

MO HealthNet Managed Care Annual Quality Report for CY2012 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 three health plans. All health plans operate in all three regions. The MO HealthNet Division (MHD) is required to monitor MO HealthNet Managed Care health plans (MCHPs) to ensure compliance with the MO HealthNet Managed Care contracts.

The MHD has conducted an evaluation of the MO HealthNet Managed Care Program for calendar year 2012 (CY2012). This evaluation has been transitioned from the state fiscal year to the calendar year to better align with other reporting requirements for MCHPs. 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 CY2012 as well as a work plan for CY2013.

This year's evaluation reflects a change in the MHD Managed Care contract and an associated transition of MCHPs. Effective July 1, 2012, a new managed care contract was awarded to two previously existing MCHPs (HealthCare USA and Missouri Care) as well as one new MCHP (Home State). Three MCHPs were not awarded a new contract (Blue Advantage Plus, Harmony Health Plan, and Molina Health Plan of Missouri).

Legislative Changes

There were no legislative changes that directly affected the MO HealthNet Managed Care Program during the 97th General Assembly, 2011 session.

Enrollment

Statewide enrollment in the MO HealthNet Managed Care Program during CY2012 decreased to 422,046 from 428,184 in CY2011 (based on December enrollment each year). Enrollment of CHIP members accounted for 11% (45,170) 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 2013 HEDIS measures reflects an increase in the statewide average of 20 measures and decrease in 10 measures from 2012 HEDIS (covering data from calendar year 2011) to 2013 HEDIS (covering data from calendar year 2012).

2013 HEDIS measures with statewide improvement over 2012 HEDIS:

- Adolescent Well-Care Visits
- Annual Dental Visits (seven separate measures covering multiple age ranges)
- Cervical Cancer Screening
- Chlamydia Screening (three separate measures covering multiple age ranges)
- Childhood Immunizations (Combo 3)
- Childhood Immunizations (Combo 10)
- Inpatient Follow-Up: 30 Days
- Well Child Visits First 15 Months of Life: 3 - 5 Visits (three separate measures)
- Prenatal Care
- Post-Partum Care

2013 HEDIS measures with statewide rates above the NCQA national rates:

- Asthma Combined
- Cervical Cancer Screening
- Chlamydia Screening (three separate measures covering multiple age ranges)
- Prenatal Care
- Post-Partum Care
- Well Child Visits in the First 15 Months of Life: 0 to 5 Visits (six separate measures)

There were slight decreases in 2013 HEDIS for the statewide rates for the Asthma Combined measure and for Well Child Visits in the First 15 Months of Life for 2, 3 and 5 Visits; however the MCHPs statewide rates continues to be above the NCQA national rates.

Analysis of the MCHPs' 2013 CAHPS measures reflects an improvement in rates in 88% of the measures over 2012 CAHPS. The only measure with a decline was "Rating of Specialist" with a decline of 0.61%. All MCHPs' 2013 CAHPS measures rank higher than the NCQA national rates.

2013 CAHPS results with statewide improvement over 2012 CAHPS:

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

2013 CAHPS results with rates above the NCQA national results:

- 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

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.

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 an access rate based on the minimum distance a member would have to travel for services from each of several different provider types. These rates are calculated for each county the MCHPs serve, with a statewide target goal of 90%. The entire Managed Care population is used in the calculation for each MCHP.

- The CY2012 network analysis completed by the DIFP determined that all MCHPs exceeded the 90% standard. All MCHPs obtained an overall network score of 100% in all regions. This is an improvement over CY2011.
- All MCHPs achieved 100% in the PCP distance standard per State regulation 20 CSR 400-7.095(3)(A)1.B. This is an improvement over CY2011.
- 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 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 1.86 (Missouri Care) to 2.91 (HCUSA) per 1,000 members, with the most prevalent issues related to transportation. Member appeals range from .35 (Missouri Care) to .40 (HCUSA) per 1,000 members, with the most prevalent issue being service denials.

Fraud and Abuse

The MO HealthNet Managed Care Contract Compliance Unit (CCU), the Missouri Medicaid Audit and Compliance Unit (MMAC), and the Managed Care health plans meet on a quarterly basis to discuss trends, program vulnerabilities, initiatives, etc. related to the health plans' fraud and abuse programs. Suspected and specific fraud cases and investigations are discussed with the health plans during the individual quarterly meetings. Additionally, the purpose of the quarterly meetings is to provide technical assistance to the health plans to identify fraud/abuse, promote best practices in fraud and abuse, and improve program outcomes.

The primary responsibilities of the CCU are:

- Designs and implements the MO HealthNet Managed Care Fraud and Abuse Plan;
- Provides technical assistance to MO HealthNet Managed Care health plans to identify fraud/abuse, promote best practices in fraud and abuse, and improve program outcomes;
- Disseminates information, coordinate efforts and comply with reporting requirements;
- Performs audits and contract reviews to assess compliance with the MO HealthNet Managed Care contract;
- Performs detection activities as outlined in the MO HealthNet Managed Care Fraud and Abuse Plan to detect potential fraud and abuse;
- Send referrals to MMAC;
- Send referrals to the health plans; and
- Serves as the liaison between the health plans and MMAC.

The primary responsibilities of MMAC are:

- Monitoring utilization and program compliance by providers and recipients;
- Disseminating reports received from the MO HealthNet Division website regarding suspected fraud and abuse concerning MO HealthNet Managed Care health plans, providers, subcontractors, members, etc. to the MO HealthNet Managed Care Unit;
- Providing technical assistance, in collaboration with the State Medicaid Fraud Control Unit (MFCU), to the MO HealthNet Managed Care Unit;
- Conducting educational trainings for Managed Care Organizations (MCO) about the prevention, detection, reporting and investigation of fraud and abuse; and facilitate opportunities for sharing best practices; and
- Taking referrals from the MO HealthNet Managed Care Unit and make appropriate referrals to MFCU and the Department of Health and Human Services, Office of the Inspector General (HHS/OIG).

Performance Improvement Projects

The focus of the Performance Improvement Projects (PIPs) is to study the effectiveness of clinical and non-clinical interventions. These projects are designed to 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. Under the

Managed Care contract, each MCHP is required to have two active PIPs, one of which is clinical in nature and one which is non-clinical.

The External Quality Review Organization (EQRO) conducted an independent external evaluation of the MCHPs' PIPs. The EQRO validated two PIPs (one clinical and one non-clinical) for each MCHP that were underway during 2012. A total of 6 PIPs were validated. Eligible PIPs for validation were identified by the MCHPs, MHD, and the EQRO. The final selection of the PIPs for the 2012 validation process was made by the MHD in February 2013. The MHD directed the EQRO to validate the statewide PIP, Improving Oral Health.

PIPs identified for validation at each MCHP:

HealthCare USA

- Readmission Performance Improvement Project
- Improving Oral Health

Missouri Care

- Notification of Pregnancy Form Receipt Improvement
- Improving Oral Health

Home State Health Plan

- Comprehensive Diabetes Care
- Improving Oral Health

The MCHPs have made significant improvements in utilizing the PIP process since the EQRO measurement process began. In the past four years the MCHPs have met a large percentage of the steps required to preparing and presenting a PIP. Each step is evaluated based upon all information gathered in the review process. These steps are graded with the goal of reaching the target of complete and accurate information, which is coded "Met".

In 2009 the MCHPs only achieved an overall rating of 79.49%. The MCHP's continue to improve in presenting valid and reliable data and exhibit a commitment to the PIP process as a method of improving quality. The 2012 rating of 92.86%, including a new MCHP, indicates an emphasis on quality initiatives.

Detailed results can be found in the 2012 MO HealthNet Managed Care External Quality Review Report of Findings can be found at <http://dss.mo.gov/mhd/mc/pdf/2012-external-quality-review-report-mohealthnet-managed-care.pdf>

Behavioral Health Reviews Conducted by Mercer Government Human Services Consulting (Mercer), MO HealthNet Division, and the Department of Mental Health Staff

Since 2008, the MHD has focused on clinical performance reviews of the Behavioral Health Organizations for the MCHPs. The 2008 review was conducted through a contract with Mercer (part of Mercer Health & Benefits LLC) for four of the MCHPs. Staff from MHD and the Department of Mental Health (DMH) conducted the behavioral health operations review for the two remaining MCHPs in 2009, and for all MCHPs beginning in 2010. The focus of the behavioral health reviews is 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.

The 2012 behavioral health case management record review findings continue to lack sufficient evidence of documentation to support MCHP active engagement in case management of their members.

All MCHPs continue to have some opportunity for improvement in the following areas;

- Coordinating the members' care with community resources;
- Providing access to inpatient diversion services (alternative services to inpatient care);
- Assisting participants with accessing providers;
- Providing comprehensive outreach strategies to assist participants prior to the occurrence of an emergency;
- Integrating behavioral/medical health;
- Providing an array and intensity of services to maintain community tenure;
- Reviewing treatment plans with providers to include addressing not only symptom reduction but members' functioning, quality of life, cultural factors, strengths, and symptom-free periods;
- Developing objective and measurable treatment goals;
- Developing recovery and resilience principles with member rather than focusing primarily on symptom severity;
- Assuring discharge planning begins at admission; and
- Improving the consistency of the application of Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS).

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 MHD Quality Assessment and Improvement (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 by MO HealthNet Managed Care Health Plans (MCHPs) and their contractors to participants of MO HealthNet Managed Care services. The CMS rules (42 CFR §433 and §438; Medicaid Program, External

Quality Review of Medicaid Managed Care Organizations) specify 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 State of Missouri contracts with the following MCHPs represented in this report:

- HealthCare USA (HCUSA)
- Home State Health Plan (Home State)
- Missouri Care (MO Care)

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

Mandatory EQR Activities

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 MHD.

Validating Performance Measures

The three performance measures validated were HEDIS 2012 measures of Annual Dental Visit (ADV), Childhood Immunization Status, Combo 3 (CIS3), and Follow Up After Hospitalization for Mental Illness (FUH).

NOTE: Because HEDIS 2012 data is actually calendar year 2011 data, the Performance Measures validation included in the report includes data from the six MCHPs that were under contract with the State of Missouri during calendar year 2011. The inclusion of all six MCHPs is necessary to present a statewide picture of HEDIS 2012. Those six MCHPs include:

- Blue Advantage Plus of Kansas City (BA+)
- Children’s Mercy Family Health Partners (CMFHP)
- Harmony Health Plan of Missouri (Harmony)
- HealthCare USA (HCUSA)
- Missouri Care (MO Care)
- Molina Healthcare (Molina)

MO HealthNet MCHP Compliance with Managed Care Regulations.

The EQRO conducted all protocol activities, with the exception of the MCHP Compliance with Managed Care Regulations Protocol. The MHD conducted these activities and requested the EQRO to review them (Compliance Review Analysis): and

Optional EQR Activity

Special Project – Case Management Record Review

The EQRO reviewed a random selection of Case Management files for each MCHP. These files were evaluated based on the requirements set forth in the MCHPs contract with the MHD to deliver MO HealthNet Managed Care services.

The 2012 MO HealthNet Managed Care External Quality Review Report of Findings can be found at <http://dss.mo.gov/mhd/mc/pdf/2012-external-quality-review-report-mohealthnet-managed-care.pdf>

Conclusion

The MO HealthNet MCHPs experienced a transition to a new contract in CY2012. Their Annual Evaluations reflect areas of changes, improvements and continued services in providing 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 continues to collaborate with the MCHPs in identifying areas for improvements as well as building upon the strengths shown in these annual evaluations. Each MCHP provided detailed analysis in their individual CY2012 Annual Evaluations. The Executive Summaries from each of these reports follow.

Note: Home State was not required to submit an Annual Evaluation for CY2012 because their contract with the State of Missouri was effective July 1, 2012.

**MO HealthNet Managed Care Health Plan Annual Quality Evaluation
Executive Summaries
CY2012**

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 2012 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 2011 to 2012 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 improvement in the 2012 NCQA annual ranking. The annual HEDIS and CAHPS scores affect this ranking. This report demonstrates what HealthCare USA has achieved since the last report in 2011, as well as what we are positioned to achieve in the coming year.

NCQA Ranking as of June 30, 2012

NCQA evaluated over 227 Medicaid health plans and ranked 115 of those based on clinical performance, member satisfaction and NCQA Accreditation. To be eligible for rankings, health plans must authorize public release of their performance information and submit enough data for statistically valid analysis. NCQA's Health Insurance Plan Rankings 2012-2013 used NCQA's established rankings methodology, which has been used and widely recognized since

2005. The NCQA Accreditation status in these rankings is as of June 30, 2012. The rankings are listed on the NCQA web site and are usually published in the U.S News and World Report.

HCUSA has been ranked 55 in the nation, which is a significant improvement from our 99 ranking last year. HCUSA ranked the highest among our competitors in Missouri. The items used in the ranking are rated using a 1-4 scale with one being the worst. To get a 4 the HEDIS rates had to be at least in the 75th percentile.

HCUSA scored a 4 in the following categories:

- Getting care quickly
- Timeliness of prenatal check-ups
- Cervical cancer screening
- Chlamydia screening
- Appropriate testing and care of children with pharyngitis

HCUSA opportunities for improvement (those that scored 1 or 2) included but are not limited to the following:

- Early Immunizations
- Adolescent Immunizations
- Breast cancer screening
- Testing for diabetics

It should be noted that HCUSA has recognized these opportunities and has interventions in place to address them. The interventions include Member Educational reminders utilizing several touch points that includes: reminder postcards, online reminder flags used by Customer Service to remind members of needed services while speaking with them on the telephone, member newsletters, community development events, wellness reminders, targeted letters for missing services, and provider education and outreach.

Missouri Care

Overview of the Quality Improvement Program

Missouri Care'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, 2012 was one of great innovation and success, with accompanying new challenges and opportunities. Missouri Care 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 improvement infrastructure.

In 2012, Missouri Care continued to have an effective quality improvement program. Missouri Care maintained its National Committee for Quality Assurance (NCQA) Accreditation, which expires September 6, 2014. Missouri Care's current NCQA Level of Accreditation is Commendable. Healthcare Effectiveness Data and Information Set (HEDIS) performance indicators continued to be closely monitored. These HEDIS measures included those required by NCQA as well as those required by the state of Missouri. This annual report describes performance in Effectiveness of Care, Access/Availability of Care, Use of Services, and Satisfaction with Experience of Care.

Missouri Care continued to enhance its quality improvement program and integration of quality across all Missouri Care departments. This integration of quality was enhanced by its NCQA Accreditation, which standards were maintained during 2012. Successful examples of quality integration throughout the health plan include continuous quality improvement activities, such as Asthma Medication Compliance, Access to Dental Services, ER Utilization, Diabetes Preventive Health Care Compliance, Follow-Up after Hospitalization for Mental Health, and Timely Post-Partum Care. In total, Missouri Care maintained 28 Process Improvement Plans (PIPs) and Quality Improvement Activities (QIAs). These initiatives represent the combined efforts of various departments, such as case managers (physical and behavioral health), quality management staff, provider relations staff, and member outreach representatives. The continued use of the Provider Preventive Care Toolkit, provider site visits, educational member and provider member newsletters, and interventions related to prevention, wellness and improving health care services are other examples of departments throughout the health plan working together to improve quality care and services for our members.

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 2012, internal and external committee members provided helpful insight and evaluation of our quality improvement program. The results of Missouri Care's quality improvement activities and committees' involvement can be seen throughout this report.