

MO HealthNet Managed Care Annual Quality Report for SFY 2011 Executive Summary

Introduction

MO HealthNet Managed Care serves participants in 54 counties of Missouri, which are divided into three regions: Eastern, Central, and Western. MO HealthNet Managed Care contracts are competitively bid and are currently awarded to six health plans. Three health plans operate in all three regions and three health plans operate in only one region resulting in a count of 12 health plans when doing regional comparisons. The MO HealthNet Division (MHD) is required to monitor MO HealthNet Managed Care health plans (MCHP) to ensure compliance with the MO HealthNet Managed Care contracts.

The MHD has conducted an evaluation of the MO HealthNet Managed Care Program for state fiscal year 2011 (SFY2011). Each MCHP's 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). Each MCHP submitted an annual evaluation for SFY2011 as well as a work plan for SFY 2012.

Legislative Changes

There were no legislative changes that directly affected the MO HealthNet Managed Care Program during the 96th General Assembly, 2010 session.

Enrollment

Statewide enrollment in the MO HealthNet Managed Care Program during SFY2011 increased to 425,017 from 421,756 in SFY2010 (based on June enrollment each year). Enrollment of CHIP members accounted for 11% (44,933) of the total.

Development, Approval and Monitoring of the QI Program

MCHPs reported on the development, approval and monitoring of their QI Program by providing reviews of their quality and compliance committees, the analysis of their quality improvement process, and the overall effectiveness of their quality improvement program.

MCHPs use the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Sets (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to uniformly measure progress in the quality of care offered to participants. By using HEDIS and CAHPS measures, the quality of care Managed Care members are receiving in Missouri can be compared to national rates.

The MHD analyzed thirty HEDIS measures submitted by the MCHPs. Analysis of the MCHPs 2012 HEDIS measures reflects a decrease in the statewide average of 12 measures and improvement in 18 measures from 2011 HEDIS to 2012 HEDIS.

2012 HEDIS measures with statewide improvement over 2011 HEDIS:

- Adolescent Well-Care Visits
- Adolescent Immunizations
- Annual Dental Visits (all age ranges, seven measures)
- Cervical Cancer Screening
- Childhood Immunizations (Combo 3)
- Childhood Immunizations (Combo 10)
- Well Child Visits First 15 Months of Life: 3 - 5 Visits (three measures)
- Well Child Visits in the Third through Sixth Year of Life
- Prenatal Care
- Post-Partum Care

2012 HEDIS measures with statewide rates above the NCQA national rates:

- Asthma Ages 5-11
- Asthma Ages 12-18
- Asthma Ages 19-50
- Asthma Combined
- Chlamydia Screening Ages 21-24
- Chlamydia Screening – Combined Rate
- Prenatal Care
- Post-Partum Care
- Well Child Visits in the First 15 Months of Life: 0 to 5 Visits (six measures)

There were slight decreases in the statewide rates for Asthma measures and Well Child Visits First 15 Months of Life: 0-2 Visits in 2012 HEDIS, however the MCHPs statewide rate continues to be above the NCQA national rates.

Analysis of the MCHPs 2012 CAHPS measures reflects an improvement in rates in 100% of the measures over 2011 CAHPS. Additionally, 62% of MCHPs 2012 CAHPS measures rank higher than the NCQA national rates.

2012 CAHPS results with statewide improvement over 2011 CAHPS:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Rating of Doctor
- Rating of Specialist
- Rating of Health Care
- Rating of Plan

2012 CAHPS results with rates above the NCQA national results:

- Getting Care Quickly
- How Well Doctors Communicate

- Customer Service
- Rating of Health Care

The MCHPs HEDIS and CAHPS scores demonstrate continued efforts to provide quality health care to Managed care members in their care. Continued collaboration between areas within quality units and health plan management will ensure interventions to improve service and clinical care.

NCQA Accreditation

The MCHPs are required to obtain health plan accreditation, at a level of "accredited" or better from NCQA by October 1, 2011. The MCHPs are required to maintain such accreditation thereafter and throughout the duration of the contract. The MCHPs have been working toward this accreditation throughout SFY2011.

Five of the six MCHPs achieved NCQA accreditation with a "Commendable" status. The sixth MCHP achieved an "Accredited" level of accreditation.

Network Analysis

The Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP) reviews the annual access plans submitted by the MCHPs to determine if Managed Care members have reasonable access to providers and specialists in their area. The DIFP calculates the enrollee access rate for each type of provider in each county the MCHPs serve with a statewide goal of 90%. The entire Managed Care population is used in the calculation for each MCHP.

- The 2011 network analysis completed by the DIFP determined that all MCHPs met and exceeded the 90% standard. Eight (8) MCHPs obtained an overall network score of 100% in their respective regions, three (3) scored 99% in their respective regions and one (1) scored 95%.
- 11 of 12 MCHPs achieved 100% in the PCP distance standard per State regulation 20 CSR 400-7.095(3)(A)1.B. The remaining health plan achieved 99%.
- All MCHPs dentist/enrollee ratios were within the benchmark dentist/enrollee ratios.

Rights and Responsibilities

Rights and Responsibilities are measured by each MCHP reviewing its member grievance and appeals; provider complaint, grievance, and appeals; as well as member confidentiality practices.

The MHD reviews quarterly reports submitted by the MCHPs to monitor member grievances and appeals as well as provider complaints and appeals. Beginning January 1, 2006 all MCHPs began using a standardized database for reporting member grievances and appeals and provider complaints and appeals.

The MCHPs report a low incidence of member grievance and appeals. Annually, member grievances range from 1.84 (Missouri Care) to 5.93 (HCUSA) per 1,000 members with the most prevalent issues related to transportation. Member appeals range from .58 (Harmony) to 2.61 (Blue-Advantage Plus) per 1,000 members with the most prevalent issue being service denials.

Fraud and Abuse

Fraud and Abuse is measured by each MCHP reviewing its prevention, detection, and investigation practices as well as training and education practices. Beginning in SFY 2006 the MCHPs started using a uniform reporting system for their quarterly reports to the MHD. When appropriate, the MCHPs report to and cooperate with the MHD Program Integrity Unit, 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.

Performance Improvement Projects (PIPs)

Performance Improvement Projects were measured by reviewing clinical and non-clinical PIPs, as well as on-going interventions and improvements.

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes, and/or the 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. The MCHPs are required by contract to have at least two active PIPs, one of which is clinical in nature and one non-clinical.

The External Quality Review Organization (EQRO) conducted an independent external evaluation of the PIPs. The EQRO validated two PIPs (one clinical and one non-clinical) for each MCHP that were underway during 2011. A total of 12 PIPs were validated. Eligible PIPs for validation were identified by the MCHPs, MHD, and the EQRO. MHD directed the EQRO to validate the statewide PIP, Improving Oral Health.

PIPs identified for validation at each MCHP:

Blue Advantage Plus

- Improving PCP Follow-Up After Non-Emergent ER Visits
- Improving Oral Health

Children's Mercy Family Health Partners

- Improving Childhood Immunizations
- Improving Oral Health

Harmony Health Plan

- Improving Asthma Management
- Improving Oral Health

HealthCare USA

- Decreasing Non-Emergent/Avoidable Emergency Department Utilization
- Improving Oral Health

Missouri Care

- Improving Oral Health
- Decreasing Emergency Department Utilization

Molina Health Care of Missouri

- Improving Oral Health
- Reducing Repeat Emergency Department Visits for Members with Asthma

Detailed results can be found in the 2011 MO HealthNet Managed Care External Quality Review Report of Findings can be found at <http://dss.mo.gov/mhd/mc/pdf/2011-external-quality-review-report-mohealthnet-managed-care.pdf>

Behavioral Health Reviews

The MHD contracted with Mercer Government Human Services Consulting (Mercer), of Mercer Health & Benefits LLC, to conduct a clinical performance review of the Behavioral Health Organizations for four (4) of the MCHPs in 2008. Staff from MHD and the Department of Mental Health (DMH) conducted a clinical performance review of the behavioral health in-house operations for the two (2) remaining MCHPs in 2009, and for all MCHPs in 2010 and 2011. The focus of the behavioral health reviews was to explore variances in behavioral health utilization and to identify any patterns of under or over-utilization that would suggest issues with access to or quality of care for Managed Care members. The reviews addressed the following areas with respect to utilization:

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

Problems Identified: Case Management Records lacked evidence of sufficient documentation across all MCHPs in the following:

- Participant case management,
- Care coordination with community resources,
- Assisting participants with accessing providers,
- Comprehensive outreach strategies to assist participants prior to the occurrence of an emergency, and
- Behavioral/medical health integration.

Case Management reviews across all MCHPs found:

- For ambulatory levels of care the documented array and intensity of services often appeared insufficient to maintain community tenure,
- Documentation of inpatient, partial, and intensive outpatient reviews did not indicate that providers regularly reviewed treatment plans with case managers:

- Objective, measurable treatment goals were not documented.
- Primary focus upon symptom severity.
- Recovery and resilience principles were not evident in Assessment or Treatment Plans,
- Treatment plans focused upon symptom reduction without addressing member functioning or quality of life, and cross-system collaboration was not evident,
- Consumer strengths and symptom-free periods were infrequently identified, and
- Cultural factors and preferences were not explored or addressed.

MCHCPs are making improvements in providing behavioral health services to its members however, they need to continue efforts in the following areas: :

- Improve customer service workflow and outreach,
- Improve consistency of application of Level of Care Utilization (LOCUS) and the Child and Adolescent Level of Care Utilization System (CAL/LOCUS),
- Expand access to inpatient diversion services (alternative services to inpatient care),
- Identify and implement best practices in service delivery for the Medicaid population,
- Assure discharge planning begins at admission; and
- Assure Behavioral Health Medical Director has direct line authority over and meaningful involvement in clinical operations, including accountability for monitoring over and under utilization.

As a result of the Behavioral Health reviews, each MCHP was required to submit a Corrective Action Plan addressing the findings and recommendations in the review report. The State in conjunction with the DMH has conducted follow up reviews of each MCHP and their Behavioral Health Organization.

The Behavioral Health Measures are reported to the QA&I Advisory Group, no less than annually, and are revised as necessary. The QA&I Advisory Group continues to address problems identified during the Behavioral Health Reviews.

External Quality Review

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished MCHPs and their contractors to Managed Care members. The External Quality Review of Medicaid Managed Care Organizations' rule specifies the requirements for evaluation of Medicaid Managed Care programs. These rules require a desk review as well as an on-site review of each MCHP.

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as described below:

Validating Performance Improvement Projects

Each MCHP conducted performance improvement projects (PIPs) during the 12 months preceding the audit; six of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division (MHD)). The MCHPs have made significant improvements in utilizing the PIP process since the EQRO measurement process began in 2004.

Validating Performance Measures

The three performance measures validated were HEDIS 2011 measures of Annual Dental Visit (ADV); Childhood Immunization Status, Combo 3 (CIS3); and Follow-Up After Hospitalization for Mental Illness (FUH).

The “Annual Dental Visits” measure has been audited in the 2007, 2008, 2009, 2010, and 2011 external quality reviews. Over the course of these review periods, the rates for all MCHPs have improved a total of 9.34%, from 32.50% in 2007 to 41.84% in 2011. Although the rates have increased for the Annual Dental Visit measure, none of the MCHPs reported a rate in 2011 higher than the National Medicaid Average of 47.8%, although one MCHP (CMFHP) was close at 47.74%.

Findings for “Follow-Up After Hospitalization for Mental Illness” conclude that Managed Care members are receiving a quality of care comparable to or higher than other Medicaid participants across the country within the 30-day timeframe the area of Follow-Up After Hospitalization for Mental Illness, but the quality of care received is not quite as high within the 7-day timeframe. In both timeframes, members are receiving a lower quality of care than the average National Commercial member. However, based on the upward trend in the rates reported, the quality of care for Follow-Up After Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes, despite a slight fall in the most recent 30-day timeframe rate.

The “Childhood Immunizations Status, Combo 3” measure has not previously been audited by the EQRO. Therefore, no valid trend data is available for the MO HealthNet Managed Care population. None of the MCHPs reported a rate in 2011 HEDIS higher than the NCQA national rate of 69.9%. The MCHPs HEDIS 2011 statewide is 57.15%.

MO HealthNet MCHP Compliance with Managed Care Regulations

The MCHPs have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially in 2004 the MCHPs did not have complete and approved written policies and procedures and MCHP processes did not exhibit compliance with contractual and regulatory requirements. In subsequent measurements, the MCHPs made concerted efforts to complete policy and procedural requirements. In 2007-2011, the review examined not only the written policy, but also conducted interviews to identify if the activities of front line and administrative staff were in compliance. The MCHPs have used previous EQRs to ensure that compliant policies are in place, and continue their efforts to ensure compliant and member focused procedures.

Special Project – Case Management Performance Review

The MO HealthNet Division (MHD) asked the EQRO to conduct a special project to follow up on the MCHPs' compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special project was to complete an in-depth follow-up review of Case Management by assessing the MCHPs improvement in Case Management service delivery and recording keeping. The EQRO also evaluated the MCHPs compliance with the federal regulations and Managed Care contract as it pertained to Case Management.

The 2011 MO HealthNet Managed Care External Quality Review Report of Findings can be found at <http://dss.mo.gov/mhd/mc/pdf/2011-external-quality-review-report-mohealthnet-managed-care.pdf>

Conclusion

The MO HealthNet MCHPs Annual Evaluations show evidence of their dedication to provide quality health care and to serve the needs of Managed Care members. MCHPs have identified strengths as well as opportunities for improvement throughout their evaluations. Standardized reporting to MHD, as well as NCQA HEDIS/CAHPS reporting, makes it possible to compare the MCHPs across the state and to measure their progress in providing quality care to its members.

The MHD is committed to working with the MCHPs and all stakeholders in building upon the strengths shown in these annual evaluations and to continue to collaborate with MCHPs to make progress in areas where there are opportunities for improvement.

Each MCHP provided detailed analysis in their SFY 2011 Annual Evaluations. The individual Executive Summaries from each of these reports follow.

MO HealthNet Managed Care Health Plan Annual Quality Evaluation
Executive Summaries
SFY2011 (July 2010 – June 2011)

Blue-Advantage Plus

In its thirteenth year of serving the Medicaid population of Western Missouri, Blue-Advantage Plus of Kansas City, Inc. (BA+) strives to improve the overall health of BA+ members by providing members with quality health care. BA+ anticipates and responds to members' needs, and BA+ helps members achieve positive health outcomes. BA+ complies with all of the contractual requirements set by Missouri's MO HealthNet program.

EQRO Audit

Behavioral Health Concepts, an External Quality Review Organization (EQRO), submitted the findings of the 2010 EQRO audit in the second quarter of SFY2011. The 2010 EQRO audit reviewed BA+ for the 2009 calendar year. The EQRO audit examined the clinical performance improvement plan (PIP) for ambulatory follow-up after hospitalization for mental health disorders and the non-clinical PIP for Improving Adolescent Well-Care. Behavioral Health Concepts stated BA+'s PIP for ambulatory follow-up after hospitalization for mental health disorders "exemplifies the commitment of the health plan and New Directions Behavioral Health (NDBH), to produce better and more productive mental health services for the benefit of BA+ members." Behavioral Health Concepts complimented BA+ on the improving Adolescent Well-Care PIP, stating "this PIP provided quantitative improvement in the process of care."

NCQA Accreditation

BA+ received accreditation at the Commendable level by the National Committee for Quality Assurance (NCQA), effective September 28, 2011. The accreditation is effective for 3 years, with an expiration date of September 28, 2014. This is the initial accreditation for Blue-Advantage Plus, beginning with the submission of documentation to NCQA on June 27, 2011. Following an on-site visit by two NCQA surveyors and two representatives of the State of Missouri Medicaid programs, BA+ received a final decision on 9/28/11 following review of the findings by the NCQA Review Oversight Committee.

URAC Accreditation

The Utilization Review Accreditation Committee (URAC) awarded BA+, a Certificate of Full Accreditation for compliance with Provider Credentialing Standards effective March 1, 2011 through March 1, 2014. Blue KC is also accredited by URAC for Health Utilization Management and Case Management. Accreditation is associated with health insurance industry best practices.

Compliance

To ensure BA+'s compliance with the MO HealthNet contract requirements, BA+ conducts a complete review of every contract requirement annually. BA+ measures compliance with each requirement and maintains documentation of the annual review in compliance binders. The results of the compliance review are reported to the Quality Council. In the event BA+ is out of compliance, the non-compliance is reported to the Compliance Committee.

HEDIS® Measures

BA+ experienced improvements in multiple 2011 HEDIS® measures. The 2011 HEDIS® rate for Follow-up after Hospitalization for Mental Illness within 7 days of discharge increased while Follow-up after Hospitalization for Mental Illness within 30 days of discharge remained the same. The 2011 HEDIS® rate for Use of Appropriate Medications for People with Asthma improved, and the 2011 HEDIS® rate for Annual Dental Visits also improved. Improvement occurred in the 2011 HEDIS® rate for Timeliness of Postpartum Care. The 2011 HEDIS® rates for Well Child Visits for the First Fifteen Months of Life, 6 or More Visits and Well Child Visits in the Third, Fourth, Fifth, And Sixth Year of Life improved. The 2011 HEDIS® rate for Adolescent Well-Care Visits also improved.

Ongoing Oversight

BA+ continues to be overseen and monitored through the Blue-Advantage Plus Oversight Committee. This cross-functional committee ensures compliance with the MO HealthNet contract and ensures BA+ meets quality standards. BA+ looks forward to another great year of providing a quality program to our members. In state fiscal year 2011, the Blue-Advantage Plus Oversight Committee met once each quarter on the following dates: 7/12/2010, 10/11/2010, 1/10/2011, and 4/11/2011.

OVERVIEW OF THE QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program provides the infrastructure for cross-departmental integration of quality improvement processes and outcomes into business activities in order to achieve the mission of Blue KC and the goals of BA+. The Blue KC mission statement is operationalized for BA+, as well as other Blue KC HMO, PPO, and Government Program products. This integration provides for rich resource availability to provide for the quality assessment and improvement program for BA+. The Quality Improvement Program ensures members receive access to quality health providers, the knowledge necessary to make informed choices, guidance through the health care system, and superior service.

Blue KC has adopted an over-arching, company-wide quality program intended to tie together and at least loosely integrate the many quality improvement activities which occur within the company. To improve quality planning, a Quality Plan will be developed each year to complement Blue KC's Three-Year Business Plan to improve the relevance of the quality improvement plan to the business plan. This important change sets the direction for the Quality Improvement Program to be formally integrated with the business plan in the future, and allows thoughtful setting of corporate quality priorities consistent with the intent of "Building the Best with Blue".

OVERVIEW OF THE EFFECTIVENESS OF THE QUALITY IMPROVEMENT PROGRAM

Quality Improvement System

With leadership transitions in 2010, an in-depth review of Blue KC's business systems and processes will result in recommendations to the Board of Directors. These recommendations will outline a strategy for carrying Blue KC forward to healthcare reform. In response to organizational and governance changes in 2010 and in anticipation of healthcare reform changes, the Quality Management Department conducted an in-depth assessment of the quality committee structure in 2010. Based on the findings, several committees expanded their descriptions to more closely align with strategic goals and accreditation standards. These changes position Blue KC to have a quality structure that will allow the flexibility and adaptability needed to meet the upcoming changes required to address healthcare reform. For 2011, the Quality Management Department conducted work process analyses and audits to assure that all processes are working at high degree of efficiency and effectiveness.

Blue KC's Quality Improvement System conducts oversight of delegated functions. New Directions Behavioral Health (NDBH), a wholly-owned Blue KC subsidiary, is the most significant delegate, with delegation of quality improvement, utilization management, case management, complaints, credentialing and health coaching. Other delegates include DentaQuest, a Medicaid dental provider delegated for initial utilization review determinations, and claims handling; CareNet, a telephone nurse advice line; and Medical Evaluation Specialists, Inc. for utilization case reviews. All semi-annual reporting and oversight audits were generally acceptable and delegates were responsive to requests for corrective action.

Staff and Technology Resources

Decentralization of clinical and service/operational performance improvement activities continues to bring challenges of oversight, training, standardization of reporting and communication. Limited resources in the Quality Management Department are carefully juggled and supplemented with contracted staff and restructuring of staff positions to support the top priorities of the department. An important function of the Quality Management Department is 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 Blue KC leadership and external reviewers.

During 2010, the Quality Management Department continued to facilitate staff development through continuing education delivered through free and reduced-cost webinars and conference calls offered by NCQA, URAC, and the Blue Cross Blue Shield Association on topics related to accreditation, quality improvement projects, and best practices. Online training on quality principles and tools was also made available to key staff for personnel development.

Technology advancements are critical to the success of Blue KC's strategic plan, particularly for the health and wellness solutions and member-centric strategies. Reorganization to provide a new Enterprise Analytics Division in 2011 provides additional support of business excellence. Additional important technology enhancements planned for 2011 will provide more robust analytic resources and positively impact the strategic plan.

Most notably, Blue KC continues to undertake several technology projects in support of a member-centric business model. One such project is the implementation of Alineo, a software system purchased by Blue KC in 2009. Blue KC's prevention, disease management, and case management programs are contained in Alineo to better facilitate and coordinate members' care. BA+ began using Alineo for case management referrals for children with special health care needs and children with elevated lead levels in 2011. This strategy's objective is to develop a straightforward cross-functional approach to business that includes keeping the member's perspective in mind during decision-making and development of process and tools. Blue KC strives to lead health plans in providing services and tools that members will value, such as the role of health advocate, anticipating that these services and tools will be the differentiator among health plans in the future.

Children's Mercy Family Health Partners

Overview of the Quality Improvement Program

The purpose of the Quality Improvement Program is to provide a framework for the continuous improvement of the health care provided to Children's Mercy Family Health Partners (CMFHP) members through assuring the provision of appropriate, affordable and accessible care. This is accomplished by identifying, evaluating and monitoring the quality of health care services provided to or proposed for plan members. All CMFHP providers are required to collaborate with the Quality Assurance and Performance Improvement activities. Activities include, but are not limited to:

- Assessing and enhancing member access to care and the availability of services, and assuring compliance with access standards.
- Promoting case management services with emphasis on the individual member to ensure that members have a medical home which focuses attention on the wellness of the member and includes personal responsibility and participation on the part of the member.
- Promoting delivery of services in a culturally competent manner to all members, including those with limited English proficiency and/or diverse cultural and ethnic backgrounds.
- Assessing and improving the satisfaction of members, providers and CMFHP employees through the development, administration and evaluation of surveys and the processing of complaints, grievances, and appeals.
- Monitoring all delegated or subcontracted activities to ensure that they are carried out in full compliance with program standards and requirements.
- Maintaining high standards for the credentialing of physicians and other providers, and assuring these standards are met.
- Developing, implementing and evaluating clinical standards of practice, guidelines and algorithms.
- Conducting reviews and evaluations of provider performance.
- Utilizing national performance measures and benchmarks in the process of measuring, recommending, and taking action on the outcomes of patient care.
- Providing a process for evaluation of quality of care.
- Assessing the quality and appropriateness of health care services provided to all members, in particular, those with special health care needs, centered on evidence-based practices.
- Utilizing demographic data to the extent available to improve care delivery.

- Utilizing information systems for initial and reoccurring reviews of health care delivery.
- Ensuring input from public stakeholders to potentially facilitate improvements in members' health status.
- Applying policies and processes to ensure Plan compliance with regulatory, contractual and MO HealthNet Managed care policy requirements, including a quality assessment and improvement program which integrates an internal quality assessment program that conforms to Quality Improvement System for Managed Care (QISMC).
- Maintaining a collaborative process of collegiality in working with MO HealthNet Division (MHD) and other MO HealthNet Managed Care plans to improve care to Medicaid recipients.

Overview of the Effectiveness of the Quality Improvement Program

The overall effectiveness of the Quality Improvement Program is demonstrated in the improved outcomes of the member satisfaction surveys for both adult and child, the clinical quality indicators, care management enhancements, disease management engagements, the utilization measure outcomes and the performance of service indicators.

QM Philosophy

Children's Mercy Family Health Partners strives to incorporate performance improvement into the daily operations of the Plan. Operational and clinical decision-making involves thorough data collection, analysis, and evaluation. All performance improvement activities are designed to maximize clinical outcomes for members through the facilitation of access to high quality, cost-effective health care

Overall Effectiveness of the Quality Improvement Program

Strengths and Accomplishments

As a result of Children's Mercy Family Health Partner's review of 2011 quality performance and improvement efforts, the following strengths and accomplishments were realized in that timeframe:

- Achieved NCQA Accreditation with a Commendable status
- Developed an organization-wide assessment of readiness for NCQA and completed the required processes and procedures to ensure compliance with all standards
- Statistically significant improvement in the Child CAHPS scores in three composite areas: Getting Care Quickly, How Well Doctors Communicate and Rating of Health Care
- Improvement in the Adult CAHPS scores in five composite areas: Getting Needed Care, Getting Care Quickly, Shared Decision Making, Health Promotion and Education and Rating of the Health Plan
- Developed a standardized member report, "Gaps in Care" which allows consistent documentation of education to members
- Updated the case management documentation system (CARE) to ensure NCQA documentation compliance with complex case management standards
- Continued a major depression disease management program
- Enhanced a diabetes disease management program with a diabetes health educator

- Continued monitors for 2010 adopted and distributed clinical practice guidelines to support optimal care outcomes to appropriate providers – Asthma, ADHD, Bronchitis-Adult, Chlamydia screening, Depression-Adult & Pediatric, Diabetes, Lead, Low back pain, Pharyngitis-Pediatric, and Routine Prenatal care.
- Continued adult wellness initiatives (i.e. newsletter and reminders)
- Continued exploration of other medias to get education to members and providers (i.e. online community, Facebook)
- Implemented monitoring system for turnaround times in clinical staff decision-making that is more inclusive than the routine audit process
- Implemented a system to begin collecting race and ethnicity information according to NCQA CLAS standards
- Developed a process to evaluate health care disparity process based on HEDIS quality indicators
- Developed a HEDIS coding quick reference guide for providers
- Improved HEDIS measures, including the following: Cervical cancer screening, Prenatal care, Postpartum care, Use of appropriate medications for asthma, Comprehensive Diabetes care (CDC)-Eye care, CDC-HbA1c testing, CDC-LDL-C Screening, CDC-Nephropathy, Follow-up care for ADHD medication for Initiation phase and Continuation phase, Antidepressant medication management for Acute phase and Continuation phase, and Annual dental visits
- Continued smoking cessation initiatives in Health Improvement
- Continued to develop new mechanisms for detecting fraud and abuse, including claims review and an enhanced Fraud and Abuse Committee
- Continued Medical Management and Behavioral Health Care Coordination with New Directions

Harmony Health Plan

Overview of the Quality Improvement Program

This was a year of progress by the Quality Organization. For the entire contract year, we had an engaged Medical Director, dedicated, knowledgeable, efficient quality improvement staff, and the benefit of our new centralized field Quality Improvement department with increased access to “best practices” and resources. The stability of the QI organization and the support from the corporate and field QI organization has enabled us to increase our data analytics, meet the multiple QI contractual requirements, and implement some new programs such as the Targeted Medical Record Review Program. The Targeted Medical Record Review Program gives PCPs and their office staff specific documentation based on the patients’ records about why they are not meeting the HEDIS or EPSDT requirements.

Several of the initiatives implemented by Harmony have been implemented by the entire organization. The local Provider Pay for Performance program, based on reaching or exceeding the 50th, 75th or 90th percentile of the targeted HEDIS measures, is now the company’s Pay for Performance program.

Once again, this year like the last, quality is a priority for the entire organization. Improving our quality scores, both HEDIS and CAHPS, is one of the top five priorities for all employees. As an example, it is a major metric on which Provider Relations staff are evaluated during their performance reviews, and upon which all key management are evaluated for any incentive payout. This change in philosophy has created more resources to work on implementing quality initiatives.

Despite the implementing of the HEDIS Action Plan, which tracks all of our HEDIS interventions by measure and by month, and despite the initiation of new initiatives and continuation of older initiatives in 2010, we were not as effective as we had anticipated for either HEDIS or CAHPS. Our goal was to have statistically significant improvement for the majority of the HEDIS and CAHPS measures, but we did not. We only had statistically significant improvement for five HEDIS measures. We anticipate that the impact of many of these initiatives and the addition of some robust new interventions will make an impact in 2011 and improve these rates significantly for HEDIS 2012.

Executive Assessment of QI Program

A. Purpose

Harmony Health Plan of Missouri continuously works to improve its Quality Improvement Program and monitor the overall effectiveness of the program. This Quality Improvement Program Evaluation compares the health plan's results to its work plan activities, metrics, and goals. This summary document evaluates the overall effectiveness of the program, non-clinical and clinical aspects of the program, and market specific activities. The Executive Summary highlights the 2010 Quality Improvement activities with additional detail provided in the overall program evaluation.

B. Company Overview

WellCare, founded in 1985, is a leading provider of managed care services dedicated to government sponsored health care programs. Harmony Health Plan of Missouri, Inc. a wholly-owned subsidiary of WellCare, manages the provision of covered health services to eligible Medicaid members through a diverse network of qualified, multidisciplinary providers. Harmony Health Plan of Missouri is committed to the delivery of effective quality health services that focus on member quality of life, prevention, safety, and health outcomes. The information presented in this document reflects an evaluation of the effectiveness of the 2010 Harmony Health Plan of Missouri's Quality Improvement Program.

The program evaluation summarizes all quality improvement activities and includes descriptions of outcomes, limitations, and any barriers to improvement identified during the previous year.

The document also includes recommendations for the upcoming year based upon identified program strengths and challenges. In this way, the QI Program Evaluation provides the basis for strategic planning and resource allocation for the following year's QI Program Description and QI work plan. It does this by both evaluating the effectiveness of previous interventions and identifying additional opportunities for improvements in clinical and service quality for our members.

C. Timeframe for Reporting

This evaluation covers twelve (12) months of program activity. In 2010, effort was focused on continuing to improve processes to collect data that was meaningful and relevant to service the population served. As data were collected, analysis of trended data continued, enabling identification of areas appropriate for process improvement.

D. Components of Assessment

Quality Improvement (QI) Work Plan activities are designed to monitor and evaluate the appropriateness and quality of services to members, pursue opportunities to improve services, and resolve identified problems contributing to meaningful improvement in clinical care and member services.

Program Highlights

In 2010, program highlights for Harmony Health Plan of Missouri included:

- **EPSDT**
 - Collaborated with DHSS (Department of Health and Senior Services) updating policies and procedures to meet new contractual requirements for the annual EPSDT medical record reviews.
- **HEDIS**
 - Collaborated with local FQHC's (Federally Qualified Health Centers) identifying members for improved encounter information.
 - Implemented the HEDIS Action Plan, which allowed monthly tracking of all activities related to improving the HEDIS rates.
 - Distributed member-specific "care gap" reports, and continued the Provider Pay for Quality Program.
 - Provided individual targeted Member outreach through the Harmony Hugs program (for pregnant members), HEDIS centralized telephonic member outreach, HEDIS education and screening program (ESP), HEDIS targeted outbound member mailings for diabetic eye exams, HEDIS post-partum enhanced discharge planning, and Health Screening reminder letters.
 - Improved identification of members for disease management programs and increased number of members in the DM program. Reviewed processes to improve data collection methodology in 2011.
- **Member Satisfaction Survey**
 - Assessed custom questions for revision in 2011 to focus on emergency room utilization and provider availability.
- **Lead Screening**
 - Collaborated with DHSS to improve coordination of data between health plan and DHSS for lead case assessment and management.
 - All staff trained in the use of MOHSAIC, the State's case management data base.
- **Ethics**
 - All associates completed the Code of Conduct and Business Ethics Training (iCare).
- **Confidentiality**
 - All associates completed HIPAA training, which included required modules that cover:

- HIPAA Awareness
 - Electronic Security
 - HIPAA Enforcement Rule
 - The Stimulus Act and HIPAA
- **Accreditation**
 - Initiated process to become NCQA accredited by October 1, 2011.
 - Completed NCQA accreditation process by successful submission of the Inter-Active Submission Survey Tool on April 21, 2011 and completed on-site review on June 20 and 21, 2011.
 - “Commendable” accreditation status awarded on July 7, 2011. .This status was based on a total score based only on standards which were scored at 99.9%. .However, when the 2011 HEDIS and CAHPS measures were added into the standards score in August the accreditation status changed to “Accredited” .The score can change each year based on the annual update of the HEDIS and CAHPS scores.

2010 Key Objectives

- Promote efforts to achieve coordination of care across delivery settings, paying attention to appropriate patient safety practices.
- Engage providers with actionable and targeted data for member “care gaps” and incent and reward providers to increase completion of preventive services to their members.
- Engage and assist members to receive preventive services through mailing, phone calls, and the Harmony Hugs program for pregnancy-related services.
- Pursue methods to increase practitioner compliance to accepted clinical practices guidelines and documentation standards, evidenced by improved medical record review scores and / or increased preventive and / or chronic care service utilization.
- Initiate meaningful and targeted interventions to achieve utilization rate in select preventive and chronic condition care measures.
- Achieve increases in key member and provider satisfaction indicators.
- Initiate identification of and action regarding process improvement opportunities that have both centralized and decentralized components.
- Increase focus on sound data analysis, including examination of barriers, and development of meaningful interventions that address identified opportunities to improve the level of health care services and delivery.
- Increase focus on market specific strategies and adherence to contractual requirements.

Evaluation of the Overall Effectiveness of the QI Program

In 2010, Harmony had 105 performance metrics with goals listed. Harmony Health Plan of Missouri combines like performance measures into one metric category. Of those goals, 51 were at or better than the goal for a 48.6% compliance rate; 19 were partially met for a compliance rate of 18.1%.

Harmony has considered the roles and responsibilities of key staff, the adequacy of resources, committee structure, and practitioner participation and leadership involvement in the QI Program and has determined to restructure or change the QI program for the subsequent years as indicated below:

- During 2010, QI resources (personnel and fiscal) were realigned under the umbrella of Field Quality Improvement, with the creation of the position of Vice President of Field Quality Operations. This realignment assured that the roles and responsibilities of key staff were consistent across all Medicaid markets, creating best practices.
- The major Committee structure change in 2010 was the removal of Pharmacy and Therapeutics from under the Quality Improvement Committee (QIC) to align under the Utilization Medical Advisory Committee (UMAC). In addition, the UMAC now includes the Medical Policy Committee (MPC).

Harmony has evaluated all aspects of the QI Program's performance, including the following common barrier themes:

- Providers lack of communication with their members.
- Members lack of understanding regarding their benefits and utilizing their providers.
- Need for effective members and provider education.

Harmony also describes the program's overall effectiveness as follows:

- Harmony has successfully promoted efforts to achieve coordination of care across delivery settings paying attention to safe clinical practices in both hospital and practitioner office settings. Hospital compliance with providing emergency room discharge summaries to primary care practitioners on a timely and consistent basis. Practitioner compliance to the Diabetes and Asthma clinical practice guidelines, opportunities for improvement were identified and provider education toolkit was created and mailed.
- Harmony has successfully increased focus on sound data analysis, including examination of barriers, and development of meaningful interventions including member and provider initiatives that addressed and identified opportunities to improve the level of health care and service delivery.

HealthCare USA

Overview of the Quality Improvement Program

HealthCare USA's mission is to improve MO HealthNet recipients' access to quality health care by providing a comprehensive network of providers and community organizations in order to achieve improved health outcomes. HealthCare USA achieves this mission by continuing to improve outcomes, decreasing costs and increasing membership. Quality improvement and utilization management programs support achievement of the mission in a variety of ways.

The mission of HealthCare USA's Quality Improvement Program is to increase the value of HealthCare USA services to the State of Missouri, HealthCare USA members, providers and staff by identifying opportunities and making improvement based on the measurement, validation and interpretation of data. The Quality Improvement Program provides the framework for HCUSA to continually monitor, evaluate and improve the quality and safety of care and service provided to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds. It provides an ongoing evaluation process that lends itself to improving identified opportunities. The Quality Improvement Program supports an organization-wide commitment to quality of care and service and incorporates leadership involvement in on-going improvement.

Overview of the Effectiveness of the Quality Improvement Program

HealthCare USA's 2011 annual evaluation reflects the continuous evolution of a program incorporating the best available knowledge that focuses on achieving superior outcomes by establishing positive, collaborative relationships with providers, community organizations and members across diverse settings. Through ongoing data collection and analysis, HealthCare USA's Quality Improvement Program has continued to successfully identify, prioritize and address areas of opportunity. HealthCare USA's extensive experience and record of success are demonstrated by the number and variety of programs undertaken and the results achieved in internal measures and by independent audit activities. Continuous improvements in 2010 to 2011 include, but are not limited to EPSDT ratios and HEDIS rates, outcomes of CAHPS surveys, and reducing avoidable emergency department visits. A commitment to ongoing improvement is evident in a variety of projects, such as achievement of NCQA accreditation at the commendable level. This report shows what HealthCare USA has achieved since the last report in 2010, as well as what we are positioned to achieve in the coming year.

HealthCare USA's Quality Improvement Program has been effective in meeting and exceeding many of the goals set for individual projects and organizational objectives. 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, safety, satisfaction and costs across all three regions.

Missouri Care

Overview of the Quality Improvement Program

Missouri Care Health Plan's Quality Improvement Program monitors, evaluates and improves the continuity, quality, accessibility and safety of health care services provided to members. It assesses members' care, delivery systems and satisfaction, while optimizing health outcomes and managing costs. The comprehensive program is integrated throughout Missouri Care and its provider network, and it incorporates continuous quality improvement (CQI) processes. Quality management activities are integrated with other systems, processes and programs throughout the health plan.

Quality management is a plan-wide endeavor. It is integrated by interdepartmental monitoring processes and activities, business application systems, databases that are accessible to all areas and a structure of oversight committees with representation from the plan and the provider network.

The purpose of the quality improvement program is to continuously identify areas of success and prioritize improvement opportunities with available resources to help assure delivery of care and services consistent with the Institute of Medicine six aims for care that is safe, effective, efficient, timely, equitable and patient-centered.

The Quality Improvement Program supports an organization-wide commitment to quality of care and service and incorporates leadership involvement in on-going improvement.

- Specifics of the quality management program are to:
- Provide a framework for the continuous assessment and improvement of all aspects of care and services received by individual members and populations
- Identify and improve the processes, systems and practices that will improve member outcomes Promote the recognition and use of approved medical standards, practice guidelines, best practices, targeted benchmarks, data collection, analyses and clinical indicators
- Address identified health care, service, and safety issues and bring them to satisfactory resolution according to approved medical standards, best practices, and practice guidelines
 - Collaborate with the health care community to improve members' outcomes and support community health initiatives
- Incorporate the evaluation of technology into quality activities to improve members' health outcomes

Overview of the Effectiveness of the Quality Improvement Program

For Missouri Care, State Fiscal Year 2011 (SFY 11) was one of great innovation and success, with accompanying new challenges and opportunities. Missouri Care Health Plan continued to expand into the East and West regions of Missouri. With this growing membership came new state and community partnerships, and quality and service improvement programs. Missouri Care enhanced its health care home and case management models building upon the health plan's long-existing quality management and improvement infrastructure.

In SFY11, Missouri Care Health Plan continued to have an effective quality management and improvement program. Per the requirement of the October 1, 2010 contract with the state of Missouri, Missouri Care underwent Accreditation through the National Committee for Quality Assurance (NCQA); receiving a Commendable three-year Accreditation status. Healthcare Effectiveness Data and Information Set (HEDIS) performance indicators continued to be closely monitored. Missouri Care expanded its HEDIS data collection to include a total of twenty-six HEDIS measures. These HEDIS measures included those required by NCQA as well as those required by the state of Missouri¹. This annual report describes performance in Effectiveness of Care, Access/Availability of Care, Use of Services, and Satisfaction with Experience of Care.

A major goal and accomplishment of the quality improvement program was a program that was integrated across all Missouri Care departments.

Successful examples of this integration included the development of new cross-departmental work groups, including the Quality Improvement Work group and the Cultural Competency Committee inclusive of the Community Outreach Advisory Council on Health (COACH). There were five interdepartmental continuous quality improvement activities: Asthma medication Compliance, Access to Dental Services, ER Utilization, Diabetes Preventive Health Care Compliance, and Follow-Up After Hospitalization for Mental Health, Timely Post-Partum Care. These initiatives represented the combined efforts of case managers (physical and behavioral health), Quality staff, Provider Relations staff, Community Outreach representatives as well as customer service representatives. The continued use of the Provider Preventive Care Toolkit and Site Visits was also an interdepartmental success. Quality and Provider Relations staff teamed up

to inform and give & receive feedback from providers and office personnel on methods to increase preventive health screenings and well-child care visits.

Missouri Care maintained existing partnerships and forged new partnerships with key community organizations, in its effort to demonstrate successful care and quality service improvements for all members. Missouri Care continues to have a strong quality committee structure. During SFY 11, internal and external committee members provided helpful insight and evaluation of our quality improvement program. During this time we also improved documentation, tracking, and evaluation of quality improvement projects. The results of these activities can be seen throughout this report.

Molina Healthcare of Missouri

Molina Healthcare of Missouri (Molina) is a wholly owned subsidiary of Molina Healthcare, Inc. Molina's mission is to promote health and provide health services to low income families and individuals covered by government programs. Molina strives to provide or arrange for the provision of healthcare services to the eligible Medicaid population in the Eastern, Western and Central regions of the MO HealthNet Managed Care Program.

Molina has served patients since 1995. For all plan members, Molina emphasizes personalized care that places the healthcare provider in a pivotal role of managing healthcare. Molina is responsible for managing the provision of accessible, appropriate, cost-effective, high quality health care services for its members throughout the continuum of care, as defined by the MO HealthNet program. The health plan assists members as they move through the managed care system, reducing barriers to care, and supporting members in reaching optimal health. It is the objective of Molina to provide superior health care to its members and the community.

Overview of the Quality Improvement Program

The Quality Improvement (QI) Program is established to provide the structure and key processes that enable Molina to carry out its commitment to ongoing improvement of care and service, and improvement of the health of its members. The QI Program assists Molina to achieve these goals. It is an evolving program that is responsive to the changing needs of Molina's customers and the standards established by the medical community, regulatory and accrediting bodies.

Molina maintains the following values, assumptions, and operating principles for the Quality Improvement Program (QIP):

- The QIP provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry "best practice" or on standards set by regulators or accrediting organizations.
- The QIP is applicable to all disciplines comprising the health plan, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.

- Every Molina employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with NCQA Standards and achievement of accreditation demonstrates the commitment to quality improvement by Molina.
- Information about the QIP is available for members and providers upon request.

Overview of the Effectiveness of the Quality Improvement Program

Through the implementation of quality improvement-oriented goals, Molina's QI Program proves its effectiveness by encompassing the quality of acute, chronic and preventive health care as well as services provided in both the inpatient and outpatient setting to Molina's population as determined by age, disease categories, risk status and products. The scope of service includes but is not limited to, those provided in institutional settings, ambulatory care, home care, and behavioral health. Contracted provider groups, primary care and specialty practitioners and ancillary providers may render these services.

Molina has defined the following goals for the QI Program:

- Design and maintain programs that improve the care and services provided to Molina members. These programs must have defined outcomes within identified member populations, to allow measurement and to ensure relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members. Through ongoing and systematic monitoring, interventions and evaluation improve Molina structure, process, and outcomes.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals.
- Facilitate organizational efforts to achieve and maintain State and local regulatory compliance and NCQA accreditation.
- Improve the skills and knowledge of staff and practitioners to support Molina's core values, and work effectively with both members and staff in a diverse work environment.
- Develop organizational strategies, programs and policies to enhance the institutionalization of cultural competence.
- Continually expand and improve both translation and linguistic services to better serve members.