2002

Missouri MC+ Managed Care Program

External Quality Review

Report of Findings

AUTHORS:
Janet Reed, PhD, MHA
Vice President, BHC, Inc.,
Director, Performance Management Solutions Group

Jutta Hopkins, PhD, RN
Health Services Researcher
Performance Management Solutions Group

William Chase, MPPA, MSCIS
Senior Research Analyst/Data Manager
Performance Management Solutions Group

Table of Contents

List of Figures

List of Tables

Acknowledgements

Susan Eggen   **MC+ Operations Unit Manager**
Missouri Department of Social Services
Division of Medical Services

Randall Rust   **Medicaid Specialist, Contract Compliance**
Missouri Department of Social Services
Division of Medical Services

Garland Land   **Director, Community Information Management and Epidemiology**
Member of the Quality Assessment and Improvement (QA& I) Advisory Group
Department of Health and Senior Services

Wayne Schramm   **Project Specialist**
Missouri Department of Health and Senior Services
Bureau of Health Data Analysis

Rich Koon, Ph.D.   **Manager, Research Planning**
Missouri Department of Social Services
Division of Data Processing

Bonnie Washek   **Social Services Supervisor**
Missouri Department of Social Services
Division of Family Services

Gary Harbison   **Director, Outcomes Evaluation**
Missouri Department of Mental Health
Chairperson, MC+ QA & I Mental Health Advisory Subgroup

Paula Nickelson   **Deputy Director**
Division of Maternal Child Health
Missouri Department of Health and Senior Services
Chairperson, MC+QA & I Maternal and Child Health Advisory Subgroup 2002

Executive Summary

Purpose of External Quality Review Organization (EQRO)

The purpose of the External Quality Review (EQR) of Medicaid Managed Care is to provide an independent review of the quality of care provided by Managed Care organizations contracted with States to provide health care services to Medicaid recipients.

> *External quality review* means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid recipients.[1]

The Centers for Medicare and Medicaid Services in 42 CFR Parts 433 and 438; Medicaid Program, External Quality Review of Medicaid Managed Care organizations specify the requirements of States in implementing Medicaid Managed Care. The Final Rule and protocols describe the potential activities of an External Quality Review Organization and suggested approaches.[2] The following is an excerpt from the Final Rule for External Quality Review of Medicaid Managed Care organizations.

§ 438.358 Activities related to external quality review.
(a) *General rule.* The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.
(b) *Mandatory activities.* For each MCO and PIHP, the EQR must use information from the following activities:
> (1) Validation of performance improvement projects required by the State to comply with requirements set forth in § 438.240(b)(1) and that were underway during the preceding 12 months.
> (2) Validation of MCO or PIHP performance measures reported (as required by the State) or MCO or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in § 438.240(b)(2).
> (3) A review, conducted within the previous 3-year period, to determine the MCOs or PIHPs compliance with standards (except with respect to standards under §§ 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of § 438.204(g).
(c) *Optional activities.* The EQR may also use information derived during the preceding 12 months from the following optional activities:
> (1) Validation of encounter data reported by an MCO or PIHP.
> (2) Administration or validation of consumer or provider surveys of quality of care.
> (3) Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO.
> (4) Conduct of performance improvement projects in addition to those conducted by an MCO or PIHP and validated by an EQRO.
> (5) Conduct of studies on quality that focus on a particular aspect of clinical or non clinical services at a point in time.
(d) *Technical assistance.* The EQRO may, at the State's direction, provide technical guidance to groups of MCOs or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

§ 438.364 External quality review results.
(a) *Information that must be produced.* The State must ensure that the EQR produces at least the following information:
> (1) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. The report must also include the following for each activity conducted in accordance with § 438.358:
>> (i) Objectives.
>> (ii) Technical methods of data collection and analysis.
>> (iii) Description of data obtained.
>> (iv) Conclusions drawn from the data.
> (2) An assessment of each MCOs or PIHPs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients.
> (3) Recommendations for improving the quality of health care services furnished by each MCO or PIHP.
> (4) As the State determines methodologically appropriate, comparative information about all MCOs and PIHPs.
> (5) An assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
(b) *Availability of information.* The State must provide copies of the information specified in paragraph (a) of this section, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, recipient advocacy groups, and members of the general public. The State must make this information available in alternative formats for persons with sensory impairments, when requested.

BHC Qualifications

This is the second consecutive year Behavioral Health Concepts, Inc. (BHC) has served as the External Quality Review Organization for Missouri's MC+ Managed Care Program. BHC, Inc. is a full- service consulting firm (with corporate offices in Columbia, Missouri), providing direct services, program evaluation, and organizational consulting. The Performance Management Solutions Group (PMSG) is the quality improvement and program evaluation division of BHC that is responsible for the External Quality Review. BHC is certified by the Centers for Medicare and Medicaid Services (CMS) as a Peer- Review- Like (PRO- Like) Entity in all United States and territories. States receive 75% federal financial participation for using Peer Review Organizations (PRO) or PRO- Like entities to conduct the External Quality Review. BHC also meets the criteria of an External Quality Review Organization as defined in the Final Rule on External Quality Review Organizations for Medicaid Managed Care.

Qualifications of external quality review organizations (§ 438.354)
Ü *Competence.* The EQRO must have at a minimum the following:
    Staff with demonstrated experience and knowledge of—
      o   Medicaid recipients, policies, data systems, and processes;
      o   Managed Care delivery systems, organizations, and financing;
      o   Quality assessment and improvement methods; and
      o   Research design and methodology, including statistical analysis.
      o   Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.
      o   Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.
Ü *Independence.* The EQRO and its subcontractors are independent from the State Medicaid agency and from the MCOs or PIHPs that they review.

Introduction

The Executive Summary provides an outline of the Accomplishments, Promising Practices and Opportunities for Improvement for the Missouri MC+ Managed Care Program, based on the 2002 Calendar Year External Quality Review. In conducting the External Quality Review, primary and secondary data were collected through analysis of documents, interviews, medical records, and Managed Care Organization (MCO) site visits. Data sources included secondary analysis of provider network analysis reports (from the Missouri Department of Insurance), quarterly complaint and grievance data of members and providers (from the Division of Medical Services and MC+ MCOs), Maternal and Child Health Trend Indicators (vital statistics and hospital data from the Department of Health and Senior Services), primary data collection and analysis of medical records, documentation and data submitted to the EQRO by the Managed Care organizations (MCOs), site visits to each MCO, and interviews with State program management and administrative staff involved in the implementation of the MC+ Managed Care Program.

The Executive Summary is intended to provide a brief overview of the data, findings, and recommendations from in- depth analysis described in the full report and individual MCO reports (under separate cover; see Volume II). It is recommended that any program or policy decisions be based on the in- depth description of findings, processes, and interpretation of the data presented as well as other sources of data available to decision- makers. In all cases, attempts were made to use the most recent and valid data available at the time of the writing of this report.

In any evaluation, data sources present some limitations, so it is important for the reader to be aware of the strengths and limitations of each source. In some cases, provisional data were used to provide the most recent available information for decision-making and program improvement. Also, given the length of time between data collection and publication, it was not possible in many cases to provide comparison or benchmark data from calendar year 2002 on the State or National level. Finally, it will be important for the reader to understand the differences between <u>absolute</u> (the measure of performance relative to an established standard) and <u>relative</u> (the measure of an MCO or Region relative to past performance, or other health MCOs) differences. Many of the analyses constitute relative differences between MC+ Managed Care Regions (Central, Eastern, Western), groups (Medicaid and non-Medicaid), or time periods (since MC+ Managed Care began vs. the most recent data year available). Data sources referenced in the Executive Summary as well as their strengths and limitations are described in the Introduction and Background sections of the report. Protocols, glossary, and endnotes are provided in the Appendices.

Accomplishments and Promising Practices
State

Improved Monitoring of MCO Standards, Compliance, and Quality

∨ **The Division of Medical Services (DMS) continues to refine contractual arrangements with Managed Care organizations to improve the reporting, quality monitoring, and clinical performance of the Managed Care organizations. This includes the use of standard and well- recognized industry data sets such as The Health Employer Data Information Set (HEDIS), vital statistics, hospital discharge data, and consumer satisfaction data (Consumer Assessment of Health Plans; CAHPS).**

∨ **DMS quality improvement staff has developed a structure for MCO quality improvement studies, processes and data collection.**

∨ **DMS staff has responded to the new Managed Care regulations in a pro- active manner, ensuring re- contracting with MCOs in accordance with newly- issued federal regulations. A specific audit tool and process has been developed to provide a standard format for ensuring compliance across MCOs.**

∨ **DMS staff has assertively followed- up on compliance issues regarding the documentation of provider network filings and the monitoring of dental subcontractors.**

Increased Efficiencies in the Administration of Managed Healthcare Services

∨ **The DMS has undergone a strategic planning initiative to improve the efficiency of their system in implementing MC+ Managed Care and Fee- for- Service healthcare service administration and purchasing. Goals and strategies were developed and implemented to reduce paperwork and the duplication of effort for multiple purposes. This has been accomplished through increased electronic exchange of MCO documents, quality improvement data reporting, and frequent communications.**

∨ **Division of Family Services (DFS) staff has improved systems that update and maintain member addresses, making it easier for front- line DFS staff to update member addresses, thus reducing the rate of returned mail upon MCO enrollment.**

Improved Interagency Coordination with State/Community Agencies and MCOs

Significant strides have been made in interagency coordination at the State, county, and in some cases, local levels in integrating systems of care for health and mental health services for MC+ Managed Care Members. The following are examples of the progress that has been made and that has continued throughout 2002.

∨ **The Division of Medical Services has a longstanding collaborative relationship for service delivery and quality improvement with the Department of Health and Senior Services (DHSS) and the MCOs since the inception of MC+ Managed Care.**

∨   DMS has implemented a comprehensive collaborative process with DHSS that has resulted in providing MCOs and the EQRO downloads of immunization data. The State health laboratory now provides regular reporting to DMS of lead testing of all Medicaid children. This information is communicated to the MCO for linking with member data sets and care coordination.

∨   DMS has worked closely with DHSS to coordinate public healthcare services. DMS and DHSS staff has provided local public health agencies (LPHAs) with education on Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) services and billing for these services.

∨   DMS has maintained an open forum for collaboration and communication between MCOs and other State agencies (The Departments of Mental Health, and Health and Senior Services) through the Quality Assessment and Improvement Advisory Group (QA & I Advisory Group). MCO quality improvement staff reported that these meetings are a vital forum for their quality improvement initiatives, especially those that involve a great deal of interagency education and presentations on interventions with MC+ Managed Care members.

∨   The Maternal and Child Health (MCH) Subgroup has reviewed a number of MCH Indicators as well as best practices.

∨   DMS created an interagency taskforce that is implementing a new Prenatal Risk Assessment process. The process is being tested for Fee for Service recipients and managed care members. The form is a major component of an expanded assessment process to identify high risk pregnant members and recipients for entry into case management.

∨   The Mental Health Advisory Subgroup has developed and continues to collect data submitted by all MCOs and their behavioral health organization (BHO) contractors on indicators of mental health penetration, service use, and substance abuse treatment. The BHOs have worked collaboratively through this Subgroup to establish protocols for an Uniform Consent Form for the exchange of information for treatment across agencies; and the notification of C- STAR services. The group continues to work on protocols and education of court staff to promote appropriate court- ordered referrals for medical treatment.

∨   The Medical Directors' Subgroup, comprised of all MCO Medical Directors adopted the Fee- for- Service Synagis protocol, and revised the EPSDT forms.

∨   DMS staff has worked extensively with DFS staff in collaboration with the Mental Health Advisory Subgroup to facilitate coordination of behavioral health services through local family service offices, for children not in State custody, and for those whose mental health benefits are carved- out. This has led to the identification of providers who will see children under both MC+ Fee- for- Service and Managed Care payment mechanisms so as to provide continuity in care when child custody changes.

∨   DMS staff coordinated the transfer of data from the Women, Infants, and Children Program (WIC) regarding pregnant women to facilitate MCO identification. This activity has been a positive step in interagency coordination which facilitates the

management of care able to be conducted by the MCOs. It is anticipated that the rates of identification and the rates of pregnant women seen in the first trimester of pregnancy will improve as a result.

Carryover of Lessons Learned from MC+ Managed Care to Fee-for-Service MC+

There has been an increased focus on identifying, collecting, and monitoring data for process, outcomes, and quality improvement initiatives within the Fee- for- Service system. This is done through integration of responsibilities between quality services staff. This staff consisting of three (3) full time equivalents perform the quality function for the Managed Care and Fee- for- Service programs at DMS. Several protocols developed for MC+ Managed Care have been modified for application to the Fee- for- Service program (e.g., EPSDT form revisions, universal consent forms for mental health services, and standard prenatal risk protocols).

Improved Access to Care for MC+ Managed Care Members

Service use for children and MC+ Managed Care Members was examined through the use of the Maternal and Child Health (MCH) Trend Indicators, analysis of the administrative claims data for 2002, and examination of the aggregate Mental Health Indicators compiled by the Mental Health Advisory Subgroup.

∨   MCH Trend Indicator analysis found that there were statistically significant improvements in acute care service use for children in nearly all MC+ Managed Care Regions since the MC+ Managed Care Program began.

∨   Review of encounter claim data from previous external quality reviews found increases in service use as evidenced by the rates (per 1,000 members) of encounter claim submissions for all types of claims between CY1998 and CY2002.

∨   Review of the same data for the past year (CY2001 to CY2002) showed that the rate of each type of claim (per 1,000 members) leveled off or declined for all but pharmacy claims, which increased from 1,828 to 2,764 per 1,000 members. The use of prescriptions increased by 13% from CY2001 to CY2002.

∨   Encounter claim data showed that for all services, rates of services per recipient increased for all ages, from birth to 21 years, between CY2001 and CY2002. Those one year of age and under as well as those 15 years of age and older received more services on average.

∨   Encounter claim data showed that a full 35% of hospital admissions were for childbirth, either assigned to a newborn or delivery- related Diagnostic- Related Group (DRG).

∨   Between CY2000 and CY2001, Mental Health Indicator data showed increased outpatient mental health visits, decreased mental health inpatient admissions, increased rates of ambulatory follow- up after discharge from psychiatric hospitalization, and decreased substance abuse admissions.

V   **Based on Mental Health Indicators, improvements in total mental health penetration rates for all ages were observed statewide and in the Central and Western Regions between CY1999 and CY2001.**

V   **Missouri Department of Insurance (MDI) network filing reports indicated that network adequacy for PCPs, specialists, facilities, ancillary services, and the network as a whole were above threshold in all MC+ Managed Care Regions.**

V   **MC+ Managed Care Member complaint data analysis showed that the rate (per 1,000 members) of documentation of member medical and non-medical complaints increased from CY2001 to CY2002, indicating improved documentation of member concerns.**

V   **The rates of MC+ Managed Care Member transportation complaints increased, likely due to targeted efforts at addressing member transportation issues.**

Improved Quality and Effectiveness of Care Delivered

Quality and effectiveness of care were examined using MC+ Managed Care Member and Provider complaint data, and medical record review for EPSDT and prenatal services. Accomplishments in the quality of care for MC+ Managed Care Members were documented.

V   **Improved rates of EPSDT services based on medical record review findings included:**

   m   **The most frequently documented EPSDT components were interim histories (75%) and physical examinations (71.8%).**

   m   **Improved immunization rates (63.6% in CY2002).**

   m   **Improved blood lead level testing at 12- and 24-months of age (29.8% in CY2002), with the greatest improvement shown in the Eastern Region.**

V   **Improved rates of prenatal care based on MCH Trend Indicator data included:**

   m   **In CY2002, 80% of pregnant women in MC+ Managed Care initiated and obtained prenatal care during the first trimester.**

   m   **The rate of birth weight over 2,500 grams remained stable (89.0% in CY2002).**

   m   **Births to mothers less than 18 years of age declined slightly between CY2001 and CY2002 (7.6% to 7.0%, respectively).**

V   **There appeared to have been improvements in the documentation and delivery of EPSDT services. MCOs have improved participation ratios above 80% in specific age cells. The State has allowed MCOs to supplement the HCFA-416 data submitted from encounter claims with denied claims data. This has appeared to improve the ability to capture data regarding the documentation of care that is provided to MC+ Managed Care Members.**

V   **DMS and MCOs are continuing their work with DHSS on lead screening and findings of high lead levels in children. DMS staff has created a five-page flow chart that details the frequency and exchange of data between DMS, DHSS, and MCOs regarding lead screening results. DMS created an interagency taskforce that had extensive interagency planning sessions to design a data flow system so that MCOs,**

DHSS, and DMS systems all captured the same information on member lead toxicity screening and results. The data flow chart process was implemented January 1, 2003.

∨ DMS staff identified that WIC offices were conducting lead testing. The DMS taskforce collected information regarding this process and provided recommendations to DHSS. DHSS identified best practices for WIC offices to spotlight their performance. DHSS documented the process and communicated recommendations for change to all the WIC clinics to integrate lead reporting into their processes. Currently, the lead testing information flows into DHSS and is reported to DMS.

∨ DMS staff has consistently worked to improve monitoring and oversight processes. [These activities have resulted in significant progress.] The type and nature of the monitoring and administration of health care services at the State level has improved with DMS leadership, through the State Department of Social Services (Divisions of Medical and Family Services), Mental Health (Division of Comprehensive Psychiatric Services), and Health and Senior Services (Division of Maternal and Child Health, and the Community Health Information and Epidemiology Division). The system as a whole has clearly moved beyond the implementation stage of serving MC+ Managed Care Members to having impacted service use through collaborative monitoring and continuous quality improvement activities with MCOs and other State agencies. Given the declining budget and the need to retain MC+ MCOs and Providers, it will be important to continue to minimize administrative burden, paperwork, and reporting requirements for State staff and MCOs in favor of focusing on quality improvement mechanisms.

Managed Care Organizations (MCOs)

Compliance with Standards and Operations

∨ All MCOs had approved Fraud and Abuse compliance plans and were prepared to be HIPAA compliant with HIPAA Privacy Rules as of April 13, 2003.

∨ MCOs are increasingly incorporating flow-through language with subcontractors to ensure that State standards are met, conducting routine oversight, implementing corrective action plans, passing on incentives and reducing payments for below threshold performance on indicators, and re-contracting for services as necessary.

∨ MCOs have worked to improve the ability to reach and screen members at the time of enrollment. A longstanding issue has been the adequacy of member contact information and the mobility of the population, with MCOs receiving large quantities of returned mail upon mailing of member information packets. Over the past several years, almost all MCOs have developed data systems that are not overwritten by routine State administrative data transfers. This allows them to keep up-to-date contact information on members.

∨ Claims processing has been a focus of many MCO efforts, with increased encouragement of providers to submit claims electronically so as to better automate

the adjudication and review process as well as improve timely payment. A range of 40- 85% of providers in MCOs were reported to be filing electronically.

∨ MCOs are using nationally- recognized criteria for credentialing and re- credentialing providers as well as auditing of delegated credentialing (National Committee on Quality Assurance, NCQA; Utilization Review Accreditation Committee, URAC).

∨ Oversight of providers and vendors has improved. MCOs are meeting regularly with each vendor and monitoring performance through specific performance measures. This has been instituted in the past with behavioral health vendors and is increasingly being implemented for dental and transportation vendors.

∨ MCOs are increasingly conducting formal auditing of behavioral health organizations' operations and structures in accordance with NCQA Quality Improvement Standards for clinical care programs, disease management programs, data and information and management, provider network adequacy, quality improvement committees, and quality improvement projects. This resulted in clear Performance Improvement Plans (PIPs).

Improved Access to Care for MC+ Managed Care Members

∨ There have been reports of improved relations between the MCOs and the Eastern Region Ombudsman office by two of the three Eastern Region MCOs.

∨ Several MCOs are actively seeking input into their processes from members, incorporating comprehensive screening and member education into new member welcome calls, and implementing innovative outreach to hard- to- reach members.

∨ Provider network adequacy has increased, with little provider turnover/attrition, and MCOs are increasingly working with providers face- to- face.

∨ MCOs are working with providers on increasing EPSDT rates by implementing Fee- for- Service payment, paying rates higher than Fee- for- Service MC+ rates, reviewing EPSDT as a routine part of any quality reviews, providing performance incentives, and educating them about the need for well- child visits at six years of age.

∨ The completion of immunization rates has been addressed through capture of data from State public health databases, mailing of lists of immunizations to caregivers for feedback and updates, and notifying caregivers of when siblings are due for immunizations or EPSDT visits.

∨ MCOs have worked on educating providers about behavioral health issues and purchasing blocks of time from behavioral health providers in advance to ensure access to MC+ Managed Care Members. They have also conducted member education through the development of brochures and specific mailings to members.

∨ MCOs continue to work on identifying the medical needs of Children with Special Health Care Needs (CSHCN), and those in need of case management for lead toxicity.

V   **MCOs are increasingly identifying pregnant women for prenatal and preventive services as well as the identification of risk factors.**

Improved Effectiveness and Quality of Care

MCOs are increasingly developing mechanisms for monitoring the delivery as well as the outcomes of care provided to MC+ Managed Care Members, to improve the processes and outcomes of care.

V   **The Medical Directors Subgroup of the QA & I Advisory Group has implemented the State mandated EPSDT standard form statewide. This will likely provide consistent messages to providers in the State who serve MC+ Managed Care Members. This format has also been adopted by some schools for their physical examinations, and is being introduced to the Missouri Athletic Association for use with sports physical examinations for adolescents. This uniform reporting and documentation tool is likely to lessen the confusion of the provider who sees patients from multiple MC+ Managed Care and commercial MCOs. There have also been anecdotal reports of providers adopting this form across their practice. The more that primary care provider administrative tasks are simplified, the more likely that care will be better documented, consistently provided, and improved over time.**

V   **MCOs are in the formative stages of developing culturally competent healthcare delivery practices. A number of MCOs demonstrate some innovative and promising approaches to the identification and treatment of member needs.**

Opportunities for Improvement
State

ü   **Given the complexity of public health services, it is critical that the State continue to support the established infrastructure of State agency coordination and MCO quality improvement groups and initiatives. These processes have resulted in better coordination among public health and MC+ Managed Care Program service delivery and quality improvement statewide.**

ü   **Inpatient mental health admission rates have increased, with speculation that it is related to MCOs reporting that behavioral health organization crisis teams are not allowed into hospital emergency rooms, perhaps related to Emergency Medical Treatment and Active Labor Act (EMTALA) provisions. It is possible that some admissions are preventable. Related questions include: 1) Are there pre- authorization requirements? 2) Are they using prudent layperson criteria? 3) Are the admissions appropriate? 4) Are these primarily children in DFS custody?**

ü   **There are several substantial limitations to using administrative data and monitoring data as proxies for assessing the quality and outcomes of care (e.g., based on claims, time lag in data, sensitivity to measures over time, day- specific eligibility and sampling issues, etc.). It is recommended that DMS, in collaboration with MCOs, continue to develop methods and mechanisms to supplement standard reporting of administrative/claims data to assess the quality and completeness of care provided to MC+ Managed Care Members.**

ü   **MCOs uniformly report that it is difficult to identify MC+ Managed Care Members on special needs files and enrollment files for specific special needs, and that the ability to coordinate with the caseworkers of children in foster care has been problematic. It is recommended that DMS continue to work with DFS staff to obtain additional identifying information on members so as to facilitate MCO screening of pregnant members and those with special health care needs.**

ü   **After transportation complaints, a large proportion of MC+ Managed Care Member complaints reported across all MC+ Managed Care Regions were due to the denial of services. This was particularly noted in the Eastern and Western Regions, and should be further explored for quality improvement projects. Adding the provider specialty to the reporting process would facilitate identification of specific services being denied.**

ü   **Similarly, a large proportion of MC+ Managed Care provider complaints reported were due to the denial of claims as well as complaints regarding the State or MCO. Also, the rate of provider medical complaints declined. Given the desire to have high rates of complaints to provide feedback for improvement, it is recommended that efforts be directed at capturing these complaints, and further exploring the complaints for denial of claims. Provider education could be directed at some of the most common complaints, or uncovered services that are denied.**

ü   **It is recommended that in addition to tracking and monitoring the utilization of services (EPSDT, lead testing, well- child and prenatal care), that MCOs be required to document the initiation, completion, and findings of two studies each year. If a study is ongoing or the MCO desires to continue the same study the following year, a summary and interpretation of findings as well as the refinements to the study in the subsequent year(s) should be documented. This will be the focus of ongoing EQR and State monitoring activities, consistent with the federally- mandated quality improvement protocols.**

Managed Care Organizations

ü   **Although it is not always possible for MCOs with commercial products to separate non- clinical service indicators by product line, clinical quality improvement studies should always clearly separate MC+ Managed Care Members in sampling analytic procedures and reporting.**

ü   **Although low compared to transportation and denial of services complaints, the rate of MC+ Managed Care Member complaints regarding the ability to obtain an appointment with a provider increased from .23 to .31 per 1,000 members between CY2001 and CY2002. This was the second most frequent access complaints after transportation. This is an area for MCOs to monitor across providers. This, along with specific areas of below- threshold network adequacy should be monitored closely to ensure that members are able to access needed care either through providers at a greater distance, or through out- of- network providers. The denial of services complaints, reasons, and provider types should also be monitored as well.**

ü   **It is recommended that providers be kept informed of MCO Performance Improvement Projects including the formulation of projects, goals, baseline and on- going assessment, results, etc., since they can directly impact the success or failure of a project. Mental Health Network's (MHNET) reporting of medical record review components and aggregate rates in the provider newsletter of performance is one method of communicating to providers how their performance is being measured to help them improve their documentation.**

ü   **One finding of the medical record review was that the EPSDT forms were not being completely filled out by providers. Although services were likely rendered, the documentation on the form did not reflect this. This was particularly true with dental screens, possibly due to providers interpreting this item as a requirement for a dental exam rather than observations of teething, general dentition, etc.**

ü   **There continues to be a need for emphasis on lead screening and testing with MC+ Managed Care providers and members. Providers are using Lead Risk Assessment forms. Provider representatives could provide updated ones and collect the old ones as they visit offices. MCOs should consider alternatives to venipuncture for lead testing and the availability and use of combination vaccines to improve completed vaccination rates. MCOs should encourage providers to prepare for immunizations and lead testing at the time of the EPSDT visit to minimize missed opportunities due to transportation or other access problems. Administration of immunizations and lead testing on siblings could also be done at the same time.**

ü   MCOs should encourage providers to conduct EPSDT at the time of acute care visits. There was little documentation of EPSDT services in the medical record at the time of acute care visits.

ü   MCOs report that providers are confused about the changes in the mandatory EPSDT forms. One recommendation for provider representatives is that they frequently check the stock of forms being used by providers to ensure that the most recent forms are being used. Given that representatives from several MCOs may be visiting the same offices and the forms (e.g., prenatal risk, EPSDT, and lead risk assessment) are standard across all MCOs, this would provide frequent education of provider office staff (who may have turnover) as well. MCOs should continually educate providers and their staff about the nature of the components of the EPSDT forms and the importance of completion.

ü   The Pregnancy Risk Assessment Form return rates to MCOs are low. For the pregnancy case management process, other primary care access issues should be addressed, including pregnant women's access to dental care, lead testing and follow- up, and smoking cessation. MCOs could develop incentives (e.g., public recognition in newsletters) for providers for the achievement of a pre- established return rate of prenatal notification and risk identification forms.

ü   Consistent with national trends, the rate of low birth weight has remained essentially unchanged since 1997; and the rate of Cesarean section deliveries increased from CY1997 to CY2002.

ü   Smoking during pregnancy was noted on medical record review to have higher rates than previous EQR findings. Further, there was limited documentation in MC+ Managed Care Member records of consultation regarding smoking cessation efforts and patient education regarding smoking during pregnancy. The improvement of provider intervention and documentation of efforts to intervene with members who are smoking during pregnancy should be a priority.

ü   Medical record review findings also indicated a high rate of documentation of emotional and behavioral risks among pregnant women (e.g., chronic or recent mental illness, risk of drug dependence or misuse, having a partner with a history of violence, and risk of physical or emotional abuse/neglect). Continued provider education through provider representatives and behavioral health vendors about the availability and methods for MC+ Managed Care Members to access services is a recommended priority. The domestic violence initiatives in place are a strong effort in this direction, and should be adopted across all MC+ MCOs.

ü   Other prenatal risk factors identified during the medical record review include infections, preterm labor, hypertension, and anemia. MCOs should monitor these conditions and their treatment, especially as there was little information in medical records about the type of infections.

ü   **Given the increased rates of emergency room utilization for primary care and mental health care in 2002, it is recommended that MCOs continue to foster the establishment of urgent care clinics as well as access to mental health services at the clinics to reduce the rate of unnecessary or avoidable hospitalizations.**

ü   **If they are not already doing so, MCOs should collaborate and use MOHSAIC and STELLAR data; develop methods of identifying members on the State diskette as being in need of case management; and implement coordination of care with LPHAs and WIC clinics.**

Based on the common projects conducted by MCOs and the findings of this EQR, there are a number of Performance Improvement Projects that could be implemented statewide and would be relevant to all MCOs. These are described in the final sections of the report.

Introduction and Background

Purpose of External Quality Review Organization (EQRO)

The purpose of the External Quality Review (EQR) of Medicaid Managed Care is to provide an independent review of the quality of care provided by Managed Care organizations contracted with States to provide health care services to Medicaid recipients.

External quality review means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid recipients.[3]

The Centers for Medicare and Medicaid Services, 42 CFR Parts 433 and 438; Medicaid Program, External Quality Review of Medicaid Managed Care organizations specify the requirements of States in implementing Medicaid Managed Care. The Final Rule and protocols describe the potential activities of an External Quality Review Organization and suggested approaches.[4] The following is an excerpt from the Final Rule for External Quality Review of Medicaid Managed Care organizations.

§ 438.358 Activities related to external quality review.
(a) *General rule.* The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.
(b) *Mandatory activities.* For each MCO and PIHP, the EQR must use information from the following activities:
　　(1) Validation of performance improvement projects required by the State to comply with requirements set forth in § 438.240(b)(1) and that were underway during the preceding 12 months.
　　(2) Validation of MCO or PIHP performance measures reported (as required by the State) or MCO or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in § 438.240(b)(2).
　　(3) A review, conducted within the previous 3-year period, to determine the MCOs or PIHPs compliance with standards (except with respect to standards under §§ 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of § 438.204(g).
(c) *Optional activities.* The EQR may also use information derived during the preceding 12 months from the following optional activities:
　　(1) Validation of encounter data reported by an MCO or PIHP.
　　(2) Administration or validation of consumer or provider surveys of quality of care.
　　(3) Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO.
　　(4) Conduct of performance improvement projects in addition to those conducted by an MCO or PIHP and validated by an EQRO.
　　(5) Conduct of studies on quality that focus on a particular aspect of clinical or non clinical services at a point in time.
(d) *Technical assistance.* The EQRO may, at the State's direction, provide technical guidance to groups of MCOs or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

§ 438.364 External quality review results.
(a) *Information that must be produced.* The State must ensure that the EQR produces at least the following information:
　　(1) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. The report must also include the following for each activity conducted in accordance with § 438.358:
　　　　(i) Objectives.
　　　　(ii) Technical methods of data collection and analysis.
　　　　(iii) Description of data obtained.
　　　　(iv) Conclusions drawn from the data.
　　(2) An assessment of each MCOs or PIHPs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients.
　　(3) Recommendations for improving the quality of health care services furnished by each MCO or PIHP.
　　(4) As the State determines methodologically appropriate, comparative information about all MCOs and PIHPs.
　　(5) An assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

(b) *Availability of information.* The State must provide copies of the information specified in paragraph (a) of this section, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, recipient advocacy groups, and members of the general public. The State must make this information available in alternative formats for persons with sensory impairments, when requested.

BHC Qualifications

This is the second consecutive year Behavioral Health Concepts, Inc. (BHC) has served as the External Quality Review Organization for Missouri's MC+ Managed Care Program. BHC, Inc. is a full-service consulting firm providing direct services, program evaluation, and organizational consulting, with corporate offices in Columbia, Missouri. The Performance Management Solutions Group (PMSG) is the quality improvement and program evaluation division of BHC that is responsible for the External Quality Review. BHC is certified by the Centers for Medicare and Medicaid Services (CMS) as a Peer-Review-Like (PRO-Like) Entity in all United States and territories. States receive 75% federal financial participation for using Peer Review Organizations (PRO) or PRO-Like entities to conduct the External Quality Review.

As a PRO-Like entity contracted with the State of Missouri to conduct the External Quality Review, BHC qualifies as a Health Oversight Entity under the Health Insurance Portability and Accountability Act (HIPAA), which became effective April 14, 2003. The Health Oversight Entity designation permits disclosures of Protected Health Information (PHI) from Covered Entities for the purpose of oversight of the health care system; and for entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards.

BHC meets the criteria of an External Quality Review Organization as defined in the Final Rule on External Quality Review Organizations for Medicaid Managed Care.

Qualifications of external quality review organizations (§ 438.354)
ü *Competence.* The EQRO must have at a minimum the following:
   Staff with demonstrated experience and knowledge of—
      o   Medicaid recipients, policies, data systems, and processes;
      o   Managed Care delivery systems, organizations, and financing;
      o   Quality assessment and improvement methods; and
      o   Research design and methodology, including statistical analysis.
      o   Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.
      o   Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.
ü *Independence.* The EQRO and its subcontractors are independent from the State Medicaid agency and from the MCOs or PIHPs that they review.

Sources of Data

Provider Network Adequacy

Provider network adequacy rates were examined for calendar years 2001 and 2002, based on network filings of MCOs to the Missouri Department of Insurance as of December 31 of the previous year. This is the same process used for commercial and Medicare Managed Care Organizations (MCOs) in the State of Missouri. Managed Care Organizations made a number of improvements throughout the year of 2002, which are not necessarily reflected in the filings submitted as of December 31, 2001. The data reflect an individual MCOs capability to serve the <u>entire</u> MC+ Managed Care population in the respective regions of operation. Although detailed in the provider network adequacy filings, the data presented do not reflect county-level access standards and availability of specific providers or provider shortages in specific regions. Finally, the data alone do not provide an understanding of the <u>reasons</u> for which network adequacy may have changed, which were gleaned from site visits and document reviews. Additional detail is provided in individual MCO reports.

Mental Health and Substance Abuse Treatment Access and Utilization

In CY2000, the Mental Health Advisory Subgroup of the MC+ Quality Assessment and Improvement Advisory Group (QA & I Advisory Group) began compiling data for a number of Mental Health Indicators for members served by MCOs and their behavioral health vendors (see Appendix A for the protocol). Data from CY1999 to CY2001 were available for the present review and are summarized for all MC+ MCO Members statewide and regionally. Performance indicators were calculated and submitted for compilation by the Mental Health Subgroup Chairperson. For the present report, the aggregate indicator data were averaged for each MC+ Managed Care Region. Although aggregating the data in this way is not a scientifically sound methodology, it does provide some information for examining patterns of utilization across regions. The statewide indicator figures were calculated from raw data, and in some instances are not consistent with the average of the regions. The statewide figure is the more precise metric against which individual MCO or regional figures can be compared.

Because of the State-to-State variation in the administration of mental health benefits under Medicaid Managed Care, it is difficult to identify direct comparison figures or benchmarks for utilization measures among Medicaid Managed Care recipients in other states. It should also be noted that the figures presented do not take into account variations in provider availability, local practice patterns, or differential member characteristics related to need and utilization.

Member Complaint and Grievance Data

Member and provider complaint and grievance data are presented for CY2001 and CY2002, based on the total of the quarterly submissions of MCOs to the Division of Medical Service's (DMS) Quality Management Program. Data for CY2001 were provisional last year, but are final at this time. Figures for CY2002 are provisional. The data reflect the MCOs logging and recording of complaints from providers and members throughout the year. They are categorized into medical and non-medical complaints and further divided into specific types of medical and non-medical complaints.

For purposes of the present evaluation, complaints were examined with regard to access and quality of care. The number of complaints was converted into a rate per 1,000 members to provide a standard metric for a comparison across regions and from CY2001 to CY2002.

Maternal and Child Health (MCH) Indicators and Trends

The Maternal and Child Health Indicators and Trends Report is compiled quarterly by the Department of Health and Senior Services, Community Health Information Management and Epidemiology Division (DHSS, CHIME). Aggregate data from Medicaid baseline (1995, the first year for which a full set of data were available) to the present were available for a number of maternal and child health indicators, compiled from publicly reported vital health statistics and hospital discharge data sets. Data for CY2002 are provisional and are estimated to be 99% complete as of March 26, 2003.[5] BHC, Inc. calculated an odds ratio[6] to determine the significance of change since the MC+ Managed Care Program began (CY1997 for all MC+ Managed Care Regions) on Medicaid and non-Medicaid groups for a number of child and maternal health indicators. This examined changes from the Baseline MC+ Managed Care Year (CY1997, when all regions were implemented) to the most recent data year available (CY2001 or CY2002). The odds ratio tests whether there are significant increases or decreases in rates <u>within</u> groups since MC+ Managed Care began. The percent change in rates was also calculated for the Medicaid and non-Medicaid groups. Odds ratios that were significant at the .05 level (95% Confidence Interval; CI) and the Lower and Upper Confidence Limits are reported (Lower Confidence Limit=LCL; Upper Confidence Limit=UCL). If the 95% confidence interval (CI) contains the value of 1, then the odds ratio is <u>not</u> statistically significant (n.s.).

Medical Record Review

BHC, Inc. conducted a medical record review of MC+ Managed Care records to supplement information obtained from other data sources. Two major topics, Healthy Children and Youth Program/Early, Periodic, Screening, Diagnosis and Treatment (HCY/EPSDT) and prenatal care, were explored. Registered Nurses experienced in maternal-child care, quality improvement, and medical record abstraction were engaged by Sneed, Inc., a Minority-owned Business Enterprise (MBE), certified by the State of Missouri to conduct the medical record review.

Cases for review were selected by BHC using MCO enrollment and encounter claim data for MC+ Managed Care Members. Specific selection criteria are described in the EPSDT and prenatal sections of this report. A total of 2,003 medical records, with 2,400 components (when seen by more than one provider) were requested from 1,302 providers. The medical record sample included a 100% oversample based on historically low response rates. Most (75%) of the requested medical records were identified as being held with one provider; and 15% required requests from two providers. The maximum number of providers contributing to one individual was nine. The medical records were reviewed at BHC offices in Columbia, MO. A $12 payment per medical record was paid to those providers who submitted requested medical records (or components). Providers were allowed one month to submit medical records. MCOs were actively involved in the medical request process and contributed to the EQRO obtaining 124% of the required number of records.

Standard abstraction protocols were developed to provide the nurse reviewers with instructions for completing medical record reviews in a consistent and complete manner (Appendix B and C). Training regarding specific elements of EPSDT and prenatal care was carried out over a 4-day period followed by Interrater Reliability (IRR) testing. Quality was monitored throughout the abstraction and data entry processes and inconsistencies identified during the monitoring process were corrected.

All personally-identifiable information was treated as privileged and confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA), and abstracted information was entered into customized databases via a Teleform® scanning system for analysis and secure storage. Software used for data analyses included Microsoft Access and Excel; and the Statistical Package for the Social Sciences (SPSS®), v. 11.5.

The CY2002 medical record review appears to have been more successful than in the previous year, primarily due to the improved response rate and the completeness of the medical records. However, as in previous years, major limitations in the medical record review data source should be considered. Specifically, these limitations are: (1) medical records received may not be complete for the entire course of care, possibly due to multiple providers; (2) non-submission of medical records by selected providers (which could result in a provider-related bias); and (3) the absence of care management records which may contain additional information. This limits the ability to make direct MCO-to-MCO comparisons.

Site Visits

On-site visits were conducted at each MCO during the months of February and March, 2003. The Project Director, Medicaid Consultant, and Quality Improvement Consultant conducted all document reviews and site visits. Prior to site visits, MCOs were asked to submit a number of documents and complete a pre-site visit protocol (see Appendix D) to facilitate review of compliance with standards and operations. Information from these interviews was used to supplement data and to document and review MCO healthcare delivery practices. Improvements in the evaluation process this year included a higher response rate and yield of medical records for review, the addition of longitudinal data and analysis of performance indices, and the focus on improvement in health care for MC+ Managed Care Members in each MC+ Managed Care Region of the State (Eastern, Central, and Western). It is anticipated that this will contribute to the ability of MCOs, program planners, and other stakeholders to identify common accomplishments and opportunities for improvement on a regional and statewide basis. Individual reports for each MCO are provided under separate cover. These reports address the strengths, weaknesses, and opportunities for improvement for each MCO.

Organization of Report

The present report is organized to emphasize the systemic nature of the MC+ Managed Care Program, first describing policy and program changes over the past year, with progressively more detail about the healthcare delivery environment and characteristics of members. Second, findings examine service use, access, and the quality and effectiveness of care. Third, program accomplishments, promising practices, barriers, and opportunities for improvement are discussed. Protocols, a glossary, and endnotes are provided in the Appendices.

Description of the MC+ Managed Care Program

During 2002, the MC+ Managed Care Program has undergone a number of changes in the areas of policy, recipient benefits and eligibility, interagency coordination, administrative simplification, and interaction with Fee-for-Service delivery mechanisms. The next section summarizes these changes. The second section describes changes in quality improvement and monitoring. The third section describes the MCOs, and the fourth section provides descriptive data about MC+ Managed Care Members. All of these levels of programming and service delivery overlap and interact with one another, contributing to the health status of MC+ Managed Care Members.

Program Changes[7]

Policy

Impending federal healthcare legislation which impacted the administration of the Medicaid Managed Care program resulted in the MCOs and the State agency preparing for changes in 2002. The Medicaid Managed Care regulations were revised and finalized on August 13, 2002, with an August 13, 2003 implementation date; and HIPAA was finalized with implementation of the Privacy Rule on April 14, 2003. Changes relative to the Medicaid Managed Care rule were incorporated into contracts with MCOs in the Eastern and Central Regions in February, 2003; and will be incorporated into the Western Region MCO contracts by the compliance deadline of August, 2003. Changes from a complaint and grievance process to a grievance and appeal process were implemented January 2003 for the August 2003 implementation deadline as well. The Security Rule for HIPAA was finalized in 2003, with implementation in October, 2003. Although plans are in place to ensure compliance by DMS, the State financing situation prohibits an entire re-engineering of the data management system for HIPAA. Instead, the State has developed a translator to convert data for transactions.

Benefits and Eligibility

One of the most significant challenges faced by the State during calendar year 2002 was the budgetary crisis that has impacted State budgets and Medicaid programs nationwide. As with many other states, Missouri Medicaid officials have been faced with difficult choices for managing the Medicaid program within budgetary constraints. During the 2002 calendar year (effective July 1, 2002), several changes were made:

- **Dental Benefits for Adults.** Coverage for dental care of adults, 21 years of age and older, was reduced temporarily July 1, 2002. Benefits were restored under court injunction as of August 21, 2002 stopping the Department of Social Services from reducing Medicaid dental services for adults.

- **Eyeglasses for adults.** This benefit, with the exception of one pair following cataract surgery, was eliminated temporarily for adults, on July 1, 2002, but was restored on February 24, 2003.

- **Male circumcision.** This benefit was eliminated, unless medically necessary.

- **Eligibility for Adults.** Effective July 1, 2002, eligibility for the uninsured parent groups of noncustodial parents and Parent's Fair Share was eliminated. Eligibility for the uninsured parent group, Extended Transitional Medical Assistance, moved from two years of additional coverage to one year of additional coverage and eligibles must maintain income below 100% of the FPL versus 30% of the FPL. The uninsured parent group, Women's Health Services moved from two years of coverage to one year of coverage for these services. Eligibility for Adult Medicaid coverage under §1931 moved from 100% of the federal poverty level (FPL) to 77% of the FPL.

- **Non-Prescription Drugs.** The MC+ Program discontinued coverage for over-the-counter (OTC) medications, as of July 1, 2002. Coverage for all non-prescription drugs was eliminated except for insulin and those medications that are covered through the Medicaid exceptions process. It is anticipated that MCOs will continue to cover this benefit for their members as a preventive and cost management measure, using prior authorization procedures and formularies.

- **Outpatient Hospital-Based Services.** Hospital outpatient services were capped by the MCOs at a dollar amount no greater than the inpatient per diem.

Quality Improvement and Assessment

State Monitoring of MCOs[8]

DMS Quality Management staff consists of three full-time positions for MC+ Managed Care and Fee-for-Service quality improvement and monitoring activities. Staff works closely with one another and with the MCOs to ensure the development and implementation of quality improvement projects and studies in accordance with State and federal requirements. Staff is involved with the identification of needs across State agencies and participates in efforts to better coordinate services for recipients. This integration of Managed Care and Fee-for-Service Medicaid quality management has likely contributed to much of the positive carryover of practices and effective coordination of resources to all Medicaid recipients. This has been a part of a concerted effort on behalf of DMS management staff. State reviews are increasingly focused on outcomes and less on processes of health care delivery by MCOs, indicating maturation of the program from an implementation to a quality improvement focus.

DMS Quality Assessment staff also coordinate the QA & I Advisory Group and Subgroups, conduct site visits, monitor complaints and grievances, monitor fraud and abuse, and approve MCO quality improvement projects. For 2001, follow-up site visits were conducted in October 2002. Quality Management staff followed up on outstanding issues with full-day site visits. Credentialing and case management reviews were conducted on-site as well. As part of the on-going monitoring, DMS approves the MCO work plans for the upcoming year. There were a number of initiatives implemented by DMS quality management staff and activities conducted by the QA & I Advisory Subgroups.

Interagency Coordination

The MC+ Managed Care Program has a long history of involvement from a number of State agencies through the QA & I Advisory Group and its associated subgroups since the inception of the program in 1995.

This collaboration has continued to grow and mature. The following is a summary of some examples of interagency coordination (led by DMS quality management staff) with State agencies.

This is a process of continuous quality improvement at the State agency level, with input and feedback from the MCOs. The following is a summary of the interagency linkages and sample activities that DMS staff have initiated to improve the quality of care delivered to MC+ Managed Care Members.

Department of Mental Health (DMH).

DMS staff has spearheaded collaborative efforts with the Department of Mental Health (DMH) and providers have revised the Comprehensive Psychiatric Services (CPS) protocol to be consistent between Managed Care and Fee-for-Service recipients. Education on the CPS protocol for wraparound services for Managed Care members and services, was conducted for DMH administrative agents and with MCO representatives. DMH, with the assistance of DMS, continues to educate C-STAR providers regarding communication with MCOs resulting in an increase in communication with each education session.

Department of Health and Senior Services (DHSS).

DMS quality management staff has formed taskforces to collaborate with DHSS staff to improve coordination and care delivery. This involved facilitation of care coordination between MCOs and LPHAs, and WIC clinics through data exchange and quality improvement data monitoring and participation in the QA & I Advisory Subgroups. Public health data collected by DHSS are used by DMS to set benchmarks for health care improvement. DHSS reported good interaction with DMS in regard to suggestions for the Consumer Guide produced by DHSS. The DHSS awarded performance-based contracts to LPHAs which supported the efforts for documentation and billing for services provided to MC+ Members by public health providers. Billing by LPHAs will assist the Managed Care MCOs with gathering the necessary data to assess utilization of services. Previous work by the DMS Interagency taskforce and provided at the Maternal and Child Health (MCH) Advisory Subgroup has led to the revision of the auditing process for prenatal case management for Medicaid recipients. Although not accustomed to billing or submitting encounter claims for public health services, LPHAs are being encouraged by DMS to at least submit encounter claims for the administration of immunizations. Physicians are also requested to submit encounter claims when the immunizations are administered through the Vaccines for Children (VFC) program. This will allow for a better accounting of vaccination rates and reduce the potential for children to be over-immunized when there is not a readily accessible record of immunizations.

In 2002, there was increased sharing of public health data with the Division of Medical Services and Managed Care organizations for children who obtained services (e.g., immunizations and lead testing) through local public health agencies (LPHAs) and WIC (Women, Infants and Children nutrition programs) clinics. This was partly accomplished through DMS' Interagency Lead Treatment Agreement with DHSS. Additionally, DMS staff

have targeted improved coordination with the MCOs and DFS to improve care and communication with the Alternative Care Program in the Western Region, exchanging service utilization data regarding dental services. This enhances the ability of the respective Fee-for- Service and Managed Care Programs to manage the care of children in foster care who may transition between programs. There are plans to prioritize other areas of service delivery for coordination.

DMS and DHSS staff are working with the MCOs to gather information on premature births. A critical problem with infant mortality in St. Louis and Pemiscott Counties was identified through this process and more information will be gathered to address these issues.

Prenatal Risk Assessment.
A new risk assessment tool was developed by a DMS interagency taskforce and piloted on Fee- for- Service and Managed Care members during 2002. The tool combined the Substance Abuse and Pregnancy Subgroup issues with those on general prenatal care. All LPHAs will use this tool and MCOs are in favor of using the tool as well. This will allow comparison of Fee- for- Service and Managed Care risk assessments, as well as increased standardization of healthcare delivery, quality assessment and documentation.

Department of Social Services (DSS).

DMS staff has worked closely with DFS Social Services Staff to identify methods of coordinating care for children and families enrolled in MC+ Managed Care. An Interagency Work Group was formed with representation from MC+ MCOs, Managed Care Behavioral Health Organizations (BHOs), DFS, DMH, and DMS. Division of Family Services (DFS) program management staff in St. Louis have worked with staff from the Department of Mental Health for the past four years to coordinate health and mental health services for children in the custody of the State. This has resulted in more efficient use of State funds. The MC+ Resource Guide was produced for DFS workers to assist them in understanding how to access the MCOs and what services would be covered. As of June 2003, over 600 workers across the State participated in the training. The training and coordination was associated with a decline in the use of Children's Treatment Service (CTS) funds in the Eastern Region. A formalized communication network has been set up to address the need for coordination of service for DFS clients who are enrolled in Managed Care.

Most of the coordination efforts began in the Eastern Region of the State. Efforts then shifted to the Central Region, which experiences the most difficulty with communication due to the rural nature of the area. The Central Region has benefited from the improved coordination of services in an interesting way. There has been an increased availability of mental health providers noted since the decrease in availability of Children's Treatment Services (CTS) funds. Providers who previously only accepted CTS funds are now enrolling in Managed Care networks and are working with MCOs and behavioral MCOs. The Mental Health Advisory Subgroup has also addressed other issues, with cross- representation on the MCH Subgroup (primarily the behavioral health organizations, BHOs; and DMH) such as the management of children referred for court- ordered evaluations and treatment.

Goals for 2003.

In February 2003, DMS began to pilot a Prenatal Case Management Tool developed by a DMS interagency workgroup. There is currently a DHSS relational database program for this

tool, but there is some concern about the cost of updates. The MCOs are searching for a Medicaid Managed Care Prenatal Case Management Tool that will be more appropriate.

Administrative Simplification

In addition to the program changes and interagency coordination taking place at the State level, there have been a number of changes within the Department of Social Services (DSS) and Division of Medical Services (DMS) to improve the ability to provide administrative support to MCOs on behalf of MC+ Members.

Update of Member Addresses.

As of late 2002, a department-wide initiative at DSS was undertaken, with the goal of developing a streamlined system of updating member addresses at DFS offices. This involves easier access to editing screens for member information and the ability to change member information in multiple databases at one time to ensure the most up-to-date and timely contact information. The mailing of member packets to incorrect addresses is costly for Managed Care organizations, as they are compelled to send out member packets using first class mail so as to obtain returned mail and capitalize on their ability to obtain a forwarding address for members. This cost savings and increased ability to contact members will permit MCOs to continue to improve the access to and quality of healthcare services for MC+ Managed Care Members.

Contract Compliance Audit Tool.

During 2002, there were organizational changes within DMS to separate the functions of contract compliance and quality assessment/monitoring. Throughout the year, contract compliance staff developed audit tools to assess MCO contract compliance, assess the content of denial notices sent to members, and assess vendors contracted with MCOs. These tools correspond to federal and State contract requirements.

Strategic Planning.

DMS staff performed an internal strategic planning and an assessment of strengths, weaknesses, opportunities, & threats (S.W.O.T. Analysis). Goals for decreasing paperwork, reducing duplication of effort, and increasing the speed of reporting were developed. For quality management, the use of data management and retrieval systems allows for ready querying of data files for decision support functions. In addition, the State requires electronic submission of policies and documents by MCOs, for archiving, review, and contract compliance purposes. To attain the goal of reducing paperwork, MCO policies and documents are exchanged and retained electronically with DMS staff whenever possible. Several clinical and administrative data warehouses and retrieval algorithms were developed to facilitate quality improvement functions. Standardized reporting formats for all MCOs are also under development (e.g., screening outcomes of children with special healthcare needs (CSHCN), lead test reporting, grievances, and appeals).

Carryover of Lessons Learned from MC+ Managed Care to Fee-for-Service MC+.

There are a number of system improvements and mechanisms in place as a result of Missouri's implementation of Managed Care that are not able to readily be captured from administrative or medical record data that likely have an impact on the quality of care

provided not only to members enrolled in Managed Care, but also to recipients enrolled in Fee- for- Service Medicaid. Some examples include:

- The development of standard protocols for Managed Care that were adopted by the Fee- for- Service system (e.g., use of standard EPSDT forms, use of standard prenatal risk assessment protocols, universal consent forms for mental health services).

- The interagency education and understanding of public health, mental health, education, and human service delivery systems among state agencies providing services for the public good as well as MCOs and providers.

- An increasing focus on identifying and collecting data for process, performance, and outcome measures to assess service use, access, and quality outcomes of care.

Quality Management Plan

The Quality Management Plan (Managed Care Quality Assessment and Improvement Plan) was proposed August 26, 2002 to be consistent with the Proposed Medicaid Managed Care Rules. MCOs are required to meet program standards for monitoring and evaluation of systems as outlined in the Managed Care contract, Federal and State regulations, and the Quality Management Plan. MCOs are required to submit quarterly reports of utilization and quality assessment. Quarterly reports from MCOs are due to the State at the beginning of the months of March, June, September, and December. Annual Evaluations (for 2002 – 2003) are due April 30th of the subsequent calendar year. MCOs are required to report HEDIS and non- HEDIS MC+ Managed Care quality measures to DHSS (as required by all licensed MCOs in the State of Missouri), and directly to DMS. On a quarterly basis, twenty- four indicators are collected and reported for each MC+ Managed Care region by DHSS.

For 2004, the DMS Quality Services is instituting a Quality Assessment and Improvement Project Review Report for MCOs to submit prior to implementing Performance Improvement Projects (PIPs). This process involves documentation of a 10- step process from assessing study methodology to achieving and sustaining improvement, and the application of study results to improve performance. The entire process involves submission of the project methodology to the State 30 days prior to initiation of a Performance Improvement Project (Phase I); collecting data and submitting for review within 30 days of project implementation (Phase II); analyzing and interpreting data, to be submitted to the State within 60 days of project initiation (Phase III); providing feedback of findings for service improvement within 30 days prior to the submission of the project outcomes reporting to the quality review committee (Phase IV); and evaluating the Performance Improvement Program, with submission of the report within 6 months of project initiation, and annually thereafter (Phase V). The State is responsible for providing feedback or approval on each Phase to the MCOs within 30 days of submission.

There are a number of standing and ad hoc subgroups of the Quality Assessment and Improvement (QA & I) Advisory Group which consist of representatives from several state agencies and departments; MCO administrative staff; clinical staff from all agencies; and DMS MC+ Program managers. The standing groups are the Maternal and Child Health Advisory Subgroup (MCH Subgroup), the Mental Health Advisory Subgroup, and the Medical Directors' Subgroup.

Maternal and Child Health (MCH) Advisory Subgroup

The MCH Subgroup has traditionally been chaired by a staff member from the DHSS. The Maternal and Child Health Subgroup convenes quarterly. Group efforts have led to the re-examination of some longstanding policies and procedures impacting health care services to all Medicaid recipients in the state. This opportunity has led DHSS to examine how they work with DMS staff. The DHSS staff value the opportunity to meet with DMS and to have input into new Managed Care contracts.

EPSDT Initiative.

The MCH Subgroup has embarked on an EPSDT Initiative during 2002. During 2001, the MCH subgroup identified best practices which were presented by the QA & I Advisory Group. The Subgroup then decided to focus on one important issue for 2002, placing priority on EPSDT. At future meetings, the group will prioritize the top ten solutions for action. This group currently meets quarterly. DHSS was able to provide support for a facilitator to work with the group to identify the major issues leading to low rates for EPSDT. Public Health administrators and nurses were invited to participate with the group for interagency collaboration. In a stepwise manner, they will incorporate other systems that provide EPSDT services, such as the Department of Elementary and Secondary Education (DESE) and DMH to examine service delivery to maximize efficiency and access. One of the activities of the group was to identify how and in what manner the public agencies and MCOs delivered EPSDT services so as to identify duplication and fragmentation of services. The group identified issues related to members, providers, and systems and are now prioritizing these issues for action. For corrective action, the group will decide who will address the issues and the time frame for action.

The group will update the data and revisit best practice issues with attention given to the measurement of health outcomes. The MCH Subgroup has been updating best practices for 1) inadequate prenatal care; 2) inadequate WIC participation; 3) smoking during pregnancy; and 4) immunizations. In 2003, the MCH Subgroup is looking to expand its membership with the addition of one to three representatives from the School Nurse Council and a representative from the Local Public Health Agency Council.

Mental Health Subgroup

The Mental Health Advisory Subgroup meets quarterly and is comprised of representatives from the MCOs, Department of Mental Health (DMH), Administrative Agents, the DMH Division of Comprehensive Psychiatric Services, alcohol and drug abuse providers, and the Missouri Department of Insurance (MDI). Although most DMS meetings are held via conference calls, the Mental Health Subgroup members have agreed to continue to meet face-to-face at their own expense.

Standard Data Reporting.

The Mental Health Advisory Subgroup has continued to standardize data collection for utilization of mental health services. The Mental Health Subgroup, lead by the DMH Outcomes Coordinator of the Department of Mental Health has collected three consecutive years of data from behavioral health organizations across the MCOs, with several based on HEDIS reporting methods. The sharing of information has helped to raise awareness of service coverage by the various MCOs and encourages MCOs to critically review their

coverage policies. Data collected for three consecutive years include penetration, service use, and follow- up after hospitalization. These data are summarized by region in the present report, from CY1999 through CY2001.

Use of Medication.

Psychotropic medication utilization has increased, and been targeted as a topic for quality improvement among MCOs and the State. DHSS, DMH, and providers have revised protocols to be consistent across Managed Care and Fee- for- Service recipients. Protocols for wraparound services for Managed Care members and the education of administrative agents about MCOs and their agency services have also been implemented.

Goals for 2003.

Until recently, the group has been primarily focused on process issues. As of Spring 2003, the group has begun to discuss specific quality improvement projects. MHNet, a behavioral health organization, shared a project directed at provider satisfaction related to improvement of clean claim filing and improved turn around time for payment of claims. Missouri Care provided information on their project work on domestic violence. Additional goals outlined by this group for 2003 include:

- Measurement of the impact of the use of the Universal Consent Form developed by the Subgroup.

- Development of a separate C- STAR form and use for coordination among providers.

- Continuation of standardized data collection and movement to indicator standards and practice guidelines.

Medical Directors Subgroup

Medical Directors from each of the MCOs convene on a quarterly basis to address areas for medical management and provider network quality improvement. Like the other subgroups, the resources for supporting travel and meeting expenses have been eliminated. As a result, the group has been meeting via teleconference. The following are some examples of activities conducted during 2002:

Standardized Protocol Development.

Medical Directors, as well as the Managed Care organizations and DMS, continue to focus on standardization of procedures and protocols among MCOs. This is to reduce confusion by providers who are enrolled with more than one MC+ MCO, and to improve compliance with the documentation of healthcare services. Medical Directors requested one statewide EPSDT Audit Tool (for medical record audits and QI documentation across the State). The Medical Directors will review, annually, the standard EPSDT forms for possible revision. The Fee- for- Service Synagis protocol was adopted by Medical Directors.

Goals for 2003.

For 2003, Medical Directors also plan to re- evaluate the First Health Baseline Risk Assessment Form. DMH has made some suggestions for mental health (MH) risk factors to be included on this form. Because of budgetary problems, the Medical Directors Group has moved to conference calls for their meetings. With this change, the group has experienced a reduction in time necessary for meetings. Therefore, a decision was made to move to

quarterly meetings following the June 18, 2003 meeting. All meetings will be held prior to the scheduled QA & I Advisory Group meetings so input can be passed along to this group.

MCOs and Members

The MC+ Managed Care Program continues to be implemented in 10 counties in the Eastern Region, 18 counties in the Central Region, and 9 counties in the Western Region of the State. The number of recipients in 2002 was 226,027 in the Eastern Region; 126,722 in the Western Region; and 60,259 in the Central Region.

During Calendar Year 2002, there were a total of seven MCOs providing healthcare services to MC+ Managed Care Members. Care Partners exited the Eastern Region in December, 2002 representing a complete withdrawal of Care Partners from MC+ Managed Care. MissouriCare and HealthCare USA continued to operate in the Central Region. Mercy Health Plan, HealthCare USA, and Community Care Plus provided services to recipients in the Eastern Region. Family Health Partners, Firstguard and Blue Advantage Plus continued to operate in the Western Region. In February 2002, HCUSA began operating in the Western Region, making it the only MCO operating in all three MC+ Managed Care Regions of the State. Figure 1 illustrates the proportion of enrollees in each MCO.

Figure 1. MC+ Managed Care Program Enrollment, 2002.
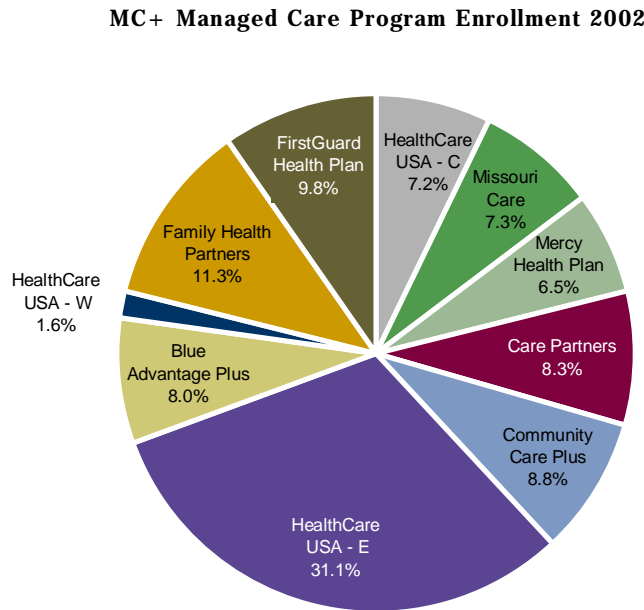
MC+ Managed Care Program Enrollment 2002

Source: Enrollment from Missouri Department of Social Services, Division of Medical Services, 2002

Figure 2 illustrates point-in-time enrollment in MC+ Managed Care as of December 27, 2002 for each Region, by eligibility group (Title XXI Adults and Children, and Title XIX enrollees). HealthCare USA's membership in the Eastern Region alone represents over one-third of MC+ Managed Care Members. The remaining MCOs had 6.5% to 11.3% of MC+ Managed Care recipients enrolled as members. HealthCare USA's membership in the Western Region, as of December 2002, was 1.6%. The MC+ Managed Care membership consists primarily of those receiving benefits through Title XIX (85% or more in each region) and children enrolled in Title XXI (approximately 10%); with relatively few adults receiving benefits through Title XXI (not visible on Figure 2 due to small proportion).

Figure 2. Enrollment in MC+ Managed Care as of December 27, 2002.
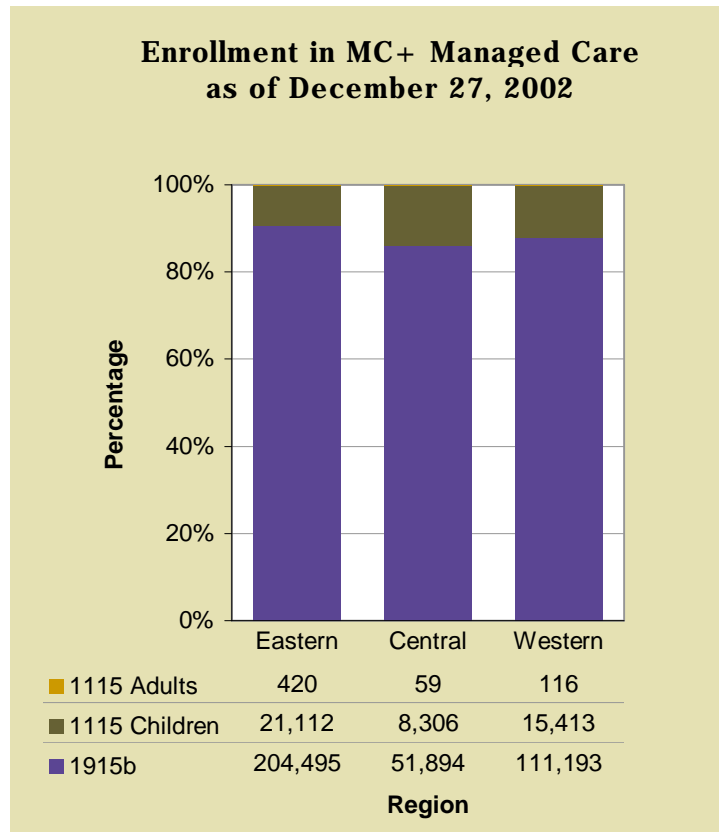
	Eastern	Central	Western
■ 1115 Adults	420	59	116
■ 1115 Children	21,112	8,306	15,413
■ 1915b	204,495	51,894	111,193

Source: Enrollment from Missouri Department of Social Services, Division of Medical Services, 2002

Figures 3 and 4 show the county- level distribution of MC+ Managed Care Members in June 2001 and June 2002. The distribution of MC+ Managed Care Members is summarized by County in Figure 3. Quintile categories show MC+ Members in five groups. The dark blue area demonstrates the seven (7) highest counts of MC+ Managed Care Members, while the lighter tan area shows eight (8) counties with the lowest concentration of MC+ Managed Care Members. Member counts by County are generally consistent with Missouri urban and rural county patterns, with the Central Region being primarily rural.

Figure 3. County Level Distribution of MC+ Managed Care Members.
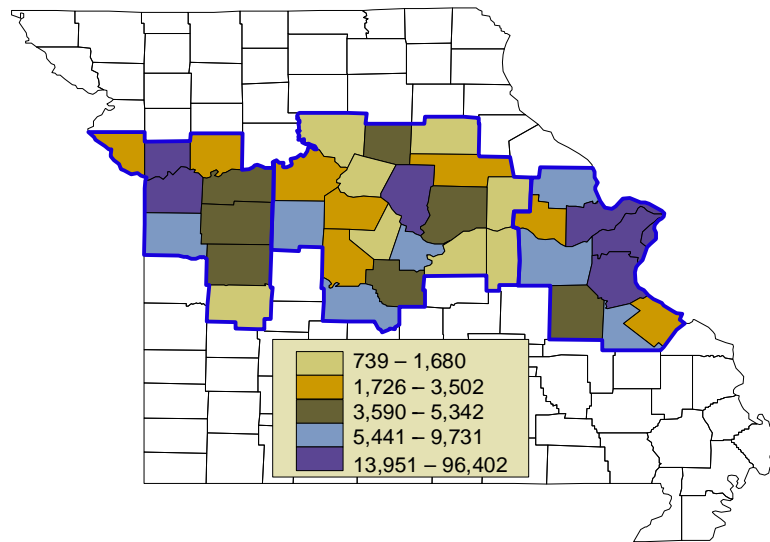
Source: Missouri Department of Social Services, Division of Medical Services, MMIS, Enrollment and Beneficiary Data, 2002

The MC+ Managed Care Member growth pattern is also summarized in Figure 4. This map illustrates a county-level analysis between June 30, 2001 and June 30, 2002. The seven (7) dark blue counties represent the areas of highest growth, ranging from an increase of 1,447 to 7,091 (see Table 1). The eight (8) lighter tan counties show areas of either a reduction (2,871) to a small increase (29) in MC+ Managed Care Members (see Table 2).

Figure 4. MC+ Member Growth Pattern.

	-2,871 - 29
	73 - 140
	157 - 332
	450 – 1,245
	1,447 – 7,091
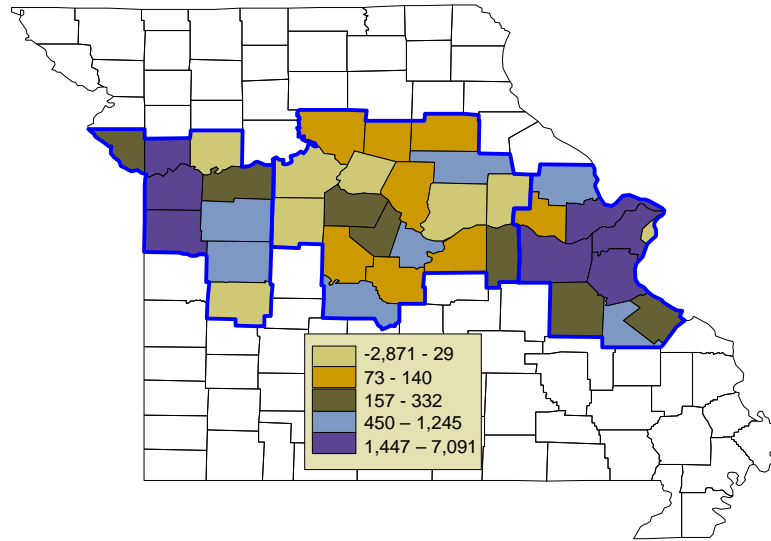
Source: Missouri Department of Social Services, Division of Medicaid Services, MMIS, Enrollment and Beneficiary Data, 2002

Table 1. Highest Growth Counties for MC+ Managed Care.

Highest Growth Counties
St. Louis
St. Charles
Jefferson
Franklin
Jackson
Clay
Cass

Source: Missouri Department of Social Services, Division of Medical Services, MMIS, Enrollment and Beneficiary Data, 2002

Table 2. Lowest Growth Counties for MC+ Managed Care.

Lowest Growth Counties
St. Louis City
Pettis
Saline
Montgomery
Howard
Callaway
St. Clair
Ray

Source: Missouri Department of Social Services, Division of Medical Services, MMIS, Enrollment and Beneficiary Data, 2002

Member Characteristics

Enrollment data from DMS were examined to obtain summary information about MC+ Managed Care Members. The number of active members on June 30, 2002 (390,657) was summarized by MCO and Region. This section includes data on the age, gender and race characteristics of MC+ Managed Care Members.

Figures 5 through 7 illustrate MC+ MCO Member characteristics, (gender, age, and race). Aside from the overrepresentation of women in the 21-and-over age group, the gender of members was similar across all age groups.

Demographic data are also summarized by gender (see Figure 5). These characteristics are very stable across MCOs and Regions. Females account for almost sixty percent (58.0%) of the statewide MC+ Managed Care Membership, with males accounting for the forty percent (42.0%) balance.

Figure 5. Gender of MC+ Managed Care Members.
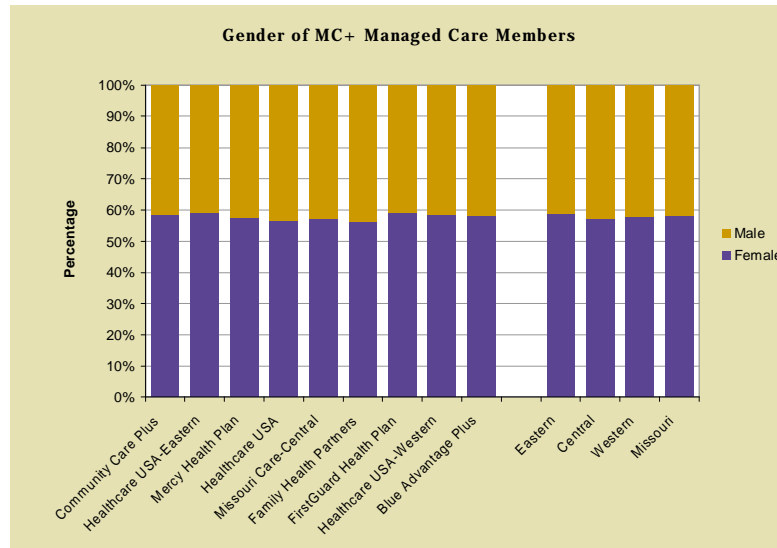
Source: Missouri Department of Social Services, Division of Medical Services, MMIS, Enrollment and Beneficiary Data, 2002

Eight (8) categories were used to summarize member age characteristics. Figure 6 summarizes this data by MCO and MC+ Managed Care Region. The age distribution varies little across MCOs, and Regions. Table 3 shows more than thirty percent (30.9%) of the population above 21, while the balance (69.1%) was 20 years old or younger. A large proportion of members were over 21 years of age, primarily reflecting the use of MC+ Managed Care by pregnant women (See Figure 6).

<div align="center">

Table 3. MC+ Managed Care Age Categories.

Age Categories: Missouri Total Percentages
Less than 1 year = 6.1%
1- 2 years = 6.1%
3- 5 years = 10.9%
6- 9 years = 14.6%
10- 14 years = 18.4%
15- 18 years = 10.3%
19- 20 years = 2.4%
> 21 years = 31.2%

</div>

Source: Missouri Department of Social Services, Division of Medical Services, MMIS, Enrollment and Beneficiary Data, 2002

Figure 6. Age Distribution of MC+ Managed Care Members.
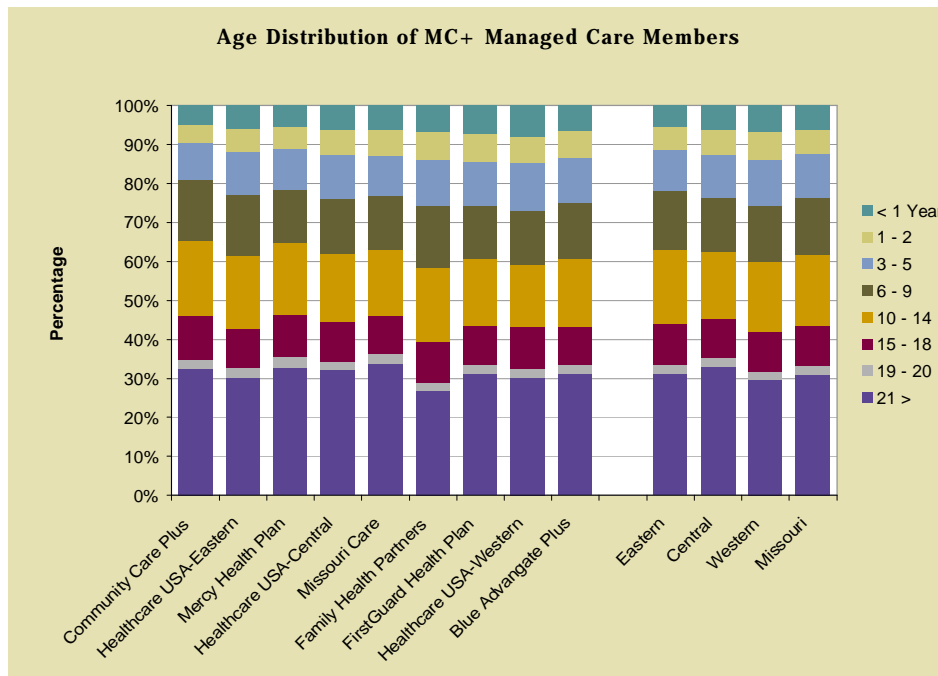
Source: Missouri Department of Social Services, Division of Medical Services, MMIS, Enrollment and Beneficiary Data, 2002

Racial demographic data shows that some differences exist regionally, yet the distribution between MCOs remains similar within Regions (see Figure 7). There are four (4) demographic categories: *Caucasian, African American, Other* (consisting of American Indian/Alaska Native, Asian, Multi- racial, Native Hawaiian/Pacific Islander, and Discontinued) and a final *Unknown* category. The MC+ Managed Care population statewide was fifty- six percent (55.7%) *Caucasian*, and thirty- nine percent (39.0%) *African American*, while the remaining racial category (Other) accounted for less than two percent (1.3%). Four percent of the population (4.0%) was *Unknown*. In the Eastern Region, a little less than half (49.0%) of the members were *African American, Caucasians* accounted for a little more than forty- five percent (45.4%), with the remaining racial categories accounting for exactly one percent (1.0%) and the remaining five percent (4.5%) of members *Unknown*. Within the Central Region, members were over eighty percent (82.8%) *Caucasian*, thirteen percent (13.3%) *African American*, and other racial categories accounted for exactly one percent (1.0%). The remaining proportion (2.9 %) of members were *Unknown*. Within the Western Region, a slim majority (56.5%) of members were *Caucasian*, with *African Americans* accounting for a little less than forty percent (37.9%). The remaining racial categories accounted for less than two percent (1.8 %), with four percent (4.3%) of members of *Unknown* race.

For MC+ Managed Care Members across the State, there were approximately the same number of *Caucasian* and *African American* members. However, there were clear regional differences, with the largest proportion of *African American* members in the Eastern Region, and the largest proportion of *Caucasian* members in the Central Region.

Figure 7. Race of MC+ Members.
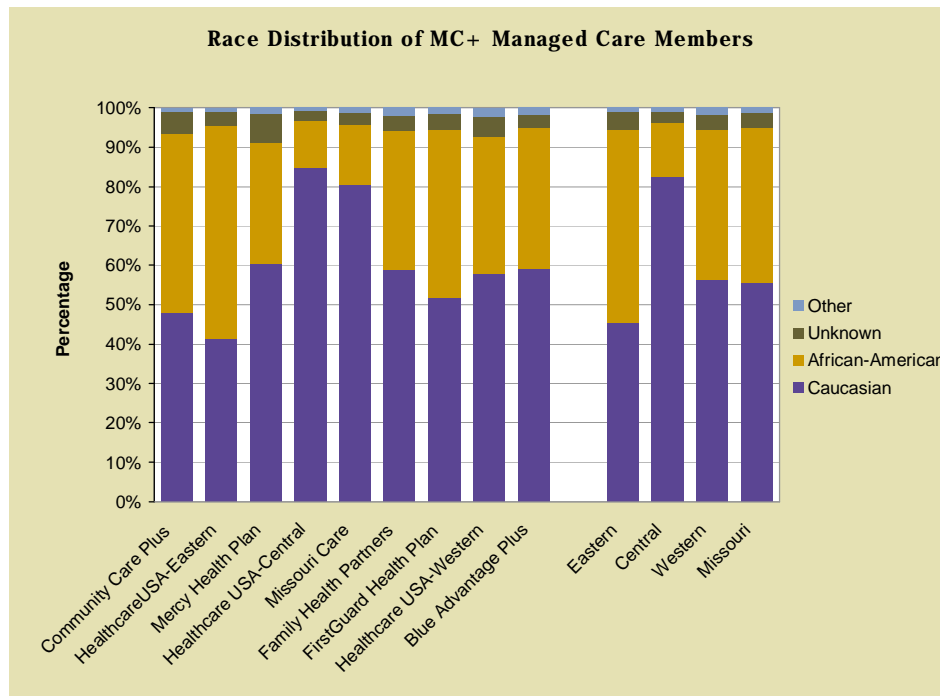
Missouri Department of Social Services, Division of Medical Services, MMIS, Enrollment and Beneficiary Data, 2002

Findings

Service Use

Several sources of data were used to examine service use among MC+ Managed Care Members. First, several indicators of acute care service use among children were examined using MCH Trend Indicator data available for Medicaid and non- Medicaid. Additionally, data for MC+ Managed Care Members by MC+ Managed Care Region were available. Data for these indicators are presented from prior to the implementation of MC+ Managed Care (1995) through the most recent available data year (2001). Second, the utilization of services was examined through analysis of the State encounter claims and administrative databases. These include primary care utilization for acute and preventive services. Utilization of EPSDT, immunizations, lead screening, and prenatal care are presented in the section on <u>Quality and Effectiveness of Care</u>. Third, data on the utilization of mental health services as reported by the Behavioral Health Organizations (BHOs) to the Mental Health Subgroup of the QA & I Advisory Group are presented. These indices can reflect a number of factors, including access to care, help- seeking patterns, changes in medical or insurance practices, or increases in disease prevalence.

Four MCH Trend Indicators were examined to assess the change in child health service utilization over time (percent change); to compare the use of services from Medicaid and non- Medicaid populations; and to examine the variation in utilization across the MC+ Regions for children and adolescents. Data from the Eastern, Central, and Western Regions were examined. The four indicators are:

- Preventable hospitalizations under 18 years of age

- Emergency room visits under 18 years of age

- Asthma emergency room visits, 4- 17 years of age

- Asthma admissions under age 18 years of age

Child Health Service Indicators

Preventable Hospitalizations.

Figures 8 and 9 show the rates of preventable hospitalizations statewide and by MC+ Managed Care Region from 1995 (before MC+ Managed Care began in any of the Regions) through 2001. Figure 8 shows the rates of preventable hospitalizations per 1,000 members for those enrolled in Medicaid, and those not enrolled in Medicaid in the Managed Care Regions of the State (Eastern, Central, Western). The figure illustrates a statistically significant <u>**decline**</u> **of 30.8% in preventable hospitalizations for those enrolled in Medicaid (95% CI: 1.52, 1.36) since MC+ Managed Care began (1997 to 2001), while the rates for those not enrolled in Medicaid** <u>**increased**</u> **significantly by 60.1% (95% CI: .65, .60) during the same time period. Although the rate was much higher for Medicaid than non-Medicaid populations (18.3 vs. 5.9) in 1995, the difference was much smaller in 2001 (9.1 vs. 7.8), suggesting that Managed Care helped to slow the rate of preventable hospitalizations among MC+ Managed Care Members such that they more closely approximate that of the general population.**

Figure 8. Preventable Hospitalizations Under Age 18, All MC+ Managed Care Regions.
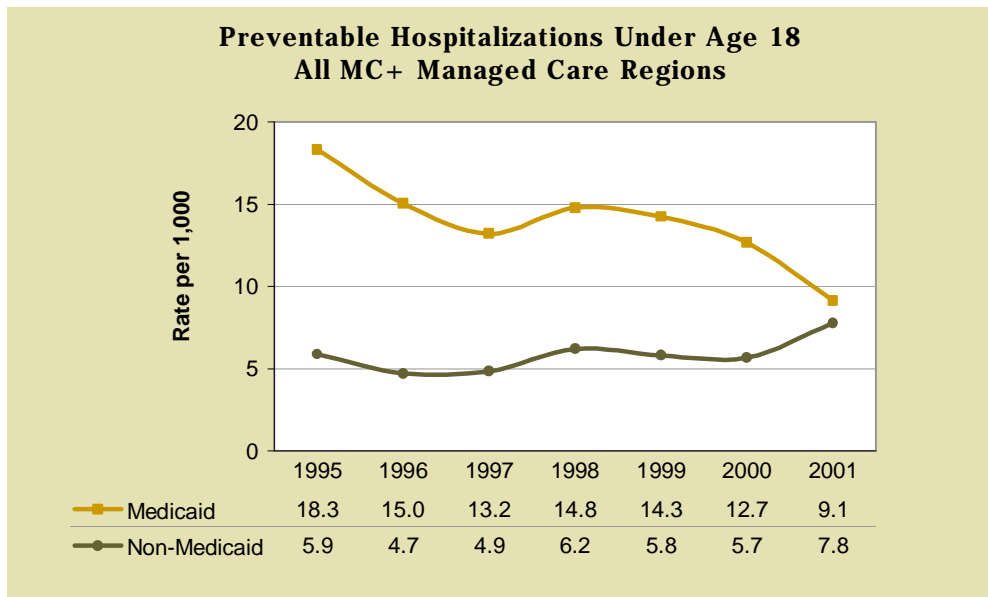
**Preventable Hospitalizations Under Age 18
All MC+ Managed Care Regions**

	1995	1996	1997	1998	1999	2000	2001
Medicaid	18.3	15.0	13.2	14.8	14.3	12.7	9.1
Non-Medicaid	5.9	4.7	4.9	6.2	5.8	5.7	7.8

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995. The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide the same results. Figures for 2000 and 2001 are provisional. *Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

Figure 9 shows the rate of preventable hospitalizations for MC+ Managed Care Members by Region. Prior to implementation of MC+ Managed Care (1995), the Eastern Region rates were the highest of all three regions. Over the last three data years, the rates of preventable hospitalization, although still the highest in the Eastern Region, have declined to become more consistent with those in the Western and Central Regions. This may be due to more standardized practices and management of utilization and preventive services through the monitoring and administration of health care services.

Figure 9. Preventable Hospitalizations Under Age 18, Each MC+ Managed Care Region.
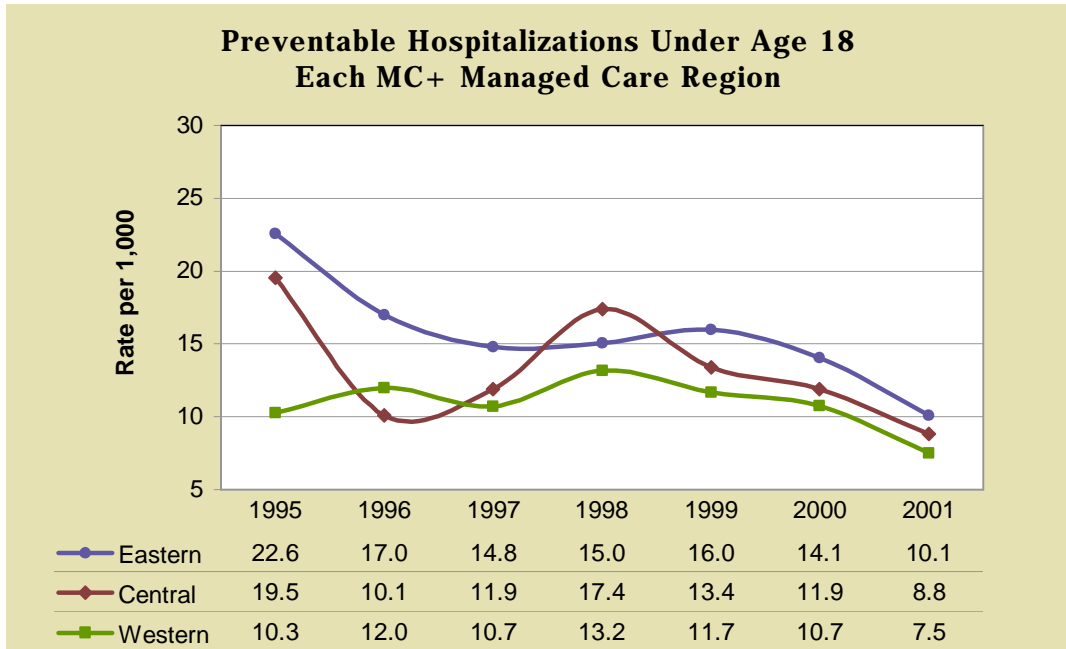
**Preventable Hospitalizations Under Age 18
Each MC+ Managed Care Region**

	1995	1996	1997	1998	1999	2000	2001
Eastern	22.6	17.0	14.8	15.0	16.0	14.1	10.1
Central	19.5	10.1	11.9	17.4	13.4	11.9	8.8
Western	10.3	12.0	10.7	13.2	11.7	10.7	7.5

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995.

The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide the same results. Figures for 2000 and 2001 are provisional.

Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Emergency Room Visits

Figures 10 and 11 show the rates of emergency room visits statewide and by MC+ Managed Care Region from 1995 (before MC+ Managed Care began) through 2001. Figure 10 shows the rate of emergency room visits for those under 18 years of age enrolled in Medicaid (MC+) and those not enrolled in Medicaid in the Managed Care Regions of the State. The figure illustrates a statistically significant <u>decrease</u> (17.9%) in emergency room visits since MC+ began (1997 to 2001; 95% CI: 1.23, 1.21), while there was a statistically significant <u>increase</u> in the rates of emergency room visits for those not enrolled in Medicaid (27.9%; 95% CI: 0.79, 0.78) during the same time period.

Although the rates of emergency room visits under age 18 was higher in the Medicaid than the non- Medicaid population during 2001 (512.3 vs. 361.5, per 1,000), this difference is much smaller than it was in 1995 (765.8 vs. 273.6 per 1,000).

Figure 10. Emergency Room Visits Under Age 18, All MC+ Managed Care Regions.

**Emergency Room Visits Under Age 18
All MC+ Managed Care Regions**

	1995	1996	1997	1998	1999	2000	2001
Medicaid	765.8	633.2	624.2	656.2	643.4	577.3	512.3
Non-Medicaid	273.6	258.6	282.6	273.1	283.6	307.0	361.5

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995. The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide the same results. Figures for 2000 and 2001 are provisional. *Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

Figure 11 shows the rate of emergency room visits under 18 for MC+ Managed Care Members by Region. Prior to implementation of MC+ Managed Care (1995), the rates of emergency room visits were higher in the Western Region (805.9 per 1,000) than in the Eastern and Central Regions (748.5 and 743.2, respectively). However, in 2001, the rate of emergency room visits was lowest in the Western Region (492.6 per 1,000) than in the Eastern and Central Regions (507.6 per 1,000 and 574.1 per 1,000, respectively).

Figure 11. Emergency Room Visits Under Age 18, Each MC+ Managed Care Region.
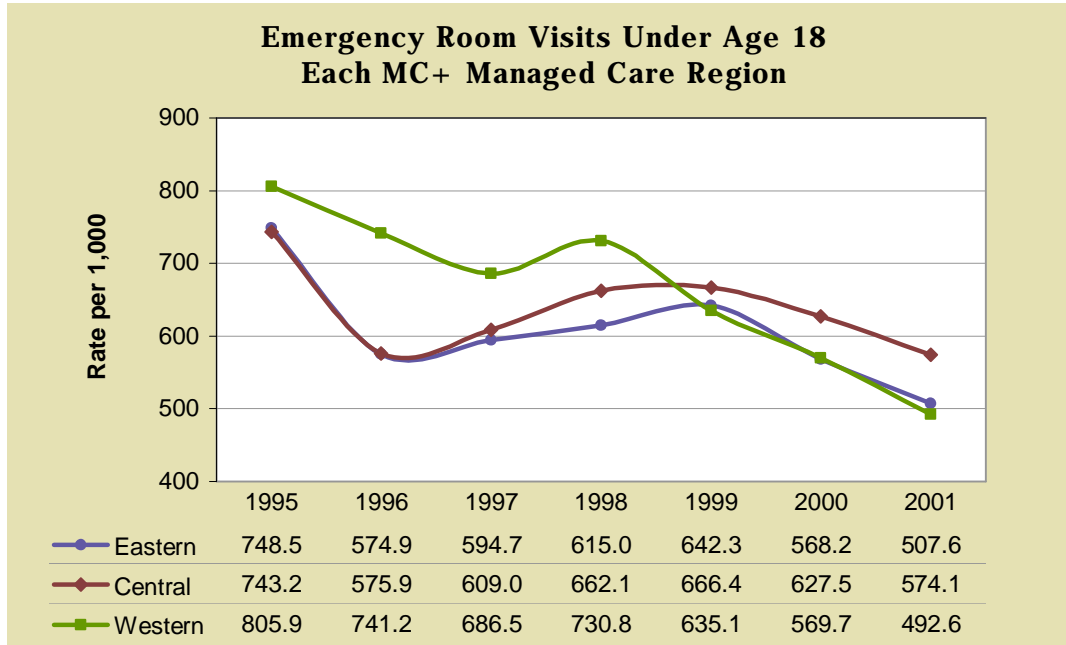
**Emergency Room Visits Under Age 18
Each MC+ Managed Care Region**

	1995	1996	1997	1998	1999	2000	2001
Eastern	748.5	574.9	594.7	615.0	642.3	568.2	507.6
Central	743.2	575.9	609.0	662.1	666.4	627.5	574.1
Western	805.9	741.2	686.5	730.8	635.1	569.7	492.6

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995. The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide the same results. Figures for 2000 and 2001 are provisional. *Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

Asthma Emergency Room Visits, 4-17 Years of Age

Figures 12 and 13 show the rates of asthma emergency room visits, for members 4-17 years of age statewide and by MC+ Managed Care Region from 1995 (before MC+ Managed Care began) through 2001. Figure 12 shows the rate of asthma emergency room visits per 1,000 members for those enrolled in Medicaid and for those not enrolled in Medicaid in the Managed Care Regions. The figure illustrates statistically significant declines in both Medicaid and non-Medicaid rates of asthma emergency room visits from 1997-2001. The rate of asthma emergency room visits among the Medicaid group decreased 21.9% (95% CI: 1.34, 1.22), while the rate in the non-Medicaid group decreased by 10.2% (95% CI: 1.16,1.06). The rates of asthma hospitalizations for Medicaid was quite variable between 1995 and 1997, but has shown a steady decline since MC+ began (30.4-23.7 asthma emergency room visits per 1,000 members). For the non-Medicaid populations, the rates remained stable and low (7.2-6.5 per 1,000 members in 2001).

Figure 12. Asthma Emergency Room Visits, 4-17 Years of Age, All MC+ Managed Care Regions.
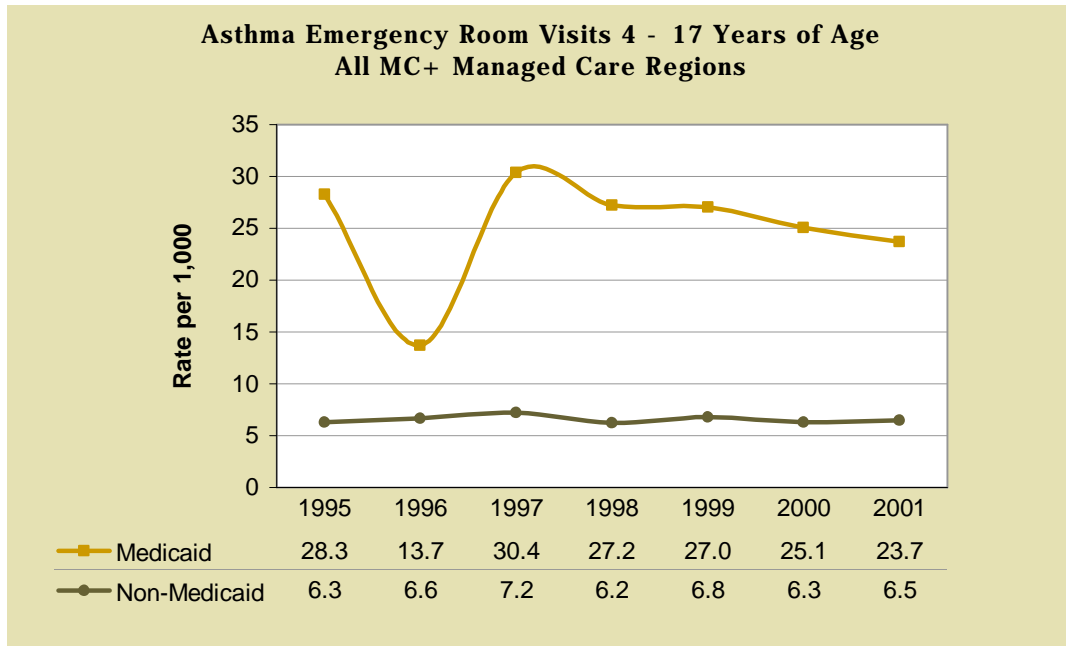
**Asthma Emergency Room Visits 4 - 17 Years of Age
All MC+ Managed Care Regions**

	1995	1996	1997	1998	1999	2000	2001
Medicaid	28.3	13.7	30.4	27.2	27.0	25.1	23.7
Non-Medicaid	6.3	6.6	7.2	6.2	6.8	6.3	6.5

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995. The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide the same results.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Figure 13 shows the rate of asthma emergency room visits for MC+ Managed Care Members by MC+ Managed Care Region. Prior to implementation of MC+ Managed Care, the rate of asthma emergency room visits was lowest in the Central Region (10.4 per 1,000 members in 1995), followed by the Western and Eastern Regions. This trend continued through 2001.

Figure 13. Asthma Emergency Room Visits 4-17 Years of Age, Each MC+ Managed Care Region.
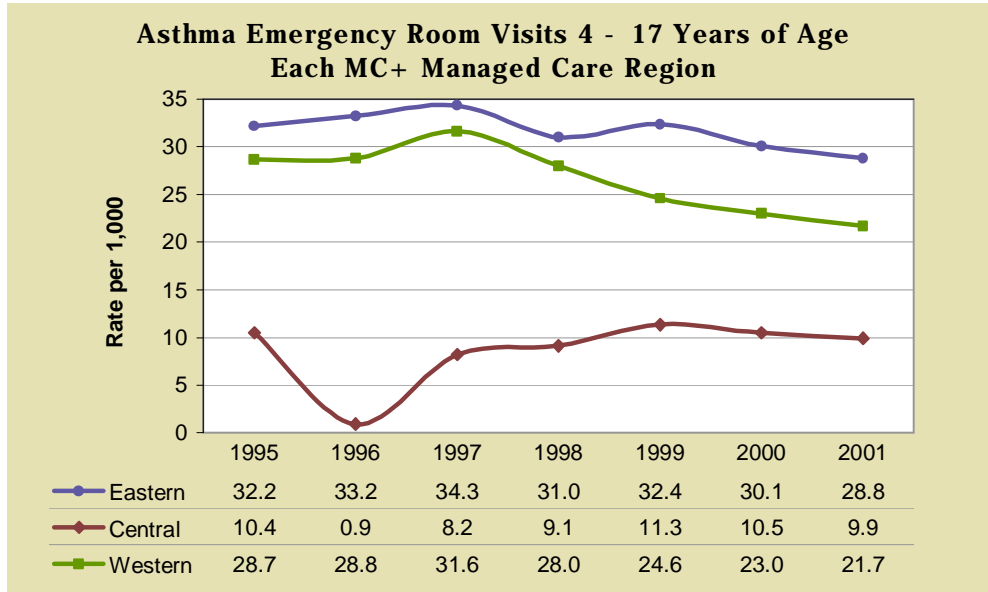
Asthma Emergency Room Visits 4 - 17 Years of Age Each MC+ Managed Care Region

	1995	1996	1997	1998	1999	2000	2001
Eastern	32.2	33.2	34.3	31.0	32.4	30.1	28.8
Central	10.4	0.9	8.2	9.1	11.3	10.5	9.9
Western	28.7	28.8	31.6	28.0	24.6	23.0	21.7

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995. The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide the same results.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Asthma Admissions Under 18

Figures 14 and 15 show the rates of asthma admissions for those under 18 years of age statewide and by MC+ Managed Care Region from 1995 (before MC+ Managed Care began) through 2001. Figure 14 shows the rate of asthma admissions under 18 per 1,000 Members for those enrolled in Medicaid and those not enrolled in Medicaid, in the Managed Care Regions. The first figure illustrates a statistically significant decline in both Medicaid and non-Medicaid asthma admissions under 18 years of age since 1997, when MC+ began (in all three regions). The rate of asthma admissions under age 18 for the Medicaid group decreased by 46.5% (95% CI: 2.03, 1.71), while for the non-Medicaid group, it decreased by 21.4% in the same time period (95% CI: 1.38, 1.16). The rate of asthma admissions in 2001 for the Medicaid group more closely approximated the non-Medicaid group (3.5 per 1,000 vs. 1.3 per 1,000, respectively) in 2001 than in 1995 (6.0 vs. 1.5 per 1,000 members, respectively).

Figure 14. Asthma Admissions Under Age 18, All MC+ Managed Care Regions.
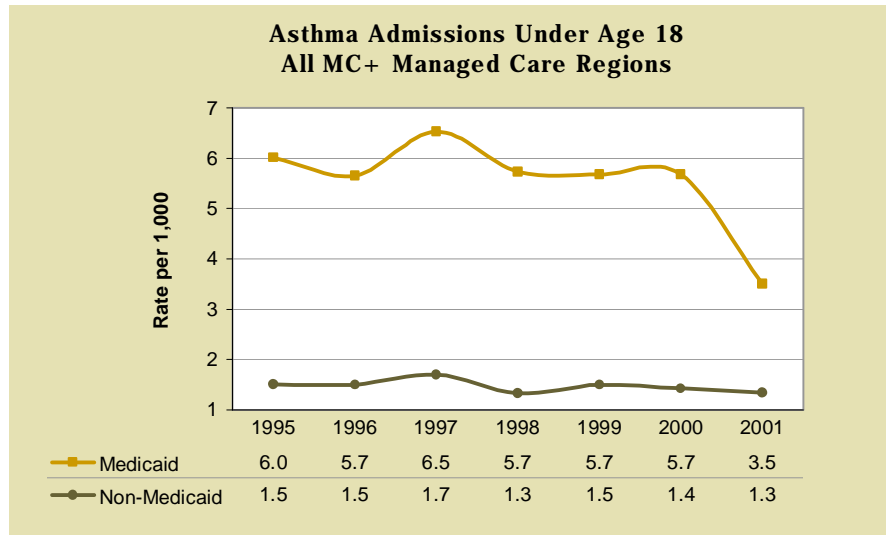
Asthma Admissions Under Age 18
All MC+ Managed Care Regions

	1995	1996	1997	1998	1999	2000	2001
Medicaid	6.0	5.7	6.5	5.7	5.7	5.7	3.5
Non-Medicaid	1.5	1.5	1.7	1.3	1.5	1.4	1.3

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995. The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide the same results. Figures for 2000 and 2001 are provisional. *Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

Figure 15 shows the asthma admission rate per 1,000 members for MC+ Managed Care Members by Region. Prior to the implementation of MC+, the Eastern Region rates were the highest, and continue to be the highest in 2001. However, the rate of asthma admissions under age 18 declined in all regions since MC+ Managed Care began.

Figure 15. Asthma Admissions Under Age 18, Each MC+ Managed Care Region.
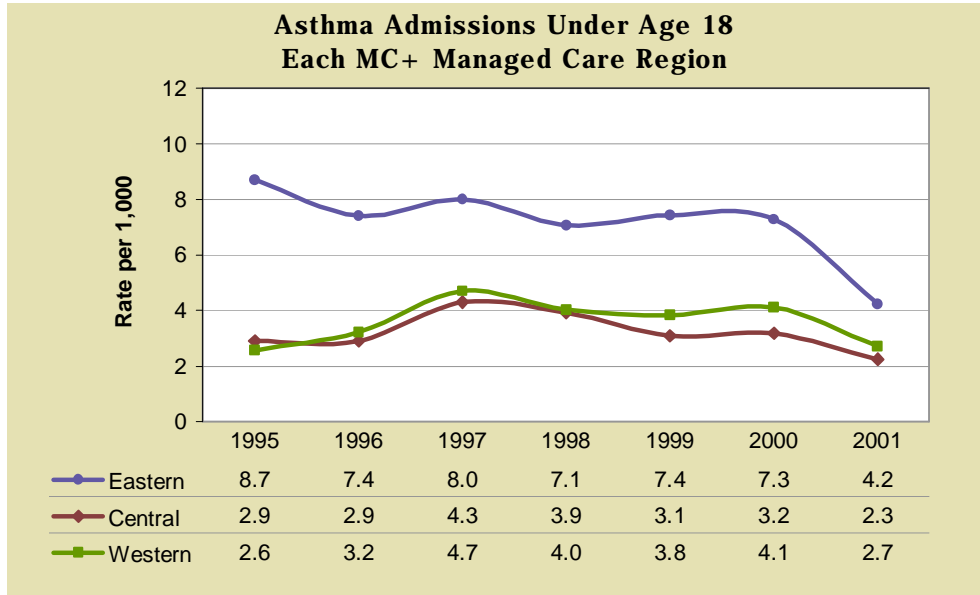
**Asthma Admissions Under Age 18
Each MC+ Managed Care Region**

	1995	1996	1997	1998	1999	2000	2001
Eastern	8.7	7.4	8.0	7.1	7.4	7.3	4.2
Central	2.9	2.9	4.3	3.9	3.1	3.2	2.3
Western	2.6	3.2	4.7	4.0	3.8	4.1	2.7

Notes: Statewide figures are aggregated from Regional data. Non-Medicaid includes commercial vendors. Baseline Managed Care Year = 1997; Baseline Medicaid Year = 1995. The percent change given in the text was calculated using actual numerators and denominators taken out to three decimal places. Calculating a percent change using the rates in this table may not provide 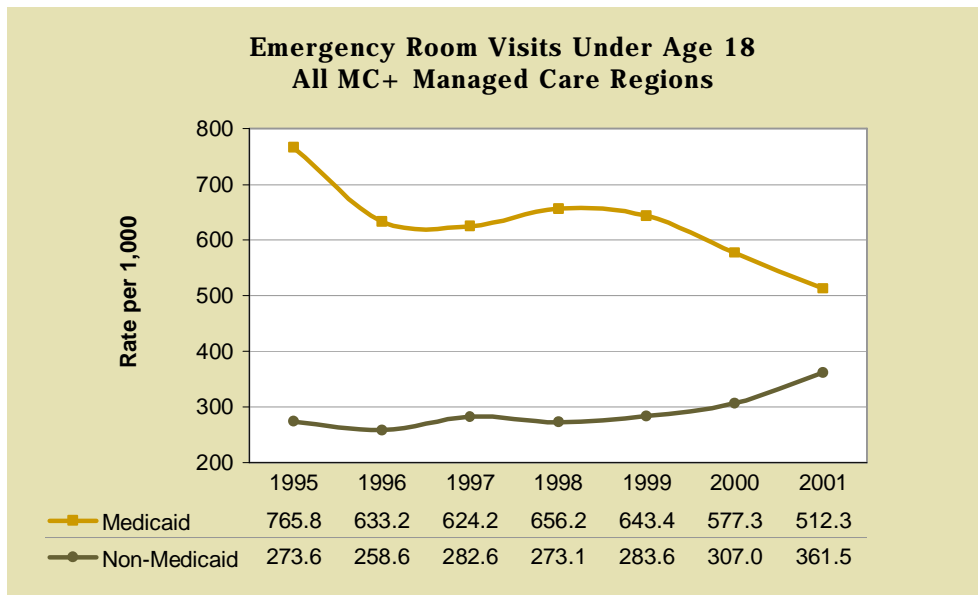the same results. Figures for 2000 and 2001 are provisional. *Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

MC+ Managed Care Encounter Claims

Encounter data were obtained from DMS to evaluate the overall level and types of services provided by MC+ MCOs.[9] In addition to utilization of MC+ Managed Care services over time, the use of services through CY2002 was examined for the number and types of encounters by region and by type of claim. Detail regarding the most frequent Diagnosis-Related Groups (DRGs) and classes of pharmacy claims is presented.

DMS Encounter Claim Summary.

The number of encounter claims continues to stabilize after an increase in CY2000. DMS data indicated that a total of 5,735,018 encounter claims were submitted in CY2002. The number of encounter claims per 1,000 members has shown an overall 35.7% percent increase since CY1998. A total of 13,886 encounters per 1,000 members were processed in CY2002, compared to 10,235 encounters per 1,000 members during CY1998. Figure 16 shows the number of encounter claims per 1,000 members by region and statewide MC+ Managed Care for CY1998 through CY2002. The increases occurred in the Central Region (87.1%), followed by the Eastern Region (46.5%), and the Western Region (2.0%).

Figure 16. Encounter Claims Processed in CY2002, MC+ Managed Care Program.
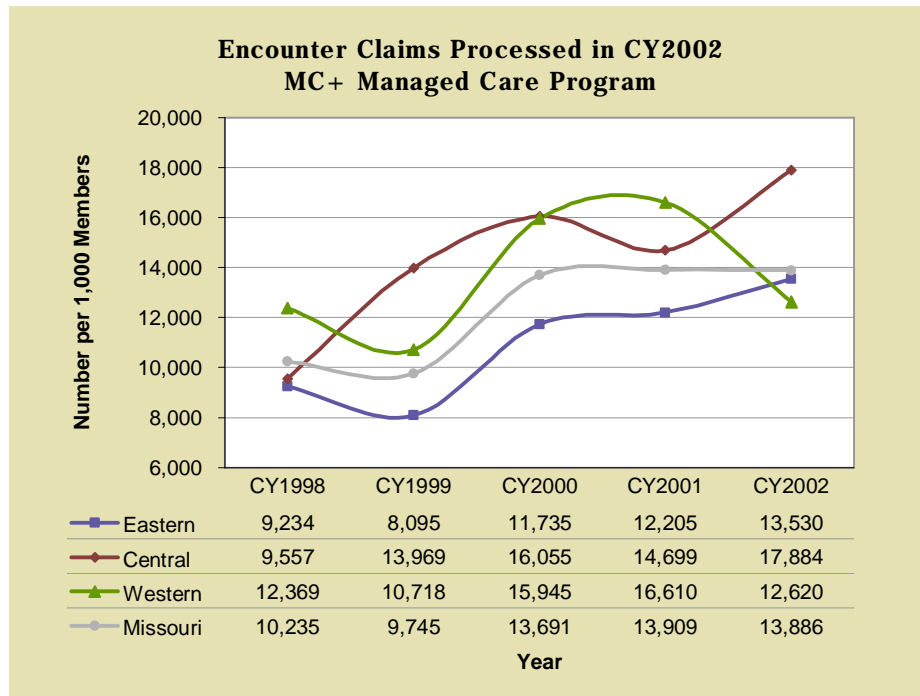
**Encounter Claims Processed in CY2002
MC+ Managed Care Program**

	CY1998	CY1999	CY2000	CY2001	CY2002
Eastern	9,234	8,095	11,735	12,205	13,530
Central	9,557	13,969	16,055	14,699	17,884
Western	12,369	10,718	15,945	16,610	12,620
Missouri	10,235	9,745	13,691	13,909	13,886

Source: Missouri Department of Social Services, Division of Medical Services, Encounter Claims Processed Report, February 2003

The DMS data showed that 5,360,057 and 6,102,769 service encounters were submitted during CY2001 and CY2002, respectively. For CY2002, this calculated to a mean of 15.1 services per recipient receiving services, with a range of 10.8 to 26.1 services. The average number of services per recipient by age was also assessed, as shown in Figure 17. As seen, higher numbers of visits occurred in infants, and again during the childbearing years.

Figure 17. Average Number of Services per MC+ Managed Care Member.
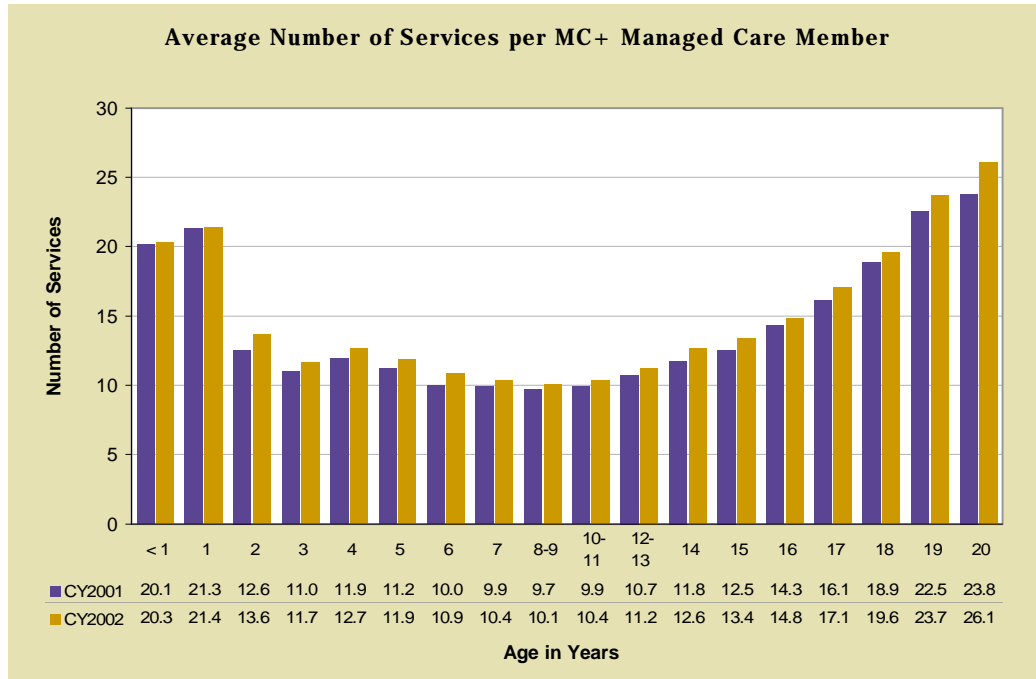
Average Number of Services per MC+ Managed Care Member

	< 1	1	2	3	4	5	6	7	8-9	10-11	12-13	14	15	16	17	18	19	20
CY2001	20.1	21.3	12.6	11.0	11.9	11.2	10.0	9.9	9.7	9.9	10.7	11.8	12.5	14.3	16.1	18.9	22.5	23.8
CY2002	20.3	21.4	13.6	11.7	12.7	11.9	10.9	10.4	10.1	10.4	11.2	12.6	13.4	14.8	17.1	19.6	23.7	26.1

Age in Years

Source: Missouri Department of Social Services, Division of Medical Services, Data Scan/Panorama Ad hoc Request, May 2003

Types of Encounters.

In addition to the number of encounter claims, the types of claims were examined. Claim types are designated as Pharmacy, Inpatient, Medical, Outpatient, Home Health, and Dental. Home Health encounters may be included in other claim types and are, therefore, under-reported. Figure 18 shows the rates per 1,000 members for each of the claim types from CY1998 to CY2002. As seen, Medical, Outpatient, and Pharmacy claims comprise the majority of the claims.

Figure 18. MC+ Managed Care Encounter Claims Processed in CY2002, by Type.
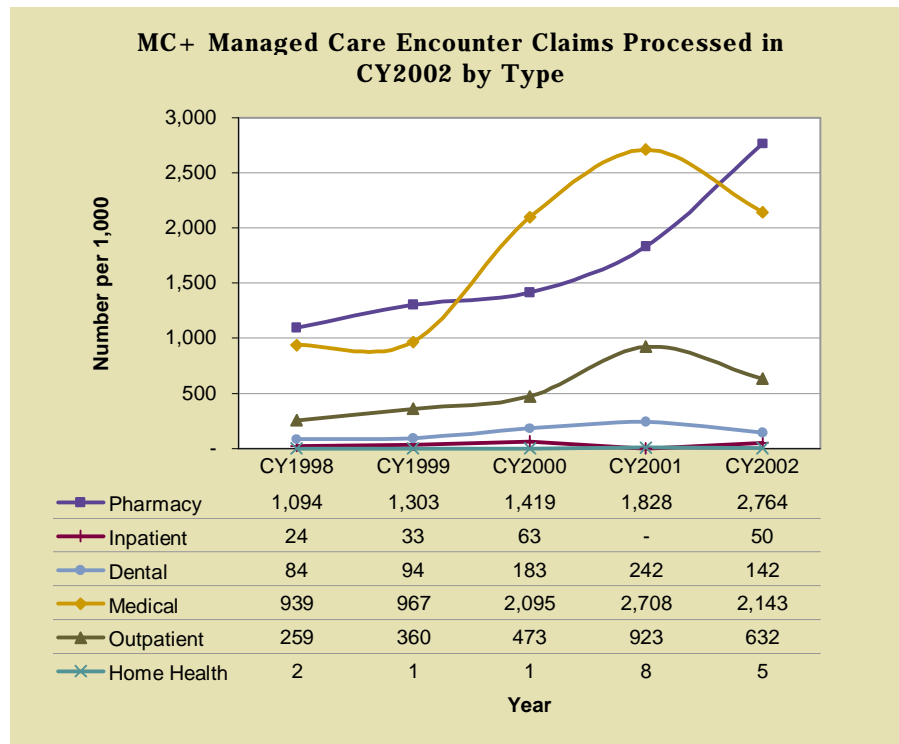
The CY2002 inpatient rate as not calculated due to inconsistencies in encounter data.
Source: Missouri Department of Social Services, Division of Medical Services, Encounter Claims Processed Report, February 2003; 2001 E.

The change from CY1998 to CY2002 recipients showed considerable variability based on the claim type. Home Health claims showed the greatest increase, however, overall initial frequencies of the claims were low, with 2,000 claims per 1,000 recipients increasing to 12,000 per 1,000 recipients so relative increases are larger (150% change). Pharmacy claims increased from 5,410 to 6,695 (23.7% change). Inpatient claims increased from 102 to 120 (17.6% change), Dental claims decreased from 413 to 343 (16.9% change), Medical claims increased from 4,003 to 5,118 (27.9% change), and Outpatient claims increased from 1,103 to 1,530 (38.7 percent change).

Inpatient Claims.

The DMS data also provided additional information regarding inpatient admissions. A total of 483 different DRGs were assigned to the CY2002 admissions. Analysis showed that ten of these DRGs accounted for 59.3% of the inpatient admissions during CY2002. The leading reasons for hospitalization were for childbirth, with 35.0% of the admissions assigned either to a newborn or delivery DRG. The top ten DRGs were:

- **DRG 391, Normal Newborn. This DRG accounts for 28,370 (12.1%) of the total DRGs. Conditions included in this DRG are major personality disorders, such as schizophrenia, catatonia, manic disorders, bipolar affection disorders, and paranoia.**

- **DRG 468, Extensive Operating Room Procedure, Unrelated to the Principal Diagnosis. This DRG accounts for 25,299 (10.8%) of the total assigned DRGs. As this is generally a high cost DRG, the prevalence of this DRG may warrant additional inquiry regarding admission reasons and/or coding.**

- **DRG 373, Vaginal Delivery, No Medical Complications. This DRG accounts for 23,466 (10.0%) of the total assigned DRGs.**

- **DRG 430, Psychoses. This DRG accounts for 16,290 (6.9%) of the total assigned DRGs.**

- **DRG 389,390, Term Neonate Major Problems and Neonate, Other Significant Problems. These two DRG account for 17,577 (7.5%) of the total assigned DRGs.**

- **DRG 370,371, Cesarean Section with CC and Cesarean Section without cc. These two DRGs account for 14,301 (6.1%) of the total assigned DRGs.**

- **DRG 185, Dental Diagnosis. This DRG accounts for 6,862 (2.9%) of the total assigned.**

- **DRG 98, Bronchitis, Asthma P. This DRG accounts for 7,077 (3.0%) of the total assigned DRGs.**

Pharmacy Claims.

In follow-up to the summary claims data provided by DHSS, MC+ Managed Care pharmacy claims were assessed to evaluate the various types of prescriptions written for MC+ Managed Care Members. The data provided by DMS showed a total of 143,716 recipients received a total of 20,094,444 prescriptions during CY2002 an increase from 17,487,407 in CY2001, a 14.9% change. The average number of prescriptions per Medicaid recipient was 26.0 in CY2002, up from 24.4 in CY2001. The majority of prescriptions were classified as prescription drugs according to the following DEA classes, as shown in Figure 19.

- **Class I: High Abuse Potential, No Medical Use**

- **Class II: High Abuse Potential, Severe Psychological or Physical Dependence Possible**

- **Class III: Less Abuse Potential, Moderate or Low Physical Dependence or High Psychological Dependence**

- **Class IV: Less Abuse Potential, Limited Physical or Psychological Dependence**

- **Class V: Limited Abuse Potential, Limited Physical or Psychological Dependence**

- **Rx: Prescription (Not Classified Under the Controlled)**

- **OTC: Over-the-Counter Product**

Figure 19. MC+ Managed Care Prescription Drug Use.

Drug Classification	Class I	Class II	Class III	Class IV	Class V	RX	OTC Product	Totals
CY2001	0.00	5.63	3.38	7.14	1.70	20.80	5.27	24.42
CY2002	0.00	6.27	3.57	7.20	1.71	22.65	4.39	26.01
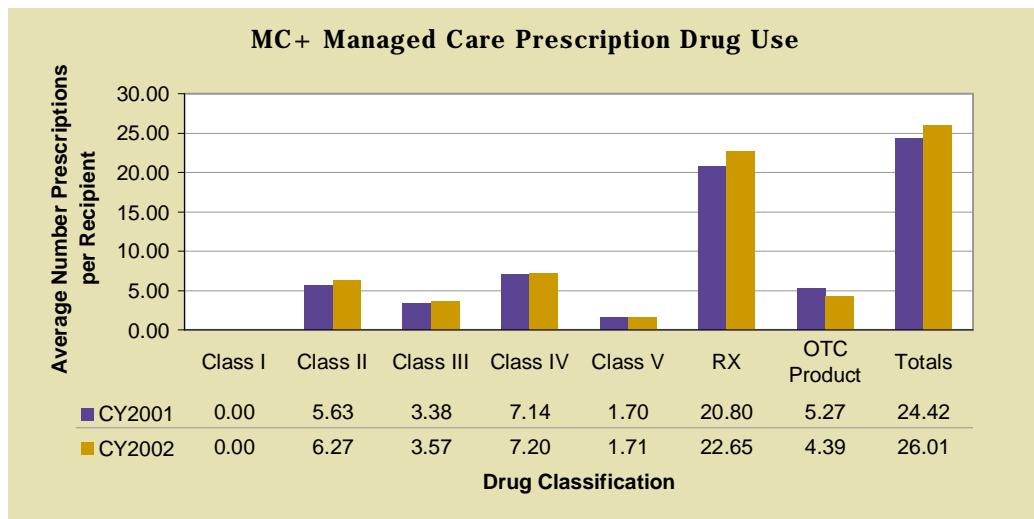
Note: Class I drugs are those with no medical use and have a high abuse potential. Some are legal for limited research use only. Examples of Class I drugs include marijuana, heroin, methaqualone, and designer drugs. Encounter claims for these drugs would not be expected.
Source: Missouri Department of Social Services, Division of Medical Services, Data Scan/Panorama Ad hoc Request, May 2003

MC+ Managed Care Mental Health Service Use

The mental health component of the MC+ Managed Care Program is integrated into the monthly per- member per- month capitated payment made to MC+ MCOs for most members. There is a carve- out for members who are in State custody for whom mental health services are provided on a Fee- for- Service basis.

In 2000, the Mental Health Subgroup of the MC+ QA & I Advisory Group began compiling data for a number of Mental Health Indicators for members served by MC+ MCOs and their mental health subcontractors. Data from 1999 to 2001 were available for the present review and are summarized for all MC+ MCO Members statewide and regionally. Performance indicators were calculated and submitted for compilation by the Mental Health Subgroup Chairperson. For the present report, the aggregate indicator data were averaged for each MC+ Managed Care Region. Although this is not a scientifically sound methodology, it does provide some information for examining patterns of utilization across regions. The statewide indicator figures were calculated from raw data, and in some instances is not consistent with the average of the Regions. It is the more precise metric against which individual MCO or regional figures can be compared.

Because of the State- to- State variation in the administration of mental health benefits under Medicaid Managed Care, it is difficult to identify direct comparison figures or benchmarks for utilization measures among Medicaid recipients in other states. It should also be noted that the figures presented do not take into account variations in provider availability, local practice patterns, or differential member characteristics related to need and utilization.

Outpatient Mental Health Visits.

Outpatient mental health visits represent treatment in the least restrictive setting. This includes initial assessment, consultation, psychotherapy, medication management and in-home counseling. This indicator excludes C- STAR, category of Aid 4 (COA4) children, mental health services delivered by the primary care provider, and non claims- paid services. From 1999 to 2001, the average rate of outpatient visits per 1,000 MC+ Managed Care Members increased from 222.1 per 1,000 members to 290.7 per 1,000 members (see Figure 20). This trend in increased outpatient visits per 1,000 members was observed in all three MC+ Managed Care Regions. For 2001, the rate was highest in the Central Region (471.9 per 1,000 members) and lowest in the Eastern Region (203.3 per 1,000 members). The rate in the Western Region most closely approximated the statewide rate (286.4 per 1,000 and 290.7 per 1,000, respectively).

Figure 20. Mental Health Outpatient Visits, MC+ Managed Care Program.
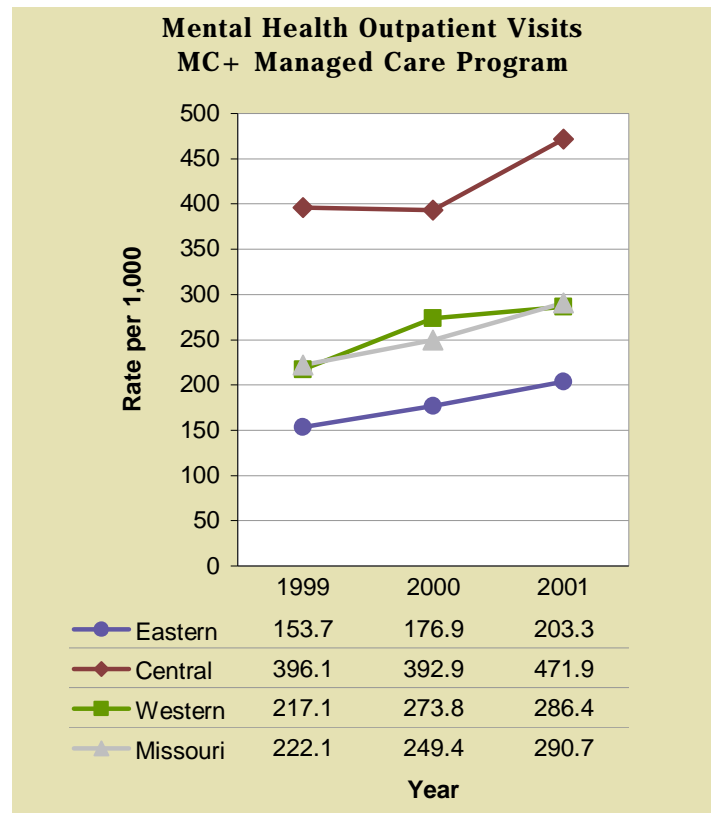
**Mental Health Outpatient Visits
MC+ Managed Care Program**

Rate per 1,000

	1999	2000	2001
Eastern	153.7	176.9	203.3
Central	396.1	392.9	471.9
Western	217.1	273.8	286.4
Missouri	222.1	249.4	290.7

Year

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+, 2003

Inpatient Mental Health Admissions and Days.

Inpatient treatment involves hospitalization in a specialty behavioral health hospital or treatment unit. The average rate of inpatient admissions per 1,000 MC+ Managed Care Members increased between 1999 and 2000 (from 6.3 to 11.3 per 1,000 members) and declined in 2001 (8.3 per 1,000; see Figure 21). This trend was noted in the Central and Eastern Regions. In the Western Region, which consistently had the lowest rates of inpatient admission, the rate increased. In 2001, the rate of inpatient admissions per 1,000 members was highest in the Eastern Region (8.6 per 1,000 members) and lowest in the Central Region (7.9 per 1,000).

Figure 21. Mental Health Inpatient Admissions, MC+ Managed Care Program.
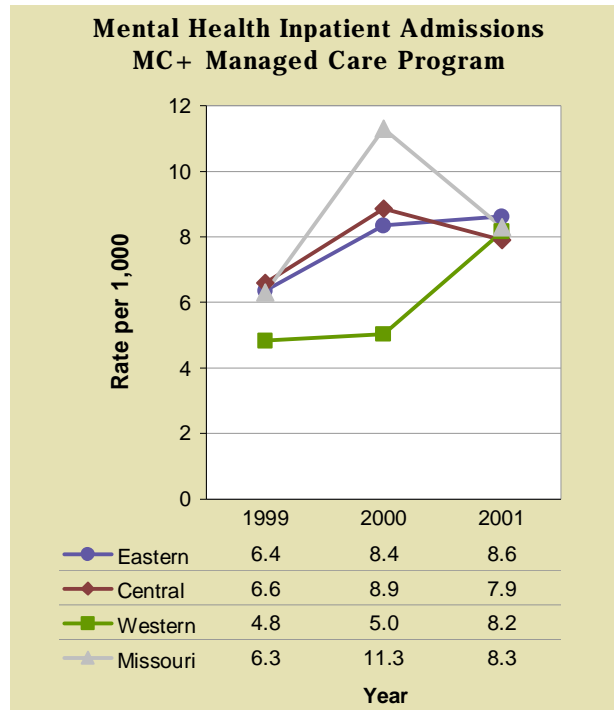
Mental Health Inpatient Admissions MC+ Managed Care Program

	1999	2000	2001
Eastern	6.4	8.4	8.6
Central	6.6	8.9	7.9
Western	4.8	5.0	8.2
Missouri	6.3	11.3	8.3

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+, 2003

The rate of inpatient days includes 23- hour inpatient and all 24- hour facility- based care, per the Health Employer Data Information Set (HEDIS) 2001 definition. The rate of mental health hospitalization days per 1,000 MC+ Managed Care Members increased from 1999 to 2000 (an average of 31. 5 days per 1,000 to 40.4 days per 1,000), then declined slightly to 37.8 days per 1,000 in 2001 (see Figure 22). This trend was observed across all three MC+ Managed Care Regions, with the rates relatively consistent in all three regions during 2001 (38.5 days per 1,000 members in the Eastern Region, 36.3 days per 1,000 members in the Central Region, 38.1 days per 1,000 members in the Western Region). The rate of days per 1,000 members increased the most in the Western Region and is currently consistent with those observed in the Central and Eastern Regions.

Figure 22. Mental Health Inpatient Days, MC+ Managed Care Program.
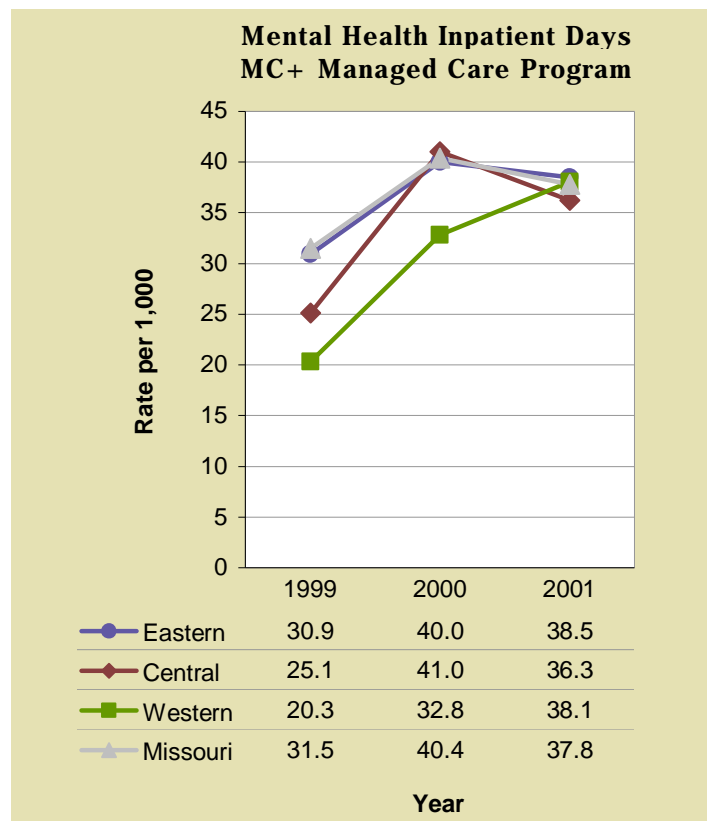
**Mental Health Inpatient Days
MC+ Managed Care Program**

	1999	2000	2001
Eastern	30.9	40.0	38.5
Central	25.1	41.0	36.3
Western	20.3	32.8	38.1
Missouri	31.5	40.4	37.8

Year

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+, 2003

Mental Health Ambulatory Follow- Up Visits.

Ambulatory follow- up refers to the percent of members who had an ambulatory day or night mental health visit within 7 or 30 days of discharge. This is a function of both mental health provider and member behavior. The average rate of 7- and 30- day follow- up after discharge increased in all three MC+ Managed Care Regions of the State over the last three years of available data (see Figures 23 and 24). The average rate of follow- up 7 days after discharge increased steadily from 1999 (17.8%) to 2001 (29.7%), with the Western Region having the highest rate (35.2%) and the Eastern Region having the lowest rate (24.2%). Commercial MCOs reporting their performance on this indicator evidenced rates ranging from 46.1% to 53.0% nationwide in 2001.[1]

Figure 23. Mental Health Ambulatory Follow-Up Visit (7 Days), MC+ Managed Care Program .

Mental Health Ambulatory Follow- Up Visit (7 Days) MC+ Managed Care Program

	1999	2000	2001
Eastern	16.7%	20.7%	24.2%
Central	10.4%	30.4%	32.4%
Western	26.1%	29.4%	35.2%
Missouri	17.8%	27.6%	29.7%

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+, 2003

Ambulatory follow-up 30 days after discharge showed an increase from 35.8% to 53.3% between 1999 and 2001, with all MC+ Managed Care Regions showing a similar increase. The highest rates were evidenced in the Central and Western Regions (57.5% and 57.7%, respectively) and the lowest was noted in the Eastern Region (48.0%) for 2001 (see Figure 24). Commercial MCOs reporting their performance on this indicator evidenced rates ranging from 68.8% to 74.8%. The HEDIS rate for Missouri MCOs (all MCOs) was 72.4%, while the rate for MC+ MCOs was 53.3%.[10]

Figure 24. Mental Health Ambulatory Follow-Up Visit (30 Days), MC+ Managed Care Program.
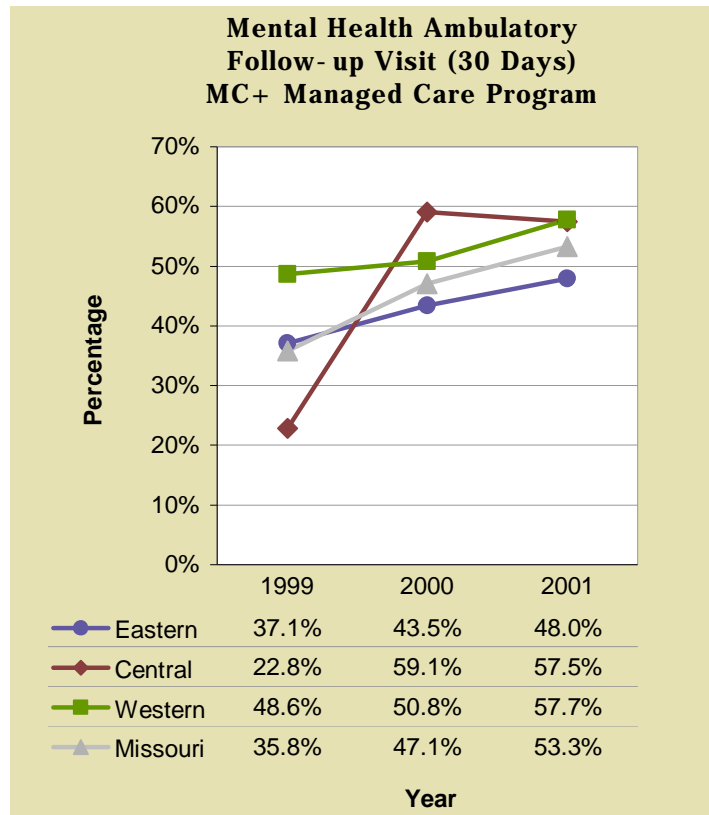
	1999	2000	2001
Eastern	37.1%	43.5%	48.0%
Central	22.8%	59.1%	57.5%
Western	48.6%	50.8%	57.7%
Missouri	35.8%	47.1%	53.3%

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+ Managed Care, 2003

Inpatient Substance Abuse Admissions.

The MC+ Managed Care statewide rate of substance abuse treatment inpatient admissions has remained relatively stable since 1999 (1.2 per 1,000 members in 1999 and 1.1 per 1, 000 members in 2001). In the Eastern and Western Regions, there were declines in the rates per 1,000 between 2000 and 2001, while in the Central Region, there was an increase between 2000 and 2001 (see Figure 25). Nevertheless, the Western Region rate was the lowest in 2001 (0.6 per 1,000 members), while the rate in the Eastern Region was the highest (1.6 per 1,000 members).

Figure 25. Inpatient Substance Abuse Admissions, MC+ Managed Care Program.

Inpatient Substance Abuse Admissions MC+ Managed Care Program

	1999	2000	2001
Eastern	2.4	2.4	1.6
Central	0.5	0.6	1.1
Western	0.1	0.8	0.6
Missouri	1.2	1.5	1.1

Year

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+, 2003

Substance Abuse Days.

The rate of substance abuse days includes inpatient days for substance abuse and detoxification. The rate of substance abuse days per 1,000 MC+ Managed Care Members statewide ranged from 2.7 days per 1,000 members in 1999 to 5.1 days per 1,000 members in 2000, and 3.3 days per 1,000 members in 2001. The rates across each MC+ Managed Care Region varied substantially, with a rate of 1.1 per 1,000 members in the Central Region to 5.3 days per 1,000 members in the Eastern Region during 2001 (see Figure 26).

Figure 26. Inpatient Substance Abuse Days, MC+ Managed Care Program.
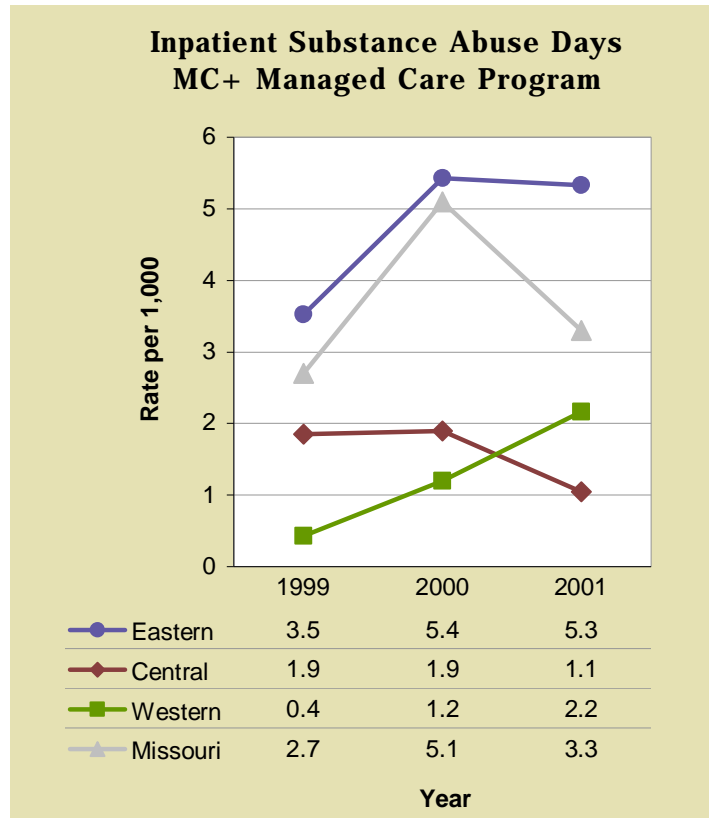
Inpatient Substance Abuse Days MC+ Managed Care Program

	1999	2000	2001
Eastern	3.5	5.4	5.3
Central	1.9	1.9	1.1
Western	0.4	1.2	2.2
Missouri	2.7	5.1	3.3

Year

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+, 2003

Other Indicators.

The Mental Health Subgroup has monitored a number of other indices for MC+ Managed Care quality improvement that are currently being refined. These include penetration rates for children, adolescents, adults, and elderly; partial hospitalization admissions and days; alternative service use; and residential service use. It is anticipated that the supplementary measures as well as the standardization of definition of these measures will provide solid quality improvement and utilization indicators for monitoring access to care in the least restrictive environment as well as access to and utilization of long-term care.

Summary of MC+ Managed Care Service Use

> **Service use for children and MC+ Managed Care Members was examined through the use of the MCH Trend Indicators, analysis of the administrative claims data for 2002, and examination of the aggregate Mental Health Indicators compiled by the Mental Health Subgroup of the QA & I Advisory Group.**

- **Based on MCH Trend Indicators, there were statistically significant improvements in acute care service use for children[11] in nearly all MC+ Managed Care Regions since MC+ Managed Care began, including reductions in:**

  m **Preventable hospitalizations**

  m **Emergency room visits**

  m **Asthma emergency room visits**

  m **Asthma hospitalization admissions**

- **Analysis of administrative claim data found increases in service use for MC+ Managed Care Members, as evidenced by encounter claims submissions, for all types of claims between CY1998 and CY2002. These included:**

  m **Home health**

  m **Outpatient**

  m **Medical**

  m **Dental**

  m **Inpatient**

  m **Pharmacy**

- **Administrative claims data showed that from CY2000 to CY2001, the rate of claims (per 1,000 MC+ Managed Care Members) leveled off or declined for all but pharmacy claims, which increased from 1,828 to 2,764 per 1,000 members.**

- **Administrative claims data showed that for all services, rates of services per MC+ Managed Care recipient increased for all ages from birth to 21 years, between CY2001 and CY2002. Those one year of age and under as well as those 15 years of age and older received more services on average.**

- **Administrative claims data showed that for MC+ Managed Care inpatient claims, the most frequent Diagnosis-Related Groups (DRGs) were:**

  m **Normal newborn (12.1%)**

  m **Extensive operating room procedure (10.8%)**

  m **Vaginal delivery, no medical complications (10.0%)**

  m **Psychoses (6.9%)**

  m **Term neonate with problems (7.5%)**

  m **Cesarean Section (6.1%)**

  m **Dental diagnosis (2.9%)**

  m **Bronchitis, Asthma (3.0%)**

- **Administrative claims data showed that a full 35% of MC+ Managed Care hospital admissions were for childbirth, either assigned to a newborn or delivery- related DRG.**

- **Mental Health Indicator data showed the following statewide changes in mental health service utilization for MC+ Managed Care Members between CY1999 and CY2001.**

  m **Increased outpatient mental health visits**

  m **Decreased mental health inpatient admissions**

  m **Stable mental health inpatient days**

  m **Increased rate of mental health ambulatory follow- up**

  m **Decreased substance abuse admissions**

  m **Decreased substance abuse days**

Access to Care

MC+ Managed Care Mental Health Penetration Rates

Access to care was examined using available aggregate data from Mental Health Indicators, the provider network adequacy analysis, and complaints and grievances from members and providers submitted by the MCOs. Penetration rates represent the unduplicated number of members accessing services in the calendar year, adjusted for average monthly member enrollment for the same year. Total mental health penetration rates (all age groups) steadily increased from an average of 5.2% to 5.9% statewide between 1999 and 2001 (see Figure 27). This is consistent with specialty mental health penetration rates of 5.6% to 5.9% per year.[12] "Excellent behavioral health networks have penetration rates of 8% to 10% or greater, whereas average ones will have a rate between 5% and 6%".[13]

Figure 27. Total Mental Health Penetration Rates, MC+ Managed Care Program.
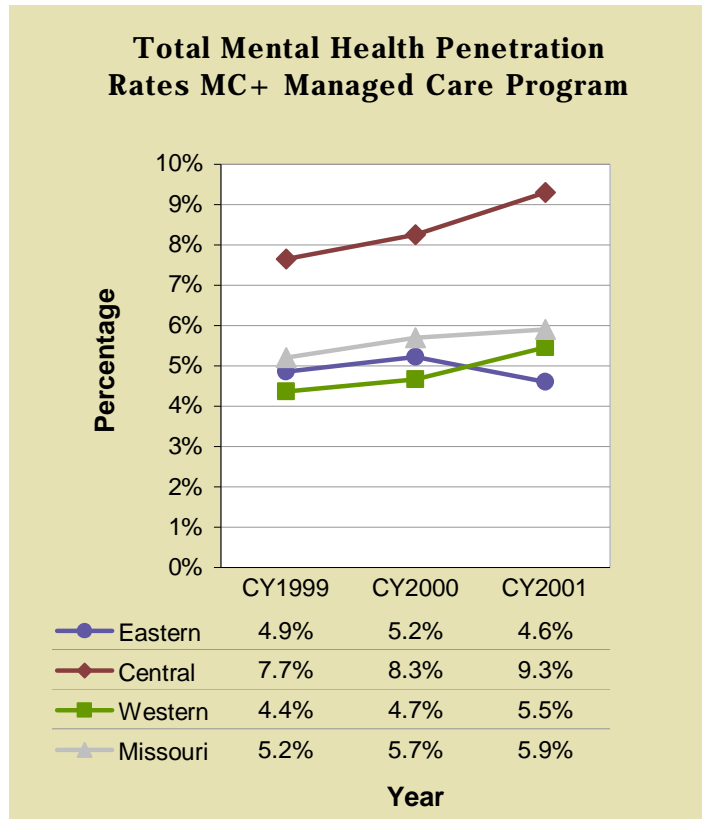
Total Mental Health Penetration Rates MC+ Managed Care Program

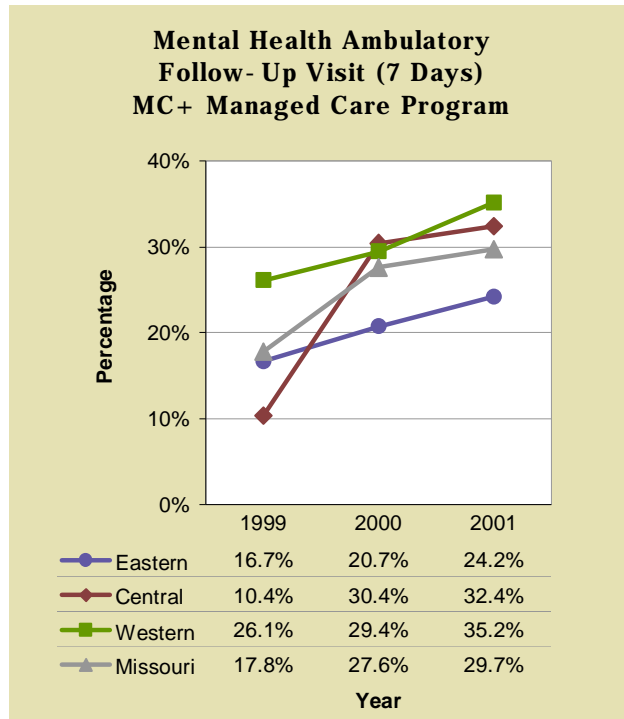|	CY1999	CY2000	CY2001
Eastern	4.9%	5.2%	4.6%
Central	7.7%	8.3%	9.3%
Western	4.4%	4.7%	5.5%
Missouri	5.2%	5.7%	5.9%

Source: Missouri Department of Mental Health and Missouri Department of Social Services, Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group for MC+, 2003

MC+ Managed Care Network Adequacy
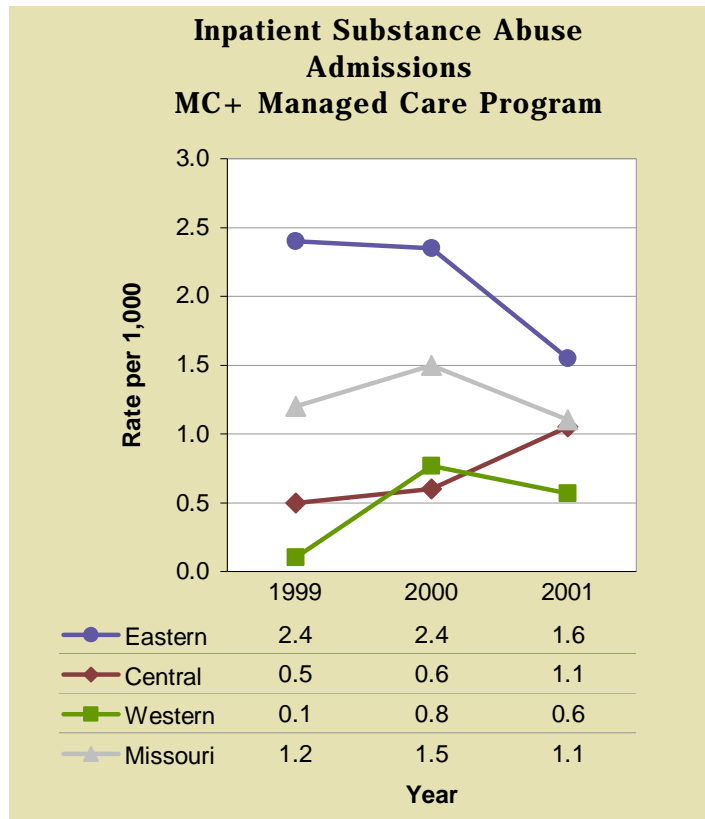
Another method of evaluating access to care is through examination of the adequacy of the MC+ Managed Care provider network. Providers are the individual physicians and health care providers as well as hospital and hospice facilities. To evaluate access and provider availability, the Provider Network Adequacy Filings for calendar years 2001 and 2002 were examined. This is based on network filings of MCOs to the Missouri Department of Insurance (MDI) as of December 31, 2000 and December 31, 2001, respectively. This is the same process used for commercial and Medicare MCOs in the State of Missouri. Managed Care Organizations made a number of improvements throughout the calendar year 2002, which are not all reflected in the data filings submitted as of December 31, 2001, but are detailed in their individual reports. The data presented reflect the assessment of the capacity of each MCO to serve the <u>entire</u> MC+ Managed Care population in the respective Regions. Although detailed in the provider network adequacy filings, the data presented do not reflect MCO - or county- level access standards, actual availability of specific providers, whether panels are open or closed, or provider shortages in specific regions. Finally, the data alone do not provide explanation of the reasons for which network adequacy may have changed, which were gleaned from site visits. Additional detail regarding improvements and strategies for assuring access for each MCO is provided in individual MCO reports. Several areas of provider network adequacy were examined. They include:

- **Primary Care Providers (PCPs; e.g., family practitioners, internists, pediatricians)**

- **Specialists (e.g., Psychiatrists, Oncologists, Rheumatologists)**

- **Facilities (e.g., tertiary care, specialty rehabilitation or behavioral health facilities)**

- **Ancillary Services (e.g., occupational therapists, physical therapists, speech/language pathologists)**

- **Overall adequacy (a summary of PCPs, specialists, facilities, and ancillary services)**

Figure 28 shows the rates of network adequacy by MC+ Managed Care Region and statewide for each type of provider. The MDI has set a standard of 95% adequacy of providers by county and by provider for MCOs.

Figure 28. Network Adequacy, CY2002, MC+ Managed Care Program.

Network Adequacy CY2002
MC+ Managed Care Program

	PCP	Specialists	Facilities	Ancillary Services	Overall Network
Eastern	100.0	97.5	98.8	96.9	98.1
Central	100.0	98.8	99.8	98.5	99.0
Western	100.0	97.8	99.2	97.6	98.3
Missouri	100.0	98.0	98.9	97.4	98.6

Type of Provider
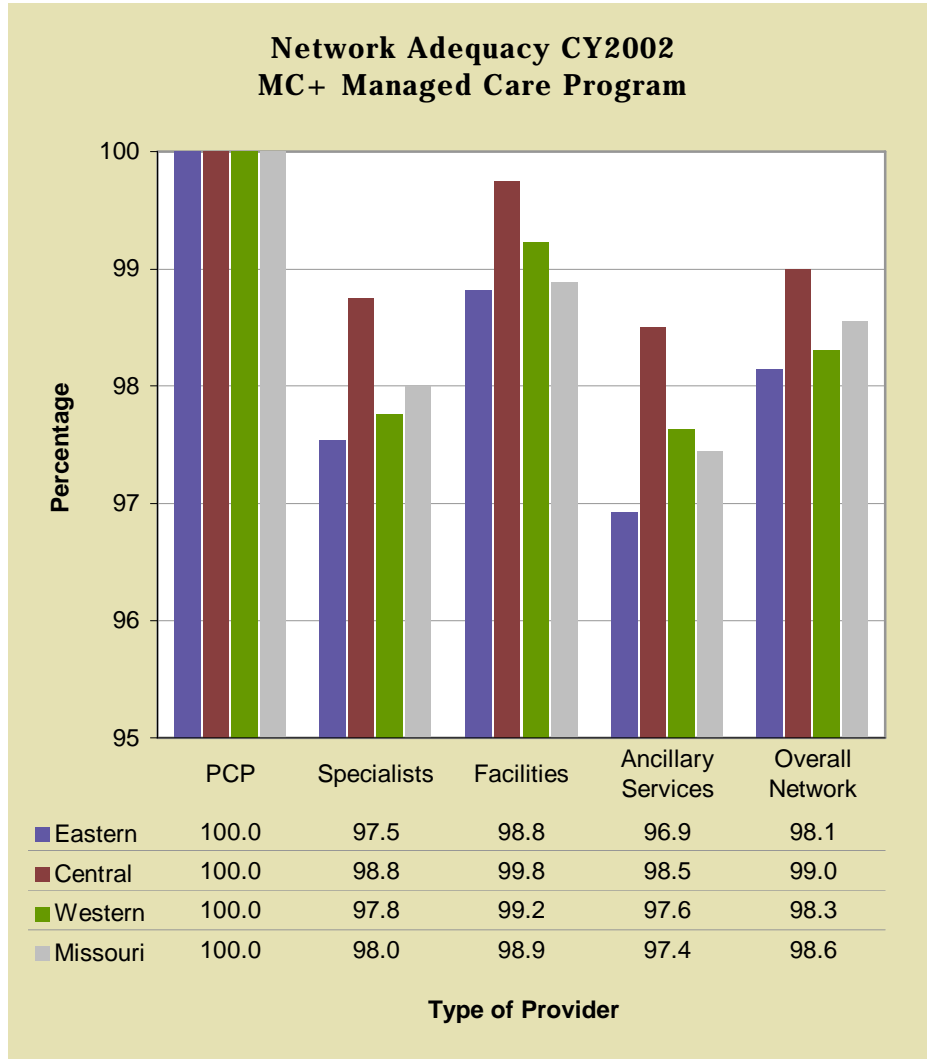
Source: Missouri Department of Insurance, 2003

Statewide.

There were noted improvements in provider network adequacy in each of the MC+ Managed Care Regions between 2001 and 2002:

- Overall network provider adequacy (across PCPs, specialists, facilities, and ancillary services) increased from 97.7% to 98.6%, remaining above the 95% threshold.

- Rates of ancillary services increased from 94.7% to 97.4%, above the 95.0% threshold.

- Rates of facilities coverage increased from 97.0% to 98.9%, remaining above the 95.0% threshold.

- Rates of PCP and specialty providers remained stable (100.0% and 98.0% adequacy for PCPs and specialists, respectively), above the 95.0% threshold.

A majority of the changes in provider network adequacy that occurred on a regional level represent improvements in and stability of the provider network from 2001 to 2002, and bring a number of areas of network adequacy into compliance with MDI criteria which specify that each MCO meet or exceed the 95% threshold of adequacy for providers in each MC+ Managed Care county, or request and obtain exceptions for provider shortages. The following is a summary of provider network adequacy by MC+ Managed Care Region.

Eastern Region.

- Overall network rates and rates for PCPs, specialists, facilities, and ancillary providers increased slightly in the Eastern Region, remaining above the 95.0% threshold (ranging from 96.9% to 100.0%).

- The rate of hospice providers increased from 83.5% to 92.0%.

- The rate of child/adolescent outpatient psychiatric facilities increased from 92.0% to 98.0%, above threshold.

- The rates of adult outpatient psychiatric facilities increased from 80.0% 94.0%.

- Rates for geriatric facilities increased from 92.0% to 96.0%, above threshold.

- Although remaining below threshold, the rates of adult inpatient intensive psychiatric treatment improved, from 86.0% to 93.0%.

- There was a decline in network adequacy rates for child/adolescent psychiatry providers, from 94.0% to 93.5%.

- Radiology network adequacy rates declined from 95.3% to 93.0%, below threshold for adequacy.

- Rheumatology rates declined from 97.0% to 94.3%, below threshold.

- There was a decrease in audiology service providers from 93.3% to 92.3%.

- There was a decline in the rates of speech/language therapists from 100.0% to 94.5%, below threshold.

- The Eastern Region remained below threshold in tertiary hospital facilities from 93.0% to 93.7%.

- There was a small decline in network adequacy rates for physical medicine and rehabilitation specialties, from 94.5% to 93.8%.

- Infectious disease specialty rates increased from 72.8% to 78.3%, although remaining below threshold of 95.0% adequacy.

Central Region.

- Overall network rates and rates for PCPs, specialists, facilities, and ancillary providers increased slightly in the Central Region, remaining above the 95.0% threshold (ranging from 98.5% to 100.0%).

- Emergency medicine filings in the Central Region increased from 50.0% to 100.0%, above threshold.

- Network adequacy for pathology increased from 64.5% to 100.0% adequacy, above threshold.

- There was stability in adequacy rates for ancillary service providers (98.5%), above threshold.

- There was stability in the rates for facilities (99.8%), above threshold.

Western Region.

- Overall network rates and rates for PCPs, specialists, facilities, and ancillary providers increased slightly in the Western Region, remaining above the 95.0% threshold (ranging from 97.6% to 100%).

- The Western Region improved ancillary provider network adequacy from an average of 91.7% to 97.6% from 2001 to 2002, raising the rate of ancillary service providers above the 95.0% threshold.

- There was an increase in the rates of home health providers, from 91.3% to 100.0% above threshold.

- There was an increase in the rate of hospice providers, from 74.0% to 87.3%, although still below threshold.

- The rates of child/adolescent psychiatry providers declined from 91.8% to 83.3%, remaining below threshold.

- The rates of rheumatology specialists remained slightly below threshold (93.7%).

MC+ Managed Care Member and Provider Complaints

MC+ Managed Care Member and Provider Complaints are another source of feedback regarding access to care and quality of care. Managed Care Organizations report quarterly to the Division of Medical Services (DMS) Quality Management Program the quantity and type of complaints received from members and providers. Figures for CY2001 were provisional last year, but are final at this time. Figures for CY2002 are provisional. Member and provider complaints are categorized into medical and non-medical complaints, with subcategories within each of these areas. BHC, Inc., calculated complaint rates per 1,000 members based on point-in-time MC+ Managed Care member enrollment to provide standard comparisons.

Member and provider complaints are encouraged as a mechanism for identifying opportunities for improvement within the system. The DMS has worked closely with a number of MCOs to <u>increase</u> the rate and tracking of complaints so as to better monitor the issues involved in healthcare delivery for MC+ Managed Care Members. Thus, the number or absolute rate of complaints should not be used to assess the relative effectiveness of MCO operations, but should be used to identify the types of issues raised by providers and members so as to prioritize areas for improvement.

Prior to presenting data on complaints related to access to care, the definitions of complaint data categories for members and providers, as well as medical and non-medical complaints are discussed to provide an overview of changes from CY2000 to CY2002. Specific complaints that relate to the quality of care are presented in a subsequent section of this report.

Member complaints: Medical.

- **Quality of Care includes the treatment not helping the patient, perceived lack of concern on the part of the provider, disagreement with the provider over treatment, disagreement with the provider regarding the diagnosis, complaints about emergency room treatment or delays, and other similar complaints.**

- **Appointment complaints include problems getting an appointment, the length of time before an appointment can be scheduled, and other similar complaints.**

- **Denial of Services refer to complaints regarding the denial of services, such as an emergency room visit, specialist referral, prescriptions, dental treatment, or other treatment.**

- **Other complaints include difficulty reaching the PCP office or receiving return phone calls, member requests to change PCPs, and other similar complaints.**

Figure 29 summarizes the rates of all MC+ Managed Care Member medical complaints by Region, from CY2000- CY2002. The findings indicate:

- The rate of member medical complaints ranged from .68 to 1.61 complaints per 1,000 members between CY2000 and CY2002.

- The rate of member medical complaints increased from .83 to 1.49 per 1,000 members between CY2000 and CY2002.

- The Eastern Region had the highest rate of member medical complaints in CY2002 (1.61 per 1,000 members). This increase may be due at least in part to the efforts to increase the rate of complaints and documentation of complaints.

Figure 29. Member Medical Complaints, CY2000-CY2002, MC+ Managed Care Program.
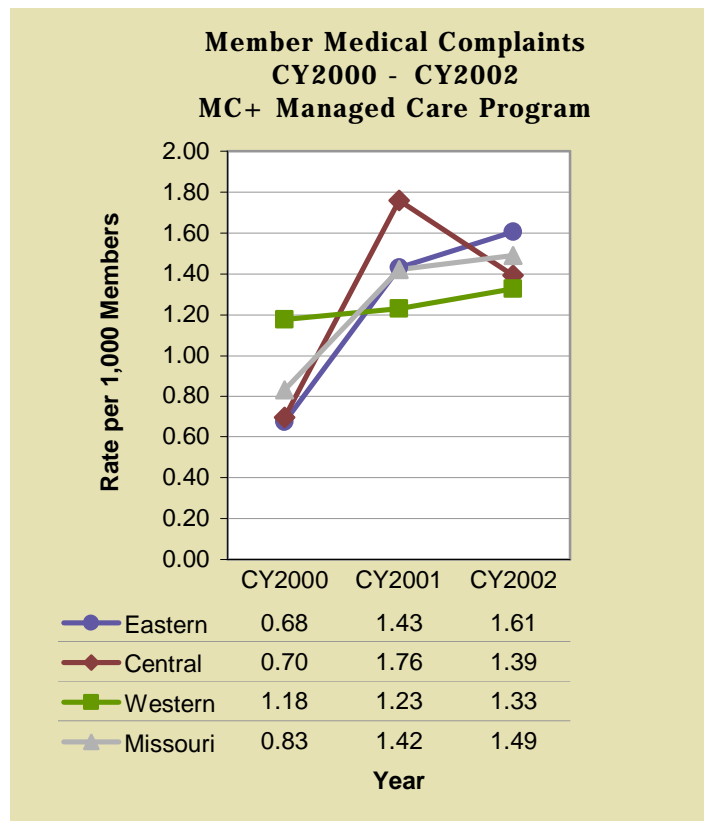
Member Medical Complaints
CY2000 - CY2002
MC+ Managed Care Program

	CY2000	CY2001	CY2002
Eastern	0.68	1.43	1.61
Central	0.70	1.76	1.39
Western	1.18	1.23	1.33
Missouri	0.83	1.42	1.49

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Member Complaints: Non- Medical.

- **Transportation complaints involve the ride not showing, the ride showing up late, inability to obtain transportation, rude behavior on the part of transportation personnel, ride not scheduled, and other transportation- related complaints.**

- **Interpreter complaints include requests for an interpreter.**

- **Denial of Claims involve the denial of claims, including denial of claims for treatment, emergency room services, etc.**

- **Waiting complaint refers to complaints regarding the provider office, such as excessive office wait time and other complaints.**

- **Staff Behavior refers specifically to behavior of the provider, office personnel, emergency room staff, and other personnel involved in the treatment of the member.**

- **Other complaints include the member being charged for services at the time services are rendered, the member receiving bills for services, the PCP being unavailable or refusing to see the member, the facility not being clean, and other complaints.**

Figure 30 illustrates the rates of all MC+ Managed Care member non-medical complaints by Region, from CY2000-CY2002. The findings indicate:

- **The rate of member non-medical complaints per 1,000 members ranged from .65 to 8.36 across the regions between CY2000 and CY2002, with the Eastern Region showing the highest rate of member non-medical complaints in CY2002.**

- **The rate of non-medical complaints increased steadily in the Eastern Region between CY2000 and CY2002.**

Figure 30. Member Non-Medical Complaints, CY2000-CY2002, MC+ Managed Care Program.

Member Non-Medical Complaints CY2000 - CY2002 MC+ Managed Care Program

	CY2000	CY2001	CY2002
Eastern	1.90	4.94	8.36
Central	0.65	1.76	1.96
Western	2.69	2.98	5.07
Missouri	1.97	3.90	6.41

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Provider complaints: Medical.

Data for provider complaints were available for 2001 and CY2002. The following are the definitions for provider medical complaints.

- **Quality of Care complaints include member non- adherence to treatment, members missing appointments and not receiving appropriate treatment, and other similar concerns.**

- **Denial of Services includes the denial of pharmacy authorizations, emergency services, and other treatment.**

- **Denial of Referrals involves the denial of specialist referrals.**

- **Other complaints include specialist accessibility, the member not appropriately using the emergency room, the member not listed as eligible, and inability to reach the member.**

Figure 31 shows the rates of provider medical complaints by Region from CY2001- CY2002. The rate of provider medical complaints declined over the last year in the Central Region, while the rates increased slightly in the Eastern and Western Region and remained stable in the Eastern Region.

Figure 31. Provider Medical Complaints, CY2001-CY2002, MC+ Managed Care Program.
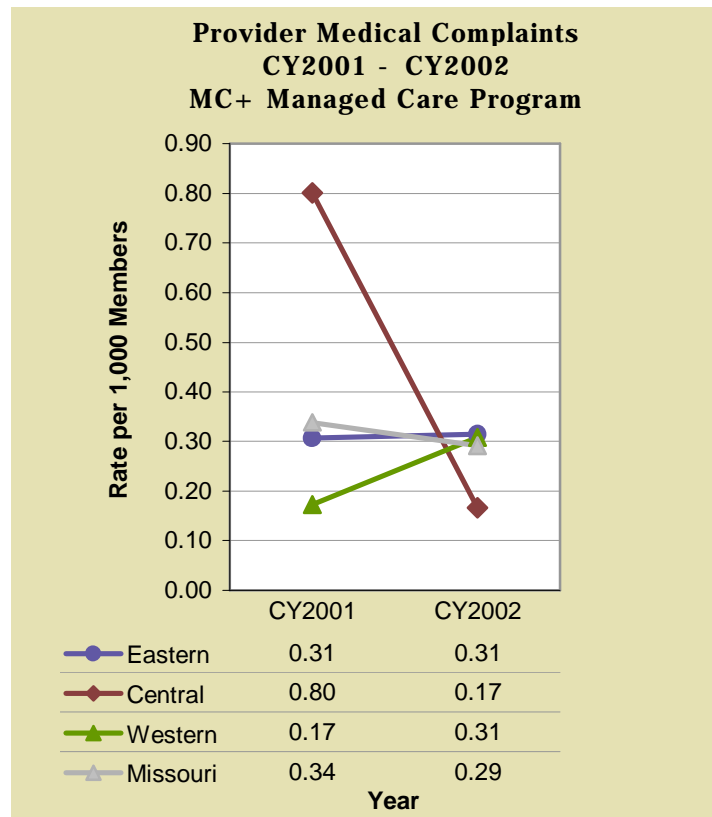
Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Provider Complaints: Non- Medical.

The following are definitions of provider non- medical complaints:

- **Transportation complaints include the member missing an appointment as a result of transportation difficulties, the member arriving too late or early for the appointment, and other similar complaints.**

- **Interpreter complaints include difficulty with interpreter services for a member.**

- **Billing and Prior Authorization include issues related to the process of prior authorization for services and payment for services. This category was discontinued in CY2002.**

- **Complaints Regarding State or MCOs include claims being denied incorrectly, difficulty getting the provider on the telephone, the provider not receiving enough reimbursement, and MCOs denying services. This category was new for CY2002.**

- **Denial of Claims include no authorization for services, benefit not covered, non-participating provider payment, and hospitalization denials.**

- **Other complaints include member behavior, member requesting to be disenrolled, and provider inability to get the claims processed.**

Figure 32 shows the rate of provider non-medical complaints by region, from CY2001-CY2002. The same pattern of provider non-medical complaints was observed in the Central Region, with the rates declining between CY2001 and CY2002. The non-medical complaint rate increased in the Eastern and Western Regions between CY2001 and CY2002.

Figure 32. Provider Non-Medical Complaints, CY2001-CY2002, MC+ Managed Care Program.

**Provider Non-Medical Complaints
CY2001 - CY2002
MC+ Managed Care Program**

	CY2001	CY2002
Eastern	11.29	13.25
Central	12.60	8.60
Western	1.99	3.24
Missouri	8.75	9.50

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Member Complaints: Access.
Member and provider complaint data are collected and reported for a number of specific medical and non-medical complaints, as defined earlier. To examine member and provider-reported issues related to access, specific categories of complaints were reviewed. This section provides an overview of the types of issues and their relative importance to members and providers. Member complaint data for CY2002 were examined further to provide information about the ability of members to access care. Access to care was examined using the following member complaint categories as defined earlier:

- **Transportation**

- **Denial of Services**

- **Appointment**

- **Denial of Claims**

- **Waiting**

- **Other Non-Medical complaints**

- **Interpreter**

Figure 33 illustrates the types of member access complaints by MC+ Managed Care Region. The most frequent complaints related to access to care were complaints regarding transportation services, followed by denial of services, problems with the timeliness of appointments, waiting, denial of claims, other non-medical complaints, and interpreter complaints. The proportion of transportation complaints was lower in the Central than in the Eastern and Western Regions. Managed Care Organizations report that transportation needs are less of an issue to members in the Central Region than in the Eastern and Western Regions. Transportation complaint rates are highest in the Eastern Region (7.04 per 1,000 members). This is at least in part due to some strong efforts on the part of the State and MCOs to improve the documentation of transportation complaints by the vendor.

Figure 33. Member Access Complaints, CY2002, MC+ Managed Care Program.
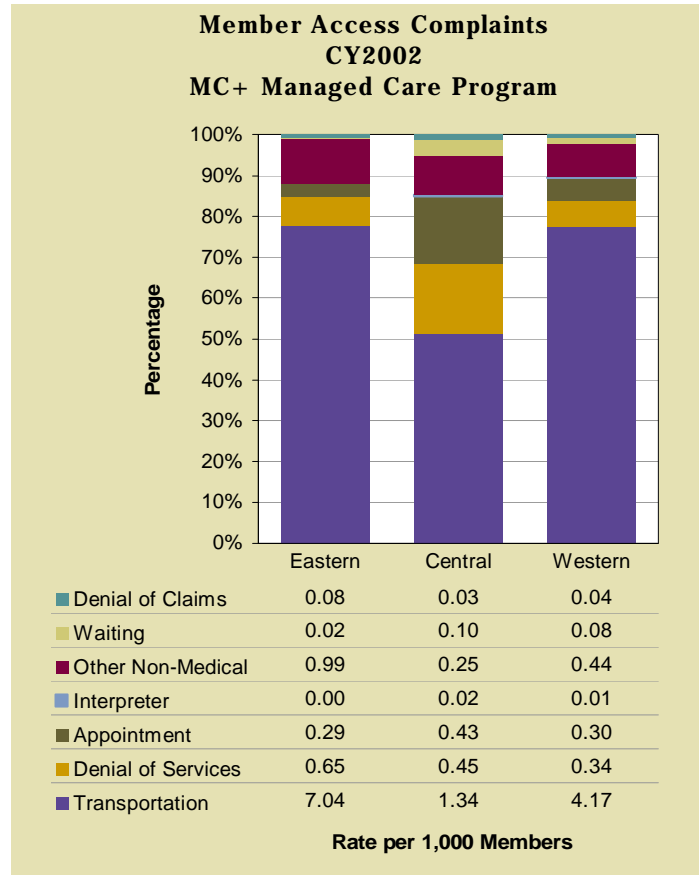
Member Access Complaints
CY2002
MC+ Managed Care Program

	Eastern	Central	Western
■ Denial of Claims	0.08	0.03	0.04
■ Waiting	0.02	0.10	0.08
■ Other Non-Medical	0.99	0.25	0.44
■ Interpreter	0.00	0.02	0.01
■ Appointment	0.29	0.43	0.30
■ Denial of Services	0.65	0.45	0.34
■ Transportation	7.04	1.34	4.17

Rate per 1,000 Members

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

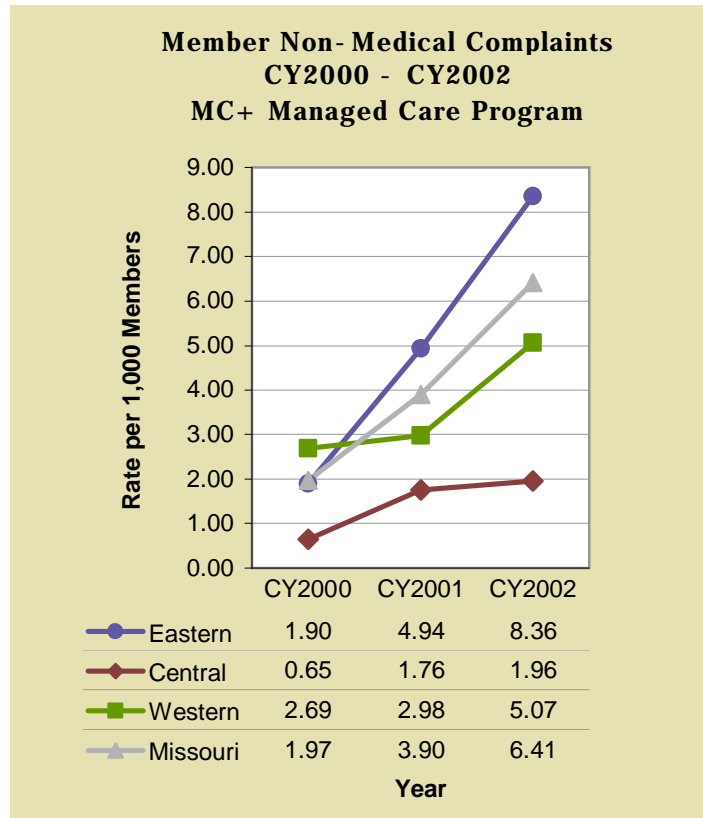**In the Central Region, other complaints were primarily related to:**

- **Denial of service**

- **Problems with timeliness of getting an appointment**

- **Other non- medical issues**

In the Eastern and Western Regions, the most frequent complaints involved:

- **Other non- medical complaints**

- **Denial of services**

- **Problems with timeliness of getting an appointment.**

Figures 34 through 39 illustrate the subcategories of member access complaints, for the most frequent complaints. Although only approximately 10% of members actually use transportation services, a majority of all access complaints related to the quality of these services. A majority of complaints regarding transportation services related to the ride showing up at a time other than the scheduled time (Late/Early, 55.8%), followed by the ride not showing up at all (No- Show, 35.0%).

Figure 34. Member Transportation Complaints, CY2002, MC+ Managed Care Program.
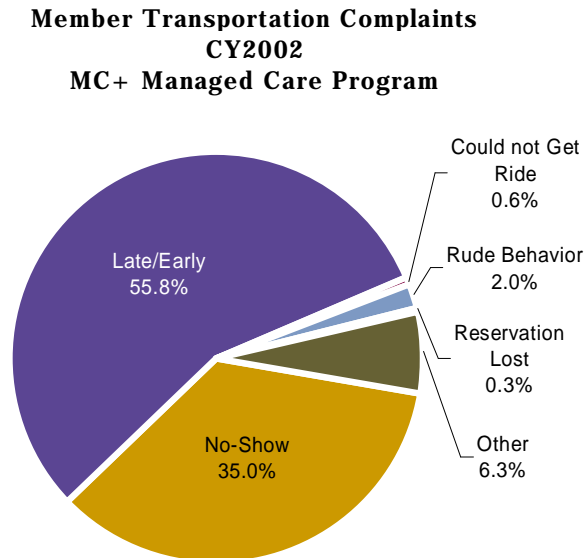
**Member Transportation Complaints
CY2002
MC+ Managed Care Program**

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

The denial of services was the next highest rate of complaints per 1,000 MC+ Managed Care Members (see Figure 35). Specific complaints were regarding the denial of treatment (59.9%), followed by the denial of a prescription (20.3%), denial of a primary care physician or dental appointment (12.9%), denial of other services (5.1%), and denial of specialty care (1.8%).

Figure 35. Member Denial of Services Complaints, CY2002.

**Member Denial of Services
Complaints CY2002
MC+ Managed Care Program**

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Another type of member complaint examined to evaluate the accessibility of care was the complaints regarding the timeliness of appointments (see Figure 36). MC+ Managed Care Members in the Eastern and Western Regions reported fewer timeliness of appointment complaints than those in the Central Region. A majority of these complaints were comprised of complaints regarding the ability to get an appointment (53.8%), the length of time to get an appointment (42.3%), and other appointment complaints (3.8%). Thus, although the provider network is adequate to serve the population of MC+ Managed Care Members, there are some concerns expressed by members about being able to get an appointment within a timeframe that is perceived to be reasonable.

Figure 36. Member Timeliness of Appointment Complaints, CY2002, MC+ Managed Care Program.

Member Timeliness of Appointment Complaints CY2002 MC+ Managed Care Program

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003
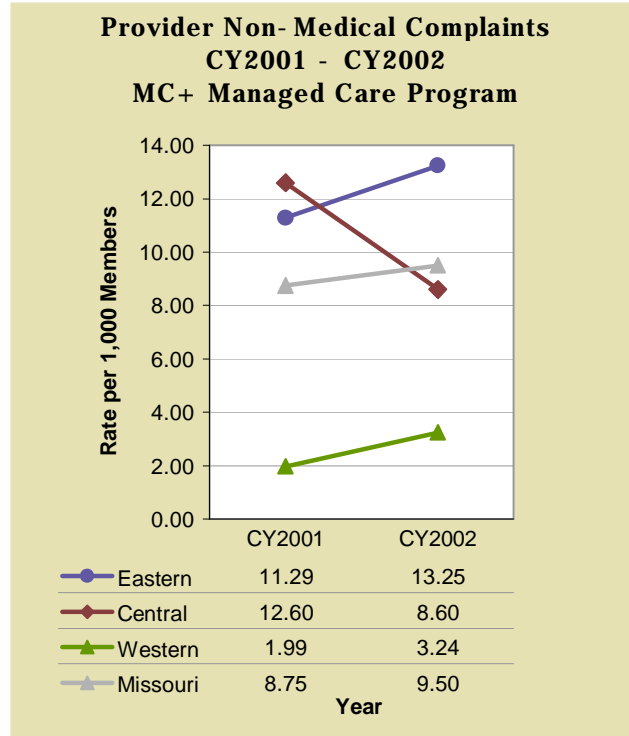
MC+ Managed Care Member complaints regarding the denial of claims consisted of complaints regarding the denial of claims for treatment (83.3%) and other services (16.7%; see Figure 37).

Figure 37. Member Denial of Claims Complaints, CY2002, MC+ Managed Care Program.

**Member Denial of Claims Complaints
CY2002
MC+ Managed Care Program**

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

The time that MC+ Managed Care Members wait in the office is also considered an access to care indicator. The complaints regarding waiting in provider offices related to the amount of time spent waiting in the office 61.9% (see Figure 38), or some type of delay during the appointment (38.1%).

Figure 38. Member Office Waiting Complaints, CY2002, MC+ Managed Care Program.

**Member Office Waiting Complaints
CY2002
MC+ Managed Care Program**

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Other MC+ Managed Care member non- medical complaints potentially impacting access to care were also examined (see Figure 39). The most significant complaint in this category was the member receiving bills (68.1%), followed by other non- medical complaints (21.7%), and the member being charged at the time of the appointment (6.4%). However, it should be noted that all of these complaints combined occurred at very low rates (.03 to .04 per 1,000 members).

Figure 39. Other Member Non-Medical Complaints, CY2002, MC+ Managed Care Program.

Other Member Non- Medical Complaints
CY2002
MC+ Managed Care Program

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Interpreter complaints were reported only in the Western Region, at a rate of .01 per 1,000 members.

Provider Complaints: Access

Access to care was examined using the following provider complaint types:

- **Denial of Claims**

- **Provider Complaints with the State or MCO**

- **Denial of Services**

- **Transportation**

- **Interpreter**

- **Other Non-Medical**

Figure 40 shows the types of MC+ Managed Care provider complaints by Region. To evaluate access from the perspective of providers, the most significant complaints of providers were examined. The highest rate of complaints from providers related to the denial of claims, complaints with the State or MCO, denial of services, other non-medical issues, transportation, and interpreter services.

Figure 40. Provider Access Complaints, CY2002, MC+ Managed Care Program.
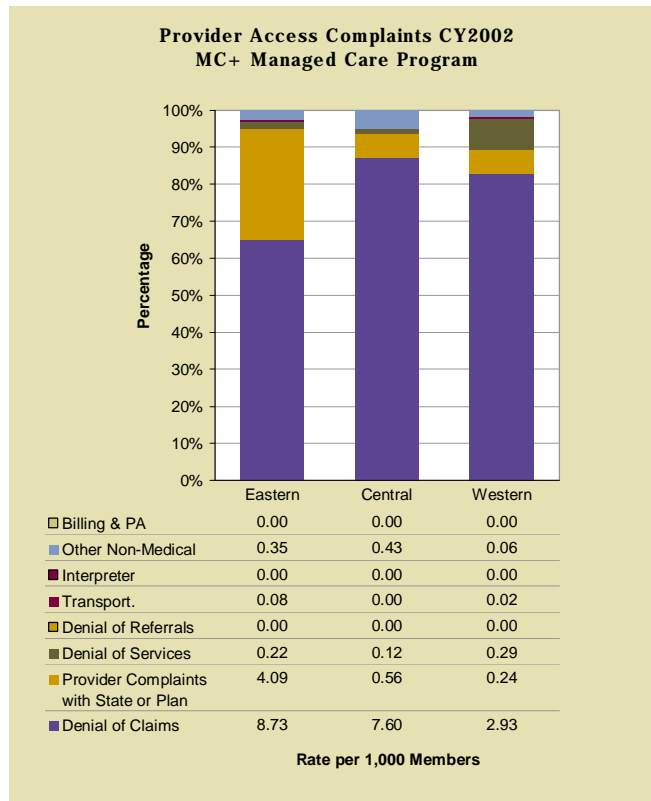
Provider Access Complaints CY2002 MC+ Managed Care Program	Eastern	Central	Western
Billing & PA	0.00	0.00	0.00
Other Non-Medical	0.35	0.43	0.06
Interpreter	0.00	0.00	0.00
Transport.	0.08	0.00	0.02
Denial of Referrals	0.00	0.00	0.00
Denial of Services	0.22	0.12	0.29
Provider Complaints with State or Plan	4.09	0.56	0.24
Denial of Claims	8.73	7.60	2.93

Rate per 1,000 Members

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Denial of claims constituted the largest proportion of provider complaints across all of the MC+ Managed Care Regions, ranging from 2.93 to 8.73 complaints per 1,000 members. The next highest rates of complaints were about the State or MCO, the denial of services, transportation complaints, other non-medical complaints, and complaints regarding interpreter services.

Although the denial or payment of claims is not directly related to a member seeking or receiving services, this is one aspect of the system that may influence the participation of providers in the MC+ Managed Care Program (see Figure 41). The rate of complaints regarding the denial of claims was the lowest in the Western Region. Of the denial of claims complaints received from providers, the most frequent were complaints in which no authorization was provided because treatment was approved in advance (34.1%), followed by timely filing (29.5%), and no authorization for hospitalization (23.5%).

Figure 41. Provider Denial of Claims Complaints, CY2002, MC+ Managed Care Program.

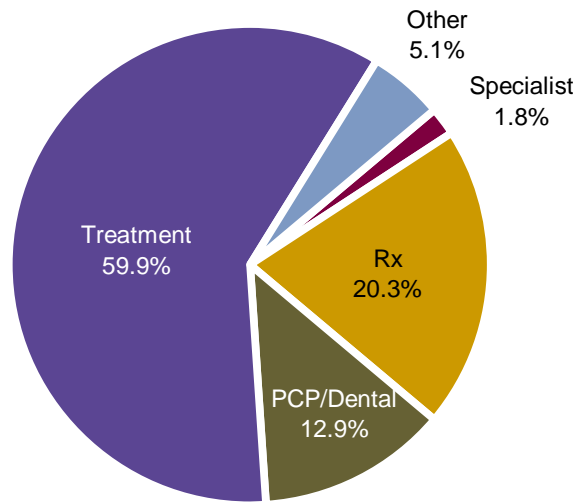**Provider Denial of Claims Complaints**
CY2002
MC+ Managed Care Program
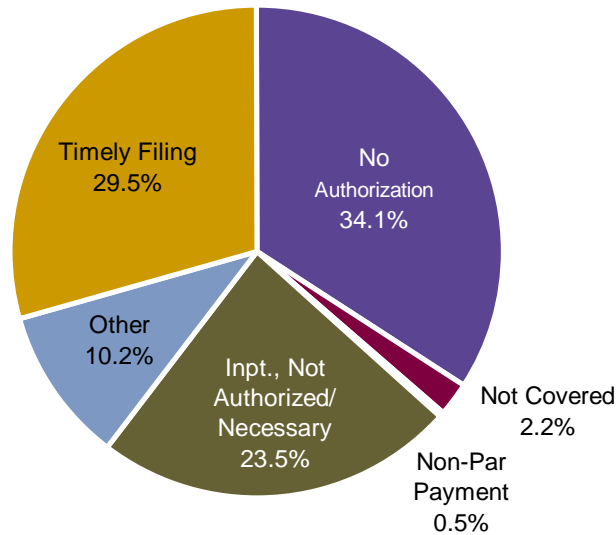
Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Another systems issue that may impact the long-term accessibility to healthcare is the manner in which MCOs and the State manage healthcare services for MC+ Managed Care Members. The Central and Western Regions had the lowest rates of provider complaints with the State and MCO than observed in the Eastern Region.

Provider complaints with the State or MCO were the second most frequent complaint relating to access of care, ranging from .24 to 4.09 per 1,000 members (see Figure 42). Of these complaints, the majority involved complaints that the rates of reimbursement are not enough (92.5%). Few complaints regarding MCOs incorrectly denying a claim (4.6%), and other related issues (2.3%) were reported.

Figure 42. Provider Complaints with State or MCO, CY2002, MC+ Managed Care Program.

Provider Complaints with State or Plan
CY2002
MC+ Managed Care Program

Provider Not Getting Claim in System 0.2%

Plan Incorrectly Denied Services 0.0%

Claim Denied, Member not Showing as Enrolled 0.4%

Rates Not Enough or Incorrect 92.5%

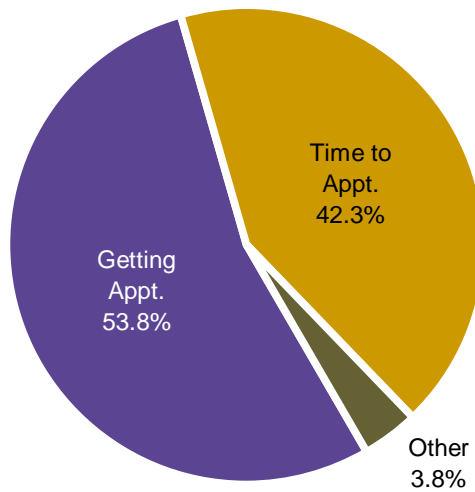Plan Incorrectly Denying Claim 4.6%

Other Provider Complaints 2.3%

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

The rate of complaints from MC+ Managed Care providers regarding the denial of services ranged from .12 to .29 per 1,000 members (see Figure 43). Of these, the most frequent complaint regarding the denial of services related to the treatment (61.7%), followed by prescription denials or an inability to verify the member's eligibility (29.8%). Very few complaints were related to the denial of emergency room (1.1%) treatment and other denials (7.4%).

Figure 43. Provider Denial of Services Complaints, CY2002, MC+ Managed Care Program.

**Provider Denial of Services Complaints
CY2002
MC+ Managed Care Program**

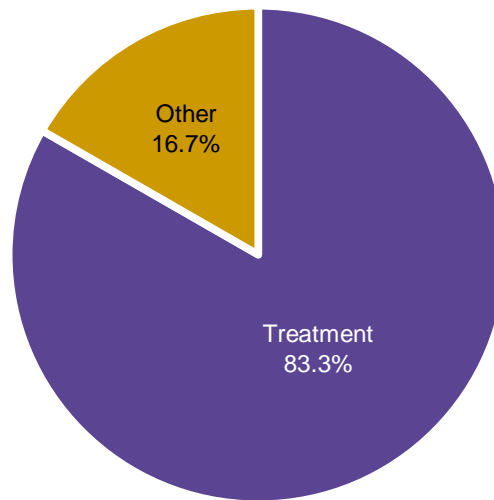*Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003*

One of the least frequent complaints per 1,000 MC+ Managed Care Members from providers was related to the transportation of the member. The rate of provider complaints ranged from 0 to .08 per 1,000 members (see Figure 44). Transportation complaints included the ride not showing up and/or the member missing the appointment (81.0%), the member not being on time for the appointment (9.5%), and other complaints regarding transportation services (9.5%).

Figure 44. Provider Transportation Complaints, CY2002, MC+ Managed Care Program.

**Provider Transportation Complaints
CY2002
MC+ Managed Care Program**

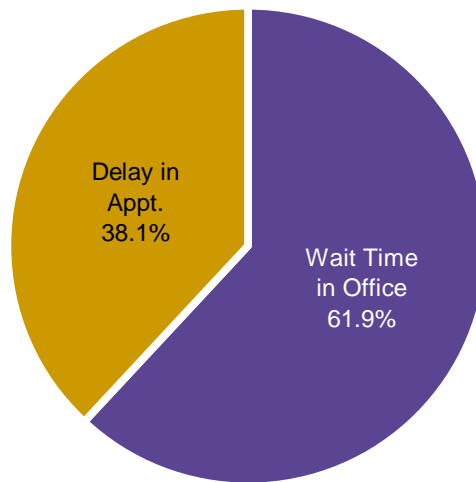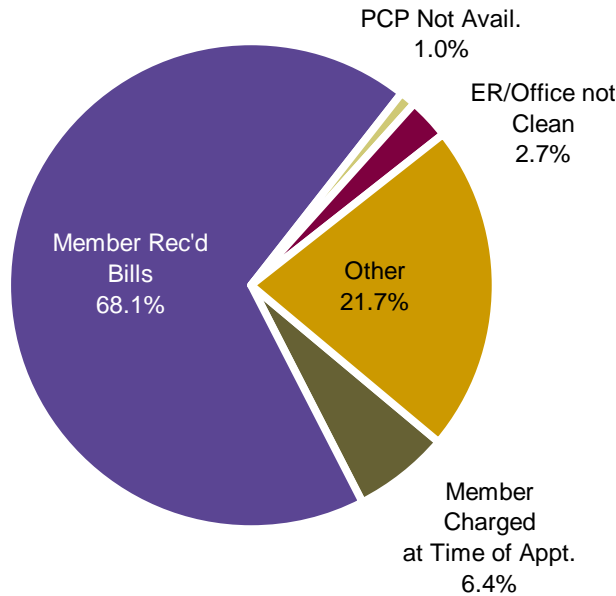*Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003*

Summary of Access to MC+ Managed Care

Access to care was examined through Mental Health Indicator data for penetration rates, Missouri Department of Insurance (MDI) network adequacy filings submitted by MC+ Managed Care MCOs, and complaints reported to MCOs by members and providers.

- **Based on Mental Health Subgroup Mental Health Indicator data, improvements in total mental health penetration rates for all ages of MC+ Managed Care Members were observed statewide, and in the Central and Western Regions between CY1999 and CY2001.**

- **MDI network filing reports indicated that network adequacy for PCPs, specialists, facilities, ancillary services, and the overall network were above threshold in all regions.**

- **Member complaint data analysis showed that the rate (per 1,000 members) of documentation of member medical and non- medical complaints increased from CY2001 to CY2002, indicating improved documentation of member concerns.**

- **Member complaint data analysis showed that the rate of provider documentation of medical complaints increased, while the rate of provider non- medical complaints decreased from CY2001 and CY2002.**

- **Examination of specific member complaints related to access were primarily accounted for by complaints regarding:**

    m **Transportation (e.g., ride showing up late or early; ride not showing up)**

    m **Denial of Services (e.g. treatment, prescription, primary care physician, dental appointment, specialty care)**

    m **Timeliness in getting an appointment.**

- **The rates for transportation complaints are likely due to targeted efforts with the vendor statewide to improve services and quality improvement mechanisms.**

- **Provider complaints regarding access were primarily comprised of complaints regarding:**

    m **Denial of Claims**

    m **Provider complaints with the State or MCO**

    m **Denial of Services (e.g., treatment, prescriptions, ER, or inability to verify member's eligibility)**

Quality and Effectiveness of Care

Quality and Effectiveness of Care were evaluated across MC+ Managed Care Regions using complaint data and through medical record reviews. Member and provider complaints will be summarized and followed by studies examining the effectiveness of care delivered to MC+ Managed Care Members (the Healthy Children and Youth Program and prenatal care).

MC+ Managed Care Member Complaints

Member and provider complaints were used to examine issues related to the quality of care provided through the MC+ Managed Care Program. Detailed definitions of complaints are provided in the previous section on access to care. For member complaints, the following complaint types were examined:

- **Quality of Care**

- **Other Medical Complaints**

- **Staff Behavior**

Quality of care complaints from MC+ Managed Care Members were the most frequent type of quality of care complaint, ranging from .35 to .51 per 1,000 members across regions (see Figures 45- 46).

Figure 45. Member Quality of Care Complaints, CY2002, MC+ Managed Care Program.
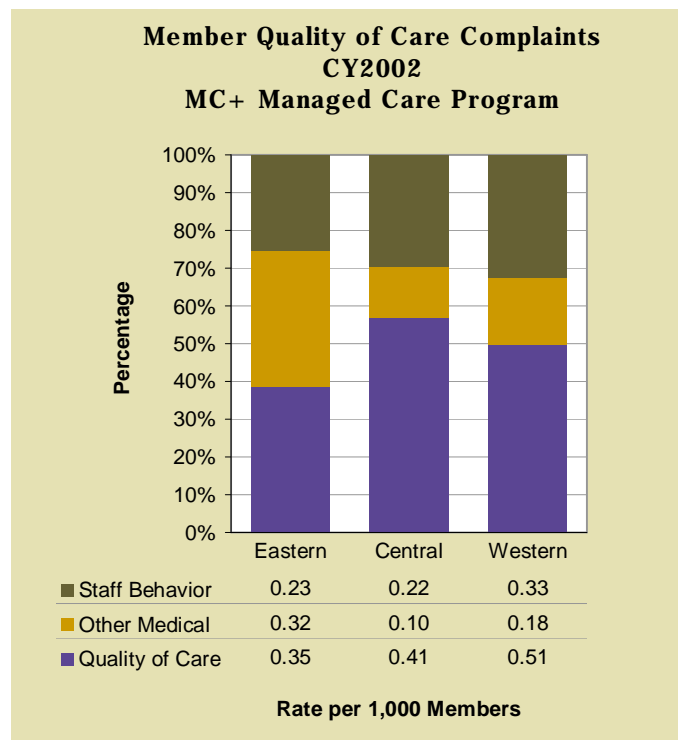
|	Eastern	Central	Western
■ Staff Behavior	0.23	0.22	0.33
■ Other Medical	0.32	0.10	0.18
■ Quality of Care	0.35	0.41	0.51

Rate per 1,000 Members

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Of the MC+ Managed Care member quality of care complaints, the most frequent complaints involved other quality complaints (35.9%), followed by the member disagreeing with treatment (34.1%), the treatment not helping (23.4%), and the member disagreeing with the diagnosis (6.6%; see Figure 46).

Figure 46. Member Quality of Care Complaints, CY2002, MC+ Managed Care Program.
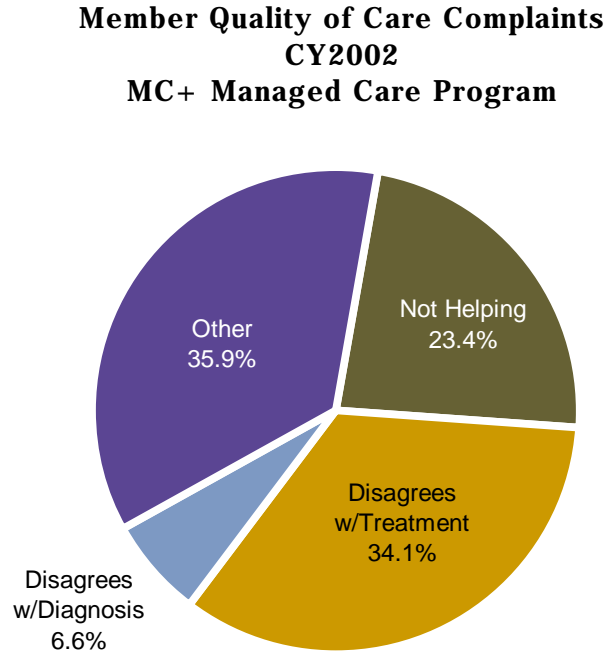
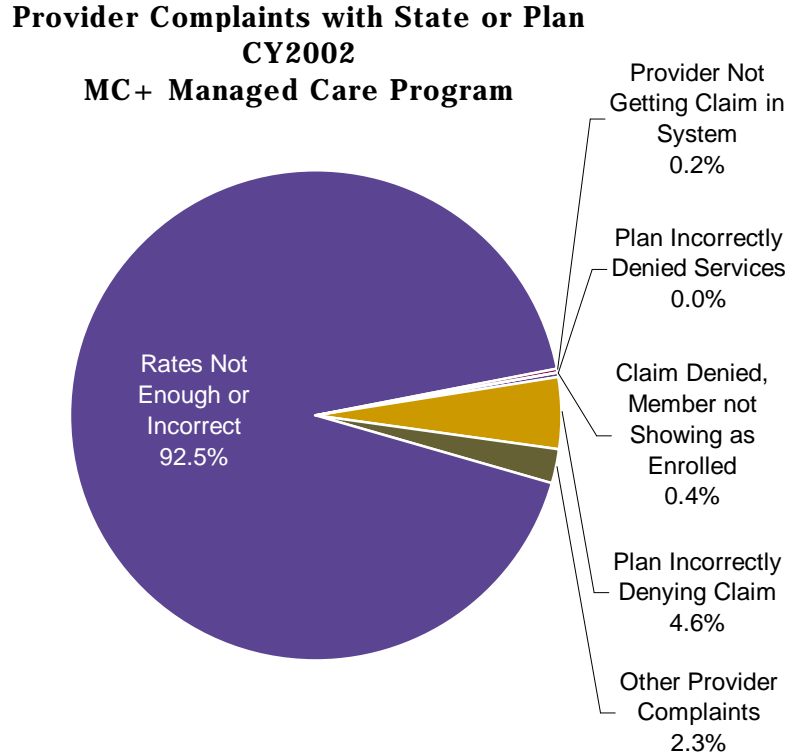**Member Quality of Care Complaints
CY2002
MC+ Managed Care Program**

Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

The next most frequent MC+ Managed Care member complaints relating to the quality of care were complaints about provider office staff. Although this may not directly influence the quality of care, it may influence the member's perception and confidence in the quality of care he or she is receiving. The most frequent complaint about office staff involved the primary care provider's attitude toward or treatment of the member (59.4%; see Figure 47), followed by the attitude of office staff (33.0%), and other office staff complaints (7.5%).

Figure 47. Member Office Staff Behavior Complaints, CY2002, MC+ Managed Care Program.

**Member Office Staff Behavior Complaints
CY2002
MC+ Managed Care Program**
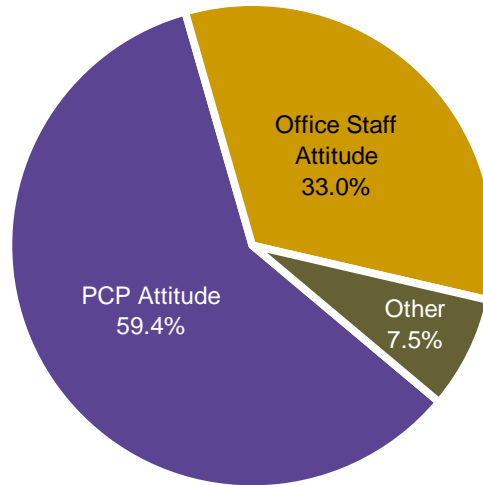
Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Other MC+ Managed Care member quality of care complaints were the next most frequently- reported quality complaint by members (see Figure 48), with the greatest proportion described as other (43.1%), the primary care provider not being available (29.4%), and the member being dissatisfied with the primary care provider (27.5%).

Figure 48. Other Member Medical Complaints, CY2002, MC+ Managed Care Program.

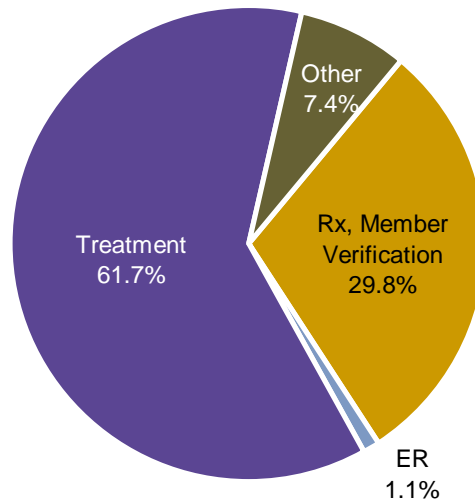**Other Member Medical Complaints
CY2002
MC+ Managed Care Program**
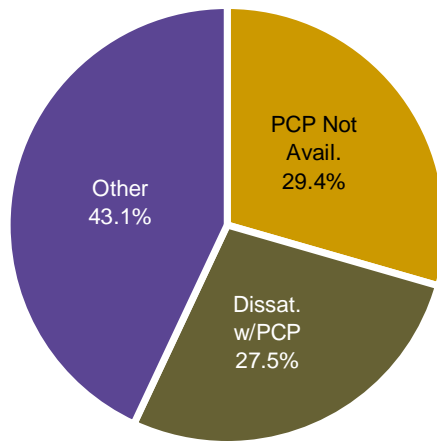
Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

For MC+ Managed Care provider complaints, the following complaint types were examined:

- **Quality of Care**

- **Other Medical**

Provider quality of care complaints comprised the majority of provider quality of care-related complaints, as there was only one other medical complaint received by a provider in the Eastern Region (the rate per 1,000 is shown as .00 due to rounding; see Figure 49). The rate of quality of care complaints ranged from .02 to .09 complaints per 1,000 members across regions (the smaller rates do not appear on the figure; see Figure 50). Of the quality of care complaints, the most frequent complaint involved members missing appointments (53.8%), followed by the member not adhering to treatment (26.9%), and other complaints (19.2%).

Figure 49. Provider Quality of Care Complaints, CY2002, MC+ Managed Care Program.

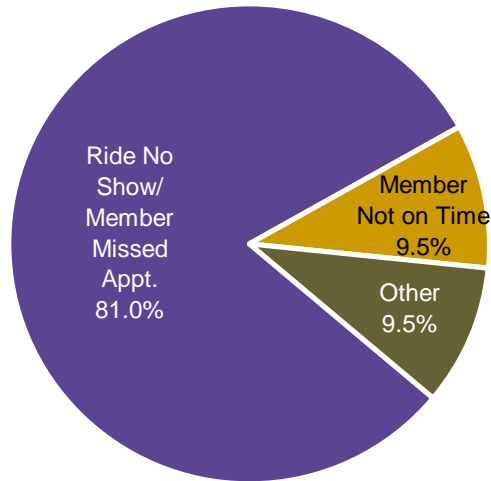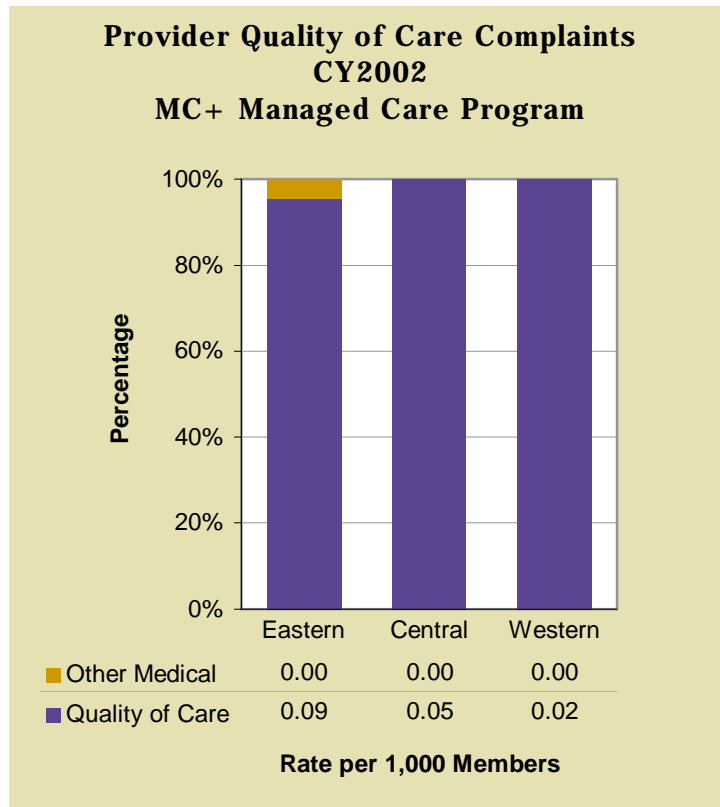*Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003*

Figure 50. Provider Quality of Care Complaints, CY2002, MC+ Managed Care Program.

Provider Quality of Care Complaints
CY2002
MC+ Managed Care Program
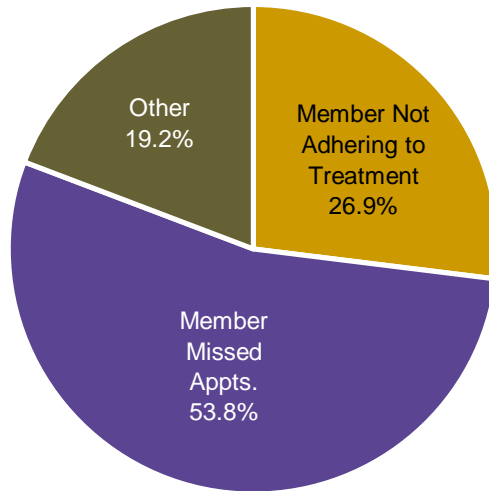
Source: Missouri Department of Social Services, Division of Medical Services, aggregate quarterly complaint and grievance data, 2003

Healthy Children and Youth (HCY) Program

The Healthy Children and Youth (HCY) Program in Missouri is a primary and preventive health care program for all Medicaid- eligible children and youth under the age of 21 years. The goal of the program, also known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT), is to have a health care home for each child, that is, to have a primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child's health care needs. The primary care provider should follow the screening periodicity schedule, perform interperiodic screens when medically necessary, and coordinate any specialty care needs.[14] Table 4 shows the ages at which EPSDT screenings should be conducted.

Table 4 . EPSDT Periodicity Schedule.

EPSDT Periodicity Schedule	
Newborn (2-3 Days)	3 Years
By One Month	4 Years
2-3 Months	5 Years
4-5 Months	6-7 Years
6-8 Months	8-9 Years
9-11 Months	10-11 Years
12-14 Months	12-13 Years
15-17 Months	14-15 Years
18-23 Months	16-17 Years
24 Months	18-19 Years
	20 Years

Every recipient under the age of 21 years (or his or her legal guardian) is informed of the HCY program by the Division of Family Services (DFS) at the initial application for assistance, and reminded of the program at each annual re- determination review by DMS and/or the MC+ MCOs. DMS has made program requirements and procedures available to MCOs and providers via the Internet, provider manuals, and Medicaid Provider Bulletins.

A full HCY/EPSDT screen (see Table 5) includes a comprehensive unclothed physical examination as well as a comprehensive health and developmental history including assessment of both physical and mental health developments, health education (including anticipatory guidance), appropriate immunizations according to the child's age, laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated), lead screening according to established guidelines, hearing screening, vision screening, and dental screening (after the age of 6 months).

Table 5. EPSDT Screening Components.

EPSDT Screening Components
Comprehensive Unclothed Physical Examination
Comprehensive Health and Developmental History
Health Education (Anticipatory Guidance)
Appropriate Immunizations
Laboratory Tests as Indicated
Lead Screening
Hearing Screening
Vision Screening
Dental Screening

To assist providers with service coordination and documentation, DMS and the MCOs have developed standard age-specific HCY/EPSDT forms that include all required examination components and examples of activities that comprise these components. The use of these forms was made mandatory by DMS in CY2002, and ongoing efforts are made to inform providers about and to encourage the use of these tools.

Data Sources and Methods.

To evaluate the level of EPSDT services provided by the MC+ MCOs, a variety of data sources were used in this evaluation. These included:

- **Medical record review**

- **Literature reviews**

- **CY1998 to CY2001 EQRO findings**

Documentation of EPSDT services were evaluated by conducting a medical record review of 1,094 children who were 0-72 months of age during CY2002. A stratified random sample of 2,003 children was drawn by MCO proportionate to the total number of children enrolled in each MCO. Children selected for the sample were continuously enrolled in the same MCO for at least 12 months. Children who were two (2) years of age during CY2002 were over-sampled in order to obtain an adequate number of cases for analysis of immunizations.

Medical records were requested from primary care providers. CY2002 MC+ encounter data was used to identify the primary care providers for the selected cases. The MCOs verified that the children in the sample were enrolled in their MCOs and provided up-to-date provider contact addresses. Of the 2,003 cases requested, 1,094 were received and met review criteria.

HCY/EPSDT elements, including the types of components and dates of services were abstracted from the medical records by registered nurses, using a standard data collection instrument (Appendix B and C). Laboratory data was collected for assessment of mandatory blood lead levels for the children who were 12-and-24 months of age. To ensure that the MCOs received credit for all exams completed, BHC allowed the inclusion of elements contained in any part of the medical record (e.g., progress notes, developmental charts, provider-specific forms) as well as information documented on the DMS HCY/EPSDT forms.

Documentation of EPSDT Services.

Records for 1,094 (54.6%) of the 2,003 sampled MC+ Managed Care children were received and deemed valid for inclusion in the EPSDT evaluation. Data documenting HCY/EPSDT visits, visit components, immunization status, and lead testing were obtained. Of the 1,094 records reviewed, a total of 952 (87.0%) had documentation of at least one provider visit (HCY and/or acute care) during CY2002, providing a gross level of validation of the sampling process and the encounter claims database. Figure 51 shows the number and percentage of children by the number of visits documented in CY2002.

Figure 51. Number of Visits in CY2002 per MC+ Managed Care Member.

**Number of Visits in CY2002
per MC+ Managed Care Member**

	Eastern	Central	Western	Missouri
■ 5 or More	37	16	24	77
■ 3-4	80	33	84	197
■ 1-2	335	119	224	678
■ None	97	10	35	142

Number
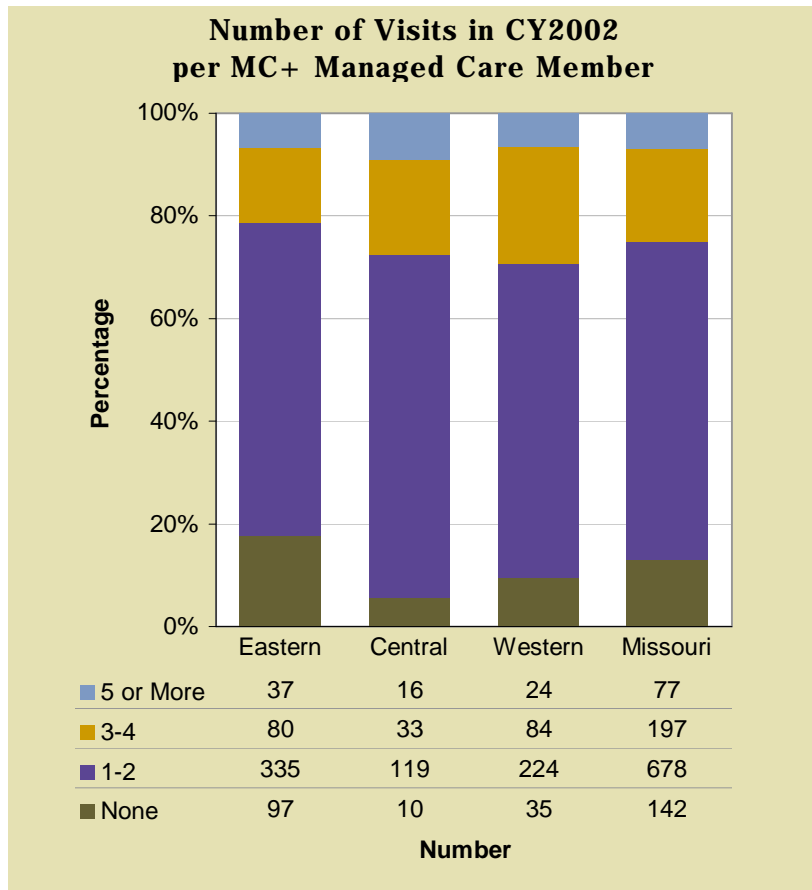
Source: BHC, Inc., Medical Record Review, April 2003

Of the <u>cases</u> with at least one provider visit, 803 (84.3%) had documentation of at least one HCY component. The remaining 149 (15.7%) had documentation of acute care services without mention of HCY/EPSDT components (potential missed opportunities). Visit dates for a number of cases fell slightly outside the expected visit dates and were not included in the

HCY/EPSDT counts, although in a clinical sense, the timing of the visits was quite appropriate. The figures are thus a conservative estimate of the actual care delivered.

The highest HCY/EPSDT rates for the 1,094 children were for *Interim History* (793, 72.5%) and *Unclothed Physical Examination* (786, 71.8%), respectively. Some of these components occurred during acute care visits. Verbal lead screening and dental screens were not required until 6 months of age so fewer children were eligible for these screenings. Of the 936 cases eligible for the verbal lead and dental screenings, 387 (41.3%) had documentation of *Verbal Lead* and 479 (51.2%) had documentation of *Dental Screens.* Figure 52 shows the percentage of eligible cases receiving at least one HCY screening component during CY2002.

Figure 52. MC+ Managed Care Members Receiving at Least One Screening in CY2002.
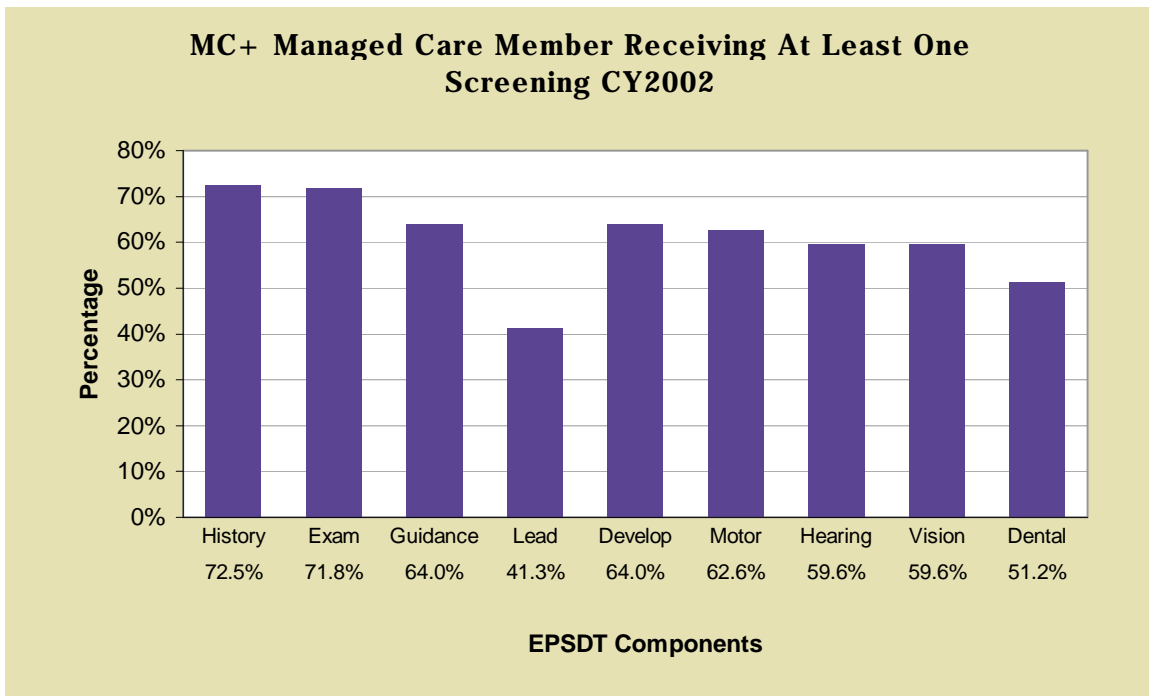
Source: BHC, Inc., Medical Record Review, April 2003

Figure 53 shows the percent of visits in which <u>all</u> of the components listed in Table 5 were documented during an EPSDT visit. Of the 1,977 <u>visits</u> reviewed, 316 (16.0%) included all expected HCY/EPSDT components; 1,157 (58.5%) documented four or more components; and 1,426 (72.1%) documented at least one component. This compares to the previous years' medical record reviews as shown in Figure 53, indicating an increase from CY1998 (4.3%) to CY2002 (16.0%). This is partially attributed to a more complete administrative data set and improved methods of obtaining complete provider records.

Figure 53. EPSDT Visits with All Components Documented, CY1998-CY2002, MC+ Managed Care Members.

EPSDT Visits with All Components Documented CY1998- CY2002 MC+ Managed Care Member

	1998	1999	2000	2001	2002
Eastern	4.3%	11.8%	15.3%	3.7%	16.9%
Central	5.3%	13.1%	19.7%	4.4%	10.1%
Western	3.8%	10.6%	27.0%	2.8%	15.3%
Missouri	4.3%	11.8%	20.9%	3.5%	16.0%
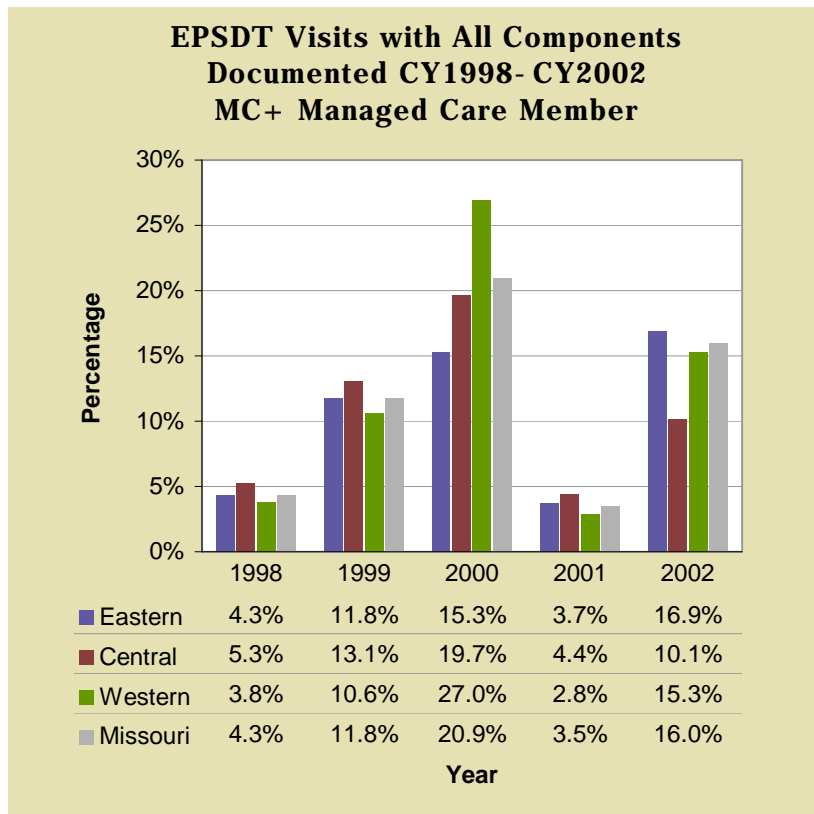
Note: Dental component is a screen conducted during the EPSDT visit, not an examination by a dentist.
Source: BHC, Inc., Medical Record Review, April 2003

Immunization Documentation.

State Medicaid agencies are required by Section 1905 (r)(1) of the Social Security Act to provide appropriate immunizations under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, according to the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) schedule. Under this requirement, appropriate immunizations must be provided during a full HCY screening

unless medically contraindicated or declined by the parent or guardian. If a vaccine was not available, it should have been documented in the child's medical record as "vaccine not available". As the vaccine became available, a follow- up vaccine should have been documented when the child was immunized.[15]

DMS communicated the immunization requirements and billing procedures to MC+ MCOs and providers through its provider communications staff and a Special Provider Bulletin. The *Recommended Childhood Immunization Schedule* for CY2002, developed by the ACIP was included in these communications. A copy of the schedule for CY2002 is shown in Figure 54.

Figure 54. Recommended Childhood Immunization Schedule United States, 2002.
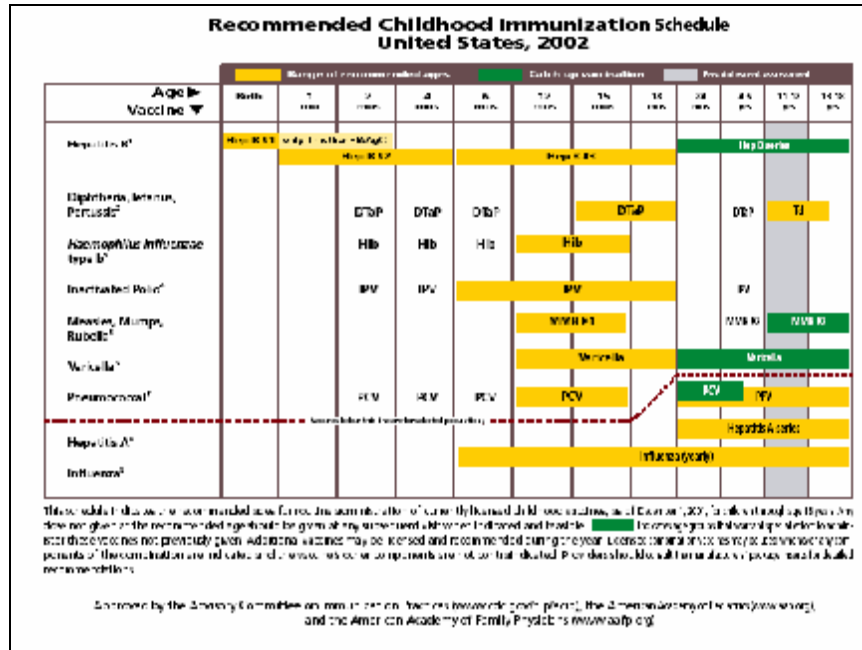
Source: Department of Social Services, Division of Medical Services, February 2002

Immunization status of MC+ Managed Care Members was evaluated for 450 children who were age 2 years during CY2002. Figure 55 shows the percent of eligible children who had documentation of vaccine administration within the specified timeframes. As seen, there was variation in the rates of administration by Region, but these differences were not statistically significant. The variations are likely due medical record submission rates, and different sampling and data collection methods. One reason for the variation is that the CY2001 and CY2002 medical record reviews did not count immunizations unless specific vaccination names and administration dates were documented (consistent with HEDIS® methodology). Previous medical record review gave credit for nonspecific notations, such as "Up-to-Date" resulting in higher rates than those obtained in CY2001 and CY2002.

Figure 55. Immunizations Documented by MC+ Managed Care Region, CY1998-CY2002.

Immunizations Documented By MC+ Managed Care Region CY1998-2002

	Eastern	Central	Western	Missouri
■ 1998	55.5%	42.6%	40.8%	41.4%
■ 1999	34.8%	42.8%	46.3%	44.5%
■ 2000	72.6%	75.2%	78.3%	77.6%
■ 2001	70.4%	60.8%	58.9%	59.5%
■ 2002	67.3%	59.6%	59.8%	63.6%

Region
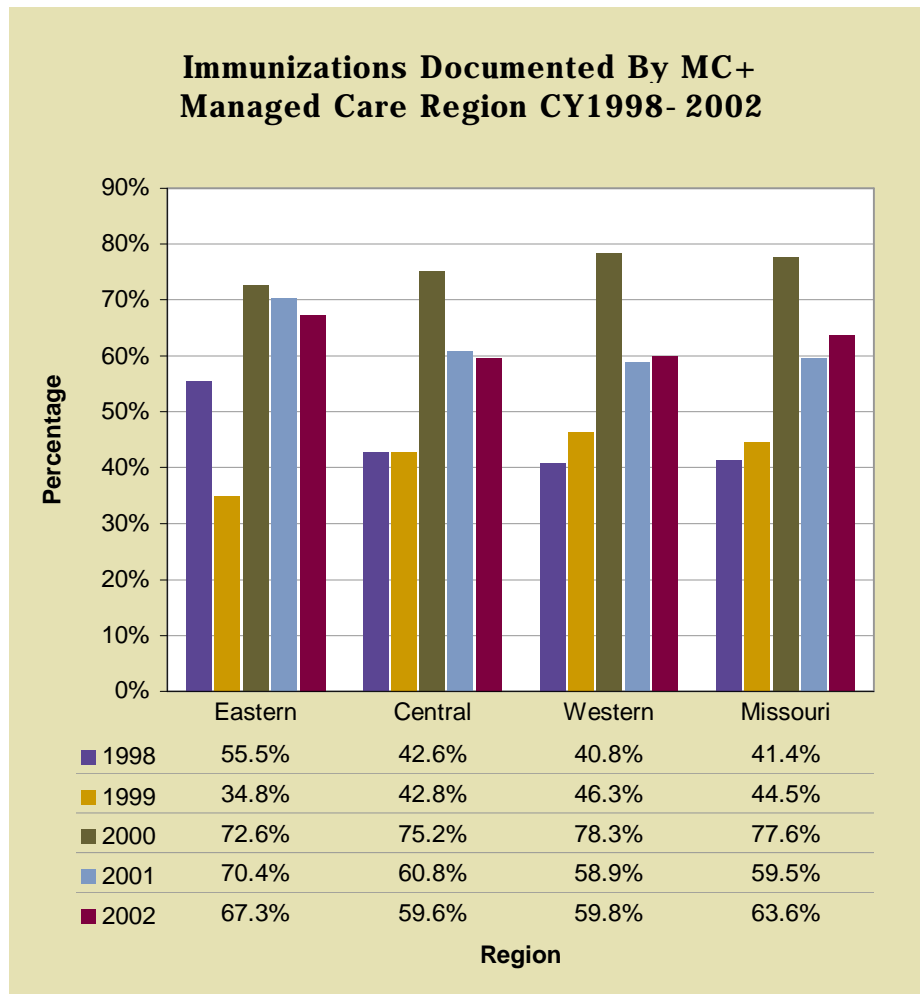
Note: CY2000 rates may be higher because credit was given for nonspecific medical record notations such as "Vaccinations Up-to-Date". CY2001 and CY2002 required specific vaccination names and dates.
Sources: BHC, Inc., Medical Record Review, April 2003; BHC, Inc., Medical Record Review April 2002; MPCRF EQRO Reports for CY1998; CY1999 and CY2000.

Figure 56 and the following sections describe the ACIP recommendations and show MC+ Managed Care Regional documentation rates for Hepatitis B (HepB), Diphtheria, Tetanus, Pertussis (DTaP), *Haemophilus Influenza* type B (HiB), Inactivated Polio (IPV), Measles, Mumps, and Rubella (MMR), Varicella (VZV), and Pneumococcal (PCV).

Figure 56. Percent MC+ Managed Care Members with Documented Vaccines.

Percent MC+ Managed Care Member with Documented Vaccines

	Hep B	DTP	HiB	IPV	MMR	VZV	PCV
Eastern	66.8%	61.0%	75.4%	79.7%	82.3%	77.6%	28.4%
Central	63.6%	63.6%	62.3%	80.3%	70.1%	54.5%	23.4%
Western	58.9%	59.6%	68.8%	73.8%	73.8%	73.8%	9.9%
Missouri	63.8%	61.1%	71.1%	77.9%	77.6%	72.4%	21.8%
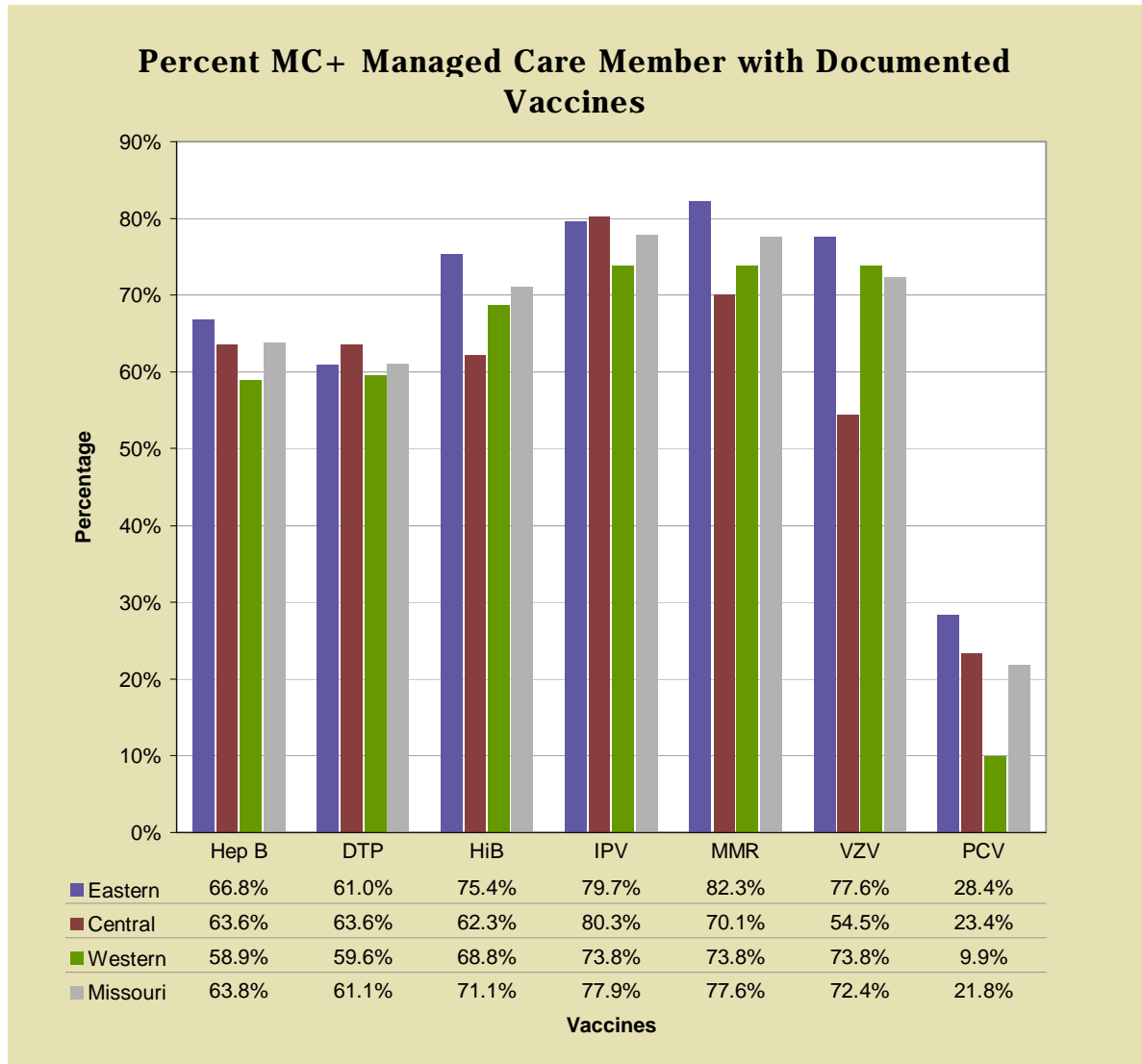
Vaccines

Source: BHC, Inc., Medical Record Review, April 2003

Hepatitis B Documentation.

The *Recommended Childhood Immunization Schedule* for 2002 recommended that three Hepatitis B vaccinations be given between birth and 18 months of age. The Hepatitis B measurement criterion for this evaluation was three Hepatitis B vaccinations with different dates of service, with at least one vaccination between six months of age and the second birthday. Abstraction included immunizations from single and combination vaccines (e.g., COMVAX).

Analysis showed that 284 of the 450 (63.1%) MC+ Managed Care children in the sample had documented Hepatitis B vaccinations within the specified timeframe, and 3 (0.7%) cases had documentation of contraindications or other reasons not to administer the immunization. This resulted in an overall 63.8% documentation rate. Frequencies and rates by region were 155 of 232 (66.8%) in the Eastern Region, 49 of 77 (63.6%) in the Central Region, and 83 of 141 (58.9%) in the Western Region. These regional differences were not significant using a Chi-Square test (χ^2 = 0.537, $\underline{p}$ < .05).

Diphtheria, Tetanus, Pertussis (DTaP) Documentation.

The *Recommended Childhood Immunization Schedule* for 2002 recommends that four DTaP vaccinations be given between 2 and 18 months of age with a minimum age of 6 weeks. DTaP measurement criteria for this evaluation included documentation of the first vaccination 42 days or greater after birth and four vaccinations by the second birthday. Of 450 MC+ Managed Care children who turned two years of age during CY2002, 271 (60.2%) had documented vaccinations within the timeframes. Four (0.8%) cases had documentation of parental decline or other reasons not to administer the immunization. This resulted in an overall 61.1% documentation rate. Regional numbers and rates were 49 of 77 (63.6%) in the Central Region, 142 of 232 (61.2%) in the Eastern Region, and 84 of 141 (59.6%) in the Western Region. These regional differences were not significant using a Chi- Square test (χ^2 = 0.083, $\underline{p}$ < .05).

Haemophilus Influenza Type B (HiB) Documentation.

The *Recommended Childhood Immunization Schedule* for 2002 recommended that four HiB be given between 2 and 15 months of age, with a minimum age of 6 weeks. The measurement criterion for this evaluation was at least four HiB with different dates of service by the child's second birthday, with at least one of them falling on or between the child's first and second birthday. HIB vaccines administered prior to 42 days after birth were not counted. In addition to 319 (70.9%) MC+ Managed Care cases with documented HiB immunizations administered within the time period, one (0.2%) case listed a contraindication. This resulted in an overall 71.1% documentation rate. Regional numbers and rates were 48 of 77 (62.3%) in the Central Region, 175 of 232 (75.4%) in the Eastern Region, and 97 of 141 (68.8%) in the Western Region. These regional differences were not significant using a Chi-Square test (χ^2 = 0.924, $\underline{p}$ < .05).

Inactivated Polio (IPV) Documentation.

The *Recommended Childhood Immunization Schedule* for 2002 recommended a child receive three IPV vaccinations between 2 and 18 months of age, with a minimum age of 6 weeks. The IPV measurement criterion for this evaluation was IPV administration with at least three different dates of service on or before the second birthday. IPV administrations prior to 42

days after birth were not included. Two of the 450 MC+ Managed Care records were excluded due to mismatches of birthdates and vaccine dates. Of 448 eligible children who turned two during CY2002, 349 (77.9%) received the immunizations within the measurement timeframes. Frequencies and rates by region were 61 of 76 (80.3%) in the Central Region, 184 of 231 (79.7%) in the Eastern Region, and 104 of 141 (73.8%) in the Western Region. These regional differences were not significant using a Chi-Square test (χ^2 = 0.218, p < .05).

Measles, Mumps and Rubella (MMR) Documentation.

The *Recommended Childhood Immunization Schedule* for 2002 recommended the first MMR vaccine be given between 12 and 15 months of age, with a minimum age of 12 months. The MMR measurement criterion for this evaluation was at least one MMR with a date of service falling between the child's first and second birthday. Of 450 MC+ Managed Care children who turned two years of age during CY2002, analysis showed that 346 (76.9%) had documented vaccinations within the specified timeframe, and three children (0.7%) had documentation of contraindications or parental decline. This resulted in an overall documentation rate of 77.6%. Documentation frequencies and rates by region were 54 of 77 of 141 (70.1%) in the Central Region, 191 of 232 (82.3%) in the Eastern Region, and 104 of 141 (73.8%) in the Western Region. These regional differences were not significant using a Chi-Square test (χ^2 = 0.846, p < .05).

Varicella (VZV) Documentation.

The *Recommended Childhood Immunization Schedule* for 2002 recommended the first VZV be given between 12 and 15 months of age, with a minimum age of 12 months. The VZV measurement criterion for this evaluation was at least one VZV with a date of service falling between the child's first and second birth date. The medical record review of 450 medical records showed 316 (70.2%) MC+ Managed Care cases had documented VZV immunizations administered within the specified time period and ten (2.2%) cases had documented reasons for not administering the vaccination (i.e., parental decline, medical contraindication, and 'other'). This resulted in an overall 72.4% documentation rate for this vaccine. Regional numbers and rates by region were 42 of 77 (54.5%) in the Central Region, 180 of 232 (77.6%) in the Eastern Region, and 104 of 141 (73.8%) in the Western Region. These regional differences were not significant using a Chi-Square test (χ^2 = 2.699, p < .05).

Pneumococcal (PCV) Documentation.

The *Recommended Childhood Immunization Schedule* for 2002 recommended that four PCV vaccinations be given between 2 and 15 months of age, with a minimum age of 6 weeks. Medical record review of 450 MC+ Managed Care children, who turned two years of age during CY2002, showed that 96 (21.3%) had documented PCV vaccinations, and two (0.4%) cases had documentation of parental decline or contraindication to administer the immunization resulting in an overall 21.8% documentation rate. Regional numbers and rates were 18 of 77 (23.4%) in the Central Region, 66 of 232 (28.4%) in the Eastern Region, and 14 of 141 (9.9%) in the Western Region. These regional differences were significant using a Chi-Square test (χ^2 = 12.032, p <.05).

Considerable improvement in the rates was shown when three vaccinations were used instead of the four recommended by the ACIP. Using this measure, 207 MC+ Managed Care cases had documentation of three or more PCV vaccines, providing an overall 46.0% documentation rate. Regional numbers and rates were 36 of 77 (46.8%) in the Central

Region, 121 of 232 (52.2%) in the Eastern Region, and 50 of 141 (35.5%) in the Western Region. These regional differences were not statistically significant using a Chi- Square test (χ^2 = 3.776, **p** < .05).

<u>Completed 4:3:1:3:3 Series Documentation.</u>

A common measure of completeness of immunization protocols is measurement of four DTap/DT vaccinations, three IPV vaccinations, one MMR, three HiB vaccinations, and three Hepatitis B vaccinations as specified above. Medical record review of 450 MC+ Managed Care children who turned two years of age during CY2002 showed that 177 had documentation of a completed 4:3:1:3:3 series (i.e., vaccinations or parental decline or other reason not to administer the immunization). This resulted in an overall 39.3% documentation rate. Regional numbers and rates were 27 of 77 (35.1%) in the Central Region, 104 of 232 (44.8%) in the Eastern Region, and 46 of 141 (32.6%) in the Western Region. These regional differences were not statistically significant using a Chi- Square test (χ^2 =2.710, **p** < .05).

Provider Immunization Survey.

In addition to medical record review, a survey of 1,302 MC+ Managed Care providers was conducted to obtain information regarding provider opinions and practices regarding childhood immunization. A one- page survey was sent to primary care providers and pediatricians from whom medical records were requested.

A total of 231 (17.7%) surveys were returned within the allocated timeframe. Of these, 30 appeared to be duplicates due to the same provider receiving and returning more than one survey and were excluded from analysis, resulting in a total of 201 valid responses. Another 20 responses were received after the deadline and were not considered in the analyses. Responses were voluntary and anonymous, thus introducing a likely respondent bias. Findings of this survey are descriptive, and represent only those practitioners who responded. The number of responses received indicates a high level of interest in the topic of immunizations and provided useful information for evaluating MC+ services.

The majority, 148 (73.6%) of the responses were received from private group or solo practices. Twenty- three providers (11.4%) were from Federally Qualified /Rural Health Clinics or Health Departments and 23 (11.4%) identified themselves as "Other" (primarily affiliated with hospital or academic facilities). Seven responders (3.5%) did not identify their affiliation.

Eighty- one (40.3%) identified their practice specialty as Pediatrics and 79 (39.3%) as Family Practice. Eight others (4.0%) listed their specialty as Internal Medicine, Multispecialty, or Health Department Clinic and 33 (16.4%) did not provide specialty information.

A total of 138 (68.7%) respondents provided estimates of the number of children age 0- 6 years in their practice. These estimates ranged from 10 to 57,000 children. The facilities with large practices identified themselves as university/academic centers. Some respondents did not specify a number and entered a question mark in the response space. One pediatrician simply said "too many". Fifty percent (50%) of the respondents who provided this information had 590 or fewer children age 0- 6 years in their practice.

One hundred sixty- six (82.6%) respondents provided estimates of the number of children in their practices that were up- to- date with their vaccines. One hundred thirty- two (79.5%) of the respondents to this question estimated that 80% or more of the children in their practice were up- to- date and 98 (59.0%) estimated that 90- 100% of the children in their practice were up- to- date. Figure 57 shows the distribution of estimates of up- to- date vaccinations.

Figure 57. MC+ Managed Care Provider Report of Up-to-Date Immunizations.

MC+ Managed Care Provider Report of Up- to- Date Immunizations

- 1-69 Percent Complete 4.8%
- 70-79 Percent Complete 15.7%
- 80-89 Percent Complete 20.5%
- 90-100 Percent Complete 59.0%
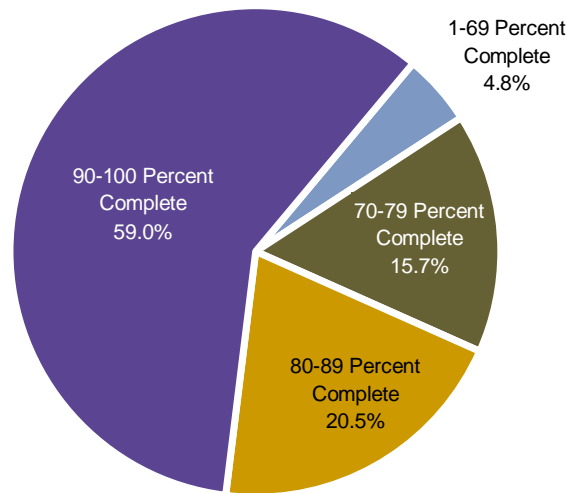
Note: Percent of 166 respondents who provided an estimate of children who were up-to-date with their immunizations.
Source: BHC, Inc., Provider Immunization Survey, April 2003

A total of 179 (89.1%) MC+ Managed Care providers indicated that they used one or more immunization guidelines. A total of 164 (91.6%) of these providers stated they used either the DMS or ACIP guidelines. Other 'guidelines' that were mentioned were: "AAFP/AAP" (American Association of Family Physicians/American Academy of Pediatricians), "MODHS" (Missouri Department of Health and Senior Services), "AMA" (American Medical Association), "CDC" (Centers for Disease Control and Prevention), and "VFC" (Vaccines for Children Program).

Of the 201 survey respondents, 194 (96.5%) responded to the question asking whether they had a systematic way to identify and recall patients in need of vaccines. A total of 144 (74.2%) of these providers indicated they had a process to do so. Some providers indicated more than one type of system resulting in a total of 194 systems. The systems that were identified were

- Chart review at the time of the visit (n =103; 53.1%)

- Periodic chart reviews (n = 35; 18.0%)

- Manual tickler systems (n = 23; 11.9%)

- Computerized reminder systems (n = 16; 8.2%)

- Use of an immunization registry (n = 4; 2.1%)

- Other systems (n = 13; 6.7%)

Of the 201 MC+ Managed Care Provider survey respondents, 179 (89.1%) replied to the question "Have preschool immunization rates in your practice had been assessed within the past year?" Of those that responded, 108 (60.3%) stated the rates had been assessed within the past year. Sources of the assessments were cited as including individual clinic/medical group audits, county health departments, Head Start, HEDIS audits, VFC, and private organizations conducting research. Figure 58 shows the types of identification/recall systems listed by providers.

Figure 58. MC+ Managed Care Provider Report of Type of Recall Systems Indicated.
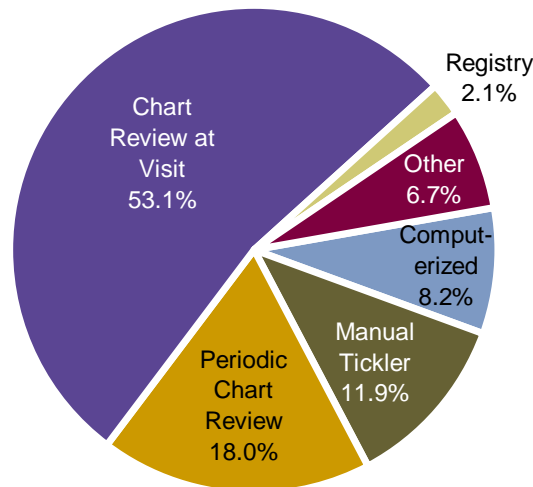
Source: BHC, Inc., Provider Immunization Survey, April 2003

Of the 201 MC+ Managed Care Provider survey respondents, 191 (95.0%) replied to the question, "To what degree did the vaccine shortage affect your ability to vaccinate children in your practice?" Of those that answered, 41 (21.5%) stated the shortage had been significant. Figure 59 shows the distribution of responses. As the surveys were anonymous, the responses could not be linked to immunization rates seen in the medical record review, although several providers commented on the pneumococcal (Prevnar) shortage.

Figure 59. MC+ Managed Care Provider Report of the Impact of the CY2002 Vaccine Shortage.

MC+ Managed Care Provider Report of
CY2002 Vaccine Shortage Impact
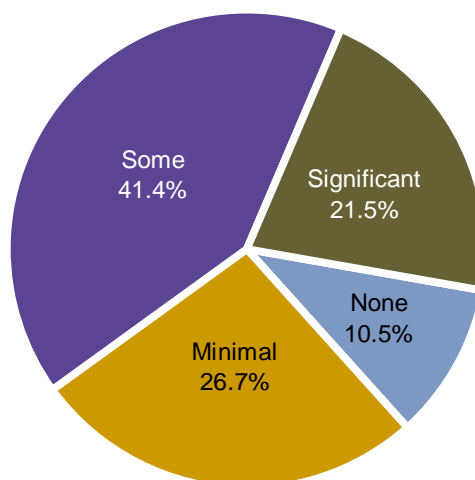
Source: BHC, Inc., Provider Immunization Survey, April 2003

Of the 201 MC+ Managed Care Provider survey respondents, 191 (95.0%) replied to the question "For those children in your practice who are not up- to- date on their vaccinations, what do you believe are the reasons and/or barriers?" Multiple responses and written comments were allowed. Reasons given for immunizations not being up- to- date were:

- **Parental unwillingness or decline to immunize (n = 64; 33.5%)**

- **Failure to make or keep preventive care appointments (n = 177; 92.7%)**

- **Lack of medical necessity (n = 6; 3.1%)**

- **Cost (n = 18; 9.4%)**

Additional comments provided by responders are listed in Table 6.

Table 6. Additional Comments of MC+ Managed Care Providers.

Reasons for Not Up-to-Date	Comments Regarding Immunization
Vaccine shortage/unavailable (DTaP, Varicella, PCV listed)	All that get check-ups get immunizations
Child illness	Health department just down street, we don't give vaccinations
Lost to follow up	Parents need education by media and other agencies -
Social issues/situations	Pediatricians can't do it all
Transient population	Difficult to get ahold of parents, often moving, phone changes
Low socio-economic/single parents	Parents need to be held accountable
Parents forget to bring children to immunization	Enough vaccine provided by VFC. No problem with UTD
Transfer foster children from PCP to PCP	New combination vaccines can help with overall compliance
Schools, confusion of PCP	Hope peutaraleur vaccine could be approved
Missing records	We are looking forward to Pediarix
Media coverage of negative outcomes	

Screening Children for Lead Toxicity.

Lead toxicity is a serious public health problem nationally and in Missouri. The Centers for Disease Control and Prevention (CDC) report approximately one million children younger than 6 years of age in the United States have blood lead levels of 10 μg/dL or higher, levels high enough to adversely affect their intelligence, behavior and/or development.[16] Recent studies indicate that even lower levels may adversely affect children. One study demonstrated that an increase from 1 to 10 μg/dL is proportionately associated with cognitive declines in which IQs declined by 7.4 points as lifetime average blood lead concentrations increased from 1 to 10 μg/dL. A second study reported delayed puberty for levels as low as 3 μg/dL.[17]

The key to prevention and early intervention of lead poisoning rests with screening those populations at risk. The General Accounting Office (GAO) reported in its widely- distributed 1998 study that the prevalence of lead poisoning in children who were enrolled in Medicaid was nearly five times that of non- Medicaid children. In addition, the study found that 60% of all children with lead poisoning (i.e., blood lead levels greater than 10 μg/dL /dL), and 83% of all children with blood lead levels greater than 20 μg/dL were enrolled in Medicaid.[18] This finding makes lead screening especially important for Missouri and national Medicaid Agencies. The Department of Health and Human Services' Healthy People 2010 initiative has set a goal is to eliminate blood lead levels ≥10 μg/dL among children age 1- 5 by the year 2010.[19]

Testing, treatment and prevention of access to lead hazards are key elements to finding, and ultimately eliminating childhood lead poisoning. Because lead poisoning is often a result of continued exposure to lead with a gradual accumulation in a child's body, signs and symptoms of toxicity often mimic other problems and may not be detectable until a dangerous blood lead level is reached. Children with low levels of lead poisoning often do not appear acutely ill, and the condition may not be noted by parents or providers. Screening is, therefore, crucial. Within the MC+ program, MCOs are required to test children for lead as part of the HCY screen. The provision of lead case management for those children with elevated levels is also required as part of the MC+ MCO contract.

Lead screening for children enrolled in the Missouri MC+ Program consists of two activities. The first is an oral screen (verbally- administered questions indicating risk of exposure) administered to all children six through 72 months at the time of the EPSDT visit. The Division of Medical Services (DMS) has provided a standard form for provider use in administering the questionnaire and documenting screening results and blood levels. As risks are subject to change, subsequent risk assessments could change a child's risk category, subsequent interventions, or follow- up. If the answers to all questions on the screen are negative, the child is generally not considered to be at- risk for a high degree of lead exposure. However, if the answer to any question is "yes", a child should be considered at-risk for high doses of lead exposure, and a blood lead level must be drawn.

The second method of screening is through a blood laboratory test. This test is to be administered at 12- and 24- months of age, or if a "positive" response is obtained on the verbal questionnaire. The blood lead level (BLL) test is a simple procedure that can be conducted in many physician offices, public health clinics, or other primary care sites. It typically requires that a blood sample be collected from a child through a venipuncture or a capillary fingerstick. The blood is then analyzed (in- house or at an outside laboratory facility). A capillary fingerstick blood occasionally results in false positive readings and any elevated BLL found through this method is to be validated by the venipuncture method. DMS and the Missouri Department of Health and Senior Services issued a "Missouri Medicaid Bulletin" in December 2000 that gives health care providers information regarding the screening requirements and available resources[20].

In CY2002, BHC evaluated the level of lead screening for MC+ Managed Care Members by conducting a medical record review and examining lead data reported to DMS. DMS and the MCOs have initiated an ambitious effort to increase BLL rates and improve reporting to the State. The data collected from this reporting is expected be a valuable resource when fully implemented and will enable the State, MCOs, and providers to focus on specific opportunities for improvement.

Medical Record Review.

Medical records of 1,094 MC+ Managed Care children were reviewed for documentation of verbal lead screens during HCY visits during CY2002. The review identified verbal lead screening documentation in 394 cases (36.0%). Of the cases with documented verbal lead screens, a total of 135 (34.3%) contained at least one positive response. The standard State form was used at least once in 291 (26.6%) of the 1,094 cases reviewed. In 394 cases in which verbal lead screening was documented, the form was used 73.9% of the time. Figure 60 shows the proportion of positive verbal screening responses by MC+ Managed Care Region, compared with negative numbers.

Figure 60. MC+ Managed Care Member Verbal Lead Screen Status.

	Eastern	Central	Western	Missouri
■ Positive	79	24	32	135
■ Negative/Missing	470	154	335	959
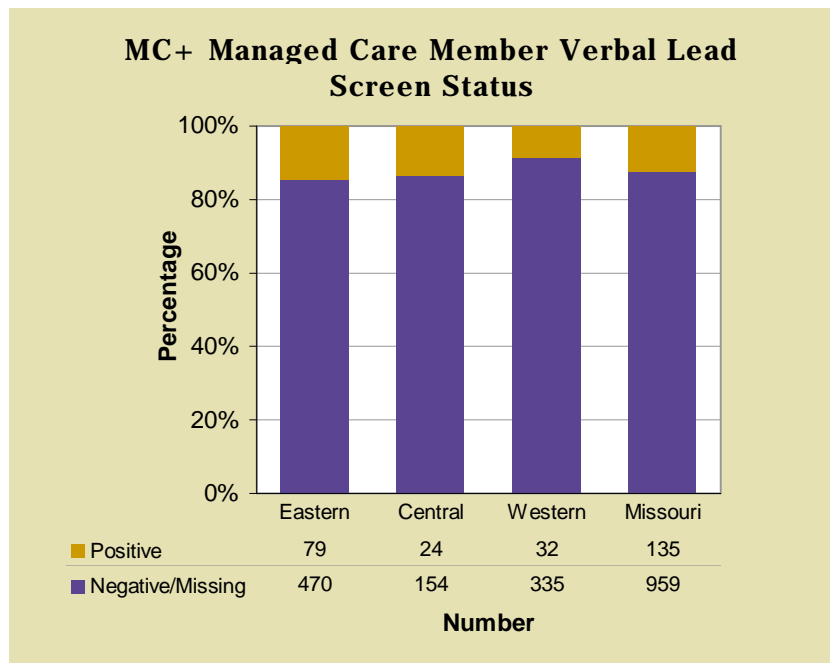
Source: BHC, Inc., Medical Record Review, April 2003

In addition to the verbal lead screening, MC+ Managed Care medical records were evaluated for documentation of blood lead tests. A total of 283 (25.9%) of all cases had documentation that a BLL was drawn at some time during CY2002. The majority of the BLLs drawn were venous. BLL values ranged from 0- 58 μg/dL, with a mean of 5.5 μg/dL (excluding those values that were reported in a general manner such as "< 10" μg/dL).

Rates for 114 MC+ Managed Care children who were 12 months of age during CY2002 showed that 54 (47.4%) had a blood lead level during the year. The range of values for the 36 cases for which a specific documented value was available was 1‑18 µg/dL, with a mean of 4.6 µg/dL (see Figure 61).

Figure 61. MC+ Managed Care Members Blood Lead Levels Drawn at 12 Months of Age.
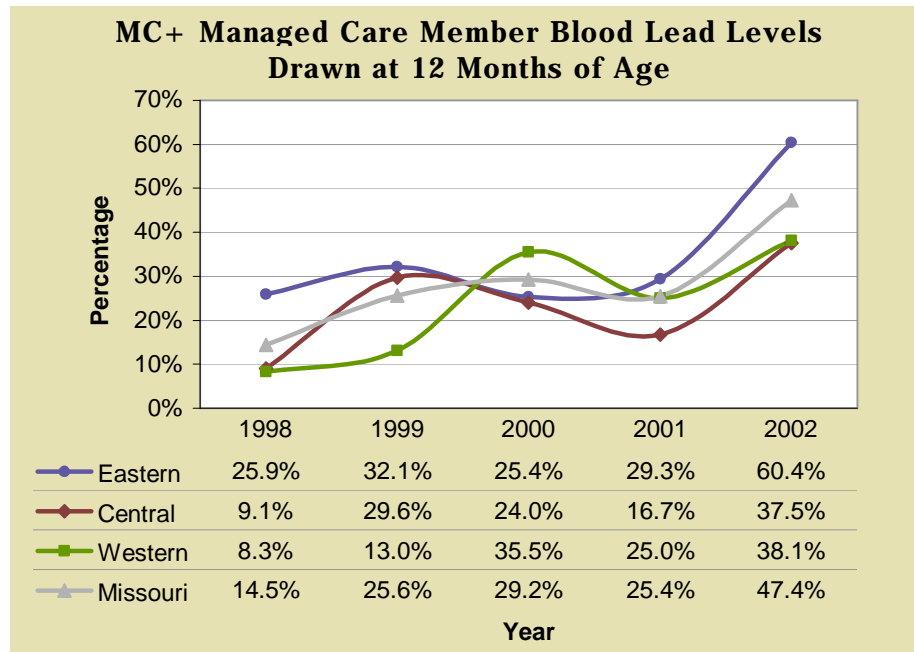
	1998	1999	2000	2001	2002
Eastern	25.9%	32.1%	25.4%	29.3%	60.4%
Central	9.1%	29.6%	24.0%	16.7%	37.5%
Western	8.3%	13.0%	35.5%	25.0%	38.1%
Missouri	14.5%	25.6%	29.2%	25.4%	47.4%

Sources: BHC, Inc., Medical Record Review, April 2003; BHC, Inc., Medical Record Review April 2002; MPCRF EQRO Reports for CY1998; CY1999 and CY2000

Rates for 450 MC+ Managed Care children who were 24-months of age during CY2002 showed that 133 (29.6%) had a blood lead level during the year. The range of values for the cases with a specific documented value was 0-22 µg/dL, with a mean of 5.1 µg/dL. The decrease in CY2002 in the Central Region may have been an aberrancy due to the small number of eligible records. CY2000, as in many indicators, showed elevated rates, compared to previous and subsequent years (see Figure 62).

Figure 62. MC+ Managed Care Member Blood Lead Levels Drawn at 24 Months of Age.
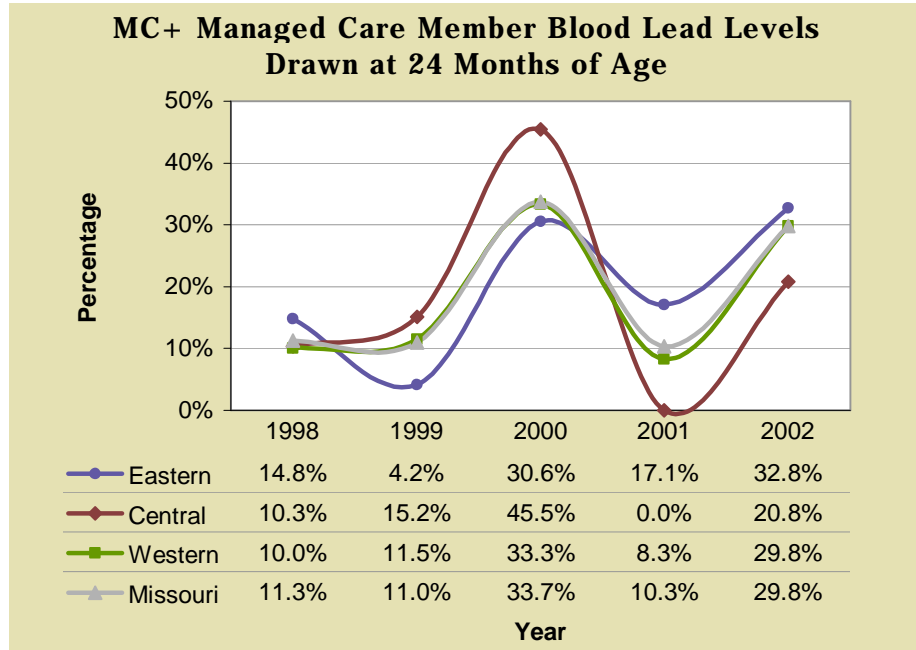
MC+ Managed Care Member Blood Lead Levels Drawn at 24 Months of Age					
	1998	1999	2000	2001	2002
Eastern	14.8%	4.2%	30.6%	17.1%	32.8%
Central	10.3%	15.2%	45.5%	0.0%	20.8%
Western	10.0%	11.5%	33.3%	8.3%	29.8%
Missouri	11.3%	11.0%	33.7%	10.3%	29.8%

Sources: BHC, Inc., Medical Record Review, April 2003; BHC., Inc. Medical Record Review April 2002; MPCRF EQRO Reports for CY1998; CY1999 and CY2000

DMS Lead Reporting Evaluation.

DMS provided BHC with blood lead testing data for MC+ Managed Care Members the first six months of CY2002 to obtain a preliminary assessment of lead testing based on provider reporting. As one of Missouri's new blood lead initiatives, Reporting Rule 19 CSR 20-20.020 requires all blood lead test results to be reported to the Missouri Department of Health and Senior Services (DHSS) regardless of the age of the individual or the reported blood lead level.[21] Data elements provided to BHC were:

- **MCO identification number**
- **Recipient name**
- **Recipient age (in years)**
- **Date of blood lead test**
- **Method of blood lead test (venous, capillary, unknown)**
- **Blood lead value**

A total of 12,340 blood lead tests for 10,686 unique MC+ Managed Care Members were included in the DMS file for the period from January 1, 1002 through June 30, 2002. Of these, 8,240 (66.8%) tests were from the Eastern Region, 993 (8.0%) from the Central Region, and 3,107 (25.2%) from the Western Region. One to 7 BLLs were reported for each recipient with 9,268 (86.7%) having one BLL. Recipient ages were from 0- 21 years of age. Of these, 99.8% were six years of age and younger. A total of 7,898 (64.0%) of the blood lead levels were reported as having been a venous draw, 3,475 (28.2%) capillary, and 967 (7.8%) were unknown. Figure 63 shows the distribution of reported BLLs by region.

Figure 63. Distribution of Blood Lead Levels Reported in CY2002, MC+ Managed Care Region.

**Distribution of Blood Lead Levels
Reported in CY2002
MC+ Managed Care Region**
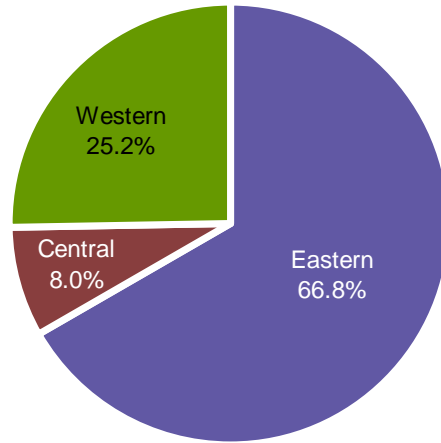
Source: DMS Lead Reporting Data File, April 2003

Blood lead level results for MC+ Managed Care children ranged from 0-105 μg/dL with a mean of 5.0 μg/dL. Of the 12,340 tests, 1,299 (10.5%) were elevated (i.e., BLL of 10 μg/dL or greater). Most of the elevated tests, 1,033 (79.5%), were from the Eastern Region, 65 (5.0%) were from the Central Region, and 201 (15.5%) were from the Western Region. These regional differences were significant using a Chi-Square test (χ^2 = 81.70, p < .05) indicating the acuity and prevalence of lead toxicity in the Eastern Region of the State. Figure 64 shows blood lead level results by region and blood lead level group.

Figure 64. Blood Lead Level Screening by MC+ Managed Care Region, January - June 2002.

Blood Lead Level Screening by MC+ Managed Care Region January - June 2002

	Eastern	Central	Western	Missouri
■ 70-120 mcg/dL	2	0	0	2
□ 45-69 mcg/dL	5	0	4	9
■ 20-44 mcg/dL	174	18	37	229
■ 10-19 mcg/dL	852	47	160	1,059
■ 0-9 mcg/dL	7,207	928	2,906	11,041

Number
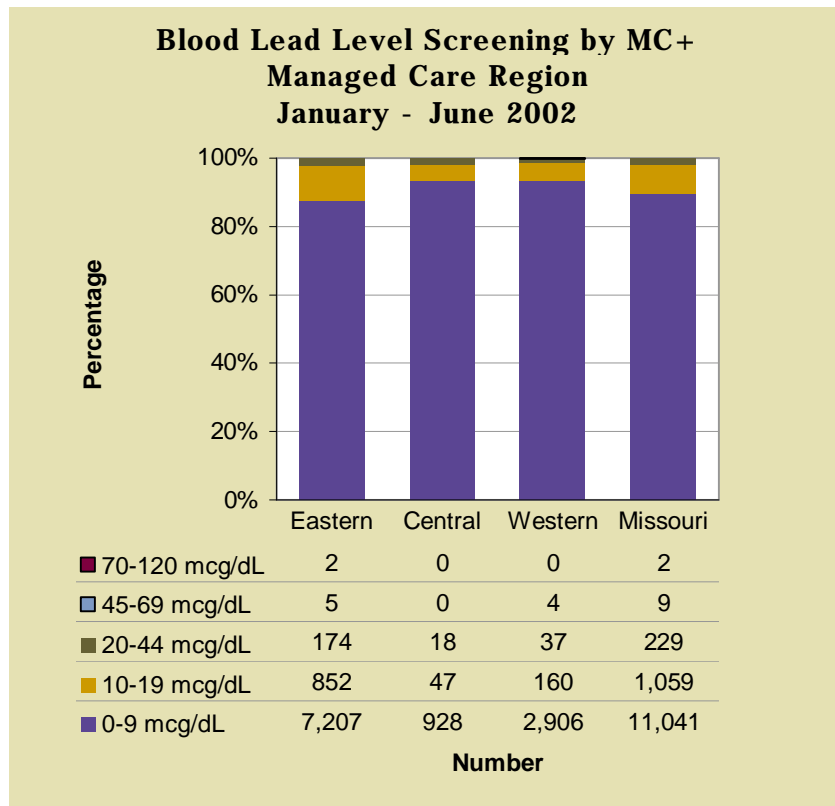
Source: DMS Lead Reporting Data File, April 2003

Eleven (0.8%) of the 1,299 elevated test results were greater than 45 μg/dL, the level at which chelation therapy should be considered. Seven of the tests were in the Eastern Region and four in the Western Region. These 11 tests were for eight individuals. Five of the tests (4 individuals) were reported as capillary levels without documentation of a confirmatory venous level. Additional data regarding these eight individuals were obtained from CY2002 encounter claims which indicated seven of the eight individuals had encounter claims for BLLs (see Data Validation section for comparisons of dates of service).

Prenatal Care

Prenatal care has been reported to predict the subsequent utilization of both maternal and child health services in the postnatal period. The Centers for Disease Control and Prevention (CDC) identified three major components of prenatal utilization: (1) Risk assessment; (2) Treatment for medical conditions or risk reduction; (3) Education. Each of these components can contribute to improved natal and maternal outcomes by identifying risks and helping women address issues as poor nutrition, smoking, substance abuse, and environmental stressors. Women who had inadequate or no prenatal care had greater infant morbidity and mortality in the postnatal period and significantly lower levels of maternal postnatal visits, well-child visits, immunization completions, and acute care visits. Nearly 80% of the women who are at high risk for delivering a low birth weight baby can be identified on the first prenatal visit.[22]

A total of 18,156 pregnancies with live births were reported for MC+ Managed Care women during CY2002. As part of the monitoring of the prenatal care of the women enrolled in the program, BHC evaluated select Maternal Child Health (MCH) indicators and documentation of prenatal visits, risk assessments, and referrals for identified problems and needs. Three data sources were used to assess prenatal care and services during CY2002:

- **DHSS Maternal Child Health (MCH) Indicators**

- **EQR Medical Record Review**

- **DHSS Missouri 2001 Prenatal Drug Prevalence Study**

Maternal Child Health (MCH) Indicators.

The Missouri Department of Health and Senior Services (DHSS) obtains birth certificate data for Missouri residents on an ongoing basis and produces quarterly maternal and child health (MCH) data reports. Summary data for CY1994 through CY2002 were provided by DHSS. From this data, BHC produced charts showing trends for Medicaid (MC+ Managed Care and Fee-for-Service)[23] and non-Medicaid and each of the three MC+ Managed Care Regions for CY1995 to CY2002.

In addition to the trend charts, BHC calculated the percent change over time, from CY1997 to CY2002 (since MC+ began). Statistical significance tests were conducted (odds ratio) for Medicaid and Non-Medicaid groups in the MC+ Managed Care Regions since MC+ Managed Care began. Significance was calculated using 95% confidence levels. Additional detail is provided in Sources of Data. The following sections briefly discuss the clinical or policy significance of each of the eight indicators, changes over time, and comparisons of Medicaid and non-Medicaid and the three MC+ Managed Care Regions. The indicators assessed for this evaluation were:

- **Trimester in Which Prenatal Care Began**

- **Low Birth Weight (Less than 2500 grams)**

- **Cesarean Section Deliveries**

- **Smoking During Pregnancy**

- **Spacing Less Than 18 Months Since Last Birth**

- **Births to Mothers Under 18 Years of Age**

- **Repeat Teen Births**

- **Percent of Prenatals Enrolled in WIC**

<u>Trimester Prenatal Care Began.</u>

Accepted standards of prenatal visit periodicity indicate that prenatal care should begin early and continue throughout the pregnancy. Provisional CY2002 birth statistics for the Missouri Medicaid Region MC+ recipients indicate a total of 18,156 pregnancies with live births during CY2002. Of these, 14,315 (78.8%) received prenatal care during the first trimester, 3,021(16.6%) during the second trimester, and 543 (3.0%) during the third trimester. A total of 277 (1.5%) did not receive any prenatal care (see Figure 65).

Figure 65. Trimester Prenatal Care Began, CY2002.

**Trimester Prenatal Care Began
CY2002**
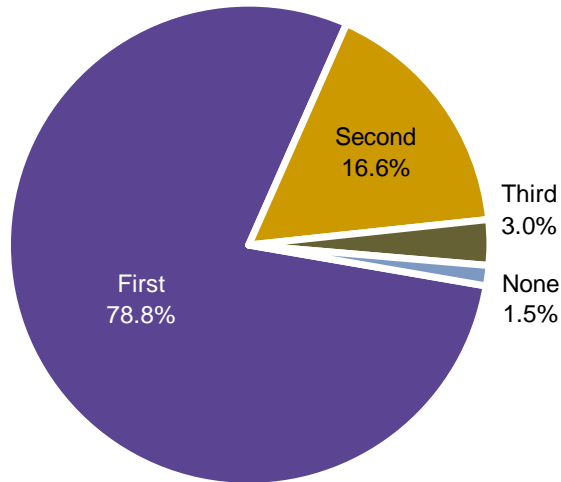
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Figures 66 and 67 show the rates of pregnant women with live births receiving care within the first trimester of pregnancy in all MC+ Managed Care Regions (Figure 66) and by individual MC+ Managed Care Regions (Figure 67) from CY1995 (before MC+ began) through CY2002. The first figure illustrates a statistically significant increase in the Medicaid group. The rate of first trimester visits for the Medicaid group increased by 6.8% (95% CI: 0.96, 0.91; p < .05), while for the non-Medicaid group it increased by 1.6% in the same time period (95% CI: 1.0, 0.97; p < .05).

Figure 66. Prenatal Care Began in First Trimester, All MC+ Managed Care Regions.

**Prenatal Care Began in First Trimester
All MC+ Managed Care Regions**

	1995	1996	1997	1998	1999	2000	2001	2002
Medicaid	72.8%	73.0%	73.8%	74.9%	76.6%	78.8%	78.7%	78.8%
Non-Medicaid	93.1%	93.0%	92.9%	93.1%	93.8%	93.7%	93.9%	94.4%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Figure 67 shows the rate of first trimester visits for MC+ Managed Care Members, by Region. Prior to implementation of MC+ Managed Care, the rates of first trimester visits were higher in the Western Region (75.1%) than in the Eastern and Central Regions. (74.3% and 71.4%) However, in CY2002, the rate of trimester visits was higher in the Eastern Region (79.5%) than in the Central and Western Regions (76.8% and 79.2%).

Figure 67. Prenatal Care Began in First Trimester, Each MC+ Managed Care Region.

**Prenatal Care Began in First Trimester
Each MC+ Managed Care Region**

	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	70.9%	71.4%	72.0%	73.2%	75.5%	79.2%	79.1%	79.5%
Central	72.7%	74.3%	75.9%	77.0%	79.5%	77.8%	77.6%	76.8%
Western	74.0%	75.1%	75.5%	76.6%	76.6%	78.8%	78.7%	79.2%

Note: Percent changes in tables may differ slightly from text due to rounding
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

The improvements in early prenatal care are consistent with national trends which indicate that 83.2% of women are receiving prenatal care in the first trimester[24]. However, as noted earlier, it is those women that do not seek early medical care that are at increased risk of low birth weight and/or poor infant or postnatal outcomes and plans. MCOs, thus need to continue efforts to improve early prenatal care.

Low Birth Weight.

Low birth weight (LBW) is the risk factor that is most closely associated with neonatal death. Thus, improvements in infant birth weight can contribute substantially to reductions in the infant mortality rate. Of all infants born at low birth weight, the smallest (those weighing less than 1,500 grams) are at highest risk of dying in their first year. Some researchers have proposed that further improvement in the survival of very low birth weight (VLBW) babies is nearly impossible, and reduction in the underlying rate of VLBW is currently the only

available method of reducing neonatal mortality rates. Another important issue is the long-term effects of LBW on affected infants who survive their first year, as these infants are more likely to experience long-term developmental and neurological disabilities than are infants of normal birth weight. Recent increases in LBW are due largely to preterm delivery related to increases in multiple gestation.[25]

Approximately two-thirds of infants with LBW and 98% of infants with very low birth weight (VLBW) are born preterm. Preterm birth is associated with a number of modifiable risk behaviors including the use of alcohol, tobacco, or other substances during pregnancy; low pre-pregnancy weight; and low weight gain during pregnancy.[26] Tobacco use is the most preventable cause of LBW. Smoking accounts for 20-30% of all LBW births in the U.S.[27] The affect of smoking on LBW rates appears to be attributable to intrauterine retardation rather than preterm delivery. Fifty-four percent of smokers continue to smoke after learning of pregnancy.[28] VLBW is primarily associated with preterm birth, which may be associated with the use of illicit drugs during pregnancy. Other important risk factors for preterm births are vaginal infections and domestic violence.[29]

Provisional birth statistics for CY2002 indicate that 1,900 (10.1%) of 18,874 live MC+ Managed Care births had a low birth weight defined as less than 2500 grams (5 pounds, eight ounces). Figure 68 shows the proportion of births per weight category. As seen, 89.9% of the births were 2,500 grams or greater. A total of 382 (2.1%) births were under 1,500 grams, or VLBS.

Figure 68. Birth Weight (in Grams) for MC+ Managed Care Births, CY2002.

Birth Weight (in Grams) for MC+ Managed Care Births CY2002
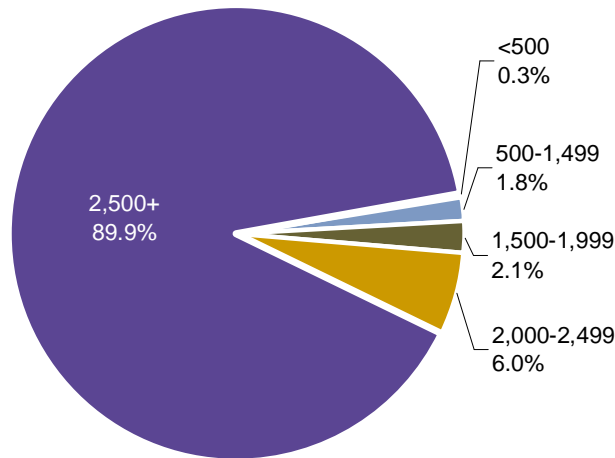
2,500+ 89.9%
<500 0.3%
500-1,499 1.8%
1,500-1,999 2.1%
2,000-2,499 6.0%

Note: Percent changes in tables may differ slightly from text due to rounding.
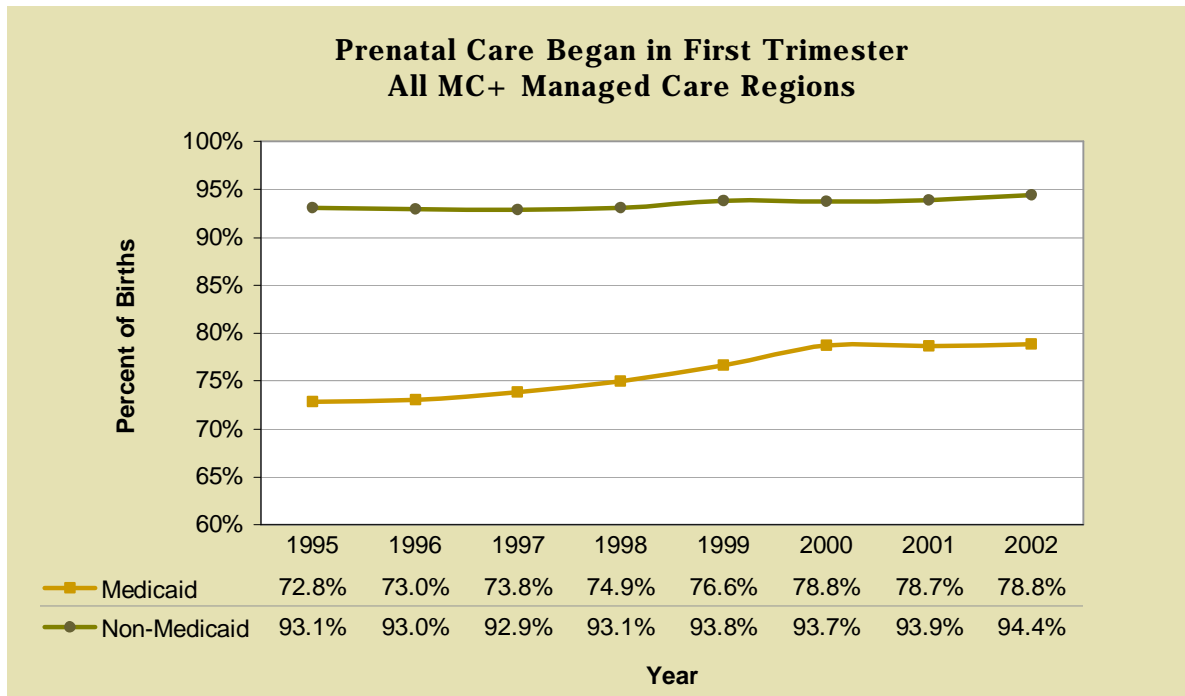*Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

Figures 69 and 70 show the rates of infants born with LBW statewide (Figure 69) and by regions (Figure 70) from CY1995 (before MC+ began) through CY2002. The first figure illustrates a statistically significant increase for the non-Medicaid in low birth weights. The rate of low birth weights for the Medicaid group decreased by 3.6% (95% CI: 1.10, 0.97; p < .05), while for the non-Medicaid group it increased by 7.4% in the same time period (95% CI: 0.98, 0.88; p < .05). These findings are consistent with national experience which shows the percentage of newborns born at low birth weight rose from a low of 6.8 percent in 1985 to 7.6 percent in 1998 and currently rivals the rates reported nearly thirty years ago. Some of the incidence in low birth weight is due to an increase in the proportion of multiple births.[30]

Figure 69. Low Birth Weight (< 2500 Grams), All MC+ Managed Care Regions.

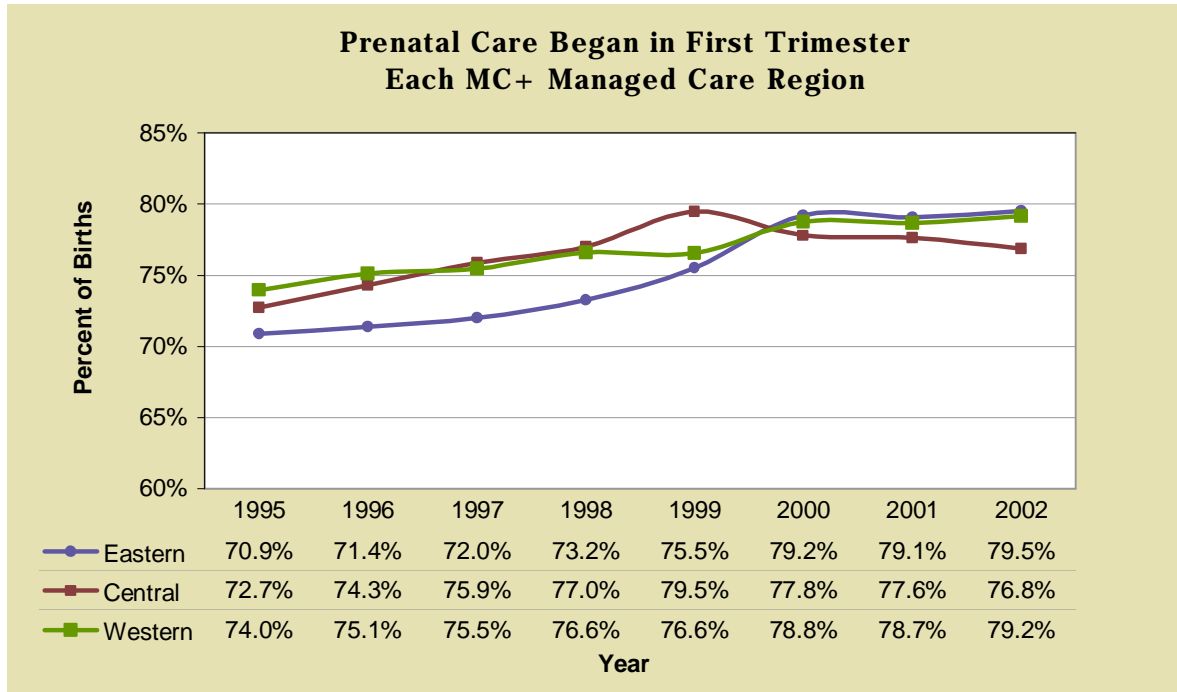|	1995	1996	1997	1998	1999	2000	2001	2002
Medicaid	10.5%	10.3%	10.4%	10.6%	10.4%	10.0%	9.6%	10.1%
Non-Medicaid	6.5%	6.3%	6.8%	6.8%	6.8%	6.8%	6.9%	7.3%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Lack of significant change was also reflected at the regional level when comparing CY1997 and CY2002 rates. The Eastern, Central and Western Regions all showed small declines in rates since MC+ Managed Care began. Figure 70 shows the rate of LBW for MC+ members, by region. Prior to implementation of MC+ Managed Care, the rates of LBW were higher in the Eastern Region (11.2%) than in the Central and Western Regions (8.8% and 10.1%). In CY2002, the rate of LBW remained higher in the Eastern Region (11.1%) than in the Central and Western Regions (8.8% and 9.0%).

Figure 70. Low Birth Weight (< 2500 Grams) Each MC+ Managed Care Region..

Low Birth Weight < 2500 Grams
Each MC+ Managed Care Region

	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	10.9%	11.2%	11.3%	11.2%	11.4%	11.2%	10.5%	11.1%
Central	8.5%	8.8%	9.0%	9.8%	9.7%	9.3%	9.1%	8.8%
Western	9.8%	10.1%	9.9%	10.5%	9.5%	9.0%	8.7%	9.0%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

<u>Cesarean Sections.</u>

The rate of Cesarean Sections is measured as an indicator of utilization of services and as a quality of care indicator. Cesarean Sections are generally indicated for (1) repeat cesarean (elective; patient does not desire a trial of labor); (2) dystocia or failure to progress in labor; (3) breech presentation; (4) transverse lie; and (4) concern for fetal well-being (i.e., fetal distress).

Provisional Missouri birth statistics for CY2002 indicate that 4,344 (23.0%) of live MC+ Managed Care births were born by cesarean section. Figures 71 and 72 show the rates of cesarean sections statewide (Figure 71) and by Regions (Figure 72) from CY1995 (before MC+ began) through CY2002. The first figure illustrates a statistically significant increase in both Medicaid and non-Medicaid in cesarean section rates. The rate of cesarean sections for the Medicaid group increased by 32.5% (95% CI: 0.79, 0.72; <u>p</u> < .05), while for the non-Medicaid group it increased by 29.2% in the same time period (95% CI: 0.80, 0.75; <u>p</u> < .05).

Figure 71. Cesarean Section Deliveries, All MC+ Managed Care Regions.

	1995	1996	1997	1998	1999	2000	2001	2002
Medicaid	17.1%	18.1%	17.4%	18.4%	18.8%	19.3%	21.5%	23.0%
Non-Medicaid	22.2%	21.9%	21.5%	22.2%	23.4%	24.3%	25.5%	27.8%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Regional data comparing CY1997 and CY2002 rates indicate statistically significant increases in the rates of cesarean section in all three regions. Figure 72 shows the rate of cesarean sections for MC+ Managed Care Members, by Region. Prior to implementation of MC+ Managed Care, the rates of cesarean section were higher in the Eastern Region (18.3%) than in the Central and Western Regions. (17.0% and 16.1%) However, in CY2002, the rate of cesarean section was higher in the Central Region (26.3%) than in the Eastern and Western regions (24.1% and 19.6%).

Figure 72. Cesarean Section Deliveries, Each MC+ Managed Care Region.

Cesarean Section Deliveries
Each MC+ Managed Care Region

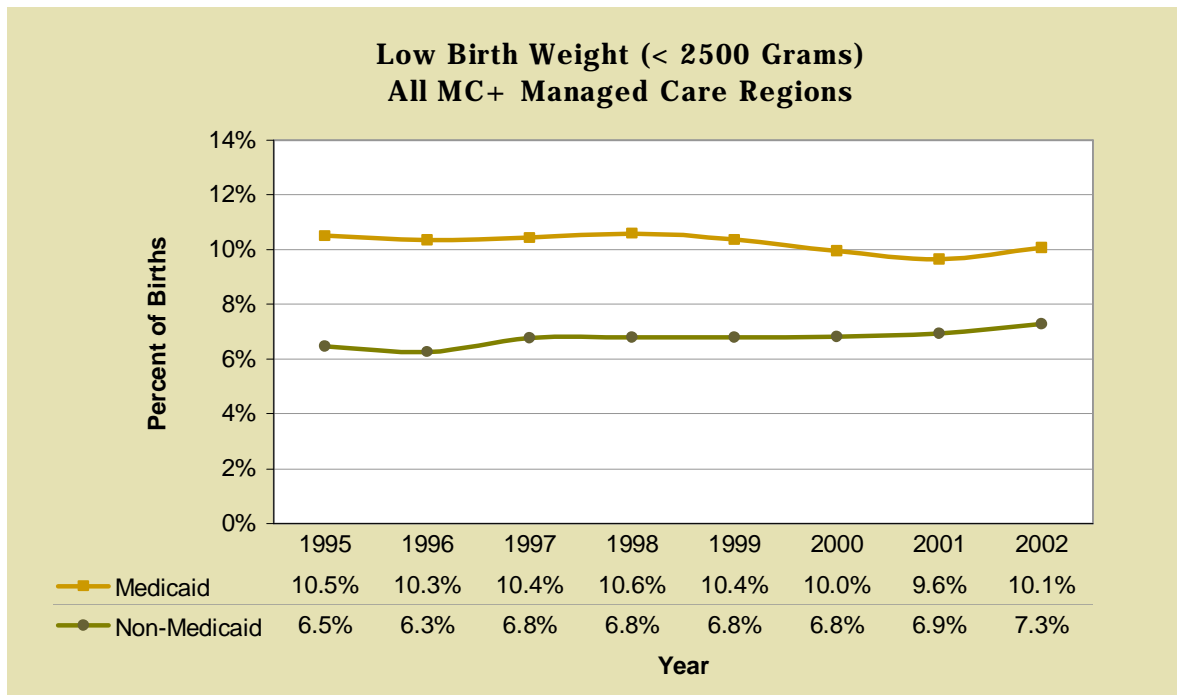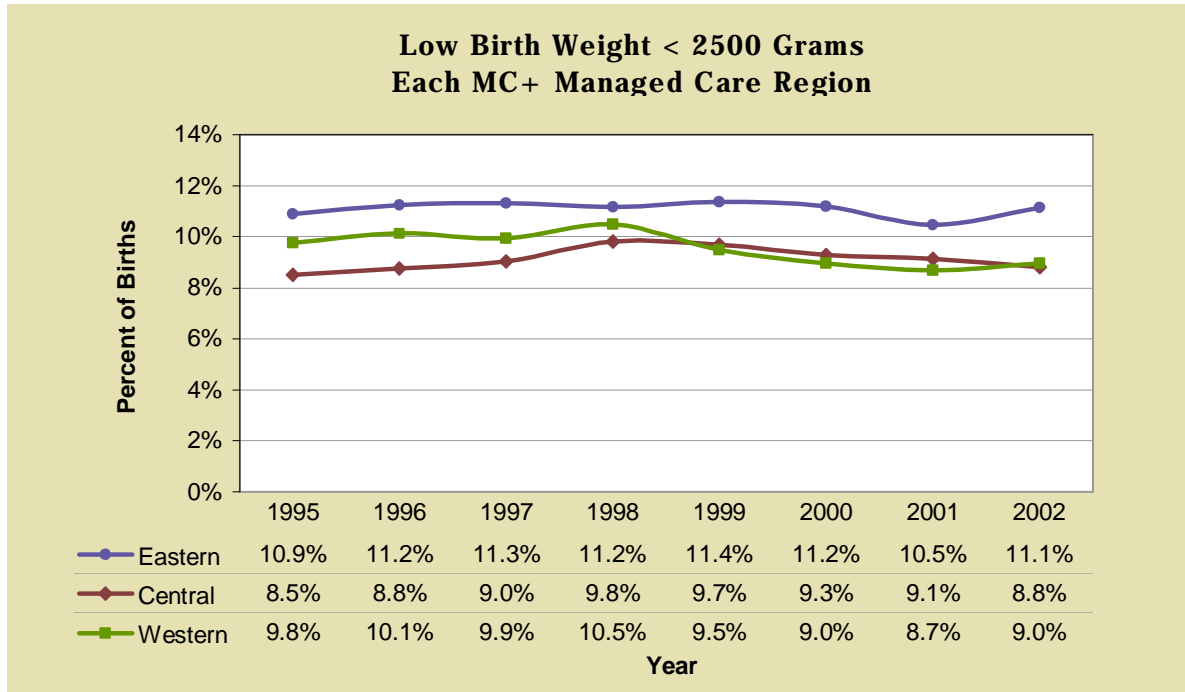|	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	16.3%	18.3%	16.8%	18.9%	19.1%	19.1%	22.2%	24.1%
Central	18.3%	17.0%	21.7%	19.5%	22.1%	23.7%	24.3%	26.3%
Western	14.7%	16.1%	14.7%	16.0%	16.0%	16.7%	19.2%	19.6%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Smoking During Pregnancy.

Smoking during pregnancy is the most preventable cause of poor pregnancy outcomes in the United States. Health consequences of smoking during pregnancy are serious for the pregnant woman, the infant and other children in the home. National data suggest that, in a given visit with a clinician, most smokers are not advised to quit smoking and are not assisted with cessation.[31] Smoking during pregnancy is linked to 20% of low birth weights.[32] A pregnant woman who smokes is between 1.5 and 3.5 times more likely than a nonsmoker to have a low birth weight (LBW) baby.

Cigarette smoking has been associated with increased risk of ectopic pregnancy or spontaneous abortions (miscarriages). Infants whose mothers smoked during pregnancy have 2.3 times the risk of SIDS (Sudden Infant Death Syndrome) than infants of nonsmoking

pregnant mothers and for infants exposed to maternal smoking both during pregnancy and after birth, the risk of SIDS is 3 times the risk for infants not exposed. Annually, an estimated 150,300 cases of lower respiratory infection in infants and children are attributable to environmental tobacco smoke. Most ETS exposure in infants and young children is from maternal smoking. In addition to health consequences, there are significant financial costs. Smoking- attributable neonatal health care costs for the Medicaid system total almost $228 million, or about $738 per smoker whose delivery is paid for by states' Medicaid programs.[33]

Provisional MCH data for MC+ Managed Care Regions, based on Missouri birth statistics for CY2002 indicate that 5,227 (27.7%) of mothers of live births in MC+ Managed Care Regions smoked during the pregnancy. Figures 73 and 74 show the rates of pregnant women who smoked statewide (Figure 73) and by MC+ Managed Care Region (Figure 74) from CY1995 (before MC+ Managed Care began) through CY2002. The first figure illustrates a statistically significant decrease in both Medicaid and non- Medicaid in pregnant women who smoked. The rate of smoking for the Medicaid group decreased by 7.6% (95% CI: 1.12, 1.04; **p** < .05), while for the non- Medicaid group it decreased by 28.2% in the same time period (95% CI: 1.46,1.32; **p** < .05).

Figure 73. Smoking During Pregnancy, All MC+ Managed Care Regions.
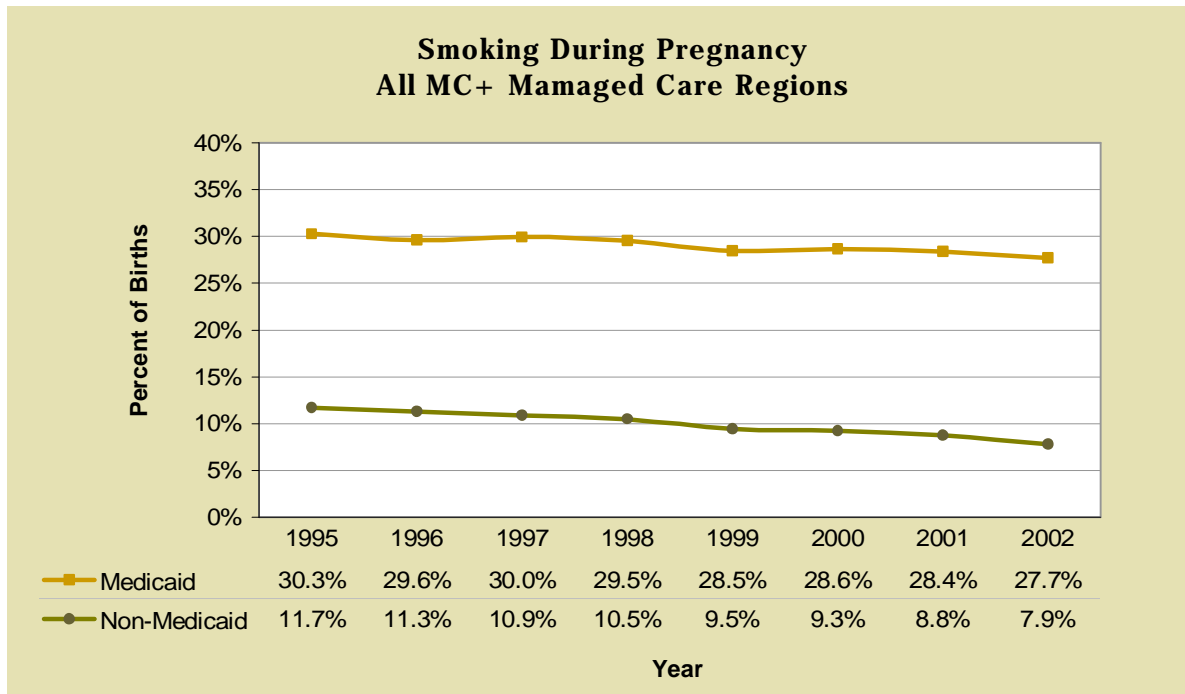
Note: Percent changes in tables may differ slightly from text due to rounding.
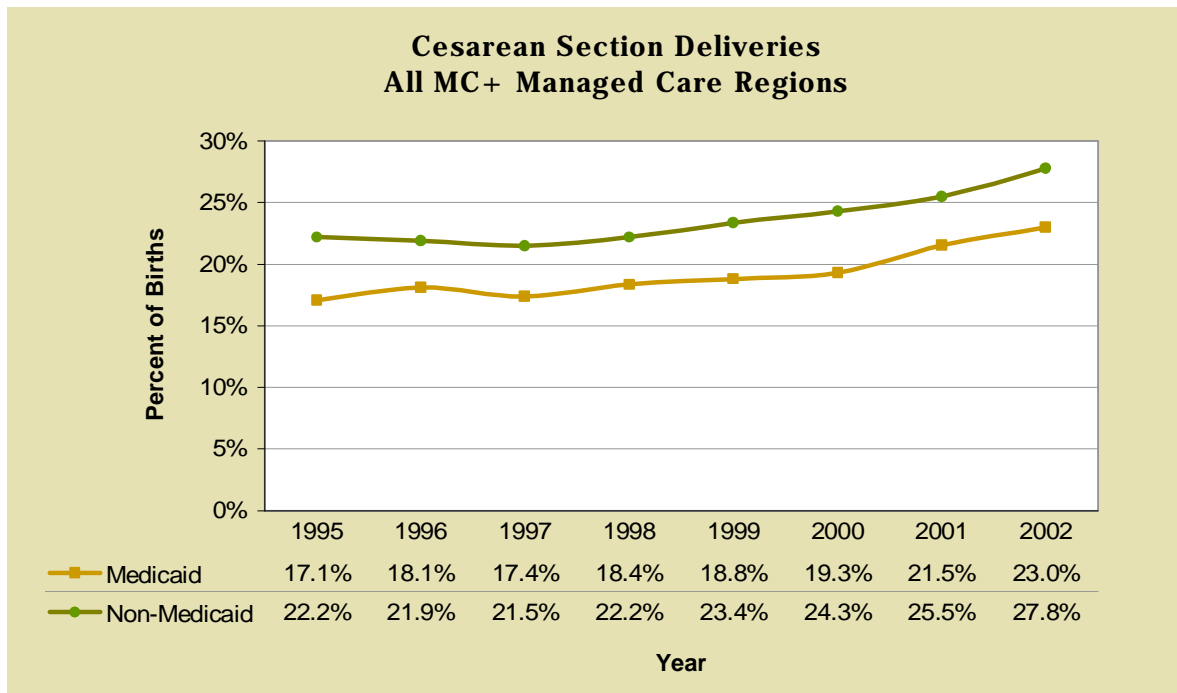*Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

Figure 74 shows the rate of smoking by pregnant MC+ Managed Care Members, by Region. Prior to implementation of MC+ Managed Care, the rates of smoking were higher in the Central Region (37.7%) than in the Eastern and Western Regions (24.8% and 30.3%) In CY2002, the rate of smoking remained higher in the Central Region (37.4%) than in the Eastern and Western Regions (26.1% and 25.6%).

Figure 74. Smoking During Pregnancy, Each MC+ Managed Care Region.

**Smoking During Pregnancy
Each MC+ Managed Care Region**

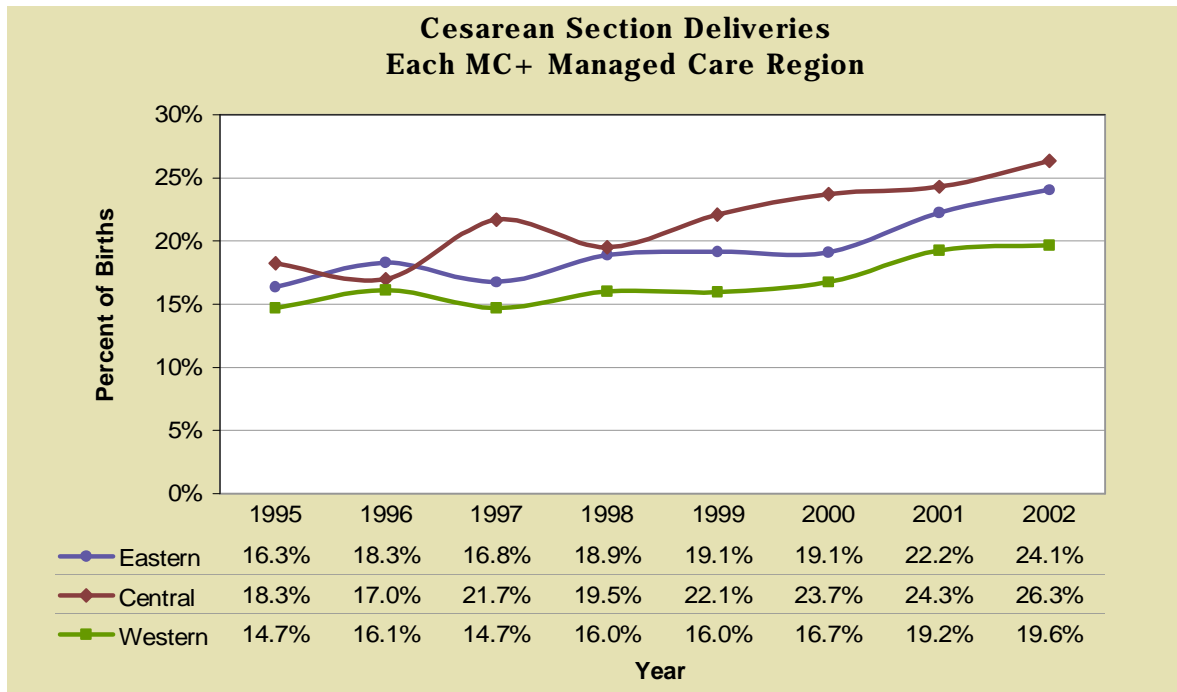|	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	26.5%	24.8%	26.1%	24.5%	24.1%	24.6%	26.7%	26.1%
Central	36.7%	37.7%	37.4%	37.9%	36.0%	38.3%	36.8%	37.4%
Western	31.9%	30.3%	29.5%	29.9%	28.7%	27.2%	27.1%	25.6%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

The Missouri smoking rates are similar to other nationally reported rates. In 1999, 21% of all U.S. women smoked and 12.3% of all women giving birth reported smoking during pregnancy. In 1998, the proportion of pregnant women covered by Medicaid who smoked during their last three months of pregnancy ranged from 15.8% to 38.5% in 15 states. On average, smoking among pregnant women on Medicaid was 2.5 times that of pregnant women without Medicaid coverage.[34]

Spacing Less than 18 Months Since Last Birth.

According to Healthy People 2010, encouraging women of all ages to space their pregnancies adequately can help lower the risk of adverse prenatal outcomes including low birth weight, preterm birth, and small for gestational age. To the extent that very closely spaced pregnancies are unplanned, unintended pregnancy may increase the risk of low birth weight. Health care providers can help all new mothers understand that they can become pregnant soon after delivery and should assist them with contraceptive education.[35]

Provisional birth statistics for CY2002 indicate that 1,490 (14.5%) of mothers of live births in Medicaid Managed Care Regions who had a prior live birth within 18 months, and the year of last birth was known, had a birth with spacing of less than 18 months since the previous birth.

Figures 75 and 76 show the rates of inadequate spacing statewide (Figure 75) and by MC+ Managed Care Region (Figure 76) from CY1995 (before MC+ Managed Care began) through CY2002. The first figure illustrates a statistically significant decrease in the Medicaid group. The rate of inadequate spacing for the Medicaid group decreased by 7.6% (95% CI: 1.16, 1.04; p < .05), while for the non-Medicaid group it decreased by 0.7% in the same time period (95% CI: 1.17, 1.01; p < .05).

Figure 75. Spacing Less Than 18 Months Since Last Birth, All MC+ Managed Care Regions.
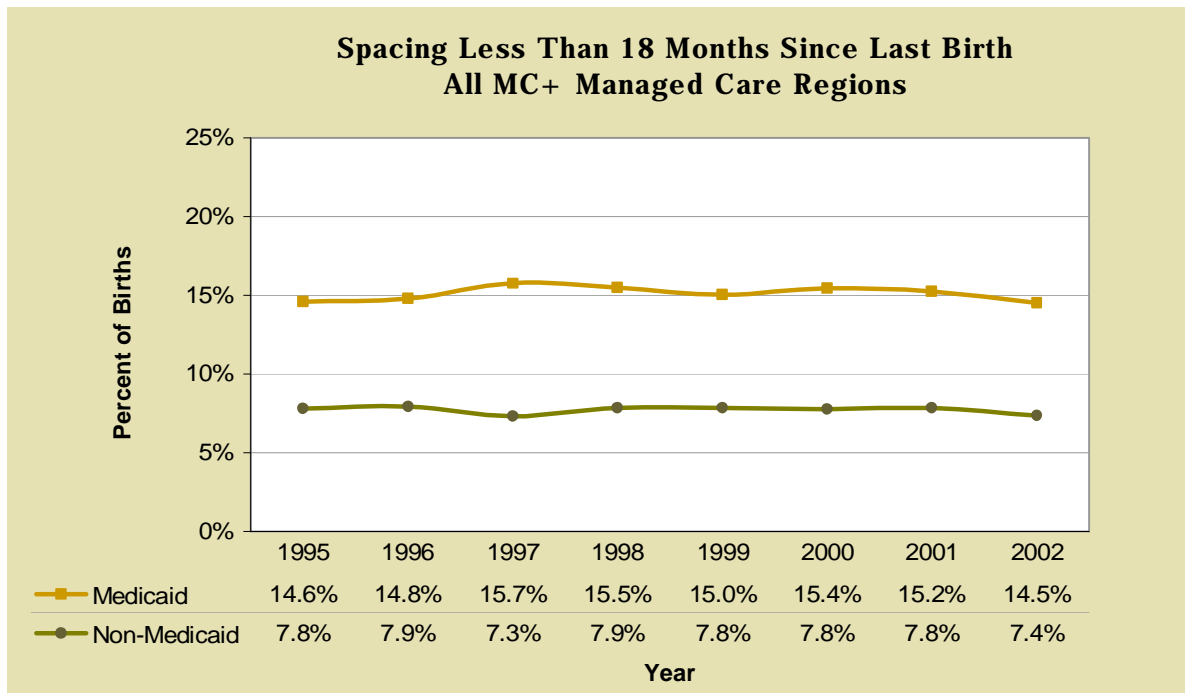
Spacing Less Than 18 Months Since Last Birth
All MC+ Managed Care Regions

	1995	1996	1997	1998	1999	2000	2001	2002
Medicaid	14.6%	14.8%	15.7%	15.5%	15.0%	15.4%	15.2%	14.5%
Non-Medicaid	7.8%	7.9%	7.3%	7.9%	7.8%	7.8%	7.8%	7.4%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Figure 76 shows the rate of inadequate pregnancy spacing for MC+ Managed Care Members, by Region. Prior to implementation of MC+, the rates of inadequate spacing were higher in the Western Region (15.7%) than in the Eastern and Central Regions (14.5% and 13.2%). However, in CY2002, the rate of inadequate spacing was higher in the Eastern Region (15.6%) than in the Central and Western Regions (13.3% and 13.6%).

Figure 76. Spacing Less Than 18 Months Since Last Birth, Each MC+ Managed Care Region.

Spacing Less Than 18 Months Since Last Birth
Each MC+ Managed Care Region

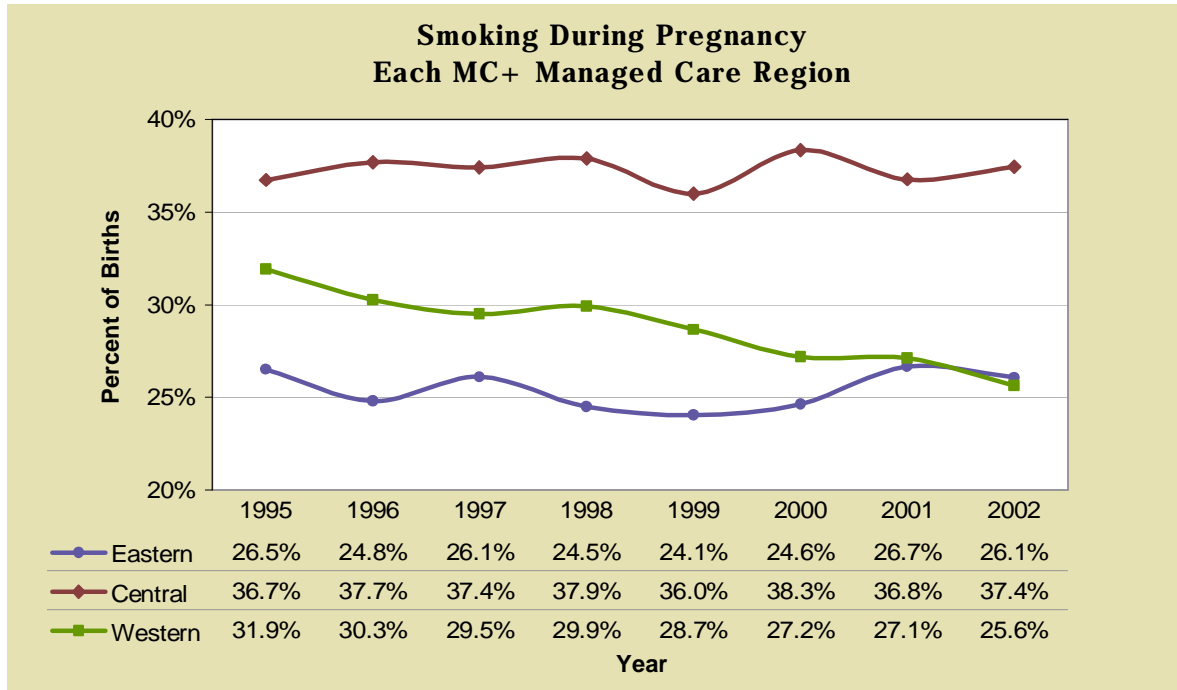|	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	16.9%	14.5%	14.4%	15.4%	15.5%	14.4%	15.2%	15.6%
Central	13.6%	13.2%	15.8%	13.5%	13.6%	16.7%	14.2%	13.3%
Western	14.9%	15.7%	17.5%	16.3%	14.7%	15.3%	15.1%	13.6%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Births to Mothers Under 18 Years of Age.

Pregnant adolescents younger than 17 years have a higher incidence of medical complications involving mother and child than do adult women, although there are emerging data that these risks may be greatest for the youngest of teenagers. The incidence of LBW (< 2500 grams) is more than double the rate for adults, and the neonatal death rate (within 28 days of birth) is almost three times higher.[36] Adolescent pregnancy has been associated with other medical problems including poor maternal weight gain, preterm birth (less than 37 weeks gestation), pregnancy-induced hypertension, anemia, and sexually transmitted diseases. In addition to medical risks, pregnant and parenting teens are at risk for dropping out of school, not completing high school or post-secondary schooling, having another baby, and not finding employment at a livable wage.[37]

Provisional Missouri MC+ Managed Care Region birth statistics for CY2002 indicate that 1,312 (7.0%) of births were mothers under the age of 18 years at the time of birth. Figures 77 and 78 show the rates of births to mothers under the age of 18 years statewide (Figure 77) and by MC+ Managed Care Region (Figure 78) from CY1995 (before MC+ Managed Care began) through CY2002. The first figure illustrates a statistically significant decrease in both Medicaid and non-Medicaid in mothers less than 18 years of age.

The rate of mothers less than 18 years of age for the Medicaid group decreased by 31.3% (95% CI: 1.56, 1.35; $p < .05$), while for the non-Medicaid group it decreased by 23.4% in the same time period (95% CI: 1.46, 1.15; $p < .05$).

Figure 77. Births to Mothers Less Than 18 Years of Age, All MC+ Managed Care Regions.

	1995	1996	1997	1998	1999	2000	2001	2002
Medicaid	10.4%	10.3%	10.1%	9.3%	8.7%	8.3%	7.6%	7.0%
Non-Medicaid	2.2%	2.0%	2.0%	2.1%	1.9%	1.8%	1.6%	1.5%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Regional data comparing CY1997 and CY2002 indicate decreases for all three Regions. Figure 78 shows the rate births to mothers under 18 years of age for MC+ Managed Care Members, by region. Prior to implementation of MC+ Managed Care, the rates of births to mothers under 18 years of age were higher in the Eastern Region (10.7%) than in the Central and Western Regions. (8.3% and 10.6%). In CY2002, the gap was diminished with the Western Region (7.1%) just slightly higher than the Eastern and Central Regions (7.0% and 6.6%).

Figure 78. Births to Mothers Less Than 18 Years of Age, Each MC+ Managed Care Region.

Births to Mothers Less Than 18 Years of Age Each MC+ Managed Care Region

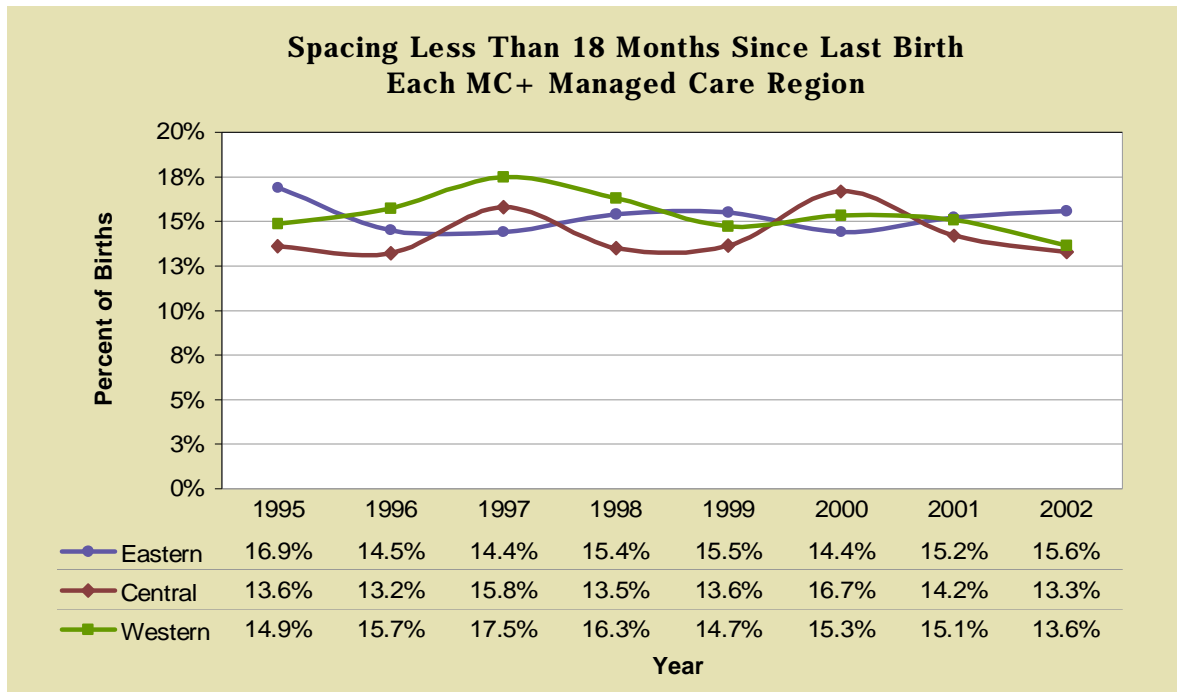|	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	10.6%	10.7%	10.2%	9.4%	9.0%	8.1%	7.6%	7.0%
Central	9.2%	8.3%	8.8%	8.2%	7.8%	6.8%	7.1%	6.6%
Western	10.8%	10.6%	10.7%	9.4%	8.6%	9.1%	7.7%	7.1%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003
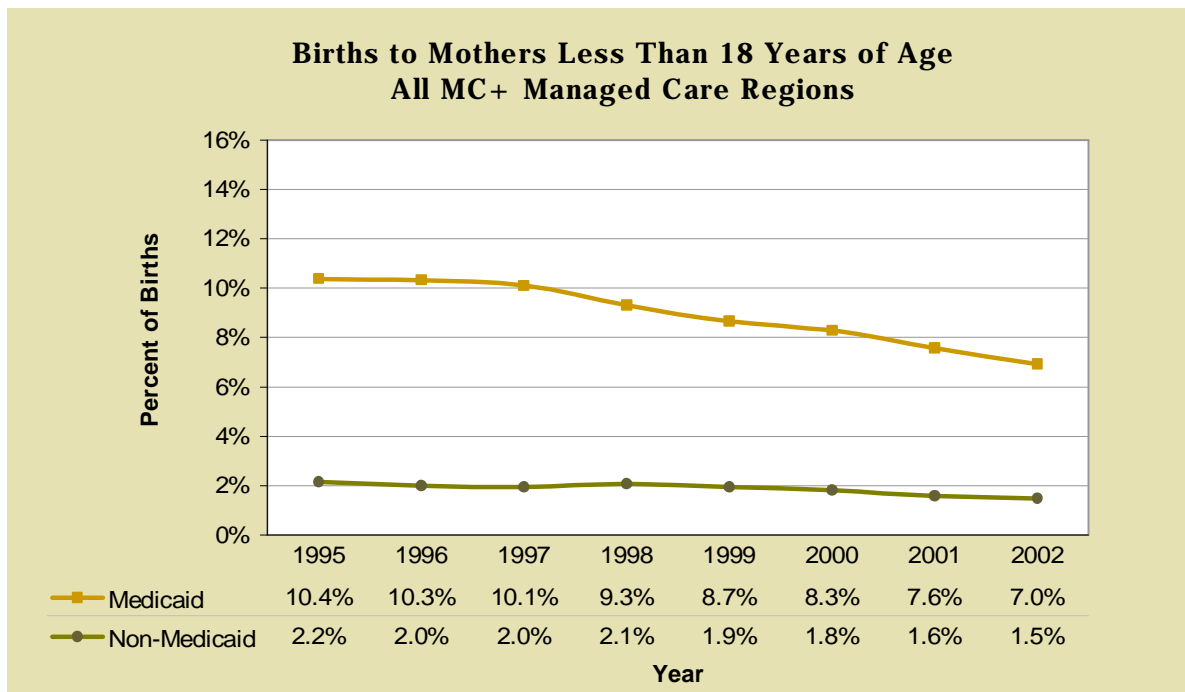
<u>Repeat Teen Births</u>.

According to Healthy People 2010, encouraging women of all ages to space their pregnancies adequately can help lower the risk of adverse prenatal outcomes including low birth weight, preterm birth, and small for gestational age. In 1997, nearly one in five births to teen mothers was a birth of a second order or higher. [38]

Provisional birth statistics for CY2002 indicate that 901 (4.8%) of births in the MC+ Managed Care Regions were repeat births in MC+ Managed Care Regions to teenage mothers. Figures 79 and 80 show the rates of repeat births to teenage mothers statewide (Figure 79) and by Region (Figure 80) from CY1995 (before MC+ Managed Care began) through CY2002. The first figure illustrates a statistically significant decrease in both Medicaid and non-Medicaid in repeat births to teenage mothers. The rate of repeat births to teenage mothers for the Medicaid group decreased by 22.6% (95% CI: 1.41, 1.18; p < .05), while for the non-Medicaid group it decreased by 27.8% in the same time period (95% CI: 1.66, 1.11; p < .05).

Figure 79. Repeat Teen Births, All MC+ Managed Care Regions.

Repeat Teen Births
All MC+ Managed Care Regions

Year	1995	1996	1997	1998	1999	2000	2001	2002
Medicaid	6.7%	6.4%	6.2%	6.2%	5.8%	5.8%	5.2%	4.8%
Non-Medicaid	0.6%	0.6%	0.7%	0.8%	0.7%	0.6%	0.7%	0.5%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Regional data comparing CY1997 and CY2002 indicate decreases for all three MC+ Managed Care Regions. Figure 80 shows the rate of repeat teenage births for MC+ Managed Care Members, by Region. Prior to implementation of MC+ Managed Care, the rates of repeat teenage births were higher in the Western Region (7.2%) than in the Eastern and Central Regions (6.6% and 4.8%). In CY2002, the rate of repeat teenage births remained higher in the Western Region (5.1%) than in the Eastern and Central Regions (4.9% and 3.8%).

Figure 80. Repeat Teen Births, Each MC+ Managed Care Region.

Repeat Teen Births
Each MC+ Managed Care Region

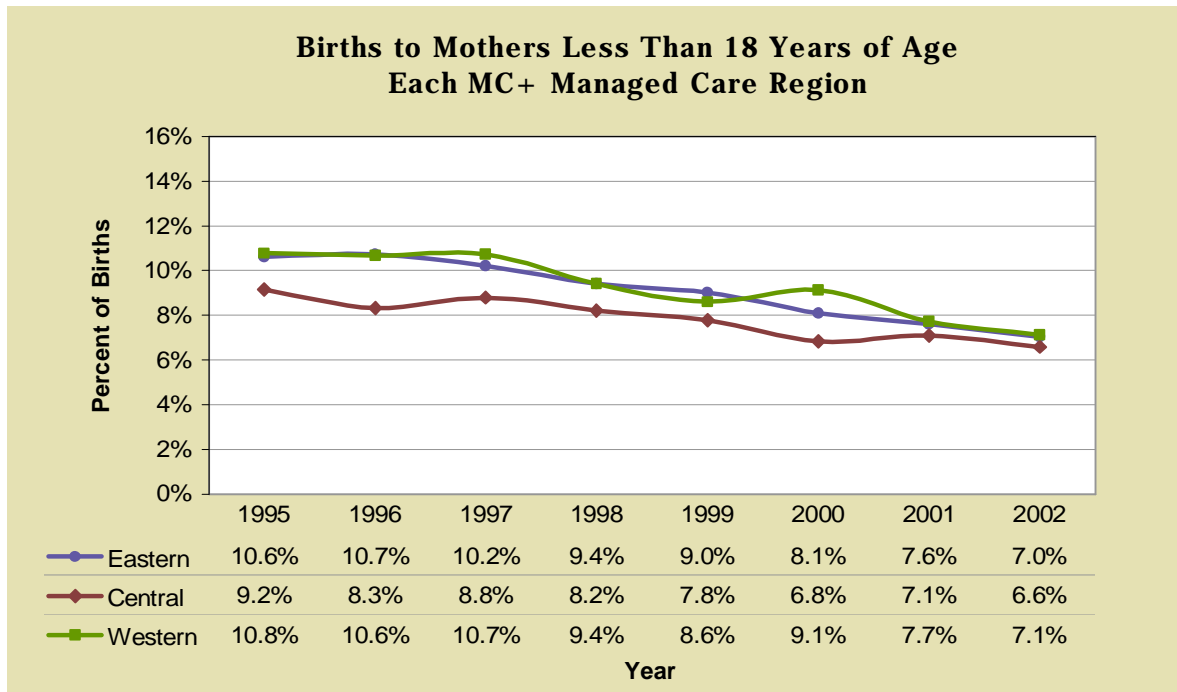|	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	7.3%	6.6%	6.5%	6.6%	5.9%	5.8%	4.9%	4.9%
Central	5.1%	4.8%	4.5%	5.1%	4.6%	5.3%	4.3%	3.8%
Western	6.6%	7.2%	6.3%	6.1%	6.4%	6.2%	5.9%	5.1%

Note: Percent changes in tables may differ slightly from text due to rounding.
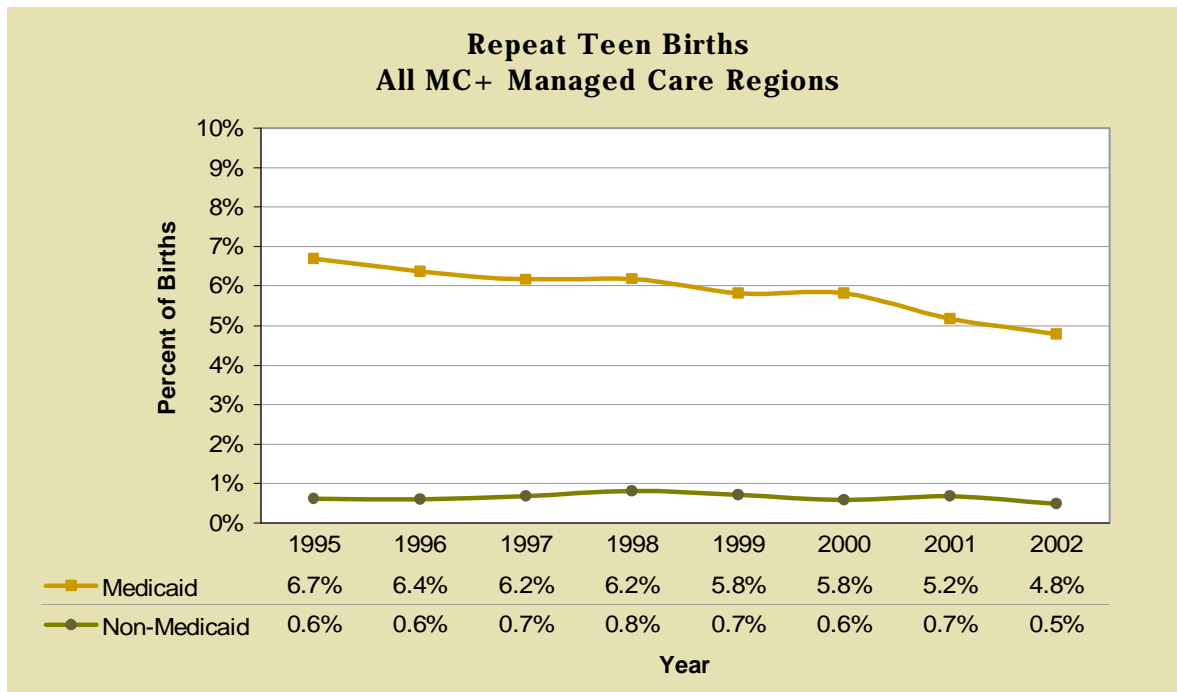*Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003*

Prenatals on WIC.

Appropriate maternal nutrition is vital during pregnancy. Birthweight is the best indicator of a newborn's health. Low preconceptual weight and inadequate weight gain during pregnancy are the most important contributors to intrauterine growth retardation and low birth weight. Studies have shown that participation by prenatal women in the Supplemental Nutrition Program for Women, Infants, and Children (WIC) has resulted in longer gestations, higher birthweight babies and higher likelihood of receiving prenatal care.[39]

Provisional birth statistics for CY2002 indicate that 14,365 (76.1%) of prenatal women in MC+ Managed Care Regions were on WIC. Although the number of women is up from CY1997 (N=13,869) the percentage of women is decreased from 80.2%. Figures 81 and 82 show the rates of prenatal women enrolled in the WIC program statewide (Figure 81) and by MC+ Managed Care Region (Figure 82) from CY1995 (before MC+ Managed Care began) through CY2002. The first figure illustrates a statistically significant decrease in both Medicaid and non-Medicaid prenatal women enrolled in the WIC program. The rate of prenatal women enrolled in the WIC program for the Medicaid group decreased by 5.1% (95% CI: 1.08, 1.03; p < .05), while for the non-Medicaid group it decreased by 9.9% in the same time period (95% CI: 1.16, 1.06; p < .05).

Figure 81. Prenatals on WIC, All MC+ Managed Care Regions.

Prenatals on WIC
All MC+ Managed Care Regions

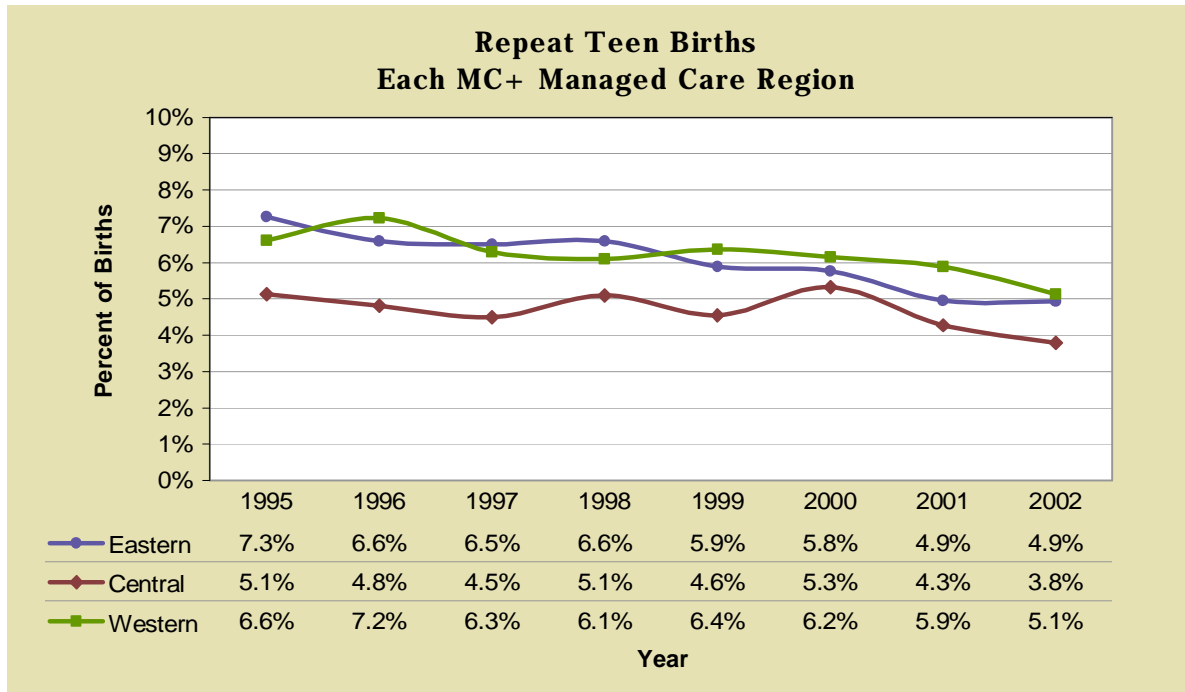|	1995	1996	1997	1998	1999	2000	2001	2002
Medicaid	77.7%	79.4%	80.2%	78.5%	77.2%	75.6%	75.9%	76.1%
Non-Medicaid	9.1%	10.7%	11.4%	11.7%	11.4%	11.2%	11.0%	10.3%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Figure 82 shows the rate of WIC participation for MC+ Managed Care Members, by Region. Prior to implementation of MC+ Managed Care, the rates of WIC participation were close in all three Regions, with the Western Region (78.3%) just above the Eastern and Central Regions. (76.6% and 76.1%) However, in CY2002, the rate of WIC participation was higher in the Central Region (80.6%) than in the Eastern and Western Regions (73.1% and 78.6%).

Figure 82. Prenatals on WIC, Each MC+ Managed Care Region.
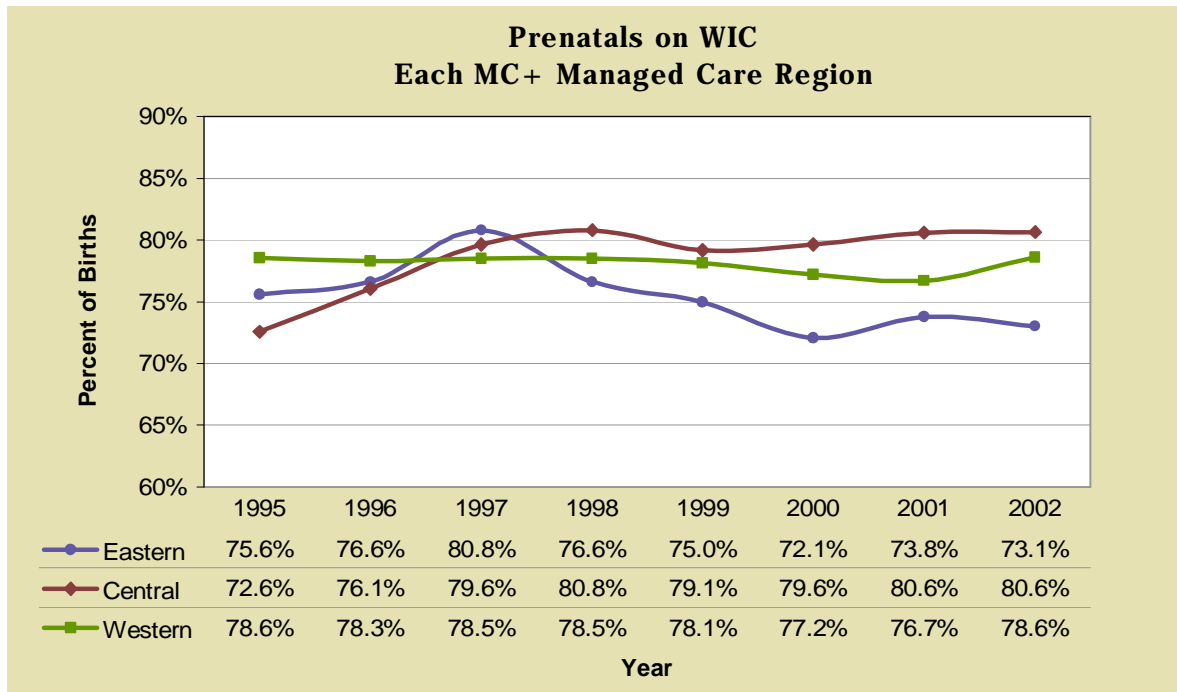
**Prenatals on WIC
Each MC+ Managed Care Region**

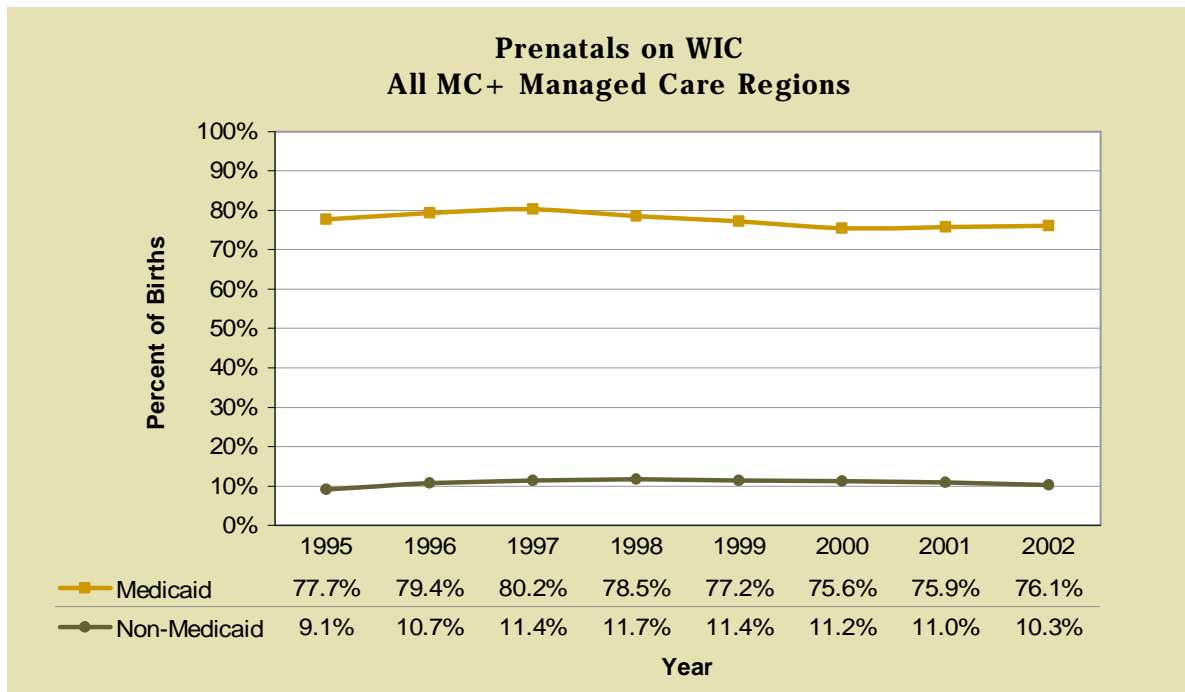|	1995	1996	1997	1998	1999	2000	2001	2002
Eastern	75.6%	76.6%	80.8%	76.6%	75.0%	72.1%	73.8%	73.1%
Central	72.6%	76.1%	79.6%	80.8%	79.1%	79.6%	80.6%	80.6%
Western	78.6%	78.3%	78.5%	78.5%	78.1%	77.2%	76.7%	78.6%

Note: Percent changes in tables may differ slightly from text due to rounding.
Source: Missouri Department of Health and Senior Services (DHSS), Community Health Information and Epidemiology (CHIME), 2003

Medical Record Review.

This EQR assessment was conducted to evaluate the degree to which medical records documented prenatal care for MC+ Managed Care Members who delivered a child between January 1, 2002 and December 31, 2003. It addresses prenatal visits, medical risks (e.g. hypertension, diabetes, anemia), socioeconomic risks (e.g., domestic abuse, housing), behavioral risks (e.g., smoking, drug abuse, alcohol use), and educational/referral interventions (e.g., WIC, smoking cessation).

The following sections describe the medical record review findings.

- **Demographic information (age, race, marital status)**
- **Number of prenatal visits**
- **Pregnancy risk assessments**

- **Nutrition assessments and interventions**

- **Smoking status and interventions**

- **Substance abuse status and interventions**

- **Complications of this pregnancy**

- **Delivery Information**

<u>**Medical Record Review Methods.**</u>

The sampling frame for the study population consisted of female MC+ Managed Care Members who delivered single or multiple live or stillborn infants during CY2002 and whose encounter claims were available for selection on November 8, 2002. All women were identified as having had a delivery using ICD- 9- CM and CPT- 4 codes related to pregnancy/ delivery diagnoses and procedure codes. Additional eligibility required continuous enrollment in an MC+ MCO for at least 43 days prior to the delivery. A sample size of 400 cases was established and a 100% oversample was drawn to allow for missing and unusable patient charts, and to allow for the deletion of recipients who did not have at least one prenatal visit during the study period. Cases were randomly selected from claims proportionate to the number of total eligible claims per MCO and requests were sent directly to providers. With the assistance of the MCOs a total of 447 (55.9%) medical records were received. A total of 34 cases were excluded because the records were for non- pregnancy related visits, resulting in 413 cases available for review. An additional 31 cases were eliminated from the study after review because documentation submitted included only delivery or postnatal information, or the delivery was prior to CY2002. This resulted in a total of 382 cases eligible for analysis.

An abstraction protocol was developed to collect information from the eligible medical records. Measures were selected and grouped according to common sections of prenatal medical records and other areas of special interest as follows:

- **Demographic information**

- **Prenatal visit information**

- **Vital signs (e.g., weight, blood pressure)**

- **Risk assessments**

- **Complications**

- **Delivery information (when available)**

The medical records were reviewed at BHC offices and abstracted information was entered into the BHC database via a Teleform® scanning system. Interrater Reliability (IRR) was carried out and quality control monitored throughout the abstraction and data entry processes. All personally identifiable information was treated as privileged and confidential in accordance with HIPAA, federal and state laws and regulations. Collected data were entered into customized databases for analysis and secure storage. Software used for data analyses included Microsoft Access and Excel; and the Statistical Package for the Social Sciences (SPSS®), v. 11.5.

The study analyzed general patterns of care and significant differences between the three MC+ regions and the total MC+ sample. Statistical methods were used to evaluate difference between the study groups at the 95% confidence level.

No effort was made to evaluate variation among individual MCOs as such study is appropriate for larger sample sizes addressing more focused issues.

The major limitations in the medical record review are those resulting primarily from incomplete or missing medical records. Specifically these limitations were: (1) medical records were not complete for the entire pregnancy, possibly due to lack of comprehensive medical records resulting from multiple providers or transfer of providers; (2) non-submission of medical records by selected providers which could result in a provider-related bias; and (3) care management records which may have contained additional information regarding risk assessment, and interventions were not available for this review.

<u>Demographics.</u>

A total of 382 pregnant MC+ Managed Care women whose medical records were reviewed had documentation of one or more prenatal visits during CY2002. Of these, 158 women (41.4%) were in the Eastern Region, 98 (25.7%) in the Central Region, and 126 (33.0%) in the Western Region. The mean age at the first documented prenatal visit was 23.0 years, with a range of 13.5 years to 41.9 years. Five (1.3 %) of the women were age 15 years or less, and ten (2.6%) were age 35 years or older. Figure 83 shows the number of women in each age category by region and for statewide MC+.

Figure 83. Age Category by MC+ Managed Care Region.

Age Category by MC+ Managed Care Region

	Eastern	Central	Western	Missouri
■ 35>	4	4	2	10
■ 30-34	6	8	10	24
■ 25-29	34	17	27	78
■ 20-24	59	45	50	154
■ 15-19	52	23	36	111
■ <15	3	1	1	5

Number
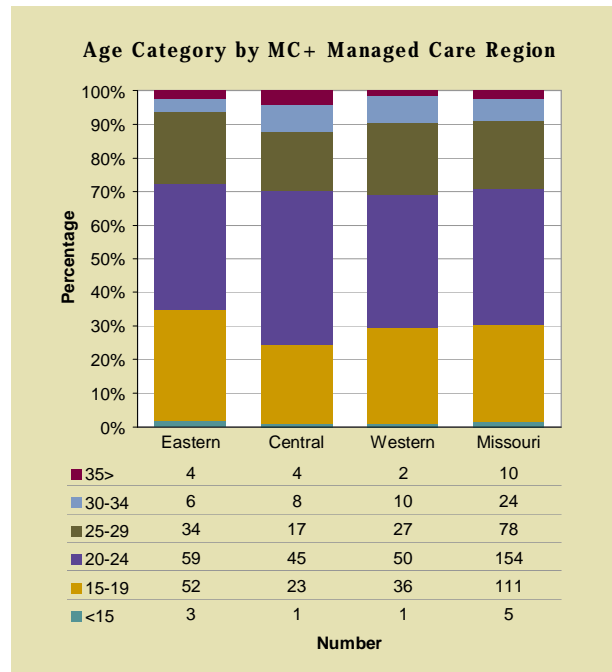
Source: BHC, Inc., EQR Medical Record Review, April 2003

Race and ethnicity information was collected for 382 MC+ Managed Care women in the study. Of the 245 (64.1%) cases for whom this information was available in the medical record, 146 (59.6%) were identified as 'White', 87 (35.5%) 'Black', and 12 (4.9%) as 'Other'. Figure 84 shows breakdowns by region for the 245 women for whom race/ethnicity was available.

Figure 84. Race/Ethnicity by MC+ Managed Care Region.

Race/Ethnicity by MC+ Managed Care Region

	Eastern	Central	Western	Missouri
■ Other	1	1	10	12
■ African American	49	6	32	87
■ White	49	48	49	146

Number
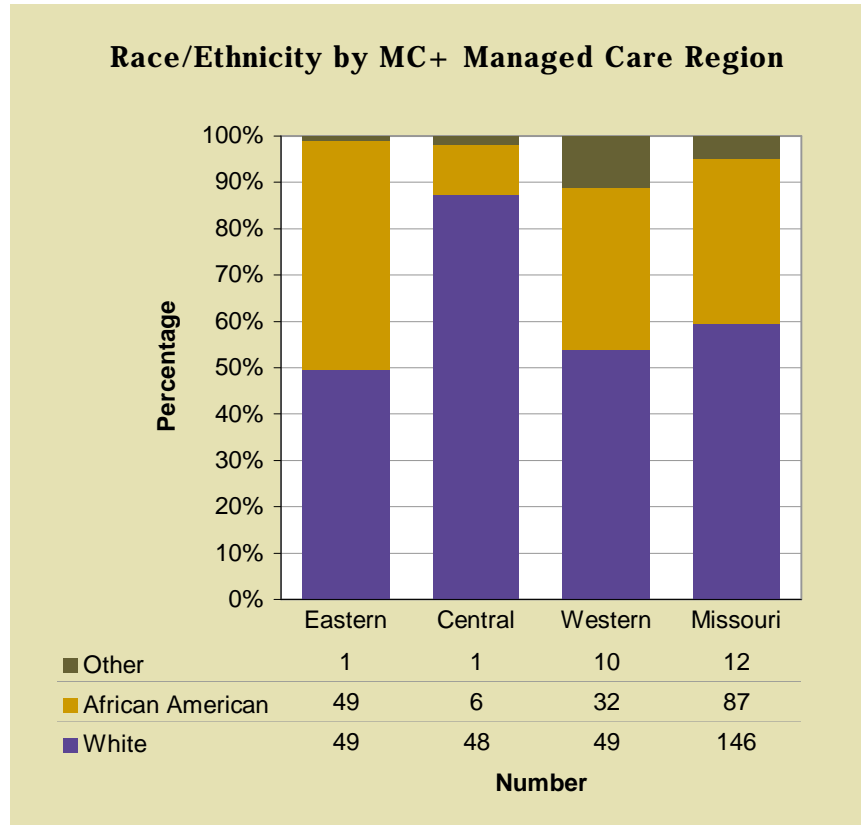
Source: BHC, Inc., EQR Medical Record Review, April 2003

A third demographic for which information was gathered was marital status. Of the 382 MC+ Managed Care cases reviewed, this information was available in the medical record for 299 (78.3%) of the women. Of these, 78 (26.1%) were identified as 'Married', 202 (67.6%) 'Single' and Divorce/Separated 19 (6.3%). Figure 85 shows breakdowns by region.

Figure 85. Marital Status by MC+ Managed Care Region.

Marital Status by MC+ Managed Care Region

	Eastern	Central	Western	Missouri
Divorced/Separated	6	3	10	19
Married	18	29	31	78
Single	96	44	62	202
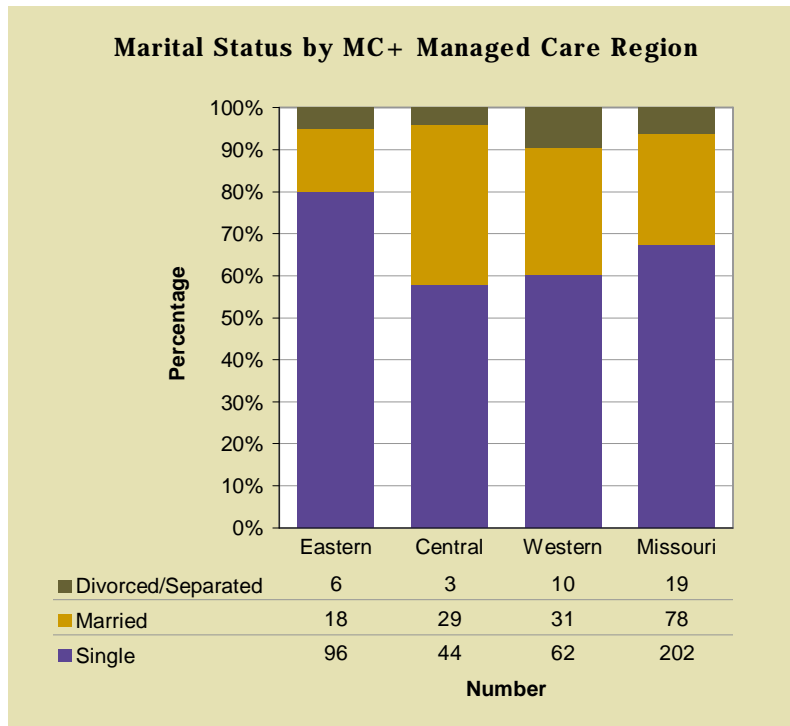
Number

Source: BHC, Inc., EQR Medical Record Review, April 2003

<u>**Prenatal Visits.**</u>

All of the 382 MC+ Managed Care pregnant women whose medical records were reviewed had documentation of one or more prenatal visits. The mean number of visits documented per pregnancy was 10.3, with a range of 1 to 21 visits (see Figure 86).

Figure 86. Number of Prenatal Visits, MC+ Managed Care Region.

Number of Prenatal Visits by MC+ Managed Care Rigion

	Eastern	Central	Western	Missouri
■ 16 or More	5	9	3	17
■ 11-15	72	55	56	183
■ 6-10	61	29	45	135
■ 5 or Less	20	5	22	47

Number
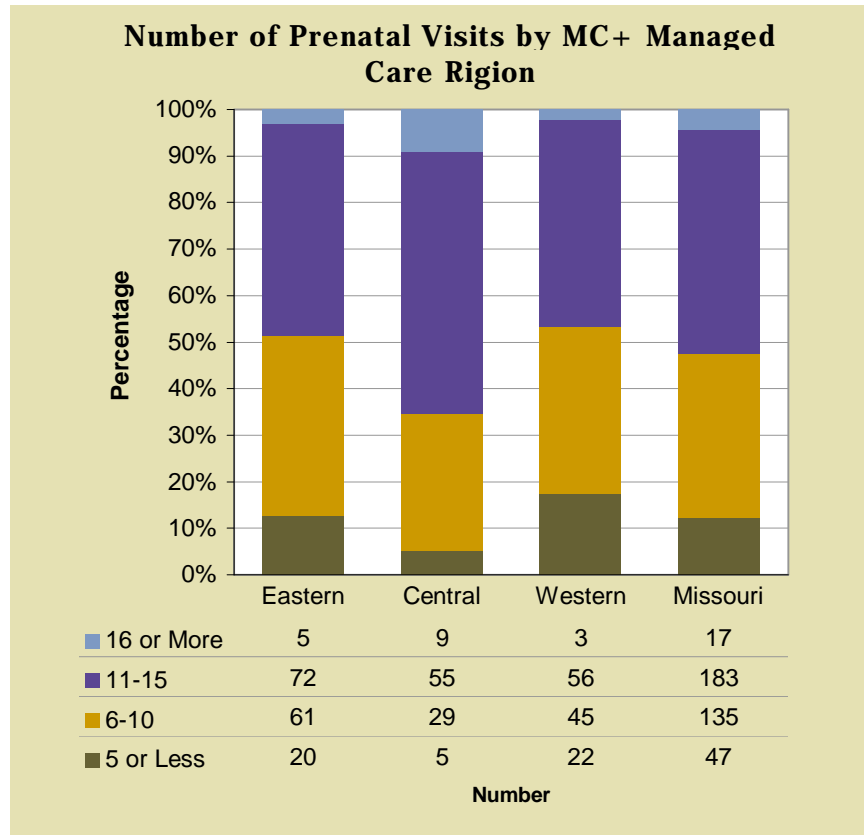
Source: BHC, Inc., Medical Record Review, April 2003

<u>**Prenatal Risk Assessments.**</u>

MC+ MCOs are required to provide prenatal case management services for all at-risk pregnant women. The initial case management and admission encounter is required to be face-to-face, and to include an assessment of the participant's needs. Based on the assessment, the case manager formulates an individualized plan of management designed to accomplish/meet the intended objectives. Medical records must document that prenatal case management services were provided. A risk appraisal form for pregnant women must be part of the participant's record. MCOs may use the Department of Health and Senior Services (DHSS) form or any form that contains, at a minimum, the information required in the DHSS Risk Appraisal form.[40]

The medical records of MC+ Managed Care women were reviewed to determine whether prenatal risk assessments had been documented. The review indicated that 333 (87.2%) cases had documentation of at least one risk. The mean number of documented prenatal risks was 2.1, with a range of 0- 11 risks. The highest number and percentage of documented risks was 138 (41.4%) in the Eastern Region, followed by 110 (33.0%) in the Western Region and 85 (25.5%) in the Central Region.

A total of 57 (14.9%) of the 382 cases had a DHSS *Pregnancy Risk Assessment Form* in the medical record. Other medical records contained pregnancy risk information in narrative notes regarding physical, social or other conditions or documentation on American College of Obstetrics and Gynecology (ACOG) forms. One observation made by abstracting nurses was that frequently there was documentation of a risk (e.g., smoking, nutrition, social issues) in the narrative notes or on the ACOG form, but the risk was not checked on the *Pregnancy Risk Assessment Form.*

<u>Smoking.</u>

An assessment of smoking status by the pregnant MC+ Managed Care women was conducted. Results indicated that 150 (39.3%) of the women included in the study smoked cigarettes during their pregnancy. For the 87 cases for which information was available regarding the amount smoked, 42 (48.3%) indicated the woman smoked one or more packages of cigarettes per day. Of the 150 women who smoked, 75 (50.0%) had documentation in the record that she had counseled to reduce or stop smoking. Four (2.7%) of the women had documentation of referral to a smoking cessation program or other intervention. This is consistent with national data that suggest, in a given visit with a clinician, most smokers are not advised to quit smoking and are not assisted with cessation.[41] Assessment of the three MC+ regions showed differences in the rates of smoking, with the Central Region experiencing the highest rate (43.9%), followed by the Western Region (40.5%) and the Eastern Region with the lowest rate (35.4). No significant difference was seen by age (see Figure 87).

Figure 87. Smoking Status by Age Group by MC+ Managed Care Region.

Smoking Status by Age Categoty and MC+ Managed Care Region

	Eastern	Central	Western	Total
30+	4	5	4	13
20-29	36	26	31	93
<20	16	12	16	44

Number
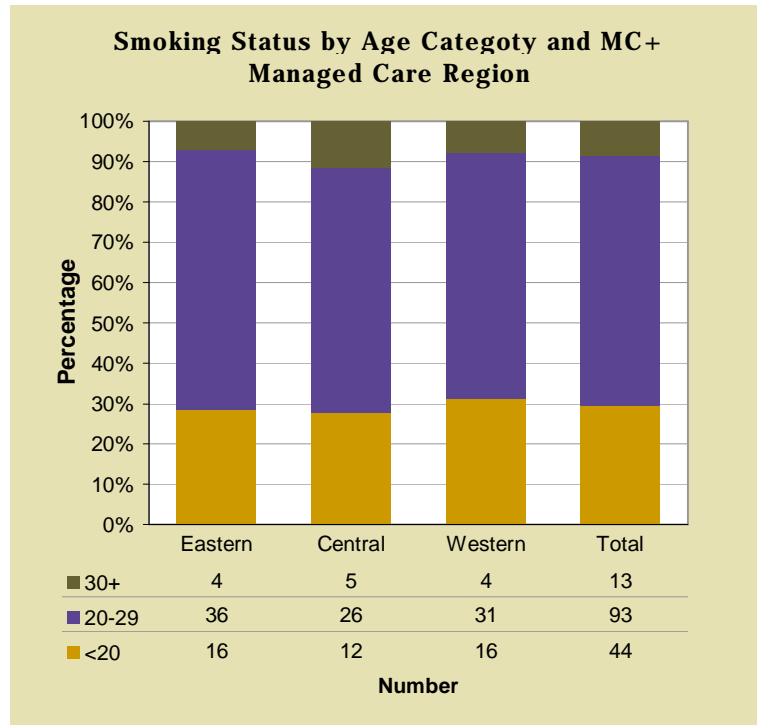
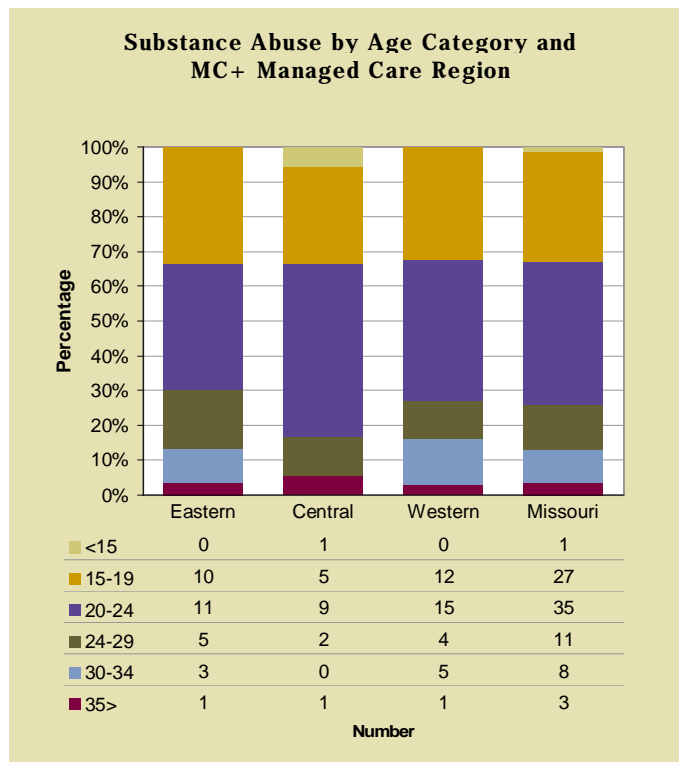*Source: BHC, Inc., EQR Medical Record Review, April 2003*

Substance Abuse Status.

A range of effects, including spontaneous abortion, LBW, and preterm delivery, have been associated with prenatal use of licit and illicit drugs, including alcohol, tobacco, cocaine, and marijuana. As discussed above, tobacco is associated with LBW and spontaneous abortion. Heavy alcohol use is associated with FAS (fetal alcohol syndrome), and even moderate alcohol use has demonstrated effects on preterm growth.[42]

The medical record review showed that a total of 85 MC+ Managed Care women (22.3%) had documented substance abuse (other than tobacco) either prior to the pregnancy or during the pregnancy. Of the 85 cases, 19 (22.4%) were documented as using substances during the pregnancy and 66 (77.6%) were reported as having used substances prior to the pregnancy. Of the cases in which substances were abused, marijuana was the most frequently reported in 63 (74.1%) of the cases. 13 (15.3%) also reported cocaine/crack cocaine use, 7 (8.2%) of the cases amphetamines. Thirty women (35.3%) reported use of more than one substance, generally marijuana and alcohol. Four cases (21.1%) of the 19 who reported current substance abuse women were documented as having been referred to a substance abuse program such as C-STAR.

The mean age of the 85 women who had documentation of substance use/abuse was 22.9 years. Variation in the documentation of substance use was seen in the three regions, with 30 women (19.0%) in the Eastern Region; 18 (18.4%) in the Central and 37 (29.4%) in the Western Region reporting substance use (see Figure 88).

Figure 88. Substance Abuse by Age Category and MC+ Managed Care Region.

Substance Abuse by Age Category and MC+ Managed Care Region				
	Eastern	Central	Western	Missouri
<15	0	1	0	1
15-19	10	5	12	27
20-24	11	9	15	35
24-29	5	2	4	11
30-34	3	0	5	8
35>	1	1	1	3

Source: BHC, Inc., EQR Medical Record Review, April 2003
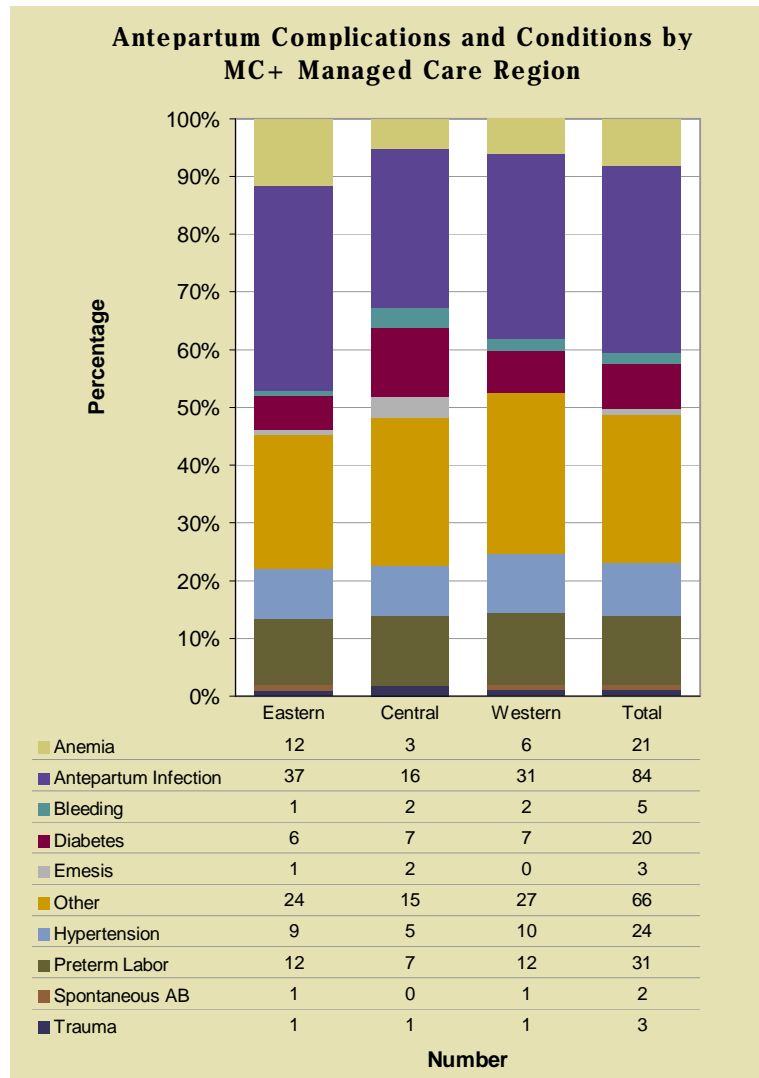
Nutritional Assessments.

A total of 45 (11.8%) of the 382 MC+ Managed Care cases reviewed had documentation of a nutritional problem. Of the 29 (7.6%) cases for which a description of the problem was provided, the most common was nausea and vomiting. Weights were documented as part of the prenatal visit assessment. The mean weight at the first documented visit was 164.9 pounds, with a range from 85 pounds to 332 pounds. Obesity was documented as a risk for seven women (1.8%), although based on recorded weights during prenatal visits, this risk factor appears to be underdocumented. Of the 368 women for whom initial weights were available, 73 (19.8%) were between 200 and 332 pounds at the first prenatal visit, suggesting possible nutritional problems that were not documented in the risk assessments. One person (<1%) was documented on the *Pregnancy Risk Assessment Form* as being underweight, while five (1.3%) had documented weights of less than 100 pounds at the first prenatal visit. This suggests using only the *Pregnancy Risk Assessment Form* for data collection results in underestimating nutritional and/or weight related risks.

A total of 45 (11.8%) of the cases had documentation of either being referred to or enrolled in the WIC program. Eleven (2.9%) were also referred to a nutritional program or nutritional counselor. The medical record rate for WIC participation was considerably lower than the 76.1% reported in the MCH Indicators and is most likely a medical record documentation issue for this type of information.

Complications/Conditions during This Pregnancy.

Information was gathered regarding complications and medical conditions occurring during pregnancy. Two hundred (52.4%) of the MC+ Managed Care women included in the medical record review had one or more complications and/or conditions during the pregnancy, with a range of 1 to 6 complications/conditions. The most common complication/condition that was noted was antepartum infection with 84 (22.0%) cases. Other conditions included the following: 31 (8.1%) had preterm labor, 24 (6.3%) pregnancy induced/ influenced hypertension, 21 (5.5%) anemia, 20 (5.2%) had diabetes, 5 (1.3%) experienced bleeding in the second half of the pregnancy, 3 (0.8%) had emesis, 3 (0.8%) had trauma (e.g. motor vehicle accident), 2 (0.5%) had a spontaneous abortion, 1(0.3%) Prolonged Placental Insufficiency (PPI) and 65 (17.0%) had miscellaneous conditions indicated as 'other' (see Figure 89).

Figure 89. Antepartum Complications and Conditions by MC+ Managed Care Region.

Antepartum Complications and Conditions by MC+ Managed Care Region

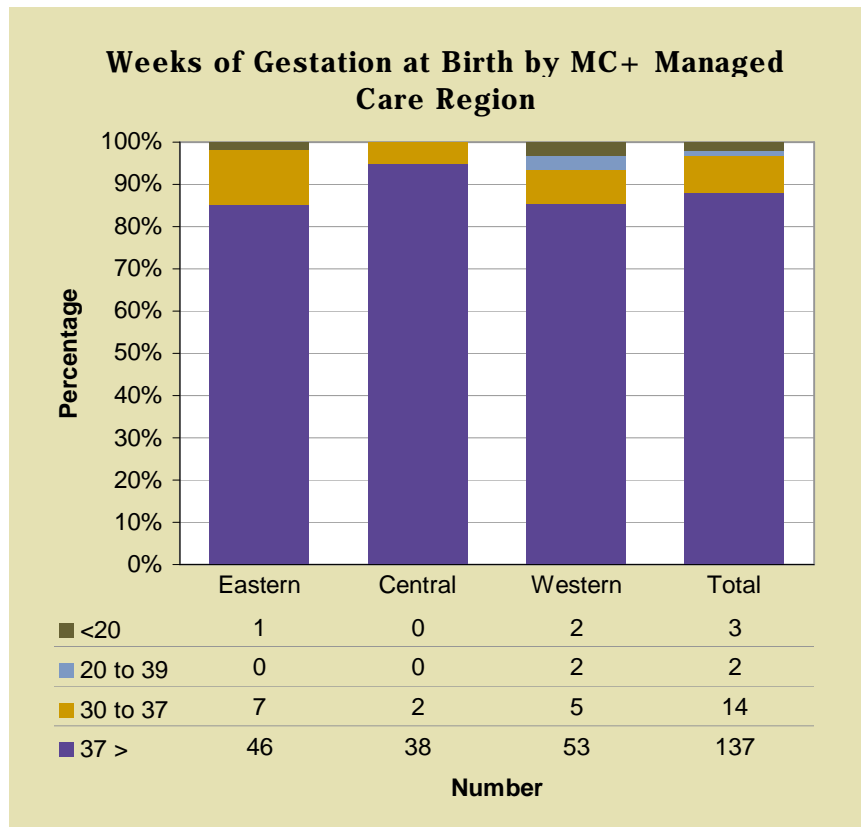|	Eastern	Central	Western	Total
Anemia	12	3	6	21
Antepartum Infection	37	16	31	84
Bleeding	1	2	2	5
Diabetes	6	7	7	20
Emesis	1	2	0	3
Other	24	15	27	66
Hypertension	9	5	10	24
Preterm Labor	12	7	12	31
Spontaneous AB	1	0	1	2
Trauma	1	1	1	3

Number

Source: BHC, Inc., EQR Medical Record Review, April 2003

Delivery and Infant Information.

Of the 302 MC+ Managed Care deliveries for which documentation was available, 224 (74.2%) of the deliveries were vaginal, and 78 (25.8%) were via cesarean section. A total of 298 (98.7%) deliveries resulted in a live birth, with three cases having twins. Of the four cases not resulting in a live birth, two (0.7%%) were spontaneous abortions (one at 16 weeks and the other at 18 weeks gestation) one (0.7%) at 37 weeks gestation had congenital anomolies, and one (0.7%) was 31 weeks gestation and 1300 grams at birth (very low birth weight). Figure 90 shows the gestational age groups for the 156 births for which gestation was documented.

Figure 90. Weeks of Gestation at Birth, by MC+ Managed Care Region.

Weeks of Gestation at Birth by MC+ Managed Care Region

	Eastern	Central	Western	Total
■ <20	1	0	2	3
■ 20 to 39	0	0	2	2
■ 30 to 37	7	2	5	14
■ 37 >	46	38	53	137

Number

Source: BHC, Inc., EQR Medical Record Review, April 2003

Fifty- six (18.5%) of the 302 MC+ Managed Care deliveries had documentation of one or more complications or incidents. The most frequently occurring complication was laceration (perineal, cervical, or vaginal). A total of 13 (4.3%) delivery- related lacerations were documented. Infrequent but major complications included placental complications (previa or abruption), maternal hemorrhage (one case resulting in hysterectomy), fetal distress, a lacerated cord, and a maternal seizure during labor. Post natal and follow- up case management was not evaluated.

2001 Missouri Prenatal Drug Prevalence Study.

A study conducted by the Missouri Department of Health and Senior Services also provided information regarding the MC+ population with respect to drug and smoking prevalence. The *2001 Missouri Prenatal Drug Prevalence Study* provides information regarding the prevalence of smoking by pregnant MC+ members.[43] The study, which is a follow- up to previous studies conducted in 1993 and 1997, concluded that the most prevalent substance used during pregnancy during CY2001 continued to be tobacco. The study estimated a prevalence of 33.3% of pregnant MC+ Managed Care women using tobacco. Figure 91 shows prevalence of prenatal tobacco use by payment source including MC+. As seen in the figure, the MC+ population experienced higher utilization rates than the self- pay and private insurance groups. The prevalence was significantly higher ($p < 0.05$) than that for both private insurance and self- pay at a 95 percent confidence interval. Additionally, the study showed no real change from 1993 to 1997 and to 2001.

**Figure 91. Prenatal Tobacco Utilization by Payer Source CY2001.**
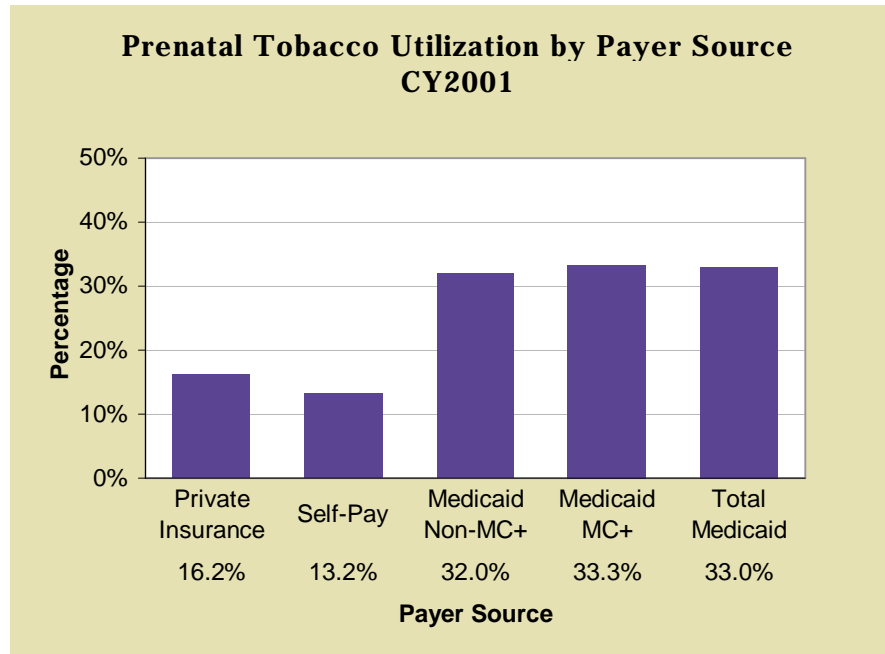
Source: Department of Health and Senior Services, 2001 Drug Prevalence Study, 2002

The finding of no real change is in contrast to findings described in this EQR report, and suggest that tobacco usage as measured by urine cotinine results in considerably higher smoking rates than those reported in birth certificate and medical record data. A concern cited by DHSS, based on their 2001 study, is an increase in denial of tobacco use by women at the time of delivery.

Urine cotinine measured for the women in the study showed a pattern of no change in tobacco usage for the 1993-2002 period, while chart review (self-report) showed a decrease of over 23% for the same time period for the same women. A similar decrease in tobacco use was noted from birth certificate data for the DHSS study hospitals. Figure 92 illustrates the findings by data collection method.

.

Figure 92. Prenatal Tobacco Utilization by Data Collection Method CY2001.
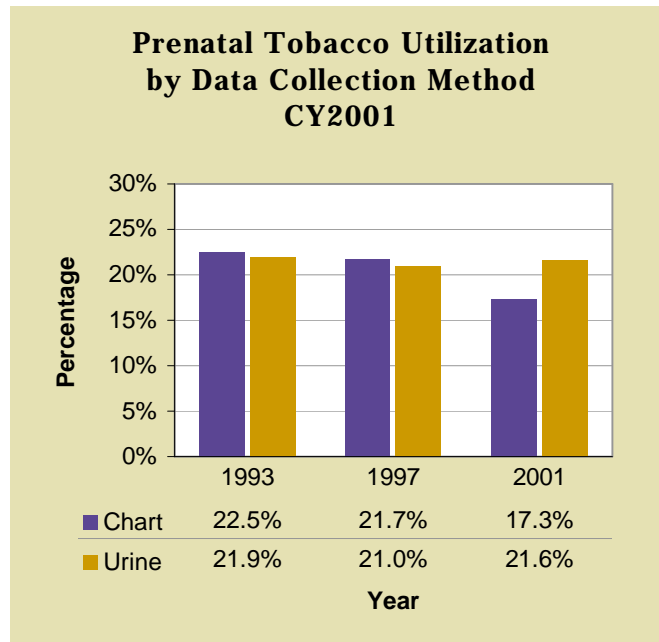
Source: Department of Health and Senior Services, 2001 Drug Prevalence Study, 2002

For MC+ MCOs, this finding may indicate a stimulus to investigate how risks (including smoking) are identified in the provider settings, how thoroughly the findings are documented, and if alternative screening methods should be considered.

Summary of MC+ Managed Care Quality and Effectiveness of Care

Quality and effectiveness of care were examined using member and provider complaint data and medical record review for EPSDT and prenatal services.

Member quality of care complaints consisted of concerns regarding:

- **Quality of Care (e.g., treatment not helping, member disagrees with treatment)**

- **Staff Behavior (e.g., PCP attitude, office staff attitude)**

- **Other Medical Complaints (e.g., PCP not available, general dissatisfaction)**

- **Effectiveness of Care for EPSDT Services based on the medical record review indicated:**

  - m **EPSDT rates were improved from CY2002 with the exception of higher rates in CY2000.**

  - m **EPSDT components of care were generally well documented, with the highest rates being documented for interim histories (72.5%) and physical examinations (71.8%).**

  - m **The lowest rates were for verbal lead screening (41.3%) and dental examinations (51.2%), although the rates were improved from CY2001**

  - m **One finding during the medical record review was that EPSDT forms were not being completely filled out, and although services were likely rendered, the documentation on the form did not reflect this. This appeared to be particularly true with dental examinations, possibly due to providers interpreting this to be a dental exam by a dentist, not their observations of teething, etc.**

  - m **Immunization rates have also shown improvement from CY1998 (41.4%) to CY2002 (63.6%), with the exception of higher rates reported in CY2000.**

  - m **Differences in immunization rates between the MC+ regions were not statistically different with the exception of pneumococcal vaccine (PCV), which showed a statewide rate of 21.8%, with a range of 9.9% to 28.4%. Potential reasons for the lower rates may be due to a vaccine shortage and provider documentation practices.**

  - m **A fully completed series of 14 vaccinations for 5 diseases within specified timeframes resulted in a 39.3% documentation rate.**

  - m **Blood lead levels drawn at 12-and-24 months of age showed improvement from CY1998 (11.3%) through CY2002 (29.8%). The increase in rates was greatest in the Eastern Region.**

- **DMS, in collaboration with DHSS and the MCOs, has developed and implemented a comprehensive system of blood lead level reporting that will allow for ongoing monitoring of lead screening, blood lead levels and follow up. The system is currently being implemented and initial findings are being used to improve the process. This reporting system promises to be of great benefit, especially as acceptable lower blood lead level limits are being redefined.**

Effectiveness of Care for Prenatal Services indicated:

- In CY2002, almost 80% of MC+ Managed Care women initiated prenatal care during the first trimester of their pregnancy, the period during which vital fetal development is occurring and a healthy lifestyle and medical care is essential.

- MCH Trend Indicators showed an increase in 1st trimester visits from CY1997 (73.8%). The data also showed that in CY2002, 89.0% of the MC+ births were over 2,500 grams. The rate of low birth weights has essentially remained the same from 10.4% in 1997 to 10.1% in CY2002, in keeping with national trends. Cesarean section deliveries increased from in CY1997 (17.4%) to CY2002 (23.0%), again consistent with national trends that have shown increased rates in recent years.

- Based on medical record review data, smoking continued to be of concern, although MCH data showed a decrease from CY1997 (30.0%) to CY2002 (27.7%).

- Medical record review findings showed higher rates of smoking with 39.3% of the women documented as smoking at some time during the pregnancy. Limited documentation of consultation in medical records and smoking cessation efforts was noted in the medical records.

- Risk assessments documented in the medical record review indicated that in addition to medical risks, a substantial number of the pregnant women had emotional or behavioral risks:

  o Chronic or recent mental illness or psychiatric diagnosis (9.9%)

  o Risk of drug dependency or misuse (8.6%)

  o Having a partner with a history of violence (1.8%)

  o Documented risk of physical or emotional abuse/neglect (2.9%).

- The medical record review also showed that a substantial number had documentation of some type of medical risk during the pregnancy including:

  o Infection (22.0%)

  o Preterm labor (8.1%)

  o Hypertension (6.3%)

  o Anemia (5.5%).

Database Validation

Claims Encounter Database

DMS provided BHC with a claims encounter database which was used for conducting EQR activities. As part of that function, BHC validated components of the database provided to BHC on November 27, 2002 for completeness and accuracy. Encounters were based on the "Last Date of Service Field as of November 26, 2002. The data base included all processed claims (paid and unpaid).

The database included a total of 24,640,396 processed encounter claims during CY2002. Service dates for the claims ranged from CY1979 through CY2042 (beyond the present date). Claims with CY2002 service dates comprised the majority of the claims, with 20,827,468 (84.5%). CY2001 had 3,707,000 (15.0%) claims and CY2000 had 80,014 (0.3%). The remainder accounted for 25,914 (0.1%) of the claims. The outlier years are most likely due to data entry errors and comprise only a small proportion (1%) of the overall processed claims. It is unknown at which stage of edits the fiscal intermediary rejects claims with implausible service dates.

To validate the database, BHC examined the data MC+ Managed Care totals and by claim types. However, results were strikingly different from those provided by DMS in hardcopy format and BHC is continuing to work with the information services staff at DMS to obtain definitions and algorithms so that they can be consistently applied to these encounter data.

After determining that the overall database was adequate for identifying recipients with at least one service date during CY2002, BHC used the claims encounter database for the medical record sample selection. A total of 2,449 members, based on MCO enrollment data, were matched to the CY2002 encounter database and those with one or more service dates were selected for inclusion in the medical record review. The sample listing based on enrollment and encounter databases were provided to the MCOs for verification that the recipient was enrolled in the MCO. A total of 2,293 (93.6%) of the sample recipients were verified by the MCOs as being enrolled in their MCO during CY2002. The MCOs ability to match members ranged from a low of 79% to 100%. In addition, MCOs were asked to provide the names and addresses of the primary care providers for the identified individuals. The MCOs were able to match a provider with each individual they identified as being in their MCO during CY2002. Subsequent validation of MCO listings and provider-level services using the encounter database proved to be problematic due to use of MCO provider identification numbers and inconsistent use of rendering and referring provider identifiers.

The next step of the database validation consisted of comparing return rates and responses from providers. Of requests for 2,449 medical records for 2,003 recipients sent to providers, 566 (23.1%) requests were returned with a notation that the provider did not have any information regarding these individuals (either not a patient or was not seen in CY2002). A total of 38 requests (1.6%) were undeliverable or had an incorrect address.

This validation indicates that use of the encounter file is useful for identifying MC+ members who had received services during CY2002.

DMS Blood Lead Reporting File

A second method of validating the CY2002 MC+ Managed Care encounter claims was to match dates of service against eight individuals identified in the DMS Lead Testing File that had blood lead levels 45 μg/dL or greater. Providers are required to submit blood lead testing results to the Department of Health and Senior Services on an ongoing basis. They are also required to submit encounter claims for the services.

To determine if the claims for these blood lead tests were being submitted to the State, BHC compared a dataset provided by the Division of Medical Services (DMS) for the first six months of CY2002 against the encounter claims data.

Table 7 shows the comparison of the blood lead level dates for eight individuals who were in the State dataset and had one or more extremely high blood lead level (greater than 45 μg/dL), and would have been expected to have more than one blood lead level. As seen in the table, overall encounter claims were submitted for seven of the eight recipients. The comparison shows that seven of the eight claims had at least one blood lead level (CPT Code 83655) during the first six months of CY2002. However, there is some discrepancy in comparing service dates, and it is unknown which of the dates is more accurate. Additional follow- up can be conducted by matching these dates to medical records that were obtained for review.

Table 7. Comparison of Blood Lead Level Dates, DMS and Claims Encounter Files.

Recipient	Date of Service (DHSS Lead File)	Date of Service (Encounter Database)	Comments
1	April 29, 2002 June 14, 2002	April 29, 2002 June 12, 2002	The DHSS and encounter claims files each had two blood lead levels. There is a slight difference in the date of the second test, possibly due to a data entry error.
2	January 10, 2002 January 10, 2002	January 10, 2002 February 22, 2002 April 25, 2002	Two tests with the same date were listed in the DHSS file. Encounter claims had three tests, with one of the dates being the same as listed in the DHSS file.
3	June 10, 2002	June 13, 2002	One test in the DHSS file and one in the encounter claims file. There is a slight difference in the dates, possibly due to a data entry error.
4	June 18, 2002	NONE	One lead test documented in DHSS file, none noted in the encounter claims file.
5	May 21, 2002	May 1, 2002 May 1, 2002 May 22, 2002	One lead test documented in the DHSS file, three encounter claims were noted, with two of the three having the same date, and the third encounter having a slightly different date from that noted in the DHSS file.
6	May 31, 2002	January 16, 2002 March 20, 2002 March 25, 2002 April 25, 2002 May 1, 2002 May 31, 2002	One blood level documented in DHSS file and six noted in encounter claims file. The date for the DHSS listing matched one of the encounter claims files.
7	May 9, 2002	April 15, 2002 May 28, 2002	One blood test documented in DHSS file and two noted in the encounter claims. The dates in the DHSS file do not match either of the dates in the encounter file.
8	January 7, 2002 January 7, 2002	February 5, 2002	Two tests with the same date were documented in the DHSS file and one test with a different date was noted in the encounter claims.

Accomplishments and Promising Practices

State

Improved Monitoring of MCO Standards, Compliance, and Quality

∨ **The Division of Medical Services (DMS) continues to refine contractual arrangements with Managed Care organizations to improve the reporting, quality monitoring, and clinical performance of the MCOs. This includes the use of standard and well-recognized industry data sets such as The Health Employer Data Information Set (HEDIS), vital statistics, hospital discharge data, and consumer satisfaction data (Consumer Assessment of Health Plans; CAHPS).**

∨ **DMS quality improvement staff has developed a structure for MCO quality improvement studies, processes and data collection.**

∨ **DMS staff has responded to the new Managed Care regulations in a pro-active manner, ensuring re-contracting with MCOs in accordance with newly-issued federal regulations. A specific audit tool and process has been developed to provide a standard format for ensuring compliance across MCOs.**

∨ **DMS staff has assertively followed-up on compliance issues regarding the documentation of provider network filings and the monitoring of dental subcontractors. There is now a focus on monitoring dental contractors across all MCOs, by requesting annual reports on subcontractor monitoring and oversight. This is an excellent approach to maintaining accountability at the MCO level as well as at the subcontractor level.**

Increased Efficiencies in the Administration of Managed Healthcare Services

∨ **The DMS has undergone a strategic planning initiative to improve the efficiency of their system in implementing MC+ Managed Care and Fee-for-Service healthcare service administration and purchasing. Goals and strategies were developed and implemented to reduce paperwork and the duplication of effort for multiple purposes. This has been accomplished through increased electronic exchange of MCO documents, quality improvement data reporting, and frequent communications.**

∨ **Division of Family Services (DFS) staff has improved systems that update and maintain member addresses, making it easier for front-line DFS staff to update member addresses, thus reducing the rate of returned mail upon MCO enrollment. This is a promising practice that will likely allow more members to receive MCO communications, provider directories, and health screening in a timely manner.**

Improved Interagency Coordination with State/Community Agencies and MCOs

Significant strides have been made in interagency coordination at the State, county, and in some cases, local levels in integrating systems of care for health and mental health services for MC+ Managed Care Members. The following are examples of the progress that has been made and that has continued throughout 2002.

∨ The Division of Medical Services has a longstanding collaborative relationship for service delivery and quality improvement with the Department of Health and Senior Services (DHSS) and the MCOs since the inception of MC+ Managed Care. The MCH Trends analysis, designed by DMS and DHSS, conducted by the Community Health Information Management and Epidemiology (CHIME) Division at the Department of Health and Senior Services has been cited nationally as a model for sharing and access to public data sets for the purpose of public health needs assessment and planning, and is a promising practice for using readily available public health data for monitoring Medicaid Managed Care. The data provided by these efforts was used to assess the quality and improve the system.

∨ DMS has recently provided MCOs and the EQRO downloads of DHSS immunization data; and the State health laboratory has provided regular reporting of all lead testing conducted on all children for linking with member data sets by MCOs. It is recommended that the respective Departments support the continued development of public health databases and systems that lend themselves to linking with administrative/claims databases to better capture the completeness of care provided to MC+ Managed Care Members from multiple community-based providers. These data are otherwise unavailable to MCOs, but are integral to the ability to coordinate and manage the care of individual members.

∨ DMS has worked closely with DHSS to coordinate public healthcare services. DMS has assisted DHSS in providing local public health agencies (LPHAs) with education on Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) services and billing for these services. A promising practice for improving quality for MC+ Managed Care Members and others is that DHSS has established performance-based contracts with providers (LPHAs), creating an incentive for them to track the services through billing.

∨ MCOs work collaboratively with DMS and other State agencies (The Departments of Mental Health, and Health and Senior Services) through the Quality Assessment and Improvement Advisory Group (QA & I Advisory Group). MCO quality improvement staff report that these meetings are a vital forum for their quality improvement initiatives, especially those that involve a great deal of interagency education and presentations on interventions with MC+ Managed Care Members.

∨ The Maternal and Child Health (MCH) Advisory Subgroup has reviewed a number of MCH Indicators as well as best practices. A DMS interagency taskforce is implementing a new version of a Prenatal Risk Assessment Form.

∨ The Mental Health Advisory Subgroup has developed and continues to collect data submitted by all MCOs and their behavioral health organization (BHO) contractors on indicators of mental health penetration, service use, and substance abuse treatment. The BHOs have worked collaboratively through this Subgroup to establish protocols for an Uniform Consent Form for the exchange of information for treatment across agencies; and the notification of C-STAR services. The group continues to work on protocols and education of the legal system for court-ordered referrals.

∨ The Medical Directors' Subgroup, comprised of all MCO Medical Directors has revised the EPSDT forms, and adapted a Synagis protocol, which was adopted for the Fee-for-Service population.

∨ The DFS has worked closely with the Mental Health Advisory Subgroup to facilitate coordination of behavioral health services through local family service offices, for children not in State custody, and for those whose mental health benefits are carved-out. This has led to the identification of providers who will see children under both MC+ Fee-for-Service and Managed Care payment mechanisms so as to provide continuity in care when child custody changes.

∨ The transfer of data from the Women, Infants, and Children Program (WIC) regarding pregnant women to facilitate MCO identification has been a positive step in interagency coordination which facilitates the management of care able to be conducted by the MCOs. It is anticipated that the rates of identification and the rates of pregnant women seen in the first trimester of pregnancy will improve as a result.

Carryover of Lessons Learned from MC+ Managed Care to Fee-for-Service MC+

There has been an increased focus on identifying, collecting, and monitoring data for process, outcomes, and quality improvement initiatives within the Fee-for-Service system. This is done through integration of responsibilities between quality management staff for the Managed Care and Fee-for-Service programs at DMS. Several protocols developed for MC+ Managed Care have been modified for application to the Fee-for-Service program (e.g., EPSDT form revisions, universal consent forms for mental health services, and standard prenatal risk protocols).

Improved Access to Care for MC+ Managed Care Members

Service use for children and MC+ Managed Care Members was examined through the use of the Maternal and Child Health (MCH) Trend Indicators, analysis of the administrative claims data for 2002, and examination of the aggregate Mental Health Indicators compiled by the Mental Health Subgroup of the QA & I Advisory Group.

∨ MCH Trend Indicator analysis found that there were statistically significant improvements in acute care service use for children in nearly all MC+ Managed Care Regions since the MC+ Managed Care Program began.

∨ Analysis of encounter claim data found increases in service use as evidenced by the rates of encounter claim submissions for all types of claims between CY1998 and CY2002.

∨ Encounter claim data showed that from CY2000 to CY2001, the rate of claims (per 1,000 members) leveled off or declined for all but pharmacy claims, which increased from 1,828 to 2,764 per 1,000 members. The use of prescriptions increased by 13% from CY2001 to CY2002.

∨ Encounter claim data showed that for all services, rates of services per recipient increased for all ages, from birth to 21 years, between CY2001 and CY2002. Those one year of age and under as well as those 15 years of age and older received more services on average.

∨ Encounter claim data showed that a full 35% of hospital admissions were for childbirth, either assigned to a newborn or delivery-related Diagnostic-Related Group (DRG).

∨ Between CY2000 and CY2001, Mental Health Indicator data showed increased outpatient mental health visits, decreased mental health inpatient admissions, increased rates of ambulatory follow-up after discharge from psychiatric hospitalization, and decreased substance abuse admissions.

∨ Based on Mental Health Indicators, improvements in total mental health penetration rates for all ages were observed statewide and in the Central and Western Regions between CY1999 and CY2001.

∨ Missouri Department of Insurance (MDI) network filing reports indicated that network adequacy for PCPs, specialists, facilities, ancillary services, and the network as a whole were above threshold in all MC+ Managed Care Regions.

∨ MC+ Managed Care Member complaint data analysis showed that the rate (per 1,000 members) of documentation of member medical and non-medical complaints increased from CY2001 to CY2002, indicating improved documentation of member concerns.

∨ The rates of MC+ Managed Care Member transportation complaints increased, likely due to targeted efforts at addressing member transportation issues.

Improved Quality and Effectiveness of Care Delivered

Quality and effectiveness of care were examined using MC+ Managed Care Member and Provider complaint data, and medical record review for EPSDT and prenatal services. Accomplishments in the quality of care for MC+ Managed Care Members were documented.

∨ Improved rates of EPSDT services based on medical record review findings included:

m The most frequently documented EPSDT components were interim histories (75%) and physical examinations (71.8%).

m Improved immunization rates (63.6% in CY2002).

m Improved blood lead level testing at 12- and 24-months of age (29.8% in CY2002), with the greatest improvement shown in the Eastern Region.

∨ Improved rates of prenatal care based on MCH Trend Indicator data included:

m In CY2002, 80% of pregnant women in MC+ Managed Care initiated and obtained prenatal care during the first trimester.

m The rate of birth weight over 2,500 grams remained stable (89.0% in CY2002).

m Births to mothers less than 18 years of age declined slightly between CY2001 and CY2002 (7.6% to 7.0%, respectively).

∨ There appeared to have been improvements in the documentation and delivery of EPSDT services. MCOs have improved participation ratios above 80% in specific age cells. The State has allowed MCOs to supplement the HCFA-416 data submitted from

encounter claims with denied claims data. This has appeared to improve the ability to capture data regarding the documentation of care that is provided to MC+ Managed Care Members.

∨ DMS and MCOs are continuing their work with DHSS on lead screening and findings of high lead levels in children. A five- page flow chart was developed by DMS which details the frequency and exchange of data between DMS, DHSS, and MCOs regarding lead screening results. There were extensive interagency planning sessions to design a data flow system so that MCOs, DHSS, and DMS systems all captured the same information on member lead toxicity screening and results. The data flow chart process was implemented January 1, 2003. The data regarding lead levels reported from MCOs is sent to DHSS and is put into Stellar, a public health surveillance database. DMS reports all the results from LPHAs to MCOs for follow-up and care coordination. This is a promising practice that will likely allow MCOs and the State to better document the care that members are receiving across public health and private MCO providers, and identify and intervene with members earlier.

∨ Lead testing is being conducted in WIC offices as well. Information flows into DHSS and is reported to DMS. DHSS has set up best practices for WIC offices to spotlight their performance.

∨ Progress continues to occur in the type and nature of the monitoring and administration of health care services at the State level, through the State Department of Social Services (Divisions of Medical and Family Services), Mental Health (Division of Comprehensive Psychiatric Services), and Health and Senior Services (Division of Maternal and Child Health, and the Community Health Information and Epidemiology Division). The system as a whole has clearly moved beyond the implementation stage of serving MC+ Managed Care Members to having impacted service use through collaborative monitoring and continuous quality improvement activities with MCOs and other State agencies. Given the declining budget and the need to retain MC+ MCOs and Providers, it will be important to continue to minimize administrative burden, paperwork, and reporting requirements for State staff and MCOs in favor of focusing on quality improvement mechanisms.

Managed Care Organizations (MCOs)

Compliance with Standards and Operations

∨   **All MCOs had approved Fraud and Abuse compliance plans and were prepared to be HIPAA compliant with the privacy requirements as of April 13, 2003. Family Health Partners assessed each workstation and developed fax capability at each workstation to allow for increased confidentiality. Physical security of administrative data was enhanced through the enclosure of specific workstations. MCOs have adopted the "HIPAA HIPPO" as a symbol and reminder of security issues, and implemented creative training tools such as "HIPAA Jeopardy" quizzes for staff.**

∨   **MCOs are increasingly incorporating flow- through language with subcontractors to ensure that State standards are met, conducting routine oversight, implementing corrective action plans, passing on incentives and reducing payments for below threshold performance on indicators, and re- contracting for services as necessary. One MCO (Blue Advantage Plus) has developed a database of State and federal contract compliance requirements to communicate with staff and facilitate oversight of vendors and providers. In monitoring behavioral health vendors, Family Health Partners, CommCare has conducted chart reviews for behavioral health services, reviewing at least 30 charts at each Community Mental Health Center (CMHC), with a checklist of 27 items and a goal of 85% of the criteria met. This threshold was met and exceeded during 2002 (97%- 98%). One item measured is the involvement of the PCP and consent for the behavioral health provider to communicate with the PCP, with a standard of 85%, which was met in 2002. CommCare provides incentives for submission of encounter data by CMHCs, with corrective action plans and financial penalties for rates lower than threshold.**

∨   **MCOs have worked to improve the ability to reach and screen members at the time of enrollment. A longstanding issue has been the adequacy of member contact information and the mobility of the population, with MCOs receiving large quantities of returned mail upon mailing of member information packets. Over the past several years, almost all MCOs have developed data systems that are not overwritten by routine State administrative data transfers. This allows them to keep up- to- date contact information on members. Other strategies that MCOs have implemented include working with the school districts (Eastern Region MCOs) and transportation vendors (Missouri Care) to obtain updated contact information. Rates of returned mail have dropped from approximately 30% to 16% as a result. A new process that is promising is the delegation of the New Member Welcome Call to the transportation vendor from Family Health Partners to Medical Transportation Management (MTM).**

∨   **Claims processing has been a focus of many MCO efforts, with increased encouragement of providers to submit claims electronically so as to better automate the adjudication and review process as well as improve timely payment. A range of 40- 85% of providers in MCOs were reported to be filing electronically. Blue Advantage Plus has received requests from LPHAs to submit claims electronically. Other MCOs are conducting more oversight (FirstGuard) or changing vendors (Family Health Partners) to improve their claims processes. Many MCOs report that at least half of the claims are paid within 7 days. At least two MCOs reported well- developed**

provider warm-lines (Healthcare USA) with electronically available copies of claims for immediate reference and assistance (Mercy Health Plans) of provider offices.

∨ MCOs are using nationally-recognized criteria for credentialing and re-credentialing providers as well as auditing of delegated credentialing (National Committee on Quality Assurance, NCQA; Utilization Review Accreditation Committee, URAC). MCOs are also auditing delegated credentialing files using nationally-recognized standards and tools. MCOs review provider performance, utilization, and grievance data in reviewing provider performance.

∨ Oversight of providers and vendors has improved. MCOs are meeting regularly with each vendor and monitoring performance through specific performance measures. This has been instituted in the past with behavioral health vendors and is increasingly being implemented for dental and transportation vendors. Mercy Health Plan has developed a Delegated Oversight Audit Tool as well as detailed action plans with dates, persons responsible, and status updates.

∨ MCOs are increasingly conducting formal auditing of behavioral health organizations' operations and structures in accordance with NCQA Quality Improvement Standards for clinical care programs, disease management programs, information and management, provider network adequacy, quality improvement committees, and quality improvement projects. This resulted in clearer Performance Improvement Plans (PIPs).

Improved Access to Care for MC+ Managed Care Members

∨ There have been reports of improved relations between the MCOs and the Eastern Region Ombudsman office by two of the three Eastern Region MCOs.

∨ Mercy Health Plan's New Member Welcome call checklist incorporates multiple aspects of member communication, screening, and education, and serves as a model for ensuring that when members are contacted, they are provided with information relating to their rights, services, grievance process; and offered the opportunity to provide information that allows the MCO to better coordinate care.

∨ Several MCOs are actively seeking input into their processes from members, incorporating comprehensive screening and member education into new member welcome calls, and implementing innovative outreach to hard-to-reach members. Missouri Care has a Member Advisory Group consisting of approximately 15 members that meets on a quarterly basis, and Mercy Health Plans conducts focus groups with MC+ Managed Care Members to obtain feedback.

∨ Family Health Partners has conducted some innovative outreach to hard-to-reach groups, while Blue Advantage Plus has placed MC+ labels on food pantry bags. Blue Advantage Plus has also established school-based health clinics within the Kansas City School District.

∨ MCOs and their vendors have worked to increase the number of providers for their members. Several MCOs' behavior health vendors have purchased blocks of time in advance to ensure timely access to care (Community Care Plus/Magellan; Healthcare

USA/Mental Health Net; Mercy Health Plan/Unity Managed Mental Health Care); and a number of dental vendors have worked with dental schools (Blue Advantage Plus) to increase access to hygienists and screening for more urgent procedures (Family Health Partners).

∨ **Provider turnover rates are reported to be low, ranging from 1‑7% annually.**

∨ **Several MCOs (Missouri Care, Family Health Partners) have been reimbursing providers above the usual Medicaid rates on a Fee‑for‑Service basis for EPSDT services in order to improve the delivery of this service. At least one other MCO (Mercy Health Plan) is moving toward a Fee‑for‑Service system of reimbursing providers in an effort to improve the submission of claims and documentation of preventive care.**

∨ **Areas targeted for provider education include pharmacy utilization, behavioral health screening, and psychotropic drug utilization. Behavioral health vendors (Family Health Partners/CommCare; Blue Advantage Plus/New Directions Behavioral Health) have engaged providers in continuing education about behavioral health issues. Blue Advantage Plus/New Directions Behavioral Health has implemented prevention programs for behavioral health including the Anniversary Program and Grade Card Program, where members are called on the Anniversary of events that precipitated crises, and when grade cards are issued.**

∨ **Magellan Behavioral Health Services purchased blocks of provider time in the Eastern Region to ensure access to Community Care Plus members and also requires that providers in the network join the network to serve all members of the MCO. Mercy Health Plans is one MC+ Managed Care MCO that requires providers in their network to serve their members regardless of whether they are enrolled in a commercial product or an MC+ Managed Care product. This may improve retention and commitment of the provider network, but also complies with the spirit of Medicaid Managed Care, which is to allow MC+ Managed Care Members access to the same quality of care available to commercially insured individuals.**

∨ **Missouri Care has developed a promising practice for the education of providers and their staff regarding clinical and non‑clinical issues. This MCO developed a provider education program separate from provider administration, known as the DR. TIPS Program (Tools and Information for Provider Success). This consists of a brief reference guide, with forms such as EPSDT, lead screening and referral forms for Missouri Care case management. They also distribute the provider guide from the State regarding MC+ and MC+ For Kids. In April, 2003, Missouri Care will be distributing the "Hot Tips" for HIPAA reference for providers as well.**

∨ **Behavioral health vendors have participated with MCOs in conducting education of primary care and behavioral health providers in the appropriate use of psychotropic medication (Mental Health Net/Healthcare USA, New Directions Behavioral Health/Blue Advantage Plus). They are educating DFS workers as well as providers about behavioral health issues and the appropriate use of psychiatric medications for ADHD and depression. This is conducted through dinner meetings with PCPs, with psychiatrists making educational presentations. They have also instituted a PCP**

helpline for psychiatric nurses or physicians, taking approximately 300 phone calls during 2001.

∨   Blue Advantage Plus/New Directions Behavioral Health has worked to improve the documentation of care for behavioral health services delivered to members. For children with ADHD, they have encouraged the implementation and use of family therapy codes through financial incentives. Blue Advantage Plus/New Directions Behavioral Health has focused on developing reader- friendly brochures and mailings for members to educate them on various behavioral health issues and treatment.

∨   To ensure delivery of EPSDT services, the Quality Manager and Medical Director at FirstGuard check the preventive service history, document missed opportunities for preventive care, and provide this feedback to providers when other quality of care issues arise. This is a routine part of the medical record review in any quality of care complaints/issues.

∨   Blue Advantage Plus has conducted a Childhood Immunization project since 1995 and continues with on- going evaluation and revisions to interventions. The MCO has begun sending Members a list of immunizations compiled from their encounter data and MOHSAIC, with a member incentive of a Dr. Suess book for returning confirmation or correction of the immunization record. This helps to update member records. Blue Advantage Plus recently developed an intervention which involves mailing lists to providers of all family members for whom a well- child visit is due at the time any other child in the family is scheduled for a visit can be considered innovative and should be assessed for its effectiveness.

∨   The identification of children with lead toxicity improved in 2002 for Mercy Health Plans, through collaborative efforts with DMS and DHSS. The number of children enrolled in the first six months of 2002 was 35, an increase from the annual rates of 16 and 12 in 2001 and 2000, respectively.

∨   MCOs continue to work on identifying the medical needs of Children with Special Health Care Needs (CSHCN). Missouri Care has used a standardized screening instrument for the identification of Children with Special Health Care Needs. It is recommended that ongoing data collection and correlation of responses on this survey with utilization and member characteristic data be used to provide a more refined method of accurately identifying members in need of services. Also, data using the long form should be used to determine the characteristics and needs of members with special health care needs. Community Care Plus uses administrative data, liking this with the diskette provided by the State to facilitate identification and screening of CSHCN (Community Care Plus).

∨ MCOs are increasingly identifying pregnant women for prenatal and preventive services. An increase in pregnancy notification forms sent to the MCO by providers for Family Health Partners was reported. Blue Advantage Plus incorporates procedures into its prenatal case management program to check on the need for EPSDT services for pregnant members who are 21 years old or younger. Community Care Plus, Mercy Health Plans, and Family Health Partners have identified additional risk factors, with a recent focus on assessing obesity during pregnancy. Blue Advantage Plus notified members of the new prenatal case management program offered last year. This member notification, sent on letterhead with the identification of the program resulted in unexpectedly high levels of response from members. This suggests that periodic individualized mailings, independent of newsletters may be more effective than lengthy newsletters for communicating with members and reminding them of the important services available to them. Missouri Care, through a quality improvement study, identified domestic violence as a risk factor during pregnancy. Missouri Care and Health Care USA are implementing interventions to provide pregnant women with information about services and supports in the community.

∨ Provider network adequacy has increased, with little provider turnover/attrition, and MCOs are increasingly working with providers face-to-face.

∨ MCOs are working with providers on increasing EPSDT rates by implementing Fee-for-Service payment, paying rates higher than Fee-for-Service MC+ rates, reviewing EPSDT as a routine part of any quality reviews, providing performance incentives, and educating them about the need for well-child visits at six years of age.

∨ The completion of immunization rates has been addressed through capture of data from State public health databases, mailing of lists of immunizations to caregivers for feedback and updates, and notifying caregivers of when siblings are due for immunizations or EPSDT visits.

∨ MCOs have worked on educating providers about behavioral health issues and purchasing blocks of time from behavioral health providers in advance to ensure access to MC+ Managed Care Members. They have also conducted member education through the development of brochures and specific mailings to members.

∨ MCOs continue to work on identifying the medical needs of Children with Special Health Care Needs (CSHCN), and those in need of case management for lead toxicity.

∨ MCOs are increasingly identifying pregnant women for prenatal and preventive services as well as the identification of risk factors.

Improved Effectiveness and Quality of Care

MCOs are increasingly developing mechanisms for monitoring the delivery as well as the outcomes of care provided to MC+ Managed Care Members, to improve the processes and outcomes of care.

∨   **Community Care Plus has developed a brief format for work plans that details clinical and non- clinical indicators that are measured, the goals for the current year, whether or not the goals were met, the performance on the goal, and the plan of action for improving performance in the current year.**

∨   **Blue Advantage Plus has conducted a Population Study and Follow- Up. The scope of the Population Study and key results are impressive and indicate a commitment to meeting the needs of the membership. Opportunities for improvement were identified by the MCO from this study.**

∨   **Mercy Health Plan's measurement of lead case management, using lead toxicity levels and a change score as an outcome (initial lead level/most current lead level) represents a promising practice for case management as well as evaluation of the effectiveness of case management. They report an average index of 1.85, indicating an 85% decline in initial and follow- up lead levels.**

∨   **Missouri Care conducted a "Post- Mortem" analysis of HEDIS indicator rates and identified interdepartmental barriers using a fishbone diagram. This process provides an excellent example of how to develop and prioritize interventions and measures for quality improvement projects.**

∨   **Mercy Health Plan has studied the impact of case management on hospitalization rates, and is in the process of identifying the functional outcomes of interventions for children with special health care needs.**

∨   **Missouri Care's study of risk factors for pregnant women which identified domestic violence as one of the strongest risk factors, is a promising practice for the conduct of quality improvement studies. This led to the Domestic Violence Initiative with collaborations with community agencies.**

∨   **The Medical Directors Subgroup of the QA & I Advisory Group has implemented the State mandated EPSDT standard form statewide. This will likely provide consistent messages to providers in the State who serve MC+ Managed Care Members. This format has also been adopted by some schools for their physical examinations, and is being introduced to the Missouri Athletic Association for use with sports physical examinations for adolescents. This uniform reporting and documentation tool is likely to lessen the confusion of the provider who sees patients from multiple MC+ Managed Care and commercial MCOs. There have also been anecdotal reports of providers adopting this form across their practice. The more that primary care provider administrative tasks are simplified, the more likely that care will be better documented, consistently provided, and improved over time.**

∨   **MCOs are in the formative stages of developing culturally competent healthcare delivery practices. A number of MCOs demonstrate some innovative and promising approaches to the identification and treatment of member needs.**

∨ In 2002, Missouri Care was congratulated by DMS for education and outreach activities for immigrants and refugees residing in the Central Region. The Missouri Care Cultural competency program is organized and multi-faceted. Cultural sensitivity training has been implemented throughout the organization and provider network, needs assessment is on-going, and significant resources (both monetary and personnel) have been dedicated to the program, which benefits from the experience of a staff member with an educational background in cultural/linguistic anthropology. Employee training on cultural and linguistic competence is ongoing (there were 7 sessions in 2002). Multi-cultural health resource and language training are provided to Family Health Center, to include cultural insight into the Bosnian refugee population. Missouri Care has sponsored provider workshops on cultural sensitivity and appropriate cultural issues; handouts, interactive video references distributed at health fairs, site visits, etc. Missouri Care and the local FQHC conducted a joint training program on the needs of Bosnian women receiving perinatal care, specifically their needs as survivors of genocide practices and recognition and treatment of post-traumatic stress disorder.

∨ The Cross-Cultural Health Care Resource Guide was recognized for other MCOs to use as a guide by the Division of Medical Services, and Family Health Partners is to be congratulated for its efforts in this area. The guide provides a summary of the social and health practices of 17 cultural groups for staff, providers, and vendors.

∨ Staff training on cultural issues was conducted in 2002 by Blue Advantage Plus/New Directions Behavioral Health (management, line staff, clinical staff, providers and staff) within the organization. New Directions Behavioral Health has also assisted with training of provider office staff on the cultural/socioeconomic issues of MC+ Managed Care Members.

∨ Cultural competency programming at Mercy Health Plan has involved marketing and member services tools translated into several languages, low literacy materials, and evaluation of risk factors among various racial and ethnic groups of Member as well as health disparities for case finding and provider education.

∨ FirstGuard has translated its member handbook into Braille, available upon request.

Opportunities for Improvement

State

ü   Given the complexity of public health services, it is critical that the State continue to support the established infrastructure of State agency coordination and MCO quality improvement groups and initiatives. These processes have resulted in better coordination among public health and MC+ Managed Care Program service delivery statewide. This would entail continued data support from the Department of Health and Senior Services (DHSS) on the identified indicators as well as HEDIS indicators and consumer satisfaction data collection; continued standardization of risk assessment, case management, and interagency coordination of protocols, especially with the identification and definition of children with special health care needs; and continued coordination and sharing of staff resources between the State Department of Insurance and the Division of Medical Services for the assessment of provider network adequacy for MC+ Managed Care organizations, with standards consistent with commercial Managed Care organizations.

ü   Inpatient mental health admission rates have increased, with speculation that it is related to MCOs reporting that behavioral health organization crisis teams are not allowed into hospital emergency rooms, perhaps related to Emergency Medical Treatment and Active Labor Act (EMTALA) provisions. It is possible that some admissions are preventable. Related questions include: 1) Are there pre- authorization requirements? 2) Are they using prudent layperson criteria? 3) Are the admissions appropriate? 4) Are these primarily children in DFS custody? One challenge to the provision of behavioral health services to some MC+ Managed Care Members is the elimination of Children's Treatment Service funds from the Department of Social Services budget. Other issues that have likely impacted access to preventive behavioral health services is the increasing need for MCOs to screen and manage members who are referred for court- ordered evaluations or treatment, and State budget cuts impacting State Public Mental Health Agency facilities/administrative agents.

ü   There are several substantial limitations to using administrative data and monitoring data as proxies for assessing the quality and outcomes of care (e.g., based on claims, time lag in data, sensitivity to measures over time, day- specific eligibility and sampling issues, etc.). It is recommended that DMS, in collaboration with MCOs, continue to develop methods and mechanisms to supplement standard reporting of administrative/claims data to assess the quality and completeness of care provided to MC+ Managed Care Members. This is important, as the MC+ Managed Care program expends significant effort coordinating services with other agencies to reduce duplication of services and to increase access for members. MCOs report that they are collecting all available sources of data on members from community providers to supplement encounter claims for the purpose of managing the continuity of care from multiple providers. Models such as the exchange of data spreadsheets for the screening of CSHCN and lead testing findings already exist and should continue to be refined to allow for the identification of improvements and outcomes where they may exist. MCOs are hopeful that standardized data sets as implemented through HIPAA

will facilitate the ability to identify important member information (e.g., language identifiers), eliminate the errors associated with local code modifiers, and address clean claims legislation concerns. MCOs report that EPSDT rates have appeared to have been hampered by the fact that the second or third claim is not captured. Thus, if a member was seen when ill and received a well-child check, this may not be captured or counted. Other concerns surrounding the accuracy of EPDT claims data is whether claims are being denied by the claims' administrator's system.

ü   MCOs uniformly report that it is difficult to identify MC+ Managed Care Members on special needs files and enrollment files for specific special needs, and that the ability to coordinate with the caseworkers of children in foster care has been problematic. It is recommended that DMS continue to work with DFS staff to obtain additional identifying information on members so as to facilitate MCO screening of pregnant members and those with special health care needs. Continued collaboration among MCOs, possibly through the MCH Subgroup is recommended to identify optimal methods for identifying CSHCN based on information from the State diskette.

ü   There are concerns about the lack of integration of public health systems on a national level, which may contribute to the current rates of EPSDT service delivery. For example, the supply of vaccines to LPHAs and providers who participate in the Vaccines for Children (VCF) program can be intermittent, impacting the ability to provide needed vaccinations when children present for care and resulting in lack of continuity of care. Furthermore, the pediatric periodicity schedule is not consistent with the periodicity schedule promulgated by the American Academy of Pediatrics, to which many providers subscribe. Also, in national and statewide efforts to improve access to care for children and families, grant programs do not require coordination of data with public health agencies or their agents, such as Managed Care Organizations, hindering the MCOs ability to document, coordinate and manage the care of members. Finally, procedures for educating and expecting local WIC clinics and LPHAs to conduct blood lead testing, pregnancy management, and EPSDT services does not appear to take into account the varying capacity to implement these services and thus coordinate with MCOs, or allow MCOs the opportunity to document care obtained by members. Local clinics providing services will need to develop the capacity to exchange data with MCOs to improve the coordination of care. This may also service to generate additional revenue for local clinics that could be used to expand services and programs.

ü   After transportation complaints, a large proportion of MC+ Managed Care Member complaints reported across all MC+ Managed Care Regions were due to the denial of services. This was particularly noted in the Eastern and Western Regions, and should be further explored for possible performance improvement projects. Adding the provider specialty to the reporting process would facilitate identification of specific services being denied.

ü   Similarly, a large proportion of MC+ Managed Care Provider complaints reported were due to the denial of claims as well as complaints regarding the State or MCO. The overall rate of provider medical complaints declined from 2002 to 2003. Given the desire to have high rates of complaints to provide feedback for improvement, it is recommended that efforts be directed at capturing these complaints, and further

exploring the complaints for specific claims denied. Provider education could be directed at some of the most common complaints, or uncovered services that are denied. One complicating factor related to providers is the continued concern over the adequacy of Medicaid rates, which will not likely improve given the current State fiscal situation. Also, MCOs expressed concerns about retaining hospitals in their networks, as they are requesting 30- 40% increases in reimbursement to be consistent with Medicare rates. Hospitals want a proportion of billed charges OR Medicare rates and rate increases. This has made it difficult to negotiate contracts with some facilities. According to MCOs, the gap between the rates of reimbursement of Medicare or Commercial products and Medicaid products is widening, making it increasingly difficult to secure and maintain providers who are willing to service Medicaid recipients.

ü   It is recommended that in addition to tracking and monitoring the utilization of services (EPSDT, lead testing, well- child and prenatal care), MCOs be required to document the initiation, completion, and findings of two studies each year. If a study is ongoing or the MCO desires to continue the same study the following year, a summary and interpretation of findings as well as the refinements to the study in the subsequent year(s) should be documented. This will be the focus of ongoing EQR and State monitoring activities, consistent with the federally- mandated performance improvement protocols. MCOs have reported that the application and approval process for focused studies is very time consuming and makes it difficult to implement studies within specified timeframes. Although the elements and format are useful for review and state- monitoring, it is recommended that a streamlined process of approval/documentation be developed to enhance MCOs ability to focus on the implementation of the projects.

Managed Care Organizations

ü   Although it is not always possible for MCOs with commercial products to separate non- clinical service indicators by product line, clinical quality improvement studies should always clearly separate MC+ Managed Care Members in sampling analytic procedures and reporting.

ü   Although low compared to transportation and denial of services complaints, the rate of MC+ Managed Care Member complaints regarding the ability to obtain an appointment with a provider increased from .23 to .31 per 1,000 members between CY2001 and CY2002. This was the second most frequent access complaint after transportation. This is an area for MCOs to monitor across providers. This, along with specific areas of below- threshold network adequacy should be monitored closely to ensure that members are able to access needed care either through providers at a greater distance, or through out- of- network providers. The denial of services complaints, reasons, and provider types should also be monitored as well.

ü   It is recommended that providers be kept informed of MCO Performance Improvement Projects including the formulation of projects, goals, baseline and on-going assessment, results, etc., since they can directly impact health outcomes. Mental Health Network's (MHNET) reporting of medical record review components

and aggregate rates in the provider newsletter of performance is one method of communicating to providers how their performance is being measured to help them improve their documentation and understand expectations.

ü   One finding of the medical record review was that the EPSDT forms were not being completely filled out by providers. MCOs report that providers are confused about the changes in the mandatory EPSDT forms. Although services were likely rendered, the documentation on the form did not reflect this. This was particularly true with dental screens, possibly due to providers interpreting this item as a requirement for a dental exam rather than observations of teething, general dentition, etc. Feedback regarding completion of components should be given to providers along with education regarding the requirement for components with especially low completion rates.

ü   There continues to be a need for emphasis on lead screening and testing with MC+ Managed Care providers and members. Providers are using outdated Lead Risk Assessment forms. Provider representatives could provide updated ones and collect the old ones as they visit offices. All forms available to providers on the MC+ website should include the most recent revisions.

ü   MCOs should consider alternatives to venipuncture for lead testing and the availability and use of combination vaccines to improve completed vaccination rates. MCOs should encourage providers to prepare for immunizations and lead testing at the time of the EPSDT visit to minimize missed opportunities due to transportation or other access problems. Administration of immunizations and lead testing on siblings could also be done at the same time. MCOs should encourage providers to conduct EPSDT at the time of acute care visits. There was little documentation of EPSDT services in the medical record at the time of acute care visits.

ü   The Pregnancy Risk Assessment Form return rates to MCOs are low. For the pregnancy case management process, other primary care access issues should be addressed, including pregnant women's access to dental care, lead testing and follow- up, and smoking cessation. MCOs could develop incentives (e.g., public recognition in newsletters) for providers for the achievement of a pre- established return rate of prenatal notification and risk identification forms. A challenge raised by case managers is that they are not notified by providers when members change from low- to high- risk. Frequent communication and education of providers will be important. MCO case managers should consider at least limited efforts at meeting providers face- to- face to establish a relationship (e.g., high- volume OB providers, or those who consistently have low rates of pregnancy notification).

ü   Consistent with national trends, the rate of low birth weight has remained essentially unchanged since 1997; and the rate of Cesarean section deliveries increased from CY1997 to CY2002.

ü   **Smoking during pregnancy was noted on medical record review to have higher rates than previous EQR findings. Further, there was limited documentation in MC+ Managed Care Member records of consultation regarding smoking cessation efforts and patient education regarding smoking during pregnancy. The improvement of provider intervention and documentation of efforts to intervene with members who are smoking during pregnancy should be a priority, and may be a focus for a statewide performance improvement project.**

ü   **Medical record review findings also indicated a high rate of documentation of emotional and behavioral risks among pregnant women (e.g., chronic or recent mental illness, risk of drug dependence or misuse, having a partner with a history of violence, and risk of physical or emotional abuse/neglect). Continued provider education through provider representatives and behavioral health vendors about the availability and methods for MC+ Managed Care Members to access services is a recommended priority. The domestic violence initiatives in place are a strong effort in this direction, and should be adopted across all MC+ MCOs.**

ü   **Other prenatal risk factors identified during the medical record review include infections, preterm labor, hypertension, and anemia. MCOs should monitor these conditions and their treatment, especially as there was little information in medical records about the type of infections.**

ü   **Given the increased rates of emergency room utilization for primary care and mental health care in 2002, it is recommended that MCOs continue to foster the establishment of urgent care clinics as well as access to mental health services at the clinics to reduce the rate of unnecessary or potentially avoidable hospitalizations. The purchase of blocks of provider time for MC+ Members is an innovative approach to increasing access to needed services to avert crises.**

ü   **If they are not already doing so, MCOs should collaborate and use MOHSAIC and STELLAR data; develop methods of identifying members on the State diskette as being in need of case management; and implement coordination of care with LPHAs and WIC clinics.**

Based on the common projects conducted by MCOs and the findings of this EQR, there are a number of Performance Improvement Projects that could be implemented statewide and would be relevant to all MCOs. They include clinical and non-clinical performance improvement projects.

- *Clinical.*

- <u>Preventive services</u>

    m **Given the lower rate of primary care/EPSDT services for 5-7 year olds and for 14–20 year olds, education of providers and members as well as interventions with schools, State, and community providers is recommended for a performance improvement project.**

- m **Several MCOs have implemented some screening initiatives for identifying post-partum depression. The relative effectiveness of sending members screening forms and educating providers on methods to facilitate behavioral health service access should be examined.**

- **High-volume services**

  - m **High-volume services have occurred primarily in pharmacy and behavioral health. Interventions could focus on member and provider education for specific pharmacy use to assess whether the appropriateness of pharmacotherapeutics use has improved over time.**

  - m **One finding of the encounter claims data analysis was that the DRG of Extensive Operating Room Procedure constituted over 10% of inpatient DRGs. Additional study of this DRG and associated diagnoses may be warranted to determine if these were preventable.**

  - m **The corresponding use of psychotropic medication, therapy, utilization of acute services, and outcomes should be examined to determine if there are specific patterns of need for provider/member education or access issues.**

- **High-risk services**

  - m **Recent initiatives have focused on updating and standardizing a Pregnancy Risk Assessment protocol and the identification of risk factors, (e.g., obesity, smoking, domestic violence, substance use). This should be used along with medical record reviews to examine the identification, types of risks, and the follow-up care provided for specific risk factors. This could also be linked with birth outcomes and member characteristics to identify the most modifiable risk factors.**

- **Coordination/Continuity of care**

  - m **The effectiveness and outcomes of lead case management would be an excellent performance improvement project. A number of interventions at the State and MCOs have been implemented for the identification of members with high lead levels and those in need of testing. The rates of lead testing as well as the lead levels of those identified as in need of case management should be examined from baseline (before January 1, 2003) and on a periodic basis.**

Non-Clinical.

- **Grievances/Appeals**

  - m **Reasons for provider denial of claims should be examined to determine if additional education regarding member benefits is required and to ensure that services that are eligible are being reimbursed.**

  - m **Reasons for member denial of services complaints should be examined as a component of evaluating access to care, especially access to specialty providers that may be in short supply in some rural regions of the State.**

  - m **Reasons and barriers identified for members waiting for appointment should also be examined to identify opportunities for improvement in access to care.**

- **Access/Availability**

  m **Several individuals have discussed and recommended that members be encouraged at the time of the new member welcome call to schedule an appointment with a primary care provider as soon as they are assigned if they respond positively to any of the Baseline Health Screening questions. The use of this method to improve rates of utilization of preventive care upon enrollment and assignment could be examined.**

- **Cultural Competence of Healthcare Delivery**

  m **Ethical and racial health disparities should be examined to further identify high-risk members and facilitate access to care through member and provider education as well as the impact on utilization and outcomes.**

Appendix A: MC+ Mental Health Utilization & Penetration Rate Report

MC + Mental Health Utilization & Penetration Rate Report

January – December: Calendar Year 2001 (CY2001)

MC+ Mental Health Subgroup of the MC+ Quality Assurance and Improvement Advisory Committee
Data is collected to measure access to services and to support quality improvement
Completed Report due Monday, July 1, 2002

Plan Name: _____

MC+ Region: __Central __Eastern __Western

Number of months of operation this year: _ 12months _Other: #of months:_____

Contact Person for this report: _____

Title: _____

Telephone:(   )_____-_____ ext:_____   FAX:(   )_____-_____

E-Mail Address: _____

Contents

1. Utilization

  a. Total Members
  b. Members Behavioral Health Utilization
  c. Inpatient Days/1000
  d. Inpatient Discharges/1000
  e. Residential Days/1000
  f. Inpatient SA Days/1000
  g. Inpatient SA Discharges/1000
  h. Partial Hospital Days/1000
  i. Partial Hospital Discharges/1000
  j. Outpatient Visits/1000
  k. Alternative Services/1000
  l. List of Alternative Services
  m. 30 Day Ambulatory Follow-Up
  n. 7 Day Ambulatory Follow-Up

2. Penetration Rate

3. CSTAR Notification of Care Activity Reports

4. Penetration Work Sheet

5. Utilization Work Sheet

6. Sample Calculations

Please note included comment sections. These are provided to record any reporting difficulties.
General comments are also welcome.
Send questions to erinniehaus@mail.medicaid.state.mo.us or call 573-751-6963.

1. Utilization Data:

a. Total Members for each of the following age groups:

0 – 12 years	_____
13 – 17 years	_____
18 – 64 years	_____
65 + years	_____
TOTAL MEMBERS	_____

Average monthly members _____

b. Total Members utilizing behavioral health services in the following age groups:

0 – 12 years	_____
13 – 17 years	_____
18 – 64 years	_____
65 + years	_____
TOTAL	_____

General Utilization Formula (see more details about formulas and examples in Section 6):

$$\left(\frac{\text{Number of [admissions], [discharges] or [days] over 12-month period}}{\text{Total member months (Summation of monthly enrollment, January through December)}} \right) X \ 12,000$$

c. Inpatient Days/1000:	Inpatient days included 23 hour inpatient, and all 24 hour facility Based care. (HEDIS 2001)
Comments on this measure:	

d. Residential Days/1000:	24 hour care (sub-acute or residential that is NOT acute inpatient). (HEDIS 2001)
Comments on this measure:	

e. Inpatient Discharges/1000:	Inpatient discharges included 23 hour inpatient, and all 24 hour facility Based care. (HEDIS 2001)
Comments on this measure:	

f. Inpatient Substance Abuse Days/1000:	Include inpatient days for substance abuse and detox - Do not include CSTAR, respite, or residential.
Comments on this measure:	

g. Inpatient Substance Abuse Discharges/1000:	Include inpatient discharges for substance abuse and detox - Do not include CSTAR, respite, or residential.
Comments on this measure:	

h. Partial Hospital Days/1000:	Number of partial hospital days - Do not include CSTAR, respite, or residential.
Comments on this measure:	

i. Partial Hospital Discharges/1000:	Number of partial hospital discharges - Do not include CSTAR, respite, or residential.
Comments on this measure:	

j. Outpatient Visits/1000:	Include initial assessment, counseling, psychotherapy, medication management, and in-home counseling. *This category may include in-home services.* <u>Do not</u> include CSTAR, category 4 children, PCP mental health services, and non-claims-paid services.
Comments on this measure:	

k. Alternative Services/1000:	Include any service not included in other categories.

l.
List types of services included in Alternative Services:
May include in-home counseling, sub-acute stand-alone residential, home health nursing services, respite intensive outpatient, wraparound, etc.
1. _____
2. _____
3. _____
4. _____
5.

Comments on this measure:

m. 30 Day Ambulatory Follow-Up: _____ % ambulatory follow-up (30 days)	The percentage of members who had an ambulatory or day/night mental health visit within 30 days of hospital discharge.
Comments on this measure:	

n. 7 Day Ambulatory Follow-Up: _____ % ambulatory follow-up (7 days)	The percentage of members who had an ambulatory or day/night mental health visit within 7 days of hospital discharge.
Comments on this measure:	

2. Penetration Rate:

Penetration Formula (see more details about formulas and examples in Section 6):
Number of unduplicated members accessing services over 12-month period
Divided by
Averaged monthly member enrollment from 1/01 through 12/01 = X

Then multiply X by 100 to convert to a percentage rate

a. _____ Total Penetration Rate

Comments on this measure:

Penetration Rate by Age
Using HEDIS 2001 age breaks.
Note: This data is obtained from the Mental Health Utilization HEDIS report.

b. Percent of total health plan members,
DO NOT INCLUDE CHILDREN IN AID CATEGORY 4.

_____% (0-12 yrs.)   _____% (13-17yrs.)   _____% (18-64 yrs.)   _____% (65+ yrs.)

c. Percent of total health plan members receiving behavioral health services: (Usually sum of these percentages is close to the total penetration rate entered in 2a above).
DO NOT INCLUDE CHILDREN IN AID CATEGORY 4.

_____% (0-12 yrs.)   _____% (13-17 yrs.)   _____% (18-64 yrs.)   _____% (65+ yrs.)

d. Age distribution of members who received behavior health services: (= 1b categories/total in 1b. The percentages should sum to 100%).
DO NOT INCLUDE CHILDREN IN AID CATEGORY 4.

_____% (0-12 yrs.)   _____% (13-17 yrs.)   _____% (18-64 yrs.)   _____% (65+ yrs.)

Comments on this measure:

<div style="border:2px solid teal; padding:10px">

3. Number of CSTAR Notification of Care Activity Report
January – December 2001

Number of CSTAR Notification of Care Activity Reports received by the plan from CSTAR providers.

</div>

January - December	
January	*July*
February	*August*
March	*September*
April	*October*
May	*November*
June	*December*
Grand Total:	
Comments on this measure:	

4. Mental Health Services
Penetration Rate Work Sheet
January – December 2001

Note: Please Return Worksheet

A.   Total Number of Unduplicated Members   _____

B.   Number of Months of Data Available   _____

C.   Number of Unduplicated Members Accessing Care   _____

D.   Average Monthly Enrollment   _____

   C
  -----   Multiplied by 100   =   _____
   D   divided by (12 divided by B)   **Penetration Rate**

Penetration Formula (see examples in Section 6)

Number of unduplicated members accessing
 Services in the months covered in this report.

              Divided by   *Multiplied by 100*

  (Average Monthly Member enrollment divided by
           12 divided by X)
(X is the number of months plan data is available)

5. Mental Health Services
Utilization Work Sheet
January – December 2001

Note: Please Return Worksheet

A.   Number of Discharges or Days   _____

B.   Overall Enrollment of Plan Data Available   _____
      (Member months)

      A   X 12,000   =   _____
      -----   Days/Discharges per 1000
      B

Formula

Number of admissions (or days) in the report period
For the number of months worth of data available

          Divided by   *Multiplied by 12,000*

Total Member Months
(Add monthly enrollment together for the months
in the report period)

6. SAMPLE CALCULATIONS

<u>Per 1000 Utilization Data:</u>

(Example no. 1c.1)

If you have:

1500 inpatient days, over a 12 month period, and your total member months is 120,000 (10,000 members per month for 12 months)

The formula is:

$$\frac{1500}{120,000}$$ Multiplied by 12,000 = .0125 X 12,000 = 150 inpatient days per 1000

(Example no. 1e.1)

If you have:

500 Discharges, over a 12 month period, and your total member months is 120,000 (10,000 members per month for 12 months)

The formula is:

$$\frac{500}{120,000}$$ Multiplied by 12,000 = .00416 X 12,000 = 49.9 discharges per 1000.

If you have:

165 admissions, over a 4 month period, and your total member months is 40,000 (10,000 members per month for 4 months)

The formula is:

$$\frac{165}{40,000}$$ Multiplied by 12,000 = .004116 X 12,000 = 49.9 admissions per 1000.

(Example no. 1c.2)

If you have:

500 inpatient days, over a 4 month period, and your total member months is 40,000 (10,000 members per month for 4 months)

The formula is:

$\underline{\quad 500 \quad}$
40,000   Multiplied by 12,000 = .0125 X 12,000 = 150 inpatient days per 1000

Penetration Rate:

(Example no. 2a.1)

If you have:

1500 unduplicated members accessing care over 12 months, and your averaged monthly enrollment (regardless of the number of months) is 30,000 per month

The formula is:

$\underline{\quad 1500 \quad}$ X 100 $\underline{\quad 1500 \quad}$ X 100
(30,000   divided by 12/12)   =   30,000   = .05 x 100 = 5%

(Example no. 2a.2)

If you have:

500 unduplicated members accessing care over 4 months, and your averaged month enrollment (regardless of the numbers of months) is 30,000 per month.

The formula is:

$\underline{\text{500}\quad}$ x 100 $\underline{\text{500}\quad}$ X 100
(30,000 divided by 12/4)   =   10,000   =   .05 X 100 = 5%

Notes: The last two formulas can be tricky. You must compute the part in parenthesis prior to dividing the numerator and denominator, then multiplying by 100. For example, in the last formula you divide 500 by 10,000 (30,000 divided by 3). If you enter data into the calculator without computing the parenthesis first, your outcome will not be correct. If you have a full year's worth data, as in the second example on this page, then the denominator (30,000) will not change. If you have less than a full year's worth of data, as in the third example, then your denominator will change as a result of computing the formula within the denominator in order to compensate for less than 12 months worth of data.

Appendix B: EPSDT Protocols

%VRTLAST_NAME%   %IDCN%

HCY Screening		
1st EXAM	2nd EXAM	3rd EXAM

SCREENING DATE   ☐☐ / ☐☐☐ / ☐☐   ☐☐ / ☐☐☐ / ☐☐   ☐☐ / ☐☐☐ / ☐☐

(MM / DD / YY)   (MM / DD / YY)   (MM / DD / YY)

	1st EXAM	2nd EXAM	3rd EXAM
DMS Form Used	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DMS Form Complete	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Interval History	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Unclothed PE	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Anticip Guidance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Verbal Lead Screen	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
State Lead Form Used	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Positive Lead Response	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Development	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Fine/Gross Motor Skills	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vision	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Exam Type	Referral	Exam Type	Referral	Exam Type	Referral
Full Screen (I - X)	☐	☐	☐	☐	☐	☐
Partial Screen (I - V)	☐	☐	☐	☐	☐	☐
Developmental Screen	☐	☐	☐	☐	☐	☐
Hearing Screen	☐	☐	☐	☐	☐	☐
Vision Screen	☐	☐	☐	☐	☐	☐
Dental Screen	☐	☐	☐	☐	☐	☐
Acute Care Visit	☐	☐	☐	☐	☐	☐

%VRTLAST_NAME%   %IDCN%

	4th EXAM	5th EXAM	6th EXAM
<u>SCREENING DATE</u>	☐☐ / ☐☐☐ / ☐☐	☐☐ / ☐☐☐ / ☐☐	☐☐ / ☐☐☐ / ☐☐
	(MM / DD / YY)	(MM / DD / YY)	(MM / DD / YY)

	4th EXAM	5th EXAM	6th EXAM
DMS Form Used	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DMS Form Complete	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Interval History	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Unclothed PE	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Anticip Guidance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Verbal Lead Screen	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
State Lead Form Used	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Positive Lead Response	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Development	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Fine/Gross Motor Skills	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vision	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Exam Type	Referral	Exam Type	Referral	Exam Type	Referral
Full Screen (I - X)	☐	☐	☐	☐	☐	☐
Partial Screen (I - V)	☐	☐	☐	☐	☐	☐
Developmental Screen	☐	☐	☐	☐	☐	☐
Hearing Screen	☐	☐	☐	☐	☐	☐
Vision Screen	☐	☐	☐	☐	☐	☐
Dental Screen	☐	☐	☐	☐	☐	☐
Acute Care Visit	☐	☐	☐	☐	☐	☐

%VRTLAST_NAME%   %IDCN%

Immunization Data

VACCINE	IMMUNIZATION DATE	REASONS FOR NOT IMMUNIZING

Hepatitis B-1   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other
☐ Hospital

Hepatitis B-2   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other

Hepatitis B-3   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other

DTaP DTP DT   1   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other

DTaP DTP DT   2   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other

DTaP DTP DT   3   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other

DTaP DTP DT   4   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other

DTaP DTP DT   5   ☐ / ☐ / ☐

☐ Contraindicated   ☐ Vaccine Shortage
☐ Parental Refusal   ☐ Not Documented
☐ Not Age Appropriate   ☐ Other

%VRTLAST_NAME%   %IDCN%

Immunization Data (continued)

VACCINE	IMMUNIZATION DATE	REASONS FOR NOT IMMUNIZING	
DTP/Hib-1	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
DTP/Hib-2	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
DTP/Hib-3	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
DTP/Hib-4	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hib-1	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hib-2	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hib-3	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hib-4	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hib/Hep-1	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hib/Hep-2	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hib/Hep-3	☐ / ☐ / ☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other

%VRTLAST_NAME%   %IDCN%

Immunization Data (continued)

VACCINE	IMMUNIZATION DATE	REASONS FOR NOT IMMUNIZING

IPV-1 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

IPV-2 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

IPV-3 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

IPV-4 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

MMR-1 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

MMR-2 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

Varicella-1 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

Varicella-2 ☐☐ / ☐☐ / ☐☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

%VRTLAST_NAME%   %IDCN%

Immunization Data (continued)

VACCINE	IMMUNIZATION DATE	REASONS FOR NOT IMMUNIZING	
Td-1	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Td-2	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Td-3	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Td-4	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hepatitis A-1	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hepatitis A-2	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Hepatitis A-3	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Pneumococcal-1	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Pneumococcal-2	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Pneumococcal-3	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other
Pneumococcal-4	☐☐ / ☐☐ / ☐☐	☐ Contraindicated ☐ Parental Refusal ☐ Not Age Appropriate	☐ Vaccine Shortage ☐ Not Documented ☐ Other

%VRTLAST_NAME%   %IDCN%

Immunization Data (continued)

VACCINE	IMMUNIZATION DATE	REASONS FOR NOT IMMUNIZING

Influenza-1   ☐ / ☐ / ☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

Influenza-2   ☐ / ☐ / ☐

☐ **Contraindicated**   ☐ **Vaccine Shortage**
☐ **Parental Refusal**   ☐ **Not Documented**
☐ **Not Age Appropriate**   ☐ **Other**

Blood Lead Levels

BLL DATE   BLL VALUE   METHOD   REFERRAL

BLL-1   ☐ / ☐ / ☐   ☐   ☐ V   ☐ C
☐ Health Plan   ☐ Clinical Specialist
☐ Health Dept   ☐ Other

BLL- 2   ☐ / ☐ / ☐   ☐   ☐ V   ☐ C
☐ Health Plan   ☐ Clinical Specialist
☐ Health Dept   ☐ Other

BLL- 3   ☐ / ☐ / ☐   ☐   ☐ V   ☐ C
☐ Health Plan   ☐ Clinical Specialist
☐ Health Dept   ☐ Other

BLL -4   ☐ / ☐ / ☐   ☐   ☐ V   ☐ C
☐ Health Plan   ☐ Clinical Specialist
☐ Health Dept   ☐ Other

BLL -5   ☐ / ☐ / ☐   ☐   ☐ V   ☐ C
☐ Health Plan   ☐ Clinical Specialist
☐ Health Dept   ☐ Other

BLL -6   ☐ / ☐ / ☐   ☐   ☐ V   ☐ C
☐ Health Plan   ☐ Clinical Specialist
☐ Health Dept   ☐ Other

BLL -7   ☐ / ☐ / ☐   ☐   ☐ V   ☐ C
☐ Health Plan   ☐ Clinical Specialist
☐ Health Dept   ☐ Other

Additional Comments

PLACE ADDITIONAL COMMENTS HERE (Please print):

Finish time *

☐ ☐ : ☐ ☐

* IN MILITARY TIME

Sign Here

Appendix C: Prenatal Protocols

%VRTLAST_NAME%   %IDCN%

Prenatal Care Visits					

	Date of Visit (MM / DD / YY)	Gestation Weeks	BLOOD PRESSURE Systolic	Diastolic	Weight (in Lbs)
First Prenatal Visit	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 2	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 3	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 4	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 5	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 6	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 7	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 8	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 9	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐

Additional Visits (If necessary)					
Visit 10	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 11	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 12	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 13	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 14	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 15	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 16	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐

%VRTLAST_NAME%   %IDCN%

Additional Visits (If necessary)

	Date of Visit (MM / DD / YY)	Gestation Weeks	BLOOD PRESSURE Systolic	Diastolic	Weight (in Lbs)
Visit 17	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 18	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 19	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 20	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 21	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 22	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 23	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 24	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 25	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 26	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 27	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 28	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 29	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 30	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 31	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐
Visit 32	☐☐ / ☐☐ / ☐☐	☐☐	☐☐☐	☐☐☐	☐☐☐

%VRTLAST_NAME%   %IDCN%

Prenatal Risk Assessment

Did patient have a risk assessment completed?   ☐ **Yes**   ☐ **No**

If yes, give date   ☐☐ / ☐☐ / ☐☐
                    (MM / DD / YY)

Was a copy of the State form in the chart?   ☐ **Yes**   ☐ **No**

Prenatal Care Began   ☐☐ weeks   or   ☐☐ months

Approximate Due Date

☐☐ / ☐☐ / ☐☐
(MM / DD / YY)

DOCUMENTED RISK FACTORS   DOCUMENTED

1.   Mother's age 17 years or less at time of conception.   ☐

2.   Mother's education less then 8 years.   ☐

3.   Gravida greater than or equal to 7.   ☐

4.   Currently smoking   ☐

5.   Mother's age 35 years or greater at time of conception.   ☐

6.   Pre-pregnancy weight less than 100 lbs.   ☐

7.   Previous fetal death (20 weeks gestation or later).   ☐

8.   Previous infant death.   ☐

9.   History of incompetent cervix in current or past pregnancy.   ☐

10. History of diabetes mellitus including gestational diabetes in current or past pregnancy.   ☐

11. Multiple fetuses in current pregnancy.   ☐

12.. Pre - existing hypertension (a history of hypertension -- 140/90 mm HGs or greater --
      antedating pregnancy or discovery of hypertension -- 140/90 or greater -- before the
      20th week of pregnancy).   ☐

13. Pregnancy - influenced hypertension in current pregnancy (blood pressure is 140/90 or
     greater, or there has been an increase of 30 mm Hg systolic or 15 mm Hg diastolic over
     baseline values on at least two occasions six or more hours apart).   ☐

14. Prior low birth weight baby (<2500 grams or 5 lbs. 8 oz.).   ☐

15. Prior preterm labor (<37 completed weeks gestation).   ☐

16. Preterm labor: current pregnancy.   ☐

17. Seropositive for HIV antibodies.   ☐

%VRTLAST_NAME%   %IDCN%

Prenatal Risk Assessment (continued)

18. Interconceptional spacing < 1 year. ☐
19. Living alone or single parent living alone. ☐
20. Considered relinquishment of infant. ☐
21. Unfavorable environmental conditions. ☐
22. Late entry into care (after 4th month or 18 weeks gestation). ☐
23. Homelessness. ☐
24. Alcohol abuse by client. ☐
25. Alcohol abuse by partner. ☐
26. Drug dependence or misuse by client. ☐
27. Drug dependence or misuse by partner. ☐
28. Physical or emotional abuse/neglect of client. ☐
29. Physical abuse of children in the home. ☐
30. Neglect of children in the home. ☐
31. Partner with history of violence. ☐
32. Chronic or recent mental illness and /or psychiatric treatment. ☐
33. Elevated blood lead level 15 - 19 µg/dl or greater. ☐
34. Other, identify: ☐☐☐☐☐☐☐☐☐ ☐
99. None of the above. ☐

Was care management provided? ☐ Yes ☐ No

By whom? ☐ Health Plan ☐ Provider ☐ Unknown ☐ Other ☐☐☐☐☐☐☐☐☐☐

Smoking Cessation

Did patient smoke during pregnancy? ☐ Yes ☐ No

	# of packs per day		# of cigarettes per day
If yes, Indicate pre-pregnancy amount:	☐☐	OR	☐☐
Indicate pregnancy amount:	☐☐	OR	☐☐

Was the patient counseled to stop smoking? ☐ Yes ☐ No

If yes, by whom ☐ Doctor ☐ Nurse ☐ Unknown ☐ Other

Was the patient referred to a Smoking Cessation Program? ☐ Yes ☐ No
Were there any other interventions? (e.g. patch, medication) ☐ Yes ☐ No
Did the patient decrease the amount smoked during pregnancy? ☐ Yes ☐ No
Did the patient quit smoking during pregnancy? ☐ Yes ☐ No

%VRTLAST_NAME%   %IDCN%

Substance Abuse

Was nonmedical substance use documented?   ☐ **Yes**   ☐ **No**

If yes, Indicate substance(s) being abused:

☐ **Prior to Pregnancy, but not Current**   ☐ **Current**

☐ **Prior to Pregnancy, but not Current**   ☐ **Current**

☐ **Prior to Pregnancy, but not Current**   ☐ **Current**

Was patient referred to Substance Abuse Program? (e.g. C-STAR)   ☐ **Yes**   ☐ **No**

Nutrition

Did patient have a nutrition problem documented?   ☐ **Yes**   ☐ **No**

(See list)

Was patient referred to or enrolled in WIC?   ☐ **Yes**   ☐ **No**

Was patient referred to or enrolled in another Nutritional Program? ☐ **Yes**   ☐ **No**

If so, which program?

Complications of This Pregnancy

Anemia	☐ **Yes** ☐ **No**		Hyperemesis gravidarum	☐ **Yes** ☐ **No**	
Gestational diabetes	☐ **Yes** ☐ **No**		Pregnancy-induced hypertension	☐ **Yes** ☐ **No**	
Prolonged placental insufficiency	☐ **Yes** ☐ **No**		Bleeding in 2nd half of pregnancy	☐ **Yes** ☐ **No**	
Trauma during pregnancy	☐ **Yes** ☐ **No**		Spontaneous abortion	☐ **Yes** ☐ **No**	
Pre-term labor	☐ **Yes** ☐ **No**		Antepartum infection	☐ **Yes** ☐ **No**	
Other	☐ **Yes** ☐ **No**				

%VRTLAST_NAME%   %IDCN%

Labor & Delivery

INFANT 1

Date of delivery: ☐☐ / ☐☐ / ☐☐   Weeks gestation at birth: ☐☐

Type of delivery: ☐☐☐☐☐☐☐☐☐☐

Lbs   Ounces   Grams

Weight of infant 1: ☐☐   ☐☐   OR: ☐☐☐☐

Apgar Score: (one minute) ☐☐   (Five minutes) ☐☐

INFANT 2

Date of delivery: ☐☐ / ☐☐ / ☐☐   Weeks gestation at birth: ☐☐

Type of delivery: ☐☐☐☐☐☐☐☐☐☐

Lbs   Ounces   Grams

Weight of infant 2: ☐☐   ☐☐   OR: ☐☐☐☐

Apgar Score (one minute): ☐☐   (Five minutes): ☐☐

DELIVERY COMPLICATION(s)

1 ☐☐☐☐☐☐☐☐☐☐☐   2 ☐☐☐☐☐☐☐☐☐☐☐

3 ☐☐☐☐☐☐☐☐☐☐☐   4 ☐☐☐☐☐☐☐☐☐☐☐

INFANT COMPLICATION(s)

1 ☐☐☐☐☐☐☐☐☐☐☐   2 ☐☐☐☐☐☐☐☐☐☐☐

3 ☐☐☐☐☐☐☐☐☐☐☐   4 ☐☐☐☐☐☐☐☐☐☐☐

Additional Comments

ADDITIONAL COMMENTS (Please Print):

Finish time *   Sign Here

☐☐ : ☐☐

* IN MILITARY TIME

Appendix D: Pre- Site Visit Protocol

Missouri External Quality Review 2002

Health Plan Name: _____

Name and Title of Person Completing this Form:

_____

Subcontractors

1. **Please list all services delegated for MC+ members during calendar year 2002, the names of the subcontractors, the contract start date, and the contract stop date, if applicable. Please indicate whether or not the vendor was on a corrective action plan during 2002, and for what reason(s).**

Service	Vendor Name	Start Date	Stop Date	Corrective Action Plan (Y/N)

Vendors

2. **Please list any vendors that were on corrective action plans during 2002, the reason(s) and the status.**

Vendor Name	Reason	Disposition

3. **With what school-based dental providers did your plan contract during 2002?**

Name	Date of contract

Providers

4. **Please provide a summary of the number of pediatric subspecialties enrolled in your network with open panels to serve MC+ members in 2002.**

Number	Pediatric subspecialty	Number	Pediatric subspecialty
	Allergy/immunology		Nephrology
	Anesthesiology		Neurology
	Cardiology		Neurosurgery
	Child and Adolescent Psychiatry		Ophthalmology
	Critical Care		Oral surgery
	Dermatology		Orthopedics
	Developmental/Behavioral Medicine		Otolaryngology
	Emergency Medicine		Pediatric Surgery
	Endocrinology		Plastic Surgery
	Gastroenterology		Pulmonology
	Genetics		Radiology
	Hematology/Oncology		Rheumatology
	Infectious Disease		Urology
	Neonatology/Perinatology		

Quality Improvement

5. **Please list the name of each clinical guideline or protocol <u>in effect</u> for MC+ members during 2002, the date implemented, the date disseminated to providers, and the date(s) of studies examining implementation and outcomes of the guidelines.**

Guideline	Date Implemented	Date Disseminated	Date Evaluated

6. **Please list the Performance Improvement Plans <u>completed</u> during 2002 for MC+ members in the following areas.**

Type	Name(s) and brief description of plan(s)	Date Completed
<u>Clinical</u>		
Prevention of acute/chronic conditions		
High volume services		
High risk services		
Continuity and coordination of care		
<u>Non- Clinical</u>		
Grievances, appeals		
Access/availability of services		
Cultural competence		

Staff Training

7. **Please list the dates of staff in-services during 2002 for the following (inset as many row s or attachments as necessary):**

Topic	Staff roles (e.g., provider reps, IS, management, etc)	Date	Mandatory Training ? (Y/N)
HIPAA			
Fraud and Abuse			
Interagency Coordination (please specify the type)			

Case Management/Care Management

8. **For those members under 21 years of age, what proportion of your MC+ members received health plan case management (including that received by any subcontractors)?**

9. **Of those members that received case management, from which vendors did they receive case management? Please list.**

10. **Of the following types of activities, which one <u>best</u> describes your health plan's activities with members (check <u>one</u> only)?**

   ❑ *Case management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patient's/families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance outcomes.*

   ❑ *Care Coordination is a method of coordinating the provision of health care so as to improve its continuity and quality.*

   ❑ *Disease Management is the process of intensively managing a particular disease or syndrome. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. It is similar to case management, but more focused on a defined set of problems relative to an illness or syndrome.*

11. What components are a <u>routine</u> part of the case management program (Check <u>all</u> that apply)?

    q **Use of clinical practice guidelines;**

    q **Provider and patient profiling;**

    q **Specialized physician and other practitioner care targeted to meet members special needs;**

    q **Provider education;**

    q **Patient education;**

    q **Claims analyses; and**

    q **Quarterly and yearly outcome measurement and reporting.**

Appendix E: Documents Requested From Health Plans

1. Script for new member orientation phone call and health screen. We are looking to see how new members are oriented to the health plan as well as when and how the health screens are conducted. A description of procedures and/or flow charts would also be helpful.
2. Any vendor and subcontractor corrective action plans from 2002. If you have written plans for subcontractors or vendors to respond to or improve, please send us copies so that we can get an idea of some of the quality or access issues that may have arisen, how they were addressed, and how the vendors are responding.
3. Policies and procedures for adoption of practice guidelines. We are interested in how your plan determines which guidelines to put into place, how they are communicated, and how they are evaluated (as well as how often).
4. Record of interpreter services provided/reimbursed (number of persons, language, frequency for each person). We are interested in the utilization of interpreter services for health plan members, and the different types of interpreter services requested (e.g., on- site interpreter, language line, TDD, foreign language, Braille, etc.)
5. Provider credentialing criteria and procedures for review. We are interested in the criteria used by your plan for enrolling primary care providers (e.g., OB/GYN, family practitioners, internists, pediatricians) in your network to serve MC+ members, and what criteria you use to review them. Please also include policies on the role of provider profiling in provider credentialing and evaluation.
6. Guidelines/protocols for pregnant members (prenatal guidelines). Please submit the protocols and procedures used to identify new members, address risk factors, and provide care.
7. Copies of reports of performance improvement projects completed during 2002. We are interested in the results and evaluation of projects completed during 2002, including methods of sampling, analysis, findings, and actions taken as a result.
8. Work Plan for 2002 and progress. Please submit a copy of the work plan identified for 2002 as well as the progress on that work plan.
9. Work Plan for 2003. Please submit a copy of your 2003 Work Plan.

Appendix F: Physician Survey

2003 MC+ Physician Vaccination Survey

We are BHC, of Columbia, MO, and are conducting the External Quality Review for the Medicaid program (MC+) on behalf of the State of Missouri. As part of that contract, we are conducting a study on childhood vaccinations in the State of Missouri. In addition to the medical chart review, we are asking for your input on childhood vaccinations in order to get a clinical perspective. As with the chart review, all of the answers to this survey are confidential, and will be combined with all of the other physician responses to ensure confidentiality. Please take a minute to complete this brief survey. We would like to thank you in advance for your input and cooperation.

1.Type of Practice

☐ **Private Solo Practice**
☐ **Private Group Practice**
☐ **Health Department Clinic**
☐ **State Health Department Cinic**
☐ **County Health Department Clinic**
☐ **Federally Qualified/Rural Health Center**
☐ **Other** _____

2.Practice Speciality

☐ **Pediatrics**
☐ **Family Practice**
☐ **Internal Medicine**
☐ **Multispecialty**
☐ **Health Department Clinic**
☐ **Other** _____

3. Approximately how many children age 0-6 are in your practice?   _____

4. Approximately what percent of children in your practice are "up-to-date" with the recommended childhood vaccinations?   _____

5. Which clinical immunization guidelines/schedules do you use in your practice?

☐ **State of Missouri, Division of Medical Services (DMS)**   ☐ **Institute for Clinical Services Improvement (ISCI)**

☐ **Advisory Committee on Immunization Practices (ACIP)**   ☐ **Other** _____

6. Does your practice/clinic have a systematic way to identify and recall patients in need of vaccines?   ☐ **Yes**   ☐ **No**

    If yes, what kind of system do you use?

☐ **Recall system, computerized**   ☐ **Chart reviews at time of EPSDT or office visit**
☐ **Recall system, manual/tickler file**   ☐ **Registry**
☐ **Periodic chart reviews**   ☐ **Other** _____

7. Have preschool immunization rates in your practice been assessed within the past year?   ☐ **Yes**   ☐ **No**

    If yes, by whom?

☐ **Own Practice/Clinic Staff**   ☐ **Managed Care Organization**

☐ **State Health Depatment**   ☐ **Other** _____

    What were the rates for 2-year-olds for the 4 DTP/DTaP, 3 Polio, and 1 MMR series?   _____

9. During CY 2002., to what degree did the vaccine shortage affect your ability to vaccinate children in your practice?

    ☐ **Not at all**   ☐ **Minimal**   ☐ **Some**   ☐ **Significant**

10. For those children in your practice who are not "up-to-date" on their vaccinations, what do you believe are the reasons and/or barriers?

☐ **Cost/reimbursement issues**   ☐ **Parental unwillingness or refusal**

☐ **Not medically necessary**   ☐ **Preventive care appointments not made/kept by parent**

☐ **Other** _____

11.Additional Comments Regarding Vaccination and/or Guidelines:

_____

Glossary

ACOG: American College of Obstetrics and Gynecologists

ACIP: Advisory Committee on Immunization Practices

BHO: Behavioral Health Organization

CAHPS: Consumer Assessment of Health Plans Survey

CASA: Clinical Assessment Software Application

CDC: Centers for Disease Control and Prevention

CHCS: Center for Health Care Strategies

CHIME: Community Health Information Management and Epidemiology, Missouri Department of Health and Senior Services

Chi- square: A statistical test that is used to examine the probability of a change or difference in rates is due to chance.

CI: Confidence Interval

CMHC: Community Mental Health Centers

CMS: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

COBRA: Consolidated Omnibus Budget Reconciliation Act

COPD: Chronic Obstructive Pulmonary Disease

CQI: Continuous Quality Improvement

CSHCN: Children with Special Health Care Needs

C- STAR: Comprehensive Substance Treatment and Rehabilitation

CTS: Children's Treatment Services; funds for the treatment of children in State custody.

CY: Calendar Year

DCN: Department Control Number

DFS: Division of Family Services, Missouri Department of Social Services

DHHS: Department of Health and Human Services

DHSS: Missouri Department of Health and Senior Services

DMH: Missouri Department of Mental Health

DMS: Division of Medical Services, Missouri Department of Social Services.

DNKA: Did not keep appointment

DRG: Diagnosis- Related group

DSS: Missouri Department of Social Services

EDI: Electronic Data Interchange

EDS: Electronic Data Systems

EMTALA: Emergency medical Treatment and Labor Act

EPSDT: Early, Periodic Screening, Diagnosis and Treatment

EQR: External Quality Review

EQRO: External Quality Review Organization

FFS: Fee-for-Service

FQHC: Federally-Qualified Health Center

FPL: Federal Poverty Level

FTE: Full-Time Equivalent

HCFA: Health Care Financing Administration (now CMS)

HCY: Healthy Children and Youth, the Missouri Medicaid EPSDT program

HEDIS: Healthplan Employer Data and Information Set

HRSA: Health Resources and Services Administration

HIPAA: Health Insurance Portability and Accountability Act

HIPP Program: Health Insurance Premium Payments

HMO: Health Maintenance Organization

HRSA: Health Research and Services Administration, U.S. Department of Health and Human Services

ICF-MR: Intermediate Care Facility-Mental Retardation

IDCN: Individual Document Control Number

IPA: Individual Provider Association

IRR: Inter-rater reliability

IVR: Integrated Voice Response

JCAHO: Joint Commission on Accreditation of Healthcare Organizations

LBW: Low Birth Weight

LPHA: Local public health agency

LCL: Lower Confidence Limit

MAF: Medical Assistance for Families

MCH: Maternal and Child Health

MCO: Managed Care Organization

MDI: Missouri Department of Insurance

MFCU: Medicaid Fraud Control Unit

MHA: Missouri Hospital Association

MIS Director: Management Information Systems Director

MIU: Medicaid Investigation Unit

MOHSAIC: Missouri Health Strategic Architectures and Information Cooperative, Missouri Department of Health and Senior Services

MRDD: Mentally Retarded/ Developmentally Disabled

NCLS: National Council of State Legislatures

NCQA: National Committee for Quality Assurance

NHLBI: National Heart, Lung and Blood Institute

N.S.: Not significant.

OIG: Office of the Inspector General

PBM: Pharmacy Benefits Manager

PCCM: Primary Care Case Management

PCP: Primary Care Physician

PHI: Protected Health Information

PHP: Prepaid Health Plan

PIP: Performance Improvement Project

PMPM: Per- member per- month

PRO: Peer Review Organization

Pro- Like Entity: Peer Review Organization- Like Entity

QA: Quality Assurance

QA & I Advisory Group: Quality Assurance and Improvement Group

QI: Quality Improvement

QISMC: Quality Improvement Systems for Managed Care

RsMo: Revised Statutes of Missouri

RWJ: Robert Wood Johnson Foundation

SED: Seriously Emotionally Disturbed

SLAITS: State and Local Area Integrated Telephone Survey

SCHIP: State Children's Health Insurance Program

TANF: Temporary Assistance to Needy Families

TPA: Third Party Administrator

UCL: Upper Confidence Limit

UM: Utilization Management

VLBW: Very Low Birth Weight

WIC: Women, Infants and Children Program

Endnotes

[1] (Federal Register, Final Rule, External Quality Review of Medicaid Managed Care organizations, 3586 – 3638).

[2] (Federal Register, Vol. 68, No. 16, January 24, 2003).

[3] (Federal Register, Final Rule, External Quality Review of Medicaid Managed Care organizations, 3586 – 3638).

[4] (Federal Register, Vol. 68, No. 16, January 24, 2003)

[5] Personal communication with Wayne Schramm, DHSS.

[6] Kleinman, J.C., Kiely, J.L. (1991). Infant Mortality. Healthy People 2000 Statistical Notes, Winter 1991, 1(2). U.S. Department of Health and Human Services, Centers for Disease Control. Washington, DC: National Center for Health Statistics.

[7] http://www.dss.state.mo.us/dms/dated/memo062602.htm, downloaded February 4, 2003; Information also gathered through interviews with State administrative staff, program management staff, and MC+ Quality Assessment and Improvement Advisory Group members representing the Departments of Health and Senior Services and the Department of Mental Health.

[8] Information obtained through administrative interviews with State administrative staff and program management personnel.

[9] Data provided included a report listing *Encounters Processed during 12- Month Period ending December 28, 2002 (Winter 2003),* an ad hoc request for inpatient and pharmacy data using the DMS Data Scan and Panorama systems (May 7, 2003), and recipient level DHSS encounter data files (November 8, 2002).

[10] Quality Compass (2002). NCQA.

[11] The only exception was for asthma emergency room visits in the Central Region, which actually increased.

[12] Regier, D.A. , Narrow, W.E., Rae, D.S., et al. (1993). The de facto U.S. mental and addictive disorders service system: epidemiologic catchment area prospective 1- year prevalence rates of disorders and services. Archives of General Psychiatry, 50, 85- 94.

[13] Pomeranty, J.M. (2002). Drug Benefit Trends, 14(9), 33- 34.

[14] Missouri Department of Social Services, Division of Medical Services, Physicians Manual. November 2001.

[15] Missouri Department of Social Services, Division of Medical Services, Special Bulletin. Volume 24, No. 8, May 1, 2002.

[16] Centers for Disease Control and Prevention. Recommendations for Blood Lead Screening of Young Children in Medicaid: Targeting a Group at High Risk, Vol. 49, No. RR 14:1. December 8, 2000.

[17] Barclay, L., Skylar, B., "Acceptable" Lead Level Not Low Enough. Medscape Medical News. 2003. http//www.medscape.com. Downloaded April 23, 2003.

[18] United States General Accounting Office, Health, Education, and Human Services Division. Medicaid: Elevated Blood Lead Levels in Children. GAO/HEHS- 98- 78. February 1998.

[19] Healthy People 2010. http:/www.healthypeople.gov/Document/HTML/Volume 2/16MICH.htm. Downloaded June 21, 2003.

[20] Missouri Department of Health and Senior Services, Medicaid Bulletin, December 2000.

[21] Blunt, M., Missouri Secretary of State. Communicable and Environmental Disease Reporting Rules. (October 31, 2002). www.sos.state.mo.us/adrules/csr/current/19csr/19c20-20.pdf. Downloaded June 21, 2003.

[22] Missouri Department of Health and Senior Services, FFY 2004 MCH Program Guidance. March 2003.

[23] Data are for Medicaid recipients in the MC+ Managed Care Regions of the State. Data do not separate Managed Care and Fee-for-Service recipients. It is expected that since MC+ Managed Care enrollment is mandatory for most eligible recipients residing in the MC+ Managed Care Regions, the data represent primarily MC+ Managed Care Members.

[24] Health Resources and Services Administration, Maternal Child Health Bureau, Child Health USA 2002. http://mchb.hrsa.gov/chusa02. Downloaded June 21, 2003.

[25] Health Resources and Services Administration, Maternal Child Health Bureau, Child Health USA 2002. http://mchb.hrsa.gov/chusa02. Downloaded June 21, 2003.

[26] Missouri Department of Health and Senior Services, FFY 2004 MCH Program Guidance. March 2003.

[27] Texas Medicaid Managed Care 2000. Star Pregnancy Focused Study: Final Technical Report. January 26, 2001.

[28] Missouri Department of Health and Senior Services, FFY 2004 MCH Program Guidance. March 2003

[29] Healthy People 2010. http:/www.healthypeople.gov/Document/HTML/Volume2/16MICH.htm. Downloaded July 23, 2003.

[30] Health Resources and Services Administration, Maternal Child Health Bureau, Child Health USA 2002. http://mchb.hrsa.gov/chusa02. Downloaded June 21, 2003.

[31] MC+ QA & I / MCH Subgroup. Smoking During Pregnancy Indicator. September 22, 1999.

[32] Missouri Department of Health and Senior Services, Maternal, Child and Family Health, Bureau of Family Health. Perinatal Substance Abuse Manual. June 2000.

[33] Centers for Disease Control and Prevention, Health & Economic Impact: Smoking Cessation for Pregnant Women. July 2002.

[34] Centers for Disease Control and Prevention, Health & Economic Impact: Smoking Cessation for Pregnant Women. July 2002.

[35] Missouri Department of Health and Senior Services, FFY 2004 MCH Program Guidance. March 2003.

[36] Medem: Medical Library. Adolescent Pregnancy: Current Trends and Issues, 1998. Downloaded April 14, 2003.

[37] Missouri Department of Health and Senior Services, FFY 2004 MCH Program Guidance. March 2003.

[38] Missouri Department of Health and Senior Services, FFY 2004 MCH Program Guidance. March 2003.

[39] MC+ QA & I / MCH Subgroup. Smoking During Pregnancy Indicator. September 21, 2000.

[40] Missouri Department of Social Services, Division of Medical Services, MC+ Managed Care Policy Statements. Revised July 2002.

[41] Missouri Department of Health and Senior Services, FFY 2004 MCH Program Guidance. March 2003.

[42] Missouri Department of Health and Senior Services, Maternal, Child and Family Health, Bureau of Family Health. Perinatal Substance Abuse Manual. June 2000

---

[43] Missouri Department of Health and Senior Services, Center for Health Information Management and Evaluation, <u>Missouri 2001 Prenatal Drug Prevalence Study</u>, October 2002, Vol. 36, No. 08.

2002

Missouri MC+ Managed Care Program

External Quality Review

Community Care Plus

AUTHORS:
Janet Reed, PhD, MHA
Vice President, BHC, Inc.,
Director, Performance Management Solutions Group

Jutta Hopkins, PhD, RN
Health Services Researcher
Performance Management Solutions Group

William Chase, MPPA, MSCIS
Senior Research Analyst, Data Manager
Performance Management Solutions Group

Site Visit Date   Wednesday, March 12, 2003

Subcontractors

Behavioral Health: **Magellan**
Pharmacy: **Express Scripts/DPI**
Dental: **Doral Dental**
Transportation: **Medical Transportation Management**

Compliance with Standards and Operations

Enrollee Rights and Protections

- **Member services representatives are educated on fraud and abuse and refer any cases of suspected fraud or abuse to the Director of Member Services.**

- **The Utilization Management Director examines quarterly reports for the high profile drugs that are reimbursed by Express Scripts or Community Care Plus.**

Credentialing and Re-credentialing

- **Credentialing is conducted directly by Community Care Plus for individual providers; and through oversight for hospital-based providers and JCAHO or URAC- accredited provider groups.**

- **The re-credentialing process will be conducted every three years, consistent with NCQA standards.**

Vendor Oversight

- **For transportation vendors and services, Community Care Plus and Medical Transportation Management (MTM) have identified preferred vendors for transportation services based on complaints.**

- **Magellan Behavioral Health Services filed for bankruptcy and had obtained an additional $50 million from investors to remain solvent at the time of the site visit. However, Community Care Plus informed Magellan of the intent not to renew the current contract with Magellan, which remains in effect until September, 2003. Community Care Plus monitors carefully the financial issues on a weekly basis. This information has been posted on the Magellan web site for providers to access, and member representatives at Magellan and Community Care Plus have been educated to respond to questions regarding the availability and continuity of behavioral health services.**

- **Magellan instituted a re-contracting initiative with providers to make contract terms more consistent with the state contract and federal Medicaid rules.**

Access

Member Services

- **During the transition from the MCO exiting the Eastern Region, Community Care Plus enrolled approximately 12,000 new members. This process was facilitated by attempts to notify members about the network and ensure that there was no change in provider if they were also in the Community Care Plus network. This was accomplished through the management information system (AMISYS) that maintains provider and member information. This system has a number of features built in to prompt staff and requires follow-through by member services and other staff to bring a member issue to resolution. This system also forms the basis for claims, EPSDT, and HEDIS reporting.**

- **Organizationally, Community Care Plus has combined claims and members services staff. Given the increase in enrollment, Community Care Plus has expanded member services staff and cross-trained existing staff to handle the increased volume. They maintain a member services staff to member ratio of 1 to 5,000. There has been no turnover in member services staff in the past 2 years.**

- **MCOs are in place to develop a web-based tool for referencing and updating the provider directory. Currently, the member services department has access to real-time updates of the provider directory in order to facilitate access to appropriate providers.**

Provider Network[1]

- **The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance indicates that the overall network adequacy for Community Care Plus was 98%. Recommendations were made to re-code pediatric infectious disease specialists to infectious disease specialists so as not to result in an underestimate of these specialists in the network. In response to inadequate (below 95%) level of providers in St. Francois County, Community Care Plus contracted with Mineral Area Regional Medical Center and Parkland Health Center and was in the process of credentialing and recruiting physicians as of August, 2002.**

- **The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance (MDI) indicates that as of December 31, 2001:**

  - **Community Care Plus' network adequacy for PCPs, specialists, facilities, and ancillary service providers was above the 95.0% threshold in 2002, with an overall network adequacy rate of 98.0%.**

  - **There was increased adequacy for ancillary services, from 92.0% to 99.0%, above the 95.0% threshold.**

  - **Documentation of infectious disease specialists increased from 0.0% to 19.0%.**

  - **Rates for anesthesiologists increased from 89.0% to 94.0%.**

  - **There was improved adequacy for neurology 94% to 100%, above threshold.**

  - **There was improved adequacy for radiology from 91% to 96%, above threshold.**

  - **There was improved adequacy for hospice, from 65.0% to 100.0%.**

- m **Provider network adequacy for CCP for rheumatology specialists declined from 95% to 85%.**

- **The following exceptions were provided:**

  - m **Home Health, Hospice, Occupational Therapy, Tertiary Hospitals in Franklin County.**

  - m **Tertiary Hospital and Infectious Disease in Jefferson County.**

  - m **Tertiary Hospital and Infectious Disease in St. Louis County.**

  - m **Tertiary Hospital and Infectious Disease in St. Louis City.**

  - m **Hospice, Tertiary Hospital, and Infectious Disease in Lincoln, Ste. Genevieve, St. Francois, St. Charles, Warren, and Washington Counties.**

- **Community Care Plus maintains a policy that they will accept any willing provider into their network that meets credentialing standards and reviews network adequacy on a quarterly basis.**

- **To enhance access to dental services, Community Care Plus has worked with Bridgeport Dental services to develop a multi- specialty dental clinic, for endodontic, orthodontic, and pediodontic care.**

- **Magellan Behavioral Health improved the adequacy of their network and access to pediatric psychiatrists by purchasing blocks of times for appointments.**

- **Magellan has added a rural clinic (Community Counseling Center) in Ste. Genevieve County to increase access.**

- **Network adequacy is examined quarterly, using the same standards applied by the annual MDI analysis.**

- **The Community Care Plus provider turnover rate during 2002 was less than 1% with attrition primarily related to death and termination of practices. One behavioral health provider discontinued behavioral health services (Mineral Area Mental Health).**

- **Magellan was working with the public behavioral health administrative agents in Farmington (Southeast Missouri Mental Health Center and St. Anthony's) to improve access**.

Utilization/Medical Management

- **The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:**

  - m **The total penetration rate for behavioral health services was 3.8% in 2001, up from 2.8 in 2000.**

  - m **Outpatient visits increased steadily from 1999 to 2001, from a rate of 117.0 to 163.2 per 1,000 in 2001.**

  - m **The rate of alternative services was .8 per 1,000 in 2001.**

  - m **Partial hospital admissions per 1,000 decreased to .2 per 1,000; and partial hospitalization days declined to .6 per 1,000 in 2001.**

  - m **There were 1.3 residential days per 1,000 in 2001, an increase from 0 in the previous two years.**

- m **Inpatient admissions increased steadily from 4.6 to 8.9 per 1,000 in 2001, while inpatient days followed a similar pattern, with 17.1 days per 1,000 and 30.4 per 1,000 in 2001.**

- m **Inpatient substance abuse admissions increased from 4.6 to 8.9 per 1,000 between 1999 and 2001. Inpatient substance abuse days per 1,000 increased from 1.3 to 2.1 per 1,000 between 1999 and 2001.**

- m **The 7‐day follow‐up rate increased from 16.6% to 25.8% between 1999 and 2001. The 30‐day follow‐up rate after hospitalization increased from 30.0% to 47.3% between 1999 and 2001.**

- **Penetration increased over the past three years, with increased access attributed to the purchasing of blocks of provider time.**

- **Although 2002 member satisfaction survey results were not available at the time of the site visit, the 2001 report indicated increased satisfaction with the amount of time the member waited to be seen for the first appointment, and the HEDIS indicator "30‐day follow‐up after hospitalization".**

- **Behavioral health penetration has increased during 2002, as has emergency room utilization.**

- **Magellan Behavioral health has noted an increase in Community Care Plus member outpatient utilization, consistent with nationwide trends.**

- **The rate of behavioral health appointments not kept (Did Not Keep Appointment; DNKA) is not monitored.**

- **Magellan Behavioral Health has worked with Community Care Plus to coordinate the communication between primary care providers and behavioral health providers for identifying high‐risk cases, with close monitoring of re‐admissions.**

- **An intervention was implemented to educate providers as well as to place quantity limits on specific medications so as to prompt utilization review.**

- **The Medical Director provided information about less expensive alternatives to specific medications as well as the efficacy of some of the less expensive medications to the behavioral health provider network.**

Quality

Clinical Guidelines

- **Clinical guidelines include Post‐Partum Depression and pharmacy guidelines.**

- **Asthma, diabetes, lead toxicity, EPSDT, high risk pregnancy, baby care, post‐partum depression, member/provider complaints and grievances.**

Performance Improvement Projects

Community Care Plus (Community Care Plus) identified several areas as Performance Improvement Projects for 2002 such as Asthma, Diabetes, Lead, EPSDT, High Risk Pregnancy, Baby Care, Post‐Partum Depression, and Smoking Cessation. The Quality Improvement Work Plan also listed Childhood and Adolescent Immunizations, Prenatal and Postpartum Care, Chlamydia Screening, and Appropriate Asthmatic Medication. Community Care Plus uses HEDIS measures for new projects.

- **The OB Statistics report from 2002 summarizes frequencies of live births, low birth weight (less the 1500 grams, and 150 – 2,499 grams), types of deliveries, case management outcomes, and a 5- year trend of indicators. Some data are presented by eligibility group (1915b, 1115) as well as by county or region.**

- **Community Care Plus conducted an audit of medical records to verify performance of EPSDT services according to claims data. EPSDT rates have increased from 2001 to 2002 among specific rate cells, while the 5 – 7 year old rate cell and the adolescent rates of EPSDT declined. Results of an EPSDT audit of medical records indicated that 80% of approximately 200 – 300 records had paid claims as well as documentation of EPSDT.**

- **Community Care Plus started participating in an ongoing collaborative project with Magellan Behavioral Health Services in October 2002 to screen new mothers for Post- Partum Depression. Depression educational material is sent to new mothers with a survey for them to return to Magellan for their review and follow up as necessary. Community Care Plus intends to continue the project and compare their results to other Medicaid MCOs also participating in the study. Magellan and Community Care Plus work closely together in member outreach and coordination of communication between PCPs and behavioral health providers for high- risk cases.**

- **To improve pharmacy utilization, Community Care Plus clinical staff identified several key questions related to high volume drugs (e.g., anti- inflammatory drugs, top 10 high- volume medications), such as:**

  m **What are the outlier drugs?**

  m **Who are the outlier prescribers?**

  m **Are there quality issues that need to be addressed?**

  m **Are there over- and under- utilization issues?**

Community Care Plus then implemented an effort aimed to educate providers on less expensive alternatives to specific medications as well as the efficacy of these drugs. Quantity limits were also instituted so as to prompt timely utilization review and act as triggers for review of member needs.

- **Community Care Plus identifies Children with Special Health Care Needs (CHSCN) through the monthly DMS diskette, review of the baseline health assessment information provided at enrollment, encounter data, and lead testing results. Case Management is provided by disease- specific case managers for areas such as high risk, asthma, sickle cell, cerebral palsy, lead, EPSDT and immunizations. Analysis of the effectiveness of the case management efforts was not provided but is clearly needed for this fragile population.**

Cultural Competency

- **Community Care Plus did not furnish any documentation of an organized, comprehensive plan for cultural competence. No information was found to substantiate improved processes/outcomes related to cultural competency**

Grievance Systems

- **Transportation complaints increased, partially due to the increase in membership as a result of the close- out of one MCO in the Eastern Region and the increased focus on obtaining this data from the vendor.**

- **The rate of member medical complaints was 1.15 per 1,000 members in 2002, a slight increase from the rate in 2001 (1.08 per 1,000 members), but lower than the Eastern Region rate and the rate for all MC+ Managed Care MCOs (1.61 per 1,000 members and 1.49 per 1,000 members, respectively). Member medical complaints were primarily accounted for by complaints regarding quality of care (.52 per 1,000 members). There was a decline in member medical complaints regarding access to appointments between 2001 and 2002 (from .21 per 1,000 members to .14 per 1,000 members).**

- **The rate of member non- medical complaints in 2002 was 5.00 per 1,000 members, an increase from 2001 (3.78 per 1,000 members), but lower than the Eastern and statewide MC+ Managed Care MCO rates (8.36 per 1,000 members and 6.41 per 1,000 members, respectively). Like all other MC+ Managed Care MCOs, the rate of member non- medical complaints was primarily accounted for by complaints relating to transportation services (4.75 per 1,000 members).**

- **The rate of provider medical complaints for Community Care Plus in 2002 was 0, a decline from .12 per 1,000 members in 2001. The rate of provider non- medical complaints in 2002 was .19 per 1,000 members, lower than the Eastern MC+ Managed Care and statewide MC+ Managed Care MCO provider non- medical complaint rates (3.25 per 1,000 members and 9.50 per 1,000 members, respectively).**

Case Management

Community Care Plus subscribes to the following definition of case management:

> **"Case management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patient's/families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance outcomes".[3]**

As a routine part of the case management program, Community Care Plus uses:

- **Clinical practice guidelines**

- **Provider and patient profiling (for lead testing and EPSDT)**

- **Provider education**

- **Patient education**

- **Quarterly and annual outcome measurement and reporting**

- **Case management/medical management staff include disease- specific case managers for:**

  m **High Risk**

- m **Asthma**

- m **Sickle Cell**

- m **Cerebral Palsy**

- m **Lead**

- m **EPSDT and Immunizations**

- **Prenatal case management includes the following:**

  - m **The high risk screening criteria for pregnant women are comprehensive, including all elements of the State Risk Appraisal Form, as well as identification of members with a pre-pregnancy weight greater than 200 pounds.**

  - m **The welcome call to new members includes screening for pregnancy and an offer of assistance to access prenatal care.**

  - m **One goal that Community Care Plus has is to reduce the rate of providers not notifying the MCO of pregnant members from 17% to 10% of deliveries.**

  - m **Collaborates with provider to follow-up on patients who did not keep their prenatal care appointments.**

  - m **Developed and implemented a Baby Care Program for pregnant members which follows mother and infant to six weeks post-partum.**

Interagency Coordination

- **The CEO participates in the Access to Care Subcommittee of the St. Louis Regional Commission on HealthCare.**

- **Magellan Behavioral Health attends regional meetings to coordinate behavioral health and social services for children and families. Magellan will be developing and recommending an assessment to be conducted to meet court requirements for evaluation that address many of the court-referred issues.**

- **Community Care Plus developed and implemented Baby Care Program for pregnant women members which follows mother/infant to six weeks post-partum.**

- **Community Care Plus collaborated with Magellan to add rural health clinic in Ste. Genevieve to improve access to care.**

Community Care Plus

2002 External Quality Review Findings

Conducted on Wednesday, March 12, 2003

The results of the on-site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for Community Care Plus in providing care to MC+ Managed Care Members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

∨ Community Care Plus added over 12,000 new members as a result of another MCO exiting MC+ Managed Care. They combined and cross-trained member services staff as a result.

∨ There has been improved claims processing. Community Care Plus appears for have excellent information systems for claims, providers, and members. Community Care Plus has capitalized on using the claims system and chart audits to better measure the rates of EPSDT, immunizations, etc...

∨ One Credentials Committee demonstrates good follow-up of providers who have had malpractice claims; and vendor oversight.

∨ Community Care Plus has identified preferred vendors based on their performance.

∨ Community Care Plus increased access of child psychologists and child psychiatrists by paying for blocks of time and reserving them in advance and experiences less than 10% provider turnover.

∨ There was an increase in providers for preventative care access to preventive care services through contracts with two local public health agencies.

∨ Community Care Plus has increased claims for EPSDT among the birth to six-year olds. A medical record audit and claims validation resulted in 80% documentation of EPSDT visits for which there were claims.

∨ There was an increased penetration rate and ambulatory follow-up rate between 2000 and 2001 for behavioral health services.

∨ There was an increase in inpatient days and admissions for behavioral health and substance abuse services between 2000 and 2001.

∨ There was increased utilization of residential and partial hospitalization services for behavioral health between 2000 and 2001.

∨   **There was an increase in outpatient visits and alternative services between 2000 and 2001.**

∨   **There was an improved and stable provider network for ancillary services, infectious disease specialists, anesthesiologists, neurology, radiology, and hospice services.**

∨   **Member medical complaints for quality of care and the ability to obtain appointments declined between 2001 and 2002.**

∨   **All member non-medical complaints, with the exception of those regarding transportation services declined between 2001 and 2002.**

∨   **There are low provider and member services staff turnover rates (less than 1% and 0%, respectively) over the past year.**

∨   **Community Care Plus has established Urgent Care Centers to address the high rates of emergency room utilization. The CEO is also participating on the Access to Care Subcommittee of the St. Louis Regional Commission on Health Care. It is recommended that the rate of emergency room utilization be monitored to assess the effectiveness of the Urgent Care Clinics access. It is also recommended that if not already in place, access to emergent behavioral health services be considered.**

∨   **There is good flow-through language regarding member rights.**

∨   **Provider medical complaints were negligible for 2002, and provider non-medical complaints declined from 2001 to 2002.**

∨   **Community Care Plus has placed a provider relations representative and nurse (outreach) in the expansion counties for better access to providers and members.**

∨   **Community Care Plus has worked with Bridgeport Dental Services to develop multi-specialty clinics so as to reduce the 4 – 6 month wait for dental services.**

∨   **Community Care Plus has well-documented minutes for meetings with vendors. Vendors have been prepared for HIPAA and fraud and abuse compliance requirements.**

∨   **Physician profiling and education have been conducted to identify the most commonly used drugs; outliers; over- and underutilization; and the cost effectiveness of specific classes of drugs.**

∨   **There is excellent documentation of processes, goals and progress on quality work plans.**

∨   **Screening of CSHCN members by matching with lead screening and baseline health screening databases as well as encounter and lead results is a strength for identification and outreach.**

Opportunities for Improvement

To improve member outreach, the following recommendations are made.

ü **Obtain updated member addresses and contact phone numbers from the transportation vendor and develop a shadow system for capturing and maintaining updated member addresses. Consider using first-class mail to only new members. Bulk mailing could potentially be used for members whose address was updated in the system in the last 6 months.**

ü **To improve EPSDT performance, it is recommended that Community Care Plus work with providers to educate them on the need to conduct a primary care visit at six years of age, per state Medicaid requirements. Several other promising practices for educating providers have been identified in the aggregate report.**

ü **Continue to clarify coding of EPSDT claims.**

ü **Implement quality improvement studies and identify outcomes for behavioral health for clinical issues.**

ü **It is recommended that Community Care Plus document the rate of missed appointments by members for behavioral health services (DNKA).**

ü **Work with PCPs and behavioral health providers to identify protocols and guidelines for the diagnosis and management of ADHD.**

ü **Follow-up on the efficacy and cost-effectiveness of the Prenatal Depression Screening Program in increasing the utilization of behavioral health services for pregnant members, as well as outcomes (e.g., the rates of hospitalization among post-partum mothers).**

ü **Re-examine physician prescribing patterns following the implementation of provider education. This can be a Performance Improvement Project for high volume services for 2003.**

ü **Continue with plans to examine emergency room utilization, collaboration with other MCOs and St. Louis Public Schools, collaboration with the Interagency Task Force participation in the Access to Care Subcommittee of the St. Louis Regional Commission on Health Care, and coordination between transportation vendor and FQHCs to provide bus passes for those who attend clinics along the bus routes.**

ü **Implement a reminder system to providers to send risk assessment forms and notify prenatal case managers of changes in risk status. This may be able to be done by provider representatives as well as case managers.**

ü **Measure the changes in access and emergency room utilization of members who attend the People's Health Center, which extended its hours to 10 p.m. Continue to encourage providers in the expansion areas to expand hours in order to offset the impact of the absence of urgent care clinics in these counties.**

ü **Work with the DHSS to obtain data downloads from MOHSAIC to obtain data on Community Care Plus member immunizations. A contact name was provided to Community Care Plus staff at the time of the site visit.**

Ü   **Continue to maintain involvement with community-based agencies and providers.**

Ü   **For measurement of prenatal case management, use the available data to make connections with the interventions that have been implemented, by quarter. Although it may not be possible to separate the effectiveness of multiple activities, the monitoring of change in relation to changes in processes will provide some information about progress and need for any changes.**

Ü   **Continue facilitating and encouraging the establishment of urgent care clinics to focus on decreases in ER utilization.**

Ü   **Community Care Plus members would benefit from a developed cultural competency program which allows for the identification of cultural and/or language needs of its members. Questions regarding interpreter needs or specific health risks should be incorporated into the welcome call.**

Ü   **Care Partners' transition was effective in identifying members with special health care needs who were receiving case management, DME, Synagis, home health services, and specific medications for follow-up by other MCOs.**

Ü   **Other medical complaints and denial of services complaints increased for members between 2001 and 2002.**

Ü   **The overall rate of member non-medical complaints increased, accounted for by the increase in member complaints regarding transportation. This is primarily due to a change in the reporting of member complaints by the transportation vendor. However the data regarding complaints should be used to improve transportation services and expectations for vendors and members as well as monitor progress over time.**

Ü   **Opportunities for improvements in provider network for rheumatologists exist. Given that the network analysis is somewhat conservative and that there is a shortage of such specialists, it is recommended that access to needed services be monitored closely. It may be that the MCO would need to facilitate access on a member-by-member basis; or that there is not a high need for the Community Care Plus membership.**

Ü   **Community Care Plus data collection efforts for clinical studies can be useful for provider education purposes, however the organization of projects needs to be enhanced. Clearly identifying the goal and study questions of the project and specific areas to be measured, interventions planned, subsequent outcomes, and analysis of success or failure will assist Community Care Plus efficiently focus their efforts in performance improvement. We encourage Community Care Plus continue with the projects listed since the areas are all critical to the provision of quality health care.**

Ü   **Data collection for quality improvement studies are good for provider education purposes, but needs to be clear about measures, the study question, the intervention(s) being studied, and the subsequent outcomes. Then ask, "Did the intervention work?" Prior to implementing and intervention, indices and baseline data should be collected for comparison with post-intervention performance.**

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003
[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group, 2003
[3] This definition was provided in the RFP B3Z02226 for MC+ Managed Care, with permission of the Center for Case Management, 6 Pleasant Street, South Natick, MA, 01760

2002

Missouri MC+ Managed Care Program

External Quality Review

Mercy Health Plan

Site Visit Date   Thursday, March 13, 2003

Subcontractors

Behavioral Health: **Unity Health Network**

Dental: **Doral Dental**

Transportation: **MTM**

Compliance with Standards and Operations

Enrollee Rights and Protections

- Member services staff are trained to report suspected fraud and abuse to their supervisor, who reviews cases with them and refers suspected cases to the quality department for further review. Anonymous compliance hotline and adverse event forms are also an available mechanism for reporting fraud and abuse. Fraud and abuse plans are reported quarterly to the Board. Training on fraud and abuse is conducted annually and upon the hiring of new employees.

- Mercy Health Plans uses prepared materials from the Office of Inspector General (OIG) and the Department of Health and Human Services (DHSS) as well as the State (Division of Medical Services). Employees re-sign confidentiality and compliance forms, code of conduct, and conflict of interest forms annually.

- Mercy Health Plans participates with the other two MCOs in the region in a Universal Lock-In policy for members. All three Eastern Region MCO Directors developed a three-step behavioral intervention for suspected fraud and abuse with high profile medications. The first step is to refer a member for psychiatric evaluation to determine if there is an unmet behavioral health or substance abuse treatment need associated with high medication use or seeking. The second step involves examining the progress of the lock-in, and the third step is the final lock-in itself.

Claims Processing

- Claims processing has improved, with the goal of claims payment to be made within 6 days for electronic claims, and 12 days for paper-based claims.

- Approximately 85% of claims are filed electronically, with 65% of those never having to be examined.

- Electronic claims are auto-adjudicated within 2 - 3 days, with checks written within one week.

- Mechanisms have been put into place to increase the number of state claims acceptance. Mercy reports the current rate of acceptance for institutions ranges from 50% - 78%. The file for providers is the next one to improve. There appears to be some loss in data upon transfer to Verizon.

- To improve the timeliness of payment for providers in 2003, Mercy Health Plan will be scanning all transactions to provide an electronic reference for claims and provider questions about the status of claims processing.

Credentialing and Re-credentialing

- **Credentialing is delegated for Unity Managed Mental Health, Doral Dental, and Sister's of St. Mary's. Mercy Health Plan has developed a Delegation Oversight Audit Tool that is used to assess compliance (full, significant, partial, minimal, or no compliance) with several criteria as well as initial credentialing and re-credentialing file worksheets. Summary worksheets to assess the rate of compliance are used to make a final determination of credentialing status.**

- **Mercy Health Plans conducts annual quality improvement and utilization management review with providers.**

- **For those providers for which credentialing is delegated, Mercy Health Plan audits the pharmacy rules. Utilization management staff reviews records for dental and behavioral health. In addition, behavioral health provider files are audited annually.**

Vendor Oversight

- **Credentialing and re-credentialing files are audited for behavioral health and dental vendors, and pharmacy rules are audited on an annual basis. Both Unity Managed Mental Health and Doral Dental vendors were on corrective action plans during 2002. Mercy Health plans developed detailed, task oriented, objective goals, priorities, person(s) responsible, and timeframes for compliance and monitored these through regular meetings and updates of the status of each item. This method is a model for oversight compliance. The main priorities in the Doral Dental compliance plan included management, contract compliance, network operations, utilization, quality, and contract compliance. At the time of the site visit, the MCO was 65% complete. For Unity Managed Mental Health, the goals focused on less traditional service development, more outcome focused, more useful reporting, and more culturally sensitive treatment. A majority of the goals had been implemented, were in process, or were initiated at the time of the site visit. Both documents clearly indicated expected goals and targets providing good communication between the vendor and MCO.**

- **Vender oversight is conducted quarterly through regular meetings with dental and transportation vendors, with established agendas for reviewing quality indicators and the status of any corrective action plans. Behavioral health oversight is conducted through quarterly meetings with the vendor as well as case management coordination.**

- **The Pharmacy and Therapeutics (P & T) and Vendor Oversight Committees report findings to the local Quality Improvement Committee (QIC), which reports to the Board Quality Committee, which ultimately reports to the Board of Directors.**

- **Oversight and pre-authorization for case management for the high-risk case management vendor, StatusOne, is conducted by the medical director and special needs coordinator.**

Access

Member Services

- **Mercy Health Plans enrolled approximately 10,600 new members as a result of one MCO exit in the Eastern Region.**

- **There has been no member staff turnover in the past 5 years.**

- **Member services staff are provided with incentives and quarterly bonuses for the recording of grievances.**

- **Mercy Health Plans has developed a mechanism to avoid corrected addresses from overwriting incorrect addresses during file transfer from the State. The rate of undeliverable mail to members has decreased from 35% to approximately 10% or less.**

- **Another method used to improve outreach to members is through obtaining member telephone numbers from the local school district (which was reported to be of modest value), and through the use of addresses and telephone contact information obtained by the transportation vendor, Medical Transportation Management (MTM).**

- **Mercy Health Plans has worked to improve member involvement and actively seeks member input and feedback. In March, 2003, a focus group was scheduled to obtain member input regarding how well Mercy Health Plan compares to other MCOs, the clarity of the materials, and the ease of enrollment.**

- **The provider directory is updated weekly on the web page, offering a search of providers by Mercy Health Plan product and region. There is a reported increase in the number of MC+ Managed Care Members accessing this web-based feature.**

Provider Network[1]

The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance indicates that as of December 31, 2001, Mercy Health Plans' (Mercy Health Plans) provider network adequacy was 98% overall, with the overall adequacy falling below threshold in two counties, St. Francois and Washington Counties.

- **The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance (MDI) indicates that as of December 31, 2001:**

  - **Jefferson and the Eastern Mercy Health Plan's network adequacy for PCPs, specialists, facilities, and ancillary service providers were above the 95.0% threshold in 2002, with an overall network adequacy rate of 98.0%.**

  - **There was an increase in facility adequacy, from 92.0% to 99.0% between 2001 and 2002.**

  - **There was an increase in basic hospital facilities, from 95.0% to 100.0%.**

  - **There was an increase in inpatient intensive treatment facilities for children/adolescents from 92.0% to 100.0%.**

  - **There was an increase in adult inpatient intensive treatment facilities for adults, from 87.0% to 97.0%.**

  - **There was an increase in outpatient child psychiatric facilities rates, from 86.0% to 99.0%.**

- m **There was an increase in outpatient adult psychiatric facilities rates, from 70.0 to 93.0%, approaching the 95.5% threshold.**

- m **There was an increase in geriatric outpatient facility rates, from 88.0 to 99.0% threshold**

- m **There was an increase in the rate of availability of pharmacies, from 95.0% to 100.0%**

- m **The rate of Child/Adolescent psychiatry specialists remained stable, from 77.0% to 76.0%, below the threshold of 95%.**

- m **Provider network adequacy for Mercy Health Plan for ancillary providers declined below threshold, from 98% to 94%.**

- m **There was a decrease in audiologist rates, from 100.0 to 95.0%.**

- **Expansion region (Lincoln, St. Francis, Ste. Genevieve, Warren, and Washington Counties) provider network has been more challenging to maintain than remaining counties. Mercy Health Plans has added Local Public Health Agencies (LPHAs) in St. Louis City, and in Jefferson, St. Louis, and Washington Counties. They also added the Washington County Hospital and physician network.**

- **The MCO requested that each dental provider "take a family". This was considered a modestly effective strategy for improving dental care networks, complicated by the dearth of dental care providers in the region.**

- **In 2003, Mercy Health Plan will focus on adding OB, ENT, orthopedic, and neurology specialists to its network. Also, a new information management system was implemented in January, 2003 to facilitate the auto-assignment of new MC+ Managed Care members to providers so as to better manage the panel size limits of providers. The new system is anticipated to be able to ensure that members are assigned to providers within the same county.**

- **The rate of provider turnover was approximately 6 – 7 %, associated with provider (especially specialty providers) dissatisfaction with the fee schedule. Many providers are closing their panels. Mercy Health Plans has increased the fee schedules somewhat, especially for administration of immunizations.**

- **Mercy Health Plans is moving toward a fee-for-service model for providers, with approximately 30 – 40% of providers being capitated.**

Provider Education, Training, and Performance

- **Provider offices are visited frequently, especially in the expansion region, which seems to have improved provider satisfaction.**

- **Mercy Health Plans identifies providers who are "Blue Ribbon" providers, and posts quality "report cards" on the Internet annually.**

- **Incentives are also distributed to provider groups based on overall performance, with the distribution to individual providers left to the clinic administration.**

Utilization/Medical Management

- **The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:**

- **The total penetration rate for behavioral health services was 4.6% in 2001.**

- **Outpatient visits increased from 1999 to 2001, from a rate of 177.0 to 205.0 per 1,000 in 2001.**

- **The rate of alternative services was 0 per 1,000 in 2001.**

- **Partial hospital admissions were 1.0 per 1,000, consistent with 1999 rates; and partial hospitalization days declined from 4.0 in 1999 to 2.5 per 1,000 in 2001.**

- **There were 0 residential days per 1,000 in 2001.**

- **Inpatient admissions declined from 12.0 per 1,000 in 1999 and 2000 to 9.3 admissions per 1,000 in 2001, while inpatient days declined from 58.0 to 48.6 days per 1,000 between 1999 and 2001.**

- **Inpatient substance abuse admissions increased from 7.0 per 1,000 in 1999 and 2000, to 2.1 per 1,000 in 2001. Inpatient substance abuse days per 1,000 increased from 5.0 to 6.2 per 1,000 between 1999 and 2001.**

- **The 30-day follow-up rate after hospitalization increased from 60.0% to 51.0% between 1999 and 2001. The 7-day follow-up rate remained stable at 21.0% in 1999 and 2001.**

- **Unity Managed Mental Health has instituted a pre-authorization procedure for Strattera, a highly popular non-stimulant medication for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).**

- **The MCO found that a large proportion of emergency department services are for otitis media and chest congestion.**

Quality

Quality Management

- **The Sisters of Mercy Health Care System emphasizes Three Pillars: People, Service, and Capital which permeates their philosophy of interacting within and outside the organization.**

Clinical Guidelines

- **Mercy Health Plan has adopted clinical practice guidelines for lead poisoning prevention, asthma, congestive heart failure, cardiovascular disease, diabetes, lead poisoning prevention and treatment, high risk pregnancy, and treatment after acute myocardial infarction.**

- **All clinical guidelines are reviewed and evaluated annually, with the exception of the StatusOne clinical guidelines for high risk, high cost members, which are reviewed quarterly.**

Performance Improvement Projects

Mercy Health Plan's response to the EQRO request for information regarding Performance Improvement activity and work plans cited information related to all HMO product lines of business in Missouri, including Commercial, Medicare and Medicaid MC+ Managed Care. Some activities were implemented statewide, with aggregate data for all lines of business. The responses that were specific to the MC+ Managed Care program were reviewed. There was very little discussion on presentation of initiatives to the Missouri Quality Improvement Committee (MQIC).

- **Analysis of the HEDIS combination- 2 results for Immunization Rates showed continued low compliance rates based on a comprehensive medical record review. Mercy staff members worked on developing methods to improve these rates with outreach to both members and providers. The MQIC directed the MCO to adopt a 90% compliance rate as its benchmark proxy measure for effective immunizations instead of the full immunization compliance rate due to the vaccine shortage. The MC+ Managed Care average rate for this measure over the previous two years was 63%, however it was recognized that accurate encounter data had been problematic and the MCO had implemented a program to address this issue. Mercy Health Plan staff was working with the Missouri Department of Health and Senior Services (DHSS) to achieve an acceptable exchange of immunization data to and from the MOHSAIC database system. Mercy was also collaborating with DHSS and local health clinics to encourage consistent billing practices, thereby allowing the MCO to capture more comprehensive encounter data. Physician profiling is planned to assist in improving encounter data and member outreach.**

- **Mercy initiated the EPSDT Quality Improvement Project in 2002 with the goal of increasing HCFA- 416 rates to 80% participation. The task force identified several interventions such as member outreach programs, identification of members in need of services, identification of providers not billing for EPSDT services, and performing medical record audits for comprehensive EPSDT documentation and billing practices. Using HEDIS results as the baseline measurement, Mercy Health Plan considered this as an on- going project, with the 2002- 2003 QI Work Plan reflecting necessary revisions.**

- **Mercy Health Plan identified children at risk for lead toxicity through the county and city Departments of Health and provided case management for those with lead levels of 15 µg/dL or greater. The MCO is closely monitoring the rates of exposure and to actively pursue data from the DHSS on members residing in the Doe Run / Herculaneum area. We encourage Mercy Health Plan to continue active involvement in the critical issue of lead exposure for residents of the Eastern Region as well as participation in community activities that can have a positive impact on reducing lead exposure.**

- **The Lead Case Management and measurement of efficacy of interventions for lead toxicity (e.g., lead toxicity ratio) is an excellent example of case finding and measurement of interventions through a lead ratio (initial lead level/current lead level) which allows for individual and aggregate measurement of progress.**

- **In partnership with provider home care agencies and Nurses for Newborns, Mercy Health Plan has an on- going prenatal case management program that identifies, assesses and provides interventions for pregnant women, especially those determined to be high risk. Baseline measurements were taken in 2000 and annually**

thereafter, showing the estimated gestational ages (EGA) of initiation of prenatal care and Case Management, EGA at delivery, birthweight, and Apgar scores. The amount of time to initiation of prenatal care and case management appear to be increasing. Mercy Health Plan interpreted this to mean that the length of time it takes women to qualify for coverage has increased.

- Mercy Health Plan and Unity Managed Mental Health (UMMH) have been involved in an on-going project since 2000 (MC+ Managed Care Pregnant Women's Study) to "increase the detection and treatment of mental health and substance abuse disorders among MC+ Managed Care eligible pregnant women". The goal of improving pregnancy outcomes and increased penetration to necessary medical and behavioral health services is under routine evaluation. The behavioral health vendor, Unity Managed Mental Health (UMMH), has conducted a quality study to assess the number of pregnant women who accessed mental health services, with approximately 13% of members obtaining authorization of services. Using claims data, the penetration rate was 6%. As a result, a screening process for pregnant members was implemented with four screening questions administered by the Mercy Health Plan case manager. In 2003, UMMH will examine quarterly penetration and utilization data to determine the efficacy of the intervention in identifying and treating depression in women.

- In February 2002, Mercy surveyed 344 PCPs to assess compliance with 24-hour availability. Twelve percent (12%) were found to be non-compliant and were required to implement an after-hours answering service.

- Another quality study initiated by UMMH in 2002 was to study the intervention of educating primary care providers through direct mail and newsletters regarding patient education, diagnosis, medication management, and referrals for therapy. This was based on findings that approximately 80% of prescriptions for antidepressant medications are being prescribed by internists who have prescribed apparent sub-therapeutic doses or higher than necessary doses. Medical record audits were conducted prior to and following dissemination of the guidelines.

- Outcomes are being assessed for disease management programs, examining hospitalization rates for those with asthma receiving case management (2002). Results indicated that those there were no differences in emergency room utilization for those in case management relative to those who were not in case management. In fact, emergency room utilization increased. However, hospitalization rates declined. Other outcomes to be examined in 2003 include functional status, with MCOs to correlate functional status with outcomes such as lead levels, body mass index, and Hbca1.

Cultural Competency

- Mercy Health Plan submitted a summary of translation services itemized by the number of requests per language/per month and the 2002 total. Bosnian was the most requested language, with Spanish the second.

- Interpreter resources and benefits are addressed in the Welcome Call checklist.

- The Member Handbook contains references to visual and hearing impaired (TDD line) resources, interpreter services, etc

- As part of the 2002 Performance Improvement Plan, Mercy Health Plan completed a "Cultural Competence Member/Provider Manual Upgrade". The Upgrade

incorporated re-education into the practitioner re-orientation program on processes to access interpreters; planning revision of member materials in languages common to the member population, including multi-module CD project of culturally-specific information for distribution to providers; and a QAPI Project for PremierPlus members relating to cultural/linguistically appropriate services projected for 2003.

- Special needs unique to the Texas membership (primarily Hispanic) were identified and incorporated into the UMMH Action Plan.

- Mercy Health Plan reported collaborating with local refugee/immigrant advocates on the development of an audio CD in four languages (English, Spanish Bosnian, Vietnamese).

Grievance Systems

- Grievances and appeals are maintained separately from member services files.

- The rate of member medical complaints increased from 2001 to 2002 (.78 per 1,000 members to 1.20 per 1,000 members). However, this rate was lower than the rate for all Eastern Region MCOs (1.61 per 1,000 members) and all MC+ Managed Care MCOs (1.49 per 1,000 members). Member medical complaints were primarily accounted for by complaints regarding denial of services (.64 per 1,000 members).

- The rates of member medical complaints regarding quality of care as well as complaints regarding appointments declined from 2001 to 2002.

- The rate of member non-medical complaints was 3.03 per 1,000 members in 2002, an increase from the rate in 2001 (2.73 per 1,000 members). This is lower than the Eastern Region rate of member non-medical complaints (8.36 per 1,000 members) as well as the rate for all MC+ Managed Care MCOs (6.41 per 1,000 members). Most of the member non-medical complaints were accounted for by "other" member non-medical complaints (1.16 per 1,000 members). There was a decrease between 2001 and 2002 in the rate of complaints regarding staff behavior, denial of claims, and waiting for appointments.

- The rate of provider medical complaints as reported by Mercy Health Plan remained at 0 for 2002, as in 2001. The rate of provider non-medical complaints was 4.79 per 1,000 members in 2002, a decrease from 6.36 per 1,000 members in 2001. This rate is lower than the Eastern Region rate (13.25 per 1,000 members) as well as the rate for all MC+ Managed Care MCOs (9.50 per 1,000 members). There was a decline in provider complaints regarding denial of claims between 2001 and 2002.

Case Management

- The MCO is moving toward a model of disease management, with case management as a component. Approximately 9 – 10% of the MC+ Managed Care population was receiving case management services through Mercy Health Plan and its vendors, StatusOne, and Unity Managed Mental Health Services.

- Mercy Health Plan defines case management as:

  "a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patient's/families with

> complex issues'; insuring and facilitation the achievement of quality, clinical, and cost outcomes' intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance health outcomes".[3]

- Routine aspects of Mercy Health Plans case management program include the use of clinical practice guidelines, provider and patient profiling, specialized physician and other practitioner care targeted to meet members special needs, provider education, patient education, claims analyses, and quarterly and yearly outcome measurement and reporting.

- Mercy Health Plans works with Status One, a company that profiles and identifies high cost, high risk cases for case management.

- Mercy Health Plans recently hired a social worker to participate in case management, who will facilitate discharge planning on the utilization management team, expand connections with community resources, and conduct case management for cases with fewer acute physical concerns and numerous psychosocial issues. The MCO would like to add Occupational, Physical, and Recreational Therapists to the utilization staff as well.

- Mercy Health Plans has opened more lead case management cases in the first half of 2002 (n = 35) than in the full year of 2001 (n = 16), indicating better testing and identification of children. This was attributed to targeting the Doe Run area and working closely with the Department of Health and Senior Services.

- All children with special health care needs (CSHCN) are screened from the list provided by the State for identification of need for medical case management. Mercy Health Plans examines claims and medications to assess utilization of services.

- To identify those in need of lead case management, Mercy Health Plan uses the baseline health risk assessment obtained at the time of enrollment, home health utilization, and state laboratory results. The MCO has employed a ratio comparing lead test results over time to assess the outcomes of lead case management in reducing lead toxicity.

- There are 2.5 FTE case managers, each focusing on different areas: pediatrics, lead toxicity, neonatal intensive care, emergency room, cardiology, hi-risk pregnancy, transplants, psychiatry, obesity, and alcohol/substance abuse.

Interagency Coordination

- The Chief Medical Officer of Mercy Health Plan is involved with the Diabetes Coalition.

- The Chief Medical Officer serves as Vice Chairperson of the Missouri Partnership for Smoking on Health, providing local physicians with materials on community–based smoking cessation programs.

- Mercy Health Plan continues its community support with active participation in several other Eastern Region projects, such as the St. Louis Lead Prevention Coalition, the Maternal, Child, Family Health Coalition, and sponsorship of an annual domestic violence conference. Mercy Health Plan is also involved with numerous community and health fairs and in August 2002 the MCO collaborated with the St.

Louis City Department of Health in a block party for a high disparity region of St. Louis (zip code 63118). Several other community agencies and the St. Louis City DOH Lead van participated and the party provided opportunities to educate the public regarding health and wellness issues such as lead screening, EPSDT evaluation, immunizations and prenatal care.

Mercy Health Plan

2002 External Quality Review Summary

Conducted on Thursday, March 13, 2003

The results of the on-site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for Mercy Health Plans in providing care to MC+ Managed Care Members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

∨ **Mercy Health Plan improved claims processing through identification of edits and rejected records.**

∨ **Vendor oversight is thorough and provides accountability. This was noted in Mercy Health Plan's audit procedures for credentialing and re-credentialing of providers and delegated providers; their audit of records for behavioral health and dental vendors; regular meetings with MTM, UMMH, Doral; the Project list for Advance PCS; the detailed format for corrective action plans with vendors; specific performance indicators for non-delegated re-credentialing evaluation of providers; and the formal auditing of behavioral health organizations' operations and structures in accordance with NCQA Quality Improvement Standards for clinical care programs, disease management programs, data and information and management, provider network adequacy, quality improvement committees, and performance improvement projects. The delegated Oversight Audit Tool is a Promising Practice for monitoring vendor performance and ensuring accountability.**

∨ **Mercy Health Plan added 10,600 new members due to close-out of another MCO. Member services has improved, with access to a web-based provider directory; a new member welcome call checklist; reduction in the rate of return mail (with a 15% return rate of mail); the use of St. Louis City Schools and MTM to obtain updated member addresses; and the addition of a Bosnian staff member. There was a decline in member complaints regarding the quality of care, the ability to obtain an appointment, staff behavior and denial of service, indicating improved access to healthcare between 2001 and 2002. There was also a decline in the rate of member complaints regarding denial of claims and waiting during an appointment, with a stable rate of transportation complaints. The Utilization Management Department collaborated with the pharmacy vendor to monitor fraud/abuse, with action steps for member for lock-in.**

∨ There was an improved and stable provider network in the areas of pharmacy, geriatric outpatient facilities, outpatient adult psychiatric facilities, outpatient child psychiatric facilities, adult inpatient intensive treatment facilities, inpatient intensive treatment facilities for children/adolescents, basic hospital facilities, and overall facility adequacy. Mercy Health Plan also added local public health clinics in rural areas, is working with FQHCs to provide school-based services, and has developed a relationship with St. Johns to develop child psychiatry access.

∨ Improvements in provider relations include more face-to-face interactions with providers, auto-assignment of members to providers with consideration for panel size, moving from a capitated to a fee-for-service model of payment for better capture of claims, reduced referrals for in-network specialists, and increased (85%) electronic claims submissions for providers. Mercy Health Plan has also developed a "Blue Ribbon Physician's Network recognizing and rewarding physicians for well member care. There were negligible provider medical complaints during 2002, with a decline in overall provider non-medical complaints between 2001 and 2002.

∨ In the area of quality management and improvement, Mercy Health Plan has improved EPSDT data collection and claims processing partly by using a fee-for-service payment; developed a method of measurement of outcomes for lead case management interventions to examine effectiveness of the program as a whole as well as on individual treatment outcomes; and studied the effectiveness of case management on utilization for asthma hospitalization. The quality improvement study designs were well developed, implemented, and applied in decision-making regarding the delivery of care. Mercy Health Plan is also on the leading of edge of examining functional outcomes especially as they relate to health outcomes.

∨ Mercy Health Plans model of case management is oriented toward a psychosocial perspective, with the recent addition of a social worker to the staff to facilitate discharge planning, expand connections to community resources and conduct case management. The case management model is considered a part of an overall disease management program that articulates roles and responsibilities, education protocols, and care plans. Case management records, treatment plans, and progress notes were well incorporated and easy to follow.

∨ For Cultural Competency, the cultural competency program was appropriately integrated into the Performance Improvement Plan. Mercy Health Plan appears to be using quantitative measurements to identify the target population and conduct needs assessments. The Action Plan submitted by UMMH is a comprehensive and coordinated plan for health care delivery to a specific cultural group, and includes a disease management link to ethnicity. Also, marketing and member services marketing tools were developed for specific groups to increase access to healthcare services. In the future, Mercy Health Plan plans to reduce literacy and access barriers with a linguistically and culturally sensitive product line. Staff have developed patient education materials for healthy living and domestic violence in a number of different languages.

∨ Between 2000 and 2001, there was increased access to ambulatory visits for behavioral health services, indicating a more preventive orientation in the least restrictive setting.

∨ **Mercy Health Plan established a monthly meeting with St. Louis City and County DFS office staff to facilitate care for children in state custody. Mercy's community involvement is clearly evident and well documented; the MCO should be proud of its community support and continue with this valuable interest in improving the health of Eastern Region MC+ Managed Care eligible members. The organization also follows a model of integrating employees, providers and members, called the Pillars of Care, and actively seeks input from all regarding their satisfaction and needs.**

Opportunities for Improvement

Ù **It is not clear what level of case-by-case interagency coordination is being conducted for behavioral health. The case management model appears to be primarily utilization review. We would encourage more documentation of care management. Given the excellent model of case management documentation found for Mercy Health Plan case management, it is recommended that this same format be considered for behavioral healthcare.**

Ù **It is recommended that Mercy reassess its progress on the immunization initiative to determine effectiveness of their efforts in improving immunization rates of 0-2 year old members. Follow-up analysis of targeted local health clinics' billing practices could be considered an efficient short-term study to determine improved compliance. Comparison of baseline billing rates to post-education rates could be easily measured by reviewing claims data.**

Ù **It is suggested that Mercy Health Plan continue with their EPSDT QI initiative, document routine analysis of ratios reported on the HCFA-416 report, and provide summaries to the MQIC for its recommendations and comments.**

Ù **We encourage Mercy Health Plan to continue active involvement in the critical issue of lead exposure for residents of the Eastern Region as well as participation in community activities that can have a positive impact on reducing lead exposure.**

Ù **Mercy is encouraged to follow-up with providers regarding contract compliance with regard to 24-hour availability and present summaries of these issues to Quality Management.**

Ù **Most information was generalized to all product lines. Mercy does have an excellent tracking tool for monitoring Performance Indicators and they are encouraged to separate results by region and/or product line to determine areas that may need focused attention.**

Ù **Mercy Health Plans has identified patient functional status as an outcome for some of their quality improvement initiatives. This is an excellent outcome measure and we would encourage the use of this type of measure.**

Ù **Other MCOs report positive results from adding ancillary service professionals (e.g., physical or occupational therapists) to facilitate utilization management and case management. Mercy Health Plan seems to understand this value, and we would encourage this as a method for improving care.**

Ü   **There was an increase in provider denial of claim complaints, member denial of services complaints, and other non- medical complaints from 2001 to 2002.**

Ü   **Efforts at improving provider network adequacy for child/adolescent psychiatry providers and ancillary providers (especially audiologists) should continue.**

Ü   **It is recommended that Mercy Health Plan and units examine the decreased penetration rate for all age groups, decreased ambulatory follow- up at 7- and 30- days post- discharge, and decreased partial hospitalization admissions and days for behavioral health services between 2000 and 2001. This may be related to some of the reported increases in inpatient psychiatric utilization in 2002.**

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003

[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group, 2003

[3] This definition was provided in the RFP B3Z02226 for MC+ Managed Care, with permission of the Center for Case Management, 6 Pleasant Street, South Natick, MA, 01760

2002

Missouri MC+ Managed Care Program

External Quality Review

Healthcare USA

AUTHORS:
Janet Reed, PhD, MHA
Vice President, BHC, Inc.,
Director, Performance Management Solutions Group

Jutta Hopkins, PhD, RN
Health Services Researcher
Performance Management Solutions Group

William Chase, MPPA, MSCIS
Senior Research Analyst, Data Manager
Performance Management Solutions Group

Site Visit Date   **Tuesday, March 11, 2003**

Subcontractors

Behavioral Health: **MHNet**

Dental: **US Dental (Eastern), Bridgeport Dental (Western), US Dental (Central)**

Transportation: **MTM**

Compliance with Standards and Operations

Enrollee Rights and Protections

- **HealthCare USA has trained all staff for HIPAA implementation and is prepared to send privacy notices in new member packets as soon as they are approved by the State and the Coventry Health Care corporation legal department.**

- **HealthCare USA uses a Customer Service Console (CSC) for orienting new members and responding to member inquiries or grievances. The CSC protocol has been updated to be compliant with HIPAA privacy policies. HealthCare USA uses the members confidential Medicaid number as the member password for telephone communications with members.**

- **Suspected fraud and abuse is referred to the compliance officer. Additional fraud and abuse training of staff is pending final review of the method for examining claims by Coventry Health Care. This was to be submitted to the State within two weeks following the site visit.**

- **The Fraud and Abuse plan was approved by DMS. All staff was trained in December 2001. The 2002 training was delayed due to changes at the Coventry Corporate level. Training will be completed when editing of educational material is finalized.**

- **There is a corporate code of ethics in place, as well as a corporate compliance hotline through which staff may anonymously report concerns regarding suspected member or provider fraud or abuse.**

Claims Processing

- **Large physician groups are familiar with electronic billing, as they file claims electronically with commercial insurance companies. Fifty percent of claims are passed through the system without problems. There has been no major increase in filing electronically. The focus is on the use of the web by physicians in the Central Region.**

- **HealthCare USA employs WebMD, an on- line system for providers in the Eastern Region and MCOs to use this for the Western and Central Regions as a gateway for electronic claims processing. HealthCare USA has contracted with a billing vendor to increase filing of electronic claims. Management staff report fewer lost claims as a result. Payments are deposited directly into provider accounts twice weekly, with weekly remittances regarding paid, denied, and pending claims sent to providers.**

The filing of electronic claims allows for ready identification of providers who may require education and assistance with claims submissions and provides timely feedback regarding the status of claims submission.

- **HealthCare USA maintains a warm-line for technical assistance to provider offices for claims processing.**

- **Approximately 57% of claims are auto-adjudicated.**

- **MHNet, the behavioral health vendor, reported the rate of paid claims as 99.5% within 3 days and 100% within 5 days. Feedback and education on the most common errors is provided in quarterly newsletters.**

- **The rapid turnaround in claims and payment appear to have led to increased provider satisfaction, consistent with the low provider turnover rate.**

- **Providers are least satisfied with the variation between Medicaid local codes and commercial codes.**

Credentialing and Re-credentialing

- **Providers in the Central Region are primarily independent, while those in the Eastern Region have more delegated credentialing. Those in the Western Region have mixed credentialing.**

- **Larger provider groups have delegated credentialing, with HealthCare USA conducting annual audits of policies and procedures and medical record reviews conducted in accordance with NCQA standards.**

- **For independent providers, credentialing and re-credentialing follow standard NCQA criteria for medical record reviews. HealthCare USA also reviews grievance data and malpractice claims; and conducts site visits.**

Vendor Oversight

- **HealthCare USA meets regularly with behavioral health, dental and transportation vendors for oversight.**

- **One method of oversight of providers for the completion of well-child care that has been implemented by HealthCare USA is the review of medical records. For those claims where medical record documentation does not support the claim for a full EPSDT exam, providers are required to refund the 25% additional reimbursement they are provided for full EPSDT examinations. Provider education regarding claim submission is also conducted based on this information.**

- **HealthCare USA is requiring vendors to comply with all contract requirements of the state, modeling subcontracts after their contract with the State. They conduct audits by reviewing policies and conducting vendor education. A grid containing contract "musts" and "shalls" was developed for this purpose. Providers respond to the grid and the Quality Management Committee (QMC) reviews responses to determine if all requirements are met.**

- **MHNet, the behavioral health vendor for HealthCare USA maintains an office in the Eastern Region, where all administrative staff is located.**

Access

Member Services

- **Provider directories are reviewed and updated regularly. They are mailed out annually. Member newsletters are mailed quarterly to update members on network changes. The provider directory is also available from the HealthCare USA website. HealthCare USA recorded 700 hits in the first month of operation.**

- **HealthCare USA has implemented a new web page (chchcusa.com) with a search feature/function and monthly updates of the provider network.**

- **Four additional member services staff have been added to accommodate the influx of new members in the Eastern Region due to one MCO exit. There are currently 3 Spanish speaking member services representatives, and one Bosnian member services representative. Bosnian-speaking member services representatives are most in need in the Eastern Region, while Spanish-speaking member services representatives are in the greatest demand in the Central Region.**

- **A full-time member services representative trainer was hired in 2002. Customer representatives receive initial training with periodic follow-up. Three weeks of training is provided for all new staff. Senior staff observes new staff to assist with concerns and questions, and provide consultation with issues that could be either complaints or suspected fraud or abuse.**

- **HealthCare USA is not certain of the rate of receipt of completed baseline health screening forms that are transferred from the enrollment vendor (First Health) on the eligibility file. They call all members who have not been enrolled in the MCO in the last 90 days, as many members may have simply changed eligibility categories.**

- **HealthCare USA maintains a shadow address file in their system so that when administrative files from the State are transferred, former addresses do not overwrite current addresses obtained by member services representatives through their contact with members. As a result of verifying member addresses at the time they call HealthCare USA and validating member addresses against any medical records that are reviewed, HealthCare USA has reduced its rate of returned mail from 30% to 16%, resulting in more members receiving necessary information for their healthcare.**

- **One change that HealthCare USA has implemented to improve member services is to add two physicians as member advocates who work closely with the member as well as community-based advocates to access services. They report compliments from the local Ombudsman office regarding this change, and MCO to add one more member advocate. Results of the child CAHPS survey used by HealthCare USA indicate relatively high satisfaction in 2002.**

- **HealthCare USA developed and revised several new member orientation and outreach procedures that have been in place since 2000. Protocols include the identification and outreach for 1) members that present to the emergency room, 2) pregnant members, and 3) members with lead levels > 10 μg/dL which are to be followed by the Outreach Coordinator for the Health Education Initiatives Program. The goal of the program is to identify members who may have needs relating to having a high risk pregnancies, asthma, emergency room utilization, pregnancy, being a new member,**

having special needs, noncompliance, and preventive care services. The flow charts which illustrate procedures detail the reason for point of entry (e.g., identification by State files based on lead screening or assignment to the MCO).

- At the new member welcome call, information regarding primary care provider selection, the identification card, the welcome packet, well child services, and other MCO services (member services, nurse hotline, transportation, and mental health) are reviewed with the member.

- HealthCare USA has found on the Consumer Assessment of Health Plans Survey (CAHPS) that members are able to access services.

Provider Network[1]

- The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance indicates that as of December 31, 2001, HealthCare USA achieved overall scores greater than 95.0% in the Central and Eastern Regions. Exceptions were granted for:

  m Central Region: Tertiary hospitals for Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Howard, Miller, Moniteau, Monroe, Morgan, Osage, Pettis, Randolph, and Saline.

  m Eastern Region: Home Health for Franklin, Lincoln, and Warren Counties.

  m Eastern Region: Hospice for Franklin, Lincoln, Ste. Charles, St. Francois, Ste. Genevieve, Warren, and Washington Counties.

- There was 100.0% network adequacy for PCPs, specialists, and ancillary service providers in the Central and Eastern Regions, with nearly all types of specialist, facility, and ancillary provider rates above the 95.0% threshold.

- The Outpatient Adult Psychiatric facility rate in the Eastern Region increased from 91.0% to 99.0%, above threshold.

- The Western Region Access Plan is being filed by HealthCare USA by March 30, 2003, for approximately 7,125 members. HealthCare USA indicated that they are working to identify additional ancillary providers through St. Luke's Hospital to serve the Western Region members. HealthCare USA had previously been licensed to operate in the Western counties in 1996, filing with the Department of Insurance in 2001.

- There has been little provider turnover over the past year, excluding turnover resulting from providers changing practice locations. One concern for the provider network that arose during the year was the possible closing of the Washington University Provider Network (WUPN), consisting of over 800 providers. At the time of the site visit, this provider remained in business and in the provider network.

- HealthCare USA maintains provider representatives in Jefferson City and Columbia for the Central Region providers; in the Western Region; and in the Eastern Region. There are eight representatives in the Eastern Region, four in the Central Region, and one in the Western Region. Providers have given positive feedback about the timely responsiveness of provider representatives, which also seems to have led to increased provider satisfaction. Representatives regularly visit hospitals and private providers.

- **Additional staff have been added to accommodate the approximately 47,000 of the 53,000 or more members that were transitioned from a MCO exiting the Eastern Region in 2002.**

- **HealthCare USA has observed provider movement from group-to-group in the Eastern Region.**

- **HealthCare USA is currently working on rate negotiations with University Hospitals in the Central Region. There is a focus on recruiting OB/GYN providers and providers in the Central Region.**

- **A number of physicians that have relationships with institutions other than Children's Mercy Hospital (Western Region) are interested in joining the network.**

- **HealthCare USA has noted an increasing trend toward providers and hospitals shifting costs to MCOs. Hospitals want proportion of billed charges OR Medicare rates and rate increases. The MCO has had to make choices with hospitals related to pricing.**

- **For behavioral health specialists, MHNet identifies gaps in the network and takes recommendations from DFS and PCPs for additional behavioral health providers, following up with recruitment efforts.**

- **HealthCare USA has instituted a Quality Award for one provider each year, awarded to People's Health Center in 2002. People's Health Center has extended their hours of operation in an effort to increase access to preventive care.**

- **Although HealthCare USA does not use a provider profiling mechanism publicly, they do maintain and monitor records of provider performance and refer members to those providers that perform best on indicators of quality.**

Provider Education, Training, and Performance

- **In 2002, HealthCare USA targeted high-volume providers in the Eastern and Central Regions for EPSDT compliance. Providers were educated on forms and documentation. HealthCare USA reviewed claims and audited records for use of the form. If providers did not meet compliance requirements, they were placed on review and re-audited. Several providers were required to rebate funds to HealthCare USA for not meeting criteria. HealthCare USA MCOs to expand this profiling practice. Providers achieving compliance were given the Quality Award for recognition.**

- **MHNet publishes a newsletter to behavioral health specialty providers with reports of annual performance evaluation programs assessing service accessibility, clinical guideline measurement, results of member satisfaction surveys, and review of specific elements of documentation in medical records.**

- **HealthCare USA has instituted a Physician Grand Rounds for providers and their offices, for which they provide Continuing Medical Education (CME) units and during which they provide brief highlights of each department at the MCO.**

- **PCP forums are also held with presentations conducted by psychiatrists.**

- **MHNet participates with HealthCare USA in the education of providers with their provider representatives active in provider education. Staff reported that it continues to be a challenge to get providers directly involved in such activities, but that they**

will continue provider education forums in the outlying Eastern Region Counties to be more accessible.

- MHNet regularly reports on the elements reviewed in provider records as well as provider performance indicators. Provider performance on their prescribing patterns is measured, with feedback and educational materials given to higher- prescribing providers regarding best practices (e.g., stimulants), therapeutic/behavioral interventions, and formulary decisions.

- In 2003, MHNet will be working with county health departments to provide behavioral health services on- site.

- In the Western Region, MHNet is participating in an initiative to educate primary care providers about questions to use for the diagnosis of depression. Clinical guidelines are included in the Provider Administration Manual for the treatment of Bipolar Disorder, Schizophrenia, Major Depression, and alcohol/substance abuse disorders. Provider report cards are distributed, with information on members receiving medication and therapy.

- MHNet has identified "champions", providers who have been determined to follow clinical guidelines (approximately 50 psychiatrists and 50 allied health providers). Such providers automatically obtain approval for 11 sessions of treatment, with no paperwork necessary (aside from the risk assessment, impairment index, and suicidality assessment).

Utilization/Medical Management

- Inpatient utilization as well as emergency room utilization for behavioral health services has increased over the past year. This is attributed to increased severity of illness, involuntary commitments, and caution with EMTALA laws and prudent layperson criteria for emergency room utilization.

- Overall claims for behavioral health services have increased significantly since September 2001. The increase of kept appointments from 30% to over 60% is attributed to increased levels of general distress (possibly related to world events and US economy), preventive education, outreach, post- discharge follow- up, and provider education.

- The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:

Central Region.

- The total penetration rate for behavioral health services was 9.6% in 2001, slightly higher than the average rate for all MC+ Managed Care MCOs.

- Outpatient visits have steadily increased over the past three years, with the rate per 1,000 of 525.6 in 2001.

- The rate of alternative services has also increased, from 2.7 per 1,000 in 1999 to 14.9 per 1,000 in 2001.

- Partial hospital admissions per 1,000 decreased to .4 per 1,000; and partial hospitalization days declined to 1.3 per 1,000 in 2001.

- There were 0.0 residential days per 1,000 in 2001.

- **Inpatient admissions increased from 6.6 to 9.0 per 1,000 between 1999 and 2001, while inpatient days per 1,000 increased from 27.0 to 52.6 per 1,000 in the same time period.**

- **Inpatient substance abuse admissions increased from .6 to 1.7 per 1,000 between 1999 and 2001, while inpatient substance abuse days per 1,000 increased from 6.6 to 9.0 in the same time period.**

Eastern Region.

- **The total penetration rate for behavioral health services was 5.7% in 2001, consistent with the average rates for all MC+ Managed Care MCOs.**

- **Outpatient visits have steadily increased over the past three years, with the rate per 1,000 of 286.1 in 2001.**

- **The rate of alternative services has also increased, from 5.5 per 1,000 in 1999 to 33.3 per 1,000 in 2001.**

- **Partial hospital admissions per 1,000 increased to 1.0 per 1,000; and partial hospitalization days declined to 2.5 per 1,000 in 2001.**

- **There were no residential days per reported in 2001.**

- **Inpatient admissions increased from 4.4 to 8.4 per 1,000 between 1999 and 2001 while inpatient days increased from 19.5 to 40.6 per 1,000 in the same time period.**

- **Inpatient substance abuse admissions increased from 1.0 to 1.9 per 1,000 between 1999 and 2001 while inpatient substance abuse days increased from 3.0 to 7.6 per 1,000 in the same time period.**

- **The 30-day follow-up rate after hospitalization increased from 40.3% to 50.0% between 1999 and 2001. The rate in the Central Region for the same time period increased from 41.0% to 54.3%. The 7-day follow-up rate increased from 21.0% to 25.1% between 1999 and 2001 in the Eastern Region; and from 18.0% to 26.7% for the Central Region.**

- **MHNet management reports that the increased claims and timely payments have improved provider willingness to see patients more rapidly. The rate of members being seen within 5 days of referral in 2002 was 99.5%, with 100% being seen within 30 days. This has been due to a six sigma initiative that has been implemented at MHNet. In 2002, the goal of obtaining a psychiatric consultation in 24 hours was met.**

- **MHNet has moved toward care coordination (with family services, alcohol and substance abuse treatment program referrals, and with court systems) and a disease management approach (using intensive targeted case management for those with serious emotional disturbance and severe/persistent mental illness).**

- **There is good communication between MHNet and HealthCare USA Case Managers, e.g., HealthCare USA advises MHNet members with substance abuse and MHNet informs HealthCare USA of pregnant members.**

- **MHNet identified an initiative for 2003 to increase follow-up. They have sent letters to all administrative agents to allow contact while a member is hospitalized.**

- **HealthCare USA has implemented utilization management review of Durable Medical Equipment (DME) needs and high cost cases to consider the long-term costs and needs of members through the review of cases by an Occupational Therapist.**

- **For disease management, HealthCare USA has begun to examine semi-annual reports of the "Top Five" diagnoses.**

- **There was a 2.8% rate of claims denied during 2002. The primary reason for denial of claims was due to lack of medical necessity, followed by timely notification and lack of medical information.**

Quality

Quality Management

- **The Medical Director of MHNet participates on the Quality Management Committee, chaired by the HealthCare USA Medical Director.**

- **Representatives from all HealthCare USA Departments and providers from all three regions sit on the QMC, including a practicing psychiatrist. HealthCare USA has three quality improvement coordinators, all RNs, with one FTE Information services staff and one health educator.**

- **HealthCare USA manages quality primarily through medical record reviews. Staff has found that providers continue to require education regarding EPSDT and Lead Risk Assessment forms and processes.**

- **HealthCare USA found physicians are still unaware of lead risk. There was also a lack of understanding on how to fill out EPSDT forms and confusion regarding how much to complete on the examination.**

- **They use MOHSAIC for immunization information, but are not able to utilize it well. They contract with LPHAs and are able to add findings from EPSDT reviews to supplement immunization information.**

- **HealthCare USA monitors claims for members whom are due immunizations and when there is no record of an immunization claim, the MCO performs outreach to members.**

- **HealthCare USA has dealt with the inconsistencies in AAP and (state) Medicaid requirements for the well-child examination of six-year olds by identifying their members as in need of examinations at six years of age due to their higher levels of risk for healthcare problems associated with socioeconomic circumstances. Providers are educated annually to see children at-risk.**

- **HealthCare USA has examined closely the analysis of HCFA-416 databases, identifying inconsistencies in the State and the American Association of Pediatrician recommendations for an annual well-child examination of 6 year olds. They have identified needs for outreach for six-year olds as well as 14-20 year olds (especially males).**

- **HealthCare USA has taken an assertive stance with providers about the need to use the mandatory EPSDT forms to document the provision of well-child care for members, and are instituting penalties (such as closing panels) to providers who consistently do not use these forms.**

- In conducting a focused study on children born with low- or very low birthweight (LBW, VLBW), HealthCare USA found that the home health agencies with which they contracted were using different forms for identifying high risk pregnancies, making quality comparisons and a focused study difficult to conduct. This has led to the identification of one home health agency that excelled in identifying members with high risk pregnancies through telephone administration of the State pregnancy risk assessment. The home health agency was able to contact approximately 65% of pregnant members.

- In addition to addressing the ability of providers to meet member needs, HealthCare USA has also taken steps to improve member adherence to treatment and prevention services. This includes following up with members who have missed dental appointments, and sending list of names of members who have not had blood lead levels documented to the State.

Clinical Guidelines

- HealthCare USA uses InterQual criteria as their clinical guidelines. These are reviewed annually by the Quality Management Council (QMC) for revisions. During weekly medical management meetings, procedures for automatic approval and prior authorization are reviewed.

Performance Improvement Projects

- A Quality Improvement (QI) Focus Study on ADHD was initiated in the Spring of 2002 with the goals of ensuring members taking ADHD pharmaceutical agents are receiving appropriate assessments, care and follow- up according to AAP guidelines; decreasing the use of these agents; and developing a best practice approach to the treatment of ADHD. HealthCare USA's process for this project included weekly meetings with their mental health subcontractor; review of pharmacy utilization data; assessment of the community; education of providers by HealthCare USA and MHNet staff; and distribution of AAP's ADHD clinical practice guidelines to providers. A report entitled "ADHD Provider Study of Practice Patterns 2002" was presented to the QMC at their December 2002 meeting. Future MCOs for evaluation of the effectiveness of this project are not finalized but according to the QMC presentation, it may occur in the "next couple of years, but not in 2003".[3]

- From March 2001 to October 2002, HealthCare USA performed more than 3,400 EPSDT reviews. Results of these audits were discussed by the HealthCare USA EPSDT Committee to determine if further interventions were needed, including peer- to- peer education or closing a provider's panel. The project showed that providers continue to need education regarding completion of the state- required EPSDT form and the components of an exam.

- The Herculaneum Lead Project involved reviewing PCP records and the STELLAR database for completion of lead tests for pregnant members and those less than 21 years of age. Case management was verified for members with levels greater than 15 μg/dL plus PCPs of members less than 6 years old without lead test results were notified of the need for the service. They have accomplished this through sending lists of 2 years olds due for immunizations to providers as well as conducting their own outreach to notify parents to get their children immunized. The date of completion of this project was May 2002. Given the importance of this issue, it is suggested that the Lead Project be an ongoing project with measured compliance

rates to show effectiveness of the program. Continued provider education regarding lead exposure, screening and testing was identified as an area for improvement. The project has significant potential for members residing in the Herculaneum/Doe Run area and we recommend HealthCare USA continue their efforts with this initiative. Lessons learned from the Herculaneum Lead Project may be carried forth through all regions of the state if they can be identified as a best practice.

- The Immunization Accessibility Focus Study was completed in December 2002. HealthCare USA determined through medical record review, claims data and MOHSAIC that the baseline immunization rate of two year olds was 90.41%. Because the overall rate was greater than 90%, the state required minimum threshold, the decision was made that no initiative was to be implemented. It is suggested that HealthCare USA continue with monitoring of the immunization status of its 0- 2 year old members and provide ongoing education efforts to members and providers.

- In June 2002, HealthCare USA collaborated with three other MC+ Managed Care MCOs to train providers and their staff regarding the Smoking Cessation During Pregnancy. This is an excellent example of a collaborative project among MCOs. HealthCare USA planned to host a training class in the Central Region; however there was no discussion as to whether this was performed. We suggest that the MCO follow- up with the attendees to reinforce their educational efforts.

- For 2003, one focused study will examine NICU admissions as a sentinel event as well as increased C- Section rates.

Cultural Competency

- HealthCare USA has identified high- volume providers for targeting members with various backgrounds to provide culturally appropriate materials (e.g., coloring books for lead education of Bosnian- speaking members) at provider offices.

- A cultural competency program has been incorporated into daily operations, resulting in more collaboration among departments and more awareness for diversity.

- The telephone system now offers a prompt at the onset of the telephone call to allow a member to choose among several languages (English, Spanish, Bosnian).

- During 2002, there were a total of 1,094 requests for interpreter services through Interlingua Medical Interpretation, the vendor for interpreter services. The most frequent requests were for Bosnian (45%), Vietnamese (18%), and Dar/Farsi/Persian (10%).

- HealthCare USA published a Bosnian translation of the lead risk handbook.

- HealthCare USA employed additional Bosnian and Spanish speaking staff for case management & operations staff.

- The 2003 Workplan includes proposal to reduce racial & ethnic health care disparities & improve health.

Grievance Systems

Central Region.

- **The rate of member medical complaints per 1,000 members declined from 2001‑2002 (2.19 per 1,000 members to 1.27 per 1,000 members, respectively). The rate of medical member complaints per 1,000 members in 2002 was slightly lower than the rate for Central Region MCOs and all MC+ Managed Care MCOs, (1.39 per 1,000 members for Central Region MCOs, and 1.49 per 1,000 members for all MC+ Managed Care MCOs). The rate of "other" Member medical complaints declined the most between 2000 and 2001 (from .37 per 1,000 to .07 per 1,000 members). The rate of complaints regarding appointments remained stable from 2001 to 2002 (.40 per 1,000 members for 2001 and 2002). Member medical complaints regarding the denial of services accounted for the greatest proportion of medical complaints in 2002 (.53 per 1,000 members) followed by complaints regarding getting appointments (.40 per 1,000 members).**

- **The rate of member non‑medical complaints in 2002 was relatively consistent with the rate in 2001 (2.21 per 1,000 members in 2002, and 2.26 per 1,000 members in 2001). Non‑medical complaints in 2002 for HealthCare USA, Central Region were higher than the other Central Region MCOs (1.96 per 1,000 members), but lower than all MC+ Managed Care MCOs combined (6.41 per 1,000 members). Complaints regarding denial of claims remained stable between 2001 and 2002 (.03 per 1,000 members for each year). Like all other MCOs, the rate of complaints regarding transportation services accounted for the greatest proportion of member non‑medical complaints (1.30 per 1,000 members) in 2002. Member non‑medical complaints regarding staff behavior increased somewhat between 2001 and 2002 (.20 per 1,000 members and .33 per 1,000 members, respectively).**

- **The rate of provider medical complaints for HealthCare USA in the Central Region was .33 per 1,000 members, a decline from 1.52 per 1,000 members in 2002. The rate of provider medical complaints in the Central Region for HealthCare USA was higher than other Central Region MC+ Managed Care MCOs (.17 per 1,000 members), and was comparable to the rate for all MC+ Managed Care MCOs (.29 per 1,000 members). Complaints regarding denial of services accounted for the greatest proportion of provider medical complaints in 2002 (.23 per 1,000 members), although this represents a decline from 2001 (1.18 per 1,000 members). The rate of provider non‑medical complaints for HealthCare USA in the Central Region was 17.25 per 1,000 members in 2002, a decline from 23.01 complaints per 1,000 members in 2001. The rate of complaints for denial of claims was the highest, at 15.28 per 1,000 members. The rate of 17.25 per 1,000 members for provider non‑medical complaints was higher than all Central Region MCOs (8.60 per 1,000 members) and all MC+ Managed Care MCOs (9.50 per 1,000 members).**

Eastern Region.

- **The rate of member medical complaints per 1,000 members in 2002 was 1.87, an increase from 1.66 per 1,000 members in 2001. This is slightly higher than the Eastern Region rate of member medical complaints (1.61 per 1,000 members) as well as the rate for all MC+ Managed Care MCOs (1.49 per 1,000 members). Denial of services accounted for the greatest proportion of member medical complaints in**

2002, at .86 per 1,000 members. Rates of quality of care and "other" member medical complaints declined between 2001 and 2002 in the Eastern Region for HealthCare USA. Complaints regarding appointments increased from .16 to .37 per 1,000 members between 2001 and 2002, and the rate of complaints for denial of services increased from .62 to .86 per 1,000 members from 2001 to 2002.

- The rate of member non-medical complaints in 2002 increased from 2001 (9.70 per 1,000 members in 2002 and 5.78 per 1,000 members in 2001, respectively). This rate is slightly higher than the rate for all Eastern Region MCOs (8.36 per 1,000 members) and all MC+ Managed Care MCOs (6.41 per 1,000 members). The rate of complaints regarding transportation services was 9.96 per 1,000 members in 2002, an increase from 4.32 per 1,000 members in 2001. The rate of denial of claims declined greatly from 2001 to 2002 (.20 per 1,000 members in 2001 and .05 per 1,000 members in 2002), as did complaints regarding waiting time for an appointment (.07 per 1,000 members to .01 per 1,000 members in 2002). Member non-medical complaints regarding staff behavior remained stable from 2001 to 2002 (.19 per 1,000 members in each year).

- The rate of provider medical complaints per 1,000 members in 2002 was .54 per 1,000 members, similar to the rate in 2001 (.56 per 1,000 members). This rate is higher than all Eastern Region MCOs (.31 per 1,000 members) and the rate for all MC+ Managed Care MCOs (.29 per 1,000 members). The rate of denial of services accounted for most of the provider medical complaints (.39 per 1,000 members), followed by quality of care (.15 per 1,000 members).

- The rate of provider non-medical complaints for HealthCare USA in the Eastern Region was 22.17 per 1,000 members, a very slight increase from 2001 (20.94 per 1,000 members). This rate is higher than the rate for all Eastern Region MCOs (13.25 per 1,000 members) and all MC+ Managed Care MCOs (9.50 per 1,000 members). The rate of complaints for denial of claims accounted for the greatest proportion of provider non-medical complaints (14.80 per 1,000 members) but represents a decline since 2001 (18.01 per 1,000 members).

Western Region.

- Calendar year 2002 was the first year for collection of complaints regarding HealthCare USA's operation in the Western Region. The rate of member non-medical complaints was 2.39 per 1,000 members, higher than the Western Region and statewide rates for MC+ Managed Care MCOs (1.33 per 1,000 members; and 1.49 per 1,000 members, respectively). These were primarily accounted for by member complaints regarding access to appointments (1.34 per 1,000 members).

- The rate of member non-medical complaints in the Western Region for HealthCare USA was 3.59 per 1,000 members, lower than the Western and statewide rates for MC+ Managed Care MCOs (5.07 per 1,000 members and 6.41 per 1,000 members, respectively). These complaints were primarily accounted for by complaints regarding transportation services (1.79 per 1,000 members).

- Provider medical complaints in the Western Region were .15 per 1,000 members, lower than the Western and statewide MC+ Managed Care MCO rates (.31 per 1,000 members and .29 per 1,000 members, respectively). Provider medical complaints were primarily accounted for by complaints regarding quality of care (.15 per 1,000 members).

- Provider non-medical complaints were 3.14 per 1,000 members, comparable to the Western Region MCO rate (3.24 per 1,000 members), and lower than all MC+ Managed Care MCOs (9.50 per 1,000 members). The rate of provider non-medical complaints was primarily accounted for by complaints regarding denial of claims (2.99 per 1,000 members).

Case Management

- HealthCare USA best describes MCO case management activities as a clinical system that focuses on the accountability of an identified individual or group for:

  - "coordinating a patient's care (or group of patients) across an episode or continuum of care;

  - negotiating, procuring, and coordinating services and resources needed by patient's/families with complex issues;

  - insuring and facilitation the achievement of quality, clinical, and cost outcomes;

  - intervening at key points for individual patients' addressing and resolving patters of issues that have a negative quality cost impact; and creating opportunities and systems to enhance outcomes."[4]

- Approximately 3% of members receive "complex" case management based on a total membership of 150,000 across all three regions.

- Case management services are provided by MHNet in collaboration with HealthCare USA case managers for those with co-occurring behavioral health needs.

- For children with special health care needs (CSHCN), the MCO receives health screening information weekly and attempts to make contact with members within one week. The outreach includes telephone and mailed contact material. Members in need of case management are assigned to case managers. They also review the

diskette from the State. Two LPNs conduct screening of children identified by the State as potentially having medical needs.

Interagency Coordination

- **HealthCare USA and MHNet meet weekly with the interagency coalition to support coordination of member services among the MCO, BHO, DFS, and other agencies.**

- **HealthCare USA has partnered with People's Health Center to educate children in elementary schools. People's Health Center is also conducting screenings and submitting claims to HealthCare USA for these services. To improve the rates of EPSDT for the targeted age ranges, HealthCare USA is working with the St. Louis City School Board and three pilot high schools to improve the rates of EPSDT among 14 – 20 year olds, with the provision of services three days per week by People's Health Center.**

- **Along with other MCOs, HealthCare USA is working with the Missouri High School Athletic Association to use the state-mandated EPSDT forms for their sports physicals.**

- **HealthCare USA has previously initiated an EPSDT Interagency Committee and continues to hold meetings. The MCO is visiting DFS offices to establish relationships with workers and facilitate information sharing.**

HealthCare USA

2002 External Quality Review Summary

Conducted on Tuesday, March 11, 2003

The results of the on-site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for HealthCare USA in providing care to MC+ Managed Care members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

ν   HealthCare USA appears to have a good understanding of the differences between regions in providers and in members.

ν   Increased clean claims submissions and timely payment were attributed to increased provider satisfaction. HealthCare USA has also developed a warn-line for provide billing questions and assistance.

ν   HealthCare USA is to be commended on their collaboration with other MCOs on the Smoking Cessation During Pregnancy training program and their innovative approach for formal continuing education of providers through CME Grand Rounds.

ν   Education of providers on psychiatric issues, guidelines, and depression screening is also conducted.

ν   There were a number of improvements in the provider network, including above threshold network adequacy in the Central and Eastern Regions. There was an improvement in the rate of provider complaints in the Eastern and Central Regions, especially with regard to complaints regarding the denial of services and denial of claims. The provider turnover rate is also below 10% (6-7%).

ν   In addition to some of the performance requirements for network providers on EPSDT, the behavioral health vendor (MHNet) rewards and identifies "Champions" based on performance. These individuals receive referrals and reduced pre-authorization requirements. MHNet publishes the results of its chart audits in the newsletter for the entire provider panel.

ν   Improvements in member services include the addition of on-line provider directories with monthly updated information are accessible by advocates and members; the addition of a member advocate for facilitating education and advocacy of members, with physicians as member advocates. The rate member

complaints in the Central Region for medical and non-medical complaints improved. HealthCare USA is partnering with People's Health Clinic to improve the ability to obtain updated member addresses and decrease the mail return rate from 30% to 16%.

∨ In the area of cultural competency, HealthCare USA has created a Bosnian translation for the Lead handbook; and identified high-volume providers for particular ethnic groups.

∨ Identification of preferred providers and adherence to clinical guidelines with beginning profiling has been implemented, with rewards through reduced administrative burden on providers who follow clinical guidelines. HealthCare USA has also added Bosnian and Spanish staff members as Customer Representatives.

∨ HealthCare USA has made progress in assuring that members receive appropriate and needed services, as evidenced by the EPSDT, Lead, Immunizations, and ADHD Projects. Improved efforts in outreach and education of members and providers, data collection and recognition of additional data sources such as MOHSAIC and the STELLAR database, and collaboration with contractors, agencies and other MCOs were significant strengths of HealthCare USA's 2002 quality improvement activities. HealthCare USA has identified targeted areas for specific EPSDT rate cells and developed targeted interventions aimed at members, providers, and interagency collaborations with schools, internists, and athletic associations. This includes year through contract language from the state to providers; and requiring providers to rebate a proportion of fees for below threshold documentation of EPSDT services.

∨ With regard to behavioral health services, there was improved access to substance abuse services in the Central Region; improved access to specialists and ancillary service provider as well as outpatient psychiatric facilities in the Eastern Region; and improved penetration, access and ambulatory follow-up between 1999 and 2001.

∨ Another promising innovative approach to case management is the contracting of telephone risk screening for pregnant members to a home health agency.

Opportunities for Improvement

Ü HealthCare USA has attempted to improve member adherence to treatment and prevention services by following up with members who have missed dental appointments, and with providers for members with toxic blood lead levels. The effectiveness of these efforts should be evaluated as a possible model for improving member adherence.

Ü MHNet case management charts were difficult to follow. It is recommended that a user-friendly format that documents treatment interventions, a treatment plan, and notes be developed. This may be due to the transition from pre-authorization to coordination with other agencies.

Ü **Fraud and abuse training was pending revision by the corporate office at the time of the site visit. It is recommended that this be followed up by DMS during their audit process.**

Ü **It is recommended that HealthCare USA continue to enforce the use of mandatory forms for EPSDT and prenatal risk identification. HealthCare USA is to be commended for their firm stance with providers on these issues.**

Ü **Continue to follow- up on interventions from focused studies and monitor the outcomes for indices that have achieved goals (e.g., EPSDT services for children under one year of age).**

Ü **HealthCare USA experience with providers, members, and systems in all three regions can serve as a valuable resource for other MCOs. It is recommended that staff continue to provide education and technical assistance with the state and other MCOs.**

Ü **Examine the effectiveness of the intervention with the St. Louis City Schools for increasing the rates of EPSDT for youth in the 14 – 20 year old age range. This could be used as a best practice if shown to be effective.**

Ü **Now that there is one vendor and one standard form used to identify high risk pregnancies, continue with the MCOs to conduct the focused study on low- and very low birthweight members attempted prior to implementation of this process to determine if high risk pregnancies are being identified by the tool.**

Ü **To improve the effectiveness of their performance improvement projects, indices should be more objectively measured at pre- determined timelines and the results presented on a regular basis to the Quality Management Committee (QMC). Although many of the projects are on- going, periodic measurement will facilitate identification of improvements and variation associated with specific intervention.**

Ü **Continue to collaborate with the State regarding screening data on Children with Special Health Care Needs who are and are not receiving case management. Given that HealthCare USA is the highest volume provider for the MC+ Managed Care program, the State may wish to identify methods for assisting HealthCare USA in developing more efficient methods of screening children. It is recommended that HealthCare USA attempt to match members identified as special needs members by the State with utilization and claims data to readily identify those with a history of needs, and screen the remainder.**

Ü **HealthCare USA's phone script for member outreach is detailed and well- defined. It is recommended that the number of calls and the number of completed appointments be tracked to determine the effectiveness of the outreach.**

Ü **HealthCare USA is to be complimented on its immunization outreach activity with a 90.41% rate for two- year olds. It is recommended that they continue their efforts to maintain and/or improve this rate in populations or geographic areas that are lagging.**

Ü **An opportunity for improvement in provider network exists in the area of adult psychiatric facilities in the Central Region.**

Ü   **Given the lower rates of utilization, it will be important to ensure access to partial hospitalization services, substance services, and follow-up for behavioral health services in the Eastern Region.**

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003
[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group, 2003
[3] QMC meeting minutes, 12/18/02.
[4]This definition was provided in the RFP B3Z02226 for MC+ Managed Care, with permission of the Center for Case Management, 6 Pleasant Street, South Natick, MA, 01760

Site Visit Date   Thursday, March 13, 2003

Subcontractors

Behavioral Health: **Unity Health Network**

Dental: **Doral Dental**

Transportation: **MTM**

Compliance with Standards and Operations

Enrollee Rights and Protections

- Member services staff are trained to report suspected fraud and abuse to their supervisor, who reviews cases with them and refers suspected cases to the quality department for further review. Anonymous compliance hotline and adverse event forms are also an available mechanism for reporting fraud and abuse. Fraud and abuse plans are reported quarterly to the Board. Training on fraud and abuse is conducted annually and upon the hiring of new employees.

- Mercy Health Plans uses prepared materials from the Office of Inspector General (OIG) and the Department of Health and Human Services (DHSS) as well as the State (Division of Medical Services). Employees re-sign confidentiality and compliance forms, code of conduct, and conflict of interest forms annually.

- Mercy Health Plans participates with the other two MCOs in the region in a Universal Lock-In policy for members. All three Eastern Region MCO Directors developed a three-step behavioral intervention for suspected fraud and abuse with high profile medications. The first step is to refer a member for psychiatric evaluation to determine if there is an unmet behavioral health or substance abuse treatment need associated with high medication use or seeking. The second step involves examining the progress of the lock-in, and the third step is the final lock-in itself.

Claims Processing

- Claims processing has improved, with the goal of claims payment to be made within 6 days for electronic claims, and 12 days for paper-based claims.

- Approximately 85% of claims are filed electronically, with 65% of those never having to be examined.

- Electronic claims are auto-adjudicated within 2 - 3 days, with checks written within one week.

- Mechanisms have been put into place to increase the number of state claims acceptance. Mercy reports the current rate of acceptance for institutions ranges from 50% - 78%. The file for providers is the next one to improve. There appears to be some loss in data upon transfer to Verizon.

- To improve the timeliness of payment for providers in 2003, Mercy Health Plan will be scanning all transactions to provide an electronic reference for claims and provider questions about the status of claims processing.

Credentialing and Re-credentialing

- **Credentialing is delegated for Unity Managed Mental Health, Doral Dental, and Sister's of St. Mary's. Mercy Health Plan has developed a Delegation Oversight Audit Tool that is used to assess compliance (full, significant, partial, minimal, or no compliance) with several criteria as well as initial credentialing and re-credentialing file worksheets. Summary worksheets to assess the rate of compliance are used to make a final determination of credentialing status.**

- **Mercy Health Plans conducts annual quality improvement and utilization management review with providers.**

- **For those providers for which credentialing is delegated, Mercy Health Plan audits the pharmacy rules. Utilization management staff reviews records for dental and behavioral health. In addition, behavioral health provider files are audited annually.**

Vendor Oversight

- **Credentialing and re-credentialing files are audited for behavioral health and dental vendors, and pharmacy rules are audited on an annual basis. Both Unity Managed Mental Health and Doral Dental vendors were on corrective action plans during 2002. Mercy Health plans developed detailed, task oriented, objective goals, priorities, person(s) responsible, and timeframes for compliance and monitored these through regular meetings and updates of the status of each item. This method is a model for oversight compliance. The main priorities in the Doral Dental compliance plan included management, contract compliance, network operations, utilization, quality, and contract compliance. At the time of the site visit, the MCO was 65% complete. For Unity Managed Mental Health, the goals focused on less traditional service development, more outcome focused, more useful reporting, and more culturally sensitive treatment. A majority of the goals had been implemented, were in process, or were initiated at the time of the site visit. Both documents clearly indicated expected goals and targets providing good communication between the vendor and MCO.**

- **Vender oversight is conducted quarterly through regular meetings with dental and transportation vendors, with established agendas for reviewing quality indicators and the status of any corrective action plans. Behavioral health oversight is conducted through quarterly meetings with the vendor as well as case management coordination.**

- **The Pharmacy and Therapeutics (P & T) and Vendor Oversight Committees report findings to the local Quality Improvement Committee (QIC), which reports to the Board Quality Committee, which ultimately reports to the Board of Directors.**

- **Oversight and pre-authorization for case management for the high-risk case management vendor, StatusOne, is conducted by the medical director and special needs coordinator.**

Access

Member Services

- **Mercy Health Plans enrolled approximately 10,600 new members as a result of one MCO exit in the Eastern Region.**

- **There has been no member staff turnover in the past 5 years.**

- **Member services staff are provided with incentives and quarterly bonuses for the recording of grievances.**

- **Mercy Health Plans has developed a mechanism to avoid corrected addresses from overwriting incorrect addresses during file transfer from the State. The rate of undeliverable mail to members has decreased from 35% to approximately 10% or less.**

- **Another method used to improve outreach to members is through obtaining member telephone numbers from the local school district (which was reported to be of modest value), and through the use of addresses and telephone contact information obtained by the transportation vendor, Medical Transportation Management (MTM).**

- **Mercy Health Plans has worked to improve member involvement and actively seeks member input and feedback. In March, 2003, a focus group was scheduled to obtain member input regarding how well Mercy Health Plan compares to other MCOs, the clarity of the materials, and the ease of enrollment.**

- **The provider directory is updated weekly on the web page, offering a search of providers by Mercy Health Plan product and region. There is a reported increase in the number of MC+ Managed Care Members accessing this web-based feature.**

Provider Network[1]

The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance indicates that as of December 31, 2001, Mercy Health Plans' (Mercy Health Plans) provider network adequacy was 98% overall, with the overall adequacy falling below threshold in two counties, St. Francois and Washington Counties.

- **The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance (MDI) indicates that as of December 31, 2001:**

  - **Jefferson and the Eastern Mercy Health Plan's network adequacy for PCPs, specialists, facilities, and ancillary service providers were above the 95.0% threshold in 2002, with an overall network adequacy rate of 98.0%.**

  - **There was an increase in facility adequacy, from 92.0% to 99.0% between 2001 and 2002.**

  - **There was an increase in basic hospital facilities, from 95.0% to 100.0%.**

  - **There was an increase in inpatient intensive treatment facilities for children/adolescents from 92.0% to 100.0%.**

  - **There was an increase in adult inpatient intensive treatment facilities for adults, from 87.0% to 97.0%.**

  - **There was an increase in outpatient child psychiatric facilities rates, from 86.0% to 99.0%.**

- m **There was an increase in outpatient adult psychiatric facilities rates, from 70.0 to 93.0%, approaching the 95.5% threshold.**

- m **There was an increase in geriatric outpatient facility rates, from 88.0 to 99.0% threshold**

- m **There was an increase in the rate of availability of pharmacies, from 95.0% to 100.0%**

- m **The rate of Child/Adolescent psychiatry specialists remained stable, from 77.0% to 76.0%, below the threshold of 95%.**

- m **Provider network adequacy for Mercy Health Plan for ancillary providers declined below threshold, from 98% to 94%.**

- m **There was a decrease in audiologist rates, from 100.0 to 95.0%.**

- **Expansion region (Lincoln, St. Francis, Ste. Genevieve, Warren, and Washington Counties) provider network has been more challenging to maintain than remaining counties. Mercy Health Plans has added Local Public Health Agencies (LPHAs) in St. Louis City, and in Jefferson, St. Louis, and Washington Counties. They also added the Washington County Hospital and physician network.**

- **The MCO requested that each dental provider "take a family". This was considered a modestly effective strategy for improving dental care networks, complicated by the dearth of dental care providers in the region.**

- **In 2003, Mercy Health Plan will focus on adding OB, ENT, orthopedic, and neurology specialists to its network. Also, a new information management system was implemented in January, 2003 to facilitate the auto-assignment of new MC+ Managed Care members to providers so as to better manage the panel size limits of providers. The new system is anticipated to be able to ensure that members are assigned to providers within the same county.**

- **The rate of provider turnover was approximately 6 – 7 %, associated with provider (especially specialty providers) dissatisfaction with the fee schedule. Many providers are closing their panels. Mercy Health Plans has increased the fee schedules somewhat, especially for administration of immunizations.**

- **Mercy Health Plans is moving toward a fee-for-service model for providers, with approximately 30 – 40% of providers being capitated.**

Provider Education, Training, and Performance

- **Provider offices are visited frequently, especially in the expansion region, which seems to have improved provider satisfaction.**

- **Mercy Health Plans identifies providers who are "Blue Ribbon" providers, and posts quality "report cards" on the Internet annually.**

- **Incentives are also distributed to provider groups based on overall performance, with the distribution to individual providers left to the clinic administration.**

Utilization/Medical Management

- **The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:**

- **The total penetration rate for behavioral health services was 4.6% in 2001.**

- **Outpatient visits increased from 1999 to 2001, from a rate of 177.0 to 205.0 per 1,000 in 2001.**

- **The rate of alternative services was 0 per 1,000 in 2001.**

- **Partial hospital admissions were 1.0 per 1,000, consistent with 1999 rates; and partial hospitalization days declined from 4.0 in 1999 to 2.5 per 1,000 in 2001.**

- **There were 0 residential days per 1,000 in 2001.**

- **Inpatient admissions declined from 12.0 per 1,000 in 1999 and 2000 to 9.3 admissions per 1,000 in 2001, while inpatient days declined from 58.0 to 48.6 days per 1,000 between 1999 and 2001.**

- **Inpatient substance abuse admissions increased from 7.0 per 1,000 in 1999 and 2000, to 2.1 per 1,000 in 2001. Inpatient substance abuse days per 1,000 increased from 5.0 to 6.2 per 1,000 between 1999 and 2001.**

- **The 30-day follow-up rate after hospitalization increased from 60.0% to 51.0% between 1999 and 2001. The 7-day follow-up rate remained stable at 21.0% in 1999 and 2001.**

- **Unity Managed Mental Health has instituted a pre-authorization procedure for Strattera, a highly popular non-stimulant medication for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).**

- **The MCO found that a large proportion of emergency department services are for otitis media and chest congestion.**

Quality

Quality Management

- **The Sisters of Mercy Health Care System emphasizes Three Pillars: People, Service, and Capital which permeates their philosophy of interacting within and outside the organization.**

Clinical Guidelines

- **Mercy Health Plan has adopted clinical practice guidelines for lead poisoning prevention, asthma, congestive heart failure, cardiovascular disease, diabetes, lead poisoning prevention and treatment, high risk pregnancy, and treatment after acute myocardial infarction.**

- **All clinical guidelines are reviewed and evaluated annually, with the exception of the StatusOne clinical guidelines for high risk, high cost members, which are reviewed quarterly.**

Performance Improvement Projects

Mercy Health Plan's response to the EQRO request for information regarding Performance Improvement activity and work plans cited information related to all HMO product lines of business in Missouri, including Commercial, Medicare and Medicaid MC+ Managed Care. Some activities were implemented statewide, with aggregate data for all lines of business. The responses that were specific to the MC+ Managed Care program were reviewed. There was very little discussion on presentation of initiatives to the Missouri Quality Improvement Committee (MQIC).

- **Analysis of the HEDIS combination‑2 results for Immunization Rates showed continued low compliance rates based on a comprehensive medical record review. Mercy staff members worked on developing methods to improve these rates with outreach to both members and providers. The MQIC directed the MCO to adopt a 90% compliance rate as its benchmark proxy measure for effective immunizations instead of the full immunization compliance rate due to the vaccine shortage. The MC+ Managed Care average rate for this measure over the previous two years was 63%, however it was recognized that accurate encounter data had been problematic and the MCO had implemented a program to address this issue. Mercy Health Plan staff was working with the Missouri Department of Health and Senior Services (DHSS) to achieve an acceptable exchange of immunization data to and from the MOHSAIC database system. Mercy was also collaborating with DHSS and local health clinics to encourage consistent billing practices, thereby allowing the MCO to capture more comprehensive encounter data. Physician profiling is planned to assist in improving encounter data and member outreach.**

- **Mercy initiated the EPSDT Quality Improvement Project in 2002 with the goal of increasing HCFA‑416 rates to 80% participation. The task force identified several interventions such as member outreach programs, identification of members in need of services, identification of providers not billing for EPSDT services, and performing medical record audits for comprehensive EPSDT documentation and billing practices. Using HEDIS results as the baseline measurement, Mercy Health Plan considered this as an on‑going project, with the 2002‑2003 QI Work Plan reflecting necessary revisions.**

- **Mercy Health Plan identified children at risk for lead toxicity through the county and city Departments of Health and provided case management for those with lead levels of 15 μg/dL or greater. The MCO is closely monitoring the rates of exposure and to actively pursue data from the DHSS on members residing in the Doe Run / Herculaneum area. We encourage Mercy Health Plan to continue active involvement in the critical issue of lead exposure for residents of the Eastern Region as well as participation in community activities that can have a positive impact on reducing lead exposure.**

- **The Lead Case Management and measurement of efficacy of interventions for lead toxicity (e.g., lead toxicity ratio) is an excellent example of case finding and measurement of interventions through a lead ratio (initial lead level/current lead level) which allows for individual and aggregate measurement of progress.**

- **In partnership with provider home care agencies and Nurses for Newborns, Mercy Health Plan has an on‑going prenatal case management program that identifies, assesses and provides interventions for pregnant women, especially those determined to be high risk. Baseline measurements were taken in 2000 and annually**

thereafter, showing the estimated gestational ages (EGA) of initiation of prenatal care and Case Management, EGA at delivery, birthweight, and Apgar scores. The amount of time to initiation of prenatal care and case management appear to be increasing. Mercy Health Plan interpreted this to mean that the length of time it takes women to qualify for coverage has increased.

- Mercy Health Plan and Unity Managed Mental Health (UMMH) have been involved in an on-going project since 2000 (MC+ Managed Care Pregnant Women's Study) to "increase the detection and treatment of mental health and substance abuse disorders among MC+ Managed Care eligible pregnant women". The goal of improving pregnancy outcomes and increased penetration to necessary medical and behavioral health services is under routine evaluation. The behavioral health vendor, Unity Managed Mental Health (UMMH), has conducted a quality study to assess the number of pregnant women who accessed mental health services, with approximately 13% of members obtaining authorization of services. Using claims data, the penetration rate was 6%. As a result, a screening process for pregnant members was implemented with four screening questions administered by the Mercy Health Plan case manager. In 2003, UMMH will examine quarterly penetration and utilization data to determine the efficacy of the intervention in identifying and treating depression in women.

- In February 2002, Mercy surveyed 344 PCPs to assess compliance with 24-hour availability. Twelve percent (12%) were found to be non-compliant and were required to implement an after-hours answering service.

- Another quality study initiated by UMMH in 2002 was to study the intervention of educating primary care providers through direct mail and newsletters regarding patient education, diagnosis, medication management, and referrals for therapy. This was based on findings that approximately 80% of prescriptions for antidepressant medications are being prescribed by internists who have prescribed apparent sub-therapeutic doses or higher than necessary doses. Medical record audits were conducted prior to and following dissemination of the guidelines.

- Outcomes are being assessed for disease management programs, examining hospitalization rates for those with asthma receiving case management (2002). Results indicated that those there were no differences in emergency room utilization for those in case management relative to those who were not in case management. In fact, emergency room utilization increased. However, hospitalization rates declined. Other outcomes to be examined in 2003 include functional status, with MCOs to correlate functional status with outcomes such as lead levels, body mass index, and Hbca1.

Cultural Competency

- Mercy Health Plan submitted a summary of translation services itemized by the number of requests per language/per month and the 2002 total. Bosnian was the most requested language, with Spanish the second.

- Interpreter resources and benefits are addressed in the Welcome Call checklist.

- The Member Handbook contains references to visual and hearing impaired (TDD line) resources, interpreter services, etc

- As part of the 2002 Performance Improvement Plan, Mercy Health Plan completed a "Cultural Competence Member/Provider Manual Upgrade". The Upgrade

incorporated re- education into the practitioner re- orientation program on processes to access interpreters; planning revision of member materials in languages common to the member population, including multi- module CD project of culturally- specific information for distribution to providers; and a QAPI Project for PremierPlus members relating to cultural/linguistically appropriate services projected for 2003.

- Special needs unique to the Texas membership (primarily Hispanic) were identified and incorporated into the UMMH Action Plan.

- Mercy Health Plan reported collaborating with local refugee/immigrant advocates on the development of an audio CD in four languages (English, Spanish Bosnian, Vietnamese).

Grievance Systems

- Grievances and appeals are maintained separately from member services files.

- The rate of member medical complaints increased from 2001 to 2002 (.78 per 1,000 members to 1.20 per 1,000 members). However, this rate was lower than the rate for all Eastern Region MCOs (1.61 per 1,000 members) and all MC+ Managed Care MCOs (1.49 per 1,000 members). Member medical complaints were primarily accounted for by complaints regarding denial of services (.64 per 1,000 members).

- The rates of member medical complaints regarding quality of care as well as complaints regarding appointments declined from 2001 to 2002.

- The rate of member non- medical complaints was 3.03 per 1,000 members in 2002, an increase from the rate in 2001 (2.73 per 1,000 members). This is lower than the Eastern Region rate of member non- medical complaints (8.36 per 1,000 members) as well as the rate for all MC+ Managed Care MCOs (6.41 per 1,000 members). Most of the member non- medical complaints were accounted for by "other" member non- medical complaints (1.16 per 1,000 members). There was a decrease between 2001 and 2002 in the rate of complaints regarding staff behavior, denial of claims, and waiting for appointments.

- The rate of provider medical complaints as reported by Mercy Health Plan remained at 0 for 2002, as in 2001. The rate of provider non- medical complaints was 4.79 per 1,000 members in 2002, a decrease from 6.36 per 1,000 members in 2001. This rate is lower than the Eastern Region rate (13.25 per 1,000 members) as well as the rate for all MC+ Managed Care MCOs (9.50 per 1,000 members). There was a decline in provider complaints regarding denial of claims between 2001 and 2002.

Case Management

- The MCO is moving toward a model of disease management, with case management as a component. Approximately 9 – 10% of the MC+ Managed Care population was receiving case management services through Mercy Health Plan and its vendors, StatusOne, and Unity Managed Mental Health Services.

- Mercy Health Plan defines case management as:

    "a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patient's/families with

> complex issues'; insuring and facilitation the achievement of quality, clinical, and cost outcomes' intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance health outcomes".[3]

- Routine aspects of Mercy Health Plans case management program include the use of clinical practice guidelines, provider and patient profiling, specialized physician and other practitioner care targeted to meet members special needs, provider education, patient education, claims analyses, and quarterly and yearly outcome measurement and reporting.

- Mercy Health Plans works with Status One, a company that profiles and identifies high cost, high risk cases for case management.

- Mercy Health Plans recently hired a social worker to participate in case management, who will facilitate discharge planning on the utilization management team, expand connections with community resources, and conduct case management for cases with fewer acute physical concerns and numerous psychosocial issues. The MCO would like to add Occupational, Physical, and Recreational Therapists to the utilization staff as well.

- Mercy Health Plans has opened more lead case management cases in the first half of 2002 (n = 35) than in the full year of 2001 (n = 16), indicating better testing and identification of children. This was attributed to targeting the Doe Run area and working closely with the Department of Health and Senior Services.

- All children with special health care needs (CSHCN) are screened from the list provided by the State for identification of need for medical case management. Mercy Health Plans examines claims and medications to assess utilization of services.

- To identify those in need of lead case management, Mercy Health Plan uses the baseline health risk assessment obtained at the time of enrollment, home health utilization, and state laboratory results. The MCO has employed a ratio comparing lead test results over time to assess the outcomes of lead case management in reducing lead toxicity.

- There are 2.5 FTE case managers, each focusing on different areas: pediatrics, lead toxicity, neonatal intensive care, emergency room, cardiology, hi-risk pregnancy, transplants, psychiatry, obesity, and alcohol/substance abuse.

Interagency Coordination

- The Chief Medical Officer of Mercy Health Plan is involved with the Diabetes Coalition.

- The Chief Medical Officer serves as Vice Chairperson of the Missouri Partnership for Smoking on Health, providing local physicians with materials on community–based smoking cessation programs.

- Mercy Health Plan continues its community support with active participation in several other Eastern Region projects, such as the St. Louis Lead Prevention Coalition, the Maternal, Child, Family Health Coalition, and sponsorship of an annual domestic violence conference. Mercy Health Plan is also involved with numerous community and health fairs and in August 2002 the MCO collaborated with the St.

Louis City Department of Health in a block party for a high disparity region of St. Louis (zip code 63118). Several other community agencies and the St. Louis City DOH Lead van participated and the party provided opportunities to educate the public regarding health and wellness issues such as lead screening, EPSDT evaluation, immunizations and prenatal care.

Mercy Health Plan

2002 External Quality Review Summary

Conducted on Thursday, March 13, 2003

The results of the on‑site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for Mercy Health Plans in providing care to MC+ Managed Care Members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

∨ **Mercy Health Plan improved claims processing through identification of edits and rejected records.**

∨ **Vendor oversight is thorough and provides accountability. This was noted in Mercy Health Plan's audit procedures for credentialing and re‑credentialing of providers and delegated providers; their audit of records for behavioral health and dental vendors; regular meetings with MTM, UMMH, Doral; the Project list for Advance PCS; the detailed format for corrective action plans with vendors; specific performance indicators for non‑delegated re‑credentialing evaluation of providers; and the formal auditing of behavioral health organizations' operations and structures in accordance with NCQA Quality Improvement Standards for clinical care programs, disease management programs, data and information and management, provider network adequacy, quality improvement committees, and performance improvement projects. The delegated Oversight Audit Tool is a Promising Practice for monitoring vendor performance and ensuring accountability.**

∨ **Mercy Health Plan added 10,600 new members due to close‑out of another MCO. Member services has improved, with access to a web‑based provider directory; a new member welcome call checklist; reduction in the rate of return mail (with a 15% return rate of mail); the use of St. Louis City Schools and MTM to obtain updated member addresses; and the addition of a Bosnian staff member. There was a decline in member complaints regarding the quality of care, the ability to obtain an appointment, staff behavior and denial of service, indicating improved access to healthcare between 2001 and 2002. There was also a decline in the rate of member complaints regarding denial of claims and waiting during an appointment, with a stable rate of transportation complaints. The Utilization Management Department collaborated with the pharmacy vendor to monitor fraud/abuse, with action steps for member for lock‑in.**

∨ There was an improved and stable provider network in the areas of pharmacy, geriatric outpatient facilities, outpatient adult psychiatric facilities, outpatient child psychiatric facilities, adult inpatient intensive treatment facilities, inpatient intensive treatment facilities for children/adolescents, basic hospital facilities, and overall facility adequacy. Mercy Health Plan also added local public health clinics in rural areas, is working with FQHCs to provide school-based services, and has developed a relationship with St. Johns to develop child psychiatry access.

∨ Improvements in provider relations include more face-to-face interactions with providers, auto-assignment of members to providers with consideration for panel size, moving from a capitated to a fee-for-service model of payment for better capture of claims, reduced referrals for in-network specialists, and increased (85%) electronic claims submissions for providers. Mercy Health Plan has also developed a "Blue Ribbon Physician's Network recognizing and rewarding physicians for well member care. There were negligible provider medical complaints during 2002, with a decline in overall provider non-medical complaints between 2001 and 2002.

∨ In the area of quality management and improvement, Mercy Health Plan has improved EPSDT data collection and claims processing partly by using a fee-for-service payment; developed a method of measurement of outcomes for lead case management interventions to examine effectiveness of the program as a whole as well as on individual treatment outcomes; and studied the effectiveness of case management on utilization for asthma hospitalization. The quality improvement study designs were well developed, implemented, and applied in decision-making regarding the delivery of care. Mercy Health Plan is also on the leading of edge of examining functional outcomes especially as they relate to health outcomes.

∨ Mercy Health Plans model of case management is oriented toward a psychosocial perspective, with the recent addition of a social worker to the staff to facilitate discharge planning, expand connections to community resources and conduct case management. The case management model is considered a part of an overall disease management program that articulates roles and responsibilities, education protocols, and care plans. Case management records, treatment plans, and progress notes were well incorporated and easy to follow.

∨ For Cultural Competency, the cultural competency program was appropriately integrated into the Performance Improvement Plan. Mercy Health Plan appears to be using quantitative measurements to identify the target population and conduct needs assessments. The Action Plan submitted by UMMH is a comprehensive and coordinated plan for health care delivery to a specific cultural group, and includes a disease management link to ethnicity. Also, marketing and member services marketing tools were developed for specific groups to increase access to healthcare services. In the future, Mercy Health Plan plans to reduce literacy and access barriers with a linguistically and culturally sensitive product line. Staff have developed patient education materials for healthy living and domestic violence in a number of different languages.

∨ Between 2000 and 2001, there was increased access to ambulatory visits for behavioral health services, indicating a more preventive orientation in the least restrictive setting.

∨ **Mercy Health Plan established a monthly meeting with St. Louis City and County DFS office staff to facilitate care for children in state custody. Mercy's community involvement is clearly evident and well documented; the MCO should be proud of its community support and continue with this valuable interest in improving the health of Eastern Region MC+ Managed Care eligible members. The organization also follows a model of integrating employees, providers and members, called the Pillars of Care, and actively seeks input from all regarding their satisfaction and needs.**

Opportunities for Improvement

Ù **It is not clear what level of case- by- case interagency coordination is being conducted for behavioral health. The case management model appears to be primarily utilization review. We would encourage more documentation of care management. Given the excellent model of case management documentation found for Mercy Health Plan case management, it is recommended that this same format be considered for behavioral healthcare.**

Ù **It is recommended that Mercy reassess its progress on the immunization initiative to determine effectiveness of their efforts in improving immunization rates of 0- 2 year old members. Follow- up analysis of targeted local health clinics' billing practices could be considered an efficient short- term study to determine improved compliance. Comparison of baseline billing rates to post- education rates could be easily measured by reviewing claims data.**

Ù **It is suggested that Mercy Health Plan continue with their EPSDT QI initiative, document routine analysis of ratios reported on the HCFA- 416 report, and provide summaries to the MQIC for its recommendations and comments.**

Ù **We encourage Mercy Health Plan to continue active involvement in the critical issue of lead exposure for residents of the Eastern Region as well as participation in community activities that can have a positive impact on reducing lead exposure.**

Ù **Mercy is encouraged to follow- up with providers regarding contract compliance with regard to 24- hour availability and present summaries of these issues to Quality Management.**

Ù **Most information was generalized to all product lines. Mercy does have an excellent tracking tool for monitoring Performance Indicators and they are encouraged to separate results by region and/or product line to determine areas that may need focused attention.**

Ù **Mercy Health Plans has identified patient functional status as an outcome for some of their quality improvement initiatives. This is an excellent outcome measure and we would encourage the use of this type of measure.**

Ù **Other MCOs report positive results from adding ancillary service professionals (e.g., physical or occupational therapists) to facilitate utilization management and case management. Mercy Health Plan seems to understand this value, and we would encourage this as a method for improving care.**

Ü   **There was an increase in provider denial of claim complaints, member denial of services complaints, and other non- medical complaints from 2001 to 2002.**

Ü   **Efforts at improving provider network adequacy for child/adolescent psychiatry providers and ancillary providers (especially audiologists) should continue.**

Ü   **It is recommended that Mercy Health Plan and units examine the decreased penetration rate for all age groups, decreased ambulatory follow- up at 7- and 30- days post- discharge, and decreased partial hospitalization admissions and days for behavioral health services between 2000 and 2001. This may be related to some of the reported increases in inpatient psychiatric utilization in 2002.**

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003

[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group, 2003

[3]This definition was provided in the RFP B3Z02226 for MC+ Managed Care, with permission of the Center for Case Management, 6 Pleasant Street, South Natick, MA, 01760

2002

Missouri MC+ Managed Care Program

External Quality Review

Missouri Care

Site Visit Date   Thursday, March 20, 2003

Subcontractors

Behavioral Health:	**Magellan Behavioral Health.**
Dental:	**Mid-Missouri Dental**
Transportation:	**Medical Transportation Management**

Compliance with Standards and Operations

Enrollee Rights and Protections

- **Member services representatives undergo fraud and abuse training at the time of new hire. When cases of suspected abuse occur, they are discussed with the supervisor and the case is referred to the compliance officer. There is a toll-free number for the compliance hotline. This is forwarded to the corporate office which investigates any suspected fraud and abuse. There has been one call in the past one and one-half years from one staff member. There was one case of pharmacy abuse in which the State facilitated lock-in for the member. To address HIPAA, the corporate office in Phoenix has implemented a "train the trainer" approach to training for all staff. In addition, Missouri Care has implemented desktop procedures and more intensive training for member service representatives so they can log and code the type of information and request for protected health information (PHI).**

- **Most referrals for Protected Health Information (pursuant to the Health Information Portability and Accountability Act) from attorneys are regarding Motor Vehicle Accidents (MVAs) and are handled by the corporate office.**

Claims Processing

- **Three vendors are used for claims. Through the monitoring of claims, Missouri Care identified a large number of pended claims and claims paying at different amounts. For 2003, Missouri Care has implemented a new version of their Claims Processing System (QMAX). As a result, they increased processing of claims from 450 to 2,300 claims per hour, with fewer pended claims. On average, claims are paid within seven days. The emphasis is on improving provider satisfaction by rapidly paying claims. Missouri Care will be focusing on providers to improve the rate of electronic claims submission so providers can also benefit from the prompt pay rules.   Currently, 40-50% of claims are filed electronically. The southwestern part of the region is currently being targeted through provider services for Internet-based claims submission by providers.**

- **To assess claims submission and errors, the Information Technology department examines patterns of errors among providers and conducts appropriate provider education. One area that is problematic is the type of service code because the management information system cannot override inappropriate modifiers. The Corporate Office also supports the processing of encounter claims by examining kick payments, re-insurance and previous year's claims that are outstanding.**

Credentialing and Re-credentialing

- **Missouri Care has developed a review data base for ease in conducting reviews and credentialing. Provider profiling data are reviewed at the time of re- credentialing.**

- **For delegated credentialing, Missouri Care annually audits files using an NCQA tool. Delegated credentialing is conducted with Children's Mercy Hospital in Kansas City, Capitol Regional Medical Center in Jefferson City, and Magellan Behavioral Health.**

- **At the time of the site visit, The University of Missouri- Columbia was under a corrective action plan for credentialing. Missouri Care will re- audit files in April, 2003.**

Vendor Oversight

- **Missouri Care is currently using an NCQA audit tool for monitoring the transportation vendor, Medical Transportation Management (MTM). The transportation vendor, MTM has opted to apply for NCQA accreditation.**

- **Missouri Care meets quarterly to review Utilization Review quality complaints with each of its vendors. Annually, Missouri Care conducts a full oversight review using specific audit tools.**

- **In 2002, Magellan was placed on a corrective action plan for eligibility file processing. This had to do with processing eligibility files weekly instead of daily, which was resolved at the time of the site visit.**

- **As of May 2003, Missouri Care will be contracting with CommCare for behavioral health network services. Magellan Behavioral Health will facilitate transition from their services to CommCare for members in the Central Region as well as participate in the Central Region Inter- Agency planning Committee.**

Access

Member Services

- **Missouri Care has two member services representatives both whom have a tenure of three years. There has been no turnover in the past three years.**

- **Missouri Care has a 5% target for call abandonment rate, and has achieved a 3% level for the first two months of 2003.**

- **Missouri Care reports that their overall return mail rate is 6%, and the completion of data regarding the Baseline Health Screen at the time of enrollment is approximately 20%. Missouri Care has identified differential rates of return mail. For example, the Health Risk Assessment (10- 12%) has a higher return mail rate than the Pregnancy Risk Assessment. For members once enrolled and in theMCO, the return mail rate is 10- 12%. The new member packet return mail rate is at approximately 6%.**

- **Missouri Care keeps a shadow file for updating addresses. Missouri Care uses phone numbers and addresses obtained from their transportation vendor, Medical Transportation Management (MTM) and the US Postal Service for forwarding addresses. Their experience with new member calls is that phone numbers are less reliable than addresses. If unable to contact the member by phone, a post card is sent.**

- **Directories are mailed to members annually and are provided upon request as well as at the time of enrollment. The provider directory is updated annually in hard copy format. However, every two weeks, Member Services receives a new hard copy format of the updated provider directory file for reference when members call for referrals. In 2003, Missouri Care plans to get their provider directory web- enabled.**

- **Missouri Care reports that on the CAHPS survey, member satisfaction was at approximately 94% or 95% (of members who are satisfied or highly satisfied) and satisfaction with member services was 88% for 2001. Missouri Care also has a member advisory group that meets quarterly, with approximately 15 families participating.**

Provider Network[1]

- **The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance (MDI) indicates that as of December 31, 2001:**

    o **Missouri Care's network adequacy for PCPs, specialists, facilities, and ancillary service providers was above the 95.0% threshold in 2002, with an overall network adequacy rate of 100.0%.**

    o **PCP, specialist, ancillary services, and facility rates remained above 95% in 2002.**

    o **There was improved documentation of emergency medicine specialists, from 50.0% to 100.0% between the 2001 and 2002 filings.**

    o **Rates of Audiology services were below threshold, at 94.0%.**

- **Magellan Behavioral Health was working with the University to increase behavioral health provider network adequacy at the time of the site visit. Columbia has a number of child psychologists which could be enrolled.**

- **Missouri Care continues to maintain 2 provider representatives for the North and South Regions, divided by I- 70. These provider representatives conduct monthly visits to approximately 107 provider offices, with a performance goal to visit 95% of the offices each month. Ancillary providers and specialists are visited once quarterly. There has been no provider representative turnover in the last three years. Missouri Care attributes its provider satisfaction to face- to- face interaction with providers.**

- **The corporate office conducted a provider satisfaction survey which showed favorable results. As a follow- up to internal changes initiated by Missouri Care, a more focused survey was conducted by the MCO. The follow- up survey indicated that providers were more satisfied than previously, especially with reimbursement and prior authorization. They reported a 77- 85% increase in satisfaction. The focused survey requested providers to rate the MCO relative to other MCOs.**

- **There were few provider complaints, with most being related to member non- compliance. Missouri Care is considering a policy change to allow provider changes once per month if necessary. Most calls to the Provider Relations Department were inquires regarding claims.**

- **The provider turnover rate in 2002 was approximately 5% in the second quarter for PCPs, with no turnover in specialists and a 4% increase in specialists. One difficulty with the JCMG contract was that Missouri Care was not contracted with St. Mary's Hospital, where JCMG providers prefer to admit. This made it difficult, as providers did not wish to refer members to Capitol Region, the hospital that is contracted with Missouri Care.**

- **For dental services, there was a 28% penetration rate. Dr. Fitzsinger was trying to access the school systems to provide fluoride brush and sealant programs. He is also working with additional providers who may be willing to take on a few Medicaid members. These providers would not be included in the Provider Directory, but would be available to take emergency cases. The dental network expanded in 2002.**

- **During 2002, US Dental attempted to work with some of the FQHCs and LPHAs but with limited success, as these entities appear not to be interested in reimbursement or engaging in the billing process. Missouri Care has a contract with Pulaski County FQHC, but US Dental has not been able to contract with their dentists. There has been more work from the provider relations side with the LPHAs regarding domestic violence, EPSDT, case management, and lead which has resulted in the development of some case management contracts with LPHAs.**

Provider Education, Training, and Performance

- **Representatives deliver provider manuals to provider offices on a monthly basis. Missouri Care has developed a program called Doctor TIPS (Tools and Information for Provider Success), developed by the quality specialists. This consists of a brief reference guide, with forms such as EPSDT, lead screening and referral forms for Missouri Care case management. They also distribute the provider guide from the State regarding MC+ Managed Care and MC+ Managed Care For Kids. In April, 2003, Missouri Care will be distributing something called "Hot Tips" for HIPAA reference for providers.**

- **The provider manual is distributed annually to providers. Missouri Care is working on the provider manual to make it more user-friendly. The manual will be more focused on claims and billing with different manuals for hospitals and other providers. The provider manual will separate physicians and primary care providers from specialists, and will follow more closely the format of the state's billing manual.**

- **Missouri Care produces a provider newsletter which contains HEDIS findings and always contains an article by the Medical Director. Pharmacy-related articles are targeted. Additional information is delivered to providers monthly by provider representatives.**

- **There is a high turnover rate among provider office staff. Provider representatives conduct training with staff members, especially regarding local codes and do follow-up retraining.**

- **The Doctor TIPS program is more clinical in orientation, providing information and brief reference regarding lead EPSDT and filter paper capillary lead testing.**

- **Provider profiling is conducted on prescriptions and emergency room utilization. Missouri Care has found that it is preferable not to present peer-related information.**

Utilization/Medical Management

- **Baseline screening is conducted on all new members. Missouri Care uses the Baseline Health Screen information to mail screening forms to members to identify special needs.**

- **The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:**

  o **The total penetration rate for behavioral health services was 9.0% in 2001.**

  o **Outpatient visits increased from 2000 to 2001, with the rate of 418.2 per 1,000 in 2001.**

  o **The rate of alternative services was .1 per 1,000 in 2001.**

  o **Partial hospitalization admissions per 1,000 decreased to .2 per 1,000; and partial hospitalization days declined to .5 per 1,000 in 2001.**

  o **There were 1.2 residential days per 1,000 in 2001, an increase from 0 in the previous two years.**

  o **Inpatient admissions increased from 6.6 to 9.0 in 2000 and leveled off at 6.8 per 1,000 between 2000 and 2001, while inpatient days followed a similar pattern, with 23.2 days per 1,000 in 1999, 32.1 per 1,000 in 2000, and 19.9 per 1,000 in 2001.**

  o **Inpatient substance abuse admissions increased from .4 to .7 per 1,000 between 1999 and 2000, and returned to .4 per 1,000 in 2001. Inpatient substance abuse days per 1,000 increased from 1.7 to 1.9 per 1,000 between 1999 and 2000, and declined from 1.2 per 1,000 in 2001.**

  o **The 30-day follow-up rate after hospitalization increased from 50.4% to 60.6% between 1999 and 2001. The 7-day follow-up rate increased from 22.7% to 38.1% between 1999 and 2001.**

- **Magellan noted that HEDIS figures were audited. Magellan receives the weekly Health Risk Assessment for individuals who have self-identified on the Baseline Health Risk Assessment form or the Child and Adolescent Health Measurement Initiative (CAHMI) Survey. Magellan meets weekly with Missouri Care as needed for children with severe behavioral health needs.**

- **Magellan is working with Missouri Care on identifying whether or not a child who is being treated with psychotropic medication is also being referred for behavioral health treatment. The one difference in the Central Region behavioral health utilization is that there appear to be more behavioral health providers who are also more outpatient-oriented. However, inpatient utilization is still high. In 2001, inpatient utilization was 4.7 per 1,000 members and in 2002, it increased to 7.7 per 1,000 members. This represents approximately a 60% increase in inpatient utilization. Outpatient services also increased from 2001-2002, approximately 35%, from 824 per 1,000 to 1,113 per 1,000 members.**

- **Missouri Care has instituted a preferred drug listing. Previously, medication requests underwent prior authorization processes at the local office. In 2003, this function was moved to the corporate office. Pharmacy denials were typically due to a medication not being a "first line" medication or prescribing a drug not recommended for that age group. For pharmacy utilization, prescriptions for ADHD, atypical anti-psychotics for children, and anti-depressants were the most significant and frequently used medication. In addition, Missouri Care has worked closely with residential facilities especially in providing a bell and pad for children with enuresis in addition to nasal spray or medication for bedwetting.**

- **For monitoring, Missouri Care regularly receives reports on medications with overrides, prior approvals, polypharmacy use, and high-dollar medication use.**

- **Emergency room utilization has decreased, especially the use of the emergency room for dental related services.**

Quality

Quality Management

- **Missouri Care bases its approach to quality improvement on NCQA and QISMC standards and guidelines. By using a company wide approach to projects, staff is able to communicate to members and providers and improve the processes of initiatives in an efficient manner.**

- **Missouri Care has actively worked with LPHAs, providing them with billing tools and guidelines to help facilitate the billing for EPSDT services, thus improving the documentation. Missouri Care found the use of the WIC data provided on state diskette very helpful in identifying 15 new pregnant members they would not have otherwise identified as readily. In addition, Missouri Care has also provided training to WIC clinics on the use of MEDTOX (filter paper blood lead testing) and blood lead level testing. Missouri Care reports that MEDTOX appears to be as reliable as blood lead level testing. They have found that there has been an increase in the lead toxicity levels as well.**

- **Missouri Care has tracked EPSDT participant ratios on a quarterly basis since September, 2000 as they relate to specific member and provider interventions, which allows for the assessment of the relative effectiveness of these interventions. One area that has been helpful in improving EPSDT performance rates is the acceptance of denied administrative claims by the State for the HCFA-416 data reports. This model was also used to assess the effectiveness of physician's education for lead testing.**

- **The Post-Partum Depression Screening Program was initiated in October, 2002. Using all live births from Missouri Care, Magellan provided a depression screen to all new mothers. A total of 422 screening tools were sent with 58 returned. Six months of data are being reviewed. CommCare will continue screening all new mothers during the transition from Magellan Behavioral Health. No results were available at the time of review. Missouri Care also plans to review all cases of pregnant women to see if referrals have been made for behavioral health services.**

- **Missouri Care found that approximately 50% of children on the Special Needs Diskette are children who are in foster care, making it difficult to specifically identify their need based on Medicaid Eligibility Code alone. One recommendation by Missouri Care is that DFS caseworker's names are provided on the file to facilitate better coordination between Missouri Care and Family Services. One concern identified has been that DFS caseworkers were not aware they were designated contact persons for MCOs to coordinate care with children in foster care.**

- **Children with Special Health Care Needs are identified through the CAHMI survey, sent out to individuals who are listed on the Special Needs Diskette. The CAHMI survey assesses functional, service, and dependency issues. If three or more items out of the seven total items are endorsed, the MCO works with the case manager through a program at the University of Missouri- Columbia (MOPEDS) who will conduct a home visit. Missouri Care has found the use of the CAHMI effective in increasing the rate of identifying Children with Special Health Care Needs. This also allows some continuity for the case manager who may use the full 100 question CAHMI survey with the member or caregiver to identify any other needs or prioritize special needs. This survey addresses asthma, medical, and psychosocial needs among others. To facilitate provider communication regarding identification of children's needs, letters are also copied to providers when they are sent to members.**

- **In 2003, Missouri Care will institute a quality improvement program to identify pregnant women earlier. The goal is to increase early access to prenatal care from 80% to 95%. Missouri Care is also collaborating with local health departments in the central area to identify pregnant women earlier.**

Clinical Guidelines

- **Milliman and Robertson Utilization Review Criteria and Interqual Utilization Review Criteria are used and reviewed for appropriateness on an annual basis.**

- **Guidelines for the management of persistent asthma and diabetes mellitus were incorporated in July 2002, with evaluation to be conducted in 2003.**

Performance Improvement Projects

Review of the 2003 Work Plan shows continuation of ongoing projects with regularly scheduled evaluations and measurements of status and results. Providers are kept informed of improvements and areas of continued need, and staff and management are directly involved in performance improvement. Specific performance improvement initiatives conducted by Missouri Care include the following:

- **Emergency Services Utilization. Missouri Care performed an intensive analysis of member utilization of emergency services during January through September 2001. After reviewing discharge diagnoses and weekday vs. weekend time of visit, Missouri Care determined that 43% of the visits were appropriate. Further analysis suggested that members either chose or were assigned to PCPs whose offices were not near their homes and access to providers for adult care was lacking in the western portion of the region. Because almost half of the ER visits were considered appropriate, the MCO recognized that it would be more efficient to concentrate on addressing non-emergent visits. The following corrective action plan was developed to address issues identified in the study:**

- o **Members who have not been seen by their PCP would be contacted and encouraged to schedule a visit;**

- o **High ER utilization members will be placed in case management as appropriate;**

- o **Members will be encouraged to select local PCPs and Missouri Care will attempt to expand the provider network in areas of need;**

- o **The Medical Director will contact providers with closed panels and encourage them to accept new patients;**

- o **PCP assignment procedures will be reviewed and revised to prevent improper assignments;**

- o **Advocate better access with dental subcontractor;**

- o **Develop ER activity report to monitor for over- utilization patterns.**

Missouri Care has instituted a process of following- up on individuals who are discharged from the hospital, reviewing whether or not they understood discharge instructions, and making sure they have medication to avoid re- admission. This was conducted in the first and second quarters of 2002. It is believed that 50% of re- admissions are for the same diagnosis. As a result, there was evidence of a 14% decline in re- admissions for particular diagnosis. Missouri Care has also tracked denials for facilities and found that many of these were administrative denials, especially for not notifying Missouri Care.

- • **EPSDT and Lead Initiative. Missouri Care continues to perform ongoing evaluation of its EPSDT and Lead Initiatives program, revising interventions as necessary with continued emphasis on provider and member education and outreach. Results show improved participation rates as evidenced by HCFA 416 methodology and HEDIS results. Lead testing according to Missouri Care data has progressively increased from 8.56% and 5.97% for one- and two- year olds respectively to 29.02% and 17.24%, proving the effect of their ongoing efforts. EPSDT rates have also improved but by a lesser degree. The MCO not only provides reminders to members but also provides monthly outreach postcards and quarterly reports of members due for exams to PCPs. Missouri Care actively collaborates with many different community and state agencies and uses a company- wide approach in communicating the EPSDT and Lead Testing message while performing outreach. Missouri Care has begun to download data from the MOHSAIC system, finding approximately 700 matches between members and immunizations that were not previously captured. Although they were able in the past to enter data into the MOHSAIC system on member immunizations, they were not able to retrieve it.**

- • **For the mandatory EPSDT forms, Missouri Care has been educating providers about the requirement for using this form through the Doctor TIPS program and the informal feedback indicates that these forms are being used consistently among many providers. Some providers have even instituted "EPSDT" Clinic Days. Missouri Care plans to audit the use of the form in 2003. One trend found was that general practitioners over 50 years of age were less likely to use the form. TheMCO is interested in looking at how well the EPSDT process is working.**

- **HEDIS rates for childhood and adolescent immunizations remained stable for children and adolescents from 2000 to 2001 (60% for childhood immunizations and 43% for adolescent immunizations). Rates of well child visits in the first 15 months; the 3rd, 5th year; and in adolescence increased for 2000 to 2001 (67%, 71%, and 63%, respectively for 2001).**

- **Overall, Missouri Care finds that the HCFA-416 rate for EPSDT participation ratio was 51% overall, with the highest rate being up to 59%. Missouri Care has attempted to replicate the HCFA-416 calculations, has had some differences in calculation, and believes that the rates for children under 1 year of age are underestimates. Missouri Care is enforcing the use of annual visits consistent with the periodicity schedule of the HCFA-416 reports for 6 year olds, and the school system is reinforcing this message. Providers are billing Missouri Care for sports physicals, to facilitate coordination of care for adolescent males who tend have the lowest EPSDT rates.**

- **HEDIS Initiatives. Missouri Care considers HEDIS results to be reflective of its preventive care programs for the members, however, like other MCOs, has recognized that there are barriers in collecting accurate data proving that services have been rendered. In addition to aggressive outreach activities, the MCO is focusing efforts on improving its ability to collect data and educate providers on correct billing procedures. HEDIS results for 2002 were not available at the time of the review but the MCO has shown stable or improved rates for most HEDIS initiatives over the 1999 through 2001 reporting years. Missouri Care finds HEDIS data to be a reliable indicator of the care that is being documented and provided to members. They have HEDIS indicators audited for consistent forms and documentation and also receive technical assistance. However, they are not able to give provider-level feedback on this.**

- **Children with Special Health Care Needs (CSHCN). The CSHCN program's key is early identification and efficient medical management through the continued collaborative efforts with various partners and Missouri Care staff. Those children with special complex needs that require extended coordination of services are referred to the Missouri Partnership for Enhanced Delivery of Services (MO-PEDS), a continuing collaborative project under a Robert Wood Johnson grant, with the University of Missouri – Columbia Department of Child Health and Children's Hospital, the Bureau of Special Health Care Needs and Missouri Care. The goal of this program is to "promote quality improvements in the system of health care for children with special health care needs and their families". Through intensive screenings and ongoing assessments, the program has managed the care of 22 Missouri Care members and overall satisfaction rate has been 95%. Further evaluation of services provided under the MO-PEDS program is in progress.**

- **Readmission Intervention Project. A three-month study was initiated in August 2002, which involved contacting members within two and seven days of discharge from the hospital with the goal of reducing preventable readmissions by 25% and reducing Emergency Room utilization. Analysis of the project was scheduled for November 2002. However, results were not presented in documentation. Missouri Care is encouraged to continue with the project to determine the effectiveness of follow-up for discharged members.**

- **Dr. TIPS (Tools and Information for Provider Success). Missouri Care has designed a program for provider education offering comprehensive, helpful information, sample tools for documentation, and ways to collaborate with theMCO to improve services such as EPSDT and Lead screening and testing. Dr. TIPS was mentioned throughout Missouri Care's summary of 2002 performance improvement projects as a useful form of communication to providers. As another example of potentially effective provider outreach, it is suggested that the MCO assess provider acceptance to Dr. TIPS including use of the tools and whether there are other areas that providers may need information.**

- **Prenatal Assessment of Domestic Violence. Missouri Care conducted a study on the risk factors for high risk pregnancies with a survey on teen pregnancies. The hypothesis was that substance abuse would be the prime factor. The finding was that domestic violence was the strongest predictor of high risk pregnancy. Domestic violence was identified as the strongest predictor of high risk pregnancy with a low birth weight baby occurring. As a result, Missouri Care developed a Domestic Violence Program, which is an excellent example of using data to develop quality improvement initiatives and projects. Utilizing the approaches learned at a Center for Health Care Strategies conference, "Towards Improving Birth Outcomes", Missouri Care analyzed birth outcome data from a comprehensive plan-created prenatal database and determined that domestic violence was the primary modifiable risk factor for low and very low birth weight babies in its membership. TheMCO also concluded that most providers were uncomfortable asking questions about domestic violence and members were reluctant to share personal experiences. To address this issue, Missouri Care developed the following materials and programs:**

  o **Provider training to identify, assist, and provide services to domestic violence victims;**

  o **Screening tool and reference guide using American College of Obstetrics and Gynecology (ACOG) information;**

  o **Resource directory containing tools, provider materials and ACOG resources, and**

  o **Supplies for provider offices and bathrooms allowing easy and discreet access for members in need. Missouri Care is planning to write a grant to expand information for providers/patients about community services (i.e. hotline, pamphlets, exam room information).**

As part of the Domestic Violence Program, Missouri Care staff reviewed emergency care to determine if it was related to domestic violence. Provider acceptance of this project has been very high and reported domestic violence cases increased by the beginning of third quarter 2002 as compared to the previous year. Missouri Care is seeking in 2003 to expand access to community services and a list of statewide shelter and hotline access through distributions in police departments, shelters, provider examination rooms and women's restrooms. Missouri Care has applied for a Best Practice grant to continue the initiative and is to be highly commended for the activities.

Cultural Competency

- **Missouri Care conducted an audit of the primary language spoken by members as transmitted on the eligibility file and concluded that foreign language counts do not accurately reflect the distribution of the non-English speaking population. Of 31,293 total members, 59.0% were English speaking, while 48.9% were "unreported" languages. The next largest group was Spanish speaking (.5%), followed by "other" (.34%), Russian (.11%), Vietnamese (.05%), Arabic (.03%), and Chinese (.02%). The large amount of incomplete items on this form makes it difficult to accurately determine the distribution of the population's primary language competencies. Additional data on the language of members compiled from the Health Baseline Assessment indicated three hundred sixty three (363) members self-reported as non-English speaking, with Spanish being the most frequent (160); 44% of the non-English speaking population.**

- **Missouri Care has identified incomplete reporting on the Baseline Health Assessment Form for a high-frequency foreign language (Bosnian). There has been a noted increase in Hispanic & Bosnian members in the Central Region.**

- **The Member Handbook provides text in both English & Spanish on how to access interpreter services, as well as accessibility for visually and hearing impaired.**

- **The New Member Packet includes flyers and pamphlets with English, Spanish, and Bosnian translations, consistent with Missouri Care's assessment of the language needs of the member population.**

- **Patient education materials are available in English, Spanish, Bosnian and Vietnamese, and are distributed to local clinics as well as the Refugee & Immigration Service office. Missouri Care advertises services in various local Spanish publications and resource centers. Spanish Missouri Care materials are distributed at the Spanish WIC clinic.**

- **The compliance hotline & inbound greeting on the 1-800 line contains a foreign language greeting with instructions for accessing interpreter services.**

- **Missouri Care benefits from the experience of a staff member with an educational background in cultural/linguistic anthropology. Employee training on cultural & linguistic competence is ongoing (There were 7 sessions in 2002). Multi-cultural health resource and language training are provided to Family Health Center, to include cultural insight into the Bosnian refugee population. Missouri Care has sponsored provider workshops on cultural sensitivity and appropriate cultural issues; handouts, interactive video references distributed at health fairs, site visits, etc. Missouri Care and the local FQHC conducted a joint training program on the needs of Bosnian women receiving perinatal care, specifically their needs as survivors of genocide practices and recognition and treatment of post-traumatic stress disorder. In 2002, Missouri Care was recognized by DMS for outstanding achievement in education and outreach activities for immigrants & refugees residing in the Central Region.**

- **Language needs are incorporated into internal reports for medical management projects (EPSDT, etc.).**

- **Health Baseline surveys are "flagged" & referred to medical/case management for quality follow-up when the need for language or TDD is documented.**

- **Cultural competency program is organized and multi-faceted. Cultural sensitivity training has been implemented throughout the organization and provider network, needs assessment is on-going, and significant resources (both monetary and personnel) have been dedicated to the program.**

- **Missouri Care and the local FQHC conducted a joint training program on the needs of Bosnian women receiving perinatal care, specifically their needs as survivors of genocide practices and recognition and treatment of post-traumatic stress disorder. Missouri Care plans to monitor any increase in behavioral health referrals to assess outcomes.**

Grievance Systems

- **Missouri Care noticed an increase in appeals at UMC after the Hunter Group came in (n=90 appeals, with a typical average of 20-33 appeals). Thirty-nine percent of these appeals were overturned in 2002. Many of the reasons included the patient not having an ID card. Most denial letters are sent out within 1 business day (84%), within two days (11%), or within 3 days (3.5%). In 2003, Missouri Care plans to institute a quality improvement project for the identification of pregnant women based upon the observed reduction in identification of pregnant women from 95% to 80%. Missouri Care believes this may be related to ME code data which has been used regularly as a tool to identify pregnant women.**

- **The rate of member medical complaints in 2002 was 1.52 per 1,000 members, a slight increase from 1.29 per 1,000 members in 2001. This rate is slightly higher than the rate for all Central Region MCOs (1.39 per 1,000 members), and lower than the rate for all MC+ Managed Care MCOs (1.49 per 1,000 members). Complaints regarding quality of care represented the highest proportion of member medical complaints, at .56 per 1,000 members. The rate of complaints regarding denial of services declined greatly between 2001 and 2002 (.61 per 1,000 members and .36 per 1,000 members, respectively).**

- **The rate of member non-medical complaints in 2002 was 1.71 per 1,000 members, a slight increase from 2001 (1.22 per 1,000 members). This rate is lower than all Central Region MCOs (1.96 per 1,000 members) and the rate for all MC+ Managed Care MCOs (6.41 per 1,000 members). Like all other MCOs, the largest proportion of member non-medical complaints consisted of complaints about transportation services (1.38 per 1,000 members). The rates of denial of claims and complaints regarding waiting and staff behavior all declined from 2001 to 2002.**

- **There are fewer complaints about transportation vendors not showing up and more complaints about them being late to provide transportation.**

- **There were no provider medical complaints recorded in 2001 or 2002 for Missouri Care. The rate of provider non-medical complaints in 2002 was .07 per 1,000 members, a decline from 1.44 per 1,000 members in 2001. This rate is lower than all Central Region MCOs (8.60 per 1,000 members) and all MC+ Managed Care MCOs (9.50 per 1,000 members). Provider non-medical complaints consisted primarily of denial of claims (.03 per 1,000 members).**

Case Management

- **Although Missouri Care uses all definitions of case management described in the state contract for managed care, the one that is most frequently used is:**

    o **"coordinating the provision of health care so as to improve its continuity and quality."**

- **On a daily basis, Missouri Care examines a log sheet from each provider hospital and reviews it for case management needs. Some of the most frequent diagnoses for Emergency Room are otitis media and pharyngitis.**

- **Members are identified for case management through HealthConnect 24, the UMC Nurse Call Line that manages all of Missouri Care members. The Nurse Call Line faxes daily to Missouri Care a list of all members who called, whose cases are then reviewed for the need for case management.**

- **The Boone County Health Department is contracted with Missouri Care to provide case management for perinatal cases.**

Interagency Coordination

- **Magellan Behavioral Health is working with the Behavioral Health Subgroup to identify procedures for communicating between the PCP and behavioral health provider.**

- **Magellan Behavioral Health has had more success in the Central Region working with providers and DFS supervisors than in any other region, with the Central Region rapidly incorporating experiences of the Eastern Region. Also, some of the issues and concerns with the system are much less complicated in the Central than in the Western Region.**

- **Missouri Care and Magellan worked with the State Mental Health Subgroup to develop the universal consent form for members receiving behavioral health services.**

- **Missouri Care has identified a problem of coordination with methadone treatment facilities. These facilities provide methadone maintenance to members, which is carved out of the C-STAR Program. There are an increasing number of these facilities, but none are Medicaid providers.**

- **Missouri Care plans to work through the new behavioral health vendor to improve coordination with the courts for children court-ordered for evaluations in the future.**

Missouri Care Health Plan

2002 External Quality Review Summary

Conducted on Thursday, March 20, 2003

The results of the on-site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for Missouri Care in providing care to MC+ Managed Care members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

∨ **There were improved and stable rates of provider network adequacy for PCP, specialist, and ancillary services as well as facility rates. Documentation of emergency medicine specialists increased between 2001 and 2002.**

∨ **There were improved rates of member medical complaints, especially with regard to the denial of services; and there were improved rates of member non-medical complaints.**

∨ **There were increased penetration rates for behavioral health services between 2000 and 2001.**

∨ **There were very few provider complaints in 2001 and in 2002; and provider turnover is low (5%).**

∨ **The development of user friendly provider manuals and guides such as Dr. TIPS and HIPAA TIPS is also strength in the area of provider education and training.**

∨ **Missouri Care is to be commended for its ability to engage members on a regular basis for its Member Advisory Group consisting of approximately 15 families. They also have the lowest rate of returned mail (6%) in the State, partially due to the greater stability of the population.**

∨ **Performance Improvement Projects and measurements as well as the leadership of the Quality Management Department are a significant strength. The method, planning, measurement, and feedback to all departments regarding the effectiveness of clinical and non-clinical interventions facilitate decision-making and have resulted in demonstrated improvements in healthcare delivery. The method of linking interventions with rates allows for the assessment of their effectiveness. Also, database capabilities are increasing such that outcomes (e.g., birth outcomes) may be linked with interventions. By performing ongoing analysis of the status of projects, theMCO is able to revise and improve its actions in a timely manner in its pursuit of improvement. We encourage continued activity in the above projects and look forward to the results of the innovative prenatal domestic violence initiative.**

∨ **A HEDIS Post-Mortem Barrier Analysis and Workplan were conducted to identify barriers noted across various aspects of consumer, provider, MCO, and health system issues and focus intervention efforts. There were improvements in HEDIS measures from 1999 - 2001 as a result (60% rate of childhood immunizations, 84% on timeliness of prenatal care, and 67% on well-child visits in the first 15 months of life). Missouri Care uses audited HEDIS measures to assess performance and finds that they accurately reflect the quality of care.**

∨ **Missouri Care has effectively incorporated lead screening at WIC Clinics and worked with LPHAs. A major accomplishment is the increase in lead testing rate at 12- and 24-months of age.**

∨ **Increases in the EPSDT Participation Ratio were evidenced between 2001 and 2002. As one mechanism for improving rates, Missouri Care regularly reviews the completion of EPSDT services for those engaged in ancillary services and awaits completion of overdue EPSDT before re-authorizing services.**

∨ **The identification of domestic violence as a major risk factor for pregnant women, education of providers, and goal of expanding provider education and member accessibility to community-based support services is a strength which highlights the effectiveness of the QI program in identifying unmet needs, risk factors, and areas for intervention.**

∨ **Missouri Care has developed an active cultural competency program, identifying members with language needs for medical management; on-going needs assessment; and training providers in the medical issues of specific populations. This was recognized by DMS as an outstanding achievement.**

∨ **The screening total for children to assess whether medical necessity for those with special healthcare needs exists is a strength, as it employs a standard screening tool which takes into account the level of need and functioning of the child rather than diagnosis alone. This is a promising practice which also holds potential for evaluation and monitoring.**

Opportunities for Improvement

ü **The rate of electronic claims submission is approximately 40-50%, whereas it is at least 60% in other MCOs. It is recommended that Missouri Care continue to encourage providers to submit claims electronically for faster reconciliation and payment. It is recognized, however, that the more rural nature of the provider network likely contributes to provider resource availability or reticence to this technology.**

ü **Opportunities for improvements in provider network include improvement in Audiology services.**

ü **There were decreased inpatient admissions and days for behavioral health and substance abuse disorders between 2000 and 2001. There were also decreased ambulatory visits for behavioral health between 2000 and 2001.**

Ü **It is recommended that evaluation of the CAHMI short- and long- forms be conducted to determine the factors that are most related to the effectiveness of case management, and the characteristics of members identified for case management.**

Ü **Continue with plans to improve EPSDT through schools and LPHAs.**

Ü **Missouri Care may wish to obtain self- report information from caregivers about children whom are overdue for EPSDT services or immunizations to supplement reporting and capture of EPSDT completion rates.**

Ü **Continue to work with methadone treatment facilities to coordinate methadone treatment for members.**

Ü **There were increased member complaints regarding quality of care, ability to obtain appointments, and transportation services. These should continue to be monitored for quality improvement purposes.**

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003
[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Group, 2003

2002

Missouri MC+ Managed Care Program

External Quality Review

Family Health Partners

AUTHORS:
Janet Reed, PhD, MHA
Vice President, BHC, Inc.,
Director, Performance Management Solutions Group

Jutta Hopkins, PhD, RN
Health Services Researcher
Performance Management Solutions Group

William Chase, MPPA, MSCIS
Senior Research Analyst, Data Manager
Performance Management Solutions Group

Site Visit Date   Thursday, February 27, 2003

Subcontractors

Transportation:	**Medical Transportation Management (MTM)**
Dental:	**Bridgeport, Inc.**
Mental Health:	**CommCare, Inc.**

Compliance with Standards and Operations

Enrollee Rights and Protections

- At the time of the site visit, Family Health Partners had obtained an extension from the State for submission of the Fraud and Abuse plan. Family Health Partners has assessed each department for strengths and weaknesses with regard to fraud and abuse, and has provided education on the detection of fraud and abuse. The MCO also maintains an Internal Audit Committee, with representation from every department.

- The Compliance Plan and training of employees on confidentiality, security, and patient rights/protections is conducted through the Employee Manual distributed by Children's Mercy Hospital. In addition, employees are required to meet with each department manager at Family Health Partners for orientation and review of departmental policies and procedures. Employees are oriented within the first month of employment at Family Health Partners, and provided with their own copy of the Corporate Integrity Plan notebook. Policies are also available on-line, via the Family Health Partners Intranet. Policies include how to file a report and methods of providing a report confidentially. Employees are able to call the Family Health Partners or Children's Mercy Hospital compliance hotline.

- On a quarterly basis, a random sample of claims is conducted for 10% of each examiner's claims to assess accuracy of financial and procedural coding.

- Employees are provided with the opportunity at the time of any exit interviews to file fraud/abuse reports. The Administrative Oversight Committee (AOC) meets weekly to discuss any possible compliance issues.

- Although not required to be implemented until April 2003, Family Health Partners has prepared for HIPAA training in a number of ways. The Corporate Compliance Officer has met with every Family Health Partners employee to conduct an individual assessment of their job roles and duties, and how they handle, store, and/or transmit Protected Health Information (PHI). Results of this and an organizational assessment have lead to the physical seclusion and increased security of the finance department, installation of fax capabilities at each workstation deemed necessary, and implementation of password protection/desktop security of computers.

- Education on HIPAA will be conducted formally by the end of March for all employees. Ongoing training is conducted through email tips and trivia ("HIPAA Jeopardy") as well as the employee newsletter.

- **A non-punitive method of maintaining vigilance to the protection of health information is the requirement of the last person in the office to check all work areas for unsecure information, secure it, and place a "HIPAA hippo" picture at the workstation as a reminder.**

- **To improve security, the finance department was moved to an enclosed area.**

Claims Processing

- **Family Health Partners (Family Health Partners) had 98% clean claims within 30 days as a result of a strong effort to assess claims error reports and follow-up on a daily basis. The MCO is having problems with the data processing vendor and are seeking a better vendor.**

- **Family Health Partners implemented a major upgrade in software for claims audits/flow, and the ability to randomly sample claims.**

Credentialing and Re-credentialing

- **Provider credentialing policies were updated in 2002 and finalized in early 2003, to include re-credentialing every 3 years.**

- **Provider oversight is conducted for approximately 50% of the network (Children's Medical Center, Truman Medical Center, and St. Luke's Hospital), employing chart audits which incorporate NCQA criteria.**

- **Family Health Partners also credentials ancillary providers.**

- **During 2002, 150 of 154 providers due for re-credentialing were reviewed, exceeding the 75% goal for this benchmark indicator.**

Vendor Oversight

- **Oversight is conducted through regular meetings with vendors, reviews of claims and outstanding claims, review of complaints, and the annual review of quality reports.**

- **Vendors have moved toward a paperless referral process, and (mental health, dental, and transportation) participate in Medical Management Committee.**

- **Family Health Partners has retained the same dental vendor (Bridgeport Dental Services) since 2000.**

- **Oversight is conducted through the Medical Oversight Committee, which receives reports from Quality Management, Pharmacy and Therapeutics, and Credentialing Committees. The Medical Oversight Committee reports to the Board of Directors.**

Access

Member Services

- **Member and provider satisfaction has improved since last year, as has access to services.**

- **To improve access to dental care services and address a high volume of denials for non-covered orthodontic services, Bridgeport instituted a process of having referrals for orthodontic services screened for medical necessity by a dental hygienist at the UMKC dental school. This has improved the access to dental care by reducing the time for screening at appointment time by orthodontists for non-covered services. Additional screening is also conducted by the Children's Mercy Hospital Cleft Palate Clinic.**

- **Family Health Partners planned to print a new provider directory in March, 2003, after incorporating all updated provider information.**

- **There are currently six Customer Service representatives at Family Health Partners, with one open position and no turnover in 2002.**

- **Customer services representative positions are supplemented by claims representative positions, which requires cross-training and facilitates a faster response to member issues. This has also facilitated identification of claims issues for correction.**

Provider Network[1]

- **The provider turnover rate was less than 3% for Family Health Partners in 2002.**

- **According to the 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance (MDI), Family Health Partners overall network adequacy was 99%, above the 95% threshold. The 2002 Network Adequacy Analysis conducted by the MDI indicates that as of December 31, 2001:**

  m **Family Health Partners' network adequacy for PCPs, specialists, facilities, and ancillary service providers were above the 95.0% threshold in 2002, with an overall network adequacy rate of 99.0%.**

  m **Family Health Partners improved ancillary provider network adequacy from 94.0% to 98.0% adequacy, raising the rate above the required threshold (95.0%) for adequacy.**

  m **Network adequacy for specialists in neurology and pathology improved from below threshold to above threshold rates of adequacy (from 91.0% to 98.0% for neurology; and from 93.0% to 96.0% for pathology) between 2001 and 2002.**

  m **Although below threshold, the rate of adequacy for hospice improved from 67.0% to 89.0% adequacy.**

  m **Rates of specialists in rheumatology remained stable, at 91.0%; while Family Health Partners evidenced a reduction in the rates of child/adolescent psychiatrists, from 100.0% to 73.0%.**

  m **Reduction in inpatient geriatric intensive treatment facilities, from 100.0% to 92.0%, below threshold.**

- m Family Health Partners demonstrated a stable rate of adequacy for tertiary hospital facilities, at 91.0% for 2001 and 2002.

- Family Health Partners was granted network exceptions for home health in Cass county; and hospice in Clay, Johnson, Lafayette, Platte, and Ray counties.

- Exceptions in St. Clair County included home health, hospice, dermatology, infectious disease, nephrology, and physical medicine/rehabilitation.

- A requested exception for cardiology was not granted due to the nearest network provider being located more than 25 miles from the nearest available provider.

- To address the difficulty maintaining provider network adequacy for orthopedic specialists, Family Health Partners is taking the approach of requesting a number of providers to each accept just one patient.

- Approximately 90 additional providers were added to the network of behavioral health providers due to the increased need for services from Division of Family Services (DFS) referrals, court-ordered evaluations, and custody issues.

- To facilitate provider retention, Family Health Partners providers $20 more than the Medicaid fee-for-service rates for EPSDT services.

- A provider survey was conducted in November, with additional mailings occurring in January due to low response rate. Findings indicated higher satisfaction than in the past. Family Health Partners attributes this to the increased frequency of face-to-face interactions with provider offices by provider representatives.

- The provider network is maintained through a specialized network database and software package (CACTUS).

Provider Education, Training, and Performance

- PCP offices are visited monthly, with specialists and hospitals being visited twice annually. Family Health Partners maintains 3 full-time provider representatives, with one for hospitals and two for other providers. One provider representative was added in 2002 to improve the amount of face-to-face contact time with providers.

- Newsletters are sent to providers every other month, with topics such as pre-certification, billing and coding, and paperless referral processes.

- In 2003, provider manuals will be revised to be briefer and useful as a quick reference guide.

- PCP medical records are reviewed for availability of routine, urgent, and emergent care.

- Family Health Partners and CommCare planned a series of educational programs for behavioral health providers. A pharmacy utilization review is used to facilitate identification of timely topics. The education will also be conducted with the Family Health Partners provider network as a whole.

Utilization/Medical Management

- **Medical Directors' rounds occur three times weekly, with discussion of high risk cases.**

- **Three nurses are located on-site at Children's Mercy Hospital, St. Luke's Hospital, and St. Joseph's Hospital. All other pre-certifications are conducted by telephone. Case management is triggered by ER reports, claims, and utilization review. Previously, the roles of case managers and pre-certification staff were less defined.**

- **CommCare, the behavioral health vendor of Family Health Partners brought utilization review activities in-house during 2002, to conduct authorizations for inpatient services. The Community Mental Health Centers (CMHCs) conduct their own authorizations for outpatient services with oversight by CommCare.**

- **The CommCare Quality Improvement and Community Relations Committees have representation from the CMHCs. Utilization management is conducted for inpatient services, with case managers working with the CommCare Medical Director and referencing medical necessity criteria for prior authorization.**

- **CommCare has developed its own criteria for medical necessity, based on community norms and with involvement from the Quality Improvement Committee and Board Certified Psychiatrists. Criteria are reviewed annually.**

- **Chart reviews for behavioral health services were conducted for at least 30 charts at each Community Mental Health Center (CMHC), with a checklist of 27 items and a goal of 85% of the criteria met. This threshold was met and exceeded during 2002 (97% - 98%).**

- **One item measured is the involvement of the PCP and consent for the behavioral health provider to communicate with the PCP, with a standard of 85%, which was met in 2002.**

- **CommCare provides incentives for submission of encounter data by CMHCs, with corrective action plans and financial penalties for rates lower than threshold.**

- **For 2003, CommCare will be working with Family Health Partners to identify mental health warning signs.**

- **The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:**

  - **The total penetration rate for behavioral health services was 5.6% in 2001.**

  - **Outpatient visits increased from 1999 to 2001, from a rate of 243.2 to 301.5 per 1,000 in 2001.**

  - **The rate of alternative services was 2.4 per 1,000 in 2001.**

  - **Partial hospital admissions per 1,000 were to .7 per 1,000, relatively consistent with 1999 rates (.6 per 1,000); and partial hospitalization days declined from 1.3 in 1999 to 2.4 per 1,000 in 2001.**

  - **There were 2.3 residential days per 1,000 in 2001, an increase from 0 in 1999.**

  - **Inpatient admissions increased from 4.5 per 1,000 in 1999 to 7.5 in 2001. Inpatient days increased from 17.1 to 34.2 days per 1,000 between 1999 and 2001.**

- m **Inpatient substance abuse admissions increased from 0 per 1,000 in 1999 to .3 per 1,000 in 2001. Inpatient substance abuse days per 1,000 increased from .1 to .9 per 1,000 between 1999 and 2001.**

- m **The 30- day follow- up rate after hospitalization increased from 51.0% to 57.9% between 1999 and 2001. The 7- day follow- up rate increased from 30.0% to 34.0% in 1999 and 2001.**

- m **The 7- day follow- up rates presented by CommCare indicated that 58% of patients discharged were seen; and 96% had follow- up appointments. The 30- day follow- up rate was reported to be 98%. Re- admission rates were 15% at 30 days post- discharge, and 20% at 90 days post- discharge.**

- **Denials are tracked routinely, with improvements in the results of follow- up.**

- **From January to August 2002, there were a total of 69 denials, a majority of which were denied due to lack of medical necessity.**

Quality

Quality Management

- **Family Health Partners has been under new leadership, with a new CEO appointed in March, 2002.**

- **The "Iceberg Award" is used to reward employees for internal performance improvement projects.**

- **The Quality Action Committee (QAC) was formed in October, 2002 to meet separately and review quality of care. This committee is chaired by the Medical Director and reports to the Medical Oversight Committee. Data reviewed include the Consumer Assessment of Health Plans (CAHPS) Survey, review and follow- up on quality of care complaints or issues, review PCP changes, and examine EPSDT encounters.**

- **Quality data combine contractual targets, Healthy People 2010, and HEDIS indicators as comparisons of benchmarks for performance, and trending Family Health Partners rates from 1999 – 2001.**

- **The MCO now has a data warehouse that provides linked data for use in quality studies.**

- **2003 clinical Quality Improvement (QI) programs will include examining re- admission rates, increasing coordination between PCPs and mental health providers, developing a case management scale to be able to predict the level of intensity of mental health services, and reduce utilization through reducing utilization in small increments. CommCare is in the process of developing a Depression Screening tool and plans to link this with pharmacy data for antidepressant medications.**

- **The Corporate Dashboard Reports provides ongoing reporting of call abandonment, average response times, rate of returned mail (5.09%), the number of sanctioned providers (0), and 24- hour availability of providers (100%).**

Clinical Guidelines

- CommCare is working with Family Health Partners to conduct pharmacy profiling for PCPs and specialists to identify psychotropic medication issues and potential behavioral health needs.

- CommCare has also developed mixed medical and behavioral health protocols, such as OB and behavioral health protocols.

Performance Improvement Projects

Family Health Partners (Family Health Partners) provided extensive summaries of its performance improvement projects for the 2002 EQRO review. The MCO is assertive in its approach to timely issues as summarized below and uses an effective approach to present summaries of its projects. The descriptions however did not consistently report measured data or the committees' interpretation of results. Family Health Partners notes that all projects are on-going and is commended for recognizing the value of its efforts to improve the quality of health care provided to its members.

- Prenatal, Delivery and Post-Delivery Services. From May 2002 through August 2002, Family Health Partners performed a focus study to evaluate the relationship between the timing of notification by trimester to the MCO of pregnant members and birth outcomes, including gestational age at delivery, vaginal vs. cesarean delivery, Apgar scores, and birth weights. The topic was chosen after analyzing quality indicator data presented by the Missouri Department of Health and the Missouri Patient Care Review Foundation 2000 and 2001 EQRO reports with the intent of enhancing case management efforts to improve perinatal outcomes by receiving early notification of pregnant members. Objective data were summarized in September 2002 and the decision was made to continue monitoring prenatal notifications to the MCO, collaborate with OB/GYN providers to encourage early notification to the MCO, and monitor birth outcomes. Approximately 85% of deliveries occur at hospitals, whereupon case managers meet with new mothers to provide prenatal education and information, EPSDT education, and contact information. Approximately 85% of new mothers were reached in the hospital, receiving educational materials regarding EPSDT and postnatal care.

- One nurse is designated for High Risk OB discharge planning. The MCO has identified clinics not referring pregnant mothers to the MCO for education. Family Health Partners is currently monitoring the completion and rate of Prenatal Notification Forms (PNF), the timing of notification, and the relation between this and other indicators such as Apgar scores, birthweight, gestational age at time of birth, and length of gestation. A database has approximately 500 cases from November 2002 through February 2003, and providers increased submission of pregnancy notification forms to the MCO. The pregnancy notification form and risk assessment are being sent to case managers to implement case management. Family Health Partners conducted a study to determine the number of members who accessed prenatal care during the second (18%) and third trimesters (12%) who would have been eligible for case management had the MCO been notified of patients. This study and data can be used to identify providers in need of performance monitoring and education.

- **EPSDT Outreach. Family Health Partners has concentrated efforts since 1998 to develop its EPSDT outreach and delivery program according to contractual requirements. In response to the notification from the Division of Medical Services in 2002 regarding the low EPSDT rates among MC+ Managed Care MCOs, Family Health Partners initiated a concentrated evaluation and analysis of the current outreach services. The study was conducted in an organized manner by first evaluating existing data and comparing the participation ratios for each age group and rate cell. The analysis identified specific areas of needed improvement such as adolescent males having the lowest participation ratio. Family Health Partners recognized several groups as first line health resources, including providers, families, school nurses, and community stakeholders, and evaluated their current activities to improve potential outreach by these groups. Interventions now include:**

  - **EPSDT reminders by telephone and mail to members;**

  - **focused provider education and medical record review;**

  - **direct EPSDT education to the Kansas City Missouri School District school nurses; and**

  - **increasing community awareness of the EPSDT program by forming a task force and providing education to various community groups.**

The Kansas City school district will begin billing for EPSDT services and Family Health Partners is working with LPHAs to get them to bill for services and increase the documentation of EPSDT services. Another approach to improving data capture used by Family Health Partners is downloads of MOHSAIC data in preparation for HEDIS audits.

- **Family Health Partners recognized needed improvement in lead screening and testing and the accurate capture of data indicating these services were rendered. Evaluation of current activities identified missed opportunities for both members and providers. Members did not always follow providers' orders for the lead testing and service providers such as WIC offices, clinics, public health agencies, did not consistently bill for their services or forward results to the MCO for reimbursement or data collection. Interventions have included focused education to providers and members, collaboration with various community agencies to ensure earlier identification of members and data submission, and designating a Family Health Partners Case Manager to ensure continuity of care, consistency of interventions and improve tracking. Family Health Partners plans to continue monitoring the effectiveness of their lead screening and testing activities. Baseline measurements were not cited in documentation provided therefore it is suggested that Family Health Partners report baseline data and future results to their Quality Management Committee at regular intervals. Lead testing is conducted through capillary sampling which is reportedly associated with increases in venous blood draws. Additional evaluation of such interventions are planned for 2003. Family Health Partners is working directly with laboratory vendors to increase the receipt of lab results, and are tracking all children with Blood Lead Levels greater than 10 μg/dL. The MCO also provides information to PCPs regarding results. Case management is conducted with all children who have blood lead levels of 10 μg/dL or greater. The MCO has found that many are being conducted by the LPHAs.**

- **Parent education regarding the importance of lead screening is conducted partially through the new mother educational materials distributed after delivery.**

- **Reduction of Inappropriate Utilization of Emergency Department (ED) Services.** Family Health Partners initiated this utilization management project in 2002 with plans to continue into 2003. The premise of the project is that inappropriate use of emergency services can lead to non-compliance with preventive services, a lack of coordination of care between providers, and increased costs of services. Family Health Partners developed the following reports in relation to the project:

  - Members with more than 2 ED visits in 60 days;
  - Monthly ED Utilization of all members visiting ED;
  - Weekly Children's Mercy Hospital ED visits by members;
  - Monthly Nurse Advice vendors' utilization reports.

Analysis of the above reports identified areas of concern for the MCO and staff is focusing efforts to provide case management activity as necessary and educate members through various means. Family Health Partners plans to continue to monitor the effectiveness of their interventions and create methods to decrease inappropriate utilization.

- **Family Health Partners has developed an extremely comprehensive approach to identify and manage children with special health care needs (CSCHN). Family Health Partners recognized that it needed to assess its current ability to identify CSHCN early and how well it was coordinating the services that this population requires. By critically evaluating processes in place, Family Health Partners was able to address areas of needed improvement and implemented several new interventions including, but not limited to, the following:**

  - Development of a case management quick reference guide for providers to identify triggers for referral; staff and provider education;
  - CSHCN task force to explore methods of identifying, defining, stratifying and intervening with this population;
  - collaboration with community agencies and appropriate providers such as DFS, Children's Mercy Hospital, and CommCare; and
  - Development of an asthma management program, *KC Camp*, with the Asthma Clinic at Children's Mercy Hospital.

- **For children with special health care needs (CSHCN) and children in alternative care (approximately 600 children), Family Health Partners was planning on hiring one FTE position to track healthy children in alternative care and follow-up on them.**

- **The Special Needs Committee consists of representatives from the Quality Improvement, Medical, and Case Management departments. Those with special needs are identified through ICD-9 codes and claims history for case finding. Family Health Partners found that most of those who were identified through this process had already received case management, or were screened at some point for the needs for case management. For 2003, Family Health Partners will be working to address children in Category of Aid 4 (COA4) outside of Jackson County.**

- **Children enrolled in the Care Management Organization (CMO) are monitored by the Special Needs Coordinator. There has been a range of one to three cases at any time requiring monitoring.**

- **Care Management Organization client coordination is conducted by case managers if they are located in the Western Region. The Special Needs Coordinator also attends case staffings at First Steps as well as court hearing.**

- **Family Health Partners will be monitoring the effectiveness of these new programs. It is recognized that objective data regarding CSHCN programs is difficult to collect, but Family Health Partners is encouraged to develop ways to report processes and improvement in these areas to its Quality Management Committee.**

- **Family Health Partners formed a Medical Surgical Behavioral Health Task Force in the fourth quarter of 2001 to recognize the processes in place for identification and management of members in need of behavioral health services. In collaboration with CommCare, the behavioral health subcontractor, Family Health Partners worked to improve the coordination of services by developing programs to identify members in need and refer when necessary; educating PCPs regarding referrals; reviewing encounter data to identify top diagnoses and utilization of psychotropic drugs; discussing cases at monthly Medical Director Rounds; and notification to Family Health Partners Case Managers of all inpatient admissions by CommCare. Family Health Partners has collected data showing improvement in coordination of services and is encouraged to continue with this project and report results on a routine basis to appropriate committees.**

- **Reduction of Racial and Ethnic Health Care Disparities to Improve Health Status. Family Health Partners reviewed the demographic results of the 2000 U.S. Census and identified 19 different cultural populations in the Kansas City area. It was recognized that MCO staff, providers and community groups needed education of this diverse population in order to decrease any disparities in providing health care. As a result, a local resource guide listing area organizations that offer appropriate services was developed and disseminated to staff, providers, community agencies and other groups. The *Cross-Cultural Health Care Resource Guide* has been developed and Family Health Partners is to be congratulated for its efforts in this area.**

Cultural Competency

- **Family Health Partners identified an increase in the number and diversity of cultural populations in Kansas City from 2000 U.S. Census figures.**

- **Materials on Family Health Partners services are disseminated to immigrant families upon arrival in U.S.**

- **Approximately 50% of customer service staff speak English & Spanish, one case manager speaks English & Spanish.**

- **There were no requests for other language interpreters or Braille services were made in 2002.**

- ***AT&T Language Line* is available for non-English speaking members.**

- **The *Member Handbook* and other materials are available in other languages; and member materials available in alternative formats (software) for visually impaired**

- **The goal for reduction of racial and ethnic health care disparities was incorporated in 2002 Quality Improvement Work plan for providers to use when treating minority populations, which includes information on 17 cultural groups; and is distributed to staff, network providers, & community organizations.**

- **Family Health Partners developed and distributed a local resource guide listing area organizations offering services targeting specific cultural populations. The manual distributed to providers describes the health and social beliefs and practices of a number of ethnic populations.**

- **Provider languages spoken are maintained in the CACTUS provider network database. Family Health Partners is able to identify approximately 50% of members' language and is able to match members with providers upon member request.**

Grievance Systems

- **There were a total of 205 grievances in 2002, with 25 of them being due to quality of care.**

- **The rate of member medical complaints in 2002 was 1.63 per 1,000 members, an increase from 2001 (1.22 per 1,000 members). This rate was slightly than other Western Region MCOs (1.33 per 1,000 members) and all MC+ Managed Care MCOs (1.49 per 1,000 members). The rate of complaints regarding denial of services declined from .56 per 1,000 members to .26 per 1,000 members between 2001 and 2002. Member medical complaints were primarily accounted for by complaints regarding quality of care (.73 per 1,000 members), which declined from 2001 (.58 per 1,000 members).**

- **The rate of provider medical complaints was .47 per 1,000 members, an increase from 2001 (.04 per 1,000 members). This rate is higher than the Western Region MC+ Managed Care MCOs and all MC+ Managed Care MCOs (.31 per 1,000 members and .29 per 1,000 members, respectively). Provider medical complaints were primarily accounted for by complaints regarding denial of services (.47 per 1,000 members). The rate of provider non-medical complaints was 4.10 per 1,000 members, an increase from .47 per 1,000 members in 2001. This rate is higher than all Western Region MCOs, but lower than all MC+ Managed Care MCOs (3.24 per 1,000 members and 9.50 per 1,000 members, respectively). The rate of complaints regarding denial of claims accounted for the majority of provider non-medical complaints (3.93 complaints per 1,000 members). The rates of complaints regarding billing and prior-authorization declined.**

Case Management

Family Health Partners subscribes to the case management definition as follows:

"Care Coordination is a method of coordinating the provision of health care so as to improve its continuity and quality".[3]

- **Case management teams consist of nurses and social workers, to address medical and social issues. A social worker manages CSHCN and those requiring case management for lead toxicity. Nurses conduct high risk OB, pediatric, and adult case management.**

- **For those children with Serious Emotional Disturbance (SED), the Family Health Partners case manager is informed of those receiving Targeted Case Management (TCM), who then reviews the treatment plan and needs for coordination of health care. When physical health needs are identified, the case is referred to the Pediatric case management nurse.**

Interagency Coordination

- **Children in Alternative Care are primarily managed through the Samuel Rogers and Swope Parkway Health Centers. Approximately 50% of the children listed on the CSHCN diskette are enrolled in the Alternative Care program.**

- **The Special Needs Coordinator manages the lead program, participating in community- based task forces.**

Family Health Partners

2002 External Quality Review Summary

Conducted on Thursday, February 27, 2003

The results of the on-site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for Family Health Partners in providing care to MC+ Managed Care members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

˅ A new process that is promising is the delegation of the New Member Welcome Call to the transportation vendor, Medical Transportation Management (MTM). This allows for the update of member addresses and contact information through the transportation service.

˅ The maturation of the Information Systems department has improved the ability of operations and quality of care staff to identify issues to be targeted. One example is the improvement in claims processing as a result of daily claims error analysis (98% clean claims).

˅ Through a developed shadow system for updating and maintaining members' addresses, Family Health Partners has reduced the return mail rate to 6%.

˅ Vendor oversight is conducted regularly, with quality management reporting and representation of vendors on the Medical Management Committee, and Family Health Partners auditing provider credentialing files of vendor providers.

˅ Family Health Partners has successfully contracted with a dental provider organization that has developed a mechanism to enhance access and efficiently employ the provider network for orthodontic service screening and authorization; conducts outreach (screening and education) in collaboration with city and county health departments; and indices of quality and utilization.

˅ Examples of innovative outreach efforts include conducting dental screening at a POW-WOW of the Indian Council of Many Nations in Grain Valley, Missouri; and conducting education on tooth decay secondary to continual baby bottle use with teenage mothers (Start Right/Teen Moms), and education/supplies to their toddlers. Another approach used is the screening of those who are referred for orthodontic needs is the screening of members through UMKC School of Dentistry, to provide access as well as determine whether the specific orthodontia services are a covered benefit.

∨ Family Health Partners has worked with the Behavioral Health Organization (BHO) to conduct provider training regarding the appropriate use of psychotropic medication.

∨ Improved and stable provider network for hospice, neurology, pathology, ancillary provider, PCPs, specialists, and facilities.

∨ Medical rounds involve the review of high risk cases by case managers (nurses and social workers) for high risk cases with the Medical Director, to provide peer review, support, and coordination of care. Because of the special relationship with Children's Mercy Hospital, Family Health Partners is able to closely monitor member needs and react in a timely manner to special issues as they develop.

∨ Family Health Partners uses a number of different benchmarks to examine their quality of care, including Healthy People 2010, NCQA HEDIS measures, and contractual targets for indices of care. Family Health Partners is commended for its quality improvement activities. Management is active and concentrates their efforts appropriately, performing extensive education to Family Health Partners staff, providers and community groups.

∨ The database linking Prenatal Notification Forms (PNF) to outcomes such as the rates of visits during the 1st, 2nd, and 3rd trimesters; gestational age; birth weight; and Apgar scores is an improvement in process and quality monitoring.

∨ Family Health Partners has instructed a database to match individual member and provider cultural/ethnic membership for matching, upon member request.

∨ Family Health Partners also developed and distributed comprehensive cultural resource guide.

∨ Member complaint rates regarding denial of services, denial of claims, and waiting during an appointment declined between 2001 and 2002.

∨ Interagency coordination and case management are conducted with teams of social workers and nurses, for both pediatric and adult populations. The Special Needs Coordinator works closely with vendors and internal case managers to follow- up and monitor children in the Alternative Care program and in behavioral health case management services. This provides a strong psychosocial component to case management.

∨ There was increased follow- up post- discharge for behavioral health services between 2000 and 2001; inpatient days and admissions increased between 2000 and 2001; residential and partial hospitalization rates increased for behavioral health services between 2000 and 2001; and outpatient visits for behavioral health services increased between 2000 and 2001.

∨ For CSHCN Family Health Partners formed a Special Needs Committee to review cases identified through ICD- 9 Codes and claims history for case finding and follow- up.

Opportunities for Improvement

Ü **For the pregnancy outcomes database, it is recommended that for process purposes, the number of PNF forms received at each trimester be compared against the total number of deliveries, to determine the rate of communication and identify providers that need to improve. For outcome and quality of care, it is recommended that the population risk factors be assessed in relation to the birth outcomes to identify risk factors that may be able to be impacted or identified earlier. The study is well-organized and is an improvement in process and quality monitoring. It is suggested that the MCO compare the number of Prenatal Notification Forms received to the total number of deliveries, thereby determining the effectiveness of their communication to the providers and identifying those that continue to need assistance in communicating information to the MCO. It is also suggested that risk factors be associated with birth outcomes to determine their impact. Analysis of the risk factors and birth outcomes could identify where the MCO needs to focus obstetric case management activity.**

Ü **Given that Family Health Partners and its dental vendor are delivering dental screening services, it is recommended that to the extent possible, these screens be recorded as a component of the EPSDT process.**

Ü **It is recommended that Family Health Partners add a statement to the New Member Welcome Call script that indicates the need for the member to schedule an appointment with their primary care provider if they have answered positively to any of the First Health screening questions. In the event that this information is available at the time of the New Member Welcome Call, it is recommended that this data be transferred to the vendor as part of the screening process and to cue members who did respond positively to the baseline health screening questions to attend a visit with their primary care provider.**

Ü **Continue to work with CommCare on identifying process improvements as well as clinical improvements, such as implementing some clinical pathways and identifying varying levels of intensity of case management services.**

Ü **There was a decrease in alternative services for behavioral health services between 2000 and 2001. Family Health Partners may wish to examine the reasons and ensure that members are continuing to receive care in the least restrictive settings.**

Ü **Provider medical complaints increased between 2001 and 2002, accounted for by an increase in denial of services complaints. Provider non-medical complaints also increased, accounted for by complaints regarding denial of claims complaints. It is recommended that the reasons for these complaints be studied further.**

Ü **Member complaints regarding quality of care, ability to obtain an appointment, staff behavior, and other non-medical complaints increased between 2001 and 2002. The largest increase was for member complaints regarding transportation. It is recommended that the reasons for these complaints be studied further.**

Ü **It is recommended that Family Health Partners continue with the study and quality improvement project to address racial and ethnic health disparities and link them with the provider education and case finding/screening capabilities. Also, it is**

recommended that they maximize the ability to match member language and provider language through the CACTUS database by sending annual notices to Non-English members, in their language, a list of providers that speak the same language; and the same ethnicity, or treat a large group of patients of their ethnicity.

ü   **Opportunities for improvements exist in provider network rheumatology, child/adolescent psychiatry, geriatric intensive treatment facilities, and tertiary care hospital facilities. Given the provider shortages in many areas of the state, it may not be possible to ensure adequacy for all members, specialists, and counties. However, it is recommended that access to these specialties be carefully monitored for the Family Health Partners membership; to facilitate timely access to services.**

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003

[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Group, 2003

[3] This definition was provided in the RFP B3Z02226 for MC+ Managed Care, with permission of the Center for Case Management, 6 Pleasant Street, South Natick, MA, 01760

2002

Missouri MC+ Managed Care Program

External Quality Review

FirstGuard Health Plan

Site Visit Date   Wednesday, February 26, 2003

Subcontractors

Behavioral Health: **Magellan, 1997**

Dental: **Doral Dental, 1997**

Transportation: **Swope Parkway Health Center**

There were no corrective action plans with any vendors during calendar year 2002.

Compliance with Standards and Operations

Enrollee Rights and Protections

- Customer care specialists undergo 2 weeks of classroom training on the system, benefits, all products; also complete one-on-one training with Team Leader.

- Any complaints are forwarded to the Grievance Coordinator for follow-up and possible detection of member or provider fraud or abuse.

- There has been some turnover in the Compliance Officer (two in the past 14 months).

- Refresher training occurred last March/April, with F&A training in the last 6 months.

- HIPAA refresher training was scheduled for April, 2003, in time for the compliance date.

- All new training (e.g., HIPAA, compliance training) is rolled into new employee orientation.

- Fraud and abuse reporting is communicated with members primarily through the member handbook and packets, welcome calls, and newsletters.

- Emergency and post-stabilization services are paid without question, as it is more cost efficient than not authorizing payment.

Claims Processing

- There has been an increase in electronic claims submissions by providers over the past year. The MCO received many calls from providers regarding payment and found that most delays were due to the provider not following administrative rules.

- There has been a decrease in days to 99% clean claims (approximately 6 days).

- PBM dispensing fees are paid quarterly in arrears for pharmacies with fewer than 25 members. Claims were adjudicating on time at the time of the site visit.

- Acceptance of claims to the State is 97% and FirstGuard is working on identifying rejects for the remaining 3% of claims.

- FirstGuard is working on improving the logic for EPSDT submissions as well as the file layout to improve HEDIS reporting processes and outcomes.

- Rejected claims from providers have dropped every month across each month for 2002. Encounter rejections are a red flag which prompt further review.

- The contract officer conducts site visits to the claims vendor to assess processes, increase accuracy, and improve the timeliness of submissions.

Credentialing and Re-credentialing

- Credentialing and re-credentialing is conducted every 3 years.

- For dental, behavioral health, and vision vendors, credentialing is conducted according to NCQA standards.

- Approximately 80% of providers (148 of 184) were re-credentialed as of November, 2002.

- A total of 133 new providers were credentialed as of November, 2002.

- The Credentialing committee reviews denial logs, utilization management, and claims as part of the re-credentialing process.

Vendor Oversight

- Vendor oversight is conducted through quarterly meetings with each vendor, reviewing utilization data, denials, appeals, and resolutions.

- Oversight meetings are structured and provide specific feedback.

- In 2003, FirstGuard will be issuing an RFI for behavioral health services to identify whether there are other options. They stressed this is not due to performance issues.

- A change in PBM was effected in July 2002 to coordinate MO and KS contracts. This allowed FirstGuard to leverage their volume by negotiating reduced rates, request customer service identification of FirstGuard members calling the MCO, having on-line eligibility updates, and prior authorizations. Unified reports and comparisons are also conducted for the 2 state Medicaid recipients.

- A contract with the Third Party Administrator was renegotiated, effective January 2003, with better benchmarks, timeliness of claims, and claims processing.

Access

Member Services

- Approximately 40% of members are able to be contacted by telephone. The member services directory updated nightly on line, with a hard copy mailed out on a quarterly or semi-annual basis. Existing members receive updates on directory upon request.

- Updates in the provider directory are cued by a provider completing a change form. Reminders are placed in the provider newsletters to update as needed.

- The database operator has forms for use in updating filing errors. These are updated within three days.

- **At the present time, there is no shadow system in place to retain updated addresses of members so as to prevent state administrative files from overwriting updated addresses.**

- **It is difficult to identify pregnant members unless they explicitly state they are pregnant, or have a pregnant woman eligibility code. Otherwise, member and providers are not notifying the MCO of pregnant members, making early prenatal care difficult to deliver.**

- **First Guard has revised the Benefit Discussion Guide for member education, and trained Customer Care staff on member benefits.**

- **Call documentation was a key indicator in 2002. Rates increased above threshold for the year overall. The documentation of calls increased during October 2001, likely due to increased call volume which was possibly secondary to exit of another Western Region MCO.**

- **A Secret Shopper study was conducted December 2002 to assess provider access and 24 hour availability.**

Provider Network[1]

- **The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance indicates that as of December 31, 2001, FirstGuard had 2,290 physicians, 513 facilities, and 150 ancillary providers in its network. The overall adequacy for the entire MC+ Managed Care network was 98.0%, above the 95% threshold. In addition, the analysis found the following:**

    - m **The rate of adequacy for ancillary service providers improved from below threshold (94.0%) to above threshold (98.0%).**

    - m **FirstGuard improved the rate of infectious disease specialists from 91.0% to 94.0%, and the rate of pulmonary disease specialists from 93.0% to 98.0%.**

    - m **The rate of adequacy for hospice services improved from 67.0% to 86.0%, although remaining below threshold.**

    - m **The rates of specialists in allergy, dermatology, nephrology, pathology, rheumatology, and urology remained stable and below threshold (93.0%, 91.0%, 94.0%, 93.0%, 91.0%, and 93.0%, respectively).**

    - m **The rates of specialists in neurology and orthopedics declined from 2001 to 2002, remaining below the 95.0% threshold (97.0% to 93.0%f or neurology; and 94.0% to 93.0% for orthopedics).**

    - m **The rate of tertiary hospital facilities remained below threshold at 91.0%.**

    - m **St. Clair County was below the 95% threshold, and FirstGuard was advised to request exceptions under the alternative compliance mechanism for each specialty and for Tertiary Care in St. Clair County that fell below threshold.**

- **Exceptions were granted for the following:**

    - m **Home health providers in Cass and Johnson Counties.**

    - m **Hospice in Cass, Clay, Lafayette, Platte, and Ray Counties.**

- In addition, FirstGuard conducts a monthly network management meeting which is interdepartmental in nature, with credentialing, quality, Medical Director, and IT departments involved.

- FirstGuard tracks movement in and out of the network and reasons, but provider turnover is considered low. Changes in practice location (e.g., teaching hospitals) is one of the more common reasons, but not usually a movement out of the network.

- Facilities are not involving members in discharge planning, and Magellan is working to conduct outreach after discharge.

- Provider satisfaction was assessed, with positive feedback from providers about the web site, the ease of obtaining information, and the turnaround on approvals.

Provider Education, Training, and Performance

- The Provider Administration Manual (PAM) is mailed at least once/year for refresher. It includes quality, utilization, and prior authorization forms. This was revised in August, 2002.

- Provider Alerts are issued for any changes, as needed.

- Provider forms and the PAM are available on the FirstGuard web site.

- A Provider "Road Show" is conducted annually, inviting providers to lunch or dinner. There were 55 sessions with 1,100 providers across MO and KS, with additional sessions as requested for hospitals. There are approximately 6 – 60 providers attending at a time. The goal for 2003 is to reach every provider office.

- Quarterly newsletters, including routine issues and reminders from all departments.

- FirstGuard has initiated a web site which is updated nightly. Monitoring of the web sites shows an increase in hits for claims issues and verification of eligibility.

- Provider profiling has not been possible due to some data issues and the ability to identify individual providers, group practices, etc. However, FirstGuard is working to identify some valid measures of provider performance. Currently, the MCO is using quality of care complaints and will examine episode groups as a possible measure.

Utilization/Medical Management

- Behavioral health re-admission rates were approximately 9.0% for 2002. The 7- and 30-day follow-up rates after hospitalization are being monitored through HEDIS measures through the Mental Health Subgroup. There is currently an ambulatory workgroup for high-volume facilities.

- Currently, PCPs are managing a large proportion of children with ADHD. There are no requirements or guidelines for mental health screening or referral by PCPs. A new medication, Stratera, which is a non-stimulant neuroleptic is currently on the market and has fewer side effects as well as improves activity levels in the evenings may impact the cost of pharmacy services.

- The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:

- m **The total penetration rate for behavioral health services was 4.7% in 2001. Outpatient visits decreased from 1999 to 2001, from a rate of 213.8 to 186.8 per 1,000 in 2001.**

- m **The rate of alternative services was .1 per 1,000 in 2001.**

- m **Partial hospital admissions per 1,000 were to .3 per 1,000 a decline from 1999 rates (.8 per 1,000); and partial hospitalization days declined from 2.8 in 1999 to .3 per 1,000 in 2001.**

- m **There were 1.5 residential days per 1,000 in 2001, an increase from 0 in 1999.**

- m **Inpatient admissions increased from 4.3 per 1,000 in 1999 to 7.9 in 2001. Inpatient days increased from 18.1 to 36.2 days per 1,000 between 1999 and 2001.**

- m **Inpatient substance abuse admissions increased from 0.2 per 1,000 in 1999 0.7 per 1,000 in 2001. Inpatient substance abuse days per 1,000 increased from 0.9 to 2.8 per 1,000 between 1999 and 2001.**

- m **The 30-day follow-up rate after hospitalization increased from 51.7% to 53.9% between 1999 and 2001. The 7-day follow-up rate increased from 24.1% to 26.0% in 1999 and 2001.**

- **The Utilization Management Committee Agenda regularly includes follow-up of previous items, medical necessity denials, catastrophic cases, oversight of vendors, benefit review, and professional services.**

- **There were a total of 46 denials, 9 of which involved Speech/Language Pathology (SLP) services, a non-covered benefit. Review of the SLP benefit indicates that in order to be covered, the SLP need must be secondary to injury, disease, or other condition, excluding developmental or language delays.**

- **Other denials were due to behavioral health (2) services, and other non-covered benefits (e.g., Clomiphene, intrathecal pump, TENS units)**

Quality

Quality Management

- **FirstGuard has recently instituted the Wooden Apple Award for employee recognition to improve internal quality standards.**

- **The Quality Management Improvement Team meets monthly, interdepartmental, except UM, which meets separately. The team discusses regularly Administration, Quality Improvement, and Medical Denial Tracking Log and Key Indicators in each area. These are tied directly to the work plan.**

- **The Quality management department has been asked by other departments to conduct training. Departments have been provided with education regarding the measurement of process and outcomes using an adaptation of the Malcolm Baldrige service excellence procedures.**

- **Disease state management programs have not been able to be sustained due to phasing out of the commercial product.**

- **Diabetes management represents few individuals, but the MCO is trying to improve case management.**

Clinical Guidelines

- **Guidelines for pain management are not being followed by providers. There is concern in the provider community about the attention given to over- and under-utilization of pain management medication, especially Oxycontin. The most common reason this is prescribed is lower back pain. Providers need to conduct better documentation of the need for greater than recommended or typical doses, and question requests/reasons for premature refills. There is one provider who has developed best practices, and a toolkit/materials are available for the education of providers on pain management. FirstGuard is also working with Pfizer on education of providers about appropriate pain management, monitoring over utilization, and distributing information in provider newsletters.**

Performance Improvement Projects

Review of FirstGuard's 2001, 2002, and 2003 Quality Improvement Work Plans shows continuation of long term projects with comprehensive activities, abstraction of relative data and analysis of outcomes. FirstGuard's (FirstGuard) presentation of material was well organized and provided updated material related to Performance Improvement projects completed in 2002 and those considered ongoing.

- **Data issues for EPSDT and lead appear to be insurmountable at the present time to serve quality improvement or provide profiling purposes. There seems to be a significant lag in the data for immunizations, as evidenced by increased rates of immunizations for previous years when data are reported. There has also been as much as a 30% discrepancy between data from DMS, DHSS, and FirstGuard.**

- **EPSDT rates have improved, although there is inconsistent use of the mandatory form.**

- **Preventive and Clinical Guidelines. FirstGuard presented a comprehensive list of preventive and clinical guidelines produced to provide common evidence- based recommendations for area primary care providers. This is a collaborative effort through the Kansas City Quality Improvement Consortium (KC- QIC) and members include local MCOs, payor groups, providers, representatives from medical societies, and recognized organizations. The guidelines are reviewed according to a scheduled timeline and revised as necessary by the Quality Management Committee. FirstGuard has made the clinical guidelines available on their MCO's web site allowing easy access to area providers. It was identified that providers are not following guidelines for pain management and that providers need to improve documentation of the need for greater than recommended or typical doses, and question requests for early refills. FirstGuard is working with Pfizer on education of providers regarding appropriate pain management through provider newsletters and is also monitoring for over- utilization of pharmaceutical agents. PCP acceptance and utilization of other guidelines was not discussed. It is suggested that FirstGuard assess the effectiveness of the preventive and clinical guidelines by surveying PCPs for their feedback.**

- **Asthma Disease State Management.** In March 2000, FirstGuard entered into a contract with Express Scripts, Inc. for an Asthma Disease State Management program to offer enrollment to members with asthma. According to the annual Quality Management Program Evaluation 2001, program expenses were higher than savings generated, however it was recognized that discontinuation could result in increased hospital admissions and/or Emergency Room visits. According to the 2001 annual report, enrollment in the program was adversely affected by refusal to participate or the inability to reach members by phone or mail. It is suggested that if enrollment continued low during 2002, FirstGuard could focus an effort to promote this program to appropriate members. Cost savings could potentially outweigh expenses for a short-term project of this nature.

- **Post Partum Depression.** FirstGuard continues to collaborate with their behavioral health provider, Magellan Behavioral Health, on the Post-Partum Depression Project. This program focuses on the prevention and early detection of Post-Partum Depression by educating new mothers on the issue and requesting they complete and return a survey to Magellan. As an early member of the initiative with Magellan, the FirstGuard and Magellan collaboration on Post-Partum Depression was reported as a "best practice" initiative in 2001. Response rates and those who accept referrals are increasing. It is suggested that since several MCOs are participating in this project that response rates be compared and methods of outreach for MCOs with higher rates be discussed in open forums. Studies regarding post-partum depression screening and follow-up have been conducted by Magellan, the behavioral health vendor. A total of 21% score positively on the screen. In the second quarter of 2002, 67% of those who scored positively and accepted a referral were seen by a provider.

- **Guardian Angel Program.** FirstGuard's Guardian Angel program provides two phases of comprehensive care management and outreach for prenatal care and EPSDT services. FirstGuard performs outreach to the pregnant woman according to a schedule dictated by risk stratification from information collected from the provider and/or the member. Those considered to be high risk are placed in the Tender Loving Care Zone, a program initiated in May 2001, and are contacted on a weekly basis until they are considered out of the "Zone". Despite the fact that results of prenatal case management indicate little impact on birth outcomes, focused attention to the high-risk pregnant woman is valuable and necessary. Results of prenatal case management indicate little impact on birth outcomes. The rate of LBW remains at about 11%, consistent with the rest of the state. FirstGuard uses Healthy People 2010, March of Dimes Perinatal Statistics, and Medicaid-specific population best practices for prenatal case management. Children with acute and chronic conditions are placed in the Guardian Angel Program for closer follow-up and management as needed

- **Regarding EPSDT services, FirstGuard** mails monthly reminders to both members and providers for children due for screenings and monitors for under utilization of these services. FirstGuard and other Western Region MCOs are working with the Missouri Academy of Pediatrics exploring the possibility of allowing sports physicals to constitute EPSDT examinations. This represents an innovative approach to addressing the missed opportunities for the older child accessing screening and diagnostic services and we encourage further investigation.

- **Children with Special Health Care Needs (CHSCN). FirstGuard provides ongoing case management to CSHCN including those with elevated lead levels. According to information provided, FirstGuard refined the procedure for identification of these children and they are assigned as necessary to the Special Needs Case Management Nurse. The number of members in case management is high and it is recommended that FirstGuard perform a cost-benefit analysis of the program to determine efficient use of resources. Tracking of members has been identified as problematic and we encourage FirstGuard make improvements to their systems. This information should be presented to Quality Management on a routine basis for discussion on its benefits and suggestions for continued effectiveness.**

Cultural Competency

- **In 2002, there were 1,700 calls placed using the Language Line (average 150/month), with Spanish being the most commonly requested language.**

- **Interpreter services are not tracked by individual user & frequency.**

- **The Member Handbook was converted to Braille. This has not been requested to date. FirstGuard has an informal agreement with Alphapointe to provide additional copies if needed.**

- **The number of incoming calls via TDD lines is not differentiated/tracked.**

- **FirstGuard contracts with Language Line Services to provide language interpretation via telephone. On-site interpreter services are provided by multi-lingual staff on an as needed basis, but are not tracked.**

- **The *NurseLine* brochure contains information about interpreter services and toll free access in both English and Spanish languages.**

- **The *Member Handbook* has instructions in both English and Spanish on how to access the toll-free assistance line, interpreter services and information brochures in other languages.**

Grievance Systems

- **Quality of care complaints are received by the Quality Manager. Those involving a vendor are inquired about at the quarterly oversight meeting, or sooner, if necessary.**

- **The Grievance Coordinator determines the distinction between fraud and complaints. Complaints/grievances are then channeled back to individual member services representatives for resolution, except for those regarding quality of care.**

- **Quality of care complaints are followed up by a request for medical records, a review of care, and a rating of 2 or 3 (potential or actual quality of care concern). Those rated a 3 are reviewed with the Medical Director. Quality of care complaints are recorded on brightly colored paper and placed in a credentialing file. There are rarely more than 2 in a provider credentialing file at the time of re-credentialing. Some of the more common quality of care complaints have included misdiagnosis and follow-up on ER visits, or inappropriate pain management.**

- **The most common member complaint is rude office staff.**

- **Many complaints are due to bills for visits, and unchaperoned examinations.**

- When quality of care becomes an issue for follow-up, the Quality Manager and Medical Director check the preventive service history, document missed opportunities for preventive care, and provide this feedback to providers. This is a routine part of the medical record review in any quality of care complaints/issues.

- The rate of member medical complaints was .57 per 1,000 members, lower than the Western Region and statewide MC+ Managed Care MCO rates (1.33 per 1,000 members and 1.49 per 1,000 members). This represents a decline in medical complaints from 2001 to 2002 (.98 per 1,000 members in 2001). Member medical complaints were primarily accounted for by complaints regarding quality of care (.22 per 1,000 members), although this represents a decline from 2001 (.33 per 1,000 members). The most notable decline in member medical complaints was in the area of waiting for appointments (.29 per 1,000 members in 2001, to .07 per 1,000 members in 2002). There was also a decline of "other" member medical complaints between 2001 and 2002.

- The rate of member non-medical complaints in 2002 was .79 per 1,000 members, a decline from 2001 (2.71 per 1,000 members). This is also substantially lower than the rate for Western Region and all MC+ Managed Care MCOs (5.07 per 1,000 members, and 6.41 per 1,000 members, respectively). Member non-medical complaints were primarily accounted for by complaints regarding transportation services (.39 per 1,000 members) and staff behavior (.30 per 1,000 members). Both represent declines from rates from 2001.

- The rate of provider medical complaints in 2002 was .02 per 1,000 members, a decline from 2001 (.20 per 1,000 members). This is lower than the Western Region and state rates (.31 per 1,000 members and .29 per 1,000 members, respectively). The rate of denial of services primarily accounted for provider medical complaints (.02 per 1,000 members).

- The rate of provider non-medical complaints was .47 per 1,000 members, an increase from 2001 (.29 per 1,000 members), and a substantially lower rate than observed in the Western Region MCOs (3.24 per 1,000 members) and all MC+ Managed Care MCOs (9.50 per 1,000 members). The rate of provider non-medical complaints were primarily accounted for by the rate of complaints regarding denial of claims (.37 per 1,000 members).

Case Management

As of 2/21/03, there were 1,162 members in case management.

FirstGuard subscribes to the following definition of case management:

Case management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patient's/families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance outcomes.[3]

- FirstGuard meets with the case managers of children in the Alternative Care Program, under the Consent Decree. They are working on providing information on healthy children to the program to lessen the burden of follow-up.

- **For children with special health care needs the case manager reviews cases of all children on the state diskette, determine whom to call for follow- up, and includes other special needs children in case management as needed.**

- **For Prenatal Case Management, FirstGuard is continuing the Tender Loving Care (TLC) program by Guardian Angel Staff. FirstGuard announced that TLC program plan meets 2010 Plan and March of Dimes best practices for Medicaid population.**

- **FirstGuard participated in MCH QA&I Subcommittee and the Mental Health Subcommittee to raise and standardize initial assessment of prenatal members.**

- **Prenatal Case Management had little effect on the rate of babies born with low birthweight (LBW).**

- **FirstGuard collaborated with Magellan Behavioral Health to identify and treat post- partum depression. Very few members were identified as in need of treatment.**

- **The case management program targets pregnant members with education about smoking, pre- term labor, delivery within past 3 years and pre- eclampsia during the 20- 30 weeks of pregnancy. Pregnant women with high risk criteria are offered case management.**

- **Outreach interventions are conducted to improve early prenatal care access.**

Interagency Coordination

- **FirstGuard and other Western Region MCOs are currently working with the Missouri Academy of Pediatrics through the legal and regulatory issues of allowing sports physicals to constitute EPSDT examinations.**

- **The State's desire to move lead screening to WIC clinics has been a concern in being able to manage care and determine the responsible party for follow- up of high lead levels.**

- **Coordination of services is conducted with First Steps, public schools, and other agencies and occurs upon referral of the member/parent to each of these services as needed.**

- **FirstGuard would like to work with DFS on coordinating care for COA4 children who will be transitioning to COA1 or 2 for behavioral health services, and are working with the Mental Health Subgroup on this.**

FirstGuard Health Plan

2002 External Quality Review Summary

Conducted on Wednesday, February 26, 2003

The results of the on- site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for FirstGuard Health Plan in providing care to MC+ Managed Care members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

∨ **Member complaints regarding the quality of care, ability to obtain an appointment, and other medical complaints declined between 2001 and 2002.**

∨ **FirstGuard was the only MCO for which member transportation complaints declined. Denial of claim and other member non- medical complaints also declined between 2001 and 2002.**

∨ **Staff orientation, training, and education incorporate new training content and refresher sessions, and reflect the collegial, positive, goal- oriented climate.**

∨ **There was improved provider network adequacy in hospice, infectious disease specialists, pulmonary disease specialists, ancillary service providers, facilities, and PCPs.**

∨ **Provider medical complaints and those regarding the denial of services declined between 2001 and 2002.**

∨ **Timely payment to providers has reduced days to clean claims, and has likely led to improved provider satisfaction.**

∨ **FirstGuard facilitates provider- member communication around the central issue of reminding members to bring their identification cards to appointments.**

∨ **Contracting processes have improved, allowing FirstGuard to improve claims processes and especially pharmacy benefits.**

∨ **Vendor oversight is a strength, with support from contracting and the involvement of the Medical Director.**

∨ **The finance department won an internal award ("Wooden Apple") for achieving a number of process improvements and ability to measure changes over time.**

∨ **There is cross- over and ability to cross- reference the progress achieved on Key Indicators with the goals of the Work Plan.**

∨ There were increased ambulatory follow- up at 30 days post- discharge for behavioral health services between 2000 and 2001.

∨ There were increased inpatient admissions and days for behavioral health and substance abuse services between 2000 and 2001.

∨ There were increased alternative services between 2000 and 2001.

Opportunities for Improvement

Ù FirstGuard is encouraged to work with Magellan or subsequent behavioral health vendors on increasing the follow- up after discharge as a result of:

  m Decreased rate of ambulatory follow- up 7 days post- discharge for behavioral health services between 2000 and 2001.

  m Decreased outpatient visits and partial hospitalization days and visits for behavioral health between 2000 and 2001.

Ù Encourage providers to use best practices in developing informed consent for treatment via a treatment plan for those in need of pain management. The Toolkit FirstGuard has can be used for dissemination to targeted providers conducting pain management or prescribing Oxycontin can be used for provider education.

Ù Continue to monitor PCP prescriptions for and treatment of ADHD to ensure that children who are not being managed well have access to mental health screening and referrals as needed.

Ù FirstGuard reported the inability to separate out members receiving case management who are under 21 years of age as well as those who are followed by subcontractors. They are encouraged to make improvements to their systems to enable tracking of members in case management.

Ù Focus on improving cultural competency by identifying member needs and targeting members for outreach and education. Consult with other MCOs regarding the programs they have instituted.

Ù Provider complaints regarding the denial of claims increased substantially.

Ù Member complaints regarding denial of services, office waiting, and staff behavior increased slightly between 2001 and 2002.

Ù Opportunities for improvements exist in the provider network for specialists in allergy, dermatology, nephrology, pathology, rheumatology, neurology, orthopedics and urology, orthopedics, and tertiary hospital facilities.

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003

[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Advisory Group, 2003

[3] This definition was provided in the RFP B3Z02226 for MC+ Managed Care, with permission of the Center for Case Management, 6 Pleasant Street, South Natick, MA, 01760

2002

Missouri MC+ Managed Care Program

External Quality Review

Blue Advantage Plus

Site Visit Date   Friday, February 28, 2003

Subcontractors

Transportation:	**Medical Transportation Management**
Behavioral Health:	**New Directions Behavioral Health (NDBH)**
Dental:	**Doral Dental**

There were no formal corrective action plans for subcontractors in calendar year 2002.

Compliance with Standards and Operations

Enrollee Rights and Protections

- **Blue Advantage Plus has developed a Compliance Database of all MC+ Managed Care contractual requirements incorporated across the corporation and other BCBS products, with monthly reporting of compliance and risk assessment to the Corporate Compliance Committee and the BCBSKC Steering Committee. Quarterly reports are provided to the Audit Committee of the Board of Directors.**

Claims Processing

- **Claims are typically paid within one week.**

- **There has been an increase in electronic claims submission from 60% to 80% from 2001 to 2002. The rate of accepted claims on first pass is 60%.**

- **Blue Advantage Plus has detected some billing errors that may be affecting the EPSDT rate. Follow-up education is conducted with provider offices to improve capture of data.**

- **The Claims Department received the Showcase for Quality Award (across all departments) for dramatically increasing in the number of claims processed.**

- **Two Local Public Health Clinics (LPHs) have requested to submit claims electronically.**

Credentialing and Re-credentialing

- **The Credentialing Committee is chaired by the Medical Director, who conducts and determines the necessity for external peer review.**

- **Providers are re-credentialed every three years using National Committee on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) criteria.**

- **In addition to the verification of prime sources for credentialing and re-credentialing of providers, performance monitoring of member complaints and quality of care issues are also reviewed. If a provider exceeds the threshold on monthly revenue, they can be identified for early re-credentialing review.**

- **Two vendors, Doral Dental, and New Directions Behavioral Health (NDBH) have delegated credentialing processes.**

- **Dental provider credentialing files are audited annually (10%), with no concerns noted by Blue Advantage Plus.**

Vendor Oversight

- **The Delegated Oversight Committee meets monthly and monitors complaints from vendors (Doral Dental and New Directions Behavioral Health; NDBH). The Committee audits utilization, claims, appeals, and credentialing processes.**

- **Oversight with NDBH is strong, with clear activities and timelines developed at the beginning of each contract year, and policies and procedures are audited annually. Blue Advantage Plus delegates credentialing to NDBH and is considering delegating second level appeals to NDBH.**

- **Meetings are conducted monthly with the transportation vendor (Medical Transportation Management; MTM) to discuss subcontractor and member issues (e.g., supplying car seats and seat belts) related to transportation. There is approximately 2% utilization of transportation services. Blue Advantage Plus has required MTM to reduce the notification by members for non- emergency medical transportation (NEMT) from 5 days to 2 days. An action plan was developed with MTM, with member complaints being transmitted to Blue Advantage Plus on a weekly basis for follow- up. Blue Advantage Plus revised the transportation protocols and requirements to mirror those of the State (e.g., requiring the members to obtain a ride from a family member or friend if such access exists, and providing bus passes if necessary).**

Access

Member Services

- **There are currently 7 full- time equivalent positions for Blue Advantage Plus member services, with a total of 16 staff cross- trained on the FACETS management information system. Each time a member calls, the system issues an error message if there has not been a Verification of Address and Phone number (VAP). An additional address field for updated or secondary contact information has been added to maintain updated contact information that may be different from state supplied contact information.**

- **The turnover rate of staff in member services is less than 10%.**

- **Rates of call waiting and call abandonment evidenced a decline over the year, with goals being met. The average call waiting time in December, 2002 was 20.2 seconds (better than the target of 30 seconds), and the abandonment rate was 3.4% (better than the target of 5%).**

Provider Network[1]

- **The 2002 Network Adequacy Analysis conducted by the Missouri Department of Insurance (MDI) indicates that as of December 31, 2001:**

  m **Blue Advantage Plus' network adequacy for PCPs, specialists, facilities, and ancillary service providers were above the 95.0% threshold in 2002, with an overall network adequacy rate of 98.0%.**

  m **Blue Advantage Plus improved ancillary provider network adequacy from 87.0% to 97.0% adequacy, rising above the required threshold for adequacy.**

  m **Specialty provider network adequacy improved from below to above threshold between 2001 and 2002 for pediatrics (93.0% to 97.0%), adult general psychiatry (87.0% to 98.0%), and radiology (91.0% to 100.0%).**

  m **Provider network adequacy improved from below to above threshold rates in audiology (93.0% to 97.0%), home health (87.0% to 100.0%), occupational therapy (82.0% to 97.0%), physical therapy (82.0% to 98.0%), and speech/language therapy (87.0% to 100.0%).**

  m **Rates of all types of facilities remained above the threshold (95.0%).**

  m **Rates of adequacy for specialists in psychology declined below threshold (93.0% to 87.0%), while those in endocrinology remained stable (93.0%).**

  m **Rates of adequacy for facilities remained stable and below the threshold, at (87.0%).**

- **Exceptions to the network adequacy standards were granted for the following:**

  m **St. Clair County: Tertiary Hospitals, general dentistry, home health, hospice, allergy, dermatology, infectious diseases, nephrology, neurology, OB/GYN, physical medicine/rehabilitation, rheumatology, and urology.**

  m **Cass County: home health, hospice**

  m **Henry County: home health**

  m **Johnson County: home health**

  m **Lafayette County: home health, hospice**

- **Exceptions requested but <u>not</u> granted were:**

  m **Henry County: hospice**

  m **St. Clair County: hospice, emergency medicine, endocrinology, gastroenterology, pediatrics, psychiatry- adult/general, and psychiatry – child/adolescent, general dentistry, and psychologists/other therapy.**

- **The network adequacy analysis noted that the provider directories should reflect the board certification status of Blue Advantage Plus providers. This issue was reported internally at Blue Advantage Plus and was considered satisfactory, with a request for follow-up from Blue Advantage Plus as the situation was resolved.**

- **The adequacy of orthopedic services has been a concern for Blue Advantage Plus.**

- **Blue Advantage Plus completed their re-contracting initiative in 2002, with the finalization of contracts with ancillary and allied health providers.**

- **Reimbursement is provided at 108% to 110% of Medicaid fee schedules for PCPs and specialists.**

- **To address the need to maintain OB providers, Blue Advantage Plus provides incentives to all BCBS providers who conduct deliveries to Blue Advantage Plus members, with increased payment for all deliveries. Deliveries are reviewed and incentives are provided on a quarterly basis, initiating in the third quarter of 2002.**

- **The provider turnover rate was reported to be less than 10%.**

- **Provider service representatives visit offices twice each quarter. High volume providers are targeted and visited once each quarter. Internal representative are assigned to confirm information and availability.**

- **Provider satisfaction has remained stable from 2001 to 2002 for providers and specialists with over $30,000 in charges.**

- **Provider complaints are reviewed in Quality Management Committee.**

- **To improve access to dental care, the MCO is adding clinics in day care center. There is a hygienist at St. Vincent's Day Care Center, and the dental vendor has worked with the UMKC Dental schools to make a dental hygienist available to see children every Friday, and submit claims to Doral Dental.**

- **Twenty-four hour access to providers is monitored and results are reviewed by Quality Improvement and Provider Services Departments.**

Provider Education, Training, and Performance

- **One innovative step taken by NDBH for children with ADHD is to encourage the implementation and use of family therapy codes through financial incentives. They have found that although providers report conducting family therapy, it is difficult to change their billing patterns.**

- **NDBH is educating DFS workers as well as providers about behavioral health issues and the appropriate use of psychiatric medications for ADHD and depression. This is conducted through dinner meetings with PCPs, with psychiatrists making educational presentations. They have also instituted a PCP helpline for psychiatric nurses or physicians, taking approximately 300 phone calls during 2001.**

- **NDBH will be conducting profiling of psychiatric medication use for psychiatrists during 2003.**

Utilization/Medical Management

- **In December 2002, Blue Advantage Plus mailed to members a brief letter from the medical director describing the available mental health services. Included in this mailing were the Child Abuse Resource Guide and some member education materials about signs and symptoms as well as resources for alcohol/drug problems, Attention Deficit Hyperactivity Disorder, and depression. This was accomplished through the assistance of grant funding from Eli Lily. An increase in calls to New Directions was evidenced following the mailing. Similar information was placed in food boxes being distributed in households by a community organization.**

- **Discharge planning is conducted by the Prevention Coordinator while the member is hospitalized, if possible. Otherwise, the Prevention Coordinator attempts to contact the member within 72 hours to ensure they have follow- up appointments within 7- days post- discharge.**

- **Approximately 35 – 40% of psychiatric hospitalizations represent the member's first contact with NDBH. NDBH has assessed whether or not individuals identified a need on the Baseline Health Assessment form upon enrollment, but found that most did not acknowledge any mental health or substance abuse issues.**

- **NDBH has implemented a prevention program whereupon the Prevention Coordinator contacts former inpatients two months prior to the anniversary of a significant event that may have lead to the need for services (e.g., suicide attempt, divorce, trauma); and where members are contacted near grade- card time.**

- **NDBH reports for 2002 that the 7- day follow- up rate is the highest of all MC+ Managed Care MCOs.**

- **The latest available Behavioral Health Indicators for access to behavioral health services (calendar year, 2001) indicate the following[2]:**

  - **The total penetration rate for behavioral health services was 6.1% in 2001.**

  - **Outpatient visits increased from 1999 to 2001, from a rate of 194.2 to 371.0 per 1,000 in 2001.**

  - **The rate of alternative services was 32.2 per 1,000 in 2001.**

  - **Partial hospital admissions per 1,000 were to 1.3 per 1,000 a decline from 2000 rates (8.6 per 1,000), but consistent with 1999 rates (1.3 per 1,000); and partial hospitalization days increased from 4.9 in 1999 to 5.7 per 1,000 in 2001.**

  - **There were 1.7 residential days per 1,000 in 2001, an increase from 0 .8 per 1,000 days in 1999.**

  - **Inpatient admissions increased from 5.7 per 1,000 in 1999 to 9.1 in 2001. Inpatient days increased from 25.7 to 43.8 days per 1,000 between 1999 and 2001.**

  - **Inpatient substance abuse admissions increased from 0.3 per 1,000 in 1999 1.7 per 1,000 in 2001. Inpatient substance abuse days per 1,000 increased from 0.1 to 0.7 per 1,000 between 1999 and 2001.**

  - **The 30- day follow- up rate after hospitalization increased from 43.2% to 61.4% between 1999 and 2001. The 7- day follow- up rate increased from 24.2% to 45.5% in 1999 and 2001.**

- **On- site review nurses go to all hospitals for one- to- one contact with hospitalized members.**

- **Utilization management is conducted through the Medical Management Committee, attended by vendors (AirLogics, the asthma and COPD case management vendor, as well as New Directions Behavioral Health).**

- **New Directions and Blue Advantage Plus have been co- managing those patients with eating disorders. The 2001 Blue Advantage Plus population study indicated the greatest increase in costs from 2000 to 2001 for those with this class of diagnoses.**

- **Approximately 9% of those reviewed for medical case management are referred for case management services.**

- **In 2002, a discharge follow- up program was implemented for all high volume facilities. They found that in many cases, patients did not have clear instructions about medication. Staff are attempting to avoid re- admissions and are identifying which members to call. Currently, they call members with cardiac problems within five days as well as those discharged from the emergency room with Durable Medical Equipment (DME) or home health services. Blue Advantage Plus now maintains 2 FTE nurses on- site at North Kansas City Hospital to identify those going to the emergency room within 2 hours.**

Quality

Quality Management

- **Blue Advantage Plus (Blue Advantage Plus) has a comprehensive Quality Improvement System Work Plan that utilizes a company- wide approach for all products offered by Blue Cross Blue Shield of Kansas City (BCBSKC). The Work Plan tracking system closely monitors all programs at regularly scheduled intervals and progress is reported to Quality Management Committees and the Board of Directors routinely. Oversight of vendors is through the Delegated Oversight Committee with frequent face- to- face meetings allowing prompt action to resolve any problems or formulate action plans to address needs. Blue Advantage Plus/BCBSKC has developed a comprehensive list of Clinical Practice Guidelines which are distributed to providers through their Physician Office Guide and their company web site.**

- **For 2003, Blue Advantage Plus will be examining their Asthma Disease Management Program.**

- **Another topic to be examined will be the management of depression. There are few depression diagnoses made, with speculation that this is due to protections for patient confidentiality and that providers are accustomed to avoiding this diagnosis because Medicare does not reimburse for it.**

Clinical Guidelines

The following are the clinical guidelines that were in place during 2002:

- **Post- acute myocardial infarction management**

- **Cholesterol management**

- **Secondary prevention of myocardial infarction**

- **Evaluation and management of chronic health failure in the adult**

- **Hypertension**

- **Pregnancy/prenatal care**

- **COPD management**

- **Asthma management**

- **Diabetes management**

- **Preventive health guidelines for low risk adults and children**

Performance Improvement Projects

- **The Blue Advantage Plus EPSDT program is on- going, with an increased focus in late 2001. EPSDT services for children age 0 through 6 years are coordinated through Children's Mercy Hospital on a capitated basis, with incentives for performance of EPSDT over 80% in each rate cell passed through to the provider. Interventions have included adding school- based clinics as providers; focused education to members and providers through mass mailings, articles, and participation in community events; monthly reminders to members and providers; and collaboration with other MC+ Managed Care MCOs and agencies. A recently developed intervention of sending lists to providers of all family members for whom a well- child visit is due at the time any other child in the family is scheduled for a visit can be considered innovative and should be assessed for its effectiveness. Blue Advantage Plus tracks the interventions on a quarterly basis but admits that it is difficult to assess the impact of any single process. Contracting with key providers such as school- based clinics and LPHAs is felt to be of high value and Blue Advantage Plus is pursuing these providers as necessary. The MCO has detected some billing errors that may be adversely affecting the EPSDT rate and it is conducting education to correct these errors. No- shows continue to occur. However, Blue Advantage Plus has begun to send physicians lists of all family members for whom a well- child visit is due at the time any other child is scheduled for a visit. In 2002, Blue Advantage Plus achieved the 80% or greater target for EPSDT services in 6 of the 14 rate cells, an improvement from 2001, when they met or exceeded the goal in 2 rate cells. This represents an overall 6.56% increase from 2001 to 2002.**

- **Childhood Immunizations. Blue Advantage Plus initiated its Childhood Immunization project in 1995 and continues with on- going evaluation and revisions to interventions. The MCO has begun sending members a list of immunizations compiled from their encounter data and MOHSAIC with a member incentive of a Dr. Suess book for returning confirmation or correction of the immunization record. Blue Advantage Plus has been accessing the DOH MOHSAIC system for tracking and recording immunizations of members for several years. Since Childhood Immunizations is a HEDIS driven project, current rates were not available at the time of the review, but according to the Work Plan, reports are routinely presented to Quality Management and the Board.**

- **Medical Transportation Management Complaints. Blue Advantage Plus meets monthly with Medical Transportation Management (MTM), the transportation vendor, to discuss subcontractor and member issues and complaints related to transportation. An action plan was developed with MTM to notify Blue Advantage Plus of member complaints on a weekly basis for timely follow- up. Changes to services have included reduction of the timeframe for non- emergency medical transportation from five days to two days and revision of MTM protocols and requirements to mirror those of the State. Blue Advantage Plus considers monitoring of MTM services as an on- going project.**

- **Asthma Management.** Asthma disease management was listed as one of the on-going Performance Improvement Projects. Children's Mercy Hospital and AirLogics provide case management. Data from 2001 showed an increase for asthma related services and both subcontractors were to be informed and asked to improve their case management of these members. Blue Advantage Plus is planning a review of the Asthma Disease Management Program in 2003.

- **Depression Management.** Blue Advantage Plus works closely with New Directions Behavioral Health on multiple projects with Depression Management identified as a formalized performance improvement project since 1999. Recent information was not included in documentation however it was noted that there are plans to examine why few depression diagnoses are made.

- Documentation presented by Blue Advantage Plus also discussed several other less formalized but quite significant projects, the most noteworthy being the Blue Advantage Plus 2001 Population Study. The purpose of the study was to validate the need for targeted disease management program for asthma, and prioritize other quality improvement initiatives such as the On Track At Two childhood immunizations, well woman check-up reminders, and depression management. Results of the study were reported on September 9, 2002 to MCO management. Other key findings of the study included:

  - Additional efforts to increase EPSDT will be needed to improve preventive care.

  - Blue Advantage Plus has established a work group led by the Government Programs and Compliance Department that will report its plans and progress to the Quality Improvement Committee and Quality Council on a semi-annual basis.

  - Asthma related services have increased.

  - Emergency services utilization remained stable for 2001, but a segment of the population continues to use the ED as the primary place of care. Interventions have included monitoring members who have frequent ED visits and educating those members by phone to visit their PCP. A suggested project for the ED utilization issue is to perform an analysis of the diagnoses/presenting complaints for the visits, particularly for the 0-6 year old population. If a trend of routine, non-urgent complaints is identified, focused education to the parents could be a potential area of savings. Young parents may not be aware of MCO benefits and appropriate PCP comprehensive care.

  - Data on race and ethnicity of the membership is only available from responses to the Medicaid CAHPS survey and because the rate of response is typically low for this survey, the data may not accurately reflect the membership of the MCO or the region's population. Blue Advantage Plus planned to consult DMS regarding improvement of methods to collect information related to race and ethnicity in order to better serve the membership and increase cultural competency among its staff.

  - Utilization of behavioral health services continue to increase, indicating that NDBH is reaching more members and providing more services. BCBSKC is confident that access to behavioral health services has significantly improved and expects services and costs to plateau in 2003.

  - Psychiatric costs for ADHD increased by over 50% in the previous year.

     m **Obstetric costs decreased by 4.9% PMPM, however Blue Advantage Plus recognizes that OB and Neonatology services continue to be major health care needs for this population. Continued improvement of prenatal assessment is needed and education and case management efforts must include the unique requirements of the Medicaid membership.**

Cultural Competency

- **Blue Advantage Plus prides itself as a corporation on the cultural diversity of its management/staff, earning a "People's Choice Award" for diversity in the workplace.**

- **Staff training on cultural issues was conducted in 2002 by New Directions Behavioral Health (management, line staff, clinical staff, providers & staff) within the organization.**

- **NDBH has also assisted with training of provider office staff on the cultural/socioeconomic issues of MC+ Managed Care members.**

- **Blue Advantage Plus reported 176 members out of a total of 32,940 as non-English speaking, and an additional 17,626 were reported in the "other" language category. Blue Advantage Plus Provides TDD services and an AT&T interpreter line, but does not use a separate billing format to monitor usage. For the period 01/01 to 08/02, there were 918 total calls, with an of average 40-50 calls per month. A total of 860 of the 918 (93.6%) were Spanish-speaking members.**

- **The Member Handbook text in English & Spanish includes numbers to call for interpreter services, access to a TDD line, and information on how to obtain products for the visually-impaired and in other languages.**

- **As part of 2002 Quality Improvement System Work Plan, Blue Advantage Plus conducted an availability analysis to determine the cultural, racial, ethnic, and linguistic needs of its members.**

Grievance Systems

- **At the time of site review, Blue Advantage Plus was continuing to collect information on member complaints. No grievances were reported during 2002.**

- **The rate of member medical complaints was 1.42 per 1,000 members, slightly higher than the Western Region MC+ Managed Care MCO rate (1.33 per 1,000 members) and comparable to the rate for all MC+ Managed Care MCOs (1.49 per 1,000 members). Member medical services were primarily accounted for by complaints regarding quality of care (.58 per 1,000 members), although this represented a decline from 2001 (.96 per 1,000 members). Rates regarding complaints about not being able to get appointments also declined.**

- **The rate of member non-medical complaints was 7.03 per 1,000 members, higher than the Western Region and statewide MC+ Managed Care MCO rates (5.07 per 1,000 members and 6.41 per 1,000 members). These were primarily accounted for by complaints regarding transportation (7.27 per 1,000 members). There was a decline in complaints regarding denial of claims (from .55 to .06 per 1,000 members) and waiting for an appointment (from .07 per 1,000 members to .03 per 1,000 members) between 2001 and 2002.**

- **The rate of provider medical complaints was .45 per 1,000 members, higher than the Western Region and statewide rates for MC+ Managed Care MCOs (.31 per 1,000 members and .29 per 1,000 members, respectively). These were primarily accounted for by complaints regarding denial of services (.42 per 1,000 members). However, there was a decline between 2001 and 2002 in provider complaints regarding the quality of care.**

- **The rate of provider non-medical complaints was 4.69 per 1,000 members, higher than the Western Region MCOs (3.24 per 1,000 members) but lower than all MC+ Managed Care MCOs (9.50 per 1,000 members). These were primarily accounted for by complaints regarding denial of claims (4.00 per 1,000 members).**

Case Management

- **Blue Advantage Plus subscribes to the following definition of case management:**

  "Case management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patient's/families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance outcomes."[3]

- **Blue Advantage Plus has found that a high proportion of those children identified as in need of case management on the special health care needs listing provided by the State are in need of asthma case management.**

- **Children in foster care and the Alternative Care program are case managed by the two Federally-Qualified Health Care Centers (FQHCs), Swope Parkway and Samuel Rogers Health Centers. Blue Advantage Plus has identified a person to coordinate claims and pharmacy utilization data as well as medical records, but does not formally open case management files for these children.**

- **Blue Advantage Plus has developed a flow chart to reflect the processes of identification of members in need of case management for lead toxicity. They employ the state provided information about the lead testing results of MC+ Managed Care members as obtained from the state laboratory. Parents of members with lead levels greater than 19 μg/dL are then sent a letter, which is carbon copied to the PCP and LPHA. Within one month, the Blue Advantage Plus case manager checks with the LPHAs for repeat lead levels and values. If the level is 10 μg/dL or below, a letter is sent to the physician and LPHA advising that follow-up is not necessary; if the level in 10 – 14 μg/dL, the MCO sends a letter to the parent of the member, recommending follow-up testing in two to three months, with a copy sent to the physician and LPHA; and if the two venous lead levels are reported as 15 μg/dL three months apart or more, or if there is one venous level greater than 20μg/dL, the member is placed on a clinical pathway for Managing Elevated Lead Levels.**

- **The prenatal program was brought in-house in 2002, with Blue Advantage Plus using the Little Stars program, with its own identification and materials. The Healthy Deliveries Prenatal Program was in place during 2002, being replaced by the Little Stars Prenatal Program in 2003. The emphasis of the Little Stars program is on MC+**

Managed Care members. There are currently approximately 300 mothers enrolled in the program. All new enrollees are screened along with all potential special needs members. Approximately 300 members are enrolled in the program. When the program was announced via a letter distributed to members in December 2002, there was a surprising response for requests to enroll in the program. The member is assessed for risks at specified intervals during the pregnancy with the care plan changed accordingly. The screen includes EPSDT and domestic violence issues. Referrals to childbirth classes and for substance abuse or mental health needs are documented. A six week post- partum visit is scheduled and family planning choice is identified by the member. Different programs were identified for those less than 28 weeks gestation and those greater than 28 weeks gestation.

Interagency Coordination

- **NDBH participates on the Western Region Interagency Collaborative that coordinates care for children in the Alternative Care program, those in state custody that are not in the Alternative Care program, and those who may be court- ordered for evaluation or treatment.**

- **Blue Advantage Plus is involved with numerous community projects and agencies and has contracted with school- based health clinics, LPHAs, and UMKC Dental School to assist in the coordination and provision of services for their members. Collaboration with other MC+ Managed Care MCOs is evident and commended. Improvement in the Blue Advantage Plus claims system should prove beneficial in data collection and reporting. Vendor oversight is intensive and promotes efficient and timely follow- up to address any issues or member needs. We urge Blue Advantage Plus continue with present programs and develop action plans to address issues identified in the Population Study. Since many of these issues are related to current performance improvement projects, Blue Advantage Plus should be able to revise the appropriate programs as necessary and monitor results for effectiveness, reporting to Quality Management according to the existing schedule.**

- **Blue Advantage Plus staff are currently working with LPHAs. A meeting was recently held in the Western Region, co- led by Blue Advantage Plus and Platte County Health Department. Blue Advantage Plus has developed good communication developed with nine local health departments in the Kansas City area to assist with members needs/outreach.**

- **Blue Advantage Plus has entered into contract with Westport Edison School Clinic, Children's Mercy Hospital, and the Kansas City School district school- based health clinics.**

Blue Advantage Plus

2002 External Quality Review Summary

Conducted on Friday, February 28, 2003

The results of the on-site review, review of documentation, and review of data provided for analysis indicated a number of accomplishments and opportunities for improvement for Blue Advantage Plus in providing care to MC+ Managed Care members. Also, some barriers and possible resolution to the barriers were discussed. These are summarized below.

Accomplishments

∨   Claims processing has improved. Billing errors and diagnoses/codes are increasingly being coded properly. There has been an increase in electronic claims submissions, with an elimination of claims delays due to Coordination of Benefits and education providers and office staff. A significant shift was noted in the approach of LPHAs, with two LPHAs requesting to file their claims electronically. This is reflective of the success of the coordination between the MCO and LPHAs.

∨   The Claims Department received the Blue Advantage Plus Showcase of Quality Award for the most improvement in the organization.

∨   The compliance program database allows for monitoring of contractual requirements and compliance of vendors with state and federal regulations.

∨   Blue Advantage Plus outreach programs have shown continued improvement, with Blue Advantage Plus facilitating the process of placing MC+ Managed Care eligibility information on food bank items. The letters to members regarding the new prenatal program served as an effective outreach and reminder strategy, as evidenced by the strong and unanticipated response from members. In addition, the patient education materials developed and disseminated by New Directions Behavioral Health were another strategy for outreach. The effectiveness of this strategy should be evaluated. Finally, Blue Advantage Plus provided additional brochures on the Child Abuse/Neglect procedures supplied to the Independence health clinic. Blue Advantage Plus has effectively used resources and grants to provide outreach to MC+ Managed Care members.

∨   Blue Advantage Plus recently completed their multi-year re-contracting initiative, adding ancillary and allied health providers to this process.

∨   Blue Advantage Plus implemented a physician profiling and incentive program for leveraging OB/GYN participation from commercial product providers by providing higher rates of reimbursement for deliveries. Blue Advantage Plus also provides reimbursement for EPSDT at 108-110% of Medicaid fees.

∨ Accomplishments in the area of vendor oversight include the use of audit procedures for credentialing of Doral Dental providers; oversight of policies and procedures for the behavioral health network, and increased expectations for non- emergent medical transportation services.

∨ Blue Advantage Plus follows national standards for the credentialing of providers for the MC+ Managed Care provider network.

∨ New Directions has received data from Blue Advantage Plus regarding medication to assist in utilization management and case management. We encourage use of this for identifying children in alternative care as well.

∨ In 2002, Blue Advantage Plus achieved the 80% or greater target for EPSDT services in 6 of the 14 rate cells, an improvement from 2001, when they met or exceeded the goal in 2 rate cells. This represents an overall 6.56% increase from 2001 to 2002.

∨ Blue Advantage Plus received a Peoples' Choice Award for cultural competency practices within the organization.

∨ Blue Advantage Plus has improved in the intensity of Interagency coordination, as evidenced by contracting with the school district to initiate a school- based health clinic (Westport- Edison and Kansas City Schools); bill and track dental services delivered in a day care center (UMKC dental school providing screenings at St. Vincent's Day Care), and in working with the Division of Family Services and court systems to meet the needs of MC+ Managed Care youth and their families.

∨ NDBH provided good access measures of providers and response times for NDBH, but we would like to see Depression Guideline results and provider satisfaction surveys have more information regarding Blue Advantage Plus members in particular. Behavioral health prevention programs include the Anniversary Program and Grade Card Program. Evaluations of their efficacy and impact would facilitate the identification of best practices.

∨ The overall rate of member non- medical complaints increased, accounted for primarily by the increase in member complaints regarding transportation. This is primarily due to a change in the reporting of member complaints by the transportation vendor, but Blue Advantage Plus has been working closely with the vendor to improve performance.

∨ A number of improvements in provider network adequacy were noted between 2001 and 2002.

∨ The scope of the Population Study and key results are extremely impressive and indicate a commitment to meeting the needs of the membership. Opportunities for improvement were identified. This study and the data can be used for identifying modifiable factors in the prevention and management of acute and chronic conditions

Opportunities for Improvement

Ü **Opportunities for improvements in the provider network for psychology, endocrinology, and facilities are present. Opportunities for improvements in provider network for rheumatologists also exist. However, there are a number of provider shortages. It is recommended that member access to these services be monitored carefully to ensure that access and timelines are not impacted for members; and to ensure that access to services is provided to members on a case by case basis.**

Ü **It is recommended that Blue Advantage Plus and its behavioral health vendor continue education with DFS, interagency coordination, primary care providers, and staff at the MCO and provider offices that work with members of Blue Advantage Plus.**

Ü **Continue monitoring, tracking and follow- up mechanisms for healthy children in Alternative Care.**

Ü **A suggested project for the ED utilization issue is to perform an analysis of the diagnoses/presenting complaints for the visits, particularly for the 0- 6 year old population. If a trend of routine, non- urgent complaints is identified, focused education to the parents could be a potential area of savings. Young parents may not be aware of MCO benefits and appropriate PCP comprehensive care.**

Ü **There was a decline in admissions for substance abuse treatment between 2000 and 2001. The reasons for this should be examined by Blue Advantage Plus and the behavioral health vendor to asses whether access issues or needs for provider and member education exist.**

Ü **Assess characteristics of inpatients with no previous behavioral health hospitalizations. There may be some specific diagnoses, primary care utilization patterns, or opportunities for member education or that can be targeted for utilization management and use of preventive or alternative services. The possibility of increased ED use being related to behavioral health needs should also be examined.**

Ü **Conduct a study on lead levels and efficacy of lead case management as well as ongoing monitoring of lead levels. There have been a number of data quality and flow improvement projects implemented at the state level to improve the timeliness and comprehensiveness of information about member lead testing. These should be used to provide regular monitoring, case management, and follow- up for members.**

Ü **Assess retention of OB/GYNs for Blue Advantage Plus deliveries with the new incentives. If effective, consider this model for other network provider specialties.**

Ü **Baseline, interim, and follow- up measures of interventions and initiatives to improve processes and outcomes should always be planned prior to the implementation of the intervention. Some recommended areas for assessment of quality include:**

> m **Measure the implementation and outcomes of depression and ADHD guidelines for Blue Advantage Plus members.**
>
> m **Request inclusion of Blue Advantage Plus members in the NDBH member survey to obtain specific information about member needs.**
>
> m **Assess the effectiveness of outreach and process interventions with prenatal letters (e.g., participation rate, level of member involvement, inquiries, etc.)**
>
> m **A variety of interventions have been implemented for EPSDT, representing a comprehensive and aggressive approach to improving the completion and documentation of EPSDT services to members. Blue Advantage Plus has documented these interventions by quarter, but indicate that it is difficult to assess the independent impact of any one intervention. However, they indicate that the interventions that seem to be the most effective are identifying key providers, such as schools, and obtaining contracts with schools to bill for services. Interventions and changes in EPSDT rates by quarter should continue to be documented and monitored to provide data for hypotheses about the relative impact of interventions.**

Ü **Provider medical complaints regarding the denial of services and denial of claims increased between 2001 and 2002. This should be an area of focus for provider service representatives.**

Ü **"Other" medical complaints and denial of services complaints increased for member between 2001 and 2002. Member medical complaints regarding denial of services, transportation, and other non-medical reasons increased between 2001 and 2002. Transportation complaints accounted for the largest increase in member non-medical complaints, likely due to a change in documentation of complaint by the transportation vendor. Nevertheless, these complaints should be monitored and used to improve services to members for transportation as well as refinement of claims systems to address issues where possible.**

---

[1] *Source:* Missouri Department of Insurance Network Adequacy Analysis, 2003
[2] *Source:* Mental Health Subgroup of the Quality Assessment and Improvement Group, 2003
[3] This definition was provided in the RFP B3Z02226 for MC+ Managed Care, with permission of the Center for Case Management, 6 Pleasant Street, South Natick, MA, 01760.