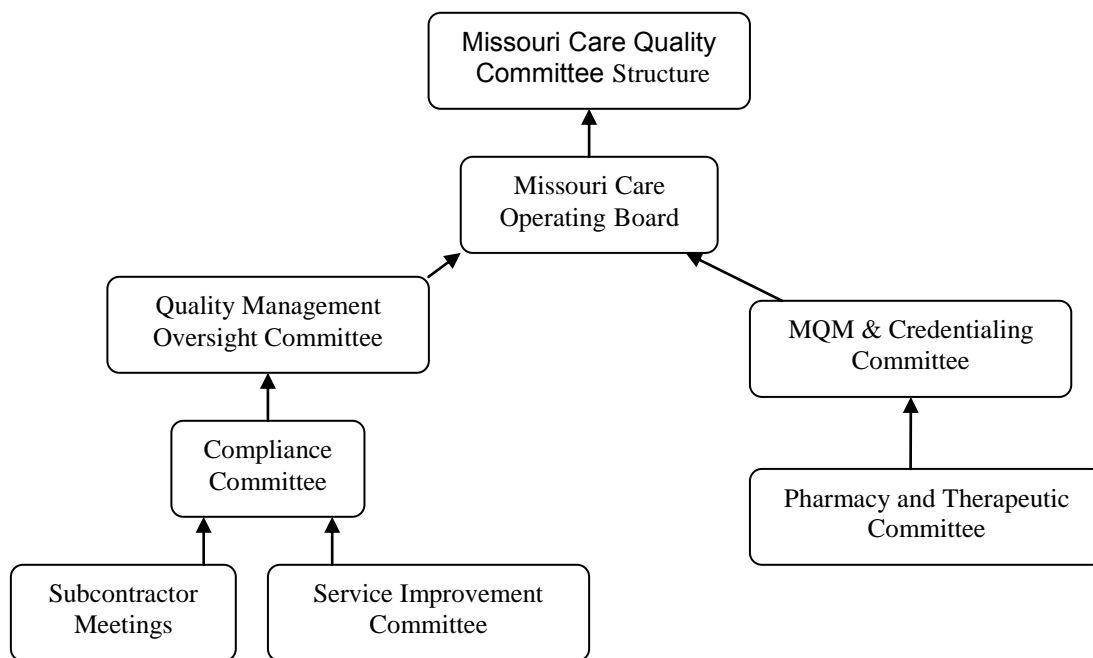
Medical Quality Management Committee (MQM)
The MQM Committee advises and makes recommendations to the Chief Medical Officer (CMO) and to the QMOC on matters pertaining to the quality of care and services provided to members. During SFY07, the MQM Committee met every other month. The committee reviewed ten potential quality of care cases that were elevated to the committee by the CMO. After reviewing the cases the committee determined that there were no quality of care concerns in seven of the cases, follow-up was required in two of the cases, and one case was sent for external review by a subspecialist. Missouri Care Health Plan completed follow-up per the committee's recommendations on the two cases and sent the third case to a subspecialist for review. The

external reviewer found that no quality of care issues existed. All cases are tracked and reviewed for trends.

The committee also advised Missouri Care on performance improvement projects, approved the annual Quality Management and Utilization Plans and Work Plans, and provided input on HEDIS improvement initiatives.

Credentialing Committee
The Credentialing Committee advises the CMO on the credentialing and re-credentialing of health care providers for participation in the Missouri Care provider network. The committee is made up of a diverse body of providers from the Missouri Care network. The committee met six times in SFY07. During SFY07, 70 providers were presented to the committee for initial credentialing and 39 were presented for recredentialing. The committee recommended approval of 69 of the initial credentials and 39 of the recredentials. The committee chose to deny one provider initial credentials and pend one recredentialing decision in order to seek more information; that provider was later recommended for approval by the committee. The committee also reviewed the annual audit reports of the six delegated credentialing organizations and the results of one pre-delegation audit. Corrective action was taken on one delegate.

Pharmacy and Therapeutics Committee (P&T)
The chief medical officer is responsible for directing and overseeing management of Missouri Care's pharmacy services with the advice and participation of the Pharmacy and Therapeutics Committee (P&T). Missouri Care contracts with Express Scripts, Inc. (ESI) for pharmacy benefits management. ESI administers the pharmacy benefit through a network of pharmacy providers. However, Missouri Care is responsible for oversight of pharmacy activities, utilization and quality concerns, resource management, and complaints. The P&T committee accomplished the following during this reporting period: formulary review, clinical pharmacy reviews (requests for prior authorization and non-formulary drugs) and tracking high volume, high cost drugs. The P&T committee also implemented the following pharmacy benefit changes: adding PA to all behavioral health classes of medications for members less than five years of age; QVAR added to formulary given favorable profile of efficacy and value, and discussion of Polypharmacy Project to address misuse/abuse of narcotics. Missouri Care's pharmacy generic fill rate increased from 68 percent in 2005 to 75.2 percent during this reporting period of July 1, 2006 to June 30, 2007. The P&T and ESI Committees met four times during this reporting period. ESI continues to work
on decreasing the price of single-source brand prescriptions and fulfilling contractual obligations of being Missouri Care's Pharmacy Benefit Manager.

Service Improvement Committee (SIC)
The SIC advises and makes recommendations to the QMOC and/or Missouri Care management about member and provider issues. In 2006, 106 issues were brought to SIC and all were resolved.

Quality Management Oversight Committee (QMOC)
The committees previously described and the compliance committee report to the QMOC. The QMOC integrates quality management activities throughout the health plan and the provider network. The committee is made up of the Missouri Care management team. It met every other month during SFY07. The committee reviews the minutes and issues from the other quality committees. Additionally, each
department manager reports on his or her own internally developed measures of quality. The content and completeness of the measures were reviewed during the SFY07 and revised as appropriate.

Compliance Committee
The Missouri Care Compliance Committee is a part of the existing Missouri Care QMOC. The Compliance Committee is comprised of the same permanent members of the QMOC. During compliance meetings, issues are discussed that include, but are not limited to, HIPAA issues, policies and procedures, state notifications, state reporting requirements, and fraud and abuse. The Compliance Committee tracked 111 issues in 2006. Most of the reported issues were resolved within the same month. All issues can be identified by one of the following four categories:

• Reportable Compliance Items
Reportable compliance items include search warrants, interviews/investigations, risk management issues, reports to the compliance hotline or exit interviews. There were seven reportable compliance items reported in 2006. All issues have been resolved.

• Suspected Fraud and/or Abuse
Suspected fraud and/or abuse items include issues related to providers, members, employees or subcontractors. There were 22 suspected fraud and/or abuse items reported in 2006. Cases included various pharmacy lockins for members referred to Missouri Care from the State for aberrant drug utilization patterns and/or behavior and state referrals of providers who had lost their licensure.

• Security Incident
A security incident can include issues related to human life and safety, systems and data, or facilities. There were three security incidents reported in 2006. All three were system issues that have been resolved.

• Privacy
A privacy issue can include review of proposed disclosure, request for records, accidental disclosures or complaints. There were 77 privacy items reported in 2006. They included accidental disclosures of PHI, balance billing members, incorrect PayTo, one subpoena for member information, member requests for records, proposed disclosures of member PHI and claims issues. Compliance issues can be reported verbally or in writing to the compliance officer or any member of
management. Members, providers, employees or others may report issues anonymously on Missouri Care's compliance hotline.

Analysis of Quality Improvement Process

Missouri Care's process of quality improvement is one of constant evaluation. Missouri Care annually reviews its Quality Management Plan to identify if it needs to be changed to improve quality initiatives and to evaluate whether Missouri Care is adhering to the plan. Missouri Care also develops a quality management work plan each year. (See Appendix for the 2008 work plan.) The plan is used to set priorities and to guide the quality initiatives for the year. It is referenced and updated as needed throughout the year. The plan is also used at the end of the year to identify quality processes that were successful and processes that need to be changed or replaced in the next year. The Quality Department is responsible for the overall quality plan, but Missouri Care strives to have a quality program that is integrated across departments. Missouri Care also relies on its provider network to evaluate and make recommendations to its quality improvement process.

Overall Effectiveness of the Quality Improvement Program
   Strengths and Accomplishments

Below are the highlights of Missouri Care successes in delivering quality services to members and network providers in 2006 and SFY07:

• Increased EPSDT participation rate to 70.78% in calendar year 2006.
• Increased rating of Customer Service in the annual Consumer Assessment of Health   Plans (CAHPS) Survey to 79.3% in 2007 from 70.9% in 2006.
• Increased performance from 2006 to 2007 (2006 measurement year) on the following HEDIS measures:
   Adolescent Immunizations Combo 2 and all submeasures;
   Adolescent Well Care;
   Cervical Cancer Screening;
   Childhood Immunizations Combo 3 and the Varicella and Pneumococcal submeasures;
   Timeliness of Prenatal Care;
   Postpartum Care:
   Chlamydia Screening combined rate and both submeasures,
   Follow-up after Hospitalization for Mental Illness 7 and 30 day;
   Use of Appropriate Medications for People with Asthma combined rate and all submeasures; and
   Annual Dental Screenings combined rate and all submeasures with the exception of the 19 to 21 age group.

• Exceeded the National Committee on Quality Assurance's (NCQA) 75th percentile benchmark for Medicaid Managed Care Plans on the following HEDIS measures:
   Adolescent Immunization
   Hepatitis B submeasure;
   Cervical Cancer Screening; Childhood Immunizations Combo 3 and
   Pneumococcal submeasure;
   Timeliness of Prenatal Care; Postpartum Care;
    Well Child Visits in the First 15 months of Life; and Chlamydia Screening for the 21 to 25 age group.

- Implemented performance improvement projects to improve member access/compliance with follow-up appointments within seven (7) days of discharge from an inpatient stay for mental illness and to increase compliance of members diagnosed with persistent asthma who fill a controller medication.
- Maintained phone abandonment rate at 1.93 percent, 2.76 percent, and 2.28 percent for Prior Authorization, Behavioral Health and Member Solutions Departments, respectively. This is well below the goal of less than 5%.
- Maintained average speed of answer for phone calls at 10 seconds, 9 seconds, and 11 seconds respectively for Prior Authorization, Behavioral Health, and Member Solutions respectively. This is below the goal of 30 seconds.
- Developed and began distribution of a Preventive Care Toolkit for primary care provider offices.
- Reviewed and revised internal department markers for quality performance.
- Achieved NCQA accreditation of disease management program.
- Posted 71% EDI claims submission in 2006, up from 68% in 2005.
- Paid clean claims in an average of 12 days, 4 days faster than the prior reporting period.
- Improved pharmacy generic fill rate from 68% in 2005 to 75.2% during the reporting period.

Opportunities for Improvement
The following are areas for improvement:
- Improve dental access/annual HEDIS dental screening rates
- Improve well child visits for member three, four, five, and six years of age (HEDIS measure)
- Continue to improve lead testing rates
- Decrease emergency department utilization

Blue Advantage Plus

Quality and Compliance Committee
BCBSKC has an integrated quality and compliance system for its managed care programs. Under the direction of the governing bodies for each managed care program, the Quality Council is the internal committee responsible for day-to-day operations of the quality assessment and improvement program, and for approving recommendations made by other committees relative to the Quality Improvement Program. Other important quality management and compliance-related committees include the Delegated Oversight Committee, joint BCBSKC/New Directions Delegated Oversight Committee, Medical and Pharmacy Management Committee, Care Connections Advisory Council, Peer Review Committee (formerly the Quality Improvement Committee), and the BA+ Oversight Committee. These committees meet regularly to evaluate performance toward meeting goals, and to address quality concerns. Minutes and other appropriate documentation are available for each of these Committees.
The roles, functions, and responsibilities of each Committee within BCBSKC are included in the Quality Improvement System Description and Committee Charter. The committee chair is responsible for reporting and functioning of the Committee. The roles, functions and responsibilities of the Medical Director are clearly defined in the job description and the Quality Improvement System Description.

The Compliance Committee is chaired by the Vice President, Chief of Audit, Compliance, and Budget. The Committee meets monthly to address compliance issues. The Compliance Committee acts on reports of oversight activities from the Delegated Oversight Committee, the joint BCBSKC/New Directions Behavioral Health Delegated Oversight Committee, and the BA+ Oversight Committee. Minutes and other appropriate documentation are available.

Analysis of Quality Improvement Process
NCQA & URAC Accreditation –BCBSKC is fully accredited by the National Committee for Quality Assurance (NCQA) and the American Accreditation HealthCare Commission, Inc. (URAC) for certain of its health Plans and programs. BCBSKC received the accreditation status of "Excellent," the highest level possible, for its commercial HMO product, Blue-Care, by the National Committee for Quality Assurance (NCQA). The company's Preferred-Care Blue PPO product was also accredited, receiving "Full" accreditation, the highest level awarded for PPO products by NCQA. BCBSKC also received "Full" accreditation, the highest level awarded, from URAC for its commercial HMO and PPO products, achieving best practice in several areas noted for their excellence in performance. Accreditation has been found to be associated with industry best practices. Accredited companies are more likely to measure and report quality performance.

BCBSKC's corporate policies and procedures, and quality assessment and improvement program structure, are designed to meet or exceed NCQA and URAC's standards. This infrastructure also supports BA+'s QA&I activities, ensuring that BA+ members and providers, and the State of Missouri benefit from gains in managing administrative costs and improving service and quality of healthcare that are realized from the BCBSKC Quality Improvement Program. Achieving the highest level of quality is clearly the expectation of the BCBSKC organization.

While the State of Missouri does not require NCQA or URAC Accreditation, there is a significant benefit to the member, provider, and State for a Plan that achieves these accreditations. The benefit to the MC+ member, provider, and the State is the development of the policies and processes adopted which provides a springboard to make quality member-centered decisions for the MC+ program, taking into account the differences in the MC+ program. The level of quality achieved by benchmarking against NCQA and URAC Accreditation has become a standard for BCBSKC through all of our programs, including BA+. The State and the member benefit from being a part of an organization that has attained such a distinction. The State and members are getting a quality provider of services when they see BCBSKC is NCQA and URAC accredited.

Overall Effectiveness of the Quality Improvement Program
Member Touchpoint Measures (MTM) are the key performance measurements used to monitor service levels and to drive service improvement efforts. MTM measures include enrollment timeliness, member-level accuracy, group-level accuracy, claims timeliness, claims dollar accuracy, claims processing accuracy, inquiry timeliness, inquiry accuracy, telephone blockage rate and telephone abandon rate. These MTM measures are the primary means of quantitative evaluation of BCBSKC's performance in the "vital few" areas of operations performance for 2006.

During 2006, service performance continued to be excellent with an average MTM score of 97.2 points out of 100 possible points. Quarterly MTM scores ranged from 95.10 to 99.90; performance exceeded target in seven of 12 months during 2006, and exceeded difficult/attainable goals in four months. The key area of focus moving from 2005 to 2006 was in Membership Accuracy and Timeliness, and Telephone Accessibility (Abandon Rate).

In 2006, BCBSKC continued to excel as a leader in service in the Kansas City market based on feedback from our Brokers and Employer Groups. BCBSKC's MTM results continued to perform in the top tier of Blue Cross and Blue Shield Plans. In 2006, BCBSKC began the process of transitioning to the new 2007 MTM measurement methodology, by conducting dual measurement for key indicators of performance to identify and address potential issues before the new methodology was fully implemented.

Service performance met or exceeded goal levels on a consistent basis in the areas of claims timeliness, inquiry timeliness and telephone blockage rate. Service levels fluctuated slightly from quarter to quarter (with some quarters below goal and others at or above goal levels) but remained at or above goal levels for the year in the areas of enrollment timeliness, group-level accuracy, claims processing accuracy, claims timeliness and inquiry timeliness. In the areas of inquiry accuracy, claims accuracy, and member-level enrollment accuracy, performance was nearly at goal for the year with performance under goal by a fraction of a percent.

Several service improvement initiatives were launched and/or completed during 2006 in order to ensure that our service levels continue to be a market differentiator for BCBSKC:

Implemented New Call Center Technology, which included a new VoIP system with a speech-enabled Interactive Voice Response (IVR) system, screen pops for CSRs, NICE recording for all calls, and skill-based call routing;

Continued actions begun in 2005 to leverage technology enhancements and Web self-service for members, providers and groups;

Implemented new standard operating procedures related to illegible documents and handling instructions, COB-related issues, Medicaid overpayment reclamations, and others;

Expanded cross-training of staff and cross-departmental back-up systems, such as pooling resources from multiple business areas to focus on inventory reduction for ITS host, to provide flexibility in addressing staffing and inventory issues;

Launched a redesigned EOB, implemented in September 2006; and

Implemented new recognition program for customer service representatives earning positive results on the customer service satisfaction survey, and continued the 100% club for quality in claims, customer service and membership areas.

Strengths and Accomplishments
During 2006, the Medical Management Division continued the process begun in 2005 to re-engineer medical management. By February 2007, the first phase was completed with the successful launch of CareConnection, a comprehensive and integrated care management model. CareConnection is built on the strengths of the traditional core medical management functionality (Utilization and Case Management) and leverages state-of-the-art technology to integrate business processes, data and communications to allow a true patient-centric model across the care continuum. Traditional medical management and distinct health management programs (Healthy Companion, Healthy Living and A Healthier You), are integral parts of the CareConnection strategy. Each program functions independently as well as in an integrated fashion to optimize health outcomes for our members.

CareConnection will combine the medical management processes aimed at ensuring the delivery of high quality, medically appropriate health care services, provided in appropriate clinical settings, with programs that educate, inform and encourage our members to take accountability for their health. These new programs will focus on preventing or delaying the onset of disease, providing timely information for health care decision-making, promoting adherence to evidence based medicine, and encouraging members' healthy behaviors.
The objectives of the CareConnection program are to:

a. Leverage predictive modeling and other technology to identify members who are at greater risk for hospitalizations and chronic disease;

b. Stratify members by illness risk and focus high cost, high touch interventions on those with greatest risk and therefore greatest opportunity for impact. Low risk members will receive low cost population-based interventions;

c. Integrate program services across departments, using a customer-centric systems platform, allowing for more comprehensive and seamless interactions with members; and

d. Utilize the technology to integrate the services across departments within CareConnection.

By October 1, 2007, CareConnection will be expanded for BA+ members to include diseases of diabetes mellitus, asthma, chronic obstructive pulmonary disease, and heart failure, in addition to multiple preventive health reminders specific to sex and age groups.

Opportunities for Improvement
Due to the distributed nature and number of performance improvement activities across the company, continued strong collaboration between the areas of Quality Management, Operations Support Services, Operations Performance Improvement, Population Management and Care Management is needed to ensure that strong interventions to improve service and clinical care are ongoing, meaningful to the population, and measured and documented in a way that is acceptable to BCBSKC leadership and external reviewers. Meaningful integration of the quality improvement program goals with those of the corporate business plan will continue to focus on the following broad areas: improving the quality of health outcomes, decreasing healthcare costs, and improving service.

During 2006 and early 2007, changes continue to be implemented that directly and indirectly support the pursuit of business excellence and provide resources for the systems and processes supporting quality improvement. Examples of such system changes are the CareConnection program roll-out, the roll-out of a more customer-focused Member Connection and Service Team, and additional analytical tools made available through the Information Access Division.

Decentralization of clinical and service/operational performance improvement activities brings challenges of oversight, training, standardization of reporting, and communication. New management in key areas of population management, care management, and Web services bring opportunities to conduct training on business requirements (e.g., standards and corporate goals) while planning for quality improvement. The Quality Management Department continues to facilitate agreement on strong interventions to improve service and clinical care that are meaningful to the population served, and measured and documented in a way that is acceptable to BCBSKC leadership and external reviewers.

During 2006, quality skills training was conducted using curriculum developed to meet business needs identified in 2005. Management and staff in Medical Services and Care Management Divisions received training on qualitative/causal analysis, Plan-Do-Check-Act methodology, and rapid cycle change, using the model used by the Institute of Healthcare Improvement.

As part of the launch of the Healthy Lifestyles Motivators Team, approximately 40 cross-divisional officers, management and staff received a three day training session on customer-centered culture (known as C3) and outcomes-based quality improvement using the framework of "Eight Dimensions of Excellence." Robin Lawton, the author of the C3-8D model, is an internationally recognized expert in creating rapid strategic alignment between enterprise objectives and customer priorities.

During 2006, Human Resources began implementation of "Blue University." This employee orientation and ongoing educational curriculum will include a supervisor training component and updated "BCBSKC 101" and "BCBSKC 201" courses which focus on aspects of the managed care industry and BCBSKC's business functions. A new performance evaluation process, supported by pre-loaded accountabilities and weights, competency library, writing tools and electronic processes was implemented in 2006 to promote more objective, accountability-based performance feedback and measurement.

Children's Mercy Family Health Partners

Quality and Compliance Committee

The Children's Mercy Family Health Partners (CMFHP) Board of Directors has ultimate authority and responsibility for oversight of the Quality Management Program.

1. Quality Management activities are reported to the Board of Directors by a Medical Director or appropriate staff at least quarterly.
2. The Medical Oversight Committee (MOC) approves the Quality Management Plan and substantive modifications to the plan.

The MOC has the authority and responsibility to direct the development and implementation of the internal Quality Management Plan, provide overall direction in matters of medical management and monitor the quality of care that CMFHP members receive. The committee meets quarterly to provide program oversight.

> The Medical Oversight Committee does oversight of the Health Services Committees: Medical Management Committee and Quality Management Committee, which includes the subcommittees that report to them. In addition, the MOC reviews annual work plans, audit results, physician satisfaction surveys, risk management issues and activities of subcommittees. MOC completes quarterly review of clinical care, quality of service, UM reports, Provider and Pharmacy profile reports, service standards and other quality improvement activities.

Analysis of Quality Improvement Program
During 2006, Children's Mercy Family Health Partners (CMFHP) continued efforts to increase communication and collaboration with both external and internal stakeholders.

Throughout the year, CMFHP continued incorporating all departments in the Performance Improvement process. Staff routinely received information regarding Key Performance Indicators and Performance Improvement projects through various avenues, including: monthly all staff meetings, Administrative Oversight Committee meetings, monthly newsletters, quarterly Medical Management Committee meetings, and Quarterly Medical Oversight Committee meetings.

In addition, CMFHP continued to put significant effort into oversight and collaboration with subcontracted vendors, specifically Bridgeport Dental, CommCare Behavioral Health (until 2/1/07), New Directions Behavioral Health (after 2/1/07), MTM Transportation, and Logisticare (January 1, 2007 to June 30, 2007). Through quarterly oversight meetings, data review and discussion occurred to help facilitate performance improvement projects, improve reporting of key indicators, and monitoring of health plan performance indicators.

Preventive Programs
Children's Mercy Family Health Partners supports and facilitates preventive programs and services for its members whenever possible. In 2006, CMFHP's preventive programs and services included:

- Asthma disease management program
- HeLP (Healthy Lifestyles) PCP and member education program
- Education on immunizations for children and adolescents
- Education on well care visits to children and adolescents
- Education on nutrition and exercise through a Food Power Program
- Education on postpartum depression to members post delivery
- Notification to members with no history of Primary Care Provider visits
- Increasing access to Primary Care Providers through ER Case Management initiative

- Well-woman outreach
- Breast cancer screening outreach
- Lead screening outreach

Overall Effectiveness of the Quality Improvement Program
Strengths and Accomplishments

As a result of Children's Mercy Family Health Partner's review of 2006 quality performance and improvement efforts, the following strengths and accomplishments were realized in 2006 and the first two quarters of 2007:

- Maintained a strong asthma disease management program with demonstrated outcomes
- Implemented a Healthy Lifestyles Program (HeLP), modeled after the asthma management program with PCP education and Health Coaching components
- Implemented a Performance Improvement Project aimed at improving rates of Well Child Care in the First 15 Months of Life
- Implemented inter-rater reliability audits for Quality Appeals Nurses
- Implemented an Inter-Rater Reliability process for Medical Directors
- Reinstated quarterly Provider Advisory Council (PAC) meetings
- Increased community involvement through active participation in organizations, such as the Medical Managers Association, RHC's, and FQHC's
- Implemented a peer audit program in claims
- Completed development of a case management documentation and tracking system
- Expanded ER case management to other high volume facilities
- Established a Provider Service Excellence award
- Continued focus on Hispanic community outreach
- Implemented new transportation vendor for non-emergency transportation services (NEMT)
- Developed a customer service training manual
- Developed a quarterly Disease Management Committee
- Developed a quarterly Health Improvement Committee
- Established the Quality Management Committee
- Reviewed and revised Quality of Care triggers and completed education of the Health Services staff
- Maintained an active Member Advisory Committee and demonstrated improvement from member feedback obtained as a result of the committee

Opportunities for Improvement

As a result of Children's Mercy Family Health Partner's review of 2006 quality performance and improvement efforts, the following opportunities for improvement were identified as initiatives for 2007-2008:

- Expand Asthma and HeLP programs to new PCP offices and expansion counties
- Complete enhancement of the electronic case management system for next version modifications
- Establish an initiative to include dental screening education in PCP offices

- Pursue new translation services contract
- Enhance Community Advisory Council (CAC) to include social service agency participation
- Complete JCAHO requirements for renewal of asthma management program certification
- Implement collaborative effort to support member use of Children's Mercy Hospital obesity education program, Promoting Health In Teens And Kids
- Implement a clinical Performance Improvement Project based on analysis of HEDIS indicator results from 2006
- Implement a non-clinical Performance Improvement Project

HARMONY HEALTH PLAN OF ILLINOIS, INC.
HARMONY HEALTH PLAN OF ILLINOIS, DBA HARMONY HEALTH PLAN OF MO
HARMONY HEALTH PLAN OF ILLINOIS, DBA HARMONY HEALTH PLAN OF IN
The WellCare Group of Companies

QUALITY IMPROVEMENT PROGRAM DESCRIPTION 2007 - 2008

I.   Organization Mission Statement

Harmony Health Plan of IL (MO & IN)/WellCare Health Plans, Inc. is dedicated to delivering quality, affordable healthcare enhancing our members' health and quality of life; creating a rewarding and enriching environment for our associates; and providing a competitive return for our investors.

II.   Purpose

The purpose of the Quality Improvement program is to establish a systematic process of Quality Improvement that will ensure a comprehensive, integrated plan-wide system to assess and improve the quality of clinical care and services provided to its members.

III.   Goals

The goals of the Quality Improvement Program are:
1) To improve the quality of services delivered to its members
2) To ensure the availability of, and access to, qualified and competent providers
3) To provide members with quality health care within a system that promotes efficient use of resources and supports the physician-patient relationship
4) To ensure provider input into the Quality Improvement Program activities
5) To ensure care will consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards of care, and this plan document.

IV.   Objectives

The objectives of the Quality Improvement Program are to:
1) Monitor and evaluate health care and plan services
2) Monitor and verify clinical competence
3) Establish and apply clinical indicators/standards
4) Implement action plans in response to identified opportunities for improvement
5) Evaluate the effectiveness of action plans and take additional action when needed
6) Evaluate member satisfaction with health care and other plan services
7) Evaluate provider satisfaction with the health plan programs and services
8) Manage the utilization of resources
9) Maintain record keeping of all Quality Improvement program activities
10) Report findings, actions taken, and their outcomes to the Board of Directors, Plan administration and Plan staff, providers, and members.

V.   **Scope**

The Quality Improvement Program addresses the key areas of access, availability, utilization, quality of care, clinical competence, credentialing, appeals and grievances, member satisfaction, provider satisfaction, and administrative services. All product lines, demographic groups, care settings, and types of services are included in the program.

The program establishes indicators, standards, and benchmarks to use in the evaluation of these areas. Compliance with the established standards is measured, and the results of this measurement are profiled. The resulting information is used in the identification of opportunities for improvement in the quality of health care and other services, and the development of program initiatives. Evaluation of the effectiveness of actions taken and program initiatives is performed. The Quality Improvement Program activities are communicated to the Board of Directors, Quality Improvement Committee, Medical Advisory Committee, administration, staff, providers, and members.

VI.   **Quality Improvement Strategy**

The Quality Improvement Program incorporates continuous quality improvement processes. This strategy is demonstrated by the structure of the Quality Improvement Program's committees and sub-committees, the QI program description, work plan and annual evaluation. The strategy incorporates the continuous tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained.

VII.   **Organizational Structure**

a. **Board of Directors**
    The Board of Directors has overall accountability and responsibility for the quality of health care and other services rendered to its members. The Board of Directors will support and have the final authority and responsibility for the assurance of a comprehensive and integrated Quality Assessment and Improvement program.

b. **Chief Executive Officer**
    The Chief Executive Officer is a member of the Board of Directors and Quality Improvement Committee and has the authority to act on behalf of the Board of Directors. The Chief Executive Officer provides the resources, equipment and personnel reasonably required to maintain and support the quality improvement program. As the quality improvement department identifies the need for additional resources relating to the quality improvement process, whether within the quality improvement department or in another area, the Senior Vice President of Health Services presents a proposal to the Plan's Chief Executive Officer for evaluation and approval.

c. **Senior Vice-President, Health Services**
    The Senior Vice President, Health Services directs all programs under the Health Services Department and assures that decisions are based on medical necessity, appropriateness, and quality. These programs include Utilization Management, Quality Improvement, Appeals and Grievances, Credentialing, Pharmacy and Behavioral Health Services. The Senior Vice President reports directly to the Chief Executive Officer.

d. **Medical Director, Corporate Quality Improvement**

The Corporate QI Medical Director provides executive leadership to the Corporate Quality Improvement program and oversees the Corporate Quality Improvement Strategic Planning Team. The Corporate QI Medical Director also provides functional leadership over the Plan Quality Improvement programs.

e. **Director, Corporate Quality Improvement**

The Director of Corporate Quality Improvement is accountable to Harmony Health Plan of IL/WellCare Health Plans, Inc. The Corporate Director is Senior Management for the operation of all corporate and health plan quality assessment and improvement services, functions, and procedures. The Corporate Director presides over the design, implementation, and maintenance of a comprehensive and standardized Quality Improvement program across all lines of business. The Corporate Director leads the Quality Improvement program including short-term and long-term planning, data collection, program evaluation, and intervention. The Corporate Director ensures that the Quality Improvement program utilizes the most cost-effective means to achieve business objectives and remains in full compliance with federal and state laws as well as Company policy.

f. **Medical Director**

The Medical Director has been delegated the authority to develop, implement and evaluate the quality improvement program's monitoring activities and actions. The Medical Director has overall accountability for the integration, coordination and execution of the Plan Quality Improvement program activities. He/she is responsible for oversight of accreditation, if applicable, and compliance with State and Federal regulations. The Medical Director is an integral part of the process for planning and developing quality improvement criteria and activities and participates in all meetings held in preparation for the Medical Advisory Committee and Quality Improvement Committee meetings.

g. **Director, Quality Improvement**

The Director of Quality Improvement integrates and coordinates the overall quality improvement operations of the Plan, with the support of the Medical Director, Director of Corporate Quality Improvement, Medical Advisory Committee, Quality Improvement Committee, Chief Executive Officer and Board of Directors. The Quality Improvement Director works to promote consistency in the Plan's quality improvement activities and serves as the resource person for quality references, clinical indicators, etc.
In addition, quality improvement staff with personnel in each clinical and administrative department to identify problems related to the quality of care for all covered professional services; prioritize problem areas for resolution and design strategies for change; implement improvement activities and measure the success of those interventions.

VIII. Committee Structure

a. **Board of Directors**

Purpose: The Board of Directors has overall accountability and responsibility for the quality of health care and other services rendered to its members. The Board of Directors

will support and have the final authority and responsibility for the assurance of a comprehensive and integrated Quality Assessment and Improvement program.

Chairperson: Chief Executive Officer and/or designee
Membership: Board of Director Members, Chief Executive Officer and/or designee, Regional President, Senior VP Health Services, Medical Director, Representative(s) of Executive Management or designees
Frequency: Meets Quarterly but not less than 4 times per year
Minutes: Minutes are recorded and maintained for each meeting

b. **Quality Improvement Committee**
   Purpose: Is responsible for promoting the goals and objectives of the health plan by:

1) Demonstrating corporate commitment to high quality care and to the organization's quality improvement.
2) Ensure quality improvement measures are integrated throughout the organization.
3) Requiring that objective measures be used to evaluate the quality of care and service being provided.
4) Ensuring that quality improvement processes are in place and working effectively to improve quality.
5) Reviewing and approving the annual Quality Improvement and Utilization Management Program Descriptions, work plans, and evaluations.
6) Centralizing and coordinating the integration of health plan activities.
7) Monitoring ongoing health plan activity toward health plan goals and objectives.
8) Providing oversight of the following activities and providing recommendations for improvement:
   i. Quality measurement studies
   ii. HEDIS® performance measures
   iii. Disease management programs
   iv. Member and provider surveys
   v. Medical record review
   vi. Appeals and grievance
   vii. Pharmacological reviews
   viii. Utilization Management reviews
   ix. Credentialing and re-credentialing reviews
   x. Pharmacy and Therapeutics review
9) Overseeing credentialing and re-credentialing activities for the health plan providers.
10) Monitoring activities of contracted and delegated agencies, including but not limited to behavioral health.
11) Providing a forum for the review, revision, and approval of health plan policies and procedures, guidelines, standards.
12) Overseeing application and enforcement of national confidentiality policy.
13) Ensuring compliance with regulatory and accrediting bodies.
14) Monitoring activities of the Quality and Utilization Management subcommittees.
15) Publicize findings to appropriate staff and departments within the plan.
   Chairperson: Chief Executive Officer and/or designee
   Membership: President, Senior VP Health Services, Medical Director, Director of Corporate Quality Improvement, Director of Quality Improvement, Director of Health Services Operations, Director of Credentialing, Director of Appeals and Grievances,

Representative(s) of Executive Management or designees, VP Provider Relations or designee, VP Provider Contracting or designee, VP Human Resources or designee, SVP Operations or designee, VP Operations or designee, Risk Management or designee, SVP Sales and Marketing or designee, SVP, General Counsel or designee, SVP Finance or designee, HIPAA Compliance Officer or designee, Director, Customer Service or designee, Corporate Development or designee.
Frequency: Meets monthly but not less than 9 times per year
Minutes: Minutes are recorded and maintained for each meeting
Reports to: Board of Directors

c. **Medical Advisory Committee**
Purpose: Is the principal physician committee that oversees all clinical quality improvement, utilization management and behavioral health activities.
The Medical Advisory Committee is responsible for promoting the goals and objectives of the health plan by:

1) Reviewing and approving the annual Quality Improvement and Utilization Management Program Descriptions, work plans, and evaluations.
2) Monitoring ongoing health plan activity toward health plan goals and objectives.
3) Analyzing and evaluating summary data from the following activities and providing recommendations for improvement.
4) Quality measurement studies; HEDIS® performance measures; Disease management programs; Member and provider surveys; Medical record review; Utilization Management reviews.
5) Providing a forum for the review, revision, and approval of health plan policies and procedures, guidelines, standards, etc.
6) Providing peer review of all professional and technical activities.
7) Publicizes quality improvement findings to the appropriate staff and departments within the Plan.
8) Reports the findings and recommendations to the appropriate executive authorities.

Chairperson: Medical Director or designee
Membership: Medical Director, Senior Vice President of Health Services, Representative(s) of Executive Management or designees and Physician Advisors representing primary care, surgery, obstetrics, and sub-specialties as assigned, Director of Corporate Quality Improvement or designee, Director of Quality Improvement and Director of Health Services Operations or designee
Frequency: Meets quarterly but not less than 4 times per year
Minutes: Minutes are recorded and maintained for each meeting
Reports to: Quality Improvement Committee

d. **Credentialing Committee**
Purpose: Is the principal physician committee that oversees health plan credentialing and re-credentialing activity. The committee also provides peer review for quality of care issues. The Credentialing Committee reports to the Quality Improvement Committee.

The functions of the Credentialing Committee are to:
1) Perform the credentialing and re-credentialing of all health plan providers, including facilities, to assure that all providers meet minimum practice parameters established by the health plan and the physician community at large.

2) Conduct peer review on cases forwarded to Committee and develop recommendations for improvement initiatives.
3) Provide a forum for the review, revision, and approval of credentialing policies and procedures, standards, etc.
4) Provide peer review oversight of delegated credentialing activities.

Chairperson: Medical Director or Designee
Membership: Medical Director, Director of Credentialing or designee, Physician Advisors representing primary care, surgery, obstetrics, and sub-specialties, as assigned.
Frequency: Meets monthly but not less than 6 times per year
Minutes: Minutes are recorded and maintained for each meeting
Reports to: Quality Improvement Committee

e. **Delegation Oversight Committee**

Purpose: Coordinates and oversees all delegated activities ensuring that delegated entities adhere to contractual, regulatory, and accreditation requirements.
The Delegation Committee ensures compliance with regulatory, contractual, and accreditation standards by:
1) Maintaining appropriate policies and procedures
2) Monitoring potential delegation activities
3) Completing pre-delegation audits
4) Executing delegation implementation
5) Completing annual delegation audits
6) Monitoring agencies on corrective action
7) Monitoring vendor reporting and data submission

Chairperson: Director of Corporate Quality Improvement or designee
Membership: Utilization Management, Quality Improvement, Claims, Credentialing, Network Development, Customer Service, Behavioral Health, Medical Director, Regulatory Affairs
Frequency: Meets monthly but not less than 8 times per year
Minutes: Minutes are recorded and maintained for each meeting
Reports to: Quality Improvement Committee

f. **Appeals and Grievance Committee**
Purpose: Has final authority of all member and provider medical necessity appeals. Review administrative and benefit member and provider medical necessity appeals and grievances and make final determinations.
Chairperson: Medical Director or designee
Membership: Medical Director; Director of Appeals & Grievance; Appeals & Grievance staff, as appropriate; Physician Advisor(s); One (1) health plan employee; Representatives from Legal or Compliance, as necessary. Voting members include the Medical Director, Physician Advisors, and one (1) health plan employee, all whom have been unaffiliated with the case prior to the review.
Frequency: Meets weekly but not less than 45 times per year
Minutes: Minutes are recorded and maintained for each meeting
Reports to: Medical Advisory Committee

g. **Pharmacy and Therapeutics Committee**

Purpose: The Pharmacy and Therapeutics Committee is an advisory group of physicians and pharmacy providers. The Committee is responsible for recommending the adoption of, or assisting in the formulation of, broad professional policies regarding evaluation, selection, and therapeutic use of drugs by the health plan physicians. The Committee also recommends or assists in the formulation of programs designed to meet physicians' and pharmacy providers' needs with regard to complete current knowledge on matters related to drug use. The Committee also assists in the detection of possible or potential problems for health plan beneficiaries as it relates to the prescription drug program.

The Committee accomplishes its goals and objectives by:

1) Serving in an advisory capacity to physicians, the Quality Improvement Committee, and pharmacy providers, in all matters pertaining to the use of drugs (including investigational drugs).
2) Establishing suitable educational programs for physicians and pharmacists on matters related to drug use.

Chairperson: Medical Director or designee
Membership: Medical Director, Vice President of the Pharmacy Department, Pharmacy Directors, Participating practitioners.
Frequency: Meets at least quarterly.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Quality Improvement Committee

h. Quality Improvement Interventions Workgroups
Purpose: The committee functions as multidisciplinary task force to identify opportunities for improvement identified through tracking and trending data, disease management clinical issues, administrative issues, cost of care issues, HEDIS and QISMC. The goal is to maintain continuity and consistency in organizational wide projects and not to duplicate efforts.
Chairperson: Medical Director or designee
Membership: Includes, but not limited to, Medical Director, Quality Improvement, Utilization Management, Customer Service, Medical Data Analysis, Provider Relations, Legal Affairs and other ancillary departments as identified.
Frequency: Meets monthly but not less than 4 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

i. Customer Service Quality Improvement Workgroup
Purpose: The committee functions as a multidisciplinary task force to identify opportunities for improvement in customer service. The committee reviews data relevant to member and provider complaints and appeals to ensure that individual member and provider issues are addressed, resolutions are appropriate and timely, the process is compliant with regulatory standards, and identified issues are referred for system response through the quality improvement process. Dedicated to the continuous quality improvement process, the committee facilitates open and consistent communication among, members, providers the QIC and the company's departments. The committee's focus is on systemic analysis of access and quality of service provided to the members under the health care contract.

The committee is responsible for:

1) Identifying areas of necessary quality improvement through analysis of trends found in member satisfaction surveys, analysis of complaint and appeal data, member requests for PCP changes, and member dis-enrollments.
2) Targeting interventions, implementing process improvements and establishing tracking mechanisms to monitor and evaluate progress.
3) Developing performance goals and indicators, reviewing trends, and evaluating progress
4) Facilitating member focus groups for the purpose of improving the delivery of health care by obtaining member input to policies and benefits.
5) Reporting identified barriers to improvement in processes, progress, and implementation to the MAC.

Chairperson: Director of Customer Service or designee
Membership: Includes, but not limited to, Representatives from Operations, Health Services, Provider Relations, Legal Affairs, Quality and other ancillary departments as identified.
Frequency: Meets monthly but not less than 8 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

j. **Utilization Management Review Workgroup**
Purpose: The committee functions as an executive work group to oversee the analysis of Utilization Management trends related to process, impact, and outcomes.
The committee has the following functions:
1) Analyzing objective measures which are used to evaluate the quality of care and service being provided.
2) Ensuring that efficient processes are in place and working effectively to improve quality.
3) Monitoring utilization activity toward health plan goals and objectives.
4) Ensuring compliance with regulatory and accrediting bodies.

Chairperson: Senior Vice President, Health Services or designee
Membership: CEO or designee, Senior Vice President, Finance Vice President or designee, Provider Relations or designee, Medical Directors, Vice President, Behavioral Health, Vice President, Pharmacy, Director, Inpatient Services, Director, Credentialing, Director, Appeals & Grievance, Director, Health Care Management, Director, Health Services, Director, Outpatient Services, Director(s), Quality Improvement, Director, Corporate Quality Improvement
Frequency: Meets monthly but not less than 8 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

k. **Consumer Advisory Workgroup**
Purpose: The workgroup functions as a forum for additional member communication and focuses upon member issues. The work group provides feedback to the Plan on areas impacting member's issues including but not limited to utilization of services, quality of care, quality of service, appeals and grievances (the work group will not have authority to resolve specific complaints but instead to refer such issues to the Plan's other committees and workgroups).
Chairperson: Director, Marketing or designee

Membership: Director Marketing or designee, Provider Relations or designee, Director, Health Services or designee, Director Quality Improvement, currently enrolled member(s)
Frequency: Meets quarterly but not less than 4 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

IX. Scope and Methodology
a. Quality Management Measurements

1) Indicators and clinical practice guidelines are identified to monitor important processes of care/service. The indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable). The indicators reflect structures of care, processes of care, outcomes of care or administrative and service systems within the delivery of care to include but not limited to utilization management, credentialing, member satisfaction, medical record review, and monitoring and resolution of member complaints and appeals, availability and accessibility of practitioners, Plan accessibility, health management systems to monitor chronic conditions, and preventive care. The indicator or practice guideline will be designed to measure accessibility, appropriateness, continuity, efficacy, efficiency, safety, timeliness, or cost effectiveness.

2) HEDIS® measures will be incorporated into the quality improvement program. The selection of measures will be governed by contractual requirements for the Medicaid products and/or accreditation requirements for all products. Based on analysis of the results, quality initiatives will be developed and implemented to improve performance. Initiatives are reassessed on an annual basis to evaluate their effectiveness and compare levels of performance with prior periods. Separate from the HEDIS® activities will be the annual member satisfaction survey. This will be performed by an independent State contracted by the Plan. Results of HEDIS® are reported to the required State, federal and local agencies.

3) Utilization Management parameters including but not limited to minimum aspects of care as noted in Exhibit A of the contract:

    (a) for pregnant women:
        (1) number of prenatal visits;
        (2) provision of ACOG recommended prenatal screening tests;
        (3) neonatal deaths;
        (4) birth outcomes;
        (5) length of hospitalization for the mother; and
        (6) length of newborn hospital stay for the infant.

    (b) for children:
        (1) number of well-child visits appropriate for age;
        (2) immunization status;
        (3) lead screening status;
        (4) number of hospitalizations;
        (5) length of hospitalizations; and
        (6) medical management for a limited number of medically complicated conditions as agreed to by the Contractor and Department.

    (c) for adults:
        (1) preventive health care (e.g., initial health history and physical exam; mammography; papanicolaou smear).

(d) for medically complicated conditions/chronic care (such conditions specifically including, without limitation, diabetes and asthma):

(1) appropriate treatment, follow-up care, and coordination of care for Enrollees of all ages; and

(2) identification of Enrollees with special health care needs and processes in place to assure adequate, ongoing assessments, treatment plans developed with the Enrollee's participation in consultation with any specialists caring for the Enrollee, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner.

(3) Case management plan; and

(4) Chronic care action plan.

(e) for behavioral health:

(1) behavioral health network adequate to serve the behavioral health care needs of Enrollees, including services specifically for Enrollees under age 21 and pregnant women;

(1) Enrollee access to timely behavioral health services

(2) An individualized plan or treatment and provision of appropriate level of care

(3) Coordination of care between the CBHPs, MCO behavioral health subcontractor or internal program and the PCP

(4) Provision of follow up services and continuity of care

(5) Involvement of the PCP in aftercare

(6) Member satisfaction with access to and quality of behavioral health services; and behavioral health service utilization

b. **Case and Disease Management**

Case Management and Disease Management Programs assist members with complex, chronic, catastrophic or special health care needs.

Goals of Case Management and Disease Management Programs include:
- Identification of members with a chronic, catastrophic or special health care needs
- Providing opportunities for members to participate in a Disease Management or Case Management Program
- Provide education to members to empower them to make behavior changes to ensure the choices they make will improve their health
- Education of providers with regards to current standards of care and coordination of care including but not limited to treatment plans

Harmony identifies members who may benefit from Case Management or Disease Management services through varied sources:
- The pre-certification process
- High risk maternity screening
- Health risk assessments
- Claims data analysis
- HFS Data sources
- Pharmacy utilization analysis
- Provider referral
- Self or family referral

- Frequent admissions and
- Trigger diagnosis that often benefit from case management or disease management involvement

Establishment and implementation of a treatment plan or plan of care that meets the following requirements:
- Is appropriate
- Includes an adequate number of direct access visits to specialists
- Is time specific and updated periodically
- Ensures cooperation with and among providers and considers the beneficiary's input

Intervention and education will improve quality of life, improve health outcomes, and decrease medical costs.

c. **Data Collection Process**
On both a routine and ad hoc basis, Harmony Health Plan of IL/WellCare Health Plans, Inc. collects and analyzes information from both internal and external sources to monitor the services it provides to its members. Providers are contractually required to allow access to facilities, enrollee records and appropriate staff. Information is collected about plan operations, access and utilization issues, clinical encounters and outcomes. The information resulting from such analyses and studies is reviewed by staff internally and presented to the Quality Improvement Committee. If issues are identified, action plans are developed to resolve those issues.

1) Data Sources
The data sources listed below provide a basis for identification of problems but should not be considered all-inclusive.
   a) The patient's office medical record.
   b) The patient's hospital record.
   c) The patient's skilled nursing facility record.
   d) The patient's skilled home health care record.
   e) Beneficiary/Physician/Staff complaints.
   f) Grievances.
   g) Survey recommendations.
   h) Utilization review findings.
   i) Monitoring and evaluation activities.
   j) Claims data

2) Collection Method
   a) The departments/services involved will be responsible for data collection in areas where their process is being evaluated.
   b) Data collection from any type of medical record or medical data will be collected by or under the direction of licensed nursing personnel.
   c) Data collection requiring a medical opinion to be rendered will be performed by a physician.

3) Sample Size
The sample will vary for each type of monitor and will be outlined in the monitoring activities. The following reviews will have the following standards:
   a) Medical Record Review – A random sample of 30 high volume physicians (and/or accreditation schedule), review 5 to 10 records per physician

     b) Per HEDIS® specifications as applicable
   4) Frequency of Data Collection
    Monitoring will be ongoing. A calendar of expected monitoring for the calendar year will be formulated. Revision of the calendar will be done based on reprioritization of projects and new events.
   5) Indicators
    At a minimum the following areas will be reviewed on an ongoing basis:
     a) Management of specific diagnosis and chronic conditions;
     b) Appropriateness and timeliness of care;
     c) Comprehensiveness and compliance with the plan of care;
     d) Special screening for, and monitoring of, high risk individuals or conditions may include (but are not limited to) the following areas, relevant to the demographic and health characteristics of the plan's population:
      1) Childhood immunizations and well visits
      2) Adolescent immunizations and well visits
      3) Pregnancy
      4) Asthma
      5) Cancer Screening – Cervical and Breast
      6) Hypertension
      7) Diabetes
      8) Adult Health Screening
      9) Pediatric Health Screening

d. Concerns/Complaints/Appeals

The Explanation of Coverage instructs members to contact the health plan regarding issues they may have. Members may contact Customer Service or submit their complaint in writing to the Appeals and Grievance Department. Member issues are documented in the appropriate logs and/or databases. On a monthly basis, reports are generated, and reviewed by the appropriate committees. The committees are responsible for reviewing the reports to identify trends and develop corrective actions. The committees also monitor actions that have been implemented to ensure problem resolution/progress.

e. Member Satisfaction

The CSQIW reviews the results of customer satisfaction surveys. Low or inadequate scores are reviewed and a root cause analysis is completed. Changes in work flows and/or processes are implemented to improve the customer satisfaction scores. The work group continues to monitor the scores regularly to ensure that the changes that were made adequately impact customer satisfaction.

f. Access/Availability Monitoring

Access and availability is monitored yearly, and as needed to assure adequate provider accessibility for our members. The geo-access report evaluates member-driving distance from PCP, Specialists, Ancillary Providers and hospitals, and evaluates access for members within 30 and 60 minutes of available providers in the network. The report is reviewed by, the Medical Advisory Committee and the Quality Improvement Committee. In addition, ASA, Hold Times and Call Abandonment rates are monitored on an ongoing basis to assure adequate access to customer services for members and providers. Access and availability is also

monitored through the Customer Satisfaction Survey on a yearly basis, which is evaluated by our CSQIW, MAC, QIC and BOD.

g. Provider Satisfaction

The provider network is surveyed as needed to assess provider satisfaction with Harmony Health Plan of IL/WellCare Health Plans, Inc.. The survey results are then reviewed and analyzed by the Customer Service Quality Improvement Workgroup and an action plan is developed to address the areas identified as needing improvement. The results and action plan are presented to the QIC and BOD for approval and recommendations.

h. Practice Guidelines and Preventive Health Guideline Review

Practice Guidelines for certain diseases and Preventive Health Guidelines are developed, revised and adopted on a yearly basis, utilizing the US Preventive Services Task Force guidelines. These Practice and Preventive Health Guideline reviews are presented to the MAC, QIC and Board of Directors and then distributed to providers as appropriate and to enrollees/potential enrollees upon request.

Practice Guidelines and Preventive Health guideline criteria:

a. are based on valid and reliable clinical evidence or consensus of providers in the particular field;

b. consider the needs of enrollees;

c. are adopted in consultation with affiliated providers; and

d. are periodically (at least annually) reviewed and updated as appropriate.

i. Credentialing

Credentialing is the process by which the peer review body (Credentialing Committee is made up of participating providers) evaluates the individual applicant's background, education, training, experience, demonstrated ability, patient admitting capabilities, licensure, regulatory compliance and health status (as applicable) by means of primary source verifications obtained in accordance with regulatory, accreditation and Company policy and procedure. Information and documentation on individual practitioners or facilities is collected, verified, reviewed and evaluated, in order to approve or deny provider network participation. Approved practitioners are assigned a specialty and scope of practice that is consistent with their boards of certification, accredited training or licensure, as applicable. Specialty designation and scope of services of approved facilities is consistent with recognized industry service standards and/or standards of participation developed by the Company, which may include certification, licensure, and/or accreditation, as applicable to provider type. Re-credentialing shall be undertaken at least every three years. The monitoring and evaluation of the quality and appropriateness of patient care, clinical performance and utilization of resources of physicians will be incorporated in the re-credentialing process and will be accomplished through the following activities:

1) Credentialing including Re-credentialing:
   Scope of practice will be reviewed as outlined in Policy and Procedure. Input from the Quality Assessment and Improvement activities will be used on an ongoing basis to assure that the scope of practice and credentials are commensurate with the practitioner's actual practice and abilities.

2) At the time of re-credentialing, in addition to information obtained through the re-credentialing application, site survey (as applicable) and primary source verification process, relevant findings from any of the Quality Assessment and Improvement

activities listed below may be considered as part of the re-credentialing process of the practitioner or other health care provider:

a) Medical Record Review
b) Diagnosis Specific Screens
c) Age Specific Screens for Preventive Care
d) Utilization Review Screens
e) Sentinel Events
f) Peer Review
g) Risk Management Issues
h) Patient Complaints and Grievances
i) Member Satisfaction
j) Quality of Care and/or Quality of Service issues

j. Peer Review

1) All aspects of peer review are deemed confidential, including findings and documents and are protected from disclosure under state law. All persons involved with peer review activities will adhere to the confidentiality guidelines applicable to Medical Staff Committees.

2) Peer review is the responsibility of the Medical Director. The Credentialing Committee will perform as part of the Plan's peer review committee and written minutes will be maintained for each meeting. Peer review shall include the following responsibilities and authority:

   a) Review practice methods and patterns of individual physicians and other health care professionals.
   b) Morbidity/Morality review.
   c) Grievances related to medical treatment.
   d) Evaluate the appropriateness of care rendered by professionals.
   e) Implement corrective action when deemed necessary.
   f) Develop policy recommendations to maintain or enhance the quality of care provided to the beneficiaries.
   g) Conduct a review process that includes appropriateness of diagnosis and subsequent treatment.
   h) Maintenance of medical records requirements.
   i) Adherence to standards generally accepted by professional group peers, and the process and outcome of care.
   j) Review of written and oral allegations of inappropriate or aberrant service.

3) All peer review will be documented on a peer review form to be housed in the Quality Improvement department for the purpose of tracking and trending.

4) Peer review that resulted in a favorable review will be summarized to the Credentialing Committee on a monthly basis. Issues requiring further review, action, or disciplinary action will be forwarded to the next scheduled Credentialing Committee meeting. If the issue requires immediate action, a committee meeting can be called as necessary in accordance with the policy. Any issues that are felt to be litigious in nature will be referred to Risk Management immediately.

5) Any quality deficiencies that result in a suspension or termination of a practitioner will be forwarded to Risk Management prior to being reported by Credentialing to the National Practitioner Data Bank, Department of Professional Regulation and the DOI.

a. Reporting by Incident
Level 1 – no exposure or potential for adverse effect:
A - No quality issue: not reportable
B - Confirmed quality issue: not reportable
Level 2 - potential for adverse effect:
A - No quality issue: not reportable
B - Confirmed quality issue (known complication): not reportable
Level 3 – actual adverse effect (non-life threatening):
A - No quality issue (known complication): not reportable
B - Confirmed quality issue: not reportable
Level 4 – actual adverse effect (non life threatening) resulting in bodily harm, incorrect surgery or unrelated surgery:
A - No quality issue (known complication): reportable
B - Confirmed quality issue: reportable
Level 5 – Nosocomial infection:
A - No quality issue (known complication): reportable
B - Confirmed quality issue: reportable
Level 6 – actual major adverse effect (life threatening or death):
A - No quality issue (known complication): reportable
B - Confirmed quality issue: reportable

b. Reporting by Action
1. Reportable
Termination as a result of a quality of care issue
Termination as a result of unprofessional behavior
Imposing restriction on privileges
2. Not Reportable
Track and trend
Focus review
Deferment of members
Requiring CME's
Counseling

6) The information gathered on individual practitioners will be compiled into a physician profile and will be submitted to Credentialing to be used in coordination with any other performance monitoring activities, including utilization review, risk management, and resolution and monitoring of member grievances, for the purpose of re-credentialing.

7) Peer review is conducted by the Medical Director or a member of the Quality Improvement Committee. The Medical Director will utilize the expertise of plan affiliated specialists if necessary to complete the review. All reviews are reported through the Quality Improvement Committee, the committee has final authority to over-ride the peer reviewer's decision, if deemed inappropriate.

k. **Risk Management**
Risk Management and Quality Improvement will have a cooperative and collaborative relationship pertaining to quality of care issues. Referrals will be made between the departments as issues are identified. Outcomes of investigations, peer review and actions taken will be coordinated between the departments. Referrals will be made to Risk Management, in writing, as appropriate.

l. **Pharmacy**

Harmony Health Plan of IL/WellCare Health Plans, Inc.'s Pharmacy Services have been carved out by the State of IL Department of Health and Family Services.

m. Utilization Management

The goal of the Utilization Management Program is to ensure timely and cost-effective utilization of facilities and services throughout the health plan and its affiliates through ongoing monitoring, evaluation, and intervention. The Utilization Management Program supports compliance with regulatory and accreditation standards. For further description, please see the Utilization Management Program Description.

n. Ethics

Harmony Health Plan of IL/WellCare Health Plans, Inc.'s corporate ethics and compliance program, entitled the *Trust Program*, consists of five structural components:

   1) the written elements of the compliance Organization
   2) the core values
   3) the Standards of Conduct
   4) the Compliance Organization
   5) the Policies and Procedures underlying the *Trust Program*

The Trust Program is designed to assist Harmony Health Plan of IL/WellCare Health Plans, Inc. to conduct its business in accordance with applicable federal and state laws and Harmony Health Plan of IL/WellCare Health Plans, Inc.'s high standards of business ethics. Additionally, the Trust Program is intended to satisfy the requirements of the Federal Sentencing Guidelines, the Department of Health and Human Services and the regulations of the Office of the Inspector General. The Trust Program provides a framework for action within Harmony Health Plan of IL/WellCare Health Plans, Inc. and is a pre-requisite to achieving business goals.

o. Confidentiality

All QI program documents, including meeting minutes of the Quality Improvement Committees and Subcommittees and results of the review of medical records and clinical studies, are subject to the Company's policies and procedures for handling confidential information.

p. Delegation

Delegation occurs when the health plan gives another entity the authority to perform administrative and/or clinical functions on behalf of the health plan. Functions that may be delegated include authorizations, Case Management, concurrent review, credentialing, network development, quality improvement, etc.

While authority to perform a function may be delegated to an entity, the health plan is responsible for ensuring the entity's compliance with internal standards and requirements, as well as federal, state, and accreditation standards. The functional areas perform rigorous oversight of each entity to which administrative/clinical functions have been delegated. Oversight activities include but are not limited to:

   1) Pre-delegation site visits
   2) Thorough evaluation of the entity's programs, policies, procedures, and service delivery capabilities
   3) Annual audits (at a minimum)
   4) Evaluation of corrective actions, where applicable

q. Regulatory Compliance

Policies, procedures, committees, reporting and quality initiatives insure that the Plan will comply with local, state and federal quality improvement requirements as outlined (but not limited to the items below):

- The plan shall have an ongoing quality improvement program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its Medicaid population.
- The plan's written policies and procedures shall address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement, evaluation of enrollees' health care needs, and effective action to promote quality of care.
- The plan shall define and implement improvements in processes that enhance clinical efficacy, provide effective utilization, and focus on improved outcome management achieving the highest level of success.
- The plan and its quality improvement program shall demonstrate in their care management how specific interventions better manage the care and impact healthier patient outcomes.

The goal shall be to provide comprehensive, high quality, accessible, cost effective, and efficient health care to Medicaid beneficiaries.

- The plan shall provide a written descriptive QI program that identifies staff specifically trained to handle the Medicaid business and delineates how staffing is organized to interact and resolve problems, define measures and expectations, and demonstrate the process for decision making (ie: project selection, interventions) and reevaluation.
- The plan shall cooperate with the State and External Quality Review Organization (EQRO) vendor. The State will set methodology and standards for QI performance improvement with advice from the EQRO. Prior to implementation, the State and/or the EQRO shall review and approve the QI program. If the plan has submitted and received approval for the present calendar year, an extension may be granted for the submission of new projects.

The quality improvement program shall be based on the minimum requirements listed below.

a) The plans QI governing body shall monitor, evaluate, and oversee results to improve care. The governing body shall have written guidelines and standards defining their responsibilities for:
   - Supervision and maintenance of an active QI committee,
   - Ensuring ongoing QI activity coordination with other management activity, demonstrated through written, retrievable documentation from meetings or activities,
   - Planning, decisions, interventions, and assessment of results to demonstrate coordination of QI processes,
   - Oversight of QI program activities, and
   - A written diagram that demonstrates the QI system process.

b) The plan shall have a quality improvement review authority which shall:
   - Direct and review quality improvement activities,
   - Assure that quality improvement activities take place throughout the plan;

- Review and suggest new or improved quality improvement activities;
- Direct task forces/committees in the review of focused concern;
- Designate evaluation and study design procedures;
- Publicize findings to appropriate staff and departments within the plan;
- Report findings and recommendations to the appropriate executive authority; and
- Direct and analyze periodic reviews of member's service utilization patterns.

c) The plan shall provide for quality improvement staff specifically trained to handle the Medicaid business which have the responsibility for: identifying their Medicaid beneficiaries' needs and problems related to quality of care for covered health care and professional services, measuring how well these needs are met, and improving processes to meet these needs. The plan shall evaluate ways in which care is provided, identify outliers to specific indicators, determine what shall be accomplished, ascertain how to determine if a change is an improvement, and initiate interventions that will result in an improved quality of care for covered health care and professional services. The plan shall prioritize problem areas for resolution and design strategies for change; implement improvement activities and measure success.

d) The systematic process of quality assessment and improvement shall be objective in systematically monitoring and evaluating the quality and appropriateness of care and services delivery (or the failure of delivery) to the Medicaid population through quality of care projects and related activities. Opportunities for improvement shall be on an ongoing basis. The plan shall assess, evaluate, decrease inappropriate care, decrease inappropriate service denials, and increase coordination of care. The plan shall document in its QI program that it is monitoring the range of quality of care across services and all treatment modalities. This review of the range of care shall be carried out over multiple review periods and not only on a concurrent basis.

e) At least 3 State-approved quality-of-care projects must be performed by the plan. Each study/project must include a statistically significant sample of Medicaid lives. The plan shall provide notification to the State prior to implementation. The notification shall include the general description, justification, and methodology for each project and document the potential for meaningful improvement. The plan shall report at least annually to the State. The report shall include the current status of the project, including but not limited to goals, anticipated outcomes, and ongoing interventions. The results shall be reported no less than annually. Each project shall have been through the plan's quality process, including reporting and assessments by the quality committee and reporting to the board of directors:

f) Pursuant to 42 CFR 438.240, the project shall focus on clinical care and non-clinical areas (i.e. health services deliver). These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. The Centers for Medicare and Medicaid Services (CMS), in consultation with states and other stakeholders, may specify performance measures and topics for performance improvement projects. If CMS specifies performance improvement projects, the plan will participate and this will count towards the State-approved quality-of-care projects. Each

individual CMS project can be counted as one of the State-approved quality of care projects. The quality-of-care projects used to measure performance improvement projects shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall:

1. Target specific conditions and specific health service delivery issues for focused individual practitioner and system-wide monitoring and evaluation.

2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions.

3. Use appropriate quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

4. Implement system interventions to achieve improvement in quality.

5. Evaluate the effectiveness of the interventions.

6. Provide sufficient information to plan and initiate activities for increasing or sustaining improvement.

7. Monitor the quality and appropriateness of care furnished to enrollees through focused utilization, disease and case management programs. (Enrollees include all age groups, disease categories, special risk and special health care needs as identified by HFS, Providers, Health Services, Member Services, Enrollee self referral etc.)

8. Reflect the population served in terms of age groups, disease categories, and special risk status.

9. Ensure that appropriate health professionals analyze data.

10. Ensure that multi-disciplinary teams will address system issues.

11. Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal or benchmark.

12. Identify and use quality indicators that are measurable and objective.

13. Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis.

14. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

The plan's quality improvement information shall be used in such processes as re-credentialing, re-contracting, and annual performance ratings of individuals. It shall also be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member grievances. There shall also be a link between other management activities such as network changes, benefits redesign, medical management systems (e.g., pre-certification), practice feedback to physicians, patient education, and member services.

The plan's quality improvement program shall have a peer review component with the authority to review practice methods and patterns of individual physicians and other health care professionals, morbidity/mortality, and all grievances related to medical treatment; evaluate the appropriateness of care rendered by professionals; implement corrective action when deemed necessary; develop policy recommendations to maintain or enhance the quality of care provided to Medicaid enrollees; conduct a review process which includes the appropriateness of diagnosis and subsequent treatment, maintenance of medical records requirements, adherence to standards generally accepted by professional group peers, and the process and outcome of care; maintain written minutes of the meetings; receive all written and oral allegations of inappropriate of aberrant service; and educate recipients and staff on the role of the peer review authority and the process to advise the authority of situations or problems.

Quality improvement activities have the following (but are not limited to) characteristics consistent with the following local, state and federal Guidelines excerpt:
Important problems or concerns in the care of patients are identified. Sources of identifiable problems include, but are not limited to:

1) Unacceptable or unexpected results of ongoing monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, prescribing errors for medications, specific diagnoses, and so forth
2) the clinical performance and practice patterns of health care practitioners
3) medical record review for quality of care and completeness of entries
4) other professional and technical services provided
5) assessment of patient satisfaction
6) direct observation
7) staff concerns
8) accessibility
9) medical/legal issues
10) wasteful practices
11) over utilization and under utilization

The frequency, severity, and source of suspected problems or concerns are evaluated. Health care practitioners participate in the evaluation of identified problems or concerns.

Measures are implemented to resolve important problems or concerns that have been identified. Health care practitioners as well as administrative staff participate in the resolution of the problems or concerns that are identified.

The problems or concerns are reevaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, alternative corrective actions are taken as needed to achieve and sustain improvement.

Through the organization's designated mechanisms, quality improvement activities are reported, as appropriate, to the proper personnel, the chief executive officer, and the governing body.

Findings of quality improvement activities are incorporated into the organization's educational activities.

Appropriate records of quality improvement activities are maintained.

Organizations will have a process in place to review key indicators in comparison with other similar organizations. This comparison could be a "report card" detailing performance or outcome measures appropriate to the organization. The organization will utilize standardized minimum data sets to facilitate comparison of data and information within and among organizations.

The organization's performance improvement system should include, but is not limited to:

1) Use of selected indicators based on systematic, ongoing collection and analysis of reliable data
2) Measure changes in performance related to measure/indicators
3) Use of collected data that reflects performance of practitioners/providers who serve the enrollees/patients and reflect the care requirements of the patient served
4) The capacity to demonstrate and sustain significant improvement
5) Use of benchmarks that are based on state, local or national standards
6) A reduction in gaps over time from benchmark norms.

AHCA and CMS have the right to view all documents relating to quality assessment and improvement activities.

X.   Quality Improvement Work Plan
Annually the Quality Improvement Department develops a Quality Improvement work plan for the upcoming year. The work plan integrates QI reporting and studies from all areas of the organization, and includes requirements for external reporting.

The work plan includes the following elements:
1) Documents a written measurable objective for each QI activity planned
2) Includes an attachment of all clinical care and service indicators, benchmarks, performance goals and previous year results
3) Schedules of reporting to Board of Directors and QIC
4) Schedules of reporting to outside regulatory agencies
5) Includes the department responsible for implementation and management, initiation date, timeframe, monthly updates and the targeted completion date
6) The work plan is approved by the Board of Directors and QIC

XI.   Quality Improvement Annual Evaluation
The Quality Improvement Program Description and Work plan determine the program structure and activities for a period of one calendar year.   At least annually the Quality Improvement Department will facilitate a formal evaluation of the QI Program Description and Work plan.

The annual evaluation will identify the outcomes and includes the following areas:
1) Identifies the Board of Directors' oversight and evaluation of the QIC, the effectiveness of the QI structure, and the organizational structure that supports the implementation of QI activities.
2) Evaluates and identifies the results, barriers, improvements and plans for the upcoming year.
3) Evaluates the resources, training, scope and content of the program and provider participation.
4) Is developed with participation and support from the Corporate Quality Improvement Department

5) Identifies quantifiable improvements in care and service
6) Identifies limitations of the program and recommendations for the upcoming year.
7) The evaluation is presented to the QIC and Board of Directors for final approval and recommendations.

WellCare Health Plans, Inc.
The WellCare Group of Companies
WELLCARE OF FLORIDA, INC. ♦ COMPREHENSIVE HEALTH MANAGEMENT, INC. ♦ HEALTHEASE OF FLORIDA, INC.
WELLCARE OF NEW YORK, INC. ♦ WELLCARE OF CONNECTICUT, INC. ♦ HARMONY BEHAVIORAL HEALTH, INC.
HARMONY HEALTH PLAN OF ILLINOIS, INC. ♦ WELLCARE OF LOUISIANA, INC.
WellCare of Georgia, Inc. ♦ WellCare Prescription Insurance, Inc.

Signature Page
Quality Improvement Program Description 2007 - 2008

Approved by the Medical Advisory Committee on   Date: _____

Approved by the Quality Improvement Committee on   Date: _____

Approved by the Board of Directors on   Date: _____

Approved: _____   Date: _____
       (Medical Director, Quality Improvement)

Approved: _____   Date: _____
       (Senior Vice President, Health Services)

Approved: _____   Date: _____
       (President, CEO)

POPULATION CHARACTERISTICS

Population Characteristics

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

In 2006, HealthCare USA saw a continuing decline in membership related to the significant changes of Missouri's Medicaid program in 2005. As of December 31, 2006, HealthCare USA's total membership was 150,748. This includes 10 counties in the Eastern region with a membership of 119,545. The Central region totaled 18 counties with a membership of 20,824. The Western region included 9 counties with a membership of 10,379.

HealthCare USA experienced a significant jump in membership in the Western region with the purchase of FirstGuard in February, 2007. The membership purchase accounted for an increase of 30,000 plus members. As of June 30, 2007, HealthCare USA's total membership was 175,699. This includes 118,721 members in the Eastern region, 20,171 members in the Central region and 36,807 members in the Western region. HealthCare USA's membership continues to be comprised of children (84.8% are 21 years of age and under) and pregnant women.

Race/Ethnicity
HealthCare USA's Community Development department has established strong partnerships with agencies and organizations dedicated to improving the lives of minority cultures and disparate populations in Missouri. Some of the agencies are: Black Health Care Coalition, Coalition of Hispanic Organizations, Hispanic Chambers of Commerce, Mexican Consulate, Urban League, Black Leadership Roundtable, NAACP, Caring Communities and Clergy Coalition.

Some of the ethnic events that HealthCare USA has either sponsored or participated in include:
- National Urban League Conference
- Greater St. Louis Hispanic Festival
- Festival of Nations
- Fiesta in Florissant
- Fiesta Hispanica
- Fiesta in the Heartland
- Better Family Life Resource Fair
- Black History Family Health Fair

Not only do we recognize and support ethnic communities within our regions, but we also acknowledge the differences between urban and rural communities. We have strengthened our partnerships in many rural areas by regularly attending monthly community action agency meetings and participating in local events such as:
- Randolph County Back-to-School fair, Moberly, MO
- Children's Parade in Jefferson City
- Baby Shower Osage Health Department, Linn, MO
- Montgomery County PAT Head Start Screening

- Preschool and Kindergarten screening, Jonesburg, MO

Special Needs
Members with special needs continue to be identified primarily by MO HealthNet at the time of enrollment. The majority of members identified are less than 21 years old. Adults who are identified are referred through other sources such as readmissions data or PCP referrals. In 2006, 78% of the special needs members identified were in Eastern Missouri, 12% in Central and 10% in Western. The demographics drastically changed in 2007, when 42% identified were from Western Missouri, 49% from Eastern and 9% from Central. This change was a result of the acquisition of the FirstGuard membership in February 2007.

Languages Identified
HealthCare USA membership is comprised of people speaking languages other than English and those with visual or hearing impairment. The principal languages are English and Spanish as defined by the State contract. Other languages with a significant membership include Vietnamese, Arabic, Chinese Mandarin and Russian (see chart below).

Membership June 2007

Language	Count	Rate
English	115,268	64.36%
Undecided	63,203	35.29%
Spanish	393	0.22%
Vietnamese	101	0.06%
Arabic	61	0.03%
Russian	45	0.03%
Chinese	25	0.01%

This diverse membership requires both translation and interpreter services. HealthCare USA employs some bilingual staff in the customer service department. HealthCare USA provides telephonic and face-to-face translation services throughout all three regions by contracting with the following agencies: Language Access Metro Project (LAMP), Jewish Vocational Services, A-Z Translating Services, and AAA Translation. Interpreter services are provided through Deaf Inter-Link, Deaf Expression, Inc., DEAF Way and International Institute. In the first half of 2007, there were 889 requests for translations, a significant increase from 2006. Of the 2006 requests, 69% were provided face to face and in 2007, 59% were face to face. The breakdown is shown below.

	CY 2005	CY 2006	2007 01-06
ALBANIAN	2	1	0
AMHARIC	0	0	1
ARABIC	14	84	45
BOSNIAN/CROATIAN/SER	33	145	75
CHINESE-CANTONESE	3	5	2
CHINESE-MANDARIN	3	6	3
DARI (AFGANI)	0	179	80

ETHIOPIAN OROMO	1	0	0
FRENCH	0	1	1
HINDI	2	0	0
KOREAN	0	5	0
PERSIAN (FARSI)	2	8	5
RUSSIAN	4	147	24
SOMALI	8	90	45
SPANISH	150	383	503
SWAHILI	0	0	4
TURKISH	0	2	2
URDU	1	1	0
VIETNAMESE	30	175	80
Total	**253**	**1232**	**870**

HealthCare USA's 24-hour nurse hotline employs bi-lingual staff and provides translation services in 150 different languages, as well as support for those needing TTY and Relay services. In addition to 24 hour access to TTY and Relay services, HealthCare USA has the member handbook available in Braille. In 2006 there were 27 instances in which interpretation services were utilized and in the first 2 quarters of 2007, interpretation services were utilized 29 times.

Opt-Outs

In 2006, there were 27 requests for opt outs reported from May through December. 12 were approved, 14 were denied. One was never effective. In Jan – June 2007, there have been 45 requests to opt out. 42 approved for opt out, 3 denied for opt out, 1 pending. Three of these requests were for members who were not effective with HealthCare USA at the time of the request. The reasons for the request were:

	2006	**2007**
Better Benefits	Unavailable	23
Doctor takes FFS	Unavailable	8
Medically Complicated	Unavailable	1
No Information Given	Unavailable	14
Total	27	46

HealthCare USA will continue to track opt out requests in a detailed manner as has been done in 2007 to find ways to better satisfy members needs.

Mercy CarePlus

Race/Ethnicity

All members will be treated equally, fairly and provide covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or mental disability, except where medically indicated.

Special Needs
MCP continues to increase identification and outreach to children with special health care needs. Special Needs members are identified in a variety of ways. The MO HealthNet Division ("MHD") sends an electronic file of children with special health care needs monthly to MCP. The Special Needs Coordinator evaluates the data, and for each member (or parent or guardian) contact is attempted. Members (or parents/guardians) are educated on available benefits and the necessary resources are provided in an effort to prevent complications or unnecessary delays in seeking care.

Another method of identifying children with special needs is via the MCP Utilization Review staff. Hospitalized children who develop special needs through illness, injury or premature birth are identified by UR and referred to the Special Needs Coordinator. The intent of this program is to identify members with special needs, coordinate care and initiate case management services. When multiple needs are identified and coordination of care is required, the Special Needs Coordinator will refer the member to the appropriate Special Needs Case Manager. The Special Needs Case Managers are responsible for the evaluation and management of complicated medical cases, high-risk social situations and those members with unique medical needs.

Languages Identified
Access to care is a key component of creating positive health outcomes. MCP has implemented the following to eliminate barriers to care:
- Member Services bi-lingual translators on site – Bosnian and Spanish
- Community Outreach and Education services
- Translators through LAMP (office) and Language Line (telephone)
- Spanish prompt added to phone tree
- Translated marketing and educational materials

MCP examines opportunities for continuously improving multilingual services offered to its members with English language barriers. MCP tracks data on the volume of members who have been identified as speaking a language other than English. MCP's 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 MCP's practitioner orientation program is education on processes to access interpreters for members.

Opt-Outs
The data below reflects the members who were approved for opt out of MCP as reported to MCP by MHD. MCP will continue to track and manage the member opt out information.

Opt Outs	1QFY07	2QFY07	3QFY07	4QFY07	FYTD
	17	12	8	10	47

Harmony

Race/Ethnicity
- Caucasian – 67%
- African American – 13%
- Hispanic – 14%
- Other – 6%

Special Needs
- Cases Provided - 26
- Cases Outreached – 26

Languages Identified
- English @ 4012
- Hispanic @ 16
- Other 5058

Opt-Outs
- Cases provided and processed according to State protocols

Missouri Care

Race/Ethnicity
The State provides Missouri Care with race and ethnicity data on enrolled members. Missouri Care does not currently utilize this information. This information is not captured in QMACS, our data management system.

Special Needs
Missouri Care recognizes the challenges families with children with special health care needs face when navigating the health care system. These children often have complex medical, social and mental health care needs. Missouri Care is contracted with the University of Missouri Hospitals and Clinics, which has specialists capable of providing a medical home to children with special health care needs. Missouri Care has worked to provide better access to health care services for children with special health care needs. In 2004, Missouri Care brought the management of behavioral health in house. This process allows for the integration of physical and behavioral health and has improved clinical outcomes. Missouri Care recognizes families of children with special health care needs may become lost in the health care system.

Most providers have neither the time nor resources to identify and find these children. Missouri Care, with its sources of data and case management nurses, can reach more families with children with special health care needs than individual providers. Missouri Care uses the following sources of data to identify their target population of children with special health care needs:

- Division of Medical Services monthly file
- Predictive modeling*
- Pharmacy utilization
- Inpatient utilization
- Durable Medical Equipment requests
- ER utilization

Missouri Care utilizes the 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 ongoing physical, emotional, behavioral, developmental or other health condition. By identifying children with special heath care needs early, Missouri Care can help these members obtain access to appropriate services. In addition, Missouri Care continues to contract with MO-PEDS (Missouri Partnership of Enhanced Delivery of Services) to improve the quality of care for rural and underserved children with special health care needs. MO-PEDS utilizes the medical home model of care by increasing the availability of care coordination in 18 counties in central Missouri. In this reporting period, 854 members were identified with special needs as reported by MO HealthNet. Following completion of the CSCHN screener, 256 were enrolled in case management.

*The predictive modeling database is a proprietary database used to identify members likely to be future high utilizers based on claims and diagnostic data. The system determines the member's potential risk level and predicts whether or not case management interventions can effectively improve the member's outcome.

Languages Identified
Missouri Care tracks the number of members who speak a language other than English. In 2006, approximately 2.91 % of members were identified as speaking a language other than English. The majority of these members, 55.02 % identified Spanish as their primary language. Interpreter services are available for all members regardless of their native language, and written materials are available to members in Spanish. Members are informed of these options in the member handbook. Missouri Care also attempt to call all new members. If during a new member call, a member or household identifies Spanish as his/her primary language, a Spanish-translated member handbook is mailed to the member.

Opt-Outs
During SFY07, four opt outs were reported to the health plan by the Department of Medical Services (currently MO HealthNet). Three of the opt outs were disenrolled from the plan and one was disenrolled prior to enrollment. The reasons for disenrollment were: doctor takes straight Medicaid, better benefits, and no reason or non-classified reason given.

Blue Advantage Plus

Race/Ethnicity

BA+ is sensitive to the ethnic composition of its members. The following table illustrates the membership ethnicity. BA+ does not vary in cultural and ethnic membership compared to the general population demographics of the Kansas City Metro Area.

Race	Count	% of Total
White (Non-Hispanic)	16,869	60%
Black (Non-Hispanic)	10,090	36%
Asian or Pacific Islander	220	1%
Hispanic	327	1%
Other/Unidentified	780	3%
TOTAL	28,286	100%

Special Needs

The BA+ Special Programs Coordinator coordinates the flow for referrals made by the MO HealthNet Division for members with Special Health Care Needs, Lead Case Management and Consent Decree. BCBSKC has a policies and procedures that outline the processes followed. The process has been enhanced by incorporating reporting and assessment protocols that identifies more information about the special needs member. 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. Referrals are made as needed to New Directions Behavioral Health, the High Risk Prenatal program and the Asthma Disease State Management program.

Utilizing the Special Health Care Needs data to identify members with Special Health Care Needs is a requirement of MHD. 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.

Special Needs Statistics

Members in Lead Case Management	FY2007
Lead Level 0-14	36
Lead Level over 15	0
Consent Decree	869
Modified Consent Decree	465
Special Health Care Needs Children	
Number on list	582
Number referred for case management assessment	14

Languages Identified

During the BA+ enrollment process, each member's primary language is identified. BA+ provides interpretation services to assist members in communicating with BA+. The use of the AT&T language line provides an alternative for communication when language differences exist. Ongoing monitoring of the language line usage provides a mechanism for evaluating significant differences in BA+ member's needs.

Measurement is conducted on a quarterly basis to determine what languages are spoken by members. The following is an analysis of the information provided through the State Eligibility File transmission. Even though we have not exceeded the contract requirement of 200 members or five percent of membership who speak a single language other than English as a primary language (contract requirement 2.8.2), BA+ does provide some materials in Spanish.

Language Spoken

	3Q06	4Q06	1Q07	2Q07
Blank	9225	9611	10055	10440
American	10	4	8	8
Arab	0	0	0	0
Chinese	2	2	2	2
English	16553	15167	14794	15090
No Response	0	0	0	0
Other	2878	2035	1639	1381
Polish			1	1
Russian			1	1
Spanish	116	107	99	111
Vietnamese	22	18	20	23
Total	28806	26944	26619	27057

Opt-Outs

According to the termination information provided by the State of Missouri Division of Medical Services, nine members opted out of BA+ for SSI in FY2007.

Children's Mercy Family Health Partners

Languages Identified

Children's Mercy Family Health Partners (CMFHP) membership consists of individuals who have a variety of primary languages. The following is a breakdown of our membership in 2005 and 2006 and the primary languages spoken:

Language	2005 Members	2006 Members
American Sign	25	28
Arabic	35	18
Chinese	5	6
Cambodian	2	1
English	44,173	41,778
Haitian	0	2
Polish	0	0
Russian	2	2
Spanish	1,285	1,593
Tagalog	10	24
Vietnamese	69	61
Other	228	184
TOTAL	45,834	43,697

Summary by language of translation services:

Based on the numbers above, CHFHP has a large Hispanic population. CMFHP has five full time Hispanic Customer Service representatives who are available from 7am to 6pm (Monday through Friday) to assist the Hispanic community. CMFHP also employs a full time Hispanic Community Outreach Representative who answers questions and provides outreach activities to those who are prospective members. This representative can also provide back-up to Customer Service in answering questions for members.

CMFHP also has access to the AT&T language line that can be used to assist non-English speaking members with translation services.

In 2005 and 2006, CMFHP did not identify anyone who needed communication accommodations outside of the services described above.

Summary of services to members with visual or hearing impairments or disabilities:
Children's Mercy Family Health Partners utilizes access to a toll free TDD line. When requested, copies of printed materials are provided via cassette or in large print versions.

Inventory by language of member materials translated:
The following materials are provided in English and Spanish:

- Quarterly member newsletter (Connection)
- Financial guideline cards
- Member brochures
- Non-Emergency Transportation brochure
- Member Handbook
- CMFHP information handout
- First Touch OB Case Management brochure

Inventory of member materials available in alternative formats:
CMFHP utilizes access to a toll free TDD line. When requested, copies of printed materials are provided via cassette or in large print versions.

Summarization of grievances regarding multilingual issues:
During 2005 and 2006, CMFHP had one reported incident regarding multilingual issues. The incident involved a member who had scheduled an appointment at the Teen Clinic at Children's Mercy Hospital. The mother was upset that the staff may not have understood her because of her Hispanic accent. The concern was resolved by having the Teen Clinic contact the mother and apologize for any misunderstanding. The Office Manager assured CMFHP and the member that language was not a problem, as the Teen Clinic has several Hispanic staff members working at the front desk.

Race/Ethnicity
Race and Ethnicity are not data elements that we receive in our data from the State, therefore we are unable to report on race and ethnicity.

Special Needs
CMFHP has dedicated a full-time Outreach Coordinator to identify and screen our Special Health Care Needs population. In 2006 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
2006	1,093	3	1,093	268

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.

Opt-Outs

In 2005, CMFHP had 17 members opt out of CMFHP. In 2006, we also had 17 members opt out. The following describes the types of "Opt Outs" for these 2 years:

	2005	**2006**
DSS Opt-Out	1	0
Alternative Care Opt-Out	2	13
SSI Opt Out	14	4
Total	**17**	**17**

Quality Indicators

Quality Indicators

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Performance Measures

HealthCare USA continues to calculate the MO HealthNet Managed Care Performance Measures as required by the State contract. The measures are calculated and reported in accordance with NCQA specifications. Reported measures are calculated using NCQA certified software and results are audited by an NCQA certified auditor. HEDIS rates were reported for Central, Eastern, and Western Missouri. This analysis will include both HEDIS 2006 and 2007 results since the 2005 Annual Evaluation only contained HEDIS 2005 results.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. To ensure the validity of results, all data are rigorously audited by independent, certified auditors using a process designed by NCQA. HEDIS data collection and reporting process is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service and reliably compare the performance of health care plans.

HEDIS is utilized as a means of evaluating the effectiveness of quality indicators and to determine interventions needed to improve the health of current and future members. The goal of HealthCare USA is to meet and exceed the National and State Medicaid average each year. Several improvement processes have been implemented in order to improve the HEDIS results over the past two years.

HealthCare USA developed an interdepartmental committee that meets monthly to discuss EPSDT and HEDIS measures. The committee analyzes results and brainstorms ideas to improve each indicator, including revising education to our membership to increase compliance for wellness and education programs for providers on HEDIS measures and initiatives for improvement.

HEDIS results and initiatives are also reported to the Quality Management Committee, Executive Quality Committee, and Board of Managers. Feedback from these committees, which includes network providers, is requested.

HealthCare USA recognizes the challenges presented in our Western region. The membership is newer to the plan and the area is more rural. Therefore, HealthCare USA has been focusing initiatives in the Western region. These initiatives include health fairs for wellness screening, focused member education, and member incentives.

Childhood and Adolescent Immunizations
Medical record review was utilized starting in HEDIS 2006 in order to obtain the most accurate rates and will continue through 2008. HealthCare USA continues EPSDT and immunization reminders for children and adolescents.

In Spring 2007, a member incentive focus study program was initiated in an attempt to increase the rates of adolescent immunizations and the accuracy of the data. The program was piloted in the western region because this region has the most opportunity for improvement. A member receives a $15 Target gift card when a complete immunization record, signed by their provider, is mailed to HealthCare USA. The goal is to increase the rate of adolescent immunizations in the Western region.

Cervical Cancer Screening
HealthCare USA uses Coventry Health Care's member reminder system to assist in educating eligible members regarding cervical cancer screening and Pap smears via the flyer "Staying Healthy: A Guide For Women." The recipients are all members who meet HEDIS specifications for cervical cancer screening but are non-compliant. This mailing began in 2006 and continues bi-annually. Members are also educated at least once per year in the member newsletter. The audience for the newsletter is all members.

Chlamydia Screening
HealthCare USA began a performance improvement project in 2006 which addressed provider and member education regarding chlamydia. An educational flyer, "Staying Healthy: A Guide to Women" is sent to all non-compliant, eligible members once per year as prompted through Coventry's member reminder system. Members are also educated at least once per year in the member newsletter.

Mental Health Follow Up Within 7 and 30 Days
HealthCare USA has worked with MHNet in their implementation of a performance improvement project to address follow up after discharge. This project is active and will be reflected in HEDIS 2008.

Use of Appropriate Medications for People with Asthma
HealthCare USA has continued to strive for improvement through planning in 2007 of a member incentive focus study to entice members to see their PCP, their school nurse or other support person, and their pharmacy. In addition, asthma case management was re-evaluated and developed into a disease management program. Members with asthma are stratified by several indicators into severity categories. This allows for more focus and intensity on the members with asthma who have the greatest risk for adverse outcomes including morbidity and mortality.

Annual Dental Visit
HealthCare USA has been pro-active in providing dental care to our members. During back to school fairs and at dental fairs, dental assessments have been conducted by a hygienist. Any members identified as needing additional interventional services of a dentist are called by Customer Service Representatives shortly after the fair and assisted in locating a dentist. Transportation is also arranged when necessary.

Well Child Visits
HealthCare USA continues to send proactive reminders to members about EPSDT visits, and sending retrospective reminders for those not numerator compliant. HealthCare USA is an integral partner and leader in the State-wide initiative to improve adolescent well care.

Prenatal and Postpartum
HealthCare USA's utilized a method of acquiring dates of prenatal visits from internal referral data. Medical record review was utilized for HEDIS 2007 to garner the most accurate reflection of our rates. A maternity incentive plan is being piloted in the Eastern region to encourage women to schedule and keep their prenatal and postpartum appointments. Reflection of the member incentive plan will be seen in HEDIS 2008.

Another intervention is a focus study in the Central and Western regions that provide a bill-above for any provider who submits a claim for a postpartum visit. The belief is providers are not submitting claims for postpartum visits because the postpartum visit is part of the global authorization. Reimbursing the provider for submitting the postpartum visit claim enables HealthCare USA to access the data and "thanks" the provider for their effort. Results of this project will be available in 2008.

Emergency Department Visits
HealthCare USA has developed a Performance Improvement Project for Emergency Department (ED) utilization for non-emergent and avoidable reasons. This PIP identifies those with 3 or more visits to the ED with a non-emergent diagnosis code in a 6 month time period. These members are reviewed for possible case management or disease management needs. An educational flyer is mailed to each member. This flyer has information on first aid topics such as how to treat minor cuts and scrapes to how to take a temperature. Each first aid topic also includes suggestions on when to consult a PCP or seek immediate care.

2007 HEDIS Results

Eastern Region	Medicaid Average			
Measure	**2006**	**2007**	**2006**	**2005**
Effectiveness of Care				
Childhood Imms Combo 2	70.36%	64.12%↑	41.53%↑	14.96%
Adolescent Imms Combo 2	42.35%	57.64%↑	39.58%↑	3.16%
Cervical CA Screening	65.03%	70.79%	71.43%	66.33%
Chlamydia Screening	49.13%	69.14%↑	62.70%↓	64.56%
MH-Follow Up Within 30 Days	56.7%	48.89%	49.25%	49.53%
MH-Follow Up Within 7 days	39.18%	26.75%	28.28%	29.79%
Access/Availability of Care				
Asthma Meds-Combo	85.71%	86.43%	85.51%↑	64.36%
Annual Dental Visit	42.70%	32.52%↑	29.81%↓	30.30%
WCV Ages 3-6	63.32%	59.78%	58.84%↑	57.62%
Adolescent WCV	40.55%	36.49%↑	35.55%↑	34.01%

WCV 1st 15 mos-6 or more	48.61%	43.76%↑	40.76%↑	38.68%
Prenatal	79.07%	80.09%↑	52.66%↑	49.94%
Postpartum	56.99%	52.78%↑	37.00%↑	34.04%
Utilization				
MH Utilization-% Members Receiving Any Services		6.03%	5.93%	5.95%
Identification of Alcohol & Other Drug Services-Any CD Services		0.77%	0.81%	0.78%
Ambulatory Care				
Outpatient Visits/1000 mbr mos		223.0	214.30	208.15
ED Visits/1000 mbr mos		69.57	62.56	58.10
Surgery-Procedures/1000 mbr mos		3.48	3.50	3.05
Obs Room Stays Resulting in Discharge/1000 mbr mos		2.52	3.47	3.21

↓↑Indicates a statistically significant change from the previous year's plan result.

Childhood and Adolescent Immunizations both showed a statistically significant increase for each year from the previous year's results.

The Cervical Cancer Screening 2006 result increased from 2005, but the 2007 result was decreased. All three years were above the 2006 Medicaid average.

The Chlamydia Screening rate decreased significantly from 2005 to 2006, but remained above the 2006 Medicaid average. The 2007 result increased significantly from 2006.

Mental Health Follow Up Within 7 and 30 Days has remained fairly stagnant since 2005, but the 7 day rate has shown a decline of about 3% over the past few years

Use of Appropriate Medications for People with Asthma increased dramatically from 2005 - 2006, however there was a technical specification change in the measure that yields the data incomparable.

The 2007 Annual Dental Visit rate showed a statistically significant increase in rates of annual dental visits.

There was statistically significant improvement in Well Child Visits in the first 15 months of life and ages 3 to 6 from 2005 to 2006. The 2007 rates are significantly improved again in the first 15 months of life, 6 or more visits.

Adolescent Well Child Visits showed statistically significant improvement both years.

Prenatal and Postpartum rates in 2006 showed a significant improvement, and 2007 showed a dramatic improvement.

Central Region	Medicaid Average			
Measure	**2006**	**2007**	**2006**	**2005**
Effectiveness of Care				
Childhood Imms Combo 2	70.36%	71.30%↑	23.38%↑	34.91%
Adolescent Imms Combo 2	42.35%	28.01%↑	15.74%↑	1.95%
Cervical CA Screening	65.03%	68.01%	70.34%↑	67.30%
Chlamydia Screening	49.13%	55.20%↑	44.75%	47.50%
MH-Follow Up Within 30 days	56.77%	56.38%	60.54%	58.72%
MH-Follow Up Within 7 days	39.18%	29.53%	34.69%	38.37%
Access/Availability of Care				
Asthma Meds-Combo	85.71%	85.67%	86.08%↑	70.09%
Annual Dental Visit	42.70%	32.73%↑	25.05%↑	22.41%
WCV ages 3-6	63.32%	61.34%	61.59%↑	55.96%
Adolescent WCV	40.55%	39.06%↑	36.19%↑	33.46%
WCV 1st 15 months-6 or more	48.61%	72.65%↑	68.53%↑	59.85%
Prenatal	79.07%	92.07%↑	53.82%	50.43%
Postpartum	56.99%	69.00%↑	51.11%	52.85%
Utilization				
MH Utilization-%Members Receiving Services-Total		8.77%	8.82%	8.96%
Identification of Alcohol & Other Drug Services: Total		1.00%	0.96%	0.94%
Ambulatory Care				
Outpatient Visits/1000 mbr mos		354.89	349.14	332.20
ED Visits/1000 mbr mos		76.62	70.62	67.40
Surgery-Procedures/1000 mbr mos		5.03	5.55	5.26
Obs Room Stays Resulting in Discharge/1000 mbr mos		2.02	4.64	5.07

↓↑Indicates a statistically significant change from the previous year's plan result.

Both Childhood and Adolescent Immunizations showed a statistically significant increase for each year from the previous year's results.

The 2006 Cervical Cancer Screening result increased from 2005, but the 2007 rate declined. All three years were above the 2006 Medicaid average.

The Chlamydia Screening rate decreased from 2005 to 2006, but increased a statistically significant amount in 2007.

Mental Health Follow Up Within 7 and 30 Days has shown a decline over the past few years.

The rate of Use of Appropriate Medications for People with Asthma rate from 2005 to 2006 increased dramatically and the 2007 rate has remained stagnant. However, there were changes in the specifications that make the data not comparable.

The 2006 and 2007 Annual Dental Visit showed a statistically significant increase in rates from the previous year's result.

There was statistically significant improvement in Well Child Visits the first 15 months of life over both years, and Well Child visits ages 3 to 6 from 2005 to 2006.

Adolescent Well Child Visits has shown statistically significant improvement both years.

Prenatal and Postpartum rates showed a dramatic improvement in 2007 in both timeliness of prenatal care and postpartum visits.

Western Region	Medicaid Average			
Measure	2006	2007	2006	2005
Effectiveness of Care				
Childhood Imms Combo 2	70.36%	66.44%↑	**59.79%↑**	22.01
Adolescent Imms Combo 2	42.35%	26.42%↑	**18.59%↑**	1.23
Cervical CA Screening	65.03%	53.74%↓	55.96%	52.35
Chlamydia Screening	49.13%	59.22%	54.07%	53.96
Asthma Meds-Combo	85.71%	80.28%	86.79%↑	56.92
MH-Follow Up Within 30 Days	56.77%	53.85%	41.67%	42.22
MH-Follow Up Within 7 Days	39.18%	28.21%	20.83%	24.44
Access/Availability of Care				
Annual Dental Visit	42.70%	25.46%↑	23.19%	21.77
WCV ages 3-6	63.32%	49.79%	47.50%↑	41.65
Adolescent WCV	40.55%	24.35%	23.67%	22.20
WCV 1st 15 Months-6 or More	48.61%	43.72%↑	32.11%	27.06
Prenatal	79.07%	90.74%↑	40.58%	38.32
Postpartum	56.99%	65.05%↑	34.42%	29.26
Utilization				
MH Utilization-% Members Receiving Services-Total		3.47%	3.17%	3.67%
Identification of Alcohol & Other Drug Services-Any CD Services		0.86%	1.01%	0.76%
Ambulatory Care				
Outpatient Visits/1000 mbr mos		290.40	273.66	235.95
ED Visits/1000 mbr mos		86.17	60.67	58.88
Surgery-Procedures/1000 mbr mos		3.76	3.50	2.83
Obs Room Stays Resulting in Discharge/1000 mbr mos		2.37	1.78	1.89

↓↑Indicates a statistically significant change from the previous year's plan result.

Childhood and Adolescent Immunizations both showed a statistically significant increase for each year from the previous year's results.

The 2006 Cervical Cancer Screening rate increased from 2005, but the 2007 result was decreased. All three years were above the 2006 Medicaid average.

Chlamydia Screening decreased from 2005 to 2006 but the 2007 rate increased a statistically significant amount.

Mental Health Follow Up Within 7 and 30 Days has shown a decline over the past few years.

Use of Appropriate Medications for People with Asthma increased from 2005 to 2006 increased, and the 2007 rate has remained stagnant. However, the specifications were changed making the rates incomparable.

2007 Annual Dental Visit showed a statistically significant increase in rates.

There was statistically significant improvement in Well Child Visits the first 15 months of life over both years, and ages 3 to 6 from 2005 to 2006.

Adolescent Well Child Visits showed statistically significant improvement both years.

The Prenatal and Postpartum showed a dramatic improvement in 2007 versus 2006 for both timeliness of prenatal care and postpartum visit.

CAHPS Summary

HealthCare USA utilized the NCQA developed CAHPS Survey to measure the satisfaction of the membership in each of the three regions across Missouri. DSS Research conducted this survey for HealthCare USA and has done so for the past several years, making comparisons between the years easily available. DSS Research also makes available a comparison between the current year results and the previous years Medicaid average. An analysis and final report is developed by DSS Research upon completion of the survey.

The survey is mailed to parents of those members 17 years and younger who have been continuously enrolled in the plan for at least 5 of the last six months of the measurement year. HEDIS specifications for survey measures were followed for the data collection. A possible total of two mailers, each followed by a reminder postcard, were sent to each member. Fifty-six days after the second reminder postcard was mailed and no response was received, telephone interviewing was initiated. A total of 81 days was allowed to collect all completed surveys.

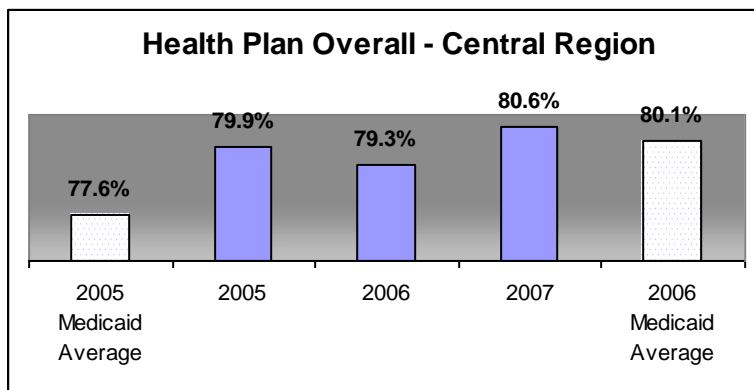*Eastern Region*
For 2006, a sample of 604 members was obtained in which the overall sampling error ±4.0% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 37.6%.

For 2007, a sample of 561 members was obtained in which the overall sampling error is $\pm$ 4.1% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 34.8%.

Results for Health Plan Overall
The Health Plan Overall was higher than the 2005 results and significantly higher than the 2005 Medicaid average. In 2007, the results were lower than 2006, but higher than the 2006 Medicaid average.
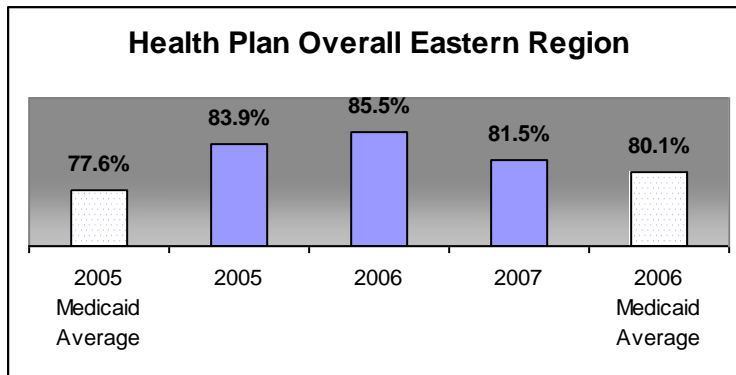
Health Plan Overall Eastern Region

|				
77.6%	83.9%	85.5%	81.5%	80.1%
2005 Medicaid Average	2005	2006	2007	2006 Medicaid Average

Source: CAHPS 2007 Results compiled by DSS Research

Although all survey measures drive the overall health plan rating, customer service and complaints are directly under the health plan's control. For 2006 and 2007, the customer service composite score average increased and was significantly above the Medicaid average.

For 2006, the reported complaint/problem resolution within 7 days increased and was above the 2005 Medicaid average, and the satisfaction with complaint/problem resolution decreased from the previous year but remained above the 2005 Medicaid average.

For 2007, the customer service composite score average increased from 2006 and was significantly above the 2006 Medicaid average. The percentage of reported complaints or problems increased from last year and is above the 2006 Medicaid average. The reported complaint problem resolution within 7 days decreased from 2006 and is below the 2006 Medicaid average. Satisfaction with complaint/problem resolution decreased from last year and is below the 2006 Medicaid average.

Health Care Overall
Health Care Overall for 2006 is higher than the 2005 results and was significantly higher than the 2005 Medicaid average. The 2007 results were significantly lower than the 2006 results and lower than the 2006 Medicaid average.
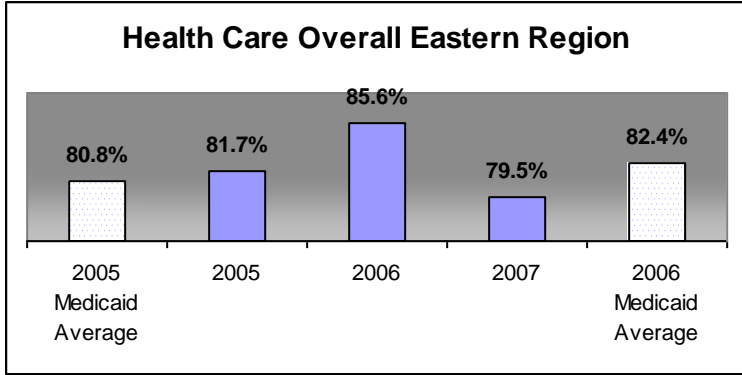
Health Care Overall Eastern Region

80.8%	81.7%	85.6%	79.5%	82.4%
2005 Medicaid Average	2005	2006	2007	2006 Medicaid Average

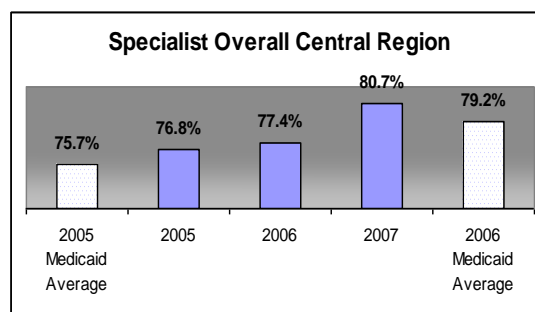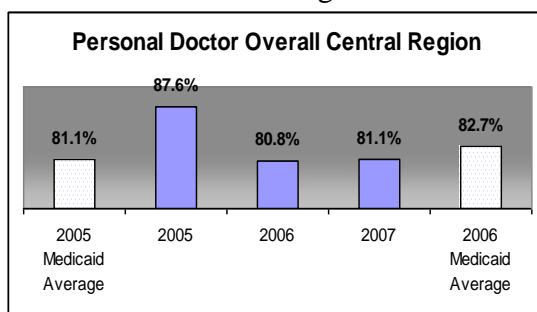Source: CAHPS 2007 Results compiled by DSS Research

Getting needed care and getting care quickly heavily influence overall health care ratings.

For 2006, the getting needed care composite score increased from 2005 and is above the 2005 Medicaid average. For 2007, the getting needed care composite score decreased from 2006 and is below the 2006 Medicaid average. The greatest opportunity for improvement revolves around seeing a specialist.

For 2006, the getting care quickly composite score increased from last year and is above the 2005 Medicaid average. For 2007, the getting care quickly composite score average increased from 2006 and is above the 2006 Medicaid average. The greatest opportunity for improvement revolves around being taken to the exam room within 15 minutes of appointment.

Personal Doctor Overall and Specialist Overall
The Personal Doctor Overall rating for 2006 was higher than 2005 and higher than the 2005 Medicaid average. The 2007 rating is lower than last year and significantly lower than the 2006 Medicaid average. The Specialist Overall rating for 2006 is higher than the 2005 rating and higher than the 2005 Medicaid average. The 2007 rating is lower than last year and significantly lower than the 2006 Medicaid average.

Personal Doctor Overall Eastern Region

81.1%	82.5%	83.5%	78.7%	82.7%
2005 Medicaid Average	2005	2006	2007	2006 Medicaid Average

Specialist Overall Eastern Region

75.7%	77.1%	78.4%	70.7%	79.2%
2005 Medicaid Average	2005	2006	2007	2006 Medicaid Average
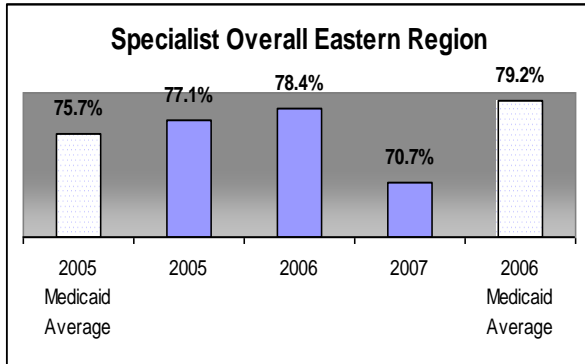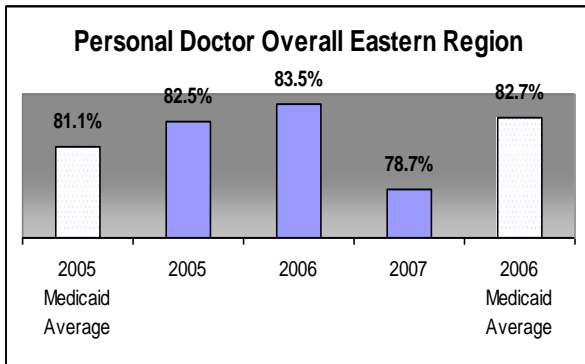
Source: CAHPS 2007 Results compiled by DSS Research   Source: CAHPS 2007 Results compiled by DSS Research

How well doctors communicate and courteous and helpful office staff heavily influence personal doctor and specialist ratings.

For 2006, how well doctors communicate composite score decreased from 2005 but was significantly above the 2005 Medicaid average. For 2007, how well doctors communicate composite score decreased from 2006 and was below the 2006 Medicaid average. The greatest opportunity for improvement in the composite revolves around doctors spending enough time with patients.

For 2006, the courteous and helpful office staff composite score average increased from the prior year and is significantly above the 2005 Medicaid average. The 2007 score decreased from last year and is below the 2006 Medicaid average. The greatest opportunity for improvement revolves around doctors having helpful office staff.

Central Region
For 2006, a sample of 632 members was obtained in which the overall sampling error ±3.9% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 39.2%.

For 2007, a sample of 629 members was obtained in which the overall sampling error is ± 3.9% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 39.1%.

Results for Health Plan Overall
The Health Plan Overall for 2006 was lower than the 2005 results and higher than the 2005 Medicaid average. In 2007, the results were higher than 2006 and higher than the 2006 Medicaid average.

Health Plan Overall - Central Region

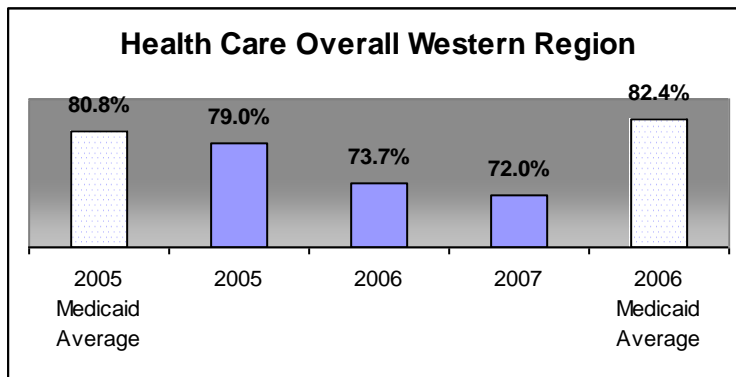| Category	Value
2005 Medicaid Average	77.6%
2005	79.9%
2006	79.3%
2007	80.6%
2006 Medicaid Average	80.1%

Source: CAHPS 2007 Results compiled by DSS Research

Although all survey measures drive the overall health plan rating, customer service and complaints are directly under the health plan's control. For 2006, the customer service composite score average increased significantly from 2005 but was below the 2005 Medicaid average. For 2007, the composite score increased from 2006 and was above the 2006 Medicaid average.

For 2006, the reported complaint/problem resolution within 7 days increased from 2005 and was above the 2005 Medicaid average, and the satisfaction with complaint/problem resolution increased from the previous year and was above the 2005 Medicaid average.

Health Care Overall

Health Care Overall for 2006 is lower than the 2005 results and higher than the 2005 Medicaid average. The 2007 results were higher than the 2006 results and significantly higher than the 2006 Medicaid average.
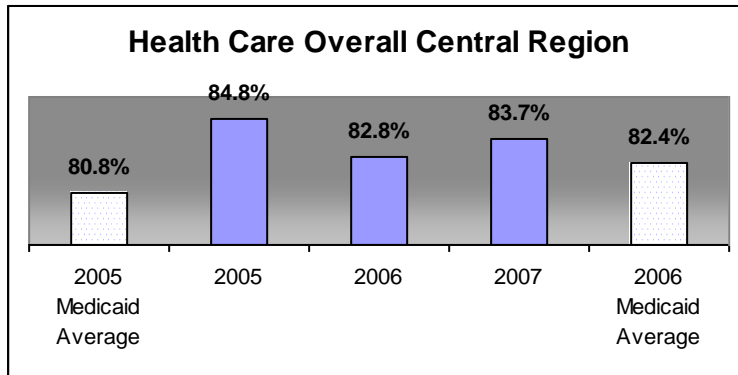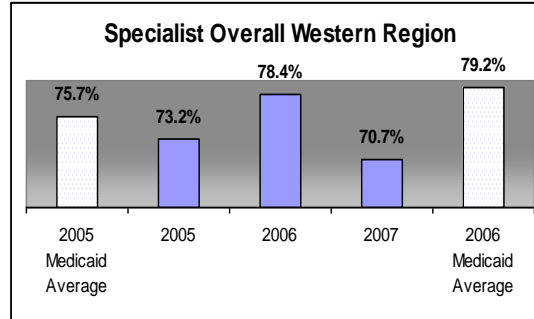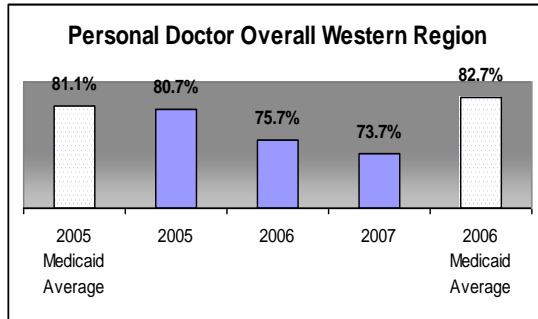

Source: CAHPS 2007 Results compiled by DSS Research

Getting needed care and getting care quickly heavily influence overall health care ratings.

For 2006, the getting needed care composite score decreased from 2005 and was below the 2005 Medicaid average. For 2007, the getting needed care composite score increased from 2006 and was above the 2006 Medicaid average. The greatest opportunity for improvement revolves around seeing a specialist.

For 2006, the getting care quickly composite score decreased from the prior year and was above the 2005 Medicaid average. For 2007, the getting care quickly composite score average decreased from 2006 and was significantly above the 2006 Medicaid average. The greatest opportunity for improvement revolves around being taken to the exam room within 15 minutes of appointment.

Personal Doctor Overall and Specialist Overall

The Personal Doctor Overall rating for 2006 was significantly lower than 2005 and lower than the 2005 Medicaid average. The 2007 rating is higher than last year and lower than the 2006 Medicaid average. The Specialist Overall rating for 2006 is higher than the 2005 rating and higher than the 2005 Medicaid average. The 2007 rating is higher than last year and higher than the 2006 Medicaid average.

Source: CAHPS 2007 Results compiled by DSS Research   Source: CAHPS 2007 Results compiled by DSS Research

How well doctors communicate and courteous and helpful office staff heavily influenced personal doctor and specialist ratings.

For 2006, how well doctors communicate composite score equaled the 2005 score was significantly above the 2005 Medicaid average. For 2007, how well doctors communicate composite score decreased from 2006 and was above the 2006 Medicaid average. The greatest opportunity for improvement in the composite revolves around doctors spending enough time with patients.

For 2006, the courteous and helpful office staff composite score average decreased from the prior year and is significantly above the 2005 Medicaid average. The 2007 score decreased from last year but was above the 2006 Medicaid average. The greatest opportunity for improvement revolves around doctors having helpful office staff.

Western Region
For 2006, a sample of 422 members was obtained in which the overall sampling error ±4.8% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 26.7%.

For 2007, a sample of 435 members was obtained in which the overall sampling error is ± 4.7% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 27.2%.

Health Plan Overall
The Health Plan Overall for 2006 was higher than the 2005 results but lower than the 2005 Medicaid average. In 2007, the results were higher than 2006 and lower than the 2006 Medicaid average.
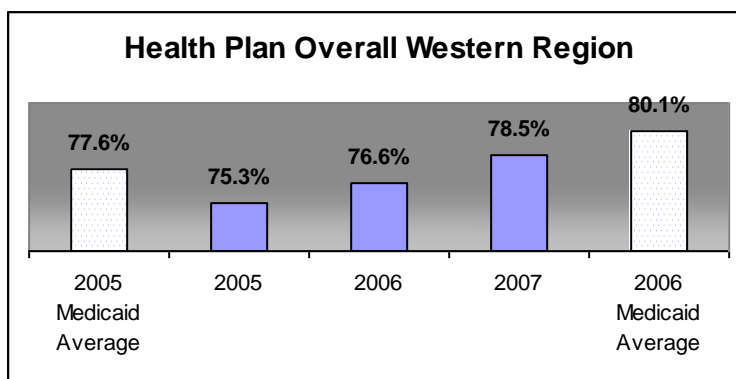
Source: CAHPS 2007 Results compiled by DSS Research

Although all survey measures drive the overall health plan rating, customer service and complaints are directly under the health plan's control. For 2006 the customer service composite score average increased from 2005 but was below the 2005 Medicaid average. For 2007, the composite score decreased from 2006 and was below the 2006 Medicaid average.

For 2006, the reported complaint/problem resolution within 7 days increased from 2005 but was below the 2005 Medicaid average, and the satisfaction with complaint/problem resolution increased from the previous year but was below the 2005 Medicaid average.

For 2007, the reported complaint/problem resolution within 7 days increased from 2006 and was below the 2006 Medicaid average, and the satisfaction with complaint/problem resolution decreased from the previous year and was below the 2006 Medicaid average.

Health Care Overall
Health Care Overall for 2006 is lower than the 2005 results and higher than the 2005 Medicaid average. The 2007 results were higher than the 2006 results and significantly higher than the 2006 Medicaid average.

Health Care Overall Western Region

80.8%	79.0%	73.7%	72.0%	82.4%
2005 Medicaid Average	2005	2006	2007	2006 Medicaid Average

Source: CAHPS 2007 Results compiled by DSS Research

Getting needed care and getting care quickly heavily influence overall health care ratings. For 2006, the getting needed care composite score increased from 2005 but was below the 2005 Medicaid average. For 2007, the getting needed care composite score decreased from 2006 and was significantly below the 2006 Medicaid average. The greatest opportunity for improvement revolves around seeing a specialist.

For 2006, the getting care quickly composite score increased from the prior year and was below the 2005 Medicaid average. For 2007, the getting care quickly composite score average decreased from 2006 and was significantly below the 2006 Medicaid average. The greatest opportunity for improvement revolves around being taken to the exam room within 15 minutes of appointment.

Personal Doctor Overall and Specialist Overall
The Personal Doctor Overall rating for 2006 was significantly lower than 2005 and lower than the 2005 Medicaid average. The 2007 rating is higher than last year and lower than the 2006 Medicaid average. The Specialist Overall rating for 2006 is higher than the 2005 rating and higher than the 2005 Medicaid average. The 2007 rating is higher than last year and higher than the 2006 Medicaid average.

Personal Doctor Overall Western Region

81.1% — 2005 Medicaid Average
80.7% — 2005
75.7% — 2006
73.7% — 2007
82.7% — 2006 Medicaid Average

Source: CAHPS 2007 Results compiled by DSS Research

Specialist Overall Western Region

75.7% — 2005 Medicaid Average
73.2% — 2005
78.4% — 2006
70.7% — 2007
79.2% — 2006 Medicaid Average

Source: CAHPS 2007 Results compiled by DSS Research

How well doctors communicate and courteous and helpful office staff heavily influence personal doctor and specialist ratings.

For 2006, how well doctors communicate composite score decreased from 2005 was below the 2005 Medicaid average. For 2007, how well doctors communicate composite score decreased from 2006 and was significantly below the 2006 Medicaid average. The greatest opportunity for improvement in the composite revolves around doctors spending enough time with patients.

For 2006. the courteous and helpful office staff composite score average decreased from the prior year and was below the 2005 Medicaid average. The 2007 score decreased from last year and was significantly below the 2006 Medicaid average. The greatest opportunity for improvement revolves around doctors having helpful office staff.

What HealthCare USA is Doing
An interdepartmental committee was formed to review, analyze, and make recommendations for identified areas of improvement. Each area of the CAHPS survey, by region, was discussed in detail. Actions taken in response to survey or actions already in place:
- Member education regarding results of survey
- Provider education regarding results of survey
- Track "request to change provider" results from CSO to identify trends/issues in providers.
- Provider office staff complaints/grievances are followed up by Provider Relations.
- Member education regarding their rights and responsibilities during an office visit.
- Provider standard of care of no more than 1 hour in waiting room after appointment time monitored by Provider Relations.
- Geo Access surveys by provider relations to identify and remedy issues in access to care for all three regions and by primary care provider and specialty.
- Constant monitoring of the provider network to identify opportunities for growth.
- Implementation of a performance improvement project addressing complaint resolution.

Trends in Missouri Medicaid Quality Indicators
This secondary-source report is received by HealthCare USA at the MO HealthNet Managed Care QA&I Advisory Group Meeting. HealthCare USA reviews this data and compares it to the HEDIS Indicators by Missouri MO HealthNet Managed Care Health Plans Within Regions, Live Births report as well as internal data such as HEDIS rates.

Eastern Missouri
The rate for timeliness of prenatal care declined in 2006 from January to September from 2005. It is unclear how much this rate was affected as a result of the changes in criteria to qualify for Medicaid services versus other factors. There was a significantly smaller number of women with documented prenatal care in the first trimester and a significantly higher number of women with documented prenatal care in the third trimester. Total births 500 grams or more significantly increased in the same timeframe in 2006 and has been increasing since 2003. All other live birth indicators had no significant changes from 2005.

Length of stay for maternal and mental health admissions remained fairly consistent in recent years. Asthma admissions and ER visits for those under 18 years all declined since 2004 and admissions for those 18-64 remained the same. All ER visits for those under 18 years increased only slightly where as visits for those 18-64 increased significantly. The rate of hysterectomies and vaginal hysterectomies both decreased, which has been the trend since 2003. Preventable hospitalizations have continued to trend upward since 2003.

Central Missouri
In a majority of the live birth indicators there was no significant change from previously reported years. There was a significant increase in spacing less than 18 months since last birth, percent of women on WIC and a decrease in total births 500 grams or more.

Data available for length of stay, admissions, and emergency room visits was available for CY 2005 and prior. Maternal length of stays remained fairly consistent from 2003 – 2005. Behavior health length of stay increased from 2005. Asthma admissions and ER visits had insignificant changes, though visits for those under age 18 increased slightly. ER visits for those under 18 years old increased while visits for those 18-64 years decreased. The overall rate of hysterectomies decreased as well as the rate of vaginal hysterectomies. The rate of preventable hospitalizations increased from 2004, but is still less than the rate for 2003.

Western Missouri
Western Missouri followed the same trend as Eastern Missouri with a decline in first trimester prenatal care. Birth statistics remained consistent with the only significant changes being an increase in the number of vaginal births after cesarean and a decrease in the rate of repeat cesarean sections.

Maternal length of stay remained the same while behavioral health length of stay decreased. All admissions and ER visits for asthma increased in 2005 from 2004. ER visits for under age 18 increased while ages 18-64 decreased. Hysterectomies and vaginal hysterectomies both declined from previous years rates. Preventable hospitalizations under the age of 18 has gradually increased since 2003.

HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births
HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births (secondary-source reporting) are tracked according to MO HealthNet and are reported at the MO HealthNet QA&I Advisory Group Meeting. HealthCare USA analyzes this data to determine

how we compare to other MO HealthNet Plans in the State, where we have improved and worsened, and how we can plan to improve the care of the MO HealthNet membership.

Cesarean Sections per 1000 by Region
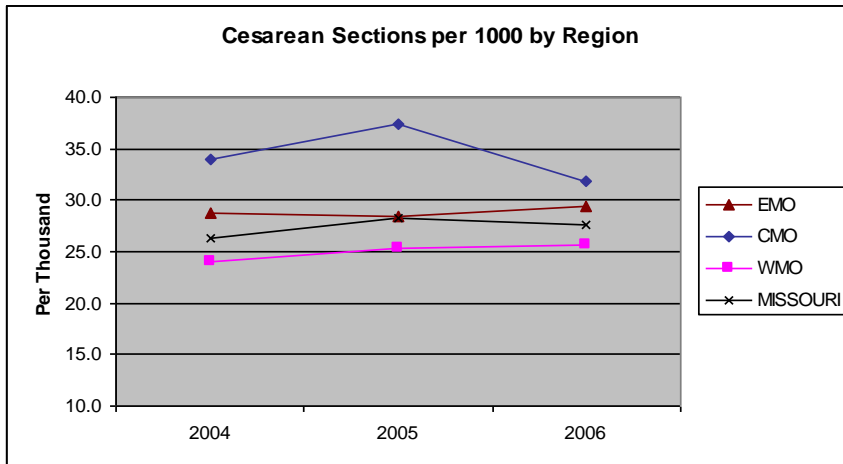
Source: MO HealthNet

The rate of cesarean sections has remained steady in Eastern and Western Missouri where it is similar to the State MO HealthNet rate. The rate in Central Missouri has declined, although it still remains significantly higher than the MO HealthNet rate.

VBAC Rate per 1000 by Region
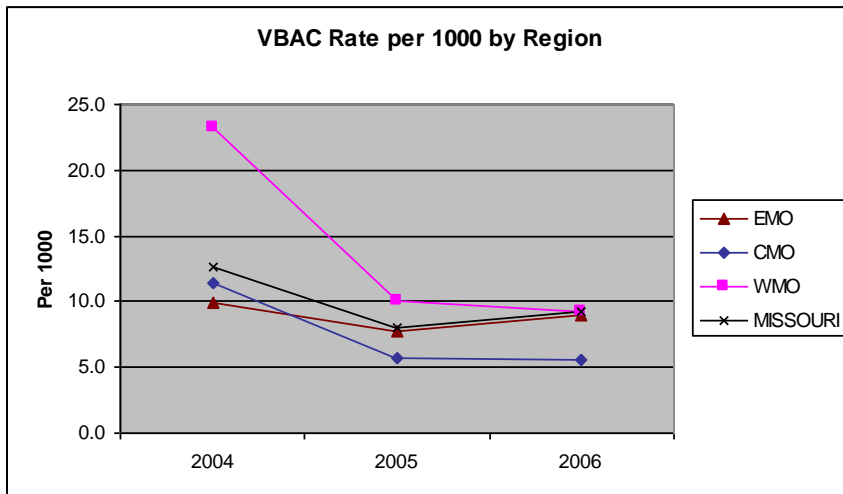
Source: MO HealthNet

The rate of vaginal birth after cesarean (VBAC) has significantly declined in Western since 2004. All regions now are similar to the State MO HealthNet average.

Adequacy of Prenatal Care by Regions
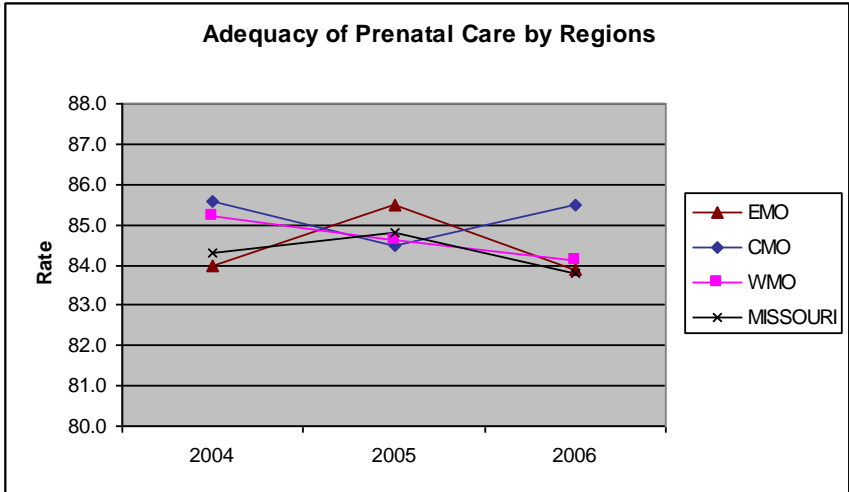
Source: MO HealthNet

The adequate prenatal care rate has remained fairly consistent since 2004 and does not significantly differ from the State MO HealthNet rate.

Early Prenatal Care by Region
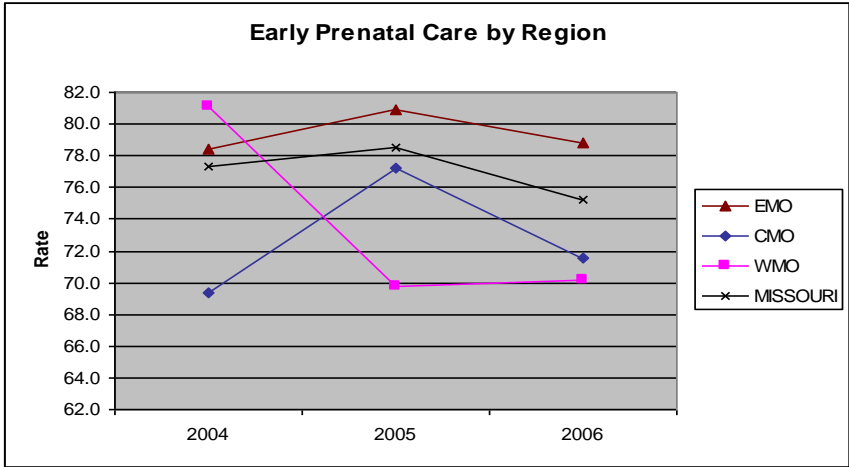
Source: MO HealthNet

The rate of early prenatal care has declined in Eastern and Central Missouri since 2005 and remained consistent in Western Missouri. The Eastern rate is significantly higher than the MO HealthNet rate, where Central and Western do not significantly differ.
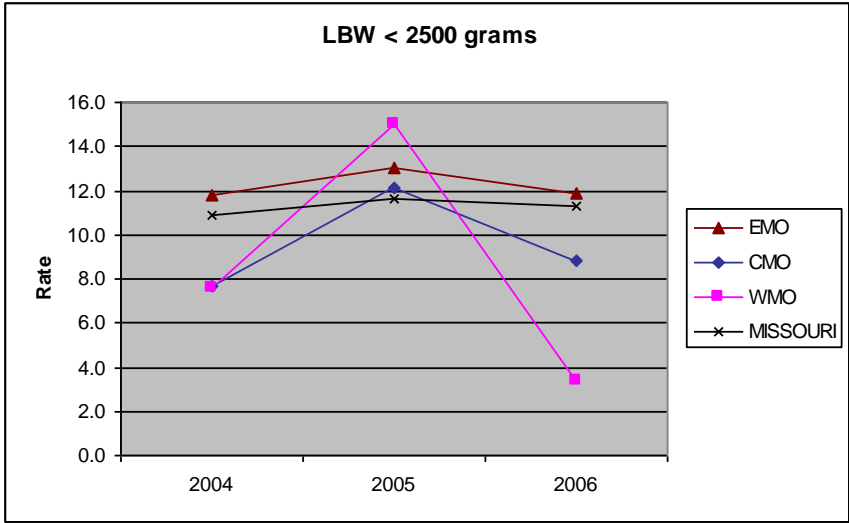
LBW < 2500 grams

Infants delivered at less than 2500 grams has decreased in all three regions of the HealthCare USA membership. The rate in the western region is significantly lower than the MO HealthNet rate.

LBW <2500 grams
Delivered in Level II/III Hospital
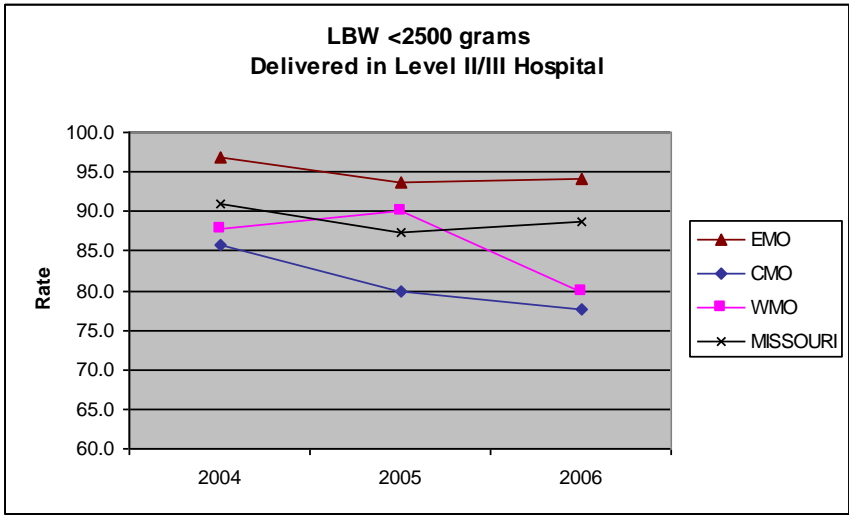
Eastern Missouri has the highest rate of infants less than 2500 grams delivered at level II or II hospitals, most likely due to the number of hospital in this category in Eastern Missouri. This is significantly higher than the MO HealthNet rate, where as Central and Western Missouri are both below the MO HealthNet rate.

**VLBW <1500 grams
Delivered in Level II/III Hospital**
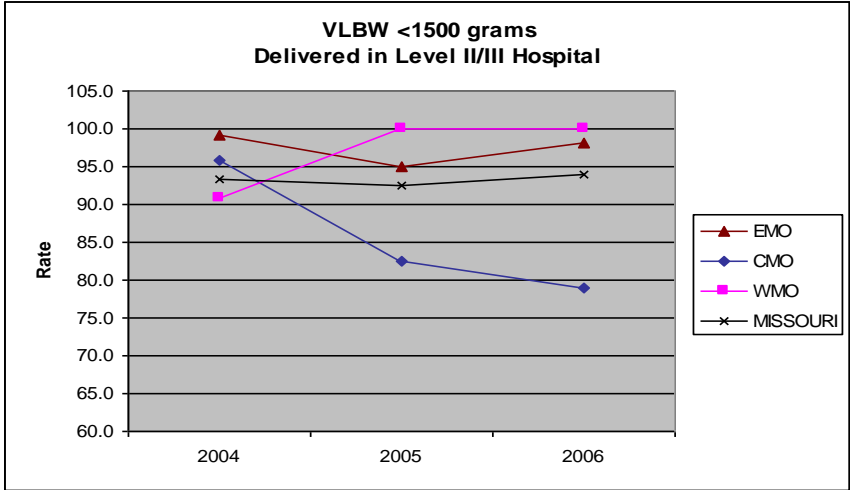
Source: MO HealthNet

The rate of infants less than 1500 grams delivered at a level II or III hospital in Eastern Missouri is comparable to the MO HealthNet rate. There was a very small number of births in this category in Central (19) and Western (13) Missouri in 2006, thus making the numbers incomparable.

Smoking During Pregnancy
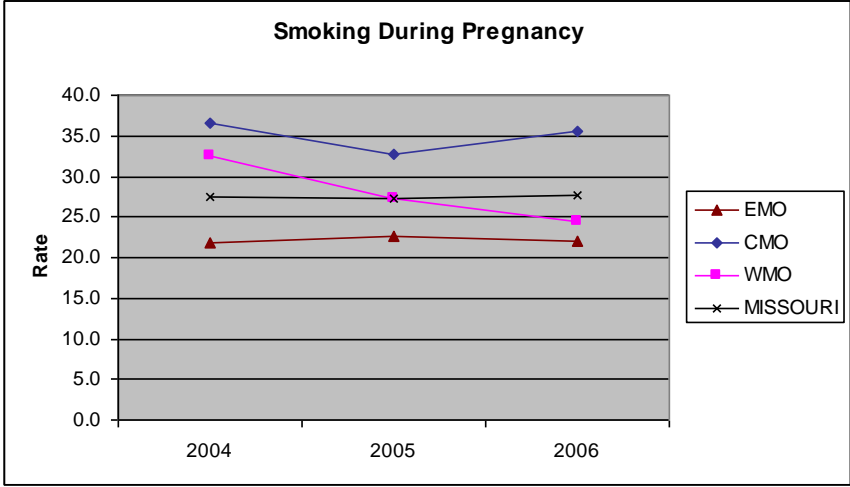
Source: MO HealthNet

The rates of smoking during pregnancy have declined in Eastern and Western Missouri, and are both significantly lower than the MO HealthNet rate. However, the rate in Central Missouri has increased since 2005 and is significantly higher than the MO HealthNet rate. HealthCare USA has begun coverage of smoking cessation products and encourages all pregnant women to stop smoking.

19
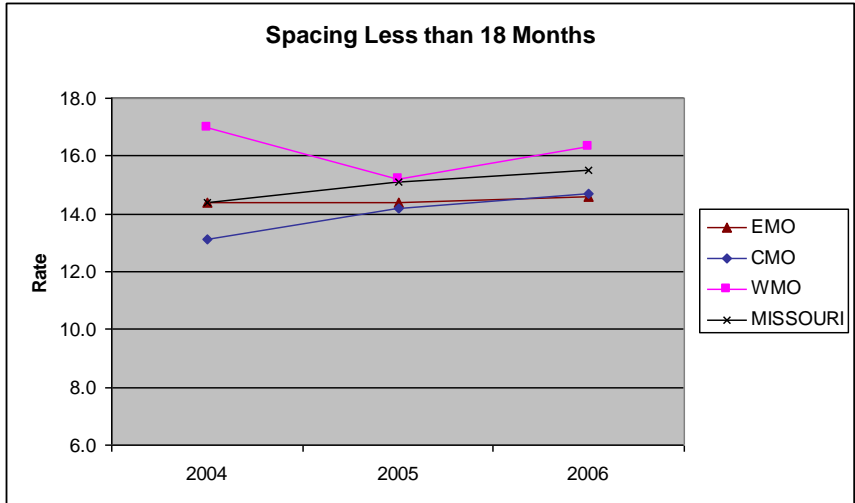
Spacing Less than 18 Months

Birth spacing of less than 18 months has increase slightly across the State MO HealthNet members. Central and Western Missouri have followed these trends, while Eastern Missouri remains steady. All three regions are at the MO HealthNet rate.

Births to Mothers <18 Years
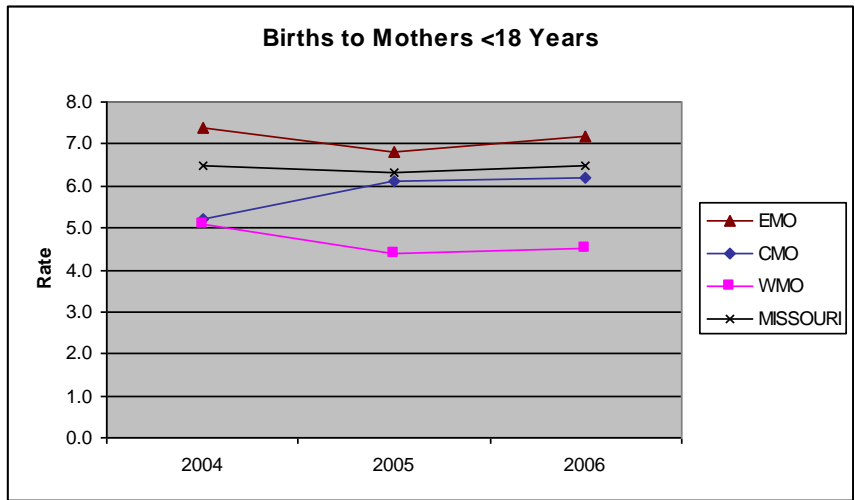
Births to women less than eighteen (18) years old in Eastern region is significantly higher than the MO HealthNet rate and Western Missouri is significantly lower. Central Missouri has slightly increased but is in line with the MO HealthNet rate.

Repeat Births to Teen Mothers (<20 Years)
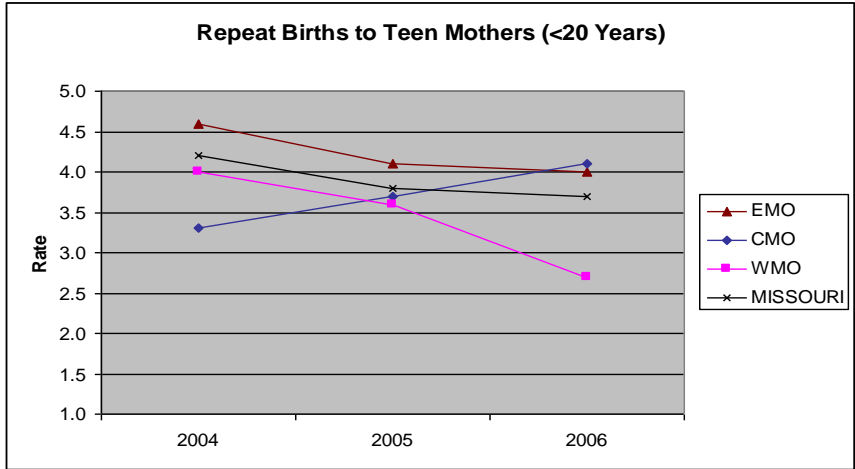
Data retrieved from the claims data warehouse

Repeat births to mothers less than twenty (20) years old has declined in Eastern and Western Missouri but has increased in Central Missouri. All regions are similar to the MO HealthNet rate across Missouri.

Prenatal WIC Participants
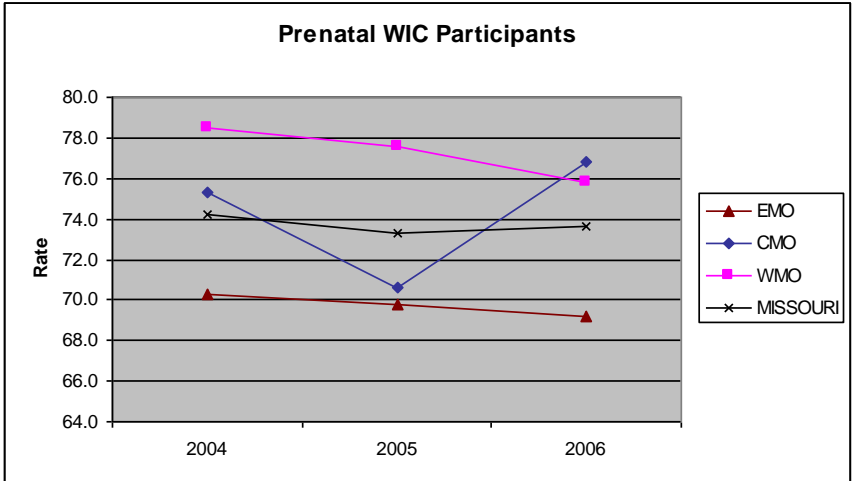
Source: MO HealthNet

The rate of prenatal WIC participants varies across the State. The Eastern region is significantly lower than the MO HealthNet rate and the Central region is significantly higher than the MO HealthNet rate. Western Missouri participation has declined, but is similar to the MO HealthNet rate.

Mercy CarePlus

Performance Measures
MCP monitors performance on a monthly basis. The performance measures are presented to MCP's Managers meeting and Quality Improvement Committee for review, identification of trends, recognition of goal achievement, and establishment of corrective actions.

The performance measures are divided into three categories. Customer Service indicators are focused on membership activity, phone metrics, and timeliness of claims payment. Quality Improvement indicators focus on provider complaints, grievances and appeals, member grievances and appeals and credentialing. Medical Management indicators are focused on authorization and referral calls, days/1000, obstetrics and utilization management.

Trends in Missouri Medicaid Quality Indicators
The following HEDIS data was reported to DHSS for MCP in the Eastern Region. All of the measures were within the 95% confidence interval.

	Reported Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval
Childhood Immunization: DTP	69.59%	65.02%	74.16%
Childhood Immunization: MMR	86.62%	83.20%	90.03%
Childhood Immunization: IPV/OPV	85.89%	82.40%	89.38%
Childhood Immunization: Hib	83.21%	79.48%	86.95%
Childhood Immunization: Hepatitis B	85.16%	81.60%	88.72%
Childhood Immunization: VZV	82.97%	79.21%	86.72%
Childhood Immunization: Pneumococcal Conjugate	61.56%	56.73%	66.38%
Childhood Immunization: Combo 3	52.55%	47.61%	57.50%
Childhood Immunization: Combo 2	62.04%	57.23%	66.86%
Adolescent Immunization: MMR	79.56%	75.54%	83.58%
Adolescent Immunization: Hepatitis B	76.40%	72.17%	80.63%
Adolescent Immunization: VZV	42.82%	37.92%	47.73%
Adolescent Immunization: Combo 1	72.51%	68.07%	76.94%
Adolescent Well-Care Visits	29.49%	28.52%	30.47%
Use of Appropriate Meds for People w/ Asthma: 5-9 years old	89.84%	80.77%	91.27%
Use of Appropriate Meds for People w/ Asthma: 10-17 years old	89.84%	85.95%	93.74%
Use of Appropriate Meds for People w/ Asthma: 18-56 years old	71.60%	61.17%	82.04%
Use of Appropriate Meds for People w/ Asthma: combined	85.66%	82.56%	88.76%
Chlamydia Screening: 16-20 years old	63.33%	60.39%	66.27%
Chlamydia Screening: 21-25 years old	65.22%	61.67%	68.78%
Chlamydia Screening: combined	64.09%	61.84%	66.34%

Cervical Cancer Screening	61.25%	59.35%	63.14%
Annual Dental Visits: 4-6 years old	33.64%	32.10%	35.19%
Annual Dental Visits: 7-10 years old	40.59%	39.17%	42.01%
Annual Dental Visits: 11-14 years old	34.07%	32.73%	35.42%

HEDIS Indicators by Missouri MC+ Managed Care Health Plans Within Regions, Live Births
The following HEDIS data was reported to MHD for MCP in the Eastern Region. All of the measures were within the 95% confidence interval.

	Reported Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval
Well Child Visits in the first 15 Months of Life: 0 visits	6.9%	5.57%	8.28%
Well Child Visits in the first 15 Months of Life: 1 visit	4.5%	3.40%	5.64%
Well Child Visits in the first 15 Months of Life: 2 visits	5.4%	4.16%	6.58%
Well Child Visits in the first 15 Months of Life: 3 visits	9.8%	8.24%	11.41%
Well Child Visits in the first 15 Months of Life: 4 visits	14.8%	12.89%	16.65%
Well Child Visits in the first 15 Months of Life: 5 visits	19.9%	17.74%	21.97%
Well Child Visits in the first 15 Months of Life: 6 or more visits	38.7%	36.15%	41.30%
Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	52.83%	51.44%	54.23%
W/in 7 Days of Discharge Mental Illness Hospital	24.68%	20.29%	29.07%
W/in 30 Days of Discharge Mental Illness Hospital	46.31%	41.25%	51.37%
Timeliness of Prenatal Care	83.94%	80.27%	87.61%
Postpartum Care	59.85%	54.99%	64.71%

Harmony

Performance Measures
Trends in Missouri Medicaid Quality Indicators
HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

Performance Measures/HEDIS (This is the Health Plans first fiscal year with the State of Missouri therefore HEDIS, CAHPS and PIP Quality initiative baseline data will be collected in 2008 for CY 2007, rates noted at this time are approximate and subject to change.)
- Childhood Immunizations - 37%
- Adolescent Immunizations - 5%
- Cervical Cancer Screenings - 26%
- Chlamydia Screening - 49%
- Follow-up after Mental Illness Hospitalization - 11%
- Prenatal/Postnatal Care @ 70.67% and 37.33%
  - Frequency 0 – 20% @ 21.87%
  - Frequency 21 – 40% @ 10.67%
  - Frequency 41 – 60% @ 9.33%
  - Frequency 61 – 80% @ 12.00%
  - Frequency 81 – 100% @ 46.13

Performance Measures/HEDIS (This is the Health Plans first fiscal year with the State of Missouri therefore HEDIS, CAHPS and PIP Quality initiative baseline data will be collected in 2008 for CY 2007, rates noted at this time are approximate and subject to change.)
- Annual Dental Visits @ 19.13%
- CAHPS Surveys – Not Applicable for 2007 (new health plan status)
- Well Child Visits (0 – 15)
  - (0) Visit – 17.78%
  - (1) Visit – 6.67%
  - (2) Visit – 6.67%
  - (3) Visit – 16.67%
  - (4) Visit – 10%
  - (5) Visit – 17.78%
  - (6) Visit – 24.44%
- Well Child Visits (3 – 6) – 39.75%
- Adolescent Well Visits – 19.13%
- Ambulatory Care – 50.76%
- Mental Health Utilization - 11%
- Alcohol and other services 30%

Performance Measures - Ambulatory

Age	Outpatient		ER		Amb Surg		Observation	
	Visits	Visits/K	Visits	Visits/K	Procedure	Procedure/K	Stays	Stays/K
<1	2,289	283.64	762	94.42	20	2.48	4	0.5
1 – 9	2,341	84.07	1,371	49.24	28	1.01	3	0.11
10 - 19	1,961	88.6	838	37.86	19	0.86	22	0.99
20-44	3,639	227.94	1,207	75.6	47	2.94	90	5.64
45-64	162	169.99	42	44.07	2	2.1	3	3.15
65-74	0	0	0	0	0	0	0	0
75-84	0	0	0	0	0	0	0	0
85+	0	0	0	0	0	0	0	0
Unknown	0		0		0		0	
Total	10,392	138.62	4,220	56.29	116	1.55	122	1.63

Performance Measures - Ambulatory

Trends in MO Quality Indicators This is the Health Plans first fiscal year with the State of Missouri therefore HEDIS, CAHPS and PIP Quality initiative baseline data will be collected in 2008 for CY 2007, rates noted at this time are approximate and subject to change.

- Trimester Care – Trending 2nd trimester
- Delivery Methods
  - C-Section (next page)
  - VBACS (next page)
- Fetal Demise - 0
- Maternal LOS – 2.17
- Behavioral Health LOS – 18.29
- ER Visits/K – 56.29
- Hysterectomies – 2

Quality Indicators – Birth/Methods

Age	Discharges	Discharges/K	Days	Days/K	Average Length of Stay
Total Deliveries					
10 - 14	1	0.18	2	0.36	2
15-19	79	12.08	196	29.97	2.48
20-34	307	26.46	636	54.82	2.07
35-49	16	5.76	40	14.41	2.5
Total	403	15.11	874	32.76	2.17

Total Vaginal Deliveries: Live Births					
10 - 14	1	0.18	2	0.36	2
15-19	68	10.4	143	21.87	2.1
20-34	221	19.05	420	36.2	1.9
35-49	11	3.96	27	9.73	2.45
Total	301	11.28	592	22.19	1.97
Total Cesarean Deliveries: Total Live Births					
10 - 14	0	0	0	0	0
15-19	11	1.68	53	8.11	4.82
20-34	86	7.41	216	18.62	2.51
35-49	5	1.8	13	4.68	2.6
Total	102	3.82	282	10.57	2.76

Missouri Care

Performance Measures

Missouri Care tracks several performance measures in accordance with contract requirements and for internal quality purposes. Performance is measured in the following areas: effectiveness of care, access/availability of care, use of services, and satisfaction with the experience of care.

Effectiveness of Care

Missouri Care reports the following HEDIS measures of effectiveness of care: Childhood Immunization Status (CIS), Adolescent Immunization Status (AIS), Cervical Cancer Screening (CCS), Chlamydia Screening in Women (CHL), Follow-up After Hospitalization for Mental Health Illness (FUH) and Use of Appropriate Medications for People with Asthma (ASM). The following graph depicts Missouri Care's performance on these measures for HEDIS 2005 to 2007 (measurement years 2004 through 2006).

Effectiveness of Care - HEDIS
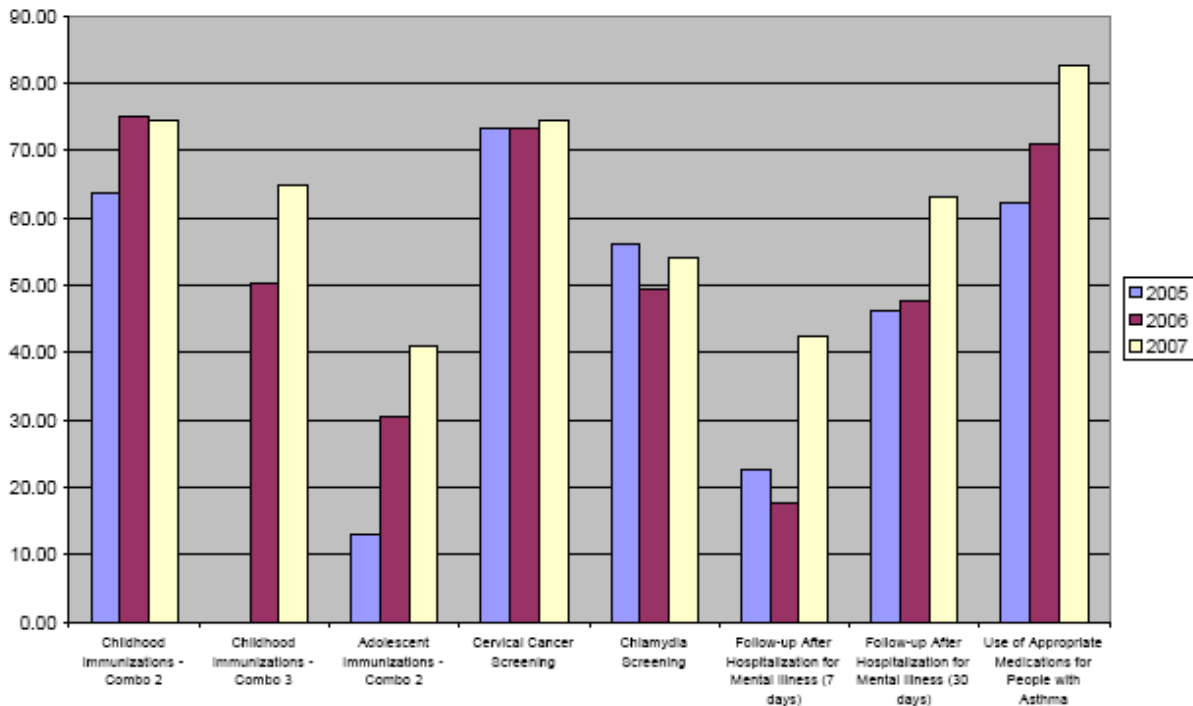
As illustrated in the above graph, Missouri Care has shown improvement in Childhood Immunizations Combo 3, Adolescent Immunizations Combo 2, Cervical Cancer screening, 7- and 30-Day Mental Health Follow-up After Hospitalization, and Use of Appropriate Medications for People with Asthma. Childhood Immunizations Combo 2 and Chlamydia Screening decreased during this time period. The slight decrease in Childhood Immunizations Combo 2 from 2006 to 2007 was not significant. The decline in the Chlamydia screening rate can partially be explained by changes in the composition of the eligible population. There was a decrease in the number of eligible members age 21-25, but little change in the 16-20 age group. Members in the 21-25 age group tend to be more compliant with this measure than younger members. The large increase in Childhood Immunizations Combo 3 from 2006 to 2007 can largely be attributed to increased compliance with the pneumococcal conjugate vaccine (PCV). There were also relatively large increases in the Mental Health 7- and 30-Day Follow-up and Use of Appropriate Medications for People with Asthma measures. In 2006, Missouri Care Health Plan implemented performance improvement projects targeting both of these measures. These initiatives are outlined in the Performance Improvement Project section of this report. The HEDIS 2007 Cervical Cancer Screening and Childhood Immunization Combo 3 rates are both above the 2006 NCQA HEDIS 75th percentile benchmarks for Medicaid.

Access/Availability of Care

Missouri Care reports the following access/availability of care measures: Timeliness of Prenatal Care (TOPC), Postpartum Care (PPC) and Annual Dental Visits (ADV). The following graph depicts Missouri Care's performance on these measures for HEDIS 2005 to 2007 (measurement years 2004 through 2006).

Access/Availability of Care
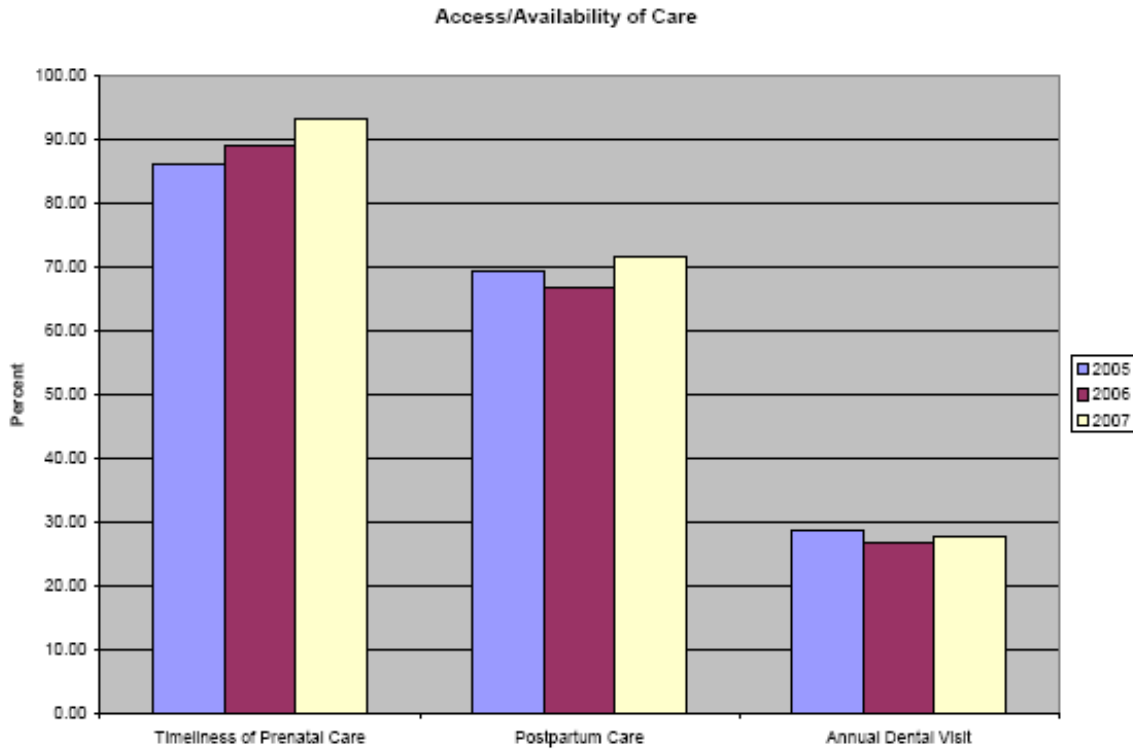
Timeliness of Prenatal Care and Postpartum Care rates are both above NCQA's 2006 75th percentile benchmarks for Medicaid. Timeliness of Prenatal Care exceeded the 90th percentile in 2007. Missouri Care continues to educate members through health education materials and case management on the importance of prenatal and postpartum care. Access to dental care continues to be a challenge in mid-Missouri. Missouri Care is working with our dental vendor to increase access for members.

Use of Services
The indicators for use of services are the HEDIS measures of Well-Child Visits in the First 15 Months of Life (Well Child 1), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (Well Child 2), Adolescent Well Care Visits, Ambulatory Care, Mental Health Utilization, and Identification of Alcohol and Other Drug Services. The following graph depicts Missouri Care's performance on the Use of Services Well Child measures for HEDIS 2005 to 2007 (measurement years 2004 through 2006).

Use of Services
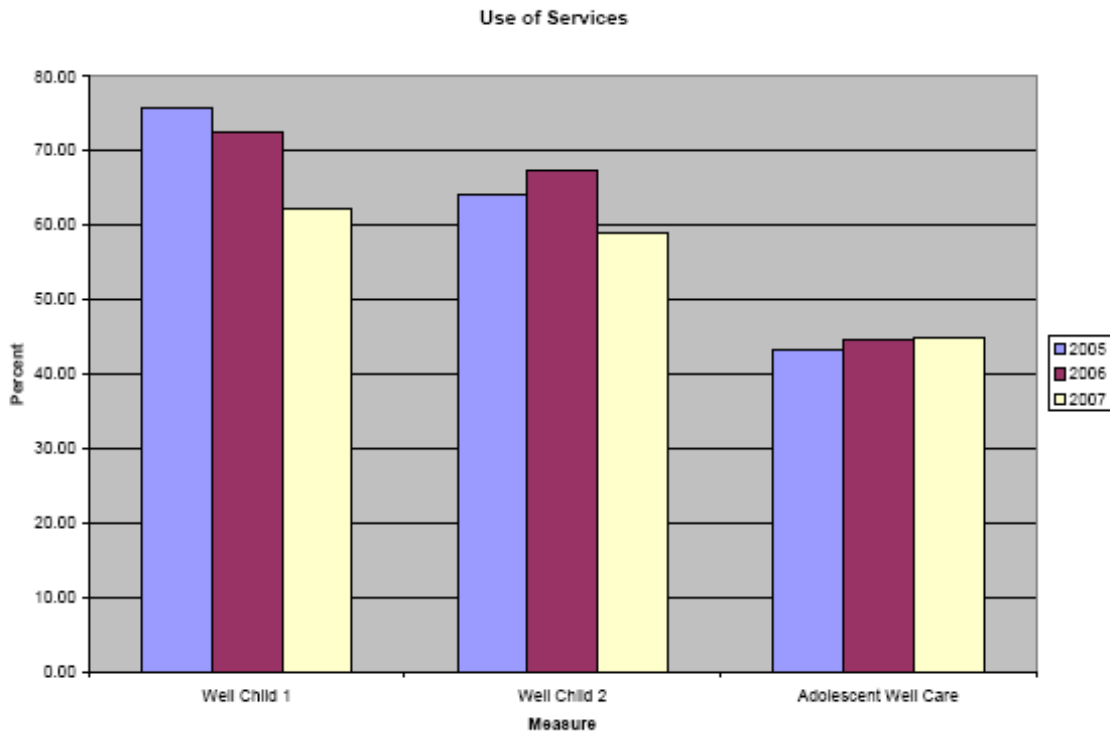
Well-Child Visits in the First 15 Months of Life (Well Child 1) and Well Child Visits at Three, Four, Five, and Six years of age (Well Child 2) significantly decreased from 2006 to 2007. This decline is attributable to measurement error in 2005 and 2006. Missouri Care Health Plan identified this issue early in 2007. The rates for these measures likely remained stable or increased slightly from 2006 to 2007 as Missouri Care's EPSDT participation rate increased during this same time period. Even with the decrease, the Well Child 1 rate remained above NCQA's 75th percentile benchmark for Medicaid plan. The Adolescent Well Care measure has shown slight increases across the three years. In 2007, Missouri Care has been focused on raising the Well Child 2 screening rate as this measure is below the NCQA 50th percentile for Medicaid plans.

The Ambulatory Care HEDIS indicators for HEDIS 2005 through 2007 (measurement years 2004 through 2006) are graphed below. Outpatient visits per 1000 members have increased across the three years, while ER visits declined slightly from 2005 to 2006 and remained relatively unchanged in 2007. Ambulatory surgery/procedures decreased from 8.24/1000 members for HEDIS 2005 to 5.94/1000 members for HEDIS 2007. Observation room stays resulting in discharge decreased by almost 50% between HEDIS 2006 and HEDIS 2007. The decrease in ambulatory surgery/procedures was largely due to the change in member mix due to the eligibility cuts during this time period. The reduction in observation rooms stays was a direct result of provider education regarding the criteria for obstetrical observations.

Ambulatory Care/1000 Members
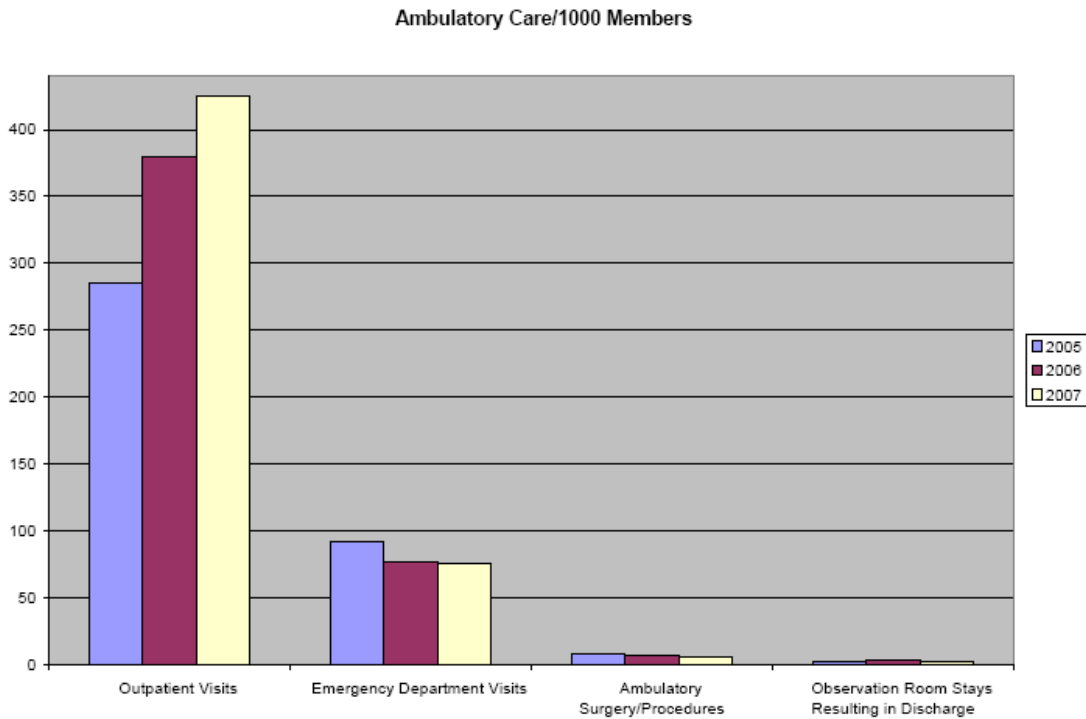
Mental Health Utilization and Identification of Alcohol and Other Drug Services
The 2006 and 2007 HEDIS rates for Mental Health Utilization are depicted below. Use of all services, inpatient services and ambulatory services increased slightly across the two years. This is likely due to the change in member mix. During this time period the plan saw a decrease in healthy adult members. The 2006 HEDIS (2005 measurement year) was the first year that behavioral health services were managed internally by the plan. Presented is the data from the two years the services have been managed internally. The Identification of Alcohol and Other Drug Services was reported for the first time in 2007. This measure replaced the Chemical Dependency Utilization measure. The percentage of members receiving any chemical dependency services, inpatient chemical dependency services and ambulatory chemical dependency services in calendar year 2006 were 1.42%, .64%, and .94% respectively.

Mental Health Utilization
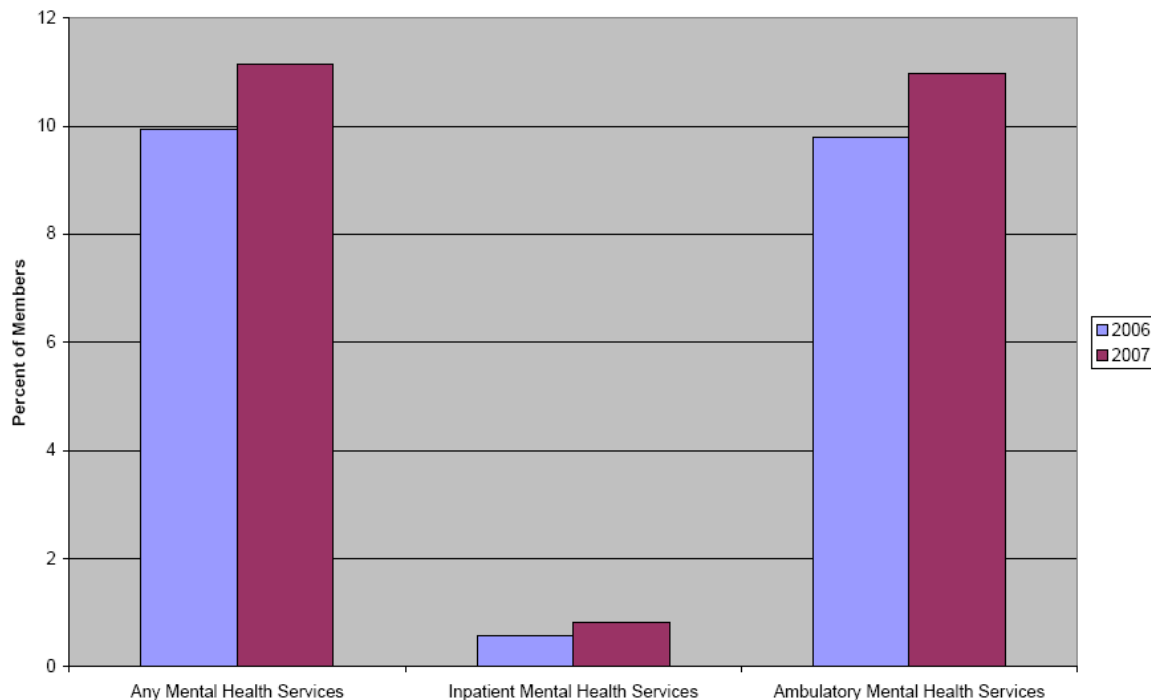
CAHPS Survey

Composite results of the CAHPS 3.0H Medicaid Child Survey are presented below. There were no significant changes in the rating from 2005 to 2007 in the composite results. From 2005 to 2007 there was a significant increase in the members reporting they were able to find a provider they were happy with and a significant increase from 2006 to 2007 in members who say they are able to obtain care right away for illness or injury. There was a significant decrease from 2006 to 2007 among members stating that provider office staff treats them with courtesy and respect, but the overall positive response rate on this question remains high at 92.7% in 2007. The composite rating for customer service in 2007 was significantly above the 2006 CAHPS Booklet (Medicaid Child).

Composites/Ratings	2005 Summary Rates	2006 Summary Rates	2007 Summary Rates
Getting Needed Care Quickly	80.2%	79.4%	81.4%
Getting Care Quickly	81.3%	76.7%	81.3%
How Well Doctors Communicate	92.3%	90.9%	91.9%
Courteous and Helpful Office Staff	91.5%	94.9%	92.0%
Customer Service	76.3%	70.9%	79.3%
Rating of Personal Doctor	77.6%	76.7%	78.4%
Rating of Specialist	75.5%	69.2%	76.4%

Rating of Health Care	76.9%	78.3%	79.6%
Rating of Health Plan	74.1%	73.1%	77.5%

Trends in Missouri Medicaid Quality Indicators

MO HealthNet tracks the following maternal child health indicators to evaluate the health status of the Missouri Medicaid population. The table below compares Missouri Care to the other plan(s) within the central region. No significant trends were noted with the exception of Smoking during Pregnancy. This indicator showed an increase from 36% to 40.2% in 2006. Previous attempts to mitigate this risk factor have been less than successful. Missouri Care recognizes smoking as a major risk factor for poor birth outcomes and is currently partnering with Kevin Everett and the Father's Project. The Father's Project provides smoking cessation to pregnant women and their partners. Most recently, the Father's Project received funding for Chantix, a smoking cessation product. Smoking cessation is currently not a covered benefit for Missouri Care members. All members identified as smoking during pregnancy are referred to the Father's Project.

Indicators by Managed Care Health Plans (Secondary Source Reporting)
Indicator 2006 2005 2004 Total Deliveries

Indicator	2006	2005	2004	Total Deliveries
Method of Delivery				
Cesarean Sections-*Missouri Care*	28.3	31	26.9	1,915
Central Region Total	29.9	33.9	30.2	3,271
Vaginal Birth after C/S-*Missouri Care*	10	11.7	14.4	270
Central Region Total	8.1	8.7	12.8	470
Total Deliveries = Total live births				
Adequate Prenatal Care *Missouri Care*	82.3	82.7	81.6	1,702
Central Region Total	83.5	83.5	83.3	2,791
Total Deliveries = Total live births with known prenatal care				
Data based on births in a managed care plan at delivery, irrespective of length of enrollment				
Early Prenatal Care- *Missouri Care*	73.6	76.7	72.8	367
Central Region Total	72.7	79.5	76.5	663
Total Deliveries = Total live births to continuously enrolled women up to 289 days prior to delivery				
One gap of up to 45 days was allowed				
Low Birth Weight (< 2500 gms)-*Missouri Care*	8.7	6.7	9.8	165
Central Region Total	8.8	9.3	8.7	281
Total Deliveries = Total live births to continuously enrolled women for 12 mos prior to delivery				
One gap of up to 45 days in the 175 days to delivery was allowed				
LBW delivered in Level II/III hospital- *Missouri Care*	75.8	73.4	71.1	165
Central Region Total	76.5	76.8	77.8	281
Total Deliveries =Total live births with birth weight less than 2500 gms				
VLBW delivered in Level II/III hospital- *Missouri Care*	84.2	87.5	69.2	19

Central Region Total	81.6	84.6	86.5	38

Total Deliveries =Total live births with birth weight less than 1500 gms

Smoking during Pregnancy- *Missouri Care*	40.2	36	38.5	1,915
Central Region Total	38.4	34.5	37.6	3,271

Total Deliveries = Total live births

Spacing < 18 months - *Missouri Care*	15.1	12.2	16.6	1,009
Central Region Total	14.9	13.1	14.9	1,780

Total Deliveries =Total second or higher order live births with know spacing

Births to mothers < 18 y/o - *Missouri Care*	6.5	6.2	5.2	1,915
Central Region Total	6.4	6.2	5.2	3,271

Total Deliveries = Total live births

Repeat births to teen mothers- *Missouri Care*	3.2	2.4	4.2	1,915
Central Region Total	3.6	3	3.8	3,271

Total Deliveries = Total live births

Prenatal WIC participants- *Missouri Care*	78.3	77.7	78.3	1,898
Central Region	77.7	74.5	76.9	3,208

Total Deliveries = Total live births with known WIC participant

HEDIS Indicators by Missouri MC+ Managed Care Health Plans Within Regions, Live Births
MO HealthNet provides the following data on Trends in Medicaid Quality Indicators. Three indicators showed significant changes during January to September 2006, from Calendar Year 2005. Third quarter CY 2006 data will not be available until November 2007. The indicator, Spacing < 18 months since last birth, reported a slight increase from January to September 2006. Missouri Care's Perinatal Case Management Department emphasizes to members the importance of spacing of pregnancies to reduce the risk of poor birth outcomes. Case managers reinforce the importance of the postpartum visit in addressing family planning and spacing of pregnancies. Total live birth or stillbirth fetuses 500 grams or more noted an increase. Missouri Care tracks and reports all births greater than 350 grams or greater than 20 weeks. Percent of prenatals on WIC noted an increase from 76.6% to 79.3%. All pregnant members are referred to the WIC program by Missouri Care Perinatal Case Managers and Missouri Care providers.

Trends in Medicaid Quality Indicators (Secondary Source Reporting)

		CY 2005 Births	Percent	Jan- Sept 2006 Births	Percent	Significant Change
1	*Trimester Prenatal Care Began*					
	First	2,484	75.80%	1,911	77.20%	No
	Second	670	20.40%	483	19.50%	No
	Third	107	3.30%	62	2.50%	No
	None	17	0.50%	18	0.70%	No

	Total	3,278		2,474		
2	*Inadequate Prenatal Care*	579	18.80%	430	18.40%	No
3	*Birth Weight (grams)*					
	< 500	11	0.30%	3	0.10%	No
	500-1499	41	1.20%	25	0.90%	No
	1500-1999	69	2.00%	46	1.70%	No
	2000-2499	198	5.70%	150	5.60%	No
	2500+	3,127	90.70%	2,446	91.60%	No
	Total	3,446		2,670		
4	*Low Birth Weight (<2500 grams)*	319	9.30%	224	8.40%	No
5	*Method of Delivery*					
	C-Section	1,135	32.90%	815	30.50%	No
	VBAC	46	91.10%	28	7.30%	No
	Repeat C-Section	459	90.90%	355	92.70%	No
	Vaginal	1,806		1,473		
	Total	3,446		2,671		No
6	*Smoking During Pregnancy*	1,212	35.20%	1,021	38.20%	No
7	*Spacing < 18 mos since last birth*	242	12.80%	250	16.60%	Yes
8	*Births to mothers < 18 years of age*	189	5.50%	153	5.70%	No
9	*Repeat Teen Births*	107	3.10%	106	4.00%	No
10	*Fetal Deaths (20+wks)*	14	4.10%	19	7.10%	No
11	*Total live births or stillborn fetuses 500 grams or more*	3,446	172%	2,682	212.80%	Yes
12. 13.	*Percent of prenatals on WIC*	2,638	76.60%	2,117	79.30%	Yes
14	*VLBW not delivered in level III hospitals*	14	26.90%	4	14.30%	No
15	*Average maternal length of stay (days) Inpatient admissions*	3,051	2.50%	N/A		
16	*Average behavioral health length of stay (days) Inpatient admissions*	444	7.90%	N/A		
17	*Asthma inpatient admissions ages 4-17 Inpatient admissions*	52	1.50%	N/A		
18	*Asthma emergency room visits ages 4-17*	341	9.60%	N/A		
19	*Asthma admissions under age 18*	108	2.20%	N/A		

Inpatient admissions

20	Asthma admissions ages 18-64	25	1.40%	N/A
21	Emergency room visits under age 18	33,854	686.6	N/A
22	Emergency room visits ages 18-64	20,792	1201.3%	N/A
23	Hysterectomies	128	9.90%	N/A
24	Vaginal hysterectomies	53	41.40%	N/A
25	Preventable hospitalization under age 18	588	11.80%	N/A

Missouri Care requires that all facilities complete and submit a Birth Notification within one business day of a member's delivery. This allows for tracking and reporting of all birth outcomes. In this reporting period, Missouri Care received notification of 2,021 deliveries and 2,039 newborns. Average gestational age of newborns was 38.4 weeks. Only 12 newborns were born at 28 weeks or less, 48 were 29 – 34 weeks and 1,977 were 35 or more weeks, 21 newborns weighed less than 1500 grams (1.03%), 133 weighed 1500 to 2500 grams (6.52%), and 1,883 weighed 2500 or more grams (92.35%). Missouri Care's percentage of babies greater than 2500 grams was noted to be higher at 92.3% compared to the Central Region rates of 91.6%. In addition, Missouri Care's percentage of babies born less than 2500 grams was lower at 7.55% as compared to the Central Regions rate of 8.4%. Missouri Care's c-section rate remained stable at 27% for this reporting period.

Blue Advantage Plus

Performance Measures
Trends in Missouri Medicaid Quality Indicators
HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

See Attachment QI 1

Children's Mercy Family Health Partners

Performance Measures

HEDIS (Health Plan Employer Data & Information Set)

Children's Mercy Family Health Partners must meet program standards for monitoring and reporting of HEDIS Quality Indicators as outlined in the Mo Health Net managed care contract. An annual report of the MCOs HEDIS Quality Indicators is due in accordance with the state

contract. All data is reported to the Administrative and Medical Oversight Committees and the Board of Directors (Governing Body). Data points are plotted over time and compared with State and national benchmarks. Opportunities for improvement are discussed and evaluated.

Improvement initiatives implemented based on Children's Mercy Family Health Partners' HEDIS Indicator results included:

- Yearly Wellness Schedule included in a Member Newsletter and as a "Hot Topic" for members calling our Customer Service line. Wellness schedule includes information for children, adolescents, women and men (Spring 2007)
- Collaborate with Behavioral Health Subcontractor to improve Mental Health Follow up in 7 and 30 days post-hospitalization, and
- The addition of required statistical analysis of rates from year to year to the HEDIS audit contract.

In the following slides, several abbreviations are used.
FHP	Children's Mercy Family Health Partners
OOW	Out of Window
HP	Healthy People 2010
RFP	MO Health Net Contract-Request for Proposal

All vertical axes numbers are percentage of the population receiving services

Childhood Immunizations
Combo 2*

CY 2006 Target = 90%

Legend:
- FHP Combo 2 (42% increase)
- FHP 2006 OOW
- HP 2010 Target
- RFP Target
- HEDIS 2006 Medicaid Mean

Data labels: 51.58, 48.42, 52.31, 56.69, 57.47, 66, 67.15

Years: 1999, 2000, 2002, 2003, 2004, 2005, 2006

*Audited Measure

3

Childhood Immunizations
Combo 3

Legend:
- FHP Combo 3 (119% increase)
- FHP 2006 OOW
- RFP Target
- Medicaid Mean

Data labels: 41.44, 56.93

Years: 2005, 2006

1st Reporting year 2006

4

Adolescent Immunization
Combo 2*

CY 2006 Target = 90%

Legend:
- ◆ FHP Combo 2 (158% Increase)
- ■ FHP 2006 OOW
- ▲ HP 2010 Target
- ■ HEDIS 2006 Medicaid Mean

Data labels: 19.71 18.98 22.14 31.14 37.23 39.15 36.98

*Combo 1 + VZV

*2001 NCQA/DMS Rotation

X-axis: 1999 2000 2002 2003 2004 2005 2006

6

Cervical Cancer Screening*

CY 2006 Target = 73.9%

Legend:
- ◆ FHP Result (3.15% decrease)
- ■ HP 2010
- ▲ HEDIS 2006 Medicaid Mean

Data labels: 68.95 68.73 64.77 61.38 67.19 67.19 64.73

*Audited Measure

X-axis: 2000 2001 2002 2003 2004 2005 2006

9

38

Chlamydia Screening (16-26)*

CY 2006 Target = 68.44%

Values shown: 50.09, 53.36, 58.08, 58, 62.24, 59.23, 59.54

Legend:
- FHP Results (18.6% increase)
- HEDIS 2006 Medicaid Mean

*Audited Measure

10

Use of Appropriate Medication For People with Asthma (Combined Rate 5-59)*

CY 2006 Target =92%**

Values shown: 58.94, 85.43, 66.57, 72.77, 89.34, 90.57

Legend:
- FHP Result (42% increase)
- HEDIS 2006 Medicaid Mean

*Audited Measure

9
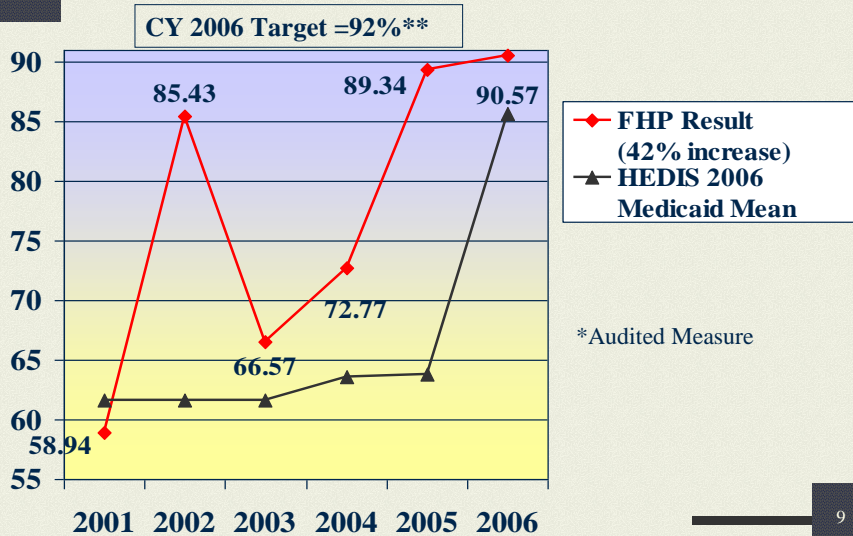
39

Mental Health F/U after Hosp (7days)

CY 2006 Target = 44%

- FHP Result (78.2% increase)
- HEDIS 2006 Medicaid Mean

48.5
42.9   45.2
40.9
38.8
34
30
27.9

1999 2000 2001 2002 2003 2004 2005 2006
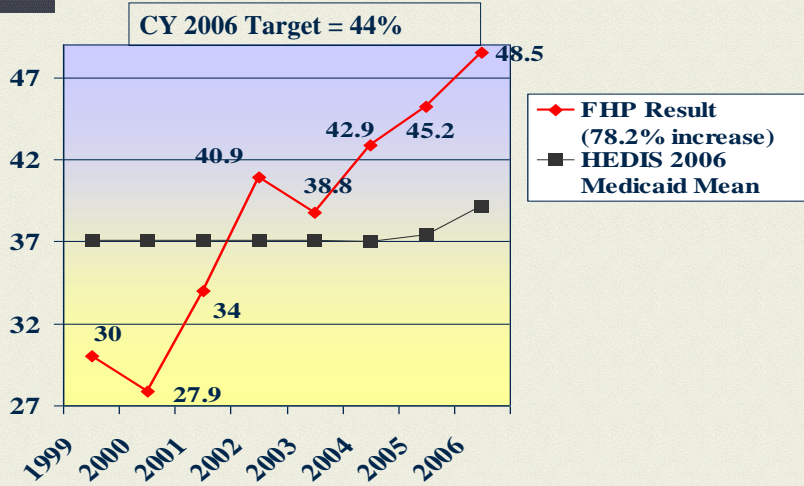
13

Mental Health F/U after Hosp (30 days)

CY 2006 Target = 70%

- FHP Result (71.8% increase)
- HEDIS 2006 Medicaid Mean

88.4
71.5
68.5
64.9
60.9
57.9
53.3
51

1999 2000 2001 2002 2003 2004 2005 2006

14

40
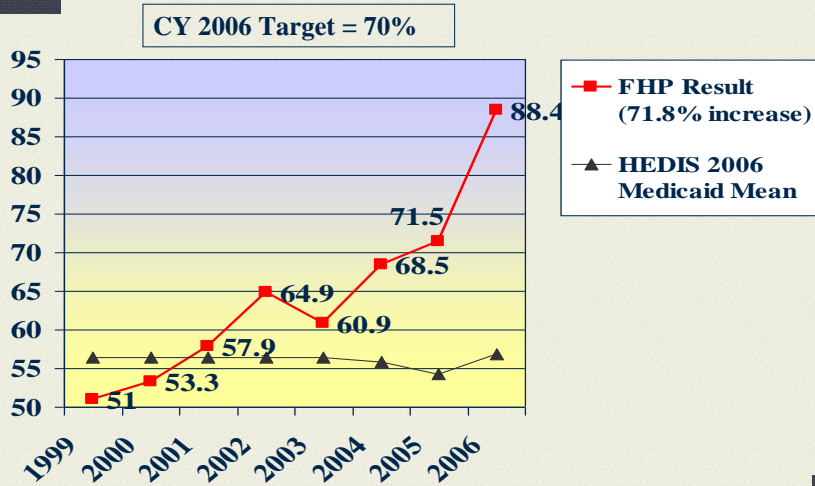
Timeliness of Prenatal Care

CY2006 Target = Monitor

Chart: FHP Result (6% decrease) and HEDIS 2006 Medicaid Mean, years 2000–2006.
Data points: 78.35 (2000), 90.51 (2002), 74.21 (2004), 75.43 (2005), 79.51 (2006).
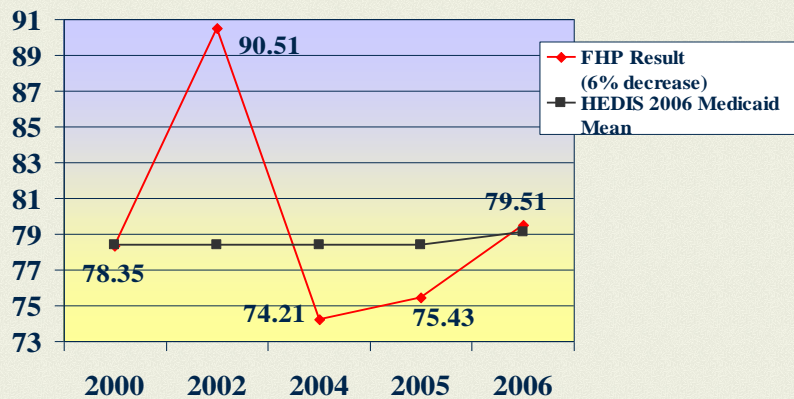
Postpartum Care

CY 2006 Target = Monitor

Chart: FHP Result (5.4% increase) and HEDIS 2006 Medicaid Mean, years 2000–2006.
Data points: 55.23 (2000), 53.77 (2002), 48.18 (2004), 56.69 (2005), 57.28 (2006).

Annual Dental Visits*

CY 2006 Target = 40%

FHP Results (13.6% increase)
HP 2010
HEDIS 2006

*Audited Measure
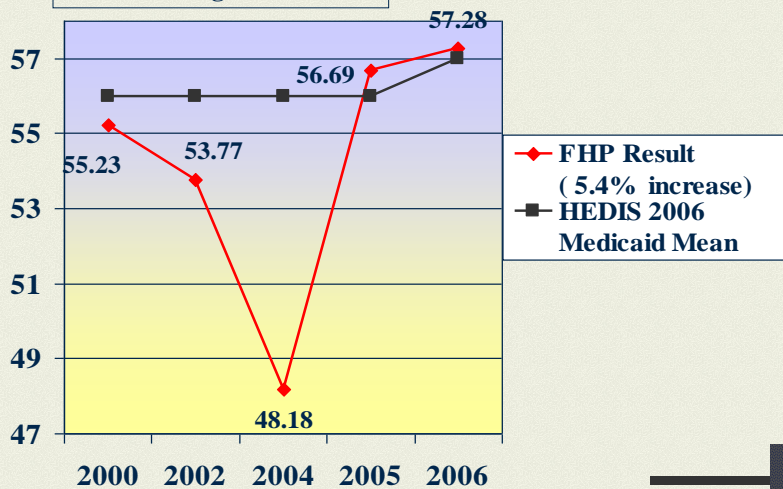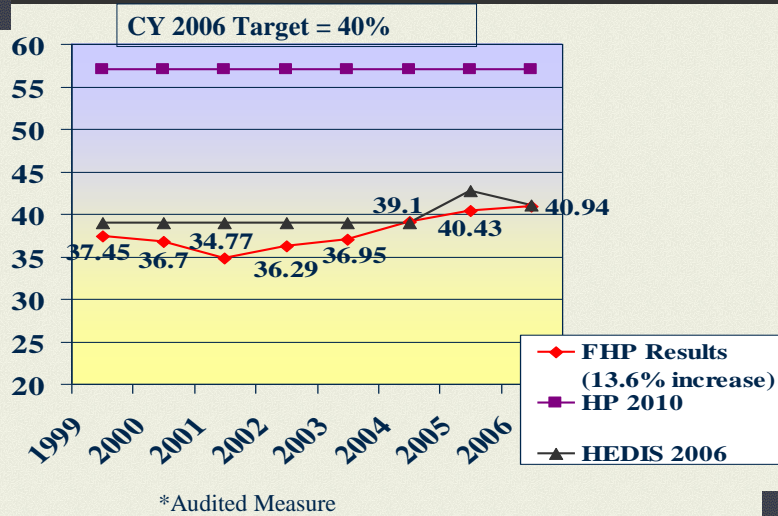
7

Six or More Well Child Visits in 1st 15 months of Life

FHP (185% increase)
HEDIS 2006 Medicaid Mean
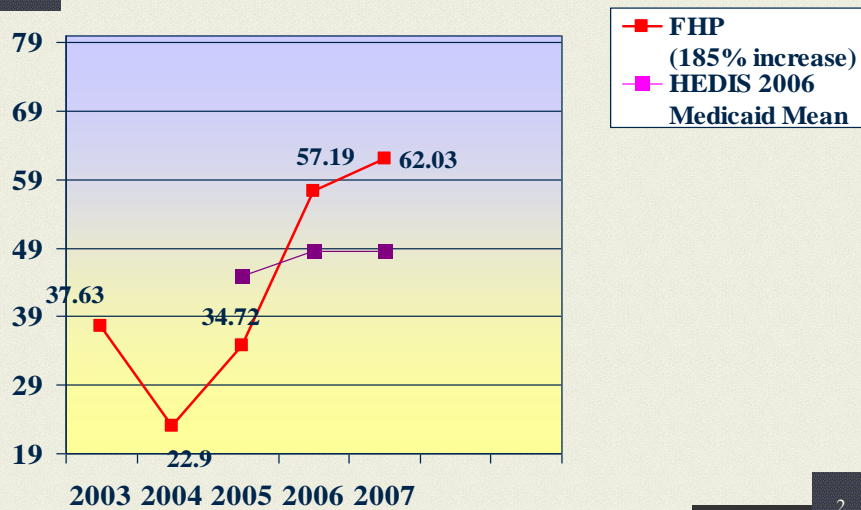
2

Well Child Visits 3-6 years

CY 2006 Target = 80%

FHP Result (41% increase)
HP 2010
RFP Target
HEDIS 2006 Medicaid Mean

55.37 49.55 48.8 46.5 47.8 56.3 72.75 66.3

Adolescent Well Care*

CY 2006 Target = 80%

FHP Result (8.7% increase)
HP 2010 Target
RFP Target
HEDIS 2006 Medicaid Mean

38.86 32.79 32.33 30.3 32.9 33.1 33.1 42.82

*Note HEDIS Measure different from periodicity schedule

*Audited Measure
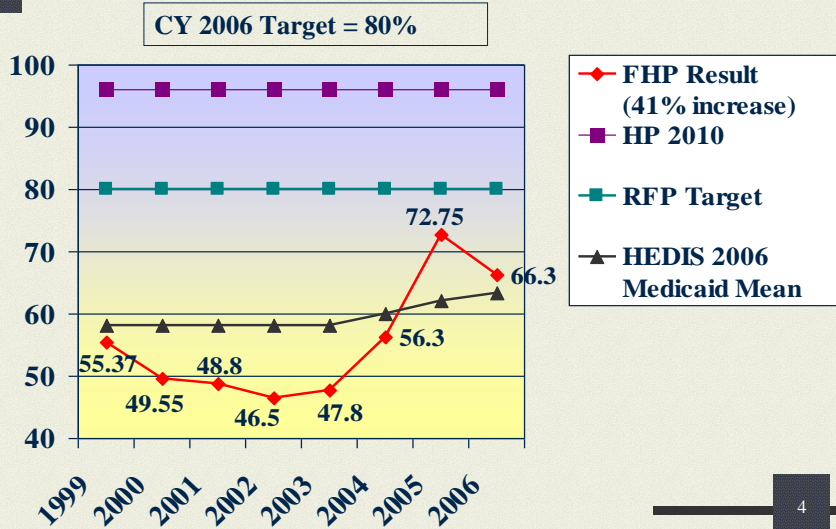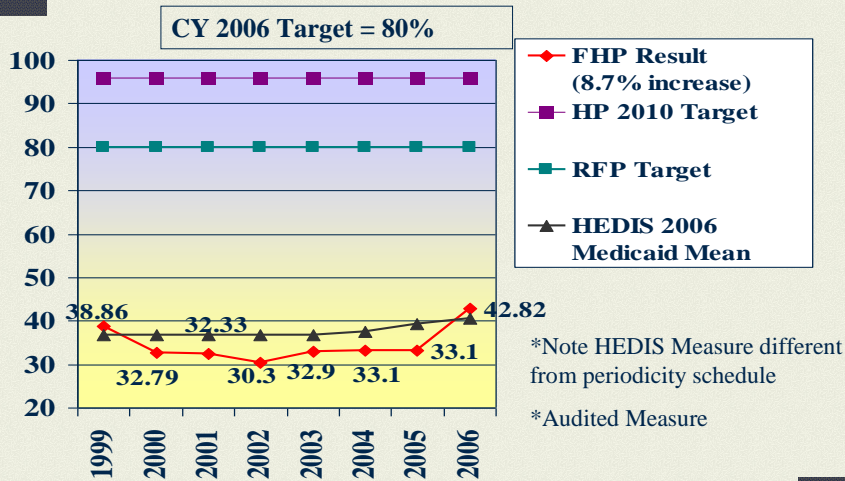
Ambulatory Care
(ER Visits/1000mbrs)

Legend:
- FHP Results (35% increase)
- HEDIS 2006 Medicaid Mean

Data points: 59.56, 54.87, 60.62, 61.41, 77.93

Years: 2001, 2002, 2004, 2005, 2006

17

Ambulatory Care
(Out patient visits/1000mbrs)

Legend:
- FHP Results (3% increase)
- HEDIS 2006 Medicaid Mean

Data points: 235.92, 296.79, 365.29, 370.9, 337.25

Years: 2001, 2002, 2004, 2005, 2006
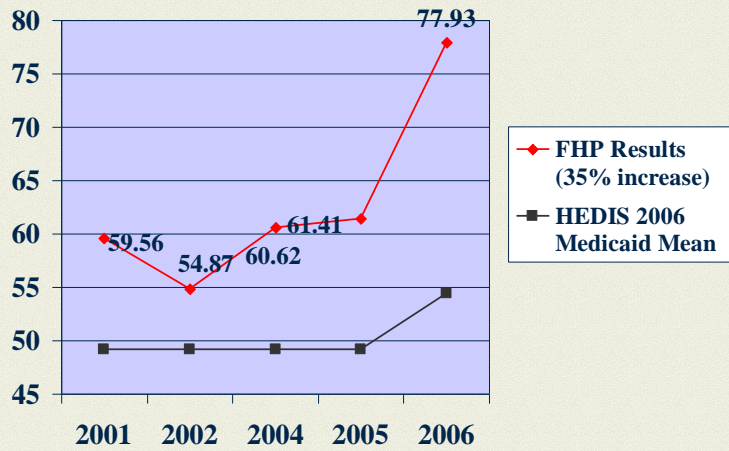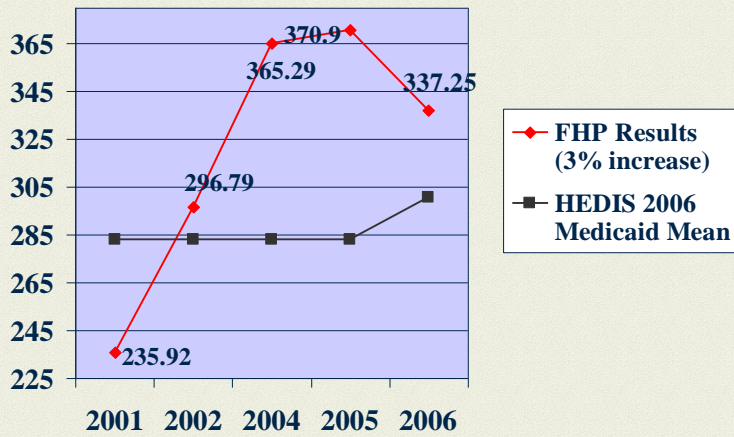
18

Ambulatory Care
(Amb Surg Proc/1000mbrs)

Legend:
- FHP Results (43.3% increase)
- HEDIS 2006 Medicaid Mean

Data points: 3.64, 3.42, 4.29, 4.67, 4.71

Years: 2001, 2002, 2004, 2005, 2006
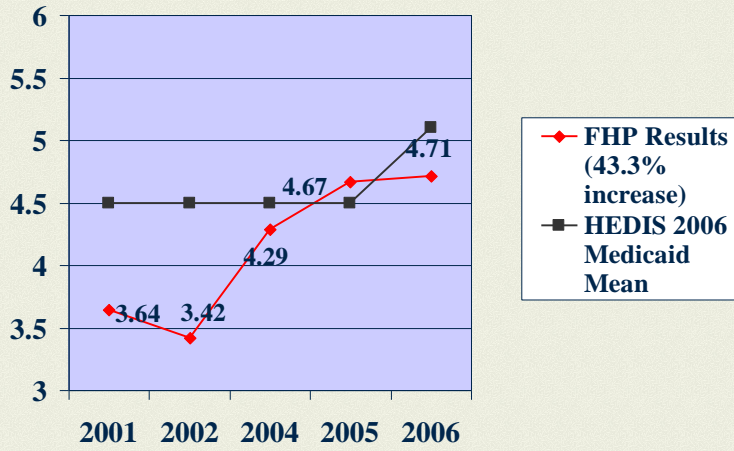
Mental Health Utilization
Any MH Service

CY 2006 Target = Monitor

Legend:
- FHP Result (123.2% increase)
- HEDIS 2006 Medicaid Mean

Data points: 4.82, 4.54, 5.39, 6.95, 7.82, 8.3, 8.46, 7.53

Years: 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006
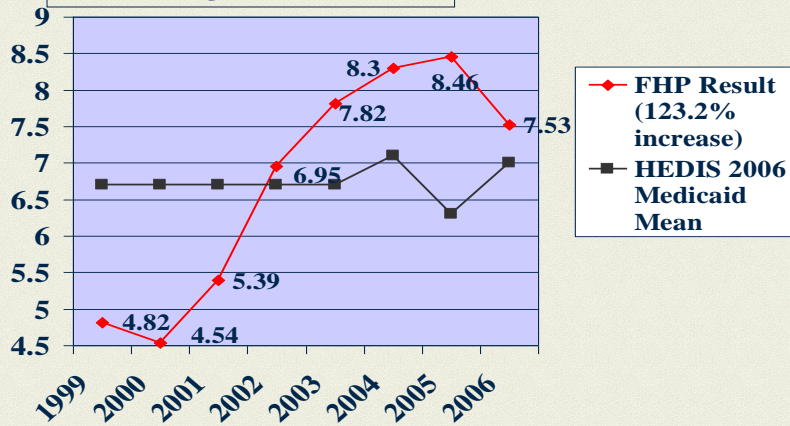
Identification of Alcohol and Drug Services - Any AD Service
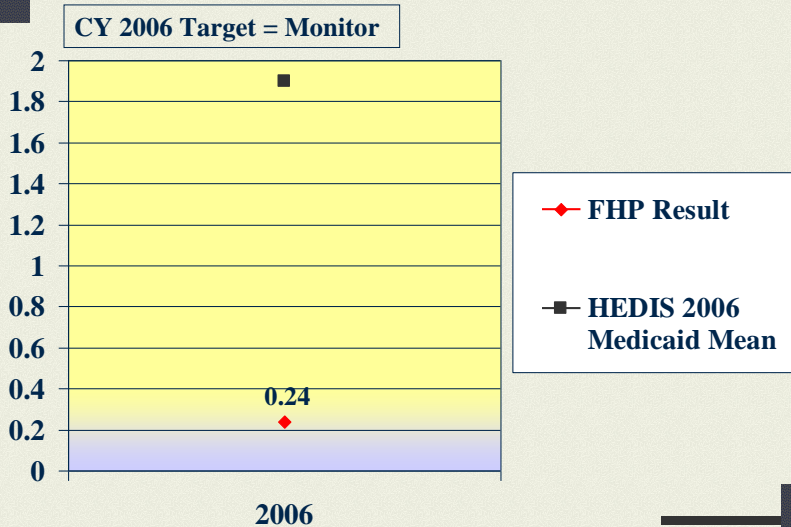
CY 2006 Target = Monitor

FHP Result

HEDIS 2006 Medicaid Mean

0.24

2006

4

Trends in Missouri Medicaid Quality Indicators
HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

HEDIS indicators MO Health Net Maternal Outcomes for Western Region

The Department of Health and Senior Services calculates and reports Maternal and Child Quality Indicators based on data from birth certificate information. Opportunities for improvement are discussed and evaluated.

Improvement initiatives implemented based on Children's Mercy Family Health Partners' Maternal-Child indicator results included:
- Outreach to members and providers to increase the rate of prenatal care initiation in the first trimester of pregnancy,
- Targeted OB case management to outreach to high risk pregnant women for improved birth outcomes,
- Addition of an Administrative Assistant to the OB case management group for processing of pregnancy notification forms, screening of risk factors, referral to an OB Case Manager, general OB education for all newly pregnant members, and coordination of services with OB provider offices,
- Increased provider reimbursement for provision of global services to identified high risk members

Please see the following graphs for demonstration of Children's Mercy Family Health Partner's tracking and trending of maternal child indicators.

CMFHP Maternal Health Indicators
Percent of Women With Prenatal Care
(Based on DHSS Data 2006 - Total deliveries =Total live births to women with know prenatal care)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP
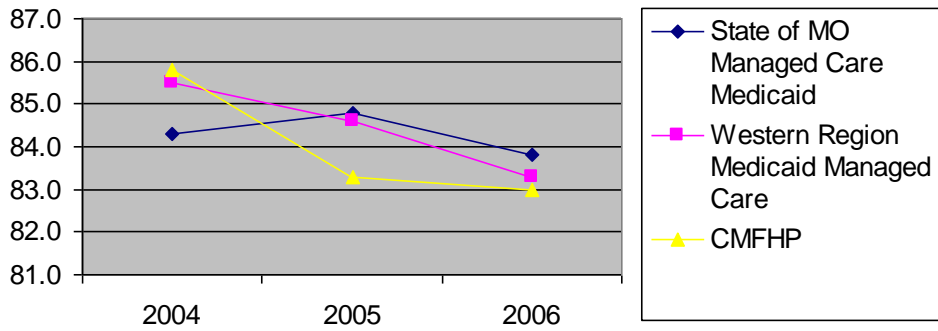
CMFHP Maternal Health Indicators
Percent of Women Receiving Early Prenatal Care
(Based on DHSS Data 2006- Total deliveries=Total live births to continuously enrolled women for 280 days prior to delivery)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP
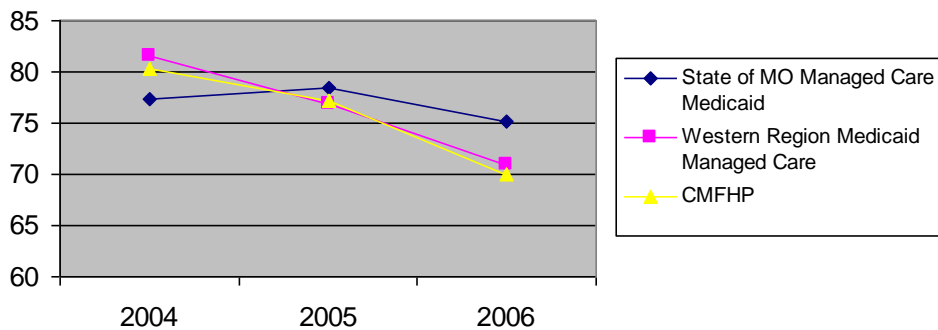
CMFHP Maternal Health Indicators
Percent of Prenatal WIC Participants
(Based on DHSS Data 2006)
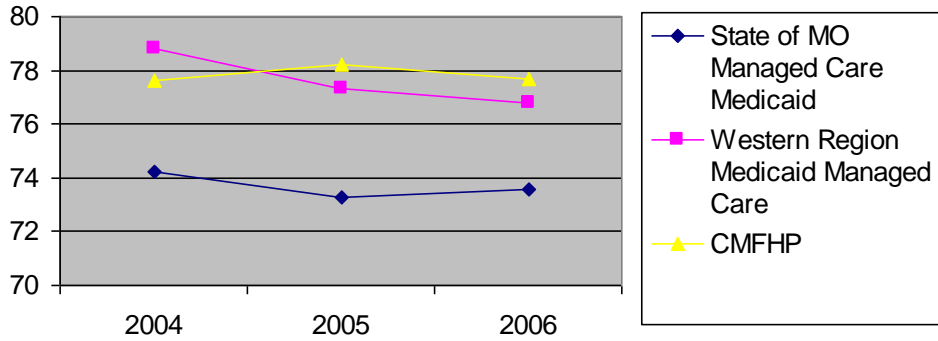
CMFHP Maternal Health Indicators
Percent of Repeat Births to Women <20 years
(Based on DHSS Data 2006)
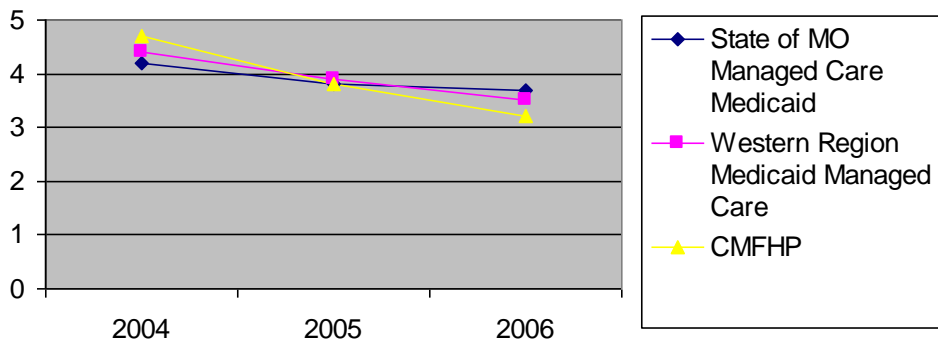
**CMFHP Maternal Health Indicators
Percent of Births to Women <18 years
(Based on DHSS Data 2006)**
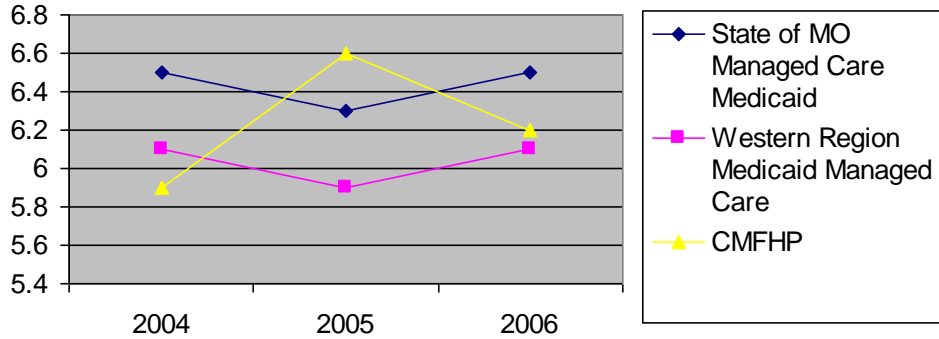
**CMFHP Maternal Health Indicators
Percent of Women with Birth Spacing <18 Months
(Based on DHSS Data 2006)**

CMFHP Maternal Health Indicators
Percent of Women Smoking During Pregnancy
(Based on DHSS Data 2006)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Health Indicators
Cesarean Section Deliveries
(Based on DHSS Data 2006)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP
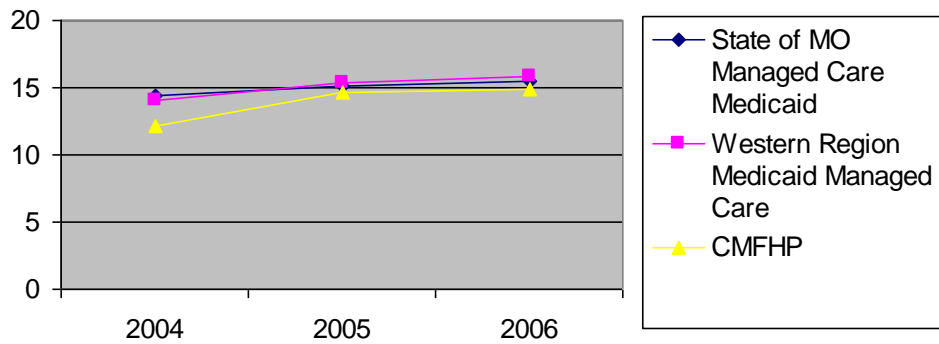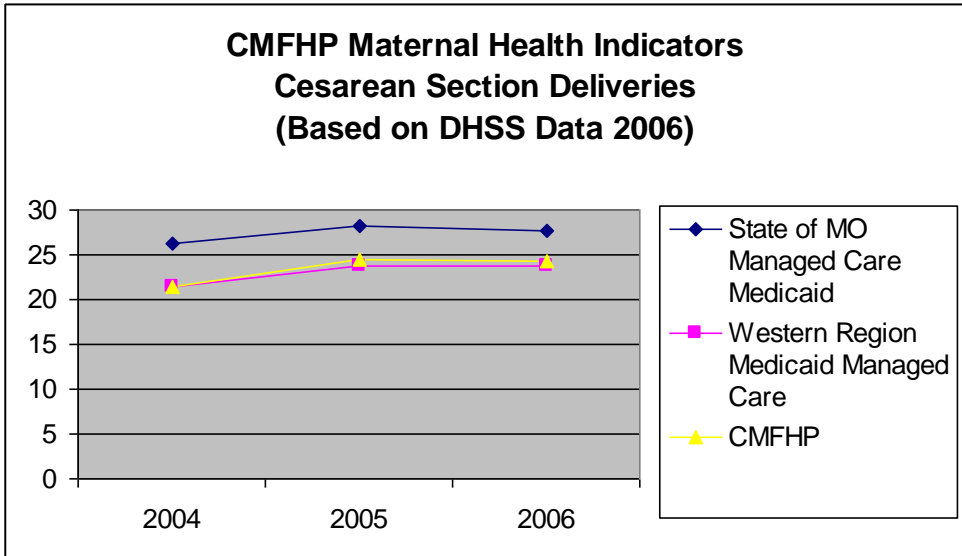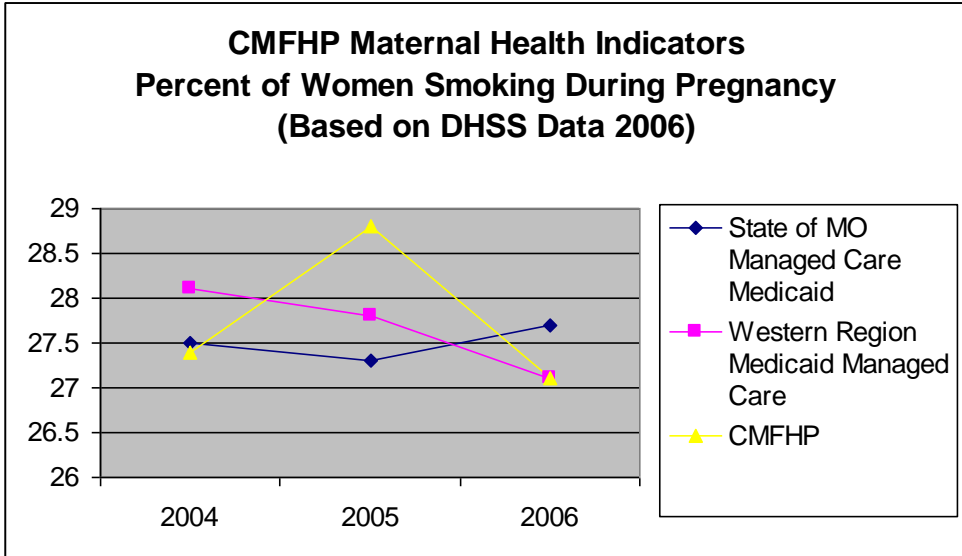
CMFHP Maternal Health Indicators
Vaginal Deliveries After C/S
(Based on DHSS Data 2006)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Health Indicators
Percent of Low Birth Weight Deliveries (<2500 Grams)
(Based on DHSS Data 2006)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Health Indicators
Percent of LBW Deliveries in Level II/III Hospitals(<2500 Grams)
(Based on DHSS Data 2006)

CMFHP Maternal Child Health Indicators
Percent of VLBW (Infants <1500 Grams)
Delivered in Level II/III Hospitals
(Based on DHSS Data)
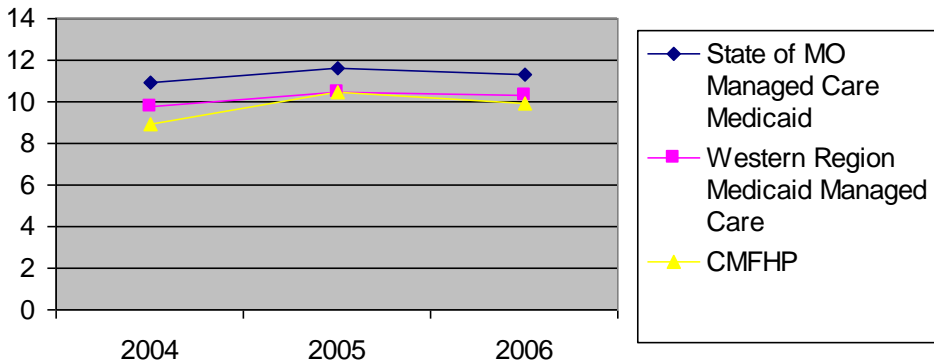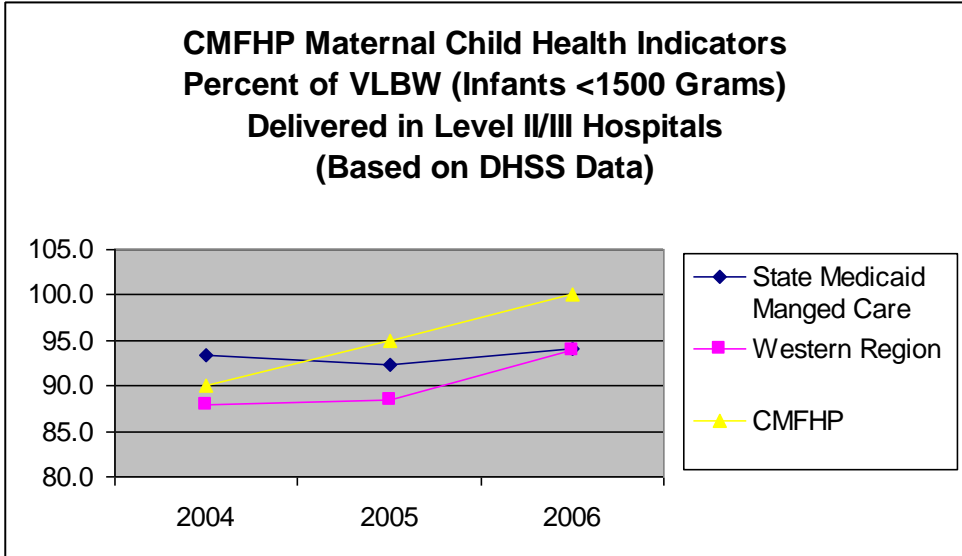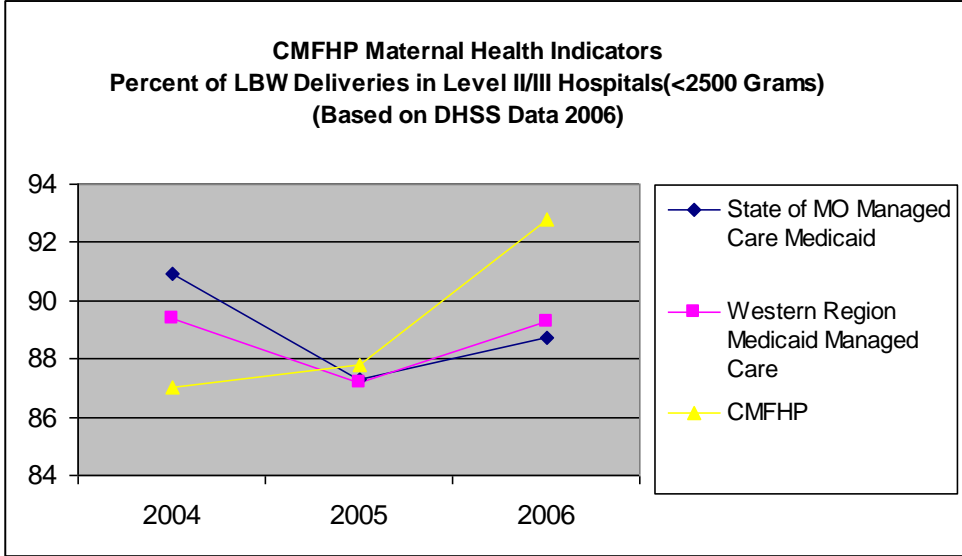
Attachment QI 1

QUALITY INDICATORS

Performance Measures

<u>Effectiveness of Care</u>

1	(H) Childhood Immunization Status (CIS)	Combo 2	Combo 3
		72%	61%
2	(H) Adolescent Immunization Status (AIS)	Combo 2	
		17%	
3	(H) Cervical Cancer Screening (CCS)	68%	
4	(H) Chlamydia Screening in Women (CHL)	56%	
5	(H) Follow-up after Hospitalization For Mental Health Disorders (FUH)		
	7-day follow-up	59%	
	30-day follow up	76%	
6	(H) Use of Appropriate Medications for People with Asthma (ASM)		
	Ages 5-9	92%	
	Ages 10-17	91%	
	Ages 18-56	83%	
	Combined	90%	

<u>Access/Availability of Care</u>

7	(H) Prenatal and Postpartum Care (PPC)	
	Timeliness of Prenatal Care	40%
	Postpartum Care	56%
8	(H) Annual Dental Visit (ADV)	
	2-3 y/o	12%
	4-6 y/o	37%
	7-10 y/o	45%
	11-14 y/o	37%
	15-18 y/o	31%
	19-21 y/o	17%
	Combined	34%

Satisfaction with the Experience of Care

9 (H) CAHPS 3.OH Child/Adult Survey		2007	2006	2005	2004	2003
	Getting Needed Care	80%	81%	84%	81%	79%
	Getting Care Quickly	78%	80%	79%	79%	79%
	How well Doctors Communicate	89%	92%	90%	90%	89%
	Courteous and Helpful Office Staff	90%	92%	91%	90%	91%
	Customer Service	64%	77%	77%	72%	75%
	Rating of Personal Doctor	80%	78%	78%	79%	77%
	Rating of Specialist	79%	77%	86%	80%	71%
	Rating of Health Care	82%	80%	76%	82%	80%

Use of Services

10	(H) Well child Visits in the First 15 Months of Life (W15)	
	0 visits	3%
	1 visits	5%
	2 visits	6%
	3 visits	9%
	4 visits	16%
	5 visits	23%
	6 or more visits	39%
11	(H) Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)	56%
12	(H) Adolescent Well-Care Visits (AWC)	33%

13	(H) Ambulatory Care (AMB)	Ambulatory Care (Total)		Outpatient Visits		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
		Age	Member Months	Visits	Visits/ 1000 Member Months	Visits	Visits/ 1000 Member Months	Procedures	Procedures / 1000 Member Months	Stays	Stays/ 1000 member Months
		<1	23498	19428	826.79	2126	90.48	102	4.34	36	1.53
		1--9	132581	38707	291.95	5922	44.67	440	3.32	43	0.32
		10--19	97431	18994	194.95	4220	43.31	211	2.17	106	1.09
		20--44	52769	15383	291.52	5848	110.82	550	10.42	419	7.94
		45--64	3660	1367	373.5	295	80.6	72	19.67	4	1.09
		65--74	4	4	1000	0	0	1	250	0	7.64
		75--84	0	0	NA	0	NA	0	NA	0	1.09
		85+	0	0	NA	0	NA	0	NA	0	0.00
		Unknown	0	0		0		0		0	
		Total	309943	93883	302.9	18411	59.4	1376	4.44	608	1.96

14	(H) Mental Health Utilization - Percentage of Members Receiving Inpatient, Intermediate Care and Ambulatory Services (MPT)	Not Reported					

15	(H) Identification of Alcohol and Other Drug Services (IAD)	Inpatient Chemical Dependency Services		Intermediate Chemical Dependency Services		Ambulatory Chemical Dependency	
		Number	Percent	Number	Percent	Number	Percent
		132	0.51%	0	0.00%	194	0.75%

TRENDS IN MISSOURI MEDICAID QUALITY INDICATORS

1	Trimester Prenatal Care Began:		2006		Significant		
			Births	Percent	Change***		
		First	4,212	78.3%	Yes		
		Second	970	18.0%	Yes		
		Third	154	2.9%	No		
		None	44	0.8%	Yes		
		Total	5,380				
2	Inadequate Prenatal Care						
	Percentage of Visits		<21	21-40	41-60	61-80	81+
	Percentage of accessing prenatal care		73%	16%	4%	3%	5%
3	Birth weight (grams) - total number of births by weight category for each live birth.		2006		Significant		
			Births	Percent	Change***		
		<500 Grams	21	0.4%	No		
		500-1499 Grams	77	1.3%	No		
		1500-1999 Grams	100	1.7%	No		
		2000-2499 Grams	338	5.8%	No		
		2500 Grams	5,334	90.9%	No		
		Total	5,870				
4	Low Birth Weight (<2500 grams)		Births	Percent	Change***		
			536	9.1%	No		
5	Method of Delivery		Births	Percent	Change***		
		C-Section	1,363	23.2%	No		
		VBAC	68	12.1%	Yes		
		Repeat C-Section	493	87.9%	Yes		
		Total	5,872				
6	Smoking During Pregnancy		Births	Percent	Change***		
			1,500	25.5%	No		
7	Spacing <18 months since last birth		Births	Percent	Change***		
			557	16.7%	No		
8	Births to mothers <18 years of age		Births	Percent	Change***		
			338	5.8%	No		
9	Repeat teen births		Births	Percent	Change***		
			204	3.5%	No		
10	Fetal Deaths (20+ weeks) Rate per 1000 Live Births		Births	Rate	Change***		
			21	3.6	No		
11	Total live birth or stillbirth fetuses 500 grams or more		Births	Rate	Change***		
	Rate per 1000 population		5,864	197.6	No		

12	Percent of pregnant women on Women's Infants and Children Program (WIC)	Births	Percent	Change***
		4,584	78.1%	No
13	VLBW not delivered in level 111 hospitals	Births	Percent	Change***
		17	17.7%	No

14	Average maternal length of stay (days), Inpatient admissions	Total	Days
		5,920	2.7

15	Average newborn length of stay (days), Inpatient admissions	Average Length of Stay	
	Total Newborns	3.64	
	Total Well Newborns	2.23	
	Total Complex Newborns	16.04	

16	Average behavioral health length of stay (days), Inpatient admissions	Total	Days
		7,790	7.9

17	Asthma admissions under age 18, Inpatient admissions Rate per 1000 Populaiton	Number	Rate
		218	1.1

18	Asthma admissions 4-17 Inpatient admissions Per 1000 Population	Number	Rate
		149	1.0

19	Asthma admissions ages 18 - 64, Inpatient admissions	Number	Rate
		836	1.2

20	Emergency room visits under age 18 Per 1000 Population	Number	Rate
		51,598	266.3

21	Emergency room visits ages 18 - 64 Per 1000 Population	Number	Rate
		######	344.8

22	Hysterectomies Per 1000 Population	Number	Rate
		1,769	5.1

23	Vaginal hysterectomies	Number	Percent
		590	33.4%

24	Preventable hospitalization under age 18 Per 1000 Population	Number	Rate
		1,089	5.6

***Statistically significant change between CY2005 and Jan-Sept 2006 at .05 level of significance using Chi-square test

HEDIS® Indicators by Missouri Medicaid Managed Care Plans within Regions: Live Births
Blue-Advantage Plus of Kansas City, Inc.

Indicator Name	2005 Rate*	2004 Rate*	2003 Rate*	Significantly different from MEDICAID Managed Care	State Rate	2005 Number	Total Deliveries
CESAREAN SECTIONS	23.3	22.8	22.1	Low	Low	409	1,757
VAGINAL BIRTH AFTER CESAREAN (VBAC)	4.8	13.8	16.4	***	***	8	166
ADEQUACY OF PRENATAL CARE	86.8	85.9	86.8	High	Low	1,438	1,656
EARLY PRENATAL CARE	81.7	84.4	81.4	No	Low	348	426
LOW BIRTH WEIGHT (LBW, LESS THAN 2500 G)	7.2	9.6	9.6	Low	No	30	414
LOW BIRTH WEIGHT (LBW, LESS THAN 2500 G) DELIVERED IN LEVEL II/III HOSPITALS	84.0	89.0	91.5	No	No	121	144
VERY LOW BIRTH WEIGHT (VLBW, LESS THAN 1500 G) DELIVERED IN LEVEL II/III HOSPITALS	76.7	68.4	96.3	Low	No	23	30
SMOKING DURING PREGNANCY	28.4	29.4	27.9	No	High	499	1,757
SPACING LESS THAN EIGHTEEN MONTHS	15.9	14.6	14.0	No	High	163	1,024
BIRTHS TO MOTHERS LESS THAN 18 YEARS	5.1	6.1	6.8	Low	High	90	1,757
REPEAT BIRTHS TO TEEN MOTHERS (LESS THAN 20 YEARS)	3.8	3.4	3.7	No	High	66	1,757
PRENATAL WIC PARTICIPANTS	74.8	79.0	77.3	No	High	1,309	1,750

*Per/1000

Accessibility
of
Services

Accessibility of Services

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Average Speed of Answer
Call Abandonment Rate

Pre-authorization Department
The pre-authorization staff continue to strive to meet the authorization needs of the provider network. The department uses an automatic call distribution system (ACD) to monitor and track telephone statistics. In 2006 and 2007, abandonment rate and average speed to answer were measured and analyzed.

Pre-authorization Statistics
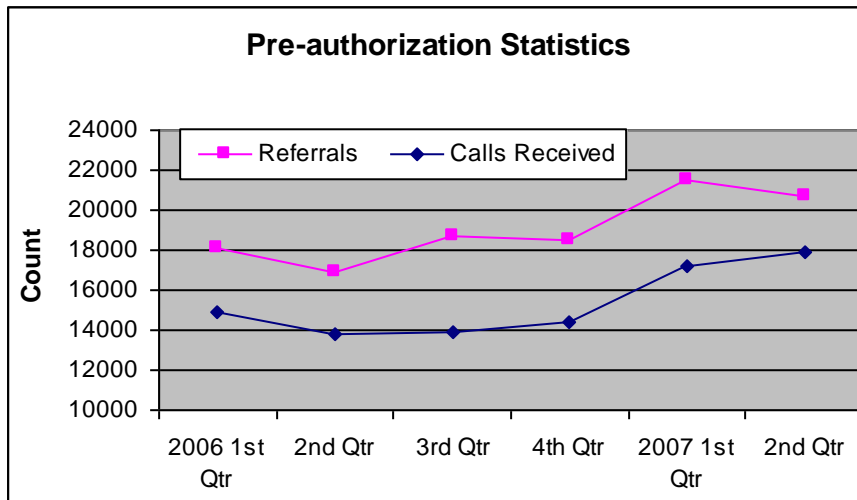
Source: ACD System

The total number of calls received and referrals completed significantly increase in 1st quarter 2007 after the acquisition of the FirstGuard membership.

Pre-auth Call Abandonment Rate
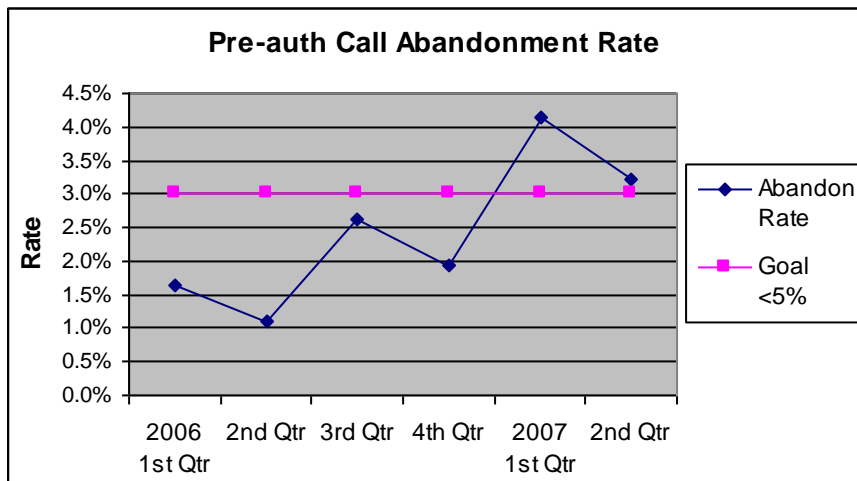
Source: ACD System

The abandonment rate remained below the goal of 5% until 1st quarter 2007 with the increased call volume of the FirstGuard acquisition.

Pre-auth Average Speed to Answer
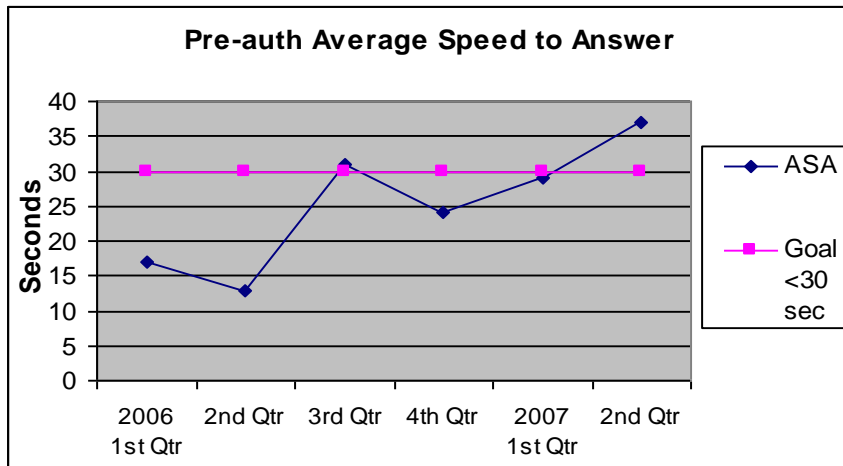
Source: ACD System

The average speed to answer (ASA) has been calculated by taking the average of the monthly averages. The ACD system provides summarized data on the ASA on a monthly basis. The ASA exceeded the goal of 30 seconds in 3rd quarter 2006 and 2nd quarter 2007 due to staffing changes.

Customer Service Organization
The member services department at HealthCare USA maintained a focus in 2006-2007 to ensure high-quality customer service through ongoing monitoring of several key indicators. In 2006-2007, the member services department monitored Call Volume, 1st Call Resolution, Average Speed of Answer, Call Abandonment Rate, Telephone Service Level, Average Handle Time, Call Accuracy, Doc Bear Club Education and Language Access.

CSO Calls Answered

Source: ACD System

2

CSO Average Speed to Answer
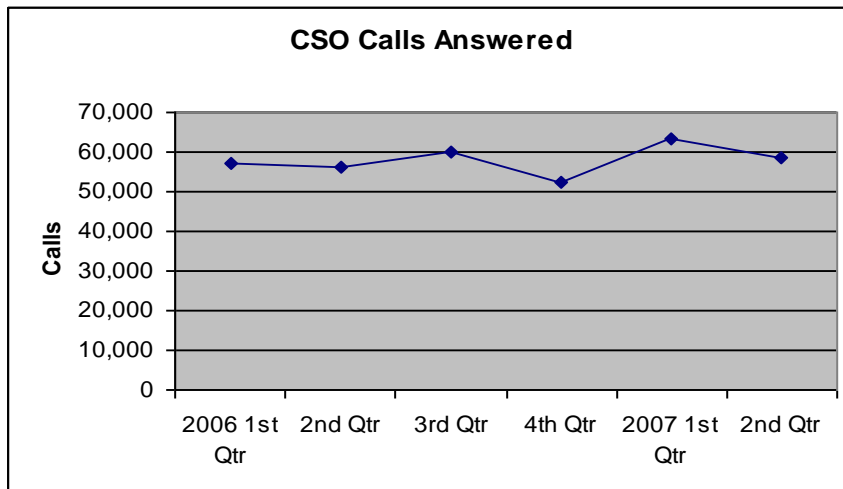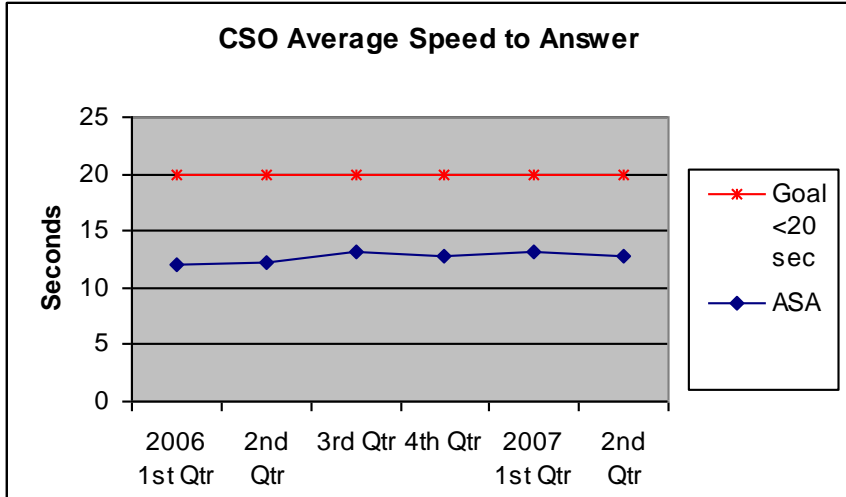
Source: ACD System

The call volume in 2006 decreased slightly (1%) as compared to 2005. The call volume in 2007 increased by 9.2% as compared with 2006. The overall contributing factor was a membership increase between the 1st and 2nd quarter of 2007. This membership increase was related to the acquisition of an additional 30,000 members from FirstGuard. Despite an increase in call volume, the rate of average speed to answer has remained below goal of 20-30 seconds.

CSO Service Level
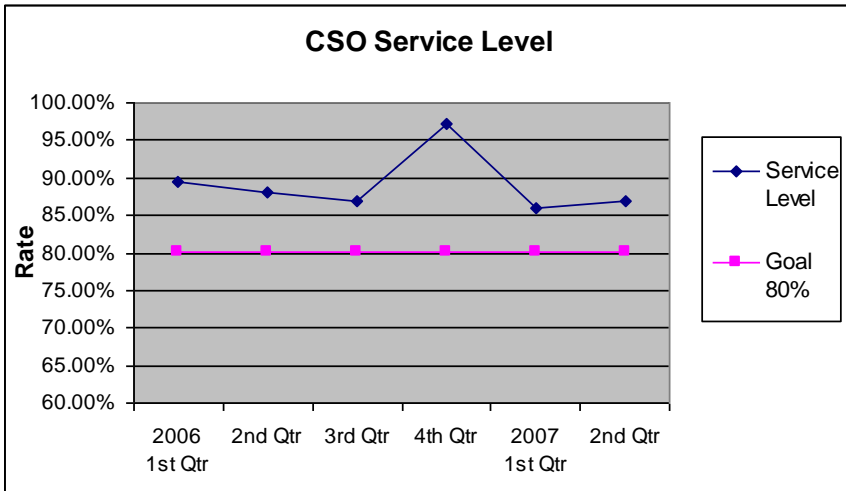
Source: ACD System

The overall rating for customer service has remained well above the 80% target.

CSO Abandonment Rate
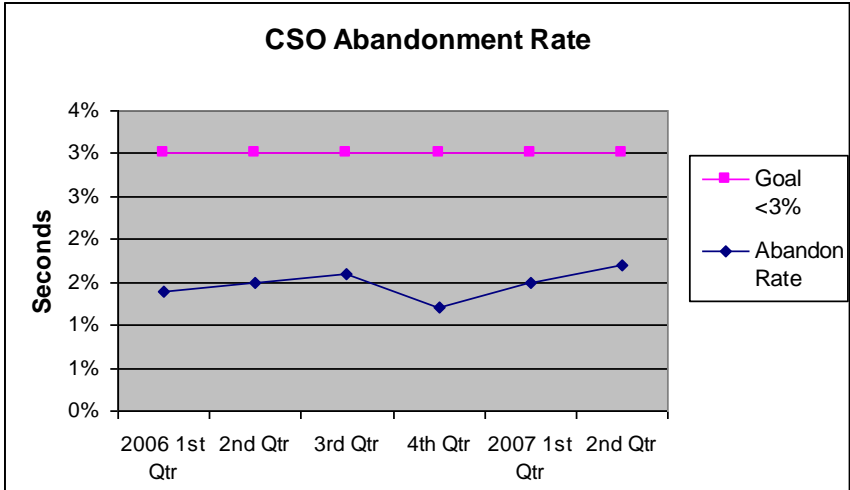
Source: ACD System

The call abandonment rate remained consistent with either meeting or exceeding the performance goal. The member services department holds bi-weekly team meeting with all staff members to review all policies and procedures on a continuous basis.

Management staff review top provider calls on a monthly, quarterly and yearly basis to identify any trends related to calls, this includes reviewing requests to change PCP. The top four calls for 2006-2007 are as followed:

Top Four Calls 2006	**Top Four Calls 2007**
Eligibility	Eligibility
ID Card Requests	Claim Status
PCP Inquires	Member Retention
Claim Status	PCP Change

The member services department is committed to continuing efforts in 2007 related to ongoing monitoring through the purchase of web based programs utilized to monitor member service calls for quality and track and trending purposes.

Six (6) to eight (8) week training classes are conducted for all new hires that encompasses system overview, benefit review, contract review, provider selection, HIPPA guidelines, navigator review, customer service standards, call tone, documentation, complaints and appeals, member rights, remittance advices, web services, transportation, boys and girls clubs, direct provider and call monitoring procedures. All employees are brought back to training after 90 days to receive additional training on claims processing.

Training programs continue in 2007, with interest in career development of employees, including but not limited to, call tone, documentation, grammar, and outbound call monitoring. A learning management system has been implemented to deliver training for the development of current staff and enhance learning opportunities for staff with visions of growth in the organization.

Non-Routine Needs Appointments
Routine Needs Appointments
Access to Emergent and Urgent Care
24 Hour Access/After Hours Availability

Includes Non-Routine Needs Appointments, Access to Emergent and Urgent Care and 24 Hour Access/After Hours Availability

2006 Access and Availability Study
In 2006, the Provider access study included a random sample of primary care providers, OB/GYN providers and high-volume specialists across all three regions of the network. Of all types, 425 network provider practices were represented

Primary Care Providers	320
OB-Gyn Providers	45
High-volume Specialists	60

Source: CPD

Provider Relations conducted random telephonic surveys with providers in all 3 regions to assure access and compliance with contractually required appointment standards, as noted in the Provider Accessibility Standard section of the 2006 Provider Reference Guide. In addition, calls were conducted after-hours to PCPs to ensure compliance with after hours availability standards.

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

Appointment Standard – OB/GYN
- OBs will see a first trimester member within seven (7) calendar days of first request.
- OBs will see a second trimester member within seven (7) calendar days of first request.
- OBs will see a third trimester member within three (3) calendar days of first request.
- OBs will see a member identified as "high-risk" within three (3) days or immediately if emergency exists.

Appointment Standard – Specialist
- Specialists will see a member immediately for emergent care.
- Specialists will see a member within 24 hours for an urgent care appointment.
- Specialists will see a member four routine care with symptoms, within five business days.

Provider After Hours Access Standard

- Participating providers 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.

Study Results
Primary Care - Appointment Standards
- 97% of providers surveyed met these appointment standards
Primary Care - After Hours Access Standards
- 93% of providers surveyed met the after hours availability access standard

OB/Gyn - Appointment Standard:
- 90% of providers surveyed met these appointment standards
OB/Gyn - After Hours Access Standard:
- 92% of providers surveyed met the after hours availability access standard

High-volume Specialist Appointment Standard:
- 90% of providers surveyed met these appointment standards
High-volume Specialist After Hours Access Standard:
- 97% of providers surveyed met the after hours availability access standard

Providers identified in this study as not meeting the required standard for access and availability were contacted by their regional Provider Relations Representative and further educated regarding the standards and the provider's obligation to comply. Demographic updates such as phone number changes, physicians who left the practice, etc. were also identified and corrected.

For the providers identified as not meeting the required after-hours access or coverage, follow-up contacts via Provider Relations revealed errors by provider's office staff such as failure to roll phones over to the after hours phone service, outdated after hours messages or disconnection issues. In each case, the provider responded to feedback from HealthCare USA and corrected the issue immediately.

Following each survey, Provider Relations staff also gave feedback to the randomly selected providers regarding the results of their assessment.

Provider Relations will continue ongoing monitoring of the Primary Care, OB/Gyn and high-volume network providers for appropriate access and availability, and implement interventions as necessary. In 2007, the provider appointment access survey portion will be completed by the local provider relations representative during a routine provider visit to measure compliance of the access and availability standards and to assess average waiting times for appointments. After hours access and availability will be verified after-hours by placing a phone call to the practice outside of normal operating business hours for availability determination.

Network Adequacy – Provider/Enrollee Ratios

Network adequacy is a key area in performance monitoring for appropriate access to health services for our membership. HealthCare USA reviews and analyzes network adequacy and availability throughout the year and performs a formal geo-access analysis annually. This provides management, contracting, and provider relations necessary information to establish priorities in developing the network and closing any gaps in access that may occur.
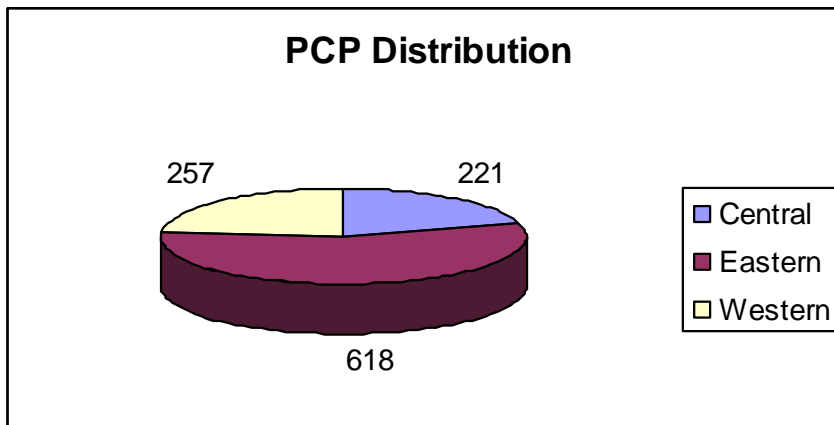
Provider Access

HealthCare USA submits an annual Network Adequacy filing to the Missouri Department of Insurance (MDI) for analysis and scoring. For period ending December 31, 2006, HealthCare USA members had 100% access to Primary Care Providers in Central, Eastern and Western regions in Missouri.

Primary Care Providers for Period ending 12/31/06				
Region	Central	Eastern	Western	Total
# Providers	221	618	257	1096
Member to Provider Ratio	94.51	193.64	40.71	137.79

Specialty Care Providers for Period ending 12/31/06				
Region	Central	Eastern	Western	Total
# Providers	343	3198	632	4173
Member to Provider Ratio	60.89	37.42	16.56	36.19

Hospital Providers for Period ending 12/31/06				
Region	Central	Eastern	Western	Total
# Providers	12	29	28	69

Data retrieved from GEO access report results
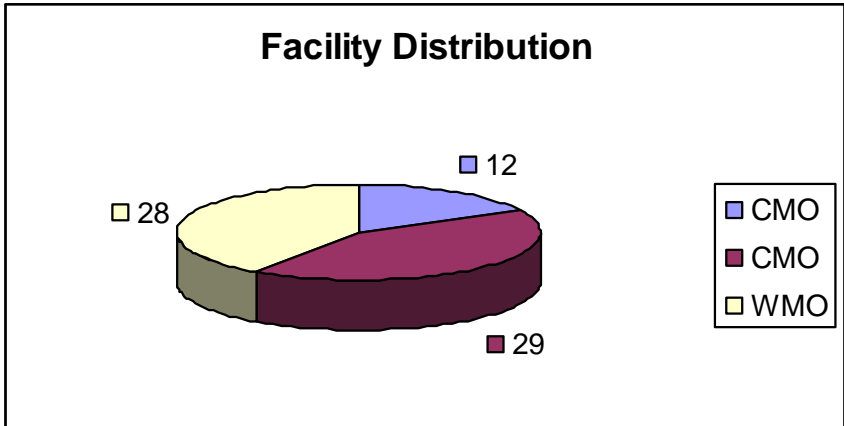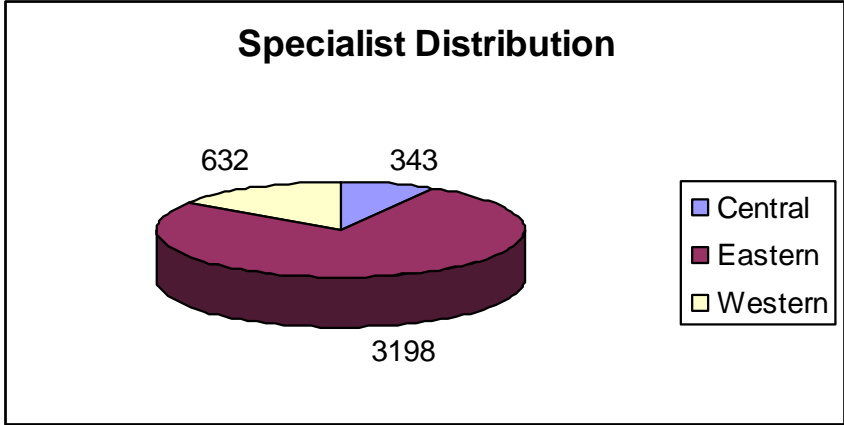
PCP Distribution

257 221

618

- Central
- Eastern
- Western

Specialist Distribution

632   343

3198

- Central
- Eastern
- Western

Facility Distribution

□ 12

□ 28

□ 29

- CMO
- CMO
- WMO

Primary Care Providers for Period ending 6/30/07				
Region	Central	Eastern	Western	Total
# Providers	231	615	339	1185
Member to Provider Ratio	98.32	188.85	28.65	125.37

Specialty Care Providers for Period ending 6/30/07				
Region	Central	Eastern	Western	Total
# Providers	407	3177	895	4479
Member to Provider Ratio	55.81	36.56	10.85	33.17

Hospital Providers for Period ending 6/30/07				
Region	Central	Eastern	Western	Total
# Providers	14	30	29	73

Data retrieved from Geo Access report results

PCP Distribution

339   231   615
Central, Eastern, Western

Specialist Distribution

895   407   3177
Central, Eastern, Western

Facility Distribution

29   14   30
Central, Eastern, Western
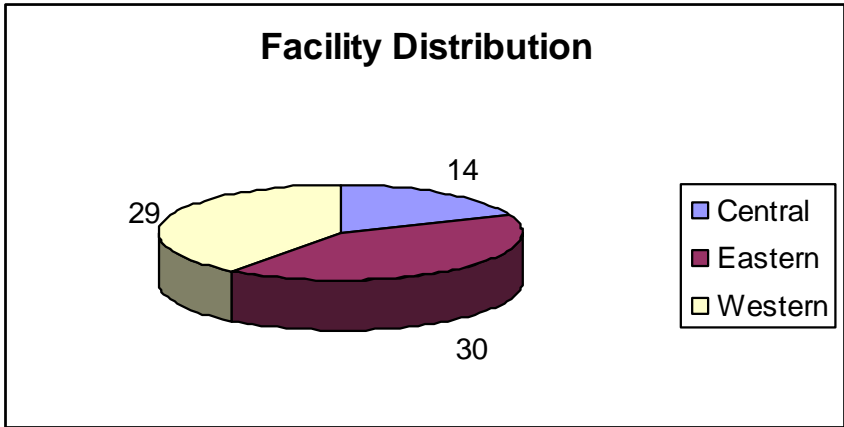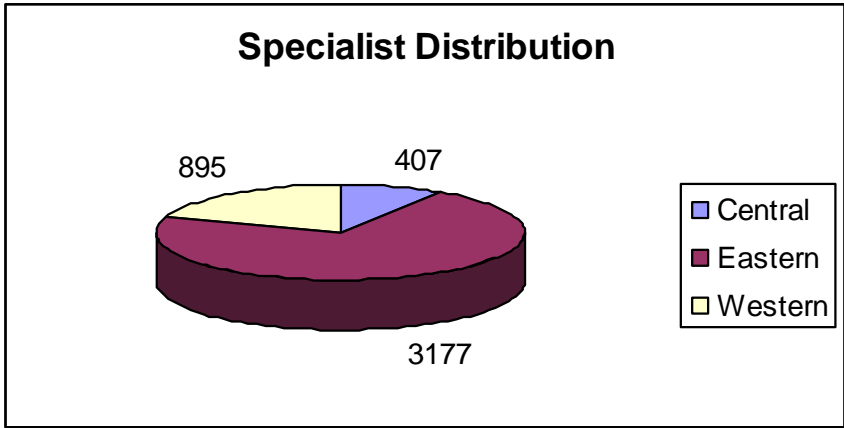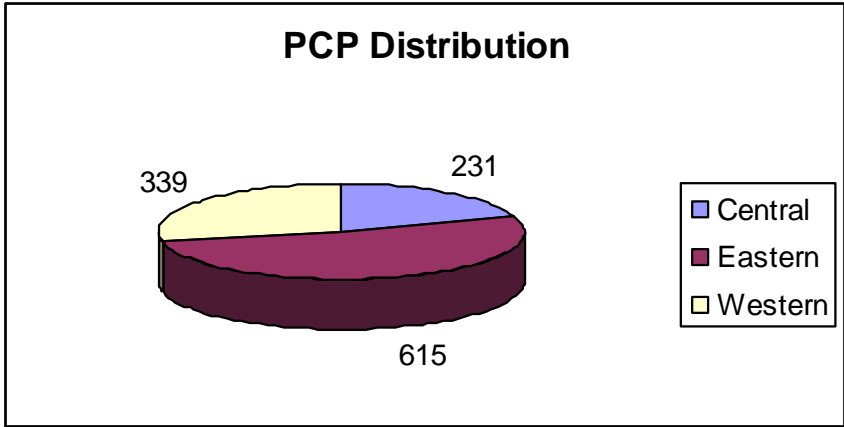
The preceding data represents the distribution of Primary Care Providers, Specialists and Hospitals across the Central, Eastern and Western regions.

HealthCare USA's Network Adequacy data was sent to the Missouri Department of Insurance for scoring and analysis. For period ending December 31, 2006 HealthCare USA received the following scores for network adequacy.

Provider Type	Central Region	Eastern Region	Western Region
Primary Care	100%	100%	100%
Specialists	98%	98%	100%
Facilities	98%	100%	100%
Ancillary	100%	100%	100%
Overall Score	99%	100%	100%

Data retrieved from Geo Access report results

HealthCare USA recognizes that access and availability monitoring is important in ensuring appropriate health care for members and will continue to monitor in 2007 and 2008.

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

Doral Dental's 2007 Geo Access study revealed that 99.9% of members had the desired access to a dental provider, one (1) provider within thirty (30) miles. There were a total of 234 providers at 144 locations across the MO HealthNet regions. Doral actively recruits new dentists to join the network of providers.

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

MHNet's final Geo Access study revealed 97.5% of members in Central Missouri had desired access to a mental health provider, 99.9% of members in Eastern Missouri had desired access and 98.3% in Western Missouri had desired access. MHNet continues to actively recruit providers in all three regions to strengthen the provider network.

Open /Closed Panels
For the 2006 closed panel study, HealthCare USA had an overall percentage of 27% closed PCP panels. In reviewing the providers with closed panels, provider relations determined the reasons for the closed panels as follows:

- 3% closed to all new patients
- 18% closed to all Medicaid patients
- 2% closed to only HealthCare USA patients
- 3% closed at the request of provider

Efforts by provider relations with providers to open their panels did not meet with any success in 2006. Further evaluations were completed by region to determine if additional PCP recruitment would be required or if members were experiencing access issues.

Cultural Competency
HealthCare USA provides employee diversity training through the Coventry program entitled Footprints, an online session that educates all employees about respecting the differences of others in the workplace. The presentation consists of a series of slides, case studies and questions that challenge and enhance each participant's understanding of the importance of valuing and respecting coworkers' differences. Certificates are awarded upon completion and participation is tracked.

MHNet continues to make every effort to keep cultural and linguistic competence integrated into their mission, values and principles, and daily operations. MHNet's provider network represents a diversity of races and ethnicities and languages. In the HealthCare USA network of behavioral health providers the following languages are represented: Arabic, Asian, Indian, Bengali, Chinese, Croatian, Farsi, French, German, Hebrew, Hindi, Italian, Persian, Philippine, Polish, Portuguese, Punjabi, Romanian, Russian, Serbo, Spanish, Thai, Turkish, Bosnian and Ukrainian. MHNet offers lectures, seminars and workshops tailored to address cultural influences and issues related to behavioral health.

Similarly, Doral Dental USA, HealthCare USA's dental vendor, publishes languages spoken by dentists and their office staff in the dental directory. Languages represented are: Spanish, Vietnamese, American Sign Language, French, Indian, Italian, Russian, and Farsi.

Request to Change Practitioners
HealthCare USA began a more thorough analysis of member requests to change PCPs in July 2006. Data prior to July 2006 is inaccurate and incomparable. The most common reason for members to change PCPs is due to enrollment or access issues or for no cause. In 1st quarter 2007, there was in increase in the number of requests to change PCPs due to the acquisition of the FirstGuard membership. Requests to change due to enrollment/access issues, for no cause and per provider request all increased first quarter and have slightly decreased since then. Analysis of this data revealed that a majority of the requests came from the Western region.

Other reasons for request to change PCP are quality of care and quality of service. All quality of care concerns are investigated by the Quality Improvement Department and referred to the Medical Director and Peer Review Committee, as appropriate. There was a sudden significant increase in the number of quality of service concerns in 3rd quarter 2006. After review of these cases, it was determined that the CSO reps needed to be re-educated on the definition of this category. After this intervention, quality of service reasons declined and analysis of the data revealed appropriate category selection.

Most Common Request to Change PCP

Source: Navigator
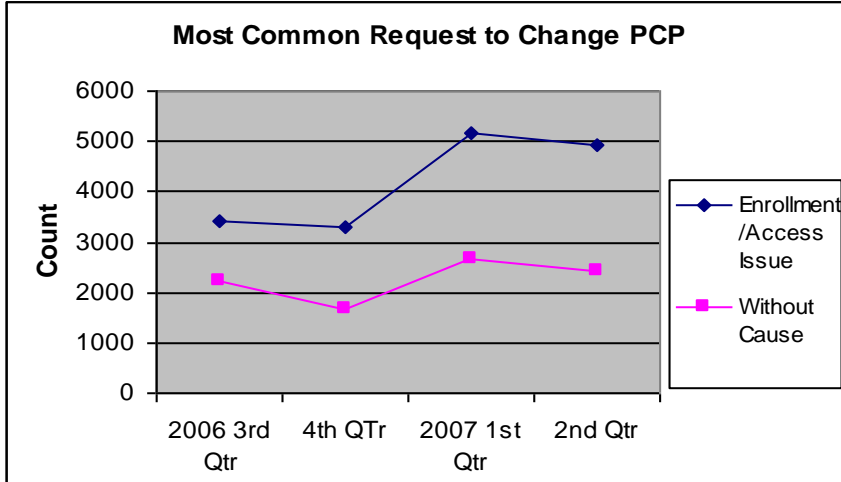
Other Requests to Change PCP
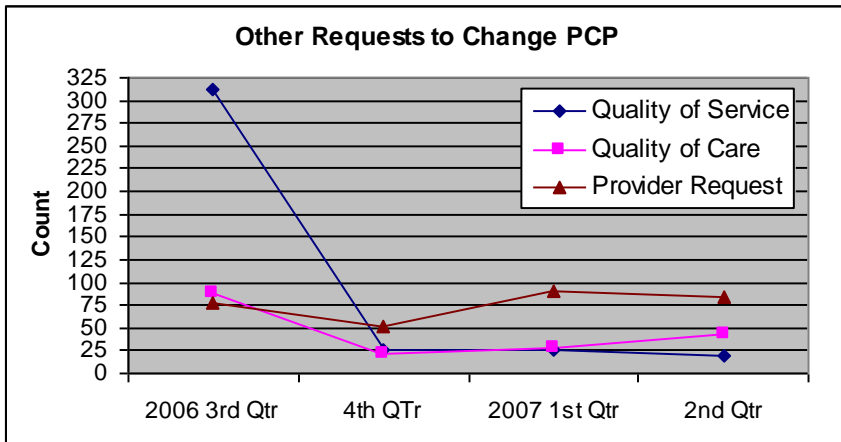
Source: Navigator

Requests to change are also reviewed for purpose of fraud and abuse detection. Members are tracked to determine the number of PCP change requests made and the reasons for the requests. Members with frequent changes are investigated and forwarded to the compliance analyst when appropriate.

Changes per Member	3rd Qtr 2006	4th Qtr 2006	1st Qtr 2007	2nd Qtr 2007
4	0	1	2	0
3	1	1	16	8
2	101	81	506	222
1	4176	4877	6917	7031
Total	4278	4960	7441	7261

Source: Navigator

Mercy CarePlus

Average Speed of Answer
As reflected in the data below, MCP's Average Speed of Answer remained above the goal of 80% of calls answered within 30 seconds.

ASA	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	84%	89%	89%	90%	91%	93%	92%	95%	90%	92%	94%	94%

Call Abandonment Rate
The goal of <5% of calls abandoned was met as reflected in the data below.

Abandonment Rate	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	3.5%	2.0%	2.2%	2.2%	2.5%	2.1%	2.0%	1.6%	2.3%	1.4%	1.2%	1.4%

Non-Routine Needs Appointments
Practitioners make every effort to see the patient within an average of one hour from his/her scheduled appointment. This includes time spent both in the lobby and in the examination room before being seen by the provider. Providers can be delayed when they incorporate urgent cases, when a serious problem is found, or when a patient has an unknown need that requires more services or more education than was estimated at the time the appointment was made. In addition, members who are late for their appointment may not be able to be seen within the one-hour period. MCP requires its participating providers to meet contractually required access standards as set forth below:

Medical & Other	
Routine care without symptoms	30 Days
Non-Routine care with symptoms	Within five (5) business days for PCPs/ three (3) calendar days for Specialists
Urgent, non-life threatening care	Within 24 Hours
Emergent (Serious) Medical/Behavioral Health Services	Must be available immediately 24 hours per day, 7 days per week
Mental Health	
Behavioral Health Non-Emergent	5 business days
Behavioral Health Upon PCP's request	Within seventy-two (72) hours
Mental health and substance abuse after care	The lesser of: =<7 days after hospital discharge 1 calendar week; or 5 business days

Routine Needs Appointments
See appointment standards information above.

Access to Emergent and Urgent Care
See appointment standards information above.

Network Adequacy – Provider/Enrollee Ratios
MCP has developed a geographically accessible network for members throughout the seven-region service area. It is of sufficient number, range, and depth to ensure that covered benefits are available to members in a timely manner. MCP providers include hospitals, physicians, advanced practice nurses, mental health providers, substance abuse providers, pharmacies, dentists, emergent and non-emergent transportation services, emergency medical services, dental health care, and ancillary health care services, etc.

Network Adequacy
MCP tracks and monitors its provider network adequacy on an on-going basis. Various reporting tools are used to identify areas of improvement. Member inquiries and grievances are monitored by the Provider Services department for trends in network adequacy. In addition, the network is reviewed using the State-required distance standards found in Exhibit A to 20 CSR 400-7.095(1)(E) as a guide. Any known deficiencies are referred to the appropriate Network Development Manager to proactively recruit targeted providers. Appointment standards and waiting times are also tracked and trended using member inquiries and grievances. Provider complaints, grievance and appeals are also reviewed for any issues relating to provider appointment availability. Provider Service Representatives also use their time spent on-site at provider offices to review appointment books and observe the appointment process first hand. MCP Medical Management Department works closely with both the Network Development and Provider Services Departments to refer and resolve provider-identified issues.

Currently, MCP has 1400 participating primary care providers in its network. Of all providers, 95.5% have open panels. This results in a PCP to participant ratio of approximately 1:50. MCP acknowledges when providers must limit patient panel load due to extenuating circumstances as such conditions could compromise patient care.

24 Hour Access/After Hours Availability
MCP maintains a toll-free participant services telephone number. The toll-free participant services telephone including telecommunication service to accommodate deaf participants. After normal business hours, MCP provides twenty-four (24) hours coverage to provide needed authorization of services during evenings and weekends and holidays. The MCP Nurse Advice Line is a medical triage line available to all MCP members 24-hours/day, including weekends, and holidays. Members may call the Nurse Advice Line for advice regarding self-care and/or what to do about urgent or emergent medical conditions or situations.

MCP requires that all participating Primary and Specialty Care Practitioners be available to assist/direct members' needs twenty-four (24) hours a day, seven (7) days a week. Primary and Specialty Care Practitioners should have office hours at least 20 hours per week, preferably over the span of four (4) days per week. An annual phone survey is completed for all primary care

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providers, OB-GYNs, and other health plan-designated providers. Providers are called after-hours to determine if the provider meets their contractual requirement. Provider Service Representatives visit identified providers who do not appear to meet the standard and review a corrective action plan with the provider and staff. The Provider Service Representative follows up on the corrective action plan to assure adherence.

Open/Closed Panels
PCP's may define the number of members they want to have assigned to their care, or close their panel by submitting written notification to MCP. Currently, the State of Missouri limits the number of patients per physician to 1,500 patients.

Providers may request member removal from the provider's panel for cause, however providers are expected to make every effort to resolve incompatible patient relationships and notify their Provider Relations Representative prior to making a decision to remove a member from the panel. Reasons for cause include family continuity, abusive behavior, a documented pattern of non-compliance, and failure to keep or cancel scheduled appointments. The provider must notify MCP in writing indicating reason for the request.

Cultural Competency
MCP examines opportunities for continuously improving multilingual services offered to its members with English language barriers. MCP tracks data on the volume of members who have been identified as speaking a language other than English. MCP's 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 MCP's practitioner orientation program is education on processes to access interpreters for members.

MCP makes available to its members the Relay for Missouri line to assist members that may have hearing impairments or disabilities.

MCP incorporates cultural competency training into its training opportunities for employees.

Requests to Change Practitioners
Members are allowed to change their PCP up to two (2) times per year after the initial assignment. MCP considers any request that exceeds the allowed two (2) per year on a case-by-case basis. Consideration is given to issues of provider accessibility, attitude, quality of care, enrollment and acts of insensitivity. In cases where the PCP has left the plan, members must choose or be assigned to a new provider. This is not considered as one of the two (2) times allowed per year. MCP notifies all affected members in writing at least thirty (30) days in advance of the change, and issues a new member ID card once the member is assigned to a new PCP.

Harmony

Average Speed of Answer
Call Abandonment Rate
Non-Routine Needs Appointments
Routine Needs Appointments
Access to Emergent and Urgent Care
Network Adequacy – Provider/Enrollee Ratios
*24 Hour Access/After Hours Availability*
Open /Closed Panels
Cultural Competency
Request to Change Practitioners

- **Average speed of answer**
  - **85% in less than 30 Seconds**
- **Call abandonment**
  - **0**
- **Other access to care issues**
  - **0**
- **Network adequacy/panels**
  - **According to State guidelines**
- **Access & availability**
  - **According to State guidelines**
- **Cultural competency**
  - **Authorize out of network access in order to accommodate cultural/ethnic diversity issues**

CSAT/FCR Results: Missouri Medicaid

MO Medicaid CSAT Results (Member)

MO Medicaid CSAT Results (Provider)

MO Medicaid FCR 12 week Trend
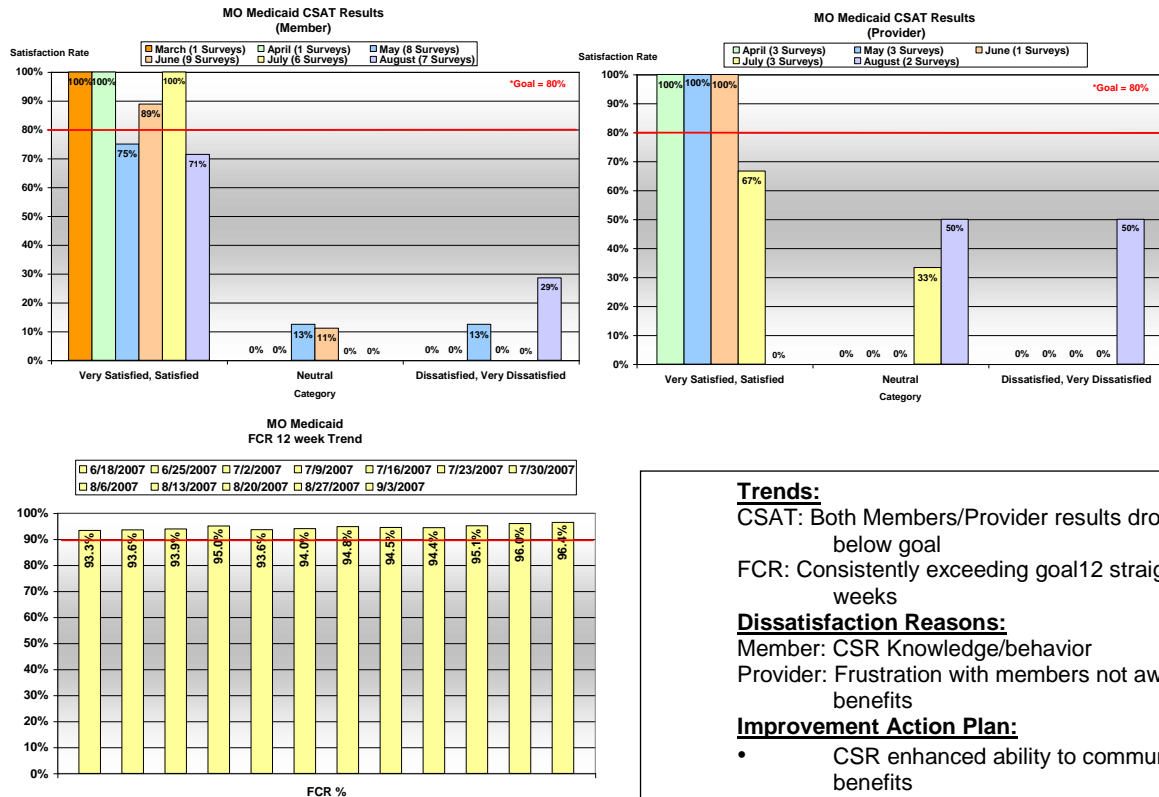
Trends:
CSAT: Both Members/Provider results drop
  below goal
FCR: Consistently exceeding goal 12 straight
  weeks
Dissatisfaction Reasons:
Member: CSR Knowledge/behavior
Provider: Frustration with members not aware of
  benefits
Improvement Action Plan:
- CSR enhanced ability to communicate benefits
- CSR enhance ability to communicate denied claims

Missouri Care

Average Speed of Answer
The average answer times in 2006 were as follows:
- Prior Authorization - 10 seconds
- Behavioral Health - 9 seconds
- Member Solutions - 11 seconds

The 2006 average answer times were slightly lower than the answer times in 2005 and all departments were well below the industry standard of 30 seconds. Missouri Care has dedicated staff committed to delivering the highest level of service.

Call Abandonment Rate
The average abandonment rates in 2006 of 1.93 percent, 2.76 percent, and 2.28 percent for Prior Authorization, Behavioral Health and Member Solutions Departments, respectively, were well below the

industry standard of 5.00 percent. The 2006 abandonment rate for prior authorization and member solutions were also below rate of abandonment for 2005. The Behavioral Health abandonment rate increased, but only slightly.

Non-Routine, Routine Needs Appointments, and Access to Emergent and Urgent Care
Missouri Care members have the right to timely health care. Emergent conditions must be treated immediately. Urgent issues should be treated the same day, and non-life threatening urgent cases should be treated within two days. Members are informed of these rights in the Missouri Care Member Handbook. A sample of 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. 173 primary care providers (PCPs) were surveyed with only two clinics out of compliance for appointment availability. The clinics that were out of compliance were notified of the findings and resurveyed at a later date. Both were found to be in compliance during the resurvey.

Network Adequacy – Provider/Enrollee Ratios
Missouri Care has a stable network of providers anchored by the University of Missouri Health Care provider network. As of 1/1/07, Missouri Care was contracted with 328 PCPs, 30 PCOs, 1,456 specialists and 358 behavioral heath providers. Missouri Care regularly monitors provider adequacy, access and availability. Missouri Care scored 100% on the latest Department of Insurance, Financial Institutions, and Professional Registrations report. As of December 2006, Missouri Care had a PCP-to-member ratio of 88 members to one primary care provider and 80 members to one behavioral health provider.

24-Hour Access/After Hours Availability
A sample of providers was surveyed 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.

Findings on after-hours messages:
90% of surveyed providers were compliant. They met standards by:
• Answering Service picks up calls and contacts provider (9.7%)
• Answering machine directs caller to provider/covering provider at alternative number (85.1%)
• Answering machine refers caller to HealthConnect 24 (2.6%)
• Other (2.6%)

Open/Closed Panels
Missouri Care monitors providers' panels monthly. Currently, 70% of Missouri Care's PCPs have open panels.

Cultural Competency
Missouri Care is committed to serving members and addressing any cultural barriers that may present as part of the process. Missouri Care maintains cultural competency initiatives to address specific cultural/language needs that might challenge a member's ability to access care or understand healthy practices that lead to optimum health outcomes. 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 (e.g., member handbook, mailings, informational communications) 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. The following items were addressed in 2006:

- Followed phone procedures to use the AT&T phone line for any member who requires translation services. In addition, members were able to call using TTY.
- Assessment of the number of members by primary language spoken (see Languages Identified, page 7 for details).
- Translated (or made available) materials in Spanish on the following topics:
  Member Handbook
  "Your Pregnancy" Booklet
  "You and Your Baby" Booklet
  EPSDT Reminder Postcards
  Lead prevention/education materials
- Provided mandatory staff training on cultural competency
- Made interpreter services available when members called HealthConnect 24 nurse advice line.

Requests to Change Practitioners
Missouri Care members have the right to change their primary care provider two times a year without cause. During SFY07, there were a total of 19,536 PCP changes. Of these changes, 4,134 requested to change to a familiar provider, 492 changed due to a location change of the member or provider, and the remainder changed for other reasons.

Blue Advantage Plus

Average Speed of Answer
Call Abandonment Rate
Telephone accessibility to members is monitored for call abandon rate and call wait time in queue (average time to answer). Performance is reported regularly to the BA+ Oversight Committee and Quality Council with recommendations for action when standards are not met.

During FY2007, an average of 3,156 calls were received each month with an average membership of 26,600. With the average speed to answer goal of no greater than 30 seconds during FY2007, callers waited an average of 30 seconds.

The goal for abandonment rate is not greater than 5%. In FY2007, the abandonment rate was 3.7%. Abandon rate varied between 1.54 to 7.0% by month

	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Call Wait Time (Goal: 30 seconds)	28.0	23.0	21.0	17.0	31	16	44	38.0	47.0	42.0	29.0	25.0
Call Abandon Rate (Goal: 5%)	3.6%	2.6%	2.1%	2.4%	4.00%	1.54%	5.41%	4.1%	7.0%	5.1%	3.8%	3.2%
Calls Received	3,243	3,607	3,125	3,327	2,931	2,719	3,625	2,666	3,340	3,354	3,126	2,812
Calls Handled	3,105	3,498	3,048	3,228	2,763	2,673	3,399	2,583	3,249	3,140	2,963	2,697

Non-Routine Needs Appointments
Routine Needs Appointments
BCBSKC maintains standards for appointment access for BA+ members to their primary care physician. These standards are formally developed and updated each year under the direction of the Quality Council.
BCBSKC-BA+ monitors member access to their physician in one or more of the following ways:

a. Appointment access - member complaints.

b. CAHPS questions regarding the member's access to routine, urgent and emergent care.

c. After-Hours Access Performance Analysis for Members annual report.

As part of the monitoring process, 29 physician offices (80 providers) that treat adult members were assessed for compliance with urgent appointment access via live phone calls during FY2007.

Results:

a. Twenty-five (85.2%) out of 29 physician offices were compliant.

      1. Of the four offices not compliant, 2 (7.1%) were solo practices.

      2. Four (13.7%) of the 29 offices are located outside the Kansas City Metro area.

b. Seventy-two out of 80 providers through August 2006 were compliant, for a rate of 90%.

c. Forty-two percent of members reported having access to a physician after business hours. (There is a large discrepancy between member satisfaction and audit results. Over 95% of the offices in 2005 were compliant with the standard, yet less than 50% of members reported this to be true. The survey tool is being reassessed to determine the cause of the discrepancy.)

d. No complaints were received from BA+ members regarding access to their physician after business hours.

Access to Emergent and Urgent Care
Urgent Care Access – Urgent Care is available to members through many sources. BCBSKC has contracts with Take Care Health to provide urgent care services for BCBSKC-BA+ members. Ten locations have been established. Take Care Nurse Practitioners, under physician supervision, utilize sophisticated medical software to follow clear clinical protocols based on guidelines established by the medical community to diagnose, treat, and write commonly used prescriptions for standard family illnesses in each Care Center. Examples of illnesses treated by Take Care Nurse Practitioners include strep throat, eye, ear and sinus infections, seasonal allergies, poison ivy and other skin rashes, insect bites and urinary tract infections. Beyond treatment of common ailments, Take Care Health Centers will provide diagnostic screenings for conditions such as diabetes and cholesterol. Take Care Health Centers treat patients over the age of 24 months and no appointments are necessary.

Emergent Care Access – Members are informed of emergent care centers in the Member Handbook. The Member Handbook contains information on how to access emergent care. In FY2007, BA+ members accessed emergent care 20,102 times. The HMO and PPO Appointment and Access Availability Standards are provided to providers annually through the Physician Office Guide.

Network Adequacy – Provider/Enrollee Ratios
BA+ has positively impacted the healthcare status of Missouri Medicaid Members by providing ongoing monitoring of BCBSKC provider networks. BCBSKC has performed monitoring of geographic availability, open panels, and appointment access.

Purpose:
This evaluation is designed to assess geographic availability for Primary Care Physicians (PCP) and high volume specialties of Obstetrics (OB/GYN), Cardiologists, and Orthopedic Surgeons by BCBSKC members enrolled in BA+.

Conclusions:
BA+' geographic network availability meets or exceeds performance standards for all availability standards measures, as detailed below:

a. The overall ratio of members to BA+ Primary Care physicians continues in 2007 to be well below the 500/1 ratio established by BCBSKC availability standards.

b. The percentage of members within the urban (Kansas City metro) area having access to at least two (2) Primary Care Physicians within an ten (10) mile radius exceeds the 90% urban standard performance goal for BA+ network.

c. The percentage of members within the basic/non-urban (suburban) service area having access to at least two (2) Primary Care Physicians within a twenty (20) mile radius exceeds the 90% basic/non-urban standard performance goal for the BA+ network.

d. The percentage of members within the rural service area having access to at least two (2) Primary Care Physicians within a thirty (30) mile radius exceeds the 90% rural standard performance goal for the BA+ network.

e. The percentage of women members 18 years old but less than 64 years of age within the urban, basic, and rural service areas having access to at least one (1) OB/GYN is well above the 90% standard performance goal for the BA+ network.

f. The percentage of members within the urban, basic, and rural service areas having access to at least one cardiologist and one orthopedic surgeon is 100% for all networks, well above the 90% standard performance goal for this high-volume specialty for all the BA+ network.

2007 Analysis of Open Practices Availability Standards Performance for BA+
BA+ evaluates the availability of PCPs with open practices. For 2007, BA+ meets or exceeds the goal that 70% of PCP's are accepting new patients.

24 Hour Access/After Hours Availability
BA+ provides a Nurse Advice Line to members 24 hours per day/7 days per week. This Nurse is available to direct members to receive care within their network. The nurse phone line also 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. In FY2007, 1,012 individual members utilized the Nurse Advice Line.

For FY2007, BA+ has not received any complaints from members in regards to accessing services after hours. BA+ maintains policies and procedures that assist with the timeliness of requests for services.

Open /Closed Panels
BCBSKC/BA+ conducts annual geographic analysis of physician networks. To be compliant with BCBSKC standards, this analysis should show that at least 90% of members have access to at least two primary care physicians (PCPs) within 10 miles for members in the urban service area, within 20 miles for members in the basic service area, and within 30 miles for members within the rural service area. The most recent analysis in 2007 found the standards were met, with 100%, 99.6%, and 99.7%, respectively, of members having access to at least two PCPs in the three measurement areas.

In addition, BCBSKC monitors the ratio of members to physicians. Below are the standards and BA+'s results for 2007.

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

Plan Name	PCP			OB/GYN			Cardiology			Orthopedics		
			Members PER Physician			Members PER Physician			Members PER Physician			Members PER Physician
	Members	Physicians	RATIO	*Members	Physicians	RATIO	Members	Physicians	RATIO	Members	Physicians	RATIO
HMO Standard			500			1,000			1,000			1,000
BA+	27,858	321	86.79	5,072	117	42.97	27,858	86	323.93	27,858	31	898.65

* Population includes only women over 18 and under 64.

Cultural Competency
Cultural Competency Activities – New Directions Behavioral Health (NDBH) has been involved in the promotion of cultural competency for BCBSKC's provider networks since 2000 by promoting workshops and presentations for area health care professionals. In 2004 surveys and focus groups were used to evaluate the program, with the guidance of a nationally recognized consultant, Edith Freeman, PhD. In part because of the surveys and focus groups, in 2005 New Directions embarked on a program to offer training on cultural competency to office staff as well as health care professionals, offered problem solving in small group luncheons, and also sponsored three cultural competency workshops around Suicide Awareness and Prevention.

In 2006, New Directions and the Cultural Competency Advisory Committee developed ideas for a website Cultural Competency Tool Kit, presented a luncheon Problem Solving workshop, and offered a 4-hour workshop centered on Evidence Based Competency.

In 2007, New Directions collaborated with two other organizations to present a culturally focused 4-hour workshop featuring a nationally recognized cognitive behavioral therapist. Plans are under way for a Fall 2007 workshop centered on Ethno Pharmacology.

Provider Network Composition – The BA+ network is 40% female. The Missouri Standard Credentialing Application does not support providing information about the ethnic background

of providers. Providers do include the primary language spoken: 2,241 providers speak English and 301 providers speak languages other than English.

Request to Change Practitioners
BA+ has established a standard operating procedure to allow a member to change their primary care provider. Children in COA 4 are allowed to change primary care providers as often as needed. The process to change primary care providers is published in the Member Handbook. Standard operating procedures help guide staff in assisting a member who wants to change their primary care provider.

Children's Mercy Family Health Partners

Children's Mercy Family Health Partners (CMFHP) has an automatic call distribution system (ACD) to monitor and track our telephone statistics. Children's Mercy Family Health Partners measures on a daily basis and aggregates to a monthly basis telephone statistics for call abandonment rate and average speed of answer (ASA) rate.

Average Speed of Answer
CMFHP's goal is that the calls will be answered in 30 seconds or less.

Total calls monitored per quarter FY 2005			
1st Q	2nd Q	3rd Q	4th Q
15,677	14,768	14,335	13,067
Average Speed of answer			
12.47 seconds	11.18 seconds	12.31 seconds	10.71 seconds

Total calls monitored per quarter FY 2006			
1st Q	2nd Q	3rd Q	4th Q
12,736	14,463	17,970	16,442
Average speed of answer			
7.39 seconds	10.06 seconds	26.5 seconds	12.67 seconds

Call Abandonment Rate
CMFHP's goal is no more than 5% of calls will be abandoned.

Total Calls abandoned per quarter FY 2005 and percentage			
1st Q	2nd Q	3rd Q	4th Q
448/ 2.86%	590/ 4%	467/ 3.26%	334/ 2.56%
Total calls abandoned per quarter FY 2006 and percentage			
399/ 3.19%	378/ 3.82%	463/ 7%	236/ 4%

CMFHP has been consistent in meeting goals for calls abandoned as well as average speed of answer. In January 2007, CMFHP implemented a new telephone system. This system allows us

to more efficiently answer, monitor and route calls from members and providers. Because of the transition and the training required on this new telephone system, CMFHP experienced a slight increase in abandonment rate during the reported period Q3, which kept us from making our goal in the 3rd reporting quarter. CMFHP also experienced a higher call volume, with 3,764 additional calls from 2005 to 2006, with the majority of the increase in calls occurring in Q3 and Q4. Otherwise, all goals were met consistently for the 12 month period.

Non-Routine Needs Appointments
Access to Emergent and Urgent Care
Children's Mercy Family Health Partners' policy addresses non-routine appointment needs as follows:

- Routine Care, without symptoms – within 30 days from the time the enrollee contacts the provider
- Routine Care, with symptoms – within 5 business days from the time the enrollee contacts the provider
- Urgent Care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by 354.600, RSMo – within twenty-four hours from the time the enrollee contacts the provider
- Emergency Care – a provider shall be available twenty four hours per day, seven days per week
- Obstetrical Care – within 1 week for enrollees in the first or second trimester of pregnancy; within three days for enrollees in the third trimester

During 2006, Children's Mercy Family Health Partners, 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, our Provider Administrative Manual outlines the appointment standards. Finally, through our Customer Service department, no significant issues were noted with respect to members being unable to access the participating provider network for non-routine appointments.

Routine Needs Appointments
Children's Mercy Family Health Partners 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 complaint, grievance, and appeal processes. During 2006, there were no significant issues identified with members being able to access providers for routine appointment needs.

In general, the Children's Mercy Family Health Partners' network of providers is compliant with the access standards for being able to deliver care to our members on a timely and consistent basis.

Network Adequacy – Provider/Enrollee Ratios
Children's Mercy Family Health Partners (CMFHP) filed its network composition with the State of Missouri Department of Insurance, as required in RSMo 354.603 and 20 CSR 400-7.095, by March 1, 2007. The State reviewed the CMFHP network and provided results indicating that the Children's Mercy Family Health Partners network was in compliance with the regulations to provide adequate access to care.

Specifically, the overall results were:

Primary Care Physicians	100% overall compliance
Specialists	100% overall compliance
Facilities	92% overall compliance
Ancillary Services	98% overall compliance

Compliance with the above categories by the Western Region counties was:

County	PCP Rate of Compliance	Specialist Rate of Compliance	Facilities Rate of Compliance	Ancillary Services Rate of Compliance	Overall Network Compliance
Cass	100%	100%	92%	100%	100%
Clay	100%	100%	100%	100%	100%
Henry	100%	96%	100%	100%	99%
Jackson	100%	99%	100%	100%	100%
Johnson	100%	100%	100%	100%	100%
Lafayette	100%	100%	100%	100%	100%
Platte	100%	100%	100%	100%	100%
Ray	100%	100%	100%	100%	100%
St. Clair	100%	95%	100%	86%	95%

24 Hour Access/After Hours Availability
On an annual basis, Children's Mercy Family Health Partners department conducts a telephonic survey to determine how our Primary Care Provider offices handle their availability after normal business hours. Calls were placed after the routine 5 pm office closing time and in the morning from 6 am – 8 am prior to office opening. We looked for the following:

- Was the phone answered, and if so, how
  - Answering Machine
  - Answering Service
  - Office personnel or provider
- Number of rings to answer
- Emergency information given
- Pager or personal number given
- Nurse Line information given

Of the one hundred thirty seven Primary Care offices that were surveyed, all provided adequate after hour availability twenty-four hours a day/7 days per 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 or 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 July 1, 2006 through June 30, 2007, there were no significant issues identified with members being able to access providers for their care needs.

Open /Closed Panels
Children's Mercy Family Health Partners tracks open/closed provider panels monthly. However, since State enrollment and eligibility is performed on a daily basis, Children's Mercy Family Health Partners recognizes the need to ensure that the data is current when members are selecting a Primary Care Provider (PCP).

During July 1, 2006 to June 30, 2007, Children's Mercy Family Health Partners had a total of 424 PCP's. Of those providers, 83 had a closed provider panel (11 of which are pediatricians) for a rate of 20% or an open panel rate of 80%. Children's Mercy Family Health Partners did not meet our internal goal of an average of at least an 85% open panel rate for this time period. However,   since our membership is over 80% pediatrics and the majority of our pediatricians have open panels we believe our members have adequate access to primary care providers, even though we have been unable to attain our overall goal of 85% of providers with 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 primary care providers into the CMFHP network.

Children's Mercy Family Health Partners also tracks member inquiries related to PCP closed panel issues. During this time period, CMFHP documented three hundred seventy nine calls related to a closed panel issue. The number may reflect limited access to a directory at enrollment and printed provider directory inaccuracies.

CMFHP customer service representatives 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 our members concerning provider status.

Cultural Competency

Children's Mercy Family Health Partners (CMFHP) has initiated innovative outreach that – in cooperation with stakeholders and local public health agencies – is reaching all cultural populations within the Western region.

With more cultural populations moving into the Kansas City area, education was needed on differing cultural beliefs and practices as they relate to health care. This education would help increase awareness and understanding of local cultural populations and ultimately help reduce the number of potential health care disparities within Children's Mercy Family Health Partners membership and throughout the Western region.

A close look at Kansas City area demographics compiled during the 2000 U.S. Census revealed an increase in the number and the diversity of cultural populations. In 2000, nineteen cultural populations were represented in the Kansas City area by at least 500 individuals. Continued presence in the local public health agencies confirmed this increase.

Children's Mercy Family Health Partners staff and provider network needed increased awareness and understanding of cultural populations present within our membership.

Effective communication of Children's Mercy Family Health Partners services was necessary for all families in the area (including current members), regardless of background.

CMFHP identified the following interventions as a way to address the above findings and to ultimately reduce the possibility of racial and ethnic health care delivery disparities:

- In 2005, we utilized the services of a full-time bilingual Community Relations representative to better educate the Spanish speaking community within the Western region about the services of Children's Mercy Family Health Partners. In 2006, we have 2 full-time representative that works on outreach efforts to this community as well as 5 full-time Customer Service representatives to assist with members' calls.

- Continued use of communication mechanisms and materials to explain MO HealthNet managed care and Children's Mercy Family Health Partners services. The materials are disseminated to families relocated to the Western region who visit local public health agencies.

- 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 Children's Mercy Family Health Partners services were distributed at local public health agencies to immigrant families arriving in the Western Region.

- Communication mechanisms and materials were made available for all members, regardless of background or physical condition, including but not limited to:
    - ~ AT&T Language Line for members with limited English proficiency
    - ~ Member handbook and other member materials in Spanish language

> ~ TTY/TDD services for hearing impaired members
> ~ Member materials in alternative formats (including software) for visually impaired members upon request.
> ~ Bilingual member newsletters

- Educate staff and providers using the Cross-Cultural Health Care Resource Guide that contains topics such as:

> ~ Background and history of each culture
> ~ Health beliefs and practices
> ~ Communication style
> ~ Religion
> ~ Languages spoken
> ~ Family structure
> ~ Food practices/diet
> ~ Children's issues

Through our outreach efforts at local public health agencies and other outreach locations, we reached a vast number of cultural backgrounds with information on MO HealthNet managed care and Children's Mercy Family Health Partners. We will continue our outreach efforts and make communication materials available regardless of background.

The Cross-Cultural Health Resource Guide has been a valuable education tool for both staff and providers and has encouraged culturally sensitive health care. We have distributed more than 8,000 guides and continue to receive additional requests throughout the health care community. The MO HealthNet Division requested permission to use the guide as a reference and benchmark for other plans developing similar tools.

Request to Change Practitioners
Children's Mercy Family Health Partners (CMFHP) allows members to change primary care physicians (PCP) at any time. CMFHP does monitor members who change PCPs more than five (5) times to ensure that members aren't abusing benefits or services; however it has discovered limited abusive practices from this report.

Fraud and Abuse

Fraud and Abuse

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

The fraud and abuse program continued to be a robust program throughout 2006 and the first two (2) quarters of 2007, by maintaining, as well as updating, the previous year's results and changes. HealthCare USA continues activities to prevent, identify, investigate and resolve fraud and abuse committed by members, providers and, if applicable, the health plan.

The fraud and abuse committee has been added to the overall Compliance Management Committee in order to assess and ensure that the fraud and abuse program adheres to all regulatory requirements. The new structure provides this committee with additional managerial input and feedback in the process of evaluating the program. The Compliance Management Committee, encompassing the fraud and abuse program, meets monthly with fraud and abuse issues and updates as a standing agenda item. Coordination, prevention and detection activities and any open cases are discussed during Compliance Management Committee meetings. This committee is interdepartmental and feedback is received from all HealthCare USA departments.

All fraud and abuse policies and procedures documenting the processes of the fraud and abuse program continue to be adhered to and reviewed on an annual basis, at minimum. These policies, as well as all HealthCare USA policies, are maintained on a shared drive where all employees can access them. All employees are notified monthly via an internal newsletter of policies that were reviewed and/or updated during the month. The fraud and abuse plan had very few changes during its annual review. Changes made did not effect the actual processes related to the fraud and abuse program or the compliance with 2.31 of our State contract. The plan was resubmitted thirty (30) days prior to implementation in accordance with 2.1.2.d of our State contract and was approved by the State agency on May 31, 2007.

Prevention, Detection, Investigation
Processes for fraud prevention, detection and investigation continue to evolve throughout the company, as well as with external parties. Processes for obtaining information related to suspected fraud and abuse investigations also continue to improve. Internal departments that are most likely to encounter or detect fraudulent activities related to members include, but are not limited to, Customer Service Operations (CSO), the Pharmacy Department, Case Management, and Provider Relations.

The Special Investigations Unit (SIU) runs reports to detect and investigate potential provider fraud and abuse cases. The SIU administers prospective and retrospective review of medical claims submitted by providers to assess billing patterns. Through analysis of claims data and medical record reviews, the Quality Improvement Department can detect potential fraud and abuse activities perpetrated by either a member or provider.

External parties HealthCare USA works with to investigate, monitor and/or report suspected fraud and abuse activities include, but are not limited to subcontractors, physicians, pharmacists, family members of enrollees, case workers, the State agency and the Office of Inspector General. Individuals who are reported receive education or corrective as necessary.

When receiving referrals from the different avenues mentioned above, an investigation is immediately initiated. The Regulatory Compliance Analyst initiates investigations by receiving all applicable information from the referring party and contacting other parties as necessary, including primary care providers (PCPs), pharmacists, etc. An initial contact is made to suspected members via an initial notification letter to offer assistance. Members are referred to Case Management or other medical management services as indicated.

All cases initially opened due to pharmacy issues are reviewed with the Pharmacy Director to assess and determine next steps. In severe cases when the lock-in program is appropriate, members will be locked in to one (1) provider to obtain all services and/or medications. Cases that deal with mental health/substance abuse are referred to MHNet, HealthCare USA's mental health subcontractor. All open cases are continually monitored. Updates related to open cases are reported to the State at least quarterly until all fraudulent and/or abusive activities cease and the case is closed. As a result of the transient nature of the MO HealthNet population, HealthCare USA maintains an open case for three months after a member terminates.

The table below shows the number of cases reported throughout the last six (6) quarters:

Quarter	Open Cases Prior to Quarter	Cases Opened	Cases Closed
Q1 '06	7	5	3
Q2 '06	9	17	8
Q3 '06	18	10	7
Q4 '06	21	14	10
Q1 '07	25	14	10
Q2 '07	29	21	17

Source: Fraud and Abuse Database

Source: Fraud and Abuse Database

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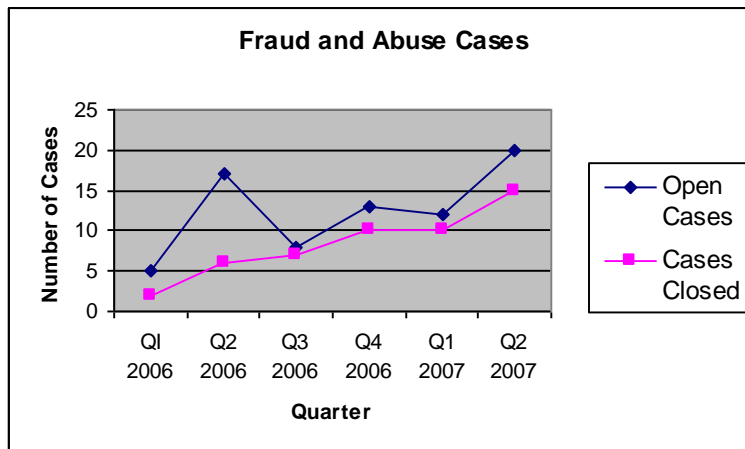
Of all fraud and abuse cases reported, approximately fifty-seven percent (57%) are related to pharmacy abuse issues. Due to the high volume of cases that relate to pharmacy, all cases, regardless of the reason the case was opened, are reviewed with the pharmacy director quarterly. Additional investigation of the remaining forty-three percent (43%) are often found to be associated with medication/pharmacy abuse.

The pharmacy lock-in program is maintained for a minimum of twelve (12) months, regardless of whether the member is terminated from the plan or not. After twelve (12) months, pharmacy cases are reviewed to evaluate the outcome of the lock in program and determine if the lock-in process should be extended or not. In cases where the member has been terminated from the plan for three months or longer, the case is closed.

As stated above, all potential fraud and abuse cases are reported to the State agency at least quarterly. Beginning July 2006, the State created a new Access database to report all fraud and abuse cases. This new database has been beneficial while eliminating the use of paper reporting, which increased the risk of violating HIPAA regulations. It also has assisted the process of on-going tracking of fraud and abuse cases. All open and closed cases, as well as detection, coordination and prevention activities are maintained in one (1) electronic location. All five (5) of these reports are submitted to the State at least quarterly.

The outcomes of the Compliance Management Committee, encompassing the Fraud and Abuse Committee, and any updates on the fraud and abuse program are reported to the State agency and HealthCare USA's Quality Management Committee (QMC) at least annually. Members of the QMC provide essential feedback related to the program.

HealthCare USA maintains an aggressive approach to monitoring, investigating and reporting suspected fraud and abuse occurrences. With the assistance of the Compliance Management Committee and the QMC, all case are investigated completely and actions taken as appropriate. Assuring timeliness of investigations and accuracy of data collection and reporting continue to be high priority. HealthCare USA continues to assess and improve processes related to fraud and abuse detection and investigations through on-going research and evaluation of new ways to minimize fraudulent and abusive activities and implementation of enhancements to the fraud and abuse program.

Training and Education
HealthCare USA staff received ongoing training and education throughout the last six (6) quarters. Mandatory annual training and in-services for all employees includes general health care fraud training. More extensive education is provided throughout the year via the internal employee newsletter, all employee meetings, interdepartmental meetings, wallpaper and bulletin board postings throughout the office. Along with periodically dispersing fraud and abuse education to employees, the Regulatory Compliance Department designated May and June of 2007 as fraud and abuse training months. Throughout these two (2) months, fraud and abuse education was stressed and continually distributed. Providing ongoing training allowed employees to understand processes to prevent, detect and report fraud and abuse.

Mercy CarePlus

Prevention, Detection, Investigation

MCP is committed to preventing, detecting, investigating, and reporting suspected fraud and abuse activities by providers, subcontractors and members. MCP monitors provider fraud for underutilization of services and beneficiary/provider fraud for over utilization of services. MCP may identify provider fraud and abuse by reviewing for a lack of referrals, improper coding (up coding and unbundling), billing for services never rendered or inflating the bills for services and/or goods provided. MCP may identify beneficiary fraud by reviewing access to services, such as improper prescriptions for controlled substances, inappropriate emergency care or card sharing.

MCP's fraud and abuse activities include the following:

- 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
- Educating employees, network providers, and members about fraud and abuse and how to report it
- Providing effective organizational resources to respond to complaints of fraud and abuse
- Maintaining procedures to process fraud and abuse complaints
- Maintaining procedures for reporting information to the state agency
- Monitoring utilization/service patterns of providers, subcontractors, and members
- Development of corrective action plans to strengthen internal control of fraud and abuse activity

All suspected fraud and abuse activities, including pharmacy lock-ins, are reported to MCP's Quality Improvement Committee as well as to the State agency on a quarterly basis. During FY2007, there were five (5) cases of suspected fraud and abuse involving providers and there were 15 members who were entered into a pharmacy lock-in.

Training and Education

Providers are educated regarding fraud and abuse as part of their orientation. This information is included in the Provider Manual. MCP may provide an article in the provider newsletter regarding the subject of fraud and abuse when appropriate. Members are educated regarding fraud and abuse through the Member Handbook.

Harmony

Prevention, Detection, Investigation
Training and Education

- Comply with State, Federal and contractual requirements regarding fraud and abuse
- Effectively detect, investigate & report suspected fraud and abuse
- Assist in the development of anti-fraud plans, policies, procedures, fraud abuse awareness education and training materials
- Assist in conducting education & training of associates, providers and members
- Assist in conducting vulnerability assessments, auditing and monitoring activities

Fraud and abuse is taken seriously at Harmony Health Plan (WellCare). Activities include education, surveillance, and reporting.

To ensure prompt reporting of fraud and abuse WellCare associates receive fraud and abuse training in October 2006. New employees receive fraud and abuse training upon hire. Associates receive ongoing information on fraud and abuse. Harmony Health Plan participated in networking with other health plans with DMS training sessions that included reporting databases.

To increase surveillance for fraud and abuse Harmony Health Plan (WellCare) has ongoing monitoring in all States, including Missouri, of providers billing and utilization practices. Harmony Health Plan continues to review federal databases for all new providers to identify debarred individuals.

One vendor reports a fraud and abuse potential issue involving an investigation of a provider in another region involving quality of care issues. Information was referred to DMS. The case was closed 2/23/07.

Missouri Care

Missouri Care maintains and implements a Fraud and Abuse Plan. The Fraud and Abuse Plan has been developed to help prevent, detect and report potential incidents of fraud and abuse to appropriate regulatory agencies.

Prevention, Detection and Investigation
Missouri Care personnel or any other party (including Missouri Care members, government agency or the public) can identify and report a potential compliance issue or concern. The identified potential compliance issue or concern is communicated to the Missouri Care compliance officer as a report (hotline call, telephone call, e-mail, written correspondence or other means). The Missouri Care compliance officer logs and documents all compliance issues or concerns that have merit.

In 2006 there were 22 fraud and/or abuse issues reported. Each issue can be placed under one of three categories: provider, member or employee.

Provider
Examples of provider fraud and/or abuse include but are not limited to: provider billing for services and supplies not rendered, upcoding and unbundling, level-of-care misrepresentations, false information on claim forms, underutilization, kickbacks for patient/member referrals, illegal self-referrals and lack of appointment availability for members.

Research into provider fraud and abuse in 2006 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
Examples of member fraud and/or abuse include forging prescriptions, using stolen ID card, loaning ID card to others to obtain services and physical, mental, sexual and/or emotional abuse of a member.

There were 13 examples of member fraud and abuse in 2006. These incidents included aberrant pharmacy utilization patterns and/or behavior and misuse of member identification card.

Each incident is monitored on an ongoing basis. If a member loses eligibility with Missouri Care, he/she is put on a watch to see if eligibility with the plan is regained. Each case is managed by the manager of Medical Management and case managers to help the member receive the necessary medical services and to help prevent abuse.

Employee
There were no incidents of employee fraud and abuse reported in 2006.

Training and Education
Each employee participates in a Missouri Care Health Plan Compliance Program training seminar conducted once per calendar year. Part of this training addresses Fraud and Abuse. Attendance for all employees at this annual Compliance Program training seminar is mandatory. An attendance log is maintained for each training seminar conducted.

Training in 2006 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.

Blue Advantage Plus

Prevention, Detection, Investigation
The 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 three full time staff members. The SIU Manager is a Licensed Practical Nurse. The Fraud Investigator is enrolled in upcoming classes for a BA in Investigations, a degree through Bellevue University. The Clinical Fraud Investigator is a Licensed Chiropractor and also holds an accounting degree 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 2006, the SIU investigated five cases of fraud and abuse, four of the cases involved members 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 implemented a new on-line training capability that will allow additional training for all employees on this and other compliance topics.

Children's Mercy Family Health Partners

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 2006:

- ➢ There were 19 fraud and abuse cases investigated in 2006, 2 providers and 17 members
- ➢ Of the 19 cases, all were resolved during 2006
- ➢ There were 6 CMFHP member cases of fraud and abuse substantiated. All of those cases were referred to DMS in order for it to make lock-in determinations
- ➢ There were 11 CMFHP member cases of alleged fraud and abuse that were investigated but not substantiated
- ➢ 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 2006:

- ➢ 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).

Information Management

Information Management

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Claims Processing – Timeliness of Claims Payment
The claims department at Healthcare USA maintained a focus in 2006-2007 to assure that high quality claims metrics were achieved and maintained. In 2007, the claims department monitored claims processed within 15 days, claims processed within 30 days, days in inventory, pends % of inventory, adjustment rate and interest. Throughout 2006 and 2007, the CSO achieved and exceeded all production standards.

Currently, the goals established are as followed:
- Claims Processed within 15 days: 92.5%
- Claims Processed within 30 Day: 99%
- Days in Inventory: 2.5-3 Days
- Pends % of Inventory: 8.5%
- Adjustment Rate: 5%

Various system enhancements continue to be implemented in the HealthCare USA's claims processing area to ensure timely and accurate claim resolution for all claim types. Claims interest reports are reviewed and analyzed on a monthly and quarterly basis to identify any training issues related to claims payment.

Weekly quality meetings have been ongoing in 2006-2007. Tracking and trending reports are run on a monthly, quarterly and/or weekly basis to assess the following areas:
- High Dollar Errors
- Top Financial Errors
- Top Statistical Errors
- Top Errors by Examiner
- Modifiers
- GMIS
- COB
- Dollar Review
- Timeliness of Payment
- Adjustments
- Interest
- Quality
- Provider Billing Areas

Adjustment reports are analyzed and reviewed on a monthly and quarterly basis to identify adjustments by department, provider specialty, billing areas and claim status types. Employees

receive feedback and additional training for ongoing professional development. Provider education is also completed when applicable.

Continuous ongoing training has been emphasized during 2006-2007. Training topics are as followed:
- Claims Training
- Provider Billing Areas
- Adjustment Training
- COB Training
- Fatal Edit Training
- Navigator Training
- HIPPA Training
- Employee Rights
- Compliance and Ethics
- Fraud and Abuse
- Various Microsoft Applications

All new claims examiners receive a training class consisting of 8-9 weeks. They review provider selection, system overview, benefits, authorizations, navigator, remittance advice, GMIS, adjustments, ICD-9, CPT coding and COB. Cross training initiatives also took place in 2006-2007 between claims and customer service in an effort to maximize resources and gain efficiencies.

In addition to the above noted quality improvement initiatives, HealthCare USA's CSO has maintained outstanding service metrics with regards to both overall claim payment quality and timeliness throughout 2006-2007. As we continue in 2007, the CSO is confident that by remaining focused on the day to day metrics, persistent application of enhancements and the continuous training of staff, HealthCare USA will continue to perform above expectations.

The following table illustrates a year to year comparison of these key indicators of claims metrics.

	CLAIMS RECD	CLAIMS PROCESSED	ENDING INVENTORY	% OVER 60 DAYS	% WITHIN 15 DAYS	%WITHIN 30 DAYS	DAYS IN INVENTORY	INTEREST	ADJUSTMENT RATE
2006 1st Qtr	362,367	363,171	8,464	0%	97.5%	99.8%	1.7	$2,527.57	2.5%
2nd Qtr	336,027	336,741	7,750	0%	97.3%	99.8%	1.6	$3,200.59	2.1%
3rd Qtr	322,964	321,960	8,754	0%	97.1%	99.8%	1.6	$6,599.40	1.6%
4th Qtr	349,170	348,337	9,587	0%	97.2%	99.9%	1.5	$4,086.46	5.6%
2007 1st Qtr	399,999	399,377	10,209	0%	98.3%	99.9%	1.2	$7,816.22	2.2%
2nd Qtr	385,292	388,733	10,854	0%	96.3%	99.9%	1.7	$2,635.54	2.4%

Source: Coventry Data Warehouse

Membership

The CSO handles all membership for HealthCare USA. Files are downloaded daily from the State. Upon completion of this download, they are loaded and processed in the IDX system. Listed below is a brief description of how each file is sent:

Reconciliation File:
HealthCare USA receives a reconciliation file from the State's IS Department (InfoCrossing) every Saturday. This file contains a snapshot of HealthCare USA's entire membership. This file is run every Monday or the first business day of the week only to add new members or term current members in the system.

Daily File:
HealthCare USA receives eligibility file from the State's IS Department (InfoCrossing) daily. This file contains all updates/changes on members' effective/termination dates as well as their demographic information. The file contains 3 components: an Eligibility file, a Health Assessment file, and a COB file. These files are loaded into an interface and processed each day.

ID Sticker Program Focus Study
HealthCare USA is looking for ways to improve the health outcomes and customer service for the Managed Medicaid population. It has been an ongoing concern that the member demographic data received is out of date or inaccurate. Families enrolled in Medicaid are often transient and frequently change contact telephone numbers and addresses, resulting in difficulty locating them for needed health care. The validity of performance data is also compromised.

Outreach, education and close monitoring are critical to promote access to services in the Medicaid population. The outcomes of outreach efforts made by HealthCare USA depend directly on the ability of staff to contact members. Outreach efforts focus on multiple aspects such as wellness reminders, special needs, case management and disease management. Disease management activities in the Medicaid environment are immature in part due to the transient nature of this population and the additional challenges and barriers encountered in managing their own health care needs.

After over two years of tracking all attempted contacts to members with special health care needs, approximately 25% of attempted contacts resulted in a successful case completion. Special needs coordinators attempted phone calls, mailings and contacts with Family Support Division (FSD) staff to obtain more recent member contact data.

The approximate return rate on mailings in the past has been 12%. Current return rate on mailings range from 14.5% in January 2007 for general health services mailings to 44.6% for new member packets mailed in January 2007. Inaccuracy of phone numbers well exceeds the returned mail rate. Approximately 60% of the phone numbers listed proved to be inaccurate.

A pilot study was completed to see if attaching a sticker to member ID cards requesting that the participant call member services as soon as they receive the ID card to update demographic information would prompt the member to call HealthCare USA and provide updated demographic data. 50,000 cards with stickers were distributed. Outcomes of the pilot study (shown in the table below) indicate success of the pilot. There was a 13.7% response rate from

the card and 3% of all the stickers or 23% of all callers made an update to demographic data. In 2008 the project will be continued with stickers being placed on all participant ID cards.

Results of ID Sticker Card Pilot Focus Study

	Cards Mailed	Returned Mail	Total Calls Received	Changes Made
Total	50000	2132	6551	1502
Rate		4.3%	13.7%	3%

Total calls received and changes made based on cards mailed minus returned mail. Data retrieved from an internal Access database.

Providers
PCP Assignment
All members are given the opportunity to select a PCP upon enrollment. Members receive an enrollment packet that contains the most current Member Handbook/Provider Directory to assist in the selection of a PCP. They are instructed to notify HealthCare USA, telephonically or by mail, of their choice of a PCP within fifteen (15) calendar days of receiving the enrollment packet from the state's enrollment broker. If no choice is made, a PCP is automatically assigned to them. Members can contact the CSO who can help members needing assistance in selecting a PCP.

Members are informed when making a PCP change of the name(s) of providers on the HealthCare USA quality best practices list. This internal list of PCPs can be considered a choice if the provider is accepting new patients and the panel requirements are met.

Members that have disabling conditions or a chronic illness may request that their PCP be a specialist. The member's request to have a network specialist as a PCP is directed to the HealthCare USA's Medical Director for review. The requested specialist is contacted to inquire if he/she is willing to accept the additional responsibilities of a PCP prior to the approval of the request. The member is notified of the request determination verbally within ten (10) calendar days of the request. The written denial of a request is confirmed upon the verbal notification of the determination to the member. The written denial notification provides notice of the member's right to appeal and the process to initiate an appeal. The process for requesting a specialist as the PCP is not applicable to OB/GYNs when the OB/GYN has agreed to being the PCP for a member.

If the member does not select a PCP within fifteen (15) calendar days of receipt of their new enrollment packet, HealthCare USA makes an automatic assignment. HealthCare USA takes into consideration known factors and assigns the member to a provider that best meets the needs of the member. The factors considered include, but are not limited to: current provider relationship, age, language needs, location, special medical needs and panel size of the provider. If circumstances are such that the member does not have a PCP assigned on the effective date with HealthCare USA, HealthCare USA will not deny services or payment for any services.

HealthCare USA notifies the member of the PCP to whom they have been assigned. Members are given the opportunity to request a change of providers. The assignment of a new PCP under

these circumstances is not considered as one (1) of the two (2) PCP changes allowed per year. HealthCare USA notifies the member of the PCP's name and
address via the new member enrollment packet and the PCP's name and phone number via the member's HealthCare USA member ID card.

Maintenance of Provider Network Data
The Coventry Provider Database (CPD) is a windows-based IDX interface that is used across all Coventry plans. The CPD will integrate the following:
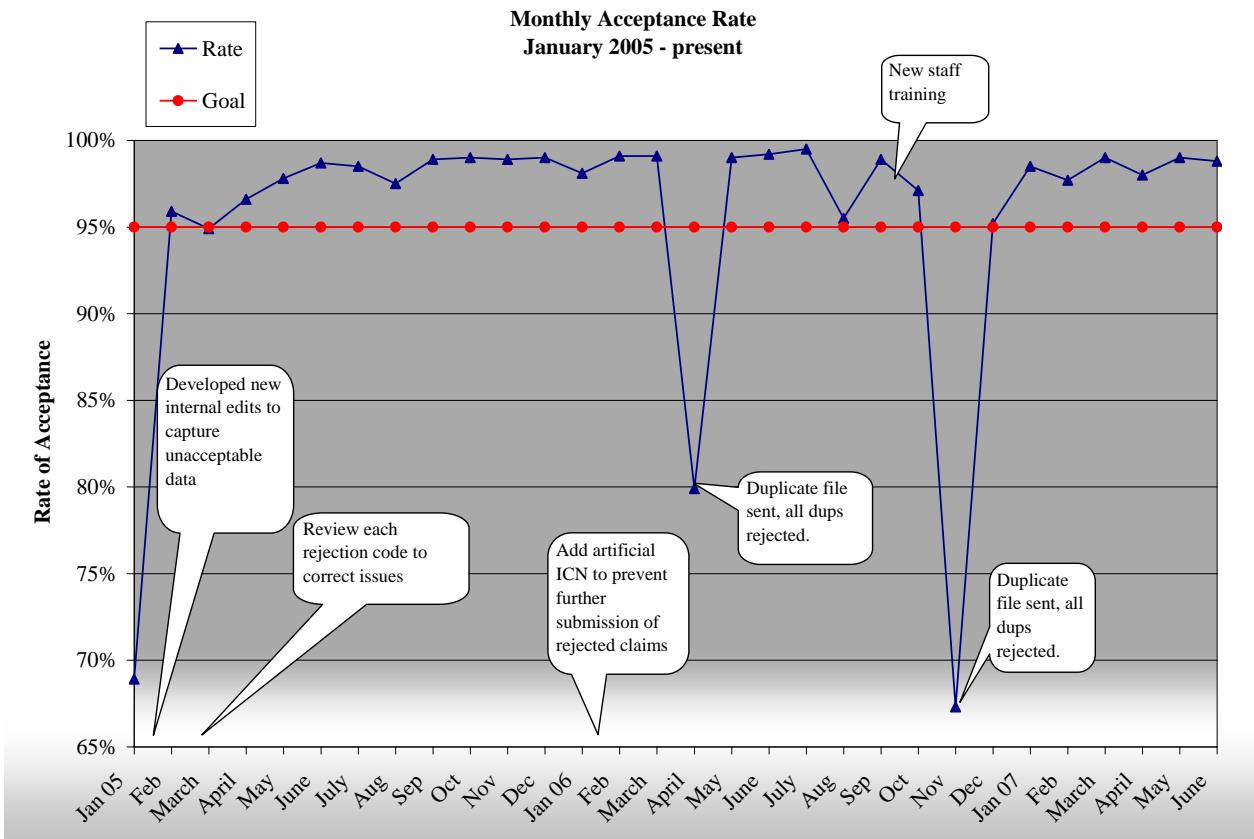- Provider credentialing
- Provider maintenance
- Provider contract instructions
- Rental network specifications
- Directory profiles

The Coventry Provider Database has the following features:
- Single point of entry for provider information (physicians, hospitals and ancillary providers) stored on a centralized provider database
- Standardized credentialing process
- User-friendly mechanism for generating reports and extracts through Cognos
- Elimination of individual plan credentialing systems
- Incorporates the current Electronic Provider Information Form (EPIF) and the many systems associated with the form
- A method to proactively work towards increasing the quality of provider directories

Encounter Data Submission
HealthCare USA has been conducting a performance improvement project for encounter data since 2005. This project was to meet the State's requirement of a 95% acceptance rate for all encounters sent to the State. The project focuses both on acceptance of claims and completeness of claims. The original focus of the project was to meet the 95% acceptance rate. This was achieved in February 2005 and has been maintained since except for two (2) months when duplicate files were sent. The focus for 2007 was completeness of data. This project is still in process and does not have any additional outcomes data as of June 2007.

Monthly Acceptance Rate
January 2005 - present

New staff training

Developed new internal edits to capture unacceptable data

Review each rejection code to correct issues

Add artificial ICN to prevent further submission of rejected claims

Duplicate file sent, all dups rejected.

Duplicate file sent, all dups rejected.

Source: MO HealthNet Encounter Data Report

Mercy CarePlus

Claims Processing – Timeliness of Claims Payment

DATE	Number of Claims	Avg. Turnaround Time	Total Days
JUL	22,371	6.35	142,011
AUG	41,063	6.33	259,888
SEP	43,094	6.20	267,183
OCT	44,570	5.64	251,553
NOV	43,568	5.95	259,404
DEC	39,838	5.82	231,777
JAN	47,076	6.93	326,284
FEB	39,555	5.79	229,023
MAR	47,153	6.54	308,522
APR	41,246	6.15	253,539
MAY	41,276	5.67	233,829
JUN	38,890	5.86	227,895

Membership

Membership Activity	Beginning Member Count	New Members Added	Terminations	Ending Member Count
JUL	68,576	301	3539	65,338
AUG	70,214	2247	3878	68,583
SEP	69,201	2721	3186	68,736
OCT	68,736	2899	3192	68,443
NOV	67,695	2470	3171	66,994
DEC	66,994	1972	2649	66,317
JAN	66,994	2347	3093	66,248
FEB	66,248	2312	2942	65,618
MAR	65,618	2524	3225	64,917
APR	64,917	2582	3826	63,673
MAY	63,673	2234	2850	63,057
JUN	63,057	2247	3811	61,493

Providers
Currently, MCP has 1400 participating primary care providers in its network.

Harmony

Claims Processing – Timeliness of Claims Payment
- Clean claims paid within appropriate time frames

Membership
- 46.9/1000

Providers
- PCPs = 338
- Specialists = 2049
- Allied = 156
- Hospitals = 26
- Ancillary = 132

Missouri Care

Claims Processing – Timeliness of Claims Payment
Missouri Care received 391,596 unique claims for calendar year 2006. Missouri Care utilized the QMACS 4.10 claim processing system developed by QCSI, and did not experience any significant downtime or disruption with the claims processing system. Missouri Care is constantly working to improve the accuracy and timeliness of claim payments. To achieve these objectives, our goals were to increase EDI claim submission percentage, increase mass adjudication and to decrease the turnaround time for clean claims payment. In 2006, on average,

clean claims were paid in 12 days. This is an improvement of four days, as compared to the prior measurement period. Additionally, in 2006, Missouri Care's EDI claims percentage was 71%, a three percent increase over 2005's 68%. Missouri Care attributes the increase to an outreach effort to providers, aimed at identifying barriers or education gaps around EDI. The health plan also raised the mass adjudication rate from 68% in 2005 to 75% in 2006 by converting several contracts to a standard payment template.

Membership
The Member Services Department performs daily and weekly audits to verify members' enrollments are correct in our system. The audits compare the State eligibility file to QMACS and then QMACS to the State eligibility file. These audits will capture any discrepancies in either file.

Providers
The Provider Relations Department performs daily audits on the provider files in QMACS to ensure that each provider is set up correctly. A separate report is generated to indicate whether an invalid NPI has been entered into QMACS. All errors are reported to the Provider Information Management Department (PIM) for correction.

Blue Advantage Plus

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. 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 Services and reported for oversight to the Delegated Oversight Committee.

	Claims Accuracy (Goal 97%)	Inquiry Accuracy (Goal 97%)	Claims Processed
Jul-06	99.56%	98.70%	27,188
Aug-06	99.51%	99.43%	27,306
Sep-06	100.00%	99.56%	27,201
Oct-06	99.62%	98.38%	33,916
Nov-06	100.00%	98.68%	22,309
Dec-06	98.50%	97.44%	26,032
Jan-07	100.00%	95.69%	27,123
Feb-07	100.00%	97.95%	25,658
Mar-07	98.96%	97.85%	24,722
Apr-07	98.44%	97.66%	30,298
May-07	100.00%	98.86%	16,312
Jun-07	100.00%	99.00%	25,199

Membership
Membership is received nightly from the State of Missouri MO HealthNet Division and uploaded to FACETS. BCBSKC staff use this information to communicate with members. Currently, BA+ has approximately 27,000 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 nightly. The entire file is sent weekly.

Children's Mercy Family Health Partners

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.

Below are the fiscal year claims processing results.

	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06
Processed	38,076	42,550	44,847	47,370	48,483	47,280
Accuracy	99.0	99.2	99.1	99.1	99.7	99.6
Days to Pay	5.1	5.2	4.8	5.5	5.1	5.4

	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07
Processed	29,969	28,852	32,486	32,486	27,910	32,412
Accuracy	99.7	98.5	98.5	99.0	99.8	99.9
Days to Pay	4.3	4.2	8.2	5.3	7.5	8.4

The trend upward in days to pay should be improved over time as newly hired and trained staff gain proficiency.

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.

Children's Mercy Family Health Partners uses a 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.

Membership
During 2006, 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 MO HealthNet Division 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 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.

Quality Management

Quality Management

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Provider Satisfaction
Coventry, in an effort to improve the quality of customer service offered to providers, has contracted with DSS to assess providers' satisfaction with the Customer Service Center. By examining providers' level of satisfaction, Coventry can proactively address issues to improve overall satisfaction with the plan. This is the third year this study is being conducted by DSS Research.

Overall satisfaction measures increased. Directional increases are observed both for HealthCare USA overall and customer service overall. Both overall measures for HealthCare USA and customer service are also higher than the Coventry Average, significantly so for HealthCare USA overall.

Overall Satisfaction

Legend:
- Completely satisfied
- Very satisfied
- Somewhat satisfied

Category	Completely satisfied	Very satisfied	Somewhat satisfied	Total
Coventry Avg	11.5%	44.5%	27.5%	83.6%
2007	12.4%	43.8%	32.7%	88.9%
2006	13.8%	39.5%	32.2%	85.5%
2005	8.8%	29.2%	41.5%	79.5%
PCP	17.0%	33.0%	39.8%	89.8%
SCP	6.2%	58.5%	23.1%	87.7%

Satisfaction With Customer Service Overall

	Coventry Avg	2007	2006	2005	PCP	SCP
Total	87.6%	90.8%	85.3%	81.2%	88.5%	93.8%
Top	12.9%	13.8%	16.0%	9.4%	18.4%	7.7%
Middle	49.8%	49.3%	42.0%	32.9%	42.5%	58.5%
Bottom	24.9%	27.6%	27.3%	38.8%	27.6%	27.7%

Satisfaction with specific plan attributes generally decreased. Fifteen questions encompass satisfaction with specific plan attributes. Although some ratings are higher than last year, most experience a slight downward shift this year. Even so, most are slightly higher than the Coventry Average. When compared to other health insurance plans, most scores show an improvement from 2006, significantly so for clarity of remittance advice. All HealthCare USA scores, except one, are higher than the Coventry Average.

Most customer service rep ratings are lower than last year. HealthCare USA's scores are also slightly below the Coventry Average in most areas this year. Customer service reps are rated according to friendliness, clarity, concern, knowledge, accuracy, thoroughness and promptness. Activities, including on-going customer service rep training have been implemented to improve these ratings.

Verify member eligibility remains the main reason for calling customer service. HealthCare USA providers report calling to verify member eligibility 63.8% of the time. The proportion of HealthCare USA providers that mention the top reason is significantly higher than the Coventry Average. Regarding claims/billing issues, the main reason for calling is related to rejected claims.

Fewer indicate issue resolution during the initial call made to customer service. More than half (53.9%) report receiving information or having their issue resolved during the call to customer service, which is a slight decrease and is lower than the Coventry Average of 62.1%. Even so, satisfaction with the number of times required to call regarding one issue increased slightly this year from 88.4% to 88.7%..

Few use means other than telephone to contact customer service or perform transactions. About one-third or fewer report "always" or "frequently" contacting customer service via

methods other than the phone, with the proportion using Provider Channel Web Pages increasing significantly from 8.6% to 19.6%. A higher proportion report performing transactions using the Internet or Physician Office Management System.

IVR usage holds steady. The most common use of the Interactive Voice Response System (IVR) is to check member eligibility. IVR usage at 38.3% is higher than the Coventry Average of 31.8%, significantly so regarding member eligibility and authorization status. The frequency of needing to make a follow-up calls to customer service is slightly higher this year, with specialists making more calls than PCPs.

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 has been implemented to enable more accurate responses and a thoroughly resolved issue on the first call. These two characteristics have been shown to be drivers of overall satisfaction with the CSR. Improvements will generate higher satisfaction levels with customer service overall. Drivers of overall satisfaction with Coventry are claims adjustment timeliness and the reconsideration process. Continued investment in web technology updates to the system for flexibility and ease of use will help drive usage of 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.

Care Coordination
Special Needs
The Special Needs Department is comprised of two 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 or Disease Management and makes referrals accordingly.

Referrals can also be made by Physicians, Social Workers, School Nurses, the member themselves or anyone responsible for the member. All referrals are followed in the same manner. The Special Needs Coordinators (SNC) attempted to reach 3607 members in 2006 and 4690 during 2007.

Special Needs Outcomes
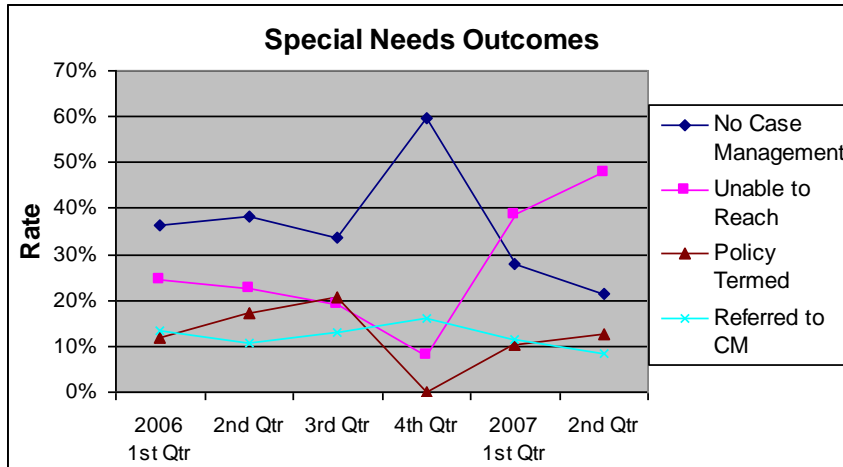
Source: NavCare case management program

In 2006, the HealthCare USA Special Needs Department focused on improving our relationships with youth residential facilities and eastern region school nurses. Visits were made by Special Needs Coordinators to each of the residential facilities to explain HealthCare USA and to answer any questions the facility nurses might have regarding MO HealthNet. The Special Needs Coordinators also met with St Louis City and County school nurses to foster our relationships. As a result we have received referrals of Special Needs members from school nurses and have a established a relationship with the facilities.

Additionally in 2006, one Special Needs Coordinator was dedicated to working in conjunction with High Risk OB doing initial assessment of members with new global authorizations indicating it may be a high risk pregnancy. This resulted in OB Disease Managers being able to concentrate their efforts on truly high risk cases.

Preauthorization
One of the most important elements in managed health care is the presence of the authorization system. It is this system that provides a key element for medical management in the delivery of medical services. There are multiple facets to an effective authorization system. Preauthorization is defined as the review strategy that helps determine appropriate utilization before care is delivered. The process also includes obtaining demographic and clinical information from the requesting provider and entering the information into the database. The distinct advantage of preauthorization is that it allows intervention prior to the delivery of patient care and services.

The Preauthorization Department is supervised by a Missouri licensed Register Nurse and is comprised of eight (8) Missouri licensed nurses who are responsible for performing medical necessity review for services requested that require preauthorization. Each case is also reviewed to determine if complex case management or disease management intervention is appropriate.

There are nine primary goals of the preauthorization process that include:

- Member eligibility is verified and benefit coverage is determined.
- Provider eligibility is verified and verification that services are provided by an appropriate contracted provider.
- Authorized services are medically necessary and provided at the most appropriate level. Preauthorization Coordinators utilize InterQual standardized criteria, clinical judgment and the Medical Director to assure that all authorized services are medically necessary and appropriate.
- The Concurrent Review Coordinator is notified that a member has been admitted as an inpatient. The Concurrent Review Nurse will begin reviewing the member's medical record to assure each inpatient day is medically necessary and appropriate for an inpatient level of care.
- Cases are identified for which a Complex Case Management evaluation is appropriate. The Preauthorization Coordinator can assist in assuring that members with complex and ongoing medical needs are appropriately evaluated for more intense medical management.
- Discharge planning is begun as soon as possible when preauthorizing elective inpatient admissions. This is the ideal time to identify the discharge plan, anticipated barriers to timely discharge, and any projected services required upon discharge (home care, durable medical equipment, skilled nursing care).
- The care takes place in the most appropriate setting. A request for inpatient services may be diverted to an ambulatory care setting, or a case may be diverted from a nonparticipating provider to a participating one.
- Data is captured for financial accruals and utilization reporting. By identifying the number and nature of hospital cases, as well as potential catastrophic cases, the Plan can more accurately predict expenses rather than waiting for claims to come in. This allows management to take action early and to avoid financial surprises. It is also the time to identify those members who have (or can be expected to) incur high-dollar costs. For reinsurance purposes, the costs must be tracked and reported to insure appropriate reimbursement.
- Quality of care issues are identified and reported appropriately.

In 2006, the position of Preauthorization Representative was filled by two (2) non-clinical personnel. These staff do not conduct any UM review or activities that require interpretation of clinical information. The Preauthorization Representatives support the preauthorization staff by taking on tasks that do not involve clinical expertise or knowledge. They work under the supervision of the pre-authorization team leader and manager of the department.

The Preauthorization Representatives serve as support for the Health Services Department by faxing information and assisting in department mailings to providers and members. They enter data into the referral system that consists of:

- Demographic information for large hospital groups.
- Newborn authorizations, which consist of statistical data
- Home health authorization for the mom and baby.

- Global referrals to cover the member prenatal care, as well as home health authorization for selected vendors.

Mental Health
MHNet and Healthcare USA have procedures in place for coordinating care for members with comorbid issues. MHNet contacts Healthcare USA complex case managers or disease managers when a member is receiving psychiatric services who is pregnant or has complex medical issues that without proper coordination could result in negative treatment outcomes. Healthcare USA also communicates to MHNet if members receiving medical treatment are identified as having behavioral health needs.

In CY 2006 – June 2007, MHNet and Healthcare USA continued collaboration to enhance the referral process for members, particularly for Children with Special Needs and High Risk OB cases, to improve efficiency and coordination of care. Enhancements include monthly joint meetings with care management staff from MHNet and HealthCare USA in which processes and specific cases are discussed and an improved shared system to track referrals. MHNet staff is also available during weekly HealthCare USA case management and grand rounds for cases involving behavioral health issues.

Dental
HealthCare USA and Doral partnered on a variety of coordination of care activities and community events in CY 2006 - June 2007:
- HealthCare USA sponsored back-to-school health fairs in 2006 and 2007, in which Doral provided dental hygienists that performed dental screenings on more than 560 children. Doral also provided toothbrushes, toothpaste, dental hygiene literature and stickers for distribution at the fairs.
- Participation in the Washington County Health & Wellness Outreach project in collaboration with the Missouri Oral Health Preventative Services Program. Doral provided hygienists for multiple screening dates in March 2007 and provided toothbrushes, toothpaste, dental hygiene literature and stickers as well.
- Participated in the Kansas City Health & Fitness Fair, the HealthCare USA Carnival and the Head Start Small Smiles Seminar.
- Member Placement Program to assist in securing dental appointments for HealthCare USA members.
- Collaborated on articles for the HealthCare USA member and provider newsletters, informing members and providers of the dental benefits and encouraging members to seek preventative dental care.

Case Management
Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs using communications and available resources to promote quality, cost-effective outcomes. – Commission for Case Manager Certification (CCMC) The goal of complex case management is to eliminate barriers care and services and encourage appropriate use of health care services on a case-by-case basis.

In 2006 and 2007, the Case Management Program continued to be an integral part of HealthCare USA's individualized, member-centered approach to meet our members' medical and psychosocial needs. The case managers are Missouri licensed nurses who serve as member advocates. HealthCare USA has nurse case managers who have appropriate clinical experience and an understanding of the health needs of Missouri's MO HealthNet Managed Care population in all three (3) regions. They coordinate services provided through the health care delivery system and community-based organizations to achieve optimal member outcomes.

There was an average of 295 members over the age of twenty-one (21) case managed each month. The top reason for enrollment of members over 21 years was trauma/medical/surgical issues. There was an average of 1649 members twenty-one (21) and under case managed each month. The top reasons for case management in this age were medical/surgical and musculoskeletal.

HealthCare USA is committed to providing quality health care for our members. We strongly support the concept that quality of care cannot be compromised for the sake of cost reduction. HealthCare USA has both an ethical and legal responsibility for clinical excellence. Our Case Management Program is designed to assure cost-effective, high-quality care and services.

All interventions listed below continued to play an active role in the case management program in 2006 and 2007.
- HealthCare USA takes an aggressive approach to identify members, methods include:
  - Self-referrals
  - New member calls
  - Health risk assessments
  - Member surveys
  - In-patient certification review
  - Providers
  - HealthCare USA's pharmacist, pre-authorization staff and member advocates.
  - Claims and utilization data analysis to detect trigger diagnoses such as cancer drugs, hospital readmission with in thirty (30) days or less, multiple hospital admissions for same diagnosis, chronic conditions and authorizations for high dollar DME.
- Implementation of a case management database to track and report data
- Initial telephonic needs assessment that includes a broad range of questions to determine individual situations and risks. Areas assessed are physical and mental health, social and emotional status, capability for self-care, member goals and current treatment plans.
- Individualized treatment plan development based on the assessment.
- Collaboration with the PCP to ensure plans of care support the medical plans.
- Consideration of needs for social, educational, therapeutic and other non-medical services such as WIC, Catholic Charities, Nurses for Newborns, counseling and the strengths and needs of the entire family.
- Development of member and provider educational materials.

Disease Management Program

Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. – Disease Management Association of America. The goal of disease management is to prevent exacerbations and/or complications related to specific diagnoses.

Asthma

The mission of the asthma disease management team is to improve the quality of life and outcomes of care for HealthCare USA members with asthma through education and collaboration with members, providers and community resources. HealthCare USA has actively managed the asthma population since 2005, in a case/disease management model. In 2007, the program was changed to stratify the asthma population to identify those individuals with a lower acuity from those with a higher acuity, that are most likely to incur adverse outcomes. The program is designed to provide more intense interventions for those at greatest risk for exacerbations.

The asthma disease management staff are State-licensed registered nurses with past clinical experience in caring for patients with asthma. Their vision is that every HealthCare USA member with asthma will live a normal life without any limitations from asthma. Their guiding principals are:

- Work proactively and collaboratively with communities and providers.
- Encourage responsibility and investment on the part of the member to ensure wellness.
- Incorporate measurable outcomes and objectives in health improvement.
- Ensure strategies draw from and compliment our mission.
- Align structure and incentives.
- Manage health and financial risks.

The HealthCare USA goals for the asthma disease management program are:

- Reduce health care costs associated with asthma by reducing asthma related hospitalizations and ED visits
- Improve quality of care and self-management skills as evidenced by:
  - Improved HEDIS measure for controller medications.
  - Improve quality of life and well being as evidenced by member reported improved ability to self-manage and health status as reported on satisfaction survey & HRA.
  - Improve member, provider and staff satisfaction with the asthma Disease Management process and services.
- Set a new all time best standard for asthma outcomes across Coventry

The asthma disease managers perform telephonic and face-to-face education and utilize community resources in the management of these members. The National Heart Lung Blood Institute (NHLBI) clinical practice guidelines are referenced for ongoing member and provider education. They manage both the adult and pediatric population, however approximately 98% of the population is pediatric.

The disease managers utilize multiple resources to assist these members. Some of the resources utilized are:

- Community based programs such as the Asthma and Allergy Foundation, the American Lung Association, the St. Louis Asthma Consortium, and the Community Asthma Program.
- School nurses are also an important resource for community collaboration.
- Pharmaceutical company educational material, spacers and peak flow meters are provided at no cost.
- Partnership with the Human Development Corporation has provided the Community Action Voicemail Service at no cost for our members who do not have access to telephone service.

Since the implementation of asthma care activities and initiatives, HealthCare USA has achieved improvements for members in all regions. The chart below shows the continued decrease in asthma admissions per 1000 members since 2003.

HCUSA ASTHMA
Admits /1000 Members
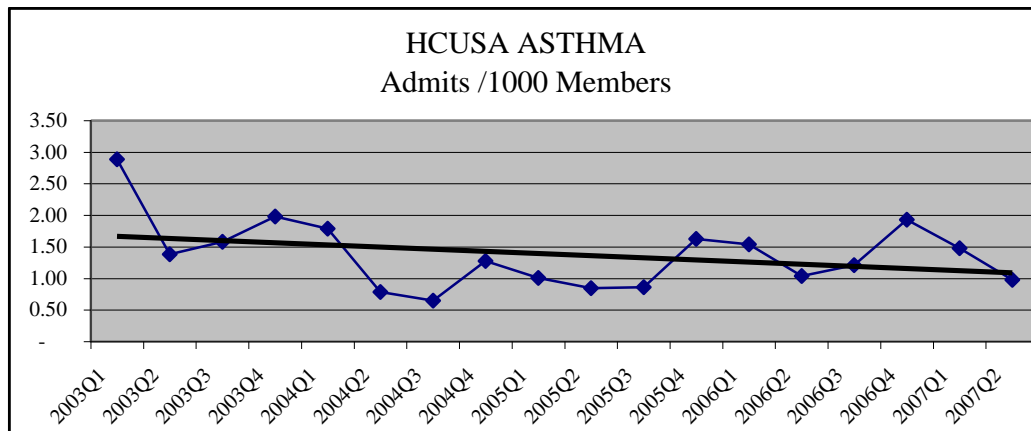
 Source: Claims Data paid through October 2007

High Risk OB
The mission of the high risk ob disease management team is to work in tandem with providers, the community and High Risk OB members to increase the number of healthy moms and babies. Since 1995, HealthCare USA has improved care for members with high-risk pregnancies through the multi-disciplinary high-risk OB case management program. In 2007, HealthCare USA developed this into a disease management program, further enhancing the services provided to members with the greatest risk of poor outcomes related to preterm labor and delivery.

The high risk OB disease management staff consists of four (4) State-licensed, experienced obstetrical registered nurses. Their vision is to improve the health of mom's and babies by eliminating preterm labor and delivery, and the complications associated with preterm delivery. Their guiding principals are:
- Work proactively and collaboratively with communities and providers.

- Encourage responsibility and investment on the part of the member to ensure wellness.
- Incorporate measurable outcomes and objectives in health improvement.
- Ensure strategies draw from and compliment our mission.
- Align structure and incentives.
- Manage health and financial risks.

Goals of the high risk OB program:
- Reduce the number of NICU admissions
- Reduce the number of preterm deliveries and complications and mortality associated with preterm delivery
- Improve member, provider and staff satisfaction with OB disease management process and services
- Reduce the cost of ED visits and hospitalizations for high risk OB members
- Be the leader in OB disease management services for Coventry

HealthCare USA identifies members for high risk OB disease management based on the following indicators:

- History of preterm delivery of preterm labor
- Gestational diabetes, uncontrolled diabetes
- Hypertension
- HELLP syndrome
- Incompetent cervix
- Multiple gestation
- Placenta abruption/previa
- PIH/pre-eclampsia
- ≥22 weeks uncontrolled vomiting
- ≥22 weeks ≤37 weeks and admitted to hospital
- Hyperemesis due to organic disease

- Previous neonatal death ≥22 weeks ega
- Sickle-cell/Hb-C disease with crisis
- ≤17 years of age
- Poor weight gain
- Intrauterine growth retardation
- Oligohydramnios
- Spontaneous premature rupture of membranes
- Thromboembolic disorder
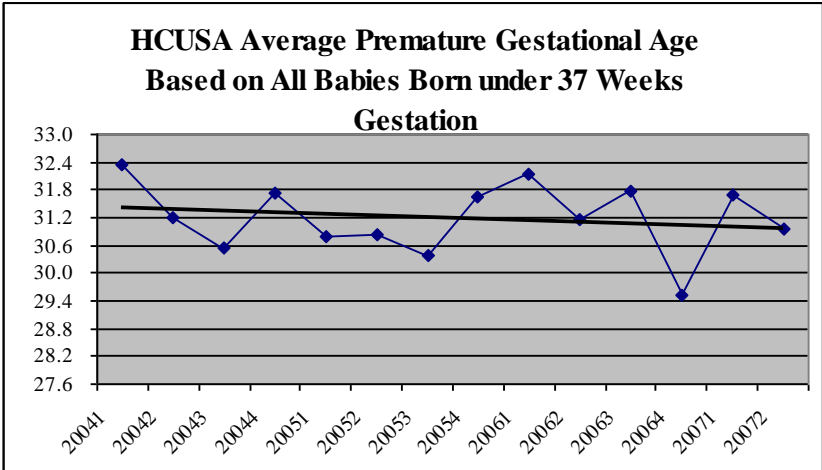- Vaginal bleeding ≥22 weeks
- Adrenal gland disorders
- Lupus

Members are referred to the high risk OB disease management through global OB requests, provider updates, UM staff and self referrals. The staff review member clinical and authorization history to determine enrollment into the program. Individualized care plans are developed with appropriate interventions and goals. Telephonic education and coordination of services are made in collaboration with PCPs, OBs, HealthCare USA Medical Directors and community resources.
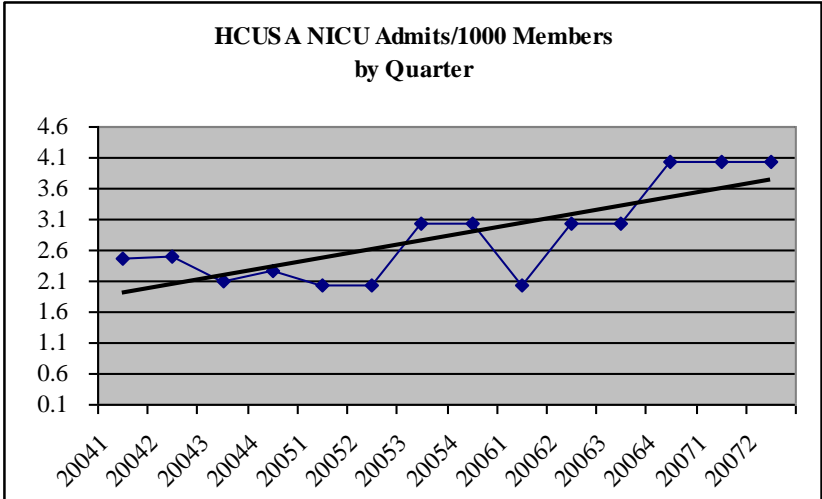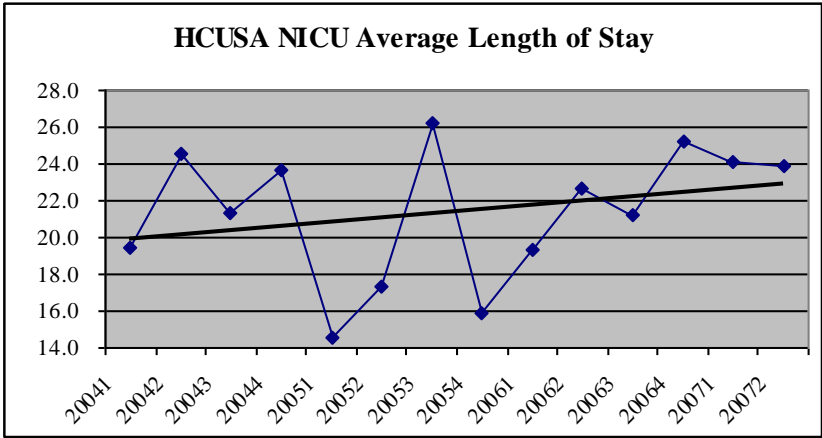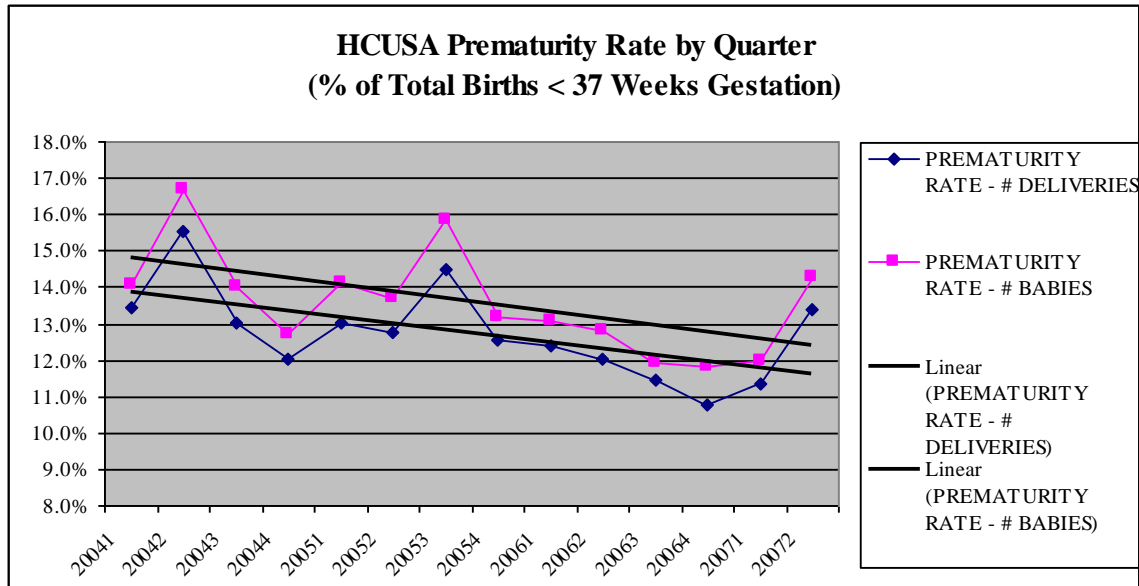
HCUSA NICU Admits/1000 Members by Quarter

Source: Claims data paid through October 2007

HCUSA NICU Average Length of Stay

Source: Claims data paid through October 2007

HCUSA Average Premature Gestational Age Based on All Babies Born under 37 Weeks Gestation

Source: Claims data paid through October 2007

11

HCUSA Prematurity Rate by Quarter
(% of Total Births < 37 Weeks Gestation)

Source: Claims data paid through October 2007

HCUSA NICU Outcomes at Delivery
as a % of all Babies Delivered
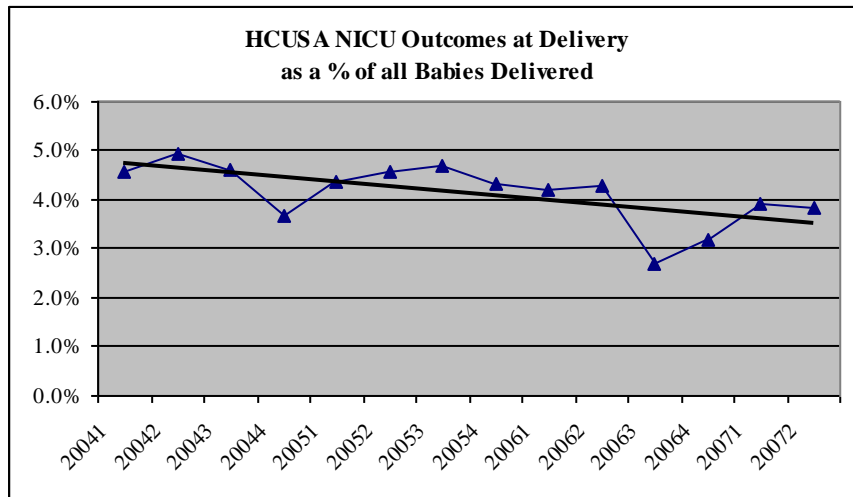
Source: Claims data paid through October 2007

As evidenced in the above graphs, the NICU admits per 1000, average length of stay and average gestational age for those born before 37 weeks have been increasing steadily since 2004. However, the overall prematurity rate of all births has shown a decline since 1st quarter 2006. There has been a decrease in the rate of NICU admits as a percentage of all deliveries.

Mental Health Care Management including Case Management
Ambulatory Care – Mental Health
MHNet continued the Quality Improvement Activity (QIA), Improving Post-Discharge Management of Members Discharged from an Inpatient Service for Mental Illness. Results of the QIA are clearly seen in the HEDIS rates for Follow-up after Hospitalization for Mental Illness; however, MHNet includes all members (including those not meeting HEDIS inclusion criteria) in discharge planning activities.

While results are mixed, MHNet continues to focus on ambulatory follow-up and dedicate significant case management resources to improving follow-up rates. Efforts include a clinician dedicated exclusively to discharge planning activities and outreach to all inpatient facilities to encourage the facilities to partner with MHNet in securing follow-up appointments for members. Further detail on this project can be found under the heading Performance Improvement Projects - Clinical.

Family Evaluation/Therapy for Adolescent/Child Members – Mental Health
MHNet continued to actively advocate family therapy for children and adolescences through educational outreach efforts to providers and members. MHNet's Practitioner Newsletter for 2006 and 2007 included an article promoting family therapy. MHNet also has a fax back initiative for providers who submit Outpatient Treatment Records requesting individual versus family therapy for treatment of a child less than 18 years of age. This initiative requests the provider to explain the rationale for individual therapy versus family therapy and allows for an additional educational outreach advocating for family therapy.

MHNet's customer service and case management process also emphasizes family therapy with initial referrals and authorizations supporting a combination of individual and family sessions for members under eighteen (18). MHNet educates providers regarding the use of CPT codes that reflect the actual level of family involvement and other issues.

Clinical Practice Guidelines
The QMC approved several new and updated clinical practice guidelines to be followed by HealthCare USA and the provider network. Links to these guidelines can all be found on the HealthCare USA website. The following grid lists the guidelines, the organization who created them, who at HealthCare USA reviewed the guidelines and date of approval by the QMC.

Guideline	Organization	Guidelines Reviewed by	Date of QMC Reviews
COPD Management	American Thoracic Society; Global Initiative for Chronic Obstructive Lung Disease (GOLD). *Updated 2004*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
Diabetes Management	American Diabetes Association *Updated 2007*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	September 2006 March 2007
HF Management	KCQIC guideline adapted from American College of Cardiology; American Heart Association *Updated 2003*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	September 2006 March 2007
Asthma Management	KCQIC Guideline Adapted from the National Institutes of Health National Heart, Lung and Blood Institute's Guidelines for the Diagnosis and Management of Asthma. *Updated 2002*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	September 2006 March 2007
Preventive Health Guideline	American Academy of Pediatrics Recommendations for Preventative Pediatric Healthcare, copyrighted 1999	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
Pregnancy Management Guideline	US Preventive Services Task Force; American College of Obstetrics and Gynecology (ACOG) *Updated 2005*	Coventry Health Care HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007

Hypertension	KCQIC guideline adapted from Joint National Committee on Prevention, Evaluation, and Treatment of High Blood Pressure (JNC7) NHLBI guidelines available at www.nhlbinih.gov/guidelines *Updated 2003*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	September 2006 March 2007
Treating major Depression in the Primary Care Setting	American Psychiatric Association (APA)	MHNet Medical Director MHNet Corporate QMC MHNet Staff HealthCare USA QMC	March 2007
Treating schizophrenia in the Primary Care Setting	American Psychiatric Association (APA)	MHNet Medical Director MHNet Corporate QMC MHNet Staff HealthCare USA QMC	March 2007
Practice Guidelines for Substance Abuse Disorders	American Psychiatric Association (APA)	MHNet Medical Director MHNet Corporate QMC MHNet Staff HealthCare USA QMC	March 2007
Practice Guidelines for Bipolar Disorder	American Psychiatric Association (APA)	MHNet Medical Director MHNet Corporate QMC MHNet Staff HealthCare USA QMC	March 2007

|			
Tobacco Control	KCQIC guideline adapted from the Institute for Clinical Systems Improvement (ICSI) Tobacco use prevention and cessation for adults and mature adolescents. *Updated 2005*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	September 2006 March 2007
Identification, evaluation and treatment of overweight and obesity in the adult	KCQIC guideline adapted from the National Heart Lung Blood Institute (NHLBI) Obesity Education Initiative *Updated 2004*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	September 2006 March 2007
Diagnosis and Management of Bronchiolitis	American Academy of Pediatrics Clinical Practice Guidelines *Updated October 2006*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
Chlamydia	California Chlamydia Action Coalition *Updated November 2002*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
Synagis	American Academy of Pediatrics *Updated 2006*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
Lead	American Academy of Pediatrics Policy Statement *Updated October 2005*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
ADHD	American Academy of Pediatrics Clinical Practice Guidelines *May 2000*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
Diagnosis and Management of Otitis Media	American Academy of Pediatrics Clinical Practice Guidelines *May 2004*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007

Recommended Adult and Pediatric Routine Immunizations	CDC, MMWR *Updated 2007*	HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
Coventry Corporate Technical Assessments	Coventry Corporate Medical Affairs-Health Services	Coventry Medical Affairs HealthCare USA Staff Members HealthCare USA Medical Director QMC	March 2007
InterQual Update 2007	Coventry Corporate Medical Affairs-Health Services	HealthCare USA Health Services HealthCare USA Medical Director QMC	March 2007

Credentialing and Re-Credentialing

HealthCare USA has the sole right to determine which primary and specialty practitioners it shall accept and retain as HealthCare USA providers. The Credentials Committee, with Medical Director leadership, provides oversight of all credentialed and re-credentialed practitioners.

HealthCare USA monitors the effectiveness of the credentialing program on a quarterly basis. The key indicators of this include:
- Turn around time for credentialing and recredentialing
- Number of providers credentialed and recredentialed for the year
- Number of providers who were terminated and/or decredentialed for the year

Providers Credentialing and Recredentialing 2005-2007
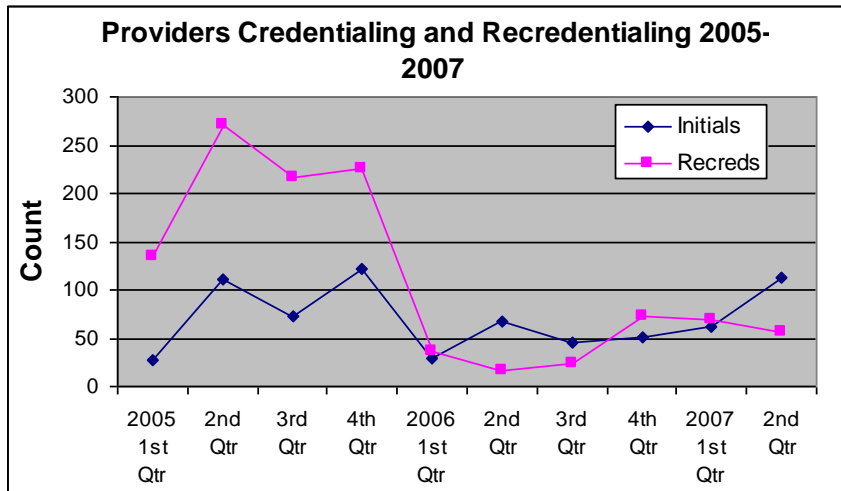
Source: Coventry Provider Database

The average turn around time for all files was 21.13 days.

HealthCare USA conducted oversight of eleven (11) delegated credentialing entities to ensure compliance with the requirements of the health Plan and the State of Missouri. The annual audit consisted of reviewing randomly selected credentialing and recredentialing files, policies and procedures, and committee meeting minutes.

It is HealthCare USA's standard that each delegated entity achieve a score of at least 80% or greater. If issues are identified during the auditing process, clarification is requested and corrective actions are taken should the facility be unable to comply. Audit results are presented to the Credentialing Committee and Quality Management Committee (QMC). Recommendations are made on an "as needed" basis.

In 2006, 100% of the audited entities attained a score of 80% or greater. HealthCare USA will continue to provide oversight of its delegated entities. 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
- SLUCare

Medical Record Review

HealthCare USA's Quality Improvement Department conducted on-site medical record reviews. This compliance review ensures maintenance of an adequate, detailed and comprehensive medical records, and conforming to evidence based clinical practice guidelines. Focus areas also included completeness and timeliness of EPSDT visits, use of HCY forms and the lead risk assessment guide, and lead testing and immunizations. In addition to increasing the volume of records and number of sites audited, a new focus for 2007 was education and notation regarding advance directives and verification of the presence of documentation for claims submitted.

Providers were audited based on the recredentialing cycle. Panel size and claims for 2006 and 2007 were taken into account when setting up an audit. Reviewers arranged an on-site visit or requested copies of documentation be mailed to HealthCare USA. A member list was chosen from claims. A chart review tool was used to objectively score each record. In addition, all dates of service for each member were compared to the medical record. Any discrepancies were noted, and further investigation was initiated.

All results from the tools were added to a database and a score was produced. A letter and summary worksheet were sent to the provider after the audit informing them of the results. Education was tailored to specifically address issues identified within the chart audit. A two page list of resources and information about issues addressed during the audit were also sent to the provider. All chart audit results were placed in the provider's credentialing files. A copy of the audit results and summary were sent to the provider representative for each provider audited. Any provider who scored below an 80% was re-audited within 180 days. A claims list from the first audit date forward was used for the re-audit.

When the Quality Improvement Department observes exceptional documentation, it is vital to acknowledge these facilities for their efforts. HealthCare USA awards exceptional offices in each region with the *Sharing the Vision for Excellence in Quality* award.

Recipients of the award for 2005 were Grace Hill Neighborhood Health Centers in St. Louis and Children's Mercy clinics in Kansas City. 2006 recipients were Dr. Armisa Cullens in Kansas City, Dr. Trent Russell in Osage, and Dr. Homer Nash and Dr. Alison Nash in St. Louis. The award included a ceremony with presentation of the award by a member of the HealthCare USA management team, a desktop award and wall plaque, and catered luncheon for the entire staff. HealthCare USA will continue this tradition for the upcoming years.

Subcontractor Monitoring
HealthCare USA maintains collaborative relationships with several entities who provide specific delegated functions in order to provide comprehensive quality services and care to the MO HealthNet Managed Care membership across the Eastern, Central and Western Missouri Regions. Within these relationships, Healthcare USA retains the authority to oversee each subcontractor for compliance with the applicable statutes, regulations, policies and procedures governing each delegated function.

During Calendar Year (CY) 2006 and through June 2007, Healthcare USA delegated the following functions to external vendors who provide expertise in each area:
Dental Services
Doral Dental USA, LLC (Doral)   January 1, 2006 – June 30, 2007

Transportation Services
Medical Transportation Management (MTM)   January 1, 2006 – June 30, 2007

Behavioral Health Services
MHNet Behavioral Health, Inc. (MHNet)   January 1, 2006 – June 30, 2007

Pharmacy
CVS/Caremark   January 1, 2006 – June 30, 2007

Healthcare USA's process for conducting ongoing monitoring of delegated vendors includes routine committee meetings with each vendor. The Oversight Committee meetings are conducted at least quarterly or more frequently as need arises. The meetings include representatives from various departments of HealthCare USA, as well as representatives from the subcontractor. The Oversight Committee is charged with reviewing and monitoring the following for compliance with applicable MO HealthNet Managed Care requirements, applicable URAC standards, as well as state and federal regulations:

- Utilization Management
- Access and Availability
- Quality Management / Quality Improvement
- Provider Complaints, Grievances, and Appeals
- Member Grievances and Appeals
- Policies and Procedures regarding each subcontractor function
- Member and Provider Satisfaction
- Coordination of Care Activities
- Member Services
- Provider Services
- Claims Processing
- Fraud and Abuse

- Member and Provider Education Initiatives
- Preventive Health Programs
- HIPAA Compliance

In addition to monitoring of the above, Healthcare USA utilizes the Oversight Committee to initiate and implement corrective actions and address opportunities for improvement with each subcontractor as needed. The oversight meetings are documented through formal agendas, sign in sheets, and minutes. The subcontractors quality improvement staff also attend and report at the HealthCare USA QMC meetings and routine care management rounds. HealthCare USA participates in MHNet's regional quality improvement committee meetings.

Healthcare USA provides additional oversight throughout the year by reviewing regular reports, materials, policies and procedures etc. required of each subcontractor. These documents are disseminated to the appropriate staff at Healthcare USA and discussed with each subcontractor via regular communication and through the formal Oversight Committee. All annual documents, i.e. annual evaluations, program descriptions, work plans, policy and procedure manuals, disaster recovery plans, etc. are also reviewed.

HealthCare USA conducted annual on-site reviews for Doral, MHNet, and MTM in CY 2006 – June 2007.   The on-site reviews included a full audit of all internal processes, policies, procedures, staff training, case management documentation, compliance with the MO HealthNet Managed Care contract, and state and federal regulations. The annual audits also incorporated a review for compliance with all applicable URAC Accreditation standards. HealthCare USA provided each subcontractor a final report depicting their compliance with the applicable areas under review as well as any corrective actions needed and the timeframes for completion of those items. Healthcare USA has incorporated the results of these reviews into the annual subcontractor evaluation.

Mercy CarePlus

QUALITY MANAGEMENT

Provider Satisfaction
MCP did not conduct a provider satisfaction survey in 2006 or 2007. However, MCP is considering conducting a provider satisfaction survey in 2008.

Care Coordination
Effective coordination for special needs members has two main impacts. First and foremost, it allows more effective, coordinated care to these individuals and better support to their families and caregivers; both of which optimize the chances for positive outcomes. Second, a goal of active case management is to make care more cost efficient, so limited Medicaid funds can be spread among more eligible Missouri residents.

Case Management
MCP's concept of case management is a more intensive support or outreach to members with a variety of clinical conditions and/or social circumstances that, if left to self-management, may reduce the possibility of a positive outcome. Identification of participants for enrollment in case

management comes from multiple sources. Case managers review the State's Children with Special Health Care Needs list to identify children who might benefit from case management. Referrals come from the preauthorization nurses and from the nurses performing chart review during the concurrent review process. Pharmacy and claims data are also a source of potential candidates. The PCP, specialist, or social worker may also refer participants. The participant, parent or guardian themselves may request assistance from the case management nurses. Also when a new participant is enrolled in MCP, a Welcome Call is initiated. During this call, the member services representative may obtain information that would prompt a referral to case management.

When a referral is received, all information pertaining to the participant is reviewed to determine whether the participant may be a candidate for case management services. If the case manager determines that additional information is needed, the nurse may contact the provider or member (parent/guardian) to assess the participant's needs. Based on the information received, a participant may be enrolled into case management and assigned a case manager.

MCP assigns case managers based on the level of expertise necessary to effectively support the condition and/or social circumstance being managed. The case manager is responsible for, but not limited to, communicating across the health care team continuum; negotiating with providers when appropriate; facilitating, coordinating and documenting individualized treatment plans, health care service(s) and/or community service resources.

The case managers work under the direction of and collaborate with the Department Manager and the Director of Medical Management. The Chief Medical Officer is directly involved with the management of participants enrolled in case management. The Medical Director's clinical team meets weekly and as needed to evaluate the participants' needs, identify areas of opportunity and redesign and update interventions and goals as needed.

MCP has policies specific to the types of cases managed under the Case Management program for conditions such as but not limited to high risk OB, lead and special needs. The case management policies are developed based on the severity of the clinical condition, community practice guidelines, benefits, availability and community service resources that promote the best outcome for the member. The Case Manager works collaboratively with the PCP, specialists and ancillary service providers to promote optimum outcomes for members.

Disease Management Program
MCP incorporated disease management into case management. See the case management information above.

Mental Health Care Management including Case Management
MCP encourages its mental health subcontractor to coordinate treatment services with the members' PCP.

Clinical Practice Guidelines
MCP uses clinical guidelines to evaluate the medical necessity of requested services and promote access to the most appropriate services at the most cost effective setting based on solid current

clinical practices. Use of nationally based criteria promotes the consistent application of available benefits based on the individual circumstances and/or condition of the member. Examples of these are: ACOG for Obstetrical Needs, KCQIC Guidelines for Management of Essential Hypertension, KCQIC Guidelines for Tobacco Control, Missouri Consensus Diabetes Management Guidelines for Adults, NHLBI Guidelines for the Diagnosis and Treatment of Asthma.

Credentialing and Re-Credentialing
MCP maintains a credentialing program that identifies criteria for participation of licensed health practitioners, and the processes involved in selection, retention and termination of participating practitioners. MCP's selection and evaluation process assures that providers available to serve MCP members are qualified to perform the services members require and can work well within the delivery system that has been developed.

MCP contracted with a CVO to perform primary source verification of credentialing applications. The CVO is also contracted to perform delegated credentialing audits. The audit includes a review of the provider's credentialing program and its compliance with MCP's policies and procedures. The delegated audit results are reported to MCP's Credentialing Committee. The committee provides guidance for any outstanding issues identified through the audit.

Medical Record Review
MCP's Provider Relations department performs an office site evaluation of providers within two years prior to the credentialing decision to ensure that offices meet requirements. Included in the office site evaluation is a medical record keeping review. The standards that are evaluated through the medical record keeping review include a secure/confidential filing system, legible file markers and the ease of locating records.

Subcontractor Monitoring
MCP subcontracts for the following services: pharmacy, mental health management, routine vision care, dental management, and transportation management. Express Scripts, Inc. manages MCP's pharmacy benefit. Express Scripts is MCP's primary provider of PBM services, specialty injectibles, and formulary and rebate management. St. John's Mercy Managed Behavioral Health provided mental and behavioral health and substance abuse services through network providers including psychiatrists, psychologists, social workers or other mental health counselors. Bridgeport Dental provides covered comprehensive dental services, including diagnostic, preventive, ancillary, restorative, endodontic, prosthodontic, and orthodontic services, and oral surgery. Medical Transportation Management manages a network furnishing non-emergency medical transportation services for eligible members. Vision Services Plan provides routine vision and eye care services for eligible members under the age of 21 and limited routine vision benefits for members 21 and over.

The subcontractors are required to adhere to the requirements contained in the State contract with MCP. Oversight meetings are held quarterly. Any noted deficiencies are addressed with the subcontractor through an action plan that details time frames and objectives. Each subcontractor is invited to attend MCP's Quality Improvement Committee periodically to present an update.

The credentialing audits of the delegated providers are presented to the Credentialing Committee.

Harmony

Tracked, trended, and reported to committees accordingly
- Provider Satisfaction
- Care Coordination
- Case & Disease Management
- Mental Health Case Management
- Clinical Practice Guidelines
- Credentialing/Re-credentialing
- Medical Record Review
- Subcontractor/Delegation Monitoring

Lead Reports
In the fiscal year from July 2006 until June 2007 there were 26 members with elevated leads. The average numbers of members in the lead case management outreach averaged 8 to 9 members per month.

Multiple attempts spanning several months were used to reach out to hard to reach members. Some of the outreach attempts included working closely with the members PCP for current contact information, checking for Harmony's most current contact information, and attempting to contact members through alternative contact numbers.

When contact was made with a member Case Management Services was offered along with providing lead educational material. The lead case manager works closely with the provider of services for the member to assure the best coordination of care, medical management, and reduction of lead levels and lead exposure.

Special Needs Report
Case Management has reached out to the 436 members identified as Special Needs. The results of Case Management reaching out to members identified with Special Needs are summarized as follows:

- Attempted to reach 436 members
- Unable to establish contact due to non working or no phone number – 396 members
- Members not established with PCP – 112 members
- Member in State custody – 1 members
- Member adopted – 1 members
- No answer multiple times – 4 members
- Left message 2 or more times – 27 members

- Refuse Case Management "OK per mother" – 2 members
- Refused Case Management without comment – 2 members
- Termed with plan – 2 members
- Accepted Case Management – 7 members

There continues to be large numbers for members with incorrect contact information both telephone and address, providing significant barriers to reaching out to these members.

See Attachment QM 1

Missouri Care

Provider Satisfaction
Missouri Care conducted a Provider Satisfaction Survey in 2006. Providers rated Missouri Care Health Plan as excellent, very good, and good more often compared to "all other plans" on the following composites/attributes: member services, provider relations, and preventive care. Missouri Care scored slightly lower than "all other plans" on the claims composite. To address this issue, Missouri Care developed educational materials and training for the claims processing team, to increase claims processing speed and accuracy.

Care Coordination
Missouri Care aims to provide comprehensive member focused medical and behavioral health services. Care Coordination program components include: fostering the concept of a medical home, providing a 24/7 nurse advice line, implementation of standardized, evidence-based clinical guidelines for decision making, case and disease management programs, and quality improvement via benchmarking, establishing performance standards and outcomes measurement.

Case Management
Missouri Care strongly believes that medical and social outcomes will improve if routine services are supported and enhanced by case management interventions that effectively address the specific needs or condition of the individual member. The Case Management Program provides, but is not limited to, the following enhancements to routine care, which are based on nationally recognized clinical guidelines and standards:

- Identification of members with complex or chronic clinical or social conditions who could benefit from case management
- Outreach and encouragement to become engaged in healthy lifestyle and related health-directed behaviors
- Comprehensive assessments
- Stratification of risk factors
- Targeted interventions
- Education
- Links to appropriate community resources
- Disease specific outreach/activities
- Tracking of outcomes

The goals of Missouri Care's Case Management Program are to:

- Ensure that a member receives needed care without interruption
- Identify barriers to care and help coordinate services and interventions that will have a positive
  impact on the member's condition and promote improved health outcomes
- Increase the number of members using their medications correctly, in both frequency and dosing
- Reduce longer-term premature morbidity (complications) and mortality of their disease/diseases
- Decrease the incidence of ER and inpatient visits, when care could be supplied either to prevent
  such visits, or in place of such visits
- Teach prevention/wellness and better overall management of disease states, resulting in healthier lifestyle choices
- Enlist family, caregiver or other support entities to aid in maintenance of wellness activities
- Track outcomes to identify opportunities to improve the program
- Assure, where possible:
    ○ Appropriate use of preventive measures
    ○ Better methods of adherence, aimed at resulting in better perceived quality of life

Missouri Care makes case management services available to all enrolled members or populations who are identified as having health problems or situations that may benefit from case management as identified by predictive modeling, health plan staff and referrals. Referrals to case management may originate with a member's primary care, attending, or treating health care professionals or providers; a family member or caregiver; health plan staff members in other departments (such as Precertification, Concurrent Review, Member Service, Quality Management); the chief medical officer or with a state agency. Members may also self refer.

Educational information promoting a healthy lifestyle is available to all case management members through a variety of resources such as the Missouri Care's Web site, newsletters, booklets and specific educational mailings.

During SFY07 Missouri Care enrolled the following contractually required populations in case management: 114 Children with Elevated Lead Levels, 256 Children with Special Needs and 639 Perinatal cases.

In this reporting period, Missouri Care implemented the following interventions to improve the existing case management programs:

- Implementation of Predictive Modeling, a proprietary database used to identify members likely to be future high utilizers based on claims and diagnostic data; the system determines

the member's potential risk level and predicts whether or not case management interventions can effectively improve the member's outcome
- Implementation of CaseTrakker™ an integrated database for collecting and tracking information about a member's medical-social health history, current medical-social conditions, case management interventions and outcomes, and for prompting timely reminders and outreach efforts by staff
- Implemented a new report, "Case Manager Alert-No Case Manager" to identify pregnant members through claims data that are not assigned to a case manager
- Finalized revisions to "You & Your New Baby," a handbook to reinforce basic information on postpartum and newborn care
- Rolled out the "Cradle Your Baby Campaign" by DMS to OB providers to encourage testing for lead poisoning during pregnancy, an opportunity for prevention of lead poisoning in children
- Updated the "Pregnancy Notification and Risk Screening" form to capture lead testing by OB providers
- Collaboration with Lutheran Family and Children's Services for case management of pregnant
members for assistance with community resources, such as housing and utility assistance
- Partnership with the ROSE Program to collaborate on case management of our high-risk pregnant members

Disease Management
Missouri Care provides disease management programs to assist health care providers in managing members diagnosed with targeted chronic illnesses. Illnesses included in disease management initiatives are asthma, diabetes, COPD, and CHF. They frequently result in exacerbations and hospitalizations (highrisk), require high usage of certain resources and have been shown to respond to coordinated management strategies. Disease management programs are structured around nationally recognized evidence-based guidelines. They include interventions designed to address a member's level of risk and reporting methods and formats to measure and monitor outcomes.

The Disease Management Program includes member and provider outreach. Interventions include an introduction letter and telephone call to the member. A letter is also sent to the member's PCP explaining the Disease Management Program. A risk assessment is administered to determine severity, medication use and management techniques. Education mailings include education materials on medications. Providers are notified of members' enrollment in the program.

Mental Health Care Management (Including Case Management)
Care Management
Missouri Care's behavioral health care manager is responsible for daily prior authorization and concurrent review operations. Duties include documenting and evaluating requests for inpatient and partial levels of care, as well as requests for outpatient services beyond the initial authorization. The function is available 24 hours a day, seven days a week, 365 days a year. Missouri Care maintains a toll-free telephone number for members, behavioral health professionals and organizational providers. Care management staff is responsible for determining

the member's enrollment and coverage of the service, determining the behavioral health provider's network affiliation, identifying potential coordination of benefits issues, and determining whether the service and level of care requested are consistent with LOCUS/CALOCUS criteria. Care management staff may authorize services if the request is supported by the review criteria and may deny authorizations for administrative reasons. However, the CMO must review any potential medical necessity denials. Only the CMO may decide to deny authorization based on clinical criteria.

The care manager informs the inpatient provider of the members' recent health care service history including psychiatric inpatient admissions, emergency room visits for the prior year, psychiatric outpatient services for the prior six months, and medications for the prior 90 days. Missouri Care's behavioral health care manager assists the inpatient facility with discharge planning. Discharge planning begins at admission. The care manager begins efforts to arrange appropriate aftercare for the member when notified of an admission. When a member has an established outpatient provider the care manager arranges the aftercare with the existing provider. If there is no existing relationship the care manager arranges the aftercare based on need and availability. This practice has led to prompt aftercare following inpatient for our members. The care manager also works with the facility to ensure the member is prescribed medications on the preferred drug list or that prior authorization requirements are met for a non preferred medication.

Case Management
Case management is an integral part of the Behavioral Health Department. Case management allows Missouri Care to coordinate care through a continuum of services. The goal of case management is to provide the best and most efficient clinical outcome for each case-managed member, as Missouri Care is concerned with over- and underutilization of services. In 2005, Missouri Care identified areas of needed improvement:

  • Improve the HEDIS rate for ambulatory follow-up after a psychiatric admission
  • Include documentation of treatment plans, assessment of goals/objectives and post-hospitalization treatment
  • Educate providers regarding case management services
  • Educate members regarding case management services

In November 2005, the Behavioral Health Department was restructured to devote one full-time employee to case management. With the restructuring, Missouri Care has instituted the following interventions:

  • The case manager contacts members post hospitalization to remind them when their appointment is scheduled and to see if they have available transportation. Appointment reminder letters are also used.
  • Missouri Care has developed an internal case management database to track all case management interventions, treatment plans, goals and objectives
  • Missouri Care informed provider offices of the availability of case management through:
        o Provider relations visits
        o Web site

   o Provider newsletters
   o Case management interventions

 • Missouri Care informed members of case management services through:
   o Mailings
   o Direct communications

Missouri Care continues to work to provide the most effective clinical outcome for each member enrolled in case management. Experience indicates that members who keep their follow-up appointments after discharge function better and are less likely to be re-admitted within a year. In the 2006 HEDIS reporting on 2005 data, Missouri Care's rate on the mental health follow-up after hospitalization within 7 days was only 17.65%, along with 47.79% for the 30 day measure. Both measures were well below the NCQA 75th percentile of 49.6% for 7 day and 73% for 30 day. With the case management interventions that were implemented in 2006 Missouri Care has shown significant improvement in these measures. HEDIS 2007 reporting on 2006 data, Missouri Care's rate on the mental health follow-up after hospitalization within 7 days increased to 42.58% and 63.16% for the 30 day. This is a significant improvement from 2006 and closing in on the NCQA 75th percentile benchmark of 49.6%.

Clinical Practice Guidelines
Missouri Care makes disease management practice guidelines available to health care professionals and encourages their use to improve the utilization of medications and treatments proven to be effective in treating certain conditions.

The disease management practice guidelines used by Missouri Care represent best practices and are based on national standards, reasonable medical evidence and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the CMO, applicable medical committees, network physicians and, if necessary, external consultants. Disease management practice guidelines are reviewed at least every two years, or as often as new information is available.

Disease management guidelines are made available to practitioners in the Provider Manual. Articles in the quarterly provider newsletter inform network providers when new guidelines and updates are available. Practitioners may request copies of guidelines at any time by contacting their provider representative or the Missouri Care office of the CMO.

Credentialing and Re-Credentialing
The credentialing and re-credentialing processes confirm the qualifications of health care professionals prior to their participation in, as well as on an ongoing basis once they become 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 and 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 SFY07, Missouri Care approved 69 new providers and re-credentialed 39 providers through the Credentialing and Medical Quality Management Committees. Missouri Care also provided oversight of approximately 1,000 providers who are under delegated credentialing agreements. Of the providers seeking credentials in SFY07, one was pended for further investigation/ discussion and was approved at a subsequent meeting. Missouri Care performed audits of its six (6) delegated credentialing organizations and a predelegation audit on one organization that requested a delegated agreement. The predelegated audit showed substantial compliance with Missouri Care and NCQA guidelines. A delegated agreement was signed. Missouri Care also sought a corrective action plan one provider who received sanctions to his DEA license.

Medical Record Review
Missouri Care conducts medical record reviews as part of its annual HEDIS hybrid record review process and during the investigation of member quality issues. During the spring of 2007, Missouri Care reviewed more than 2000 records. The following trends were noted: not all providers are requesting immunization records when a new member joins the provider's panel; providers are missing opportunities to provide well child services during routine visits; and not all providers are completing the mandatory HCY screening forms. When problems are identified, providers are educated on an individual level and trends and areas for improvement are highlighted in Missouri Care's quarterly provider newsletter.

Subcontractor Monitoring
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 retains the oversight function for quality management. Although Missouri Care delegates the authority to perform the function, it does not delegate the responsibility for assuring the function is performed appropriately.

Missouri Care performs annual audits of its subcontractors and also holds oversight meetings throughout the year.

Missouri care monitors the following 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.

Crown Optical
Crown Optical continues the expansion of the vision network for Missouri Care. They have recruited providers in the central Missouri area. In addition, they have upgraded their system to provide automated reports of member complaints as well as prior authorizations/denials. Crown did report having problems receiving claims from outside providers due to a problem with software updates, but were working to resolve the issue.

Missouri Care monitors encounters submitted from Crown Optical for completeness, accuracy, and timeliness. No additional issues were identified during the reporting period.

Bridgeport Dental (BDS)
BDS submitted encounters in a timely manner. Provider demographic data accurately shows all dental providers that are used by Missouri Care members. Missouri Care members may visit providers outside of the MC+ Central region. The Missouri Care network currently includes all providers. Ongoing updates are conducted on a monthly basis to compare additional providers and associated denied encounters.

Dental penetration rates have remained low. The dental provider was asked to submit a proposal for improving access. The provider began moving forward on part of the proposal near the end of the reporting period.

Medical Transportation Management (MTM)
MTM submitted encounters in a timely manner. MTM continues to have issues with member 'no shows'. MTM also implemented a new procedure of reporting all provider no shows as grievances. Additionally, a new process was implemented by MTM to ensure that non-eligible members were not being included in the transportation benefit.

<center>**Blue Advantage Plus**</center>

Provider Satisfaction
The input of contracted physicians is vital for evaluating the services that BCBSKC offers to providers and members. HMO Physician Satisfaction Surveys are conducted, analyzed, and reported to the Quality Council with appropriate recommendations and action plans. Surveys were mailed to 1,800 physicians (specialists and primary care physicians) and office managers. The 2007 Physician Satisfaction Survey provided the following feedback:

a.   Ninety percent (90%) of the primary care physicians, 90% of specialists, and 95% of the office managers rated BCBSKC's overall service as Excellent, Very Good or Good.

b. Ninety four percent (94%) of the primary care physicians, 95% of specialists, and 95% of the office managers stated they would definitely or probably recommend BCBSKC to colleagues who were considering becoming network providers.

Care Coordination

Continuity and Coordination of Care – BCBSKC for BA+ has implemented a comprehensive and integrated care management model in place of the traditional medical management programs. The program is known as CareConnection, is built on the strengths of the core medical management functionality (Utilization and Case Management), and leverages state-of-the-art technology to integrate business processes, data and communications to allow a true patient-centric model across the care continuum. The scope of products and services included in the transition from traditional medical management include case management, chronic condition management, early detection of disease, prevention, and wellness. Using tools that enable us to identify members with future health risks such as predictive modeling and health risk assessments, we stratify members into risk categories, engage members in programs to reduce their health risks, proactively intervene with them and their physicians as appropriate, and evaluate the effectiveness of these programs.

BCBSKC/BA+ increased staffing levels to five registered nurses and one manager for the disease management programs. A dedicated registered nurse was hired to case manage the BA+ 0-6 population exclusively.

BCBSKC/BA+ measures network access and is compliant with section (4) of 20 CSR 400-7.095 for access and availability. The following is extracted from the Department of Insurance network approval letter of July 12, 2007.

Network Access	% of Members with Access to Services
Primary Care Physicians	100%
Specialist	100%
Facilities	99%
Ancillary Services	99%
Overall	100%

For BA+ members with coexisting behavioral and medical disorders, BCBSKC/BA+ has collaborated with New Directions Behavioral Health to implement a coordination of care process to ensure that case-managed members are receiving access to needed medical and behavioral services. An audit of cases handled by each group of care managers is conducted to identify opportunities to co-case manage appropriate patients, and to identify barriers to success. Care managers from BCBSKC and NDBH meet 4-5 times a year to review a representative sample of members. Several process improvements have been implemented as a result of this audit/review process. The Health and Behavioral Health Committee receives updates and reports of the co-case management activities.

Case Management
Case management is a collaborative process with our members in which the care managers assess, plan, implement, coordinate, monitor and evaluate options and services to meet the member's health needs through communication and available resources to promote quality, cost-effective outcomes. The Case Management program is telephonically based with on-site management as needed. It is a dynamic process of on-going relationship building, communication and collaboration with clients, families, physicians and health care providers. The case management staff works to promote the optimum level of health for our members through referrals to disease state management programs, network management, benefits management and educational support. Patients with chronic, catastrophic, high-risk, or high cost conditions are referred to the Case Management Program for facilitation of an individualized plan of care. The pro-active Case Manager serves as an ongoing patient advocate, ensuring coordination of care and maximizing resources required to meet the Member's short and long term goals. There are specialty nurse care managers for disease management, pediatrics, obstetrics, physical rehabilitation and transplants.

In FY2007, BA+ assisted 1,642 members with case management services. Three hundred eighty six members were discharged from case management services.

Disease Management Program
Healthy Companion Disease State Management – The Healthy Companion Program is an education and care management support program for members with chronic disease. For the BA+ population, the targeted disease states are asthma and chronic obstructive pulmonary disease (COPD). In review of the BA+ data for FY2007, using comparisons to commercial HMO membership for BCBSKC, the following were noted:

a. Participation rates in the Healthy Companion Program for asthma/COPD continue to remain higher that all other lines of business, 96.1% for BA+ and 90.4% for commercial business.

b. HEDIS rates for the asthma medication appropriateness measure have continued to improve since 2003. Rates have improved 63.2% (2003) to 90.4% (2006) in the BA+ population.

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.

2006 Accomplishments

    a. Completed seventh year of interventions for respiratory disease state management program with 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. This was accomplished by distributing coupons for obtaining the vaccination at selected sites for those over age nine in the DSM programs. Those under nine years of age, were sent letters encouraging them to go to their PCPs for the vaccination;

    d. 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), and

    e. 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 4.6% in 2006).

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 7% for BA+ through the end of 2006.

    c. Respiratory programs measured provider and member satisfaction continually during the year and report quarterly on our experience. Member satisfaction remains above 90% for 2006. Provider satisfaction is above the 70% goal.

    d. HEDIS® 2006 measure had a slight decline from 2005 (91%, down from 92%). This decline was not significant. These are both above the 75% goal set in 2004 and overall, this measure 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. 61% and 80% decrease from baseline in ER visits for adults and children, respectively, in the program.

h. 58% and 86% decrease from baseline in inpatient admissions for adults and children, respectively, in the program.

i. For the BA+ total population, ER visits per 1000 and day per 1000 members both decreased from baseline and from previous year.

j. 58% and 61% reduction in missed days of work and school, respectively, for those in the program; there was also a 68% decrease in missed workdays 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 in 2006. Rates for PFM use went from 5.7% at baseline to over 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 20% from baseline to re-measure in the adult population.

Mental Health Care Management including Case Management

Ambulatory Care – Mental Health - In 2004, New Directions began the Personal Transition Service (PTS) Program, which provides an in-home intervention from a licensed behavioral health practitioner within 72 hours of discharge from the hospital. New Directions contracted with a local in-home provider agency to provide a follow-up visit. Visits generally take place in the member's home although an office visit option is offered.

Each member receiving inpatient care management is screened for referral to a licensed PTS Clinician by the assigned New Directions Care Coordinator. Based on the results of the screen, an appointment with PTS is scheduled within 7 days of discharge from the hospital. During the individual session, the PTS clinician:

a. Reviews medication and medication adherence.
b. Ascertains that follow-up visits have been scheduled.
c. Develops an individualized safety plan.
d. Coordinates with New Directions staff if an urgent appointment is needed.

A description of this program was submitted to the 2005 NCQA HEDIS® Update and Best Practices Conference. It was accepted due to the statistically significant change in HEDIS® ambulatory follow-up scores from FY2003 to FY2004. Dr. Maureen Hennessey, New Directions Executive Vice President & Chief Clinical Officer presented "Improving Patient Safety"

including our Ambulatory Follow-up Program and Physician Notification Program. Below is a description of the results for BA+ discharge, including the affect of the PTS program on ambulatory discharge.

In 2006, 266 BA+ members were discharged from inpatient care (not including step down to sub acute residential). The following chart shows ambulatory results. Follow up within 7 days is 219 or 82%; follow up appointments but not within 7 days is 22 or 8%; Member discharged to OON provider or Member refused is 23 or 9%; Member discharged with no follow up appointments is 2 or 1%. The following chart shows ambulatory results.
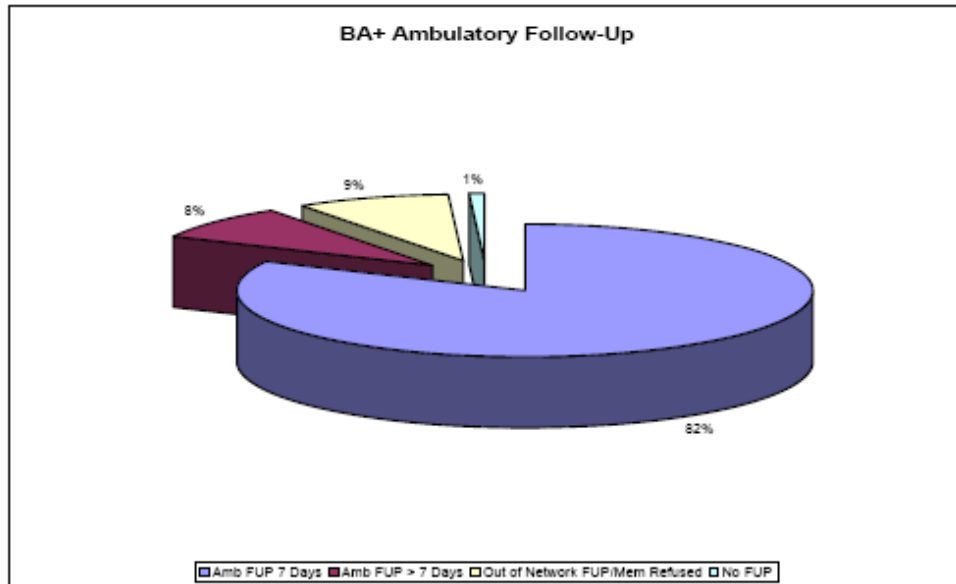
Of those receiving ambulatory follow-up in 7 days, New Directions provided services as follows, with 29% of these members receiving a PTS intervention.
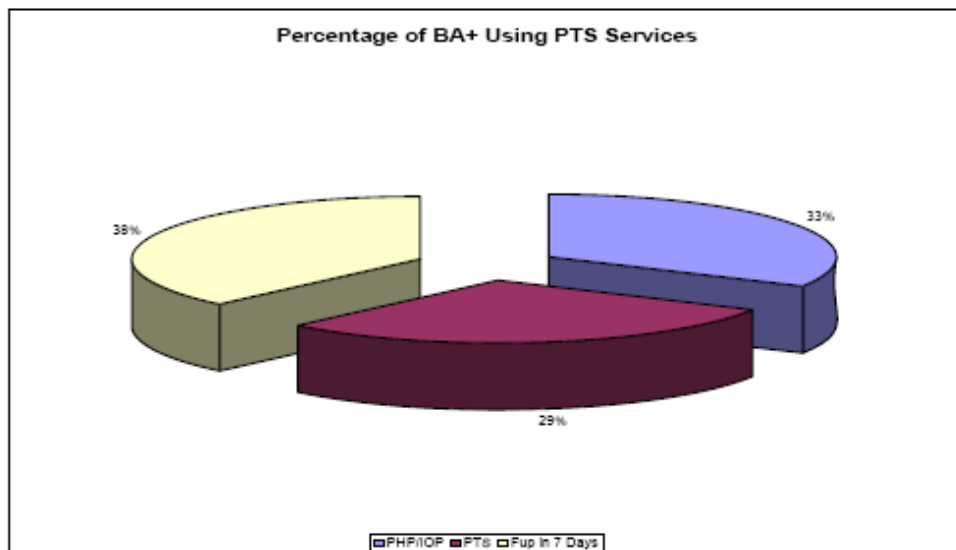
The New Directions Care Management Team tracks and trends the post discharge care received by the remaining 18% of members. Of those receiving out-of-network services, some do so because they receive intervention from DFS, DMH, or the legal system. New Directions continues to analyze barriers to ambulatory follow-up.

FAMILY EVALUATION/THERAPY FOR ADOLESCENT/CHILD MEMBERS—MENTAL HEALTH
New Directions offers BA+ members the Parents and Children Together (PACT) program, which contributes to improved mental health status by providing intensive, in-home care. A small group of affiliate clinicians who also do in home therapy have been credentialed to address geographical gaps in the PACT program. The goals of this program include:

a. Intervention with the family system.
b. Sustained medication adherence as needed.
c. Appropriate monitoring of symptoms and changes in condition in the member's (family's) natural context.
d. Motivation for treatment and self-care among individuals at risk for relapse.

A typical case for in home therapy involves a youth with a behavioral health disorder, compounded by multiple family problems. The behavioral health pathology may lead to the youth's refusal to cooperate with outpatient treatment recommendations. This may lead to an acute episode of the behavioral health problem. Aggressive behaviors and anger outbursts are not unusual. Families have financial limitations and may not have easy access to transportation. The need for a more intensive level of care increases when the family cannot follow outpatient recommendations. Often, in home intensive family therapy is brought in to avert a crisis situation. In other cases, residential or inpatient care has already been provided, and the in-home therapist is asked to provide ongoing care.

When the therapist can go into the home, the family is not burdened with the needs to find transportation and get the youth to his/her appointment on time (or at all). Once in the home, the therapist is able to intervene in an environment that tends to allow more "natural" behaviors than those seen in a professional office. This type of intervention, which is both intense and based on "teachable" situations, is effective in preventing crises, relapse, and readmissions.
In some cases, New Directions calls on our clinicians who provide in home therapy to intervene with adults. In one recent case, a woman with diabetes and heart disease was admitted with a medication overdose due to depression and anxiety. New Directions worked closely with the BCBSKC medical case manager to address concerns about the management of her diabetes and anxiety. An in-home therapist was able to help by providing emotional support and encouragement to follow medical advice. Coordination of care occurred between all of the Providers involved. As a result, a readmission for psychiatric inpatient hospitalization was avoided.

In some instances, the in-home clinicians have discovered a need for urgent services during a home visit. The clinician contacts the New Directions for immediate assistance, often averting an emerging crisis. In 2006, 95 admissions for inpatient care used the PACT program services post discharge.

Clinical Practice Guidelines
Clinical Guidelines apply to all managed care network physicians of applicable specialty. These are approved biennially by the Care Connections Advisory Committee (CCAC), and revised for approval as needed based upon updated clinical information from network practitioners and national organizations:

a. AAP – American Academy of Pediatrics
b. AAFP – American Academy of Family Physicians
c. AHRQ – Agency for Healthcare Research and Quality.
d. ACOG – American College of Obstetrics and Gynecology
e. ADA – American Diabetes Association
f. NHLBI – National Heart, Lung and Blood Institute
g. USPHSTF –United States Preventive Services Task Force

HMO physician compliance with clinical guidelines is assessed annually for a minimum of three distinct guidelines including one behavioral health guideline. Results are reported to the Quality Council with analysis and recommendations.

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 BA+ 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.

Medical Record Review
Starting in 2006, a random sample of PCP medical records was chosen from the HEDIS medical record sample. In 2006, there were 235 records reviewed and in 2007, there were 137 records reviewed. We no longer have a minimum panel size requirement and the results are aggregated. Therefore, interventions for identified deficiencies are addressed network-wide instead of by specific physician.

Subcontractor Monitoring
BA+ 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 MO HealthNet Division, 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.

New Directions Behavioral Health, L.L.C.
Type of Service: Behavioral Health – Provide all covered mental health services to all BA+ members, with the exception of the COA4 members (coverage of these members is covered by the State of Missouri Division of Medical Services).

Delegation Assignment: Claims, Utilization Management, Member Grievances and Appeals, Provider Complaints, Case Management, Credentialing and Quality Management, Care Coordination .

NDBH was placed on corrective action in 2006 for member grievances and provider complaints. Member Grievance and Provider Complaint files are reviewed quarterly (instead of annually) and meetings to educate NDBH are held at least quarterly. As a result of these actions, NDBH has improved in using the correct template and process.

Doral Dental
Type of Service: Dental Services – Provide all covered dental care services to all BA+ members having dental benefits.

Delegation Assignment: Claims, Utilization Management, Credentialing

From July 2006 through June 2007 Doral Dental did not meet BA+ performance goals set for credentialing. Doral Dental is on a Corrective Action Plan. Doral Dental is working with BCBSKC Credentialing Department to correct the deficiency. Audits shifted from quarterly to monthly in order to monitor improvement.

Medical Transportation Management
Type of Service: Medical Transportation – Provide non-emergent transportation services to BA+ members having transportation benefits.

Delegation Assignment: N/A

Corrective Action: MTM was on corrective action during FY 2007, for not meeting the abandonment rate (no greater than 5%) and speed to answer (no greater than 30 seconds) goals. MTM has been on corrective action sine December 29, 2005. BA+ meets with MTM monthly to review abandonment rates and speed to answer timeliness. BA+ is working closely with MTM to resolve this corrective action.

Corrective Action: In March 2006, MTM was placed on Corrective Action due to lack documentation of vendor performance, satisfaction scores and vendor inspections.
MTM satisfied all requirements of the Corrective Action Plan. The Corrective Action Plan was closed August 2006.

Corrective Action: In March 2006, MTM was placed on Corrective Action due to member grievances not submitted to State Programs Department within timely submission guidelines.

MTM successfully submitted member grievances within guidelines for six continuous months. The corrective action plan was closed at the May 2007 monthly meeting. MTM instituted processes for resolving this issue by re-educating its Quality Management Coordinators (QSC) and identifying a dedicated QSC for the BA+ complaint process.

Corrective Action: In March 2006, MTM was placed on Corrective Action due to resolutions not submitted to BA+ within timely submission guidelines.

MTM successfully submitted complete resolutions to member grievances within guidelines for six continuous months. The corrective action plan was closed at the May 2007 monthly meeting.

MTM instituted processes for resolving this issue by re-educating its Quality Management Coordinators (QSC) and identifying a dedicated QSC for the BA+ complaint process. The subcontractor contracts are managed within the Provider Services and Medical Services Departments of BCBSKC for BA+.

Children's Mercy Family Health Partners

Provider Satisfaction
Children's Mercy Family Health Partners conducts provider satisfaction surveys every two years. Our last survey was completed late December of 2005. We are in the process of reviewing the current survey to add additional questions.

Although a formal survey has not been done we believe that provider satisfaction has increased due to some process changed made by CMFHP. CMFHP previously paid claims every two weeks and we have now gone to a weekly payment cycle which increases the cash flow process to our provider and decreases their accounts receivable.

We have also recently introduced direct claims submission through our website at no cost to our providers. They can now file claims directly with CMFHP and no longer have the cost associated with a clearinghouse if they previously filed electronically. For those providers who previously filed claims on paper, this allows a much more timely receipt and processing of their claims payment.

CMFHP has also implemented a pay for performance initiative with our Primary Care Physicians paying them an increased administrative capitation payment for those who qualify. For those PCP's who do better then their peers providing immunizations and lead testing to our members can increase their base administrative capitation payment. This is reevaluated every year so that those currently not qualifying may qualify in the future.

Based on the comments that our providers relations representative hear from the offices during their visits, the physicians appear to be very satisfied with CMFHP. We will see if these thoughts are validated during our next survey.

Care Coordination
Case Management
Case management is an important component of medical management at Children's Mercy Family Health Partners (CMFHP). The goal of case management is to assist in facilitating healthcare services that are cost-effective, timely, and delivered in the most appropriate environment.

Children's Mercy Family Health Partner's Care Managers are structured into teams for High Risk OB, Special Health Care Needs, Lead Toxicity, Emergency Room Use, as well as categories for Pediatrics and Adults. The Manager of Clinical Services directs the day-to-day operations of case management, with oversight from the Director of Health Services and the Medical Directors.

CMFHP continuously reviews the way we identify members, the processes for interventions, the documentation of those interventions, and the measurement of outcomes. In 2005, CMFHP recognized the need to implement a case management audit process to ensure consistency in documentation and adherence to standards. In addition, CMFHP evaluated its current case management database and determined that a new software system was needed to support case management activities and provide functionality, such as reminder systems, to improve the case management process.

In response to these identified needs, CMFHP successfully implemented new, more comprehensive assessment forms, documentation standards, and audit forms for all case management specialty areas in 2005. The first audits performed in 2nd quarter 2005 allowed Health Services management to revise the form and educate staff regarding application of the new documentation and assessment standards. A quarterly audit process is now in place to evaluate each Care Manager's adherence to standards and application of guidelines.

In addition, in 4th quarter 2005, the Health Services and Information Technology staff at CMFHP began a biweekly task force to develop and implement a comprehensive case management database, incorporating the new assessment forms, case management guidelines, and reminder system functionality, as well as improved capability for reporting on case management activities. The CARE (Case Assessment and Referral Evaluation) system was implemented in mid 2006. In 2007, the task force continued meeting to establish version 2 enhancement opportunities, which are expected to be implemented in 2008.

Finally, in 2006, CMFHP entered a contract for a telemonitoring program, aimed at assisting members with chronic diseases and/or gestational related conditions to more effectively manage their medical condition(s) through the daily or weekly transmittal of vital statistics to a nurse through a phone line. The nurse has pre-established parameters, developed in collaboration with the member's physician, to assess the condition of the member and notify the member's physician of the current clinical status. CMFHP began piloting this program in early 2007 and is currently working on data scrubbing to identify members who could benefit from the telemonitoring program. This program has the potential to enhance the quality of care provided to members with chronic diseases and/ or gestational related conditions through early identification of potential risks and intervention to avoid exacerbations of disease.

Disease Management Program
The Children's Mercy Family Health Partners Disease Management programs were developed by clinical experts and use a unique approach to manage chronic disease. Rather than relying exclusively on phone consultations or patient education materials, our community educators form special relationships with primary care providers to help them implement comprehensive disease management in their offices leading to improved patient health and reduced costs.

The Children's Mercy Family Health Partners Disease Management program consists of the following highly integrated components:

- Physician office education
- Disease-specific Health Coaching

- Data analysis and reporting
- Stratified interventions
- Environmental assessment
- Provider incentives

By integrating these elements into a comprehensive program, we have demonstrated financial and clinical benefits, including reduction of health care utilization and increased provider satisfaction and patient quality of life.

Because there are no universal criteria for labeling a patient with a chronic disease, we use our database to identify members who either have been diagnosed with a chronic disease or who have a condition that may lead to a chronic disease at some time in the future. To do this, we use a combination of claims data, hospital encounters, pharmaceutical use or lab tests. By identifying members with a chronic disease early, we can be proactive to promote activities that help maintain good control of their illness and lower acute care utilization.

Provider offices are selected based on the number of health plan members in their member panel. In this way, the largest number of members can be affected by the program in the shortest amount of time. As more offices are trained, more patients receive the benefits of high quality and consistent chronic disease management.

Description of Members

Children's Mercy Family Health Partners (CMFHP) experienced a decline in membership from a high of 51,873 active members at the end of 2004 to 41,883 by the third quarter of 2006. Since the 4th quarter of 2006, membership has started to rise and at the end of 1st quarter 2007 was 44,729.

CMFHP MEMBER POPULATION
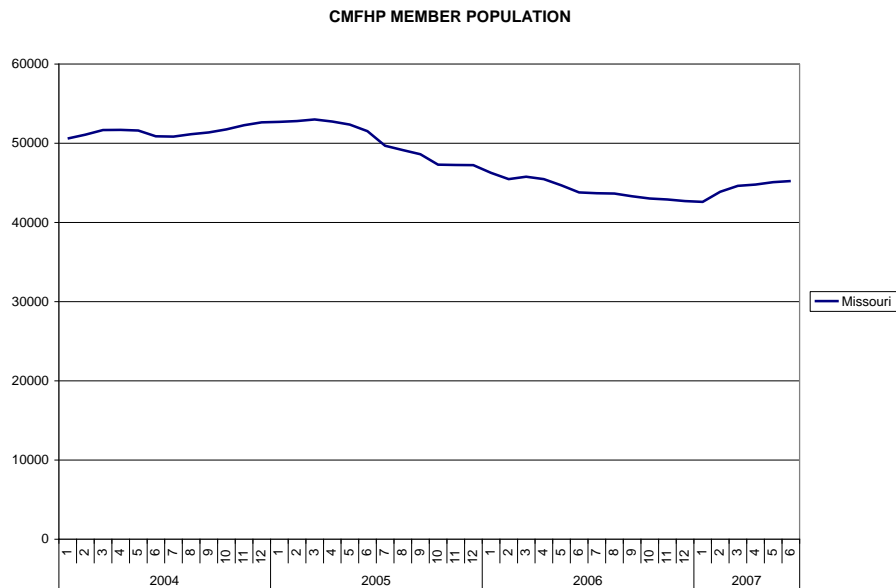
ASTHMA MANAGEMENT PROGRAM

Percent Members with Asthma by Age Group

The percent of members with asthma clearly varies with age. The overall percentage is 17% of total members with asthma. When viewed by age group, the highest percentages are found in members who are 5-9 years and 10-17 years old with 24% and 22% respectively. Between 12% and 14% of children 4 and under have asthma and 16-17% of adults have asthma. These numbers continue to rise with the most dramatic rise in the adult population. The national published national average for adults is 8%.
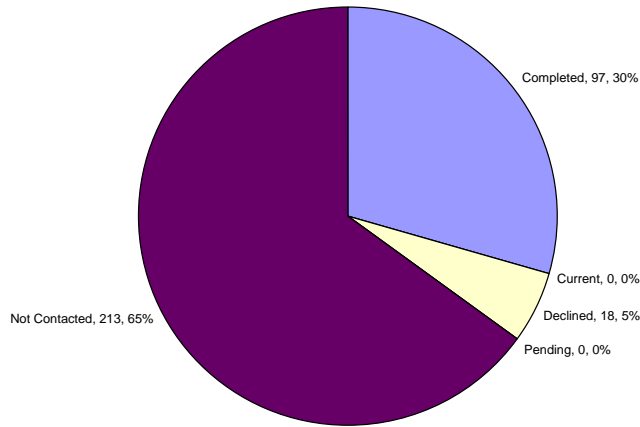
PERCENTAGE OF MEMBERS WITH ASTHMA BY AGE GROUP
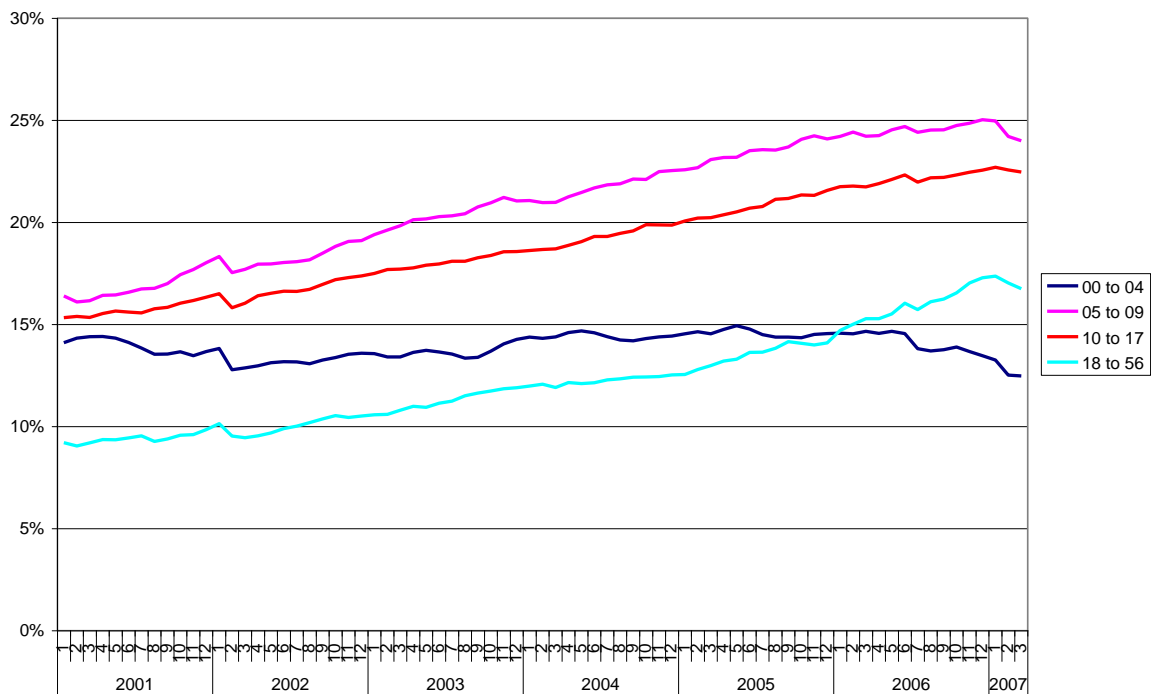
Providers Completing the Intervention (Asthma)

Results:

A total of 97 Missouri providers have completed the intervention, There are 213 providers who have not yet been contacted regarding participation in the program although they affect only 30% of FHP members.
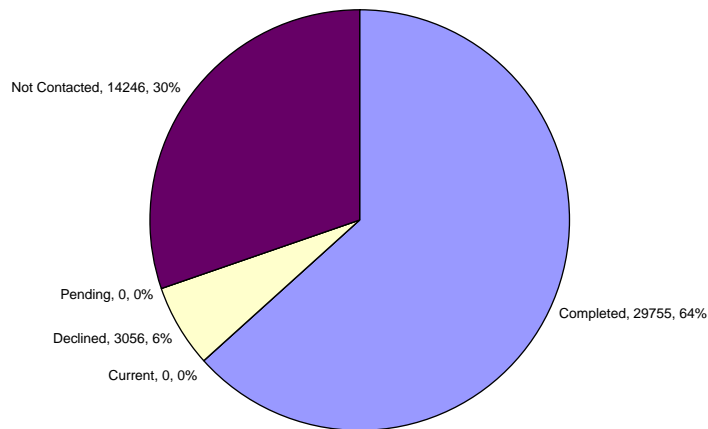
FHP Providers Participation in Asthma Program

Patients Affected by Participating Offices (Asthma)

Results:

30% of the providers care for 64% of the members. We continue to be concerned about members who are in the panels of providers who have declined to participate in the program.


FHP Members Affected by Participating Providers

Asthma Action Plans

Results:

The number of members who have an asthma action plan is shown on the right. This number continues to increase over time. At this time nearly 5000 plans have been given to over 3000 members. The discrepancy is because some members have received more than one plan, most likely related to changes in their asthma status or treatment needs. Currently, 37% of the members diagnosed with asthma in the Missouri member population have an action plan.

Members with Action Plans
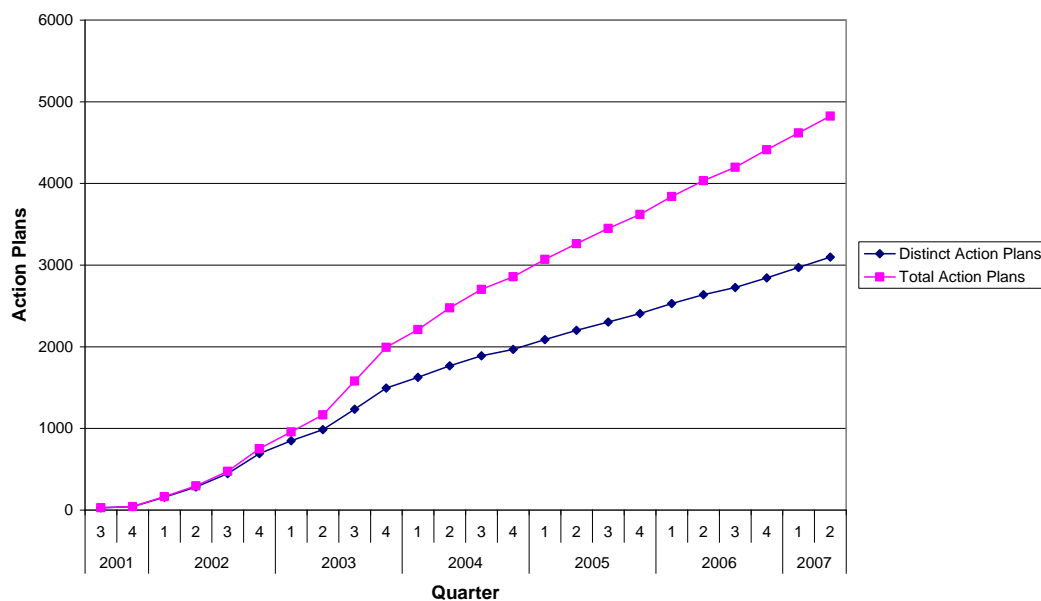
Cumulative Number of Asthma Action Plans

Analysis:

Action plans are an important tool for controlling asthma utilization. Since a major focus of the education for providers and staff involves the use of action plans, this is a good demonstration of behavior change. Initially, few or no providers provided action plans to their patients. After the intervention, the number of action plans increases to a different extent for each office and provider. We continue to advocate for provision of action plans with the goal that every member with asthma has a written action plan.

Emergency Dept. Visits and Hospitalizations for Asthma per 1000 Members

The number of ED visits for asthma was almost 8 per 1000 members in 2001. By 2004 this number had decreased to 6 per 1000 and has remained fairly constant since then. The number of hospital admissions was approximately 1.5 per 1000 in 2001 and dropped to under 1 per 1000 by 2004. This rate has remained fairly stable during this time period.

ER UTILIZATION PER 1000 MEMBERS

CDC National Benchmark is 10

IN PATIENT UTILIZATION PER 1000 MEMBERS

CDC National Benchmark is 2
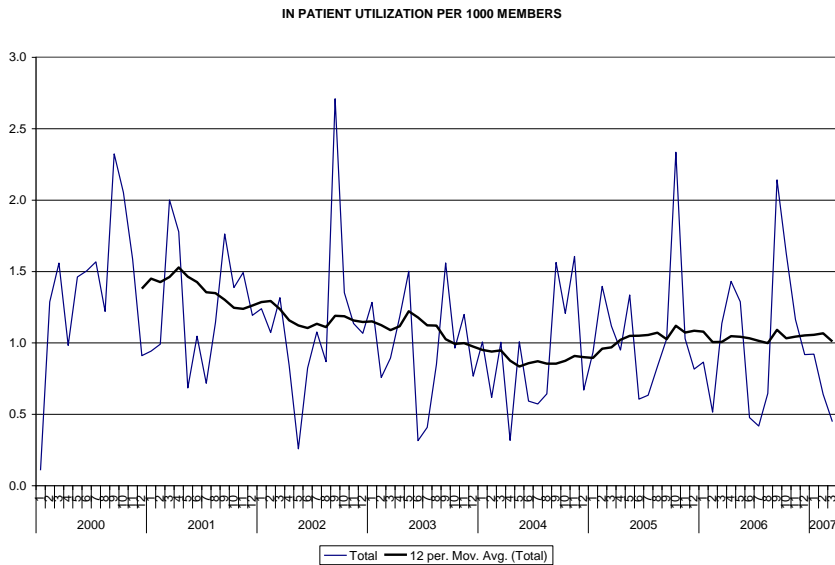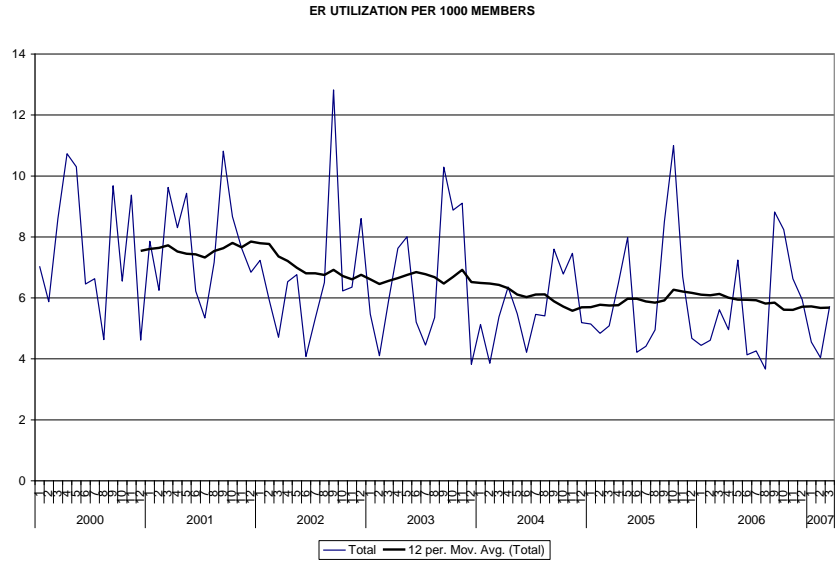
Analysis:

There is a very visible seasonal variation in both ER utilization and in-patient utilization. We are doing substantially better than national benchmarks.

Percent of Members with Asthma with ED Visit Hospitalization for Asthma

Results:

Percent ED visits has decreased to nearly 3%. The percent of members with asthma who had a hospitalization for asthma has remained stable around 0.6%.

ER UTILIZATION PERCENT OF MEMBERS WITH ASTHMA

INPATIENT UTILIZATION PERCENT OF MEMBERS WITH ASTHMA
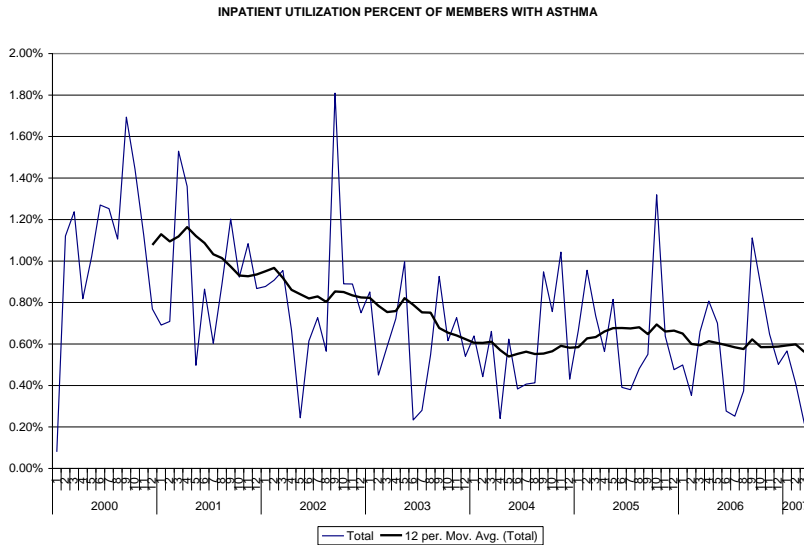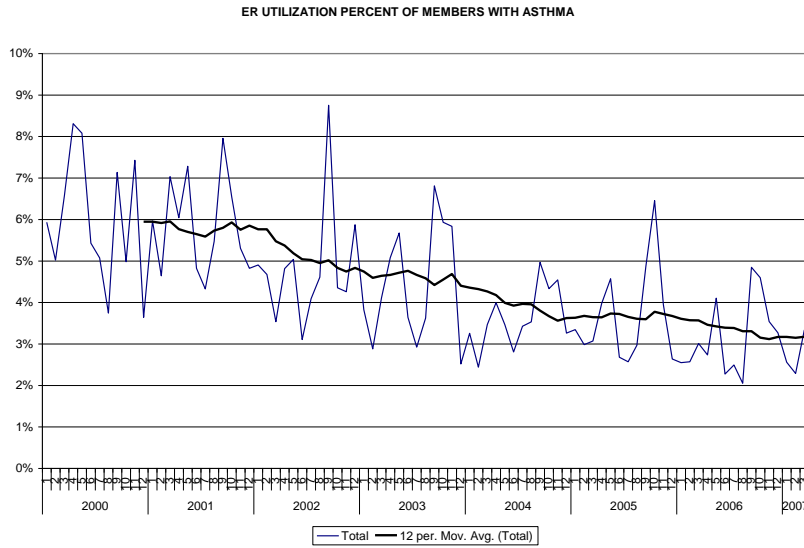
Population Health

The health of a population is hard to gauge. As a proxy, the cost of providing care can be used to estimate the health. Healthier populations cost less to care for.

There are numerous ways to measure cost. The most common way to determine the cost for utilization in a health plan is to divide the total cost of encounters for a particular condition by the total number of active health plan members who have that condition. Most cost assessments are stated on a per-month basis.

Total costs per Member per Month (PMPM)

Results:

The total cost PMPM for the health plan is shown below. The reason we have included this information is so that the asthma-specific cost information can be compared to the total population costs as a reference. The total cost per member per month for encounters excluding pharmacy costs was approximately $100 in 2002 and increased to over $120 by mid 2006.

Price per Member per Month (PMPM)
Excluding Pharmacy Costs

Total Cost PMPM
(Excluding Drug Costs)
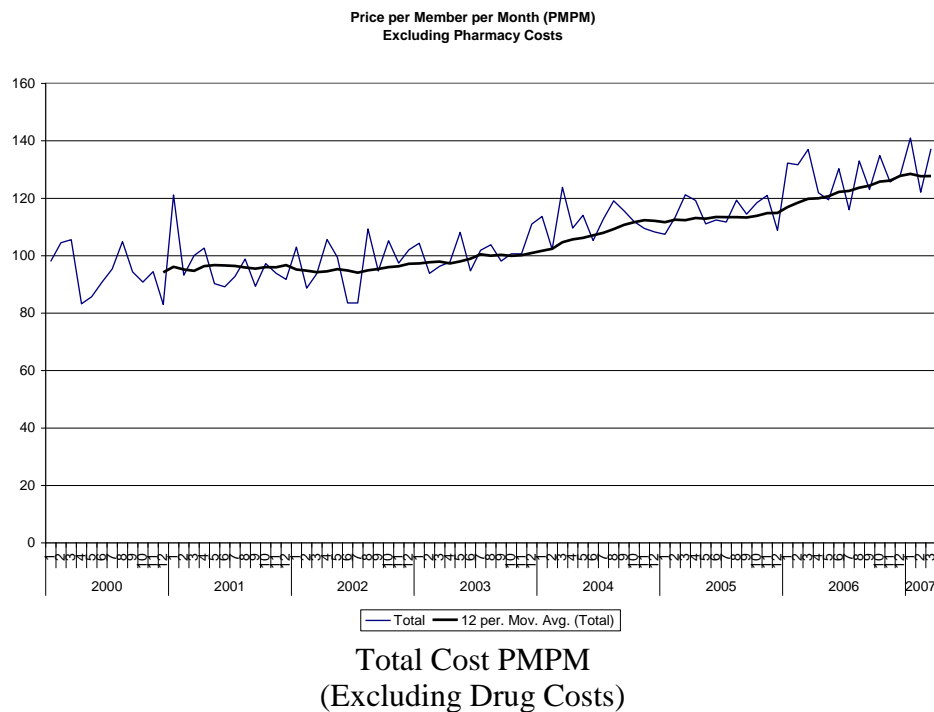
Analysis:

It is important to recognize that during this time the total number of FHP members decreased from almost 52,000 in 2004 to 43,000 in the first quarter of 2007. Trend increase is below health care inflation.

Asthma Costs per Asthmatic per Month (PAPM)

Results:

As seen in the Figure on the right, the total cost of encounters for asthma per asthmatic per month has declined between 2001 and 2004. The PAPM has started to rise in fourth quarter of 2006 into the first quarter of 2007.

Price per Asthmatic per Month (PAPM)
Excluding Pharmacy Costs
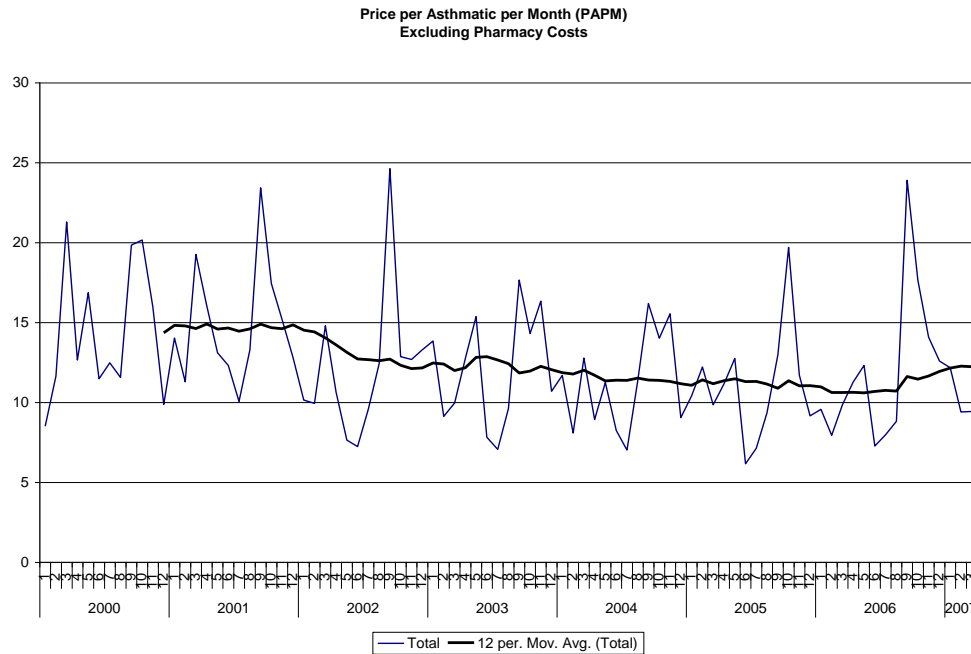
Asthma Costs PAPM Excluding Drug Costs

Analysis: There was a large rise in the fourth quarter of 2006. This is larger than the previous asthma seasons and we will need to see if this trend continues.

HEALTHY LIFESTYLES PROGRAM (HeLP)

Percent of Members with Obesity by Age Group

Results:

Discussion: The percent of members diagnosed with Obesity clearly varies with age. The overall percentage of members diagnosed with obesity is 3%. When viewed by age group, the highest percentage is found in adult members. The overall percentage of obesity diagnosis has increase very slightly over the last two years.

Percent Members with Obesity by Age Group
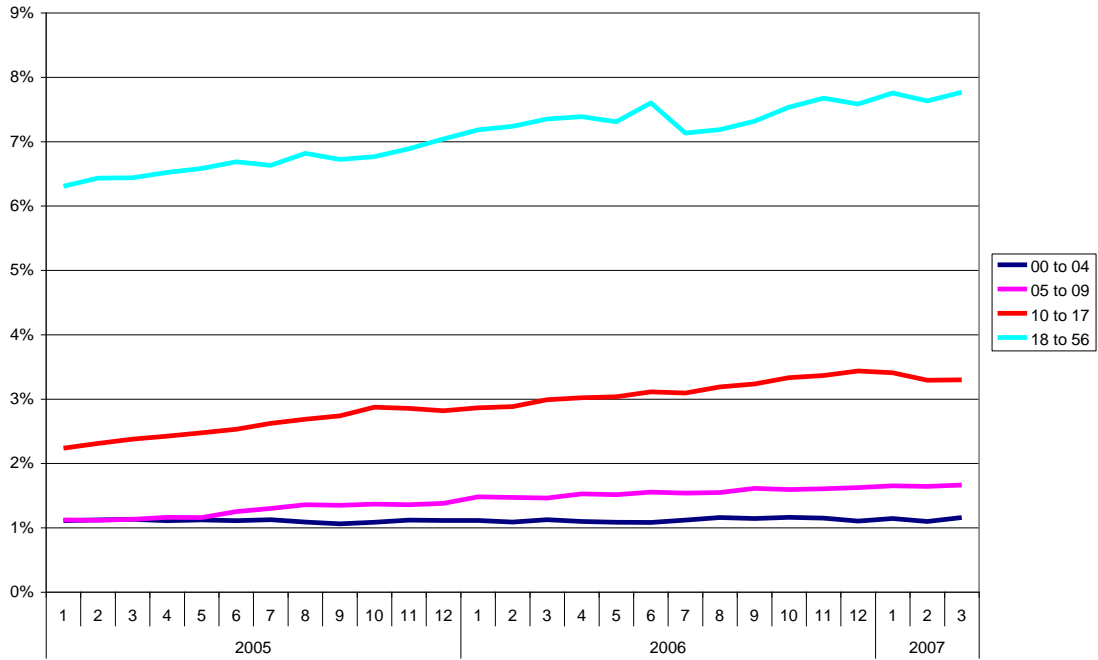
Analysis:

These percentages establish the baseline for the Healthy Lifestyles Program (HeLP) as we begin implementation in the primary care setting and offering Health Coach services to members. It is expected that diagnosis of obesity will rise with continued education of providers and staff.

Providers Completing the Intervention (HeLP)

Results:

We have 2% of the offices participating in the program and 5% of the offices pending.

Completed, 6, 2%
Current, 0, 0%
Declined, 0, 0%
Pending, 15, 5%

Not Contacted, 307, 93%
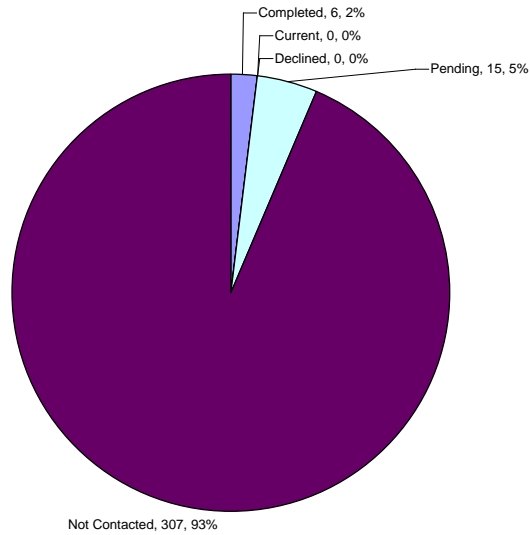
CMFHP Providers Participation in HeLP Program

Patients Affected by Participating Offices (HeLP)

Results:

The combination of those completed and those we will complete in the 3rd and 4th quarters represents 44% of the member population in Missouri.

Completed, 3647, 8%
Current, 0, 0%
Declined, 0, 0%
Pending, 16715, 36%

Not Contacted, 26695, 56%
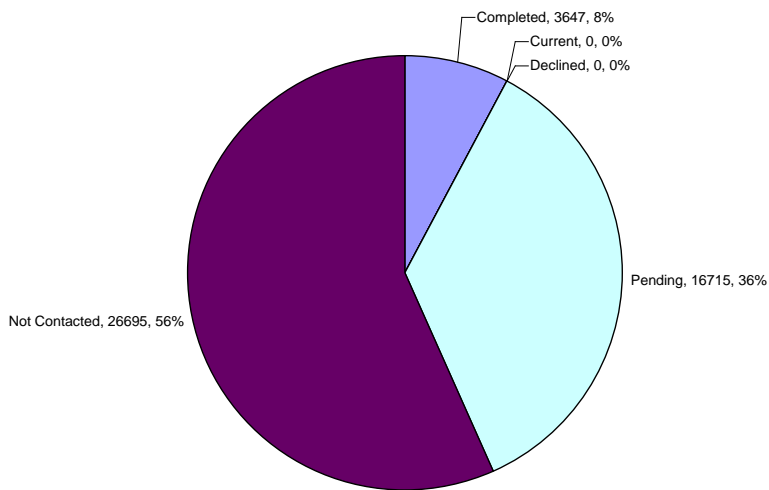
CMFHP Members Affected by Participating Providers

Health Habits Assessment

Results:

The number of members who have a Health Habits Assessment is shown in the chart below. This number continues to increase over time. At this time nearly 600 plans have been given to members.

MEMBERS WITH HEALTH HABITS ASSESSMENT
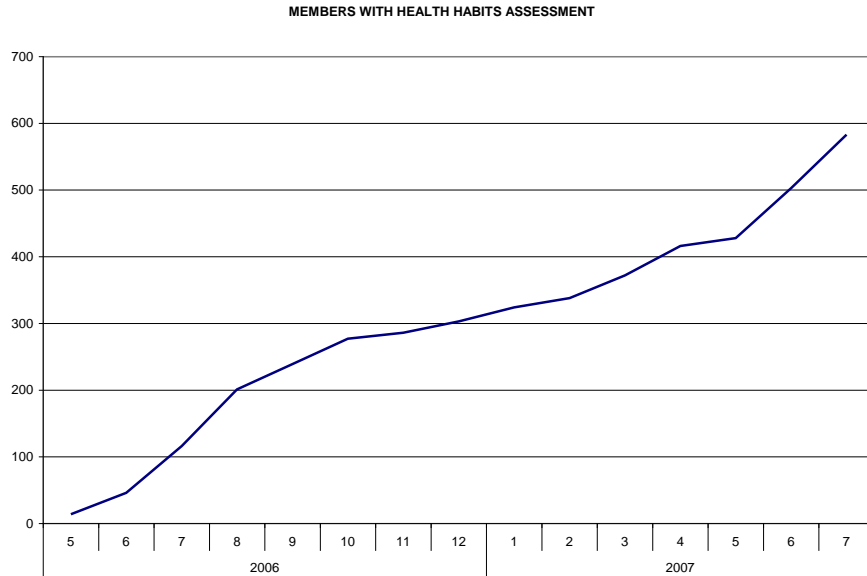
Cumulative Number of Health Habits Assessments

PERCENT OBESITY BASED ON HEALTH HABITS ASSESSMENT

PERCENT OBESITY (HHA)
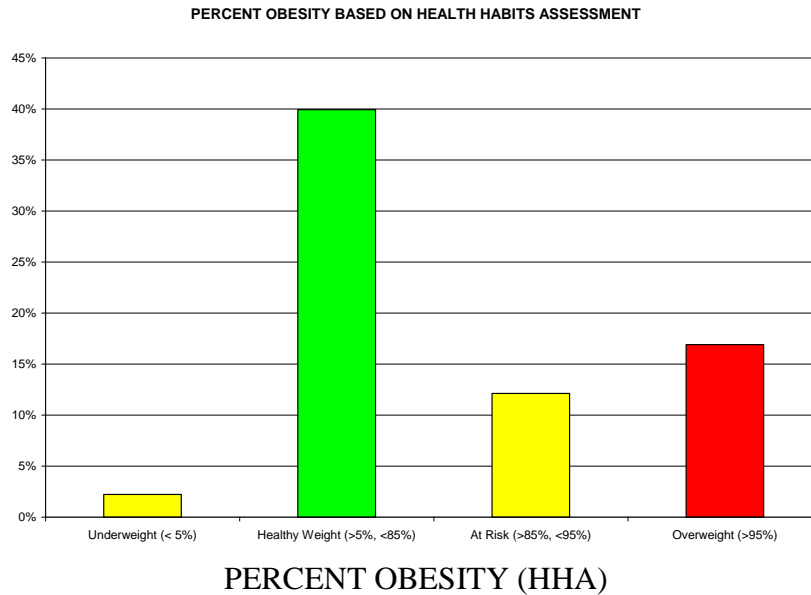
Analysis:

The Health Habits Assessment (HHA) is an important tool for obesity education. Since a major focus of the education for providers and staff involves the use of the HHA, this is a good

demonstration of behavior change. The Healthy Lifestyles Program was fully implemented in 2nd Quarter 2007. Therefore, we do not have adequate information to evaluate the behavior change. HHA's are provided to all members, regardless of weight. Therefore, the Percent Obesity (HHA) chart provides a look at the number of overweight members that are being reported from the PCP offices. We can compare the 17% reflected in this chart with the number diagnosed on the previous chart which was around 3%. We continue to advocate for provision of HHA's with the goal that every member receives an HHA.

Members with Diagnosis of Obesity with Appropriate Lab Testing

This measure demonstrates the percent of members diagnosed with Obesity who received appropriate lab tests. This is based upon 1817 members diagnosed with Obesity.
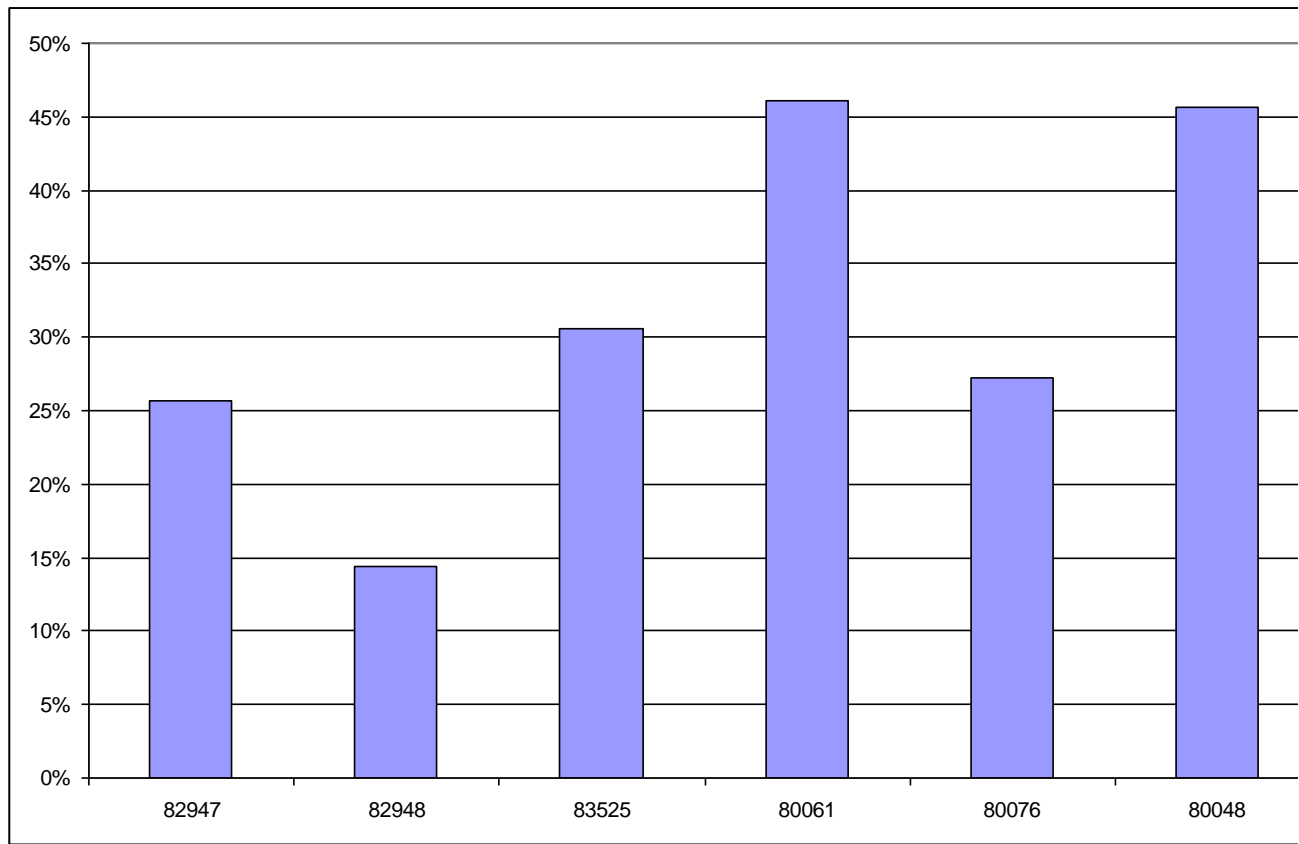
82947	Glucose, quantitative, blood
82948	Glucose, blood, reagent strip
83525	Insulin
80061	Lipid Panel
80076	Liver Panel
80048	BMP (Basic Metabolic Panel)

Analysis:

It is the goal of the program to have all members diagnosed with obesity receive these lab tests provided by their PCP.

Diagnosis of Co-Morbidities Related to Obesity

Results:

This measure demonstrates the percent of members diagnosed with Obesity who also had a diagnosed co-morbidity. This is based upon 1817 members diagnosed with Obesity.
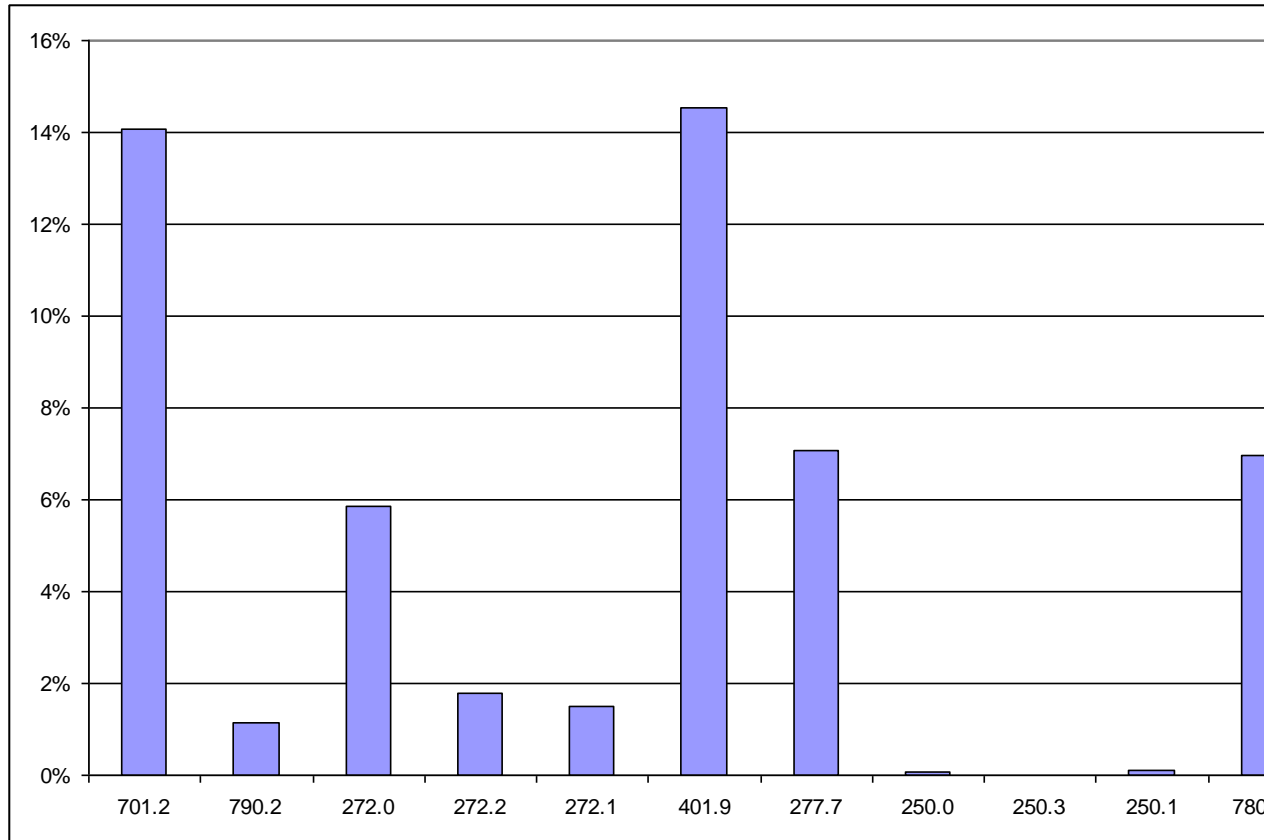
701.2	Acanthosis Nigricans
790.2	Abnormal Glucose Tolerance Test
272.0	Pure Hypercholesterolemia
272.2	Mixed Hypercholesterolemia
272.1	Hypertriglycerdemia
401.9	Hypertension
277.7	Dysemetabolic Syndrome
250.0	Type II DM, Controlled
250.3	Type II, DM, Uncontrolled
250.1	Hypoglycemia Related to Hyperinsulinemia
780.57	Sleep Apnea

Analysis:

It is the goal of the program to increase the Primary Care Provider's awareness of the co-morbidities associated with obesity and the impact at early ages.

Mental Health Care Management including Case Management

BEHAVIORAL HEALTH CARE MANAGEMENT
In 2006, Children's Mercy Family Health Partners Behavioral Health Care program was administered by CommCare. CommCare employs a multidisciplinary team approach to case management that proactively engages members in planning their own treatment, as well as coordinating a wide range of services to empower members to deal with their problems and improve their lives. Through years of dedicated service to public sector clients, CommCare's clinical staff has become expert in working with members that have multiple needs requiring both clinical services and community resources. The individual member is viewed as part of a family system and attention is paid to the contextual needs of that family. The keystone of our case management is coordination of care through a continuum of services. Our multidisciplinary team of providers is highly skilled at assessing and addressing the clinical needs of the complex patient.

The vast majority of members are maintained in outpatient settings by accessing supportive community services. For example, many members receive in-home services and family members attend parenting classes. The members with higher clinical severity receive more intensive case management.

Admissions to high intensity, acute inpatient settings are case managed throughout the episode of illness until they progress to less intensive levels of care, such as partial hospitalization. Prior to discharge from the facility, appointments are made for outpatient follow-up visits to ensure continuity of care. CommCare's Mental Health Case Managers (MHCMs) coordinate alternative levels of care or referral to other agencies.

CommCare's MHCMs stay in contact with the member after discharge to encourage keeping appointments, assess progress, and assist with any concerns the member may have. The member is called by the MHCM within seven (7) days of discharge from the facility and interviewed in the areas listed below:

- Rating of Mental Health Status (scale of 1-5) Since Discharge
- Sleeping Patterns
- Appetite
- Medication Compliance (Extensive Discussion and Education as needed)
- Details of Follow-up Appointment
- Rating of Care at Facility (1-5)
- Further Questions or Concerns of the Member

Quality Improvement monitoring is performed on these member-tracking protocols to ensure that CommCare's case management standards are maintained.

Medical-Surgical/Mental Health Integration

CommCare's care management philosophy embraces the concept that the member has more than just psychological and social needs. The member's medical-surgical treatments must be closely coordinated with the mental health services that the member is receiving. The mental health provider is required to complete a health status screen and members are advised to seek the care of their Primary Care Physician (PCP) when concerns are identified. Additionally, the MHCMs actively coordinate with the health plan on cases that have co-morbid issues.

Communication with Primary Care Physicians

To ensure that information regarding mental health care is communicated to a member's PCP, providers are required to communicate with the PCP, unless the member declines to sign a release of information. Providing this information assists the PCP in avoiding medication incompatibility and alerts the PCP to the mental health needs of the member.

CommCare's Report to the PCP Form is completed by the mental health provider at the time of admission to mental health services and sent to the PCP. It is updated, as needed, to reflect significant changes in the member's treatment plan or medication regime.

Substance Abuse Services and CSTAR

Services provided by a Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Provider are not the responsibility of the health plans providing MC+ services. CSTAR services have been "carved-out" of the MC+ program and are reimbursed on a fee-for-service basis, according to guidelines established by the Missouri Division of Alcohol and Drug Abuse. Populations served by CSTAR include pregnant women, women with children, adolescents and men eligible of receiving Medicaid benefits. However, inpatient detoxification services are the responsibility of the health plan.

When appropriate, individuals seeking substance abuse services are referred to CSTAR programs. However, in the event that such services are not geographically accessible, or if an individual chooses not to participate in a CSTAR program, CommCare will provide non-CSTAR substance abuse services.

When CommCare receives a CSTAR Notification of Care Activity Report indicating that a mental health need has been identified, the MHCM will coordinate the member's access to a mental health provider. CommCare also sends out reminders to CSTAR Providers regarding the use of this form.

High-Risk Notification Form

To identify members needing intensive case management, providers are required to complete a High-risk checklist for all members upon initiation of their services. This form is then faxed to CommCare's MHCMs who begin intensive case management of these members.

Members that have such complex needs often utilize high levels of both medical-surgical and mental health services. It is imperative that the care of these members be effectively coordinated. High-risk cases are reviewed at the weekly case management meetings with the CommCare Medical Director. The MHCM works in conjunction with all the providers and agencies that may be involved in a member's care to develop an effective, proactive treatment plan.

Special Health Care Needs Children

The state provides examples of children with special needs. These examples include, but are not limited to:

- Children with special needs due to physical and mental illness;
- Foster care children;
- Children who are seriously and emotionally disturbed (SED) and/or have substance abuse problems.;
- Children who are disabled; and
- Chronically ill children with developmental or physical disabilities

Although some of these children are not in eligibility categories that fall within the responsibility of CommCare, many are. Most eligible children are identified by the use of the High-Risk Notification Form and placed in intensive case management. CommCare also works closely with the Case Managers of the health plan to assist in the care planning of these special needs children.

Intensive Case Management

CommCare began this initiative by putting together a committee of inpatient and outpatient providers, Community Mental Health Centers, and managed care company representatives. The committee identified trends and triggers of clients that frequently readmit. Based on those triggers and trends, actions were developed that were placed into action and showed positive results. Collaboration with providers was initiated to improve communication and average length of stay. Attached graphs show an overall decrease in readmissions. CommCare's Intensive Case Management (ICM) program has grown from a small committee, into a large, fully self-sustaining case management program. The ICM offers intensive levels of in-home and in-office therapeutic services to clients in the greatest need and at greatest risk of requiring higher levels of care. ICM members have access to their therapist until late in the evening and even have access by non-typical routes such as email and telephone. The ICM therapists are highly motivated to maintain these members in the lowest level of care that is clinically safe and appropriate. Use of this program has saved countless members from needing to be locked in a

psychiatric unit, by deescalating volatile situations prior to them becoming out of control and also by teaching parents and guardians more effective coping skills to avoid escalation.

In February 2007, Children's Mercy Family Health Partners changed the behavioral health care program subcontractor to New Directions. New Directions has experience in the Medicaid managed care community and we are confident that these and other behavioral health programs will continue to serve our members.

Clinical Practice Guidelines

Clinical practice guidelines are an integral component of Children's Mercy Family Health Partner's (CMFHP) utilization management and disease management programs. CMFHP distributes clinical practice guidelines to physicians as requested. Milliman Care Guidelines are the primary resource utilized by the Pre-certification, Utilization Review, and Care Management nurses for medical necessity determination of requested services or procedures.

In addition to Milliman Care Guidelines, clinical practice guidelines are developed internally by CMFHP Medical Directors and Health Services management staff, utilizing available nationally recognized resources. All clinical practice guidelines utilized or distributed by CMFHP are reviewed through the Clinical Criteria Committee, with oversight by the Health Services Review Committee prior to implementation.

In addition, CMFHP distributes immunization and preventive guidelines annually to all network providers. These guidelines are adopted from nationally recognized sources and represent evidence-based practice standards. CMFHP maintains a policy on the adoption and distribution of clinical practice guidelines.

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 2007, Children's Mercy Family Health Partners credentialed 149 new Missouri providers and completed re-credentialing of 220 Missouri providers. We also completed the annual review of our delegated entities. Of our four delegated groups, all were at 100 percent compliance with meeting all standards. Our four delegated groups are University Physicians Associated, Bridgeport, Children's Mercy Hospital and Physicians as well as New Directions. Children's Mercy Family Health Partners continues to successfully credential and re-credential providers and facilities as well as complete delegated audits in a timely manner.

Medical Record Review
Children's Mercy Family Health Partners (CMFHP) maintains a provider network for delivery of coordinated quality medical care to members. CMFHP performs medical record reviews every three years based on the NCQA Credentialing and Re-credentialing schedule.

Since 1997, Children's Mercy Family Health Partners has coordinated a comprehensive medical record review of the Primary Care Providers' health care delivery to members similar to those described in the Request for Proposal. CMFHP uses analysis of Primary Care Provider Medical Record Reviews as a mechanism to identify areas for improvement opportunities. Medical record review performance indicators are grouped by category and prioritized. Actions are then developed to improve provision of services to members and improve provider documentation of services.

In the reporting period July 1, 2006 through June 30, 2007, no issues emerged as not meeting thresholds consistently for Medical Record Indicators. In addition, the issues identified as not meeting threshold for Clinical Quality Indicators were lead related activities and testing. CMFHP had a Performance Improvement Project (PIP) for lead screening and testing that has demonstrated statistically significant improvements in lead screening rates. CMFHP incorporated ongoing lead screening outreach activities as a result of the PIP outcomes.

To address ongoing quality improvement activities, support the success of previous findings and continue to maintain and improve documentation standards in member records, CMFHP enhanced provider education in this reporting period through the Medical Record Review Education, Provider Newsletter targeting: EPSDT – Well Care Visits; Lead Screening and billing; OB case management and Improving Access to Primary Care Providers. A Provider Newsletter was sent in September of 2006.

The tables that follow demonstrate the tracking and trending of clinical and medical record maintenance indicators for the reporting period and comparisons with previous years.

Medical Record Reviews regarding EPSDT exams and components.

	Target	FHP 7/1/2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001	FHP 2000
# of Practices/Groups Reviewed		44	46	36	17	24	64	*	*
# of PCPs Reviewed		71	148	42	36	69	185	40	90
# of Member Records Reviewed		1083	1642	801	489	689	1841	408	880
CLINICAL INDICATORS	**Target**								
Are risk factors for disease identified?	90%	100%	100%	100%	100%	98%	90%	99%	100%
Is family and personal (past medical history) documented?	90%	100%	100%	99%	99%	97%	91%	99%	99%
Is there identification of smoking?	90%	100%	100%	99%	96%	98%	97%	83%	73%
Has smoking cessation been discussed?	75%	100%	99%	94%	87%	70%	81%	16%	*
Has the effects of passive smoking been discussed?	75%	100%	99%	94%	87%	81%	83%	15%	*
Is there identification of alcohol use?	75%	100%	100%	97%	95%	97%	97%	75%	51%
Is there identification of illegal drug use?	75%	100%	100%	94%	93%	97%	95%	73%	44%
Has anticipatory guidance been discussed and/or given?	90%	100%	100%	98%	100%	96%	83%	72%	*
Education regarding sexual activity? (start age 11)	60%	100%	99%	94%	82%	95%	82%	77%	59%
Age specific adult immunization record?	60%	17%	24%	71%	68%	26%	24%	52%	36%
Documentation of early diagnostic screens?	90%	99%	100%	99%	100%	98%	86%	99%	100%
Pap Smear (start when sexually active)	70%	67%	73%	89%	80%	84%	76%	75%	61%
Mammogram(start at age 40)	75%	67%	75%	75%	57%	69%	63%	75%	61%
Lead Questionnaire included in EPSDT screening?	100%	78%	68%	78%	74%	65%	50%	46%	31%

	Target	FHP Thru 7/1/2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001	FHP 2000
Blood Lead level for any positive response on the lead questionnaire?	100%	100%	98%	92%	97%	81%	74%	74%	72%
Blood level 12 months?	100%	98%	78%	82%	82%	60%	56%	66%	47%
Blood level 24 months?	100%	100%	86%	77%	84%	53%	47%	67%	23%
Blood levels for all children aged 12 – 72 months	100%	59%	56%	56%	63%	52%	35%	89%	*
Dental referral documented?	57%	100%	96%	95%	89%	92%	83%	52%	*
Documentation of a dental screen/exam?	57%	86%	84%	88%	88%	88%	83%	79%	*
Documented height?	85%	98%	99%	99%	97%	90%	87%	87%	82%
Documented weight?	85%	100%	99%	100%	100%	99%	100%	99%	98%
Documented B/P? (start age 3)	85%	99%	96%	98%	97%	96%	96%	95%	85%

Clinical Quality Indicators (cont)	Target	FHP Thru 7/1/2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001	FHP 2000
Documented history regarding exercise?	50%	100%	100%	100%	94%	95%	86%	84%	65%
Documented history regarding diet intake?	75%	100%	100%	100%	96%	95%	87%	76%	67%
Documented hearing test/screen? (1mo-20 years & at risk)	80%	95%	92%	91%	91%	90%	81%	75%	58%
Has an Asthma Action Plan been Initiated?	80%	100%	99%	96%	84%	86%	55%	56%	*
Is there an Asthma Action Plan in the record?	80%	97%	91%	95%	62%	62%	32%	44%	*
Has the member had an HbA1c once every 6 months?	50%	92%	94%	100%	69%	86%	86%	*	*
Has the member had a foot exam with every office visit?	75%	41%	73%	86%	60%	36%	50%	*	*
Has the member had an	75%					36%	54%	*	*

				100%	53%				
annual dilated eye exam?		54%	76%	%					
Has the member had a yearly LDL?	50%	95%	94%	100 %	69%	64%	83%	*	*
Documented vision screens?(3-21 years screen- 1-36 mos & at risk)	80%	95%	90%	91%	90%	89%	79%	79%	61%

* Not Applicable Indicator

Children's Mercy Family Health Partners continues to monitor the outcomes of these medical record reviews to identify additional initiatives that will result in furthering the improvement trends.

Medical Record Maintenance Indicators

__Indicators__	Threshold	FHP Thru 7/1/2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001	FHP 2000
Are age appropriate EPSDTs documented?	80%	91%	90%	90%	88%	88%	79%	88%	63%
Is there an age specific pediatric immunization record?	90%	90%	87%	97%	97%	89%	79%	79%	65%
Presenting problems from previous office visits addressed in visits?	95%	100%	100 %	100%	100%	100 %	98%	100%	100%
Are unresolved problems from previous office visits addressed in visits?	95%	100%	100 %	100%	100%	100 %	99%	99%	99%
Is there documentation of an action/treatment?	95%	100%	100 %	100%	100%	100 %	99%	99%	100%
Does record indicate follow up dates to treatment?	95%	100%	99%	100%	100%	100 %	99%	99%	97%
Do all pages contain patient ID?	95%	100%	100 %	100%	100%	100 %	96%	99%	100%
Is documenting person signing, initialing progress/treatment notes?	95%	100%	100 %	100%	100%	100 %	100 %	100%	100%

Are all entries dated?	95%	100%	100%	100%	100%	100%	100%	99%	100%
Is the record legible?	95%	100%	100%	100%	97%	100%	100%	100%	99%
Is there a problem list?(Member seen 3 times or more)	95%	87%	82%	100%	81%	70%	72%	96%	72%
Are allergies and adverse reactions to medication prominently displayed?	95%	100%	100%	98%	85%	97%	98%	99%	90%
Is there a referral/correspondence note related to state(s) of health?	95%	100%	100%	100%	100%	100%	99%	99%	*
Is education related to medication documented?	95%	100%	100%	100%	100%	93%	99%	92%	45%
Are diagnostic test results initialed or in plan of care?	95%	100%	100%	100%	99%	99%	99%	97%	98%
Is follow up for hospitalization requested by the provider?	95%	100%	100%	100%	98%	99%	98%	93%	98%
Is urgent/ER service follow up requested by the provider?	95%	100%	100%	100%	97%	100%	97%	99%	92%
Does the DOS & ICD9 code match documentation in medical record?	100%	100%	97%	*	*	*	*	*	*
Does the DOS & CPT code match documentation in medical record?	100%	100%	99%	*	*	*	*	*	*

* Not Applicable Indicator

Subcontractor Monitoring
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. Further, performance projects and measures concerning Bridgeport are discussed quarterly and documented in CMFHP minutes. Areas that are always considered for performance projects and measures are community outreach activities as well as access for members to general dentists. Of particular concern has been and continues to be general dental access in Henry County. This county was targeted for community work plan project in 2005 and work continued in 2006 & 2007 to improve access in Henry County. In 2nd Quarter, 2007 the Henry County Health Department announced that it was going to expand its services to include general dental services. The health department plans on hiring a dental hygienist to go to schools to provide dental screenings and fluoride treatments. Bridgeport is working on collaborating with the health department to provide similar activities in other venues throughout Henry County.

During 2006, CMFHP continually monitored the encounter submissions and acceptance rates for our subcontracted providers. CMFHP continually works to ensure that encounters submitted are ultimately accepted. Over the year, progress has been made to increase our encounter acceptance rate upon the first submission. Bridgeport's overall accepted rate for July 1, 2006 to June 30, 2007 has consistently held above 98%.

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 & New Directions Behavioral Health

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, CMFHP has contracted with the Community Network for Behavioral Healthcare, Inc. (CommCare) to deliver behavioral health services to CMFHP members. CMFHP and CommCare met on a quarterly basis to review operational issues, monitored quality and utilization, and developed protocols to integrate medical and mental health services.

In addition to the quarterly oversight meetings, the clinical Manager for CommCare attended case rounds with CMFHP Case Managers monthly to discuss cases where behavioral health issues were involved. This collaboration could occur on a daily basis, as needed, to coordinate care for members needing both medical and behavioral health services.

Also, CMFHP's Director of Health Services maintained oversight of all of delegated activities, such as utilization management and credentialing. CommCare maintained URAC certification as a Utilization Review organization. The director performed annual chart reviews to ensure continued compliance with such certification. The Manager of Provider Relations performed an annual onsite review for credentialing activities. The results of these activities were reported back to the CMFHP Credentialing Committee and the Utilization Management/Medical Director Committee (now the Health Services Review Committee).

During 2006, CommCare worked on several performance projects including the following: (1) Seven (7) day Follow-Up to Inpatient Psychiatric Hospitalization; and (2) Timeliness of Credentialing.

Due to performance outcomes and general oversight issues relating to CommCare's contract, CMFHP opted to not renew CommCare's contract effective February 1, 2007. CMFHP chose New Directions Behavioral Health (NDBH) as its new behavioral healthcare provider. CMFHP developed a transition plan with CommCare to ensure that all CMFHP members were effectively and efficiently transferred from CommCare to case management with NDBH.

CMFHP and NDBH have worked in 2007 to establish regular quarterly reports as well as annual reports. These annual reports will include: appointment availability, physician inter-rater reliability; grievance trends analysis, and ambulatory follow-up after hospitalization. Another project initiated by NDBH in 2007 is the RE-Aim, which is designed to reach into the community to education a range of providers and advocates that may be interacting with CMFHP members. Some scheduled interventions include meetings with the following agencies/organizations: Baby and Child Pediatric Group, School Nurse Conference, Center School District, Healthy Steps, Tri County Mental Health, Kaw Valley Center, and Truman Medical Center OP Program. The goal is to increase education about the types of services and benefits provided by NDBH.

MTM and LogistiCare Transportation Services

Children's Mercy Family Health Partners (CMFHP) recognizes the importance to members of having available and manageable non emergent medical transportation. From July 1, 2006 to December 31, 2006, CMFHP utilized Medical Transportation Management (MTM) to provide these services. From January 1, 2007 to June 30, 2007, CMFHP changed contractors to LogistiCare to provide this necessary service to all CMFHP members. This change resulted in an increase in member grievances. In addition, the contractor did not consistently meet call center phone statistics. On July 1, 2007, CMFHP transferred back to MTM for new services. CMFHP met weekly with LogistiCare during the implementation phase of the contract with MTM. After the transition back to MTM, we continued to meet weekly with MTM. An action plan was developed for both vendors and issues were tracked. CMFHP has submitted a 2007 non-clinical Performance Improvement Project (PIP) designed toward improving non-emergent transportation services to members. The following hypotheses were submitted:

"By developing an operational action plan and conducting more frequent oversight visits with the transportation vendor, access to transportation services will increase and member grievances related to transportation services will decrease."

Results of this PIP will be available on the next annual review.

HARMONY HEALTH PLAN OF MISSOURI, INC.
The WellCare Group of Companies

QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION
2006 – 2007

OVERVIEW

The purpose of the Quality Improvement Program is to establish a systematic process of measurement, analysis and intervention to assess and improve the quality of service and clinical care provided to Harmony Health Plan/WellCare members. The measures chosen for review are comprehensive, including increasing preventive health services to members, improving clinical quality of care for members, improving customer satisfaction, decreasing cost of care without compromising quality, and decreasing administrative costs.

PART I - QI COMMITTEE STRUCTURE AND ACTIVITIES

QUALITY IMPROVEMENT COMMITTEE

The Quality Improvement Committee is responsible for promoting the goals and objectives of the health plan by overseeing the implementation of the Quality and Utilization Management Programs including clinical and service quality, utilization management, credentialing, delegation oversight, and behavioral health management. The QI Committee meets monthly but not less than eight times per year. Minutes are recorded and maintained for each meeting.

The Committee is chaired by the Chief Executive Officer or his designee. Membership is comprised of the following individuals and/or their representatives: The Medical Director, Director of Quality Improvement, Director of Health Services, Director of Credentialing, Director of Appeals and Grievances, and Representatives of Executive Management. The Committee met as indicated on approved minutes. The Committee reports to the Board of Directors.

Committee Initiatives/Focus for 2007 – 2008

- Oversight of Local, State and Federal Regulatory Compliance
- Review and approval of QI and UM Program Description, Work plan and Annual Evaluations
- Oversight of quality measurement Performance Improvement Projects
- Oversight of HEDIS performance measures
- Oversight of Clinical Quality Improvement
- Oversight of Service Quality Improvement
- Oversight of the Credentialing and Re-credentialing Program
- Oversight of Delegation Program
- Oversight of the Utilization, Disease and Case Management Program
- Oversight of the Behavioral Health Program

- Oversight of the Appeals and Grievance Program
- Oversight of the Consumer Advisory Program

MEDICAL ADVISORY COMMITTEE

The Medical Advisory Committee is the principal physician committee that oversees clinical quality improvement, utilization management, customer service quality improvement and appeals and grievances activities. The Committee meets quarterly but not less than 3 times per year. The Committee met as indicated on approved minutes. Minutes are recorded and maintained for each meeting.

The Committee is chaired by the Medical Director. Membership is comprised of the following individuals and/or their designees: Medical Directors, Representative(s) of Executive Management, and Physician Advisors representing primary care, surgery, obstetrics, and sub-specialties as assigned, Director of Corporate Quality Improvement, Director of Quality Improvement, and Director of Health Services. The committee reports to the Quality Improvement Committee.

Committee Initiatives/Focus for 2007 – 2008

- Oversight of clinical and administrative studies (Performance Improvement Projects), HEDIS Measure Performance, Disease/Case & Utilization Management Programs, Member/Provider Surveys, and Medical Record Review
- Oversight of Customer Service Quality Improvement Initiatives
- Oversight of Appeals and Grievances Activities
- Oversight of Clinical Practice Guidelines
- Oversight of Preventive Health Guidelines

APPEALS AND GRIEVANCE COMMITTEE

During 2006 – 2007, the Appeals & Grievance Committee (AGC) met as indicated on approved minutes. The Committee membership was comprised of the following individuals and/or their representatives: Medical Director; Director of Appeals & Grievance; Appeals & Grievance staff, as appropriate; Physician Advisor(s); one (1) health plan employee; Representatives from Legal or Compliance, as necessary. Voting members include the Medical Director, Physician Advisors, and one (1) health plan employee, all whom have been unaffiliated with the case prior to the review.

Committee Initiatives/Focus for 2007 – 2008

- The Appeals and Grievance Committee will continue the review of member and provider medical necessity appeals and the review of administrative and benefit grievances and appeals.
- Continue managing workflow productivity improvements as a result of enhancements to systems and operational processes.
- Continue focus on initiatives with Customer Service to evaluate trends related to provider complaints, PCP changes.
- Continue joint project with Claims to conduct root cause analysis of No Prior Authorization Denials.

CREDENTIALING COMMITTEE

The Credentialing Committee is the principal committee that reviews and makes recommendations on credentialing, re-credentialing, and peer review activity. Credentialing is performed corporately for all

WellCare Plans, including Harmony Health Plan. In 2006 – 2007 the Credentialing Committee had monthly meetings as indicated in meeting minutes.

The Committee is chaired by the Medical Director and membership includes the following and/or their designees: Director of Credentialing, and participating physicians with the following Specialties represented: Internal Medicine, Pediatrics, Surgery, Obstetrics and Gynecology, Gastroenterology and Psychiatry. The Credentialing Committee reports to the Quality Improvement Committee.

Committee Initiatives/Focus for 2007 – 2008

- Perform credentialing and re-credentialing of all health plan providers, including facilities, to assure that all providers meet the minimum practice parameters established by the health plan and the physician community at large.
- Conduct peer review on cases forwarded to the committee and develop recommendations for improvement initiatives.
- Review, revision, and approval of credentialing policies and procedures, standards, etc.
- Provide peer review oversight of delegated credentialing activities.

DELEGATION OVERSIGHT COMMITTEE

The Delegation Oversight Committee coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensured compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

The Delegation Oversight Committee reports to the Quality Improvement Committee. The Delegation Oversight Committee met as indicated in meeting minutes. The Director of Corporate Quality Improvement and/or a designee chaired the Delegation Oversight Committee meetings.

Corrective action plans are in process and will continue to be monitored through 2007-2008.

Committee Initiatives/Focus for 2007 – 2008

- Maintain appropriate policies and procedures.
- Monitoring potential delegation activities.
- Completing pre-delegation audits.
- Executing delegation implementation.
- Completing annual delegation audits.
- Monitoring agencies on corrective action.
- Monitoring vendor reporting and data submission.

PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee is the keystone for maximizing rational drug use and managing the complexities surrounding their safe and effective use for WellCare Health Plans. The purpose of the Committee is to function in an advisory, educational, and quality improvements capacity as it relates to drug use. The objective of the committee is to improve the quality of care by: promoting appropriate prescribing

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and drug selection, establishing and adopting standards of care practices, and managing the cost of pharmaceutical care.

The Committee met as indicated in meeting minutes.

Committee Initiatives/Focus for 2007 – 2008

- Recommending or assisting in the selection of drugs for the Preferred Drug List
- Recommending/assisting in the adoption of, or formulation of broad professional policies regarding evaluation, selection and therapeutic use of drugs
- Participating in the development, implementation and review of clinical pathways for medications
- Initiating and/or directing Medication Use Evaluation (MUE) studies and reviewing the results of such activities. Advise on potential problems related to the over utilization or inappropriate utilization of drugs.
- Assisting in the quality improvement program designed to detect possible or potential issues
- Providing a forum for the review, revision, and approval of policies and procedures, guidelines, standards, etc.

CUSTOMER SERVICE QUALITY IMPROVEMENT WORK GROUP

The Customer Service Quality Improvement Work Group functions as a multidisciplinary work group to identify opportunities for improvement in the customer service provided to our members and providers. The Customer Service Quality Improvement Work Group met as indicated in official meeting minutes.

The Director of Customer Service chairs the work group. Membership includes, but is not limited to, Representatives from Operations, Health Services, Provider Relations, Legal Affairs, Quality and other ancillary departments as identified. Minutes are recorded and maintained for each meeting. The work group reports to the Medical Advisory Committee

The committee reviews data relevant to member and provider grievances and appeals to ensure that individual member and provider issues are addressed, resolutions are appropriate and timely, and that the process is compliant with regulatory standards. Dedicated to the continuous quality improvement process, the committee facilitates open and consistent communication among members, providers, the QIC and other company departments.

Committee Initiatives/Focus for 2007 – 2008

- Enhance the process to review and trend grievance and appeal data to identify opportunities for improvement.
- Enhance the process to review and trend data related to PCP changes to identify opportunities for improvement.
- Enhance the process to review and trend member satisfaction data to understand root causes, process issues (e.g., claims, process issues, plan responsiveness to customer needs/expectations) to identify opportunities for improvement.
- Utilize dis-enrollment codes to identify trends and opportunities for improvement in customer satisfaction and retention.
- Continue to increase service levels and quality (e.g., grade of service, abandonment, and average speed of answer).

CONSUMER ADVISORY WORK GROUP

The Consumer Advisory Work Group functions as a forum for additional member communication and focuses upon member issues and ideas. The work group provides feedback to the plan on areas impacting member's issues including but not limited to utilization of services, quality of care, quality of service, appeals and grievances (the work group will not have authority to resolve specific complaints but instead to refers such issues to the Plan's other committee and workgroups)

The Consumer Advisory Work Group reports to the Medical Advisory Committee. Meetings are attended per official meeting minutes.

The Work Group membership should include the organization's Marketing, Provider Relations and Health Services Directors or designees and a random selection of currently enrolled members.

Committee Initiatives/Focus for 2007 – 2008

- Analysis/review of educational resources, efficacy and enhancements to resources
- Analysis/review of community resources, efficacy and enhancements to resources
- Analysis/review of benefit efficacy and enhancements to resources
- Ongoing analysis of appeals, grievances and member related issues
- Review QI and UM Program Description, Work plan and Annual Evaluations
- Review of quality measurement Performance Improvement Projects and HEDIS measures
- Review of Disease and Case Management Programs
- Review of the Behavioral Health Program

PART II - WORKPLAN INITIATIVES SCOPE AND METHODOLOGY

A. HEDIS DATA COLLECTION AND SCORES

Objective/Purpose – HEDIS measures are used to report the performance of health plans across eight domains of care: effectiveness of preventive and chronic disease care; use of services, access/availability of care, health plan stability, cost of care, informed health care choices, and satisfaction with the experience of care, and health plan descriptive information.
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Results – HEDIS 2007 (CY 2006) was not reportable as the membership did not meet the "Membership Requirements" in the HEDIS 2007 technical specification. (Note: Harmony Health Plan of MO began enrolling membership in June of 2006.) HEDIS 2008 (CY 2007) will be the baseline year for the health plan

- **Medical Record Abstraction** - Data will be collected for quality improvement analysis, reporting and intervention implementation using both administrative and medical record data abstraction. For calendar year 2007 HEDIS 2008 a minimum of 2,975 member medical records are being reviewed by the data abstraction vendor and/or internal quality staff. 66 providers and 6 provider groups have been provided with "non compliant" member reports in order to encourage additional outreach to members by provider offices prior to the close of calendar year 2007.

- **Encounter Data Project –** The Encounter Data Work Group continues to make progress toward improving the accuracy and completeness of encounter data. Regularly scheduled meetings with top

providers (100 members or greater) are being conducted to discuss provision of services, member outreach, submission rates and projected HEDIS scores.   The plan is also assisting with targeted outreach to members and provider profiling to improve performance. Electronic submission raises the bar for providers and is focused upon improving submission and acceptance of encounter data by the plan and State.

- **Member Periodicity Letters –** Mailed approximately 2,975 periodicity reminder letters based on members birthday and eligibility for targeted HEDIS measures to seek care for well child visits, adolescent visits, childhood immunizations, adolescent immunizations, breast cancer screening, cervical cancer screening, colorectal cancer screening, Chlamydia screening, flu and pneumonia vaccination.

- **Provider Education –** Distributed educational materials and held 72 educational sessions focused upon provision of services to members, all HEDIS measures but more specifically EPSDT, Well Visits, Immunizations, Asthma, Diabetes, Prenatal & Postpartum Care, Pregnancy related depression screening, and Lead screening.

- **Member Education –** In addition to monthly health fairs, the quality team provided telephonic and postal outreach and educational materials for members regarding Well Visits, Immunizations, Asthma, Cervical Cancer Screening, Chlamydia Screening, Diabetes Care, HTN Management, Prenatal and Postpartum Care, Colon Cancer Screening, and Flu and Pneumonia Vaccination.

Opportunities/Plans for 2007/2008 – HEDIS measurement and data collection improvements will be targeted using three primary strategies.

- Continue to strengthen interventions to address the primary barriers of educating and reminding providers and members of preventive health screenings and disease-specific treatments. All HEDIS measures will continue to be targeted for improvements in 2007/2008 as we work toward meeting nationally recognized rates, specifically:

  - ➢ Immunizations
  - ➢ Breast and Cervical Cancer Screening
  - ➢ Chlamydia Screening in Women
  - ➢ Mental Health
  - ➢ Asthma Medication Use
  - ➢ Prenatal & Postpartum Care
  - ➢ Annual Dental Visits
  - ➢ Well Visits (child and adolescent)

- Consider potential efficacy of Pay for Quality incentive initiatives for members and providers.
- Continue Encounter Data Submission project in order to facilitate 100% data encounter data capture and improve the integrity and completeness of HEDIS administrative data and scores.

B. MEMBER/CUSTOMER SATISFACTION SURVEY

Objective/Purpose – Assess Customer Satisfaction with Health Plan services.

Results – As membership enrollment criteria was not met for a formal NCQA survey the Health Plan is submitting the monthly Member satisfaction data (below) which indicated that the health plan is meeting or exceeding member's expectations. The Health Plan will complete a formal CAHPS member satisfaction

survey in 2008. Historically Harmony Health Plan has employed the Myers Group to conduct a NCQA approved CAHPS written member satisfaction survey response.

MO Medicaid CSAT Results
(Member)
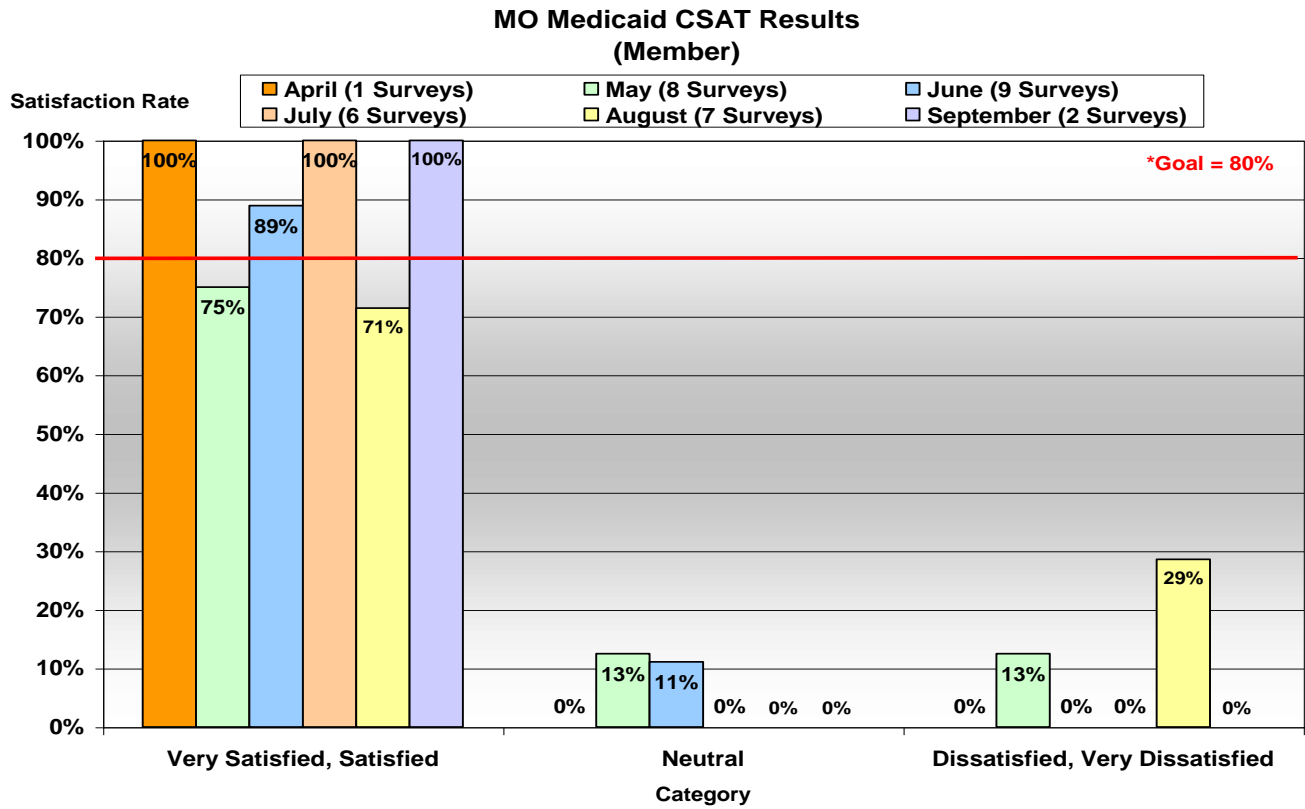
Providers report similar satisfaction levels.

MO Medicaid CSAT Results
(Provider)
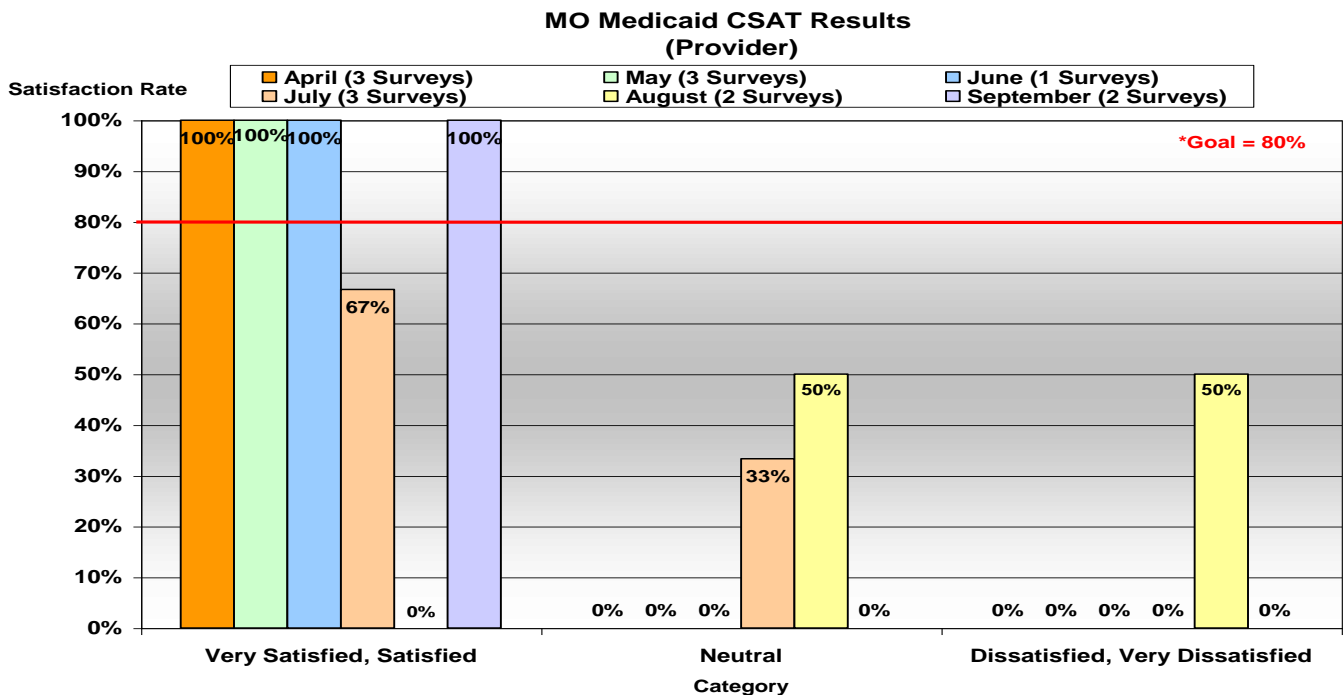
Customer Service Metrics

Metric	Target Performance	State	2007 YTD	2006 YTD
Speed of answer	80% in 30 Sec.	Harmony Missouri	**92.9%**	**86.2%**
ASA	30 Secs	Harmony Missouri	**12**	**18**
Call quality	95%	Harmony Total	**93.9%**	**90.4%**
First Call Resolution*	90%	Harmony Total	**New Metric**	
Customer Satisfaction Survey Score	80%	Harmony Total	**85.4%**	
Calls per member	≤.15 per mem per month	Harmony Missouri	**0.10**	**0.09**
Call abandon rate	≤ 5%	Harmony Missouri	**0.9%**	**1.5%**
# of calls per CSR	45 per day	Harmony Missouri	**29.4**	**41.0**

Results
- The average speed of answer consistently exceeded the 80% targeted performance goal.
- The call quality partially meets the 95% performance goal.
- The call abandonment rate consistently met the targeted performance standard.
- First Call resolution and customer satisfaction have been added to the metrics in order to assess member satisfaction on a "real time" basis.

The following interventions were initiated in 2006/2007:

- In an effort to continue to improve member satisfaction Harmony created a Dis-enrollment Work Group. The Member satisfaction survey directly impacts the customer service area. Progress will be measured in January of 2008 through an NCQA approved CAHPS survey.

- Maintained an Assist Queue staffed by Senior Representatives with over two years of experience and knowledge in all product lines to assist CSR's with inquiries and to handle escalated issues resulting in an improvement in the abandonment rates.
- The WellCare Human Resources department created an on line Wellcare University CSR workshop and various skills boosters for our associates. The training is done in a group environment by a trainer using proven training materials and modules that are a part of the University and dedicated to Customer Service. All new hires were trained, existing staff received in-service training throughout the year, and CSR's were cross-trained to handle various functions.
- Development of the Quality Assurance Audit Program to monitor whether calls are handled appropriately and in compliance with WellCare policies and procedures. CSR's are monitored randomly and scored on a monthly basis. CSR's have quality goals that must be met. CSR's are coached when errors are made and disciplinary action is taken if the CSR continues to miss their goal. Calls are randomly recorded at 4/CSR/day and audited at 2/CSR/week.
- Established minimum requirements for new hires in the Customer Service Department.
- Increased work force resulting in improvements in the abandonment rate.
- Re-wrote scripts for faster, easier and more effective routing and cross trained CSR's in multiple skills to increase productivity and efficiency.

Analysis: Harmony Health Plan/WellCare identified opportunities to continue improvement in the quality and availability of information that is provided to members.

Improvements – Increased customer satisfaction in other local markets relative to physician communication and disease prevention and health promotion education are noted, however, access and availability and emergency room utilization indicate areas for opportunities. The Customer Service Quality Improvement and Dis-enrollment Workgroups were established to review these results in detail and drill down on the root causes and create an action plan to address the deficiencies. Many of the customer complaint/satisfaction issues have already been addressed, including, ease of getting care and referrals, getting help from customer service and provider communications with members.

Plans for 2007-2008 – Continue and/or expand the interventions initiated in 2006/2007 and re-measure impact of interventions implemented in 2006/2007 using 2007-2008 CAHPS data. Member services will continue to assess data on a daily/monthly basis, identify potential issues, create interventions, implement and re-measure accordingly.

C. OVER AND UNDER UTILIZATION MONITORING

Objective/Purpose – is to ensure timely and cost effective utilization of facilities and services through the Health Plan's coordination of care activities and its' affiliations with Providers. Ongoing monitoring, evaluation, coordination of care and intervention utilization activities impact Providers and members' activities relative to over and under utilization.

Results - Authorization data is summarized below, trending year over year would suggest an increase in inpatient days per thousand and admissions per thousand; average length of stays remain constant and comparable to InterQual criteria utilization. Medical & Surgical Days/thousand remained relatively constant and maternity days appear to have trended down. HEDIS related utilization measures indicate improvement with members accessing care however, compliant/appropriate utilization of outpatient services remains under utilized as opportunities for improvement are noted in Prenatal/Postnatal and Cervical Cancer Screening measures.

Top inpatient diagnoses continue to list pregnancy, respiratory illness, abdominal pain, drug withdrawal and wounds respectively as leading indicators impacting a member's health and wellness. Outreach, Case Management and Disease Management programs have been implemented and/or revised to address ongoing chronic conditions requiring additional medical attention. Ongoing collaborative relationships with providers and facilities insure Utilization Management, social services and external vendors provide continuity of care along the health services continuum. Members are directed to return to the "Medical Home" for follow-up care.

Plans for 2007/2008

- Continue strict adherence to InterQual utilization guidelines.
- Analyze efficacy of programs Pregnancy, ER Utilization, Case and Disease Management Programs and Special Needs programs, identify potential interventions, implement and re-measure accordingly.
- Continue to improve operational effectiveness and efficiency through business process reengineering and automation.
- Continue to focus on improvement of projected HEDIS measure indictors

Harmony Hugs Prenatal Out reach programs (Hugs), Case Management and Disease management programs continue to focus efforts on member and provider outreach for Health Education and coordination of necessary services in order to facilitate positive outcomes and avoid unnecessary admissions to inpatient facilities.

Harmony Hugs Perinatal Outreach Results -

- 231 healthy deliveries (full-term, >2500grams)
- 33 Complex newborn deliveries

D. PREVENTIVE HEALTH AND CLINICAL PRACTICE GUIDELINE INITIATIVES

Goal/Purpose - to maintain up-to-date Preventive Health and Clinical Practice Guidelines as a basis for measuring member and provider adherence to current standards of care and identifying priorities for implementing quality initiatives, health screening campaigns and disease management initiatives.

Results – The following interventions were implemented to maintain current preventive health and clinical practice guidelines and to promote member and provider adherence.

- Clinical Practice Guidelines for the management of Adult Preventive Guidelines, Asthma, Congestive Heart Failure, and Diabetes Mellitus in Adults, Hypertension, and the NICU Population were reviewed, revised accordingly, presented to appropriate committees and approved by the Medical Advisory Committee.
- Monthly, but not less than quarterly membership lists alert primary care physicians to all services and screening needed for each member based on their claims/encounter data. For each new member the full address is inserted in order to facilitate the office contacting the member.
- Provider newsletters were distributed identifying projects, preventive guidelines and standards of care
- Periodicity letters were mailed to members and providers, upon entering the health plan, annually on their birthday or per periodicity schedules. The letter provides a comprehensive listing of screenings and immunizations needed. The letter also identifies if the member has: diabetes, asthma,

hypertension, hypercholesterolemia and care needed, and members in need of a LDL-C screening, PAP smear and mammogram.

- New Member Packets were sent to all new members. Packets include Preventive Health Screening outlines age specific screenings, tests and services that the member will need. The purpose of the outline is to give anticipatory guidance.

Plans for 2007/2008 – Continue to closely manage inpatient and outpatient utilization, encourage members to seek preventive services, expand the interventions accordingly and re-measure for efficacy.

E. CREDENTIALING AND RE-CREDENTIALING

Goal
- To meet new and expansion business needs in 2007-2008
- Eliminate backlog of files
- Redesign the credentialing process to meet all business needs for January 2007-2008
- Establish capacity thresholds for future expansion.

Results

The Credentialing Department implemented improvement strategies to increase efficiency and productivity in 2006-2007
- The Credentialing committee met 11 times during August 2006 through July 2007
- All Credentialing files include provider type, i.e.: PCP, Specialist, Dual PCP/Specialist (copy of sign-off sheet attached)
- Credentialing files include site evaluations for all new PCP's, OB-Gyn's and Dual PCP/Specialist (copy of site evaluation attached)
- Quality Review is performed on all providers going through re-credentialing (copy of form attached)
- Hospital privileges have been verified via website, telephone or fax; and are currently taken under application attestation.
- Verification of License, CSR and DEA are performed at initial credentialing and upon expiration using the following websites:

    o https://www.idfpr.com/dpr/licenselookup/default.asp
    o http://www.deanumber.com/

- Re-credentialing occurs every 36 months. The Corporate office located in Tampa has taken on the credentialing process for all Missouri providers and uses Cactus, a Credentialing database. Cactus is the database of record for all credentialing/re-credentialing functions. It is used to record the original credentialing date, the current credentialing date and the date due for re-credentialing. The first re-credentialing cycle is based upon the last digit of the provider's social security number which may result in being re-credentialed prior to 36 months. All subsequent re-credentialing will follow a cycle of every 36 months. Reports are queried from the database for all providers who are coming due for re-credentialing. The Missouri state application is a document which is stored in the database and pre-printed applications are generated for all providers who are due for re-credentialing as indicated by the query results. The pre-printed applications are sent via USPS with a request of a returned completed application within 14 calendar days. A second notice is sent to providers who do not respond to the original re-credentialing request. The second notice requests a response within 14 calendar days and indicates that if a response is not received, voluntary relinquishment of participation will occur. A third and final notice is sent to the providers who do not respond to the

second request as one last attempt to re-credential the provider. Any provider who fails to respond to the third and final notice will have their participation with the Plan voluntarily relinquished.

- Credentialing has weekly meetings with Provider Relations to gain insight into areas of focus for credentialing related to network needs.
- Process only complete applications for initial credentialing, and require less items of documentation.
- Eliminated need for copy of License (verification is done through state websites) and DEA Certificate (verification is done through NTIS website).
- Eliminated verification of Hospital Privileges (attestation by applicant on application form).
- Eliminated verification of OIG report (rely on NPDB for information).
- Reduced Cactus data entry without impacting Cactus reporting capabilities.
- Created a pre-printed file signature page directly from Cactus.
- Establish a clear pro-active schedule for re-credentialing for 2007-2008
- Set up complete re-credentialing merge document package in Cactus
- Partner with Provider Relations for support to
  - Send out and secure return of re-credentialing applications
  - Receive complete and timely re-credentialing application packages including site inspection evaluations as applicable
  - terminate non-responsive providers

Goals for 2007 – 2008

- To continue refining internal credentialing processes by maximizing productivity in each defined area of credentialing and proactively managing new business.
- To maintain interactive working relationships with internal business partners by facilitating the process of expanding membership growth by providing immediate response to key business partners and collaborating with Provider Operations and Configuration on, improvement of the cross-functional application tracking and reporting mechanism for management of contracting, credentialing and configuration timeliness and productivity.
- To maintain interactive working relationships with external business partners by maintaining interactive relationship with credentialing delegation agencies; adhering to business timeliness for delegation oversight; maintain quick response in obtaining copies of credentialing files from delegated agencies; and meet regulatory compliance at time of external regulatory audits.

F. DELEGATION OVER SITE

Objective/Purpose – Oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. Ensure compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

Result – Corrective action plans are in process and will continue to be monitored through 2007-2008. Policies, Procedures, Program Description templates and work plan recommendations were provided to all groups in order to assist with their corrective action plans. Substantial progress has been noted.

Goals for 2007 – 2008

- Maintain over site of policies and procedures.

- Monitor delegation activities.
- Complete pre-delegation and annual delegation audits.
- Monitor and assist agencies on corrective action.
- Monitoring vendor reporting and data submission.

G. APPEALS AND GRIEVANCES – IMPROVING OPERATING EFFICIENCIES

Objective/Purpose – This initiative was put into place to continue to improve staff productivity in the processing of appeals and grievance cases.

Results – The following interventions were put into place to attain the below results:

- Created new Database for monitoring and processing of Appeals & Grievances
- Reviewed all process flows to identify opportunities for staff productivity improvements.
- Enhanced policies and procedures to reflect appropriate language and implemented accordingly
- Cross-trained staff on other processes within the department to provide better coverage at times of decreased staffing due to vacations and sick days.
- Instituted the sending of acknowledgement and closure letters
- Improved operating metrics
- Increased the amount of automated letters

Analysis – New databases, changes in policies and procedures and additions to FTE counts have played significant roles in improving Appeal and Grievance processes.

Plans for 2007 - 2008

1) Root-cause analysis to further reduce submissions of cases in reference to the following:

   - Failure to obtain prior authorization
   - Requests and Complaints for PCP changes
   - Potential quality of care complaints

2) Continued upgrades to Appeals and Grievance Database
3) Implementation of new technology for scanning and workflow solutions
4) Review appeals and grievance issues in appropriate committees accordingly
5) Insure that Consumer Advisory workgroup members issues are addressed appropriately

H. ACCESS AND AVAILABILITY MONITORING - GEOACCESS

Objective/Purpose – To confirm that the providers are within a 30 mile radius of their membership and contract with additional providers as necessary; per regulatory requirements.

Results – Annual reports were generated for analysis of provider accessibility. GeoAccess analysis of network accessibility for high volume Medicaid ancillary services and high volume specialists demonstrated no significant gaps for ancillary providers. According to the most recent Geo access assessment, the following contracted Health Plan Provider Network data was reported:

- Primary Care Providers – 338
- Specialists – 2049 *
- Allied – 156
- Hospital's – 26
- Ancillary – 132

*Includes PCP's that reported a specialty area

Analysis: GeoAccess analysis of network accessibility, in all counties, for adequacy of network coverage for Primary care Physicians, hospitals and ancillary providers demonstrates no significant gaps.

Barriers/Root Cause – There are Specialists who are resistant to accept Medicaid rates.

Improvement/Analysis – Provider Relations staff is assessing requests for referrals to non-par providers and are initiating contracting efforts.

Plan for 2007 - 2008

- Quarterly analysis will be performed by the Provider Relations area, reporting through the Medical Advisory Committee.
- Document Table specifications and reporting timeframes and work with IT Department to improve data management capability.

I. <u>QUALITY IMPROVEMENT STUDIES –</u>

The membership did not meet the "Membership Requirements" in the Collaborative technical specification. (Note: Harmony Health Plan of MO began enrolling membership in June of 2006.) HEDIS 2008 (CY 2007) will be the baseline year for the health plan and it's membership data.)

<u>Adolescent Well Visits</u>

Objective/Purpose – To assess the frequency and compliance of Adolescent Well Visit services obtained. Parameters include the Percentage of members' who were continuously enrolled during the measurement year and who met compliance criteria in obtaining the identified number of Adolescent Well Visits and its components.

Results – Collaborative study results indicate significant opportunities for educating providers and offices staffs as to the content of a complete EPSDT/Well Visit and appropriate coding, documentation and submission methodologies.

Barriers/Root Cause - The primary presumptive barriers were lack of provider and member knowledge of and/or adherence to preventive care and disease treatment standards, particularly, in the defined age groups.

Plan for 2007/2008 - The Plan will analyze Adolescent Well Visit HEDIS/Encounter data, educate providers and members and implement additional interventions as indicated by educational efforts. Once approved by the EQRO and the State, the Health Plan will implement additional interventions and begin re-measurement activities.

<u>**Prenatal, Post Partum and Peri-natal Depression Screening**</u>

2006 – 2007 Annual QI Evaluation –Missouri. Revision_08/07

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Objective/Purpose - Improving Prenatal and Post Partum member to provider visit rates. Measure the percentage of members of child bearing age who were continuously enrolled during the measurement years and were compliant with prenatal, antenatal and post natal care and being assessed and treated by providers for peri-natal depression.

Results – HEDIS 2007 (CY2008) baseline data measurement will be completed. The Quality team has identified outlier educational opportunities specific to scheduling of prenatal visits before the end of the first trimester and post partum visits scheduled prior to 6 weeks post delivery but not before 21 days post delivery.

Plan for 2007/2008 – Harmony will continue pregnancy outreach efforts and post partum depression referrals to the mental health vendor. The Plan is also actively meeting with providers and educating them on perinatal depression screening, accurate coding and submission of encounter data. Collaborative efforts are being coordinated with external vendors. Specific provider and member educational outreach interventions will be addressed in the Perinatal/Postpartum performance improvement project. Education sessions for facility and providers clinical staff's will now be revised to include (but not limited to) the specific visit parameters noted in the HEDIS Technical specifications, Volume 2.

Member Satisfaction Survey Data

Objective/Purpose – To improve the Member's reported satisfaction with health plan internal and external functionality.

Plan for 2007/2008 – Harmony Health Plan of IL will employ the Myers Group to conduct the 2007/2008 CAHPS survey. Member Satisfaction results will be assessed in terms of strengths (satisfied) and weakness (areas of opportunity). Interventions will be implemented as indicated. The Plan will continue to identify interventions necessary to positively impact the overall satisfaction of the members. The Plan will continue Member and provider outreach efforts.

PART III – 2007 – 2008 QI PROGRAM FOCUS

The QI Program will encompass the following initiatives in 2007/2008:

- Continue to improve quality of care to members as reported by HEDIS measures
- Enhance Customer Service, Utilization Management, Appeal and Grievance, Network Access and Availability, Behavioral Health and Quality Improvement Study Reporting for each product line to include performance metrics, trended analysis, correlate interventions and potential outcomes and execute accordingly.
- Continue implementation of quality improvement studies designed to improve health outcomes, promote appropriate utilization, improve service quality and member satisfaction, and/or manage the cost effectiveness of care.
- Maintain Effective Delegation Oversight and assist with implementation of CAP objectives as necessary
- Maintain Effective Credentialing Program and insure compliance with recredentialing calendars
- Monitor and improve upon new Appeals and Grievance processes, policies and procedures according to applicable federal regulations
- Maintain Effective Utilization Management Program, insure cost effective utilization of services, encourage disease prevention and health promotion activities and redirect members to their Medical

Homes for continuity of care and decreased utilization of emergency departments as primary care facilities

- Enhance Disease Management and Case Management Programs to promote optimal health status for members with Asthma, Congestive Heart Failure, Hypertension, Diabetes, Special Needs and Chronic Medical Conditions through risk assessment, health education outreach, promoting adherence to preventive health and disease specific standards of care, and collaborating with providers to coordinate timely access to appropriate health care services.
- Monitor efficacy of new Medical Record Review process and metrics; including documentation requirements, preventive health guidelines, and meaningful trended analysis.
- Continue to streamline and focus Quality of Care Review processes to identify practice pattern or systemic issues that may negatively impact patient safety.
- Maintain compliance with regulatory and accreditation requirements.
- Monitor Network Access and Availability Reporting including Geoaccess, HSD Tables, and Physician Availability Surveys and implement interventions accordingly.
- Review reporting of trends related to disenrollment, complaint, appeals, and satisfaction survey data, complete root cause analysis and identify/implement potential best practices.
- Continue to improve Encounter Data reporting, encourage electronic transmission/submission of encounters/claims and enhance data support systems accordingly
- Continue education activities for members and providers to improve all categories of HEDIS measurement including but not limited to access to care and increased utilization of services
- Maintain adherence to BBA requirements and implement interventions as necessary

Rights and Responsibilities

Rights and Responsibilities

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Provider Complaint, Grievance and Appeal Management
The data provided has been taken from Navigator, our on line system where all provider and member issues are recorded. The information presented represents all three (3) regions (Eastern, Central and Western). Data from 2005 is not being used as a comparison. Data from 2005 was collected and analyzed using a different process, making the data not comparable to 2006 and 2007.

HealthCare USA has established an interdepartmental work group to review providers complaints, grievances and appeals and member appeals and grievances monthly. This group has the authority to initiate process and policy changes. The work group makes suggestions regarding additional training that may be needed by staff. Suggestions are made for educational information to be shared with providers through the provider newsletter.

The Director of Appeals and Grievances has also participated in several HealthCare USA provider seminars. This allows education of providers on the appropriate way to file a complaint, grievance or appeal and what to include with the case in order for HealthCare USA to make the most informed decision possible.

Complaints
There was a general decline in the number of medical complaints in 2006, however there was in increase in complaints from January through June, 2007. This is likely due to the new business from FirstGuard which we acquired in February, 2007.

Health Services management met to discuss the overturned complaints. The only trend identified was that overturns are due to additional information being received. However, there was no consistency in the types of cases or providers involved so it was determined there were no interventions that could resolve this issue.

Non-medical complaints are mainly due to claim or contract issues. Trends are analyzed to find resolutions to the issues. These resolutions vary from work a-rounds in the claims system to adjustments in the preauthorization process. Other interventions include education of providers about their contract and correct reimbursement, and continued training of claims staff on appropriate interpretation of contracts and claims processes.

The highest volume of non-medical complaints were denials for untimely filing by the providers. Providers are reminded that when submitting claims electronically they must work their edits for rejected claims. In addition, providers complain their claims are filed untimely because the

member did not provide the correct insurance information. Providers are frequently educated regarding the ARU line and are encouraged to use this when a member presents a Medicaid card.

HealthCare USA continues to focus on improving resolution timeliness. Medical complaints requiring a like or similar specialty review have been the most challenging timeframe to improve. If additional information is required from the provider, these cases do not meet the ten (10) calendar day requirement. However, a performance improvement project has been developed to improve the resolution timeliness and decrease the overall number of complaints. Several interventions have been planned and implemented in 3rd quarter 2007. Progress will continue to be tracked on a monthly and quarterly basis.

Provider Complaints 2006-2007

Source: Navigator

Member Appeals 2006-2007

Source: Navigator

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Provider Appeals 2006-2007
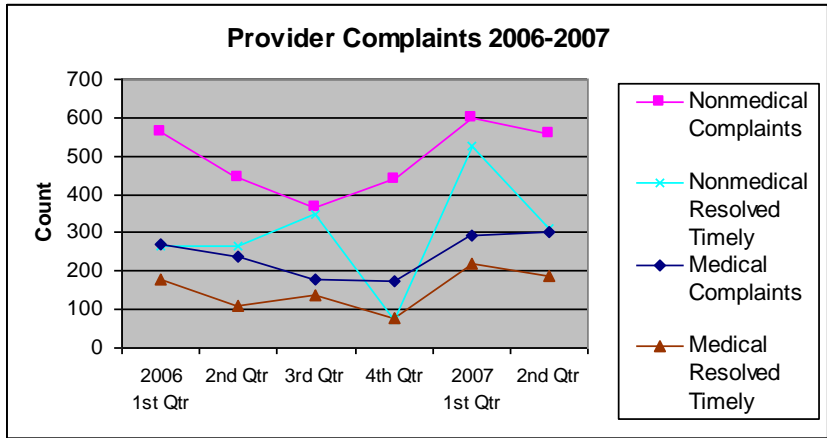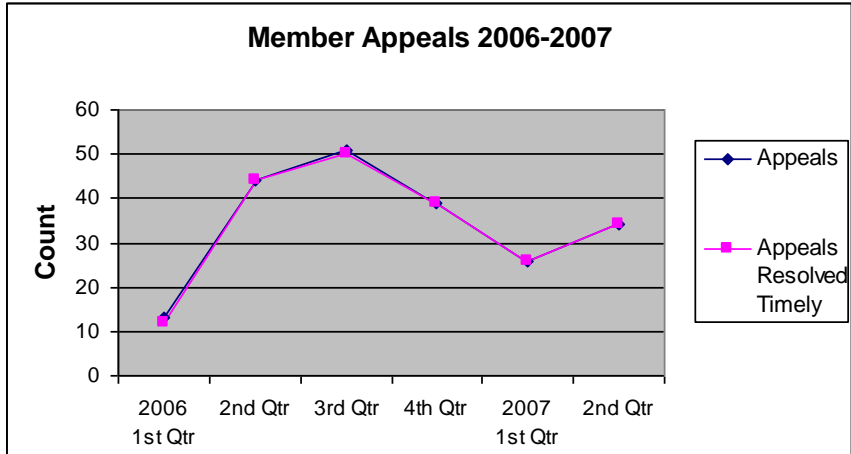
Source: Navigator
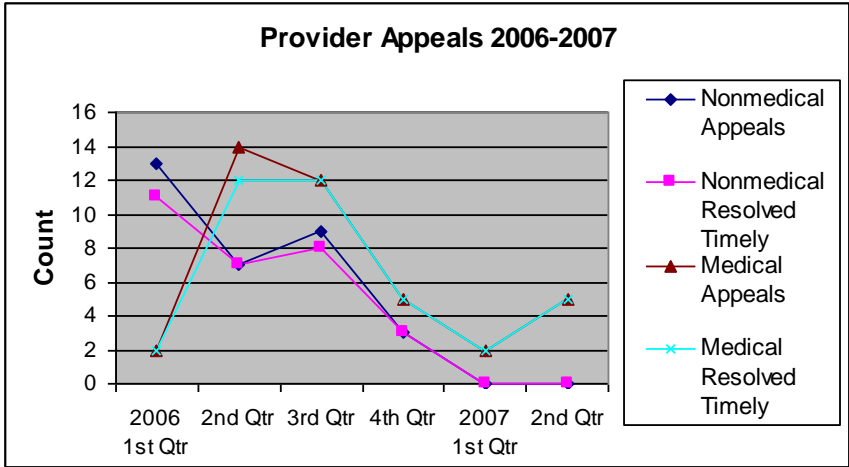
Provider Grievances 2006-2007
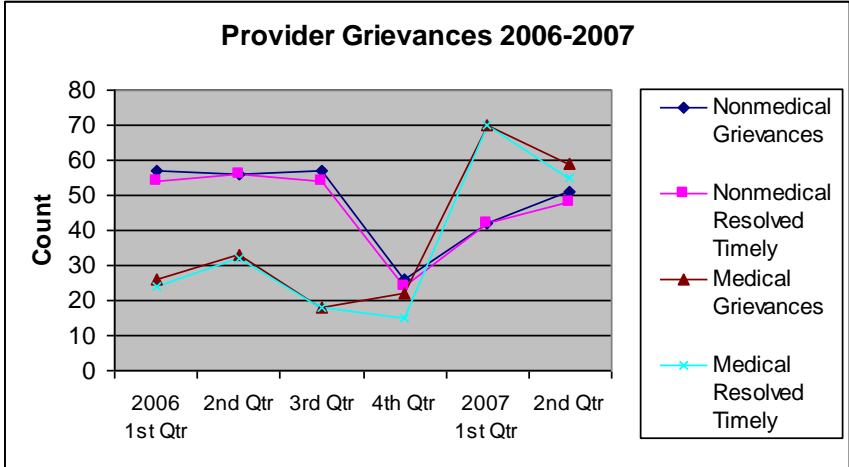
Source: Navigator

Grievances
Provider grievances remained steady in 2006 until 4th quarter, when non-medical grievances dramatically decreased. This decrease correlates with the peak of the non-medical complaint overturn rate in 3rd quarter 2006. Non-medical grievances peaked in 1st quarter 2007 in correlation with a sharp decrease in complaints 4th quarter 2006.

The most common reason for overturns continued to be additional information submitted. The 30 day time frame allowed for grievances gives staff the ability to request additional information which results in a more informed decision on the case. Timeliness for grievances remained in the 90%s.

Provider Grievances 2006-2007

Source: Navigator

Provider Grievances Overturn Rate
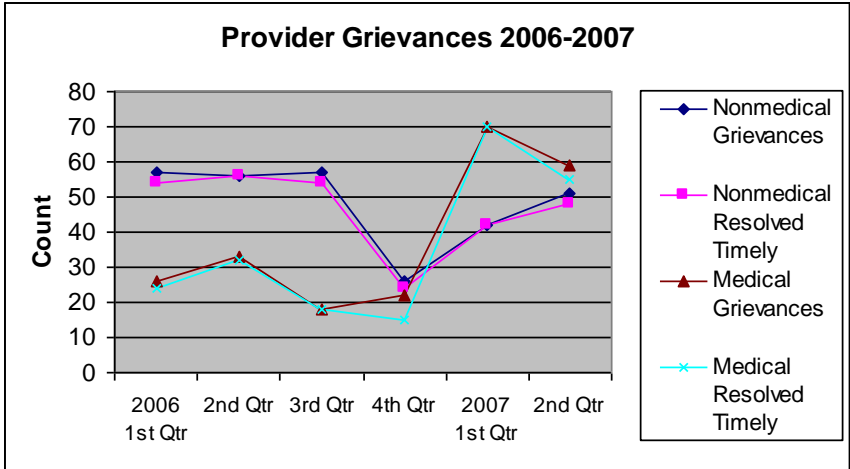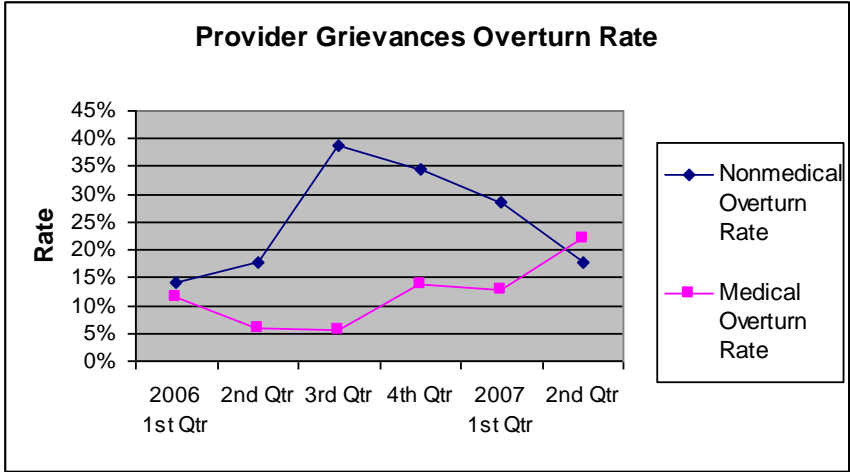
Source: Navigator

Appeals

The number of appeals received are trending downward. Making informed decisions at the grievance level as well as giving facilities and providers detailed information as to why the decision was made is contributing to this trend.

The increase in the overturn rate can be attributed to a change in Medical Directors. Appeals are sent to two physician reviewers of like or similar specialty to the requesting provider. If these two reviewers do not agree, then the appeal is sent to a third reviewer. The majority opinion of the reviewers is the decision of the appeal.

Provider Appeals 2006-2007

Source: Navigator

Provider Appeals Overturn Rate
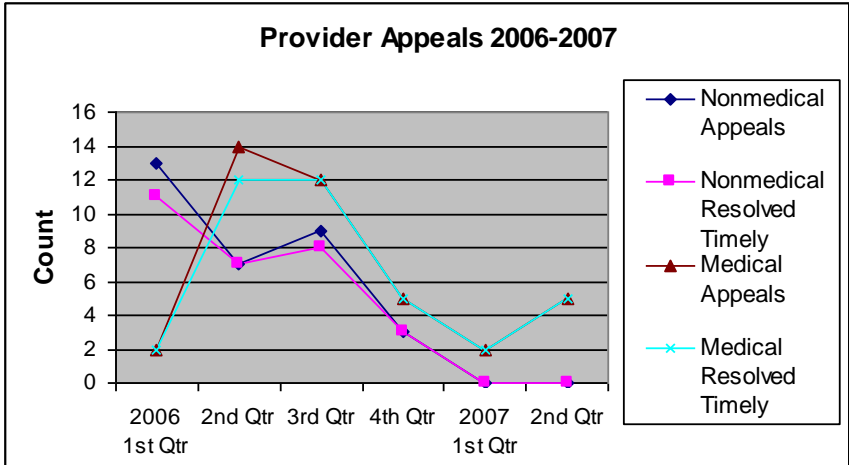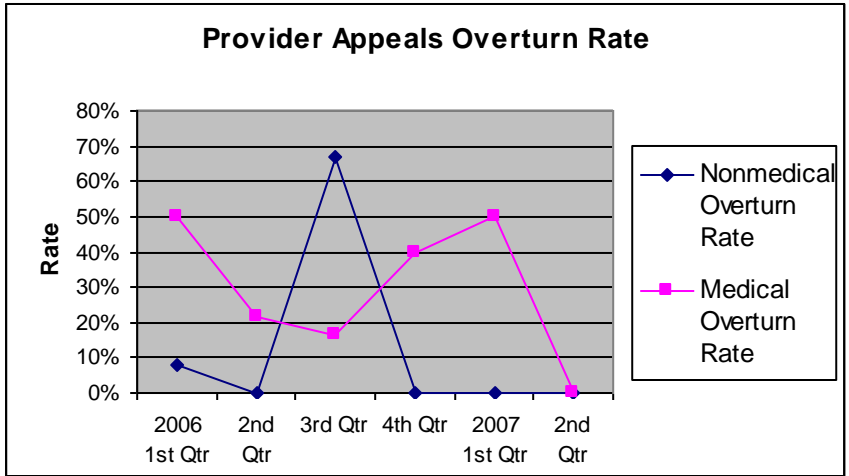
Source: Navigator

Member Grievance and Appeal Management
Member Appeals

Member appeals remained unchanged in 2005 and showed an increasing trend since 2006. The data was analyzed and no significant trends were identified.

While requests for orthodontia services has decreased, it still remains the issue with the highest number of member appeals. The wording of the denial letters for Doral has been changed to be more easily understood by the member. This may have attributed to the decrease of orthodontia appeals since January 2007.

The Member Appeals Committee continues to meet weekly. The issues that were resolved untimely were due to difficulties in getting records from physicians and/or dentists which were determined to be beneficial to the member's case. There was also a case where the Legal Advocates requested a delay in the hearing in order to present additional information.

Member Appeals 2006-2007

Member Appeals Overturn Rate

Member Grievances

Transportation and grievances against the medical provider are the highest two categories of member grievances received by HealthCare USA.

Member Grievances 2006-2007

MTM Grievances

A line chart titled "MTM Grievances" showing Count (y-axis, 0 to 1000) over quarters (x-axis). Values: 2006 1st Qtr ~90, 2nd Qtr ~50, 3rd Qtr ~120, 4th Qtr ~40, 2007 1st Qtr ~910, 2nd Qtr ~180.
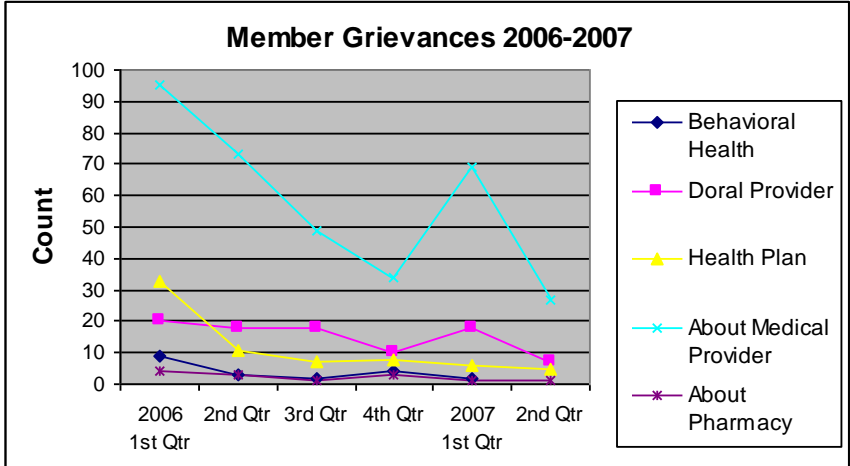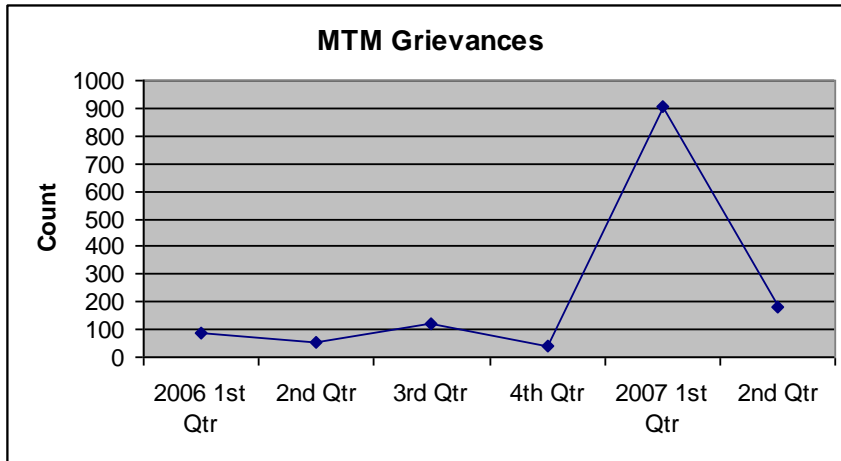
Source: Navigator

No shows are the highest category of transportation issues followed by prolonged waiting time by the member for the transportation vendor to arrive. HealthCare USA meets with MTM, the transportation vendor, monthly to monitor no shows and prolonged waits. Several issues with the specific transportation providers were identified and corrective action were taken.

MTM and HealthCare USA have been working to educate members about the mileage reimbursement if the member should use their own method of transportation. This would be an alternative to calling and having a transportation vendor pick up the member. An additional intervention implemented is HealthCare USA sending a list of pregnant members weekly to MTM to flag in their system. This enabled the transportation provider to meet the special needs of these members.

HealthCare USA worked with MTM to become more consistent at reporting member grievances in a timely manner to HealthCare USA. This affected the timeliness of grievance acknowledgement letters. MTM has changed the reporting schedule to daily and weekly and resolution timeliness of these grievances has improved.

The January 2007 findings from an internal audit identified a processing error related to transportation grievances. Staff at HealthCare USA were retrained on the process and the issue has since resolved. This process is routinely monitored by the director of appeals and grievance to ascertain that the transportation provider's reports are being received as indicated and entered into the Navigator system.

The second highest member grievance category is the member receiving bills from providers. Since 1st quarter 2006, education efforts have been made to notify members and providers of their responsibilities regarding billing. Members are reminded to provide their insurance information at the time a service is provided and providers are reminded to check eligibility, request pre-authorization if necessary and not to bill Medicaid members.

Another portion of providers who are billing members are non participating providers in states other than Missouri. Out of state providers often do not recognize Medicaid from other states

and don't bill HealthCare USA. Staff is able to work with these providers to submit a claim and prevent billing of the members.

Confidentiality
HealthCare USA maintains written policies and procedures regarding member rights and protections and complies with all federal and state laws pertaining to those rights and protections, including confidentiality. HealthCare USA ensures staff and providers take those rights into consideration when furnishing services to HealthCare USA members. All staff are required to sign a confidentiality statement at the time of hire and every year thereafter. Member rights and protections are provided in the Member Handbook, as well as the Provider Manual and include the following:

Member Rights
- Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;
- Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment and the freedom of choice among network providers;
- Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected;
- Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member;
- Each member will be provided with names, locations, telephone numbers, and any non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients;
- Each member will be provided with information on grievance and fair hearing procedures;
- Each member will be provided with the amount, duration, and scope of benefits available under the contract to which they are entitled;
- Each member will be provided with information on how to obtain benefits,   including authorization requirements;
- Each member will be provided with the extent to which, and how, they may obtain benefits including family planning services, from out-of-network providers;
- Each member will be provided with the extent to which, and how, after-hours and emergency coverage are provided including:
  - What constitutes emergency medical condition, emergency services, and post stabilization services
  - The fact that prior authorization is not required for emergency services
  - The process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent

- o The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services
  - o The fact that the member has the right to use any hospital or other setting for emergency care.
- Each member will be provided the post stabilization care services rules;
- Each member will be provided the policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- Each member will be provided cost sharing information, if any, and;
- Each member will be provided information on how and where to access any benefits that are available.

Member Responsibilities
- Each member must provide, to the extent possible, information needed by providers in caring for the member;
- Each member must contact their primary care provider as their first point of contact when needing medical care;
- Each member must follow appointment scheduling processes; and
- Each member must follow instructions and guidelines given by providers.

Mercy CarePlus

Provider Complaint, Grievance and Appeal Management
MCP assures timely, fair and consistent provision of services to its providers with regard to any dissatisfaction resulting in the filing of a complaint, grievance or appeal. Through monitoring and tracking of provider complaints, grievances and appeals, MCP is able to conduct investigations and improvement corrective action plans where necessary. The data below reflects the volume of provider complaints, grievances and appeals processed by MCP during FY2007.

Provider Complaints	1QFY07	2QFY07	3QFY07	4QFY07	FYTD
Complaints Received	286	551	587	665	2089
Complaints Upheld	160	356	331	413	1260
Complaints Overturned	126	195	243	252	816
Processed Timely	286	551	587	657	1494

Provider Grievances	1QFY07	2QFY07	3QFY07	4QFY07	FYTD
Grievances Received	37	35	97	72	241
Grievances Upheld	27	28	94	62	211
Grievances Overturned	10	7	2	10	29
Processed Timely	37	35	97	64	136

Provider Appeals	1QFY07	2QFY07	3QFY07	4QFY07	FYTD
Appeals Received	8	9	13	5	35
Appeals Upheld	8	6	12	4	30

Appeals Overturned	0	3	1	1	5
Processed Timely	8	8	13	5	21

Member Grievance and Appeal Management

MCP recognizes a member's right to file grievances and appeals and to request a State Fair Hearing at any stage of the grievance/appeal process. MCP makes a concerted effort to resolve member grievances and appeals as expeditiously and fairly as possible. Below is data reflecting the volume of member grievances and appeals processed by MCP during FY2007.

Member Grievances	1QFY07	2QFY07	3QFY07	4QFY07	FYTD
Grievances Received	78	87	6	0	171
Grievances Resolved	78	87	0	0	165
Processed Timely	78	87	0	0	165

Member Appeals	1QFY07	2QFY07	3QFY07	4QFY07	FYTD
Appeals Received	7	8	0	0	15
Appeals Upheld	6	6	0	0	12
Appeals Overturned	1	2	0	0	3
Processed Timely	7	8	0	0	15

Confidentiality

MCP complies with applicable federal and state regulations related to protecting the privacy of health information. Employees maintain confidentiality by securing member information in the work area, properly destroying reports and documents containing member information, and using discretion when discussing member information to avoid improper disclosure. Employees are required to sign a Non-Disclosure Agreement.

Harmony

- *Provider Complaint, Grievance and Appeal Management*
  - Referrals/Utilization
  - Claims
- *Member Grievance and Appeal Management*
  - Benefits
  - Dis-enrollment
  - Dental
  - PCP Changes
- *Confidentiality*
  - Provider Manuals
  - Member Manuals
  - Newsletter Reminders
  - Provider Offices

Note: Harmony also submitted in this section their Missouri Member Handbook and their Missouri Provider Manual. These documents are available for review upon request.

Missouri Care

Provider Complaint, Grievance and Appeals Management
Providers receive information packets at the time of contracting with Missouri Care. The packets contain the complaint, grievance and appeals 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 2006, 1,805 provider complaints, grievances and appeals were filed with Missouri Care. Of these, 550 were medical, 165 were behavioral health and 1090 were non-medical (claim issues and timely filing). The providers filed 1540 complaints, 227 grievances and 38 appeals. All complaints, grievances, and appeals are reviewed. In 2006, Missouri Care upheld approximately 71% of its original decisions.

Member Grievance and Appeals 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. 25 appeals and 45 grievances were received from members during 2006. All issues have been resolved. The plan's original decision was upheld in approximately 59% of the cases.

Confidentiality
Missouri Care has written policies and procedures for maintaining the confidentiality of data, including medical records, member information and appointment records for adult and adolescent STDs and adolescent family planning services.

The Missouri Care Notice of Privacy Practices provides a formal written description of how the plan may use and disclose protected health information (PHI). The notice explains members' rights to access, change, restrict or receive an accounting of disclosures of PHI. Missouri Care makes the Notice of Privacy Practice available to members in accordance with HIPAA distribution requirements. Additional copies are available to members or their representatives upon verbal or written request.

All marketing and educational materials maintain members' rights to confidentiality. Postcards are folded to protect the confidentiality of the members.

Blue Advantage Plus

Provider Complaint, Grievance and Appeal Management
Provider Complaints, 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 Provider Complaints, Grievances and Appeals, in accordance with the State of Missouri contract. Quarterly reports and annual analysis are submitted to the State. The results are presented to the BA+ Oversight Committee.

Provider Complaints, Grievances, and Appeals
   a. During FY2007, there were 293 provider complaints.
   b. During FY2007, there were 44 provider grievances.
   c. During FY2007, there were 17 provider appeals.

Member Grievance and Appeal Management
Member Grievances and Appeals are processed 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, in accordance with the State of Missouri contract. Quarterly reports and annual analysis are submitted to the State. The results are presented to the BA+ Oversight Committee.

Member Grievances and Appeals
   a. During FY2007, there were 91 member grievances.
   b. During FY2007, there were 101 member appeals.

PERFORMANCE MEASURES/ANALYSIS
Performance measures used to track Provider Complaints, Grievances, and Appeals and Member Grievances and Appeals are:

a. The timeframe for resolution of member grievances is 30 calendar days. The timeframe for resolution of member appeals is 45 calendar days.

        1. Goal is 95% compliance

2. In FY2007, member grievances were 92% compliant and member appeals were 88% compliant.

b. 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).

2. In FY2007, provider complaints were 77% compliant, provider grievances were 98% complaint, and provider appeals were 100% compliant.

Confidentiality
Protection of confidential information has always been of the highest priority at BCBSKC. BCBSKC educates employees and requires each employee sign a confidentiality agreement at the time of employment and annually. The agreement states that employees have read and accept accountability for adhering to the Standards set forth in the Code of Business Conduct and Corporate Policy and Procedures regarding conflicts of interest and confidentiality, including Corporate Policy and Procedure I-4 Conflict of Interest, Corporate Policy and Procedure I-19 Privacy of Member Information, Corporate Policy and Procedure I-20 Confidentiality of Business Information (non-PHI), and related policies, and understand and agree that any violation of these Standards can lead to disciplinary action up to and including termination for cause where appropriate. Copies of the signed documents and monitoring for compliance are retained in the Human Relations Department.

Another part of confidentiality is making sure the information that is retained or transmitted is protected and secure. In 2005, BCBSKC implemented provisions of the HIPAA Security Rule. BCBSKC continues to maintain compliancy with these rules through our Corporate Privacy and Security Office functions including among other efforts, training on HIPAA accountabilities, monitoring of privacy and security practices, reviewing and updating existing procedures and responding to member's rights for requests and authorizations.

Children's Mercy Family Health Partners

Provider Complaint, Grievance and Appeal Management
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. One issue emerged as significant and high volume in the reporting period July 1, 2006 through June 30, 2007: Claims Administrative Denials for cosmetic claims related to treatment of viral warts and minor skin lesions. To address these findings and assess the number of appeals received relating to cosmetic denial appeals, CMFHP identified the following issues:

- Claims denials for cosmetic services, a non-covered benefit, generated two hundred-sixty (260) provider complaints, grievances and appeals related to viral warts and minor skin lesions; One hundred ninety-six (196) complaints, grievances and appeals were overturned with additional information. This trending of the Provider complaints, grievances and appeals resulted in an internal review of both the medical issue as well as the processing of these types of claims.

To address these findings, CMFHP implemented the following:

- Health Services Review Committee reviewed diagnosis and procedure codes, recommended changes to the adjudication process to pay for services and treatment of viral warts and minor skin lesions. Claims implemented the change to the adjudication process in second quarter 2007. Implementation of this process change has decreased provider appeals.

Children's Mercy Family Health Partners continues to monitor the effectiveness of complaint, grievance and appeal activities and works to identify additional initiatives that will result in furthering the improvement trends.

Member Grievance and Appeal Management
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 the reporting period July 1, 2006 through June 30, 2007, two issues emerged as high volume: member grievances for transportation and services identified as cosmetic, which are not a covered benefit.

To address these findings and decrease the number of appeals received relating to transportation and cosmetic denial appeals, Children's Mercy Family Health Partners identified the following interventions:

- Tracking and trending the review of grievances regarding transportation: Resulted in a total of 147 members reporting transportation grievances.

- CMFHP identified seven (7) member appeals for denied claims related to viral warts; five (5) appeals were overturned with additional information. This trending in conjunction with the tracking and trending of the Provider complaints, grievances and appeals resulted in an internal review of both the medical issue as well as the processing of these types of claims. An adjudication process change for diagnosis and procedures related to viral warts and minor skin lesions was initiated in second quarter 2007.

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.

- The tracking and trending of the member grievances, reporting to and oversight of the Transportation Subcontractor Quarterly meetings resulted in a subcontractor change. The current transportation provider has provided increased responsiveness and preliminary results show decreased grievances.

- Tracking and trending of member appeals: identified increased member appeals related to treatment of viral warts and minor skin lesions. Health Services Review Committee reviewed diagnosis and procedure codes, recommended and implemented changes to the adjudication process to pay for services and treatment of these lesions. This change has decreased 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.

Confidentiality
At the time of employment, Children's Mercy Family Health Partners employees are required to sign a Confidentiality Agreement. These agreements are maintained in the employee's Human Resource file. The Confidentiality Agreement, in conjunction with the Code of Conduct, provides the employee with guidelines which represent the corporation's commitment to ethical behavior and actions, including the employee's responsibility to ensure confidentiality of member, provider and plan information.

Children's Mercy Family Health Partners successfully implemented HIPAA prior to April 14, 2003. All employees attended the initial mandatory HIPAA privacy and security training and are required to attend or complete the annual training online. Each employee also received education and training on privacy and security of data during their new employee orientation.

The Compliance Officer provides articles for the employee newsletter, In the Know, on a regular basis regarding privacy and security related issues. In addition, employees have access to the Hospital's Compliance department newsletter on the Hospital Intranet which hosts additional resources and information regarding privacy and security.

Utilization Management

Utilization Management

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Utilization Improvement Program Scope
The Concurrent Review staff are charged with the consistent application of nationally recognized and/or community physician developed decision support tools/protocols, timely and appropriate discharge planning, and coordination of alternative care arrangements for acute admission and/or observation stays, and arranging referrals to complex case management or disease management when appropriate.

The staff review each hospital admission using nationally recognized InterQual criteria and/or community physician developed decision support tools/protocols. Staff are responsible for ensuring consistency of services/procedures with guideline application; timely and appropriate discharge planning; coordination of alternative care; and arranging referrals to case management, complex case management or disease management when appropriate.

Discharges Per Year
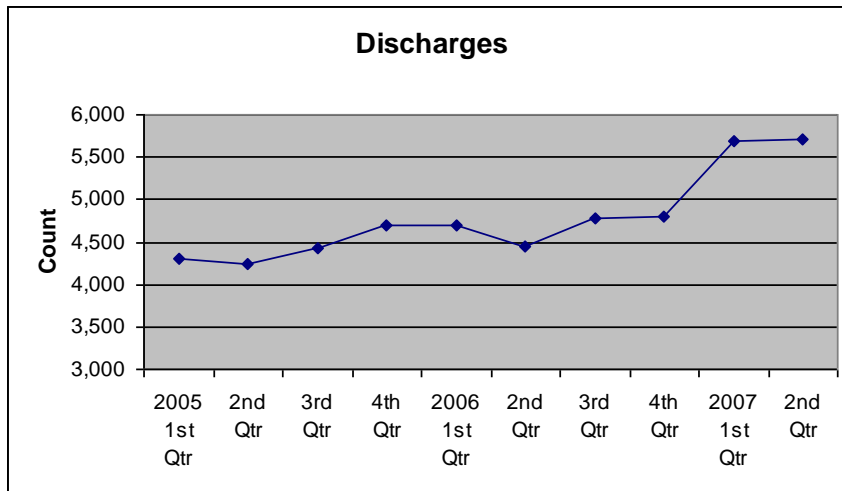
Source: Claims paid through October 2007

The rate of discharges has stayed consistent with the rate of admits to an inpatient facility as outlined below. The increase in discharges in 1st quarter 2007 was due to the acquisition of the FirstGuard membership.

Inpatient Visits
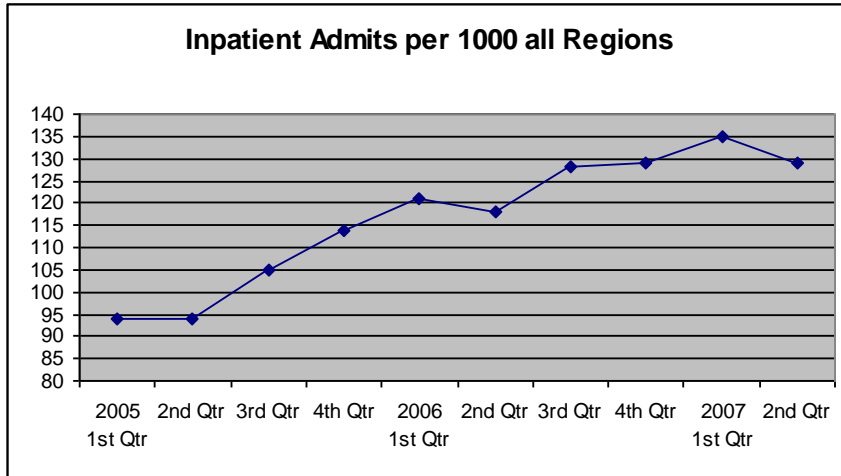
Inpatient Admits per 1000 all Regions

Source: Claims paid through October 2007

Inpatient Admits per 1000 by Region
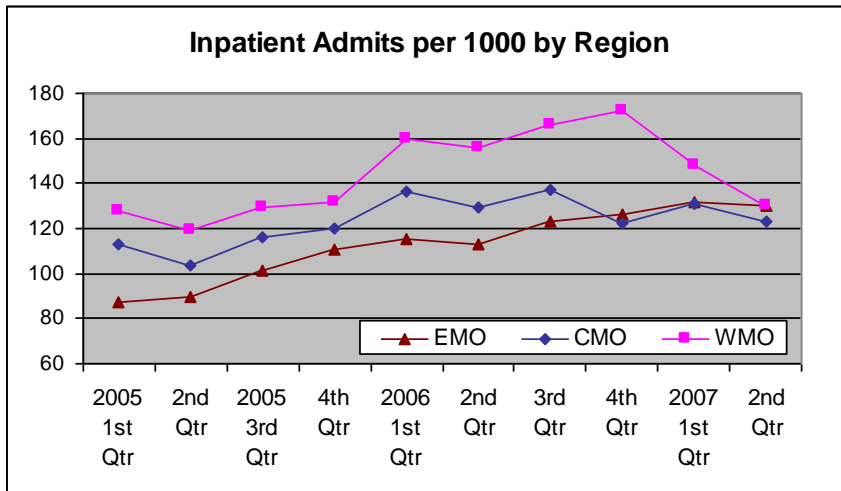
Source: Claims paid through October 2007

Inpatient admits per 1000 has had a steady increase since 2005, correlating to the State Medicaid cuts. As the healthier/working poor population of MO HealthNet members was removed from the MO HealthNet rolls, the rate of admits per 1000 increased.

Average Length of Stay

Average Length of Stay all Regions

Source: Claims paid through October 2007
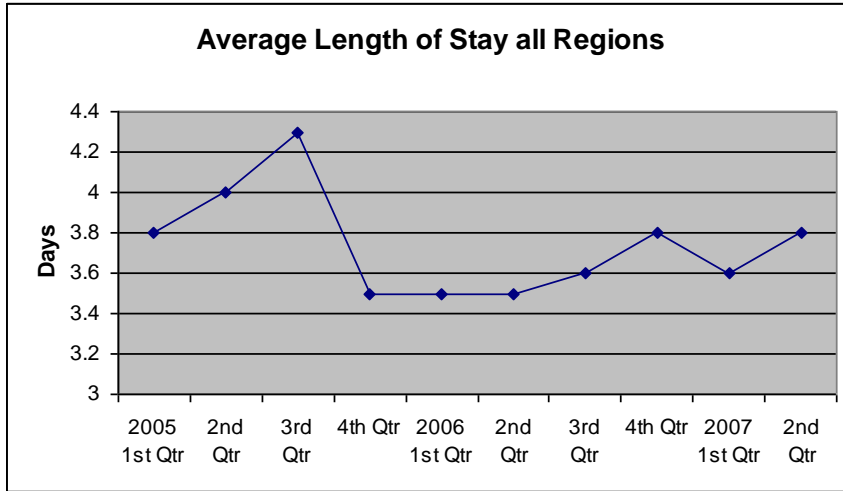
Average Length of Stay by Region
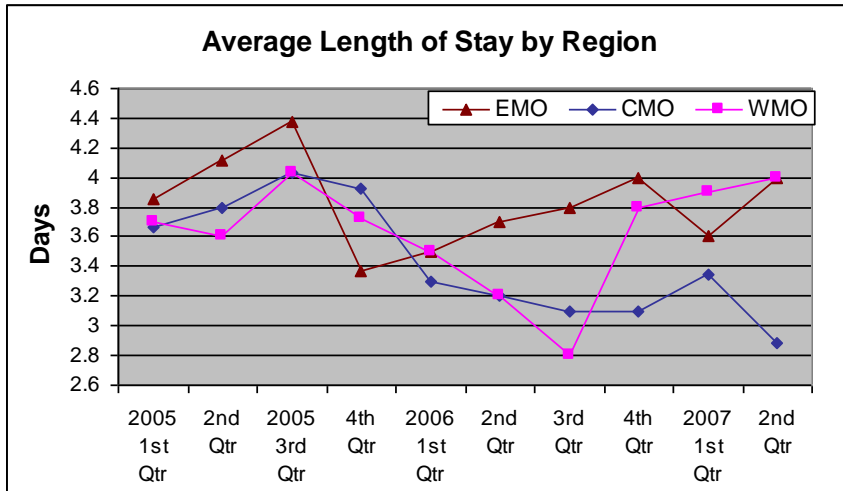
Source: Claims paid through October 2007

The average length of stay overall has shown a downward trend since 2005. However, a regional variance occurred in which there was in increase in WMO average length of stay but a decline in EMO and CMO.
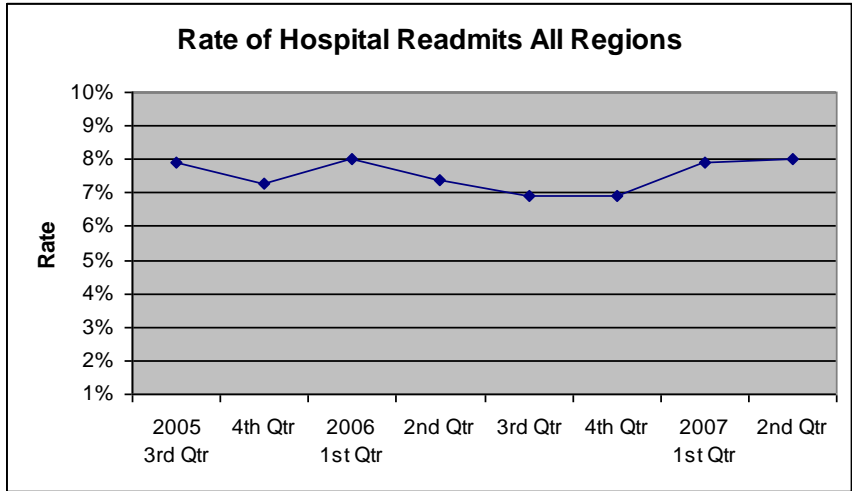
3

Re-Admissions

Rate of Hospital Readmits All Regions

Source: Claims paid through October 2007

Rate of Hospital Readmits by Region
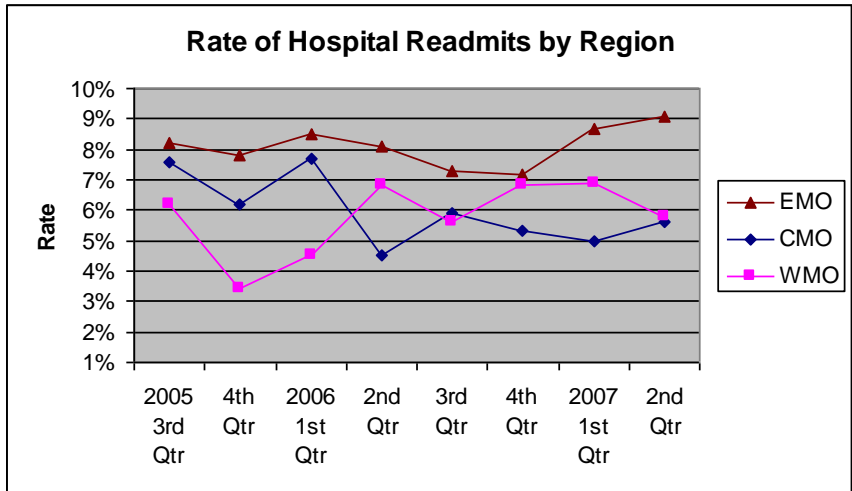
Source: Claims paid through October 2007

HealthCare USA has been tracking member readmissions within 90 days as part of the Quality Improvement program. Although the overall readmit rate has remained steady over the last several years, an opportunity still exists to reduce avoidable readmissions. HealthCare USA is in the process of developing a performance improvement project to address avoidable readmissions.

Emergency Department Utilization
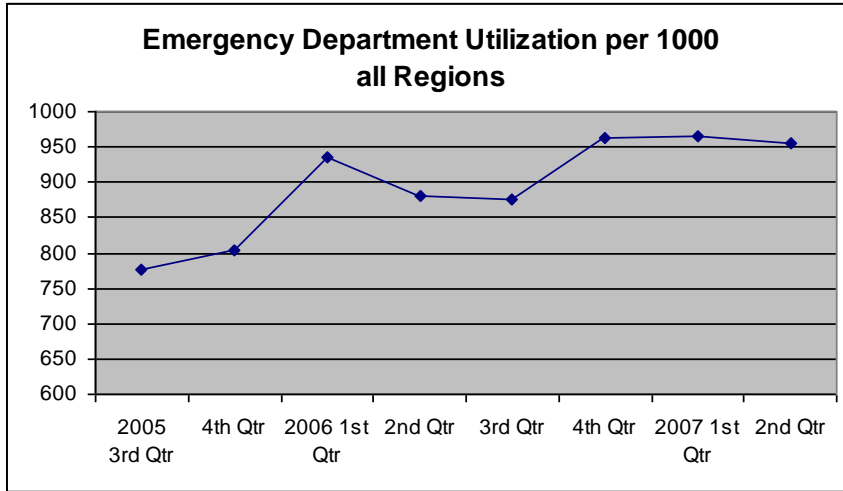
Emergency Department Utilization per 1000 all Regions

Source: Claims paid through October 2007

Emergency Department Utilization per 1000 by Region
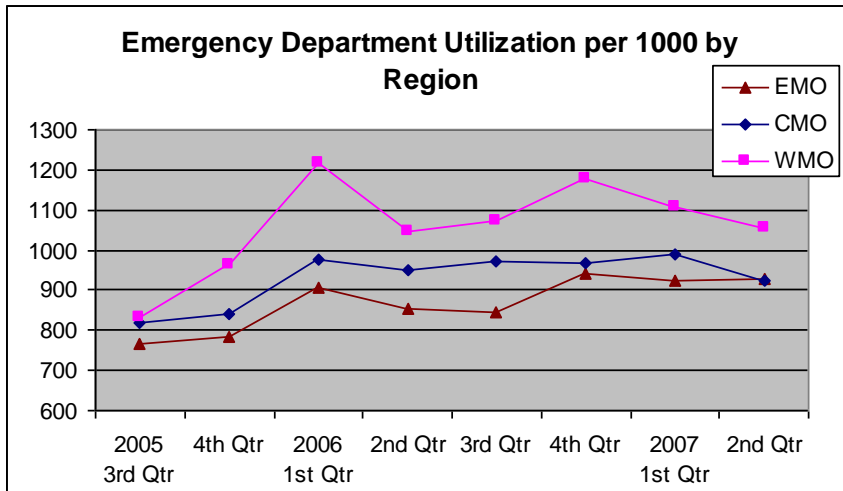
Source: Claims paid through October 2007

HealthCare USA recognizes a continued increase in ED utilization. A clinical performance improvement project has been underway and this can be found under the heading Performance Improvement Projects – Clinical, following this section.

Outpatient Visits
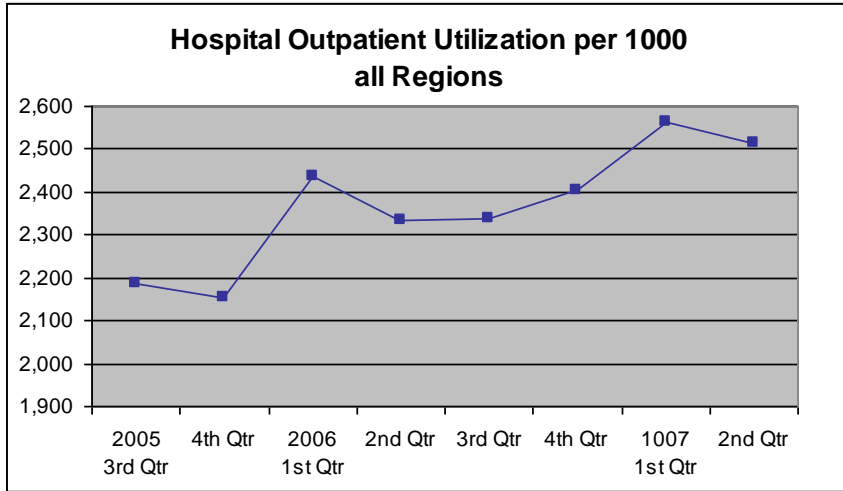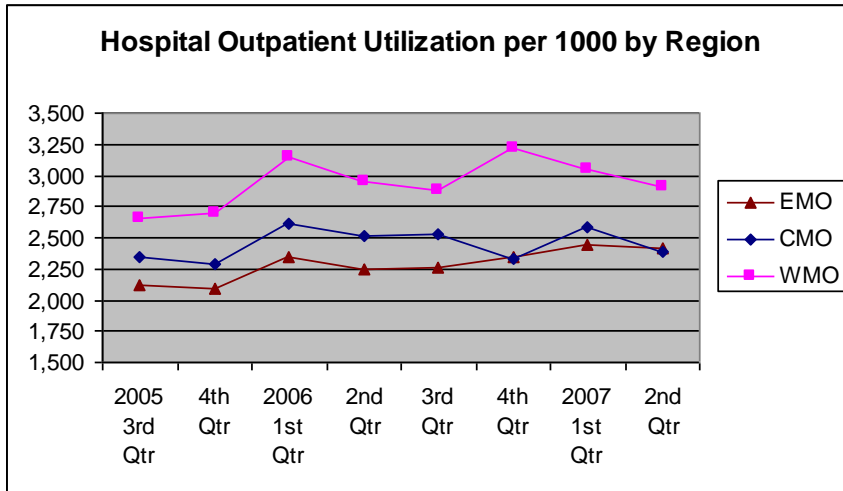
Hospital Outpatient Utilization per 1000 all Regions

Source: Claims paid through October 2007

Hospital Outpatient Utilization per 1000 by Region

Source: Claims paid through October 2007

Hospital outpatient utilization per 1000 has shown a increase overall and in each region. This is expected to be due to the Missouri Medicaid cuts with the healthier population falling off the rosters.

**Physician Services Utilization per 1000
all Regions**

Source: Claims paid through October 2007
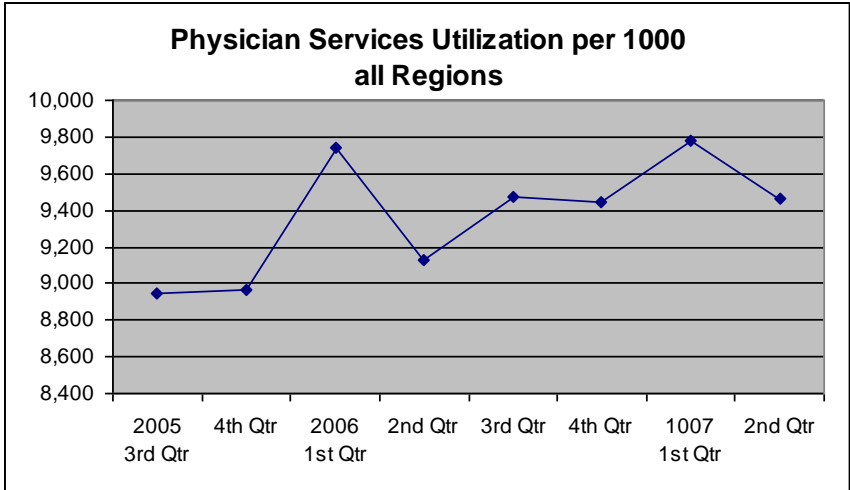
Physician Services Utilization per 1000 by Region
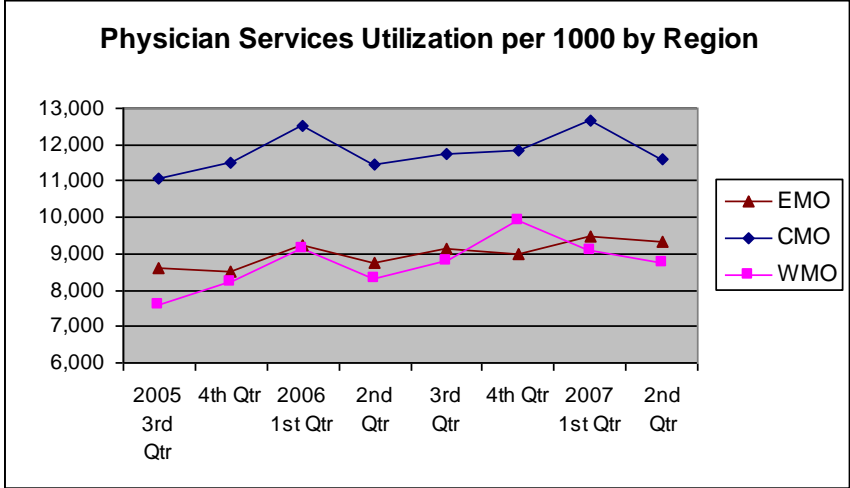
Source: Claims paid through October 2007

Physician services utilization per 1000 has shown a increase overall and in each region. Utilization does seem to by cyclic, with the most occurring in the first quarter of each year. This is expected to be due to the Missouri Medicaid cuts with the healthier population falling off the rosters.

Over/Under Utilization
HealthCare USA conducts continuous monitoring for over and under utilization of services through the analysis of claims and referral data. Many opportunities for improvement have been identified. Areas in which HealthCare USA is currently working on improving over utilization include Emergency Department (ED) Visits and readmissions. As a part of the ED project, pain management and narcotic abuse are being assessed. The Pharmacy has a lock in program for members suspected of or exhibiting drug seeking behaviors or abuse. Areas of improvement for under utilization include EPSDT visits, prenatal and postpartum care, and asthma care.

HealthCare USA has implemented a member incentive for prenatal and postpartum care to improve the rate of utilization. For every five (5) prenatal visits the member attends, they submit

to the QI department proof of their visit and they are sent a $30 gift card for Target. After attending one (1) postpartum visit and submitting proof, they are sent a $15 Target gift card. There has been a good response to the program and HealthCare USA will provide a full analysis after the program completion in January 2008.

There is a performance improvement project or process in place for each area identified as over or under utilization. Performance improvement projects can be found under the heading Performance Improvement Projects – Clinical, following this section.

Inter-Rater Reliability
All physicians and nurses involved in utilization of services activities received InterQual training and participate in routine inter-rater reliability audits. The purpose of Medical Director and nursing peer to peer audits is to improve knowledge of newer/less experienced staff and improve consistency with determinations made.

All Coventry Medical Directors routinely audit a sample of the Health Plan's medical review determinations to ensure that they are consistent, meet the Plan's policies and procedures, and are in compliance with applicable InterQual criteria or Coventry technical recommendations. The outcomes of the reviews are educational in nature and do not impact the decision previously rendered. During 2006 and 2007 first and second quarter, each Medical Director reviewed 5 cases every six (6) months. Consensus was achieved on all the cases post-test and the applicable InterQual criteria and Technology assessments were reviewed and agreed upon.

The Managers of Health Services conduct audits of health services staff on a monthly basis. Cases are randomly selected for each staff member and reviewed for accuracy, completeness and timeliness of decisions made. Cases are also reviewed to determine if appropriate referrals are made to case managers and/or disease managers.

The quality improvement clinical staff conduct peer to peer documentation and inter-rater reliability audits on disease management cases. A tool was developed to assess these cases and both the disease managers and quality improvement staff conduct theses reviews on a monthly basis and discuss outcomes at least quarterly.

Timeliness of Care Delivery
HealthCare USA utilizes the Member and Physician Reminder System (MPRS) to notify members who are in need of preventive and care management services. The system generates reminders for members who are in need of receiving necessary preventive services or services to improve the care of a specific condition. In addition, the system generates lists for providers of members who are in need of these services so that additional reminders can be sent to members' providers.

The following Preventive and Care Management reminders were sent in 2006 and 2007:
- Childhood immunizations/lead (monthly)
- EPSDT (monthly)
- High risk flu/pneumococcal (annual)
- Childhood flu for ages 6 months- 24 months (annual)
- Asthma (monthly to newly identified members)

- Diabetes (monthly to newly identified members)
- Obesity (quarterly to newly identified members)

HealthCare USA has continued to improve the EPSDT overall participation rate. There has been a steady increase in the EPSDT rate since 2000. This is identified through the participation rates reported by the State agency as well as the decrease in the EPSDT penalty applied to the capitation rate.

Calendar Year	Overall Participation Rate
2000	58.36%
2001	61.66%
2002	69.33%
2003	69.66%
2004	72.50%
2005	65.09%
2006	68.58%

During case reviews, concurrent review staff determine if care provided in the hospital is delivered in a timely manner. They refer cases to the medical director and the QI staff if there is some concern regarding the care being provided. Also, staff begin evaluating for discharge needs at the time of the admission. They make arrangements for any home health or DME needs prior to discharge to facilitate the timely delivery of care after discharge.

Timeliness of Prior Authorization/Certification Decision Making
HealthCare USA thoroughly manages the prior authorization/certification process to guarantee we follow all time restrictions on requests. In all cases, if the determination is not made within the timeframes allowed, automatic approval is given.

For elective requests, the following timeframes are maintained: Approval or denial of non-emergency services when determined as such by emergency room staff is provided by HealthCare USA within thirty (30) minutes of request. Approval or denial is provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider. For requests to extend a current course of urgent care treatment, decisions are issued within twenty-four (24) hours. Approval or denial is provided within two (2) business days of obtaining all necessary information for routine services. In no case will HealthCare USA exceed fourteen (14) calendar days following the receipt of the request for service to provide approval or denial.

For certification review, initial determinations will be provided within two (2) working days of obtaining all necessary information. Concurrent review determinations are provided within one (1) working day of obtaining all necessary information. When additional information is needed, the provider is notified within two (2) business days following the receipt of the request. All requests for services are answered within fourteen (14) calendar days of the receipt of the request for initial or concurrent review determinations.

UM Decision Making Timeframes Within 2 Days and 14 Days
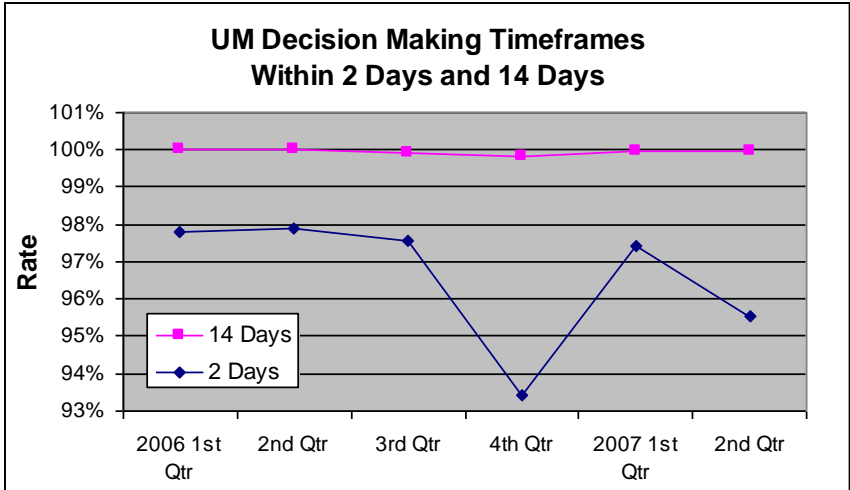
Source: IDX referral system

HealthCare USA continued efforts in educating providers and facilities on the benefits of submitting authorization requests via WebMD. The number of online submissions has slowly increased since 2005 due to this intervention and has been instrumental in reducing call volume for the preauthorization department. This project not only reduced call volume, but also improved calls abandoned and service quality.
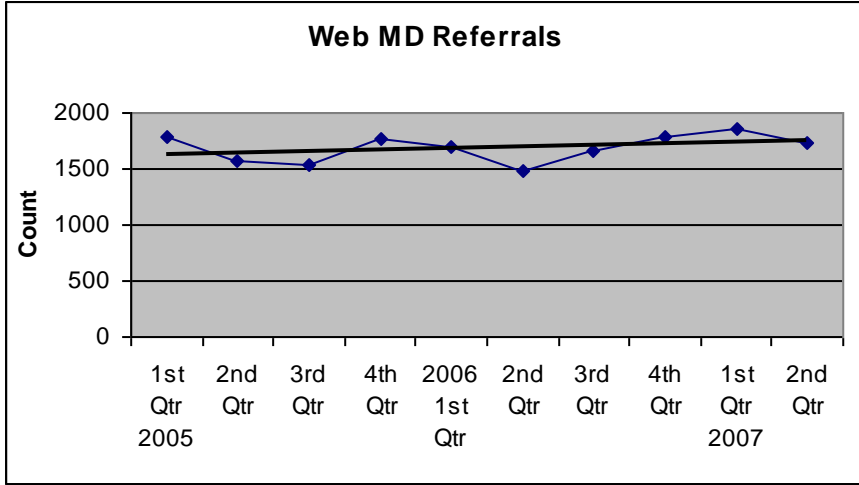
Web MD Referrals

Source: WebMD referral system

Mercy CarePlus

Utilization Improvement Program Scope

The Medical Management Departments is organized into five units which report to the Chief Medical Officer. The Preauthorization unit is responsible for prospective review of inpatient, ambulatory medical and pharmacy services to ensure that members receive the most medically appropriate services with a quality provider at the appropriate level of care. The Utilization Review Unit performs concurrent review, retrospective review and discharge planning. The Case Management/Disease Management Unit includes OB Case Managers who are responsible

for education of pregnant members, management of high-risk obstetrical patients, outpatient management and monitoring for women in preterm labor. The Case management coordinators work in conjunction with the case managers to review requests for durable medical equipment, therapies, Synagis and assist with authorizations. The special needs case managers are responsible for the evaluation and management of complicated medical cases, high-risk social situations and those members with unique medical needs. In the Pharmacy Division, the Chief Pharmacist, works closely with the Medical Director to manage the State-approved formulary and oversee the Preauthorization process for medications. In the Quality department, the QI Manager providers oversight of HEDIS and EQRO, and assesses quality of care issues including fraud and abuse. The quality department facilitates the development of Performance Improvement Projects ("PIP").

Discharges Per **Year**
MCP does not have the ability to track this data at this time.

Inpatient Visits

Inpatient Days/1000 Members	2006	2007
	391.6	375.6

Average Length of Stay
The total Average Length of Stay met MCP's goal of <3.8 as reflected in the data provided below.

ALOS	1QFY07	2QFY07	3QFY07	4QFY07
Medical/Surgical	3.1	3.3	3.5	3.6
Obstetrics	2.7	2.6	3.1	2.8
Newborn	8.9	7.9	7.5	5.0
Total	3.5	3.4	3.6	3.0

Re-Admissions
MCP does not have the ability to track this data at this time.

Emergency Department Utilization

ER Visits/1000 Members	1QFY07	2QFY07	3QFY07	4QFY07
	16,468	16,496	18,351	17,285

Outpatient Visits
MCP does not have the ability to track this data at this time.

Over/Under Utilization
MCP does not have the ability to track this data at this time.

Inter-Rater Reliability
MCP is considering conducting inter-rater reliability beginning in 2008.

Timeliness of Care Delivery
MCP does not have the ability to track this data at this time.

Timeliness of Prior Authorization/Certification Decision Making
MCP does not have the ability to track this data at this time.

Harmony

Utilization Improvement Program Scope
  (UM Work Plan Attached)

Discharges Per Year
  ● **Discharges/1000 per year @ 224**
      ● **Med Surg @ 59.5**
      ● **Observations@ 71.3**
      ● **Births @ 82.1**
      ● **NICU @ 9.5**
      ● **Rehab @ 1.1**
      ●
Inpatient Visits
  ● **Inpatient visits/1000 per year @ 199.9**
      ● **Med Surg @ 9.23**
      ● **Observations@ 1.63**
      ● **Births @ 12.11**
      ●
Average Length of Stay
  ● **Average length of stay @ 3.0**
      ● **Med Surg @ 4.0**
      ● **Observations@ 1.0**
      ● **Births @ 2.9**
      ● **NICU @ 9.9**
      ● **Rehab @ 28.0**

Re-Admissions
  ● **Readmissions/1000 per year @ 7.5%**

Emergency Department Utilization
  ● **Emergency dept utilization/1000 per year @ 56.29**

Outpatient Visits
  ● **Outpatient visits/1000 per year @ 138.62**

Over/Under Utilization
  ● **Over Utilization**

- **Emergency Department**
- **Under Utilization**
  - **HEDIS Performance Measures**

Inter-Rater Reliability
- **Inter-Rater reliability**
  - **Quarterly with scores greater than 90**
  - **Ongoing Associate education**

Timeliness of Care Delivery
Timeliness of Prior Authorization/Certification Decision Making
- **Timeliness of Care, authorization & certification decisions**
  - **Per Access & Availability Standards**
  - **Urgent/Emergent authorizations soft transferred to appropriate Associates**
  - **Certification decisions within 2 working days**

Utilization Management – Trending Inpatient

Authorization Trend Report (Excluding M3K and Advocate)
Missouri
Medicaid

	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	YTD	Trend (3/3)
Members (000)	0.0	2.0	2.0	3.0	3.0	4.0	4.0	4.0	5.0	5.0	5.0	6.0	6.0	7.0	7.0	46.0	391.4%
Days/1000	/0	282	654	745	631	734	629	1,239	713	662	560	667	581	613	517	673	14.1%
Med Surg	/0	61	291	419	216	247	237	621	323	176	124	232	165	173	207	238	-5.9%
Observations	/0	67	82	97	66	81	43	109	60	81	73	65	70	55	65	71	-17.0%
Births	/0	155	281	229	289	299	338	285	266	192	266	224	236	290	174	239	1.7%
BH	/0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	/0
NICU	/0	0	0	0	59	107	11	224	65	18	40	146	110	94	64	93	/0
Rehab	/0	0	0	0	0	0	0	0	0	194	58	0	0	0	0	29	/0
SNF	/0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	/0
Admits/1000	/0	141.2	245.3	258.1	226.6	285.8	214.6	314.3	249.5	217	208.1	200.6	234.4	201.4	199.9	224.2	4.3%
Med Surg	/0	26.9	76.7	76.2	69.7	84.4	91.6	95.9	92.2	52	39.9	47.2	58.1	44.6	62	59.5	-1.6%
Observations	/0	67.2	81.8	97.3	66.2	81.2	40.1	109.2	59.7	81.4	70.9	64.9	71.7	55.2	67.2	71.3	-15.4%
Births	/0	47.1	86.9	84.6	80.2	103.9	80.1	82.6	89.5	74.6	90.8	82.6	87.2	96.2	56.9	82.1	13.1%
BH	/0	0	0	0	0	0	0	0	0	0	0	0	0	0	3.4	0.5	/0
NICU	/0	0	0	0	10.5	16.2	2.9	26.6	8.1	2.3	4.4	5.9	17.4	5.3	8.6	9.5	/0
Rehab	/0	0	0	0	0	0	0	0	0	6.8	2.2	0	0	0	0	1.1	/0
SNF	/0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	/0
ALOS	/0	2.0	2.7	2.9	2.8	2.6	2.9	3.9	2.9	3.1	2.7	3.3	2.5	3.0	2.6	3.0	9.5%
Med Surg	/0	2.3	3.8	5.5	3.1	2.9	2.6	6.5	3.5	3.4	3.1	4.9	2.8	3.9	3.3	4.0	-4.5%
Observations	/0	1.0	1.0	1.0	1.0	1.0	1.1	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	-1.9%
Births	/0	3.3	3.2	2.7	3.6	2.9	4.2	3.5	3.0	2.6	2.9	2.7	2.7	3.0	3.1	2.9	-10.0%
BH	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	0.5	0.5	/0
NICU	/0	/0	/0	/0	5.7	6.6	4.0	8.4	8.0	8.0	9.0	24.7	6.3	17.7	7.4	9.9	/0
Rehab	/0	/0	/0	/0	/0	/0	/0	/0	/0	28.7	26.0	/0	/0	/0	/0	28.0	/0
SNF	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0	/0
MID Rate	/0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	4.3%	0.0%	0.0%	0.0%	0.0%	0.5%	0.6%	/0
Cat Rate >= 10 Days	/0	0.0%	25.3%	34.3%	18.0%	26.8%	27.3%	57.1%	25.7%	20.4%	9.7%	45.3%	25.5%	32.9%	25.8%	34.4%	40.2%
Readmit Rate	/0	0.0%	0.0%	1.6%	4.6%	4.5%	4.0%	8.5%	9.8%	4.2%	2.1%	1.0%	12.4%	11.5%	8.6%	7.5%	/0

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9/24/2007

Utilization Management – Inpatient

Age	Discharges	Discharges /1,000 Member Months	Days	Days / 1,000 Member Months	Average Length of Stay
Total Inpatient					
<1	57	7.06	252	31.23	4.42
1 – 9	40	1.44	85	3.05	2.12
10 - 19	129	5.83	419	18.93	3.25
20-44	461	28.88	1,144	71.66	2.48
45-64	5	5.25	13	13.64	2.6
65-74	0	0	0	0	0
75-84	0	0	0	0	0
85+	0	0	0	0	0
Unknown	0	0	0	0	0
Total	692	9.23	1,913	25.52	2.76

Missouri Care

Utilization Improvement Program Scope
Missouri Care's Utilization Management Program was established to integrate systems for managing, monitoring, evaluating, and improving the utilization of care and services members receive. The program was designed to assist members and providers in the appropriate utilization of care/service delivery systems, assess satisfaction with the processes, and discover opportunities to optimize members' health outcomes and manage costs.

The utilization management program is integrated with Missouri Care's Quality Management Program and pursues the plan's common principle of ensuring high quality, cost-effective, outcomes-oriented health care by balancing clinical/medical management, operations and finance components.

The purpose of the Utilization Management Program is to manage the use of health care resources so that members receive the most medically effective and cost effective health care that will improve their health outcomes. Missouri Care believes that integrated utilization processes provide the environment for optimal utilization of care and services by members and health care professionals and providers.

The utilization management program objectives are:

- To maintain systems for identifying member and health care professional/provider utilization and/or practice patterns
- To manage referrals for medical services in order to maintain continuity of care and the effective use of medical resources
- To monitor benefit coverage, medical necessity, appropriateness of services and setting, and compliance with regulatory requirements
- To identify members and/or populations whose care may benefit from case management Interventions
- To maintain integrated systems and processes for collecting utilization data and disseminating information through the health care professional/provider network and regulatory agencies, which may require special reports
- To use disease management practice guidelines to improve outcomes for members and special populations, such as the aged or the developmentally disabled
- To maintain culturally competent practices throughout the plan and its network of health care professionals and providers
- To evaluate provider/member satisfaction with the utilization process and develop strategies for improvement
- To work with health care professionals, providers, members, their families and caregivers to reduce inappropriate readmissions to hospitals, use of emergency departments or prescription medications and/or health care resources
- To develop utilization benchmarks, initiatives and target outcomes that reflect the plan's strategic expectations, directions, and goals and comply with federal, state, and local regulations and requirements
- To identify patterns of individual or systemic over- and underutilization and develop ways to address them
- To maximize the utilization of appropriate resources to improve a member's outcome or control a condition

The Missouri Care Utilization Management Plan applies to:

- All members enrolled in Missouri Care
- All covered services provided to members through contracted or non-contracted health care professionals and providers
- All contracted or non-contracted health care professionals and providers who deliver care or services to members
- All sites and facilities in-state and out-of-state (including ancillary providers) at which contracted and/or non-contracted health care professionals provide care or services to members
- All processes, activities, components, and information sources used to manage and/or make determinations for benefit coverage and medical appropriateness, including:
  - o Utilization management processes and functions: prior authorization, concurrent review, case management, disease management, medical claims review, referral management, discharge management
  - o Utilization monitoring processes (e.g., HEDIS, or others required by state regulatory or review agencies, or the plan; drug utilization reviews; physician profiles)

    o Performance monitoring processes (e.g., inter-rater reliability, telephone answer time, abandonment rates, productivity)
    o Evaluations of outcomes data

The Missouri Care operating board has final accountability for the Utilization Management Program and related processes, activities and systems. The operating board delegates authority to the chief executive officer (CEO) for allocating financial and employee resources to carry out the program. The CEO delegates authority and accountability for implementing and maintaining the Utilization Management Program to the CMO. This includes implementing and overseeing systems and processes to manage, monitor and evaluate the utilization of services members receive through the health delivery network, carrying out work-plan activities, and participating in utilization activities and processes such as, prior authorization reviews, concurrent reviews, case management and retrospective medical claims reviews.

The Manager of Medical Management, under the direction of the CMO, supervises utilization departments and functional areas (Prior Authorization, Utilization Review, Case Management) and is responsible for day-to-day program operations and activities.

The objectives, scope, organization and effectiveness of the Utilization Management Program are evaluated and approved annually by the MQM Committee and the governing board. The annual Utilization Management Program evaluation is submitted to applicable regulatory bodies for approval.

Discharges Per Year
Discharge planning is an important utilization management tool for maintaining continuity of care and preventing readmissions. Concurrent review nurses are responsible for identifying a member's discharge needs during admission/continued stay reviews and assisting hospital staff to make sure that postdischarge care is available and that the member's discharge plan is implemented.

Missouri Care's nurses assist facilities in meeting discharge planning requirements (e.g., by prior authorization of transfers to a lower level of care, coordinating referrals to ancillary services or to case management).

Concurrent review nurses work collaboratively with hospital discharge planning staff, members or their caregivers, and physicians to help coordinate the hospital's discharge planning efforts. The team approach results in better continuity of care in the safest and most cost-effective setting and allows hospital and plan personnel to attend more closely to special social, economic, cultural, and language needs that will reinforce improved outcomes for the member.

The following metrics are tracked to identify potential areas of over- or underutilization of inpatient services:
- Admissions per 1000 members
- Bed days per 1000 members
- Length of stay data

- Member outcomes (readmissions, discharge plan evaluations)
- Quality, utilization, risk management indicators

Inpatient Visits

Average Inpatient Days per Thousand	2006	2005
Maternity	157	129
Newborn	129	101
NICU	83	83
Hi Risk OB	29	18
Med/Surg/ICU	138	151

The increase in Maternity & Newborn Inpatient Days reflect the increased number of members enrolled in the MC+ for Pregnant Women program with Missouri Care in 2006.

Mental Health Inpatient Utilization

Inpatient Utilization	2006	2005
Inpatient Days per thousand	23.27	19.16
Inpatient discharges per thousand	5.74	7.06
Average length of stay	6.77	6.42

Average Length of Stay
  2005   Reporting period July 1, 2005 - June 30, 2006
  2006   Reporting period July 1, 2006 – June 30, 2007

	2006	2005
Average Length of Stay (ALOS)	2.8	3.0
Admits per Thousand	205	179
Bed Days per Thousand	581	534

* ALOS in 2006 decreased, although Admits and Bed Days per Thousand increased.

Average Length of Stay	2006	2005
Maternity	2.3	2.3
Newborn	2.0	2.0
NICU	12.6	11.2
High Risk OB	5.6	4.0
Med/Surg/ICU	2.7	3.0

*The increase in ALOS of NICU and High Risk OB may be attributed to the increased number of deliveries and newborns in 2006

Re-Admissions
Missouri Care works with health care professionals, providers, members, their families and care givers to reduce inappropriate readmissions to hospitals, use of emergency departments or prescription medications and/or health care resources. Missouri Care reports and researches all inpatient readmissions within 30 days of the last admission. Readmission rate for this reporting period was 4.42%, the goal is less than 10% of inpatient admissions are readmissions within 30 days.

Emergency Department Utilization
Missouri Care understands that members with a medical home are less likely to suffer a costly illness and go to the emergency department for care. When members have a medical home they have an improved quality of care and better outcomes. Missouri Care recognizes members have the right to access emergency health care services when and where the need arises, although many ED visits may be prevented with timely access to primary care.

Missouri Care conducted an analysis of ED utilization to explore the factors that may have contributed to the increase from 852 ED paid visits/1000 in 2005 to 918/1000 in 2006.The analysis is based on ED claims data by:
- Region
- Provider/PCP
- Age
- Diagnosis
- High Utilizers
- Pharmacy claims
- PCP Visits

Findings included:
- Geographically, visits were higher in rural areas
- Small number of high utilizers represent largest percentage of ED utilization
- Adults are the highest ED utilizers
- High utilizers tend to be narcotic seeking and substance abusers
- Rural hospitals have a disproportionate share of ED visits
- Identified high utilizers in need of case management

Past initiatives implemented to redirect members to appropriate primary care settings rather than ED for ambulatory care include:
- Monthly identification and tracking of members with high ED utilization by target report
- Monitor of pharmacy utilization for narcotic seekers; restrict members by pharmacy lockin
- Generate member profile of high utilizing members for PCP
- Generate educational materials to high utilizing members
- Monthly telephone monitoring of high utilizing members
- Conduct member assessment to determine reason for ED utilization (transportation, appointments, no PCP)
- Interface with the PCP

• Integrate members into physical/behavioral health case management

Missouri Care's analysis showed that hospital EDs continue to play a role in providing primary care to Missouri Care members. Whether this is due to factors such as hours of operation of clinics and PCP offices and/or personal choice of a hospital ED over other outpatient alternatives is not easily determined.

Missouri Care recognizes that quality of care, especially the benefits that come from continuity of care to the member by a regular medical provider may suffer when members seek health care in an ED. Missouri Care's current initiatives to address ED utilization include:
• Members with 10 or more ED visits in a year will be encouraged to have regularly scheduled appointments with their PCP
• Members in top 1% with less than 10 visits annually will be evaluated for case management
• Members seeking care with non-par facility EDs will be contacted by Member Solutions
• Members with two or more non-urgent ED visits within six months will receive a letter with educational mailing on appropriate ED usage
• Members with three or more non-urgent ED visits within six months will receive a phone call in addition to the mailing

Outpatient Visits
The prior authorization process allows Missouri Care to monitor certain outpatient referrals, services, and procedures as well as non-emergency/elective hospitalizations before the member receives the service or referral. As the initial step in obtaining medical services, the function is used to confirm that:
• The service is a covered benefit for the member, is appropriate and provided timely and costeffectively
• The setting and level of care are appropriate
• Necessary services are coordinated with other Medical Management functions (e.g., , Case Management, Disease Management) and information is communicated to applicable operations areas (e.g., Finance)

Missouri Care's outpatient utilization for this reporting period of July 1, 2006 to June 30, 2007 was 80,878 visits.

Verification of these elements before the service provided allows for timely and accurate reimbursement for health care professional and provider services.

Decisions to require prior authorization for certain services are based on data, such as utilization data that identifies services that are likely to be overutilized or costly; that indicate high-volume use; that show physician utilization trends and referrals; or that may potentially signal conditions (e.g., diabetes) that might require extensive clinical or case management intervention. Missouri Care prior authorization requirements are communicated to health care professionals and providers in the provider manual, on the plan Web site available to the network, in provider

newsletter articles, and in health professional and provider contracts. They are also available to network health professionals and providers upon request.

The Prior Authorization and Utilization Review unit is principally responsible for day-to-day prior authorization operations. Requests are evaluated and documented by licensed nurses. The function is available 24 hours a day, seven days a week and maintains a toll-free telephone number for health professionals and providers.

Prior authorization responsibilities by the nurses include: documenting requests, researching the member's files to confirm the member's enrollment and coverage of the service, determine the health professional or provider's network affiliation, identify potential coordination of benefits issues, determining whether the service and setting requested are consistent with Missouri Care's criteria for coverage, and coordinating a higher level review of the request if applicable.

Certain services may be authorized by a licensed nurse if the request is supported by approved review criteria. However, any request that does not clearly meet criteria for coverage as well as any potential denial must be reviewed by the Missouri Care chief medical officer. Only the chief medical officer may decide to deny authorization based on clinical criteria or benefit coverage. If a decision requires specialized judgment, Missouri Care maintains a list of specialist physicians available to participate in utilization reviews.

Prior authorization coverage decisions are based on nationally recognized, evidence-based criteria, when available, and are applied on the basis of individual member needs and community requirements. Criteria developed locally by practicing health professionals may be used for decisions on conditions or diagnoses not addressed by the established criteria if applicable state approval requirements are met.

Over/Under Utilization
The Utilization Review and Quality Management Units work in collaboration to develop a tool for screening and reviewing medical documents to identify potential sentinel events as well as quality, utilization, safety, or risk issues in the care or services delivered to members. Indicators for identifying potential over- and underutilization (including target and performance indicators) are developed by the Medical Management Department. Missouri Care has provided the following examples of overutilization: readmission to a psychiatric or acute facility and unplanned transfers or return to higher level of care. Indicators are reviewed and approved by the MQM Committee prior to being used. Potential issues identified during the review of medical documents (during prior authorization, concurrent, retrospective or case management reviews) or through other departments or activities are forwarded to the applicable department manager or designee for investigation and review with the CMO or designee. Potential issues are referred to the MQM Committee for evaluation and recommendation for applicable follow-up action.

Summary of Sentinel Events/Quality of Care Issues for the reporting period of July 1, 2006 to June 30, 2007

Diagnosis issue (missed, untimely or incorrect)	2
FDIU (Fetal Demise Intra-uterine > 20 weeks or > 350 grams	20
Post Op Infection	1
Readmission to a psychiatric facility within 30 days	14
Readmission to an acute facility within 10 days with same diagnosis	30
Unexpected Mortality	8
Unplanned transfer or return to higher level of care (OR/ICU/CCU/NICU/PICU)	9
Total Sentinel/Quality of Care Issues	90

The manager of medical management identifies sentinel and quality of care issues to improve the quality of care available to members. Issues are tracked in order to identify potential provider or facility trends. Further action may include additional research and review by the CMO and, if directed by the CMO, review by the MQM Committee.

Inter-Rater Reliability
Missouri Care uses Milliman Care Guidelines for utilization support in making inpatient admission, concurrent review and prior authorization decisions. Missouri Care conducts inter-rater reliability (IRR) assessments annually to evaluate the consistency of decision making and application of criteria in the prior authorization and concurrent review process. Nurses and physicians involved in the prior authorization and concurrent review process are subject to inter-rater reliability assessment. Missouri Care's goal is each participant in the IRR assessment will obtain a score of 85% or higher on the IRR. In 2006, the overall Missouri Care score was 97%. All areas exceeded the goal of 85%.

Timeliness of Care Delivery
Timeliness of Prior Authorization/Certification Decision Making
Missouri Care adheres to the regulatory requirements for the prior authorization of services. The prior authorization process allows Missouri Care to monitor certain outpatient referrals, services and procedures, as well as non-emergency/elective hospitalizations, before the member receives the service or referral.

The Prior Authorization and Utilization Review Unit is principally responsible for day-to-day prior authorization operations. Requests are evaluated and documented by licensed nurses. The function is available 24 hours a day, seven days a week and maintains a toll-free telephone number for health professionals and providers.

Prior authorization decisions are made and the health care professional, provider and/or members are notified of decisions within the following time frames:
  • Approval or denial of non-emergency services when determined as such by emergency room staff shall be provided by the health plan within thirty (30) minutes of request.

- Approval or denial shall be provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.

- Approval or denial shall be provided within two (2) business days of obtaining all necessary information for routine services. Missouri Care shall notify the requesting provider within two (2) business days following the receipt of the request for service regarding any additional information necessary to make a determination. In no case shall Missouri Care exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial.

- Involuntary detentions (96 hour detentions or court ordered detentions) or commitments shall not be prior authorized.

Missouri Care monitors prior authorization processes for:
- Timeliness of decisions and notifications to health care professionals and members
- Process performance; telephone abandonment rate, average answer time, timeliness and accuracy of data entry
- Number of authorization requests approved
- Number of authorization requests denied

Concurrent Review

The concurrent review function provides a way to evaluate admissions while a member is hospitalized. Admissions are reviewed for medical necessity and continuing services are reviewed for the appropriate use of inpatient medical resources. Concurrent review activities identify occurrences of over- or underutilization and physician practice patterns, identify ways to improve members' inpatient care outcomes and monitor the cost effectiveness of the services.

Missouri Care conducts on-site review at the University Missouri Health Center and Columbia Regional Hospital based on high-volume utilization. Daily telephonic reviews are conducted at all other facilities. Services subject to concurrent review are those provided in acute and rehabilitation facilities. Concurrent review nurses working under the direction of the CMO conduct initial reviews of members' admissions within 24 hours of the admission. The concurrent nurses use nationally recognized criteria in review of inpatient stays. Missouri Care's medical director and manager of medical management conduct daily reviews of all inpatient stays and make recommendations as indicated.

Missouri Care makes concurrent review decisions and notifies health care professionals, providers and, if applicable, members within the following time frames, unless otherwise required by the state of Missouri:

- Approval or denial for initial determinations shall be provided by Missouri Care within two (2) working days of obtaining all necessary information.
- Approval or denial for concurrent review determinations shall be provided by Missouri Care within one (1) working day of obtaining all necessary information.

- Approval or denial for retrospective review determinations shall be provided by Missouri Care within thirty (30) working days of receiving all necessary information.
- Missouri Care shall notify the requesting provider within two (2) working days following the receipt of the request of service regarding any additional information necessary to make a determination.
- In no case shall Missouri Care exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial for an initial or concurrent review.

The concurrent review process allows for discharge planning, to determine services and resources that may be necessary to effect an appropriate and timely discharge from the facility, including ongoing case management. In 2006/SFY 2007, 708 post-discharge calls were conducted by the concurrent review nurses within 24 hours of the member's discharge from the hospital.

Blue Advantage Plus

Utilization Improvement Program Scope
The Medical Management Program extends across all aspects of the healthcare delivery system, including inpatient services, outpatient services, ancillary services, home services, pharmacy services, new technology assessment, early intervention services, chronic disease management, self-care and prevention programs.

The Medical Management Program includes processes to measure, monitor, and optimize utilization of healthcare services in the above settings at the member and provider level. Management processes used by the Medical Management Department include prospective, concurrent and retrospective review processes, pro-active case and care management and disease management programs. BCBSKC-BA+ has written medical management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, and concurrent, prospective, and retrospective review of claims that comply with federal and state laws and regulations, as amended to comply with MO State contract site 2.17.5b. The Program monitors and manages to achieve optimum utilization and seeks to identify and eliminate both under and over utilization.

The Medical Management Program improves effectiveness by communicating with other areas of the company that touch members and providers regarding utilization and case management issues. It works collaboratively with Quality Management, Customer Service, Membership, Provider Services, Legal, and others as needed. Medical management policies and procedures are clearly specified in provider manuals and are consistently applied in accordance with the established utilization management guidelines.

The Vice President and Senior Medical Director of Care Management for BCBSKC is the designated senior executive responsible for the implementation of the Medical Management Program. He is the chairperson of the Quality Council, sponsor of the Medical and Pharmacy Management Committee and is a member on other senior management committees. He receives information regarding the Medical Management Program from the Medical and Pharmacy Management Committee, medical reporting, physician advisory committees and monthly meetings with the Medical Management team. He delegates oversight of some aspects of the Program to the Medical Directors, as appropriate.

UTILIZATION STATISTICS

Discharges Per Year	9.81 Per 1000 Member Months
Inpatient Visits	257.70 Per 1000 Member Months
Average Length of Stay	3.31 Days
Emergency Department Utilization	59.40 Per 1000 Member Months
Outpatient Visits	302.90 Per 1000 Member Months
Re-Admissions	Not Submitted
Over-Under Utilization	Not Submitted

Inter-Rater Reliability
Inter-rater reliability of staff and medical directors include criteria selection and medical necessity decisions.

a. The inter-rater reliability activities for the medical directors focused on peer overturned denials on appeal. Review of overturned appeals revealed that the main reason for one medical director overturning another was the receipt of additional information. Other discussion points revolved around the interpretation of benefits, clarification of the reason for the denial, and medical policy interpretation.

b. A web-based inter-rater reliability tool with automated reporting is used by the concurrent review nurses. All concurrent review nurses take five cases per quarter. The goal of 90% was met amongst all concurrent review nurses.

Timeliness of Care Delivery
BA+ maintains a network of providers to assist the member accessing the care they need in a timely manner. The Member Handbook provides the member with specific information on access standards and when care is to be delivered. The Physician Office Guide provides the access standards the provider must keep. (Please see page 31 for metrics on our continuity and coordination of care.)

The 2007 Consumer Assessment of Health Plans (CAHPS®) survey indicates that members are able to access the care they need 80.1% of the time. BA+ rates exceed the CAHPS® benchmark.

Timeliness of Prior Authorization/Certification Decision Making

BA+ monitors the timeliness of nursing review staff and medical directors as it relates to prior authorizations, concurrent reviews and retrospective reviews.

a. The scores for timely decision-making were 90% or above for FY2007. The goal was met for timeliness.

The Utilization Management Department maintains policy and procedures that provide the mandated timeframes for responding to service authorizations.

Children's Mercy Family Health Partners

Utilization Improvement Program Scope

Utilization Management Program Objectives

- Ensuring that medical necessity and appropriateness of care are the paramount drivers in decisions made concerning the authorization of health care services to members.

- Ensuring effective utilization of resources for all hospital and ambulatory care by reviewing, monitoring, reporting and acting upon issues of over-utilization, under-utilization, and inefficient or inappropriate utilization of resources and services.

- Ensuring that members receive required and appropriate health care services by monitoring the appropriateness and medical necessity of admissions and continued stays, based upon application of nationally recognized criteria, and the provision of screening, prior authorization and concurrent reviews for hospital admissions and certain outpatient procedures.

- Monitoring and assisting in the promotion, maintenance and assurance of high quality care in all areas, through prospective, concurrent and retrospective review, and the application of quality indicators to identify possible quality assurance concerns related to Utilization Management.

- Reviewing and monitoring the appropriateness and medical necessity of durable medical equipment, home health care, and other home health services.

- Assuring systematic data collection, analysis, and evaluation of performance and member results.

- Assuring the presence of a program of utilization review and that such is a collaborative effort by the physicians and other health professionals, which includes interpretation of data analysis and implementation of change when needed to practitioners.

- Provide timelines for correction/corrective action plans and assign specific health plan staff to monitor compliance and follow up.

- Assessing, coordinating and monitoring appropriate discharge planning needs, and assuring that Case Management is aware of all who have ongoing or special needs.

- Establishment of protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims to comply with federal and state laws and regulations.

- Consistent application of policies and procedures, which are clearly specified in provider contracts and/or manuals.

- Identification of over and under utilization for inpatient and outpatient services and appropriate actions to correct issues and follow up.

- Coordination of services for both covered and non-covered benefits

- Coordination of school based clinic services with benefits provided by the Plan

- Ensuring that provider and subcontractor compensation is not structured so as to provide incentives for the provider or subcontracted vendor to deny, limit, or discontinue medically necessary services to any member.

- Provide regular utilization management and quality assessment reporting to the health plan management and health plan providers, including profiling of provider utilization patterns.

The following covered services are monitored under the Utilization Management Program:

Ambulatory Services
Case Management Services
Certified Nurse Midwife Services
Core services provided by Local Public Health Departments
Corneal Transplants
Dental Services
Diabetic Self Management Services and Training
Durable Medical Equipment
Emergency Room Services
Emergent and Non-Emergent Transportation
Hearing Aides and related Services
Home Health Services
Home Medical Equipment
Hospice Services
Inpatient Services

Pre and Post Transplant Services for solid organ and stem cell transplants
Laboratory, Radiology, and other diagnostic Services
Mental Health Services
Nurse Advice Utilization and Outcomes
Personal Care Services
Physician and Advanced Practice Nursing Services
Podiatry Services
SAFE-CARE Exams (in-network or out-of-network)
Transplant Services (other than Corneal or Kidney): before and after admission for transplant, including evaluation (in-network and out-of-network, per members choice)

Utilization Management Program Organization

Children's Mercy Family Health Partners' (CMFHP) Board of Directors is ultimately responsible for Utilization Management activities. Utilization Management activities are reported to the Board of Directors by the Chairperson of the Medical Oversight Committee at least annually.

The Director of Health Services is responsible for implementation of the Utilization Management Program, under the supervision of the Chief Executive Officer and the Medical Directors.

The Chief Executive Officer, or his/her designee, ensures that the departments and Medical Directors fully support and participate in the Utilization Management Program. In addition, the Chief Executive Officer will ensure that the Utilization Management Program will be developed and implemented by professionals with adequate and appropriate experience in quality assessment, quality improvement, utilization management, and continuous improvement processes.

The Medical Oversight Committee evaluates the program activities on at least an annual basis through the Utilization Management Annual Appraisal.

The Medical Directors are responsible for oversight of the Utilization Management Program and annual approval of the Utilization Management Program and related policies. The Medical Director's responsibilities regarding Utilization Management include:

- Assure compliance with applicable state, federal, or contractor/purchaser Utilization Management Standards as described in applicable statute or HMO product contract.

- Participate in implementation, monitoring, evaluation and developing improvement of the Utilization Management Program.

- Serve as liaisons between the health plan and the network providers.

Inpatient Visits
Inpatient Cases
July 1, 2006 to June 30, 2007, Children's Mercy Family Health Partners experienced an overall decrease of 1% in inpatient cases. The pediatric hospitalizations decreased by 5% and adult

hospitalizations increased by 1%. In addition, obstetrical cases increased by 1% during this timeframe.

Inpatient Days/1000 members per year

July 1, 2006 to June 30, 2007, inpatient days per 1000 members increased overall by 6%. Pediatric days per 1000 members increased by 7% and adult days per 1000 members increased by 13%. In addition, obstetrical days per 1000 members remained constant.

Average Length of Stay

July 1, 2006 to June 30, 2007, the average length of stay for all hospitalized members increased by 13%. For adult members, the average length of stay increased by 3% and for pediatric members, the average length of stay increased by 25%. Inpatient obstetric length of stays remained constant during this timeframe. Seasonal variations may affect the trend when looking only at a calendar year of data, therefore, average length of stay is not considered a primary indicator of inpatient performance. Rather, Children's Mercy Family Health Partners looks at overall days per thousand members as a more accurate indicator of reducing unnecessary inpatient costs.

Discharges Per Year
Re-Admissions

Children's Mercy Family Health Partners (CMFHP) reviews a monthly report of readmissions to the hospital within 30 days of discharge with the same primary diagnosis. This report is currently being used by the Case Managers and Utilization Review nurses as a tool to identify premature discharge, poor discharge planning, failed outpatient treatment, or non-compliance issues. If an issue is identified related to potential premature discharge or poor discharge planning, the case is referred to the Quality Management department for investigation using CMFHP's quality of care investigation process. If the readmission is determined to be a result of member non-compliance with the treatment plan, case management is initiated in an attempt to educate the member and reinforce the treatment plan established by the member's physician.

Emergency Department Utilization
Outpatient Visits

Outpatient and Emergency Department Utilization

	Qtr1	Qtr2	Qtr3	Qtr4	Total 2006	Total 2005	%Chg
Member Months	132,522	129,431	125,786	123,950	511,689	583,410	-12%
Outpatient Medical Cost Incurred							
Emergency Room - All	2,592,869	2,367,614	2,426,701	2,543,820	9,931,005	9,629,940	3%
Outpatient Hospital	4,312,007	4,441,294	4,590,239	4,706,923	18,050,464	16,299,662	11%
Grand Total	6,904,877	6,808,908	7,016,940				8%

				7,250,744	27,981,468	25,929,602	
Outpatient Visits							
Emergency Room - All	8,529	7,740	7,423	7,655	31,347	36,701	-15%
Outpatient Hospital	23,852	21,559	20,989	21,428	87,828	93,576	-6%
Grand Total	32,381	29,299	28,412	29,083	119,175	130,277	-9%
Visits per 1000 Members							
Emergency Room	772	718	708	741	735	755	-3%
Outpatient Hospital	2,160	1,999	2,002	2,075	2,060	1,925	7%
Cost per Visit							
Emergency Room	304	306	327	332	317	262	21%
Outpatient Hospital	181	206	219	220	206	174	18%
Grand Total	213	232	247	249	235	199	18%

Over/Under Utilization
Children's Mercy Family Health Partners (CMFHP) monitors over and under utilization through a variety of reporting mechanisms on a monthly and quarterly basis. CMFHP contracts with an organization called ManagedCare.com. This organization compiles data submitted by CMFHP and prepares various utilization statistics for review at all levels (provider, facility, type of service, procedure, etc.). The database used is able to compare CMFHP's data to other similar populations in the database to establish a mean for any particular service. Use of this analysis allows CMFHP's management team to identify areas where providers are outliers among their peers.
CMFHP continues a semi-annual report card to physicians, using the ManagedCare.com data compiled, comparing each physician's medical utilization data to that of his or her peer group. The report card is an informational tool for the physicians to identify if practice variances or opportunities for improvement exist.

Through the monthly utilization reporting, as well as medical claims payment reports, CMFHP is able to identify areas of over or under utilization.

Inter-Rater Reliability
The Health Services department at Children's Mercy Family Health Partners (CMFHP) performs audits for Pre-certification, Inpatient Review Nurses, and Case Managers to measure consistency in staff's documentation and clinical decision making. The process involves review of a random sampling of cases per staff member per quarter by the Manager of Health Services or Senior Case Manager. A tool is completed on each case to identify areas of deficiencies against the documentation standards. The staff are then educated about their results during one-on-one meetings with the Manager of Health Services. In 2006, weekly complex case rounds were implemented as a way for Case Managers to collaborate on cases and enhance knowledge about

complex care coordination and available resources. The Utilization Review Nurses also meet with the Medical Director on a daily basis to review current inpatient cases and discuss application of criteria for consistency in decision-making.

In 2007, an inter-rater reliability process was established for the Medical Directors at CMFHP as a way to measure application of clinical criteria and judgment. The process is intended to identify opportunities exist for improved consistency in decision-making.

The Quality Management department at CMFHP performs inter-rater reliability on the HEDIS hybrid medical record abstraction process, the Primary Care Provider medical record review process, and the complaints/grievances/appeals process. In addition, the Quality Management department implemented an auditing tool to measure consistency in staff's documentation and processing of member grievances and appeals and provider complaints, grievances and appeals. The audit outcomes have identified processes for ongoing improvement and staff education.

Timeliness of Care Delivery
Timeliness of Prior Authorization/Certification Decision-Making
Included in monthly key indicator measuring is an indication of turnaround time on utilization management decisions. Each request is tracked for meeting standard timeframes for decision-making. Routine services require a 3 day turnaround for making a decision after all necessary information is received. Urgent services require a 24 hour turnaround time. In 2006, the average timeframe for decision-making on both inpatient and outpatient service requests was 1 day.

Performance Improvement Projects

Performance Improvement Projects (PIP)

The following information was taken from the MC+ Managed Care health plans' SFY 2007 Annual Evaluations:

HealthCare USA

Clinical

Chlamydia (January 2006 – January 2008)

Background
Chlamydia is one of the most widely spread bacterial sexually transmitted diseases, entirely curable with antibiotic treatment. Screening for chlamydia is important because three-fourths of infected people do not know they have the infection. Untreated chlamydia can lead to pelvic inflammatory disease, abdominal pain, and ectopic pregnancy in the untreated female, and preterm labor, premature rupture of membranes, low birth weight, and increased fetal and infant mortality for the pregnant female and her unborn child.

HealthCare USA recognized an opportunity to increase the screening rate of chlamydia for our members. The HEDIS 2006 rate for central region decreased from 2005 and was below the Medicaid average. Eastern region also decreased and western remained stagnant, even though both remained above the 2005 Medicaid average.

Goals
Goal for improvement was an increase by 2 percent for all ages in each region from the HEDIS 2006 results reflected in HEDIS 2007.
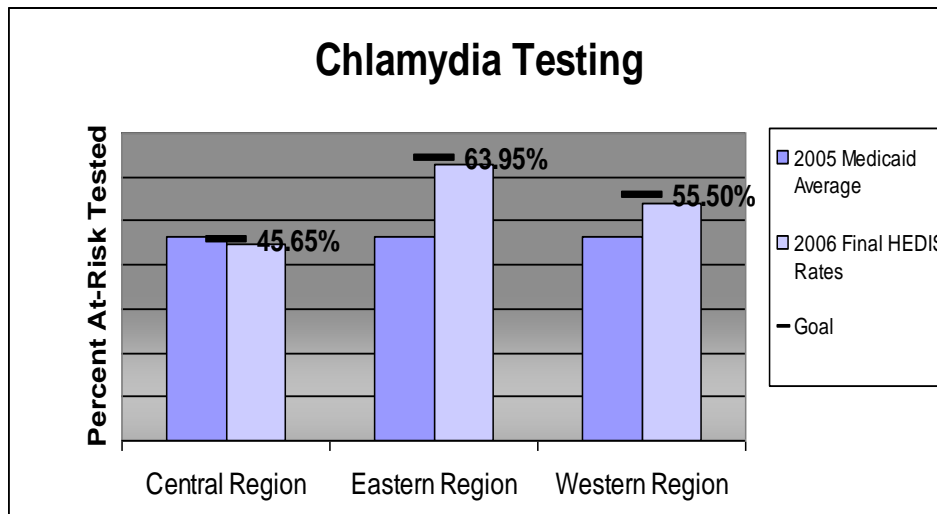
Source: HealthCare USA HEDIS results

Interventions
Provider
A one-time informational survey was sent to providers most likely to test for chlamydia: family practice, pediatricians, obstetrics-gynecologists, and internal medicine practitioners. Information gained from the survey included:
- Member perceived stigma of chlamydia infection
- Member lack of knowledge
- Lack of knowledge on testing modalities and CDC.
- Lack of knowledge on insurance reimbursement.
- Provider education:
  - Resources for testing
  - Resources for patient education
  - CDC screening guidelines
  - Plan policy for reimbursement
  - Spring and Fall 2006 (mailing)
  - July and October 2006 (newsletter)

Member
A flyer titled, "Staying Healthy: A Guide for Women" was developed educating members on routine testing for chlamydia as a routine part of a female taking care of their body. Using Coventry's member reminder system, the mailing is sent to all non-compliant members per HEDIS specification once per year. The same information was disseminated in the member newsletter. The audience of the newsletter is all plan members.
- Fall 2006 and annually (mailing)
- Fall 2006 and at least annually (newsletter)

Outcomes
HEDIS 2007 indicated we reached and surpassed our goal in all 3 regions.
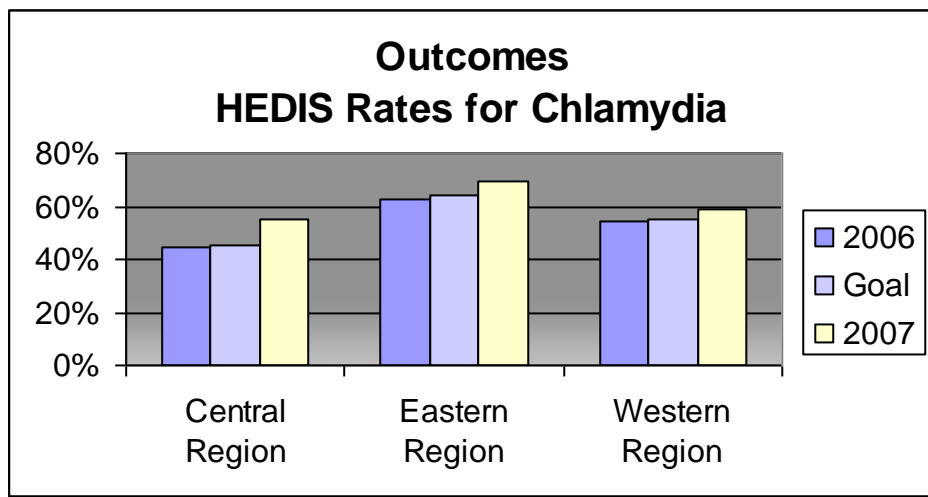
Source: HealthCare USA HEDIS results

Plan
Re-measurement will be HEDIS 2008. Rates for chlamydia testing will be analyzed annually for any opportunities for change or improvement. The member mailing "Staying Healthy: A Guide For Women" will continue annually utilizing the member reminder system. An article in the member newsletter will be provided at least annually. Provider education, in the form of an article in the provider newsletter, will also occur at least annually.

Non-Urgent/Avoidable Emergency Department Utilization
(January 2006 – January 2009)

Background
Emergency Department (ED) usage has increased nationwide, state-wide, and within HealthCare USA's member population. Over utilization of EDs result in bottlenecks within EDs and a lack of preventative care and screenings for patients who use EDs as their primary source of health care.

HealthCare USA has identified a steady increase in non-urgent and avoidable ED utilization since 2004. Otitis media, dental complaints, abdominal pain, and sprains are the top 4 reasons plan members go to the ED.

Goals
HealthCare USA would like to see a decrease in ED utilization. Indicators are:
1) HEDIS ED Utilization Rate
    a. Baseline rate HEDIS 2006 by region
    b. Rate measures all usage of the ED, not dependent on any other factors (admission, diagnosis)
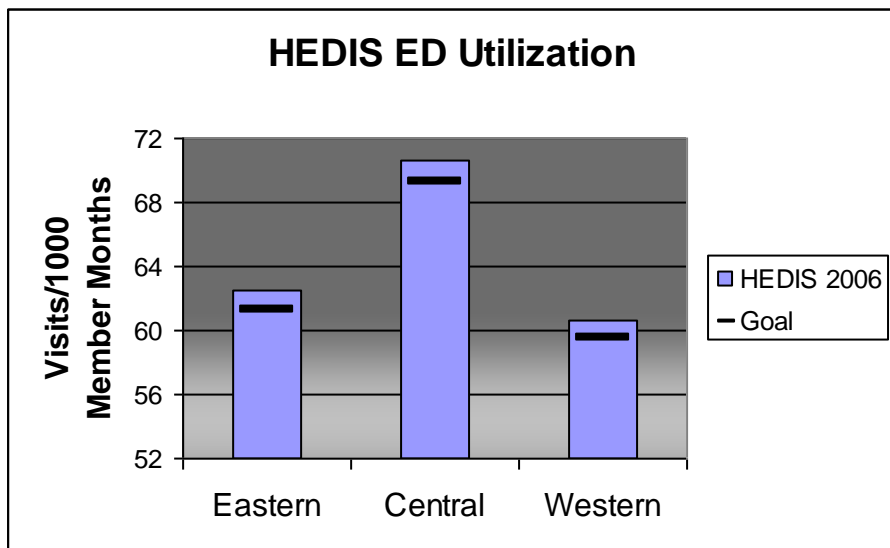
Source: HealthCare USA HEDIS results

2) ED Frequent Fliers
    a. Baseline rate 1/06-6/06

b. All members with 3 or more ED visits without admission in a rolling 6 month time period with a primary diagnosis contained in one of 15 groupings:
  i. Otitis media, dental, abdominal pain, sprains, asthma, upper respiratory infection, headache, back pain, contusions, pharyngitis, urinary tract infection, gastroenteritis, bronchitis/bronchiolitis, fever, and unspecified viral.
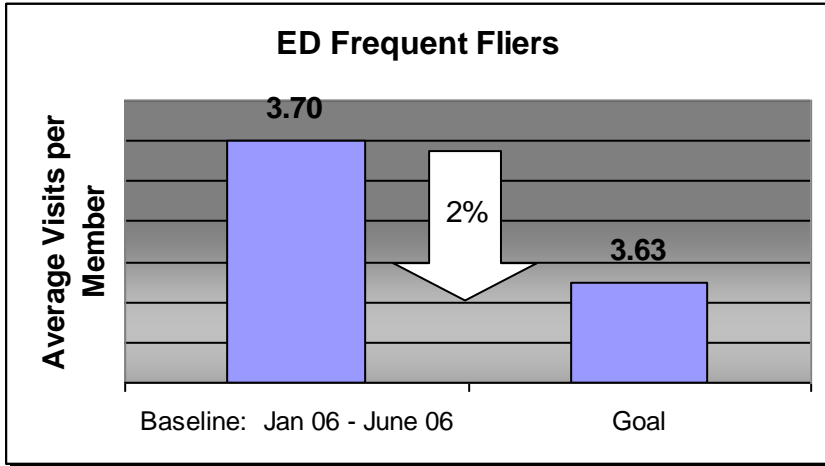
Source: HealthCare USA HEDIS results

Interventions
An educational mailer was developed suggesting to members what is considered a true emergency and when to contact their PCP. The mailer was sent to all on the ED frequent flier list (June 2006 and November 2006). An educational article, with the same content, was published in the member newsletter and sent to the entire plan membership (fall 2006).

Source: HealthCare USA HEDIS results

ED Frequent Fliers

A bar chart titled "ED Frequent Fliers" with the y-axis labeled "Average Visits per Member" ranging from 3.50 to 3.85, and the x-axis labeled "Timeframe". The bars are labeled as "Result" and a line is labeled "Goal". A callout labeled "Baseline" points to the first bar.

- Jan 06 - June 06: Result approximately 3.70 (Baseline)
- Apr 06 - Sep 06: Result approximately 3.75
- July 06 - Dec 06: Result approximately 3.73
- Goal line at approximately 3.63

Source: Claims paid through October 2007

Barrier Analysis

The education was deemed ineffective. Barrier analysis and further research indicated members may not know who their PCP is, members are not educated in the use of a PCP for sick visits or as first contact, and/or members lack first aid knowledge.

Following the barrier analysis, a second mailer was developed, the First Aid/ED mailer. This mailer addresses first aid education, such as cuts, scrapes, bruises, and fever, including how to take a temperature. For each topic covered, when to call the PCP or go to the ED is also discussed. The mailer also provides an area for the member to add their PCP contact information.

The mailing was sent to the ED frequent fliers quarterly, beginning in August 2007. An article in the member newsletter with the information in the mailer was sent to all members in spring and fall 2007. The mailer was also distributed at a variety of community events in the summer of 2007 including HealthCare USA Health fairs.

Re-measurement
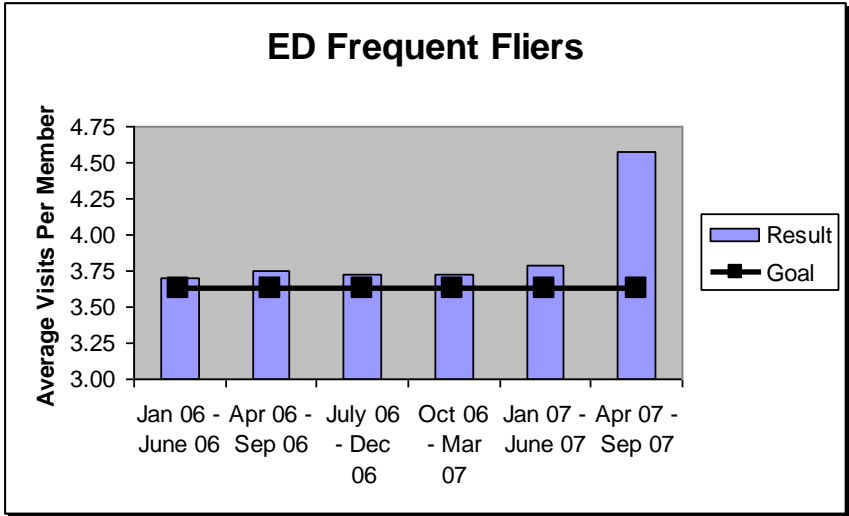
ED Frequent Fliers

Source: Claims paid through October 2007

Number of Members with 3 or More ED Visits
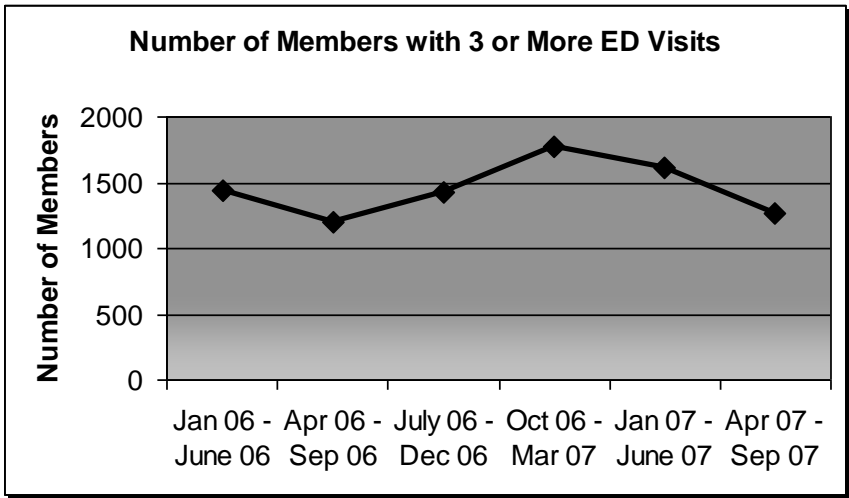
Source: Claims paid through October 2007

When analyzing the results of the most recent ED frequent flier list, an obvious increase in the average visits per member was noted. However, the gross number of individual with a high volume of ED visits decreased.

Frequency of Diagnosis Codes

Categories (x-axis): Usp viral, Headache, Otitis Media, Pharyngitis, URI, Bronch, Asthma, Dental, Gastro, UTI, Back Pain, Fever, Abd Pain, Sprain, Contusion

Legend: □ July 06-Dec 06 □ Oct 06-Mar 07 ■ Jan 07-June 07 ■ Apr 07-Sep 07
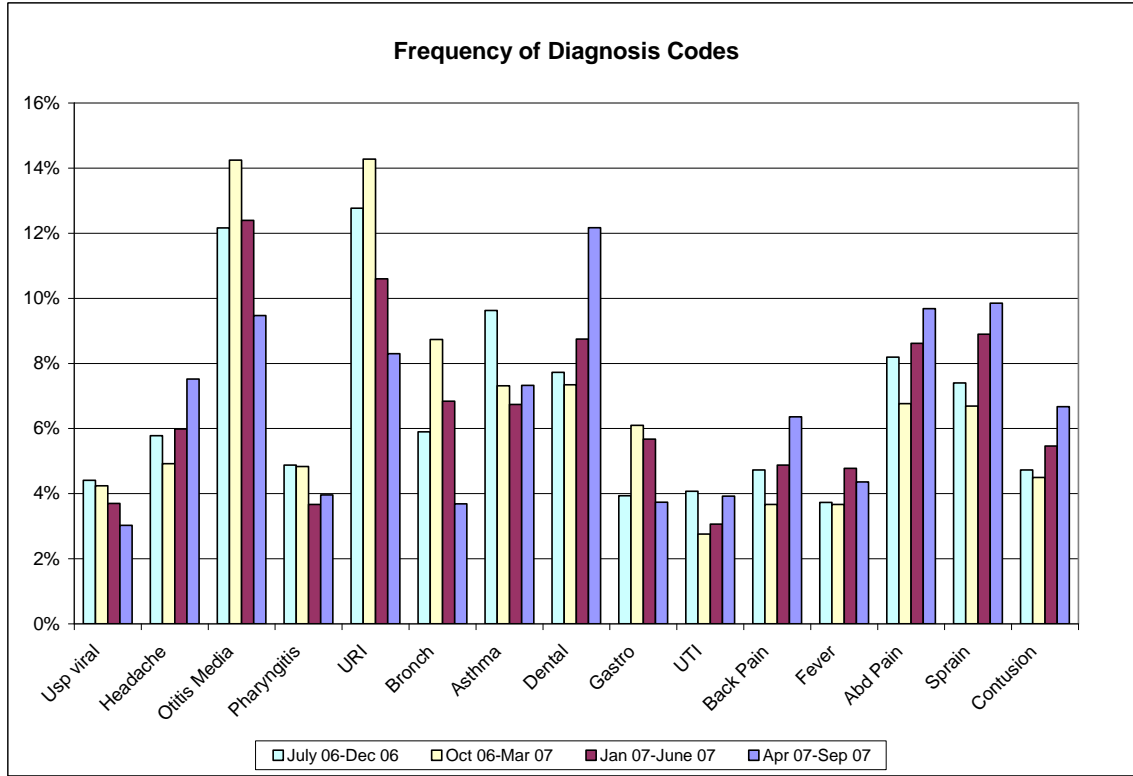
Source: Claims paid through October 2007

When analyzing the diagnosis code frequency, the groupings that increased included dental, headache/migraines, back pain, abdominal pain, sprains and contusions. Not showing an increase or showing a decrease include viral, upper respiratory, bronchitis, gastroenteritis, and fever. This is suggestive of success of the First Aid/ED brochure in reaching the members who would normally use the ED for a fever or gastroenteritis.

Interventions after this frequent flier query included:
- Mailing of First Aid/ED brochure to members in query results
- Members with asthma as a primary or secondary diagnosis were forwarded to asthma disease managers for follow up (on-going since first frequent flier query)
- Members with a high number of dental claims, especially with a claim for abscesses, were forwarded to the special needs coordinators for evaluation
- Members with more than a few diagnoses for pain related issues without a corresponding secondary diagnosis (abdominal pain with no mention of cysts, for example), members with more than several different ED locations, members with a secondary diagnosis of drug use/abuse or feigning illness, were forwarded to the plan's pharmacist for narcotic claims query and possible fraud and abuse issues.

On-going

Re-measurement will continue through the ED frequent flier query quarterly and HEDIS 2008 rate of ED utilization. Barrier analysis and identification of opportunities for improvement are on-going. A multi-departmental ED task force meets at least monthly to identify, analyze, problem solve, and affect change.

Beary Important Bundle (BIB) (January 2007-December 2008)

Background

National, State and health plan rates of preterm delivery have increased steadily over the years. A reduction in the rate of preterm births has been achieved by programs focused on early identification of high risk pregnancies, improving adequacy of prenatal care, and reduction of medical and social risk factors. HealthCare USA identified a need to decrease the preterm delivery rate for plan members.

Goals

- Decrease preterm delivery rate by 5% and preterm related complications and morbidity
- Decrease NICU admissions by 2%
- Decrease ED visits and hospitalizations
- Maintain or improve member, provider and staff satisfaction with high risk OB disease management processes and services
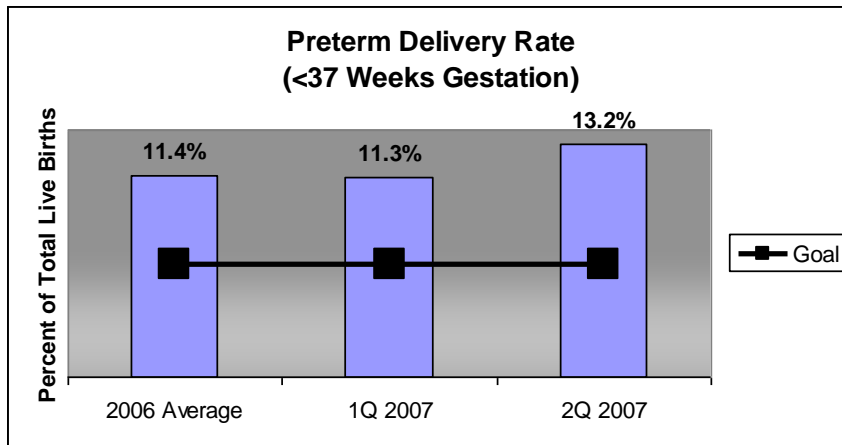
Source: Coventry Data Warehouse
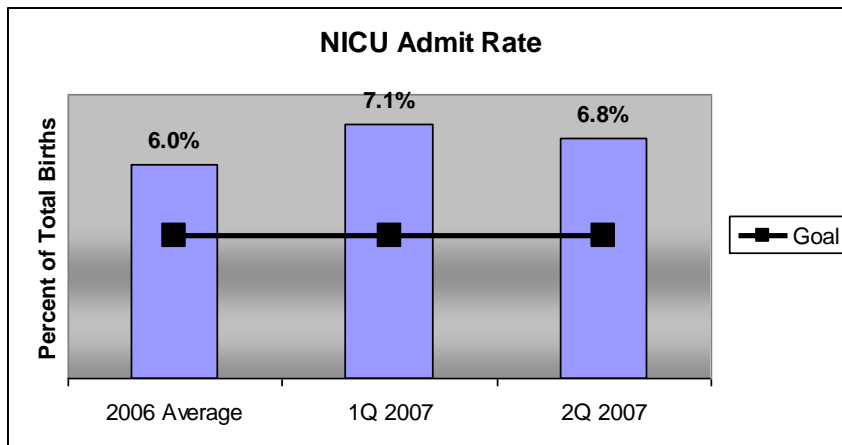
Source: Coventry Data Warehouse

Interventions

- 17P study (2005)
- Hired additional OB disease managers (2005)
- Prenatal OB member education packet developed and distributed monthly (2006)
- On-site provider education related to 17P (2006)
- 17P provider and member mailers (2006)
- Implemented Rapid Cycle Improvement methodology (2007)
- Evaluated CHCS best practices and implemented BCAP documentation process (2007)
- Revised High Risk OB program definitions and goals (2007)
- Member Identification
  - Goal: improve identification of members at risk for poor pregnancy outcomes from 26% to 50% within 6 months
  - Sticker pilot program (March 2007)
  - Postcard pilot program (August 2007)
  - CM/DM and grand rounds (August 2007)
  - Concurrent review nurses verify demographic data while in the hospital (September 2007)
  - Daily review of 720s from hospitals (on-going)
  - Daily review of 24 hour nurse call line reports (September 2007)
  - Pilot State OB Risk Assessment form as the global authorization form (November 2007)
  - Develop and add a risk assessment form to the OB member education packet (December 2007)
- Member Stratification
  - Goal: 100% of enrolled HROB members will have a complete and accurate HROB specific health and self-management risk assessment.
  - Redefined high risk OB disease management vs. case management (June 2007)
  - Identify specific medical, environmental and psychosocial risk factors with high risk OB specific health and self-management risk assessment (in process)
  - Develop and implement a process for acuity rating and service level algorithms (in process)
  - Determine which risk factors are modifiable (e.g., smoking/drug use, ability to get to prenatal care visits and member's readiness, willingness and ability to change) (in process)
- Member Outreach
  - Goal: Improve member compliance with adequate prenatal and postpartum best clinical practice guidelines ass evidence by improvement in HEDIS rates
  - BIB incentive for prenatal and postpartum visits (February 2007)
  - Revised member quality of life and satisfaction survey (July 2007)
  - Develop and implement peer to peer baby showers (November 2007)
  - Develop high risk OB six module education program and establish participation incentives (in process)
- Provider Interventions
  - Goal: improve provider access to ACOG recommendations and guidelines and improve ease of implementing best practices.
  - BIB incentive for postpartum visits (February 2007)
  - Revised the 17p data collection and reporting (July 2007)
  - Revised the provider 17P letter (August 2007)

- o Develop and implement hyperemesis "fast track" (October 2007)
- o Implement medical transportation process revisions (July 2007)
- o Deliver OB provider specific guide (November 2007)
- o Implement provider HROB satisfaction survey (November 2007)
- o Delivery provider report cards with HEDIS measures related to prenatal and postpartum care (November 2007)
- o Implement a process for on-going provider education regarding member processes and implementation of clinical practice guidelines (in process)

Outcomes

Re-measurement of preterm delivery rate, NICU admissions, and NICU average length of stay on a quarterly basis. Indicators for individual interventions are analyzed for effectiveness and utilization on an on-going basis.

Improving Post-Discharge Management of Members Discharged from an Inpatient Service for Mental Illness

Background

Compliance with planned aftercare has been shown to play a major role in decreasing the rate of re-hospitalization of mentally ill persons. Studies have shown that patients are more likely to comply with their aftercare treatment and attend their follow-up appointments if the following occur:

- Assistance is provided in making the initial aftercare appointment;
- The appointment is scheduled for patients;
- The patient and family members receive education about their illness and medications; and
- They receive a follow-up call within 48 hours of discharge.

An opportunity for improvement was identified for MHNet/HealthCare USA members who presented with a mental illness based on MHNet claims-based data. Additionally, key performance indicator data measuring compliance with ambulatory follow-up appointments after discharge from inpatient mental health treatment presented opportunity for improvement.

Goals

Ambulatory Follow-up Rate After Discharge from Inpatient Treatment for a Mental Illness Disorder

Indicator	Baseline 2003	Goal
Within 7 Days	34.7%	50.0%
Within 30 Days	58.0%	85.0%

Source: HealthCare USA HEDIS rates

Interventions

Intervention	Date Implemented	Barrier Addressed
Initiated new procedures to provide for the following after member is discharged from the inpatient service: • Provider's office is contacted to assess mbr compliance with attended scheduled f/u visit • Non-compliant mbrs are contacted by the Case Mgr to identify barriers & educate mbrs • Follow-up calls and/or preventive health initiative letters are used to encourage members to attend f/u visit. • All f/u calls and letters are documented in case mgt records.	May 2003; ongoing	Member Behavior Data Issues
Trained MHNet case managers to implement the new procedures and provided with methods for tracking process.	May 2003; ongoing	Internal Process
Initiated new procedures to provide for the following while the mbr remains in-patient: • MHNet case mgrs work with facility to arrange appointments as part of discharge process. • MHNet case mgr attempts to speak with mbr while they are in-patient to determine appt preference and barriers • Mbr is scheduled for a partial hospital program, intensive outpatient program or is scheduled to see a practitioner for a f/u visit at least once per week for the first week following d/c • All contact information is recorded in case mgt notes. • MHNet staff continue to follow-up on non-compliant members.	November 2004; ongoing	Hospital Compliance Member Behavior Data Issues
Changed goal for appointments to be scheduled post discharge and within 3 days of hospital discharge. These appts must be presented at weekly staffing. Identified regional differences in rates that are substantiated by national results.	January 2005; ongoing	Internal Process
Information on post discharge f/u included in provider newsletter, including how to get assistance with getting an appt and the importance of post discharge f/u	May 2005	Provider Education
Updated case mgt module to identify mbrs and barriers for appointments not scheduled within 3 days of d/c and for mbrs not following up with the post discharge plan.	June-December 2005; Ongoing	Data Issues
Developed educational brochure for members discharged with a diagnosis of MDD with the ambulatory f/u letters. Brochure encourages compliance with medication and post discharge appointments	September-December 2005; ongoing	Member Behavior
Hired a full-time discharge case mgr and discharge planner assistant to complete functions of discharge planning program.	May 2006; ongoing	Internal Process
Provided education and follow-up rates for 5 high volume facilities.	June-December 2006; ongoing	Hospital Compliance
Increased authorizations for in-home therapy to facility to provide additional post discharge visits for mbrs with history of non-compliance.	December 2006; ongoing	Member Behavior Internal Process

National Service Center - St. Louis
Seven Day Post Hospital Ambulatory Follow-up - Mental Illness
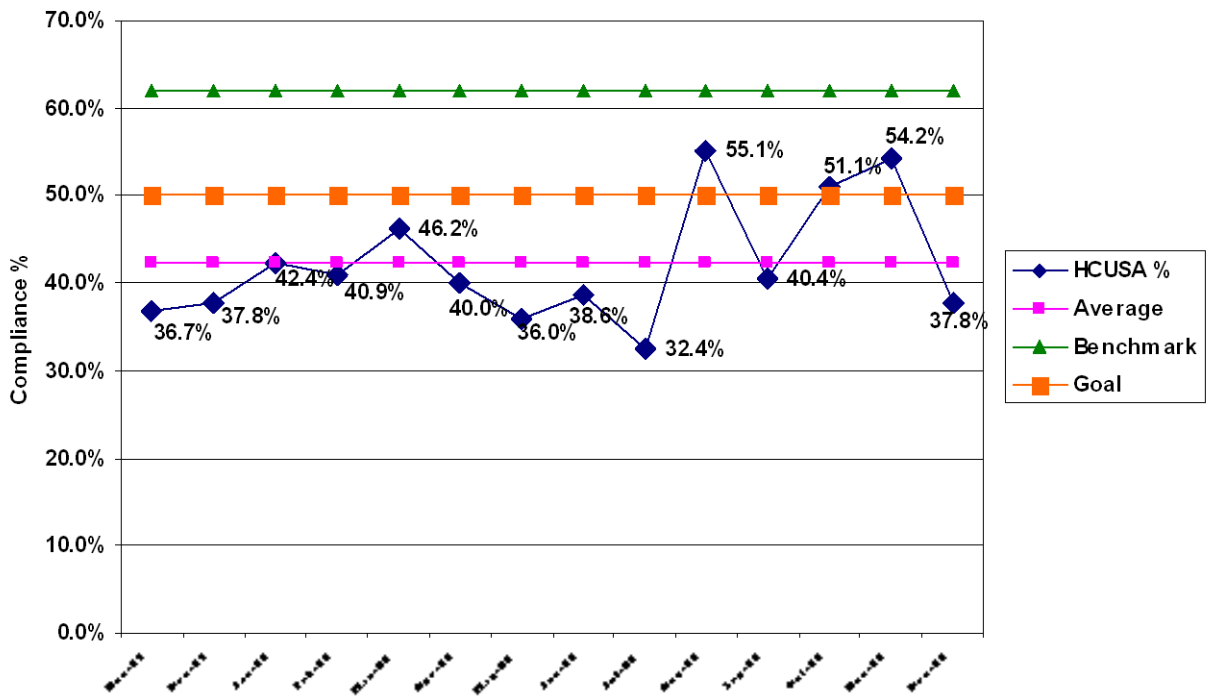
National Service Center - St. Louis
Thirty-Day Post Hospital Ambulatory Follow-up - Mental Illness
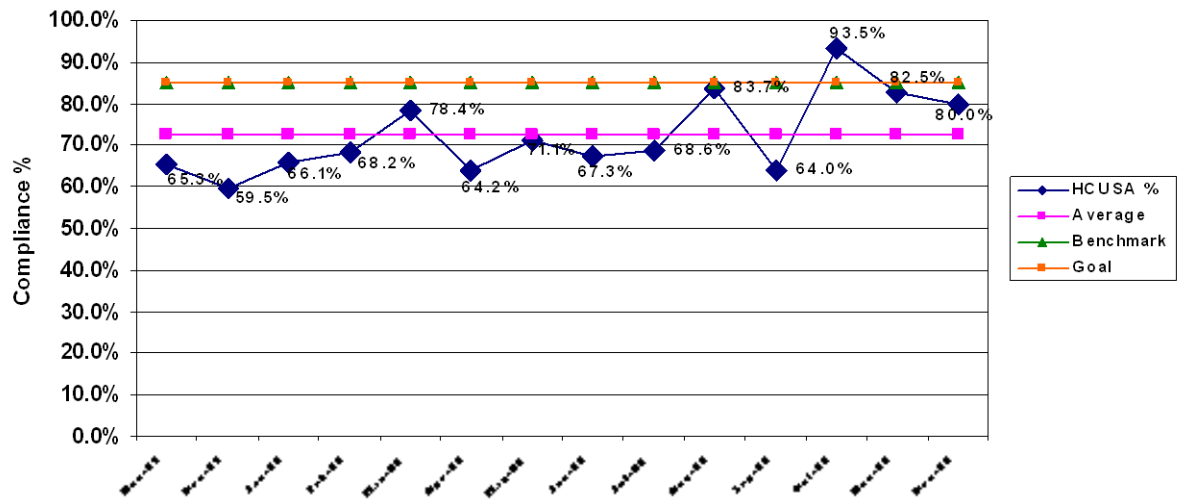
State-Wide Adolescent Well Care
In general, best practice guidelines recommend that all adolescents have an annual confidential preventive services visit during which primary care physicians screen, educate and counsel adolescents. In spite of consensus about best practices among expert organizations focused on adolescent issues, barriers to implementation of the guidelines remain.

Several studies have been done by the National Adolescent Health Information Center (NAHIC) and other healthcare organizations to identify barriers and improve the delivery of adolescent preventive services. In addition to a need for system changes, these studies identified clinician unawareness of the guidelines, a need for training to develop skills to provide preventive services confidently and reimbursement for their time to provide preventive adolescent services, among other issues as barriers.

HEDIS measures for adolescent preventive services among the Medicaid population vary widely from state to state and remain even lower than rates for patients in commercial health plans. In Missouri, the MO HealthNet 2005 statewide average for adolescent well care was 33%, well below the 2004 national Medicaid mean of 40%. Across the three regions, the rate for the eastern section was 35.5%, the rate for the central section was 36.8% and the rate for the western section was 31.1%. Much like the variation across states, rates varied across Missouri individual MO HealthNet plans from 23% - 44%.

There are multiple reasons for the MO HealthNet plans to focus a collaborative effort on improving adolescent well care. In addition to improving outcomes of care for adolescents as previously discussed, improving the rate of adolescent preventive services is consistent with the current effort to transform Missouri Medicaid. Improving compliance with guidelines for adolescent well care will help foster wellness, prevention and personal responsibility for healthcare among adolescents. Improving compliance with adolescent well care visits may also have a positive impact on compliance with adolescent immunization rates and other HEDIS measures applicable to the adolescent population. Increasing well care visit compliance may help adolescents within MO HealthNet Plans identify and establish a care home. The process of improving this HEDIS measure also supports educating providers about current best practice guidelines for adolescent preventive services.

Goals
The goal is to improve the HEDIS rate of adolescent well care by focusing on provider education as part of a coordinated State-Wide improvement effort.

The baseline rate will be the Adolescent Well Care rate from HEDIS 2007 (CY 2006). The first measurement period will be HEDIS 2008.

Interventions

Interventions	Barrier
Educational flyer to be disseminated to members through provider offices. Will include: • Education on immunizations • Education on well care • The availability of transportation • An area for the provider to fill in a future well-visit date	Member Education
Introductory letter from all MO HealthNet plans informing them of State-wide project. Will include: • Current State-wide rate of AWC • Strategies plans are using to improve rate Mailing also included a panel listing of all applicable members for that provider.	Provider Education
Article in all Plan's provider newsletter educating providers about PIP	
Education at large group meetings, such as the MO Hospital Association or other applicable meetings, with audience of providers possibly affected by	
Proposed Initiatives	
Establishment of an on-going collaborative, State-wide improvement effort focused on provider education: • Will include educational workshops in all 3 regions • Physician Champion Providers offering clinical expertise, sharing strategies for successful well visits including communication, development, mental health assessments, and education components. • QI staff from MO HealthNet plans will provide quality portion of workshops. • A Certified Professional Coding Instructor will offer coding and billing education.	Provider Education
Establishment of a Missouri-specific Bright Futures website as an on-going distance learning resource for providers. Learning modules will include: • Components of a well-child exam • Development/behavioral assessment • Oral health • Cultural competence • Communication • Family centered care Will provide resources and links for: • Immunization schedules	

- CDC growth charts
- AAP periodicity schedule

Outcomes

Provider mailing by MO HealthNet plan in August-September 2007:

Health Plan	Mailing
Blue Advantage Plus	276
Children's Mercy Family Health Partners	234
Harmony Health Plan	129
HealthCare USA	950
Mercy CarePlus	508
Missouri Care Health Plan	229

Success of the project will be evaluated in the following ways:

- An increase in the statewide Adolescent Well Care HEDIS average for the MO HealthNet Plans. Consideration will need to be taken though with the county expansion taking place in 2008. The Plans generate a numerator and denominator for the measure based upon the HEDIS Technical Specifications. As required by the State contract, the calculation of the rate is audited by a certified HEDIS auditor. The Plans report their rate by June 15th of each year. The Missouri Department of Health and Senior Services then consolidates the data to calculate a statewide Adolescent Well Care average. The 2007 HEDIS (2006 Measurement Year) rate will serve as the baseline rate for the project. Comparisons will be made yearly to identify statistically significant increases in rates from the previous year and from the baseline. Although a statistically significant increase in the statewide rate would indicate success in the intervention, the goal of the project is to reach or exceed the national Medicaid mean on the HEDIS measure.
- The establishment of provider education workshops in the three regions of the state in which the MO HealthNet Plans manage membership. In addition, attendance at the workshops will be monitored and attendees will be asked to complete a brief survey regarding the workshop.
- The successful design and launching of a Missouri-specific Bright Futures website that all providers across the state will be able to access. In addition, the utilization of the site by providers will be monitored.

Obesity

Background

The prevalence of obesity in adults and children has dramatically increased over the past 10 years. It has become a national epidemic that is becoming more of a focus for research. Today, 64.5% of adult American's are considered overweight or obese (AOA, 2003). Adults who are overweight carry the increased risk of developing ailments such as hypertension, type 2 diabetes, coronary heart disease, congestive heart failure, stroke, orthopedic conditions, psychosocial problems, and more (Haynes, 2005). It is estimated that 25% of American children and adolescents are obese or are at risk of becoming obese. Obese adolescents have a 70% chance of becoming overweight or obese as an adult. It was estimated in 2003 that approximately $800

million is spent by Missouri Medicare and Medicaid annually on obesity-attributed direct medical expenditures in adults.

A review of claims identified that 2,258 members between the ages of 2 and 20 were diagnosed with obesity or morbid obesity in 2005. Even though this number represents only 1.4% of Plan members, those counted are only the members diagnosed with obesity per a claim by their provider. If every obese member had a claim submitted by their provider with a diagnosis of obesity or morbid obesity, the true number affected would be closer to 38,282 members (based on national average for age group of 25% of the 2005 year-end Plan membership).

Of the 2,258 members who were diagnosed with obesity or morbid obesity in 2005, only 4.4% of these members had a claim for nutritional therapy billed with a diagnosis code for obesity. A sample of 243 medical records was reviewed to determine provider participation in the fight against obesity. This review found that 39.4% (95% CI, ± 6.2) of the cases had a physician referral to a nutritional therapist for obesity management. Only 7% of these members actually had a claim for nutritional therapy.

Goals
HealthCare USA's aim was to increase the rate of providers referring members for nutritional therapy by 2% and to increase the rate of members completing nutritional therapy by 2%.

	2005 Referrals	2005 Claims
Rate	6.50%	4.40%
Goal	6.63%	4.49%

Interventions

Barrier	Interventions	Completion Date/Frequency
Member Compliance	Educational mailers sent to all members with a diagnosis of obesity/morbid obesity	Initial mailing for all members diagnosed in 2005 in January 2006 and then quarterly
	Pedometers offered to members at no cost.	Winter 2006/2007 One-time
	Nutritional education provided in "The Bear Facts" HealthCare USA member newsletter.	Spring/Summer 2006 One-time and as needed
Provider Compliance	Educational mailer sent to all PCPs and Pediatricians	January 2006 One-time
	Education provided in the 2006 Provider Reference Guide	March 2006 Annually
	Education provided via the Provider Newsletter	March 2006 One-time and as needed

Outcomes
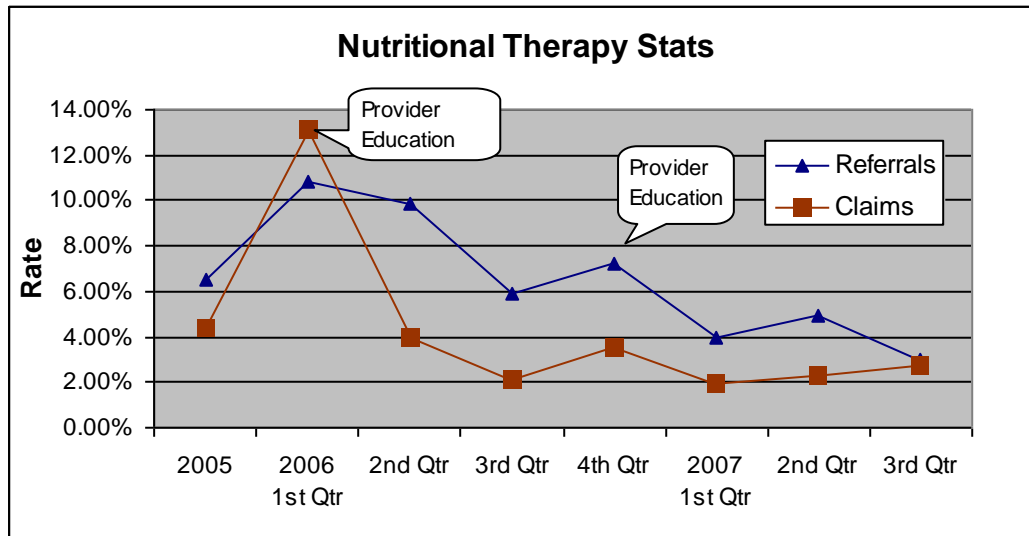
Source: Claims paid through October 2007 and IDX referral system

The rate of members diagnosed with obesity continues to increase since the initial education in first quarter 2006. The quarters in which there was the biggest increase in nutritional therapy referrals and claims are the quarters in which provider education was provided. The initial mailing to all members diagnosed with obesity in 2005 had the largest effect on member compliance, but was less effective each quarter after that, until another provider educational article was included in the Provider Newsletter

Plan

In FY 08, HealthCare USA will refocus the obesity program. The program will initially focus on the rural counties. This selection is based on recognition of the challenges facing rural members and recommendations made by the State's Medicaid Reform Commission, Missouri's House Bill 749 - Rural Health Initiative, and the 2005 Health and Human Services report entitled, Healthy People 2010. Both Healthy People 2010 and HB 749 report the need to develop interventions that address nutrition.

The program continues to target both providers and members and will remain flexible in order to maximize education impact. The first focus area will be on provider education regarding the 2007 AMA expert committee recommendations for the assessment, prevention and treatment of childhood, adolescent and adult obesity.

A provider information packet will be distributed which will include the CDC BMI-for-age growth chart and copies of the information that will be sent to members. The second focus area will be member education. Often members do not have the knowledge necessary to make healthy lifestyle choices. This will be addressed by mailing informational packets and face-to-face educational events focusing on nutrition and physical activity. Additional member activities may include paid Weight Watcher memberships.

Non-Clinical

Encounter Data Submission (10/2004 to 12/2008)

Background
Submission of encounter data is a requirement established by CMS. Utilization and cost data are the encounter data submitted by MO HealthNet plans. Encounter data submitted by HealthCare USA are approved claims only; denied claims are not included.

Encounter data is used for a variety of reasons including evaluation of health care quality and evaluation of contractor performance. The data can also be used to determine what populations of the membership are not being adequately serviced. However, incomplete data would be of little value. With complete and accurate encounter data the plan could implement more precise measures for the population with lower utilization.

Goals
HealthCare USA's encounter acceptance rate prior to implementation was 68.9%, well below the 95% Federal requirement. An improvement plan was put into place to raise the acceptance rates to the stated goal.

	Baseline (Jan 2005)	**Goal**
Encounter Acceptance Rate	68.9%	95%

Interventions

Barrier	Intervention	Completion Date/Frequency
Accuracy	Refined and developed new internal edits to capture unacceptable encounter data from being sent to the State.	Began Feb 2005 Main project completion Dec 2005 Ongoing as issues arise
	Develop a workplan to address each rejection code and determine how to solve the issue or which issues were not correctable.	Began Feb 2005 Completed Aug 2005
	Review each rejection code received from the State and remove encounters from claims system that would be rejected for this reason.	Began March 2005 Ongoing
Internal Completeness	Add artificial ICN (internal control number) to encounters rejected by the State or which will not be accepted by the State to prevent	January 2006 Ongoing

	further submission of these encounters until they are able to be reconciled.	
Provider Data Completeness	Develop reports to measure completeness of encounters received from Providers.	Begin 1st Quarter 2007
	Develop an internal reporting process to communicate rejection reasons from the State, then develop a workplan to address these reasons with providers to improve the completeness of encounter data received from providers.	Begin 2nd Qtr 2007

Outcomes
The 95% goal was reached in the month following initial implementation of the interventions. In months where the goal was not achieved, the code specific acceptance report file was reviewed to determine the cause.

Plan
The State and HealthCare USA continue to use the same methodology to measure the rates of encounter data acceptance. The State has not notified HealthCare USA of any changes in their methodology.

All three steps of this process are vital in meeting the Federal requirement for encounter data acceptance and in providing to the State accurate and complete encounter data. As HealthCare USA continues to improve the data, we will reassess the outcomes and accuracy. Each of the interventions already implemented have been adopted as permanent processes as indicated in the policy BR-112.

Appeals and Grievances (January 2007-January 2009)

Background
A grievance and appeal process is a requirement establish by the Centers for Medicaid and Medicare Services. HealthCare USA is also required per State contract to abide by resolution timeframes at each level of the grievance process.

HealthCare USA reviews outcomes of member grievances and appeals and provider complaints, grievances, and appeals at least monthly. An opportunity to improve the overturn rate and the rate of timeliness was identified. The focus of the project is to improve timeliness and reduce the number of complaints, grievances, appeals, and overturn rates.

Goals
The initial goal is to decrease complaints, grievances, and appeals by 5% and either meet or remain below the Coventry overturn rate goals. The target date is January 2008.

Member

Indicator	2006	Goal
Member Grievances-Count	304.25	288.9
Member Appeals-Count	36.75	34.9
Member Appeals Overturn Rate	27.2%	15%
Member % of Timeliness	98.64%	100%
Goal for overturn rate is corporate set rate of 15% Other goals are a decrease by 5%		

Provider

Indicator	2006	Goal
Medical Complaints-Count	215.00	204.30
Non-Medical Complaints-Count	452.50	430.00
Medical Grievances/Appeals-Count	33.50	31.81
Medical Griev/Appeals Overturn Rate	12.7%	15%-Met
Non-Medical Grievances/Appeals-Count	57.0	54.15
Non-Medical Griev/Appeals Overturn Rate	21.9%	20%
Goal for overturn rate is corporate set rate of 15% Other goals are a decrease by 5%		

Provider

Includes timeliness of resolution for all provider medical and non-medical complaints, grievances, and appeals. Goal is set by State of Missouri.

Indicator	Mean 2006	Goal
10 Days 1st Level - % Timely	54.5%	80%
30 Days 2nd Level - % Timely	93.9%	100%
60 Days 3rd Level - % Timely	92.3%	100%

Interventions

	Classification	Interventions	Date
Member Issues	High Volume OB complaints about MTM transportation	Conduct a survey for high-risk OB members to determine cause of transportation grievances	Mar 07
		Send a list of all high-risk OB members to MTM to better facilitate coordination of care efforts and prevent transportation issues with this high risk population.	Feb 07; monthly
		Restrict OB transportation to van or car transport-no bus or metro-link transport.	Feb 07
		Develop and distribute a magnet to all pregnant members with the phone number for MTM transportation service	Sep 07
		Meet monthly with MTM to address ways to improve member satisfaction and reduce grievances	Feb 07; monthly

Staff Issues	Variation in overturn rates	Analyze and trend overturns of member appeals to identify any common patterns	Mar 07; monthly
		Implement record audit process to monitor entry and response timeliness	Jan 07; monthly
		Analyze and trend overturns of provider grievances/appeals	
		Analyze and trend first level complaints for patterns	
Provider Issues	Authorization of Services Process	Auth requirement for inpatient E&M codes eliminated	Oct 07
		HCA& Children's Mercy with automatic retro-review. First review is now treated as inquiry, allowing all three levels of appeal if denied on first review	May 07
		Auth requirement removed for non-par ambulance companies billing non-emergent services for hospital-hospital transfers	Aug 07
		System fixed to not deny ambulance claims with mental health diagnoses if benefits have mental health services carved out.	Aug 07
		PR to visit providers with high numbers of appeal for untimely filing to provide education	July 07
		Include article in provider newsletter educating providers about filing timeframes	July 07
Staff Issues	Education regarding processes	New staff hired and trained. In process of recruiting additional staff.	May 07
		Staff education on process for capturing all member grievances and provider complaints	Apr 07; ongoing
		New staff orientation to department specific policies/procedures	Mar 07
		Revision of current complaint, grievances, and appeals report to include specific data to identify trends	Apr 07; ongoing
		Compliance analysts educated regarding entering update status for authorizations and transcribing MD notes to improve timeliness of process	Sep 07; ongoing
		Instituted grand rounds and case management/disease management rounds with medical director and clinical staff	Aug 07; 4x/wk
		New medical director instituted Inter-rater reliability process for physicians reviewing appeals.	Sep 07
		Member services staff educated about dental benefits, specialist benefits, and locating providers	Jun 07
		Member services staff educated regarding querying members calling with a grievance regarding receiving bills from providers to clarify whether bill is simply notification that insurance co. was billed, a request for additional insurance info/clarification or an actual bill from the provider	Jul 07

Outcomes
Tracking of outcomes through September 2007:
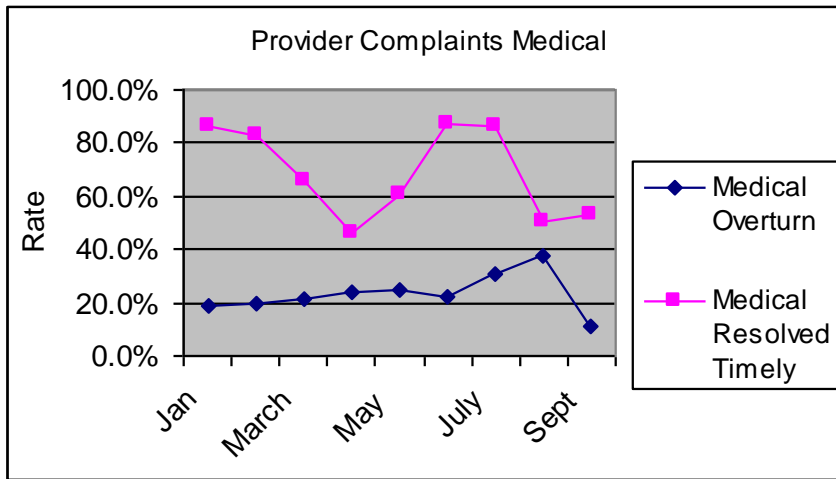
Provider Complaints Medical

Legend:
- Medical Overturn
- Medical Resolved Timely

Source: Navigator

Provider Non-Medical Complaints

Legend:
- Rate
- Overturns

Source: Navigator

Non-Medical Provider Grievances

Legend:
- Rate
- Timeliness

Source: Navigator

Provider Medical Appeals

Rate vs. Month (July, Aug, Sept)

Provider Non-Medical Appeals

Percent of Non-Medical Appeals — Overturn 0%, Timeliness 100% (2Q 07)
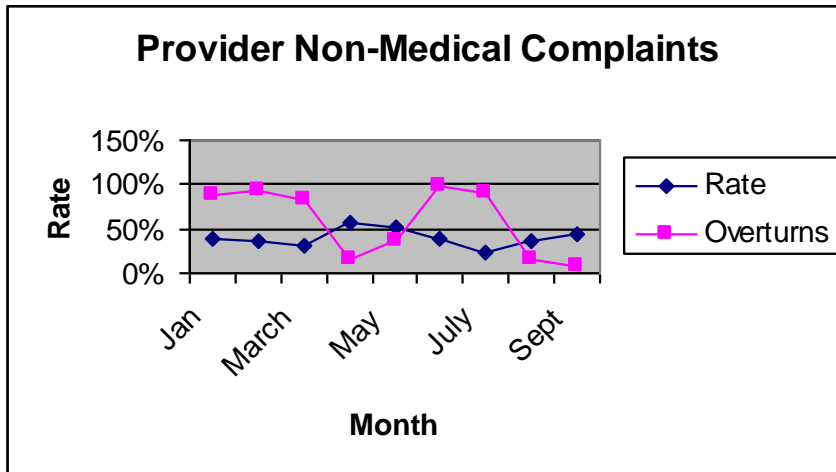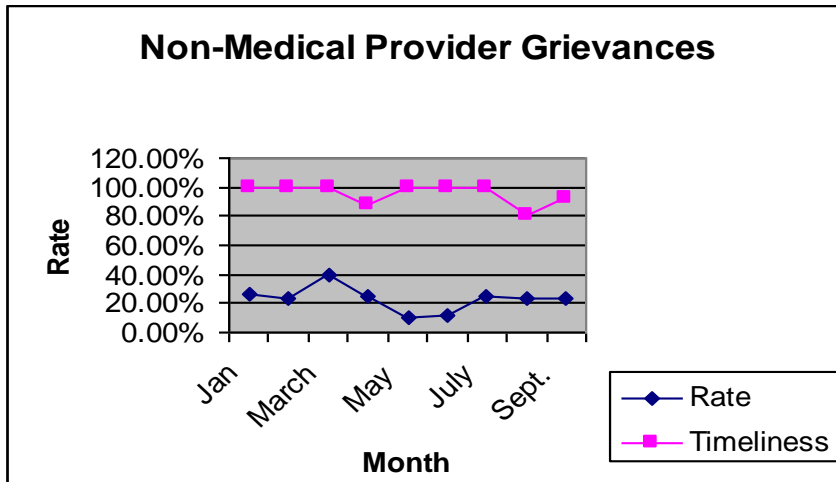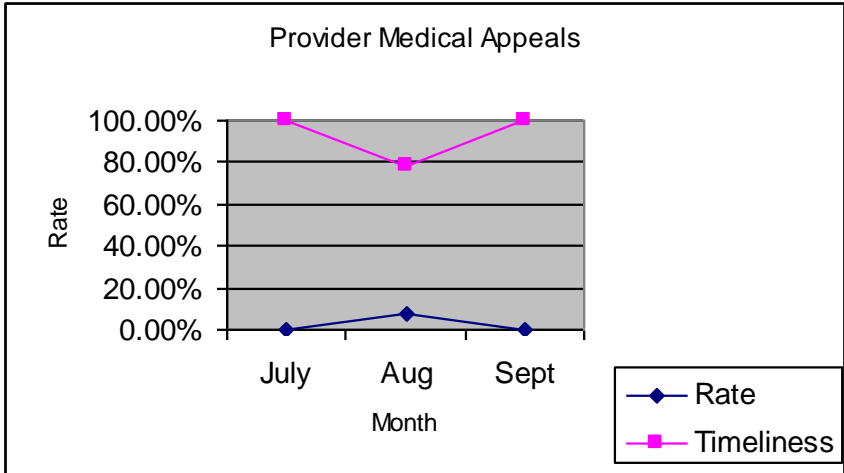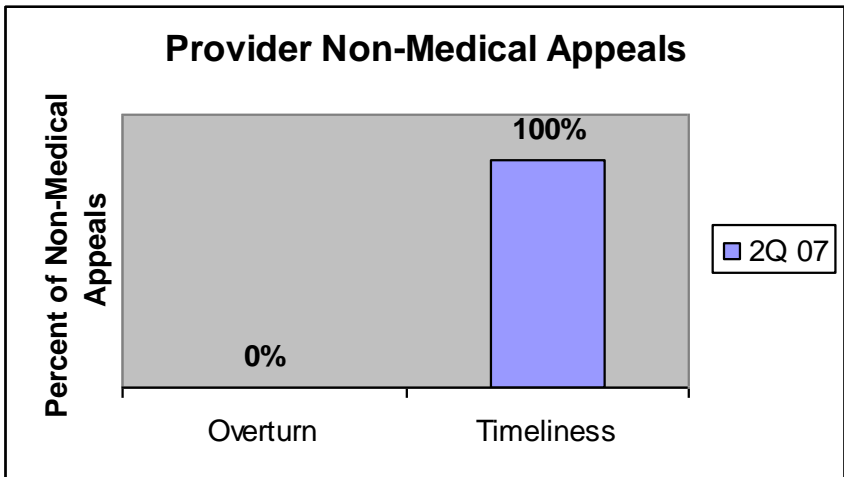
There were no provider non-medical appeals in 1st Quarter.

Member Medical Appeals

Rate vs. Month (Jan – Sept.)
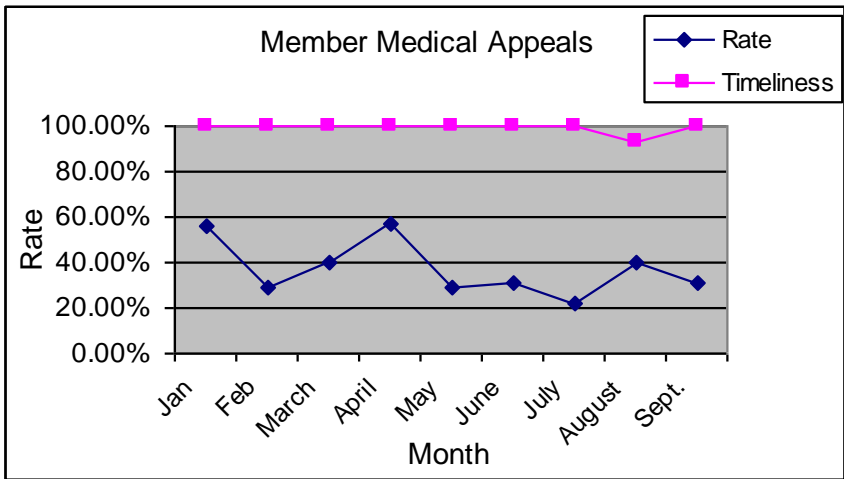
Grievance Process Tracking Log

Transportation	March	April	May	June	July
Late p/u	35	27	56	74	35
No Show	84	65	73	89	59
Rude	10	4	5	11	2
Billing Member	25	15	14	18	22
Total	154	111	148	192	118
% Timely	100%	99.76%	100%	100%	100%

Service Denials	April	May	June	July
Overturned due to Addt'l information rec'd	26	17	12	10
Claim Denials				
Timely Filing	16	0	0	0
Plan Processes				
Pre-auth	26	21	0	1
Total Overturns	68	38	12	11

Source: Navigator

Plan

Grievance Tracking log has been updated with new additional categories to better identify specific issues above and beyond the categories listed and reported in the state database.

Tracking and trending of outcomes will continue. Date for 2007 will be tabulated and analyzed for goal achievement.

On-going Interventions and Improvements
On-going interventions implemented because of Quality Projects are listed in each individual performance improvement project as listed above.

Effect on Health Outcomes and Member Satisfaction
The outcomes of each of the Performance Improvement Projects are listed with each project. Please refer to the projects as listed above.

Mercy CarePlus

Clinical

1. Early Intervention in Prenatal Case Management and the Relationship to Very Low birth Weight Babies PIP

   MCP implemented a PIP to determine if an increased rate of obstetrical ("OB") case management would affect birth outcomes. The PIP was designed to focus on whether increased rates of OB case management lead to a decrease in the rate of low birth weight (LBW, ≤2500 g), very low birth weight (VLBW, ≤1500 g) and extremely low birth weight (ELBW, ≤1000 g) babies. The results of the study concluded that increased rates of OB case management led to decreased rates of LBW, VLBW, and ELBW babies born during 2005 through May 2007. The rates are measured as per 1000 live births.

	2005	2006	2007
LBW	94.77	88.13	71.48
VLBW	22.88	17.35	16.54
ELBW	10.62	7.63	6.62

2. ADHD & Co-Morbidity Treatment Standards PIP
   St. John's Mercy Managed Behavioral Health routinely monitored top ten diagnosis trends of MCP's members. Two mental health diagnoses were consistently identified in the top four. The first being Depression, which is also the most frequently found inpatient diagnosis, and the second being Attention Deficit Disorder (ADD). Prior to this finding, St. John's Mercy Managed Behavioral Health formally adopted clinical treatment guidelines through their Quality Improvement Committee structure for the management of Depressive Disorders in 2002 and for ADD in 2003. Treatment guidelines were reviewed and revised at least every two years.

   This quality activity included the distribution of clinical treatment and medication guidelines to mental health providers, including a focused PCP distribution. In addition, St. John's Mercy Managed Behavioral Health implemented the measurement of Depression (the most frequent diagnosis) treatment adherence to nationally recognized guidelines in 2002, using a mental health provider medical record review methodology. Provider medical records were measured against eight clinical treatment indicators.

   Outcomes for this project were an overall 11.5% improvement in guideline adherence from the baseline measurement (87%) in 2002 through the latest re-measurement of 97% in 2005. The 2004 outcome led to special attention to one indicator related to documentation of member education due to this indicator being below the performance threshold. Provider educational activity was initiated and the 2005 result was improved by 33%.

   Two additional treatment standard indicators were measured by St. John's Mercy Managed Behavioral Health for mental health providers. These included completeness of medical

record documentation and documentation of PCP coordination of care. These focused activities were supported by ongoing provider education initiatives. Outcomes since 2000 indicated that the St. John's Mercy Managed Behavioral Health mental health providers reached or exceeded the performance target for medical record documentation in years 2000 through 2005, and reached or exceeded the performance target for PCP coordination of care in five of the six measurement years.

3. Coordination of Care – Pregnant Women PIP
    In 2004, St. John's Mercy Managed Behavioral Health and MCP implemented increased care coordination and case management protocols for pregnant women identified with mental health and substance abuse problems. A focus study was implemented with the objective of improving outreach and member access to mental health or substance abuse treatment services. This quality initiative involved coordination between MCP and St. John's Mercy Managed Behavioral Health care managers for pregnant and/or post-delivery women identified as having mental health or substance abuse concerns.

    During 2004, approximately 125 pregnant women were identified for this program. In 2005, interventions related to increased care coordination between St. John's Mercy Managed Behavioral Health and MCP case managers via telephonic interaction, as well as the initiation of member telephonic screening and outreach efforts by St. John's Mercy Managed Behavioral Health for positive mental health screens were initiated in 2005. A 185% improvement, (over 350 cases), was seen in pregnant women access to this program during 2005 as compared with 2004. In 2006, there was an increase to 432 cases.

    Other outcomes include:
    - 91% of the cases were initiated by MCP and 9% by St. John's Mercy Managed Behavioral Health in 2005. 88% of the cases were initiated by MCP and 12% by St. John's Mercy Managed Behavioral Health in 2006.
    - Average age is 23.5, with a range from 13 to 42 years. The majority were between 20 – 29 years of age.
    - 76.5% of the cases were pre-natal and 23.5% were ante partum in 2005. 75% of the cases were pre-natal in 2006.
    - Top three most frequent diagnoses in 2005 included Polysubstance Abuse, Depressive Disorders, and Cannabis Abuse. Top three most frequent diagnoses in 2006 included Depressive Disorders, Adjustment Disorders and Polysubstance Abuse.

    Of the 362 cases during 2005, 26.5% were identified as having access to mental health treatment services, including CSTAR programs.

Non-Clinical
1. Emergency Room Utilization PIP

    MCP implemented a PIP on emergency room utilization for asthma related diagnosis for children 5 – 18 years treated at Cardinal Glennon Children's Hospital Emergency Room. The purpose of the PIP was to determine whether the need for emergency medical intervention decreased after a member was educated following an ER visit. MCP

hypothesized that by educating members following ER visits, the member's quality of life would increase because there would be a decrease in need for emergency interventions. Based on the results of the study, there was a decrease in the ER rate/1000 members from 1.60 in Quarter 1 of 2006 to 1.42 in Quarter 4 of 2006.

On-going Interventions and Improvements
1. Pharmacy Process Improvement
   MCP has focused on maximizing quality in providing prescription medications to members by streamlining delivery and extracting excessive administrative costs from the system. MCP entered into an agreement with its subcontractor, Express Scripts, to process and pay prescription claims for network pharmacies. In this process, Express Scripts negotiated new, dramatically lower reimbursement schedules from participating pharmacies with no significant deterioration in network coverage. As part of this ongoing relationship, MCP and Express Scripts implemented numerous therapeutic clinical edits that ensure program beneficiaries receive appropriate cost effective treatment. Adhering to these protocols allows MCP and Express Scripts to authorize more costly treatments for only those members meeting the appropriate clinical criteria, while stretching available resources by ensuring members are appropriately matched with the strength of pharmacological agent necessary to treat their condition.

2. Medication Focus Studies
   MCP and Express Scripts implemented a focus study for MCP's top 100 prescribing physicians in MCP's top five therapeutic categories. The aggregate number of prescriptions and their associated costs determined the top five medications. Following analysis of that data, the prescribers were provided with additional verbal and written information on the cost-effectiveness of their prescribing options.

   Another focus study conducted in conjunction with Express Scripts evaluated the use of class 2 narcotics by members, prescribers, and pharmacies. Since it is the policy of MCP to provide safe, appropriate and cost-effective services for prescription and over-the-counter medications for eligible members and to identify inappropriate utilization of pharmacy services by its members, MCP regularly reviews profiles of members receiving class 2 narcotics. This review notes unusual quantities, dates of service, multiple prescribers, and pharmacy shopping behavior. When a particular member's pharmacy access lies outside of plan norms, MCP's case management evaluates the medical history to check for identifiable diagnoses that warrant pain control. If appropriate, members are offered pain management and/or mental health services. Members are placed into case management for follow up. If MCP's review finds no corresponding diagnosis warranting class 2 narcotics, the member is placed in MCP's Pharmacy Lock-In Program. Quarterly evaluations are completed on each member in the program. Results have shown improvement with the inappropriate utilization of Schedule II narcotics.

Effect on Health Outcomes and Member Satisfaction
As described above, each PIP focused on initiating a more positive outcome from the care received by members as well as improving the services provided.

Harmony

Clinical*
 Adolescent Immunization Collaborative

Non-Clinical*
 CAHPS 2008*

Ongoing Interventions
 Newsletters, reminder letters/telephonic outreach, one on one presentations
 Member/Provider Health Promotion/Disease Prevention Education
 Harmony Hugs Perinatal Outreach Program
 Emergency Utilization Outreach Education Program
 HEDIS score cards
 Medical Record Review
 Vendor Activities/Community Events

Effect on Health outcomes and Member Satisfaction
 Pending HEDIS 2008 Measurement*

*This is the Health Plans first fiscal year with the State of Missouri therefore HEDIS, CAHPS and PIP Quality initiative baseline data will be collected in 2008 for CY 2007, rates noted at this time are approximate and subject to change.

Missouri Care

Missouri Care submitted clinical and non-clinical Performance Improvement Projects (PIPs) that were underway in 2006 to the External Quality Review Organization (EQRO) for review. These PIPs were Increase Use of Controller Medication for Members with Asthma (clinical) and Increase Post Mental Health Hospitalization Follow-up within 7 Days of Discharge (non-clinical). We also began additional PIPs early in 2007. A summary of all active PIPs in SFY07 are presented below as well as ongoing interventions and improvements.

Clinical
Increase Use of Controller Medication for Members with Asthma
In 2006 Missouri Care initiated a PIP aimed at members with persistent asthma. The goal of the PIP was to increase the percentage of controller medication fills among members with persistent asthma. Among Missouri Care members who meet the HEDIS criteria for persistent asthma in 2005 (HEDIS 2006), only 71.09% of members had a fill of a controller medication. This is significantly below the statewide MC+ Health Plan rate of 84.58% on this measure and below the NCQA 75th percentile benchmark for HEDIS 2006 of 89.7%.
To address this issue, Missouri Care Health Plan implemented a quarterly member roster mailing to primary care providers, beginning in September 2006. Each quarter, providers receive a list of members who are identified as having persistent asthma but have not had a fill for a controller medication. The providers also receive a copy of the National Asthma Education and Prevention

Program (NAEPP) guidelines, along with sample asthma action plans to use with their members. In calendar year 2006 (HEDIS 2007) Missouri Care's rate on the asthma HEDIS measure increased to 82.75% (95% CI: 78.40-87.09). This was a significant increase from 2005 and statistically equivalent to the 2006 state average of 84.58%.

Adolescent Well Care – StateWide PIP
In 2006 the Missouri managed care health plans, through the Quality Assessment and Improvement Committee (QA&I) began working together on a statewide PIP to improve adolescent well care screenings. The Missouri managed care average in 2006 (the 2005 measurement year) on the adolescent well care HEDIS measure was 32.68%, which is well below the national NCQA 75th percentile benchmark of 47.90%. The Missouri Medicaid managed care plans, including Missouri Care, decided to work together to address the low screening rates. Missouri Care's rate on this measure was 44.53% in 2006 HEDIS (2005 measurement year) and 44.91% (95% CI: 40.10%-49.71%) in 2007 HEDIS (2006 measurement year), which is statistically equivalent to the NCQA benchmark.

In SFY07, the managed care plans met several times to design an intervention and develop provider and member education materials. The group developed a letter to be mailed to primary care providers discussing the importance of yearly well child visits for adolescents and suggesting ways to get them in for care. Along with the letter, a member information sheet was developed that providers could use to educate members and use as a flag in the member's chart to remind the provider that the adolescent needs a well child checkup. A roster of members past due for well child services will also be included in the mailing. The intervention is scheduled to be implemented early in SFY08.

WIC Partnership to Increase Well Child Checkup Compliance
After children have received all of their early immunizations, the percentage of children receiving annual well child checkups tends to decrease. For example, in calendar year 2006, 62.27% of Missouri Care children received at least six (6) well child visits by the age of 15 months, but only 58.97% of Missouri Care members 3 to 6 years of age received one (1) well child visit in the calendar year. To increase the percentage of young children receiving yearly well child exams (i.e HCY/EPSDT) and to educate parents of the importance of yearly exams for all children, Missouri Care partnered with several county WIC offices.

Beginning in January 2006, Missouri Care partnered with three WIC offices. The partnership identifies joint members. For members who have not had a recent well child exam, Missouri Care generates a flyer on the importance of well child checkups that is placed in the member's WIC folder. This information is shared with the members during their WIC visits. For members enrolled in Missouri Care and not WIC, Missouri Care mails information on WIC to the member and encourages the member to participate in the program.

Preliminary results indicate that members enrolled in WIC are more likely to have received a well child checkup this year than members not enrolled, but it is unclear if it is the intervention or the involvement in WIC that makes the difference. Approximately 30% of members receiving the flyer from the WIC office received a well child checkup in the three months following receipt of the flyer.

Non-Clinical
Post-Mental Health Hospitalization Follow-up within 7 Days of Discharge
In 2006, Missouri Care began a PIP to increase the percentage of aftercare appointments within seven (7) days for members hospitalized for a mental health diagnosis. Follow-up within seven (7) days of discharge is a HEDIS measure and thus a national standard. In the 2006 HEDIS reporting year, 2005 measurement year, Missouri Care's rate on the mental health measure was only 17.65%, which was below the NCQA 50th percentile of 38.4% for Medicaid managed care plans and well below the 75th percentile benchmark that Missouri Care Health Plan strives to achieve on all reported HEDIS measures. The 2006 75th percentile benchmark for this measure was 55.4%.

The performance improvement project included case management and care management activities aimed at members and providers. Missouri Care's care manager began working closely with hospital discharge planners to ensure an appointment is made for the member within the seven-day time frame. Missouri Care's case manager works with the members to remind them of their appointments and help them overcome barriers to attending the appointment. Missouri Care's rate on the follow-up HEDIS measure in 2007 (2006 measurement year) was 42.58% (95% CI: 35.64 – 49.53%), which was significantly higher than the 2006 rate of 17.65% and the 2006 state average of 31.46%.

Ongoing Interventions and Improvements
Missouri Care continually strives to improve access and remove barriers for members to receive preventive care services. Below are interventions and improvements that were continued or implemented in SFY07 to improve members' health and encourage utilization of preventive health care services.

Preventive Care Tool Kit
A toolkit was designed for providers, which addresses EPSDT, immunization, and lead screening/testing guidelines. The toolkit includes an overview of each topic, guidelines, required forms, recommended forms, and helpful resources. The toolkits are presented to pediatric and family practice clinics. The toolkit presentation allows Missouri Care to educate providers on our expectations for preventive services and for the clinics to share with us barriers that they have to providing these services to our members.

Did Not Keep Appointment Project
Providers notify Missouri Care of members who have missed well child checkup and/or immunization appointments. Missouri Care contacts the member's parent by letter for the first missed appointment and then by phone for subsequent appointments and educates the parent on the importance of well child visits and immunizations. Members are also educated on the importance of notifying their providers if they cannot keep a scheduled appointment.
Well Child Summer EPSDT Initiative
Parents of children ages 3-6 were mailed a flyer on the importance of yearly well child checkups. Missouri Care also did follow-up phone calls to a sample of the members to encourage an appointment to be scheduled. Additionally, Missouri Care partnered with several clinics to do

warm transfers to the clinic to schedule an appointment when we reached a member on the phone.

EPSDT Postcards
Parents or guardians of all children who are Missouri Care members are mailed an age-appropriate postcard during their birth month (and more frequently for children under two years of age) that encourages them to schedule an appointment for an EPSDT. The card gives age-appropriate information on what to expect at the appointment. It also provides information on appropriate development at each age.

Cervical Cancer Screening Postcards
Women are mailed a postcard during their birth month to remind them to schedule a yearly well woman exam. The card includes information on the importance of cervical cancer screening and screening for sexually transmitted diseases, such as Chlamydia.

Asthma Member Mailings
Members who are identified through claims data as having persistent asthma, but have not had a fill for a controller medication, are sent a letter recommending that they follow up with their primary care provider to discuss their asthma. Included in the mailing is an asthma action plan that the member can complete with their PCP.

Asthma Post Hospitalization Outreach
Missouri Care's concurrent review nurses contact all members who were hospitalized for asthma post discharge to educate the member on compliance with medications and to ensure that the member has filled medications prescribed at discharge. Missouri Care's Chief Medical Officer contacts the member's primary care provider to encourage follow-up care for the member and to educate the provider on Missouri Care expectation of following NAEPP guidelines for the treatment of asthma.

Pregnancy Booklet Mailings
All pregnant members are sent a pregnancy packet that contains a pregnancy booklet. The booklet tells the member what to expect throughout her pregnancy.

New Baby Booklet Mailings
All mothers are sent a packet after the delivery of their babies. The packet includes information on postpartum care, a "You & Your New Baby" booklet with helpful information on caring for a baby, an immunization and well child checkup schedule, an immunization record, and an appointment checklist.

Varicella (VZV) and Human Papilloma Virus (HPV) Immunization Outreach
Missouri Care conducted outreach to primary care providers and adolescent members on vaccinations appropriate for adolescents. In the fall of 2006 12 and 13 year old members were mailed information on immunizations and asked to supply Missouri Care with updated information on their VZV immunization status. This information was communicated with the member's PCP. In the spring of 2007 PCPs were mailed a list of their patients, who are also

Missouri Care members, who may be eligible for the HPV vaccine. Included in the mailing was a letter and checklist of other services to offer the member when she presented for the HPV vaccine.

Newsletters
Missouri Care publishes quarterly member, provider, and school nurse newsletters. Health education articles are included in every issue.

On-hold Messages
Missouri Care's on-hold messages contain health education and are updated quarterly.
New Member Calls Members are educated on the appropriate preventive services based on their age (or the age of their children) during new member outreach calls.

EPSDT's – Family Health Center Week
Missouri Care worked with a local Federally Qualified Health Center to promote EPSDTs during the Center's "Family Health Center Week." That week, 29 members were scheduled to receive EPSDTs at the center.

Effects on Health Outcomes and Member Satisfaction
Missouri Care continues to see positive outcomes from our interventions and performance improvement projects. Some of these outcomes can be seen in the HEDIS results present on pages 8-9. Additionally, Missouri Care's improvement on the DMS (currently MO HealthNet) EPSDT participation report is evidence of positive outcomes. Missouri Care's most recent EPSDT participation report showed an overall rate of 70.78% for calendar year 2006. The following graph depicts Missouri Care's steady improvement in the rate over time.
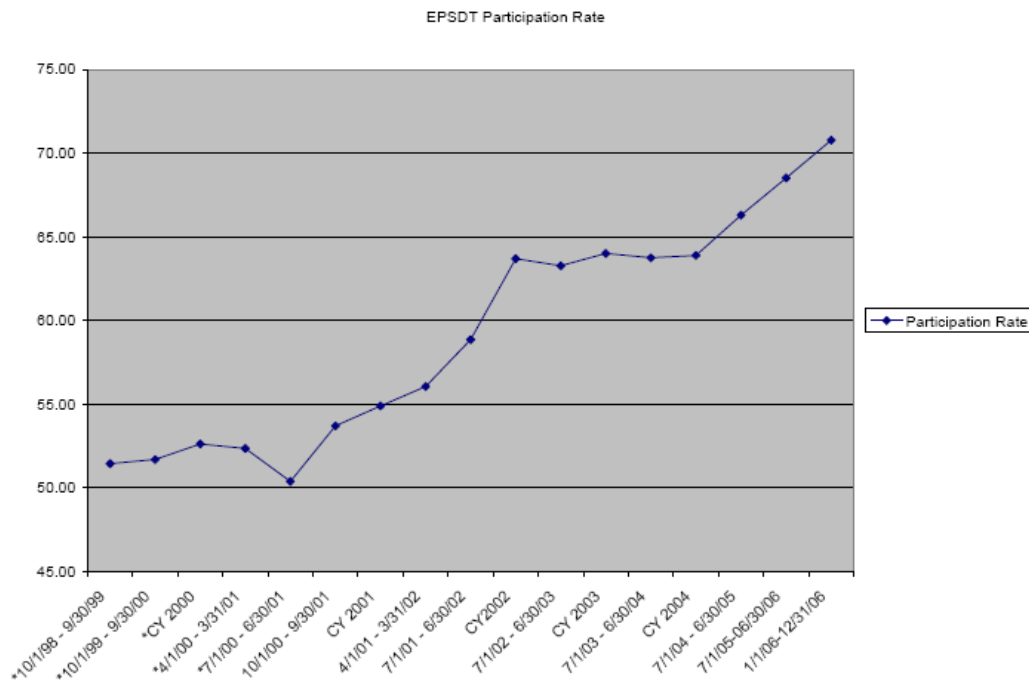
Missouri Care has recently noted an increase in calls from parents requesting additional information on immunizations and well child checkups. It is hoped that these calls are one indicator of our outreach efforts to members. We are helping members understand the importance of preventive services and they in turn are becoming more engaged in their health care. It is hoped that this will lead to even greater utilization of preventive health care services.

Blue Advantage Plus

Clinical
On-going Interventions and Improvements
Effect on Health Outcomes and Member Satisfaction

Improving Ambulatory Follow-Up and Patient Safety
Study Topic
The contract with the Department of Medical Services states (C306118007) in section 2.14.4.b.4, "For mental health and substance abuse services, aftercare appointments shall occur within seven (7) calendar days after hospital discharge."

BA+ Members discharging from inpatient care will be assigned and will adhere to a follow-up appointment with an in-Network Provider within 7 days and 30 days.

Literature Review
In 2003 and 2004, WellPoint Behavioral Health conducted the study of Improvement of Psychiatric Ambulatory Follow-up by Use of Care Coordinators (Am J Med Qual 2007; 22:95-97). This study examined whether patients discharged from inpatient psychiatric care would improve rates of follow-up appointments when designated staff (i.e., care coordinators) were assigned to coordinate care after hospital discharge. Of the 1804 psychiatric discharges, 71.6% kept an outpatient appointment within 7 days of discharge, and 88.3% kept an outpatient appointment within 30 days of discharge. These rates were a statistically significant improvement (P>.001) from the prior year's rates of 66.6% and 84.0%, respectively, when care coordinators were not used. New Directions Behavioral Health (NDBH) values the quality of life of the members served. By outreach efforts and coordination of care we expect the rate of follow up appointments to increase. When members meet and keep follow appointments, they reduce the risk of readmission by engaging in outpatient treatment.

Background
Ambulatory follow-up after discharge from the hospital for mental health diagnoses is recognized to have a positive impact on preventing or detecting the incidence, emergence or worsening of behavioral health disorders. The importance of this clinical process of after-care planning and follow-through has been established through research, resulting in selection of the 7-day and 30-day measures of follow-up for NCQA HEDIS® "Effectiveness of Care" measures. HEDIS is the Health-Plan Employer Data and Information Set. It is the most widely used set of performance measures in the managed care industry. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery

systems. HEDIS has become more than a set of measures; it is part of an integrated system to establish accountability in health care. HEDIS measures are selected by NCQA committees which are working groups of specialized physicians and practitioners in the subject area. To be selected for HEDIS, the measure must be related to evidence-based medicine, with demonstrated effectiveness in improving clinical care outcomes for the target population of patients hospitalized for mental health conditions. Effectiveness of Care measures provide information about the quality of clinical care that the health plan provides. They take into account how well the plan incorporates widely accepted primary and secondary preventive practices, recommended screening for common disease, and treatment for certain diseases or conditions.

Change in follow-up rates will be measured using HEDIS measurement data as a guideline for data collection.

Ensuring appropriate follow-up care after hospitalization for a behavioral health disorder is an important aspect of behavioral health treatment, as well as a HEDIS "Effectiveness of Care" measure. Due to inconsistencies in obtaining HEDIS data for the Mental Health Behavioral Health Organization (MBHO) Providers, and in order to be able to track performance more frequently than the annual HEDIS report allows, New Directions Behavioral Health (NDBH) has developed HEDIS-Like measures (the HEDIS-Like Measure is defined in the Base Line Methodology Section). The HEDIS-Like measure utilizes the technical specifications of what and how to measure the follow-up rates, with the exception of the continuous enrollment specification. Change in rates will be compared from year to year using the HEDIS-Like measure. In the data analysis, the HEDIS-Like measure will be compared to the certified HEDIS results when the data is available.

Study Question
Will follow-up of care and coordination, with members who are discharged from inpatient care, increase the rate of follow-up through ambulatory appointments with 7 and 30 days after discharge?

Study Indicators
The study indicators are based on the HEDIS® methodology for mental health follow-up after hospitalization for mental illness. The HEDIS® - Like indicator is a calculation that is used to reflect the HEDIS® measurement calculation. The difference between the HEDIS® indicator and the HEDIS® - Like indicator is the absence of the continuous enrollment of members.

Baseline Methodology:
The baseline methodology consisted of collecting claims data from EPOCH, a third party claims payment vendor.
The data collected specifications:

a. BA+ members.

b. Between 6 and 65 years of age as of the date of discharge.

c. Date of discharge through 30 days after discharge.

d. Medical and mental health benefits from BA+.

e. Discharge alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year.

f. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

g. If the discharge is followed by readmission or direct transfer to an acute facility for any mental health principal diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge form the facility to which the member was transferred. Although re-hospitalization might be for a selected mental health disorder, it is probably for a related condition.

h. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

i. Exclude discharges followed by readmission or direct transfer to a non-acute facility for any mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission of transfer may prevent an outpatient follow-up visit from taking place.

Data Analysis Plan
As stated earlier, the Director shares the HEDIS-like data with the Prevention and Care Coordination teams during staff meetings (when the data becomes available each quarter.) Staff discuss barriers and strategies for improvement which are incorporated into procedural changes. A report is written by the Director annually and is reviewed by the QIC and QMC where barriers and suggested courses of action are discussed.

The results of the HEDIS-Like measures will be used to characterize the impact of interventions on members who are discharged from an acute mental health hospitalization. The analysis is constructed in two parts; Quantitative and Qualitative.

Statistical Testing: Significance testing will utilize the Z test. After the first measurement year is completed, the statistical testing will be performed from the current measurement year to the previous measurement year beginning with the baseline measurement.
The Quantitative Analysis will summarize the findings and determine if any statistical significance is present.

The Qualitative Analysis will describe and discuss the interventions, which occurred during the measurement period. Barriers will be described and discussed resulting in opportunities form improvement. For each analysis cycle, the measures will be compared to baseline to evaluate the effectiveness of actions taken to improve performance. Qualitative analysis will be conducted for

each cycle to evaluate whether barriers are being removed, or whether there are as-yet-unidentified barriers which should be addressed to further improve performance on these measures

The results of the measurement period will be graphed comparing the HEDIS-Like data to certified HEDIS results. This process will assist in data validation.

Results
Ambulatory follow-up within 7 days of hospitalization

a. This first measurement period has increased over the baseline measurement from 53.0% to 56.3%.

Ambulatory follow-up within 30days of hospitalization

a. This first measurement period has increased over the baseline measurement from 74.9% to 76%.

The 2005 EQRO Report noted NDBH collaboration with in home therapy providing intensive interventions for Members and families with follow-up services with their community mental health center's for wrap around services and other beneficial interventions are "exceptional to the requirements of th.0e MC+ Medicaid Managed Care Contract".

Non-Clinical
On-going Interventions and Improvements
Effect on Health Outcomes and Member Satisfaction

Appeals Process Compliance
Study Topic
The MC+ contract requirement, C306118007 sections 2.15 and 2.16, require 100% compliance in response to: member grievances and appeals, Notice of Action (NOA) letters, and provider complaints, grievances and appeals.

Reaching and maintaining 100% compliance with the State contract, is a priority for BA+. Historically, BA+ has maintained a high level of compliance, yet never at 100%. The contract states specifically the timeframes that the member grievances and appeals, provider complaints, grievances and appeals are to be resolved. BA+ has sought to respond to the member grievances and appeals, provider complaints, grievances and appeals within the timeframes the State has required.

In 2005, it was determined that BA+ was not meeting the State's timeframes for Complaints, Grievances and Appeals. In 2006, State Programs began to evaluate the barriers that prevented timeliness of responses to members.

In 2005, the State Programs Complaint Analyst received ninety-six member grievances and twenty-nine member appeals. The majority of the grievances were transportation issues. By

increasing the response time to the member, it may increase the access to health care and issues surrounding transportation. This will assist in helping providers and members make health care decisions more quickly.

Literature Search
An internet literature search was performed in an effort to obtain external data related to medical necessity appeals and access to care and satisfaction. While no studies were found specifically related to access to care or satisfaction, intuitively the importance of timely appeal decisions can be made. Most States have regulations regarding the appeals process. The reason the subject of this Performance Improvement Plan (PIP) is important is the case can be made that the more timely a member grievance or appeal is processed and the decision is communicated to the member and physician, the more timely the member a) receives the requested service, b) Blue-Advantage Plus – Annual Appraisal of the QI Program – Program Year FY2007 48 receives an alternative covered service, or c) makes the decision to decline treatment. Timely appeals processing decreases the delay in access to care due to waiting for a decision.

Background
Prior to the development of the Performance Improvement Project several interventions were created and implemented. They were:

Subcontractor Toolkit
a. Doral Dental will continue to receive annual training and education. The Subcontractor toolkit will be updated reviewed and sent to Doral Dental.

b. New Directions Behavioral Health (NDBH) was presented and trained with a training toolkit on May 2, 2005. The toolkit included contract requirements, flowchart (demonstrating the CGA workflow), NDBH Desk Procedures, Customer/Provider Inquiry Form (CPI). Member Acknowledgement Letter template, 14-day Time Extension for Grievances template, Grievance Resolution Letter Template, and the Member Grievance audit tool. NDBH was also presented and trained with a separate toolkit for providers which included: contract requirements (for providers CGA), Flowchart (for provider CGA), NDBH Desk Procedures (for provider CGA) Complaint Determination Form (CPD), Complaint Resolution Letter Template, Audit Tool (for provider CGA) and the BA+ Notice of Action Letter template (which is sent to providers and members).

c. Medical Transportation Management (MTM) was presented and trained with a training toolkit on June 3, 2005. The toolkit included contract requirements and a flowchart of the process that MTM should use for MTM Member Grievances.

Customer Service Training
a. Training was conducted with BA+ Customer Service on Triaging Written Correspondence. The Standard Operating Procedure (SOP) 5460 was developed in February 2005 for the training. The training session educated BA+ Customer Service of the issues that should be

reviewed by the State Programs Complaint Analyst versus what should be reviewed by BA+ Written Correspondence.

b. Training was conducted with BA+ Customer Service regarding anesthesia. Providers were being incorrectly reimbursed. The claims should be reviewed by State Programs Complaint Analyst. This training was conducted in March 2005.

c. Training was conducted with BA+ Customer Service on the correct usage of NOA letters. This training was conducted in December 2005.

Medical Management Education and Training

The Manager of Quality Performance Measurement educates and trains staff for the correct usage of the NOA letters. In November 2005, education was provided to nurses, medical directors and clinical directors on policy and process for generating NOA letters and implications for not complying.

Study Question
Will training, education and restructuring the work flow of member grievances and appeals, provider complaints, grievances and appeals improve the response time to members and providers?

Study Indicators
The study indicators are based on the compliance for closing the member grievances and appeals, or provider complaints, grievances and appeals within the required timeframe. The NOA letter indicator is based on the number of correct letters sent to members.
The Appeals Process Compliance project was created to bring BA+ in compliance with the State contract, C306118007. The BCBSKC standard has been 95% compliance for complaints, grievances and appeals for members and providers. In an effort to be 100% compliant with the State contract, this project will gather data, implement interventions and strategies, and increase the compliance rate for member grievances and appeals and provider complaints, grievance and appeals.

Data Analysis Plan
Data Collection –

a. For measures 1 through 5, Data is extracted from FACETS through data tables. The data tables in FACETS include all data fields required for reporting to the State, as well as conducting required measurements. Measure 6 data is extracted from the FACETS system in the Utilization Management (UM) module by Information Access Division (IAD).

Data Analysis –

a. The data is entered into the tables to document the numerator and the denominator. Statistical testing is performed against the base line to determine if there is any significance in the

results. After the first measurement year is completed, the statistical testing will be performed from the current measurement year to the previous measurement year.

b. The results are analyzed using a quantitative and qualitative analysis process. The results are discussed and barriers reviewed to determine if the barrier has been removed by the intervention. Action will be taken on the result of the barrier being removed or if the barrier remains.

c. For the quantitative analysis, include in the analysis:

    i. Comparison with the goal/benchmark

    ii. Reasons for changes to goals

    iii. If benchmarks changed since baseline, list source and date of changes

    iv. Comparison with previous measurements

    v. Trends, increases or decreases in performance or changes in statistical significance (if used)

    vi. Impact of any methodological changes that could impact the results

d. For the qualitative analysis, describe any analysis that identifies causes for less than desired performance (barrier/causal analysis) and include the following:

    vii. Techniques and data (if used) in the analysis

    viii. Expertise (e.g., titles; knowledge of subject matter) of the work group or committees conducting the analysis

    ix. Citations from literature identifying barriers/opportunities (if any)

    x. Barriers/opportunities identified through the analysis

    xi. Impact of interventions

Results
Analysis and statistical testing of the data have demonstrated no statistical significance for all six measures when compared to the baseline measurement. The qualitative analysis revealed that the small number of complaints, grievances or appeals magnifies the data results. The project has not yielded 100% compliance for all measures, yet the measures continue to remain high.

MEMBER SATISFACTION

The 2007 Consumer Assessment of Health Plans (CAHPS®) Medicaid Child Member Satisfaction Survey was conducted from February through April of 2007. This included mixed

(mail and telephone) survey administration methodology. A total of 492 responses from the eligible member population were received, which yielded a response rate of 30.2%.

The 2004 through 2007 Summary Rate composite and rating scores for BA+ are listed below. Summary Rates represent the percentage of respondents who answer in the most positive way. In order to assess how member satisfaction scores compare with other Medicaid Child plans nationwide, a national benchmark, 2004 CAHPS® Benchmark® is also provided.

Composites/Ratings	2007 Summary Rates	2006 Summary Rates	2005 Summary Rates	2004 Summary Rates	2004 CAHPS® Benchmark (Medicaid Child)
Getting Needed Care – experiences members had in the last 6 months when attempting to get care for their child from doctors and specialists.	80.1%	81.3%	83.9%	80.8%	74.9%
Getting Care Quickly – member's experiences with receiving care or advice for their child in a reasonable time and includes experiences with time spent in the office waiting room.	77.7%	79.5%	78.6%	79.4%	77.4%
How Well Doctors Communicate – how well providers listen, explain, spend enough time with, and show respect for what members have to say.	88.9%	92.0%	89.8%	90.3%	89.4%
Courteous and Helpful Office Staff – recipient's treatment by office staff in the last six months.	89.9%	92.2%	90.6%	90.2%	90.0%
Customer Service – how much of a problem it was for members to get information and fill out paperwork in the last 6 months.	64.0%	77.0%	76.6%	71.7%	72.4%
Rating of Personal Doctor (Q5)	79.2%	78.3%	78.3%	79.1%	81.6%

Rating of Specialist (Q12)	79.4%	76.5%	85.5%	80.3%	78.0%
Rating of Health Care (Q39)	82.4%	79.8%	76.3%	81.7%	80.3%
Rating of Health Plan (Q62)	82.0%	81.2%	78.7%	78.2%	76.4%

Children's Mercy Family Health Partners

Children's Mercy Family Health Partners submitted two (2) Performance Improvement Projects in lieu of the requested reporting format.

Children's Mercy Family Health Partners
Improving Access to Primary Care Services
Performance Improvement Project
2004-2007

Definitions

CMH – Children's Mercy Hospital
ER – Emergency Room
PCP – Primary Care Physician
TMC – Truman Medical Center
CMFHP- Children's Mercy Family Health Partners
IHA – Institute for Healthcare Advancement

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.

A recent article by the Institute for Healthcare Advancement titled, *"Ten Ways to Reduce Overcrowded Emergency Rooms"* supported the implementation strategies that were utilized in this project. The article suggested that the following processes could prevent ER overuse:

- Establishing a telephone advice line
- Education to members
- Involvement of case managers [1]

In 2004, Children's Mercy Family Health Partners assigned a Case Manager, Augusta Amada, RN 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 ER visits in 60 days
- Monthly ER Utilization – all members who visit the ER in the reporting month
- All members who visit the ER 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 ER 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 ER based on appropriate triage criteria.

- Of the members who utilized the ER 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 ER 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 ER for dental services – including information on dental resources for adults.
- Mailed monthly educational letters to members identified as using the ER 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 ER Services at Truman Medical Center, our highest ER volume 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:

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

2. 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?

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

Indicators

Rate of Emergency Room Utilization. Members who have had an ER visits post intervention within a 12-month period. Claims data will be queried quarterly, utilizing the CMFHP information systems (utilizing the CMFHP information system (OAO). This data will be analyzed to determine the rate of ER utilization per 1000 members.

Use of PCP, Urgent Care and ER Visits. In late 2005, CMFHP will utilze the database provided by our ER Case Manager to identify a study population for review of utilization patterns before and after intervention. This information will include ER utilization, Urgent Care utilization, and PCP utilization.

Rate of Nurse Advice Line calls. Inclusive of entire FHP member population. Call Center data will be gathered and reviewed by the CMFHP Senior Quality Management Nurse, Johanna Groves, RN, 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. Truman Medical Center services the highest volume of Medicaid adults in the Kansas City region. 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 the following data on each member seen in the ER:
- Date of Intervention

- Demographics (name, age, date of birth, gender, full address)
- Diagnosis
- Education
- Potential barriers
- Eligibility

This collection is stored in the CMFHP ER access database.

In addition, the ER 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 ER 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.

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 the 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 and Nurse Advise Utilization 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.

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 Health Services Review Committee, chaired by Ma'ata Touslee, Director of Health Services.

A quarterly update of the project will be provided to the CMFHP Medical Management Committee, chaired by Elizabeth S. Peterson, MD.

A summary of the project will be provided to the CMFHP Community Advisory Committee chaired by Cindy Mense, Director of Customer Service for consumer/member input.

Implementation of Intervention
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 utilizing MC400, for member eligibility, PCP, claims, and authorization history.

Demographic Data Analysis

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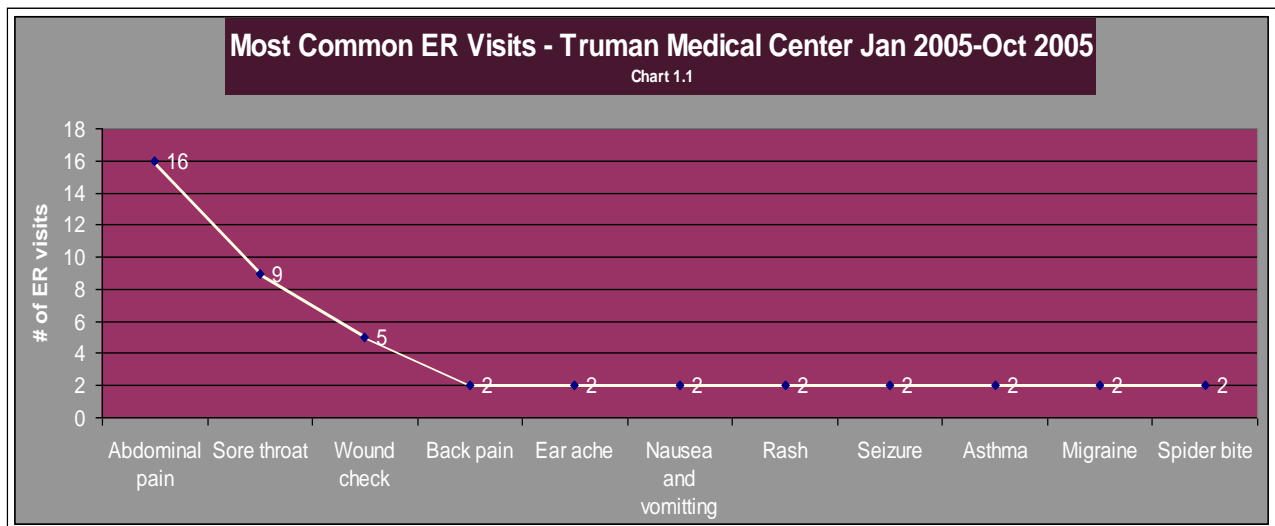
Member Seasonality
Specific months were reviewed to determine the most utilized months of the ER. Chart 1.2 displays the member seasonality from Jan 2005 through Oct. 2005.

Chart 1.2
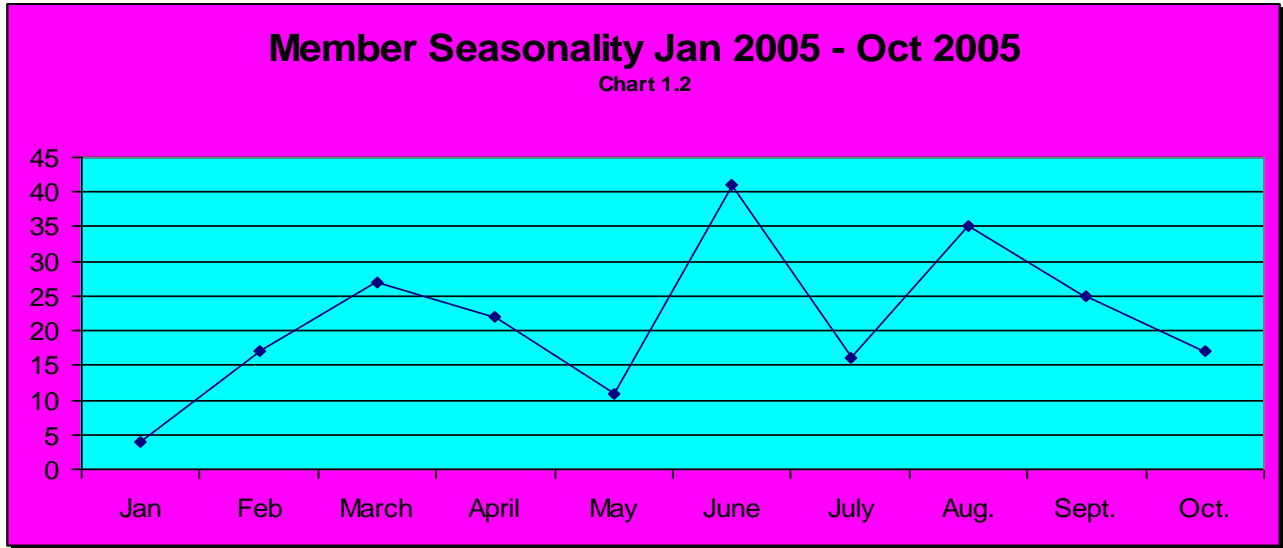
ER, PCP, UC Visits
Emergency room, primary care and urgent care visits were compiled for the 215 members from years 2003, 2004, and 2005. Chart 1.3, 1.4 and 1.5 displays the total number of visits among these 215 members from years 2003-2005.

Chart 1.3

Total # of ER visits per 215 pts (2003-2005)
Chart 1.3

Chart 1.4

Total # of PCP visits per 215 pts (2003-2005)
Chart 1.4

Chart 1.5

47

Total # of Urgent Care Visits per 215 pts. (2003-2005)
Chart 1.5

Fiscal Year

FY 2005	0
FY 2004	3
FY 2003	2

0   1   2   3   4

# of UCV
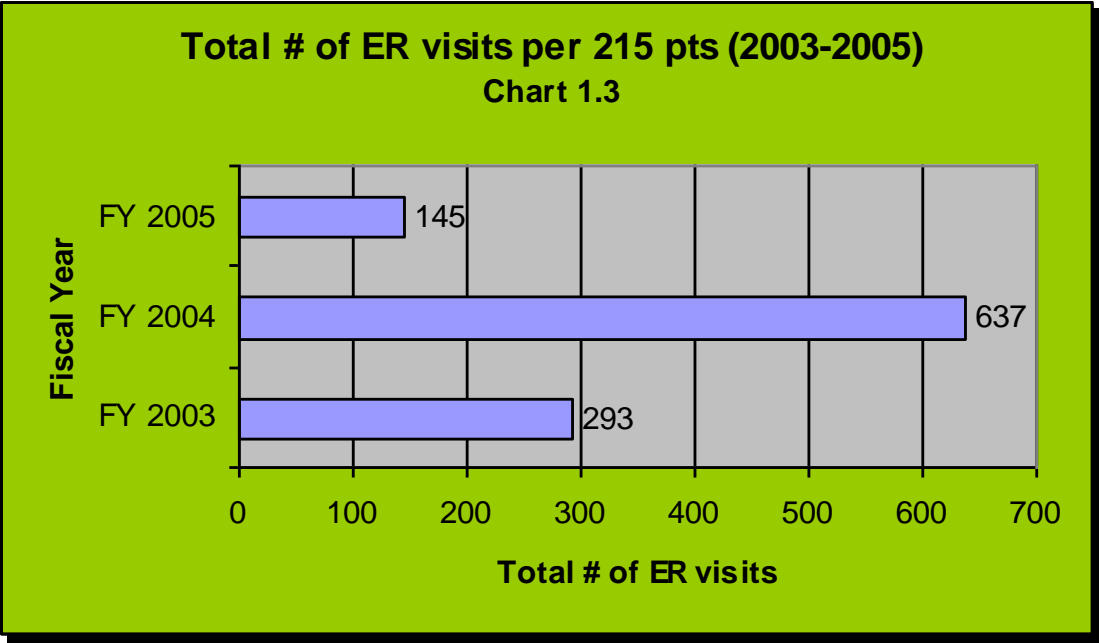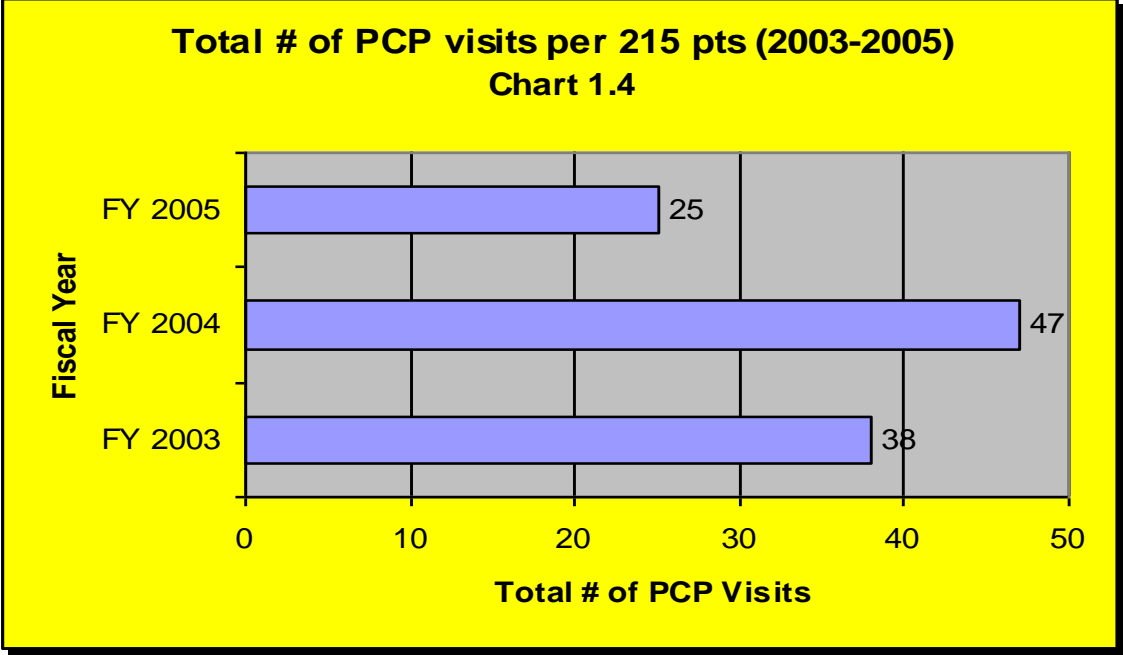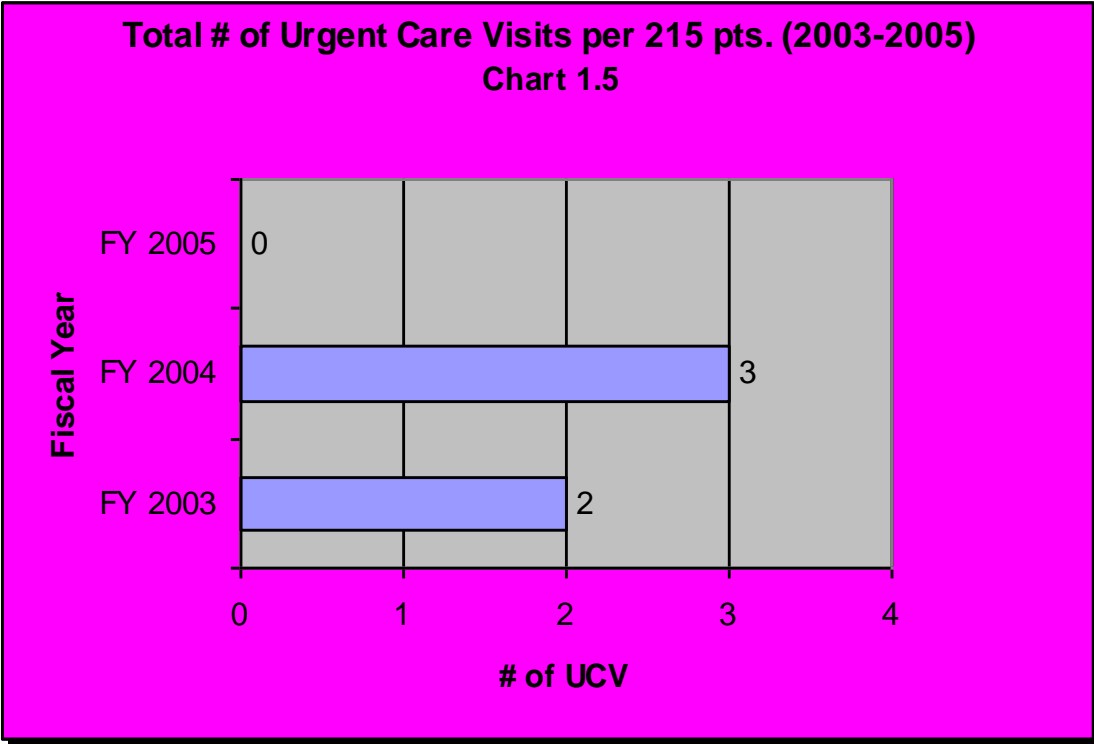
Demographics

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.

Chart 1.6

Gender Utilization 2005
Chart 1.6

10%

90%

☐ Female
■ Male

Chart 1.7

Truman ER Utilization Age Groups
Chart 1.7

33 years old	7
29 years old	7
	7
	8
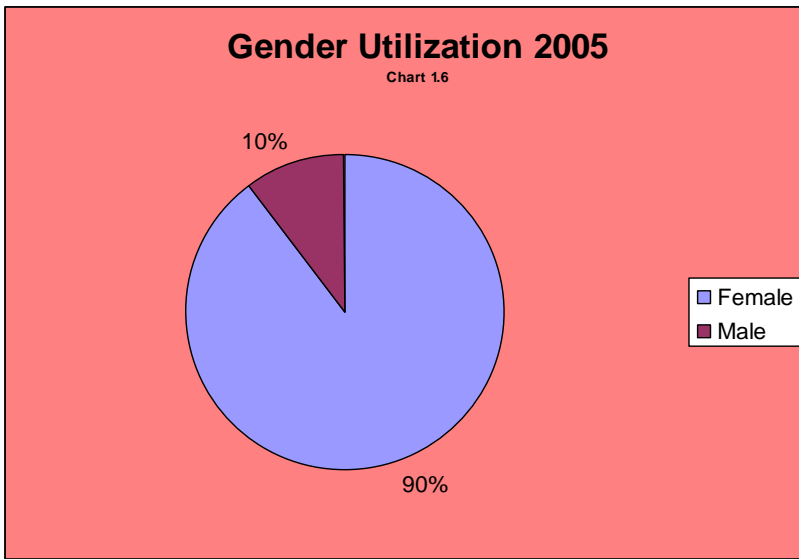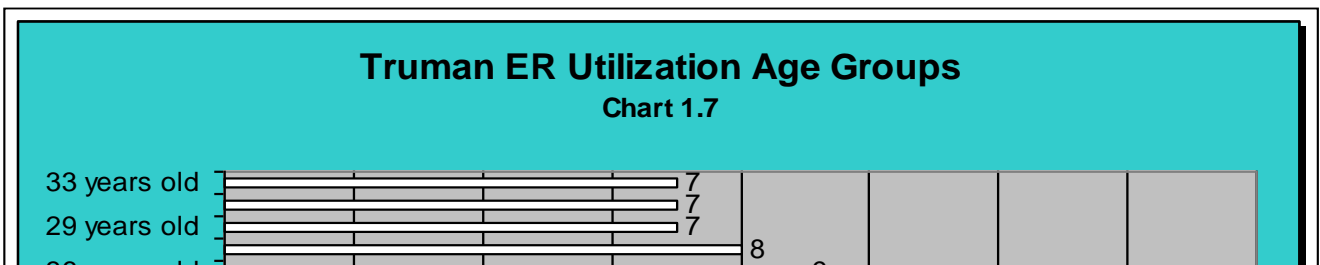
Chart 1.7

Chart 1.8 demonstrates general census data available for the top 3 zip codes where the 215 members reside.

Chart 1.8 below demonstrates overall census data for the top 3 zip codes identified from our study population.

Chart 1.8

Most Common Pt. Origin - Truman ER - Jan 2005 - Oct 2005 Chart 1.8				
	Zip Code: 64106	**Zip Code: 64127**	**Zip Code: 64130**	**Total**
Sum of 2005 Total Households	2766	7633	9879	20278
Sum of 2005 Average Household Income	33638	35449	35464	104551
Sum of 2005 Median Age	32	32	35	99
Sum of 2005 Median Household Income	24843	24505	26579	75927
Sum of 2005 Per Capita Income	14983	13543	13995	42521
Sum of 2005 Population	7090	20698	25372	53160
Sum of 2010 Average Household Income	38182	39237	38386	115805
Sum of 2010 Median Age	33	32	35	100
Sum of 2010 Median Household Income	28260	27050	28591	83901
Sum of 2010 Per Capita Income	16723	14829	15420	46972
Sum of 2010 Population	7622	20424	24322	52368
Sum of 2010 Total Households	2961	7448	9637	20046

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
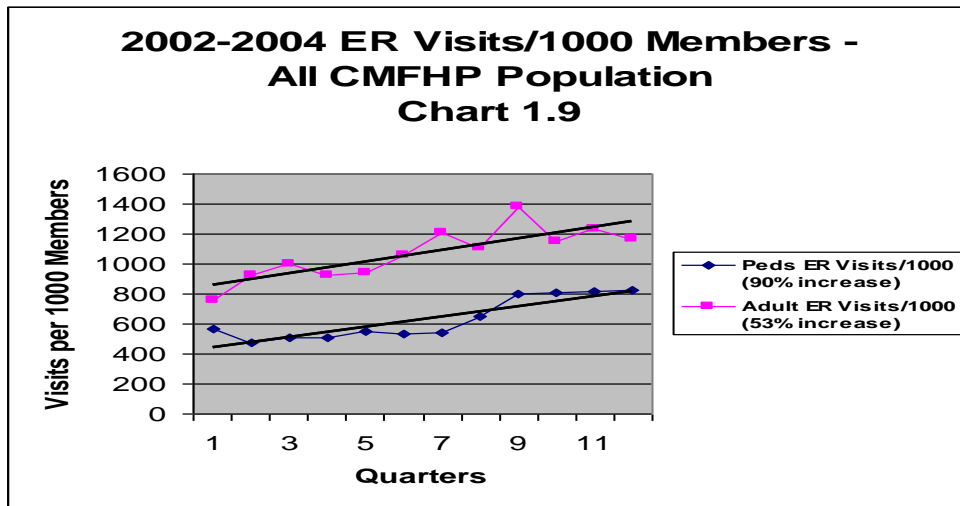
Chart 1.10
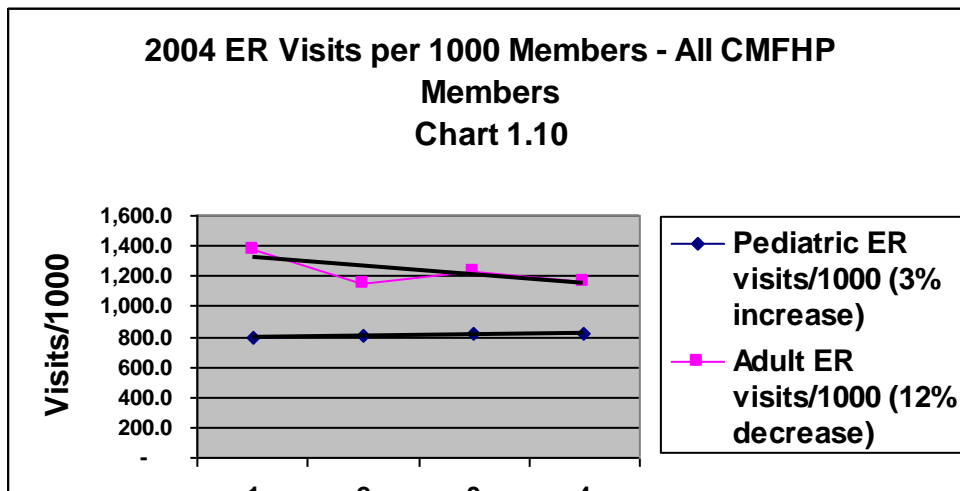
Specific information was collected to determine the months most utilized in 2003, 2004 and 2005. Charts 1.11, 1.12, and 1.13 <u>do not</u> show consistent commonality or monthly seasonality from year to year.

ER visits 2003
Chart 1.11

ER Visits 2004
Chart 1.12

ER Visits 2005
Chart 1.13

Month	Value
January	3916
February	4171
March	3695
April	3183
May	3095
June	2811
July	2649
August	2606
September	2659
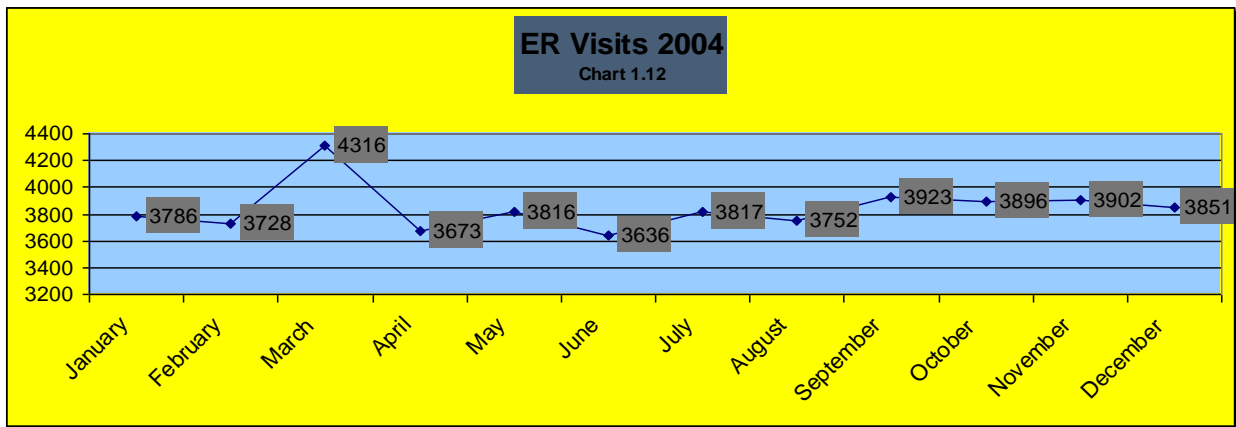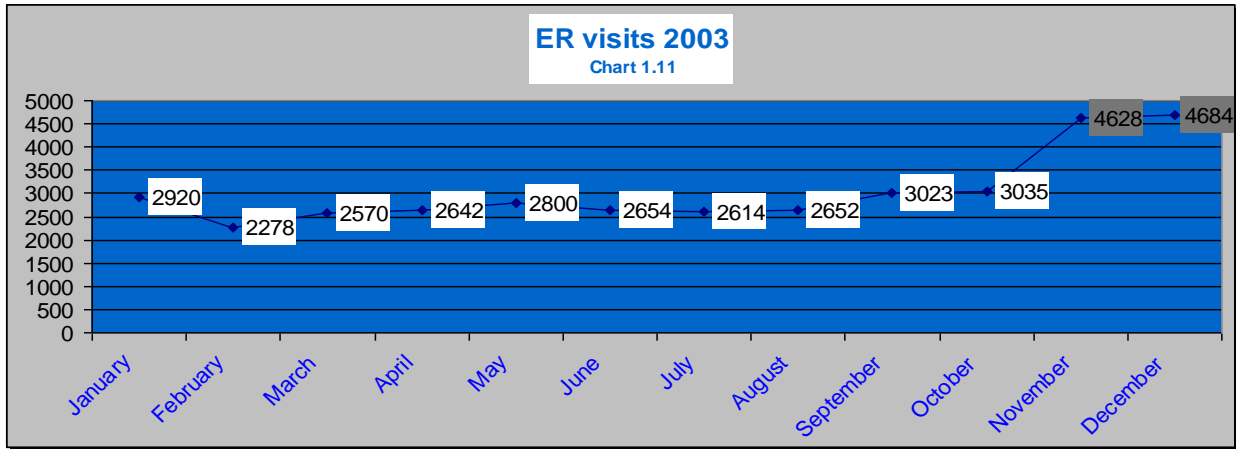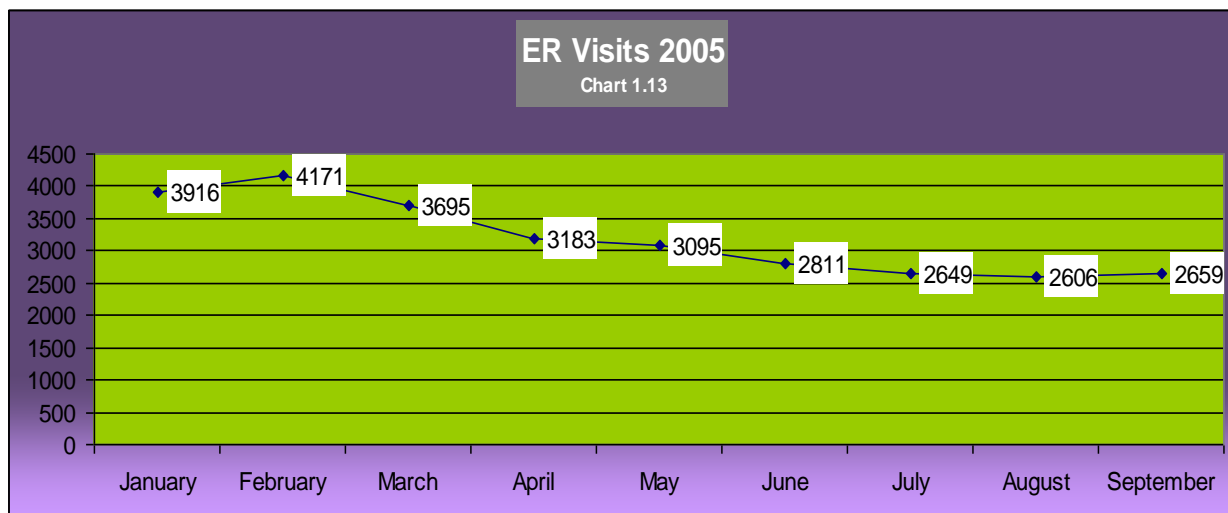
Data Analysis

Study Group 1 - 1st Quarter 2005
There were 13 continuously eligible members in 1st Quarter 2005. Overall, there was a successful reduction in ER visits. Seven eligible members decreased ER usage, resulting in a 24% decrease. However our results show that we were unsuccessful with increasing PCP visits. Our data reflects a 50% increase, but that is only an increase in a PCP visit for one member. Additionally, 4 members began using other practitioners, besides their primary care physicians and there was a 67% decrease in Health Department visits.

There were 2 members in 1st Quarter 2005 who had a significant increase in ER visits post intervention. The following additional data was collected:
- Diagnosis (Dx) – based off most reoccurring ER visit
- Successful contact – number of successful telephonic interventions
- Pharmacy data – to determine if specific members had unusual drug activity

In Qtr 1, 2005, both members that were assessed had pregnancy related problems (see Chart 1.14). Successful contact was made with both members, and neither member had any pharmacy related concerns. Due to the fact that the case management program does not intervene with pregnant members who are seen in the ER, there was no concern about the increased utilization on these 2 members, as it relates to study results.

Chart 1.14

1st Qrt 2005 ER Member's Dx
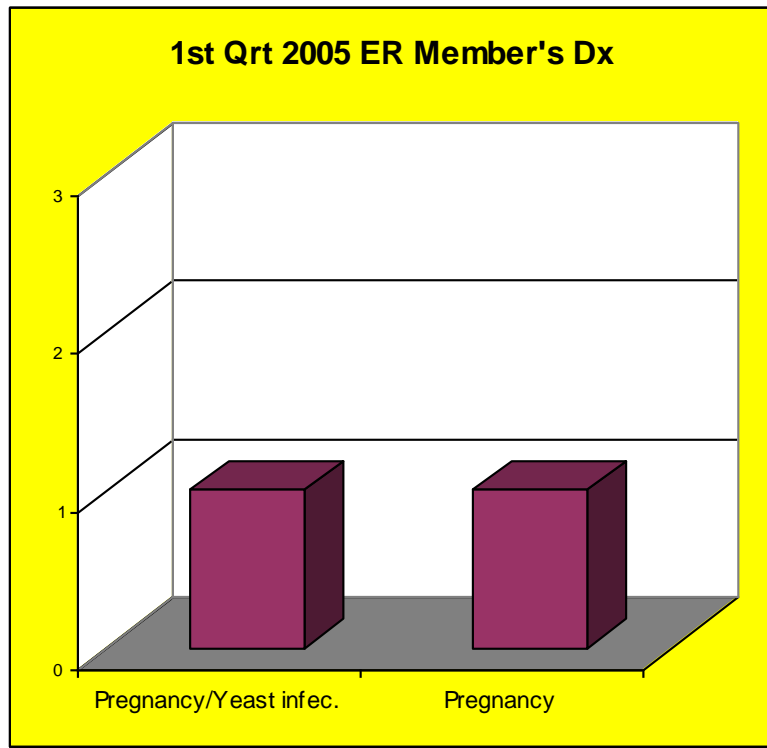
Study Group 2 - 2nd Quarter 2005
There were 15 continuously eligible members in 2nd Quarter 2005. Overall in the 2nd Quarter of 2005, there was a 27% increase in ER visits and a 300% increase in PCP visits. Additionally, there was a 74% increase in members who utilized other practitioners besides there primary care physicians and an 80% decrease in Health Department visits.

We identified six members 2nd Quarter 2005 who had a significant increase in ER visits post intervention. The following data was collected:
- Diagnosis (Dx) – based on most reoccurring ER visit
- Successful contact – number of successful telephonic interventions
- Pharmacy data – to determine if specific members had unusual drug activity

In Qtr 2, 2005, the six eligible members that were assessed were seen for a variety of diagnoses (see Chart 1.15).

Chart 1.15

2nd Qrt 2005 ER Member's Dx
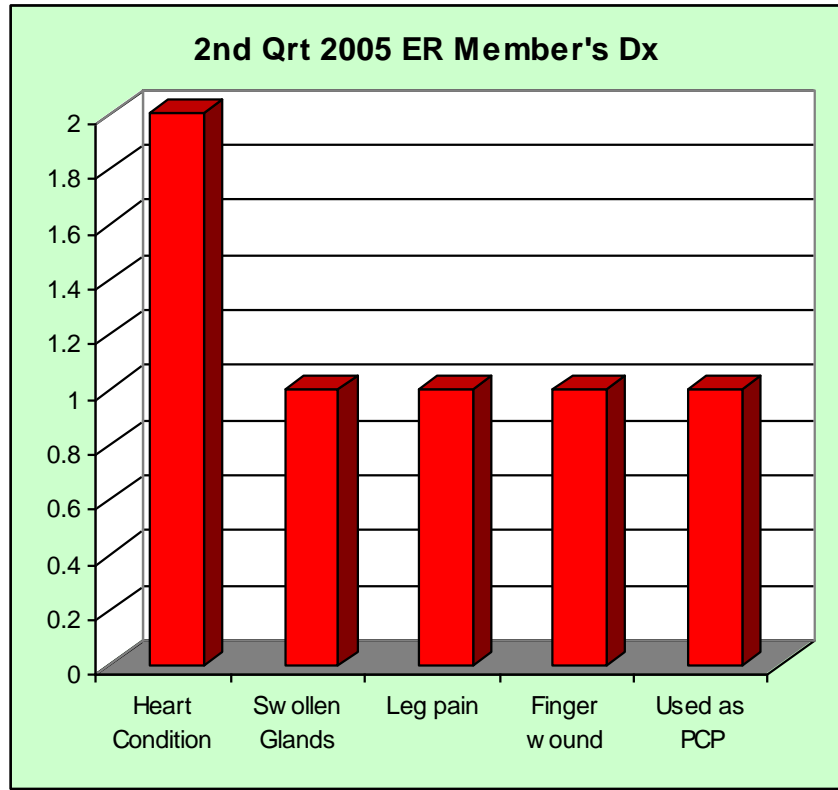
Successful contact was made with all members. There was one member who had potentially unusual drug activity due to the prescribed increase in analgesics for headaches, limb swelling and sciatica. It was recommended that this member continue with ER case management. Out of the six members in Quarter 2 of 2005, there were a total of four members that were recommended to be followed for more intense interventions by an adult Case Manager.

Study Group 3 - 3rd Quarter 2005
There were 29 continuously eligible members in 3rd Quarter 2005. Overall, there was a 100% increase in ER visits and a 24% increase in PCP visits. Additionally, there was a 100% increase in members who utilized other practitioners besides there primary care physicians and a 100% increase in Health Department visits.

We identified twelve members 3rd Quarter 2005 who had a significant increase in ER visits post intervention. The following data was collected:

- Diagnosis (Dx) – based off most reoccurring ER visit
- Successful contact – number of successful telephonic interventions
- Pharmacy data – to determine if specific members had unusual drug activity

In Qtr 3, 2005, the twelve eligible members that were assessed were seen for a variety of diagnoses (see Chart 1.16).

Chart 1.1.6

3rd Qtr 2005 Members' Dx
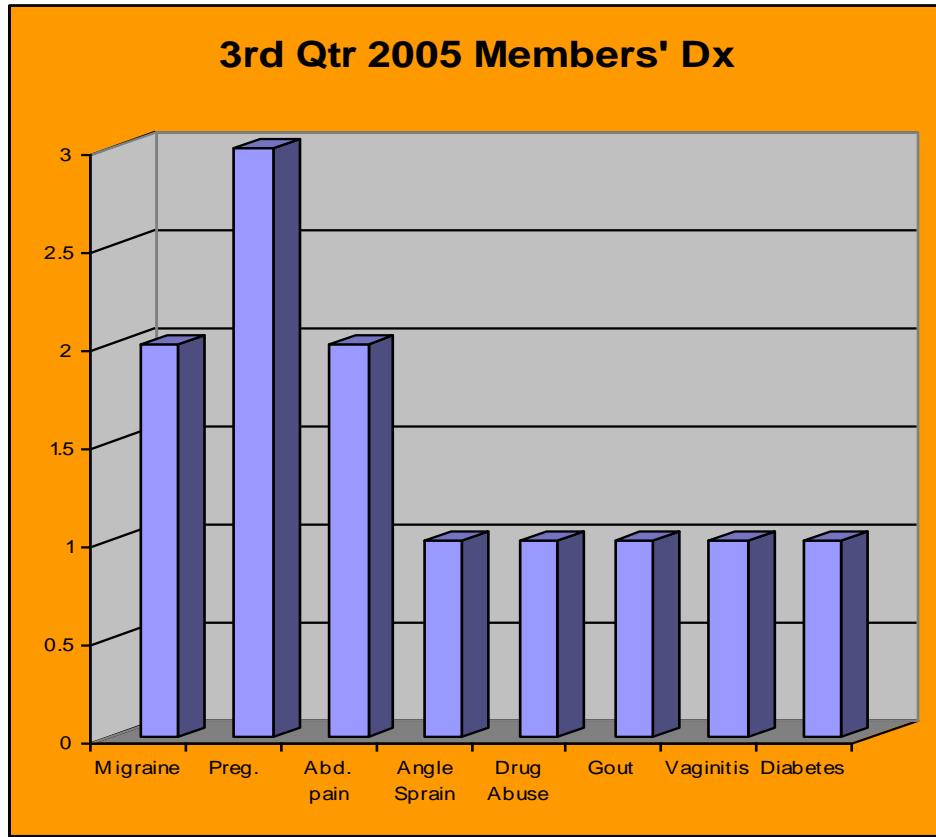
Successful contact was made with all members. There were three members who had potentially unusual drug activity due to:
- use of analgesics/antipyrexia for chronic cystitis
- use of NSAIDS
- use of anxiolytics/sedatives for drug induced depression, asthma and pain.

Out of the twelve members in Quarter 3 of 2005, there were a total of four members that were recommended to be followed for more intense intervention by an adult Case Manager.

*Note: ER data was not collected in 4th Quarter 2005 due to the absence of our ER Case Manager.

Study group 4 - 1st and 2nd Quarter 2006
There were 11 continuously eligible members in 1st and 2nd Quarters of 2006. Overall, there was a 30% decrease in ER visits and no change in PCP visits. Additionally, there was a 67% increase in members who utilized other practitioners besides there primary care physicians and a decrease in Health Department visits from one visit to none post intervention.

We identified three members in 1st and 2nd Quarter 2006 who had a significant increase in ER visits post intervention. The following data was collected:
- Diagnosis (Dx) – based off most reoccurring ER visit
- Successful contact – number of successful telephonic interventions
- Pharmacy data – to determine if specific members had unusual drug activity

In Qtr's 1 & 2 of 2006, the three eligible members that were assessed were seen for a pregnancy and chest pain (see Chart 1.17).

Chart 1.17
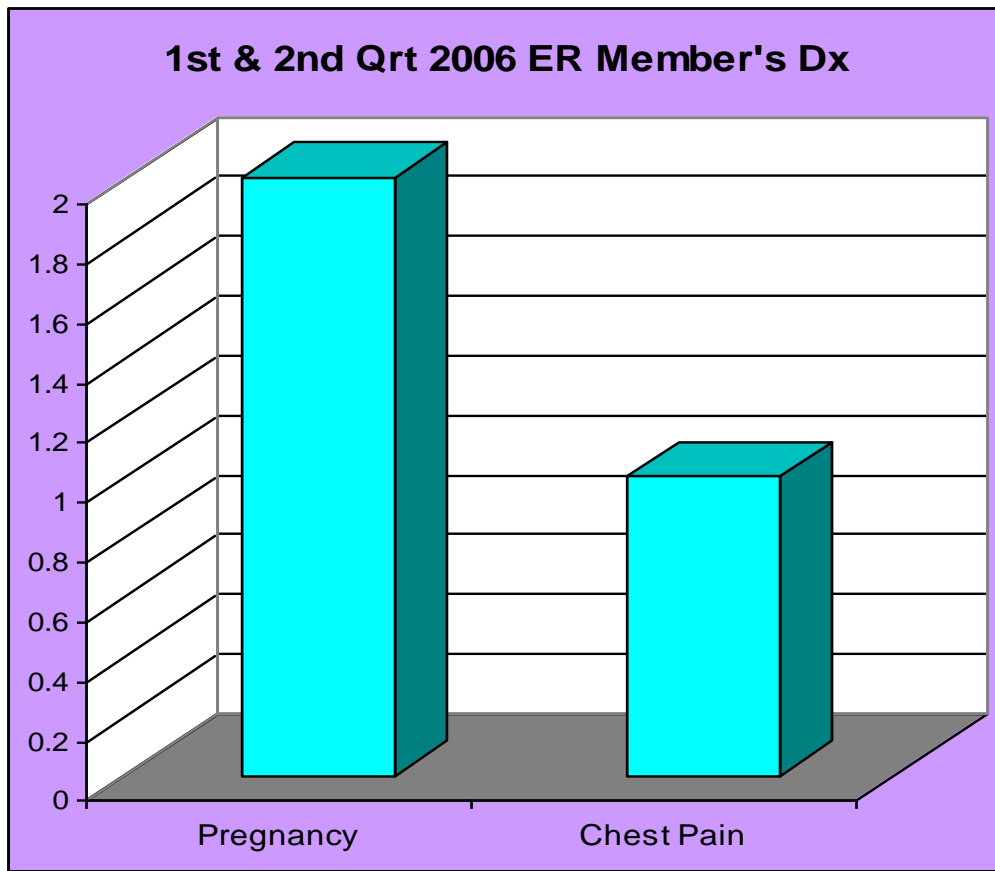
Successful contact was made with all members, and no members had any pharmacy related concerns.

ER Visits per 1000 Members
In analyzing CMFHP's overall adult ER visits per 1000 members since 1st Quarter 2004 (pre-intervention), the adult ER visits per 1000 members have decreased by 5.6% through 4th Quarter 2006. Although the results aren't significant, they do reflect an overall trend of reducing adult ER visits for CMFHP's population.

Nurse Advice Utilization per 1000 Members
In analyzing CMFHP's Nurse Advice utilization for adult members since 1st Quarter 2004 (pre-intervention), the Nurse Advice calls have decreased by 64%. The data is inaccurate, due to a change in the data collection process utilized by the vendor in 3rd Quarter 2006. Due to the significant change in the way nurse advice calls are collected and reported, a pre-intervention comparison is not able to be made. CMFHP will plan to continue to monitor nurse advice calls now through a new vendor with consistent data collection processes.

Statistical Analysis of Results

Additional analysis of ER data was completed in July 2007 by statistician, Steve Simon, PhD from Children's Mercy Hospital. Data was analyzed with all members (n=68). A paired sample t-test was performed, which showed that the mean of ER post-visits was 4.31 and the mean of ER pre-visits was 2.35. This illustrates that the intervention in place is not assisting with the goal of decreasing in ER visits in the study groups identified.

Recommendation for all study groups
In analyzing the data, it was determined that CMFHP needs to assess the specific location of all post intervention ER visits, as well as the specific provider type of post intervention office visits (e.g. specialist, Family Practitioner, Pediatrician or Gynecologist). This information will allow us to educate and redirect members to make changes to their medical home, as it appears the intervention has been successful in increasing visits to physician's offices, but not the designated PCP. In addition, because the study groups are so small, a few members who have significant increases in ER visits stand out as needing further analysis and intervention. Additional information about these members will assist CMFHP with planning future interventions through intense case management services. This information will be assessed by 4th quarter 2007.

<div align="center">Resources and Literature Review</div>

1. Mayer, Gloria (2005)*: IHA cites Ten Ways to Reduce Overcrowded Emergency Rooms* [Electronic Version]. Institute for Healthcare Advancement (IHA). Retrieved August 9, 2007 from http://www.iha4health.org/screenprint.cfm?newsletterid=51

<div align="center">

Children's Mercy Family Health Partners
Well-Child Visits in the First 15 Months of Life (W15)
Performance Improvement Project
Date of Inception: August 2006

</div>

<div align="center"><u>Definitions</u></div>

EQRO – External Quality Review Organization
OAO – Computer system for claims adjudication and authorizations
PCP – Primary Care Physician
SHCN – Special Health Care Needs
JVC – Jewish Vocational Services

<div align="center"><u>Study Topic/Problem Identification</u></div>

Children's Mercy Family Health Partners (CMFHP) has chosen a performance improvement project designed toward improving well-child screening rates among members in the first 15 months of life.

CMFHP has chosen the topic of Well-Child Visits in the First 15 months of Life due to its evaluation of rates as reported through the CMFHP annual HEDIS report. The CMFHP results of Well-Child in the First 15 Months of Life for 6 or more visits has averaged 37.5% over the past six (6) years from calendar year 2000 through calendar year 2005, compared to the HEDIS Medicaid mean of 45% in 2005. In addition, in calendar year 2005, the state of Missouri's Medicaid mean for this measure was 49.69%, well

above CMFHP's experience. In looking at CMFHP's results over time, the rate for six (6) or more visits decreased by 37% overall from 2000 to 2005.

The project plan and design will be done through the CMFHP Health Improvement Committee (formerly known as the Special Health Care Needs Committee), which includes the Director of Health Services, Ma'ata Toulsee, RN, MBA, CCM the Manager of Health Improvement/Disease Management, Greg Hanley, MBA, CHE the Manager of Quality Management, Jenny Hainey, MSN, CPHQ, the Senior Quality Management Nurse, Johanna Groves, RN, the Health Improvement Project Manager, KaMara White, MHA, Pediatric Care Managers, Dorothy Aust, RN, BSN, Sheryl Kennard, RN, CCM, Stevana McCullough, LMSW, Jayne Yunghans, RN, Mona J. Moran, RN, BSN, CCM, the Lead Care Manager, Melody Dirks, BSW and the SHCN Outreach Coordinator, Joyce Williams, LPN. The CMFHP Health Services Review Committee, chaired by Ma'ata Toulsee, RN, MBA, CCM, will have primary oversight of the project, with quarterly reporting to the CMFHP Quality Management Committee, chaired by Brenda Rogers, MD.

The project will involve outreach and input from practicing physicians, through the CMFHP Quality Management Committee. It is recommended that a "variety of strategies and interventions may improve the health of children as they matriculate through the developmental stages. These performances include group parent education, counseling, home visits, use of developmental specialists, use of parent surveys, encounter forms and/or checklists, and parent handouts, waiting room boards, and advice lines"[1].

 CMFHP interventions to date include general well-child care reminders through member letters (attachment A), immunization schedules (attachment B) , provider newsletters, distribution of well child information through various community events, and through the provider distribution of member lists due for EPSDT exams. CMFHP currently provides monthly lists of members due for their exams to thirty one (31) primary care providers.

Hypotheses

Children whose parents receive letters containing education about well-child care will be more likely to:
- ✓ Schedule a well child visit
- ✓ Receive annual EPSDT exams
- ✓ Receive recommended immunizations per schedule

Less likely to:
- ✓ Have sick child visits
- ✓ Miss recommended immunizations

Study Questions

This study is designed to answer the following question:
1. Do reminder letters to the parents of the children ages 0-15 months who need Well Child exams; result in a 50% increased rate of screenings?

Study Indicators

The rate of Well Child Care Visits in First 15 Months of Life for children continuously enrolled with CMFHP.

Study Population

The study populations included in this project are children continuously enrolled with CMFHP with birthdates ranging from 10/01/05 to 9/30/06 (0-15 months of age).

Sampling Techniques

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

Data Collection Plan

Baseline data on the entire study population focused on members identified with zero to 6 Well Child Visits in the first 15 months of life. *Eligible CMFHP* members (as of 10/1/06) were identified who had zero to five well-care visits with a primary care provider during their first 15 months of life.

Our Information Technology Department prepared a spreadsheet using the CMFHP eligibility system to identify members meeting the following parameters
- Age parameters include:

  - all children with dates of birth between 10/1/05 and 9/30/06
- PCP provider type and diagnosis codes or procedure codes for Well-child care.
  - Codes used to identify claims include: ICD 9 codes - V20.2, V70.0, V70.3, V70.5, V70.8, V70.9, and CPT codes - 99381, 99382, 99391, 99392 and 99432.

The same data collection will be pulled 6 months post intervention (July 2007) in order to complete a comparative analysis of pre and post intervention. All members that were 15 months or greater were assessed to determine if there was a change in Well Child Visits or if these members had 6 or more visits as recommended by HEDIS.

Data Analysis Plan

A comparative data analysis was performed by our Health Improvement Project Manager, KaMara White, MHA. She assessed all eligible members from the ages of 15 months or greater, who had less than 6 Well Child Visits through measuring the pre and post intervention effectiveness of the interventions. This analysis will determine if there was a change in Well Child visits within a 6-month time frame. The collected data will determine:
- If there was in increase in visits by 0-1 visits post intervention
- If there was an increase in visits by 2-3 visits post intervention
- If there was an increase in visits by 4-5 visits post intervention
- If there was an increase in visits by 6+ visits post intervention

Intervention Implementation

A mailing distribution was used as the intervention method. The letter (see attachment A) was created by our Senior Quality Management Nurse, Johanna Groves, and distributed an external service center; Jewish Vocational Services (JVS) in January of 2007, to those identified eligible members between the ages of zero and 15 months who had less than 6 Well Child visits. Well Child care information letters and recommended well care schedules were sent to the homes of the identified members through our external service center, JVS. This provided education to each family regarding the importance of scheduling EPSDT visits, including lead testing, within the first 15 months of age.

Following implementation of the intervention claims data for the study population will be queried every 6 months by our Information Technology Department in order to evaluate the effectiveness of the mailing intervention. Data will be collected from the CMFHP claims database (OAO). Data will be stored in excel spreadsheets for ongoing monitoring and reporting of outcomes.

Data Analysis/Interpretation of Study Results

CMFHP will utilize the established HEDIS standards, as determined by the National Committee for Quality Assurance (NCQA), to measure pre and post intervention data. The CMFHP results of Well-Child in the First 15 Months of Life for 6 or more visits has averaged 37.5% over the past six (6) years from calendar year 2000 through calendar year 2005, compared to the HEDIS Medicaid mean of 45% in 2005. In addition, in calendar year 2005, the state of Missouri's

Medicaid mean for this measure was 49.69%, well above CMFHP's experience. In looking at CMFHP's results over time, the rate for six (6) or more visits decreased by 37% overall from 2000 to 2005.

 HEDIS specifications are explained below:

Administrative Data
Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a primary care provider during their first 15 months of life.

To count toward the measure, the well-child visit must occur with a primary care provider, but it does not have to be the provider assigned in the CMFHP computer system to the child.

A child who had a claim/encounter from a primary care provider with the appropriate ICD-9 codes (V20.2, V70.0, V70.5, V70.8, V70.9) and CPT codes (99381, 99382, 99391, 99392, 99432) is considered to have received a well-child visit.

Assessment of Improvement and Sustainability
7/20/07 Interim Analysis:
Data was gathered for all eligible members who had < 6 Well Child Visits between the ages of 0-15 months old (n = 2097). For purposes of the interim review of results, a sub-group was analyzed 6 months after intervention to analyze preliminary post intervention data. The eligible members that turned 15 months or greater (n = 1079) from Jan 2007 – July 2007, were assessed to determine if there was an increase in Well Child visits.

Before the intervention took place, the data showed that 29% of the members ranging from 15 months old or greater had 0-1 Well Child visits, 36% had 2-3 Well Child visits and 35% had 4-5 Well Child visits. (See chart 1.1)

Chart 1.1

Total # of visits pre intervention

■ 0-1 visits	
■ 2-3 visits	
□ 4-5 visits	
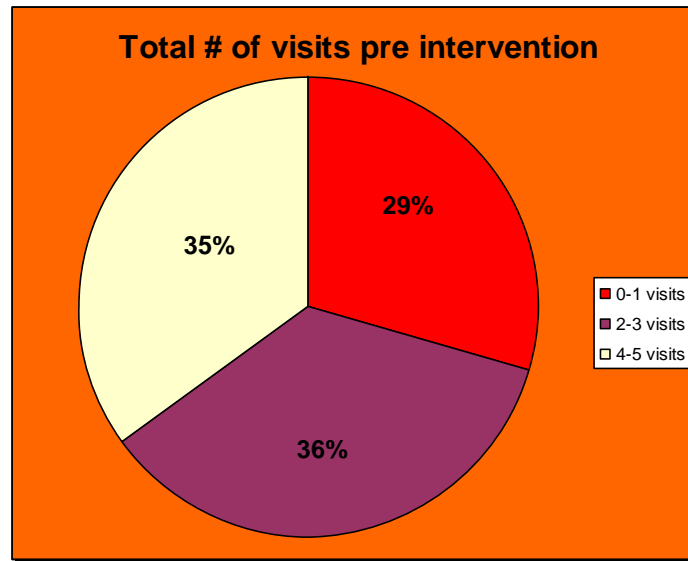
After the letters went out to the members who had <6 Well Child visits, results improved. Overall, there was a 25% increase in Well Child visits ranging from six or more visits, compared to the pre intervention data which states that there were no children in this study group who reached six or more visits. (See chart 1.2-1.13).

Chart 1.2

Total # of visits						
PRE - INTERVENTION				**POST - INTERVENTION**		
0-1 visits	317	29.38%		0-1 visits	191	17.70%
2-3 visits	383	35.50%		2-3 visits	263	24.37%
4-5 visits	379	35.13%		4-5 visits	356	32.99%
				6+ visits	269	24.93%
Total	**1079**	**100.00%**		**Total**	**1079**	**100.00%**

Chart 1.3

Total # of visits post intervention

18%
25%
24%
33%

Legend:
- 0-1 visits
- 2-3 visits
- 4-5 visits
- 6+ visits
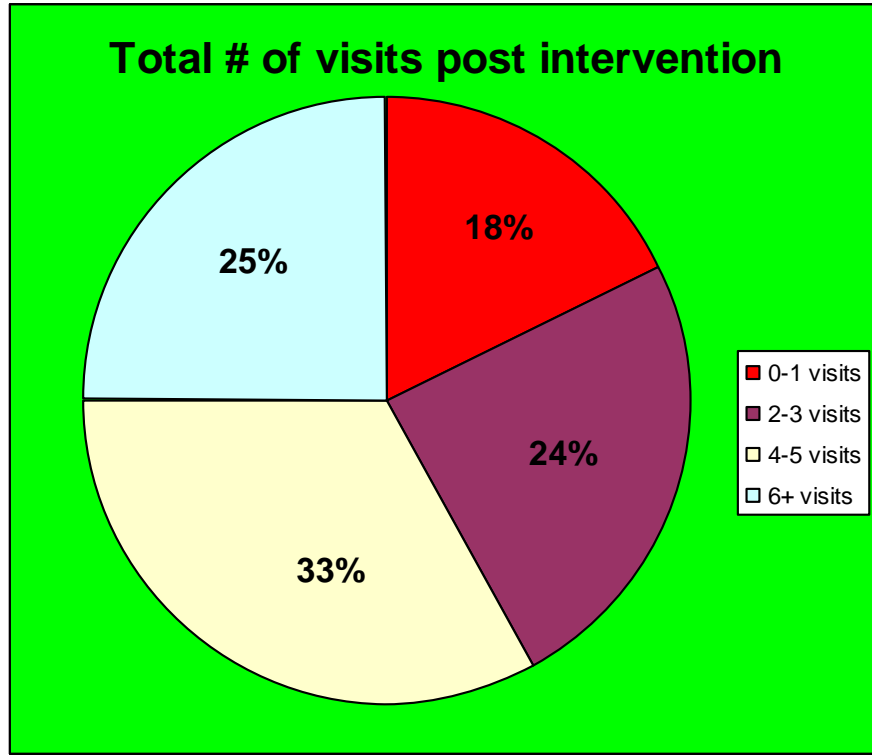
Plan for Improvement/Future Analysis

After initial intervention and measurement of results, further interventions to consider will include:

Education to the Health Departments in CMFHP's service area regarding appropriate coding and billing for well-child care exams
- Meet with Provider Relations to identify current providers
- Send focused education to the identified Health Departments regarding the coverage and billing of well child care exams
- Educate providers and members on well child care screenings:
    o Add well child care information to quarterly member newsletter
    o Add well child care information to quarterly provider newsletter
    o Add new brochures to member OB packets
    o Send PCP's a list of their members due for Well Child Care visits

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 6 months following implementation, with final claims review in April 2008 after a full year post intervention, allowing for a three month claim lag.

Additional analysis will be provided by Statistician, Steve Simon, PhD, employed by Children's Mercy Hospital.

The project team will meet monthly 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 Quality Management Committee chaired by Brenda Rogers, MD, for participating provider input.

A quarterly update will be provided to the Health Services Review Committee, chaired by Ma'ata Toulsee, RN, MBA, CCM, for internal stakeholder input.

<div align="center">

Resources/Literature Review

</div>

1. Bethell, Christina; Peck, Colleen; Schor, Edward (2006) *Assessing Health System Provision of Well Child Care: The Promoting Healthy Development Survey* [Electronic Version]. Official Journal Of The American Academy of Pediatrics, 1080-1094

2. *HEDIS 2007 Technical Specifications*: Volume 2 (2007). Washington: NCQA

3. Ilminen, G. R. (2005) *MEDDIC-MS: New Quality Performance Measure System for Medicaid Managed Care* [Electronic Version]. Patient Safety & Quality Health Care. Retrieved September 5, 2006 from http://www.shgh.com/marapr05/meddic-ms.html

4. Pub Med, Pediatrics (2006) [Electronic version]. *Compliance with Well-child Visit Recommendations: Evidence from the Medical Expenditure Panel Survey, 2002-2002*, 118(6):e1766-78. Retrieved February 2, 2007 from http://www.ncbi.nlm.nih.gov.

Attachment A

Date:

Dear Member,

It is important that all children see their Primary Care Provider (PCP) for well child check-ups. It is very important in the first 15 months of life.

According to our records, your child, (Name) has not had the recommended visits. Please schedule an appointment with (Child's Name) PCP as soon as possible.

Please call Customer Service if you need help scheduling an appointment or if you have any questions. You can call us at 1-800-347-9363.

Thank you for helping your child stay healthy!

Sincerely,
Children's Mercy Family Health Partners
Health Improvement Program

Work Plan for SFY 2008

Work Plan For Next Year (SFY 2008)

The following information was taken from the MO HealthNet Managed Care health plan's annual SFY2007 evaluations:

HealthCare USA

WORK-PLAN FOR FY 2008

Activity	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Completion Date
Program Structure					
Quality Management Committee Charter	Annual Update/revision to QMC Charter.	QMC Approval needed	Director, QI	March 2008	
Quality Management Strategy	Annual Update/revision to QI Strategy.	QMC Approval needed	Director, QI	March 2008	
Utilization Management Plan/Program Description	Annual Update/revision to UM Plan/Program Description.	QMC Approval needed	Manager, Health Services	March 2008	
Credentialing Plan/Program Description	Annual update/revision to Credentialing plan/program description.	QMC and Credentialing Committee Approval needed	Director, Appeals & Grievances	July 2007	July 2007
Annual QM Work Plan	Annual update/revision to QI/UM Work plan.	QMC Approval needed	Director, QI	Jan. 2008	
Annual QI/UM Program Evaluation	Annual written evaluation of QI/UM program outcomes.	QMC Presentation	Director, QI	Jan. 2008	
Annual Subcontractor Evaluation	Annual written evaluation of subcontractors' performance.	QMC Presentation	Director, QI	Nov. 2008	
Quality Improvement Policies and	Annual review of QI policies and procedures.	QMC Presentation	Director, QI	July 200	July 2007

Activity	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Completion Date
Procedures					
Quality Improvement Activities/Performance Improvement Projects (PIPs)					
Emergency Department Utilization Performance Improvement Project	Ongoing PIP to improve HEDIS rates for ER and urgent care center utilization.	QMC Presentation and Approval needed	Director, QI	July 2007 March 2008 As needed	July 2007
Pregnancy Outcomes Performance Improvement Project	Ongoing PIP to improve HEDIS rates for birth outcome indicators.	QMC Presentation and Approval needed	Director, QI	March 2008 As needed	July 2007
Obesity Performance Improvement Project	Ongoing PIP to improve care for children who are overweight or obese.	QMC Presentation and Approval needed	Director, QI	May. 2008 As needed	
Chlamydia Testing Performance Improvement Project	Ongoing PIP to improve HEDIS rates for chlamydia screening.	QMC Presentation and Approval needed	Director, QI	July 2007 May 2008 As needed	July 2007
Encounter Data Submission Performance Improvement Project	Ongoing PIP to improve the encounter acceptance rate for encounters sent to the State.	QMC Presentation and Approval needed	Director, QI	March 2008 As needed	
Adolescent Well-care Performance Improvement Project	Ongoing State-wide PIP to improve HEDIS rates of adolescent well-care visits.	QMC Presentation and Approval needed	Director, QI	Sept. 2007 March 2008 As needed	Sept 2007
Asthma Focus Study	Asthma Disease Management Focus Study	QMC Presentation and Approval needed	Director, QI	July 2007 March 2008 As needed	July 2007
Hospital Readmissions Performance Improvement Project	Hospital PIP to improve rate of hospital readmissions.	QMC Presentation and Approval	Director, QI	Sept. 2007 May. 2008 As needed	Sept 2007

Activity	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Completion Date
Appeals & Grievances Performance Improvement Project	Ongoing PIP to improve the rate of timely resolution at all levels of the grievance process.	QMC Presentation and Approval	Director, QI	Sept. 2007 March 2008 As needed	Sept 2007
Hyperemesis Performance Improvement Project	2008 PIP to improve the care received by members diagnoses with hyperemesis	QMC Presentation and Approval	Director, QI	TBD	
Practitioner and Provider Network					
Credentialing Committee Reports	Assess number of providers credentialed and recredentialed.	QMC Presentation	Director, Credentialing	July 2007 Nov. 2007 March 2008 May 2008	July 2007
Internal Credentialing Audit Results	Random selection of credentialing & recred files with comparison to URAC & NCQA standards for credentialing.	QMC Presentation	Director, Credentialing	Sept. 2007	Sept. 2007
Delegated credentialing oversight audit results	Complete annual report of all delegated credentialing oversight audits.	QMC Presentation	Director, Credentialing	March 2008	
Provider Access and Availability Study results	Complete annual results of provider access and availability study.	QMC Presentation	Director, Provider Relations	May 2008	
Geo-Access Results/Analysis	Complete annual geo-access analysis for network adequacy.	QMC Presentation	Director, Provider Relations	May 2008	
Significant Network Changes	Complete report detailing significant network changes affecting member access and	QMC Presentation	Director, Provider Relations	July 2007 Sept. 2007 Nov. 2007	N/A N/A

Activity	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Completion Date
	availability.			March 2008 May 2008	
Member and Provider Satisfaction					
Member Satisfaction Survey	Complete Annual CAHPS survey and analysis.	QMC Presentation	Director, QI	Sept. 2007	Sept 2007
Member grievances and appeals report	Complete quarterly member grievances and appeals report. Include statistics for turn-around time, overturn rates, and categories trended by type of grievance/appeal.	QMC Presentation	Director, Appeals & Grievances	July 2007 Nov. 2007 March 2008 May 2008	July 2007
Service Operations & Claims Processing Key Performance Indicators	Complete quarterly report for all member service KPIs including calls answered, calls abandoned, and service levels and claims processing indicators (i.e. TAT, volume, etc.)	QMC Presentation	Manager, CSO	July 2007 Nov. 2007 March 2008 May 2008	July 2007
Provider Satisfaction Survey	Review and analyze results of annual provider satisfaction survey.	QMC Presentation	Director, QI	Sept. 2007	Sept 2007
Provider Complaints, Grievances, and Appeals	Complete quarterly report including turn-around times, overturn rates, and categories trended.	QMC Presentation	Director, Appeals & Grievances	July 2007 Nov. 2007 March 2008 May 2008	July 2007
Member and Provider Communications					
Communication Plan and Program Description	Annual review of communication plan/program description.	QMC Approval	Manager, Communications	Sept. 2007	Sept 2007

Activity	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Completion Date
Provider Communication Materials	Annual review of provider communication materials (PRG, newsletters, educational mailings, etc.)	QMC presentation (e.g. grid outlining review/changes/additions /deletions)	Director, Provider Relations	July 2007	July 2007
Member Communication Materials	Annual review of member communication materials (newsletters, handbook, educational mailings, etc.)	QMC presentation (e.g. grid outlining review/changes/additions /deletions)	Program Integrity	March 2008	
Utilization Management					
UM Performance Indicators - IP Days/1000 - ALOS - Admits/1000 - Pre-Auth telephone stats - Denial Report	Review and analyze UM performance indicators for tracking and trending.	QMC Presentation	Manager, Health Services	July 2007 Nov. 2007 March 2008 May 2008	July 2007
Special Needs & Case Management Activities/Outcomes	Review and analyze results of case management activities.	QMC Presentation	Manager, Health Services	July 2007 Nov. 2007 March 2008 May 2008	July 2007
Pharmacy Utilization Statistics	Review, analyze, and interpret quarterly pharmacy data/outcomes.	QMC Presentation	Director, Pharmacy	July 2007 Nov. 2007 March 2008 May 2008	July 2007
Clinical and Preventive Care Practice Guidelines	Annual review of clinical and preventive care guidelines.	QMC Approval	Director, Health Services Medical Director	July 2007 March 2008 As needed	July 2007

Activity	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Completion Date
Internal Practice Guideline Review (Tech Assessments)	Annual review of internally developed clinical practice guidelines.	QMC Approval	Manager, Health Services Medical Director	As needed	
InterQual Criteria Review	Annual review of InterQual criteria/revisions.	QMC Approval	Manager, Health Services	March 2008	
Quality Performance Indicators					
Annual HEDIS results	Prepare detailed report and comparison analysis, with statistical analysis, on each HEDIS indicator.	QMC Presentation	Director, QI	July. 2007	July 2007
EPSDT Program	Prepare detailed report of annual EPSDT outcomes.	QMC Presentation	Director, QI	Jan. 2008	
Quality Improvement Focus Studies	Prepare detailed analysis of results for all QI focus studies.	QMC Presentation	Director, QI	July 2007 May 2008 As needed	July 2007
Balanced Score Card	Prepare detailed quarterly report for KPIs for tracking and trending.	QMC Presentation	Director, QI	Sept. 2007 Nov. 2007 March 2008 May 2008	Sept 2007
Peer Review Outcomes (adverse events, quality of care related, Medical record review)	Prepare detailed report of peer review outcomes, medical record review, etc.	QMC Presentation	Director, QI	As needed	
Primary Care Provider (PCP) Request to Change Report	Prepare detailed report of PCP requests to change.	QMC presentation	Director, QI	Sept. 2007 Nov. 2007 Jan. 2008 May 2008	Sept 2007

Activity	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Completion Date
Miscellaneous					
Fraud and Abuse Program	Prepare detailed report of fraud and abuse tracking, trending, and analysis.	QMC Presentation	Program Integrity	Nov. 2008	
Cultural Competence Program	Prepare annual detailed report of cultural competence program and statistics for employees completing cultural competence program assessment.	QMC Presentation	Director, QI	Jan. 2008	
Disease Management Programs					
Asthma Disease Management	Prepare detailed report for outcomes of program.	QMC presentation	Director, QI	Nov. 2007 May 2008	
Diabetes Disease Management	Prepare detailed report for outcomes of program.	QMC presentation	Director, QI	Nov. 2007 May 2008	
High Risk OB Disease Management	Prepare detailed report for outcomes of program.	QMC Presentation	Director, QI	Nov. 2007 May 2008	
Sickle Cell Disease Management Program	Prepare detailed report for outcomes of program.	QMC Presentation	Director, QI	TBD	

Mercy CarePlus

In order to enable MCP's Quality department to focus more intently on opportunities for improvement, MCP is attempting to increase the staffing level within the Quality department. MCP is actively recruiting a Quality Improvement Auditor who will perform audits of medical records and internal documentation in order to evaluate the level of care and appropriateness of coding and billing, ensure compliance with EPSDT requirements, and document findings to support HEDIS reporting. MCP is also actively recruiting a Quality Improvement Coordinator who will be responsible for MCP's credentialing program and quality indicator reporting as well as assist in quality projects.

Through strategic planning, MCP is committed to increasing targeted 2008 HEDIS scores through a combination of improved encounter data capture, reporting and member/provider incentives. MCP plans to focus on the following HEDIS measures: Adolescent Immunizations, Well Care First 15 Months, Childhood Immunizations, Timeliness of Prenatal Care, Asthma Medication use. In addition, MCP will focus on the following CAHPS® scores: Health Plan Overall, Health Care Overall and Health Plan Complaint and Problem Resolution.

MCP will continue to participate in the State-wide PIP for increasing the rate of adolescent well care visits. MCP will also focus on continuing the Early Intervention in Prenatal Case Management and the Relationship to Very Low birth Weight Babies PIP and is establishing a new non-clinical PIP around the Member Welcome Calls.

2007 - 2008 Quality Improvement Work Plan Harmony Health Plan of IL/WellCare Health Plans, Inc.

#	Key Initiative	Lead	Start Date	Completion Date	Status
1	**Balanced Budget Act (BBA) Compliance**				
Goal	**Insure that all documents, reports, policies & procedures and communications meet local, state and federal guidelines.**				
Objective	**Identify all documents, reports, policies & procedures and communication literature and update to meet BBA compliance.**	Quality and Compliance			
Critical Paths	a. Review, enhance and implement changes to reports, documents, P & P's and correspondence	Quality and Compliance	07/01/2007	06/30/2008	IP
	b, Create a work group to insure effective implementation across departments	Quality and Compliance	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Compliance	01/01/2008	06/30/2008	IP
	d. Present to MAC	Compliance	02/01/2008	06/30/2008	P
	e. Present to QIC	Compliance	03/01/2008	06/30/2008	P
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	P

2	Newsletters - Member and Provider	Lead	Start Date	Completion Date	Status
Goal	**Insure that member and provider newsletters meet the education work plan, local, state and federal guidelines.**			06/30/2008	
Objective	**Identify member and provider newsletters and update to meet the education work plan, corporate, local, state and federal guidelines.**	Quality, Member, Provider Services and Compliance		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Member and Provider letters.	Quality, Member, Provider Services and Compliance	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Member, Provider Services and Compliance	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Member and Provider Services	01/01/2008	06/30/2008	IP
	d. Present to MAC	Member and Provider Services	02/01/2008	06/30/2008	IP
	e. Present to QIC	Member and Provider Services	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

3	Committees/Minutes/Agenda (QM, UM, Peer, Cred/Re-Cred)	Lead	Start Date	Completion Date	Status
Goal	**Insure that Committees, Agenda and Meeting Minutes meet corporate, local, state and federal guidelines.**			06/30/2008	
Objective	**Identify all Committees, Agenda and Meeting Minutes and update to meet corporate, local, state and federal guidelines.**	Quality, Disease/Case and Utilization Management		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Committees, Agenda and Meeting Minutes.	Quality, Disease/Case and Utilization Management	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Disease/Case and Utilization Management	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Disease/Case and Utilization Management	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Disease/Case and Utilization Management	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Disease/Case and Utilization Management	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

4	Audits/Corrective Action Plans (Medical Record Reviews, EQRO, Delegated Entity, other)	Lead	Start Date	Completion Date	Status
Goal	Insure that audits, medical record reviews and corrective action plans meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify all audits/CAPs and medical record reviews, EQRO's and delegated entities and update to meet corporate, local, state and federal guidelines.	Quality, Disease/Case and Utilization Management		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to audits/corrective action plans and medical record reviews	Quality, Disease/Case and Utilization Management	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Disease/Case and Utilization Management	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Disease/Case and Utilization Management	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Disease/Case and Utilization Management	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Disease/Case and Utilization Management	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

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5	Surveys and Score Cards - Member and Provider	Lead	Start Date	Completion Date	Status
Goal	Insure that member and provider surveys and score cards meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify all member and provider surveys and score cards and update to meet corporate, local, state and federal guidelines.	Quality, and Provider Services		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Member and Provider surveys and score cards.	Quality, and Provider Services	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, and Provider Services	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, and Provider Services	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, and Provider Services	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, and Provider Services	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

6	Program Descriptions, Work Plans, Evaluations and Annual Report (QM/HE, UM/DM/CM, PR, MS, ENROLLMENT, CLAIMS/ENCOUNTERS, COMPLIANCE)	Lead	Start Date	Completion Date	Status
Goal	Insure that Program descriptions, work plans, evaluations and annual report documentation meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify all Program descriptions, work plans, evaluations and annual report documentation and update to meet corporate, local, state and federal guidelines.	Quality, Peer, Member Services, Enrollment, Claims/Encounters and Compliance		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Program descriptions, work plans, evaluations and annual report documents	Quality, Peer, Member Services, Enrollment, Claims/Encounters and Compliance	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Peer, Member Services, Enrollment, Claims/Encounters and Compliance	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Peer, Member Services, Enrollment, Claims/Encounters and Compliance	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Peer, Member Services, Enrollment, Claims/Encounters and Compliance	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Peer, Member Services, Enrollment, Claims/Encounters and Compliance	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

7	HEDIS SCORES - CY 2007, Collection 2008 (2007 Technical Spec, Provider Newsletter, Admin Data, Provider Reminder, Scrub, Chart Chase Scheduling, Chart Chases, Weekly Progress Meetings, Last efforts, Final Numbers 6/2008) EVALUATE LAST YEARS AND IMPLEMENT IMPROVEMENT PROGRAM	Lead	Start Date	Completion Date	Status
Goal	Insure that HEDIS scores meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify all HEDIS measure parameters and update the HEDIS plan to meet local, state and federal guidelines.			06/30/2008	
Critical Paths	a. Review, enhance and implement changes to HEDIS work plan guidelines	Quality, Provider and Utilization Management	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Provider and Utilization Management	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Provider and Utilization Management	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Provider and Utilization Management	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Provider and Utilization Management	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

8	Encounter Submission Improvement Project (IPA's, CAP's, FFS)	Lead	Start Date	Completion Date	Status
Goal	Insure Encounter Data submissions meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify all encounter submission guidelines and update to meet corporate, local, state and federal guidelines.			06/30/2008	
Critical Paths	a. Review, enhance and implement changes to encounter submission improvement project.	Quality, Provider and Compliance	07/01/2007	06/30/2008	IP
	a. Review, enhance and implement changes to documents, P & P's and correspondence	Quality, Provider and Compliance	10/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Provider and Compliance	01/01/2008	06/30/2008	IP
	c. Present to QIWG	Quality, Provider and Compliance	02/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Provider and Compliance	03/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Provider and Compliance	04/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	05/01/2008	06/30/2008	IP

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9	Health Education Program	Lead	Start Date	Completion Date	Status
Goal	**Insure that the health education program meets corporate, local, state and federal guidelines.**			06/30/2008	
Objective	**Identify all health education program parameters to meet corporate, local, state and federal guidelines.**	Quality, Provider, Disease/Case, Utilization Management and Member Services		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to the Health Education Program	Quality, Provider, Disease/Case, Utilization Management and Member Services	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Provider, Disease/Case, Utilization Management and Member Services	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Provider, Disease/Case, Utilization Management and Member Services	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Provider, Disease/Case, Utilization Management and Member Services	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Provider, Disease/Case, Utilization Management and Member Services	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

10	Incentive Plans - Member, Provider	Lead	Start Date	Completion Date	Status
Goal	Insure that member and provider incentive plans meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify all member, provider and employee incentive plans and update to meet corporate, local, state and federal guidelines.	Quality, Provider, Member Services, Human Resources		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to member, provider and employee incentive plans.	Quality, Provider, Member Services, Human Resources	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Provider, Member Services, Human Resources	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Provider, Member Services, Human Resources	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Provider, Member Services, Human Resources	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Provider, Member Services, Human Resources	03/01/2008	06/30/2008	IP
	f. Present to BOD	Quality, Provider, Member Services, Human Resources	04/01/2008	06/30/2008	IP
	g. Present to BOD	Medical Director	07/01/2005	06/30/2008	IP

11	Performance Improvement Projects - (3) Clinical - EPSDT, Prenatal/PostPartum, Asthma, (1) Administrative - Member Satisfaction	Lead	Start Date	Completion Date	Status
Goal	Insure that performance improvement projects meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify all performance improvement projects and update to meet corporate, local, state and federal guidelines.	Quality, Member, Provider, Disease/Case and Utilization Management		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to performance improvement projects.	Quality, Member, Provider, Disease/Case and Utilization Management	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Member, Provider, Disease/Case and Utilization Management	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Member, Provider, Disease/Case and Utilization Management	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Member, Provider, Disease/Case and Utilization Management	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Member, Provider, Disease/Case and Utilization Management	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

12	Disease/Case, Case Management and Utilization Management (Over & Under Utilization, Special Needs, Asthma, Diabetes, Hypertension, Wound Care, Maternity, High Risk OB, ER Education, Etc.)	Lead	Start Date	Completion Date	Status
Goal	Insure that over & under utilization, special needs, Disease/Case management and ER education guidelines meet corporate, local, state and federal guidelines.			06/30/2008	
Objective	Identify over & under utilization, special needs, Disease/Case management and ER education guidelines are updated to meet corporate, local, state and federal guidelines.	Utilizatization/Disease/Case management and Quality		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Over & Under utilization, special needs, Disease/Case management and ER education programs.	Utilizatization/Disease/Case management and Quality	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Utilizatization/Disease/Case management and Quality	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Utilizatization/Disease/Case management and Quality	01/01/2008	06/30/2008	IP
	d. Present to MAC	Utilizatization/Disease/Case management and Quality	02/01/2008	06/30/2008	IP
	e. Present to QIC	Utilizatization/Disease/Case management and Quality	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

13	Mental Health Vendor	Lead	Start Date	Completion Date	Status
Goal	**Insure that Mental Health Vendor activities, programs and documents meet corporate, local, state and federal guidelines.**			06/30/2008	
Objective	**Identify all Mental Health Vendor activities, programs and documents are updated to meet corporate, local, state and federal guidelines.**			06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Mental Health Vendor activities, programs and documents	Quality, Utilization and Provider Relations	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Utilization and Provider Relations	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Utilization and Provider Relations	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Utilization and Provider Relations	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Utilization and Provider Relations	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

14	Member Services - (Quality of Care and Quality of Service Grievances, PCP, Specialists, Disenrollment Analysis, Transportation, ID Cards)	Lead	Start Date	Completion Date	Status
Goal	Insure that Member Services (Quality of Care/Quality of Service, Referrals, Disenrollments, Transportation and ID replacement card requests) activities meet corporate local, state and federal guidelines.			06/30/2008	
Objective	Identify all Member Services activities and update to meet corporate, local, state and federal guidelines.	Quality, Member and Provider Services		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Member Services Activities.	Quality, Member and Provider Services	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Member and Provider Services	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Quality, Member and Provider Services	01/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Member and Provider Services	02/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Member and Provider Services	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

15	Enrollment Services - PCP assignment, Member Files, Member ID Cards)	Lead	Start Date	Completion Date	Status
Goal	**Insure that Enrollment Services (Member files, ID cards and PCP Assignment) meet corporate, local, state and federal guidelines.**			06/30/2008	
Objective	**Identify all Enrollment Services Activities and update to meet corporate, local, state and federal guidelines.**	Enrollment, Provider, Member		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to Enrollment services activities.	Enrollment, Provider, Member	07/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Enrollment, Provider, Member	10/01/2007	06/30/2008	IP
	c. Present to QIWG	Enrollment, Provider, Member	01/01/2008	06/30/2008	IP
	d. Present to MAC	Enrollment, Provider, Member	02/01/2008	06/30/2008	IP
	e. Present to QIC	Enrollment, Provider, Member	03/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	04/01/2008	06/30/2008	IP

16	Preventive Health Guideline Review	Lead	Start Date	Completion Date	Status
Goal	**Insure that Preventive Health Guidelines meet corporate, local, state and federal guidelines.**			06/30/2008	
Objective	**Identify all Preventive Health Guideline and update to meet local, state and federal guidelines.**	Quality, Utilization, Medical		06/30/2008	
Critical Paths	a. Review, enhance and implement changes to preventive health guidelines	Quality, Utilization, Medical	07/01/2007	06/30/2008	IP
	a. Review, enhance and implement changes to documents, P & P's and correspondence	Quality, Utilization, Medical	10/01/2007	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Utilization, Medical	01/01/2008	06/30/2008	IP
	c. Present to QIWG	Quality, Utilization, Medical	02/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Utilization, Medical	03/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Utilization, Medical	04/01/2008	06/30/2008	IP
	f. Present to BOD	Medical Director	07/01/2005	06/30/2008	IP

17	Clinical Practice Guideline Review	Lead	Start Date	Completion Date	Status
Goal	**Insure that Clinical Practice Guidelines meet corporate, local, state and federal guidelines.**			06/30/2008	
Objective	**Identify all Clinical Practice Guidelines and update to meet corporate, local, state and federal guidelines.**	Quality, Utilization, Medical	07/01/2007	06/30/2008	IP
Critical Paths	a. Review, enhance and implement changes to clinical practice guidelines	Quality, Utilization, Medical	10/01/2007	06/30/2008	IP
	a. Review, enhance and implement changes to clinical practice guidelines	Quality, Utilization, Medical	01/01/2008	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Utilization, Medical	02/01/2008	06/30/2008	IP
	c. Present to QIWG	Quality, Utilization, Medical	03/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Utilization, Medical	04/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Utilization, Medical	07/01/2005	06/30/2008	IP
	f. Present to BOD	Medical Director	07/01/2005	06/30/2008	IP

18	Corrective Action Plans (HEDIS & Compliance)	Lead	Start Date	Completion Date	Status
Goal	**Insure that corrective action plans are in place to meet corporate, local, state and federal guidelines.**			06/30/2008	
Objective	**Actively improve all items noted on Corrective Action Plans (HEDIS/Compliance)**	Quality, Utilization, Medical	07/01/2007	06/30/2008	IP
Critical Paths	a. Review, enhance and implement changes to impact items noted on CAP's	Quality, Utilization, Medical	10/01/2007	06/30/2008	IP
	a. Review, enhance and implement changes to items noted on CAP's	Quality, Utilization, Medical	01/01/2008	06/30/2008	IP
	b, Monitor for implementation and efficacy	Quality, Utilization, Medical	02/01/2008	06/30/2008	IP
	c. Present to QIWG	Quality, Utilization, Medical	03/01/2008	06/30/2008	IP
	d. Present to MAC	Quality, Utilization, Medical	04/01/2008	06/30/2008	IP
	e. Present to QIC	Quality, Utilization, Medical	07/01/2005	06/30/2008	IP
	f. Present to BOD	Medical Director	07/01/2005	06/30/2008	IP

Missouri Care

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Completed	Results	Barriers	Recommendations
Quality Management Plans & Evaluations											
Annual EQRO Review	Meet standards for external quality review.	Achieve "Met" on all 4 review areas (PIPS; Performance Measures; Compliance with Regulations; Validation of Encounter data)	Submission of relevant documentation-site review	Tammy Wiese/Quality Management	7/30/08						
QM Work Plan Evaluation	Evaluate effectiveness of 2008 QM Work Plan	To have completed initiatives on work plan & to have evaluated their effectiveness.	Written presentation of findings.	Tammy Wiese/Quality Management	12/31/08	Plan will be reviewed & updated quarterly.					
QM Plan	Annually review & revise QM Plan based on prior year's evaluation.	To have a comprehensive and up-to-date quality management plan.	Written plan.	Tammy Wiese/Quality Management	12/30/08						
QM Work Plan	Annually review & revise QM Work Plan based on prior year's evaluation.	To have a comprehensive and up-to-date quality management work plan for 2009.	Written plan.	Tammy Wiese/Quality Management	10/1/08						
HEDIS Intervention Plan	Based on review of the year's HEDIS results & the effectiveness of the prior year's interventions, revise the HEDIS intervention plan.	To have a comprehensive plan in place to positively impact HEDIS measures	Project plan.	Katie Dunne/Quality Management	10/1/08						
HEDIS Rate Production Plan	Create timeline/project plan for 2008 to complete HMRR data.	All records reviewed	Project plan.	Katie Dunne/Quality Management	10/1/08						
Annual Evaluation	Prepare annual evaluation for state in accordance with RFP attachment 8 exhibit 4.	To complete the evaluation by the deadline & to showcase MoCare's activities from the prior year.	Written presentation of findings.	Tammy Wiese/Quality Management	11/30/07	Evaluation to cover contract year 7/01/07-6/30/08					
HEDIS											
WIC Collaboration - Flyers	Increase WC2 rates through partnership with county WIC offices.	STI Goal to Reach NCQA's 75th%ile of 71%	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS intervention list or internal report)	Quality Management	2/1/2008 & 8/1/08	Identify members enrolled in WIC who have not had a recent well child check. Generate flyer for member's WIC file on importance of care. WIC nutritionist					
WIC Collaboration - Members not enrolled in WIC	Increase # of members enrolled in WIC. (WIC participation may be associated with increased compliance with well child screenings)	10% of eligible members not currently enrolled in WIC in selected counties will enroll after educational mailing.	Internal tracking # of members joining WIC after receiving intervention divided by total # of members receiving letter.	Quality Management	2/15/2008 & 8/15/2008 (intervention); 3/15/2008 & 11/15/2008 (evaluation)	Identify members who are eligible for WIC but not enrolled. Mail information on WIC.					
FHC Partnerships - WC2 & AWC Outreach	Improve WC2 and AWC screening rates.	WC2 Goal - STI Goal to Reach NCQA's 75th%ile of 71%. AWC Goal - Reach NCQA's 75th%ile of 47.90%	Follow HEDIS Tech Specs for rate calculation	Quality Management	Monthly	Use HEDIS intervention report monthly to generate mailing to FHC members due for WC2 & AWC services. Letter mailed by MoCare from provider.					
Summer Preschool/Kgarten Well Child Mailing	Improve WC2 rates.	STI Goal to Reach NCQA's 75th%ile of 71%	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS intervention list)	Quality Management	6/15/2008	Use HEDIS intervention report to target all 3-6 years olds without an WC check in the calendar year with a "Summer is a good time to get a check up" flyer.					
AWC Provider Mailing	Improve AWC screening rates.	Reach NCQA's 75th%ile of 47.90%	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS intervention list)	Quality Management	7/31/2008	Mail letter with AWC screening guidelines to provider with flyer for members file. Encourage scheduling AWC at member's next visit.					
AWC Mailing to Members	Improve AWC Screening rates.	Reach NCQA's 75th%ile of 47.90%	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS intervention list)	Quality Management	7/31/2008	TBD					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Completed	Results	Barriers	Recommendations
CHL Provider Mailings	Increase CHL screening rates.	Goal (STI) 58.2% overall rate.	Follow HEDIS Tech Specs for rate calculation (lists generated from monthly HEDIS intervention list)	Quality Management	Every other Month	Mail PCP list of members needing CHL screening along with stickers to flag member's file.					
Cervical Cancer Screening Birthday Cards	Maintain CCS rates and increase CHL rates.	Maintain CCS screening rate at 74.59%; increase CHL overall rate to 58.2%	Follow HEDIS Tech Specs for rate calculation (list comes from monthly on demand report)	Quality Management	Monthly	Mail women a CCS card reminder during their birth months.					
Provider Asthma Rosters	Increase ASM rates.	ASM combined rate of 85% (2006 state average - will adjust if 2007 average is higher)	Follow HEDIS Tech Specs for rate calculation (rosters generated from internal report)	Quality Management	Quarterly	Mail member rosters to PCP with members identified as having persistent asthma but who have not had a controller fill. (Include Asthma Action Plan & NAEPP Guidelines)					
Member Asthma Mailing	Increase ASM rates.	ASM combined rate of 85% (2006 state average - will adjust if 2007 average is higher)	Follow HEDIS Tech Specs for rate calculation (mailings generated from HEDIS intervention list)	Quality Management	Monthly	Send letter to member encouraging asthma checkup. Include asthma action plan. Will be sent to members on HEDIS intervention list.					
Develop provider incentive for completion of asthma action plan.	Increase ASM rates.	ASM combined rate of 85% (2006 state average - will adjust if 2007 average is higher)	Follow HEDIS Tech Specs for rate calculation	Quality Management/CMO/CEO	3/30/2008	TBD					
Develop member incentive for asthma checkup	Increase ASM rates.	ASM combined rate of 85% (2006 state average - will adjust if 2007 average is higher)	Follow HEDIS Tech Specs for rate calculation	Quality Management	7/1/2008	TBD					
Dental Vendor Monitoring	Increase Dental Rates	ADV combined rate of 30% or state average.	Follow HEDIS Tech Specs for rate calculation	Quality Management/CEO	Ongoing	Monitor dental vendor for efforts to improve dental screening rates.					
Varicella Attestation Mailing	Increase AIS rates.	Increase AIS rate to 44%. This closes in 5% of the gap between the current rate and 100%	Follow HEDIS Tech Specs for rate calculation (mailings generated from internal report)	Quality Management	6/30/2007	Mail VZV attestation letter to members with return envelope to capture VZV status & also educate on all immunizations. All returned information is shared with member's PCP.					
Performance Improvement Projects (PIPS)											

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Completed	Results	Barriers	Recommendations
Asthma Management	Increase the number of members with persistant asthma who are being prescribed controller meds.	ASM combined rate of 85% (2005 state average - will adjust if 2007 average is higher)	Follow HEDIS Tech Specs for rate calculation	Quality Management/Medical Management/CMO	Ongoing	Provider Rosters; member mailing; follow up by CR nurse after member discharged from hospital stay with asthma. CMO education of PCP when member hospitalized for asthma.					
Adolescent Well-Care	Part of a State Wide PIP to increase MO rates on HEDIS AWC measure.	State's goal is to raise the statewide average on this measure. Missouri Care's goal is to attain NCQA's 75th%ile of 47.90%	Follow HEDIS Tech Specs for rate calculation	Quality Management	Ongoing during 2007	TBD through state-wide committee					
Well-Child 2 /WIC Collaboration	Raise HEDIS Well-Child 2 rates by collaborating with local WIC agencies.	STI Goal to Reach NCQA's 75th%ile of 71%	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS intervention list or internal report)	Quality Management	Ongoing in 2007	Identify MO Care WIC participants. Notify WIC of members aged 6 months-4 years due for Well -Child Check. WIC then encourages member to seek appointment. MO Care in turn encourages members who do not participate in WIC to sign-up.					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Completed	Results	Barriers	Recommendations
Mental Health Follow Up	Increase # of members receiving 7 & 30 day follow up appointments following discharge from inpatient stay for mental health.	HEDIS 7 day f/u 45.45%; 30 day 65% (closing 5% of the gap between current rate and 100%)	Follow HEDIS Tech Specs for rate calculation (intervention based on inpatient census)	Behavioral Health	ongoing	Care manager works with inpatient facility to schedule follow up appt. Case manager works with member to ensure member keeps appointment and can get to appointment. BH manager monitors compliance of inpatient facilities in scheduling f/u appointments.					
Member PCP Assignment	Insure all members have a PCP that is identified as a medical home.	Reduce % of members who have not seen assigned PCP in prior 9 months.	Claims data.	Quality Management (will require participation from medical management, provider relations, and member services)	12/31/08	Details TBD; Develop report to identify members not seeking care from PCP. Targeted intervention to those members. Develop phone protocols for departments that interact with members to ascertain PCP preference.					
ER Utilization	Reduce ER utilization by top 1% of users and reduce use of ER for minor illnesses. This will reduce health plan cost and increase the quality of care to the member if they establish a medical home rather than using the ER.	Significant decrease in # of visits by top 1% of users. Decrease in % of inappropriate visits compared to total visits to ER.	Will use PPM and internally pulled report to measure indicators. Data tracked monthly.	Quality Management/ Medical Management,Member Services/CMO	Monthly	Details TBD. Members with >2 ER visit for a non-emergent diagnosis will be sent a letter reminding them to use their PCP & describing proper use of ER. Members who continue to frequent the ER after the letter will receive a phone call. Top 1% of utilizers will be targeted through case management and CMO working with members PCPs.					
Polypharmacy Project (BH/MH collaborative)	TBD	TBD	TBD	Ron Lacey	TBD	TBD					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Completed	Results	Barriers	Recommendations
BH/PH Integration Plan	TBD	TBD	TBD	Andrew Maters	TBD	TBD					
Prevention & Wellness											
EPSDT Postcards	Increase the # of children receiving annual EPSDT exams & staying up-to-date on imms.	Maintain WC1 rate of 62.27%; Increase WC 2 rate to 70.50%; Increase AWC rate to 47.90%; and Increase EPSDT participation to 72.35%.	See HEDIS measures for childhood imms; adolescent imms; well child 1, well child 2, & adolescent wellcare. Increase EPSDT on 416 & reduction of state sanction.	Quality Management	Monthly	Mail postcards to members during their birth month to remind them to receive their EPSDTs and stay up to date on imms. Other developmental info included on cards.					
Preventive Care Toolkits	Increase provider compliance with EPSDT, Imms, & Lead Guidelines	Improved performance on HEDIS measures of WC2, AWC, CIS, & AIC. Increased lead testing rate of 1 & 2 year old children.	HEDIS Tech Spec for HEDIS measures. Lead rates generated by internal report. Provider satisfaction with toolkit also evaluated.	Quality Management	Ongoing	Preventive Care Toolkits delivered to provider offices. Toolkits include overview, guidelines, required, and recommended forms on EPSDT, LEAD, and Imms. Toolkits presented to office managers and clinical staff.					
Well Adolescent Women Day (Pilot)	Improve adolescent females compliance with EPSDT, CCS, CHL, and immunizations.	Improved performance on HEDIS measures of AWC, AIC, and CHL.	HEDIS Tech Spec will be used for calculation of Measures.	Quality Management	11/1/08	Partner with clinic to offer Well adolescent day. Provide preventive health screenings and education to participants. Invite/encourage participation by offering special services (e.g. free massages, manicures).					
On-hold messages	Prevention & wellness topics	Increased awareness by member of P&W topics.	Topics of messages are tracked to insure a variety of messages as well as key topics are included regularly.	Quality Management	Quarterly	Update on hold messages with relevant and seasonally appropriate prevention & wellness topics.					
Education through Provider, Member, & School Nurse Newsletters.	Prevention & wellness topics	Increased awareness by members and providers of P&W topics.	P&W articles are tracked to make sure all HEDIS topics are covered annually and seasonal topics are covered as appropriate (e.g. flu shot)	Marketing (All Dept. contribute articles); QM & MM responsible health ed materials	Quarterly	Prevention & wellness articles in every issue.					
Health Education materials distributed at community events	Prevention & wellness topics	Increased awareness of community of P&W topics.	# of events attended and # of attendees are tracked.	Marketing - identifies events; QM orders & selects health ed materials.	Ongoing	Prevention & wellness materials distributed at community events such as health & back-to-school fairs.					
Member services outreach calls	Educate members on appropriate preventive services based on age.	Improved EPSDT and HEDIS performance on WC1, WC2, AWC, AIS, CIS, CCS, and PPC.	# of calls are captured through call tracking by HEDIS category.	Member Services	Ongoing	Information on preventive services is included in new member call scripts.					
Pregnancy Packet Mailing	Educate members on issues related to pregnancy (e.g. prenatal care; delivery; nutrition)	Packet sent to all pregnant members.	# sent per month is tracked.	Case Management	Ongoing	All identified pregnant members are mailed a pregnancy packet including a Pregnancy Book.					
Post Partum Mailing	Educate members on importance of postpartum care & on caring for new baby.	Packet sent to all moms who deliver.	# sent per month is tracked.	Case Management	Ongoing	New mothers are sent the "You and Your Baby Booklet".					
Lead Awareness Mailing	Remind providers of lead testing/screening guidelines.	Increase lead testing rates at 12 months to 55% and at 24 months to 27%.	% of children 15 & 27 months of age who had a blood lead test in the previous 12 months (data pulled internally).	Quality Management	30-May-08	When DHSS completes annual update to state lead map, mail updated map and screening guidelines to providers.					
Did Not Keep Appointment Initiative	Educate parents on importance of keeping well child and immunization appointments.	Improve EPSDT and HEDIS performance on WC1, WC2, AWC, & CIS.	Track % of members receiving a well child visit following DNKA letter or phone call.	Quality Management	Ongoing	Providers notify MO Care when am member does not show for a well child visit. Parent is sent a letter on importance of visits & of keeping appointments. When a 2nd notice is received, QM Nurse contacts parent to discuss barriers to care.					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Completed	Results	Barriers	Recommendations
Health baseline Mailings	Educate members on immunizations and lead guidelines.	Improved HEDIS CIS rates and blood lead testing rates.	Track # of letters sent	Quality Management	Ongoing	Mail packet of information to members who indicate on state health baseline questionnaire that they need information on immunizations or lead screening/testing					
Credentialing											
Ongoing monitoring of providers.	To monitor providers for licensure sanctions & complaints between recredentialing cycles.	Identify all providers with sanctions & quality issues & to bring them back before the MQM committee if necessary.	Ongoing monitoring activities logged monthly.	Meg Warren	Monthly	Review: OIG exclusions report; Healing Arts Newsletter (semi-annually); call tracking report; sentinel/adverse events.					
Credentialing/Recredentialing	Receive application & supporting documents & complete primary source verification following NCQA guidelines.	Meet 180 day NCQA guidelines for primary source verification. Recredential all providers every 3 years.	# of providers initial credentialed; # of providers recredentialed. Track # of providers with expired credentials.	Meg Warren	Ongoing						
Delegated Credentialing Audits	Complete audits of all delegated credentialing organizations.	Audit 100% of delegated providers annually.	% of delegated providers audited.	Meg Warren	Within 1 year of prior audit (date varies by organization) - all to be completed by 12/31/08						
Service Performance Indicators											
Provider Access Survey	Determine if appointment access standards are being met.	100% of providers surveyed will meet access standards.	Telephone Survey	Debby Langley (Physical Health Providers);	9/1/2008						
Member Satisfaction Survey	Monitor Member Satisfaction with Missouri Care & Network	Perform at or above last year's measures and the national benchmarks.	Member Survey administered by the Myers Group.	Debby Langley/Tammy Wiese/Corporate	6/1/2008						
Provider Satisfaction Survey	Monitor Provider Satisfaction with Missouri Care	Maintain performance.	Survey administered by the Myers Group	Debby Langley/Tammy Wiese/Corporate	7/1/2008						
Monitor member/provider grievances & appeals	Maintain quality services for members; address member concerns.	All grievances are addressed & closed.	Assignment to appropriate manager for resolution through SIC committee.	Debby Langley/SIC Committee	Ongoing						
Monitoring of sentinel events/quality issues.	Maintain quality care by evaluating sentinel events & quality issues.	Evaluate all sentinel events & quality concerns to determine if corrective action is needed.	All events are logged and tracked/trended. Potential quality of care issues are presented to MQM.	Brenda Moore	Ongoing						

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Quality Improvement Work Plan - 2007

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Analysis	3336	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	1/9/2007	2/12/2007			
Analysis	3352	EPSDT outcomes reporting	Semi-Annuall		Wadman, Wes	BA+OC	1/15/2007	2/12/2007			
Audit	1114	Conduct oversight audit of NDBH for claims payment activities (Medicaid).	Quarterly	NDBH	Turner, Maryann	DOC	2/8/2007	2/8/2007			
Audit	3695	Member Grievances and Provider Complaints 4Q	Quarterly	NDBH	Brennan, Judy	DOC	2/8/2007	2/8/2007			
Audit	1437	Oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	2/8/2007	2/8/2007			
Analysis	3286	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	4/10/2007	4/9/2007			
Audit	1434	Conduct oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	4/12/2007	2/8/2007			
Audit	3692	Member Grievances and Provider Complaints Q1	Quarterly	NDBH	Brennan, Judy	DOC	4/12/2007	4/12/2007			
Audit	1644	Conduct oversight audit of NDBH for claims payment activities (Medicaid)	Quarterly	NDBH	Turner, Maryann	DOC	4/12/2007	7/12/2007			
Audit	3389	Oversight Audit for NDBH Member Grievances & Provider Complaints	Annually	NDBH	Brennan, Judy	DOC	4/12/2007	4/12/2007			
Report	3279	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	4/12/2007	4/12/2007			
Report	3282	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	6/14/2007	7/16/2007			
Update	3160	Medicaid Mental Health Committee Meeting Report	Quarterly	NDBH	Unruh, Myron	ND DOC	6/21/2007	6/21/2007			

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Analysis	3292	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	7/10/2007				
Update	3351	EPSDT reporting	Semi-Annuall		Wadman, Wes	BA+OC	7/13/2007				
Analysis	1590	Blue-Advantage Plus ADD/ADHD Drugs Utilization Report	Annually		Neff, Owen	BA+OC	7/15/2007				
Report	3691	Report on Subcontractor/Delegate Oversight to State of Missouri	Annually	All	Brennan, Judy	DOC	8/2/2007				
Audit	3693	Member Grievances and Provider Complaints 2Q	Quarterly	NDBH	Brennan, Judy	DOC	8/9/2007				
Audit	1112	Conduct oversight audit of NDBH for claims payment activities (Medicaid).	Quarterly	NDBH	Turner, Maryann	DOC	8/9/2007	7/12/2007			
Audit	1436	Conduct oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	8/9/2007				
Analysis	3324	CAHPS® Survey - BA+ Member Satisfaction Report	Annually		Parrish, Susan	BA+OC	8/28/2007		QC	9/15/2007	
Approve	3284	BA+ Annual Appraisal of the Quality Improvement Program and Work Plan	Annually		Brennan, Judy	BA+OC	9/1/2007		BA+BOD	10/1/2007	
Report	3651	Annual Delegation and Marketing Guidelines Compliance Survey	Annually		Brennan, Judy	BA+OC	9/15/2007		QC	10/15/2007	
Analysis	3295	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	10/9/2007				
Report	3314	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	10/11/2007				
Audit	1435	Conduct oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	10/11/2007				
Audit	3694	Member Grievances and Provider Complaints 3Q	Quarterly	NDBH	Brennan, Judy	DOC	10/11/2007				

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	3698	Review and Update Audit Tools for Member Grievances and Provider Complaints	Annually	NDBH	Brennan, Judy	DOC	10/11/2007				
Audit	1113	Conduct oversight audit of NDBH for claims payment activities (Medicaid).	Quarterly	NDBH	Turner, Maryann	DOC	10/11/2007				
Update	3162	Medicaid Mental Health Committee Meeting Report	Semi-Annual	NDBH	Unruh, Myron	ND DOC	12/6/2007				
Report	3713	Member Satisfaction Survey for BA+	Biennially	NDBH	Unruh, Myron	ND DOC	12/6/2007				
Report	3317	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	12/13/2007				
Review	3210	Annual Evaluation of Quality Improvement System for Doral Dental	Annually	Doral	Bowen, Shelley	DOC	12/13/2007				
Audit	13	Conduct oversight audit of Doral Dental for credentialing activities.	Annually	Doral	James, Kathy	DOC	12/13/2007				

Children's Mercy Family Health Partners

GOAL		ACTIONS	TARGET DATE	SUMMARY
INFORMATION TECHNOLOGY				
1. Upgrade Systems				
	a)	Complete system upgrades necessary to support the NPI.	5/23/2007	**04/02/07 – rwc –** Received test files from SSI and ran them through the test environment on 3/27. Results weren't positive. I've placed a trouble ticket with ITel to have them look at it. **4/30/2007 – rwc -** NPI Phase II enhancements were placed in production on 4/26/07. Still no date for the taxonomy code enhancements. **6/7/2007 – rwc –** The taxonomy code enhancement is in final QA at I-Tel. I estimate it will be in our test environment in the next week. **7/9/2007 – rwc –** Installed the Taxonomy Code enhancement into Test on 6/14. Initial testing looks good. Paul is coordinating more in-depth testing with Operations. **09/11/2007 – pjb –** Operations is still testing.
	b)	Complete upgrades necessary to support UB-04 and CMS-1500 claims forms.	5/23/2007	**03/20/07 – rwc –** Wolf software is creating the batch classes for imaging. I-Tel has received a signed T&C to upgrade the databases necessary.

	GOAL	ACTIONS	TARGET DATE	SUMMARY
		c) Purchase and install a new i5 520 (AS/400)	4/15/2007	**02/20/07 – rwc –** met with vendor to iron out specifications. He promised quotes by 2/23 **04/02/07 – rwc –** Almost everything is being replicated to the new machine correctly. We are still on track for a 4/15 cut over. **4/30/07 – rwc –** We are working through some issues with replication. **05/14/07 – rwc –** Went into production today. Yay!
		d) Retire existing backup AS/400 and replace with the replaced production machine.	6/15/2007	**06/07/2007 – rwc –** Move is scheduled for 6/18. **06/18/2007 – rwc –** completed today.
		e) Purchase and install a Storage Area Network (SAN)	5/15/2007	**04/02/07 – rwc –** We'll be ordering the hardware this week. **4/6/07 – rwc –** Installed SAN today and set up volumes on servers which were running out of space.
		f) Purchase and install new Exchange Enterprise email server(s)	6/15/2007	**05/14/07 – rwc –** Software has been ordered. **6/7/2007 – rwc –** Server has been ordered and received. Louis is getting the basic server configured in preparation for loading Exchange. **7/9/2007 – rwc –** We will load Exchange on 7/10 so we can begin testing the migration.

	ACTIONS	TARGET DATE	SUMMARY
GOAL			
	g) Purchase and install DRG grouping software.	3/15/2007	**03/20/07 – rwc –** Received software last week. We need to review the installation procedure before we can begin installing it. **3/26/07 – rwc –** Software has been installed on all 8 requested PCs.
	h) Install 50Mbps network connection between Crown Center and the Riss Building	3/31/2007	**2/20/07 – rwc –** Spoke to AT&T Engineer. The tentative turn-up date is 3/28/07. **03/26/2007 – rwc –** AT&T has completed their portion of the work. It's time to schedule the cutover. **04/02/07 – rwc –** Circuit is up. We are currently burning it in and testing.

GOAL	ACTIONS	TARGET DATE	SUMMARY
	i) Install separate voicemail and CCC reporting Servers at Crown Center.	~~3/31/2007~~ 4/30/2007	**2/20/07 – rwc –** Hardware has been purchased and installed at CC. We can't proceed further until the heat issue in our server room at CC is resolved. Susan Cain is talking to the engineers. **03/20/07 – rwc –** The temperature in the server room at CC has stabilized at a reasonable temperature. We will begin working with Choice to schedule the installation. **3/26/07 – rwc-** Temperature in the server room reached 100 degrees over the weekend. We've asked CMh to move forward with purchasing a separate A/C unit for the room before we do anything else. **4/30/07 – rwc –** I've asked Choice Solutions to move forward on this once the new A/C unit installation is complete. Jim will be coordinating this. **6/7/2007 – rwc –** We have a kickoff meeting scheduled with our new vendor, Allegiant Network, on 6/8 at Crown Center. **06/18/2007 – rwc –** Someone from Allegiant networks will be here on 6/19 to begin the prep work on our new servers. **7/9/2007 – rwc –** Received license for Voice Mail Server today.

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GOAL		ACTIONS	TARGET DATE	SUMMARY
	j)	Upgrade the network connection between the Riss building and the cave.	6/31/2007	**4/5/07 – rwc** – Spoke to Everest about options. Will receive proposal next week. **4/30/07 – rwc** – received a proposal for two more T1s . We will run multilink over the three giving us an aggregate bandwidth of 4.5 Mbps between the sites. **05/14/07 – rwc** – T1 cards installed at both sites. Circuit turn up is scheduled for 5/21. After that, the additional bandwidth will need to be configured on the routers. ETA for completion, 5/28. **06/04/2007 – rwc** – Everest pushed the date back to 6/12. **7/9/2007 – rwc** – Project completed 6/12/2007.
2. Disaster Recovery				
	a)	Explore the possibility of increasing our space at the cave.	3/31/2007	**03/20/07 – rwc** – We received a drawing of the proposed space yesterday. **46/07 – rwc** – Lease addendum has been signed and construction deposit paid.
	b)	Evaluate alternatives for reducing our exposure on our new phone system	7/31/2007	
	c)	Evaluate and recommend a solution for making our email system "disaster-proof"	9/30/2007	
3. Information Systems Security				
	a)	Implement tools to monitor and report network performance	12/31/2007	**04/02/07 – rwc** – Purchased whatsup gold to monitor routers and printers via SNMP.

GOAL		ACTIONS	TARGET DATE	SUMMARY
	b)	Evaluate, purchase and implement an email encryption solution	10/31/2007	
	c)	Evaluate, purchase and implement a file/disk encryption solution.	12/31/2007	
	d)	Write internal incident response procedures	7/30/2007	
4. System Enhancements				
	a)	Complete the programming to create 835 remits for providers	3/31/2007	**2/20/07 – rwc** – Brett has completed initial programming and contact has been made with his counterpart at SSI for initial testing. **4/6/07 – rwc** – Programming is complete. We are in the process of testing with Emdeon and SSI.
	b)	Convert NSF format encounter reporting to 837 format for the state of Missouri	12/31/2007	
	c)	Complete implementation of new HEDIS reporting software	6/15/2007	**04/02/07 – rwc** – Software has been purchased and installed. IT staff and QM staff have gone through training. We generated CAHPS and preliminary numerators for our audit. Everything is going well. **4/30/07 – rwc** – According to Janet, everything is running smoothly. We'll leave this open until our report is due to the state. **7/9/2007 – rwc** – results calculated and reported to the state on 6/28/2007

GOAL	ACTIONS	TARGET DATE	SUMMARY
	d) Begin Planning and development of CARE V2	3/15/2007	**2/20/07 – rwc –** First meeting scheduled for 3/8/07. **03/20/07 – rwc –** We held the kickoff meeting on 3/8. We will have weekly meetings until requirements have been completed, approximately 4/31.
	e) Upgrade Code Review from V7 to V9	6/30/2007	**2/20/07 – rwc –** requested software and documentation from our account rep. **04/02/07 – rwc –** received software from McKesson. Will assign to Janet as soon as she has some time freed up. **6/7/2007 – rwc –** Now that HEDIS is about done, Janet has been assigned to work on this project. **7/9/2007 – rwc -** Software is installed in the test environment. Janet is coordinating testing with Operations. **09/11/2007 – pjb –** We have had problems getting CR9 to work properly. Contacted McKesson and I-Tel in efforts to resolve.
5. Staffing			

GOAL	ACTIONS	TARGET DATE	SUMMARY
	a) Hire an "Information Security and Disaster Recovery analyst"	6/1/2007	**2/20/07 – rwc –** Job Description has been forwarded to the hospital for evaluation. **04/02/07 – rwc –** Position has been approved and forwarded to HR to be posted. **04/06/07 – rwc –** position is posted and we've received first set of resume's. **4/30/07 – rwc –** So far, we haven't found any candidates we'd like to interview. **05/14/07 – rwc –** two interviews scheduled. **6/7/2007 – rwc –** We have hired Joe Saverino. He will start on 7/2.
6. Miscellaneous			
OPERATIONS			

GOAL	ACTIONS	TARGET DATE	SUMMARY
7. NPI Implementation	- Acceptance of NPI for claims - MC400 Set up - EDI, MCNet, Batch Mgr set up - Acceptance of new claim forms/layout (CMS1500/UB04) - Companion guide changes - Work closely with IT and Provider Relations	5/23/07 Implementation deferred to 2008	Receive NPI file from KS – 2/26/07 3/07 – Letters mailed to providers. Collection of returned NPI forms. DQ has loaded . As of 3/31 895 NPI's have been loaded to spreadsheet. 7/6/07 – All NPI's received have been loaded. 3 spreadsheets have been created by IT. PR to make necessary follow up contact to providers for final billing set up. Taxonomy pricing still needs to be created and tested
8. Improve EDI claims submission	- Identify EDI claim submission errors by provider (payer #, provider #) - Companion guide and MCNet changes – coordinate with NPI	3/31/07 Q2	2/23 – Letters sent to providers known to have EDI issues. 2/19 – Provider newsletter, transition issues log, KS Transition team notified that CMFHP will have claim edits in place effective 3/1 for CMFHP provider number. 7/1/07 – Most providers have correct their issues. Bob C created many fixes in the MCNet program allowing more claims to pass through. Edits at clearinghouse implemented to support correct payer #.
9. Code Review – V9	Based on MC400 implementation of V4	6/30/07	7/1/07 – Received and loaded. Currently building the knowledge bases in test.

GOAL	ACTIONS	TARGET DATE	SUMMARY
10. 835 Implementation	• Support IT with implementation of 835	3/31/07	Provide mapping support to IT – Done 4/2/07 – Communicate on web Issues Log – To date SSI only; Gateway TBD; no response Emdeon.
11. ICD-10 CM & claim changes	• Research radar screen for implementation in 2007 • Stay abreast of CMS changes – obtain contacts/website, join workgroups,		3/07 - CMS – Update related to delay in CMS 1500. Website noted for f/u. DRG's to change effective 10/1. Monitoring with State of KS
12. MO MC400 set up – improvements	• Implement set up improvements learned from KS – Ben Cats, Adj. Rules – clean up and consolidation	12/31/07	
13. Fraud & Abuse	• Review current processes and program • (Code Review, Mgmt check review) • Identify suspect billing practices – notifications from the state • Develop Pre/Post AP claim reports • Research available software • Implement DRG Software	4/30/07 Ongoing 3/31/07 Ongoing 3/31/07	3/07 – Units (99070/99218) PreAP 4/07 – Global OB PostAP DRG Software complete
14. Staff Recognition	• Company vs. Department	2/15/07	Betty notified of staff members eligible for PTO from KS implementation 7/1/07 – Senior claims analysts rewarded for validation efforts in June
15. Non-Clinical PIP	• Opportunity?		None Identified

GOAL	ACTIONS	TARGET DATE	SUMMARY
16. MC400 Training	• Develop and implement basic MC400 training	Q2 – Q4	Non-covered vs covered Fee schedules/pricing Par vs. non-par 4/07 – Developing par vs. non par training document – training scheduled for 7/11 with Health Services
17. Interest and GME payments	• Develop process to make interest and GME payments in the claims system	6/30/07 – GME 9/30/07 - Interest	5/31/07 – GME set up and payments complete.
18. PCP Incentives	•	6/30/07	See PR/Finance
CLAIMS			
19. Encounter Reject Process	• Complete work from 06 • Program queues by error type • Reporting capability • Implement encounter void and replace • MO & KS	6/30/07	
20. Automation	• Claims Inventory - Reports from MCNet and Batch Manager • Identify manual processes eligible for automation • Denial modules – MC400	12/31/07	3/07 – MCNet inventory report close to completion – No automation available for Batch Mgr. 7/07- Mailing labels generated from AP Posting process to eliminate manual addressing of envelopes.
21. Claims Audits	• Expand audit processes • Review sample sizes – automate sampling	6/30/07	7/07 – New job description for DQ Auditor. Plan to move auditing function to DQ in 3rd qtr.
22. Standard Operating Procedures	• Review and update SOP or P & P's – Prioritize so critical processes are addressed first	12/31/07	7/07 – Ongoing updates of claims processing guidelines complete.
DATA QUALITY			

GOAL	ACTIONS	TARGET DATE	SUMMARY
23. MC400 Set Up Tracking	• Develop and implement tracking tool for additions/changes to Ben Cats, Fee Schedule, State Bulletins (Access database created in 06)	6/30/07	3/07 – Tracking tool developed. Documenting fee schedule and benefit exceptions for future fee schedule loads. 7/07 - BenCat Matrix for Missouri. Need to develop one for Kansas
24. Audit Program	• Develop and implement audit program – Provider set; MC400 changes	9/30/07	7/07 - Provider set up audit completed and implemented June 2007.
25. Fee Schedule Updates	• Develop and implement a process for annual updates – Fee Schedule; CPT/HCPCS; ICD-9; KS DRG • Document contents and exceptions for all MO and KS fee schedules	6/30/07	7/07 - Kansas Fee schedule exception are being documented in an exception file in the Data Quality Folder Missouri fee schedule exceptions still to do. KS DRG – on target for end of July. CPT/HCPCS – target end of July for written process ICD9-target end of July for written process
26. State Bulletin Management	• Implement state bulletin review into Operations Guidelines • Track changes as noted in #1	03/31/07	3/07 – Complete. Table created to track all state bulletins and changes. Bulletins presented and reviewed by Ops. Guidelines Team.
COMPLIANCE			
27. Hire Fulltime Compliance Officer	a) Position is being hired by Kim Brown, Compliance Officer at CMH and Bob Finuf	4/07	
28. Transition Compliance Duties	a) Development of compliance duties work plan to assist in the transition of duties	3/15/07	

GOAL	ACTIONS	TARGET DATE	SUMMARY
29. Transition Policy and Procedure process to Compliance department	a) Specific steps to be determined after hiring of FT compliance officer	TBD	
31. Complete Mandatory Annual Compliance Training	a) Training scheduled throughout February	End of Feb 2007	
PROVIDER RELATIONS			
34. Increase PR Rep visits in Kansas and Missouri	a) Fill all openings and complete training b) Increase rep visits by end of March		On going
35. NPI Implementation	a) Letter to providers has been completed b) Group has been put together for implementation of gathering information c) IT working with I-Tel for updates to MC 400	May 23, 2007, extended to 5/23/08	4/07 initial prepopulated letter sent, IT & DQ have process to upload received NPI's in MC400, Contingency plan letter completed and will be sent with second request of NPI's
36. Credential all new providers	a) credentialing of direct contracted providers 2700 b) schedule delegated oversite audits c) assess additional staffing needs due to volume of applications that need processing	1/07	On going
38. Joint Provider Education Sessions	a) determined that this is not effective after discussion with providers unless there is a significant program change effecting both plans.		On going –we will do our own meetings
39. Data Clean up	a) provider address information b) panel sizes and/or limits c) duplicate provider numbers	Complete 4/07	4/07 This is on going but has decreased significantly as of current date
CUSTOMER RELATIONS			
Community Relations			
40. Review Customer Relations Management options to track Community Relations activities	a) Will begin to develop a list of items to track. b) Look at software to track and trend.	9/30/07	Q1: No activity. Q2: Set for Q3. Q3: Demo with Goldmine. IT setting up demo with Microsoft.
41. Enhance communication efforts to members and resources that influence member enrollment	a) Continue renewal mailings in Mo. b) Look at options to expand renewal mailings and premium reminders to Kansas after the Clearinghouse becomes current on applications c) Start outreach efforts for MC+ expansion area.	Monthly for Mo and 06/30/07 for Ks	Q1: Mo. renewals mailed. Ks. Requested we wait until Q2 to readdress this and determine if Clearinghouse is up to date on renewal applications. Q2: Looked a process of sending

GOAL	ACTIONS	TARGET DATE	SUMMARY
			renewal mailings and effectiveness. Made a decision to stop sending renewal mailings for MC+. Kansas still behind on applications and not an option currently. Began looking at distribution of eligible members within the expansion area. Will assign this territory to a seasoned rep. Q3: Began working in expansion areas. Renewal mailings continue until stock depleted.
42. Review and update all marketing materials for Community Relations, Customer Service and Health Services	a) Work with Health Writer to review all communication materials for CR and HS b) Health Writer will work with Health Services to update documents for the Health Mgt. Dept.	06/30/07	Q1: Notebooks developed with all communication materials. Began process of updating materials. Q2: Update OB, transportation, brochures, and health mgt. materials. Developed Mailer Mailer option for distribution of newsletters. Collected 139 requests for electronic submission. Q3: All materials for CR updated. Now beginning to work on updating member handbooks for both states. Progress continues on HS documents.
43. Build a closer relationship with the CMH marketing group and team up on events	a) Begin attending monthly meetings with CMH marketing b) Attend and participate in the opening of the KCK location	Monthly with KCK opening Summer 07	Q1: Attended monthly meeting. Will work with CMH on school nurses program as well as KCK opening to be determined. Krissie met with Roger at CMH marketing and reviewed all CMH marketing style guidelines. Q2: Working on CMWest for 8/2 open house and participated in Health Kids even in NKC. Q3: Open house attended. Scheduled health fair at CMW for

GOAL	ACTIONS	TARGET DATE	SUMMARY
			10/20.

44. Continue sponsorship of key events and outreach within both States	a) Look at opportunities to display and sponsor events in Kansas and Missouri to include
	   1. KidFest in Wichita in November (Title Sponsor)
	   2. KidFest in Topeka in November (Co-sponsor)
	   3. Back to School Rally with Councilman Riley
	   4. Various back to school Rallies in Ks. & Mo.
	   5. Binational Health Week (October)
	   6. Chiefs Easter Egg Hunt (Spring)
	   7. Free Swim Nights in KCMO (Summer)
	   8. Kansas State Fair (Summer)
		Through 12/31/07	Q1: Participated in following: Easter Egg Hunt with 1,000 attendees and approximately 15 Connection events.
			Q2: 2 Free Swim nights held with approx. 450 attendees. 2 staff on committee for bi-national health week.
			Q3: 14 back to school fairs, a week at State Fair and Step Out America scheduled for Sept. Working with a Wizards player, Jose, to attend events and talk about healthy eating and exercise for kids

45. Continue Hispanic community outreach	a) In Kansas and Mo, participate in Hispanic events and sponsorship to include
	   1. Cinco de Mayo (chose not to participate)
	   2. Fiesta Hispania
		Through 12/31/07	Q1: Developing relationships with key Hispanic groups in Jo, Wy and Sedgwick counties.
			Q2: Outreach to Hispanic chamber in Wichita; ESL through the Inter-Faith Ministry, El Centro in KCK, Guadalupe Center. A decision was made not to participate in Cinco de Mayo due to the heavy emphasis on adult drinks consumed at this event.
			Q3: El Centro scheduled for Oct.

46. Review opportunities to provide dental education into Kansas and continue dental education in Missouri	a) Purchase tooth brushes as give aways b) Work with State of Ks. To promote dental care	Through 12/31/07	Q1: Toothbrushes arrived. S/W Ks and they do not have any promotional opportunities we can team up on. Continue dental care education in schools. Q2: Bridgeport will provide us 350 tubes of toothpaste. In Dec, we will work on budget ideas with Bridgeport for 2008. Q3: Will begin discussions with Marcia Manter from Oral Health

GOAL	ACTIONS	TARGET DATE	SUMMARY
			Ks. Held dental clinic in Clinton with Bridgeport with 350 attendees.
47. Work with Taira on Advertising opportunities and sponsorship of community events	a) Work in conjunction with media buyer based on need and opportunities	Through 12/31/07	Q1: Notified media buyer about negotiating with Topeka KidFest. Working on Wichita media for April Fun Fest. Q2: April Fun Fest in Wichita; Pumpkin PaZoola and Parent's University in process for Q3. Have a meeting with the Wizards set. Q3: Working with Taira on media for expansion counties. Media will be present at Step out America at the Legends and the CMW event.
Community Relations			
51. Continue Food Power sponsorship and review opportunities to obtain feedback from parents	a) Work on survey that will be presented to parents in the fall to provide feedback on program	09/30/07	Q1: Received feedback from AOC on survey and will finalize Q2. Q2: Survey finalized and ready to print. Finalized contract for Food Power Young Adventure. Q3: Survey finalized and Food Power will distribute.
52. Continue wellness initiatives and outreach to churches and look at option of enhancing radio spots	a) Work with HS on possible opportunities b) Sponsor "In the Key of Life" for 1590AM radio	06/31/07	Q1: Signed contract to continue program for 07. Veronica appeared with HS and pastor requested they stay on for additional 60 minutes. Q2: In the Key of Life on 1590 presented with info on asthma, nutrition and pediatric case mgt. Q3: Discussed mission impossible and preparing for flu, and ER outreach with Augusta.
Community Relations and Provider Relations - Kansas and Missouri			

GOAL	ACTIONS	TARGET DATE	SUMMARY
53. Work in conjunction with PR on the Provider of the Quarter Award	a) Work with PR and once candidate is identified, develop award and schedule presentation	April, July, Oct	Q1: No award to present in Q1. Q2: Assisted in award for Dr. Rubin. Q3: Award and banner ready for Dr. Mitra.
54. Look at opportunities to team up with PR for a Provider marketing program	a) Work on give aways and co-sponsorships	12/31/07	Q1: No activity Q2: No activity Q3: Looking at providing children's books to provider offices with our logo. Focus will be on nutrition and exercise. Have ID'ed a book and looking at resources to purchase.
Customer Service - Kansas and Missouri			
55. Provide education/HOT Topics on inbound member calls	a) Monthly HOT topics to educate and inform members while capturing a teachable moment.	Monthly through 12/31/07	Q1: Educate on CAHP survey and Easter Egg Hunt. Q2: Educate on CAHP survey and pool parties. Recorded on hold messaging.
56. Review staffing to maintain appropriate call stats are met and determine work station requirements	b) Hire staff to get to 19 CS reps/coordinators	3/31/07	Q1: All positions hired and 19 reps/coordinators in place (6 Hispanic) Q2: One position vacated.
57. Maintain phone stats per goals	a) Achieve and maintain phone stats of <=5% abandonment rate and 30 second ASA for Ks. And Mo.	Monthly through 12/31/07	Jan Mo: 8.2%, Ks: 8.3% Feb Mo: 7.2%; Ks: 6.2% Mar Mo: 5% Ks: 4% Apr Mo: 4.85% Ks: 4.78% May Mo: 4.23% Ks: 3.8% June Mo: 3.83% Ks: 3.7%
58. Review daily and weekly member reports to reduce or automate	a) Review all reports printed by IT and automate as many as possible.	06/31/07	Q1: Automated disenrollment report for address changes and ME code report. Q2: Worked missing PCP report and found errors that were corrected.
59. Review work flow to improve	a) Review newborn process, PCP open close panel and	06/31/07	Q1: PCP assignment and PCP

GOAL	ACTIONS	TARGET DATE	SUMMARY
processes including new born notification, open/close panels & capturing non member PCP's	capturing PCP data. Look at possible non clinical PIP for newborn process.		open/close panel in place. Working on newborn process. Q2: Newborn enrollment close to completion.
60. Implement transportation vendor and follow up on any quality issues while reviewing options of bringing in house	a) Implement b) F/Up on complaints c) Obtain service goals consistent to state expectations d) Work through action plan e) Look at option of bringing in-house	06/31/07	Q1: Implemented LogistiCare. Submitted action plan. Sent term letter and working on contract language to transition back to MTM. Q2: LogistiCare phased and MTM goes live 7/1/07.
61. Develop process to electronically submit eligibility changes to Kansas and Missouri (Newborns, address/phone changes)	a) Submit track-it. b) Work with IT on how to submit to the state	06/31/07	Q1: Ks. Requested this be tabled until Q2. Part of QA&I for Mo. Q2: Still no interest by Mo and Ks to do this.
62. Develop a Customer Service training manual that will be accessible to all employees	a) Add training manual/reference guide to the CS share drive and share with all employees	12/31/07	Q1: No activity. Q2: Moved to Q4 completion goal due to CS staffing and newborn project issues. Outline and some documents in process.
63. Review translation service contract and look at options for possible new vendor	a) Review contract with ATT&T and compare to other vendors for pricing and quality.	06/31/07	Q1: Received proposal from Propio translation (used by State of Ks.) Compared to Language Line and could save $1,000 annually. Q2: Received reduced pricing from Propio. Contract language under review.
67. Develop a Community Advisory Committee (CAC) for Kansas and enhance the current CAC in Missouri to include Social Service Agencies	a) Improve Missouri CAC and implement Kansas CAC. b) 3 sites in Ks (KC, Wichita, Topeka) c) Meet quarterly	03/31/07	Q1: CAC for Mo revised and changed time to 4PM. First meeting 4/3. CAC for Ks invites ready and attendees identified first meeting in April. Q2: Meetings were success. July meetings will focus on health management programs.
Community Relations and			

GOAL	ACTIONS	TARGET DATE	SUMMARY
Customer Service			
68. Participate in the advanced ID card meetings	a) This project is being organized by the Mid America Health Coalition based on recommendations from the state of Kansas to automate medical information. Meetings are monthly.	12/31/07	Q1: Discussed options and plan to move forward. Not a lot of willingness by provider offices. Q2: Committee continues to meet. State and EDS now involved. Scheduled to submit an action plan by Q4.
69. Work on development of program to obtain feedback from members in follow up to encounters	a) Work with CS coordinators to make outbound calls to members and providers who contacted CS or met with CR to determine satisfaction.	12/31/07	Q1: No activity. Q2: Moved to Q4 goal to CS staffing and projects.
GOVERNMENT AND PUBLIC AFFAIRS			
70. Missouri – work on proposing industry friendly proactive solutions to health reform in conjunction with MAHP	a) Propose web based enrollment, research what other states are doing in this area	May 2007	02/07: Gathering information on what other states are doing 03/07: Discuss at MAHP 7/07: The state is moving forward with implementing web-based enrollment. Harmony Health Plan has agreed to help fund, MAHP is in support of this initiative. 12/07: Continuing our support through MAHP.
71. Missouri -- Support efforts to secure adequate funding	a) Track the budget as it moves through committee b) Communicate with Moody	May 2007	02/07: Hasn't yet come to committee hearing 7/07: Inflationary cost was fully funded along with an approx 10% physician increase in this 2007 12/07: Session stands in adjournment.
72. Missouri – respond to Medicaid Reform legislation	a) Track legislation b) Develop talking points and work with MAHP to educate legislators	May 2007	02/07: Legislation filed no committee action yet. 7/07: Successfully protected our market and will be working with the State to enter into the four expansion counties. 12/07: Session stands in

GOAL	ACTIONS	TARGET DATE	SUMMARY
			adjournment.
75. Both States -- Develop Product for the uninsured	a) Meet with administrators to discuss what role we could play in the development of a product for the uninsured. b) Consider private or government funding streams c) Research	Ongoing	3/07: First planning meeting set. 7/07: Met with TMC to explore partnership opportunities. This is on holding pending the State of Missouri's Premium Assistance plan. 9/07: Spoke with representatives from MARC who recommended doing something with the illegal immigrant population in the area.
HEALTH SERVICES			

GOAL	ACTIONS	TARGET DATE	SUMMARY
76. Develop HS policy and procedure committee	Determine participants	February 2007	2/22/07 Assigned the following: Amanda, Sally, Kathy, and Stevana
	Facilitate first meeting and handoff of policy tracking log	1st Q 2007	03/30/07 First meeting held and handoff completed
78. Redefine HS Committee Structure and Responsibilities	Define committee structure and composition	January 2007	1/26/07 Completed committee structure – approved at UM/MD on 1/30/07
	Complete committee responsibility matrix	February 2007	2/23/07 Completed committee matrix of responsibilities – will review at 2/27/07 AOC meeting
	Obtain participant approvals	March 2007	03/29/07 Signatures to be obtained at first meeting of each committee
	Schedule quarterly meetings and add to meeting matrix	March 2007	03/29/07 quarterly meetings scheduled and added to the matrix
79. Promote team building activities among HS staff	Facilitate cross training between areas	Ongoing	02/21/07 In late December 2006, all HS staff attended a 2 day training on all areas of the HS department. Throughout January and February 2007, cross training occurred in Pre-certification and Utilization Review for most existing staff and new staff.
	Develop cross functional teams focused on implementing specific work plan goals throughout 2007	Ongoing	
Pre-certification and U/R			
78. Complete hiring of open positions	Implement employee referral bonus program in collaboration with HR - $3000 employee incremental bonus for new hires that have at least 2 years of managed care experience	February 2007	2/22/07 Program approved and communicated to HS staff
	Evaluate feasibility of offering a sign-on bonus to potential candidates	February 2007	2/19/07 – Unable to do per HR

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Continue recruitment efforts - Complete all hiring	2nd Q 2007	03/30/07 Seven open positions remain within the dept – ongoing screening and interviewing 4/1/07 – 7 HS positions remain open – ob staffing complete - cont to meet with HR 3x/week – currently considering Wichita recruitment for UR position 5/1/07 – 5 positions open with 2 internal candidates identified; Wichita ad placed for UR; cont to meet 3x/wk with HR; completed review of nat'l Carreer Builder databank 6/1/07 – offer extended for HSC position and OB CM position filled internally – 3 open positions remain – possible Wichita candidate identified – local ads placed for remaining 2 positions 7/1/07 – Wichita position filled; 3 positions remain open (CM Supervisor, Peds CM, UR) 7/31/07 – 3 positions remain open; possible UM candidate indentified 9/4/07 – Open positions include ER Care Manager, Peds Care Manager and Adult Care Manager – continue active recruiting
79. Implement IRR process for Medical Directors	Modify Milliman process or establish new process for quarterly IRR review	2nd Q 2007	03/30/07 Milliman demo of IRR tool scheduled for Medical Directors on 4/19/07 07/01/07 IRR process drafted by Liz and approved by HS Management team – implementing in 3rd Q 2007

GOAL	ACTIONS	TARGET DATE	SUMMARY
80. Enhance KS/MO benefit comparison guide to include additional clarifications from each state	Collect information already rec'd from each state regarding benefit clarifications	1st Q 2007	03/30/07 Sally has collected information and reviewing with Clinical Criteria Committee weekly
	Develop a list of services requiring clarification	1st Q 2007	03/30/07 Services requiring clarification are being reviewed weekly through the Criteria Committee
	Submit requests to each state of services requiring clarification	Ongoing	
	Complete benefit comparison tool modifications and distribute to all staff (including PR, CS, Claims)	2nd Q 2007	7/1/07 This goal is ongoing. Tool under review during weekly Clinical Criteria Committee meetings 9/4/07 – Continue as noted above
81. Establish audit and monitoring processes for HS staff	Re-evaluate current tools for needed modifications	2nd Q 2007	4/1/07 – Tools not yet reviewed 5/1/07 – Currently reviewing tools 6/1/07 – precert tool revised and finalized; continuing review of other 2 tools 7/1/07 – all tools revised
	Educate staff on audit tools and expectations	2nd Q 2007	4/1/07 – Staff to be educated once tools revised 6/1/07 – Staff educated on new precert tool in May 7/1/07 – Remaining staff educated on tool modifications on 6/29/07
	Conduct quarterly audits of existing staff and staff here greater than 90 days (UR/Precert)	2nd Q 2007	4/1/07 – Mini audit conducted by Angie of new staff – results to be shared with staff at April OPS meeting – quarterly audit not complete 5/1/07 – Audit results shared with staff 6/1/07 – Plan to initiate condensed

GOAL	ACTIONS	TARGET DATE	SUMMARY
			audits for 2nd quarter 7/1/07 – Mini audit initiated in 2nd quarter

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Evaluate use of CARE in the quarterly audit/monitoring process	3rd Q 2007	4/1/07 – Routine CARE meetings initiated last month with IT and HS 5/1/07 – Weekly meetings with HS and IT continue 6/1/07 – Continue to meet routinely 7/1/07 – IT actively working with staff to assess needs 7/31/07 – No new changes 9/4/07 – Continue to meet with IT to discuss development issues
	Begin Care Management Audits	3rd Q 2007	4/1/07 – Audits not yet initiated – 1st CM rounds to start April 10th 7/1/07 – Mini CM audit to be initiated this month 7/31/07 – audits to be conducted in CARE during 3rd quarter 9/4/07 – mini audit to be finalized on CM's this month
	Implement online Medical Director review and documentation tool	3rd Q 2007	4/1/07 – Initial meeting held with IT to discuss concepts and implementation 5/1/07 – Macro document currently being tested by users – plan implementation once testing and revisions complete 6/1/07 – Continue with testing and revisions 7/31/07 – project on hold for now as system to complex for staff 9/40/7 – Same as noted above
83. Revise Carryover Days reporting process	Develop monthly carryover report in collaboration with IT from the OAO auth system	1st Q 2007	3/30/07 Reviewed process – already using Data Warehouse reports and manual clean up required – will keep process for now
	Develop process for Medical Director review and estimations of carryover days	February 2007	Medical director input into each carry over case LOS estimation

GOAL	ACTIONS	TARGET DATE	SUMMARY
			started in January 2007.

GOAL	ACTIONS	TARGET DATE	SUMMARY
Disease Management			
84. Expand Asthma program to KS offices	Update contracts in MO	Ongoing	**6/14 Signed contracts:** -Baby and Child Associates -Cabot Westside Clinic -Cass County Pediatric & Adolescent -Clay County Health -Northland Pediatrics -Priority Pediatrics -Swope Health Services -Samuel Rodgers Health Center
	Review claims data after first quarter to identify patient population and begin communication with providers over 200 members.	2nd Q 2007	6/14 Receiving reports as needed from IT. Establishing automated, self-service report system.
	Plan and conduct training for new Health Coach	2nd Q 2007	3/30 Waiting for JD from HR 4/10 PWF submitted to HR 5/3 Setting up interviews 6/14 Health Coach starts on 6/25. Training and orientation has been scheduled for first 3 weeks.
	Plan to expand Asthma program into 8-12 offices after hiring additional (2) FTE's.	3rd Q 2007	6/14 PWF's for positions have been sent to HR. 8/1 Setting up interviews with candidates in Wichita and Topeka
	Plan and conduct training for new Educators	3rd Q 2007	
85. Implement Healthy Lifestyles Program (HeLP) in MO and/or KS	Get KS and MO approval for all program products	1st Q 2007	3/30 Completed
	Complete signed Educator Agreements for Swope, CMH, St. Luke's, baby and Child, Cass County, Clay County, Northwest Peds, and Cabot	Ongoing	**3/30 Completed Contracts:** -Baby and Child -Cabot Westside -Cass County Peds -Northwest Peds

GOAL	ACTIONS	TARGET DATE	SUMMARY
			-Swope Health Services -Northland Pediatrics -Samuel Rodgers

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Conduct Education in Swope	2nd Q 2007	3/30 Meeting for scheduling dates 12 April 5\2 Started Program
	Conduct Education in Baby and Child	2nd Q 2007	4/17 Started
	Hire and Train Health Coach	2nd Q 2007	3/30 Waiting for JD from HR. 4/10 PWF submitted to HR 6/14 Health coach will start on 6/18 and orientation and training has been scheduled for first three weeks.
	Conduct Education in Cass	3rd Q 2007	In Progress
	Conduct Education in Clay County	3rd Q 2007	
	Conduct Education at Samuel Rodgers	3rd Q 2007	In Progress
	Conduct Education in Northwest Peds	3rd Q 2007	Completed
	Conduct Education in Saint Luke's	3rd Q 2007	3/30 St. Luke's has agreed to start in August. 9/05 In progress
	Conduct Education in CMH	4th Q 2007	
	Conduct Education in Cabot	4th Q 2007	9/5 Scheduling
86. Complete JCAHO required chart validation/IRR process	Begin chart audit process after 2nd quarter 2007 with billing code as a marker. Contracts renewed for MO that wish to continue with Asthma program.	3rd Q 2007	
87. Implement collaborative with Healthy Hawks and PHIT kids programs	Begin meetings to review and agree to terms of partnership	1st Q 2007	3/30 Terms agreement has not been reached. Follow up meeting scheduled for 2 April 4/4 Final meeting set 4/13 Terms agreed upon

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Develop agreement	1st Q 2007	3/30 Draft contract has been written and is pending outcome of 2 April meeting 4/13 Contracts forwarded for review
	Develop plan for data collection and reporting	1st Q 2007	3/30 Waiting for final list of metrics from KU and CMH. Will be discussed during 2 April meeting 4/13 Final metrics included in contract.
	Begin referring members to each program	3rd Q 2007	6/14 Both contracts have been sent to Legal at CMH for review. Expect to have completed contracts by mid-July. 8/1 Received approval from State for contract with CMH. Pending signatures on both contracts. 9/5 Received signed contract for Healthy Hawks.
88. Assess opportunities for new program development	Meet with Finance to review current programs and opportunities to collaborate on new initiatives based on claims data	1st Q 2007	3/30 Kent has agreed to be a member of the HI committee
	Coordinate with Pharmacy to discuss opportunities to collaborate on new initiatives based on utilization data	1st Q 2007	3/30 Cathy will be a member of the HI committee
	Train on ManagedCare.com to pull data to identify need for new initiatives based on claims/ utilization data	1st Q 2007	3/30 Training Completed.
	Review data to identify potential new programs	3rd Q 2007	
89. Develop a DM Advisory Council	Establish a lead person for the committee	2nd Q 2007	3/30 Completed Greg will Chair this committee
	Determine participants	2nd Q 2007	3/30 Internal participants and DM advisors have been determined. Community physicians will be

GOAL	ACTIONS	TARGET DATE	SUMMARY
			decided at first meeting.

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Facilitate first meeting	2nd Q 2007	3/30 Meeting scheduled for 1 May
90. Develop and define the FCS role and how it relates to other CM programs within the department	Establish a working group to discuss program needs and opportunities for implementing FCS position	2nd Q 2007	4/13 Position closed
	Define roles and responsibilities and referral process	2nd Q 2007	4/13 Position closed
	Establish plan for expansion of FCS referral sources	3rd Q 2007	4/13 Position closed
Case Management			
91. Develop strategies to enhance CM through telephonic interventions	Evaluate ability to partner with Home Health agencies in rural areas	2nd Q 2007	4/1/07 – 1st CM rounds meeting to start April 10th 5/1/07 – Meeting on 5/9/07 to talk about identification of par HH agencies 6/1/07 – Met with Saint Raphael in Wichita, KS 7/1/07 – Met with Craig Home Care in June to partner on telemonitoring program
	Partner with PR to educate providers about Case Management programs	3rd Q 2007	4/1/07 – No action taken yet 5/1/07 – Initial meeting with PR – currently identifying providers 6/1/07 – Continue to pursue provider identification 7/1/07 – Reports generated to identify high volume OB providers – target list in development 7/31/07 – target list of ob dr's identified for education; ob education materials completed; ob education to begin in August; peds

GOAL	ACTIONS	TARGET DATE	SUMMARY
			currently developing education material 9/4/07 – KS OB education complete except for KU (date pending); Peds currently developing target list with 1st mtg on Sept 5th

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Pilot use of telemonitoring program for high risk members in rural areas	2nd Q 2007	4/1/07 – Implementation meeting with Oxford conducted on March 8th 5/1/07 – 1st Oxford candidate identified; currently working with providers in Hutchinson 6/1/07 – 1st member identified in Hutchinson but unable to pursue due to lack of Kansas Medical Director for Oxford – meeting on 6/6/07 with Oxford as possible KU doctor identified 7/1/07 – Kansas Medical Director & HH agency secured by Oxford – 2 candidates identified for implementation on 7/9/07
92. Implement use of standardized case management guidelines into CARE system	Determine feasibility of incorporating existing Milliman guidelines into CARE documentation	4th Q 2007	4/1/07 – Initial meeting completed with IT 7/31/07 – IT currently working on Phase 2 of CARE 9/4/07 – Continue as noted above
93. Implement Complex Case Rounds	Initiate routine complex case management rounds to collaborate on cases, enhance the learning process, and facility effective management across medical disciplines	2nd Q 2007	4/1/07 – 1st CM rounds meeting to start April 10th 5/1/07 – CM rounds initiated in April and meetings continue 2x/wk 6/1/07 – Plan to change meeting frequency to once a week beginning in June
94. Develop knowledge of community resources and make available to staff	Identify community resources for Kansas members	2nd Q 2007	4/1/07 – 1st CM rounds meeting to start April 10th 5/1/07 – CM rounds initiated in April and meetings continue 2x/wk 6/1/07 – Case Managers continue to work on resource development – while resources have been developed will be a work in progress

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Develop resource library accessible by all staff	2nd Q 2007	4/1/07 – No action taken to date 6/1/07 – CMH resource library available to all staff
95. Evaluate potential for expansion of ER program in KS	Explore feasibility of expanding the ER Care Management program in the Kansas market	4th Q 2007	7/31/07 – Completed ER Care Manager PWF ; await approval 9/4/07 – KS ER Care Manager position posted in August – actively recruiting
Health Improvement			
96. Develop internal HI committee	Establish a lead person for the committee	2nd Q 2007	3/30 Completed Greg will chair this committee
	Determine participants	2nd Q 2007	3/30 Completed. This is an internal committee and all participants have been scheduled
	Facilitate first meeting	2nd Q 2007	3/30 Scheduled for 5 April 2007 4/5 DONE
97. Develop process for how data is analyzed and developed into a HI initiative		3rd Q 2007	9/5 This has been conducted as part of the HEDIS review. This will be conducted on an annual basis to identify projects and PIP study topics.
98. Transition management of PIP's from QM to HI	Hire Health Improvement Project Manager	2nd Q 2007	4/4 Pending JD from HR 4/17 PWF sent to HR 5\3 Setting up interviews 6/14 Completed
	Review past, current and future PIP plans with current managers	2nd Q 2007	6/14 Meeting scheduled for 20 June 2007
	Assume responsibility for management of PIP's	2nd Q 2007	6/14 Will be handed off effective 20 June 2007.
99. Develop a plan for promotion of HI initiatives and programs	Review current CMFHP Marketing Plan	1st Q 2007	3/30 Marketing plan has been reviewed

GOAL	ACTIONS	TARGET DATE	SUMMARY
	Establish list of all possible marketing tools available to HS	2nd Q 2007	6/14 Spreadsheet developed to coordinate all mailings and newsletter articles
	Meet with representatives from all HS areas to discuss marketing needs	2nd Q 2007	6/14 Spreadsheet developed to coordinate all mailings and newsletter articles
	Develop plan to coordinate all marketing initiatives to coordinate similar messages and take advantage of all available communication tools	2nd Q 2007	6/14 Spreadsheet developed to coordinate all mailings and newsletter articles
Quality Management			
109. Educate staff on new procedure for c/g/a database integrity	Educate staff during orientation for database entry and integrity.	1st Q 2007	02/22/07 Educated staff during orientation for integrity, updated some cells for drop down choices, to decrease multiple text entries.
110. Coordinate with IT the quarterly reporting of PCP medical record reviews and ability to measure progress toward MRR goal for the year	Identify cactus/OAO query options for db based with consideration to NPI. 6/1/07 Develop process for DB query to identify all PCPs. 7/1/07 Create quarterly report from DB queries to identify all PCPs for reviews; completed PCPs and targeted completion	3Q07	Efforts with IT from 1/1/07 to current, IT unable to write program for connection to Catcus, IT staff request assist with NPI to be loaded into both MC400 & Catcus to resolve program issues and facilitate coordinated identification of PCPs for reviews. 6/8 Meeting with MT & KRH for discussion of reviews entered into Cactus. 6/21 Meeting scheduled with PR to finalize discussion and add discussion of delegated providers not being a part of MRR as documentation reviews done within hospital and outpt credentialing programs.6/25 Telecon with PR, cactus query in place MT & JH not able to access query referenced, will f/u IT/Lesa Castillo, PR adds MRRs to Cactus, delegated

GOAL	ACTIONS	TARGET DATE	SUMMARY
			provider discussion, PR & QM to share documents for next steps.8/3/07 Cactus access conts to pend, f/u with Lesa no response from Cactus, F/u meeting for delegated Providers MRR scheduled for 8/15/07; 8/2707 QM access to Cactus cont pend, f/u with Lesa cont; Rescheduled 8/23 mtg to 8/28

GOAL	ACTIONS	TARGET DATE	SUMMARY
111. Develop IRR process for c/g/a	Create a process for quarterly inter-rater reliability of c/g/a processes applicable to both KS & MO. 6/30/2007	2Q07	DDodd orientation complete 90 days 3/18/07; KButrick started orientation part-time 3/20 – 4/2; Back to full orientation 4/3/07; Updated CGA flowcharts and created Appeal Review Committee to meet RFP & policies; KButrick transfer to OBCM, pending hire of new Appeals Nurse 6/22/07 Process established; audits per Sr QM Nurse to start 3Q07.
112. Evaluate MRR tools and standards for potential modifications	Share MRR documents/process with Dr Peterson for collaboration. 4/1/07 Identify critical indicators for PCP MRR process. 5/1/07 Update and improve process through collaborative with Dr Peterson. 6/30/07	2Q07	Met with Liz 2/27/07; initial policy changes and efforts discussed. 3/28 identified per RFP and PAM potential indicators for approval as critical indicators3/28/07 Dr Peterson working with Kathy Ripley-Hake for moving delegated providers from PCP MRRs. 6/21 meeting to discuss delegated provider MRR topic.6/25/07 MRR policy updates additional of audit tool, criteria and process done, next step to HSRC.8/3/07 Policy out for review at next meeting.8/27/07 policy approval pending
113. Establish QMC committee	Meet with Liz Peterson by 3/1/07 Identify potential candidates to seat the committee. 4/15/07 Begin QMC meetings by 6/30/2007	2Q07	Met with Liz 2/27/07; initial policy changes and efforts discussed. 3/28/07 met with Liz re: QMC and membership; Met 3/29 with Brenda re: QMC agenda and activities. First mtg 4/25/07. First QMC is scheduled for 4/11/07 First QMC meeting held 4/25/07
114. Evaluate QOC process and triggers for potential	Share QOC document with Dr Peterson for collaboration. 3/1/07 Update and improve process through collaborative with Dr	2Q07	QOC documents to Dr Peterson 2/2007 Met with Liz 2/27/07; initial policy changes and efforts discussed; met

GOAL	ACTIONS	TARGET DATE	SUMMARY
modifications	Peterson.		3/28/07; met 4/3/07; final drafts to Liz and MT 4/4/07; 4/5/07Outstanding medical record question to Kathy Ripley-Hake, 4/11/07 & 4/13/07 F/us; QOC Policies approved by HSRC & QMC. 4.25.07
FINANCE			
116. Attachment10	a. Continue to identify and hardcode non-covered services	2q07	Completed: reviewed additional benefit report created in 07 for additional codes to add. DME Supply codes for Adults were removed due to change in regs 7/1/07. Kent participating in OPS and HS group to monitor on-going
	b. ~~Automate report population of subcontractor data from encounter files~~ Restated goal: Require subcontractors to submit quarterly att 10 data supplements. Also, automate ATT 10 summary of subcontractor encounter data to validate reports provided by subcontractors.	2q07 4q07	Objective not yet met, IT resourses being focused on KS Premium Recon first and ACH p ayments. Changed objective 06/07 to request trackit for ATT subcontractor data to use only as validation of subcontractor ATT 10 reports. Use encounter reports as back up for Logisticare ATT10 data. 082007
119. ACH Provider Pay	a. Obtain specs and set up test files	2q07	Done
	b. Create communication to Providers to obtain ACH information	2q07 3q/07	Have a form completed but waiting to draft mass comm.for ACH rollout when testing complete.07 /07
	c. Set up provider ACH data table	2q07 3q07	Vendor working on table during July07.
120. Market Conduct Audit	a. Readiness review; Create data table of historical paid interest records	1q07	DOI to extract data from encounter files sent to DMS 02/07 Have not heard back from DOI; 06/07

GOAL	ACTIONS	TARGET DATE	SUMMARY
121. DOI Audit	a. Readiness review	1q07	Completed 03/07
122. Managed Care.com	a. Set up user orientation for broad base knowledge and use of tools	1q07	Completed 04/07; trained Health Improvement Group
	b. Determine MC+ Rx cost carved out by State	1q07 3q07	Problems w/ FHP file; 07/07 IT sent corrected file. Expect to see results 09/07.
	c. Request Medicaid Population benchmarking	1q07 3q07	In process- Kent inquiring 08/07
	d. Set up KS reporting	2q07	Complete ; 07/07; Operational summaries are complete. sprofiling is yet to be broken out.
	e. Develop routine/quarterly operations report for UMMed &/or AOC	3q07	In process
	f. Provide profile reports and calculation of biannual incentive pay assessment	2q07	Completed 06/07
123. Medical Bill Audit	a. Review proposals and select services/companies ie. Aim or CareAssist for DRG/ KU/ MC+ Outpatient	1q07	Completed 03/07

Annual DMS Reports

Fraud and Abuse

FRAUD AND ABUSE OPEN CASES FY 2007
ANNUAL TOTALS (unduplicated)

	BLUE ADVANTAGE PLUS	CHILDREN'S MERCY FAMILY HEALTH PARTNERS	FIRSTGUARD	MERCYCARE PLUS WESTERN REGION	HEALTHCARE USA WESTERN REGION	MISSOURI CARE	HEALTHCARE USA CENTRAL REGION	MERCYCARE PLUS CENTRAL REGION	HARMONY HEALTH PLAN	HEATLHCARE USA EASTERN REGION	MERCYCARE PLUS EASTERN REGION
TOTAL OF OPEN CASES	11	6	6	1	7	3	17	1	0	36	11
TYPE OF CASE											
Health Plan	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Provider	45%	0%	33%	0%	0%	0%	0%	0%	0%	3%	18%
Member	55%	100%	0%	100%	100%	100%	100%	100%	0%	97%	82%
Health Plan Employee	0%	0%	67%	0%	0%	0%	0%	0%	0%	0%	0%
Subcontractor	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
CATEGORY OF SERVICE											
Dental	0%	0%	33%	0%	0%	0%	0%	0%	0%	3%	18%
DME/Home Health/Personal Care	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Emergency Room	0%	17%	0%	0%	14%	33%	6%	0%	0%	0%	0%
Health Plan	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Hearing Aid	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Inpatient	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%
Lab., Radiology and Other Diag. Svcs.	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mental Health/Substance Abuse	0%	0%	0%	0%	0%	0%	0%	0%	0%	6%	0%
Optical	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	29%	33%	12%	0%	0%	11%	0%
Outpatient/Outpatient Clinic	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Pharmacy	45%	83%	67%	100%	57%	33%	82%	100%	0%	72%	82%
Primary Care	9%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Rehab Services (OT, PT, ST)	36%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Specialist Care	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Transportation	0%	0%	0%	0%	0%	0%	0%	0%	0%	6%	0%
REFERRAL SOURCE											
Health Plan	36%	0%	0%	0%	14%	33%	6%	0%	0%	31%	82%
State Agency - DMS	27%	83%	50%	100%	29%	0%	76%	100%	0%	14%	0%
State Agency - Family Support Div.	0%	0%	0%	0%	0%	33%	0%	0%	0%	0%	0%
Health Plan Member	0%	0%	0%	0%	14%	0%	0%	0%	0%	11%	0%
Health Plan Provider	36%	17%	17%	0%	14%	33%	12%	0%	0%	33%	9%
Other	0%	0%	33%	0%	29%	0%	6%	0%	0%	11%	9%

FRAUD AND ABUSE CLOSED CASES FY 2007
ANNUAL TOTALS (unduplicated)

	BLUE ADVANTAGE PLUS	CHILDREN'S MERCY FAMILY HEALTH PARTNERS	FIRSTGUARD	MERCYCARE PLUS WESTERN REGION	HEALTHCARE USA WESTERN REGION	MISSOURI CARE	HEALTHCARE USA CENTRAL REGION	MERCYCARE PLUS CENTRAL REGION	HARMONY HEALTH PLAN	HEATLHCARE USA EASTERN REGION	MERCYCARE PLUS EASTERN REGION
TOTAL OF CLOSED CASES	6	20	6	0	2	63	14	0	1	28	19
TYPE OF CASE											
Health Plan	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Provider	50%	30%	0%	0%	0%	38%	14%	0%	0%	7%	37%
Member	50%	60%	100%	0%	100%	62%	86%	0%	0%	93%	63%
Health Plan Employee	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Subcontractor	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%
Other	0%	10%	0%	0%	0%	0%	0%	0%	0%	0%	0%
CATEGORY OF SERVICE											
Dental	0%	5%	0%	0%	0%	3%	0%	0%	100%	7%	21%
DME/Home Health/Personal Care	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Emergency Room	0%	10%	0%	0%	0%	22%	0%	0%	0%	0%	0%
Health Plan	0%	0%	0%	0%	0%	0%	0%	0%	0%	4%	0%
Hearing Aid	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Inpatient	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Lab., Radiology and Other Diag. Svcs.	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%
Mental Health/Substance Abuse	0%	0%	0%	0%	0%	11%	0%	0%	0%	0%	0%
Optical	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	25%	0%	0%	0%	33%	50%	0%	0%	25%	0%
Outpatient/Outpatient Clinic	0%	5%	0%	0%	0%	2%	0%	0%	0%	0%	0%
Pharmacy	50%	45%	100%	0%	100%	16%	43%	0%	0%	57%	63%
Primary Care	17%	5%	0%	0%	0%	0%	7%	0%	0%	0%	11%
Rehab Services (OT, PT, ST)	33%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Specialist Care	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	5%
Transportation	0%	5%	0%	0%	0%	3%	0%	0%	0%	7%	0%
REFERRAL SOURCE											
Health Plan	36%	10%	50%	0%	0%	3%	21%	0%	0%	7%	68%
State Agency - DMS	27%	55%	17%	0%	0%	44%	50%	0%	100%	14%	5%
State Agency - Family Support Div.	0%	5%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Health Plan Member	0%	0%	0%	0%	0%	35%	0%	0%	0%	14%	5%
Health Plan Provider	36%	20%	33%	0%	0%	5%	29%	0%	0%	46%	11%
Other	0%	10%	0%	0%	100%	13%	0%	0%	0%	18%	11%

Member and Provider Complaint, Grievance & Appeals

FY 2007 MEMBER GRIEVANCES AND APPEALS
MC+ REGION COMPARISON
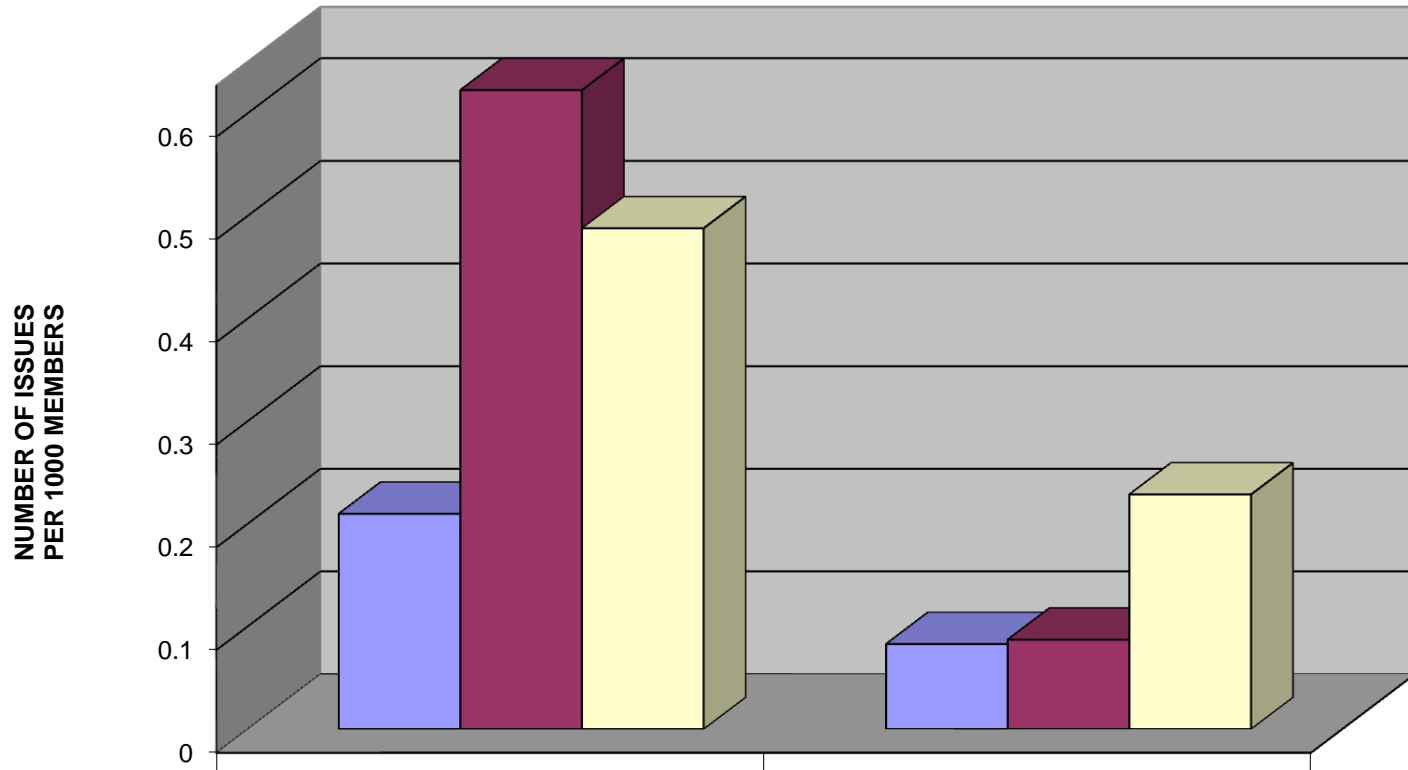
	GRIEVANCES	APPEALS
☐ CENTRAL REGION	0.209753185	0.082886339
■ EASTERN REGION	0.622613462	0.087183497
☐ WESTERN REGION	0.487989004	0.228580366

FY 2007 PROVIDER COMPLAINTS, GRIEVANCES AND APPEALS
MC+ REGION COMPARISON

	COMPLAINTS	GRIEVANCE	APPEALS
CENTRAL REGION	3.605019648	0.461401952	0.096336671
EASTERN REGION	1.815001902	0.225003875	0.048435276
WESTERN REGION	1.351180648	0.139103183	0.021805364
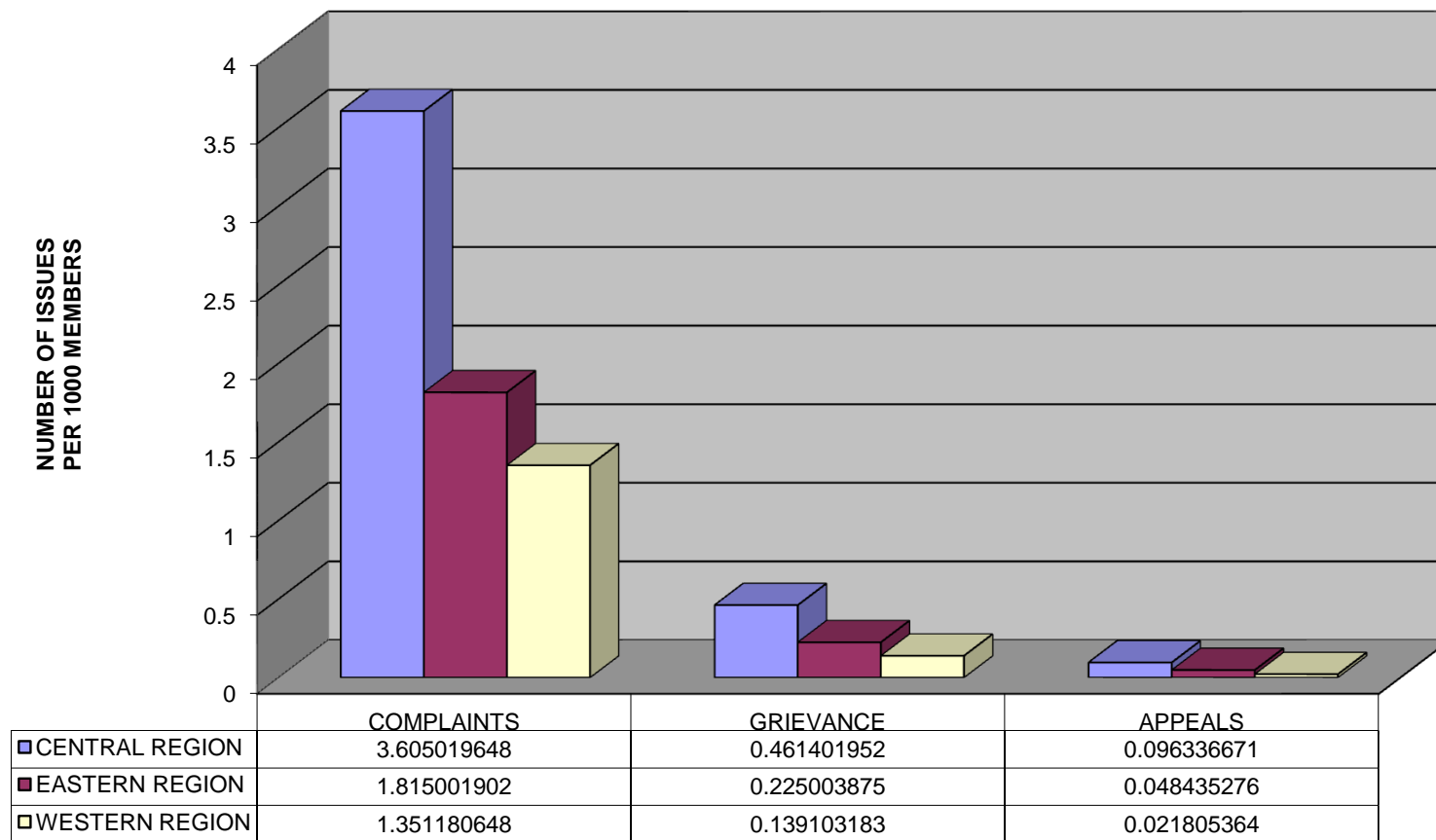
Marketing

MARKETING

MO HealthNet Managed Care health plans must submit their proposed marketing plan, all marketing materials and member education materials to MHD for written approval prior to use. Below is the total of marketing and education materials for FY2007 for each health plan as well as for Policy Studies, Inc., Missouri Primary Association and Legal Aid of Western Missouri.

Blue –Advantage Plus of Kansas City

Total Marketing Submitted	44
Total Approved	32
Total Denied	02
Total Submitted then Withdrawn	04
Total Other	06

FirstGuard Health Plan

Total Marketing Submitted	45
Total Approved	39
Total Denied	06
Total Submitted then Withdrawn	00
Total Other	00

Children's Mercy Family Health Partners

Total Marketing Submitted	113
Total Approved	109
Total Denied	01
Total Submitted then Withdrawn	03
Total Other	00

HealthCare USA

Total Marketing Submitted	177
Total Approved	157
Total Denied	04
Total Submitted then Withdrawn	15
Total Other	01

Harmony Health Plan of Missouri

Total Marketing Submitted	115
Total Approved	95
Total Denied	18
Total Submitted then Withdrawn	02
Total Other	00

Mercy CarePlus

Total Marketing Submitted	233
Total Approved	229
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	01

Missouri Care

Total Marketing Submitted	79
Total Approved	76
Total Denied	02
Total Submitted then Withdrawn	01
Total Other	00

Missouri Primary Association

Total Marketing Submitted	01
Total Approved	01
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	00

Policy Studies, Inc.

Total Marketing Submitted	05
Total Approved	05
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	00

Legal Aid of Western Missouri

Total Marketing Submitted	01
Total Approved	01
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	00

After review of the marketing materials by MHD if changes are needed the health plans are required to correct problems and/or errors as identified by MHD. MO HealthNet health plans shall return the corrected marketing plan or revised material within ten (10) business days of the receipt date of the written notice from MHD.

Marketing/Education Materials

MO HealthNet health plan marketing and education materials shall include but are not limited to a listing of in-network providers, member's rights and responsibilities, general MO HealthNet Managed Care 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 sampling of marketing and education materials submitted by the MO HealthNet health plans in FY2007. Some of the 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
Educational Materials/Brochures for asthma, dental, diabetes, ADHD, ADD, smoking cessation, obesity, emergency room usage, lead, prenatal, post-partum, heart health, flu, cancer awareness plus many more.
Grievance and Appeals Letters
Pharmacy Lock-In Letters
Immunizations (Shots)
Early Periodic Screening, Diagnosis and Treatment (EPSDT)
Case Management Letters
Health Plan Website Information

MO HealthNet health plan marketing and education submissions for FY2007 totaled 806*. This is a 56% increase over FY2006 (514)*.

*Total does not include Missouri Primary Association, PSI and Legal Aid of Western Missouri.

Networks

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

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

West Region			Blue Advantage Plus		Family Health Partners	
County	MC+ Eligibles	Distance Standard (for PCP)	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	

			FirstGuard		Healthcare USA - West	
County	MC+ Eligibles	Distance Standard (for PCP)	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	

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

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%

Legal Services

Legal Services of Eastern Missouri, Inc.

4232 Forest Park Avenue
St. Louis, Missouri 63108

FACSIMILE TRANSMISSION

Date: January 4, 2008

Please deliver to:

Name: Susan Eggen
Company: Division of Medical Services
Telephone #: (573)526-2886
Facsimile #: (573)526-4651

From:

Name: Jo Anne Morrow
Telephone #: (314)534-4200, extension 1201
Facsimile #: (314)534-1028

Re: Semi-annual report

Total number of pages including cover page _14_ .

Message:

Dear Susan,

I am happy I had a chance to talk with you. I have attached our most recent semi-annual report. Please let me know if you need anything further.

Jo Anne Morrow   Facsimile (314) 534-1028
Extension 1201

July 13, 2007

Don Dickey, Fiscal Officer
Supreme Court of Missouri
207 West High Street
P. O. Box 150
Jefferson City, Missouri 65102

Re: Grant Agreement for Contractual Legal Services between the Missouri Supreme Court
        and Legal Services of Eastern Missouri

Dear Mr. Dickey,

        I have enclosed the semi-annual report for the MC+ Consumer Advocacy Project for the
period January 1, 2007 through June 30, 2007, as required under Section 7.b.4 of the agreement.

        Thank you for your assistance. Please let me know if you have any questions.

                                Sincerely yours,

                                Jo Anne Morrow, J.D.
                                MC+ Consumer Advocacy Project

enclosure

MC+ Consumer Advocacy Project
Semi-Annual Report
July 13, 2007

1. Introduction

A. Overview of significant events in the project:

The MC+ Consumer Advocacy Project assisted six hundred ninety-two (692) MC+ applicants and enrollees during the months of January through June 2007. We met with the directors of four child care centers and a homeless shelter in the City of St. Louis and made presentations to the parents and staff at the centers. We also made presentations at professional development conferences for domestic violence advocates, public school nurses and social workers in three school districts and the St. Louis County Community Response Team. We made presentations for the staff at two St. Louis area children's psychiatric facilities and for service providers who work with the immigrant and refugee population in the St. Louis area. We did extensive outreach with the schools, Head Start programs throughout the Eastern Region and the Federally Qualified Health Centers (FQHCs).

We assisted pregnant women who are eligible for routine dental services but are denied services because providers run into barriers when they attempt to bill for them. Most pregnant women in the managed care counties are enrolled in health plans but they receive their dental services through fee-for-service Medicaid with the exception of dental services related to trauma, which they receive through their health plan. Prior to July, 2002 adults received dental services through their MC+ health plans until they were eliminated in the 2002 budget bill. A Court ordered restoration of adult dental services but the Division of Medical Services chose to cover them through fee-for-service Medicaid rather than through the health plans. A statutory amendment in 2005 again eliminated routine dental services for adults, but they were preserved for blind people and pregnant women.

The confusion caused by the frequent changes and the fragmentation of services between the two different reimbursement mechanisms for adult dental services causes billing problems for providers and results in a lack of access to dental services for pregnant women. We also received calls regarding vision services as a result of the frequent changes in coverage for adults and the fragmentation of services. For adults, the health plans cover the eye examination and glasses are covered through fee-for-service Medicaid. The providers are confused and services are denied. The adults called us when they could not obtain dental care or vision services. We worked with the providers and the Division of Medical Services to sort out the reimbursement barriers.

Misapplication of the new "affordability" standards that went into effect in July 2006 for the premium group children continued to generate calls from parents whose children were terminated or who were denied coverage. Children often were denied

cov: age due to continuing confusion regarding the complicated rules for the two premium groups. Children were terminated either because the parents could not afford to pay the premium or they had difficulty navigating the complicated premium payment process. Parents continued to have difficulty getting through on the phone line for the Premium Collections Unit. We worked with the Family Support Division to correct errors, assisted parents in obtaining MC+ coverage and in getting coverage reinstated and the children re-enrolled in their health plans. Families experienced problems with provider access and billing because of the interruption in their coverage and because of the fifteen-day waiting period for re-enrollment in the health plan following suspension and reinstatement.

A number of parents experienced problems filling their children's prescriptions through Mercy CarePlus because their files were not in the pharmacy benefit manager's computer system, a problem the health plan attributes to the State's information system (FAMIS). Other parents were unable to fill prescriptions due to misinformation provided by pharmacies. Most often the client is told that the medication is not covered or their "insurance" won't pay for it when the correct information is that the medication requires prior authorization. The client leaves the pharmacy without the medication and without any useful information on how to resolve the problem. We have been working with our contact persons at the health plans and with the pharmacies to get the prescriptions filled.

Provider access continues to be a problem for many of our clients, particularly with finding child psychiatrists and dentists. The scarcity of providers is particularly problematic in the rural counties where parents are faced with few choices and long distances to provider offices. The lack of providers is particularly acute for children with autism and with serious mental illness.

Our staff met with the HealthCare USA staff in May to discuss ways in which to improve our clients' access to services and to resolve problems. We have experienced communication difficulties with Harmony Health Plan since they entered the Eastern Region in July 2006. We have scheduled a meeting with their staff later this month. We plan to meet with the staff of Mercy CarePlus in the near future to address concerns.

B.   Summary of activities that occurred during the reporting period:

The most frequent problems encountered by our clients during January through June 2007 pertained to eligibility (106 cases), the availability of and access to providers (54 cases), recipient liability (41 cases), pharmacy (27 cases), mental health (23 cases), enrollment (21 cases), specialty care (21 cases), maternity care (11 cases) and dental care (11 cases). The most frequent problems involving providers pertained to mental health care (23 cases), specialty care (21 cases), primary care (13 cases), dental services (11 cases), emergency services (5 cases), and hospital care (4 cases). Very few of our cases involve only one problem. Most of our cases involve multiple problems and multiple family members.

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The highest volume of our cases (68 cases) came from St. Louis County, the largest population center in our region. We received a significant number of cases from the city of St. Louis and from St. Charles County and St. Francois County. Many of our referrals came from Family Support Division (FSD) caseworkers who attended our educational presentations in the past and from the notice letters and information provided by I'SD to our clients.

We continued to receive a significant number of calls from clients with recipient liability problems. The cases are very time intensive. We continue to see situations in which the client was seen by multiple providers, such as a hospital, a radiologist, a pathologist and a laboratory. Billing information is not shared among the providers and the statements sent to clients are confusing. An increasing number of our clients have bills that have been sent to collections. Some of them have resulted in court actions.

We also received a significant number of calls from clients with mental health problems. These cases also are time intensive because of the scarcity of mental health providers who are accepting new patients. Many of the calls involved children with severe mental health problems who required extended inpatient hospitalization at Hawthorn Children's Psychiatric Hospital. We are working with the administrators at the hospital and the Family Support Division to resolve systemic problems.

We continued to assist adult clients with dental services because of the scarcity of dental providers in the fee-for-service program. These cases are work-intensive. Access to dental providers for children also is a continuing problem, particularly with specialty dental services and with general dentists in the more rural areas of the region where there are few providers in the plan networks and even fewer who are accepting new patients.

Provider access and availability problems continue with primary care as well as specialty care and in the urban areas as well as in the rural areas of our region. The primary problem is misinformation given to clients by the Member Services staff of the health plans and provided in the lists distributed by PSI and provider directories distributed by the health plans. Some of the providers whose names are given to clients are no longer in the health plan's network. More frequently they are not accepting new patients. Most of the cases were resolved through our intervention with the contact person at the health plan.

Our clients' problems at the Pharmacy continue to involve eligibility and enrollment issues but increasingly involve issues related to the institution of step therapies and health plan changes in the prior authorization process. Pharmacy staff and providers are confused. Clients frequently leave the pharmacy without their medication because they were told a medication was "not covered" and it was a covered medication that required a prior authorization.

We resolved most of our clients' problems by working with our contact persons at the health plans, the Family Support Division and the Division of Medical Services.

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2. **Client Data**

A. **Total number of cases handled du ing the reporting period:**

Staff handled 293 cases during the reporting period. Staff also responded to an addi onal 299 hotline calls. Of the 293 cases activi: during the reporting period, 1 64 case: were closed. The data presented in the follo\ ing sections of the report are b ased on the 1 ;4 cases closed during the reporting period.

B. **Number of closed cases by county:**

Number of Cases	County
31	St. Louis City
68	St. Louis County
16	St. Charles County
14	Jefferson County
3	Franklin County
3	Lincoln County
20	St. Francois County
4	Ste. Genevieve County
2	Warren County
3	Washington County

C. **Number of closed cases by health plan:**

Number of Cases	Health Plan
88	HealthCare U A
55	Mercy MC+
3	Community Care Plus
9	Mercy CarePlus
8	Harmony

D. **Total number of MC+ managed care applicants and enrollees accessing the MC+ Consumer Advocacy Project: 692**

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E.   **Number of closed cases by problem type:**

Number of Cases	Problem Category
23	Mental Health
11	Dental
27	Pharmacy
5	Transportation
21	Specialty Care
13	Primary Care
5	Emergency Service
11	Maternity Care
4	Hospital Care
1	Ancillary Services
54	Availability of and Access to Providers
106	Eligibility
21	Enrollment
41	Recipient Liability
12	General Questions

F.   **Number of closed cases by resolution:**

Number of Cases	Resolved By
164	MC+ Consumer Advocacy Project
0	Mercy CarePlus Health Plan's Grievance System
0	Harmony Health Plan's Grievance System
0	HealthCare USA Health Plan's Grievance System
5	State Fair Hearing Process
131	DMS' Recipient Services Unit
138	Family Support Division
36	Enrollment Broker
167	Other (please explain)

The vast majority of our cases are resolved informally through oral and written communication with the Division of Medical Services, the Family Support Division, the health plan, PSI and other entities. The involvement of the Division of Medical Services was necessary in the resolution of 131 cases; the Family Support Division in the resolution of 138 cases; and PSI in 36 cases. Five cases involved the State Fair Hearing Process.

We worked with the health plans to resolve problems involving their members in the following number of cases: HealthCare USA, 27 cases; Mercy MC+, 22 cases; Mercy CarePlus 5 cases; and Harmony, 5 cases. None of our cases involved the health plan Member Grievance System. In 84 cases we worked with other entities such as providers, billing agencies, collection agencies and private attorneys to resolve our clients' problems.

3. Outreach contacts and collaborative efforts with community groups:

Date	Contact	Contact Method	Contact Outcome	Number Reached
1/8/07	Gloria Green, Peace of Mind Child Development Center, St. Louis	Meeting with program director	Provided MC+ information applicable to their clients and provided brochures for distribution to their workers and clients	n/a
1/8/07	Sr. Serena Downs, GASA DeSalles Child Care Center, St. Louis	Meeting with program director and provided letters for 45 parents	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	46
1/8/07	Sr. Jackie Toben, Let's Start, St. Vincent DePaul Catholic Church, St. Louis	Meeting with program director	Provided MC+ information applicable to their clients and provided brochures for distribution to their workers and clients	n/a
1/11/07	Guardian Angel Settlement Association DeSalles Child Care Center, St. Louis	Presentation to 5 parents at a parent meeting	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	5
1/17/07	ARCHS MC+ Coalition St. Louis City and County	Attended meeting and provided information re needs of MC+ clients	Collaborate with an organization of community providers, organizations and advocates and provided brochures for employees of small businesses	n/a
1/18/07	Mary Ann Hatelid, Hancock Place Elementary School, St. Louis	Phone call with social worker followed by letter with brochures	Provided MC+ information applicable to their students and sent brochures for distribution to their workers and parents	50
1/22/07	Redevelopment Opportunities for Women St. Louis	Presentation to 35 domestic violence advocates	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	35
2/2/07	School Nurse Professional Development, Vashon High School, St. Louis	Presentation to 70 nurses and social workers for St. Louis Public Schools	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	70
2/6/07	St. Louis County Community Response Team, St. Louis	Presentation to school counselors, police, case workers, DJOs and therapists	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	25

3. Outreach contacts and collaborative efforts with community groups (continued):

2/7/07	ARCHS MC+ Coalition St. Louis City and County	Attended meeting and provided information re needs of MC+ clients	Collaborate with an organization of community providers, organizations and advocates and provided brochures for employees of small businesses	n/a
2/8/07	Washington County Partnership, Potosi	Attended meeting and distributed brochures	Collaborate with an organization of community providers, organizations and advocates concerned with access to services for low-income families	n/a
2/8/07	People's Health Center St. Louis	Resource table with brochures for attendees and staff	Distributed information about the MC+ program and brochures for the MC+ Consumer Advocacy Project to attendees of the fair and clinic staff	30
2/15/07	Kelly Brown, Peoples Health Clinic, St. Louis	Phone call followed by letter with brochures	Provided MC+ information applicable to their clients and sent brochures for distribution to their workers and clients	n/a
2/16/07	Community Action Team Pattonville School District St. Louis	Presentation to 25 school social workers	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	25
2/22/07	Lincoln County Family Support Division, Troy	Presentation to income maintenance case workers and supervisor	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	30
3/12/07	Queen of Peace Shelter for the Homeless, St. Louis	Presentation to workers and residents	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	21
3/20/07	Better Family Life, Inc. Family Resource Fair St. Louis	Resource table with brochures for attendees	Distributed information about the MC+ program and brochures for the MC+ Consumer Advocacy Project to attendees of the fair	30
3/21/07	ARCHS MC+ Coalition St. Louis City and County	Attended meeting and provided information re needs of MC+ clients	Collaborate with an organization of community providers, organizations and advocates and provided brochures for employees of small businesses	n/a
3/22/07	Shriner's Children's Hospital, St. Louis	Phone call followed by letter with brochures	Provided MC+ information applicable to their clients and sent brochures for distribution to their workers and clients	n/a

3.   Outreach contacts and collaborative efforts with community groups (continued):

Date	Organization	Activity	Description	#
3/23/07	Edgewood Children's Center, St. Louis	Presentation to 45 providers of intensive in-home services	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	45
4/3/07	Hawthorn Children's Psychiatric Hospital St. Louis	Presentation to 25 case managers, nurses and administrators	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	25
4/3/07	Covenant House St. Louis	Presentation to 8 social workers, counselors and staff members	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	8
4/11/07	Public Schools in Franklin County	Letters with brochures sent to 41 school nurses and 41 counselors	Provided MC+ information and sent brochures for distribution to parents of high school, middle school, elementary school and pre-school students	82
4/11/07	Kathleen Cradick Moe St. Louis Regional Center	Phone call followed by letter with brochures	Provided MC+ information applicable to their clients and sent brochures for distribution to their workers and parents	n/a
4/18/07	Refugee and Immigrant Consortium of St. Louis	Presentation to service providers for new Americans	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems for immigrants and refugees	20
4/19/07	ARCHS MC+ Coalition St. Louis City and County	Attended meeting and provided information re needs of MC+ clients	Collaborate with an organization of community providers, organizations and advocates and provided brochures for employees of small businesses	n/a
4/20/07	Jefferson-Franklin Community Action Corp. Head Start Health Advisory Meeting	Presentation to nurses, teachers, dieticians and counselors	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	13
4/25/07	MC+ Statewide Coalition	Attended meeting and provided information re needs of MC+ clients	Collaborate with a group of community health centers, health care advocates and MC+ program representatives to improve MC+ enrollment	n/a

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3. Outreach contacts and collaborative efforts with community groups (continued):

Date	Contact	Activity	
4/26/07	Andrea Walker, Principal Compton-Drew Middle School, St. Louis	Phone call followed by letter with brochures	Provided MC+ information applicable to their students and sent brochures for distribution to their workers and parents	n/a
5/8/07	Stephanie Wade, Lemay Head Start, St. Louis	Phone call followed by letter with brochures	Provided MC+ information applicable to their students and sent brochures for distribution to their workers and parents	n/a
5/8/07	Head Start locations in St. Louis City and County and St. Charles County	Letters sent to 30 Head Start locations	Provided MC+ information applicable to their students and sent brochures for distribution to their workers and parents	n/a
5/8/07	Normandy School District St. Louis	Presentation to 13 social workers for Staff Development Day	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	13
5/10/07	Washington County Community Partnership	Presentation to providers of community services	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	n/a
5/11/07	Cindy Kraft, Parkway West Middle School St. Louis	Phone call followed by letter with brochures	Provided MC+ information applicable to their students and sent brochures for distribution to their workers and parents	n/a
5/14/07	Federally Qualified Health Centers in Metropolitan St. Louis Area	Letter with brochures and cards to 23 staff and administrators	Provided MC+ information applicable to their clients and sent brochures for distribution to their workers and parents	n/a
5/15/07	Laura Baker, Asthma & Allergy Foundation of St. Louis	Phone call followed by letter with brochures	Provided MC+ information applicable to their clients and sent brochures for distribution to their workers and parents	n/a
5/15/07	Stacey Calloway, Family Support Division St. Louis County	Phone call followed by letter with brochures	Provided MC+ information applicable to their clients and sent brochures for distribution to their workers and parents	n/a
5/16/07	ARCHS MC+ Coalition St. Louis City and County	Attended meeting and provided information re needs of MC+ clients	Collaborate with an organization of community providers, organizations and advocates and provided brochures for employees of small businesses	n/a

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3. Outreach contacts and collaborative efforts with community groups (continued):

5/17/07	Ken Smith Winfield	Phone call followed by letter with brochures	Provided MC+ information applicable to their clients and sent brochures for distribution to their workers and parents	n/a
5/21/07	Brenda Battle, Center for Diversity, Barnes-Jewish Hospital, St. Louis	Meeting with staff who serve immigrants	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and addressed frequently occurring MC+ problems for immigrants	n/a
5/25/07	Miriam Evans, ARCHS St. Louis	Letter with brochures	Provided brochures for distribution to their workers and clients	n/a
5/25/07	Evelyn Wilson, City of St. Louis Department of Health, St. Louis	Letter with brochures	Provided brochures for distribution to their workers and clients	n/a
6/15/07	St. Jane Catholic Community Center St. Louis County	Presentation to 8 potential clients	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	n/a
6/18/07	Queen of Peace Shelter for the Homeless, St. Louis	Presentation to 18 immigrants and our staff member	Provided an overview of the MC+ program and the MC+ Consumer Advocacy Project and presented case studies re frequently occurring MC+ problems	n/a
6/20/07	MC+ Statewide Coalition	Attended meeting and provided information re needs of MC+ clients	Collaborate with a group of community health centers, health care advocates and MC+ program representatives to improve MC+ enrollment	n/a
1/1/07 – 6/30/07	East Central Missouri Area Health Education Center	Serve on Board of Directors and provide information re needs of MC+ clients	Collaborate with an organization that works to improve access to healthcare in underserved communities in our region, both urban and rural	n/a

Note: We sent MC+ Consumer Advocacy Project brochures that describe our program and provide our address and phone numbers and informed them of our availability to meet with them.

4.   Concerns for the region:

We are concerned about the children in the premium groups. The rules for the two different groups are complicated and are not well understood by Family Support Division caseworkers and supervisors. We are encouraged that a number of children who lost their coverage may be eligible as a result of the Senate Bill 577 changes in the definition of "affordable" health care coverage. We also are encouraged that children in families up to one hundred fifty per cent (150%) of the federal poverty level will have all of the benefits of the non-CHIP program. We are concerned that problems may occur in the implementation phase of the new standards.

Children in the two premium groups have continued to lose their coverage even though their parents pay the premium because there is a mistake with the paperwork or with the processing of the payment. The insufficient staffing of the Premium Collection Unit and the confusing and unforgiving premium collection process have made it difficult for the parents to keep their children's MC+ coverage. We also are concerned about continuity of care and billing issues caused by the fifteen-day waiting period for re-enrollment in the health plan following suspension.

We continue to be concerned that our clients' caseworkers are not consistently implementing the changes initiated in May and June 2006. We continue to be concerned about the children who will be denied coverage because they have access to employer-sponsored insurance. The caseworker may not obtain sufficient information to evaluate the coverage. The parent may not have sufficient expendable income to pay the premium or the policy may not cover the major health care expenses for the family due to pre-existing illness exclusions or the exhaustion of annual maximums under the policy.

We continue to be concerned about working parents who suffer from serious medical conditions such as diabetes and hypertension. Obtaining insulin on a monthly basis is next to impossible. The "safety net" in both the urban and the rural counties in the Eastern Region is inadequate to address the health care needs of parents or children.

We are encouraged that more women will receive medical care as a result of the Senate Bill 577 changes in the Extended Women's Health Services program. We are concerned that problems may occur in the implementation phase of the changes. We received calls from women who were denied coverage under the existing program in error or who were unable to obtain services due to questions regarding the services that are covered under the program.

We continue to be concerned about the number of clients with billing problems and the complexity of the problems. An increasing number appear on our clients' credit reports and are difficult to resolve but important to our clients because they interfere with their ability to find suitable housing or financial assistance.

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We are concerned about the lack of appropriate mental health services for the seriously emotionally disturbed children who need inpatient hospitalization at Hawthorn Children's Psychiatric Hospital. We continue to assist children who have had multiple short stay hospitalizations at other psychiatric hospitals due to restrictive managed care measures that prevent them from receiving an adequate course of treatment. Opting out of their managed care plan remains their only option to receive the services they need.

We are concerned about continued confusion on the part of the health plan representatives who implement the Grievance System procedures. The health plan representatives have given wrong information to us and to our clients about the appeal process. The plans have delegated responsibilities to their subcontractors without providing oversight that assures compliance with Member Grievance System procedures. Our clients continue to receive notice letters that are beyond their understanding.

We continue to be concerned about the availability of providers in the health plan networks who are accepting new patients. Our clients continue to receive inadequate assistance in finding a provider when they contact Member Services staff at their health plan. We are concerned particularly about the lack of mental health and dental providers. It is becoming increasingly difficult to find child psychiatrists who are accepting new patients. There is a scarcity of dental providers particularly in the rural areas. Dental specialists such as endodontists, periodontists and orthodontists are particularly scarce.

We continue to have immigrant clients with limited English proficiency (LEP). They are not given the necessary assistance to navigate the systems for MC+ eligibility and services.

The prior authorization and step therapy requirements for medications continue to result in the interruption of treatment, particularly with the mental health drugs. Our clients are not receiving their medications. Pharmacy staff are not giving clients the information they need to advocate for themselves. Providers and advocates are unable to access the rules easily enough to prevent harmful delays.

The quarterly telephone conference calls between the staff of the MC+ Consumer Advocacy Project and the Division of Medical Services have been discontinued. The calls were helpful in the past in resolving our clients' problems and in addressing systemic issues in the MC+ managed care program. Our contact persons at the health plan have been accessible to us, with some exceptions, and we have been able to resolve most of our clients' problems without the need to pursue the health plan's grievance system or a State fair hearing. Our recent meeting with the HealthCare USA staff was productive and we are hopeful for the same result from the upcoming meetings with the other plans. Our efforts are most effective when we are able to communicate directly with the persons making the decisions for our clients.

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Richard Halliburton
Executive Director

LEGAL AID OF
WESTERN MISSOURI

August 7, 2007

AUG 2007
DMS
Managed Care

Ms. Julie Creach
Division of Medical Services
615 Howerton Court
Jefferson City, Missouri 65102

Re: Bi-annual Report

Ms. Creach:

Enclosed, please find the bi-annual report for the first half of 2007 for Legal Aid of Western Missouri's MC+ Advocacy Project.

If you have any questions about the content of the report, please do not hesitate to call me at (816) 474-6750.

Sincerely,

Katherine J. Lamb
Attorney at Law

United
Way

LSC

Legal Aid of Western Missouri
MC+ Advocacy Project

Reporting Period: January 1, 2007, through June 30, 2007

I.   **Executive Summary**

During the first six months of 2007, the MC+ Advocacy Project has carried an active load of eligibility and enrollment cases with the Family Support Division and service coverage cases with the four health plans in the Western Region, while expanding outreach efforts to individuals and community organizations.

The Project advocated for and assisted a number of MC+ applicants and enrollees with a variety of issues, although frequently occurring problem areas included proving initial eligibility for receipt of coverage; reviewing various budgeting concerns with relation to the affordable insurance provisions and payment of premiums; and, as always, assistance through the reinvestigation process. In this second six-month period following the implementation of the new citizenship and identity requirements, the Project continued to regularly assist families in meeting these sometimes onerous obligations.

The Project also advocated to the health plans on behalf of MC+ members to assist in gaining access to various health care providers, especially obstetricians, and in obtaining coverage for services requiring prior authorization, such as orthodontic coverage, and obtaining payment for services already received.

Additionally, continued outreach efforts exposed the Project to many families with MC+-eligible children who, unfortunately, were not yet enrolled in the program. For these families, Project staff explained the sometimes complicated eligibility requirements and application process, resulting in health insurance coverage for more than twenty families.

The Project continued to collaborate with several local health care committees with the common mission of achieving insurance coverage for all MC+-eligible children. Ongoing membership in the Cover the Uninsured Coalition involved planning and participation in the Cover the Uninsured Week events, including a local telethon that put the Project in touch with over 15 families who had questions about the MC+ program.

As earlier outreach efforts had indicated that many members of the Hispanic community had limited awareness of the MC+ program and their children's eligibility for insurance coverage, the Project increased involvement with local organizations that serve this population. These efforts included presentations to caseworkers at the Mattie Rhodes Center, attendees at the *Cambio de Colores* conference, and families waiting for services at the Mexican Consulate. Participation in the event planning committee for a large-scale, Bi-National Health Week health fair this fall ensured that a major focus of the event would be ensuring that eligible children are enrolled to receive MC+ health coverage.

II. Client Data

A. Cases by County:

County	Cases
Jackson	54
Clay	1
Platte	4
Cass	
Johnson	
Ray	
Lafayette	
Henry	
St. Clair	1
Gentry	1
Camden	1
Total:	62

B. Cases by Health Plan:

Health Plan	Cases
Blue Advantage Plus	3
Children's Mercy Family Health Partners	4
FirstGuard	
HealthCare USA	3
Mercy CarePlus	
Health Plan Unknown	30
Not assigned to a health plan (applicant)	20
Fee-for-service	2

C.
Total Number of Applicants: 20
Total Number of Enrollees: 43

D. Cases by Problem Type:

Problem Type	Cases
Mental Health	
Dental	2
Pharmacy	
Transportation	
Specialty Care	2
Primary Care	
Maternity Care	4
Hospital Care	
Ancillary Services	3
Availability of and Access to Providers	2
Eligibility	26
Enrollment	24
Recipient Liability	7
General Questions	2

E. Cases by Resolution:

Method of resolution	Cases
MC+ Advocacy Project	62
BA+ Complaint Grievance and Appeals	1
CMFHP Complaint Grievance and Appeals	
Healthcare USA Complaint Grievance and Appeals	
Mercy CarePlus Complaint Grievance and Appeals	
FirstGuard Complaint Grievance and Appeals	
State Fair Hearings	
FSD	26
DMS Recipient Services	3
Other	

III. Outreach Activities

DATE	CONTACT	CONTACT METHOD	CONTACT OUTCOME	NUMBER REACHED
JANUARY				
1/10/07	North KC School District Counselors mtg.	Presentation	Distributed general MC+ & Advocacy Project information	6
1/19/07	KCMBA Juvenile Law Committee	Committee Meeting	Attended meeting, discussed possibility of a MC+ CLE for lawyers representing juveniles	10
1/25/07	St. Joseph Health Taskforce	Meeting attendee, brief presentation re: services, answered questions	Distributed general MC+ & Advocacy Project information	20
1/25/07	Mtg at LAWMO St. Joseph office	Met w/ supervising atty to discuss Project	Distributed general MC+ & Advocacy Project information, provided my contact info	Provided info. materials for 200 people
1/26/07	Bi-National Health Week Committee	Committee Meeting	Attended meeting, discussed possibility of a MC+ presentation at next year's health week	25
1/29/07	Cover the Uninsured Coalition	Coalition Meeting	Attended meeting, discussed plans for spring events	15

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FEBRUARY				
2/1/07	Kansas City Health Department Health Summit Task Force	Meeting attendee, brief presentation re: services	Provided project information and contact information	15
2/2/07	Child Abuse Roundtable Discussion	Meeting attendee, brief presentation re: services	Distributed general MC+ & Advocacy Project information	50
2/7/07	Donna Tilman, West-Central Independent Living Solutions in Warrensburg	Dist. written materials	Distributed MC+ Advocacy Project information	25
2/8/07	Dominque Kizine of Van Horn High School	Dist. written materials	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	50
2/9/07	Bi-National Health Week	Small group planning meeting	Made plans for a health clinic this fall where participants could apply for MC+ and learn about the project	10
2/12/07	Cover the Uninsured Coalition	Committee meeting	Planning for April's Cover the Uninsured Week	15
2/15/07	Northeast Advisory and Access Group	Quarterly meeting	Brief presentation on services provided by the Project and LAWMO	15

2/23/07	LINC MC+ Taskforce meeting	Quarterly meeting	Discussed current MC+ issues in the KC area	10
2/23/07	Bi-National Health Week	Committee meeting	Presented our idea for the health clinic	15
2/26/07	Cover the Uninsured Coalition	Committee meeting (by tele-conference)	Planning for April's Cover the Uninsured Week	15
MARCH				
3/15/07	TMC-HH WIC and OB/Gyn Clinics	Dist. written materials	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	Provided info. materials for 300 people
3/19/07	Children's Mercy Family Health Partners	Dist. written materials	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	Provided info. materials for 400 people
3/19/07	Bi-National Health Week	Event planning committee meeting	Met to begin planning the October health clinic	5
3/21/07	NE Can Center	Community group meeting	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	Provided info. materials for 100 people
3/22/07	Rose Brooks Domestic Violence Shelter	Presentation at small group session and provided information	Distributed MC+ Advocacy Project information in English and	3 in-person, but provided info. materials

		to service providers	Spanish and general LAWMO information	for 100 people
3/27/07	NE Middle School	Presentation at parents meeting	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	50

APRIL				
4/2-4/4	Cambio de Colores	Dist. written materials at conference	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	30
4/3	Cambio de Colores	Presentation for conference attendees	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	15
4/10	Mattie Rhodes	Presentation for case workers	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	6
4/13	Maternal and Child Health Coalition	Dist. written materials	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	25

4/20	Child Abuse Roundtable Discussion	Meeting attendee, brief presentation re: services	Provided project information and contact information	40
4/24	Cover the Uninsured Week	Call to Action Telethon	Answered calls re: insurance questions; got contact information for follow up	750
4/26	Bi-National Health Week	Health fair event committee meeting	Planning for October 2007 health fair	10
4/28	Black Health Care Coalition	Health fair	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	15
4/28	Cover the Uninsured Coalition	Health fair	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	25
4/29	Samuel Rodgers/Mexican Consulate	Health fair	Distributed MC+ Advocacy Project information in English and Spanish and general LAWMO information	150
MAY				
5/2	Cover the Uninsured Coalition	Small Business Employers Breakfast	Distributed general information on MC+ and information	100

			about the MC+ Advocacy Project	
5/4	North Kansas City School District	Counselor In-Service	Distributed general information on MC+ and information about the MC+ Advocacy Project	20
5/8	Visiting Nurses Association	Dist. written materials	Distributed information about the MC+ Advocacy Project	4
5/19	Trinity United Methodist	Health Fair	Distributed general information on MC+ and information about the MC+ Advocacy Project	50
5/23	NE Cans	Committee meeting	Distributed general information on MC+, information about the MC+ Advocacy Project, and health resource guides	25
JUNE				
6/1	LINC MC+ Task Force	Quarterly meeting	Discussed current MC+ issues in the KC area	10
6/14	Migrant Farm Workers' Project	Dist. written materials	Distributed Health Resource Guides	50

6/20	MC+ Consumer Advisory Coalition	Quarterly meeting	Discussed current statewide MC+ issues	25
6/20	MPCA MC+ Coalition	Quarterly meeting	Discussed current statewide MC+ issues	30
6/23	Home Ownership Fair	Consumer fair	Distributed information about the MC+ Advocacy Project	60

IV. Concerns from Western Missouri

The Project continues to assist many families through the hurdles associated with applying for MC+. The most common obstacles clients face during the application phase are improper budgeting by eligibility specialists, difficulty in proving lack of access to affordable health insurance, and proving citizenship and identity.

Budgeting problems frequently occur when families work in seasonal or other types of employment with fluctuating income where one month's pay stubs may not adequately represent the family's income. Additionally, child support income has been attributed to parents, even when no such income is being received.

Countless families continue to face difficulties with the concept of the affordable insurance guidelines. Many private insurance companies are unwilling or unable to give the simple monthly premium quote requested by the Family Support Division,

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and it can be even more challenging for families to determine whether these private companies will offer the same level of coverage as MC+. As a result, the Project obtained the "MC+ for Kids Insurance Company Quotes" form from the FSD. Whenever possible, the Project will assist families in completing this form and providing it to the FSD if a budget completed by the Project indicates that an applicant is eligible at the premium level.

The Project continues to assist a number of families through the reinvestigation process. While this may involve assisting a family in completing the reinvestigation paperwork, more often a family will contact the Project after a failed attempt to recertify has led to the issuance of an adverse action notice.

At both the application and reinvestigation stages, families continue to struggle with provision of the necessary citizenship and identity documents mandated by the 2006 changes. These requirements are particularly burdensome for non-traditional families where grandparents or other relatives are taking care of children born out-of-state. The Project does what it can to assist families in obtaining the necessary documentation to allow medical coverage to begin.

An additional concern is that many Spanish-speaking clients are receiving follow-up letters in English, despite the fact that the family completed a Spanish application and that all follow-up contact with eligibility specialists has occurred with the

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assistance of the language line. As a result, many Spanish-speaking clients are unable to understand requests for additional information or the completion of reinvestigation paperwork, resulting in case terminations. Families are forced to reapply, despite the fact that their children continue to meet the eligibility requirements.

The Project also continues to assist a number of former Medical Assistance for Families recipients who have not been properly transferred to the Transitional Medical Assistance (TMA) program upon receipt of increased earned income. The Project also advocates for a number of TMA recipients who, despite informing their eligibility specialists of their disabilities, have not been provided with a Medical Assistance application as a part of the appropriate *ex parte* process.

Finally, the Project is helping more and more Managed Care families gain access to providers and to establish the right to coverage for a variety of services, such as orthodontia or durable medical equipment.

V. Projections

Over the next six months, the Project hopes to assist the State in raising awareness of the exciting new provisions passed through Senate Bill 577, particularly the expansion in coverage to former foster care youth between the age of 19 and 21, the

decrease in the access to affordable health insurance standards, and the changes to policy regarding pre-existing conditions.

The Project Director plans to attend the National Association of Legal Aid and Defenders Association Substantive Law Conference in July. Also, another active month of outreach is planned for August 2007, with extensive participation in local Back-to-School Fairs.

Additionally, the Project hopes to continue its broader community outreach efforts, particularly to the Hispanic community. The upcoming Bi-National Health Week fair at the Samuel U. Rodgers Community Center will provide the opportunity to speak to more than 1000 Kansas City-area residents about their MC+ healthcare eligibility and coverage.

Finally, the fall will bring a new partnership with Children's Mercy Hospital that will establish a coordinated referral system between that provider and the Project. As a result, patients who are experiencing any problems with service coverage or other issues with their health plan will be advised of the MC+ Advocacy Project by their physicians, nurses, and social workers. Legal Aid is excited about this collaboration and the opportunities it presents to help even more MC+ recipients.