2005

Missouri MC+ Managed Care Program

External Quality Review

Report of Findings

Amy McCurry, Esq., MHSA, EQRO Project Director
Mona Prater, MPA, EQRO Assistant Project Director
Stephani Worts, MBA, EQRO Research Analyst

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Performance Management Solutions Group

Prepared and Submitted by:

The Performance Management Solutions Group
A division of Behavioral Health Concepts, Inc.

2716 Forum Blvd, Suite 4
Columbia, MO 65203
(573) 446-0405 :Local Ph.
(866) 463-6242 :Toll-free Ph.
(573) 446-1816 :Fax
http://www.PMSGinfo.com
http://www.BHCinfo.com
Email: EQRO@pmsginfo.com

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LIST OF ACRONYMS

BA+	Blue-Advantage Plus of Kansas City
BHO	Behavioral Health Management Organization
CAHPS	Consumer Assessment of Health Plans Survey
CCP	Community CarePlus
CDC	Centers for Disease Control and Prevention
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
CMFHP	Children's Mercy Family Health Partners
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
CPT	Current Procedural Terminology
CY	Calendar Year
DHHS	U.S. Department of Health and Human Services
DHSS	Missouri Department of Health and Senior Services
DMS	Division of Medical Services
DSS	Missouri Department of Social Services
EPSDT	Early, Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FG	FirstGuard Health Plan
HCUSA	HealthCare USA
HCY	Healthy Children and Youth, the Missouri Medicaid EPSDT program

HEDIS	Health Plan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information Systems
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, Ninth Revision, Clinical Modification, World Health Organization
ICN	Internal Control Number
ISCA	Information Systems Capability Assessment
LPHA	Local Public Health Agency
MBE	Minority-owned Business Enterprise
MC+	The name of the Missouri Medicaid Program for families, children, and pregnant women.
MC+ MCOs	Missouri Medicaid Program Managed Care Organizations
MCO	Managed Care Organization
MDI	Missouri Department of Insurance
MHP	Mercy MC+
MMIS	Medicaid Management Information System
MOHSAIC	Missouri Health Strategic Architectures and Information Cooperative, Missouri Department of Health and Senior Services Public Health Immunization Registry
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee for Quality Assurance
N.S.	Not significant, indicating that a statistical test does not result in the ability to conclude that a real effect exists.
NSF/CMS 1500	National Standard Format/ Center for Medicare and Medicaid Services Form 1500
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project

PRO	Peer Review Organization
QA & I	Quality Assessment and Improvement Advisory Group
QI/UM Coordinator	Quality Improvement/Utilization Management Coordinator.
SMA	State Medicaid Agency, the Missouri Department of Social Services, Division of Medical Services
SPHA	State Public Health Agency, the Missouri Department of Health and Senior Services
UB-92	Universal Billing Form 92

GLOSSARY AND OPERATIONAL DEFINITIONS

Administrative Method	The Administrative Method of calculating HEDIS Performance Measures requires the MCO to identify the denominator and numerator using transaction data or other administrative databases. The Administrative Method outlines the collection and calculation of a measure using only administrative data, including a description of the denominator (i.e., the entire eligible population), the numerator requirements (i.e., the indicated treatment or procedure) and any exclusions allowed for the measure.
Accuracy (Match) Rate	The ratio of identical or correct information in the medical record and the SMA relative to the number of encounters that took place.
Accuracy of a data field	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alpha numeric) in the proper format (e.g., mm/dd/yyyy for date field).
Accuracy of the State encounter claims database	The extent to which encounters are being submitted for 100 percent of the services that are provided. [1]
Commission (or surplus encounter claim)	An encounter that is represented in the SMA encounter claims database but not the medical record; or a duplicate encounter.
Completeness of a data field	The extent to which an encounter claim field contains data (either present or absent).
Confidence interval or level	The range of accuracy of a population estimate obtained from a sample.

[1] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition

Encounter data	"Encounter data are records of health care services that have been provided to patients." [2]
Error	An error in coding or recording an encounter claim.
Fault (Error) Rate	The ratio of missing and erroneous records relative to the total number of encounters that took place[3]. The rate at which the SMA encounter claims data does not match the medical record or the MCO paid encounter claims data (the converse of match rate).
Hybrid Method	Hybrid Method requires the MCO to identify the numerator through both administrative and medical record data. The MCO reports a rate based on members in the sample who are found through either administrative or medical record data to have received the service identified in the numerator.
Interrater reliability (IRR)	A method of addressing the internal validity of a study by ensuring that data are collected in a consistent manner across data collectors.
Omission (or missing encounter claim)	An encounter that occurred but is not represented in the State encounter claims database.
Paid claim	An encounter claim that has been paid by the MCO.

[2] Medstat (1999).: A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data. Medstat: Santa Barbara. Second Edition

[3] Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in conducting Medicaid External Quality Review activities, Final Protocol, Version 1.0, U.S. Department of Health and Human Services.

Probability sample	A sample in which every element in the sampling frame has a known, non-zero probability of being included in a sample. This produces unbiased estimates of population parameters that are linear functions of the observations from the sample data[4].
Random sample	Selection of sampling units from a sampling frame where each unit has an equal probability of selection.
Reasonableness of a data field	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date); also referred to as validity of the data.
Reliability	The consistency of findings across time, situations, or raters.
Sampling frame	The population of potential sampling units that meet the criteria for selection (e.g., Medical encounter claim types from January 1, 2004 through March 31, 2004).
Sampling unit	Each unit in the sampling frame (e.g., an encounter).
Simple sample	Selection of sampling units from one sampling frame.
Unpaid claim	All unpaid and denied claims from the MCO; All claims not paid by the MCO either through capitation or through other payment methodology.

[4] Levy, P.S., Lemeshow, S. (1999). Sampling of Populations: Methods and Applications, Third Edition. John Wiley and Sons: New York.

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SECTION 1.0
EXECUTIVE SUMMARY

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1.0 EXECUTIVE SUMMARY

I.1 Introduction

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Managed Care Organizations (MCOs) and their contractors to recipients of Medicaid managed care services. The Centers for Medicare and Medicaid Services (42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rule specifies the requirements for evaluation of Medicaid managed care programs. The present report summarizes the findings of the second year of implementation of the mandatory activities for External Quality Review of the MC+ Managed Care Program in Missouri as conducted by Behavioral Health Concepts, Inc., a PRO-Like Entity certified by CMS to conduct External Quality Review (EQR) in all U.S. states and territories.

Four protocols were implemented: 1) Validating Performance Improvement Projects;[5] 2) Validating Performance Measures;[6] 3) Validating Encounter Data;[7] and 4) MCO Compliance with Managed Care Regulations.[8] Each MC+ MCO conducted performance improvement projects (PIPs) during the 12 months preceding the audit; two of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, Division of Medical Services; DMS). The three performance measures validated were HEDIS 2005 measures of Well-Child Visits in the First 15 Months of Life, Childhood Immunization Status, Combination #2, and Annual Dental Visits. Validation of Encounter Data examined the completeness, accuracy, and reliability of specific fields in

[5] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[6] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Measures: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[7] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[8] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR §400, 430, et al., Final Protocol, Version 1.0, February 11, 2003. Washington, D.C.: Author.

the SMA database; and the extent to which paid claims in the SMA were represented in the medical records of MC+ Managed Care Members. The EQRO conducted all protocol activities, with the exception of the MCO Compliance with Managed Care Regulations Protocol. The SMA conducted these activities and requested the EQRO to review them (Compliance Review Analysis).

1.2 Preparation for the 2005 External Quality Review

Preparation with the State Medicaid Agency

Effective July 1, 2005 the State of Missouri contract for the External Quality Review of the MC+ Managed Care Program (State of Missouri Contract No: C301154001, Amendment No.: 006) was revised to comply with federal requirements for states to contract with an external, independent entity to implement the mandatory protocols for External Quality Review. The first monthly meeting for planning the scope of work, technical methods and objectives, and analyses was held by the SMA on September 22, 2005. Meetings were held with the SMA and the EQRO on October 27, 2005, November 15, 2005, December 15, 2005, January 9, 2006, February 21, 2006, March 27, 2006, and April 24, 2006. Additional meetings and teleconference calls were conducted as needed between SMA and EQRO personnel.

At the first meeting in September 2005, the previous years' report was discussed, the new EQRO Project Director was introduced to the SMA, and the plan for the 2005 audit was discussed. During the month of September, the EQRO clarified the SMA's objectives for each of the protocols, developed data requests, prepared detailed proposals for the implementation and analysis of data for each protocol, and prepared materials for SMA review. Written proposals for each protocol were submitted on October 11, 2005 by the EQRO for review, discussion, revision, and approval. By November 7, 2005, the EQRO had negotiated with the SMA the data request for State encounter data to be validated. All protocols were revised, finalized and submitted to the SMA by October 2005.

Preparation of MC+ MCOs

During October 2005, preparation of MC+ MCOs for the implementation of the 2005 EQRO was conducted by the EQRO Project Director and personnel. To begin, the EQRO Project Director presented a timeline for project implementation and answered MCO questions at the October 20,

2005 MC+ Managed Care All-Plan Meeting. The EQRO Project Director and personnel then conducted orientation to the protocols and the EQRO processes with each MC+ MCO.

The EQRO Assistant Project Director arranged the dates of the teleconference calls with MC+ MCO QI/UM Coordinators or Medicaid Plan Administrators. A detailed presentation, tentative list of data requests, and the proposals approved by the SMA were sent to MC+ MCOs prior to the teleconference orientation sessions. MC+ MCOs were requested to have all personnel involved in fulfilling the requests or in implementing activities related to the protocols (e.g., performance improvement projects to be validated, performance measures to be validated, encounter data requested) present at the teleconference calls. [The orientation presentation is contained in Appendix 1.] An SMA representative attended all conference calls and received minutes of the meetings taken by the EQRO upon completion of all the calls. Conference calls with EQRO and MC+ MCO personnel occurred between October 21, 2005 and October 31, 2005. To avoid confusion and the inundation of multiple requests at once, the requests for information from MC+ MCOs were implemented in a staged approach from November 1, 2005 through December 9, 2005. All communications (letters, general and specific instructions) were submitted for review, revision, and approval by the SMA prior to sending them to the MC+ MCOs.

Development of Worksheets, Tools, and Rating Criteria

The EQRO Project Director, Research Associate, Assistant Project Director, a health services researcher, and a healthcare provider were responsible for modifying the worksheets and tools used by the EQRO during the 2004 audit. The EQRO Assistant Project Director revised the worksheet (Attachment B) of the Validating Performance Improvement Project Protocol to add detail for several items that were specific to the MC+ Managed Care Program.

For the Validating Encounter Data Protocol, the EQRO Project Director revised both the data analytic plan in collaboration with the SMA as well as methods and procedures based on the content, quality and format of data provided by the SMA and MC+ MCOs. The SMA selected the fields to validate for completeness, accuracy, and reliability of paid claims submitted by MC+ MCOs. The EQRO developed definitions of all field parameters for review, revision, and approval by the SMA. Encounter data critical field parameters were approved by the SMA at the December 15, 2005 meeting between the SMA and the EQRO.

The Validating Performance Measures Protocol worksheets were revised and updated by the EQRO Project Director to reflect the Performance Measures selected for review for HEDIS 2005. The worksheets had been developed by Behavioral Health Concepts, Inc. staff during the previous year's audit.

The SMA had already conducted the activities of the MC+ MCO Compliance with Managed Care Regulations Protocol through the state contract compliance monitoring process and the work of the EQRO involved the review and evaluation of this information (see Medicaid Program; External Quality Review of Medicaid Managed Care Organizations of 2003, CFR §438.58). The state contract for EQRO requires the review of SMA's activities with regard to the Protocol, however, additional policies and documents were requested prior to and during the on-site visits with MC+ MCOs when information was incomplete or unclear. To facilitate the review of compliance with federal regulations, the EQRO Assistant Project Director revised a previously developed cross-walk between the SMA contract requirements for Medicaid managed care and the federal Medicaid Managed Care Regulations.

The MC+ Managed Care Program consultant, who has participated in the EQRO for the past three years, reviewed and refined the tool. Feedback on inconsistencies between the Medicaid Managed Care contract and federal requirements was provided immediately to the SMA. The EQRO utilized the rating system developed during the 2004 audit to provide ratings for each MCOs' compliance. The SMA provided state compliance review information to the EQRO for all MC+ MCOs in October 2005. The EQRO staff and the consultant reviewed all available materials and met with SMA staff on October 27, 2005 to clarify SMA comments and compliance ratings; and identify issues for follow-up at site visits. Updates on MC+ MCO compliance were provided through early February 2006 to ensure that the EQRO had up-to-date information prior to the beginning of the on-site reviews. Recommended ratings were provided to SMA on April 24, 2006, which were approved for utilization in this report.

The following sections summarize the aggregate findings and conclusions for each of the mandatory protocols. The full report is organized according to each protocol and contains detailed descriptions of the technical methods, objectives, findings, and conclusions (strengths, areas for improvement, and recommendations). In addition, it provides MCO to MCO comparisons and individual MC+ MCO summaries for each protocol.

1.3 Validation of Performance Improvement Projects

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs for each MCO that were underway during the previous 12 month period at each MC+ MCO, for a total of 14 PIPs validated. Eligible PIPs for validation were identified by the MC+ MCOs, SMA, and the EQRO. The final selection of the PIPs for the 2005 validation process was made by the SMA in October 2005. PIPs are to be aimed at studying the effectiveness of clinical or non-clinical interventions, and should improve processes highly associated with healthcare outcomes, and/or healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; 3)or stability in improvement as a result of an intervention. Under the State contract for Medicaid Managed Care, MC+ MCOs are required to have two active PIPs, one of which is clinical in nature and one non-clinical. Specific feedback and technical assistance was provided to each MC+ MCO by the EQRO during the site visits for improving study methods, data collection, and analysis.

STRENGTHS

1. There was good topic identification and good intervention development for PIPs. MC+ MCO personnel were well qualified to identify study topics, areas in need of improvement, and interventions to address barriers to quality of care and health outcomes. Interventions were aimed at key aspects of enrollee care and services.
2. All aspects of the PIPs indicated significant improvement in the structure, intent, and depth of the process utilized to produce these studies. These studies incorporated many of the requirements of the Conducting Performance Improvement Projects protocol. The MC+ MCOs clearly intended to utilize improved methods of producing health care services into their day-to-day operations at the completion of the PIP when appropriate.
3. A number of the PIPS (Pre-Authorization Improvement, ADHD, Increased Blood Lead Level Testing at 12 & 24 Months, Access to Primary Care Services, Improving Lead Screening at 6-36 Months of Age, Improving Asthma Medication Management) were judged to be likely or highly likely to produce credible and valid findings to identify Best Practices.
4. MC+ MCO personnel were attentive and responsive to technical assistance for the implementation of PIPs and presented goals or plans for improving the process in the future. MC+ MCOS instituted personnel and/or role changes to improve the focus and expertise of personnel responsible for PIP implementation.

AREAS FOR IMPROVEMENT

1. Study questions should continue to be refined. In some cases the study question did not frame the purpose, intended outcomes, goals, and methods for the study. It is critical that there is a link between the study questions, measures of implementation, measures of outcomes, and analysis of findings to address the problems or issues identified.
2. Data analysis plans were not described in a number of the PIPs. The method of data collection and compilation is often dependent on the plan for data analysis. A plan should be developed prior to conducting a PIP, and modified as needed to be able to test for significant improvement or stability of performance on the outcome measures over time. Data analyses could not be evaluated without a description of the plan.
3. There were PIPs underway or ongoing that resulted in the potential for credible findings. Ensuring that the project is started early enough to provide some data and data analysis is essential in completing the validation process. It appeared that many MC+ MCOs conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs as tools to improve the organizations ability to serve members will be beneficial.

RECOMMENDATIONS

1. It is recommended that MC+ MCOs obtain additional training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings. One MC+ MCO (Children's Mercy Family Health Partners) utilized the services of a statistician from a local university to ensure valid and reliable findings.
2. In the design of PIPs, MC+ MCOs need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, "Conducting Performance Improvement Projects" were recommended by the EQRO at each MC+ MCO as a guideline to frame the development, reporting and analysis of the PIP.
3. It is recommended that a statewide PIP be identified by the SMA and the MC+ QA & I Group for planning and implementation one year prior to the planned implementation. The topic should be chosen by taking into account the findings of this report and the current topics chosen by the MC+ MCOs. Topics that are likely to affect a broad segment of the population and key healthcare outcomes should also be considered.

1.4 Validation of Performance Measures

The Validating Performance Measures Protocol requires the validation or calculation of three performance measures at each MC+ MCO by the EQRO. The measures selected for validation by the SMA are required to be submitted by each MC+ MCO on an annual basis. The measures were also submitted by the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for all Health Maintenance Organizations (HMOs) operating in the State of Missouri. They were: 1) HEDIS 2005 Childhood Immunization Status, Combination #2; 2) HEDIS 2005 Well-Child Visits in the First 15 Months of Life ; and 3) HEDIS 2005 Annual Dental Visit. Detailed specifications for the calculation of these measures were developed by the National Committee for Quality Assurance (NCQA), a national accrediting organization for managed care organizations. The EQRO examined the information systems, detailed algorithms, MC+ MCO extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol. The data reported to the SPHA was based on MC+ MCO performance during 2004. MC+ MCOs were given an opportunity to review and correct the data presented to the SPHA; and were provided with the opportunity to review EQRO findings for comment and correction.

STRENGTHS

1. MC+ MCOs have strong management information systems for the documentation and payment of services to providers and the tracking of member information. These systems and the processes for performance measure calculation are well documented and MC+ MCOs retain qualified personnel for the programming of data specifications to calculate performance measures.
2. Six of the seven MC+ MCOs incorporated external data (State Public Health Immunization Registry; the Missouri Health Strategic Architecture and Information Cooperative; MOHSAIC) to capture immunizations delivered outside the MC+ MCO for the HEDIS 2005 Childhood Immunization Status, Combination #2.
3. Six of the seven MC+ MCOs produced the HEDIS 2005 Annual Dental Visits Measure in a manner that was Fully Compliant with the specifications.
4. One MC+ MCO, that was bound to be Substantially Compliant with the calculation of the HEDIS 2005 Childhood Immunization Status, Combination # 2 measure, had a higher rate than the National Medicaid rate for this measure.
5. One MC+ MCO that was Substantially Compliant with the calculation of the HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure had a rate higher than the National Commercial and Medicaid rates for this measure.

6. Four of the seven MC+ MCOs employed NCQA-certified software for the rate calculation process, which requires passing test file procedures by NCQA for accurate and valid programming and calculation of the specifications.
7. In response to the EQRO exit interview comments and preliminary findings for this Protocol, several MC+ MCOs developed corrective action plans for improving the process of documentation, rate calculation, oversight, and staff training for the calculation of performance measures.

Areas for Improvement

1. The HEDIS 2004 Childhood Immunization Status, Combination #2 measure was unable to be validated for three of the seven MC+ MCOs and does not represent a valid measure of performance for the MC+ Managed Care Program.
2. In many cases, there was limited organizational knowledge of the process of calculating measures. This was related to the use of vendors for various aspects of claims administration and the rate calculation process.
3. There continues to be variability in the implementation of the Hybrid Method. The EQR validation used the same criteria for numerator events across all MC+ MCOs in the validation process. In addition, not all MC+ MCOs reviewed all of the medical records sampled for the Hybrid Method of calculation.

Recommendations

1. The SMA should use the results of the EQR, as much as possible, to build and negotiate rate increases for Managed Care Organizations in Missouri.
2. The SMA and SPHA should continue to support efforts to improve the utility and functionality of the State Public Health Immunization Registry (MOHSAIC) as well as encourage public, private, and non-profit providers of immunizations to use the Registry so as to obtain complete information about the level of care provided to MC+ Managed Care Members for the administration of immunizations.
3. For the calculation of the HEDIS Childhood Immunization Status, Combination #2 measure, the Hybrid Method and the incorporation of MOHSAIC data should be required by the SMA to facilitate accurate and valid MC+ MCO comparisons and a valid statewide rate for comparison of performance with other states.
4. MC+ MCOs should document policies, procedures, processes, and responsibilities of personnel and vendors involved in calculating and reporting HEDIS measures for the MC+ Managed Care Program. This should include vendor oversight and review of files and data produced to calculate the measures.

1.5 Encounter Data Validation

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

STRENGTHS

1. The majority of critical fields evaluated for each of the six encounter claim types were accurate, complete, and valid.
2. The Pharmacy, Dental, and Home Health critical fields contained valid data for the analysis of paid encounter claims.

AREAS FOR IMPROVEMENT

1. Medical records that did not have diagnosis or procedure codes that matched those in the SMA encounter claims database were in error primarily due to missing or illegible data.
2. Only two MC+ MCOs were able to produce paid and unpaid claims in valid formats for encounter data validation to assess the completeness of paid claims as represented in the SMA encounter claims database or to identify omission and commission errors related to encounter data submission.
3. All MC+ MCOs had invalid coding in the Medical Claim Types.
4. For all MC+ MCOs invalid dates were found in the Inpatient Claim Type.
5. The volume and consistency of services across MC+ MCOs and claim types were highly variable, with no patterns across MC+ Managed Care Regions observed.

RECOMMENDATIONS

1. MC+ MCOs should explore potential reasons for variation in claim types and in the proportion of each claim type to all claim types.
2. MC+ MCOs should examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
3. For the Inpatient claim type (UB-92 file layout), improve the rate of valid Discharge Dates to flag invalid entries of "99999999"and blank entries for the Units of Service field. Error checks for the Diagnosis Code field should also be conducted to ensure no blank fields.
4. It is recommended that MC+ MCOs emphasize to providers the importance of documentation of diagnostic and procedural code information in the medical record.
5. MC+ MCOs should include State issued ICN numbers (in the format issued by the State) in all data submissions to the EQR, this would allow more accurate matching of encounters between the MC+ MCO and SMA extract files.

1.6 MC+ MCO Compliance with Managed Care Regulations

The purpose of the protocol to monitor MCO Compliance with Managed Care Regulations is to provide an independent review of MC+ MCO activities and assess the outcomes of timeliness and access to the services provided by the MC+ MCOs. The protocol requires the utilization of two main sources of information to determine compliance with federal regulations. These sources of information are document review and interviews with MC+ MCO personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MC+ MCO.

The policy and practice in the operation of each MC+ MCO was evaluated against the seventy (70) regulations related to operating a Medicaid managed care program. The regulations were grouped into three main categories: Enrollee Rights and Protections, Quality Assessment and Improvement, and Grievance Systems. The category of Quality Assessment and Improvement was subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, the SMA reviewed each MC+ MCOs' policy to determine compliance with the requirements of the MC+ Medicaid Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO. The EQRO also focused on follow up to the findings reported in the 2004 report by concentrating efforts of technical assistance and assessment on the items that were rated "Not Met" in 2004. Additional document review occurred when the MC+ MCO policy submission did not meet MC+ Medicaid Managed Care contract requirements, or where clarification was necessary. A set of interview questions specific to each MC+ MCO was developed to elicit information that validated organizational practice and explored issues not fully addressed in the documents.

STRENGTHS

1. Two of the MC+ MCOs "met" (100%) applicable federal regulations and State compliance requirements. There were no regulations rated as "Unmet" for any of the MC+ MCOs. The ratings for every section of the protocol indicated an improvement in all areas of policy and procedure submission and approval, as well as practice.

2. The MC+ MCOs were aware of their need to provide quality services to members in a timely and effective manner. Where there were issues with access to services, the MC+ MCOs responded quickly and effectively.

3. MC+ MCOs remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their MC+ Members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be available to MC+ Members.

4. Across all MC+ MCOs there was recognition of the importance of being in compliance with the federal regulations. The MC+ MCOs exhibited significant improvement in their attention to the details of producing effective and required policies and procedures, and creating an environment that rewards adherence to these policies.

Areas for Improvement

1. All MC+ MCOs did not have their written policies and procedures completed to ensure that a consistent application of contractual requirements and federal regulations was occurring.

2. MC+ MCOs continued to struggle with recruitment of certain specialty physicians. Throughout discussions with MC+ MCOs the lack of orthopedic surgeons, neurosurgeons and child/adolescent psychiatrists was identified as a problem. The MC+ MCOs have made accommodations to ensure that members received the services required. Through the use of advance practice nurses, cooperative agreements with medical schools, and the willingness to reimburse at commercial insurance rates, the MC+ MCOs attempt to ensure that members have access to these services. MC+ MCOs expressed continued concern for improvement in this area.

3. The use of data for quality improvement purposes and examination of healthcare outcomes was just beginning. Continued growth in the utilization of all of the data available to drive healthcare practice and initiatives is required to improve quality and access to care.

Recommendations

1. MC+ MCOs must continue to recognize the need for timely submission of all required policy and procedures. The majority of the MC+ MCOs put a tracking or monitoring system into place to ensure timely submission of documentation requiring annual approval. These systems must be maintained to ensure that this process remains a priority for all MC+ MCOs.

2. MC+ MCOs identified the need for continuing to monitor provider availability in their own networks. Although most MC+ MCOs had the number of primary care physicians (PCPs) and specialists required to operate, they admitted that many of these PCPs had closed panels and would not accept new patients. Ensuring that there is adequate access for all members, including new members, should be a priority for all MC+ MCOs.

3. MC+ MCOs identified improvement in their Quality Assessment and Improvement programs, and how this enhanced their ability to provide adequate and effective services to members. These efforts must be relentlessly continued to ensure that the organizations remain aware of areas for growth and improvement. These efforts ensure that the quality, timeliness and access to care required for member services is maintained at an exceptional level.

SECTION 2.0
VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

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2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

2.1 Definition

A Performance Improvement Project (PIP) is defined by the Center for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care…that is designed, conducted and reported in a methodologically sound manner." The Validating Performance Improvement Projects Protocol specifies that the EQRO conduct three activities in the validation of two PIPs at each MCO that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. The State Medicaid Agency (SMA: the Department of Social Services, Division of Medical Services: DMS) elected to examine projects that were underway during the preceding 12 months. Criteria for identification of a PIP as outlined in the CMS protocols include the following:

- PIPs need to have a pre-test, intervention, and post-test
- PIPs need to control for extraneous factors
- PIPs need to include an entire population
- Pilot projects do not constitute a PIP
- Satisfaction studies alone do not constitute a PIP
- Focused studies are not PIPs: A focused study is designed to assess processes and outcomes on one-time basis, while a PIP is to improve processes and outcomes of care over time.

The State of Missouri contract for Medicaid Managed Care (RFP No. B3Z03182, Contract Amendment 002, 08/25/2003) describes the following requirements for MC+ MCOs in conducting PIPs:

> Performance Improvement Projects: The health plan must conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The health plan must report the status and results of each project to the state agency as requested. The performance improvement projects must involve the following:
>
> - Measurement of performance using objective quality indicators.
> - Implementation of system interventions to achieve improvement in quality.
> - Evaluation of the effectiveness of the interventions.
> - Planning and initiation of activities for increasing or sustaining improvement.
> - Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
> - Performance measures and topics for performance improvement projects specified by CMS in consultation with the state agency and other stakeholders.

2.2 Purpose and Objectives

The purpose and objectives of the present review were to evaluate the soundness and results of PIPs implemented by MC+ MCOs in 2005. The MC+ MCOs were to have two active PIPs in place, one clinical and one nonclinical. The validation process examines the stability and variability in change over multiple years.

2.3 Technical Methods

There are three evaluation activities specified in the protocol for Validating Performance Improvement Projects. Activity One consists of ten steps:

Activity One: Assessing the MCOs /PIHP's Methodology for Conducting the PIP

1. Step One: Review the selected study topic(s)
2. Step Two: Review the study question(s)
3. Step Three: Review selected study indicator(s)
4. Step Four: Review the identified study population
5. Step Five: Review sampling methods (if sampling was used)
6. Step Six: Review the MCOs/PIHP's data collection procedures
7. Step Seven: Assess the MCOs/PIHP's improvement strategies
8. Step Eight: Review data analysis and interpretation of study results
9. Step Nine: Assess the likelihood that reported improvement is "real" improvement
10. Step Ten: Assess whether the MCO/PIHP has sustained its documented improvement

Activity Two (Verifying PIP Study Findings) is optional, and involves auditing PIP data. Activity Three (Evaluate Overall Reliability and Validity of Study Findings) involves the judgment of whether the results and conclusions drawn from the PIP are valid and reliable. Activities One and Three were conducted by the EQRO.

Time Frame and Selection

Two projects that were underway during the preceding 12 months at each MC+ MCO were selected for validation. The projects to be validated were reviewed with SMA and EQRO staff, in October 2005. The intent was to identify projects which were mature enough for validation (i.e., planned and in the initial stages of implementation), yet still underway during calendar year 2005. The SMA made the final decision regarding the actual PIPs to be validated from the descriptions submitted by the MC+ MCOs.

Preparation of MC+ MCOs

All MC+ MCOs were contacted during October 2005 to prepare them for the 2005 External Quality Review. All MC+ MCO quality management staff or plan administrators were contacted to discuss the onset of External Quality Review Organization (EQRO) activities and to schedule training teleconferences for later in October. The MCOs were explicitly requested to have their staff or subcontractors available who would be responsible for obtaining and submitting the data required to complete all validation processes. During these teleconferences, all aspects of the EQR, including the requirements of submissions for the Performance Improvement Projects, were discussed.

The training teleconference agenda, methods and objectives, and schedule were sent to all MC+ MCOs, with approval from the State Medicaid Agency (SMA), on October 18, 2005. SMA staff agreed to participate in these conference calls, which were held in late October, allowing time for presentation of information, clarification, and questions. The original submission of data was scheduled prior to the end of the calendar year, which was prior to the completion of most of the projects to be submitted for validation. As a result additional information was accepted at the on-site reviews, or shortly afterward.

REVIEWERS

Three reviewers conducted the Validating Performance Improvement Project Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director is a licensed attorney with a graduate degree in Health Care Administration, and five years of experience in public health and managed care in two states. She conducted interviews and provided oversight to the PIP Protocol team. The Assistant Project Director was conducting her second review. She had experience with the MC+ Managed Care Program implementation and operations, interviewing, program analysis, and Medicaid managed care programs in other states, and ten years experience in program evaluation and research. The second reviewer participated in four previous MC+ Managed Care Program EQRs and on-site visits. This reviewer was knowledgeable about the MC+ Managed Care Program through her experience as a former SMA employee responsible for quality assessment and improvements, as an RN, and a consultant. All reviewers were familiar with the program improvement project requirements and validation process, as well as research methods, and the requirements of the MC+ Managed Care Program.

2.4 Procedures for Data Collection

The evaluation involved review of all materials submitted by the MC+ MCOs including, but not limited to, the materials listed below. During the training teleconferences MC+ MCOs were encouraged to review Attachment B of the Validating Performance Improvement Projects Protocol and ensure that they include information documents, tools, and other information necessary to evaluate the projects submitted, based on this tool.

- Narrative descriptions
- Problem identification
- Hypotheses
- Study questions
- Description of interventions(s)
- Methods of sampling
- Planned analysis
- Sample tools, measures, survey, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Overall analysis of the validity and reliability of each study
- Evaluation of the results of the PIPs

The EQRO Project Director, Assistant Project Director, and review consultant met with the MC+ MCO staff responsible for planning, conducting, and interpreting the findings of the PIPs during the on-site reviews occurring between February 28, 2006 and March 15, 2006. The review focused on

the findings of projects conducted during 2005. MC+ MCOs were instructed that additional information and data not available at the time of the original submission could be provided at the time of the on-site review or shortly afterwards. The time scheduled during the on-site review was utilized to conduct follow-up questions, to review data obtained, and to provide technical assistance to MC+ MCOs regarding the planning, implementation and credibility of findings from PIPs. In addition individual clarifying questions were used to gather more information regarding the PIPs during the on-site interviews. The following questions were formulated and answered in the original documentation, or were posed to the MC+ MCOs during the on-site review:

- Who was the project leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What were the interventions(s)?
- What was the time period of the study?
- Was the intervention effective?
- What did the MC+ MCO want to learn from the study?

All PIPs were evaluated by the Review Consultant and the Assistant Project Director. In addition, the projects were reviewed with follow-up suggestions posed by the Project Director, who approved final ratings based on all information available to the team.

Analysis

All PIPs submitted by MC+ MCOs prior to the site visits were reviewed using an expanded version of the checklist for conducting Activity One, Steps 1 through 10, and Activity Three (Judgment of the Validity and Reliability of the PIPs) of the Validating Performance Improvement Projects Protocol, Attachment B (see Appendix 2). Because specific criteria may not have been applicable for projects that were underway at the time of the review, some specific items were considered as "Not Applicable." Criteria were rated as "Met" if the item was applicable to the PIP, if there was documentation addressing the item, and if the item could be deemed Met based on the study design. The proportion of items rated as "Met" was compared to the total number of items that were applicable for the particular PIP. Given that some PIPS were underway in the first year of implementation, it was not possible to judge or interpret results, validity of improvement, or sustained improvements (Steps 8-10). The final evaluation of the validity and reliability of studies underway were based on the potential for the studies to produce credible findings. Detailed recommendations and suggestions for improvement were made for each item where appropriate, and are presented in the individual MC+ MCO summaries. Some items are rated as "Met" but

continue to include suggestions and recommendations as a method of improving the information presented. The following are the general definitions of the ratings developed for evaluating the PIPs.

Met:	Credible, reliable, and valid methods for the item were documented.
Partially Met :	Credible, reliable, or valid methods were implied or able to be established for part of the item.
Not Met:	The study did not provide enough documentation to determine whether credible, reliable, methods were employed; errors in logic were noted; or contradictory information was presented or interpreted erroneously.
Not Applicable:	Only to be used in Step 5, when there is clear indication that the entire population was included in the study and no sampling was conducted; or in Steps 8 through 10 when the study period was underway for the first year.

2.5 Findings

Below are the PIPs identified for validation at each MC+ MCO.

Community CarePlus	Emergency Room Utilization (Children Receiving ER Services at Cardinal Glennon Hospital) Early Intervention in Prenatal Care Management and the Relationship to the Very Low Birth Weight Babies
Mercy MC+	Medicaid Emergency Room Utilization Customer Service – Member Services Call Center
HealthCare USA	2004/2005 Pre-Authorization Improvement Project 2005 Lead Performance Improvement Project
Missouri Care	Attention Deficit Hyperactivity Disorder Performance Improvement Project Lead Performance Improvement Project
Children's Mercy Family Health Partners	Access to Primary Care Services Improving Lead Screening at 6-36 Months of Age
FirstGuard Health Plan	Improving Birth Weight Outcomes Improving Asthma Medication Management
Blue Advantage Plus of Kansas City	Lead Testing Improvement Project Improving Care for Asthmatics

STEP 1: SELECTED STUDY TOPICS

Study topics were selected through data collection and the analysis of comprehensive aspects of member needs, care, and services. Study topics intended to address a broad spectrum of key aspects of member care and services. In all cases they included all enrolled populations pertinent to the study topic without excluding certain members. Four of the 14 PIPs addressed blood lead level testing; two addressed care for members with asthma; two addressed access to care for pregnant members with the goal of reducing low birth weigh infants; one addressed ADHD treatment; one addressed access to primary care services; two addressed emergency room utilization; one addressed improving the pre-authorization process: and one addressed customer call center services. Table 1 shows the ratings for each item and PIP by MC+ MCO. All 14 PIPs provided some rationale demonstrating the extent of the need for the PIP. Many discussed literature supporting the activities to be undertaken, and provided some benchmark comparison data. While this entire section was not perfect the MC+ MCOs met all the criteria required 85.7% of the time. MC+ MCOs addressed a broad spectrum of key aspects of member care and services (12 of the 14 PIPs, 85.7%, Met this criteria and 2 Partially Met this criteria (Community Care Plus PIPs); Step 1.2). Clinical and nonclinical interventions were identified and aspects of enrollee care and services that were related to the identified problem were described. Utilization or cost issues may be examined through a PIP, but should not be the sole focus of the study. There were some descriptions of the member populations targeted for intervention in the PIPs. Because the MC+ MCOs vary widely in the member populations they serve (e.g., other state Medicaid managed care members, commercial members, or Medicare members), it was not possible to determine the extent to which the PIP identified, addressed, and measured the needs of the MC+ Managed Care Program population in all cases. In addition, PIPs should specifically indicate whether all enrolled populations within the MC+ Managed Care Program were included in the interventions. Finally, age and demographic characteristics should be described. Seven of the 13 PIPs (53.8%) Met these criteria (Step 1.3).

STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. They should be specific enough to suggest the study methods and the outcome measures. The MC+ MCOs made a concerted effort to ensure that statements were provided in the form of a question, and in most cases the questions were directly related to the hypotheses and topic selected. Eleven (78.5%) of the PIPs included clearly stated study questions (Step 2.1). For some, the study purpose identified was not consistent with the remainder of the PIP (the target population, interventions, measures, or methods).

Table 1 - Performance Improvement Project Validation Findings by MC+ MCO.

		MC+ MCO													
		CCP		MHP		HCUSA		MOCare		FHP		FG		BA+	
Step	Item	Emergency Room Utilization	Early Intervention in Prenatal Case Management	Customer Service -- Member Service Call Center	Emergency Room Utilization	Pre-Authorization Improvement Project	Lead Performance Improvement Project	ADHD	Increased Blood Lead Level Testing at 12 & 24 Months	Access to Primary Care Services	Improving Lead Screening at 6-36 Months of Age	Improving Birthweight Outcomes	Improving Asthma Medication Management	Lead Testing Improvement Project	Improving Care for Asthmatics
	1.1	1	1	2	2	2	2	2	2	2	2	2	2	2	2
	1.2	1	1	2	2	2	2	2	2	2	2	2	2	2	2
Step 1: Selected Study Topics	1.3	2	1	0	0	NA	1	2	2	2	2	2	2	1	1
Step 2: Study Questions	2.1	2	2	0	2	2	1	2	2	2	2	2	1	2	2
	3.1	1	2	2	2	2	2	1	2	2	2	1	2	2	2
Step 3: Study Indicators	3.2	1	1	0	2	2	2	2	2	2	2	0	2	1	1
	4.1	2	2	0	0	NA	2	2	2	2	2	2	2	1	1
Step 4: Study Populations	4.2	1	2	1	1	NA	1	2	2	2	2	1	2	NA	1
	5.1	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	5.2	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 5: Sampling Methods	5.3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	6.1	1	1	2	2	2	2	2	2	2	2	2	2	2	2
	6.2	1	2	2	1	2	1	2	2	2	2	2	2	2	2
	6.3	0	1	1	1	2	1	2	2	2	2	2	2	2	1
	6.4	0	1	1	1	2	NA	2	1	1	NA	2	2	NA	2
	6.5	1	1	0	0	2	0	2	2	2	2	2	2	1	2
Step 6: Data Collection Procedures	6.6	1	1	2	2	1	1	2	2	2	2	2	2	2	2
Step 7: Improvement Strategies	7.1	0	1	1	1	2	2	1	2	2	2	1	2	1	1
	8.1	NA	NA	NA	NA	2	1	NA	1	2	2	NA	2	1	1
	8.2	NA	NA	NA	1	2	2	NA	NA	1	1	NA	1	1	1
	8.3	NA	NA	NA	NA	2	1	NA	NA	NA	2	NA	2	2	1
Step 8: Analysis and Interpretation of Study Results	8.4	NA	NA	NA	NA	1	1	NA	NA	NA	2	NA	2	1	2
	9.1	NA	NA	NA	NA	2	1	NA	NA	NA	2	NA	2	2	1
	9.2	NA	NA	NA	NA	2	1	NA	NA	NA	2	NA	2	1	1
	9.3	NA	NA	NA	NA	2	NA	NA	NA	NA	2	NA	2	1	1
Step 9: Validity of Improvement	9.4	NA	NA	NA	NA	2	NA	NA	NA	NA	2	NA	2	1	2
Step 10: Sustained Improvement	10	0	NA	NA	NA	2	NA	NA	NA	NA	2	NA	NA	1	1
Number Met		3	5	6	7	19	8	13	14	15	22	11	21	10	11
Number Partially Met		9	10	4	6	2	11	2	2	2	1	3	2	12	13
Number Not Met		4	0	5	3	0	1	0	0	0	0	1	0	0	0
Number Applicable		16	15	15	16	21	20	15	16	17	23	15	23	22	24
Rate Met		18.8%	33.3%	40.0%	43.8%	90.5%	40.0%	86.7%	87.5%	88.2%	95.7%	73.3%	91.3%	45.5%	45.8%

Note: Rate Met = Number Met/Number Applicable; 2 = Met; 1 = Partially Met ; 0 = Not Met; NA = Not Applicable; Item refers to the Protocol specifications.
Source: BHC, Inc., 2005 External Quality Review Performance Improvement Project Validation.

STEP 3: STUDY INDICATORS

All PIPs either Met or Partially Met the criteria for defining and describing the calculation of study indicators. Eleven (78.5%) of the PIPs Met the criteria for using objective, clearly defined, measurable indicators while three were rated as Partially Met (CCP, MOCare, and FirstGuard PIPs) (Step 3.1). The calculation of measures was described and explained. Even when well-known measures were used (e.g., Health Employer Data Information Set; HEDIS; Consumer Assessment of Health Plans Survey; CAHPS), there was a description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Again, because MC+ MCOs vary in their method of calculation, details regarding the measures and methods of calculating them should be included in PIPs. All but two of the 14 PIPs identified at least one study indicator that was related to health or functional status; or to processes of care strongly associated with outcomes. Eight of the 14 (57.1%) were rated as "Met" (Step 3.2). The link between the intervention and the outcomes measured by the PIP should be made explicit in the narrative.

STEP 4: STUDY POPULATIONS

Several of the PIPs failed to meet the criteria for clearly defining all the MC+ Managed Care Program Members to whom the study question(s) and indicator(s) were relevant. However, 9 of the 13 (69.2%) did include adequate information to make this determination (Step 4.1). In two PIPS, which were considered non-clinical there was no applicable study population considered. The selection criteria should clearly describe the MC+ Managed Care Member populations included in the PIP and their demographic characteristics. Six of the 12 PIPs (50.0%) described data collection approaches indicating that data for all members to whom the study question applied were collected (Step 4.2). Some misunderstanding of sampling (e.g., "The sample size was determined by how many people we were able to contact during the quarter being measured") continued from the 2004 EQR, but this only occurred in two of the narratives submitted. In most cases a description was included that allowed inference of how data were collected and how participants were identified.

STEP 5: SAMPLING METHODS

None of these PIPs employed true sampling techniques. The type of sample (e.g., convenience, random) or sampling methods (e.g., simple, cluster, stratified) should be described if utilized.

STEP 6: DATA COLLECTION PROCEDURES

Twelve of the 14 PIPs (85.7%) described the data to be collected with adequate detail and description of the units of measurement used (Step 6.1). Eleven of the 14 (78.5%) PIPs clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). Some MC+ MCOs used the National Committee for Quality Assurance (NCQA) Quality Improvement Activity (QIA) Form to write PIPs, which provides a structure for reporting measures and data sources. However, when there is more than one source of data, it is important that the MC+ MCO specifically state the sources of data for each measure. It was noted to the MC+ MCOs that the strict use of this format limits the narrative and explanation that must accompany the PIP to validate each element. Eight of the 14 PIPs (57.1%) clearly described systematic and reliable methods of data collection (Step 6.3). In one case, the data collection procedures were not described. It was not possible to judge the reliability or credibility of this PIP without sufficient detail regarding data collection processes, procedures, or frequency. Eleven of the PIPs used a survey or data collection tool, however, all were not presented in a method to be able to ensure that consistent and accurate data were collected over time (Step 6.4). However, five (45.5%) Met this element and five Partially Met this element. All but one of the MC+ MCOs that utilized surveys provided instruments for review. One PIP indicated that "the database" provided for accurate data collection. When using surveys, medical records, or telephone protocols for data collection, it is important to provide the tool for review, discuss the piloting of the tool, and discuss training and interrater reliability for the recording of information on the tool. Standard provider and consumer surveys provide manuals describing the characteristics of instruments that should be incorporated into the narrative of the PIP. This level of detail was not provided in the narrative, but in most cases the calculation of the measure did include sufficient information to make a judgment allowing determination of the rating for this validation element. Eight of the PIPs (57.1%) included a complete data analysis plan, while three additional PIPs were Partially Met for specifying a plan (Step 6.5). This should be developed prior to the implementation of the PIP based on the study questions, expected relation between the intervention(s) and outcome(s) being measured (i.e. independent and dependent variables), the method(s) of data collection, and the nature of the data (e.g., nominal, ordinal, scale). Ten of the 14 (71.4%) PIPs identified in the narrative the project leader and qualifications of that individual, who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). MC+ MCO staff interviewed on-site also included team members who were involved and knowledgeable about the PIPs and methods. Additional information about all the PIP team members and their qualifications and roles

were rarely described in detail, but would have provided additional clarification and validity to the process and the measures.

Step 7: Improvement Strategies

Six of the 14 (42.9%) of the PIPs identified reasonable interventions to address the barriers identified through data analysis and quality improvement processes undertaken. Seven of the PIPs were Partially Met in this requirement. The nature of identification of the barriers, a description of barriers, and a plan for addressing barriers should be described.

Step 8: Data Analysis and Interpretation of Study Results

Four of the 8 (50.0%) PIPs were not mature enough to have data to analyze. These MC+ MCOs conducted these analyses according to the data analysis plan (Step 8.1). Of the 8 PIPs that presented baseline or re-measurement data, two (25%) presented numerical findings accurately and clearly (Step 8.2). In some instances, data were presented in formats different from those described in the calculation of measures (e.g., presenting percents in graphic format while the description of the calculation of measures indicated rates per 1,000). Six PIPs Partially Met this criteria. Axis labels and units of measurement should be reported in Tables and in Figure legends and this information should be made clearly identifiable to the reader. The data year for benchmark data should also be labeled. Of the six PIPs that presented at least one re-measurement period, four (66.6%) indicated the re-measurement period for all of the measures identified in the study (Step 8.3). Of the six PIPs describing the findings, three (50.0%) described the extent to which the intervention was effective (Step 8.4).

Step 9: Validity of Improvement

Four of the six PIPs (66.6%) with re-measurement points used the same method at re-measurement as the baseline measurement (Step 9.1). Whenever possible the baseline measure should be recalculated consistent with the re-measurement method to ensure validity of reported improvement and comparability of measurement over time. One PIP did explain that the MC+ Medicaid eligibility criteria changed during the measurement year. How this change was incorporated into the baseline information was clearly explained and documented. The same source of measures should also be used at re-measurement points. Three of the PIPs (50.0%) that were mature enough to include data analysis employed statistical significance testing to document quantitative improvements in care (Step 9.2). They were able to show statistically significant

improvement over multiple re-measurement points. Three of five (60.0%) PIPs reporting improvements had face validity, meaning that the reported improvement was judged to have been related to the intervention applied (Step 9.3). These PIPs provided some discussion or interpretation of findings by MC+ MCOs. Additional narrative in this area would ensure proper evaluation of all data and information provided. After reporting findings, there should be some interpretation as to whether the intervention or other factors may have accounted for improvement, decline, or lack of change. Four of the five PIPs (80.0%) that had reached a level of maturity to include this data did provide statistical evidence that the observed improvement was true improvement (Step 9.4). Then, barriers should be identified and addressed for the next cycle of the PIP, or reasons for discontinuing the PIP should be described.

STEP 10: SUSTAINED IMPROVEMENT

Of the four PIPs examining multiple measurement points over time, only two (50.0%) PIPs used statistical significance testing to demonstrate improvement. One PIP showed statistically significant improvement over several measurement points. The low numbers in this area are a function of the lack of maturity that many of the PIPs exhibited.

Table 2 - Summary of Performance Improvement Project Validation Ratings by Item, All MC+ MCOs

Step	All MC+ MCOs					
	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	12	2	0	14	85.71%
	1.2	12	2	0	14	85.71%
	1.3	7	4	2	13	53.85%
Step 2: Study Questions	2.1	11	2	1	14	78.57%
Step 3: Study Indicators	3.1	11	3	0	14	78.57%
	3.2	8	4	2	14	57.14%
Step 4: Study Populations						
	4.1	9	2	2	13	69.23%
	4.2	6	6	0	12	50.00%
Step 5: Sampling Methods	5.1	0	0	0	0	n/a
	5.2	0	0	0	0	n/a
	5.3	0	0	0	0	n/a
Step 6: Data Collection Procedures	6.1	12	2	0	14	85.71%
	6.2	11	3	0	14	78.57%
	6.3	8	5	101	14	57.14%
	6.4	5	5	3	11	45.45%
	6.5	8	3	0	14	57.14%
	6.6	10	4	1	14	71.43%
Step 7: Improvement Strategies	7.1	6	7	0	14	42.86%
Step 8: Analysis and Interpretation of Study Results						
	8.1	4	4	0	8	50.00%
	8.2	2	6	0	8	25.00%
	8.3	4	2	0	6	66.67%
	8.4	3	0	0	6	50.00%
Step 9: Validity of Improvement	9.1	4	2	0	6	66.67%
	9.2	3	3	0	6	50.00%
	9.3	3	2	0	5	60.00%
	9.4	4	1	0	5	80.00%
Step 10: Sustained Improvement	10.1	2	2	2	4	50.00%
Number Met		**165**	**79**	**13**	**257**	**64.20%**

Note: Percent Met = Number Met/ Number Applicable; Item refers to the Protocol specifications.

Source: BHC, Inc., 2005 External Quality Review Performance Improvement Project Validation.

2.6 Conclusions

Across all MC+ MCOs, the range in proportion of criteria that were Met for each PIP validated was 12.5% through 95.7%. Across all PIPs validated statewide, 64.2% of criteria were met. All sources of available data were used to develop the ratings for the PIP items. The EQRO comments were developed based on the written documentation and presentation of findings. All of the PIPs presented included thoughtful and complex information. For some of the PIPs, the MC+ MCO's enhanced information obtained at the on-site review. This made it clear that the MC+ MCOs intend to use this process to improve organizational functions. In several cases the performance improvement project had already been incorporated into MC+ MCO daily operations. In all cases, there was enough information provided to validate the PIPs. On-site interviews and subsequent information provided revealed in-depth knowledge of the PIPs and detailed outcomes. PIPs are to be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the MC+ MCO regarding the need to address barriers to implementation. MC+ MCO personnel involved in PIPs had extensive experience in clinical service delivery, quality improvement, and monitoring activities. It was clear that they had made a significant improvement and investment in designing valid evaluation studies using sound data collection and analysis methods. This requires technical expertise in health services research and/or program evaluation design.

Based on the PIP validation process, at least five MC+ MCOs (Family Health Partners, FirstGuard, Blue-Advantage Plus of Kansas City, HealthCare USA, and Missouri Care) had active and ongoing PIPs as part of their quality improvement program. One MC+ MCO (Community CarePlus) significantly improved their utilization of the PIP process as a tool to develop their performance and improve services to members. This MC+ MCO's PIPs were the least mature, but were vastly improved from prior submissions. The following summarizes the strengths, areas for improvement, and recommendations based on the findings of the Validation of Performance Improvement Projects activity.

Table 3 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Emergency Room Utilization	Low Confidence
Early Intervention in Prenatal Care Management	Low Confidence
Medicaid Emergency Room Utilization	Moderate Confidence
Customer Service – Member Service Call Centers	Low Confidence
2005 Lead Performance Improvement Project	Moderate Confidence
2004/2005 Pre-Authorization Improvement Project	High Confidence
Attention Deficit Hyperactivity Disorder	High Confidence
Lead Performance Improvement Project	Moderate Confidence
Access to Primary Care Services	Moderate Confidence
Improving Lead Screening at 6-36 Months of Age	High Confidence
Improving Birth Weight Outcomes	Low Confidence
Improving Asthma Medication Management	High Confidence
Lead Testing Improvement Project	Moderate Confidence
Improving Care for Asthmatics	High Confidence

Note: Not Credible = There is little evidence that the study will or did produce results that could be attributed to the intervention(s); Low Confidence = Few aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); Moderate Confidence = Many aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); High Confidence = The PIP study was conducted or planned in a methodologically sound manner, with internal and external validity, standard measurement, and data collection practices, and appropriate analyses to calculate that there is a high level of confidence that improvements were a result of the intervention. A 95% to 99% level of confidence in the findings was or may be able to be demonstrated.
Source: BHC, Inc., 2005 External Quality Review Performance Improvement Project Validation.

STRENGTHS

1. There was good topic identification and good intervention development for PIPs. MC+ MCO personnel were well qualified to identify study topics, areas in need of improvement, and interventions to address barriers to quality of care and health outcomes.
2. MC+ MCOs implemented interventions aimed at key aspects of enrollee care and services, such as medication and treatment management, risk identification and stratification for various levels of care, monitoring provider access, blood lead level screening, and preventive care.
3. The descriptions of studies and intended purposes were often clear and relevant to the rationale and problem identified.
4. Study indicators were well-defined and methods for calculating them were detailed.
5. Study designs specified the data to be collected and the sources of data for each measure.

6. Quality improvement strategies were appropriate and relevant.
7. The same methods and measures over re-measurement periods were used.
8. Additional PIPS (Pre-Authorization Improvement, ADHD, Increased Blood Lead Level Testing at 12 & 24 Months, Access to Primary Care Services, Improving Lead Screening at 6-36 Months of Age, Improving Asthma Medication Management) were judged to be likely or highly likely to produce credible and valid findings to identify Best Practices.
9. MC+ MCO personnel were attentive and responsive to technical assistance for the implementation of PIPs and presented goals or plans for improving the process in the future.
10. MC+ MCOS instituted personnel and/or role changes to improve the focus and expertise of personnel responsible for PIP implementation.

Areas for Improvement

1. Study questions should continue to be refined. In some cases the study question did not frame the purpose, intended outcomes, goals, and methods for the study.
2. There was one PIP that was focused almost exclusively on staff training and was not able to draw a relationship to improving services to members. PIPs should directly address the outcomes of care on health or functional status.
3. Data analysis plans were not described in a number of the PIPs. The method of data collection and compilation is often dependent on the plan for data analysis. A plan should be developed prior to conducting a PIP, and modified as needed to be able to test for significant improvement or stability of performance on the outcome measures over time. Data analyses could not be evaluated without a description of the plan.
4. There were PIPs underway or ongoing that resulted in the potential for credible findings. Ensuring that the project is started early enough to provide some data and data analysis is essential in completing the validation process.
5. Although it appears that many MC+ MCOs conduct PIPs as part of their quality improvement program, the continued utilization of these PIPs as tools to improve the organizations ability to serve members would be beneficial.

RECOMMENDATIONS

1. It is recommended that MC+ MCOs obtain additional training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings. One MC+ MCO (Children's Mercy Family Health Partners) utilized the services of a statistician from a local university to ensure valid and reliable findings.
2. In the design of PIPs, MC+ MCOs need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, "Conducting Performance Improvement Projects" were recommended by the EQRO at each MC+ MCO as a guideline to frame the development, reporting and analysis of the PIP.
3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions.
4. It is recommended that a statewide PIP be identified by the SMA and the MC+ QA & I Group for planning and implementation one year prior to the planned implementation. The topic should be chosen based on the present study findings and current topic identification of MC+ MCOs as important processes that are likely to affect a broad segment of the population and key healthcare outcomes.

SECTION 3.0
VALIDATION OF PERFORMANCE MEASURES

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3.0 VALIDATION OF PERFORMANCE MEASURES

3.1 Definition

The Validating Performance Measures Protocol requires the EQRO to validate three performance measures at each MC+ MCO, as selected by the State Medicaid Agency (SMA; the Missouri Department of Social Services, Division of Medical Services; DMS). The three performance measures validated by the EQRO were the HEDIS 2005 measures of Well-Child Visits in the First 15 Months of Life, Childhood Immunization Status, Combination #2, and Annual Dental Visits. Protocol activities involved the review of the data management processes of the MC+ MCO, evaluation of algorithmic compliance with performance measure specifications, and verification of either the entire set or a sample of the performance measures to confirm that the reported results are based on accurate service information.

3.2 Purpose and Objectives

The objectives for validating performance measures were to: 1) evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, MC+ MCOs; and 2) determine the extent to which MC+ MCO-specific performance measures calculated by MC+ MCOs (or by entities acting on behalf of MC+ MCOs) followed specifications established by the SMA and the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for the calculation of the performance measure(s).

REVIEWERS

Two reviewers conducted the Validating Performance Measure Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director is a licensed attorney with a graduate degree in Health Care Administration, and five years of experience in public health and managed care in two states. She conducted interviews and document review. The EQRO Research Analyst is an Information Technology specialist with a Bachelors Degree in Information Systems and a Masters Degree in Business Administration. She has work for over two years managing data in large and small databases. She conducted interviews and data analysis.

3.3 Technical Methods

The reliable and valid calculation of performance measures is necessary for calculating statewide rates; comparing MC+ MCO performance with other MC+ MCOs; and for comparing State and MC+ MCO performance with national benchmark data for Medicaid managed care and/or Commercial Managed Care Organization (MCO) members. These calculations allow MCO members to evaluate program effectiveness and access to care. State of Missouri requirements for MC+ MCO performance measurement and reporting were reviewed. The Missouri Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) contains provisions requiring all Health Maintenance Organizations (HMOs) operating in the State of Missouri to submit to the State SPHA member satisfaction survey findings and quality indicator data in formats conforming to the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) Data Submission Tool (DST) and all other HEDIS Technical Specifications[9] for performance measure descriptions and calculations. Additionally, the State of Missouri contract for Medicaid Managed Care (B3Z03182; Revised Attachment 6, Quality Improvement Strategy, 08/13/2003) stipulates that MC+ MCOs will follow the instructions of the SPHA for submission of HEDIS measures. The three measures selected by the SMA for validation were required to be calculated and reported by MC+ MCOs to both the SMA and the SPHA for MC+ Managed Care Members. The HEDIS 2005 Technical Specifications were reviewed for each of the three measures and are summarized below (see Tables 4, 5, and 6).

HEDIS 2005 Childhood Immunization Status, Combination #2 (CIS)

The following is the definition of the Childhood Immunization Status measure, an Access to Care measure, as defined by the NCQA.

The percentage of enrolled children two years of age who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B and one chicken pox vaccine (VZV) by the time period specified and by their second birthday. The measure also calculates two separate combination rates.

[9] National Committee for Quality Assurance (2003). HEDIS 2005, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

Table 4 - HEDIS 2005 Technical Specifications for Childhood Immunization Status, Combination #2 (CIS)

I. Eligible Population	
Product line:	Commercial, Medicaid (report each product line separately).
Age:	Children who turn two years of age during the measurement year.
Continuous enrollment:	Twelve months prior to the child's second birthday.
Allowable gap:	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date:	Enrolled on the child's second birthday.
Benefit:	Medical.
Event/diagnosis:	None.
II. Administrative Specification	
Denominator:	The eligible population.
Numerators:	For all antigens, the MCO may count evidence of any of the following: ▪ Evidence of the antigen of combination vaccine, ***or*** ▪ Documented history of the illness, ***or*** ▪ A seropositive test result. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the MCO must find evidence of all of the antigens. DTaP CPT: 90698, 90700, 90701, 90720, 90721, 90723; ICD-9-CM: 99.39 Diptheria and tetanus CPT: 90702 Diptheria CPT: 90719; ICD-9-CM: V02.4*, 032*, 99.36 Tetanus CPT: 90703; ICD-9-CM: 037*, 99.38 Pertussis ICD-9-CM: 033*, 99.37 OPV CPT: 90712 IPV CPT: 90698, 90713, 90723; ICD-9-CM: V12.02*, 045*, 99.41 MMR CPT: 90707, 90710; ICD-9-CM: 99.48 Measles CPT: 90705, 90708; ICD-9-CM: 055*, 99.45 Mumps CPT: 90704,90709; ICD-9-CM: 072*, 99.46 Rubella CPT: 90706,90708, 90709; ICD-9-CM: 056*, 99.47 HiB CPT: 90645,90646, 90647, 90648, 90698, 90720, 90721, 90748; ICD-9-CM: 041.5*, 038.41*, 320.0*, 482.2* Hepatitis B** CPT: 90723, 90740, 90744-90747, 90748; ICD-9-CM: V02.61*, 070.2*, 070.3* VZV CPT: 90710, 90716; ICD-9-CM: 052*, 053* **Indicates evidence of disease. A member who has evidence of disease during the numerator event time is compliant for the antigen.* *** The two-dose hepatitis B antigen Recombivax is recommended for children between 11 and 14 years of age only.*

Exclusion (optional):	Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. An MCO that chooses to exclude contraindicated children may do so only for those children where the administrative data does not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the member's second birthday. The MCO should look for contraindications as far back as possible in the member's history and may use the following contraindications and codes* to identify allowable exclusions: Any particular vaccine - Contraindication: Anaphylactic reaction to the vaccine or its components; ICD-9-CM: 999.4 DTaP – Contraindication: Encephalopathy; ICD-9-CM: 323.5 (must include E948.4 or E948.5 or E948.6 to identify the vaccine) OPV, VZV and MMR – Contraindication: Immunodeficiency, including genetic (congenital) immunodeficiency syndromes; ICD-9-CM: 279 OPV, VZV and MMR – Contraindication: HIV-infected or household contact with HIV infection; ICD-9-CM: Infection V08, symptomatic 042 OPV, VZV and MMR – Contraindication: Cancer of lymphoreticular or histiocytic tissue; ICD-9-CM: 200-202 OPV, VZV and MMR – Contraindication: Multiple myeloma; ICD-9-CM: 203 OPV, VZV and MMR – Contraindication: Leukemia; ICD-9-CM: 204-208 OPV/IPV – Contraindication: Anaphylactic reaction to streptomycin, polymyxin B or neomycin HiB – Contraindication: None Hepatitis B – Contraindication: Anaphylactic reaction to common baker's yeast VZV and MMR – Contraindication: Anaphylactic reaction to neomycin
III. Hybrid Specification	
Denominator:	A systematic sample drawn from the eligible population for each product line. The MCO may reduce the sample size using the current year's administrative rate for combination 2 or the prior years audited, product-line specific results for combination 2. For information on reducing sample size, refer to the *Guidelines for Calculations and Sampling.*
Numerators:	For all antigens, the MCO may count any of the following: ▪ Evidence of the antigen or combination vaccine, ***or*** ▪ Documented history of the illness, ***or*** ▪ A seropositive test result. For combination vaccinations that require more than one antigen (DTaP/DT and MMR), the MCO must find evidence of all of the antigens.
Administrative:	Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical Record:	For immunization information obtained from the medical record, the MCO may count members where there is evidence that the antigen was rendered from: ▪ A note indicating the name of the specific antigen and the date of the immunization, or ▪ A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. For documented history of illness or a seropositive test result, the MCO must find a note indicating the date of the event. The event must have occurred by the member's second birthday. Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "member is up to date" with all immunizations that does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.
Exclusion (optional):	Refer to the *Administrative Specification* above for exclusion criteria. The exclusion must have occurred by the member's second birthday.

Source: MMWR January 16, 1988, Volume 47(01): 8-12 *Note: NCQA follows the CDC/ACIP guidelines for immunizations. HEDIS implements these guidelines after three years to account for the look-back period in the measure and to allow the industry time to adapt to new guidelines.*

An MCO that submits HEDIS data to NCQA must provide the following data elements:

Table 5 - Data Elements for Childhood Immunization Status, Combination #2

	Administrative	Hybrid
Measurement year	x	x
Data collection methodology (administrative or hybrid)	x	x
Sampling method used		x
Eligible population	x	x
Number of numerator events by administrative data in eligible population (before exclusions)		x
Current year's administrative rate (before exclusions)		x
Minimum required sample size (MRSS) or other sample size		x
Oversampling rate		x
Final sample size (FSS)		x
Number of numerator events by administrative data in FSS		x
Administrative rate on FSS		x
Number of original sample records excluded because of valid data errors		x
Number of records excluded because of contraindications identified through administrative data		x
Number of records excluded because of contraindications identified through medical record review		x
Number of employee/dependent medical records excluded		x
Records added from the oversample list		x
Denominator	x	x
Numerator events by administrative data	x	x
Numerator events by medical records		x
Reported rate	x	x
Lower 95% confidence interval	x	x
Upper 95% confidence interval	x	x

Source: National Committee for Quality Assurance (2005). HEDIS 2005, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

HEDIS 2005 Well-Child Visits in the First 15 Months of Life (W15)

The following is the general definition of the Well-Child Visit measure and the specific parameters as identified by NCQA.

> *The percentage of enrolled members who turned 15 months old during the measurement year, who received either zero, one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life.*
>
> *A child should be included in only one numerator (e.g., a child receiving six well-child visits will not be included in the rate for five, four or fewer visits). The MCO calculated seven rates for each of the two product lines (Medicaid and commercial).*

Table 6 - HEDIS 2005 Technical Specifications for Well-Child Visits in the First 15 Months of Life (W15)

I. Eligible Population	
Product lines:	Commercial, Medicaid (report each product line separately).
Age:	15 months old during the measurement year.
Continuous enrollment:	31 days – 15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculated the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2003, and included in the rate of six or more well-child visits must have had six well-child visits by April 9, 2004.
Allowable gap:	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date:	Enrolled on the day the child turns 15 months old .
Benefit:	Medical.
Event/diagnosis:	None.
II. Administrative Specification	
Denominator:	The eligible population.
Numerators:	Seven separate numerators are calculated, corresponding to the number of members who received zero, one, two, three, four, five and six or more well-child visits with a primary care practitioner during their first 15 months of life. To count toward the measure, the well-child visit must occur with a primary care practitioner, but it does not have to be the practitioner assigned to the child. A child who had a claim/encounter from a primary care practitioner with a code listed below is considered to have received a well-child visit: **CPT Codes**: 99381, 99382, 99391, 99432 **ICD-9-CM Codes**: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 **Note:** *An MCO with internal codes, or other transaction data not cited above for Medicaid members that denote an EPSDT well-child visit may use these codes as long as they document methods used to track EPSDT well-child visits. The MCO should refer to the Practitioner Turnover measure for the definition of primary care practitioner. The MCO may also count visits in primary care practitioner offices to physician assistants and nurse practitioners, even if the practitioner is not listed as a primary care practitioner in the MCO directory, as long as the practitioner has provided any of the specified services listed within the CPT and/or ICD-9-CM Codes listed above.*
Exclusion (optional):	None.

III. Hybrid Specifications	
Denominator:	A systematic sample drawn from the MCO's eligible population. The MCO may reduce its sample size using the current year's administrative rate for six or more visits, or the prior years audited, product line-specific rate for six or more visits. **Note:** *For information on reducing sample size, refer to the Guidelines for Calculations and Sampling.*
Numerators:	Seven separate numerators are calculated, corresponding to the number of members who received zero, one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life. To count toward this measure, the well-child visit must occur with a primary care practitioner.
Administrative:	Refer to the Administrative Specification above to identify positive numerator hits from the administrative data.
Medical Record:	Documentation from the medical record must include a note indicating a visit with a primary care practitioner, the date the well-child visits occurred and evidence of all of the following: ▪ A health and developmental history (physical and mental) ▪ A physical exam ▪ Health education/anticipatory guidance.
Exclusion (optional):	None. **Note:** ▪ *Preventive services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services count, regardless of the primary intent of the visit.* ▪ *The MCO may count services that occur over multiple visits toward this measure as long as all of the services occur within the time frame established in the measure.* ▪ *Inpatient, emergency room and specialist visits do not count in this measure. The intent is to capture comprehensive well-child visits only.* ▪ *An MCO using the hybrid methodology may use a combination of administrative data and medical record review to identify well-child visits for an individual in the denominator as long as the dates of service are at least two weeks apart. For example, the MCO may count two well-child visits identified through administrative data and another visit identified through medical record review (a total of three well-child visits) for one member, if each visit shows a different date of service and the dates are at least two weeks apart.* ▪ *The MCO should refer to the Practitioner Turnover measure for the definition of primary care practitioner. This includes the use of non-physician practitioners such as nurse practitioners or physician assistant.* ▪ *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. The MCO should reference the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfurutres.org for more detailed information of what constitutes a well-child visit.*

Source: National Committee for Quality Assurance (2005). HEDIS 2005, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

An MCO that submits HEDIS data to NCQA must provide the following data elements:

Table 7 - Data Elements for Well-Child Visits in the First 15 Months of Life

	Administrative	Hybrid
Measurement year	x	x
Data collection methodology (administrative or hybrid)	x	x
Sampling method used		x
Eligible population	x	x
Number of numerator events by administrative data in eligible population (before exclusions)		x
Current year's administrative rate (before exclusions)		
Minimum required sample size (MRSS) or other sample size		x
Oversampling rate		x
Final sample size (FSS)		x
Number of numerator events by administrative data in FSS		x
Administrative rate on FSS		x
Number of original sample records excluded because of valid data errors		x
Number of records excluded because of contraindications identified through administrative data		x
Number of records excluded because of contraindications identified through medical record review		x
Number of employee/dependent medical records excluded		x
Records added from the oversample list		x
Denominator		x
Numerator events by administrative data	Each of the 7 rates	Each of the 7 rates
Numerator events by medical records		Each of the 7 rates
Reported rate	Each of the 7 rates	Each of the 7 rates
Lower 95% confidence interval	x	x

Source: National Committee for Quality Assurance (2005). HEDIS 2005, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

HEDIS 2005 Annual Dental Visit (ADV)

The following is the definition of the Annual Dental Visit measure, an Effectiveness of Care measure as defined by NCQA.

> *The percentage of enrolled members 3-21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.*

Table 8 - HEDIS 2005 Technical Specifications for Annual Dental Visit (ADV)

I. Eligible Population	
Product lines:	Medicaid.
Ages:	4–21 years as of December 31 of the measurement year. The measure is reported for each of the following age stratifications and as a combined rate: ▪ 4-6 year olds ▪ 7-10 year olds ▪ 11-14 year olds ▪ 15-18 year olds ▪ 19-21 year olds
Continuous enrollment:	The measurement year.
Allowable gap:	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date:	Enrolled as of December 31 of the measurement year.
Benefit:	Dental.
Event/diagnosis:	None. **Note:** *Although the specifications are for ages 4-21 years of age, most 3-year-olds are included because the anchor date includes children whose 4th birthday occurs anytime during the year up to December 31.*
II. Administrative Specification	
Denominator:	The eligible population for each age group and the combined total.
Numerator:	One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any of the codes listed below: **CPT Codes**: 70300, 70310, 70320, 70350, 70355 **ICD-9-CM Codes**: 23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97 **HCPCS/CDT-3 Codes**: D0120-D0999, D1110-D1550, D2110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6199, D7110-D7999, D8010-D8999, D9110-D9999 **Note:** *Current Dental Terminology (CDT) is the equivalent dental version of the CPT physician procedural coding system.*
Exclusion (optional):	None.
III. Hybrid Specification	
	None.

An MCO that submits HEDIS data to NCQA must provide the following data elements:

Table 9 - Data Elements for Annual Dental Visit

	Administrative
Measurement year	For each age stratification
Data collection methodology (administrative)	For each age stratification
Eligible population	For each age stratification
Numerator events by administrative data	For each age stratification
Reported rate	For each age stratification
Lower 95% confidence interval	For each age stratification
Upper 95% confidence interval	For each age stratification

Source: National Committee for Quality Assurance (20054). HEDIS 2005, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

Methods of Calculating Performance Measures

According to HEDIS technical specifications, there are two methods of calculating performance measures: 1) the Administrative Method and 2) the Hybrid Method. The Well-Child Visits in the First 15 Months of Life and the Childhood Immunization Status measures permit the MCO to calculate the percentages (also referred to as rates) using either the Administrative Method or the Hybrid Method. The Annual Dental Visit measure is required to be calculated using only the Administrative Method.

The Administrative Method involves examining claims and other databases (administrative data) to calculate the number of members in the entire eligible population who received a particular service (e.g., immunizations, well-child visits, or dental visits). The eligible population is defined by the HEDIS technical specifications. Those cases in which administrative data show that the member received the service(s) examined are considered "hits", or "administrative hits." The HEDIS technical specifications provide acceptable administrative codes for identifying an administrative hit.

The Hybrid Method entails the selection of a random sample of members from the eligible population during the measurement year. For the Hybrid Method, administrative data are examined to select members eligible for the measure and to identify the number of members who received the service(s) as evidenced by a claim submission or through external sources of administrative data (e.g., State Public Health Agency Vital Statistics or Immunization Registry databases). Those cases in which there are no administrative data indicating that the member received the service or all of the services required to be an "administrative hit" are identified for medical record review.

Documentation of all or some of the services in the medical record in combination with administrative data is considered a "hybrid hit."

Administrative hits and hybrid hits are summed to form the numerator of the rate of members receiving the service of interest (e.g., immunizations or well-child visit). The denominator of the rate is represented by the eligible population or those sampled from the eligible population. A simple formula of dividing the numerator into the denominator produces the rate reported to the SMA and the SPHA, expressed in percentages. There are a number of other specifications for sampling, oversampling, replacement, and treatment of contraindications for services that are further explained in the HEDIS 2005 Technical Specifications: Volume 2[10] to which the interested reader is referred.

Time Frame

According to the HEDIS technical specifications, the time frame for including members in the eligible population or sample was the measurement year of calendar year (CY) 2004 for all the measures selected. The time frame for the events of interest (e.g., immunizations, well-child visits, and dental visits) was CY2003 and CY2004.

Procedures for Data Collection

The HEDIS 2005 technical specifications for each measure validated were reviewed by the EQRO Project Director, Information Technology consultant, and a health management informatics consultant. Extensive training in data management and programming for healthcare quality indices, clinical training, research methods, and statistical analysis expertise were well represented among the personnel involved in adapting and implementing the Validating of Performance Measures Protocol to conform to the HEDIS, SMA, and SPHA requirements while maintaining consistency with the Validating Performance Measures Protocol. The following sections describe the procedures for each activity in the Validating Performance Measures Protocol as they were implemented for the three HEDIS 2005 measures validated.

Pre-On-Site Activity One: Reviewer Worksheets

Reviewer Worksheets were developed for the purpose of conducting activities and recording observations and comments for follow-up at the site visits. HEDIS 2005 technical specifications

[10] National Committee for Quality Assurance (2004). HEDIS 2005, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

were used to refine the Reviewer Worksheets for the evaluation of each item. Throughout October and November 2005, project personnel met to review available source documents and develop the Reviewer Worksheets for conducting pre-on-site, on-site, and post-on-site activities as described below. The reviews formed the basis for completing the Attachments (V, VII, X, XII, XIII, and XV) of the Validating Performance Measures Protocol for each measure and MC+ MCO. Source documents used to develop the methods for review and complete the Attachments included:

- Information Systems Capabilities Assessments (ISCA) developed by the SMA and completed by the MCOs during 2003, 2004 and 2005
- HEDIS 2005 Data Submission Tool (DST)
- HEDIS 2005 Baseline Assessment Tool (BAT)
- HEDIS 2005 Audit Report
- HEDIS 2005 SPHA Reports

Pre-On-Site Activity Two: Preparation of MC+ MCOs

Presentations, MC+ MCO orientation teleconference calls, and individual communications with personnel at MC+ MCOs responsible for HEDIS 2005 performance measure calculation were conducted between October 2005 and February 2006, with follow-up telephone calls and written communications continuing through May 2006. From October 21, 2005 through October 31, 2005, the EQRO conducted technical assistance orientation phone calls with each of the MC+ MCOs to provide education about the Validating of Performance Measures Protocol and the EQRO submission requirements. All written materials, letters and instructions were reviewed and approved by the SMA in advance. Technical objectives, methods, procedures, data sources, communication with the EQRO, and contact information for EQRO personnel were provided to MC+ MCOs prior to the teleconference calls. MC+ MCOs were requested to have in attendance the person(s) responsible for the calculation of the HEDIS 2005 performance measures validated. Teleconference meetings were led by the EQRO Project Director, with key project personnel and a representative from the SMA in attendance. Technical assistance was focused on describing the Validating Performance Measures Protocol; identifying the three measures validated; the purpose, activities and objectives of the EQRO; and defining the information and data needed for the EQRO to validate the performance measures.

Additional technical assistance was provided to the attendees of the MC+ MCO All-Plan Meeting on October 20, 2005 by the EQRO Project Director and personnel. On November 7, 2005, formal written requests for data and information from the MC+ MCOs for the validation of performance measures were made by the EQRO, to be submitted by MC+ MCOs by December 9, 2005 (see Appendix 3). Detailed letters and instructions were mailed to QI/UM Coordinators and Medicaid

Plan Administrators explaining the type of information, purpose, and format of submissions. EQRO personnel were available and responded to electronic mail and telephone inquiries; and any requested clarifications throughout the evaluation process. The following are the data and documents requested from MC+ MCOs for the Validating Performance Measures Protocol:

- HEDIS 2005 Data Submission Tool for all three measures for the MC+ Managed Care Population only. Do not include other measures or populations.
- 2005 HEDIS Audit Report. This is the HEDIS Performance Audit Report for the MC+ Managed Care Program product line and the three MC+ measures to be validated (complete report). If the three measures to be validated were not audited or if they were not audited for the MC+ Managed Care Program population, please send the report, as it contains Information Systems Capability Assessment Information that can be used as part of the Protocol.
- Baseline Assessment Tool for HEDIS 2005. The Baseline Assessment Tool is to include descriptions of the process for calculating measures for the MC+ Managed Care Program population.
- List of cases for denominator with all HEDIS 2005 data elements specified in the measures.
- List of cases for numerators with all HEDIS 2005 data elements specified in the measures, including fields for claims data and MOHSAIC, or other administrative data used. Please note that one of the review elements in the Protocol is: The "MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced."
- List of cases for which medical records were reviewed, with all HEDIS 2005 data elements specified in the measures. BHC will request MCOs to gather a maximum of 30 records per measure, based on a random sample and the MCO will be requested to send copies.
- Sample medical record tools used for hybrid methods for the three HEDIS 2005 measures for the MC+ Managed Care Program population; and instructions for reviewers.
- All worksheets, memos, minutes, documentation, policies and communications within the MCO and with HEDIS auditors regarding the calculation of the selected measures.
- Policies, procedures, data and information used to produce numerators and denominators.
- Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of:
  - Statistical testing of results and any corrections or adjustments made after processing.
  - Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.
  - Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance.
- Policies and procedures for mapping non-standard codes.
- Record and file formats and descriptions for entry, intermediate, and repository files.
- Electronic transmission procedures documentation. (This will apply if MCO sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry.)
- Descriptive documentation for data entry, transfer, and manipulation programs and processes.
- Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.
- Documentation of proper run controls and of staff review of report runs.

- Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such changes.
- Documentation of sources of any supporting external data or prior years' data used in reporting.
- Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.
- Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.
- Procedures used to link member months to member age.
- Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the MCO's process to re-draw a sample or obtain necessary replacements.
- Procedures to capture data that may reside outside the MCO's data sets (e.g. MOHSAIC).
- Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)

Pre-On-Site Activity Three: Assess the Integrity of the MCO's Information System

The objective of this activity was to assess the integrity of the MC+ MCOs' ability to link data from multiple sources. Once the Reviewer Worksheets were developed, EQRO personnel reviewed the prior year's SMA-developed and administered Information Systems Capability Assessment (ISCA); the protocols require an ISCA to be administered every other year, therefore, six of the seven MCOs were not required to submit new information for the ISCA review this year. One MCO was required to submit new ISCA information due to their utilization of a different Information System following a buy-out. EQRO personnel also reviewed HEDIS 2005 Baseline Assessment Tool (BAT) submitted by each MC+ MCO. Detailed notes and follow-up questions were formulated for the site visit review.

On-Site Activity One: Assess Data Integration and Control

The objective of this activity was to assess the MC+ MCOs' ability to link data from multiple sources and assess whether these abilities ensure the accuracy of the measures. The site visit activities addressed a series of technical, process, and competency reviews with MC+ MCO personnel (including management and technical staff) and vendors involved in the development and production of the HEDIS 2005 performance measures. The site visit activities examined the HEDIS 2005 reporting processes, databases, software and vendors for the three measures validated. This included reviewing data processing issues for generating the rates and determining the numerator and denominator counts. Other activities involved generating ad-hoc reports based on similar criteria for at least one of the measures, reviewing database processing systems, software,

organizational reporting structures, and sampling methods. The following are the activities conducted at each MC+ MCO:

- Review results of run queries (on-site observation, screen-shots, test output)
- Examination of data fields for numerator & denominator calculation (examine field definitions and file content)
- Review of applications, data formats, flowcharts, edit checks and file layouts
- Review of source code, software certification reports
- Review HEDIS repository procedures, software manuals
- Test for code capture within system for measures (confirm principal & secondary codes, presence/absence of non-standard codes)
- Review of operating reports
- Review information system policies (data control, disaster recovery)
- Review vendor associations & contracts

The following are the interview questions developed for the site visits:

- What are the processes of data integration and control within information systems?
- What documentation processes are present for collection of data, steps taken and procedures to calculate the HEDIS measures?
- What processes are used to produce denominators?
- What processes are used to produce numerators?
- How is sampling done for calculation of rates produced by the hybrid method?
- How does the MCO submit the requirement performance reports to the State?

From the site visit activities, interviews, and document reviews, Attachment V (Data Integration and Control Findings) of the Protocol was completed for each MC+ MCO and performance measure validated.

On-Site Activity Two: Assess Documentation of Data and Processes Used to Calculate and Report Performance Measures

The objectives of this activity were to assess the documentation of data collection, assess the process of integrating data into a performance measure set, and examine procedures used to query the data set to identify numerators, denominators, generate a sample, and apply proper algorithms.

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment VII (Data and Processes Used to Calculate and Report Performance) of the Protocol was completed for each MC+ MCO and measure validated. One limitation of this step was the inability of MC+ MCOs to provide documentation of processes used to calculate and report the performance measures due to the use of proprietary software or off-site vendor software and claims systems.

On-Site Activity Three: Assess Processes Used to Produce the Denominators

The objectives of this activity were: 1) to determine the extent to which all eligible members were included; 2) to evaluate programming logic and source codes relevant to each measure; and 3) to evaluate eligibility, enrollment, age, codes, and specifications related to each performance measure.

The content and quality of the data files submitted were reviewed to facilitate the evaluation of compliance with the HEDIS 2005 technical specifications. Unlike the prior year's review the MC+ MCOs did consistently submit the requested level of data (e.g., all elements required by the measures or information on hybrid or administrative data). In order to produce meaningful results, during the prior year's audit, the EQRO allowed data to be submitted in any format that the MC+ MCOs could supply. However, for this year's audit, the EQRO required that all the MC+ MCOs submit data in the format requested. This was a fairly successful approach, only one MC+ MCO did not supply the data in the format requested, more information regarding the incompleteness of that MC+ MCOs data is contained in the individual plan sections of this report.

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment X (Denominator Validation Findings) of the Protocol was completed for each MC+ MCO and performance measure validated.

On-Site Activity Four: Assess Processes Used to Produce the Numerators

The objectives of this activity were: 1) to evaluate the MC+ MCOs' ability to accurately identify medical events (e.g., immunizations, well-child visits, dental visits); 2) to evaluate the MCOs' ability to identify events from other sources (e.g., medical records, State Public Immunization Registry); 3) to assess the use of codes for medical events; 4) evaluate procedures for non-duplication of event counting; 5) examine time parameters; 6) review the use of non-standard codes and maps; 7) identify medical record review procedures (Hybrid Method); and 8) to review the process of integrating administrative and medical record data.

For the Administrative Method, validation of the numerators was conducted for all three measures using the specified parameters for the dates of service(s), diagnosis codes, and procedure codes as appropriate to the respective measures. For example, for all three measures, dates of service were required to occur between January 1, 2004 and December 31, 2004. Cases with dates outside this range were considered not valid.

Validation of numerators for the Hybrid Method followed the Validating Performance Measures Protocol for sample selection and calculation of bias related to the medical record review. The Protocol requires the EQRO to sample up to 30 records from the medical records reported by the MC+ MCO as meeting the numerator criteria (hybrid hits). In the event that the MC+ MCO reported fewer than 30 numerator events from medical records, the EQRO requested all medical records that were reported by the MC+ MCO as meeting the numerator criteria. This approach does not apply to the Annual Dental Visits measure, as the Administrative Method of calculation is required for this measure by HEDIS technical specifications.

Initial requests for documents and data were made on November 7, 2005, with submissions due to the EQRO by December 9, 2005. The EQRO required the MC+ MCOs to request medical records from the providers. On January 6, 2006, the MC+ MCOs were given a list of medical records to request, a letter from DMS explaining the purpose of the request, and the information necessary for the providers to send the medical records directly to the EQRO. The submission deadline for medical records was February 10, 2006. The record receipt rate was very good, of the 237 records contained in the sample, 235 were received by the EQRO for review. The timelines for medical record requests of a total of 60 or fewer records per MC+ MCO were within the five day time frame specified by the State of Missouri Medicaid Managed Care Contract for providing small numbers of medical records.

The review of medical records was administered by Reliable Health Care, Inc. (RHC), a temporary healthcare services provider located in Kansas City, Missouri and a Business Associate of Behavioral Health Concepts, Inc., (the EQRO). RHC is a State of Missouri certified Minority-Owned Business Enterprise (MBE) operated by two registered nurses. RHC possesses expertise in recruiting nursing and professional health care staff for clinical, administrative, and HEDIS medical record review services. The review of medical records was conducted by RNs with over 20 years of clinical experience and who were currently licensed and practicing in the State of Missouri. Two RNs participated in the training and medical record review process and both had at least three years of experience conducting medical record reviews for HEDIS measures.

Medical record abstraction tools for the Childhood Immunization Status, Combination #2, and the Well-Child Visits in the First 15 Months of Life measures were developed by the EQRO Project Director and revised in consultation with a nurse consultant, the EQRO Information Technology consultant and with the input of the nurse reviewers. The 2005 HEDIS technical specifications and

the Validating Performance Measures Protocol criteria were used to develop the medical record review tools and data analysis plan. A medical record review manual and documentation of ongoing reviewer questions and resolutions were developed for the review. A half day of training was conducted by the EQRO Project Director and staff on March 6, 2006 using sample medical record tools and reviewing all responses with feedback and discussion. The reviewer training and training manual covered content areas such as Health Insurance Portability and Accountability Act (HIPAA), confidentiality, conflict of interest, review tools, project background, Missouri's Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT; the Healthy Children and Youth; HCY Program) and forms, Association for Professionals in Infection Control and Epidemiology (APIC) guidelines, and Bright Futures Guidelines (promulgated by the American Academy of Pediatricians). Teleconference meetings between the nurses, coders, and EQRO Project Director were conducted as needed to resolve questions and coding discrepancies throughout the duration of the medical record review process.

A data entry format with validation parameters was developed for accurate medical record review data entry. A data entry manual and training were provided to the data entry person at RHC, Inc. Data was reviewed weekly for accuracy and completeness, with feedback and corrections made to the data entry person. The final databases were reviewed for validity, verified, and corrected prior to performing analyses. All data analyses were developed, reviewed, approved, and finalized by the EQRO Project Director. Attachments XII (Impact of Medical Record Findings) and XIII (Numerator Validation Findings) were completed based on the medical record review of documents and site visit interviews.

On-Site Activity Five: Assess Sampling Process (Hybrid Method)

The objective of this activity was to assess the representativeness of the sample of care provided.

- Review Information Systems Capability Assessment (ISCA)
- Review HEDIS Baseline Assessment Tool (BAT)
- Review Data Submission Tool (DST)
- Review numerator and denominator files
- Conduct medical record review for measures calculated using hybrid methodology
- Determine the extent to which the record extract files are consistent with the data found in the medical records
- Review of medical record abstraction tools and instructions
- Conduct on-site interviews, activities, and review of additional documentation
- For those MCOs that calculated the Childhood Immunization and/or Well-Child Visits measures via hybrid methodology, a sample of medical records (up to 30) was conducted to validate the presence of immunizations that contributed to the numerator.

From the review of documents and site visits, Attachment XV (Sampling Validation Findings) was completed for those MC+ MCOs that elected the Hybrid Method for the HEDIS 2005 Childhood Immunization Status, Combination #2 and the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure.

On-Site Activity Six: Assess Submission of Required Performance Measures to State

The objective of this activity was to assure proper submission of findings to the SMA and SPHA. The DST was obtained from the SPHA to determine the submission of the performance measures validated. Conversations with the SPHA representative responsible for compiling the measures for all MCOs in the State occurred with the EQRO Project Director to clarify questions, obtain data, and follow-up on MC+ MCO submission status.

Post- On-Site Activity One: Determine Preliminary Validation Findings for each Measure

Calculation of Bias

The Validating Performance Measures Protocol specifies the method for calculating bias based on medical record review for the Hybrid Method. In addition to examining bias based on the medical record review and the Hybrid Method, the EQRO calculated bias related to the inappropriate inclusion of cases with administrative data that fell outside the parameters described in the HEDIS 2005 technical specifications. For measures calculated using the Administrative Method, the EQRO examined the numerators and denominators for correct date ranges for dates of birth and dates of service as well as correct enrollment periods and codes used to identify the medical events. This was conducted as described above under on-site activities three and four. The estimated bias in the

calculation of the HEDIS 2005 measures for the Hybrid Method was calculated using the following procedures, methods and formulas, consistent with the Validating Performance Measures Protocol. Specific analytic procedures are described in the following section.

Analysis

Once the medical record review was complete, all administrative data provided by the MC+ MCOs in their data file submissions for the HEDIS 2005 Childhood Immunization Status, Combination #2 measure were combined with the medical record review data collected by the EQRO. This allowed for calculation of the final rate by the EQRO for the multiple events (measles, mumps, rubella; MMR; and Hepatitis B vaccinations, Hi B, and VZV). The next step was to remove the duplicate immunizations documented in both the medical record and in administrative data. The number of vaccinations administered during the specified age range was counted for each record. Cases that met both criteria were counted as "hits" and considered valid numerators based on medical record review.

For the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure, all administrative data provided by the MC+ MCOs in their data file submissions were combined with the medical record findings collected by the EQRO. This allowed for calculation of the final rate of multiple visits. In order for each event of a well-child visit to be met, there had to be documented evidence of all three components specified in the HEDIS 2005 technical specifications (a health and developmental history, physical exam, and health education/anticipatory guidance). The EQRO calculated the number of visits for every member of the eligible population, from zero visits to six or more visits. The rates for validation were matched with the MC+ MCOs reported rate for six or more visits.

For the calculation of bias based on medical record review for the MC+ MCOs using the Hybrid Method for the HEDIS 2005 Childhood Immunization Status, Combination #2 and Well-Child Visits in the First 15 Months of Life measures, several steps were taken. First, the number of hits based on the medical record review was reported (Medical Records Validated by EQRO). Second, the Accuracy (proportion of Medical Records Validated by EQRO/Numerator Hits by Medical Records reported by the MCO) and Error Rates (100% - Accuracy Rate) were determined. Third, A Weight of Each Medical Record was calculated (100%/Denominator reported by the MCO) as specified by the Protocol. The number of False Positive Records was calculated (Error Rate * Numerator Hits by Medical Records reported by the MCO). This represents the number of records that were not

able to be validated by the EQRO. The Estimated Bias from Medical Records was calculated (False Positive Rate * Weight of Each Medical Record).

To calculate the Total Estimated Bias in the calculation of the performance measures, the Administrative Hits Validated by the EQRO (through the previously described file validation process) and the Medical Record Hits Validated by the EQRO (as described above) were summed and divided by the Denominator reported by the MCO on the DST to determine the Rate Validated by the EQRO. The difference between the Rate Validated by the EQRO and the Rate Reported by the MC+ MCO to the SMA and SPHA was the Total Estimated Bias. A positive number reflects an overestimation of the rate, while a negative number reflects an underestimation of the rate.

Once the EQRO concluded its on-site activities, the validation activity findings for each performance measure were aggregated. This involved the review and analysis of findings and Attachments produced for each performance measure selected for validation and for the MCO's Information System as a result of pre-on-site and on-site activities. The EQRO Project Director reviewed and finalized all ratings before submitting to the SMA for final ratings on all Attachments, and completed the Final Performance Measure Validation Worksheets for all measures validated and MC+ MCOs. Ratings for each of the Worksheet items (0 = Not Met; 1 = Partially Met; 2 = Met) were summed for each worksheet and divided by the number of applicable items to form a rate for comparison to other MC+ MCOs. The worksheets for each measure were examined by the EQRO Project Director to complete the Final Audit Rating.

Below is a summary of the final audit rating definitions specified in the Protocol. Any measures not reported were considered "Not Valid." A Total Estimated Bias outside the 95% upper or lower confidence limits of the measures as reported by the MC+ MCO on the DST was considered not valid.

Fully Compliant:	Measure was fully compliant with State (SMA and SPHA) specifications.
Substantially Compliant:	Measure was substantially compliant with State (SMA and SPHA) specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid:	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which the data provided to the EQRO could not be independently validated. Significantly biased was defined by the EQRO as being outside the 95% confidence interval of the rate reported by the MC+ MCO on the HEDIS 2004 Data Submission Tool.

Once the EQRO submitted its preliminary findings to the MC+ MCOs, including a summary Validation Worksheet for each performance measure validated (See Appendix 4), the MC+ MCOs were offered the opportunity to submit comments and documentation to support the correction of factual errors or omissions in the EQRO's preliminary report (See Appendix 10). Several MC+ MCOs submitted corrective action plans to address issues identified in the preliminary report.

3.4 Findings

MC+ MCOs conduct the calculation of performance measures in collaboration with a variety of vendors and use a number of different management information systems to extract data for the calculation of measures. They are also required to undergo annual audits by NCQA-certified auditing firms that provide MC+ MCOs with recommendations for reporting or not reporting findings of specific measures to the NCQA. Regardless of the NCQA audit rating or rotation, MC+ MCOs are required to report the performance measures validated to the SMA and SPHA. Table 10 summarizes the names of HEDIS-certified software used, medical record vendors, and HEDIS auditors. Tables 11 and 12 show the method of calculation used by each MC+ MCO and the audit ratings assigned by the NCQA Auditor. This information was taken from the NCQA-certified Auditors' reports and MC+ MCO self-report to the EQRO.

Table 10 - HEDIS 2005 Software, Vendors, and Auditors for the HEDIS 2005 Measures

MC+ MCO	Name of Software	Name of Medical Record Vendor	Name of HEDIS 2005 Auditor
Children's Mercy Family Health Partners	N/A	Children's Mercy Family Health Partners	Qualis Health
Community CarePlus	MS Access, MS Excel (Novasys)	QMark/HEDISHelp	Healthcare Research Associates
Mercy MC+	Health Plan Reporter*	Mercy Health Plan	Healthcare Research Associates
HealthCare USA	Quality Spectrum* HEDIS repository by Catalyst Technologies	Not Applicable. Do not use Hybrid Method.	HealthcareData.com, LLC
Missouri Care	Austin Provider Solutions	Missouri Care	Thomson MedStat
FirstGuard Health Plan	McKesson	Primaris	Ernst & Young, LLP
Blue Advantage Plus of Kansas City	Software from ViPs, Inc. MedMeasures	QMark/HEDISHelp	Ernst & Young, LLP

Note: * NCQA-certified.

Table 11 - Summary of Method of Calculation Reported and Validated by MC+ MCOs

MC+ MCO	Well-Child Visits in the first 15 Months of Life	Childhood Immunization Status	Annual Dental Visit
Community CarePlus	Administrative	Hybrid	Administrative
Mercy MC+	Hybrid	Hybrid	Administrative
HealthCare USA	Administrative	Administrative	Administrative
Missouri Care	Hybrid	Hybrid	Administrative
Children's Mercy Family Health Partners	Administrative	Hybrid	Administrative
FirstGuard Health Plan	Hybrid	Hybrid	Administrative
Blue Advantage Plus of Kansas City	Administrative	Administrative	Administrative

Table 12 - Audit Designations from NCQA-Certified Auditors

MC+ MCO	Audit Type	Well-Child Visits in the first 15 Months of Life	Childhood Immunization Status	Annual Dental Visit
Community CarePlus	Partial	NR	R	R
Mercy MC+	Full	R	R	R
HealthCare USA	Partial	NR	NR	NR
Missouri Care	Partial	NR	R	R
Children's Mercy Family Health Partners	Partial	NR	R	R
FirstGuard Health Plan	Partial	R	R	R
Blue Advantage Plus of Kansas City	Full	NR	NR	NR

Note: NA = Measure not audited; NR = Measure not reported; R = Measure reportable; NCQA = National Committee for Quality Assurance.
Source: MCO self-report and NCQA Audit Report for HEDIS 2005

The validation of each of the performance measures is discussed in the following sections with the findings from each validation activity described. Subsequent sections summarize the status of submission of the measures validated to the SMA and SPHA, the Final Audit Ratings, and conclusions.

HEDIS 2005 Childhood Immunization Status, Combination #2

Data Integration and Control

The objective of this activity was to assess the MC+ MCOs' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2005 Childhood Immunization Status, Combination #2 measure, the sources of data included enrollment, eligibility, claim files, and State Public Health Immunization Registry (MOHSAIC) data. Table 13 summarizes the findings of Attachment V (Data Integration and Control Findings) of the protocol. The rate of items that were met was calculated across MC+ MCOs and from the number of applicable items for each MC+ MCO.

Of all the MC+ MCOs that calculated the measure, 100% Met the criteria for having accurate and established procedures for transferring data into data repositories for calculation of the measure, coordinating data integration with vendors, and following standards associated with programming and testing. All criteria were met by six of the seven MC+ MCOs that calculated the measure (85.7%) except the one for retaining copies of files or databases used for performance measure reporting. One MC+ MCO (Mercy MC+) Partially Met the criteria for retaining copies of files or databases used for performance measure reporting due to a system change the MCO could not produce the database used for HEDIS 2005 calculations, they assured the EQRO that it was available on back-up tape. Each MC+ MCO Met 92.3% to 100.0% of the criteria for data integration and control.

Table 13 - Data Integration and Control Findings, HEDIS 2005 Childhood Immunization Status, Combination #2 Measure

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCO/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.3	MCO's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCO/PIHP production activity logs, and MCO/PIHP staff review of report runs.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.11	The MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	1	2	2	2	2	2	6	1	0	7	85.7%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.13	Review the MCO's/PIHP's processes and documentation to determine the extent to which they comply with the MCO/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	2	7	0	0	7	100.0%
	Number Met	13	12	13	13	13	13	13	90	1	0	91	98.9%
	Number Partially Met	0	1	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13	13					
	Rate Met	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling numerators and denominators; and the ability to apply proper algorithms. Table 14 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the Protocol. Item 7.3 (Statistical testing of results and corrections made after processing) did not apply to the measure. Items 7.5, 7.7, and 7.10 were not applicable to HealthCare USA, as these items only apply to the use of the Hybrid Method of calculation. MC+ MCOs Met 82.8% of the criteria for applying appropriate data and process for the calculation of the HEDIS 2005 Childhood Immunization Status, Combination #2 measure. All MC+ MCOs (100.0%) Met the criteria for following data file and field definitions. Five of the seven MC+ MCOs used the Hybrid Method for calculation, and they all Met criteria for having detailed medical record review practices and reviewer training materials. External data sources (State Public Health Immunization Registry) for calculation of the measure were incorporated by six MC+ MCOs (85.7%) Community CarePlus did not incorporate State Public Health Immunization Registry (MOHSAIC) data into the calculation of the measure. Procedures for sampling were Met for all five MC+ MCOs that calculated the measure with the Hybrid method. Although MC+ MCOs frequently graphed the rates of performance over several years, only 42.9% used the calculation of statistical significance in rates from year to year as a measure of the significance of fluctuation in the measure (see items 7.8 and 7.11). Each MC+ MCO calculating the measure Met 66.7% to 100% of the criteria for documentation of data and processes.

Table 14 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2005Childhood Immunization Status, Combination #2

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	0	2	2	2	2	2	2	6	0	1	7	85.7%
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	0	2	2	2	2	6	0	1	7	85.7%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	0	0	2	2	0	2	1	3	1	3	7	42.9%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	2	2	2	2	2	2	2	7	0	0	7	100.0%
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	0	0	2	2	0	2	1	3	1	3	7	42.9%
	Number Met	6	7	5	9	7	9	4	47	2	8	57	82.5%
	Number Partially Met	0	0	0	0	0	0	2					
	Number Not Met	3	2	1	0	2	0	0					
	Number Applicable	9	9	6	9	9	9	6					
	Rate Met	66.7%	77.8%	83.3%	100.0%	77.8%	100.0%	66.7%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for calculating each measure. Table 15 summarizes the findings of Attachment X (Denominator Validation Findings) of the protocol. Items 10.5 (Identification of gender of the member), 10.6 (Calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. Of the MC+ MCOs, 100% Met the criteria for producing denominators according to specifications. Six out of seven MC+ MCOs Met all the criteria for producing denominators according to specifications, one MC+ MCO (HealthCare USA) did not meet the requirement of "properly evaluating the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure" due to HealthCare USA's not providing the codes to the EQRO for review. HealthCare USA cited the time it would take for them to provide the service codes as a reason for not providing them to the EQR. Each MC+ MCO calculating the measure Met the criteria for processes used to produce the denominators 85.7% to100.0% of the time.

Table 15 - Denominator Validation Findings, HEDIS 2005 Childhood Immunization Status, Combination #2

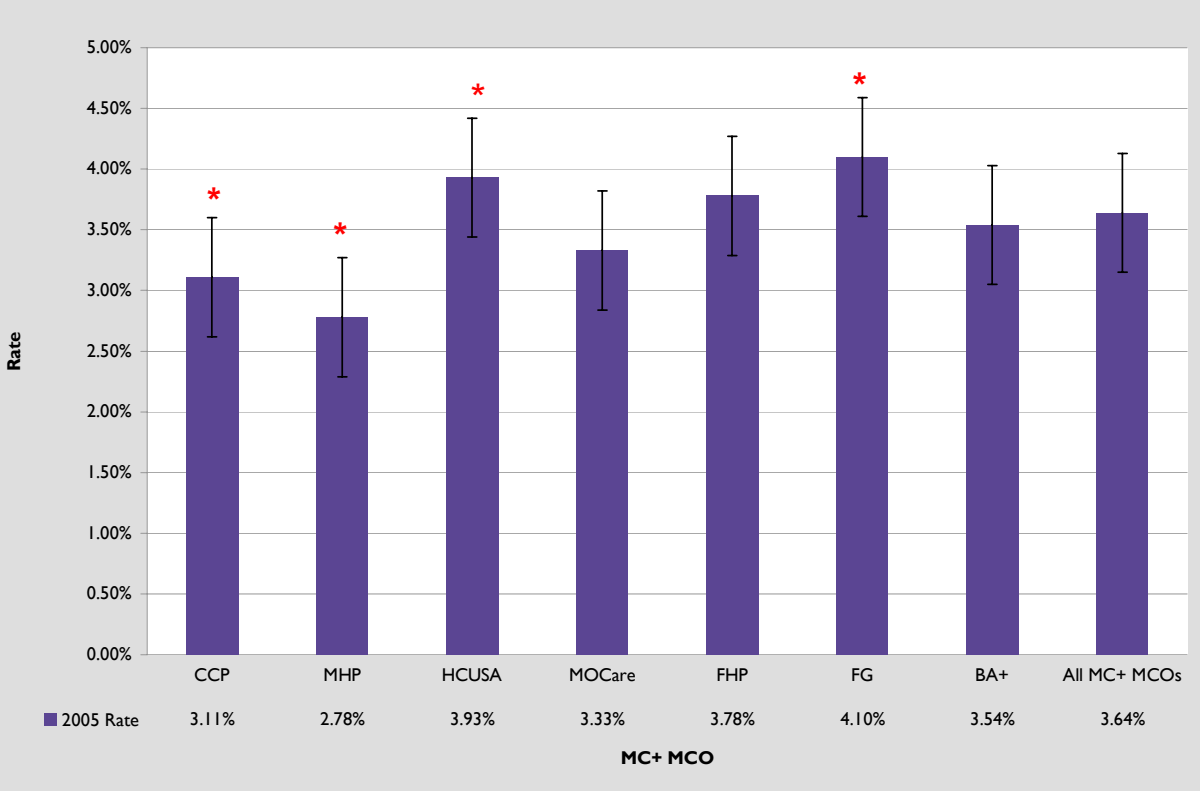
Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.5	The MCO/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCO/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCO/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	0	2	2	2	2	6	0	1	7	85.7%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.9	Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.10	Systems or methods used by the MCO/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	6	7	7	7	7	**48**	**0**	**1**	**49**	**98.0%**
	Number Partially Met	0	0	0	0	0	0	0					
	Number Not Met	0	0	1	0	0	0	0					
	Number Applicable	7	7	7	7	7	7	7					
	Rate Met	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 =Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Figure 1 illustrates the rate of eligible members per MC+ MCO, based on the enrollment of all MC+ MCO Waiver Recipients as of December 31, 2004 the end of the CY2004 measurement year. It was expected that MC+ MCOs would identify similar proportions of eligible members for the measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MC+ MCOs. Two-tailed z-tests of each MC+ MCO comparing MC+ MCOs to the rate of eligible members for all MC+ MCOs were conducted at the 95% level of confidence. FirstGuard (4.10%) and HealthCare USA (3.93%) identified significantly higher rates of eligible members than the rate for all MC+ MCOs (3.64%), while Mercy Health Plan (2.78%) identified a significantly lower rate of eligible members. The difference in rates may be due to the demographic characteristics of the member population, the completeness of claims data, or the processes of identifying eligible members. The identification of eligible members for the HEDIS 2005 Childhood Immunization Status, Combination #2 is dependent on the quality of the enrollment and eligibility files.

Figure 1 - MC+ Managed Care Program HEDIS 2005 Childhood Immunization Status, Combination #2, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test. Enrollment as of the last week in December 2003 (the measurement year) was used to calculate the rate.

Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2003.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MC+ MCOs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. Table 16 shows the numerators, denominators, rates, and confidence intervals submitted by the MC+ MCOs to the SPHA on the DST for the HEDIS 2005 Childhood Immunization Status, Combination #2 measure. The rate for all MC+ MCOs was calculated by the EQRO, thus, there is no confidence interval reported for the statewide rate. The rate for all MC+ MCOs was 28.17%, with MC+ MCO rates ranging from 18.46% (HealthCare USA) to 63.66% (Missouri Health Care).

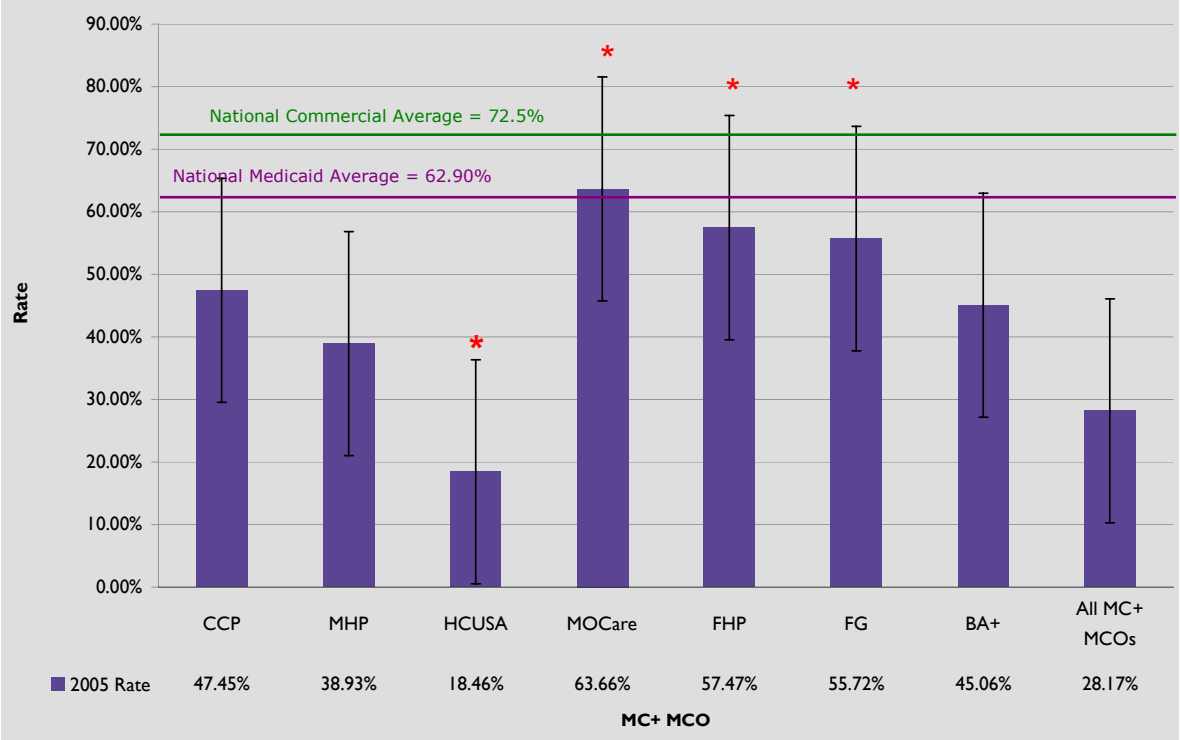
Table 16 - Data Submission for HEDIS 2005Childhood Immunization Status, Combination #2

MC+ MCO	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCO (DST)	Medical Record Hits Reported by MCO (DST)	Total Hits Reported by MCO (DST)	Rate Reported by MCO (DST)	LCL - UCL (DST)
Blue Advantage Plus	Administrative	1225	552	NA	552	45.06%	42.23% - 47.89%
Community Care Plus	Hybrid	411	9	186	195	47.45%	42.50% - 52.39%
Family Health Partners	Hybrid	395	106	121	227	57.47%	52.47% - 62.47%
FirstGuard	Hybrid	411	128	101	229	55.72%	50.79% - 60.64%
HealthCare USA	Administrative	7258	1340	NA	1340	18.46%	14.03% - 15.89%
Mercy Health Plan	Hybrid	411	90	70	160	38.93%	34.09% - 43.77%
Missouri Care	Hybrid	410	94	167	261	63.66%	58.88% - 68.44%
All MC+ MCOs		**10,521**	**2319**	**645**	**2,964**	**28.17%**	

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. The denominator is either the eligible population (for administrative method calculation) or the sample size (for hybrid method calculation). The EQRO is charged with providing MCO to MCO comparisons. Therefore, the numerators and denominators for HealthCare USA were aggregated across all three regions, which were each 100% validated. Mercy Health Plans submitted data for Combination #2; Blue-Advantage Plus of Kansas City did not calculate the measure. The statewide rate for all MC+ MCOs was calculated by the EQRO using the sum of numerators divided by the sum of denominators. There was no statewide rate or confidence limits reported to the SMA or SPHA.
Source: MC+ Managed Care Organization HEDIS 2005 Data Submission Tools (DST).

Figures 2, 3, and 4 illustrate the rates reported by the MC+ MCOs and the rates of administrative and hybrid hits for each MC+ MCO on the HEDIS 2005 Childhood Immunization Status, Combination #2 measure. The rate reported by each MC+ MCO was compared with the rate for all MC+ MCOs, with two-tailed z-tests conducted at the 95% confidence interval. The rate for all MC+ MCOs was lower than the National Commercial (72.5%) and the National Medicaid rates (62.9%). Children's Mercy Family Health Partners, FirstGuard, and Missouri Care reported rates significantly higher than the rate for all MC+ MCOs (57.47%, 55.72% and 63.66%, respectively), while HealthCare USA's combined rate (18.46%) across all three regions was significantly below the rate for all MC+ MCOs (28.17%).

Figure 2 - MC+ Managed Care Program HEDIS 2005 Childhood Immunization Status, Combination #2, Rates

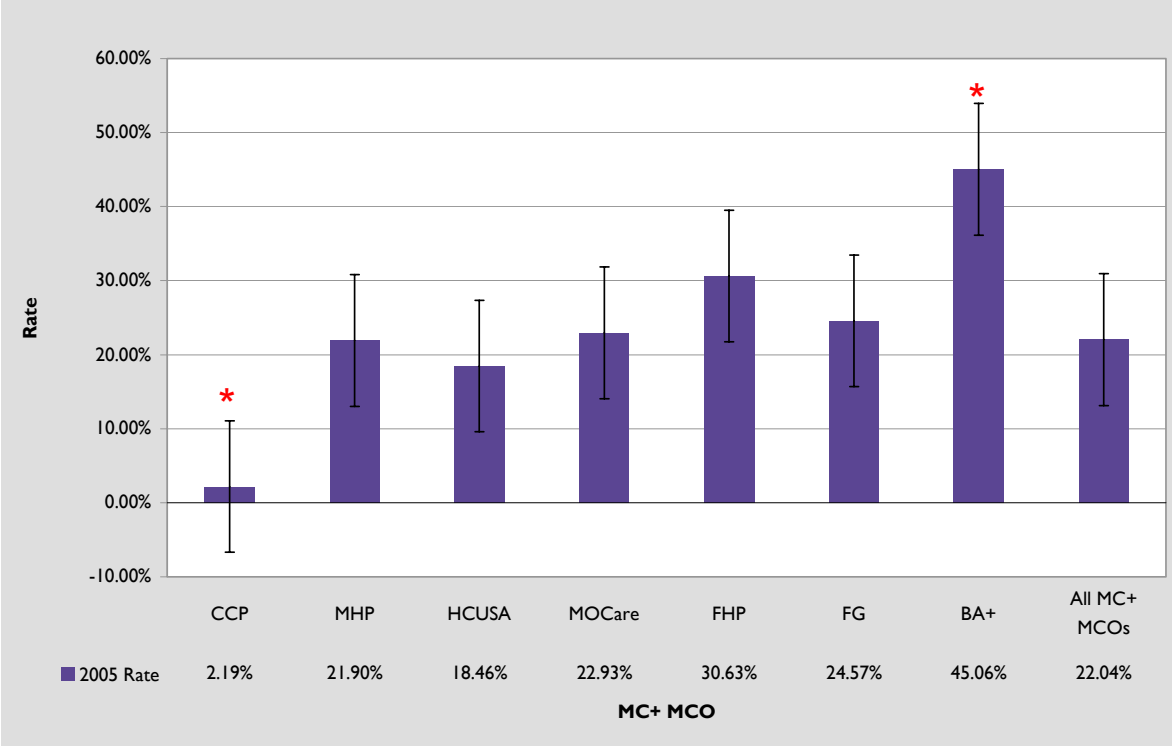


Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

When the rates of administrative and hybrid hits were examined separately (see Figures 3 and 4), Blue-Advantage Plus of Kansas City and Children's Mercy Family Health Partners reported significantly higher rates of administrative hits (45.06% and 30.63% respectively) than the rate for all MC+ MCOs (22.04%). However, Community CarePlus identified a significantly lower rate of administrative hits (2.19%) than the rate for all MC+ MCOs. This may be a function of the completeness of each MC+ MCOs claim system or claims for childhood immunizations. A possible reason for the low rate of administrative hits by Community CarePlus is the exclusion of the State Public Health Immunization Registry (MOHSAIC) data in calculating the numerators.

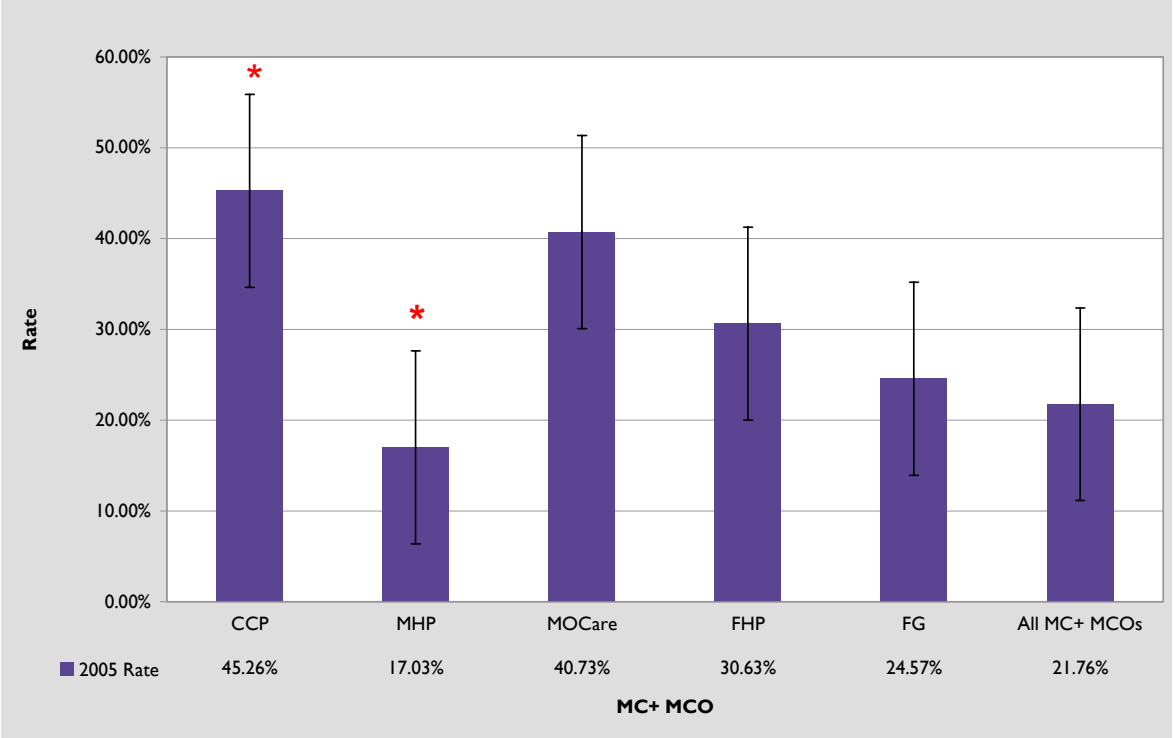
Figure 3 - MC+ Managed Care Program HEDIS 2005 Childhood Immunization Status, Combination #2, Administrative Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MC+ MCO HEDIS 2005 Data Submission Tool (DST).

For hybrid hits, Community CarePlus and Missouri Care reported significantly higher rates of hybrid hits based on medical record review (45.26% and 40.73%, respectively) than the rate for all MC+ MCOs (21.76%) using the Hybrid Method. Mercy Health Plan reported a significantly lower rate of hybrid hits based on medical record review (17.03%) than the rate calculated across all MC+ MCOs. Differences may be due to the differences in processes for carrying out medical record reviews and compiling hybrid data to calculate the rate using the Hybrid Method.

Figure 4 - MC+ Managed Care Program HEDIS 2005 Childhood Immunization Status, Combination #2, Hybrid Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MC+ MCO HEDIS 2005 Data Submission Tool (DST).

Tables 17 and 18 summarize the findings of the EQRO medical record review validation and Attachment XII (Impact of Medical Record Findings) of the Protocol. Five of the MC+ MCOs used the Hybrid Method of calculation. Three MC+ MCO selected a sample of 411 eligible members, Missouri Care selected a sample of 410 and Children's Mercy Family Health Partners selected a sample of 395, these samples were consistent with HEDIS technical specifications. A total of 150 of the 645 medical records reported as hybrid hits by MC+ MCOs were sampled for validation by the EQRO. Only those records received were included in the validation. Of the 150 medical records sampled, 148 were received for review (98.67%), and 107 were able to be validated (72.30%),

resulting in an error rate of 28.7% across all MC+ MCOs using the Hybrid Method of calculation. The number of False Positive Records (the total amount that could not be validated) was 185 of the 645 reported hits. The estimated bias for individual MC+ MCOs based on the medical record validation ranged from a 0.6% to 19.7% overestimate in the rate, with an estimated bias of 9.1% for all MC+ MCOs using the Hybrid Method. Table 19 shows the impact of the medical record review findings. The error rate ranged from 3.3% to 80.0%, with a rate of 28.7% for all MC+ MCOs using the Hybrid Method. The final estimated bias in the final rate ranged from -9.11% to 20.92%, with an average of 3.59% for all MC+ MCOs after taking into account the validation of administrative hits (see Item 12.8, Table 18).

Table 19 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.6 was not applicable as none of the MC+ MCOs used non-standard codes to determine the numerators. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable to HealthCare USA. Across all MC+ MCOs, 95.8% of the criteria for calculating the numerator were met. Six of the seven (85.7%) MC+ MCOs calculating the measures Met criteria for using complete medical event codes, correctly classifying members for inclusion in the numerator, following time parameters for the specification of the measure, and capturing data for performance indicators that could be easily underreported due to services delivered outside the MC+ MCO. Community CarePlus did not meet the criteria due to the exclusion of MOHSAIC data. Six of the seven MC+ MCOs Met 91.7% to 100.0% of the criteria for processes used to produce the numerators. HealthCare USA Met 66.7% of the criteria for processes used to produce the numerators because they did not provide the EQRO with valid service codes to validate, therefore items 13.3 and 13.4 could not be Met.

Table 17 - Medical Record Validation for HEDIS 2005Childhood Immunization Status, Combination #2

MC+ MCO	Denominator (Sample Size)	Numerator Hits by Medical Records (DST)	Number Medical Records Sampled for Audit by EQRO	Number Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of Records Received	Accuracy Rate	Error Rate	Weight of Each Medical Record
Community Care Plus	411	186	30	29	20	69.0%	66.7%	33.3%	0.002
Family Health Partners	395	121	30	30	29	96.7%	96.7%	3.3%	0.003
FirstGuard	411	101	30	29	6	20.7%	20.0%	80.0%	0.002
Mercy Health Plan	411	70	30	30	29	96.7%	96.7%	3.3%	0.002
Missouri Care	410	167	30	30	23	76.7%	76.7%	23.3%	0.002
All MC+ MCOs	**2,038**	**645**	**150**	**148**	**107**	**72.3%**	**71.3%**	**28.7%**	**0.0005**

Note: DST = Data Submission Tool; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Accuracy Rate = Number of Medical Records Validated by the EQRO/Number of Records Selected for Audit by EQRO; Error Rate = 100% - Accuracy Rate; Weight of Each Medical Record = Error Rate * Medical Record Hits Reported by MCO; Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record.
Source: MC+ MCO Data Submission Tools (DST); BHC, Inc. 2005 External Quality Review Performance Measures Validation.

Table 18 - Impact of Medical Record Findings, HEDIS 2005Childhood Immunization Status, Combination #2

Item	Audit Elements	MC+ MCO						
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+
12.1	Final Data Collection Method Used (e.g., MRR, hybrid,)	H	H	A	H	H	H	A
12.2	Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	33.33%	3.33%	NA	23.33%	3.33%	80.00%	NA
12.3	Is error rate < 10%? (Yes or No)	No	Yes	NA	No	Yes	No	NA
	If yes, MCO/PIHP passes MRR validation; no further MRR calculations are necessary.		Passes	NA		Passes		NA
	If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	See Below	NA	NA	See Below	NA	See Below	NA
12.4	Denominator (The total number of members identified for the denominator of this measure, as identified by the MCO/PIHP)	411	NA	NA	411	NA	411	NA
12.5	Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	0.002	NA	NA	0.002	NA	0.002	NA
12.6	Total Number of MRR Numerator Positives identified by the MCO/PIHP using MRR.	124	NA	NA	167	NA	101	NA
12.7	Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	62	NA	NA	39	NA	81	NA
12.8	Estimated Bias in Final Rate (The amount of bias caused by medical record review)	12.40%	None	NA	7.80%	None	16.20%	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Table 19 - Numerator Validation Findings, HEDIS 2005Childhood Immunization Status, Combination #2

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCO/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.2	The MCO/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO/PIHP.	0	2	2	2	2	2	2	6	0	1	7	85.7%
13.3	The MCO's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	0	2	2	2	2	6	0	1	7	85.7%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	0	2	2	2	2	6	0	1	7	85.7%
13.5	The MCO/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.6	Any non-standard codes used in determining thenumerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
13.9	Record review staff have been properly trained and supervised for the task.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
	Number Met	11	12	4	12	12	12	6	69	0	3	72	95.8%
	Number Partially Met	0	0	0	0	0	0	0					
	Number Not Met	1	0	2	0	0	0	0					
	Number Applicable	12	12	6	12	12	12	6					
	Rate Met	91.7%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MC+ MCOs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Table 20 summarizes the findings of Attachment XV (Sampling Validation Findings) of the Protocol. Item 15.3 (Each provider had an equal chance of being sampled) was not applicable to the HEDIS 2005 Childhood Immunization Status, Combination #2 measure; and none of the items were applicable to HealthCare USA. Item 15.9 (Documenting if the requested sample size exceeded the eligible population size) did not apply to any of the MC+ MCOs for this measure. MC+ MCOs Met criteria (98.0%) for random sampling without systematic exclusion, examining files for bias, assuring there was no correlation between samples drawn, assuring members had the same chance of being included at baseline and follow-up measurement, maintaining sample files, meeting sample size requirements of the performance measure specifications, oversampling to accommodate for exclusions, and making substitutions properly. The criteria for sample exclusions was Met by four out of five (80.0%) of the MC+ MCOs. Mercy Health Plan systematically excluded medical records sampled for the Hybrid Method by not requesting all the records that did not have administrative hits for medical record review. Of the MC+ MCOs that calculated the measure, the rate for proper sampling ranged from 90.0% to 100.0%.

Table 20 - Sampling Validation Findings, HEDIS 2005Childhood Immunization Status, Combination #2

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
15.1	Each relevant member or provider had an equal chance of being selected; no one was systematically excluded from the sampling.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.2	The MCO / PIHP followed the specifications set forth in the performance measure regarding the treatment of sample exclusions and replacements, and if any activity took place involving replacements of or exclusions from the sample, the MCO/PIHP kept adequate documentation of that activity.	2	0	NA	2	2	2	NA	4	0	1	5	80.0%
15.3	Each provider serving a given number of enrollees had the same probability of being selected as any other provider serving the same number of enrollees.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
15.4	The MCO/PIHP examined its sampled files for bias, and if any bias was detected, the MCO/PIHP is able to provide documentation that describes any efforts taken to correct it.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.5	independently, and there is no correlation between drawn samples.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.6	Relevant members or providers who were not included in the sample for the baseline measurement had the same chance of being selected for the follow-up measurement as providers who were included in the baseline.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.7	The MCO/PIHP has policies and procedures to maintain files from which the samples are drawn in order to keep the population intact in the event that a sample must be re-drawn, or replacements made, and documentation that the original population is intact.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.8	Sample sizes meet the requirements of the performance measure specifications.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.9	The MCO/PIHP has appropriately handled the documentation and reporting of the measure if the requested sample size exceeds the population size.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
15.10	The MCO/PIHP properly oversampled in order to accommodate potential exclusions	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.11	Substitution applied only to those members who met the exclusion criteria specified in the performance measure definitions or requirements.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
15.12	Substitutions were made for properly excluded records and the percentage of substituted records was documented.	2	2	NA	2	2	2	NA	5	0	0	5	100.0%
	Number Met	10	9	0	10	10	10	0	49	0	1	50	98.0%
	Number Partially Met	0	0	0	0	0	0	0					
	Number Not Met	0	1	0	0	0	0	0					
	Number Applicable	10	10	0	10	10	10	0					
	Rate Met	100.0%	90.0%	NA	100.0%	100.0%	100.0%	NA					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2005 Childhood Immunization Status Combination #2 measure. All seven MC+ MCOs calculated and submitted the measure to the SPHA and SMA. All HMOs in the State of Missouri are required to calculate and report the measure to the SPHA, and MC+ MCOs are required to report the measure to the SMA.

Final Validation Findings

Table 21 shows the final data validation findings and the total estimated bias in calculation based on the validation of medical record data and review of the MC+ MCO extract files for calculating the HEDIS 2005 Childhood Immunization Status, Combination #2 measure. Figure 5 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MC+ MCOs calculated based on data validated by the EQRO was 21.56%, while the rate reported by MC+ MCOs was 28.17% (see Table 16 and Figure 2), a 6.61% overestimate.

Table 21 - Final Data Validation for HEDIS 2005Childhood Immunization Status, Combination #2

MC+ MCO	Administrative Hits Validated by EQRO	Percentage of Medical Record Hits Validated by EQRO*	Total Hits Validated by EQRO	Rate Reported by MCO (DST)	Rate Validated by EQRO	Total Estimated Bias
Community Care Plus	9	66.67%	133	47.45%	32.36%	15.09%
Blue Advantage Plus	115	NA	115	45.06%	27.98%	17.08%
Family Health Partners	109	96.67%	226	57.47%	57.21%	0.26%
FirstGuard	233	20.00%	253	55.72%	61.61%	-5.89%
HealthCare USA (all 3 regions)	1105	NA	1105	18.46%	15.22%	3.24%
Mercy Health Plan	90	96.67%	158	38.93%	38.36%	0.57%
Missouri Care	150	76.67%	278	63.66%	67.89%	-4.23%
All MC+ MCOs	**1811**	**58.78%**	**2268**	**28.17%**	**21.56%**	**6.61%**

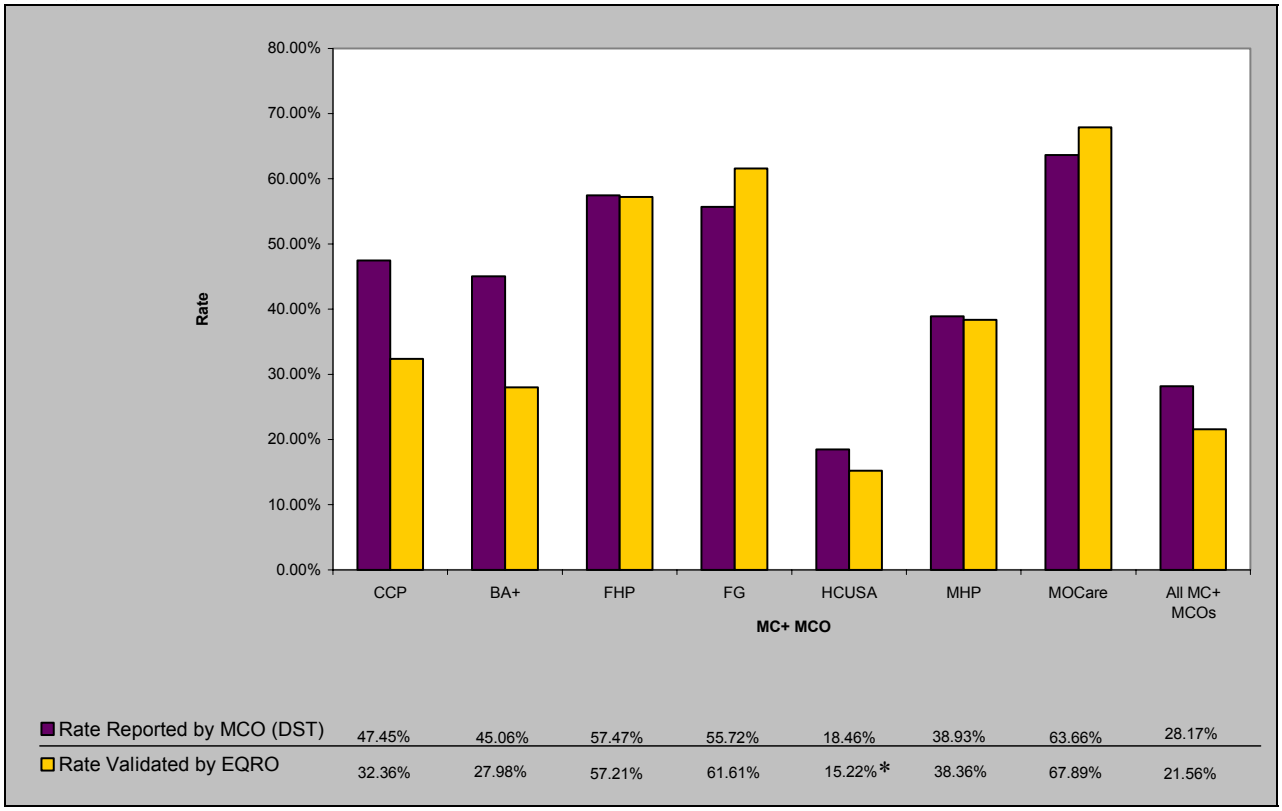
Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit; False Positive Records = Error Rate * Medical Record Hits Reported by MC+ MCO; Medical Record Hits Validated by the EQRO = Medical Record Hits Reported by MC+ MCO (DST) - False Positive Records; Total Estimated Bias = Rate Validated by EQRO using medical record review and data extract file review - Rate Reported by MC+ MCO (DST). Positive numbers represent an overestimate. The EQRO is charged with providing MCO to MCO comparisons. Therefore, the numerators and denominators for HealthCare USA were aggregated across all three regions, which were each 100% validated. Mercy Health Plans submitted data for Combination #2; Blue-Advantage Plus of Kansas City did not calculate the measure.

*For a more detailed explanation of how Medical Record Hit percentages were calculated, please see Table 17.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Performance Management Solutions Group
BHC
a Division of Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4
Columbia, MO 65203
www.bhcinfo.com/PMSG
T: 573.446.0405
F: 573.446.1816
E-mail: info@bhcinfo.com

Figure 5 - Rates Reported by MC+ MCOs and Validated by EQRO, HEDIS 2005 Childhood Immunization Status, Combination #2



*Sources: MC+ MCO HEDIS 2004 Data Submission Tool (DST); BHC, Inc., 2005 External Quality Review Performance Measure Validation. *Rate calculated by EQRO is based on data provided to the EQRO for review; data provided could not be independently validated.*

HEDIS 2005 Well-Child Visits in the First 15 Months of Life

Data Integration and Control

The objective of this activity was to assess the MC+ MCOs' ability to link data from multiple sources for the calculation of the HEDIS 2005 Well-Child Visits measure. It is related to the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2005 Well-Child Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 22 summarizes the findings of Attachment V (Data Integration and Control Findings) of the Protocol. The rate of items that were Met was calculated across MC+ MCOs and from the number of applicable items for each MC+ MCO.

Across all MC+ MCOs, 98.9% of the criteria for data integration and control were Met. All MC+ MCOs (100.0%) Met the criteria for having accurate and established procedures for transferring data into data repositories for calculation of the measure, coordinating data integration with vendors, and following standards associated with programming and testing.

Table 22 - Data Integration and Control Findings, HEDIS 2005 Well-Child Visits in the First 15 Months of Life

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCO/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.3	MCO's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCO/PIHP production activity logs, and MCO/PIHP staff review of report runs.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.11	The MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	1	2	2	2	2	2	6	1	0	7	85.7%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.13	Review the MCO's/PIHP's processes and documentation to determine the extent to which they comply with the MCO/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	2	7	0	0	7	100.0%
	Number Met	13	12	13	13	13	13	13	**90**	**1**	**0**	**91**	**98.9%**
	Number Partially Met	0	1	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13	13					
	Rate Met	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms for the calculation of HEDIS 2004 Adolescent Well-Care Visits measure. Table 23 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the Protocol. Items 7.3 (Statistical testing of results and corrections made after processing), 7.4 (Inclusion of external data sources), and 7.9 (Consistent data from measure to measure) did not apply to the measure. Across all MC+ MCOs, 79.5% of the criteria were met. All MC+ MCOs Met the criteria for following data file and field definitions (100.0%). Three of the seven MC+ MCOs (42.9%) used the Hybrid Method for calculation, and all three Met criteria for having detailed medical record review practices and reviewer training materials. Source codes and programming logic for the identification of denominators appeared accurate for all six of the seven MC+ MCOs (85.7%). One MC+ MCO (HealthCare USA) did not provide source code or programming logic to the EQRO for review. All three (100.0%) MC+ MCOs using the Hybrid Method Met the criteria for documentation of sampling procedures. Although MC+ MCOs frequently graphed the rates of performance over several years, only 42.9% used the calculation of statistical significance in rates from year to year as a measure of the significance of fluctuation in the measure (see items 7.8 and 7.11). When sampling, all three (100.0%) of the MC+ MCOs using the Hybrid Method Met the criteria for using appropriate statistical functions for determining confidence intervals for sampling. Each MC+ MCO calculating the measure Met 60.0% to 100.0% of the criteria for processes used to calculate and report the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure.

Table 23 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	0	2	2	2	2	6	0	1	7	85.7%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	0	0	2	2	0	2	1	3	1	3	7	42.9%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	2	2	2	2	2	2	2	7	0	0	7	100.0%
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	0	0	2	2	0	2	1	3	1	3	7	42.9%
	Number Met	3	6	4	8	3	8	3	35	2	7	44	79.5%
	Number Partially Met	0	0	0	0	0	0	2					
	Number Not Met	2	2	1	0	2	0	0					
	Number Applicable	5	8	5	8	5	8	5					
	Rate Met	60.0%	75.0%	80.0%	100.0%	60.0%	100.0%	60.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2005 Well-Child Visits measure, the sources of data include enrollment, eligibility, and claim files. Table 24 summarizes the findings of Attachment X (Denominator Validation Findings) of the protocol. Items 10.5 (Identification of gender of the member), 10.6 (Calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure. Six of the seven MC+ MCOs (85.7%) Met all the criteria for processes used to produce the denominators. One MC+ MCO (HealthCare USA) did Not Met the criteria for "evaluating the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure", as they did not provide service codes to the EQRO for review. 97.6% of the criteria were Met for the processes used to produce denominators.

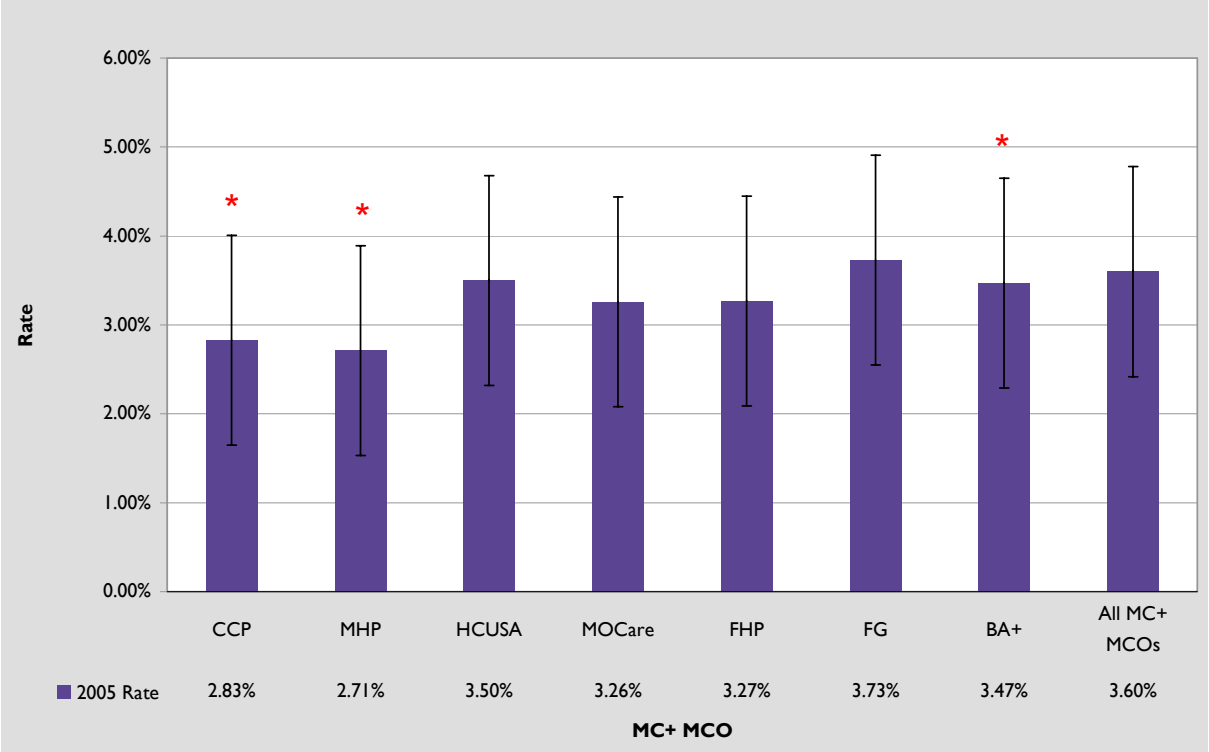
Table 24 - Denominator Validation Findings, HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.5	The MCO/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCO/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCO/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	0	2	2	2	2	6	0	1	7	85.7%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.9	Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.10	Systems or methods used by the MCO/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	6	6	5	6	6	6	6	**41**	**0**	**1**	**42**	**97.6%**
	Number Partially Met	0	0	0	0	0	0	0					
	Number Not Met	0	0	1	0	0	0	0					
	Number Applicable	6	6	6	6	6	6	6					
	Rate Met	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Figure 6 illustrates the rate of eligible members identified by each MC+ MCO, based on the enrollment of all MC+ MCO Waiver Recipients as of December 31, 2004, the end of the CY2004 measurement year. It was expected that MC+ MCOs would identify similar proportions of eligible members for the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MC+ MCOs and two-tailed z-tests of each MC+ MCO compared to the state rate of eligible members were conducted at the 95% level of confidence.

Figure 6 - MC+ Managed Care Program HEDIS 2005 Well-Child Visits in the First 15 Months of Life, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; there were no significant differences on two tailed z-tests.

Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2004.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MC+ MCOs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2005 Well-Child Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 25 shows the numerators, denominators, rates, and confidence intervals submitted by the MC+ MCOs to the SPHA on the DST. The rate for all MC+ MCOs was calculated by the EQRO, thus there is no confidence interval reported for the statewide rate. The rate for all MC+ MCOs was 38.42%, with MC+ MCO rates ranging from 23.91% (Children's Mercy Family Health Partners) to 75.69% (Missouri Care).

Table 25 - Data Submission for HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

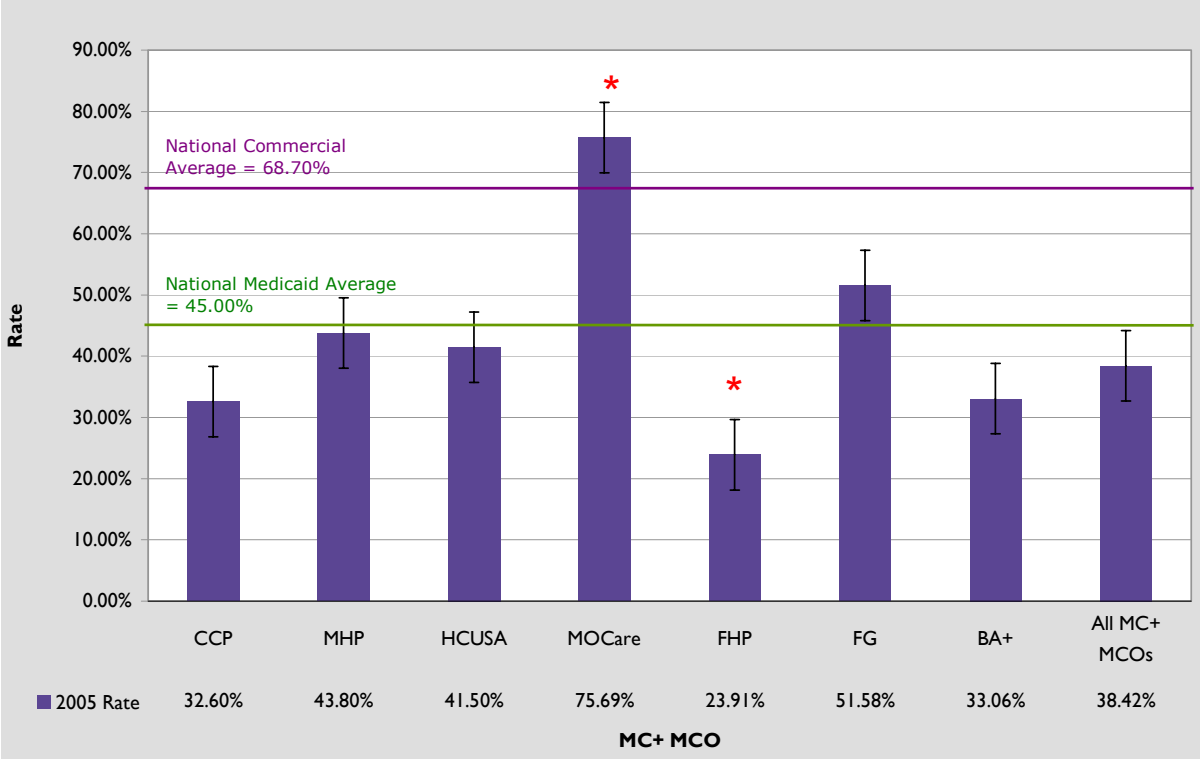
MC+ MCO	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCO (DST)	Hybrid Hits Reported by MCO (DST)	Total Hits Reported by MCO (DST)	Rate Reported by MCO (DST)	LCL - UCL (DST)
Blue Advantage Plus	Administrative	1,201	397	NA	397	33.06%	30.35% - 35.76%
Community Care Plus	Administrative	1305	426	NA	426	32.60%	28.07% - 36.98%
Family Health Partners	Administrative	1,677	401	NA	401	23.91%	21.84% - 25.98%
FirstGuard	Hybrid	411	152	60	212	51.58%	46.63% - 56.53%
HealthCare USA	Administrative	6,474	2,687	NA	2,687	41.50%	37.33% - 40.03%
Mercy Health Plan	Hybrid	411	133	47	180	43.80%	38.88% - 48.71%
Missouri Care	Hybrid	288	194	24	218	75.69%	70.57% - 80.82%
All MC+ MCOs		**11,767**	**4,390**	**131**	**4,521**	**38.42%**	

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. The EQRO is charged with providing MCO to MCO comparisons. Therefore, the numerators and denominators for HealthCare USA were aggregated across all three regions, which were each 100% validated. Medical Record Hits Validated by EQRO = Weighted number of medical records with validated hits. Community CarePlus reported numerator events from Calendar Year 2002 for the HEDIS 2004 reporting year. The statewide rate for all MC+ MCOs was calculated by the EQRO using the sum of numerators divided by sum of denominators. There was no statewide rate or confidence limits reported to the SMA or SPHA.

Source: MC+ Managed Care Organization HEDIS 2005 Data Submission Tools (DST).

Figures 7, 8, and 9 illustrate the rates reported by the MC+ MCOs and the rates of administrative and hybrid hits for each MC+ MCO. The rate reported by each MC+ MCO was compared with the rate for all MC+ MCOs. Two-tailed z-tests of each MC+ MCO comparing MC+ MCOs to the rate for all MC+ MCOs were calculated at the 95% confidence interval. The rate for all MC+ MCOs was lower than the National Commercial (68.70%) and the National Medicaid rates (45.00%). Missouri Care and First Guard reported rates significantly higher than the rate for all MC+ MCOs (75.69% and 51.58% respectively), while Children's Mercy Family Health Partners reported a rate significantly below the rate for all MC+ MCOs (23.91%).

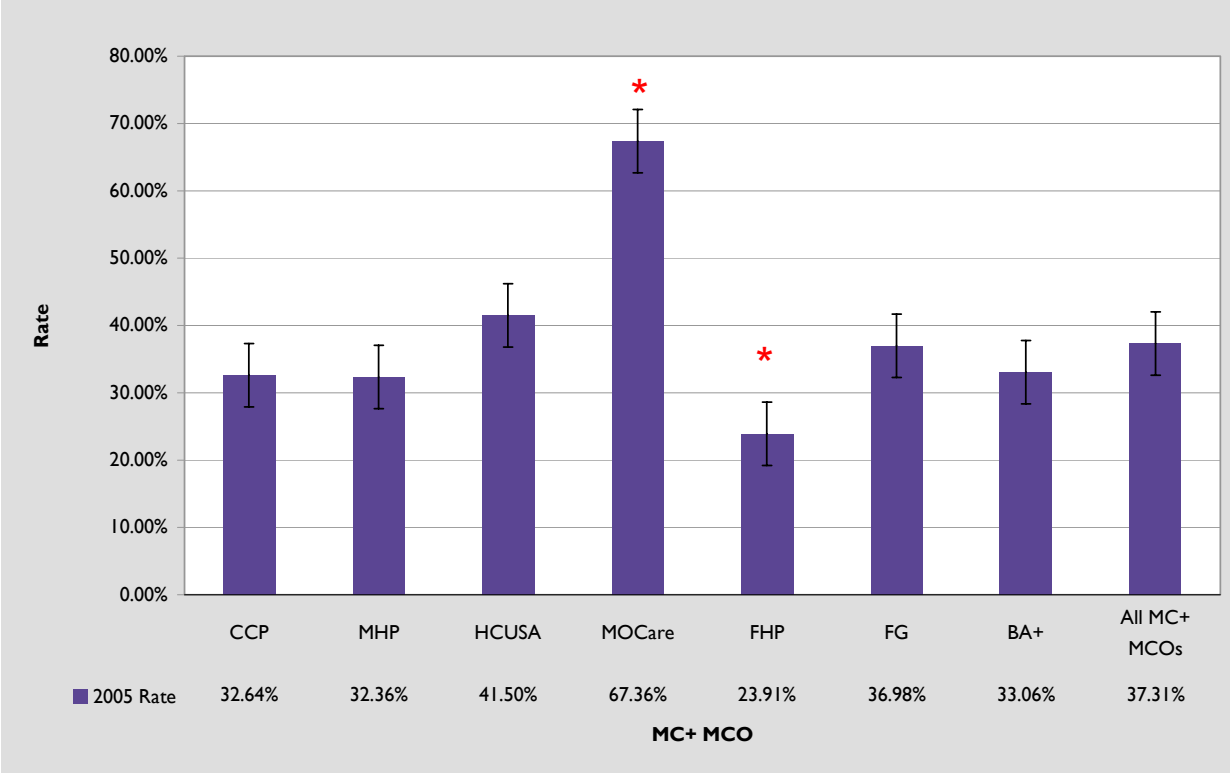
Figure 7 - MC+ Managed Care Program HEDIS 2005 Well-Child Visits in the First 15 Months of Life, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

When the rate of administrative and hybrid hits was examined separately, there was wide variability among MC+ MCOs from the administrative rate for all MC+ MCOs (37.31%). HealthCare USA and Missouri Care reported rates of administrative hits significantly higher than the rate for all MC+ MCOs (41.50% and 67.36%, respectively). Community CarePlus, Childrens Mercy Family Health Partners, Blue-Advantage Plus of Kansas City and Mercy Health Plan reported significantly lower rates of administrative hits (32.64%, 23.91%, 33.06% and 32.36%, respectively), while the rate found by FirstGuard was consistent with that of the rate for all MC+ MCOs. This may be a function of the completeness of each MC+ MCOs' claim system or the administration of claims for well-child visits.

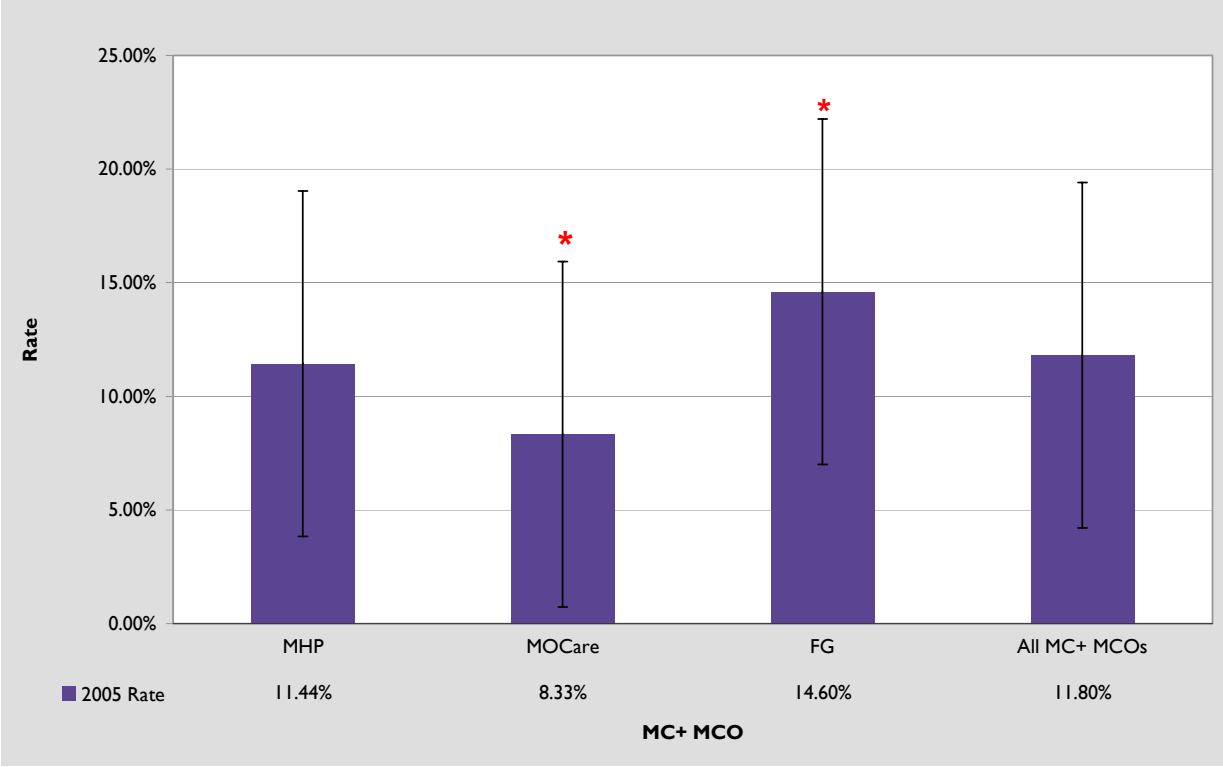
Figure 8 - MC+ Managed Care Program HEDIS 2005 Well-Child Visits in the First 15 Months of Life, Administrative Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MC+ MCO HEDIS 2005 Data Submission Tool (DST).

For hybrid hits, First Guard reported a significantly higher rate of hits based on medical record review (14.60%) than the rate calculated across all MC+ MCOs (11.80%) using the Hybrid Method. Missouri Care reported a significantly lower rate of hits (8.33%) than the all MC+ MCO rate. Differences may be due to differences in the processes for carrying out medical record reviews and compiling hybrid data to calculate the rate.

Figure 9 - MC+ Managed Care Program HEDIS 2005 Well-Child Visits in the First 15 Months of Life, Hybrid Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: MC+ MCO HEDIS 2005 Data Submission Tool (DST).

Tables 26 and 27 summarize the findings of the EQRO medical record review validation and Attachment XII (Impact of Medical Record Findings) of the Protocol. Three of the MC+ MCOs (Mercy Health Plan, Missouri Care, and FirstGuard) used the Hybrid Method of calculation. Two of the three selected a sample of 411 eligible members, consistent with HEDIS technical specifications. Missouri Care selected a sample of 288 eligible members, for undetermined reasons. A total of 87 of the 131medical records (66.4%) reported as hybrid hits by MC+ MCOs were sampled for validation by the EQRO. All 87 medical records were received for review and 56 were able to be validated (64.37%), resulting in an error rate of 35.63% across all MC+ MCOs using the Hybrid Method of calculation. The number of False Positive Records (the total amount that could not be validated) was 47 of the 131 reported hits. The error rate ranged from 14.81% to 60.00%. The estimated bias for individual MC+ MCOs based on the medical record validation ranged from a 1.2% to 8.8% overestimate in the rate, with an average overestimate of 4.20% for all MC+ MCOs. Table 26 shows the impact of the medical record review findings.

Table 26 - Impact of Medical Record Findings, HEDIS 2005 Well Child Visits in the First 15 Months of Life Measure

Item	Audit Elements	MC+ MCO						
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+
12.1	Final Data Collection Method Used (e.g., MRR, hybrid,)	A	H	A	H	A	H	A
12.2	Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	NA	30.00%	NA	14.81%	NA	60.00%	NA
12.3	Is error rate < 10%? (Yes or No)	NA	No	NA	No	NA	No	NA
	If yes, MCO/PIHP passes MRR validation; no further MRR calculations are necessary.	NA		NA		NA		NA
	If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	See below	NA	See Below	NA	See Below	NA
12.4	Denominator (The total number of members identified for the denominator of this measure, as identified by the MCO/PIHP)		411		288		411	
12.5	Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	NA	0.002	NA	0.0003	NA	0.002	NA
12.6	Total Number of MRR Numerator Positives identified by the MCO/PIHP using MRR.	NA	47	NA	24	NA	60	NA
12.7	Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	14	NA	4	NA	36	NA
12.8	Estimated Bias in Final Rate (The amount of bias caused by medical record review)	NA	2.80%	NA	0.12%	NA	7.20%	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Table 27 - Medical Record Validation for HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

MC+ MCO	Denominator (Sample Size)	Numerator Hits by Medical Records (DST)	Number Medical Records Sampled for Audit by EQRO	Number Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of Records Received	Accuracy Rate	Error Rate	Weight of Each Medical Record
FirstGuard	411	60	30	30	12	40.0%	40.0%	60.0%	0.002
Mercy Health Plan	411	47	30	30	21	70.0%	70.0%	30.0%	0.002
Missouri Care	288	24	27	27	23	85.2%	85.2%	14.8%	0.003
All MC+ MCOs	**1,110**	**131**	**87**	**87**	**56**	**64.4%**	**64.4%**	**35.6%**	**0.0009**

Note: DST = Data Submission Tool; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Accuracy Rate = Number of Medical Records Validated by the EQRO/Number of Records Selected for Audit by EQRO; Error Rate = 100% - Accuracy Rate; Weight of Each Medical Record = 100% / Denominator (Sample Size); Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record.
Source: MC+ MCO Data Submission Tools (DST); BHC, Inc. 2005 External Quality Review Performance Measures Validation.

Table 28 shows the validation of numerators based on the review of numerator extract files and the medical record review. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable to Community CarePlus, HealthCare USA, Family Health Partners, or Blue-Advantage Plus of Kansas City. Across MC+ MCOs, 92.5% of the criteria for calculating numerators were met. Two of the three MC+ MCOs calculating the measures using the Hybrid Method (Missouri Care and FirstGuard) Met all criteria (100.0%) for using the appropriate data to identify the at-risk population, using complete medical event codes, correctly classifying members for inclusion in the numerator, using consistent non-standard code maps, adequately training record review staff, and using appropriate notation for medical record reviews for the measured event. Six of the seven MC+ MCOs (85.7%) Met the criteria for correctly evaluating medical event codes when classifying members for inclusion or exclusion in the numerator for the measure. HealthCare USA did not provide the EQRO with the service codes for their numerator events file, so the EQRO could not determine the validity of the service codes. One of the three MC+ MCOs (33.3%) using the Hybrid Method carried out medical record abstractions in a reliable, accurate manner. The exclusion of members from the medical record review by only requesting records that they expected to receive results in a rating of not met for Mercy Health Plan. Missouri Care Partially Met this criteria. The MC+ MCOs Met 60.0% to 100.0% of criteria for calculating the numerator for the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure.

Table 28 - Numerator Validation Findings, HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCO/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.2	The MCO/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO/PIHP.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCO's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	0	2	2	2	2	6	0	1	7	85.7%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	0	2	2	2	2	6	0	1	7	85.7%
13.5	The MCO/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	0	NA	1	NA	2	NA	1	1	1	3	33.3%
13.9	Record review staff have been properly trained and supervised for the task.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
	Number Met	5	10	3	10	5	11	5	49	1	3	53	92.5%
	Number Partially Met	0	0	0	1	0	0	0					
	Number Not Met	0	1	2	0	0	0	0					
	Number Applicable	5	11	5	11	5	11	5					
	Rate Met	100.0%	90.9%	60.0%	90.9%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MC+ MCOs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Table 29 summarizes the findings of Attachment XV (Sampling Validation Findings) of the Protocol. Items 15.3 (Each provider had an equal chance of being sampled) and 15.9 (Documenting if the requested sample size exceeded the eligible population size) did not apply to any of the MC+ MCOs for this measure; and none of the items were applicable to Community CarePlus, HealthCare USA, Family Health Partners, or Blue-Advantage Plus of Kansas City. Across all MC+ MCOs, the criteria for sampling were Met 96.7% of the time. MC+ MCOs Met criteria (100.0%) for random sampling without systematic exclusion, examining files for bias, assuring there was no correlation between samples drawn, assuring members had the same chance of being included at baseline and follow-up measurement, maintaining sample files, meeting sample size requirements of the performance measure specifications, oversampling to accommodate for exclusions, and making substitutions properly. The criteria for sample exclusions was Met by 66.7% of the MC+ MCOs. Mercy Health Plan systematically excluded medical records sampled for the Hybrid Method by not requesting all the records that did not have administrative hits for medical record review. The MC+ MCOs using the Hybrid Method of calculating the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure Met 90.0% to 100.0% of the criteria for proper sampling.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2005 Well-Child Visits measure. All MC+ MCOs reported the measure to the SPHA and SMA.

Table 29 - Sampling Validation Findings, HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
15.1	Each relevant member or provider had an equal chance of being selected; no one was systematically excluded from the sampling.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.2	The MCO / PIHP followed the specifications set forth in the performance measure regarding the treatment of sample exclusions and replacements, and if any activity took place involving replacements of or exclusions from the sample, the MCO/PIHP kept adequate documentation of that activity.	NA	0	NA	2	NA	2	NA	2	0	1	3	66.7%
15.3	Each provider serving a given number of enrollees had the same probability of being selected as any other provider serving the same number of enrollees.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
15.4	any bias was detected, the MCO/PIHP is able to provide documentation that describes any efforts taken to correct it.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.5	The sampling methodology employed treated all measures independently, and there is no correlation between drawn samples.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.6	Relevant members or providers who were not included in the sample for the baseline measurement had the same chance of being selected for the follow-up measurement as providers who were included in the baseline.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.7	The MCO/PIHP has policies and procedures to maintain files from which the samples are drawn in order to keep the population intact in the event that a sample must be re-drawn, or replacements made, and documentation that the original population is intact.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.8	Sample sizes meet the requirements of the performance measure specifications.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.9	The MCO/PIHP has appropriately handled the documentation and reporting of the measure if the requested sample size exceeds the population size.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
15.10	The MCO/PIHP properly oversampled in order to accommodate potential exclusions	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.11	Substitution applied only to those members who met the exclusion criteria specified in the performance measure definitions or requirements.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
15.12	Substitutions were made for properly excluded records and the percentage of substituted records was documented.	NA	2	NA	2	NA	2	NA	3	0	0	3	100.0%
	Number Met	0	9	0	10	0	10	0	29	0	1	30	96.7%
	Number Partially Met	0	0	0	0	0	0	0					
	Number Not Met	0	1	0	0	0	0	0					
	Number Applicable	0	10	0	10	0	10	0					
	Rate Met	NA	90.0%	NA	100.0%	NA	100.0%	NA					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Final Validation Findings

Table 30 shows the final data validation findings for the calculation of the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure and the total estimated bias in calculation based on the validation of medical record data and review of the MC+ MCO extract files. Figure 10 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MC+ MCOs calculated based on data validated by the EQRO was 36.36%, while the rate reported by MC+ MCOs was 38.42%, a 2.06% overestimate.

Table 30 - Final Data Validation for HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

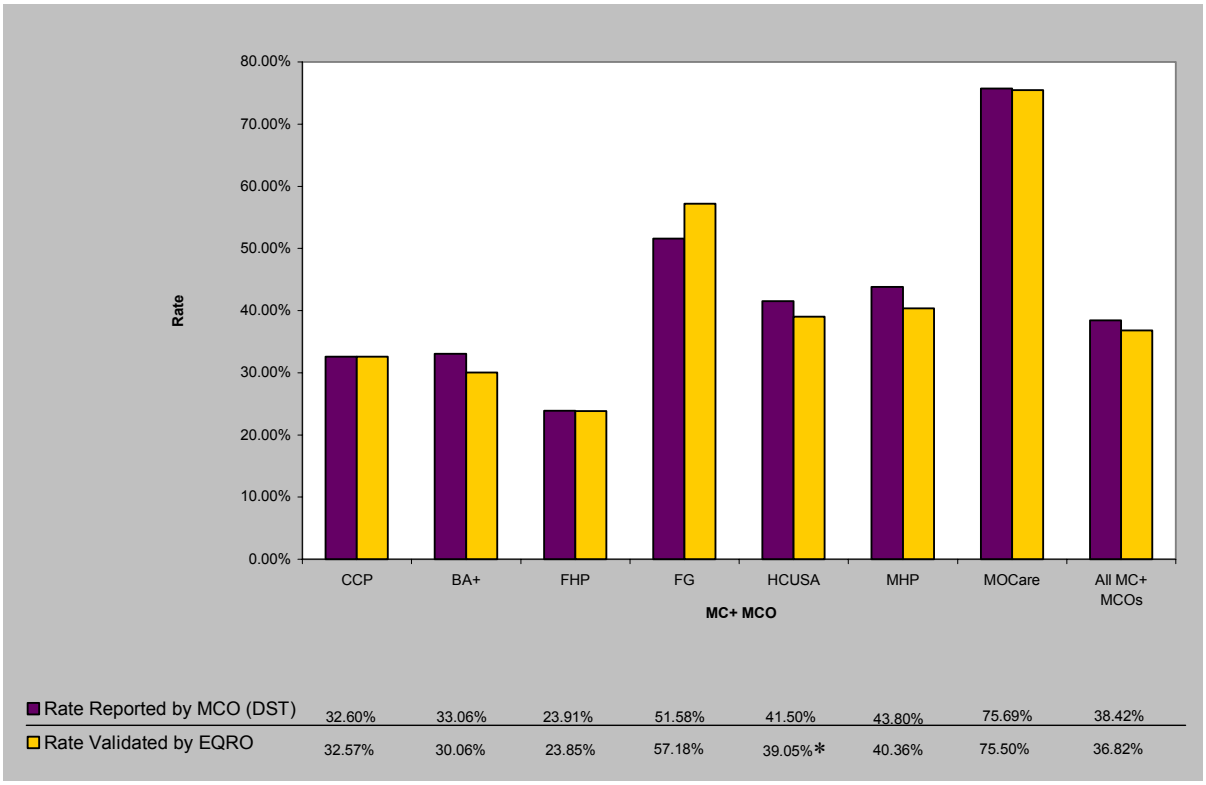
MC+ MCO	Administrative Hits Validated by EQRO	Percentage of Medical Record Hits Validated by EQRO*	Total Hits Validated by EQRO	Rate Reported by MCO (DST)	Rate Validated by EQRO	Total Estimated Bias
Community Care Plus	425	NA	425	32.60%	32.57%	0.03%
Blue Advantage Plus	361	NA	361	33.06%	30.06%	3.00%
Family Health Partners	400	NA	400	23.91%	23.85%	0.06%
FirstGuard	211	40.00%	235	51.58%	57.18%	-5.60%
HealthCare USA (all 3 regions)	2528	NA	2528	41.50%	39.05%	2.46%
Mercy Health Plan	133	70.00%	166	43.80%	40.36%	3.44%
Missouri Care	197	85.20%	217	75.69%	75.50%	0.19%
All MC+ MCOs	**4255**	**58.78%**	**4332**	**38.42%**	**36.82%**	**1.60%**

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Administrative/Medical Record Hits Validated by EQRO = Hits the EQRO was able to reproduce from the data provided by the MCO; Total Hits Validated by EQRO = Administrative Hits Validated by EQRO + Medical Record Hits Validated by EQRO; False Positive Records = Error Rate * Rate Reported by MCO; Rate Validated by EQRO = Total Hits Validated by EQRO / Denominator (DST); Total Estimated Bias = Rate Reported by MC+ MCO – Rate Validated by EQRO. Positive numbers represent an overestimated by the MCO.

*For a more detailed explanation of how Medical Record Hit percentages were calculated, please see Table 27.

Sources: MC+ Managed Care Organization HEDIS 2004 data Submission Tools (DST); BHC, Inc. External Quality Review Performance Measure Validation.

Figure 10 - Rates Reported by MC+ MCOs and Validated by EQRO, HEIDS 2005 Well-Child Visits in the First 15 Months of Life Measure



Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); BHC, Inc., 2005 External Quality Review Performance Measure Validation. *Rate calculated by EQRO is based on data provided to the EQRO for review; data provided could not be independently validated.

HEDIS 2005 Annual Dental Visit

Data Integration and Control

The objective of this activity was to assess the MC+ MCOs' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2005 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. Table 31 summarizes the findings of Attachment V (Data Integration and Control Findings) of the Protocol. The rate of items that were Met was calculated across MC+ MCOs and from the number of applicable items for each MC+ MCO.

Across all MC+ MCOs, 98.9% of the criteria were Met for having accurate and established procedures for transferring data into data repositories for calculation of the measure, coordinating data integration with vendors, and following standards associated with programming and testing. One MC+ MCO (Mercy Health Plan) Partially Met the criteria for retaining copies of files or databases used for performance measure reporting, due to a system change the MCO could not produce the database used for HEDIS 2005 calculations, they assured the EQRO that it was available on back-up tape. Each MC+ MCO calculating the measure Met 92.3% to 100.0% of the criteria for data integration and control.

Table 31 - Data Integration and Control Findings, HEDIS 2005 Annual Dental Visit

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCO/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.3	MCO's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCO/PIHP production activity logs, and MCO/PIHP staff review of report runs.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.11	The MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	1	2	2	2	2	2	6	1	0	7	85.7%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	2	7	0	0	7	100.0%
5.13	Review the MCO's/PIHP's processes and documentation to determine the extent to which they comply with the MCO/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	2	7	0	0	7	100.0%
	Number Met	13	12	13	13	13	13	13	**90**	**1**	**0**	**91**	**98.9%**
	Number Partially Met	0	1	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13	13					
	Rate Met	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms. Table 32 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the Protocol. Items 7.3 (statistical testing of results and corrections made after processing), 7.7 (sampling techniques), 7.9 (data consistency from measure to measure), and 7.10 (appropriate statistical functions for confidence intervals) did not apply to the measure. Across all MC+ MCOs, 74.3% of criteria for calculating and reporting performance measures were Met. All MC+ MCOs Met the criteria for following data file and field definitions and the integration of external data (100.0%). The criteria: "demonstration of detailed queries for identifying eligible members" was met by six of the seven MC+ MCOs (85.7%). HealthCare USA did not meet this criteria as they did not provide the service code information necessary for the EQRO to determine that the population was in fact eligible for the measure. Although MC+ MCOs frequently graphed the rates of performance over several years, only 42.9% of the MC+ MCOs used the calculation of statistical significance in rates from year to year as a measure of the significance of fluctuation in the measure (see items 7.8 and 7.11). Each MC+ MCO Met 60.0% to 100.0% of the criteria for calculating and reporting performance measures.

Table 32 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2005 Annual Dental Visit Measure

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	2	2	2	2	2	2	2	7	0	0	7	100.0%
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	0	2	2	2	2	6	0	1	7	85.7%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	0	0	2	2	0	2	1	3	1	3	7	42.9%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	0	0	2	2	0	2	1	3	1	3	7	42.9%
	Number Met	3	3	4	5	3	5	3	26	2	7	35	74.3%
	Number Partially Met	0	0	0	0	0	0	2					
	Number Not Met	2	2	1	0	2	0	0					
	Number Applicable	5	5	5	5	5	5	5					
	Rate Met	60.0%	60.0%	80.0%	100.0%	60.0%	100.0%	60.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2004 Annual Dental Visits measure, the sources of data include enrollment, eligibility, and claim files. Table 33 summarizes the findings of Attachment X (Denominator Validation Findings) of the Protocol. Items 10.5 (Identification of gender of the member), 10.6 (Calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. Across all MC+ MCOs, 98.0% of criteria for calculating and reporting performance measures were Met. Six out of seven MC+ MCOs Met all the criteria for producing denominators according to specifications, one MC+ MCO (HealthCare USA) did not meet the requirement of "properly evaluating the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure" due to the MC+ MCO not providing the codes to the EQRO for review. Each MC+ MCO Met 85.7% to 100.0% of the criteria for the process used to produce denominators.

Table 33 - Denominator Validation Findings, HEDIS 2005 Annual Dentist Visit Measure

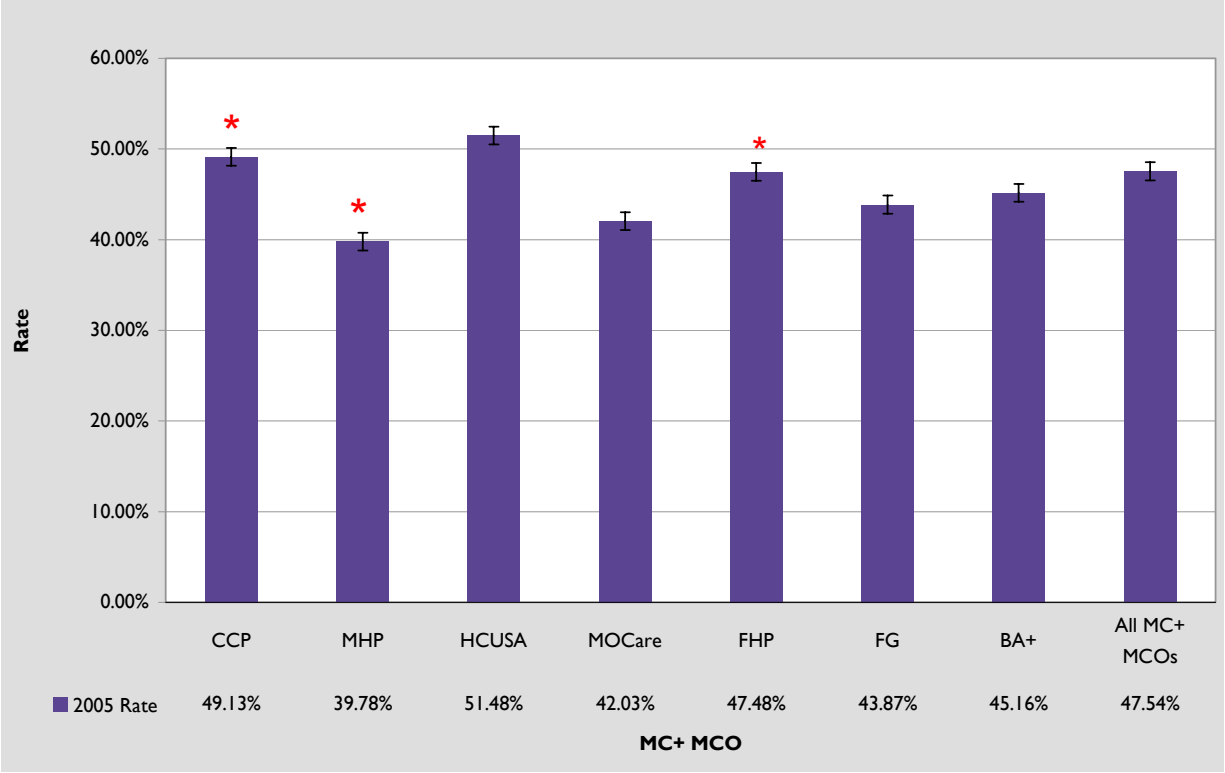
Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.5	The MCO/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCO/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCO/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	0	2	2	2	2	6	0	1	7	85.7%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.9	Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	2	2	2	2	2	2	2	7	0	0	7	100.0%
10.10	Systems or methods used by the MCO/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	6	7	7	7	7	**48**	**0**	**1**	**49**	**98.0%**
	Number Partially Met	0	0	0	0	0	0	0					
	Number Not Met	0	0	1	0	0	0	0					
	Number Applicable	7	7	7	7	7	7	7					
	Rate Met	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Figure 11 illustrates the rate of eligible members per MC+ MCO based on the enrollment of all MC+ MCO Waiver Recipients as of December 31, 2004, the end of the CY2004 measurement year. It was expected that MC+ MCOs would identify similar proportions of eligible members for the measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MC+ MCOs. Two-tailed z-tests of each MC+ MCO comparing each MC+ MCO to the state rate of eligible members for all MC+ MCOs were calculated at the 95% level of confidence. HealthCare USA and Community CarePlus identified significantly higher rates of eligible members (51.48% and 49.13% respectively) compared to the rate for all MC+ MCOs (47.54%), while Mercy Health Plan identified a significantly lower rate of eligible members (39.78%). This may be a function of the claims administration process or member characteristics.

Figure 11 - MC+ Managed Care Program HEDIS 2005 Annual Dental Visit, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test. Enrollment as of the last week in December 2004 (the measurement year) was used to calculate the rate.

Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2004.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MC+ MCOs ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2005 Annual Dental Visits measure, the procedures for the Hybrid Method did not apply, as HEDIS 2005 technical specifications allow only for the use of the Administrative Method of calculating the measure.

Table 34 shows the numerators, denominators, rates, and confidence intervals submitted by the MC+ MCOs to the SPHA on the DST. The rate for all MC+ MCOs was calculated by the EQRO, thus there is no confidence interval reported for the statewide rate. The reported rate for all MC+ MCOs was 29.76% and the rate validated by the EQRO was 29.82%, a 0.06% underestimate. Figure 12 illustrates the rates reported by the MC+ MCOs. The rate reported by each MC+ MCO was compared with the rate for all MC+ MCOs, with two-tailed z-tests conducted at the 95% confidence interval to compare each MC+ MCO with the rate for all MC+ MCOs. The rate for all MC+ MCOs was lower than the National Medicaid rate (42.70%). All MC+ MCOs reported a rate lower than the National Medicaid rate. Only Family Health Partners reported a rate (39.10%) that was comparable to the National Medicaid rate. Family Health Partners and Blue-Advantage Plus of Kansas City reported rates significantly higher than the rate for all MC+ MCOs (39.10% and 33.80% respectively), while Mercy Health Plan reported a rate (20.52%) significantly below the rate for all MC+ MCOs.

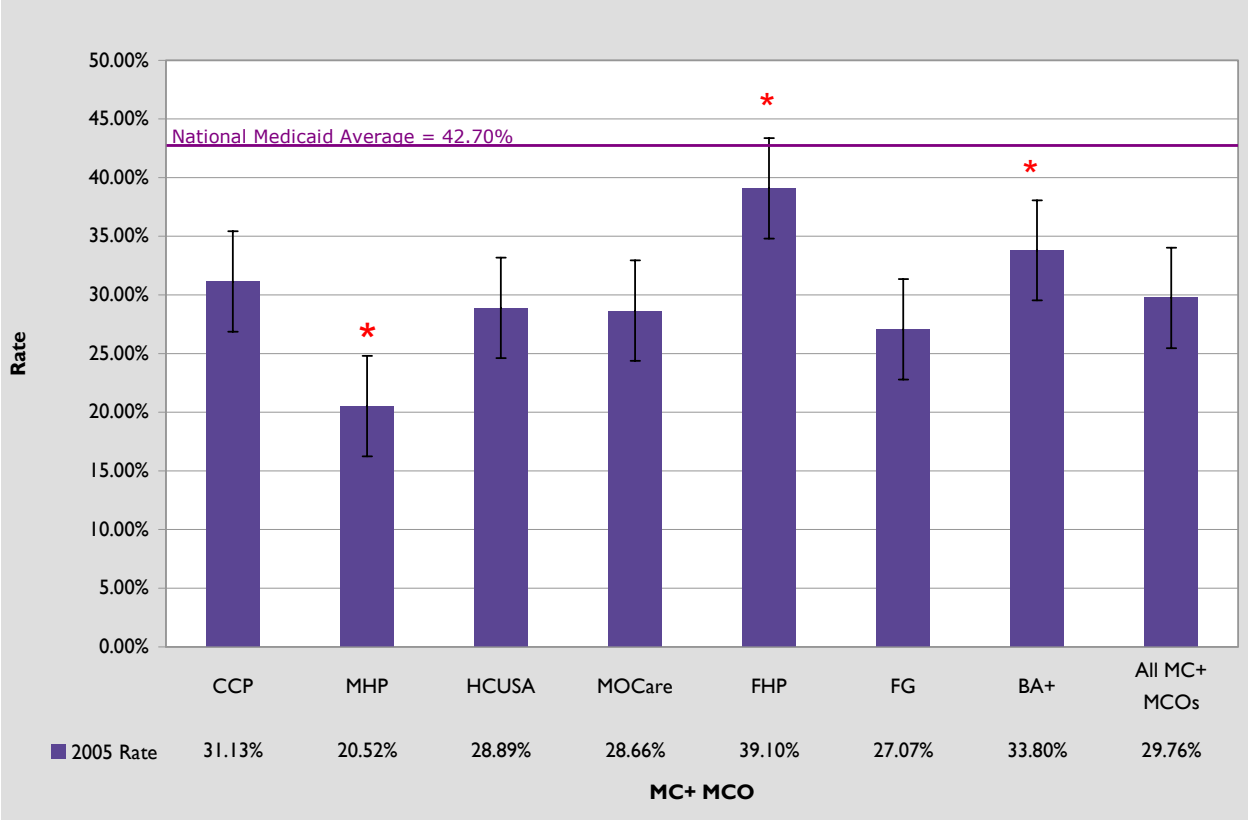
Table 34 - Data Submission and Final Data Validation for HEDIS 2005 Annual Dental Visit Measure (Combined Ages)

MC+ MCO	Eligible Member Population Reported by MCO (DST)	Administrative Hits Reported by MCO (DST)	Administrative Hits Validated by EQRO	Rate Reported by MCO (DST)	Rate Validated by EQRO	Total Estimated Bias
Community Care Plus	22621	7043	7043	31.13%	31.13%	0.00%
Blue Advantage Plus	15634	5285	5282	33.80%	33.79%	0.02%
Family Health Partners	24342	9517	9516	39.10%	39.09%	0.00%
FirstGuard	18573	5027	5027	27.07%	27.07%	0.00%
HealthCare USA (all 3 regions)	95309	27536	27679	28.89%	29.04%	-0.15%
Mercy Health Plan	18704	3838	3833	20.52%	20.49%	0.03%
Missouri Care	14900	4271	4270	28.66%	28.66%	0.01%
All MC+ MCOs	**210083**	**62517**	**62650**	**29.76%**	**29.82%**	**-0.06%**

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCO (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.

Source: MC+ Managed Care Organization HEDIS 2005 Data Submission Tools (DST).

Figure 12 - MC+ Managed Care Program HEDIS 2005 Annual Dental Visit, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Table 35 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 was not applicable to the HEDIS 2005 Annual Dental Visit measure. Items 13.8 through 13.13 relate to the Hybrid Method of calculation and were not applicable to the measure. Across all MC+ MCOs, 94.3% of the criteria for calculating numerators were met. All MC+ MCOs Met criteria for using the appropriate data to identify the at-risk population, avoiding double-counting of events, and following time parameters specified for the measure. Six of the seven MC+ MCOs (85.7%) Met the criteria for using complete medical event codes and correctly classifying members for inclusion in the numerator. HealthCare USA did not provide service codes to the EQRO so that the calculation of the numerator could be independently validated. The MC+ MCOs Met 60.0% to 100.0% of criteria for the calculation of the numerator.

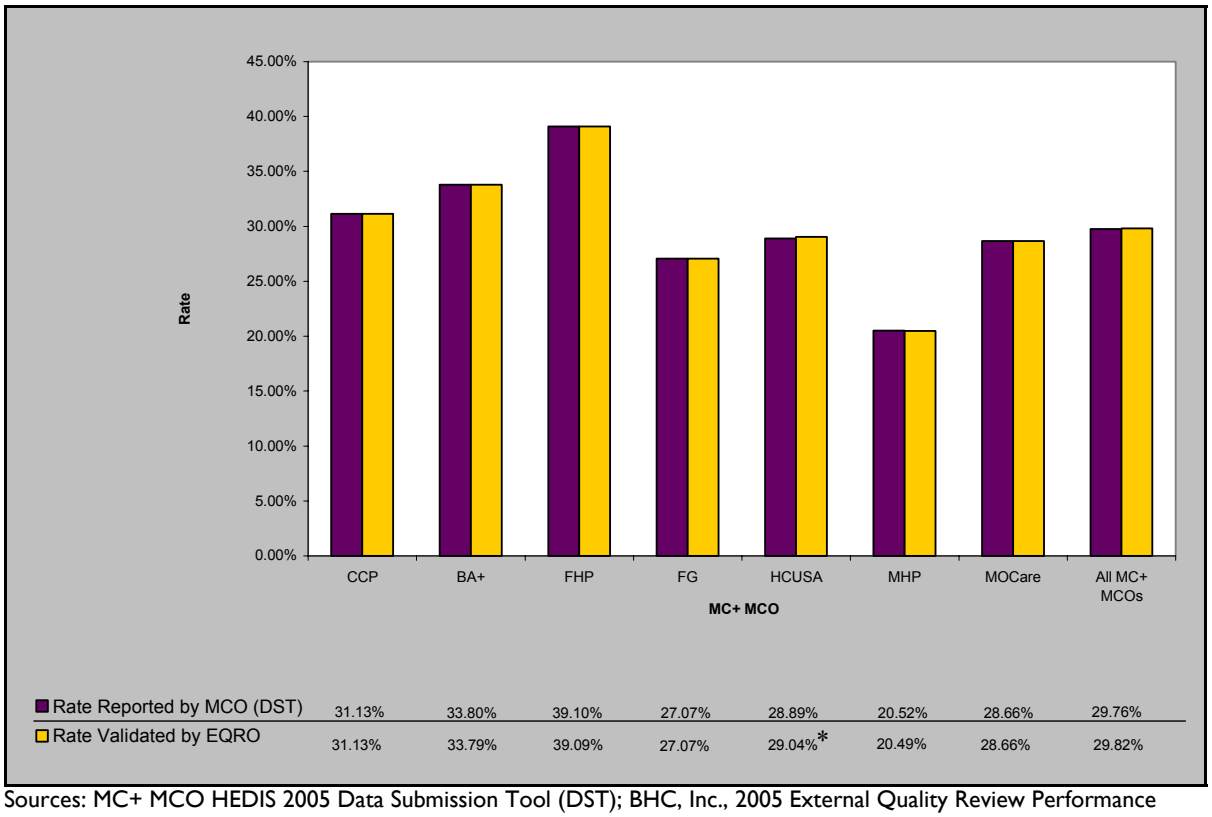
Table 35 - Numerator Validation Findings, HEDIS 2005 Annual Dental Visit Measure

Item	Audit Elements	MC+ MCO							All MC+ MCOs				
		CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCO/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.2	The MCO/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO/PIHP.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCO's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	0	2	2	2	2	6	0	1	7	85.7%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	0	2	2	2	2	6	0	1	7	85.7%
13.5	The MCO/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	2	2	7	0	0	7	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.9	Record review staff have been properly trained and supervised for the task.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	5	5	3	5	5	5	5	33	0	2	35	94.3%
	Number Partially Met	0	0	0	0	0	0	0					
	Number Not Met	0	0	2	0	0	0	0					
	Number Applicable	5	5	5	5	5	5	5					
	Rate Met	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation

Figure 13 - Rates Reported by MC+ MCOs and Validated by EQRO, HEIDS 2005 Annual Dental Visit Measure



Sources: MC+ MCO HEDIS 2005 Data Submission Tool (DST); BHC, Inc., 2005 External Quality Review Performance Measure Validation. * Rate calculated by EQRO is based on data provided to the EQRO for review; data provided could not be independently validated.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2005 Annual Dental Visit Measure. All seven MC+ MCOs calculated and submitted the measure to the SPHA and SMA. The rate reported by MC+ MCOs ranged from 20.52% to 39.10%. The rate of all MC+ MCOs calculated based on data validated by the EQRO was 29.82%, consistent with the rate reported by MC+ MCOs (29.76%), with no observed bias.

Final Validation Findings

Tables 36 through 38 provide summaries of ratings across all Protocol Attachments for each MC+ MCO and measure validated. The rate of compliance with the calculation of the Childhood Immunization Status, Combination #2 measure specifications ranged from 82.35% (HealthCare USA) to 100% (FirstGuard and Missouri Care), with a rate of 93.46% across all MC+ MCOs and items. For the calculation of the Well-Child Visits in the First 15 Months of Life measure, MC+ MCO compliance with specifications ranged from 100.0% (First Guard) to 86.21% (HealthCare USA), with

a rate of 93.85% across all MC+ MCOs and items. For the rate of compliance with specifications for the calculation of the Annual Dental Visits measure, the rate ranged from 100.0% (First Guard and Missouri Care) to 86.67% (HealthCare USA), with an average of 93.33% across all MC+ MCOs.

Table 36 - Summary of Attachment Ratings, HEDIS 2005 Childhood Immunization Status, Combination #2 Measure

All Audit Elements	All MC+ MCOs							All MC+ MCOs
	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	
Number Met	48	47	28	49	49	49	30	300
Number Partially Met	0	1	0	0	0	0	2	3
Number Not Met	3	3	6	2	2	2	0	18
Number Applicable	51	51	34	51	51	51	32	321
Rate Met	94.12%	92.16%	82.35%	96.08%	96.08%	96.08%	93.75%	93.46%

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Table 37 - Summary of Attachment Ratings, HEDIS 2005 Well-Child Visits in the First 15 Months of Life Measure

All Audit Elements	All MC+ MCOs							All MC+ MCOs
	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	
Number Met	27	43	25	47	27	48	27	244
Number Partially Met	0	1	0	1	0	0	2	4
Number Not Met	2	4	4	0	2	0	0	12
Number Applicable	29	48	29	48	29	48	29	260
Rate Met	93.10%	89.58%	86.21%	97.92%	93.10%	100.00%	93.10%	93.85%

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Table 38 - Summary of Attachment Ratings, HEDIS 2005 Annual Dental Visit Measure

All Audit Elements	All MC+ MCOs							All MC+ MCOs
	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	
Number Met	28	27	25	30	28	30	28	196
Number Partially Met	0	1	0	0	0	0	2	3
Number Not Met	2	2	5	0	2	0	0	11
Number Applicable	30	30	30	30	30	30	30	210
Rate Met	93.33%	90.00%	83.33%	100.00%	93.33%	100.00%	93.33%	93.33%

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MC+ MCO; Administrative Method was used by the MC+ MCO and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2005 External Quality Review Performance Measure Validation.

Table 39 summarizes the final audit ratings for each of the performance measures and MC+ MCOs. The final audit findings for each of the measures was based on the evaluation of processes for calculating and reporting the measures, medical record review validation findings, and MC+ MCO extract files from repositories. The ratings were based on the impact of medical record review findings and the degree of overestimation of the rate as validated by the EQRO. The calculation of measures was considered invalid if the specifications were not properly followed, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MC+ MCOs on the DST.

Table 39 - Summary of EQRO Final Audit Ratings, HEDIS 2005 Performance Measures

MC+ MCO	Childhood Immunization Status, Combination #2	Well-Child Visits in the First 15 Months of Life	Annual Dental Visit
Community Care Plus	Not Valid	Fully Compliant	Fully Compliant
Mercy Health Plan	Substantially Compliant	Substantially Compliant	Fully Compliant
HealthCare USA	Not Valid	Not Valid	Not Valid
Missouri Care	Substantially Compliant	Substantially Compliant	Fully Compliant
Family Health Partners	Substantially Compliant	Substantially Compliant	Fully Compliant
FirstGuard	Substantially Compliant	Substantially Compliant	Fully Compliant
Blue Advantage Plus	Not Valid	Substantially Compliant	Fully Compliant

Note: Not Valid = Measure deviated from Sate (SMA and SPHA) specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which data provided to the EQRO could not be independently validated.. Significantly biased was defined by the EQRO as being outside the 95% confidence interval of the rate reported by the MC+ MCO on the HEDIS 2004 Data Submission Tool; Substantially Compliant = Measure was substantially complaint with State (SMA and SPHA) specifications and had only minor deviations that did not significantly bias the reported rate; Fully Compliant = Measure was fully compliant with State (SMA and SPHA) specifications. Data from Health Care USA was aggregated across all three regions of operation to provide MCO to MCO comparisons.
Source: BHC Inc., 2005 External Quality Review Performance Measure Validation.

For the HEDIS 2005 Childhood Immunization Status, Combination #2 measure, four MC+ MCOs (Family Health Partners, FirstGuard, Mercy and Missouri Care) were Substantially Compliant with the measure specifications. The rates calculated by Community CarePlus and Blue-Advantage Plus of Kansas City calculated by the EQRO were outside the range of the confidence intervals reported by these MC+ MCOs. Community CarePlus did not incorporate administrative data from the SPHA, and this likely accounted for 8-25% of the error associated with calculating the measure. HealthCare USA did not supply the EQRO with service codes (CPT Codes or ICD-9-CM Codes) as required by the HEDIS Technical Specifications, therefore the EQRO does not have confidence in the validation rates calculated for HealthCare USA. HealthCare USA supplied the EQRO with information that had already been processed once by their data system. The information provided did not include the CPT Codes or ICD-9-CM Codes, but a category or description of what services those service codes represent. It is necessary for the EQRO to receive service codes in the CPT or ICD-9-CM format not only because that is what was requested, but also because those formats are the industry accepted standard and the only way for the EQRO to ensure that what they are matching between plans is the same information. The Childhood Immunization Status, Combination #2 measure requires data from 2003 or later, after the full implementation of the MC+ Managed Care Program. However, three of the seven plans received a "Not Valid" for this measure and as such, this measure does not provide a valid index of performance of the MC+ Managed Care Program.

During the course of examining MC+ MCO extract files, approximately 8% to 25% of administrative hits for immunizations were captured from the MOHSAIC system. Although the level of completeness of the Registry is unknown, it does serve as a useful source for contributing to a more complete accounting of immunizations for the calculation of this measure.

Six MC+ MCOs were Substantially or Fully Compliant with the specifications for calculating the HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure. One MC+ MCO (HealthCare USA) did not supply the EQRO with service codes (CPT Codes or ICD-9-CM Codes) as required by the HEDIS Technical Specifications. HealthCare USA provided information to the EQRO regarding the services, but did not provide the service codes or cross reference the service codes, because the information provided was not in the "purest" form possible (as required by the CMS protocols), the EQRO does not have confidence in the validation rates calculated for HealthCare USA. Mercy Health Plan did not follow specifications for the Hybrid Method by systematically excluding medical records from review, Mercy did not request for review all medical records that did not produce "hits" through administrative data alone. Mercy only requested the records they believed they "would receive from providers", thereby reducing the number of possible hybrid hits from the start of the Medical Record Review process. This is unrelated to the rate of medical records received for validation. There was some difference found by the EQRO in the rates reported by the MC+ MCOs and validated by the EQRO that was attributable to the interpretation of the HEDIS Technical Specifications. In the "Continuous Enrollment" requirements for determining the eligible population for this measure, the Technical Specifications specify the calculation of the child's 15-month birthday "as the child's first birthday plus 90days." However, the example detailed below the instruction specifies "…a child born on January 9, 2003, and included in the rate of six or more well-child visits must have had six well-child visits by April 9, 2004." This example equates to three calendar months, not 90 days as the "calculation" specifies. This difference in calculation is detailed in the individual MC+ MCO Performance Measures sections, later in this report. The EQRO chose to count "hits" for each method of calculation as it is unclear which method of interpretation is correct, however, the difference in calculation was not significant. Because the statewide rate for the Adolescent Well-Care Visits measure does not vary significantly from the rate validated by the EQRO, it is determined that the statewide rate does provide a valid index of performance of the MC+ Managed Care Program.

The HEDIS 2005 Annual Dental Visit measure was calculated according to specifications by nearly all the MC+ MCOs. Again as detailed earlier, one MC+ MCO (HealthCare USA) did not supply the EQRO with service codes (CPT Codes or ICD-9-CM Codes) as required by the HEDIS Technical Specifications, therefore the EQRO does not have confidence in the validation rates calculated for HealthCare USA. However, the EQRO believes that the rates calculated represent a valid index of performance of the MC+ Managed Care Program for MC+ MCO comparisons.

3.5 Conclusions

Strengths

1. Six of seven MC+ MCOs were Fully Compliant with the specifications for calculation of the HEDIS 2005 Annual Dental Visit measure which represents a valid measure of performance of the MC+ Managed Care Program.
2. One MC+ MCOs (Community CarePlus) was Fully Compliant with specifications for the HEDIS 2005 Well-Child Visits in the First 15 Months of Life.
3. Missouri Care was Substantially Compliant with the calculation of the Well-Child Visits measure and the rate exceeded the National Medicaid and National Commercial rates for this measure.
4. Missouri Care was Substantially Compliant with the calculation of the Childhood Immunization Status, Combination #2 measure and the rate exceeded the National Medicaid rates for this measure.
5. Five MC+ MCOs (Blue-Advantage Plus of Kansas City, Family Health Partners, FirstGuard, Mercy Health Plan, and Missouri Care) were Substantially Compliant and one MC+ MCO (CCP) was Fully Compliant with the specifications for calculating the HEDIS 2005 Well-Child Visits Measure.
6. FirstGuard's rate for the HEDIS 2005 Well-Child Visits measure exceeded the National Medicaid rate.
7. In calculating the measures, MC+ MCOs have adequate management information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2005 measures validated.
8. There was good integration of multiple data sources for rate calculation.
9. Among MC+ MCOs, there was generally good documentation of the HEDIS 2005 rate production process.
10. Several MC+ MCOs (Missouri Care, Mercy Health Plan, and Community CarePlus) responded to the preliminary findings of the performance measure validation by identifying corrective actions plans for the next reporting cycle.
11. The rates of medical record submission for the two measures utilizing the Hybrid Methodology were excellent, all MC+ MCOs submitted between 95% to 100% of the records requested.

Areas for Improvement

1. For one MC+ MCO (HealthCare USA) every measure was found to be Not Valid. This was due to the MC+ MCO not providing the EQRO with the data requested in its "raw" form, as required by the Protocols. The MCO supplied data with service codes that had already been translated to event names and were not in the ICD-9-CM Code or CPT Code format as requested or required by the Protocols. HealthCare USA has indicated that they are able to supply the information in the format requested and chose not to do so as it would take significant time, the EQRO expects to receive the data as requested and to be able to validate their measures in the future.
2. The HEDIS 2004 Childhood Immunization Status, Combination #2 measure was unable to be validated for three of the seven MC+ MCOs and does not represent a valid measure of performance for the MC+ Managed Care Program.

3. One MC+ MCO (Mercy Health Plan) did not follow the Hybrid Method specifications for the calculation of the HEDIS 2005 Adolescent Immunization Status, Combination #2 and Well-Child Visits measure, resulting in ratings of Not Valid for the measures.
4. Those MC+ MCOs who are not assessing the statistical significance of changes in performance measures over time, in order to validate stability or change from year to year, should incorporate statistical analysis into their HEDIS plans.

RECOMMENDATIONS

1. The SMA and SPHA should continue to support efforts to improve the utility and functionality of the State Public Health Immunization Registry (MOHSAIC) as well as encourage public, private, and non-profit providers of immunizations to use the Registry so as to obtain complete information about the level of care provided to MC+ Managed Care Members for the administration of immunizations.
2. For the calculation of the HEDIS Childhood Immunization Status, Combination #2 measure, the Hybrid Method and the incorporation of MOHSAIC data should be required by the SMA to facilitate accurate and valid MC+ MCO comparisons and a valid statewide rate for comparison of performance with other states.
3. The SMA should encourage technical assistance regarding the calculation of HEDIS performance measures, medical record review processes, and the capture of State Public Health Immunization Registry data for the calculation of performance measures.
4. The SMA should re-validate measures for which all MC+ MCOs were not Fully or Substantially Compliant on the calculation of measures and in order to determine the impact on contract performance.
5. It is recommended that MC+ MCOs retain medical record review data, records, and electronic files used to calculate and report measures or develop procedures for obtaining the small samples of medical records for future validation and audit purposes.
6. If cost is a factor for MC+ MCOs calculating performance measures using the Hybrid Method in compliance with the HEDIS, SMA and SPHA specifications, then the Administrative Method of calculation should be used.
7. Ensure that MC+ MCOs understand the need to calculate and report performance measures to the SMA and SPHA despite the NCQA requirements and schedule. Given that these measures will not always be audited by NCQA auditors due to their rotation schedule, they may be good measures to audit in the future.
8. MC+ MCOs with significantly lower rates of eligible members and administrative hits should closely examine the potential reasons for fewer members or claims identified. This may be due to member characteristics, but is more likely due to claims administration procedures and system characteristics such as the proportion of members receiving services from capitated providers. Identifying methods of improving administrative hits will improve the accuracy in calculating the measures.

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SECTION 4.0
VALIDATION OF ENCOUNTER DATA

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4.0 VALIDATION OF ENCOUNTER DATA

4.1 Definition

"For the purposes of this protocol, an encounter refers to the electronic record of a service provided to an MCO enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under Fee-for-Service (FFS) reimbursement systems."[11]

An encounter is the unit of service provided to a Member by the MCO. Encounter data provides the same type of information found on a claim form. It does not substitute for medical record documentation, but should be consistent with and supported by medical record documentation (e.g. date of procedure, type of procedure). The MC+ MCOs' contract with the State Medicaid Agency (SMA; Missouri Department of Social Services, Division of Medical Services; DMS) details the requirements for an acceptable submission of an encounter. The SMA's requirements for encounter data submitted by the MC+ MCOs include the type of encounter data and required data fields.

4.2 Purpose and Objectives

> *"Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates. However, in order for encounter data to effectively serve these purposes, it must be valid; i.e., complete and accurate…This protocol specifies processes for assessing the completeness and accuracy of encounter data submitted by MCOs and PIHPs to the State. It also can assist in the improvement of the processes associated with the collection and submission of encounter data to State Medicaid agencies."*[12]

Three objectives for the encounter validation were identified. They included: assessing the quality of data for required fields for each claim type; evaluating the representativeness (or completeness) of the SMA encounter claims database for MC+ MCO paid and unpaid claims; and validating medical records against the SMA encounter claims database. The following were the objectives and associated evaluation questions.

[11] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.
[12] Ibid.

1. The first objective was to obtain a quality baseline of the SMA encounter claim database (completeness, accuracy, and reasonableness). The alternative hypothesis was that all data fields in the SMA encounter claims database consist of valid (complete, accurate, and reasonable) encounter claim data. Appendix 5 shows the recommended minimum criteria established for completeness and accuracy of specific data fields. Several evaluation questions were addressed:
    - What is the baseline level of completeness, accuracy, and reasonableness of the critical fields?
    - What is the level of volume and consistency of services?
    - What are the data quality issues associated with the processing of encounter data?
    - What problems are there with how files are compiled and submitted by the MCO?
    - What types of encounter claim data are missing and why?

2. The second objective was to examine the match between MC+ MCO claims (paid and unpaid) and the SMA encounter paid claims database. This would facilitate identification of the level of completeness of the SMA encounter claims database as represented by MC+ MCOs paid claims. The alternative hypotheses were that 100% of MC+ MCO paid claims are represented in the SMA encounter claims database, and 0.00% of MC+ MCO unpaid claims are represented in the SMA encounter claims database. Several evaluation questions were posed:
    - What types of paid encounter data are missing and why?
    - What is the fault/match rate of paid and unpaid encounter claims in the SMA encounter claim database and the MC+ MCO claims database?
    - What services are being provided that are not being paid?
    - How many services are being provided that are not being paid?

3. The third objective was to validate the SMA encounter claims (paid) database against medical record documentation and obtain a baseline fault (error) rate for the level of accuracy of the SMA encounter claims database relative to the services delivered by MC+ MCO providers. The alternative hypothesis was that there is a 100% match between the encounter claim data in the medical record and the data in the SMA encounter claims database. Accuracy or match rates of 70% or greater are anticipated for new Medicaid managed care organizations[13]. Several evaluation questions were addressed:
    - To what extent do the claims in the SMA encounter claims database reflect the information documented in the medical record?
    - What is the fault/match rate between SMA encounter claims and medical records?
    - What types of errors are noted?

[13] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition.

4.3 Technical Methods

Time Frame

The dates of service from January 1, 2005 through March 31, 2005 were selected by the SMA for the three encounter data validation objectives.

Procedures for Data Collection

For the first objective, the SMA encounter claims extract file was used to examine the completeness, accuracy, and reasonableness of the critical fields and to calculate the rate of each claim type per 1,000 members by MC+ MCOs. There are six claim types described in the SMA Health Plan Layout Manual: I = Inpatient claim type; M = Medical claim type; O = Outpatient Hospital claim type; D = Dental claim type; H = Home Health claim type; and P = Pharmacy claim type. Inpatient, Outpatient and Home Health claim types are submitted using a Universal Billing (UB-92) file layout, Medical and Dental claim types are submitted using a National Standard Format/Centers for Medicare and Medicaid Services 1500 (NSF/CMS 1500) file layout, and the Pharmacy claims are submitted using the National Council for Prescription Drug Programs, version 3 file layout (NCPDP v.3.0). All claims are sent from the MC+ MCOs to the SMA through the SMA claims vendor, InfoCrossing, and claim types are assigned by the Medicaid Management Information System (MMIS).

After review and approval of the technical methods and objectives by the SMA, the EQRO reviewed, discussed with the SMA, and submitted a data request (see Appendix 6) for the SMA encounter claims extract file to be validated for each claim type and each MC+ MCO. The file request was made to the SMA on October 27, 2005 and received on December 15, 2005 by the EQRO. The SMA reviewed and approved the data request and parameters for the designated the fields to be validated by the EQRO.

For the second objective of comparing the SMA encounter claims with MC+ MCOs' paid and unpaid claims, the SMA encounter claims extract file was parsed by type of file layout (NSF/CMS 1500, UB-92, or NCPDP v.3.0) in preparation for matching against MC+ MCO paid and unpaid claims. A cross-walk for matching MMIS field names with those of the three national standards file layouts was developed and submitted to the SMA for review (February 8, 2005) and approval (March 29, 2005). MC+ MCOs were requested to provide paid and unpaid claims for the designated period on the sample of members selected by the EQRO. While last year the MC+ MCOs could not consistently

provide paid and unpaid claims and/or the requested file layouts which precluded the planned analyses, this year internal control numbers (ICNs) were requested to match the paid/unpaid claims to the SMA records. However, only two of the seven MC+ MCOs supplied the appropriate information required, thus limiting our analyses to these two MC+ MCOs. Additional technical assistance is required to improve the data quality required to conduct these analyses in the future. The number of Medical encounter claims in the SMA encounter claims extract file was used for sample size estimation for the third objective and analysis of the evaluation questions. To examine the degree of match between the SMA encounter claims database and medical record procedures and diagnoses, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review. Appendix 7 contains letters of request to providers for medical records, the Table of Contents for the Medical Record Review Training Manual, and copies of medical record review tools. Several challenges in requesting the data were addressed.

ANALYSES

To assess the accuracy and completeness of the SMA encounter claims database, the SMA encounter claims extract file for all MC+ MCO paid encounter claims representing services rendered from January 1, 2005 through March 31, 2005 was analyzed for completeness, accuracy, and reasonableness (validity) of the data in each "critical", or required field examined. The Inpatient, Medical, Dental, Home Health, Outpatient Hospital, Pharmacy, and critical fields were chosen by the SMA for analysis, with an established threshold of 100% for completion, accuracy, and validity:

Medical (NSF/CMS 1500) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Place of Service
Units of Service
Procedure Code
Inpatient Diagnosis (five diagnosis fields)

Dental (NSF/CMS 1500) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Units of Service
Procedure Code

Home Health (UB-92) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Units of Service
Procedure Code
Revenue Code
Inpatient Diagnosis (five diagnosis fields)

Inpatient (UB-92) Claim Type
Inpatient Claim Type
Recipient ID
Admission Type
Admission Date
Discharge Date
Bill Type
Patient Discharge Status
Inpatient Diagnosis (five diagnosis fields)
First Date of Billing
Last Date of Billing
Revenue Code
Units of Service

Outpatient Hospital (UB-92) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Place of Service
Units of Service
Procedure Code
Inpatient Diagnosis (five diagnosis fields)

Pharmacy (NCPDP v.3.0)
Recipient ID
Dispensing Date
Pharmacy Prescription Number
Drug Quantity Dispensed
Number of Days Supply
National Drug Code

Each field was examined for the presence or absence of data (completeness), the correct type and size of information (accuracy), and the presence of valid values (reasonableness) or validity using the criteria listed below. Appendix 5 contains the parameters for the validation of encounter claims fields for each of the six encounter claim types, the procedure codes, and the diagnosis codes. Appendix 5 also shows the recommended threshold for validity of specific data fields.

Completeness:	The extent to which an encounter claim field contains data (either present or absent).
Accuracy:	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alphanumeric) in the proper format (e.g., mm/dd/yyyy for date field).
Reasonableness (Validity):	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date)

For the validation of the SMA encounter claims extract file with MC+ MCO medical records, the goal was to validate the procedure code and diagnosis code fields in the SMA encounter claims database against the information provided in the medical record. The minimum number of records required for the evaluation of two variables (procedure and diagnosis) with an estimated error rate

of 30% (based on Medstat estimates[14]), reliability of 1.96 (95% statistical significance), and a meaningful difference of 55% were calculated using the number of Medical encounters in the SMA encounter claims file for each MC+ MCO (see Equation 1). There were no differences in the number of required records for MC+ MCOs, with the minimum required sample size of 88. A total of 100 encounters for each MC+ MCO were randomly selected for medical record review using a probability sample.

Figure 14 - Formula for Calculating Minimum Required Sample Size

$$n = \frac{z^2 N P_y (1-P_y)}{(N-1)\,\varepsilon^2 P_y 2 + z^2 P_y (1 - P_y)}$$

Where Py, = Estimated True Error Rate; meaningful difference between true and estimated value ; z = level of reliability; ε=1(Py - meaningful difference)/meaningful difference; N = number of Medicaid Claim Types for the period January 1, 2004-March 31, 2004; n = Minimum required sample size[15]

4.4 Findings

One limitation of the present analysis is that the encounter claim completeness and accuracy analysis was based on paid encounter claims and did not account for all claims that were submitted and rejected through system edits. Also, because the SMA encounter claims extract file was for service dates from January 1, 2005 through March 31, 2005, some service dates might extend beyond this period. For example, if the first date of service was later in the period (e.g., March 31, 2005), the last date of service may extend beyond the period specified by SMA parameters for the validation process (e.g., a Discharge Date of April 1, 2005). When last dates of service appeared to be within a reasonable period, dates outside the valid range were not interpreted and are presented for informational purposes only. In addition, the second through fifth diagnosis code fields are required when the information is available. Not all encounters had five diagnoses. Therefore, 100.00% completion of these fields would not be expected. Conclusions regarding the extent to which the encounter claims database reflects the accuracy and completeness of rejected claims cannot be drawn. Data are presented in the aggregate and are available at the MC+ MCO level in the individual MC+ MCO summaries. The findings of the encounter data validation are presented in response to each evaluation question, by claim type and critical field for all MC+ MCOs.

[14] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition.
[15] Levy, P.S. & Lemeshow, S. L. (1999). Sampling of Populations: Methods and Applications, Third Edition, John Wiley and Sons: New York; see box 3.5 for Exact and approximate sample sizes required under simple random sampling for proportions.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical fields? What Types of Encounter Claim Data are Missing and Why?

For the Medical claim type, there were a total of 997,736 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005 (see Table 40).

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete and accurate, and 99.58% valid. Invalid dates of service ranged from 01/04/2004 – 12/31/2004.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and 99.87% valid. Invalid dates of service ranged from 04/01/2005 – 10/03/2005.
5. The Outpatient Units of Service field was 100.00% complete, accurate, and valid.
6. The Outpatient Procedure Code field was 100.00% complete, accurate, and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 99.999% complete, accurate and valid. The remaining fields were left blank (incomplete, inaccurate, and invalid).
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 18.17% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 2.38% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 0.73% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.00% complete, accurate and valid. All fields were blank (incomplete, inaccurate, and invalid).

Table 40 - Encounter Data Validation of Critical Fields, All MC+ MCOs, Medical Claim Type

Critical or Fatal Field	Information Present		Correct Size		Correct Type of Information		Valid Value	
	#	%	#	%	#	%	#	%
Outpatient Claim Type [OUTPAT-CLAIM-TYPE]	997,736	100.00%	997,736	100.00%	997,736	100.00%	997,736	100.00%
Recipient ID [OUTPAT-PROCESSED-RECIP-ID]	997,736	100.00%	997,736	100.00%	997,736	100.00%	997,736	100.00%
First Date of Service [OUTPAT-FIRST-DT-SVC]	997,736	100.00%	997,736	100.00%	997,736	100.00%	996,527	99.58%
Last Date of Service [OUTPAT-LAST-DT-SVC]	997,736	100.00%	997,736	100.00%	997,736	100.00%	996,453	99.87%
Units of Service [OUTPAT-UNITS-SVC]	997,736	100.00%	997,736	100.00%	997,736	100.00%	997,736	100.00%
Outpatient Procedure Code [OUTPAT-DTL-PROC]	997,736	100.00%	997,736	100.00%	997,736	100.00%	997,736	100.00%
Outpatient Place of Service [OUTPAT-PLACE-OF-SVC]	997,736	100.00%	997,736	100.00%	997,736	100.00%	997,736	100.00%
Diagnosis 1 [OUTPAT-DX]	997,724	99.99%	997,724	99.99%	997,724	99.99%	997,724	99.99%
Diagnosis 2 [OUTPAT-DX]	181,305	18.17%	181,305	18.17%	181,305	18.17%	181,305	18.17%
Diagnosis 3 [OUTPAT-DX]	23,767	2.38%	23,767	2.38%	23,767	2.38%	23,767	2.38%
Diagnosis 4 [OUTPAT-DX]	7,261	0.73%	7,261	0.73%	7,261	0.73%	7,261	0.73%
Diagnosis 5 [OUTPAT-DX]	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total Claims	**999,140**							

Note: Based on state extract file of dates of service from January 1, 2005 - March 31, 2005.
Source: Missouri Department of Social Services, Division of Medical Services, December 15, 2005.

For the Dental claim type, there were 116,148 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid for all MC+ MCOs.

For the Home Health claim type, there were a total of 1,192 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete, accurate and valid.
4. The Last Date of Service field was 100.00% complete, accurate and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Procedure Code field was 73.83% complete and accurate (i.e., 312 fields left blank), and 70.64% valid. Invalid fields were blank or contained entries of "99601" (n = 5) or "Y9009" (n = 33).

For the Inpatient claim type, there were a total of 94,675 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005 (see Table 41).

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate, and valid.
4. The Admission Date field was 100.00% complete, accurate, and 94.96% valid. Invalid dates ranged from 02/24/2004 – 12/31/2004.
5. The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 98.15% (with 1747 entries of "99999999"). Valid values were present 93.82% of the time. In addition to the invalid "99999999" entries, invalid dates ranged from 04/01/2005 – 05/23/2005.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete with the correct number of characters (size) and accurate, and 99.95% valid. Invalid fields contained codes "00", "09", "61", and "63", which were the correct type but not listed under the valid codes list.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. The second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (95.03%, 86.03%, 70.74%, and 51.93%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate, and 95.61% valid. Invalid dates of service ranged from 10/10/2004 – 012/31/2004.
11. The Last Date of Service field was 100.00% complete and accurate, and 95.35% valid. Invalid dates of service ranged from 04/01/2005 – 05/23/2005.
12. The Revenue Code field was 99.92% complete, accurate, and valid. The Units of Service field was 100.00% complete, accurate and valid.

Table 41 - Encounter Data Validation of Critical Fields, All MC+ MCOs, Inpatient Claim Type

Critical or Fatal Field	Information Present		Correct Size		Correct Type of Information		Valid Value	
	#	%	#	%	#	%	#	%
Inpatient Claim Type [INPAT-CLAIM-TYPE]	94,675	100.00%	94,675	100.00%	94,675	100.00%	94,675	100.00%
Recipient ID [INPAT-RECIP-ID]	94,675	100.00%	94,675	100.00%	94,675	100.00%	94,675	100.00%
Admission Type [INPAT-ADMIT-TYPE]	94,675	100.00%	94,675	100.00%	94,675	100.00%	94,675	100.00%
Admission Date [INPAT-ADMIT-DT]	94,675	100.00%	94,675	100.00%	94,675	100.00%	89,908	94.96%
Discharge Date [INPAT-MED-DSCHG-DT]	94,675	100.00%	94,675	100.00%	92,928	98.15%	88,821	93.82%
Inpatient Bill Type [INPAT-BILL-TYPE]	94,675	100.00%	94,675	100.00%	94,675	100.00%	94,675	100.00%
Patient Status [INPAT-PATIENT-STAT]	94,675	100.00%	94,675	100.00%	94,675	100.00%	94,630	99.95%
Diagnosis [INPAT-DX]	94,675	100.00%	94,675	100.00%	94,675	100.00%	94,675	100.00%
Diagnosis [INPAT-DX]	89,973	95.03%	89,973	95.03%	89,973	95.03%	89,973	95.03%
Diagnosis [INPAT-DX]	81,451	86.03%	81,451	86.03%	81,451	86.03%	81,451	86.03%
Diagnosis [INPAT-DX]	66,973	70.74%	66,973	70.74%	66,973	70.74%	66,973	70.74%
Diagnosis [INPAT-DX]	49,161	51.93%	49,161	51.93%	49,161	51.93%	49,161	51.93%
First Date of Service [INPAT-FIRST-DT-SVC]	94,675	100.00%	94,675	100.00%	94,675	100.00%	90,515	95.61%
Last Date of Service [INPAT-LAST-DT-SVC]	94,675	100.00%	94,675	100.00%	94,675	100.00%	90,274	95.35%
Revenue Code [INPAT-REVENUE-CD]	94,602	99.92%	94,602	99.92%	94,602	99.92%	94,602	99.92%
Units of Service [INPAT-UNITS-SV]	94,675	100.00%	94,675	100.00%	94,675	100.00%	94,675	100.00%
Total Claims	**111,619**							

Note: Based on state extract file of dates of service from January 1, 2005- March 31, 2005.
Source: Missouri Department of Social Services, Division of Medical Services, December 15, 2005

For the Outpatient Hospital claim type, there were a total of 601,493 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005 (see Table 42).

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 94.00% complete. The remaining fields were blank (incomplete, inaccurate, and invalid). The fields were 93.97% accurate and 92.92% valid. There were a small number of fields with procedure codes less than five alphanumeric characters. A large proportion of the invalid codes were outside the specified codes (i.e., 80048-89399) when the Revenue Code ranged 300-319.
7. The Outpatient Revenue Code field was 99.96% complete and accurate and 91.83% valid. Invalid codes were primarily accounted for by invalid entries of "000" from HealthCare USA.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 67.24% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 45.95% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 23.02% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 10.51% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 772,269 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid (Recipient ID, First Date of Service, Prescription Number, Quantity Dispensed, Days Supply, and National Drug Code).

Table 42 - Encounter Data Validation of Critical Fields, All MC+ MCOs, Outpatient Hospital Claim Type

Critical or Fatal Field	Information Present		Correct Size		Correct Type of Information		Valid Value	
	#	%	#	%	#	%	#	%
Outpatient Claim Type [OUTPAT-CLAIM-TYPE]	601,493	100.00%	601,493	100.00%	601,493	100.00%	601,493	100.00%
Recipient ID [OUTPAT-PROCESSED-RECIP-ID]	601,493	100.00%	601,493	100.00%	601,493	100.00%	601,493	100.00%
First Date of Service [OUTPAT-FIRST-DT-SVC]	601,493	100.00%	601,493	100.00%	601,493	100.00%	601,493	100.00%
Last Date of Service [OUTPAT-LAST-DT-SVC]	601,493	100.00%	601,493	100.00%	601,493	100.00%	601,493	100.00%
Units of Service [OUTPAT-UNITS-SVC]	601,493	100.00%	601,493	100.00%	601,493	100.00%	601,493	100.00%
Outpatient Procedure Code [OUTPAT-DTL-PROC]	565,413	94.00%	565,209	93.97%	565,209	93.97%	558,880	92.92%
Revenue Code [OUTPAT-REVENUE-CODE]	601,255	99.96%	601,255	99.96%	601,255	99.96%	552,377	91.83%
Diagnosis [OUTPAT-DTL-DIAG-CODE]	601,493	100.00%	601,493	100.00%	601,493	100.00%	601,493	100.00%
Diagnosis [OUTPAT-DTL-DIAG-CODE]	404,296	67.24%	404,296	67.24%	404,296	67.24%	404,296	67.24%
Diagnosis [OUTPAT-DTL-DIAG-CODE]	276,401	45.95%	276,401	45.95%	276,401	45.95%	276,401	45.95%
Diagnosis [OUTPAT-DTL-DIAG-CODE]	138,490	23.02%	138,490	23.02%	138,490	23.02%	138,490	23.02%
Diagnosis [OUTPAT-DTL-DIAG-CODE]	63,196	10.51%	63,196	10.51%	63,196	10.51%	63,196	10.51%
Total Claims	**601,493**							

Note: Based on state extract file of dates of service from January 1, 2005- March 31, 2005.
Source: Missouri Department of Social Services, Division of Medical Services, December 15, 2005.

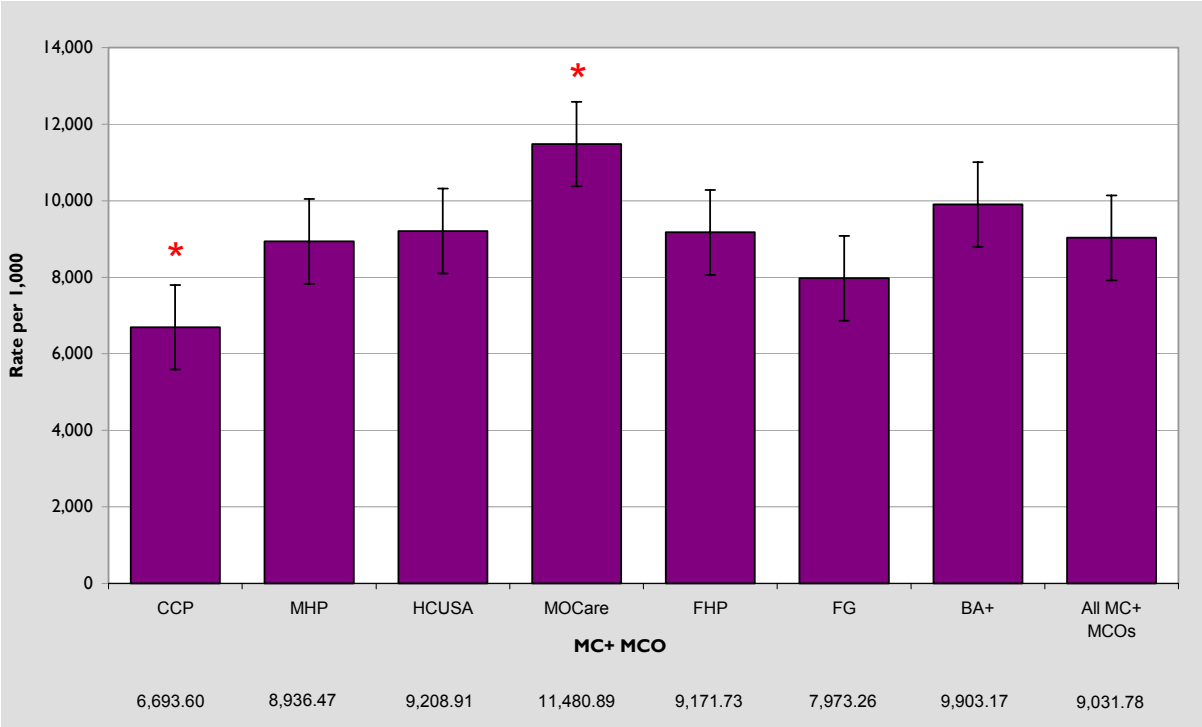
What is the Level of Volume and Consistency of Services?

One method of examining the level, consistency, and volume of services is to assess the extent to which each MC+ MCO is consistent with the remaining MC+ MCOs and the average of all MC+ MCOs services represented in the SMA encounter claims database. The level, consistency, and volume of services represented in the SMA encounter claims database is a function of the acceptance of encounter claim submissions. It is also a function of the process of manipulation of data from national standard layouts for Medical (NSF/CMS 1500); Dental (NSF/CMS 1500); Inpatient, Outpatient Hospital, Home Health (UB-92); and Pharmacy claims (NCPDP 3.0) into the State MMIS system edits. Additionally, the entry and transmission of data by MC+ MCOs, vendors, and providers, the accessibility of services, member utilization patterns, and provider practice patterns influence the data. Given the data issues experienced by the EQRO during the last audit, we feel that the results of this year (2005) data should be used as a baseline for future analysis and interpretation by the SMA and the MC+ MCOs. With the large number of members enrolled in each MC+ MCO, it was expected that factors such as physician practice patterns and member utilization patterns would not have a statistically significant impact on the findings, resulting in all MC+ MCOs having similar rates of encounters per 1,000 members as the rate for all MC+ MCOs. Statistically significant findings are more likely a function of the data quality and completeness resulting from the processing of data by providers, vendors, MC+ MCOs, and the MMIS rather than the accessibility or quality of services.

Using the SMA encounter claims extract file from January 1, 2005 through March 31, 2005, the volume of services for each claim type and MC+ MCO was examined. The rate of each claim type, regardless of the accuracy, consistency, and validity of the data was examined. The rate of claims per 1,000 members based on one quarter of data was calculated by dividing the number of members enrolled as of the last week of March 2005, by 4, then calculating the rate of claims per 1,000 members. Figures 14 through 19 illustrate the rates of claim types and the results of two-tailed z-tests comparing each MC+ MCO with the statewide rate of claims. Statistically significant differences between an MC+ MCO and the rate for all MC+ MCOs at the 95% level of statistical significance are indicated by an asterisk. The 95% upper and lower confidence limits are represented by the black bars on the y-axis. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported. When there was no statistical significance, the significance level is reported as "not significant" (n.s.).

Medical encounter claim types consist of claims submitted by providers, vendors, and MC+ MCOs. As shown in Figure 15, there was some variability across MC+ MCOs in the statewide rate per 1,000 members of Medical encounter claim types compared to the rate for all MC+ MCOs (9,031.78 Medical encounter claims per 1,000 members). One MC+ MCO (Missouri Care, 11480.89, $z = 1.62$; 95% CI: 10373.71, 12588.07; $p < .01$) showed a significantly higher rate, while one MC+ MCO (Community CarePlus, 6693.60, $z = -1.58$; 95% CI: 5586.42, 7800.78; $p < .05$) had a significantly lower rate of Medical encounter claims than the rate for all MC+ MCOs.

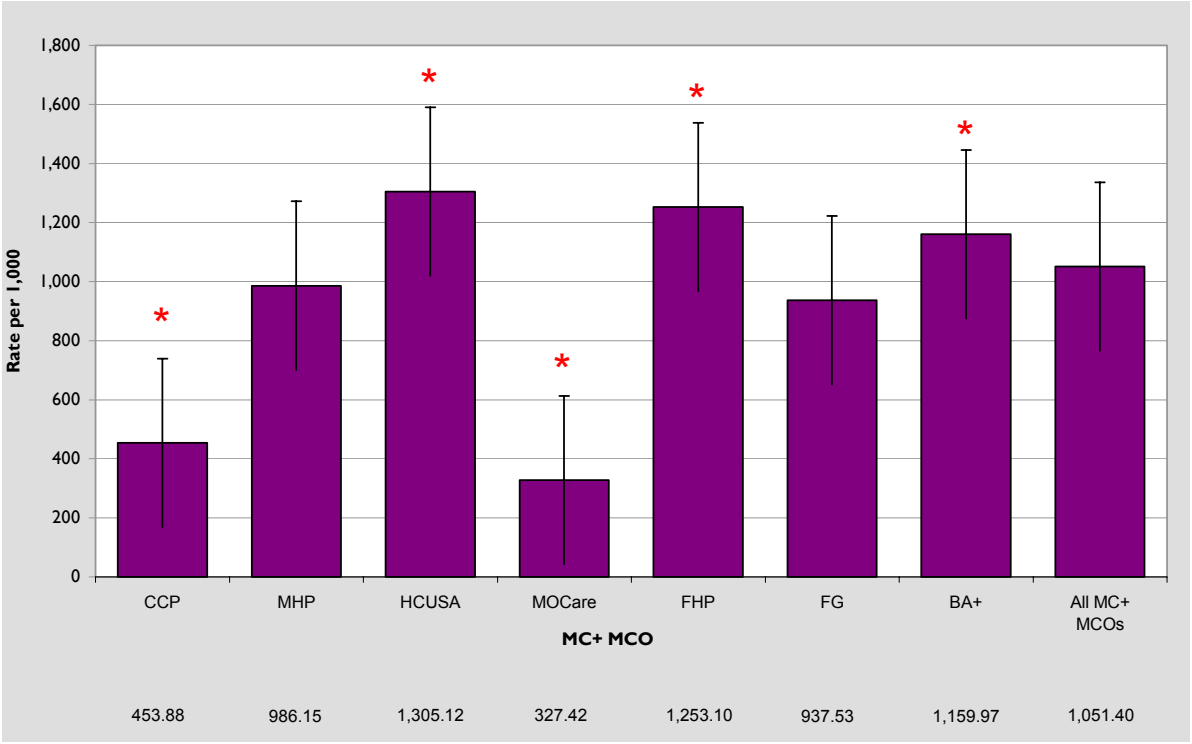
Figure 15 - Medical Encounters Claim Types per 1,000 Members, January 1, 2005 – March 31, 2005



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims January 1-2005 – March 31, 2005 / (Number members / 4) X 1,000. Enrollment as of the last week of March 2005 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Dental encounter claims consist of claims submitted by providers, vendors, and MC+ MCOs. As shown in Figure 16, there was some variability across MC+ MCOs in the rate per 1,000 members of Dental encounter claims compared to the rate for all MC+ MCOs (1051.40 Dental encounter claims per 1,000 members). Two MC+ MCOs (HealthCare USA, 1305.12, z = 1.01; 95% CI: 1019.81, 1590.42; p < .05; and Family Health Partners, 1253.10, z = .87; 95% CI: 967.80, 1538.40; p < .05) had significantly higher rates. While two MC+ MCOs (Community CarePlus, 453.88, z = -1.20; 95% CI: 168.58, 739.19; p < .05; and Missouri Care, 327.42, z = -1.53; 95% CI: 42.12, 612.72; p < .05) had significantly lower rates of Dental encounter claims per 1,000 members than the rate for all MC+ MCOs.

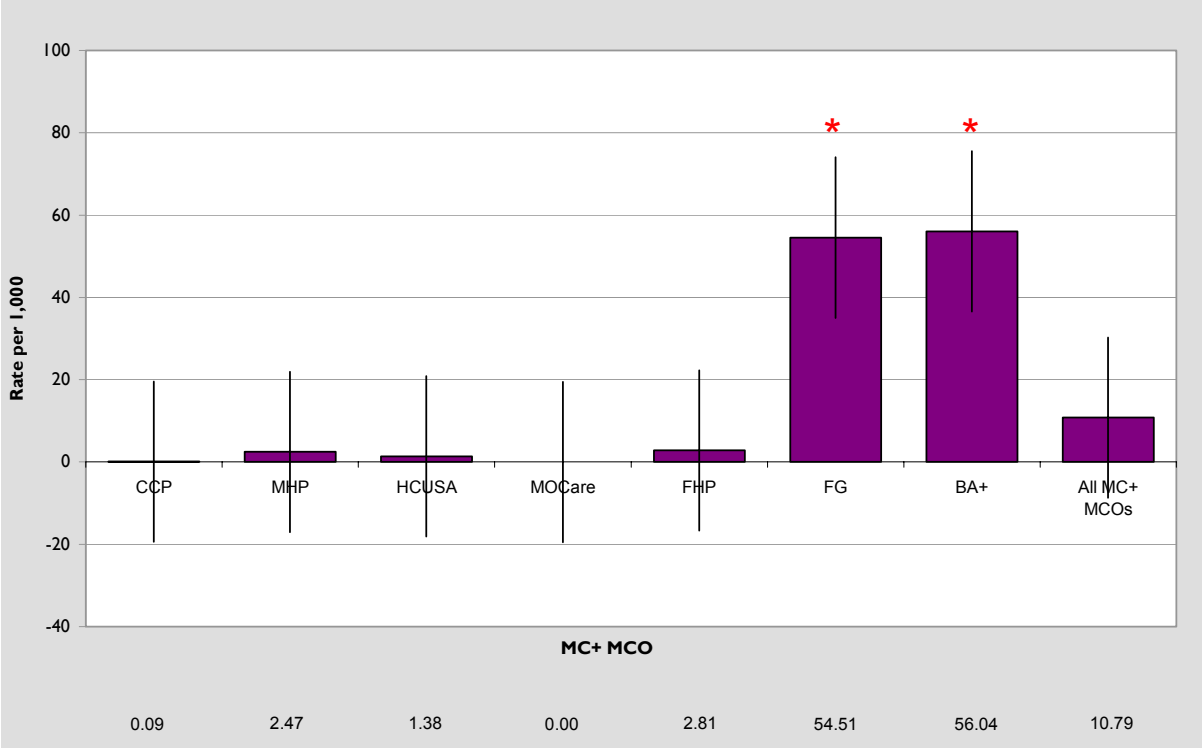
Figure 16 - Dental Encounters per 1,000 Members, January 1, 2005 – March 31, 2005



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims January 1-2005 – March 31, 2005 / (Number members / 4) X 1,000. Enrollment as of the last week of March 2005 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

There were very few Home Health encounter claim types submitted by MC+ MCOs. Two MC+ MCO (FirstGuard, 54.51, z = 1.43; 95% CI: 35.00, 74.03; p < .01 and Blue-Advantage Plus of Kansas City, 56.04, z = 1.49; 95% CI: 36.53, 75.55; p < .01) submitted significantly higher rates of Home Health encounter claims than the rate for all MC+ MCOs (10.79; see Figure 17.)

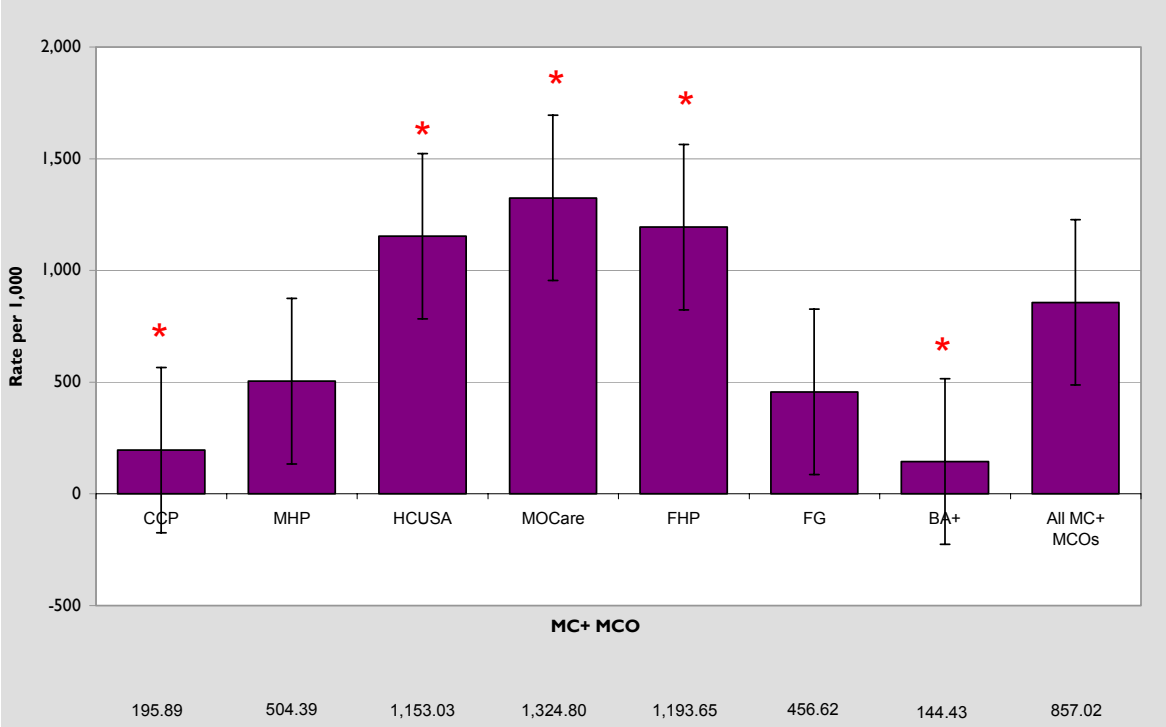
Figure 17 - Home Health Encounter Claim Types per 1,000 Members, January 1, 2005 – March 31, 2005



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims January 1-2005 – March 31, 2005 / (Number members / 4) X 1,000. Enrollment as of the last week of March 2005 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Inpatient encounter claim types consist of claims submitted by hospital facilities and MC+ MCOs. As shown in Figure 18, there was some variability across MC+ MCOs in the rate per 1,000 members of Inpatient encounter claims compared to the rate for all MC+ MCOs (857.02 Inpatient encounter claims per 1,000 members). Three MC+ MCOs had significantly higher rates of Inpatient encounter claims (Health Care USA, 1153.03, z = .89; 95% CI: 782.77, 1523.29, p < .05; Missouri Care, 1324.80, z = 1.23; 95% CI: 954.54, 1695.06; p < .05; Family Health Partners, 1193.65, z = .97; 95% CI: 823.39, 1563.91; p < .05). Two MC+ MCOs had significantly lower rates of Inpatient encounter claims (Community CarePlus, 195.89, z = -1.03; 95% CI: 0, 566.15; p < .01; Blue-Advantage Plus of Kansas City, 144.43, z = -1.32; 95% CI: 0, 514.69; p < .01) than the rate for all MC+ MCOs.

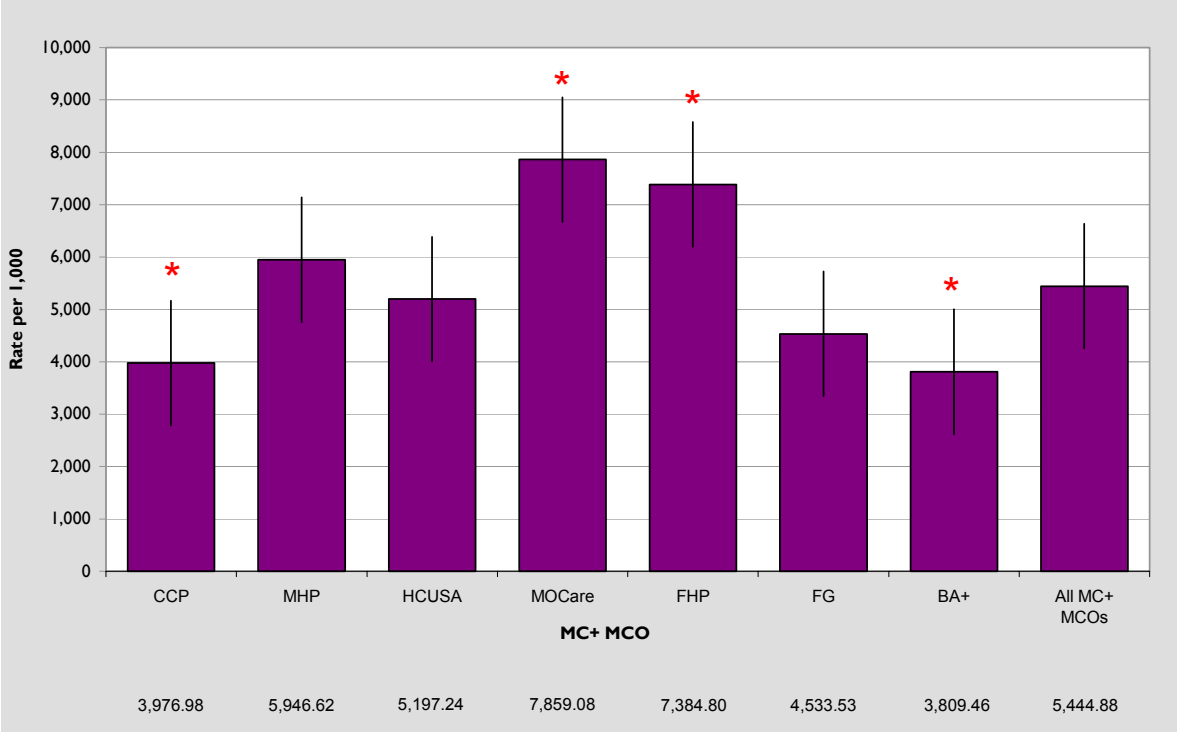
Figure 18 - Inpatient Encounter Claim Types per 1,000 Members, January 1, 2005 – March 31, 2005



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims January 1-2005 – March 31, 2005 / (Number members / 4) X 1,000. Enrollment as of the last week of March 2005 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Outpatient Hospital encounter claim types consist of claims submitted by outpatient hospital facilities and MC+ MCOs. As shown in Figure 19, there was some variability across MC+ MCOs compared to the rate for all MC+ MCOs (5444.88 Outpatient Hospital encounter claims per 1,000 members). Two MC+ MCOs had significantly higher rates of Inpatient encounter claims (Missouri Care, 7859.08, z = 1.44; 95% CI: 6667.85, 9050.32; p < .01; Family Health Partners, 7384.80, z = 1.15; 95% CI: 6193.57, 8576.04; p < .01). While two MC+ MCOs had significantly lower rates of Outpatient Hospital encounter claims per 1,000 members (Community CarePlus, 3976.98, z = -.97; 95% CI: 2785.75, 5168.21; p < .05; and Blue-Advantage Plus of Kansas City, 3809.46, z = -1.07; 95% CI: 2618.23, 5000.76; p < .05) than the rate for all MC+ MCOs.

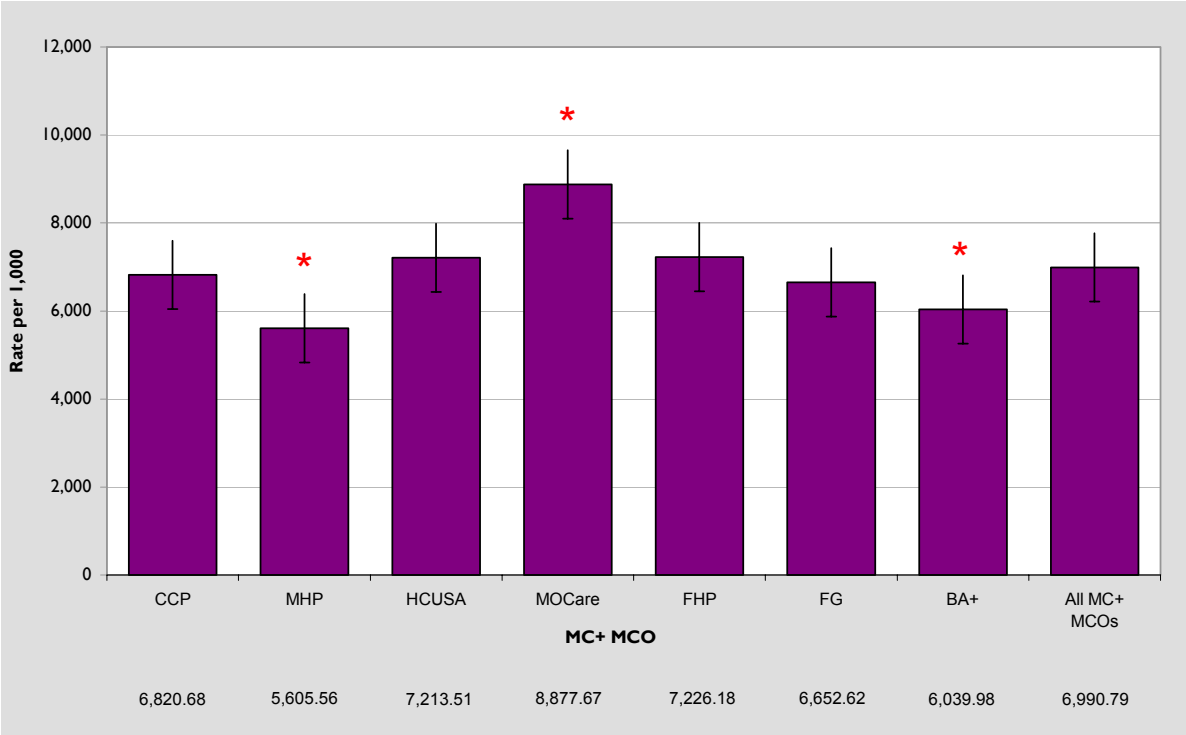
Figure 19 - Outpatient Hospital Encounter Claim Types per 1,000 Members, January 1, 2005 – March 31, 2005



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims January 1-2005 – March 31, 2005 / (Number members / 4) X 1,000. Enrollment as of the last week of March 2005 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Pharmacy encounter claim types consist of claims submitted by pharmacy providers and MC+ MCOs. As shown in Figure 20, there was some variability across MC+ MCOs in the statewide rate per 1,000 members of Pharmacy encounter claims compared to the rate for all MC+ MCOs (6990.79 Pharmacy encounter claims per 1,000 members). One MC+ MCO (Missouri Care, 8877.67, $z = 1.87$, 95% CI: 8100.94, 9654.40; $p < .05$) had a significantly higher rate of Pharmacy encounter claims. While two MC+ MCO (Mercy Health Plan, 5605.56, $z = -1.25$; 95% CI: 4828.48, 6382.29; $p < .01$; and Blue-Advantage Plus of Kansas City, 6039.98, $z = -.84$; 95% CI: 5263.25, 6816.71; $p < .05$) had a significantly lower rate of Pharmacy encounter claims per 1,000 members than the rate for all MC+ MCOs.

Figure 20 - Pharmacy Encounter Claim Types per 1,000 Members, January 1, 2005 – March 31, 2005



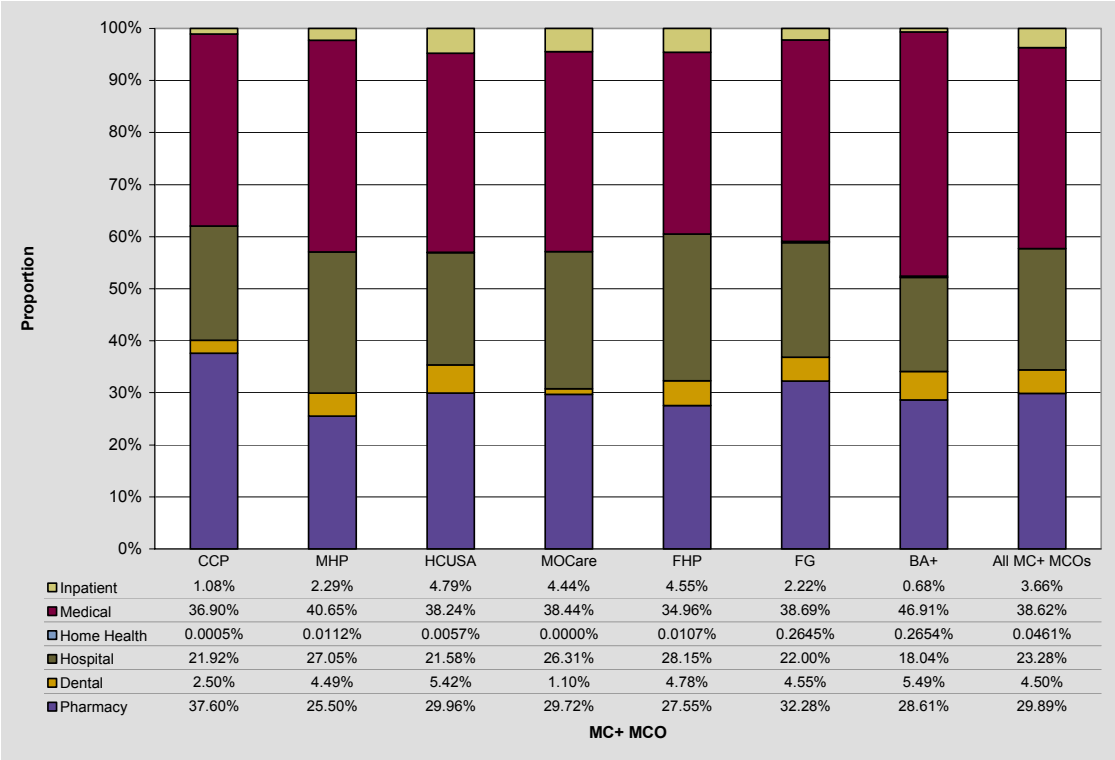
Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims January 1-2005 – March 31, 2005 / (Number members / 4) X 1,000. Enrollment as of the last week of March 2005 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.
Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Table 43 and Figure 21 show the proportion of claim types for each MC+ MCO based on the SMA encounter claims extract file. Community CarePlus had the highest proportion of Pharmacy claims relative to all other MC+ MCOs; Blue-Advantage Plus of Kansas City had the highest proportion of the Dental and Medical claim types; Children's Mercy Family Health Partners had the highest proportion of hospital claims; and HealthCare USA had the highest proportion of Inpatient claims. There were no patterns observed across MC+ Plans, suggesting that the variations are not related to member or provider practice characteristics.

Table 43 - Numerical Proportion of Claim Types per MC+ MCO, January 1, 2005 –March 31, 2005

	Pharmacy	Dental	Hospital	Home Health	Medical	Inpatient	Total
CCP	6820.68	453.88	3976.98	0.09	6693.60	195.89	18141.12
MHP	5605.56	986.15	5946.62	2.47	8936.47	504.39	21981.66
HCUSA	7213.51	1305.12	5197.24	1.38	9208.91	1153.03	24079.19
MOCare	8877.67	327.42	7859.08	0.00	11480.89	1324.80	29869.86
FHP	7226.18	1253.10	7384.80	2.81	9171.73	1193.65	26232.27
FG	6652.62	937.53	4533.53	54.51	7973.26	456.62	20608.07
BA+	6039.98	1159.97	3809.46	56.04	9903.17	144.43	21113.06
All MC+ MCOs	**6990.79**	**1051.40**	**5444.88**	**10.79**	**9031.78**	**857.02**	**23386.67**

Figure 21 - Percentage Proportion of Claim Types per MC+ MCO, January 1, 2005 – March 31, 2005



Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, December 15, 2005.

To What Extent do the MC+ MCO claims (paid and unpaid) match the State Encounter Claims Paid Claims Data Base?

Only two (Missouri Care and Health Care USA) of the seven MC+ MCOs submitted the requested internal control numbers (ICNs) generated by the SMA data system. All encounter claims submitted by Missouri Care were of "paid" claim status. Health Care USA submitted encounter claims that were "paid" or "denied" status, however no "unpaid" claims were submitted by any of the MC+ MCOs.

The ICNs were used to match the encounters of each claim type (Inpatient, Outpatient, and Pharmacy) between the MC+ MCO and the SMA extract files. A "match" was considered if the MC+ MCO sample encounter was identified in the SMA database.

What types of paid encounter data are missing and why?

There were unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) examined for Missouri Care and Health Care USA health plans.

For HealthCare USA, the majority of unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA. Within the Pharmacy Claim type, 66.67%of the thirty-three unmatched encounters were missing ICN numbers. Therefore, only 11 Pharmacy claims were legitimately missing from the SMA data. For the Outpatient data, 96.88% of the 192 unmatched claims were missing ICNs. Of the six unmatched claims with ICNs, two of those were of "denied" status and would not be expected to be present in the SMA file. Thus, only four unmatched encounters were legitimately missing from the SMA data records. For Inpatient Claims, all unmatched claims were missing ICNs.

For Missouri Care, a majority of unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA. Within the Pharmacy Claim type, 34.29% of the thirty-five unmatched encounters were missing ICN numbers. Therefore, 23 Pharmacy encounter claims were legitimately missing from the SMA extract data. For the Outpatient data, 85.58% of the 214 unmatched claims were missing ICNs. Thus, there were 33 unmatched encounters that were legitimately missing from the SMA data records. For Inpatient Claims, all unmatched claims were missing ICNs.

What is the fault/match rate of paid and unpaid encounter claims in the SMA encounter claim database and the MC+ MCO claims database?

Since only HealthCare USA and Missouri Care included internal control numbers that matched those of the SMA, BHC only conducted the planned analysis of comparing MC+ MCO encounter data to the SMA encounter claim extract file for these two MC+ MCOs.

For Health Care USA, all of the Pharmacy Claim type data submitted to the EQRO (n = 333,870) was of "paid" status. There were a total of 33 unmatched claims that were in the HCUSA encounter file and absent from the SMA data. Thus, 99.99% of the HCUSA submitted encounters matched with the SMA encounter records. For all Outpatient Claim Types (Medical, Dental, Home Health, & Hospital; n = 727,244), 79 "denied" claims were submitted by HCUSA but all other encounter claims were of "paid" status. Of the encounter claims submitted by HCUSA, a total of 192 records were unmatched with the SMA encounter data. There was a "hit" rate of 99.98% between HCUSA encounter claims and the SMA encounter data. For the Inpatient Claim Type, HCUSA submitted 53,367 encounter claims. Only 23 of these encounter claims were of "denied" status; all other claims were of "paid" status. There were a total of 40 unmatched records between HCUSA and the SMA, yielding a 99.93% "hit" rate.

For Missouri Care, all of the Pharmacy claims submitted to the EQRO (n = 78,685) were of "paid" status. There were a total of 35 unmatched claims that were in the MOCare encounter file and absent from the SMA data. Thus, 99.96% of the EQRO submitted encounters matched with the SMA encounter records. For all Outpatient Claim Types (Medical, Dental, and Hospital), MOCare submitted 174,317 "paid" encounters. Of these encounter claims a total of 214 records did not match with the SMA encounter claim extract file. There was a "hit" rate of 99.88% between MOCare encounter claims and the SMA encounter data. For the Inpatient Claim Type, MOCare submitted 11,742 encounter claims. All encounter claims were of "paid" status. Seventy-nine (79) encounters from MOCare did not match the SMA extract file, yielding a 99.33% "hit" rate.

What services are being provided that are not being paid and how many services are being provided that are not being paid?

There were no "unpaid" encounter claims submitted to the EQRO by an MC+ MCO.

To What Extent Do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

Table 44 shows the population (number of encounters), minimum required sample size, the number of encounters sampled, and the number and rate of records submitted for review. Of the 997,736 Medical encounter claim types in the SMA encounter claims extract file for January 1, 2005 through March 31, 2005, 700 encounters (100 per MC+ MCO) were randomly selected. This was an oversample, as the minimum required sample size was 88 per MC+ MCO. Providers were requested to submit medical records for review. For the 700 selected encounters, there were 607 medical records (86.71%) submitted for review. MC+ MCO submission rates ranged from 76.0% (Mercy Health Plan and First Guard) to 100.0% (Missouri Care). Encounters for which no documentation was submitted were unable to be validated. Table 45 and Figure 22 show the results of the match for procedures. Across all MC+ MCOs, 52.0% of the medical records contained matching procedure codes or descriptors. MC+ MCO match rates ranged from 42.0% (HealthCare USA and Community CarePlus) to 71.0% (Missouri Care). Two MC+ MCOs (Missouri Care, 71.0%; $z = 1.63$, 95% CI: 62.4, 79.6; $p \leq .01$; and Blue-Advantage Plus of Kansas City, 65.0%, $z = 1.11$, 95% CI: 56.4, 73.6; $p \leq .01$) had match rates significantly higher than the rate for all MC+ MCOs. While three MC+ MCOs (HealthCare USA, 42.0%, $z = -.86$, 95% CI: 33.4, 50.6, $p < .05$; Mercy Health Plan, 43.0%, $z = -.77$, 95% CI: 34.4, 51.6, $p < .05$; and Community CarePlus, 42.0%, $z = -.86$, 95% CI: 33.4, 50.6, $p < .05$) had significantly lower rates. The CMS Protocols suggest a 99% match rate as a validity criterion. The fault rate for all MC+ MCOs for the procedure was 48.0%, with MC+ MCO fault rates ranging from 29.0% to 58.0%. When considering only the documentation submitted for review, the match rate for all MC+ MCOs for procedures was 59.97%, while the match rate for diagnoses was 99.01%.

Table 44 - Encounter Data Validation Samples and Medical Record Submission Rate

MC+ MCO	Number Encounters	Minimum Sample Size	Number Encounters Sampled	Number Medical Records Received	Submission Rate
Community Care Plus	77,055	88	100	77	77.00%
Mercy Health Plan	105,046	88	100	76	76.00%
Health Care USA	426,225	88	100	91	91.00%
Missouri Care	101,758	88	100	100	100.00%
Family Health Partners	117,554	88	100	98	98.00%
FirstGuard	84,391	88	100	76	76.00%
Blue Advantage Plus	85,707	88	100	89	89.00%
All MC+ MCOs	**997,736**	**616**	**700**	**607**	**86.71%**

Note: The number of encounters represents the number of unique Medical claim types found in the SMA encounter claims extract file for the period January 1, 2005 through March 31, 2005. The minimum sample size is based on the validation of medical records for two dependent variables, the procedure code and the diagnosis code. Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation. Number Medical Records Received = Number medical records submitted by MC+ MCO providers; Number Claim Forms Received = Number claim forms submitted by MC+ MCO providers; Submission Rate = Proportion of medical records submitted of the number of encounters sampled.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, December 15, 2005. BHC, Inc. 2005 External Quality Review Validation of Encounter Data.

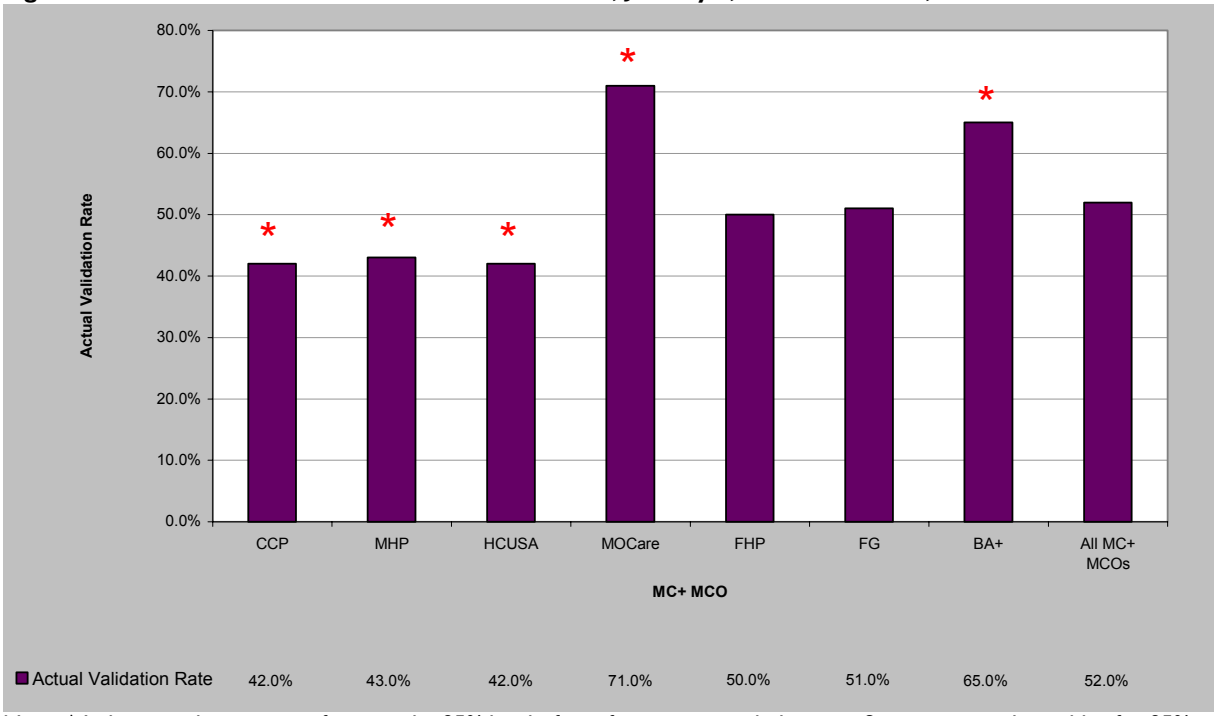
Table 45 - Procedure Validation Rate

MC+ MCO	Number Encounters Sampled	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	LCL	UCL
Community Care Plus	100	77	42	54.55%	42.00%	58.00%	33.36%	50.64%
Mercy Health Plan	100	76	43	56.58%	43.00%	57.00%	34.36%	51.64%
Health Care USA	100	91	42	46.15%	42.00%	58.00%	33.36%	50.64%
Missouri Care	100	100	71	71.00%	71.00%	29.00%	62.36%	79.64%
Family Health Partners	100	98	50	51.02%	50.00%	50.00%	41.36%	58.64%
FirstGuard	100	76	51	67.11%	51.00%	49.00%	42.36%	59.64%
Blue Advantage Plus	100	89	65	73.03%	65.00%	35.00%	56.36%	73.64%
All MC+ MCOs	700	**607**	**364**	**59.97%**	**52.00%**	**48.00%**	43.36%	60.64%

Note: Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by MC+ MCO providers for validation; Number Validated = Number of encounters for which there was a similar or matching procedure code or description on the claim form, or adequate documentation in the medical record to support the procedure code as judged by a professional medical coder. Rate Validated of Medical Records Received = Number Validated/Number Medical Records Received; Actual Rate Validated = Number Validated/Number Encounters Sampled; LCL = Lower Confidence Limit at the 95% confidence level; UCL = Upper Confidence Limit at the 95% confidence level.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file December 15, 2005. BHC, Inc. 2005 External Quality Review Validation of Encounter Data.

Figure 22 - Encounter Data Procedure Validation Rate, January 1, 2005 – March 31, 2005



Note: * Indicates values are significant at the 95% level of significance, two-tailed z-test. See corresponding tables for 95% confidence intervals.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, December 15, 2005. BHC, Inc. 2005 External Quality Review Validation of Encounter Data.

For the validation of the diagnosis, 601 (85.86%) matched the diagnosis found in the SMA encounter claims extract file across all MC+ MCOs (see Table 46 and Figure 23). MC+ MCO match rates ranged from 71.0% (Community CarePlus) to 100.0% (Missouri Care) of the medical records or claim forms for diagnosis codes. Two MC+ MCOs (Missouri Care, 100.0%, z =.98, 95% CI: 90.3, 100.0; p < .01; and Family Health Partners, 98%, z =.83, 95% CI: 88.3, 100.0; p < .05) had match rates significantly higher than the rate for all MC+ MCOs; while three MC+ MCOs (Mercy Health Plan, 76.0%, z = - .86, CI: 66.3, 85.7; p < .05; Community CarePlus, 71.0%, z = - 1.24, CI: 61.3, 80.7; p < .01; and First Guard, 76.0%, z = - .86, CI: 66.3, 85.7; p < .05) had significantly lower rates. The CMS Protocol suggests a greater than 90% validity criterion.[16] The fault rate for all MC+ MCOs on the diagnosis was 14.14%, with MC+ MCO fault rates ranging from 0% to 29.0%.

[16] Validating Encounter Data, A protocol for use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Final Protocol, Version 1.0, May 1, 2002.

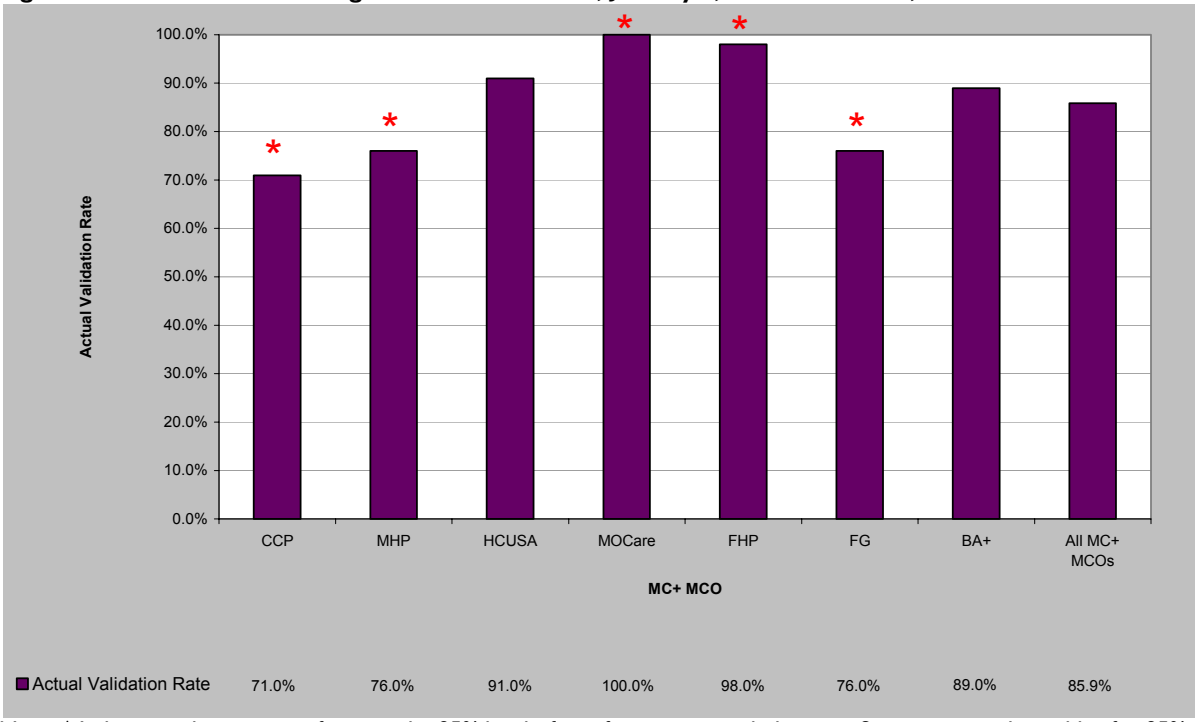
Table 46 - Diagnosis Validation Rate

MC+ MCO	Number Encounters Requested	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	LCL	UCL
Community Care Plus	100	77	71	92.21%	71.00%	29.00%	61.32%	80.68%
Mercy Health Plan	100	76	76	100.00%	76.00%	24.00%	66.32%	85.68%
Health Care USA	100	91	91	100.00%	91.00%	9.00%	81.32%	100.00%
Missouri Care	100	100	100	100.00%	100.00%	0.00%	90.32%	100.00%
Family Health Partners	100	98	98	100.00%	98.00%	2.00%	88.32%	100.00%
FirstGuard	100	76	76	100.00%	76.00%	24.00%	66.32%	85.68%
Blue Advantage Plus	100	89	89	100.00%	89.00%	11.00%	79.32%	98.68%
All MC+ MCOs	**700**	**607**	**601**	**99.01%**	**85.86%**	**14.14%**	**76.18%**	**95.54%**

Note: Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by MC+ MCO providers for validation; Number Validated = Number of encounters for which there was a matching diagnosis code, documentation or description in the medical record or on the claim form. Rate Validated of Medical Records Received = Number Validated/Number Medical Records Received; Actual Rate Validated = Number Validated/Number Encounters Sampled; LCL = Lower Confidence Limit at the 95% confidence level; UCL = Upper Confidence Limit at the 95% confidence level.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, December 15, 2005. BHC, Inc. 2005 External Quality Review Validation of Encounter Data.

Figure 23 - Encounter Data Diagnosis Validation Rate, January 1, 2005 – March 31, 2005



Note: * Indicates values are significant at the 95% level of significance, two-tailed z-test. See corresponding tables for 95% confidence intervals.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, December 15, 2005. BHC, Inc. 2005 External Quality Review Validation of Encounter Data.

What Types of Errors Were Noted?

An error analysis for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA encounter claims extract file were incorrect information (n = 6). The diagnosis code listed did not match the descriptive information in the record.

For the procedure code in the medical record, the reasons for procedure codes in the SMA encounter claims extract file not being supported by documentation in the medical record were missing information (n = 141) and incorrect codes (n = 103). Examples of incorrect information included: no code; incorrect codes; codes listed that were not supported; or codes that did not match the procedure description.

What Problems Are There With How Files Are Compiled and Submitted by the MCO?

It was not possible to conduct the planned analysis of comparing MC+ MCO unpaid claims data to the SMA encounter claims extract file due to the variability across MC+ MCOs in the submission of data with correct Internal Control Numbers (ICNs) for the encounter data validation. Two plans submitted ICN data in the correct format and the EQRO compared the claims for these plans to all the claims in the sample from the SMA encounter claims extract file.

What Are the Data Quality Issues Associated With the Processing of Encounter Data?

There were several data quality issues with SMA and MC+ MCO encounter data identified during the course of conducting the EQRO. These issues are primarily related to the manner in which data are extracted from single and multiple databases. The MC+ MCOs did not submit unpaid encounter claims from the time period of interest. Various reasons were given for the MCOs' inability to submit unpaid claims, including the claim that the MCOs do not retain this data after a denial has been issued and are therefore unable to provide unpaid encounter claims in the EQRO requested file layouts. This makes it untenable to identify errors of commission (unpaid claims in the SMA encounter claims file).

4.5 Conclusions

STRENGTHS

1. All Dental, Home Health and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MC+ MCOs. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis. The next step would be to compare MC+ MCO paid claims to the SMA encounter claims database to identify the level of completeness of this data.
2. For all MC+ MCOs, the Inpatient claim type critical fields examined were 100.00% complete, with the correct length of data 100.00% of the time. The Claim Type, Recipient ID, Admission Type, Bill Type, and Diagnosis Code fields were 100.00% valid for all MC+ MCOs.
3. For all MC+ MCOs, the Outpatient claim type critical fields examined were 100.0% complete with the correct length of data 100.0% of the time. The Claim Type, Recipient ID, Units of Service, Procedure Code, Place of Service fields were 100.00% valid.
4. For all MC+ MCOs, the first Outpatient Diagnosis Code field was 100.0% complete, accurate and valid.

5. The examination of the level, volume, and consistency of services found significant variability between MC+ MCOs in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), with no patterns of variation noted by MC+ Managed Care Region or type of MC+ MCO.
6. Of the medical records received for review, the rates of matching on the diagnosis were 99.01%. However, the medical records not submitted were unable to be validated.

Areas for Improvement

1. For the Medical claim type, there were invalid values for the Outpatient Units of Service and Outpatient Procedure Code fields, including fields of the wrong length.
2. The Procedure Code field for all MC+ MCOs in all Claim Types included some invalid information. Most of this was due to blank fields.
3. Across all MC+ MCOs, 52.0% of the medical records contained matching procedure codes. One MCO only match 42.0% of procedure codes in medical record review.
4. For the Inpatient claim type critical fields, the Admission Date, Discharge Date, Patient Status, and Revenue Code fields contained invalid values. Invalid Admission Dates ranged from 02/24/2004 – 12/31/2004. These findings may be a function of the manner in which the SMA encounter claims extract file was constructed. Invalid Discharge Date fields consisted of entries of "99999999" and invalid dates ranging from 04/01/2005 – 05/23/2005.
5. For the Outpatient Hospital claim type, critical fields with invalid data were the Outpatient Procedure and Revenue Code fields.
6. The match rates between the SMA database and MC+ MCO medical records for Medical claim type procedures were 52.0% respectively. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or illegible information.
7. It was not possible to conduct the planned analysis of comparing MC+ MCO unpaid claims data to the SMA encounter claims extract file due to the variability across MC+ MCOs in the submission of data with correct Internal Control Numbers (ICNs) for the encounter data validation. Two plans submitted ICN data in the correct format and the EQRO compared the claims for these plans to all the claims in the sample from the SMA encounter claims extract file.

Recommendations

1. The SMA should prioritize examination of the level of completeness of the SMA Dental, Home Health, and Pharmacy paid encounter claim types relative the claims submitted by MC+ MCOs. These claim types are likely to be more complete and valid sources of data on which to base initial rate setting. This can be done once an identified method of obtaining paid and unpaid claims from MC+ MCOs is developed.
2. It is recommended that the SMA institute additional edits for the Medical, Inpatient and Outpatient Hospital claim types to edit claims with blank fields or dummy values (e.g., "000" and "99999999").
3. MC+ MCOs are required to submit Revenue Codes on the Outpatient Hospital (UB-92) claim file layout regardless of the Procedure Code. The SMA should institute edits for missing data.

4. It is recommended that future encounter data validation efforts explore the variability in the number of members who are enrolled with capitated providers to assess whether or not the variability in the proportion of each claim type or rate of encounters is related to the payment method.
5. The SMA should continue to provide timely feedback to MC+ MCOs regarding the rate of acceptance of each claim type and the types of errors associated with rejected claims.
6. Additional analysis on the rate of consistency of services should examine demographic (e.g., age and gender distribution), epidemiological (diagnostic variables), and service delivery (e.g., number of users per month, rate of procedures or claim types, units of service rates) characteristics to explain variation across MC+ MCOs or Regions.
7. Medical record reviews should continue to be targeted toward validation of diagnosis and procedure codes.
8. The MC+ MCOs should provide to the EQRO Internal Control Numbers (ICNs) in the form issued by the SMA when extracting encounter claims for medical record review purposes.
9. The SMA should clarify the expectations for MC+ MCOs in the level of completeness, accuracy, and validity and which data fields are required (e.g., Diagnosis Code fields 2 through 5); provide timely feedback to MC+ MCOs when standards are not met; and develop corrective action plans when standards are not met within a reasonable amount of time established by the SMA.
10. MC+ MCOs will need to submit data to the EQRO in requested formats, using the field names and file formats requested.

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SECTION 5.0
MC+ MCO COMPLIANCE

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5.0 MC+ MCO COMPLIANCE WITH MANAGED CARE REGULATIONS

5.1 Purpose and Objectives

The External Quality Review (EQR) is conducted annually in accordance with the Medicaid Program: External Quality Review of the Medicaid Managed Care Organizations Final Rule, 42 CFR 438, Subpart E." The original objective of this portion of the 2004 review was to analyze and evaluate the MC+ Managed Care Organizations (MC+ MCOs) to assess their level of compliance with federal regulations regarding quality, timeliness and access to health care services. In the two subsequent years, beginning in 2005, the objective is to complete a follow-up review to ensure improved and continued compliance with these regulations on the part of the MC+ MCOs. To complete this process, the "Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations" (Compliance Protocol) requirements were applied to the review process, with an emphasis on areas where individual MCOs failed to comply or were in only partial compliance at the time of the prior review. Specifically, the MCOs were reviewed to assess MC+ MCO compliance with the federal Medicaid managed care regulations; with the State Quality Strategy; with the Missouri MC+ Medicaid Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous review year.

5.2 Technical Methods

Planning Compliance Monitoring Activities

Establishing Contact with the MC+ MCOs

All MC+ MCOs were contacted during October 2005 to prepare them for the 2005 External Quality Review. All MC+ MCO quality management staff and/or plan administrators were contacted to discuss the onset of External Quality Review Organization (EQRO) activities and to schedule training teleconferences for mid-October. The MCOs were explicitly requested to have those staff or subcontractors available who were responsible for obtaining and submitting the data required to complete all validation processes. During the teleconferences, all aspects of the EQR were discussed and details provided regarding all data submissions that would be required.

The training teleconference agenda, methods and objectives, and schedule were sent to all MC+ MCOs, with approval from the State Medicaid Agency (SMA), on October 18, 2005. SMA staff arranged to participate in these conference calls, which were held in late October, allowing time for presentation of information, clarification, and questions.

Gathering Information on the MC+ MCO Characteristics

During 2005 there were seven MC+ MCOs contracted with the State Medicaid Agency (SMA; Missouri Department of Social Services, Division of Medical Services; DMS) to provide MC+ Medicaid Managed Care in three Regions of Missouri. The Eastern MC+ Region included St. Louis City, St. Louis County, and eight surrounding counties. These MC+ Members were served by three MC+ MCOs: Community CarePlus (CCP), HealthCare USA (HCUSA), and Mercy Health Plan (MHP). The Western MC+ Region included Kansas City/Jackson County and eight surrounding counties. These MC+ Members were served by four MC+ MCOs: Children's Mercy Family Health Partners (CMFHP), FirstGuard, Blue-Advantage Plus of Kansas City (BA+), and HealthCare USA (HCUSA). The Central MC+ Region included eighteen counties in the center of the state. These MC+ Member were served by two MC+ MCOs: Missouri Care (MOCare) and HealthCare USA (HCUSA). HealthCare USA operated in all three MC+ regions.

Determining the Length of Visit and Dates

On-site reviews were conducted in one day, with several reviewers conducting interviews and activities concurrently. Interviews, presentations, and document reviews were scheduled throughout the day, utilizing different team members for Validating Performance Measures, Validating Performance Improvement Projects, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs). The time frames for on-site reviews were determined by the EQRO and approved by the SMA before scheduling each MC+ MCO. The first week was spent reviewing the MC+ MCOs in Eastern MC+ Region. The second review week was spent in the Western MC+ Region. A final visit occurred with the MC+ MCO in the Central MC+ Region. The following schedule lists the dates of the on-site reviews:

- February 28, 2006 – Community CarePlus
- March 1, 2006 – Mercy Health Plan
- March 2, 2006 – HealthCare USA
- March 7, 2006 – Children's Mercy Family Health Partners
- March 8, 2006 –Blue-Advantage Plus of Kansas City
- March 9, 2006 – FirstGuard
- March 15, 2006 – Missouri Care

Reviewers

Two reviewers conducted the Compliance Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director conducted backup activities and oversight to the Compliance Protocol team. The Assistant Project Director was conducting her second review. She had experience with the MC+ Managed Care Program implementation and operations, interviewing, program analysis, and Medicaid managed care programs in other states. The second reviewer participated in four previous MC+ Managed Care Program EQRs and on-site visits. This reviewer was knowledgeable about the MC+ Managed Care Program through her experience as a former SMA employee responsible for quality assessment and improvements, as an RN, and a consultant. Both reviewers were familiar with the federal regulations and the manner in which these were operationalized by the MC+ Managed Care Program prior to the implementation of the protocols.

Establishing an Agenda for the Visit

An agenda was developed to maximize the use of available time, while ensuring that all relevant follow-up issues were addressed. A sample schedule was developed that specified times for all review activities including the entrance conference, document review, Validating Performance Improvement Project evaluation, Validating Performance Measures review, conducting the interview for the Compliance Protocol, and the exit conference. A coordinated effort with each MC+ MCO occurred to allow for the most effective use of time for the EQRO team and MC+ MCO staff. The schedule for the on-site reviews was approved by the SMA in advance and forwarded to each MC+ MCO to allow them the opportunity to prepare for the review. Appendix 8 provides a sample agenda for the on-site reviews.

Providing Preparation Instructions and Guidance to the MC+ MCOs

A letter (see Appendix 8) was sent to each MC+ MCO indicating the specific information and documents required on-site, and the individuals requested to attend the interview sessions. The MC+ MCOs scheduled their own staff to ensure that appropriate individuals were available and that all requested documentation was present during the on-site review day.

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occurred with individuals from the SMA from October 2005 through April 2006 to prepare for the on-site review, and obtain information relevant to the review prior to the on-site visits. Individuals from the SMA included in these meetings were:

- Sandra Levels, Director – Program Manager
- Judith Muck – Assistant Deputy Director
- Andrea Smith – Quality Program Liaison
- Kimberly Carter, MC+ Managed Care QA & I Manager

In November 2005, Compliance Review team members met with the SMA MC+ Managed Care QA & I Manager. The latest information on MC+ MCO compliance with the MC+ Medicaid Managed Care contract requirements was reviewed. All documentation gathered by the SMA was clarified and discussed to ensure that accurate interpretation of the SMA findings was reflected in the review comments and findings. The SMA staff continued to complete their review of MC+ MCO policy submissions. They provided periodic updates on approvals throughout the EQR preparation up to the beginning of the on-site review process. SMA expectations, requirements, and decisions specific to the MC+ Managed Care Program were identified during these meetings.

Document Review

Documents chosen for review were those that best demonstrated the MC+ MCO's ability to meet federal regulations. Certain documents, such as the Member Handbook, provided evidence of communication to members about a broad spectrum of information including enrollee rights and the grievance and appeal process. Provider handbooks and provider agreements were also reviewed to ensure that consistent information was shared regarding enrollee rights and responsibilities. SMA MC+ Medicaid Managed Care contract compliance worksheets, and specific policies that are reviewed annually or that are yet to be approved by the SMA, were reviewed to verify the presence or absence of evidence that required written policies and procedures existed meeting federal regulations. Other information, such as the Annual Quality Improvement Program Evaluation, was requested and reviewed to provide insight into the MC+ MCO's report of their compliance with the requirements of the MC+ Medicaid Managed Care contract and the federal regulations. Grievance and Appeal policies, as well as a random selection of both member and provider records were reviewed at each on-site visit in an effort to obtain evidence of each MC+ MCO's compliance with their own policy. When it was found that specific regulations were "Not Met" or "Partially Met," additional documents were requested of each MC+ MCO. In addition, interview questions were developed to address the areas for which compliance was not fully established through the pre-site document review process.

The following documents were reviewed for all MC+ MCOs:

- State contract compliance ratings from 2005 and updated policies accepted through February 2006
- Results, findings, and follow-up information from the 2004 External Quality Review
- 2004 Annual MC+ MCO Evaluation, submitted April 2005

Conducting Interviews

After completing the initial document review, it was necessary to determine how policies were implemented, the progress that was made since the 2004 review, and what efforts were made to rectify areas where the MC+ MCOs were found "Not Met" or "Partially Met." On-site interviews with MC+ MCO staff enabled reviewers to obtain a clearer picture of the degree of compliance achieved, as well as any corrective action taken by each MC+ MCO. This process revealed a wealth of information about the approach each MC+ MCO took to become compliant with federal regulations. It also provided evidence of systems where their members had quality and timely services, and the degree to which appropriate access was available. The interview provided reviewers with the opportunity to explore issues not addressed in the documentation, including follow-up from the 2005 EQRO evaluation. A site visit questionnaire was developed for each MC+ MCO based on their MC+ Medicaid Managed Care contractual compliance, issues identified for clarification, and information presented in their 2004 Annual Report.

Collecting Accessory Information

Additional information used in completing the compliance determination included discussions with the EQR reviewers and MC+ MCO QI/UM staff regarding management information systems, Validating Encounter Data, Validating Performance Measures, and Validating Performance Improvement Projects. The review evaluated information from these sources to validate MC+ MCO compliance with the pertinent regulatory provisions within the Compliance Protocol. These findings were documented on the BHC MC+ MCO Compliance Review Scoring Form, and were used to make final rating recommendations.

Analyzing and Compiling Findings

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affected each MC+ MCO's contract compliance. This information was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions specific to each MC+ MCO were prepared, based on the need to investigate if practice existed in areas where approved policy was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to the MC+ MCO's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision. This information was

recorded on the MC+ MCO scoring form and can be found in the protocol specific sections of this section of the report.

Reporting to the State Medicaid Agency

In the April meeting with the SMA preliminary findings and comparisons to the ratings from the 2004 review were presented. Discussion occurred with the SMA staff to ensure that the most accurate information was recorded and to confirm that a sound rationale was used in rating determination. The SMA approved the process and allowed the EQRO to finalize the ratings for each regulation. Sufficient detail is included in all worksheets to substantiate any rating lower than "Met." Final worksheets were submitted to the SMA. The actual ratings are included in this report.

Compliance Ratings

From December 2005 through February 2006, the MCO Compliance Review Scoring Form for each MC+ MCO was updated to reflect their current level of MC+ Medicaid Managed Care contract compliance. The Scoring Form continued to present a crosswalk of contract references that created compliance with each federal regulation. The SMA instructed the EQRO to utilize the Compliance Rating System developed during the previous review. This system was based on a three-point scale ("Met," Partially Met," "Mot Met") for measuring compliance, as determined by the EQR analytic process. Appendix 9 contains the BHC MCO Compliance Review Scoring Form worksheet utilized for all MC+ MCOs. The determinations found in the Compliance Ratings considered SMA contract compliance, review findings, MC+ MCO policy, ancillary documentation, and MC+ MCO practices observed on-site. In some instances the SMA MC+ Medicaid Managed Care contract compliance tool rated a contract section as "Met" when policies were submitted, even if the policy had not been reviewed and "finally approved." If the SMA considered the policy submission valid and rated it as "Met," this rating was used unless practice or other information called this into question. If this conflict occurred, it was explained on the Compliance Review Scoring Form. The scale allowed for credit when a requirement was Partially Met. Ratings were defined as:

Met:	All documentation listed under a regulatory provision, or one of its components was present. MC+ MCO staff were able to provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the MC+ MCO was in full compliance with regulatory provisions.
Partially Met :	There was evidence of compliance with all documentation requirements, but staff were unable to consistently articulate processes during interviews; or documentation was incomplete or inconsistent with practice.
Not Met:	Incomplete documentation was present and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

5.3 Findings

Enrollee Rights and Protections

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of MCOs for the provision of information to enrollees in an understandable form and language: written policies regarding enrollee rights and assurance that staff and contractors take them into account when providing services; and requirements for payment and no liability of payment for enrollees. There were no items across MC+ MCOs that were rated as "Not Met" (see Table 47). Across all MC+ MCOs 75.82% of the regulations were "Met." This is a significant improvement over the rate of 54.9% at the time of the 2004 EQR. Three MCOs (Children's Mercy Family Health Partners, FirstGuard, Blue-Advantage Plus of Kansas City) were found to be 100% compliant. Two MCOs were less than 50% (Community CarePlus – 46.2%, Mercy Health Plan – 30.8%), however both showed improvement over their rating of 15.4% compliance rating at the time of the previous review.

Table 47 - Subpart C: Enrollee Rights and Protections

Federal Regulation	MC+ MCO							All MC+ MCOs			
	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.100(a) Enrollee Rights: General Rule	2	1	2	2	2	2	2	6	1	0	85.7%
438.10(b) Enrollee Rights: Information Requirements	1	1	1	2	2	2	2	4	3	0	57.1%
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2	2	2	2	2	7	0	0	100.0%
438.10(c)(4,5) Language and Format: Interpreter Services	1	1	1	2	2	2	2	4	3	0	57.1%
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	1	2	2	2	2	2	6	1	0	85.7%
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	1	2	2	2	2	2	2	6	1	0	85.7%
438.10(f) Information for All Enrollees: Free Choice, etc.	1	1	1	2	2	2	2	4	3	0	57.1%
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	1	2	2	2	2	2	6	1	0	85.7%
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	1	1	1	2	2	2	3	4	0	42.9%
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2	2	2	2	2	7	0	0	100.0%
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	1	2	2	2	2	2	5	2	0	71.4%
438.100(b)(3) Right to Services	1	1	2	1	2	2	2	4	3	0	57.1%
438.100(d) Compliance with Other Federal/State Laws	2	2	2	2	2	2	2	7	0	0	100.0%
Number Met	6	4	9	11	13	13	13	**69**	**22**	**0**	**75.82%**
Number Partially Met	7	9	4	2	0	0	0				
Number Not Met	0	0	0	0	0	0	0				
Rate Met	46.2%	30.8%	69.2%	84.6%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

All MC+ MCOs had procedures and practices in place to ensure that members were addressed in their prevalent language [438.10(c)(3)]; that members are treated with respect and dignity and receive information on available treatment options and alternatives [438.100(b)(2)(iii)]; and the MC+ MCO is in compliance with other state requirements [438.100(d)].

A number of MC+ MCOs (Children's Mercy Family Health Partners, Missouri Care, Community CarePlus, Blue-Advantage Plus of Kansas City) utilized EQR tools, including the MCO Compliance Review Scoring Form, to assist them in ensuring completion of required policy as well as meeting the requirements of the federal regulations. Improvement was noted in the attention the majority of the MC+ MCOs gave to meeting all standards of compliance. Tracking systems were put in place, and in some situations staff members were assigned to monitor compliance issues. The MC+ MCOs stressed their heightened awareness of the need for positive interdepartmental communication. These efforts focused on strengthening communication to enhance the organizations' ability to serve members needs.

One MC+ MCO (Children's Mercy Family Health Partners) initiated a Member Advisory Committee to provide insight into the issues faced by members in trying to obtain healthcare services. The MC+ MCO incorporated member suggestions into their operations and marketing materials. These activities were indicators of the MC+ MCO's commitment to member services and to ensuring members had quality healthcare.

Behavioral Health

All MC+ MCOs continued to operate programs for the provision of behavioral health services. Six of the MC+ MCOs subcontract with Behavioral Health Organizations (BHOs) for these services. One MC+ MCO (Missouri Care) has moved the supervision and delivery of this service in-house. One MC+ MCO (FirstGuard) underwent a transition in ownership during the 2005 review period, which also led to the provision of behavioral health services by a new subcontractor.

All MC+ MCOs provided active oversight, if not direct involvement, of their behavioral health subcontractors. Behavioral Health Services have evolved into an important resource for MC+ Medicaid Managed Care members. One MC+ MCO (Mercy Health Plan) integrated their care management system with that of their Behavioral Health Organization (BHO). This ensured that all cases with co-morbidity were targeted, and that both the PCP and behavioral health provider were

aware of services and medications members receive. This action allowed for a more holistic approach to the delivery of healthcare services for members. A number of the MC+ MCO BHOs (Community CarePlus, Mercy Health Plan, HealthCare USA, New Directions Behavioral Health, CommCare and Cenpatico) approved the use of in-home services to reach members who would not attend appointment in an office setting. This not only ensured that members obtained the help they needed, but also prevented missed appointment for providers. One MC+ MCO (New Directions Behavior Health) continued to contract with a provider agency that delivered short-term intensive in-home services in an effort to avert crisis that may lead to inpatient treatment, and to work with members to utilize all available community resources. Two MCOs (Mercy Health Plan, HealthCare USA) reported on initiatives to engage members who were pregnant, in an attempt to identify any mental health issues that might affect the mother or baby. These efforts also focused on prevention of postpartum depression. One MC+ MCO (Children's Mercy Family Health Partners) described an initiative where in-home services were provided to members following any inpatient treatment to ensure effective follow-up services. The BHO contracted with specific providers who were skilled at working in intensive in-home settings. The BHO absorbed the cost of unreimbursed services, such as after-hours telephone support, in an effort to reduce readmissions for these members. MC+ MCOs and BHOs described a number of interventions that met members' needs, but were extraordinary in normal Medicaid programs. This reflected a level of performance indicative of their strong commitment to access and quality services for all members.

Quality Assessment and Performance Improvement: Access Standards

Subpart D of the regulatory provision for Medicaid managed care sets forth 17 regulations governing access to services. These regulations call for: the maintenance of a network of appropriate providers including specialists; the ability to access out-of-network services in certain circumstances; adequate care coordination for enrollees with special healthcare needs; development of a method for authorization of services, within prescribed timeframes; and the ability to access emergency and post-stabilization services. There were no items rated as "Not Met" (see Table 48). Across all MC+ MCOs, 78.99% of the regulations were "Met," which is a substantial improvement over the rate of 60.5% at the time of the 2004 EQR. Three of the MCOs (Children's Mercy Family Health Partners, Blue-Advantage Plus of Kansas City, FirstGuard) were found to be 100% compliant.

All MC+ MCOs had policies and practice that reflected the members' right to a second opinion and a third opinion if the first two disagreed [438.206(b)(3)]. Another area where all MC+ MCOs were 100% compliant was in provider cultural competency. Evidence of this included an MC+ MCO (Mercy Health Plan) who recruited a home health provider who spoke Vietnamese solely for a member. Throughout this review period, all health plans reported incidents where they found providers who were familiar with members' cultural and language needs. Sensitivity to and respect for members' cultural needs was an area where the MC+ MCOs excelled. All MC+ MCOs were fully compliant in having SMA approved notifications of adverse actions [438.210(c)]. There were no identified incidents of incentivizing staff or contractors for utilization management decisions that were in the favor of the MC+ MCOs. All policies and practices in this area [438.210(e)] were compliant.

Some problems in the area of access to care remained evident in this review. Required documentation and approved policies did not exist in all areas. One Member Handbook (Mercy Health Plan) continued to contained confusing language concerning the need for a primary care physician (PCP) referral to obtain OB/GYN services. The MC+ MCO corrected this language, but not during the 2005 review year. Four MC+ MCOs (Community CarePlus, Mercy Health Plan, HealthCare USA, , Missouri Care) had outstanding policy or Provider Manual language in the area of emergency and post-stabilization services [438.114]. One MC+ MCO (First Guard) underwent a transition in ownership, which created number of changes, particularly in their claims and payment system. The MC+ MCO made extraordinary efforts to ensure that the problems they experienced remained transparent to members. Although they did struggle with provider issues during this period, they were able to resolve these problems. The MC+ MCO had strong relationships with their providers and maintained communication with them throughout the transition.

The MC+ MCOs made a concerted effort to ensure that members had appropriate and timely access to services. The MC+ MCOs also experienced issues with closed panels, many physicians were not able to take new patients. Additionally, they continued to express concern over the shortage of specialists in the areas of orthopedic surgery, pediatric neurology, and child/adolescent psychiatrists. All MC+ MCOs reported utilizing out-of-network providers and often paying commercial or higher rates to obtain these services. One MC+ MCO (Children's Mercy Family Health Partners) had a number of specialists who requested that they not be included on the MC+ MCO's published network, but readily agreed to service MC+ Managed Care members. A number

of the MC+ MCOs (Mercy Health Plan, HealthCare USA, Missouri Care) continued to partner with the teaching hospitals in the Regions, in order to increase their available surgical and specialist capacity.

Two MC+ MCOs (FirstGuard, Missouri Care) underwent transitions in their behavioral health service system during the 2005 review period. One MC+ MCO (Missouri Care) no longer uses a subcontracted network for behavioral health. This MC+ MCO recognized a number of advantages in directly supervising the provision of behavioral health services. They contracted with the majority of the active providers previously utilized by the subcontractor. They maintained the same toll-free telephone number for member access, and completed provider training prior to the change. Some of the benefits identified included: reducing the use of inpatient treatment; more timely and complete prior authorizations; and improved case management, particularly for members who require both physical and mental health treatment.

At the time the second MC+ MCO (FirstGuard) changed ownership, they also transitioned to a new behavioral health provider, who was a subsidiary of the new owner. During a 60-day transition period, the MC+ MCO required no prior authorizations for services to eliminate this possible barrier to member services. They maintained most of the providers who contracted with the previous subcontractor, as well as the same toll-free member access telephone number. The MC+ MCO received no member grievances associated with transition. Members were notified of any required provider changes. However, there appeared to be no adverse therapeutic effects of this transition.

Table 48 - Subpart D: Quality Assessment and Performance Improvement: Access Standards

Federal Regulation	MC+ MCO							All MC+ MCOs			
	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	1	2	2	2	2	2	6	1	0	85.7%
438.206 (b) (2) Access to Well Woman Care: Direct Access	1	1	2	2	2	2	2	5	2	0	71.4%
438.206(b)(3) Second Opinions	2	2	2	2	2	2	2	7	0	0	100.0%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	1	2	2	2	2	2	2	6	1	0	85.7%
438.206(b)(5) Out of Network Services: Cost Sharing	1	1	1	2	2	2	2	4	3	0	57.1%
438.206(c)(1)(i-vi) Timely Access	1	1	1	2	2	2	2	4	3	0	57.1%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	2	2	2	2	7	0	0	100.0%
438.208(b) Care Coordination: Primary Care	1	2	2	2	2	2	2	6	1	0	85.7%
438.208(c)(1) Care Coordination: Identification	2	2	1	2	2	2	2	6	1	0	85.7%
438.208(c)(2) Care Coordination: Assessment	1	1	2	2	2	2	2	5	2	0	71.4%
438.208(c)(3) Care Coordination: Treatment Plans	1	1	1	2	2	2	2	4	3	0	57.1%
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	1	2	2	2	2	2	5	2	0	71.4%
438.210(b) Authorization of Services	2	2	1	2	2	2	2	6	1	0	85.7%
438.210(c) Notice of Adverse Action	2	2	2	2	2	2	2	7	0	0	100.0%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	1	2	2	2	6	1	0	85.7%
438.210(e) Compensation of Utilization Management Activities	2	2	2	2	2	2	2	7	0	0	100.0%
438.114 Emergency and Post-Stabilization Services	1	1	1	1	2	2	2	3	4	0	42.9%
Number Met	8	9	11	15	17	17	17	**94**	**25**	**0**	**78.99%**
Number Partially Met	9	8	6	2	0	0	0				
Number Not Met	0	0	0	0	0	0	0				
Rate Met	47.1%	52.9%	64.7%	88.2%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Quality Assessment and Performance Improvement: Structure and Operation Standards

There are 10 Structure and Operations Standards for ensuring compliance with State policies and procedures for the selection and retention of providers, disenrollment of members, and accountability for activities delegated to subcontractors. There were no items across MC+ MCOs that were rated as "Not Met." Across MC+ MCOs, 88.6% of the regulations were "Met," which is an improvement over the rating of 65.7% from the 2004 EQR (see Table 49).

The Provider Services departments of all MC+ MCOs exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and MC+ Medicaid Managed Care requirements. Three of the MC+ MCOs (Children's Mercy Family Health Partners, Blue-Advantage Plus of Kansas City, FirstGuard) were 100% compliant with all regulations. Two additional MC+ MCOs met 90% of the regulations. Four of the individual regulations were 100% met. These included Provider Selection [438.214(d) and 438.214(e)]. The staff at each MC+ MCO understood the requirements for disenrollment. They were 100% "Met" for the applicable regulations for timeframes [438.56(e)]. Six of seven (87.5%) met all regulations for disenrollment procedures. All MC+ MCOs (100%) had appropriate grievance systems in place that met the requirements of this regulation [438.228]. A number of the MC+ MCOs (Mercy Health Plan, Blue-Advantage Plus of Kansas City, and FirstGuard) described credentialing and recredentialing policies that exceeded the requirements of the regulations. Providers were willing to submit to these stricter standards to maintain network qualifications in both the MC+ MCO and commercial networks of these MC+ MCOs. Overall, six of seven (85.7%) of the MC+ MCOs had all required policies and practices in place regarding credentialing.

All MC+ MCOs understood the required oversight of subcontractors. The compliance rate for this regulation [438.230(a,b)] improved from the 2004 rate of 14.3%, to the 2005 rate of 71.4%. The MC+ MCOs that were "Partially Met" (Mercy Health Plan, HealthCare USA) had policy or subcontractor agreements that were not yet approved by the SMA.

All deficiencies for Structure and Operation Standards related to a lack of submitted or approved policies or subcontractor agreements. The MC+ MCOs exhibited a significantly improved understanding and attention to these details and requirements during this review.

Table 49 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards

Federal Regulation	MC+ MCO							All MC+ MCOs			
	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	2	2	2	2	2	2	6	1	0	85.7%
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2	1	2	2	2	6	1	0	85.7%
438.214(d) Provider Selection: Excluded Providers	2	2	2	2	2	2	2	7	0	0	100.0%
438.214(e) Provider Selection: State Requirements	2	2	2	2	2	2	2	7	0	0	100.0%
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	1	2	1	2	2	2	2	5	2	0	71.4%
438.56(c) Disenrollment Requested by the Enrollee	2	2	1	2	2	2	2	6	1	0	85.7%
438.56(d) Disenrollment: Procedures	2	2	1	2	2	2	2	6	1	0	85.7%
438.56(e) Disenrollment: Timeframes	2	2	2	2	2	2	2	7	0	0	100.0%
438.228 Grievance System	2	2	2	2	2	2	2	7	0	0	100.0%
438.230(a,b) Subcontractual Relationships and Delegation	2	1	1	2	2	2	2	5	2	0	71.4%
Number Met	8	9	6	9	10	10	10	**62**	**8**	**0**	**88.6%**
Number Partially Met	2	1	4	1	0	0	0				
Number Not Met	0	0	0	0	0	0	0				
Rate Met	80.0%	90.0%	60.0%	90.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: MEASUREMENT AND IMPROVEMENT

There are 12 Measurement and Improvement Standards addressing the selection, dissemination, and adherence to practice guidelines; the implementation of performance improvement projects; the calculation of performance measures; the evaluation of the availability of services and assessment techniques for enrollees with special healthcare needs; and the maintenance of information systems that can be effectively used to examine service utilization, grievances and appeals, and disenrollment. All items were either "Met" or "Partially Met" for compliance with Measurement and Improvement (see Table 50). A total of 83.1% of the criteria were "Met" by the MC+ MCOs, which continues to indicate improvement in meeting federal requirements, over the 2004 rate of 61.0%. Four MC+ MCOs (Mercy Health Plan, Children's Mercy Family Health Partners, FirstGuard, Blue-Advantage Plus of Kansas City) met all the requirements (100%) in this area.

The area of practice guidelines was problematic for two MC+ MCOs (Community CarePlus and HealthCare USA). Both had new Medical Directors, who identified resistance on the part of the medical community in the St. Louis area to the acceptance or implementation of practice guidelines. The specific requirements of the regulations were related to both MC+ MCOs during the on-site review. The majority of the MC+ MCOs (71.4%-85.7%) met all the requirements for adopting, disseminating and applying practice guidelines. In the Western MC+ Medicaid Managed Care region, staff from the MC+ MCOs met with a quality enhancement group in the healthcare community (Kansas City Quality Improvement Consortium). Regional standards and practices were discussed and regionally specific standards, that met or exceeded nationally accepted guidelines, were developed. All MC+ MCOs related that they expected providers to use the practice guidelines combined with their experience and patient knowledge in their decision-making. When conflicts occurred, the Medical Director reviewed the situation and consulted with the provider in an effort to ensure that the services that were provided were in the members' best interest.

All MC+ MCOs (100%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the MC+ MCOs reported using included the InterQual Clinical Decision Support Tool and the Milliman Care Guidelines. Both sources provided evidence-based criteria and best practice guidelines for healthcare decision-making. One MC+ MCO (Missouri Care) had adopted the use of LOCUS/CALOCUS (Level of Care Utilization System/Child and Adolescent Level of Care Utilization System) for utilization management decisions in the provision of behavioral health services. The MC+ MCOs staff was able to articulate how they

utilized these tools and apply them to member healthcare management issues. They stated that they used all the information available to them ensure evidence-based practice that ensured member safety while controlling medically unnecessary care.

The MC+ MCOs were actively involved in developing and improving their Quality assessment and Improvement Programs. Two of the MC+ MCOs (FirstGuard, Children's Mercy Family Health Partners) utilized community based advisory boards, one of which (Children's Mercy Family Health Partners) included members. These groups assisted the MC+ MCOs in assessing member needs and barriers to services. Both MC+ MCOs utilized the recommendations of these groups in their operations, member information, and daily activities. All MC+ MCOs developed internal systems for monitor, analysis and evaluation of their own programs. Six of seven (85.7%) had a program and all required policy and procedures in place to meet the requirements of the federal regulations [438.240(a)(1)].

The Compliance Protocol seeks to ensure that MC+ MCOs comply with the requirements of the sections of the protocol involving Validating Performance Improvement Projects, Validating Performance Measures, Validating Encounter Data, and Health Information Systems. Detailed findings and conclusions for these items are provided in previous sections of this report and within the MC+ MCO summaries.

Table 50 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

	MC+ MCO							All MC+ MCOs			
Federal Regulation	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	1	2	2	2	2	2	2	6	1	0	85.7%
438.236(c) Practice Guidelines: Dissemination	1	2	1	2	2	2	2	5	2	0	71.4%
438.236(d) Practice Guidelines: Application	1	2	1	2	2	2	2	5	2	0	71.4%
438.240(a)(1) QAPI: General Rules	1	2	2	2	2	2	2	6	1	0	85.7%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	2	1	1	2	2	2	4	3	0	57.1%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	1	1	2	2	2	5	2	0	71.4%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2	2	2	2	2	7	0	0	100.0%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2	2	2	2	2	7	0	0	100.0%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	2	2	2	2	2	2	7	0	0	100.0%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2	1	2	2	2	6	1	0	85.7%
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2	1	2	2	2	6	1	0	85.7%
Number Met	6	11	7	7	11	11	11	**64**	**13**	**0**	**83.1%**
Number Partially Met	5	0	4	4	0	0	0				
Number Not Met	0	0	0	0	0	0	0				
Rate Met	54.5%	100.0%	63.6%	63.6%	100.0%	100.0%	100.0%				

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.

0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

GRIEVANCE SYSTEMS

Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) sets forth 18 requirements for notice of action in specific language and format requirements for communication with members, providers and subcontractors regarding grievance and appeal procedures and timelines available to enrollees and providers. All MC+ MCOs excelled (96.0%) in their compliance with the regulations related to grievances and appeals (see Table 51). There were no items rated as "Not Met." Four MC+ MCOs (HealthCare USA, Children's Mercy Family Health Partners, Missouri Care, and Blue-Advantage Plus of Kansas City) were found 100% in completing required policy, procedure, and practice in their Grievance Systems.

Grievance and Appeal reports for both members and providers were reviewed from the first quarter of 2005, as submitted to the SMA. The MC+ MCOs reported radically different numbers and types of concerns. The number of member grievances and appeals varied from one MC+ MCO (Community CarePlus) reporting 5, to another MC+ MCO (HealthCare USA) reporting 270 in the Eastern MC+ Medicaid Managed Care region. Provider complaints, grievances, and appeals varied from one MC+ MCO (Mercy Health Plan) reporting a total of 17, to another MC+ MCO (Healthcare USA) reporting 1835 for the Eastern Region. A total of 495 member grievance and appeals were reported, and a total of 3112 provider complaints, grievances, and appeals were reported from all three MC+ Medicaid Managed Care regions for this three month period.

In analyzing the Grievance System report, the most frequent issues included:

Member - Grievances and Appeals	Provider – Complaints, Grievances, and Appeals
• Transportation • Prescription Drug Issues • Appointment Availability/Continuity of Treatment • Treatment by Provider/Staff • Service Category/Prior Auth. (denial) • Claims Issue/Uncovered Benefit • Inability to Find PCP/Specialist – or Obtain an Appointment • State Fair Hearing Request	• Authorizations – Denied/Late/None • Billing Problems • Contractual Issues • Untimely Submission of Claims • Uncovered Benefit • Additional Information Required • Medical Necessity Question

The largest number of member grievance/appeals revolved around transportation issues. The largest number of provider complaints/grievances/appeals included authorization issues and untimely submission of claims. The majority of the claims were the result of payment disputes, although a number of grievances and appeals filed by providers did dispute decisions that appeared to affect the quality of care received by members.

A random selection of both member grievance and appeals, and provider complaints, grievances, and appeals were identified for on-site review. The random list was presented to each MC+ MCO at the beginning of the on-site review. The results of these reviews were presented during the Exit Interview. The review did identify problems in several of the records reviewed. Two MC+ MCOs (Mercy Health Plan, FirstGuard) exhibited problems, such as inadequate correspondence or incomplete information to substantiate the determinations made. One MC+ MCO (Community CarePlus) had inadequate documentation in the records reviewed. This MC+ MCO recognized the problems that existed in their system and made significant changes throughout the 2005 review period. They did share additional cases as examples of how records were kept, and internal reporting requirements that were in place at the time of the on-site review.

There were very few deficiencies in the Grievance System policy submission. The only regulations that were rated as "Partially Met" were the result of inadequate record keeping, and correspondence that was not available to meet the MC+ MCOs' own policy requirements. Appropriate practice for addressing member grievance and appeals, and provider complaints, grievances and appeals appeared to be in place for all MC+ MCOs.

Table 51 - Subpart F: Grievance Systems

Federal Regulation	MC+ MCO							All MC+ MCOs			
	CCP	MHP	HCUSA	MOCare	FHP	FG	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.402(a) Grievance and Appeals: General Requirements	2	2	2	2	2	2	2	7	0	0	100.0%
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2	2	2	2	2	7	0	0	100.0%
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2	2	2	2	2	7	0	0	100.0%
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2	2	2	2	2	7	0	0	100.0%
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2	2	2	2	2	7	0	0	100.0%
438.404(b) Notice of Action: Content	2	2	2	2	2	2	2	7	0	0	100.0%
438.404(c) Notice of Action: Timing	2	2	2	2	2	2	2	7	0	0	100.0%
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2	2	2	2	2	7	0	0	100.0%
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2	2	2	2	2	7	0	0	100.0%
438.408(a) Resolution and Notification: Basic Rule	2	1	2	2	2	1	2	5	2	0	71.4%
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2	2	2	2	2	7	0	0	100.0%
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2	2	2	2	2	7	0	0	100.0%
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2	2	2	2	2	7	0	0	100.0%
438.410 Expedited Resolution of Appeals	2	2	2	2	2	2	2	7	0	0	100.0%
438.414 Information about the Grievance System to Providers and Subcontractors	2	1	2	2	2	1	2	5	2	0	71.4%
438.416 Recordkeeping and Reporting Requirements	1	2	2	2	2	2	2	6	1	0	85.7%
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2	2	2	2	2	2	7	0	0	100.0%
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2	2	2	2	2	7	0	0	100.0%

Note: 0 = Not Met; 1= Partially Met, 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

5.4 Conclusions

Across all MC+ MCOs there was a substantial improvement in the area of compliance with federal regulations. There were no regulations rated as "Not Met." All individual regulations were rated as "Met" or "Partially Met." Two MC+ MCOs were 100% compliant with all requirements. Three were 100% compliant with the regulations related to Enrollee Rights and Protections. Three were 100% compliant with Access Standards. In the area of Structure and Operations all MC+ MCOs were at 60% compliance or higher. Three were100 % and two additional MC+ MCOs were 90% compliant. Four of the MC+ MCOs met all required regulations in the area of Measurement and Improvement. The area of Grievance systems was also substantially compliant across all the MC+ MCOs. Four were 100% compliant, one was 94.4%, and two were 88.9%. All sources of available documentation, interviews, and observations at the on-site review were used to develop the ratings for compliance. The EQRO comments were developed based on review of this documentation and interview responses. Several of the MC+ MCOs made it clear that they used the results of the prior EQR to complete and guide required changes. One MC+ MCO (Community CarePlus) significantly improved and stated that they utilized the compliance protocol as a tool to develop their performance and improve services to members. This MC+ MCO achieved improved compliance in every category. The following summarizes the strengths, areas for improvement, and recommendations based on the findings utilizing the Protocol for Determining Compliance with Medicaid Managed Care Regulations.

STRENGTHS

1. Two of the MC+ MCO "met" (100%) applicable federal regulations and State compliance requirements. There were no regulations rated as "Unmet" for any of the MC+ MCOs. The ratings for every section of the protocol indicated an improvement in all areas of policy and procedure submission and approval, as well as practice.

2. Three of the 13 regulations for Enrollee Rights and Protections were 100% "Met." Communicating MC+ Members' rights to respect, privacy, and treatment options, as well as communicating, orally and in writing, in their own language or with the provision of interpretive services is an area of strength for all MC+ MCOs. The MC+ MCOs maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare. The MC+ MCOs responded to physical, emotional and cultural barriers experienced by members with diligence and creativity.

3. The MC+ MCOs were aware of their need to provide quality services to members in a timely and effective manner. Where there were issues with access to services, the MC+ MCOs responded quickly and effectively.

4. Four of the 17 regulations for Access Standards were 100% "Met." These included the regulations regarding second opinions, provider cultural competency, notices for adverse actions, and compensation of utilization management activities. MC+ MCOs monitored high risk MC+ Members and had active case management programs in place. Each MC+ MCO described measures to identify and work with MC+ Members who had special healthcare needs exceeding the requirements of the MC+ Medicaid Managed Care contract.

5. Four of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, both excluded providers and state requirements; grievance systems; and subcontractual relationships and delegation. The MC+ MCOs had active mechanisms for oversight of all subcontractors in place. All MC+ MCOs improved significantly in compliance with this set of regulations.

6. Three of the 12 regulations for Measurement and Improvement were 100% "Met." Three of the seven MC+ MCOs met all of the regulatory requirements. Five of the seven MC+ MCOs adopted, disseminated and applied practice guidelines to ensure sound healthcare services for members. The MC+ MCOs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilizations management. The MC+ MCOs were beginning to utilize the data and demographics in their systems to track and trend information on members to assist in determinations of risk and prevention initiatives. Several MC+ MCOs began using member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Provider Service or Relations departments of the MC+ MCOs exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of MC+ Members.

7. Fourteen of the 18 regulations for Grievance Systems were 100% "Met." Four of the MC+ MCOs were 100% compliant with the requirements for policy, procedure and practice in the area of Grievance Systems.

8. MC+ MCOs remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their MC+ Members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be available to MC+ Members.

Areas for Improvement

1. All MC+ MCOs did not have their written policies and procedures completed to ensure that a consistent application of contractual requirements and federal regulations was occurring.

2. MC+ MCOs continued to struggle with recruitment of certain specialty physicians. Throughout discussions with MC+ MCOs the lack of orthopedic surgeons, neurosurgeons and child/adolescent psychiatrists was identified as a problem. The MC+ MCOs have made accommodations to ensure that members received the services required. Through the use of advance practice nurses, silent physician partners, cooperative agreements with medical schools, and the willingness to reimburse at commercial insurance rates, the MC+ MCOs attempt to ensure that members have access to these services. MC+ MCOs expressed continued concern for improvement in this area.

3. MC+ MCOs identified the need for additional dental providers. Recruitment was largely delegated to subcontractors. Becoming actively involved in recruitment activities would benefit members and improve the quality of and access to care.

4. The use of data for quality improvement purposes and examination of healthcare outcomes was just beginning. Continued growth in the utilization of all of the data available to drive healthcare practice and initiatives is required to improve quality and access to care.

Recommendations

1. Continue to distribute the completed compliance tools to MC+ MCOs to ensure recognition of the policies and procedures that must be completed and approved to achieve compliance with federal regulations.

2. MC+ MCOs must continue to recognize the need for timely submission of all required policy and procedures. The majority of the MC+ MCOs put a tracking or monitoring system into place to ensure timely submission of documentation requiring annual approval. These systems must be maintained to ensure that this process remains a priority for all MC+ MCOs.

3. MC+ MCOs identified the need for continuing to monitor provider availability in their own networks. Although most MC+ MCOs had the number of primary care physicians (PCPs) and specialists required to operate, they admitted that many of these PCPs had closed panels and would not accept new patients. Ensuring that there is adequate access for all members, including new members, should be a priority for all MC+ MCOs.

4. MC+ MCOs identified improvement in their Quality Assessment and Improvement programs, and how this enhanced their ability to provide adequate and effective services to members. These efforts must be relentlessly continued to ensure that the organizations remain aware of areas for growth and improvement. These efforts ensure that the quality, timeliness and access to care required for member services is maintained at an exceptional level.

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SECTION 6.0
COMMUNITY CAREPLUS

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6.0 - COMMUNITY CARE PLUS

6.1 Performance Improvement Projects

The previous sections of the 2005 EQRO report present the purpose and objectives, technical methods, procedures for evaluation, and MCO to MCO comparisons of analyses, findings, and recommendations for each of the protocols based on the aggregate analysis. This section of the EQRO report summarizes MC+ MCO specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for MC+ Managed Care Members. Please refer to the main report for detailed technical objectives, methods, and presentation of data that are referenced here for the MC+ MCO.

METHODS

Document Review

Community Care Plus supplied the following documentation for review:

- Performance Improvement Project 2005: Early Intervention in Prenatal Care Management and the Relationship to Very Low Birth Weight Babies
- Performance Improvement Project 2005: Emergency Room Utilization

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on February 28, 2006 during the on-site review, and included the following:

Marcia Albridge – Director, Business Development
Sue Danis – Manager, Performance Improvement
Beverly Thompson – Director, Medical Management
Judy Milam – Manager, Claims/Customer Service
Robin Woolfolk – Manager, Customer Service

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the Project Leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What was the intervention?
- What was the time period of the study?
- Was the intervention effective?
- What does Community CarePlus want to study or learn from their PIPs?

The maturity of the PIPs submitted for validation was not complete at the time of the initial request for this information in October 2005. The MCO was instructed that they could submit additional information that included outcomes of the intervention. The final information from Community CarePlus was received May 15, 2006.

FINDINGS

The first PIP evaluated was "Early Intervention in Prenatal Care Management and the Relationship to the Very Low Birth Weight Babies." This project asked if "early identification and intervention in prenatal case management decreases the incidence of very low birth weight babies?" Very low birth weight babies were defined as weighing less than 1500 grams at birth. The steps taken by Community CarePlus included early intervention and implementation of case management for all pregnant members. The goal was to increase members' access to prenatal care in an effort to ensure all appropriate health care was received thereby reducing the incidence of very low birth weight deliveries. The MCO found that national trends indicated an increase in very low birth weight deliveries, so Community CarePlus's stated goal was for their trend data to remain flat.

The study question was defined. The rational for the study, including the background information utilized to support the decision to select this topic, was not identified. Additional information on the literature review used to support the choice of a study topic is needed. The goal of impacting the trend to "remain flat" did not appear to have a significant impact on the identified population. The population was defined to include any MC+ member who was pregnant. Members to be included in the study were to be identified by the following methods of notification:

- Pregnancy Risk Screening Forms
- Baseline Health Assessment
- Hospital Admissions and Observations
- Welcome Calls
- OB Provider referrals

The study indicators identified were early identification of members who are pregnant and early implementation of case management services. The study did include levels of risk, which determined the intensity of case management services. The entire case management intervention was well described. The stated decision-making process for determining the level of care was "clinical and past experience." This methodology was described in detail providing confidence in the decision-making criteria to determine risk. As the study matured appropriate changes were made to increase the effectiveness of the interventions. During the first six months of 2005 Community CarePlus case managed high risk pregnancies. Throughout the remainder of the study year, all pregnancies were case managed. More significant outcomes were found as the result of this added component.

The data to be collected could be inferred from the graphs and tables presented in the study. However, the narrative does not describe a data collection plan. There is no explanation of the process to be utilized in collecting data nor is there an explanation of the measurement cycles. Additional information is needed to define causes and variables that may impact the expected outcomes. The information provided does not adequately justify or explain what factors led to the interventions chosen and how their effectiveness will be measured.

The study information did clearly define the sources used to collect data. The narrative provided did not specify a systematic method for valid and reliable data collection. Additional information should be included to ensure that consistent and accurate data is collected over the study period. Pre and post-intervention analysis will be important in determining the effectiveness of the intervention over time. The study, even with 2005 statistics, was not mature enough to measure the overall effectiveness of the interventions applied. It does appear that the study can result in credible and interpretable findings.

The stated goal of this study was to achieve a "flat" rate of incidences of very low birth weight infants. No performance improvement was anticipated. Initially the study did not indicate that it would measure any variable factors, such as increased or decreased number of pregnancies,

the increased or decreased number of members obtaining case management, or the influence of earlier determination of risk for the pregnant women. The improved study that began in June 2005 does include some of this information. The study is planned to continue throughout 2006 to ensure that outcomes can be evaluated over time. With additional time to analyze the effects of the planned interventions it does appear that the study has a potential for positive impact on MC+ Members. This will have to be determined upon completion of the study.

The second PIP evaluated was "Emergency Room Utilization (Children Receiving Emergency Room Services at Cardinal Glennon Hospital)." The focus of this study is unclear because there are two stated topics. Originally the study was designed to improve the incidents of emergency room visits at one St. Louis area children's hospital. Later, beginning in October 2005, the study was narrowed to address "Emergency Room Utilization for Asthma-Related diagnoses for Children 5 – 18 years at Cardinal Glennon Hospital." The study question that was the focus of the second topic is "Does education following emergency room visits for asthma increase the member's quality of health by decreasing emergency medical interventions?" The narrative does define why this issue was identified for improvement. It does include the references from the MCO's literature review. In the updated information provided on May 15, 2006, the rational and justification for narrowing this topic, and for choosing one facility for tracking and analysis was clarified in the study narrative. The population was identified in the topic description and included all MC+ member children age 5-18 that present to the emergency room for asthma related matters. There was no sampling conducted. The study population focused on members with special health care needs.

The hypotheses of the narrowed study are:

- By educating members following emergency room visits for asthma, Community CarePlus believes a member's quality of life will increase because there is a decrease of emergency medical interventions.

The study indicators look at the number of emergency room visits per month, and the total number of visits per member over a twelve month period. The narrative does not specify an outcome relationship and requires more detail. The interventions described in the study include:

- An initial telephone contact following the emergency room visit.
- Education on medication compliance; follow-up visits with the PCP; benefits of utilizing the PCP rather than the emergency room.
- Monthly follow-up telephone calls to ensure compliance.

The indicators are designed to provide useful information over time. With the focus change for this PIP occurring in October 2005, it is difficult to determine the effectiveness of the interventions to date. The study did include a detailed methodology for demographic and other detailed data to be retrieved. The study explained the sources for this data, although it is difficult to determine their reliability. The source for originally identifying members is the daily emergency room data sheets from Cardinal Glennon Hospital. The reliability of this methodology is unclear. The narrative does not clearly explain why Cardinal Glennon Hospital is the focus of the study. It does state that "Cardinal Glennon was the focus of the study being the main pediatric hospital where most members seek treatment." There is no data supporting this assertion. The MC+ Medicaid Managed Care region served by Community CarePlus included nine counties.

There is no data presented that supports the claim that Cardinal Glennon Hospital will yield the most information due to the volume of children seen there over other hospitals in this region. There is also no data to support why one hospital is chosen over an aggregate of all the hospitals in the region.

There was no data analysis plan identified in the narrative. The specific data to be collected was not explained. Diagrams and graphs are presented. However, how the information is pertinent to the anticipated outcomes is never explained. Data sources are defined, but it is difficult to assure that complete and accurate data will be collected. Charts include information on ER visits for asthma, how members are referred, times of day that members are seen, and days of the week members go to the ER. How any of these are related to the hypotheses or how this information relates to anticipated outcomes is not described.

It appears that reasonable interventions are planned, but this is not supported in the details of the narrative provided. The second study question was only in place for three months during 2005. This did not allow for any meaningful analysis of the information presented in the plan. With maturity, a detailed explanation of how the data collected will be used, what the expected outcomes of the planned interventions are, and how these interventions improved health care services for members, this planned study has potential for real and sustained improvement. At this time there is not enough information, data, or analysis presented to make any judgment about anticipated outcomes.

STRENGTHS

1. Although both topics had a clinical focus, they were focused on identifying and correcting deficiencies in care or services rather than on utilization of cost.

2. Both topics included well-stated study questions.

3. The topics chosen were selected to impact perceived negative outcomes for members. One study included an analysis of enrollee needs, background information, and a thorough literature review to support the choice.

4. The responses obtained at the on-site review indicated that the MCO continues development of skills in this area and has made the commitment to utilize the PIP process to assist in program and organizational development.

5. Well thought out interventions were planned in both projects.

AREAS OF IMPROVEMENT

1. Study questions, measures, and analysis were not related to one another. Quarterly data analysis was planned and stated in one PIP. The data gathered and included should have its relevance to the stated outcomes explained.

2. Data analysis should incorporate statistical significance testing to ensure that any resulting change, or lack of change, was related to the intervention.

3. Provide enough narrative to ensure that the reader understands the problem, the proposed interventions, the goals and outcomes hoped for, and how the data presented relates to all these issues and either supports program improvement, or is not effective.

RECOMMENDATIONS

1. The study design of PIPs needs to link the questions, the interventions, and the proposed outcomes to determine whether of not an intervention was effective. This can be accomplished by developing a logic model for the PIPs at the planning stage, and ensuring that adequate narrative accompanies the data and information presented to make all necessary connections.

2. Quarterly measurement should be utilized if at all possible. This will provide information on the ongoing effects of the planned program.

3. Include a non-clinical PIP in the next planning cycle.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Community Care Plus. Community Care Plus submitted the requested documents on December 8, 2005. The EQRO reviewed documentation between December 9, 2005 and February 27th, 2006. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

Document Review

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Community Care Plus (prepared by Novasys)
- Healthcare Research Associates' (HRA) HEDIS 2005 Compliance Audit Report
- NovaSys Health Network, LLC, policies and procedures related to the HEDIS rate calculation process.
- NovaSys Health Network, Community Care Plus electronic eligibility process
- Data files from the HEDIS repository containing eligible population, numerators and denominators for each of the three measures
- Decision rules & queries in the HEDIS 2005 repository used to identify eligible population, numerators and denominators for each of the three measures
- Query result files from the repository

The following are the data files submitted by Community Care Plus for review by the EQRO:

- ADV_ENROLLMENT_DATA.txt
- CIS_DEN_AND_NUM_DATA_HYBRID.txt
- CIS_DENOMINATOR_AND_NUM DATA.txt
- CIS_ENROLLMENT_DATA.txt
- W15_ENROLLMENT_DATA.txt
- WCV_DENOMINATOR_AND_NUM_DATA.txt

Interviews

The EQRO conducted on-site interviews with Cathy Mocca, Michael Boone (representing Novasys, the third party administrator for Community Care Plus) and Ainette Martinez (Bridgeport Dental) on Tuesday, February 28, 2006. Michael Boone of Novasys was responsible for calculating the HEDIS 2005 performance measures.

FINDINGS

Community Care Plus calculated the Childhood Immunization Status, Combination #2 measure using the Hybrid Method. The Well-Child Visits and Annual Dental Visit measures were calculated using the Administrative Method. MCO to MCO comparisons of the rates of Childhood Immunization Status Combination #2, Well-Child Visits, and Annual Dental Visit were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The rate for the HEDIS 2005 Childhood Immunization Status, Combination #2 measure reported to the SMA and the State Public Health Agency (SPHA) by Community Care Plus was 47.45%. This was significantly higher than the statewide rate for all MC+ MCOs (28.17%; z = .05; 95% CI: 36.35%, 58.55%; n.s.).

The rate for Community Care Plus for the HEDIS 2005 Well-Child Visits measure of 6 or more visits was 32.6%; comparable to the statewide rate for all MC+ MCOs (38.42%; z = -.62, 95% CI: 20.07%, 45.13%; n.s.). The 2005 HEDIS combined rate for Annual Dental Visit was 31.13%; comparable to the statewide rate for MC+ MCOs (29.76%, z = .22; 95% CI: 26.85%, 35.41%; n.s.).

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

Data Integration and Control

Information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of the HEDIS repository. This was done through a remote connection from the Community Care Plus location in St. Louis to the vendor's system in Little Rock, Arkansas. For the Childhood Immunization Status, Combination #2, Well-Child Visits and

the Annual Dental Visit measures, Community Care Plus was found to meet most of the criteria for having procedures in place to produce complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Community Care Plus transferred data into the repository used for calculating the HEDIS 2005 measures.

Documentation of Data and Processes

Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Community Care Plus met nearly all criteria that applied for all three measures. The two criteria that were not met involved the use of statistical significance testing to document changes in performance over time and using this information to support claims of improvement or stability in performance over time. Although many auditors conduct statistical tests to examine various aspects of data validity, such tests should be used by the MCO to assess the significance of change related to quality improvement activities and operational changes. For the Childhood Immunization Status, Combination #2 measure, the State Public Health Immunization Registry (MOHSAIC) data were not incorporated into the calculation of the rates, which may have contributed to an underestimate of the actual rate.

Processes Used to Produce Denominators

Community Care Plus met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of members eligible for the services being measured. Four hundred eleven (411) sampled members were reported and validated for the Childhood Immunization Status, Combination #2 measure. A total of 1,305 members eligible were reported and 1303 were validated for the Well-Child Visits measure. Two members were excluded from the denominator by the EQRO due to not being enrolled in Community Care Plus on their 15-month birthday. A total of 22,621 members eligible were reported and validated for the denominator of the Annual Dental Visit measure. The EQRO found the age ranges, dates of enrollment, medical events, and continuous enrollment criteria were programmed to include only those members who met HEDIS 2005 criteria. Member identification numbers and dates of birth were within valid ranges for each of the three measures. The dates of enrollment represented valid gaps in enrollment and met continuous enrollment requirements. Medical

event codes were also valid for all three measures. There were no exclusions or contraindications reported by the MCO. One record was replaced after determining that valid data errors occurred; this record was replaced with the next record from the auxiliary list, comprised of the final sample size of 453.

Processes Used to Produce Numerators

All three measures included the appropriate administrative data ranges for the qualifying events (e.g., immunizations, well-care visits, and asthma medications) as specified by the HEDIS 2005 criteria (see Attachment XIII: Numerator Validation Findings) for the Adolescent Immunization Status and Use of Appropriate Medications for People with Asthma measures. Medical record reviews were conducted for the Childhood Immunization Status measure.

For the Childhood Immunization Status measure, Community Care Plus excluded administrative events from the State Public Health Immunization Registry (MOHSAIC). There were 9 administrative hits reported and validated by the EQRO. There were 186 hits from medical record review reported by Community Care Plus. Thirty (30) of 30 medical records requested for review were received and 20 records resulted in validated hybrid hits. The EQRO validated 133 of the 195 hits reported. The rate validated by the EQRO was 32.36%; this resulted in a 15.09% estimated bias for the Childhood Immunization Status, Combination # 2 measure.

For the Well-Child Visits measure, there were a total of 425 administrative hits found in the data file; the MCO reported a total of 462 hits. The rate validated by the EQRO was 32.57%; the rate reported for this measure was 32.60%, resulting in no bias.

The Annual Dental Visit was the third measure validated. There were a total of 7,043 administrative numerator events reported and validated. The diagnosis codes and dates of service were valid. The dates of birth were in the valid range. The final rate was calculated to be 31.13%, with no bias observed.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunization Status measure. Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for each of these measures. Community Care Plus employed a 10%

oversampling rate for a final sample size (FSS) of 453, which is within specified parameters. 1 (one) replacement was reported from administrative data.

Submission of Measures to the State

Community Care Plus submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

The following table summarizes the estimates of bias and the direction of the bias. There was no bias found for both the Well-Child Visits measure and the Annual Dental Visit measure.

Table 52 - Estimate of Bias in Reporting of HEDIS 2005 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunization Status, Combination #2	15.09%	Overestimate
Well-Child Visits in first 15 months of Life	none	
Annual Dental Visit	None	

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources summarized in the Final Performance Measure Validation Worksheet for each measure. Table 53 (see below) shows that the Childhood Immunization Status, Combination #2 measure was not valid due to the validated rate falling below the 95% lower confidence limit reported by Community Care Plus.

Table 53 - Final Audit Rating for Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status, Combination #2	Not Valid
Well-Child Visits in first 15 months of Life	Fully Compliant
Annual Dental Visit	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCO. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MC+ Members qualified for the measure.

STRENGTHS

1. Calculation of the HEDIS 2005 Annual Dental Visit measure was fully compliant with specifications.
2. Community Care Plus collected and submitted 30 of the 30 medical records requested for the Performance Measure validation.
3. The data repository was very well-designed and had methodically arranged queries. Most of the queries were 'make table' queries, which received the data online from the Amisys database. The data is then 'frozen' into the HEDIS repository built-in MS Access. The source code was reviewed for accuracy and the results were verified.
4. The arrangement of the tables and queries was step-by-step and top-down, which facilitated a detailed overview of the process and it minimized the possibility of error. An example of a step-by-step methodology was having a separate member span table, which was updated as soon as the MCO received changes in members' status. This table calculated continuous enrollment in a detailed fashion and also ruled out gaps in enrollment. The EQRO conducted a validation test on the Dental measure. Standard codes such as ICD-9 and UB-92 were checked for accuracy and updated versions.
5. Up-to-date code versions were provided to Novasys by their auditor HRA, and were well-integrated into the system, producing reliable results.
6. There was excellent data integration with automated quality checks and reports. Data was collected from Amisys, the claims management system for membership, enrollment and encounter data. Pharmacy data was merged from ExpressScripts via Amisys into the warehouse. Controls for data checking and error handling were present within the Amisys system.
7. The data resided in a secure location within Perot Systems, the owners of Amisys, (located in Dallas, Texas). The data was transferred through a secure ODBC connection.
8. Information system policies were present within Novasys to maintain the integrity of the data.
9. Workflow and documentation of the working mechanisms of the HEDIS repository (used to provide external observers and subsequent users with data field definitions) is greatly improved since last year's audit.

AREAS FOR IMPROVEMENT

1. Data from external databases, such as the State Public Health Immunization Registry (MOHSAIC), for collection of childhood immunization data, was excluded from the rate calculation. The current rates are likely significantly underestimated as a result of omitting MOHSAIC data.
2. Community Care Plus has indicated a need to upgrade from an Access system of HEDIS rate calculation to an SQL system; the EQRO sees this as an area that should be pursued.
3. Continue to encourage electronic claim submissions from providers as much as possible.

RECOMMENDATIONS

1. Data from MOHSAIC for the Childhood Immunization Status measure should be incorporated into measure calculation to produce rates in a reliable manner for comparison with other MC+ MCOs. This can be done by developing a data exchange procedure with the SPHA. Once a year, MCOs send a list of eligible members to the SPHA, which will return immunization data for the members. These procedures were outlined for the MCO in April, 2005. During the site visit on March 6, 2006, the MCO indicated that they have worked with the SPHA to participate in the data exchange for the 2006 HEDIS season.
2. Continue the move to a structured data warehouse, such as SQL Server from the current MS Access repository, as it will facilitate better data retrieval and analysis.
3. Continue work with MEDLine to improve the number of electronic claims submitted by providers; this should improve accuracy and timeliness of claims.

6.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 77,055 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Outpatient Claim Type field was 100.00% complete, accurate and valid.

The Outpatient Recipient ID field was 100.00% complete, accurate and valid.

The Outpatient First Date of Service field was 100.00% complete and accurate, and 99.93% valid. Invalid dates ranged from 12/03/2005 – 12/30/2005.

The Outpatient Last Date of Service field was 100.00% complete and accurate, and 99.91% valid. Invalid dates of service ranged from 04/01/2005 – 04/29/2005.

The Outpatient Units of Service field was 100.00% complete, accurate and valid.

The Outpatient Procedure Code field was 100.00% complete, accurate, and valid

The Outpatient Place of Service field was 100.00% complete, accurate and valid.

The first Diagnosis Code field was 100.00% complete, accurate and valid.

Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 31.22% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third through fifth Diagnosis Code fields were 0.00% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 5,225 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there was one (1) encounter claim paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% with the

following exceptions. The Procedure Code and the fourth and fifth Diagnosis Code fields were blank.

For the Inpatient claim type, there were 2,255 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Inpatient Claim Type field was 100.00% complete, accurate and valid.

The Recipient ID field was 100.00% complete, accurate and valid.

The Admission Type field was 100.00% complete, accurate and valid.

The Admission Date field was 100.00% complete and accurate, and 98.18% valid. There were 41 invalid dates ranging from 12/10/2005 – 12/31/2005.

The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 97.74% (with 52 entries of "99999999"). Valid values were present 89.31% of the time. In addition to the invalid "99999999" entries, 189 invalid dates ranged from 04/01/2005 – 04/15/2005.

The Bill Type field was 100.00% complete, accurate and valid.

The Patient Status field was 100.00% complete, accurate and valid.

The first Diagnosis Code field was 100.00% complete, accurate and valid.

The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (93.48%, 82.17%, 61.46%, 41.73%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

The First Date of Service field was 100.00% complete and accurate, and 98.18% valid. There were 41 invalid dates ranging from 12/10/2005 – 12/31/2005.

The Last Date of Service field was 100.00% complete and accurate, and 91.40% valid. The 193 invalid dates of service ranged from 04/01/2005 – 04/29/2005.

The Revenue Code field was 100.00% complete, accurate and valid.

The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 45,782 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Outpatient Claim Type field was 100.00% complete, accurate and valid.

The Recipient ID field was 100.00% complete, accurate and valid.

The First Date of Service field was 100.00% complete and accurate, and valid.

The Last Date of Service field was 100.00% complete and accurate, and valid.

The Units of Service field was 100.00% complete, accurate and valid.

The Outpatient Procedure Code field was 100.00% complete and accurate, and 77.43% valid. There were 10,332 entries of the invalid code "00000".

The Revenue Code field was 100.00% complete, accurate and valid.

The first Diagnosis Code field was 100.00% complete, accurate and valid.

Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 84.68% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 40.82% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 17.70% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 7.23% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 78,518 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Community Care Plus, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. The Hospital Outpatient Procedure Code field contained a large proportion of invalid entries. For the Inpatient claim type, the Discharge Date field contained invalid entries, but this may be a function of patients who were admitted during the specified time period but were not yet discharged within the period.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Community Care Plus demonstrated significantly lower rates than the average for all MC+ MCOs for the Medical, Dental, and Outpatient Hospital claim types. This may be a function of provider panel composition or claims administration. The possibility of incomplete data cannot be ruled out given the consistent pattern of low rates across claim types. Another possible explanation is less access to care for members, or a healthier member population.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review. Of the 77,055 Medical encounter claim types in the SMA extract file for January 1, 2005 through March 31, 2005, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 77 medical records (77.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 42.0%, with a fault rate of 58.0%. The match rate for diagnoses was 71.0%, with a 29.0% fault rate.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing or illegible information (n = 29).

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 11and incorrect codes (n = 47). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

What Problems are there with How Files are Compiled and Submitted by the MC+ MCO?

It was not possible to conduct the planned analysis of comparing Community Care Plus (CCP) encounter data to the SMA encounter claim extract file because there was not an identical encounter number to key the two files. The plan was to compare MC+ MCO paid and unpaid claims to the SMA encounter claim extract file. While CCP did submit the data in the requested format (see Appendix 6) for the MC+ Managed Care Members represented in the encounter claim sample selected by the EQRO for validation, there was no way to match the encounters without an internal control number (ICN) that is identical to that of the SMA.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MC+ MCO did submit the data in the requested format, there are a number of ways to improve the data quality by improving the database system. One variable that is not currently represented is that of a unique line number. When an ICN number is submitted, it is essentially a visit number, but the numbers submitted by Community CarePlus were not the same as the ICN submitted with the state encounter data. To match up specific lines of data (each service of the encounter) this would require a unique number for each service provided for each member.

STRENGTHS

1. Data was submitted in the requested format for encounter validation and all claim types were accessed.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Dental, Outpatient Home Health, and Pharmacy claim types were 100.00% complete, accurate, and valid.
4. Community Care Plus demonstrated significantly higher rates of validation of the SMA encounter claims extract file against the medical record for the diagnosis relative to the average for all MC+ MCOs.
5. Claim Status (Paid, Denied, & Unpaid) was submitted.
6. Revenue Codes were 100% complete, accurate, and valid for both Inpatient and Outpatient Hospital claim types which were incomplete last year.

AREAS FOR IMPROVEMENT

1. For the Medical claim type, the Outpatient First Date of Service and Outpatient Last Date of Service fields contained some invalid entries, resulting in a valid rate of 99.93% and 99.91%, respectively.
2. For the Inpatient claim type, the Admission Date and the Discharge date fields contained invalid entries, resulting in a valid rate of 98.18% and 89.31, respectively.
3. The Outpatient Hospital claim type had invalid codes in the Outpatient Procedure Code field.
4. Community Care Plus demonstrated significantly lower rates than the average for all MC+ MCOs for the Medical, Dental, and Outpatient Hospital claim types.
5. Community Care Plus demonstrated significantly lower rates of validation of the SMA encounter claims extract file against the medical record for the procedure codes relative to the average for all MC+ MCOs.

RECOMMENDATIONS

1. The MC+ MCO should examine the rate of claims per 1,000 members across claim types and the rate of rejected claims for each claim submission format (UB-92, NSF/CMS 1500, NCPDP 3.0) over time to examine the consistency in claims submission and identify issues for data submission. The access to care should also be examined as a possible reason for the lower rates of encounter claims per 1,000 members.
2. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout and run validity checks after the programming of new edits.
3. For the Inpatient claim type (UB-92 file layout), improve the rate of valid Discharge Dates to flag invalid entries of "99999999".

6.4 MCO Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MCO's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the Division of Medical Services. On-site review time was used to conduct interviews with those who oversee the daily practices of the MCO. This ensures that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MCO Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the MCO and to follow-up on questions raised from the document review and from the 2004 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

Document Review

The following documents pertaining to Community CarePlus were reviewed prior to and at the on-site visit:

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Provider Contracts
- Grievance and Appeal Policies
- Grievances and Appeals related to members were reviewed, as were Complaints, Grievances, and Appeal files for providers. These files were obtained from a random selection process of actions filed in the first quarter of 2005.
- 2004 Annual Quality Improvement Annual Summary

Additional documentation made available by Community CarePlus included:

- 2005 and 2006 Marketing Plan
- Organizational Chart
- 2005 PIP ER Utilization for Asthma
- 2005 PIP Early Prenatal Intervention
- 2005 Call Center Foreign Language Reports
- CCP Welcome Packets, with correspondence, postcards, privacy/HPPPA information
- Healthy Moves 2005 CCP Member Newsletters
- 2005 Quality Monitoring Log
- CCP Policy Tracking Log
- Unity Managed Mental Health – QI Workplan 2005 – Outcomes
- Unity Managed Mental health – CCP 2005 Program Reports

Interviews

Interviews were conducted with the following group:

Plan Administration

Jerry Linder – President and CEO
Robert Profumo, MD – Medical Director
Cris Cristea – Chief Operating Officer
Beverly Thompson – Director, Medical Management
Marcia Albridge – Director, Business Development
Kathy Mocca – Manager, Business Development
Robin Woolfolk – Manager, Customer Service

Mental Health

Marcia Albridge – CCP

Unity Health Services:
Scott Frederick, Director, Managed Mental Health
Marjorie Viehland, Manager, Utilization Management and Quality Improvement

FINDINGS

Enrollee Rights and Protections

Community CarePlus made a serious effort to begin tracking and monitoring all policy required to be submitted to and reviewed by the SMA. This included policy and procedures for initial as well as annual approval materials. Additionally, the MCO developed an inventory of all written materials or purchased materials that must be approved by the SMA prior to being shared with members. A binder including all Annual Marketing Materials was compiled and shared at the on-site review. It was observed that the MCO made necessary changes that indicated their current address and telephone numbers for members to reference when they contact

Community CarePlus. The MCO stated that after their move in 2004, handout information was incorrect, but the primary toll-free contact number, accessed by members, remained the same.

The Member Handbook was approved by the SMA and is now in a recorded format to be shared with members who are visually impaired or have other challenges with written material. Certified interpreters for deaf or non-English speaking members are provided as needed. The International Institute and the Language Access Metro Project (LAMP) are the primary resources used for interpretive services by Community CarePlus. The MCO reported receiving an average of fifty-nine (59) calls per month requiring interpretive services.
Training is regularly provided to ensure that the Community CarePlus Call Center staff is knowledgeable about members' rights and responsibilities. All incoming calls are monitored and additional in-service training and coaching is provided based on information gathered. Call Center staff rotated to provide 24-hour coverage on holidays and weekends. They also assist in contacting new members. The MCO began utilizing internet resources, as well as the new member report received from the SMA, to have up-to-date information on members. In late 2005, the MCO reached a 60% success rate for contacting new members.

Community CarePlus continues to enhance case management services to members with special needs. They review all sources to identify members in need of case management, and provide them with individual attention as quickly as possible. Case managers track members who are pregnant, have high blood lead levels, have identified special healthcare needs, and any catastrophic illness. The MCO reported that they follow about twenty-five (25) members through case management services at a time. The Lead Case Manager maintains a database with information provided by the SMA, and is active in educating providers regarding the use of capillary testing to encourage blood lead level tests for children. The medical director met daily with case management staff to discuss cases and held weekly case conferences. This type of support was beneficial to the MCO and to case management activities.

The rating for Enrollee Rights and Protections (46.2%) indicates that Community CarePlus continued to have written policies and procedures that were not submitted to the SMA for review and approval. However, it should be noted that the MCO made a significant improvement in this area, has improved tracking and internal processes, and is in the process of completing policy development and submission. Community CarePlus exhibited a business like

approach and commitment to continue their efforts to improve in the completion and submission of required policies and procedures. Their stated goal was to become fully compliant with all MC+ Medicaid Managed Care contract requirements and federal regulations.

Table 54 - Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	CCP	
	2004	2005
438.100(a) Enrollee Rights: General Rule	1	2
438.10(b) Enrollee Rights: Information Requirements	0	1
438.10(c)(3) Alternative Language: Prevalent Language	1	2
438.10(c)(4,5) Language and Format: Interpreter Services	1	1
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	1	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	0	1
438.10(f) Information for All Enrollees: Free Choice, etc.	1	1
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	1
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	1	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	1
438.100(b)(3) Right to Services	1	1
438.100(d) Compliance with Other Federal/State Laws	2	2
Number Met	2	6
Number Partially Met	9	7
Number Not Met	2	0
Rate Met	15.4%	46.2%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

Unity Managed Mental Health (UMMH) is the Behavioral Health Organization (BHO) that subcontracts with Community CarePlus for mental and behavioral health services for members. The BHO presented and discussed their 2005 program reports. The reports included data on inpatient and outpatient utilization, re-admission within thirty (30) days, frequency of diagnosis, inpatient age distribution, member and provider satisfaction, primary care physician coordination of care, pregnant women's care coordination, and provider response to clinical guidelines. UMMH provided additional information on interpreting this data and the content of their 2005 activities.

UMMH developed and utilized clinical guidelines in the areas of depression and ADHD. The BHO continued work on guidelines for Pregnant Women's Care Coordination. The MCO was involved in this project. Unity Managed Mental Health found that 22% of identified pregnant members accessed mental health services. Their report indicated that their coordinated case finding efforts improved by 188% during 2005. The majority of these cases were identified by Community CarePlus case managers. The BHO and MCO expressed a continued commitment to developing guidelines and practice in the area of providing appropriate mental health support to pregnant members. Their goal is to prevent negative outcomes for the member or infant.

Case management and pain management were additional areas that the BHO was working on with the MCO.

Quality Assessment and Performance Improvement

Access Standards

All Community CarePlus prior authorization policy was approved during 2005. The MCO had a schedule to submit policies and procedures to the SMA for annual review as required. The MCO explained that currently all authorizations were received from providers telephonically. Community CarePlus staff measured the requests and accompanying information against InterQual criteria. If the decision was to deny the authorization, the information was reviewed by the medical director prior to entry into the MCO system. All authorizations were tracked and monitored. The MCO required prior authorization of all inpatient stays, MRI, CT scan, physical therapy, occupational therapy, speech therapy, certain medications, home health services and pain management. Community CarePlus made it clear that there were no prior authorizations required for emergency services, and that all emergency services are reimbursed regardless of who provided them.

A new process was implemented during 2005 to track authorization denials. Community CarePlus decreased the timeframes for responding to authorization requests. They updated their policy to ensure that denials would be overturned when adequate information was provided. Tracking and trending of information occurred and was reviewed on a monthly basis.

Some areas of provider access improved during 2005. The MCO added St. Anthony's hospital, which the MCO believed would positively impact availability of emergency services for Franklin

County members. Community CarePlus admitted that this hospital was not actually located in Franklin County, and that it would be over 50 miles for many residents to get to this hospital. However, they made assurances that St. John's Hospital in Washington and Missouri Baptist Hospital in Sullivan would see MCO members for emergencies or after hours care. Community CarePlus reported that although the Barnes-Jewish-Christian Hospital System and St. John's Mercy Hospitals were not in their network, they maintained a strong relationship with these systems. These hospitals are utilized as out-of-network providers. Community CarePlus was able to add the Barnes-Jewish-Christian (BJC) and Washington University Physicians groups to their provider panel during the past year.

Community CarePlus reported that they continue to struggle with finding several specialty providers, particularly pediatric neurologists and orthopedic surgeons. The MCO had been able to negotiate for these services because the Provider Relations staff developed individualized relationships with providers. They did report paying orthopedic surgeons 100% of billed charges.

Community CarePlus assessed provider availability annually when producing their report to the Missouri Department of Insurance. In 2005 the MCO conducted a study on the availability of 24-hour coverage by providers, as required in their MC+ Medicaid Managed Care Contract. The MCO monitored provider telephone logs, conducted blind telephone testing, and obtained input from providers directly. Community CarePlus reported doing well in this area, but admitted that there were providers who needed work and continued testing. The MCO reported that they contracted with all of the Federally Qualified Health Centers (FQHCs) in their MC+ Managed Medicaid area that improved daytime and some after-hours access.

Community CarePlus revised their access to service policy to ensure that urgent services were available within twenty-four (24) hours. The original policy stated that urgent care was required within 48 hours.

Ratings for compliance with Access Standards (47.1%) reflect a serious attempt by the MCO to complete required policy to meet the requirements of the MC+ Medicaid Managed Care contract and federal regulations. However, all required policy and procedure are not complete. Community CarePlus must continue their efforts to develop necessary policy and practice to be

in full compliance. Observations made at the time of the on-site review indicated that these efforts were underway.

Table 55 - Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison

Federal Regulation	CCP	
	2004	2005
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	1	1
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	1	1
438.206(b)(5) Out of Network Services: Cost Sharing	1	1
438.206(c)(1)(i-vi) Timely Access	1	1
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	1	1
438.208(c)(1) Care Coordination: Identification	2	2
438.208(c)(2) Care Coordination: Assessment	1	1
438.208(c)(3) Care Coordination: Treatment Plans	1	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	0	1
438.210(b) Authorization of Services	0	2
438.210(c) Notice of Adverse Action	1	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	1	2
438.210(e) Compensation of Utilization Management Activities	1	2
438.114 Emergency and Post-Stabilization Services	0	1
Number Met	4	8
Number Partially Met	10	9
Number Not Met	3	0
Rate Met	23.5%	47.1%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Community CarePlus continued to develop their credentialing standards. The MCO assured that providers maintained licensure and the right to practice in Missouri. Source One was employed to run a monthly data scan against licensing listings. This process enabled the MCO to maintain current licensure information. Community CarePlus reported that they were current on all credentialing for new physicians and on delegated credentialing. The MCO developed a work plan to ensure that the remaining provider list would be current during the

coming year. The MCO expected to be current on all providers due for credentialing within a few months.

In the fall of 2005, an after-hours survey was conducted by telephone to assess twenty-four hour primary care physician (PCP) availability. Community CarePlus worked toward making after-hours services available to prevent the unnecessary use of emergency rooms. If providers did not meet the requirements for after-hours availability, they received education on policy. Provider representatives visited these PCP offices every six weeks for follow-up, and provided additional assistance to trouble shoot specific issues. Community CarePlus developed a definition of "medical necessity" as required.

The rating for Structure and Operation Standards (80%) reflects the timely and efficient submission of policy to the SMA for their review and approval. The MCO understood that continued improvement in this area of practice was needed. However, they continued to make progress. Observations at the time of the on-site review supported Community CarePlus success at identifying and improving areas that had previously been problematic.

Table 56 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison

Federal Regulation	CCP	
	2004	2005
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	1
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2
438.214(d) Provider Selection: Excluded Providers	1	2
438.214(e) Provider Selection: State Requirements	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	1	1
438.56(c) Disenrollment Requested by the Enrollee	2	2
438.56(d) Disenrollment: Procedures	2	2
438.56(e) Disenrollment: Timeframes	1	2
438.228 Grievance System	1	2
438.230(a,b) Subcontractual Relationships and Delegation	1	2
Number Met	4	8
Number Partially Met	6	2
Number Not Met	0	0
Rate Met	40.0%	80.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Community CarePlus had not developed or implemented specific practice guidelines with providers. The MCO had a new medical director and planned to confront this issue. Concern was expressed about resistance to the use of practice guidelines in the St. Louis area. The requirements of the federal regulations regarding practice guidelines were shared with Community CarePlus. The medical director considered decisions based on "what is appropriate for the member and supports care that is based on peer review and outcome based research," as a sound benchmark. The need to comply with the requirements in the federal regulations was stressed to the MCO.

Community CarePlus instituted a number of Quality Assessment and Performance Improvement activities during 2005. Their Quality Improvement group met quarterly and included five physicians who actively participated. The MCO's goal of providing quality services to members was the focus of the group's discussions. Community CarePlus viewed this initiative as having a positive effect on the performance and focus of the MCO. A suggestion generated by this group

led the MCO to hand deliver EPSDT lists to providers. By making personal contact, the importance of performing EPSDT exams and providing feedback to the MCO was stressed. Community CarePlus worked with the Missouri Department of Health and Senior Services (DHSS) to obtain immunization information since November 2004. The MCO continues its attempts to obtain access to the DHSS MOSAIC system.

Community CarePlus reported that a major change during 2005 in the Quality Assessment and Improvement program was the development and completion of policy regarding member Grievance and Appeals, and provider Complaints, Grievances and Appeals. The MCO set up an internal monitoring process and found a 100% success rate in sending letters according to policy during the first quarter of 2006.

Community CarePlus submitted two Performance Improvement Projects (PIPs) for validation. Although these PIPs lacked maturity to allow for complete validation, they indicated substantial improvement in utilization of this process as a tool for MCO growth. The structure of both PIPs followed the federal protocol and showed a great deal of potential.

The MCO submitted all required information to complete the Validation of Performance Measures, as requested. Community CarePlus continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The details of each of these areas of validation can be reviewed within specific sections of this report.

The rating for Measurement and Improvement (54.5%) reflects a diligence toward meeting the requirements of the MC+ Medicaid Managed Care contract and federal regulations. Many policies and procedures have been submitted to the SMA for their review and approval. The MCO needed to work on the development, dissemination, and application of clinical practice guidelines. Some policy development must still occur.

Table 57 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison.

Federal Regulation	CCP	
	2004	2005
438.236(b)(1-4) Practice Guidelines: Adoption	1	1
438.236(c) Practice Guidelines: Dissemination	1	1
438.236(d) Practice Guidelines: Application	2	1
438.240(a)(1) QAPI: General Rules	1	1
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	1	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	1	2
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	2
438.242(b)(3) Health Information Systems: Basic Elements	1	2
Number Met	2	6
Number Partially Met	9	5
Number Not Met	0	0
Rate Met	18.2%	54.5%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Community CarePlus completed and submitted the majority of policy and procedures to make their Grievance System compliant with MC+ Medicaid Managed Care contract requirements and federal regulations. The MCO put processes in place to capture member and provider contacts. Although they experienced some reduction in staff, the MCO was working smarter and developed better communication between internal departments. This enhanced their ability to track and respond to member grievance and appeals, as well as provider complaints, grievances, and appeals.

Two member grievances were provided for review. Copies of the phone log were provided rather than the requested member files. Required correspondence was not included. Both

grievances related to difficulty accessing providers. In one case, a provider refused to see a child because the parent did not speak English. Provider Services staff met with the provider regarding their contractual requirements to serve MC+ Medicaid Managed Care members. They also provided education about requesting interpretive services when necessary. According to the information presented, the provider staff did not recall this incident. In the second grievance the member requested a specific provider. The MCO referred the member to their open panel protocol and offered two alternative physicians. The member explained that these physicians were too far from their home, and asked for a provider in the home community. No specific resolution was identified in the information provided.

Five provider complaints were reviewed. Three of these concerned claim denials as the result of late filing. Two were overturned and one was upheld. The fourth complaint requested an additional payment and the denial was upheld. These files did contain required information and correspondence. In one case the correspondence was mailed outside of the required timeframes. The final complaint involved a denial due to lack of authorization for inpatient psychiatric services. The case was referred to UMMH for a second level appeal. No record was found and no explanation was available.

Community CarePlus admitted that early in 2005, the time period from which the grievances and complaints were requested, their system was in disarray. They did voluntarily produce member and provider files from later in the year to exemplify the improvements the MCO made in their Grievance System during 2005. These records did contain correspondence and documentation that was in chronological order and were more complete. The MCO shared the current Grievance System policy and tracking information. It did appear that significant improvement occurred in their processes.

The rating for the Grievance System (94.4%) reflects approval of the majority of policy and procedures required to meet MC+ Medicaid Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that currently Community CarePlus was meeting all requirements of operating a functional Grievance System for both providers and members. Follow-up review of the Grievance System should occur in the future.

Table 58 - Subpart F: Grievance Systems Yearly Comparison

Federal Regulation	CCP	
	2004	2005
438.402(a) Grievance and Appeals: General Requirements	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	1	2
438.404(b) Notice of Action: Content	1	2
438.404(c) Notice of Action: Timing	1	2
438.406(a) Handling of Grievances and Appeals: General Requirements	1	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	1	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	1	2
438.410 Expedited Resolution of Appeals	1	2
438.414 Information about the Grievance System to Providers and Subcontractors	1	2
438.416 Recordkeeping and Reporting Requirements	0	1
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2
Number Met	9	17
Number Partially Met	8	1
Number Not Met	1	0
Rate Met	50.0%	94.4%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Summary

Although Community CarePlus was not 100% compliant in any area, it must be noted that the MCO made significant improvement in policy and procedure submission and approval in all areas. At the time of the 2004 EQR areas of practice not meeting compliance standards were also identified. At the time of this review improvement in many areas of performance were observed. Community CarePlus continued their commitment to members and to providing healthcare services in an effective manner by demonstrating an atmosphere of respect and dignity toward members.

During the on-site review Community CarePlus indicated that they recognized the need to improve in the development of policies and procedures, and continue to review and upgrade their organization's performance. They exhibited a commitment to these goals, and provided sound examples of the progress made during 2005. Although the MCO was not fully compliant, the improvements witnessed at this review provided a sound foundation for continued efforts to make the changes required to meet full compliance in the future.

STRENGTHS

1. Community CarePlus had specific tracking mechanisms in place to ensure that policy review, updates, and submissions occurred in a timely manner. There was evidence of attention to the detail required to have accurate and responsive policy.
2. Community CarePlus exhibited a great deal of concern and commitment regarding their responsibility in meeting the state contract requirements and federal regulations.
3. In planning for the site visit and the 2005 External Quality Review, Community CarePlus was responsive to all information and documentation requests. Additionally, the EQRO staff witnessed excellent follow-up, tracking, and submission for required information.
4. There was a distinct recognition within the organization of the need to understand and communicate throughout all departments. In conducting the interviews, staff exhibited a much firmer knowledge of the business of the MCO.
5. Continued partnership with Unity Managed Mental Health to meet the need of Community CarePlus members.

AREAS FOR IMPROVEMENT

1. Continue to utilize the resources at Community CarePlus to complete all necessary policy documentation and submission to the SMA.
2. Finalize all improvements and corrections in the Member and Provider Handbooks to ensure timely approval, which is required annually.
3. Development and utilization of established practice guidelines.

RECOMMENDATIONS

1. Continue to develop the atmosphere within Community CarePlus that motivates the attention to compliance with contractual requirements and federal regulations. A great deal of improvement was witnessed in this area. Maintaining these improvements is an important factor in continuing the confidence in the MCO.
2. Continue to utilize available data and member information in order to drive change and measure performance.
3. Continue to enhance the member grievance and appeal system, and the provider complaint, grievance and appeal system. The files reviewed at the request of the MCO from late 2005 were more complete and appeared to follow policy. Processes have been developed to internally capture member and provider contacts. Ensure that these processes are followed and continue to improve.

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SECTION 7.0
MERCY MC+

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7.0 – Mercy Health Plans

7.1 Performance Improvement Projects

The previous sections of the 2005 EQRO report present the purpose and objectives, technical methods, procedures for evaluation, and MCO to MCO comparisons of analyses, findings, and recommendations for each of the protocols based on the aggregate analysis. This section of the EQRO report summarizes MC+ MCO specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for MC+ Managed Care Members. Please refer to the main report for detailed technical objectives, methods, and presentation of data that are referenced here for the MC+ MCO.

METHODS

Document Review

Mercy MC+ supplied the following documentation for review:

- NCQA Quality Improvement Activity Form: Medicaid Emergency Room Utilization
- NCQA Quality Improvement Activity Form: Customer Service – Member Service Call Center Quality

Additional documentation was provided at or after the on-site review, and was considered in completing the validation, including:

- Policy MBS0040 – Member Demographic Verification
- Policy ER02 – Mercy On Call (Nurse Triage Service)
- Policy ER01 – Conducting Member Outreach Related to Emergency Room Utilization
- 2005 Consumer Assessment of Health plans Survey
- Policy HR5015 – Quality Monitoring Process

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on March 2, 2006 during the on-site review, and included the following:

Pat Snodgrass – Director, Performance Improvement
Anna Dmuchovsky – Chief Medical Officer
Steve Mead – Product Manager, Medicaid
Sam Fenner – MC+ Administrator

During the interviews, participants shared information and reviewed validation methods, study design, and findings. Technical assistance regarding study design and measures was provided by the EQRO. The following questions were addressed for specific performance improvement projects on-site:

Medicaid Emergency Room Utilization

- Who is the actual study population?
- How is this topic related to quality, access, and timeliness of health care services?
- What are the stated indicators related to?
- What methods will be used to collect valid and reliable data?
- How are the proposed data measures related to the desired outcomes?

Customer Service – Member Service Call Center

- How is customer satisfaction tied to the proposed intervention?
- What is the study question for this PIP?
- How will proposed indicators be defined or measured?
- What follow-up measures will be utilized to identify improvement?
- Specify what exact data sources will be analyzed to identify improvement.
- What interventions took place and how do they relate to the outcomes defining improved member services?

FINDINGS

The first PIP evaluated was "Medicaid Emergency Room Utilization." The project narrative stated the MCO believed that "excessive time in the emergency room affects one's quality of life. " Members targeted were those that had three or more emergency room visits for a low severity problem in a twelve-month period, and no physician visits during the same time period. A literature review and analysis of MCO and regional statistics was conducted to provide evidence of the effects of this type of member behavior and to support the selection of this issue as an appropriate topic for performance improvement. The narrative, in the additional information provided during and after the on-site review connected the reduction in emergency room visits for low-severity health care services to improved quality, accessibility, and timelines of care. The stated overarching goal of the project was to improve the quality of life of MC+ Members by reducing the excessive time spent in the emergency room.

A specific study population was not identified. However, the study was focused on all members that met the criteria. No group or individual in the MC+ population was excluded by the study. The narrative did incorporate two study questions to examine:

- In Mercy MC+s Medicaid population, will member education about available resources and the appropriate use of emergency room services:
  a. Decrease low severity visits;
  b. Decrease the emergency room rate/1000; and
  c. Increase primary care provider use.

- Will discussions with Mercy MC+'s Medicaid providers about access and availability decrease the Emergency Room Visit Rates (ERVR)?

Three specific and measurable indicators were identified in the project narrative. These included:

- The proportion of Medicaid members accessing the emergency room for a low severity problem.
- Emergency room visits per 1,000.
- The proportion of Medicaid providers with an emergency room visit ratio (ERVR) greater than 3.5(>60%).

There was good presentation of the methods to be used to calculate measures and the benchmarks to be used for comparison. The narrative defined the numerators, denominators, and rate calculation. The number of months Medicaid members were enrolled in the MCO was factored into the definition of the denominator in the "emergency room visits per 1000" indicator. This did not serve to exclude members, but did assist in defining a quantifiable measure.

It appears that the goals of the study are very specific. Long term outcomes are not defined. The original narrative introduces the concept of improved quality of life for members, but the identified indicators' relevance to this goal is not explained.

The narrative and calculation definition does not explain how the MCO will track specific members who are targeted for intervention. It is unclear if the gross data that will be used in the indicators outlined actually improved members quality of life, or if the MCO only achieves a reduction in frequency of emergency room visits.

No demographic information for participants of the study was identified. It was unclear whether only MC+ Members were part of the study. In the original information submitted, it appeared the participants would be included from other projects in other States. The data collection approach appeared to capture all enrollees to whom the study question applied. Participants were identified through claims and administrative databases available to the MCO. The actual sources of the data were not specified.

The planned interventions were defined and included in the project narrative. These interventions included: developing a monthly report of members meeting the project criteria; a plan for telephone contacts with members that includes a call script to ensure that all members obtain consistent information; provider contacts to discuss the requirement for providing after-hour availability, reinforcing policy to not pay for emergency room transportation for non-emergent services; policy to make an exception to the 3-day call requirement for members needing PCP services; provider letters addressing ERVRs and services available; and home visits by a community partner to members failing other interventions. The interventions described are designed to have a positive impact on both member and provider behavior. The narrative did not present hypotheses to measure if the planned approach would have the desired affect. Barriers were not described and actions to overcome barriers were not addressed. The project narrative did not clarify how the effect of these interventions would be analyzed for any positive affect on member behavior or quality of life.

Although detailed data management information and definitions were provided, no actual data analysis plan was presented. Baseline data from January through December 2003, and January through December 2004 were presented. It was possible to determine the source of some of the data, but this was not clearly stated on the form provided. The available information did not provide reliable or valid information for analysis. Planned data analyses should attempt to identify the significance of changes since the baseline was established. Since this project was just underway, and not complete there was no analyses of findings included.

The study appeared to have moderate potential for producing credible findings. The QIA Form, even with the additional information provided after the on-site review, provided limited information about the entirety of the quality improvement and the PIP that was implemented. The information provided during interviews and after the on-site review indicates that this is an

active project with potential for identifying improvement. The format of the information provided does not satisfy all the requirements of the Protocol for Validating Performance Improvement Projects.

The second PIP evaluated was "Customer Service – Member Service Call Center Quality." This PIP was identified as a non-clinical intervention. The rational for selection of this project was based upon the results of the yearly Consumer Assessment of Health Plans Survey (CAHPS), which indicated that the rates of customer satisfaction for operations remained flat or declined. The MCO also performed some internal analysis of operations. This revealed problems that stemmed from the call center. For example, there was an increase in appeal decisions overturned due to inaccurate benefit information provided from the call center. The justification for selecting this topic for a performance improvement project was "To improve the quality of the call experience for members by assessing qualitative performance against call quality attributes. Individual and group performance monitoring provides call center managers with unbiased assessments of performance – a useful tool to reward progress." The narrative did identify project goals as:

- Improved verbal and written communication to the member;
- Improved compliance with HIPAA privacy and security guidelines and preservation of member rights; and
- Achieving excellence in areas of respect and dignity toward the member.

There was no study question included in the information provided. The narrative did not make it clear how customer satisfaction was related to the proposed interventions at the call center, or how this was to be measured. The narrative did not delineate how this project would impact MC+ Members. No specific population was detailed in the information provided.

The study narrative did not provide objective and clearly defined or measurable indicators. The one measure included was "Average Call Quality Rating." It did not explain what this rating was or how it was achieved. It did state that the goal for performance improvement was to achieve an average call rating of $\geq$ 98%. There was no explanation of what this number related to, or how this measure is achieved.

The study does not explain how it will measure any positive impact on members or member services. Sources of data are not revealed. The narrative alludes to a separate "QUIP" that will track progress toward call quality objectives." It does not relate if the MCO will compare progress in the call center quality rates to the customer service rates from the annual CAHPS. All sources of data are not identified. The project does not provide an explanation of a systematic method of collecting valid and reliable data that represents the entire population to which the study applies. The documentation provided does include a survey instrument to be utilized for call monitoring. There is no accompanying explanation of how data collected from this instrument is analyzed.

The interventions for staff monitoring, the development of training programs and initiatives, and the desired impact on member information and satisfaction were discussed during the on-site review. This information is not detailed in the project documentation. The information provided does not present a complete picture of the planned interventions and the expected outcomes.

This is a twelve-month project that was not fully implemented until January 2006. There is no data available to be analyzed. No data analysis plan was provided in the narrative.

This project is far from mature. It may have some potential for a positive impact on member services, but this is impossible to assess at the present time. During the on-site review the MCO was provided with comments about the difficulty of validating the PIP in the format presented. There is only a limited relationship between the intent, methods, and outcomes in the information provided. It is not possible to evaluate if this project will produce credible findings based on the information available.

STRENGTHS

1. The first Performance Improvement Project, Emergency Room Utilization has the potential to positively impact services to members.
2. The Emergency Room Utilization Project presented an excellent justification based on the national literature review and baseline data.
3. The projects presented have the potential to lead to multi-year projects that will create growth in member services.
4. The PIPs presented addressed both clinical and nonclinical issues.

AREAS FOR IMPROVEMENT

1. Improved development and provision of adequate narrative explaining and supporting the proposed or on-going activities presented would enhance the validity or potential of the projects presented.
2. Incorporating all the data and measurements in a manner that related to the problem, interventions, outcomes, and conclusions would add credibility.
3. There is a need to clearly state a study question in each project presented in order to focus the topic and guide the interventions developed.
4. Clearly defined measure indicators must be included in all projects.

RECOMMENDATIONS

1. Utilize the "Conducting Performance Improvement Projects" protocol in reporting the PIP to ensure that all aspects of projects are covered in the narrative, or to explain any deficits.
2. In development and reporting on non-clinical PIPs, ensure that the problem, the interventions, and intended outcomes truly impact member services, and are not just a method of improving MCO internal performance.
3. Work on providing clear and reliable information and data to ensure that intended outcomes can be identified and supported.

7.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Mercy MC+. Mercy MC+ submitted the requested documents on December 9, 2005. The EQRO reviewed documentation between December 9, 2005 and February 27, 2006. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

Document Review

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Mercy MC+
- Healthcare Research Associates' (HRA) HEDIS Compliance Audit Report for 2005
- Mercy MC+'s Information Systems (IS) policies and procedures pertaining to HEDIS 2005 rate calculation
- Mercy MC+s IS policies on disaster recovery
- CRMS & HEDIS project plan
- NCQA HEDIS software certification report
- Medical record review process flowchart
- CareEnhance Resource Management System (CRMS) data warehouse and Health Plan Reporter (HPR) Manual

The following are the data files submitted by Mercy MC+ for review by the EQRO:

- ADV_File1.txt
- ADV_File2..txt
- CIS_File1.txt
- CIS_File2.txt
- CIS_File3.txt
- W15_File1.txt
- W15_File2.txt
- W15_File3.txt

Interviews

On Wednesday, March 1st, 2006, the EQRO conducted a site visit and interviews at Mercy MC+ with Patricia Snodgrass, Charles McLaughlin, Dave Reisinger, and Donna Osdyke. This group was responsible for calculating the HEDIS 2005 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS performance measures. The information systems (IS) management policies and procedures for rate calculation were consistently evaluated with the CMS Final Protocol for the Validating Performance Measures. This included both manual and automatic processes of information

collection, storing, analyzing and reporting. Due to the requirements of their data warehouse, Mercy MC+ was unable to show the EQRO the HEDIS 2005 data during the site visit.

FINDINGS

Mercy MC+ calculated the Childhood Immunization Status, Combination #2 and the Well-Child Visits measures using the Hybrid Method. MCO to MCO comparisons of the rates of Childhood Immunization Status Combination #2, Well-Child Visits, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The rate for the HEDIS 2005 Childhood Immunization Status, Combination #2 reported to the SMA and the State Public Health Agency (SPHA) was 38.93%. This figure was comparable to the statewide rate for all MC+ MCOs (28.17%; z = -.52; statewide 95% CI: 27.83%, 50.03%; n.s.).

The rate for Mercy MC+ for the HEDIS 2005 Well-Child Visits in the First 15 months of Life measure was 43.80%, comparable to the statewide rate for all MC+ MCOs (38.42%; z = .04, statewide 95% CI: 31.27%, 56.33%; n.s.). The 2005 HEDIS rate for Mercy MC+ for the Annual Dental Visit was 20.52%, significantly lower than the statewide rate for MC+ MCOs (29.76%, z = -1.62; statewide 95% CI: 16.24%, 24.80%; $p < .001$).

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity. The findings for each measure discussed within the activities are deemed appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

Data Integration and Control

For all three measures, Mercy MC+ was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Mercy MC+ transferred data into the repository used for calculating the HEDIS 2005 measures.

Documentation of Data and Processes

Mercy MC+ used NCQA-certified software from McKesson Inc. for the sampling and calculation of HEDIS measures. The EQRO was provided with a demonstration of the Health Plan Reporter (HPR) (the application module for rate calculation), as well as the CareEnhance Resource Management System (CRMS) data warehouse. The information contained in the data warehouse and shown to the EQRO during the site visit was the current HEDIS data, and not the data being validated by the EQRO. Mercy MC+ stated that they were unable to show the EQRO the data they were validating because a system upgrade required the MCO to purge all the prior year's data. Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Mercy MC+ met nearly all criteria applicable for the three measures. There were two criteria which were not met. The first involved the use of statistical significance testing to document changes in performance over time. The second criteria was to utilize this information to support claims of improvement or stability in performance over time. Although many auditors conduct statistical tests to examine various aspects of data validity, such tests should be used by the Mercy MC+ to assess the significance of change related to quality improvement activities and operational changes. The use of NCQA-certified calculation software is considered adequate for calculating the rates.

Processes Used to Produce Denominators

Mercy MC+ met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of members eligible for the services being measured. The denominator file for the Childhood Immunization Status measure contained a total of 1,912 members; Mercy MC+ reported a total of 1,309 eligible members on the DST. 411 records were selected for the sample; Mercy MC+ only provided the EQRO with service codes and service dates for the 411 members, therefore it is difficult to determine why there was a discrepancy between the eligible members found by the EQRO and those identified by the MCO. There were no members represented more than once and the dates of birth and enrollment were valid. The denominator file for the Well Child Visits measure contained a total of 1,739 members; Mercy MC+ reported a total of 1,272 eligible members on the DST. Again, 411 records were selected for the sample; Mercy MC+ only provided the EQRO with service codes and service dates for

the 411 members, therefore it is difficult to determine why there was a discrepancy between the eligible members found by the EQRO and those identified by the MCO.

For the Annual Dental Visit measure, there were a total of 18,704 eligible members reported by Mercy MC+; the EQRO validated a total of 15,488 eligible members. There were no duplicate members included and the dates of birth and enrollment were in the valid ranges.

Processes Used to Produce Numerators

Data ranges for the qualifying events (e.g., immunizations, well-care visits, and asthma medications) as specified by the HEDIS 2005 criteria were reviewed in the files submitted by Mercy MC+ (see Attachment XIII: Numerator Validation Findings). Medical record reviews were conducted for the Childhood Immunization Status and Well-Child Visit measures.
For the HEDIS 2005 Childhood Immunization Status Combination #2 measure, Mercy MC+ appropriately included administrative events from the State Public Health Immunization Registry (MOHSAIC). A total of 1,912 unique members were validated in the file; Mercy MC+ reported a total of 1,309 eligible members on the DST. The MCO only provided numerator data for the 411 members sampled; of those, all 90 of the reported administrative hits were validated. The dates of birth and dates of service were within the valid ranges. Of the 70 numerator hits reported by medical records, the EQRO sampled 30 for validation. All 30 of the medical records requested were received for review, 29 of which were validated by the EQRO. Therefore, 96.67% of the medical records could be validated for a total of 68 hybrid hits. The rate calculated by the EQRO based on validated administrative and hybrid hits was 38.36%, an overestimate of .57%. However, the accuracy of this bias is in question, as Mercy MC+ only requested 182 of the 321 records in the sample that did not contain administrative hits. Of the 182 records they requested, they only received 148. It is difficult to estimate how many additional hits may have been found through the hybrid method if the records had been requested for review. In effect, the MCO excluded 139 records from the onset of the medical record review process.

For the HEDIS 2005 Well-Child Visits measure, a total of 1,272 eligible members were reported on Mercy MC+'s DST. The EQRO found 1,739 eligible members in the files provided by Mercy MC+. The MCO only provided numerator data for the members selected for the sample of 411 members. Of those, all 133 of the reported administrative hits were validated. The dates of birth and dates of service were within the valid ranges. Of the 47 numerator hits reported by

medical records, the EQRO sampled 30 for validation. All 30 records were received, 21 of which were validated. Of the 9 records that did not have the required six well-child visits to be considered a hit, four (4) records contained 5 visits, two (2) records contained 4 visits, one (1) record contained 3 visits, and two (2) records contained 2 visits. With 70.00% of the medical records validated, a total of 33 hybrid hits were found by the EQRO. The rate calculated by the EQRO based on validated administrative and medical record hits was 40.36%. This resulted in an overestimated bias of 3.44% by Mercy MC+. Again, the accuracy of this bias is in question, as Mercy MC+ only requested 175 of the 236 records in the sample that did not contain administrative hits. Of the 175 records they requested, they only received 97. It is difficult to estimate how many additional hits may have been found through the hybrid method if the records had been requested for review. In effect, the MCO excluded 61 records from the onset of the medical record review process.

The HEDIS 2005 Annual Dental Visit was the third measure validated. There were a total of 3,838 unique numerator hits reported, of which 3,833 were validated. The dates of birth, enrollment and services were within the valid ranges. The final rate calculated by the EQRO was 20.49%, an overestimated bias of 0.03%.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunization Status and the Adolescent Well-Child Visits measures. Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for each of these measures. There were no replacements, contraindications, or exclusions reported by the MCO. All criteria for sampling were met for the two measures.

Submission of Measures to the State

Mercy MC+ submitted the DST for each of the three measures validated to the SPHA, (Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

Table 57 shows a summary of the estimated bias in the rates calculated by Mercy MC+. All three measures were overestimated by Mercy MC+, however, the Annual Dental Visit measure was only slightly overestimated, and therefore, is considered fully compliant. The overestimates of both the Childhood Immunization Status, Combination, #2 and Well-Child Visits measures were within the 95% confidence interval for the rates reported by the MCO.

Table 57 - Estimate of Bias in Reporting of HEDIS 2005 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunization Status, Combination #2	.57%	Overestimate
Well-Child Visits in first 15 months of Life	3.44%	Overestimate
Annual Dental Visit	None	

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources. These sources were summarized in the Final Performance Measure Validation Worksheet for each measure (See Table 58). The overestimates found in calculation of the Childhood Immunization Status, Combination #2 and Well-Child Visits in the First 15 Months of Life measures were within the confidence interval, and therefore, were determined to be Not Valid. The Annual Dental Measure was Fully Compliant and valid.

Table 58 - Final Audit Rating for HEDIS 2005 Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status, Combination #2	Substantially Compliant
Well-Child Visits in first 15 months of Life	Substantially Compliant
Annual Dental Visit	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCO. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MC+ Members qualified for the measure.

STRENGTHS

1. Mercy MC+ used NCQA-certified HEDIS software, CRMS/HPR of McKesson Inc. Most of the data for HEDIS measures are stored in the CRMS warehouse from which HPR is used to automatically calculate rates. There were clearly defined data fields within the application, as it automatically feeds the rates required by the State into the HEDIS Data Submission Tool.
2. Numerous validation checks in the reporting process, both manual and automatic were conducted within the software system. There were sufficient edit checks for data entry, which helped in minimizing errors.

3. There were well-documented policies and procedures for the HEDIS rate calculation measures.
4. There were full data integration, retrieval and analysis processes in place. This facilitated efficient collection of data from claims, credentialing provider, pharmacy, lab, utilization, ophthalmic and dental data sources. The State Public Health Immunization Registry (MOHSAIC) was used for collection of immunization data, and is well-integrated into the system.
5. There was a focused software development and technical analysis group for data collection, programming and analysis.
6. Data analysis incorporated tests of statistical significance to assess whether the observed changes in rates were related to a specific intervention.

AREAS FOR IMPROVEMENT

1. The MCO should have a better understanding of the mechanisms and output results of the CRMS/HPR system. Although the software is NCQA-certified, the MCO should display an interest in assuring that the system's outputs are accurate.
2. The MCO should provide the EQRO with the methodology and processes used to calculate HEDIS rates; this information is provided by other plans who utilize the same software vendor.
3. The HEDIS 2005 Annual Dental Visit measure rate was significantly lower than the average for all MC+ MCOs.

RECOMMENDATIONS

1. Improve the collection of medical records from providers by stipulating or reinforcing policies and procedures referring to medical records storing, archiving and retrieval.
2. Responsible managers should improve ownership and control of the CRMS/HPR system to have a better understanding of query structures. There is a need for the Mercy MC+ to have a better understanding of the CRMS/HPR system and how this relates to the HEDIS calculation rates.
3. The MCO should maintain a development machine or second system with the past HEDIS year's data for validation until the EQRO concludes the on-site audit.
4. The MCO should provide the EQRO with the methodology utilized by McKesson to calculate measures, or provide a McKesson representative to answer questions during the site visit that may be "proprietary".

7.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical Claim type, there were 105,046 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Outpatient Claim Type field was 100.00% complete, accurate, and valid.

The Outpatient Recipient ID field was 100.00% complete, accurate, and valid.

The Outpatient First Date of Service field was 100.00% complete and accurate, and 99.32% valid. There were 710 invalid dates of service ranging from 4/29/2005--12/31/2005.

The Outpatient Last Date of Service field was 100.00% complete and accurate, 99.29% valid. There were 571 invalid dates of service ranging from 4/01/2005--9/21/2005.

The Outpatient Units of Service field was 100.00% complete, accurate and valid.

The Outpatient Procedure Code field was 100% complete and accurate, and 99.85% valid. Invalid procedure codes consisted of 154 "99601", three "99602", and one "K0635" entries.

The Outpatient Place of Service field was 100.00% complete, accurate, and valid.

The first Diagnosis Code field was 99.99% complete, accurate, and valid. Nine fields were left blank.

Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 44.53% complete, accurate, and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third, fourth, and fifth Diagnosis Code fields were 0.00% complete, accurate, and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 11,592 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate, and valid.

For the Home Health claim type, there were 29 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate, and valid except the following.

The Outpatient Claim Type field was 100.00% complete, accurate, and valid.

The Outpatient Recipient ID field was 100.00% complete, accurate, and valid.

The Outpatient First Date of Service field was 100.00% complete and accurate, and valid.

The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.

The Outpatient Units of Service field was 100.00% complete, accurate and valid.

The Outpatient Procedure Code field was 0.00% complete, accurate and valid. All fields were blank (incomplete, inaccurate, and invalid).

The first Diagnosis Code field was 100.00% complete, accurate, and valid.

Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 89.66% complete, accurate, and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 82.76% complete, accurate, and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth and fifth Diagnosis Code fields were 0.00% complete, accurate, and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were 5,929 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Inpatient Claim Type field was 100.00% complete, accurate, and valid.

The Recipient ID field was 100.00% complete, accurate, and valid.

The Admission Type field was 100.00% complete, accurate, and valid

The Admission Date field was 100.00% complete and accurate, and 95.99% valid. There were 238 invalid dates ranging from 12/15/2005 --12/31/2005.

The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 98.23% (with 104 entries of "99999999". Valid values were present 96.21% of the time. In addition to the invalid "99999999" entries, 120 invalid dates ranged from 04/01/2005-- 04/05/2005

The Bill Type field was 100.00% complete, accurate, and valid.

The Patient Status field was 100.00% complete, accurate, and valid.

The first Diagnosis Code field was 100.00% complete, accurate, and valid.

The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (75.54%, 55.20%, 0.00%, and 0.00%, respectively).

The First Date of Service field was 100.00% complete and accurate, and 95.99% valid. There were 238 invalid dates ranging from 12/15/2005 --12/31/2005.

The Last Date of Service field was 100.00% complete and accurate, and 97.00% valid. There were 178 invalid dates of service ranging from 04/01/2005--04/30/2005.

The Revenue Code field was 99.95% complete, accurate, and valid, with 3 blank fields (incomplete, inaccurate, and invalid).

The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 69,901 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate, and valid with the exception of the Revenue and second through fifth Diagnosis Code fields. The Revenue Code field was 99.97% complete, accurate, and valid, with 23 blank fields (incomplete, inaccurate, and invalid). The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (52.88%, 24.73%, 0.00%, and 0.00%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 65,892 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate, and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Mercy MC+, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. For the Medical claim type, the Outpatient First Date of Service and Outpatient Last Date of Service fields had invalid entries (see above findings) and there were nine blank Diagnosis code fields in the first Diagnosis Code field. The Inpatient claim type had invalid Admission and Discharge Date fields and three blank Revenue Code fields in the Inpatient claim type.

To what Extent do the Claims in the State Encounter Claims Database reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review. Of the 105,046 Medical encounter claim types in the SMA extract file for January 1, 2005 through March 31, 2005, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 76 medical records (76.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 43.0%, with a fault rate of 57.0%. The match rate for diagnoses was 76.0%, with a fault rate of 24.0%.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were incorrect information (n = 24). The diagnosis code listed did not match the descriptive information in the record.

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 23) and incorrect codes (n = 20). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Medical and Dental claim types for Mercy MC+ were consistent with the average for all MC+ MCOs. The Outpatient encounter claim type rate was significantly higher than the average for all MC+ MCOs, while the rates for Home Health, Inpatient, and Pharmacy claim types were significantly lower than the average for all MC+ MCOs. This could indicate a possible access to care for

preventive services that is related to a higher need for inpatient services; or may be associated with claims administration.

What Problems are there with How Files are Compiled and Submitted by the MC+ MCO?

It was not possible to conduct the planned analysis of comparing Mercy MC+s (MHP) encounter data to the SMA encounter claim extract file because there was not an identical encounter number to key the two files. The plan was to compare MC+ MCO paid and unpaid claims to the SMA encounter claim extract file. While MHP did submit the data in the requested format (see Appendix 6) for the MC+ Managed Care Members represented in the encounter claim sample selected by the EQRO for validation, however no internal control number (ICN) was included.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MC+ MCO did submit the data in the requested format, there are a number of ways to improve the data quality by improving the database system. One variable that is not currently represented is that of a unique line number. To match up specific lines of data (each service provided within an encounter), this requires a unique number for each service provided for each member.

STRENGTHS

1. The data was submitted in the specified format which allowed BHC to assess all claim types associated with Mercy MC+.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Dental claim type was 100.00% complete, accurate, and valid.

AREAS FOR IMPROVEMENT

1. The Outpatient First Date of Service and Last Date of Service fields in the SMA encounter claims extract file for the Medical claim type were 99.319% and 99.29% valid, respectively.
2. For Outpatient Home Health claims, procedure codes were missing for all 29 encounters.
3. For the Inpatient claim type, the Discharge Date field and Revenue Code field were 96.21%, and 99.95 valid, respectively. The Revenue Code contained three blank fields.
4. For Outpatient Hospital claims, the Revenue Code field was 99.97% complete, accurate, and valid. Twenty-three fields were blank.
5. Mercy MC+ demonstrated a significantly lower rate than the average of all MC+ MCOs for validation of the SMA encounter claims extract file against the medical record for diagnosis codes and procedure codes. Reasons for medical records not matching were primarily related to missing data.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout and run validity checks after the programming of new edits, and ensure completion of Units of Service field.
2. Always include the Revenue Code regardless of the Procedure Code for the Outpatient Hospital and Inpatient claim types (UB-92 layout).
3. For the Inpatient claim type (UB-92 file layout), improve the rate of valid Discharge Dates to flag invalid entries of "99999999"and blank entries for the Units of Service field. Error checks for the Diagnosis Code field should also be conducted to ensure no blank fields.
4. It is recommended that Mercy MC+ examine the possible reasons for the lower rates of outpatient services (Medical and Outpatient Hospital claim types) and the higher rates of inpatient services through a non-clinical performance improvement project aimed at analysis of encounter claim and utilization data as well as access to care indicators.

7.4 MCO Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MCO's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the Division of Medical Services. On-site review time was used to conduct interviews with those who oversee the daily practices of the MCO to ensure that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MCO Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the MCO and to follow-up on questions raised from the document review and from the 2004 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Provider Contracts
- Grievance and Appeal Policies
- Grievances and Appeals related to members were reviewed, as were Complaints, Grievances, and Appeal files for providers. These files were obtained from a random selection of actions filed in the first quarter of 2005.
- 2004 Annual Quality Improvement Program Evaluation

Additional documentation Mercy MC+ included:

- MC+ Marketing Policy
- MC+ Marketing Plan/2005 and 2006 Community Outreach Plan
- Contract Policy Submittal Log/Mercy DMS Policy Tracking Log
- Care Issues Report
- Narrative on methods of performance for MHP programs
- Member Newsletters
- NCQA Activity: Improving the Quality of Life of Members Living With Asthma
- Executive Summary HEDIS Missouri Regions

- 2004 Corporate Quality Improvement Program
- Policies: Disenrollment Procedures, Mercy MC+ Pharmacy Lock-In, Oversight of Delegated Entities, Emergency and Post Stabilization Care – MC+

Unity Managed Mental Health supplied the following documents regarding their services to Mercy MC+ members:

- Unity Managed Mental Health – 2005 Operations Reporting (for Mercy MC+s MC+)
- Access Standards and Compliance Policy
- 2005 Member Satisfaction MHP MC+ Report
- 2005 Readmission Report
- 2005 Provider Record Survey Outcomes
- 2005 Provide Access Survey
- 2005 Update – MC+ Pregnant Women Care Coordination

Interviews

Interviews were conducted with the following group:

Plan Administration

Steve Mead, Product Manager, Medicaid
Dr. Debbie Zimmerman, Chief Medical Officer
Pat Snodgrass, Director, Performance Improvement
Liz Scott, Business Analyst
Anna Dmuchovsky, V.P., Health Resources
Susan Meiner, Director, Benefit Coordination
Donna Hauler, Manager, Member Services
Debbie Todd, Member Services
Cindy Johnson, Director, Care Coordination
Sam Fenner, MC+ Administrator

Mental Health

Scott Frederick, PHD, Director, Managed Mental Health - UMMH
Marge Viehland, Manager, Utilization Management and Q.I. - UMMH
Cindy Johnson, Care Coordination, Mercy MC+
Liz Scott, Business Analyst, Mercy MC+

FINDINGS

Enrollee Rights and Protections

Mercy MC+ reported that they purchased software to assist in tracking all policies and procedures, including those that must be reviewed on an annual basis. This will ensure timely submission to the SMA for their approval. The MCO reported that they also added a compliance officer to the staff to assist in this process. These changes are not reflected in the information obtained about Mercy MC+'s 2005 activities.

Mercy MC+ was working with a new disease management program that enabled a one-on-one relationship with nurses. This program enables complex care coordination and self-education focusing on lifestyle and teaching. Enhanced software was also utilized to capture any member with elevated lead levels. Mercy MC+ was attempting to identify children with elevated blood lead levels during any healthcare provider encounter. The MCO experienced some difficulty incorporating contacts from the St. Louis County Health Department, which they continued to refine. Mercy MC+ was actively engaged in improving their relationship with the St. Louis City Department of Health in an attempt to strengthen the provision of elevated blood lead level interventions through that source. The MCO also made efforts to improve awareness, and provide education about the need for blood lead level testing with school nurses and counselors in Jefferson County.

The MCO was making new efforts to identify members and obtain valid telephone numbers and addresses for them. Mercy MC+ contracted with a group, KAMA, Inc., an organization that updated and augmented their files once each quarter. This company accessed utility company records and other sources to obtain the most current contact information available. The MCO reported that this process assisted them in locating both new and current members more effectively.

Mercy MC+ initiated a program linking the Compliance Department with network pharmacies. This assisted in the identification of members who may have a problem with prescribed medications. Case management and pharmacy lock-in occurred to assist the member when this problem was identified. A process was put in place during 2005 for notification of providers when a member was identified as having a problem with drug abuse or polypharmancy issues.

The rating for Enrollee Rights and Responsibilities (30.8%) reflects policy that was not complete or not submitted to the SMA for their review and approval. Mercy MC+ provided a policy tracking log and draft policies to be submitted to the SMA for review and approval. Although some improvement in the submission was noted, compliance with the MC+ Medicaid Managed Care contract requirements and the federal regulations was not complete.

Table 59 - Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	Mercy MC+	
	2004	2005
438.100(a) Enrollee Rights: General Rule	1	1
438.10(b) Enrollee Rights: Information Requirements	1	1
438.10(c)(3) Alternative Language: Prevalent Language	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	1	1
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	1	1
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	1	2
438.10(f) Information for All Enrollees: Free Choice, etc.	1	1
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	1	1
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	1
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	1
438.100(b)(3) Right to Services	0	1
438.100(d) Compliance with Other Federal/State Laws	1	2
Number Met	2	4
Number Partially Met	10	9
Number Not Met	1	0
Rate Met	15.4%	30.8%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

The Behavioral Health Organization (BHO) providing mental health services to Mercy MC+'s members was Unity Managed Mental Health (UMMH). During 2005, the two organizations collaborated on a number of initiatives. Case management services were targeted to members who were pregnant. These members were identified through risk assessments, welcome calls, calls coming into Member Services, and through the quality review process. Mercy MC+ worked to improve its relationship with providers to encourage their assistance in completing the risk assessment tool. Identified members then went into a collaborative case management program with UMMH.

For all dually served members, Mercy MC+ and UMMH created a triage process to identify members with both physical and mental health care needs. To facilitate this process, early in 2005, Mercy MC+ and UMMH implemented a shared case management program. The two

organizations shared the same health information system, thus making this arrangement possible. The BHO and MCO staff met and developed a methodology for role sharing focused on approaches to members who needed both types of services. A screening process was developed that placed members into one of four categories. These included members who: refused case management; were accepted into an outreach class; received an outreach call and follow-up; or received a call and appropriate literature. As a result of improved information sharing, the Pregnant Women Care Coordination Program experienced an acute increase in members and nearly doubled in size. UMMH ensured that all pregnant women identified were referred to Mercy MC+ for health case management. Mercy MC+ referred any woman identified with mental health or substance abuse problems to UMMH for follow-up services.

Quality Assessment and Performance Improvement

Access Standards

Mercy MC+ continued to struggle to find certain specialists to join their network. This included pediatric neurosurgery, adolescent psychiatrists, orthopedic surgeons, and pain management. Mercy MC+ ensured that members had access to these specialists when appropriate, by negotiating rates and utilizing out-of-network physicians. The MCO noted that Barnes-Jewish-Christian Medical Centers were added to their network during 2005, which provided access to Washington University Medical School. Mercy MC+ was questioned about adding nurse midwives to their network. They were not able to recruit this service, and indicated they did not view this aspect of their network as a priority. The MCO stated that they have no prior authorization requirement for child psychiatry. If a member contacted the MCO requesting this service, a referral was made to UMMH to ensure that a provider was located in a timely manner.

Case management services remained an important focus for Mercy MC+. Case management was provided to all members with catastrophic illness, those in need of targeted disease management, and members with special healthcare needs. The MCO had a program for physician to physician outreach for babies at risk through a link with neonatologists ensuring better discharge planning and aftercare. This service was coordinated by discharge planners who were housed in various hospitals. Mercy MC+ Member Services and Case Management departments worked to recognize unique member needs and respond in a timely and efficient manner. Examples included recruitment and placement of a Vietnamese speaking home health

nurse and locating a dentist for a child with dental carries upon referral from an emergency room physician.

Mercy MC+ worked with area universities to develop exercise and after-school programs for all ages. They developed a fitness magazine called "*Pulse"* that focused on children's health issues. A website was developed that offered a "Kids Health, Teen Health" area and information for parents. The MCO was contacting area school superintendents and principles offering these programs.

The ratings for Access Standards (52.9%) continued to reflect policies that were not complete, or that have not yet been reviewed and approved by the SMA. Mercy MC+ did provide several policies that they submitted to the SMA prior to the on-site review. Although these updates were noted, the policies had not been reviewed or approved by the SMA. The MCO had not achieved compliance with the MC+ Medicaid Managed Care contract or federal regulations.

Table 60 - Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison

Federal Regulation	Mercy MC+	
	2004	2005
438.206(b)(1)(i-v) Availability of Services: Provider Network	1	1
438.206 (b) (2) Access to Well Woman Care: Direct Access	0	1
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	1	1
438.206(c)(1)(i-vi) Timely Access	1	1
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	2	2
438.208(c)(1) Care Coordination: Identification	2	2
438.208(c)(2) Care Coordination: Assessment	1	1
438.208(c)(3) Care Coordination: Treatment Plans	1	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	1
438.210(b) Authorization of Services	1	2
438.210(c) Notice of Adverse Action	1	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	1	2
438.210(e) Compensation of Utilization Management Activities	2	2
438.114 Emergency and Post-Stabilization Services	0	1
Number Met	6	9
Number Partially Met	9	8
Number Not Met	2	0
Rate Met	35.3%	52.9%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Mercy MC+ maintained a thorough credentialing process. All credentialing and reports of delegated credentialing were completed within required timeframes. All policy and practices regarding disenrollment were submitted to the SMA and approved.

At the time of the 2004 review, Mercy MC+ indicated that they intended to begin a quality improvement initiative that would involve a Medicaid review committee that included members. The MCO developed an MC+ Medicaid Managed Care work group internally, but has not yet involved members as participants. The MCO used this group to provide feedback and to

problem-solve about barrier reductions in member services. Mercy MC+ continued development of quality improvement efforts to increase the rate of EPSDT examinations. The MCO used exception reporting to remind providers of examinations that were due or overdue. The MCO reported that they increased their EPSDT numbers, but recognized that some examinations occurred at local health departments or other providers and were never reported as such.

Mercy MC+ continued to utilize the Blue Ribbon Physician's Network. Appointment standards and quality of care were monitored and the provider group's per member per month rate was adjusted based on their productivity. University Physicians and Barnes-Jewish-Christian Medical Group were added to this group in 2005.

The ratings for Structure and Operation Standards (90%) reflected substantial improvement in submitting all required policy to the SMA for their review and approval. Mercy MC+ continued their solid practice in this area. With completion of all required policy, the MCO will be fully compliant in meeting the requirements of the MC+ Medicaid Managed Care contract requirements and federal regulations.

Table 61 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison

Federal Regulation	Mercy MC+	
	2004	2005
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2
438.214(d) Provider Selection: Excluded Providers	2	2
438.214(e) Provider Selection: State Requirements	1	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	1	2
438.56(c) Disenrollment Requested by the Enrollee	1	2
438.56(d) Disenrollment: Procedures	1	2
438.56(e) Disenrollment: Timeframes	1	2
438.228 Grievance System	2	2
438.230(a,b) Subcontractual Relationships and Delegation	0	1
Number Met	3	9
Number Partially Met	6	1
Number Not Met	1	0
Rate Met	30.0%	90.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Mercy MC+ continued to utilize nationally accepted practice guidelines. The MCO's Internal Quality Improvement Committee continued to review medical records to ensure that these guidelines were correctly implemented. The MCO completed all required policy and practice in the area and was considered compliant in the area of practice guidelines.

The MCO had an integral quality assessment and improvement program within the organization. They utilized information from all subgroups within Mercy MC+ to analyze barriers that existed for providers and members. The Performance Improvement Department then engaged in problem solving to ensure that: providers were held to the highest standards of performance; that the MCO system supported the provision of sound healthcare services; and that members' quality, timeliness and access to these services met all requirements.

Mercy MC+ did submit two PIPs for validation. Additional information about these studies was obtained at the time of the on-site review. In the case of the non-clinical PIP submitted, there was some question about the validity and completeness of the study. These concerns are discussed in the appropriate section of this report.

The MCO submitted all required information to complete the Validation of Performance Measures, as requested. Mercy MC+ continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in a format that could be validated. The details of each of these areas of validation can be reviewed within specific sections of this report.

Ratings for the Measurement and Improvement section (100%) reflect that all required policy and practice existed to meet the requirements of the MC+ Medicaid Managed Care contract and the federal regulations.

Table 62 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison

Federal Regulation	Mercy MC+	
	2004	2005
438.236(b)(1-4) Practice Guidelines: Adoption	2	2
438.236(c) Practice Guidelines: Dissemination	2	2
438.236(d) Practice Guidelines: Application	2	2
438.240(a)(1) QAPI: General Rules	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	2
438.242(b)(3) Health Information Systems: Basic Elements	1	2
Number Met	8	10
Number Partially Met	3	0
Number Not Met	0	0
Rate Met	72.7%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Four member grievances and six provider complaints were reviewed at the time of the on-site review. One member did not receive their identification card, which was reordered and sent to the member. In another case a member could not locate an orthopedic surgeon. The MCO located an out-of-network provider who accepted the Medicaid reimbursement for providing the necessary services. One member was unhappy with their original primary care physician (PCP), stating this provider was rude and unprofessional. The situation was resolved with a referral to a new PCP. The last member presented to the PCP with back and ovary pain. The provider's staff would not schedule an appointment and stated the member needed to see a specialist. The specialist contacted by the member would not see this individual without a PCP referral. The member complained that the PCP staff treated her rudely and was not

sympathetic to her frustration. In this member's file Mercy MC+ wrote that the staff were "Advised and the complaint would be noted." The member was informed by the MCO that if she wanted another PCP, they would provide a listing, but advised that "they were not responsible for providers' staffing."

The documentation in these member records was clear and dated in sequence of contacts and correspondence. However, no follow-up letters to members were located. With the exception of the final grievance discussed, the responses generally appeared to be appropriate and timely. In the final grievance there was no additional information in the member's file and no apparent follow-up with the member or original provider.

Of the six provider complaints reviewed, three were initially denied, but upon inspection found to be emergent in nature and were paid. Another denial for services was overturned when the member's enrollment date was corrected. The next complaint was overturned due to late filing, but it was overturned. The final complaint concerned a claim that was upheld due to no prior authorization. Documentation within the provider records was more difficult to follow and no correspondence was located in these files.

The MCO indicated that policy was developed for provider complaints, grievances and appeals. However, the appearance of the records reviewed indicated that this policy was not followed at the beginning of 2005.

The rating for the Grievance Section (89%) reflects the lack of appropriate information properly filed in the records for members, or for provider complaints. Required policy is in place and has been submitted to the SMA for final approval. The MCO will be fully compliant with this section when the records of this section are in the order as required by their own policy.

Table 63 - Subpart F: Grievance Systems Yearly Comparison

Federal Regulation	Mercy Health Plan	
	2004	2005
438.402(a) Grievance and Appeals: General Requirements	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2
438.404(b) Notice of Action: Content	2	2
438.404(c) Notice of Action: Timing	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2
438.408(a) Resolution and Notification: Basic Rule	2	1
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2
438.410 Expedited Resolution of Appeals	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	1
438.416 Recordkeeping and Reporting Requirements	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2
Number Met	18	16
Number Partially Met	0	2
Number Not Met	0	0
Rate Met	100%	88.9%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Summary / Follow-up

Mercy MC+ improved in completing and submitting policy to the SMA for review and approval, however, the MCO continued to have policies and procedures to complete and submit. It was noted that no sense of urgency about completing these requirements to achieve compliance with either the MC+ Medicaid Managed Care Contract or federal regulations existed. Mercy MC+ ratings for Grievance Systems declined as the result of insufficient maintenance and practice identified in the records reviewed.

Mercy MC+ exhibits a sense of professionalism and compassion in their work with their members. Positive aspects of the practice observed at the MCO are overshadowed by the lack of attention to completing required policy and procedure.

STRENGTHS

1. Improved submission of required policies and procedures in an effort to comply with state contractual requirements and federal regulations.
2. Continued partnership with Unity Managed Mental Health, including the current collaboration in the area of case management.
3. Case Management practices, particularly the approach MHP took in the areas of special projects, lead, asthma, and all special healthcare needs.
4. Efforts to control misuse of prescription drugs including utilization of pharmacy data, identification of members, and contacting providers.
5. All MC+ community outreach efforts.
6. Focusing resources on Kids Health and Teen Health, including the utilization of web based information.

AREAS FOR IMPROVEMENT

1. Timely and complete submission of required policy and procedures.
2. Need for network development for specialty physicians and PCPs. The Provider listing in the Member Handbook indicated that there was one county bordering St. Louis County with only one PCP having an open panel. The MCO indicated that they were below the requirement of 85% of available PCPs.
3. Include any correspondence to members in the grievance and appeal files. Ensure that members are treated with respect when they have an involved problem. Provide supervisory oversight and reflection in the file of follow-up with those involved when a problem exists.
4. Increase documentation of how provider complaints, grievances and appeals are handled. Include correspondence in the file.

RECOMMENDATIONS

1. The MCO reported new software and methods for tracking annual and required policy submission deadlines. Utilize this tool to continue improvement in this area.
2. Obtain approval for, and implement, developed policy regarding provider complaints, grievances, and appeals.
3. Continue efforts to maintain current demographic data on members, including their current addresses and telephone numbers. Use of a contractor, and other methods, to focus on this issue, indicated the MCO's commitment to provide member services.
4. Continue community based partnerships and provider education efforts to improve the incidence of EPSDT examinations and implementing preventive health measures with children/members who may not access Mercy MC+ services.

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SECTION 8.0
HEALTHCARE USA

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8.0 – HealthCare USA

8.1 Performance Improvement Projects

The previous sections of the 2005 EQRO report present the purpose and objectives, technical methods, procedures for evaluation, and MCO to MCO comparisons of analyses, findings, and recommendations for each of the protocols based on the aggregate analysis. This section of the EQRO report summarizes MC+ MCO specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for MC+ Managed Care Members. Please refer to the main report for detailed technical objectives, methods, and presentation of data that are referenced here for the MC+ MCO.

METHODS

Document Review

HealthCare USA supplied the following documentation for review:

- Performance Improvement Project 2005: 2005 Lead Performance Improvement Project
- Performance Improvement Project 2005: 2004 Pre-Authorization Performance Improvement Project
- "Important Information" Lead Information Brochures
- Provider Information Letter, Poster
- "NewsLEADer" for Members, and all lead-related handouts and marketing materials
- HealthCare USA Provider Satisfaction Survey 2003
- Authorization Directory
- Coventry QuickGuide "Back Office Operations"

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on March 1, 2006 during the on-site review, and included the following:

Jackie Inglis – VP Health Services
Cathy Krueger – Supervisor, Quality Improvement
Cindy Butler – Manager, Health Services
April Gross – Supervisor, Complex Case Management

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the Project Leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What was the intervention?
- What was the time period of the study?
- Was the intervention effective?
- What does HCUSA want to study or learn from their PIPs?

The maturity of the PIPs submitted for validation was not complete at the time of the initial request for this information in October 2005. The MCO was instructed that they could submit additional information that included outcomes of the intervention. Additional clarifying written information was received from the MCO after the on-site review.

FINDINGS

The first PIP evaluated was the "2005 Lead Performance Improvement Project." The study topic, increasing the rate of blood lead level testing for children at both 12 and 24 months of age, was explained in detail. The background and explanation was presented, including the MCO's literature and data reviews, as well as references, supporting the selection of the topic. The study topic justification examines the depth of the problem of blood lead poisoning, and the inadequate attention to appropriate testing that often accompanies this issue. National and statewide statistics were considered in making the decision for choosing the topic and approach for this study.

The MC+ Medicaid Managed Care population turning ages 12 or 24 months of age during 2005 was the target of this study. The rational for targeting children of this age was presented, including a reference to the Centers for Medicare and Medicaid Services (CMS) and Missouri State requirements for blood lead level testing at these ages. The study question was: "Does member and provider education regarding lead testing at 12 and 24 months have an impact on the overall rate of lead testing at 12 and 24 months?" The MCO anticipated that blood lead level testing rates would increase for both age groups with the implementation of the educational initiative. Two separate interventions are implied with the study question

presented. The narrative does not differentiate how the impact or effectiveness of either intervention will be measured to specify individual influence.

Indicators and goals are presented in a table included in the presentation. There is no narrative explanation, which leaves some questions about the meaning of the indicators. No sampling techniques were used. The study population is described as all "children eligible with HealthCare USA who turn 12 and 24 months old 2005." The study will also target primary care physicians, pediatricians, and family practice physicians for education.

The data to be collected includes claims data pulled from the MC+ MCO data warehouse for eligible members obtaining blood lead chemistry tests within three months of their 12 month or 24 month birthday. The numerators and denominators are defined. The study provides no additional details of the data sources or how a systematic method for ensuring valid and reliable data will be determined. The study does not provide a prospective data analysis plan, although some actual data analysis is included. The narrative does identify barriers to the improvement strategy, and a proposed intervention for member, providers, the community, and MC+ MCO staff.

Data analysis was performed for figures received for the 2005 calendar year, and are compiled by MC+ Medicaid Managed Care region, as well as in an aggregate manner. Claims were analyzed quarterly. This study was planned to continue during calendar year 2006 and is not considered complete. The actual annual data for the baseline year 2004 and the first year of the intervention 2005, were included. Percentages of change were also indicated. A 2 x 2 contingency table (chi-square statistical analysis) was used to determine statistical significance between the 2004 baseline and the 2005 re-measurement data.

It is possible that the positive change identified was the result of the interventions presented, but a strong case for this was not presented. Improvements in member behavior was difficult to identify, and it could not be determined if this was the result of member or provider changes. The study does discuss a number of environmental factors that can impact the results of this study. It acknowledges the barriers to success, particularly in the Eastern MC+ Managed Care Region. The narrative described other community based interventions that occurred independently of MCO efforts, but the impact of these differences were not factored into the

results presented. The information presented does not clarify how any of the issues identified as barriers or the other factors that impact compliance in the Eastern Missouri MC+ Region might be addressed. Changes as the result of identifying these issues might be included as new components to address in the next implementation cycle of the study, but this was not addressed. The information presented, including the data analysis, provides moderate confidence that this project will have a positive impact on the topic. The variables and environmental factors listed as barriers, and the use of multiple and differing interventions, creates a number of questions about the true cause for measured change.

The second PIP evaluated was titled "2004 Pre-Authorization Performance Improvement Project." This study was considered non-clinical and focused on improving call center and pre-authorization efficiency linked to improved continuity of care for MC+ Medicaid Managed Care members. The project narrative clearly identified how provider satisfaction is tied to access and availability of services for members. This was identified as a multi-year project, with baseline statistics from 2004 with the goal of improving, stabilizing and maintaining pre-authorization telephone statistics. Background research or any literature review was not included in the information presented. The rationale presented for justifying the decision to choose this topic was based on internal data and performance review. The providers who were the focus of this study included primary care providers, OB/GYNs and orthopedic surgeons. Although this was a non-clinical PIP, not directly impacting members, the array of physicians targeted in the proposed study had the potential to improve services for all enrolled populations.

The study question included was "Will operational adjustment improve telephone statistics and provider satisfaction with pre-authorization?" The question does not relate to the access or availability of services to members, leaving this relationship implied. The study did present indicators and goals for achieving increased provider satisfaction in the timeliness for answering calls, and in the overall pre-authorization system. It did not look at direct indicators, such as provider complaints, grievance, and appeal system, which could identify problems. Overturned denials may have been another area of data that could be used in measuring outcomes for this topic, but it was not included in how the MC+ MCO is defining measurable improvement. The study defined the population as all providers requesting any pre-authorization services. No actual sampling occurred. However, the types of providers receiving surveys included only PCPs, Obstetricians, and Orthopedic specialists. The study claims that this group of physicians

"represents the majority of the HCUSA network of providers who provide the majority of services to HCUSA members." No data or other supporting documentation was provided to support this claim.

The data collection methodology was included and centered on gathering statistics from the MC+ MCOs automated call distribution system, and a Provider Satisfaction Survey. The Survey was included in the documentation provided. Data was entered into an Access database to track responses and increases or decreases over time. Chi-Square Statistical Analysis was used to determine significance from year to year. Timeframes for survey distribution were not specified. It can be assumed that these would occur annually, and in all three MC+ Regions. The study design detailed all parts of the analysis process and included a prospective data analysis plan. Interventions and improvement strategies were documented in the narrative. Barriers were described and reasonable interventions to address these issues were included.

An analysis of the findings was included for the 2003 baseline information and the 2004 re-measurement data. There were no results from the 2005 year included in the original information provided. At the time of the on-site review additional information from the 2005 call center monitoring was presented. All information presented was well documented, labeled and explained.

The plan was for this study to be completed at the end of 2005, although all final figures were not available. All available results indicated that there were no declining trends and that evidence of sustained improvement would be available when all data was completed. The MC+ MCO was including all activities involved as interventions as part of their routine call center operations. This project used a research approach to solve a non-clinical problem. The project had the long term goal of improving member services through improving services to providers. The MC+ MCO achieved statistically significant improvement on both telephone statistics and provider satisfaction. The changes that occurred as part of the interventions became part of the daily operations of the pre-authorization department. This non-clinical PIP was successful and indicated sustained improvement in MC+ MCO operations.

STRENGTHS

1. Valid topics were chosen for performance improvement for the MCO, and were supported in the narrative including the literature review presented for the first PIP reviewed.

2. The documentation provided prior to the site visit and additional information supplied at the time of the on-site review provided detailed information that enhanced the validation process.

3. The Performance Improvement Projects truly attempted to enhance the quality of services provided by HCUSA to its members.

4. Data analysis provided sound evidence that "real" improvement occurred throughout the projects.

AREAS OF IMPROVEMENT

1. Although follow-up information included a thorough narrative, the original information was more difficult to follow and evaluate.

2. The focus of the lead initiative was St. Louis City. The MCO serves three regions, and admittedly three distinct populations. There were some interventions in other regions, but St. Louis was clearly targeted. It is important to be inclusive in choosing and implementing initiatives so all members benefit.

3. Ensure that the prospective data analysis plan is included in the project planning documentation.

RECOMMENDATIONS

1. Continue with plans to use HEDIS data definitions for continuous measurement and at least quarterly re-measurement and interpretation of effectiveness of the intervention.

2. Continue with the practice of analyzing PIP effectiveness, ensuring that the interventions for improvement have been incorporated into regular HCUSA practice so real improvement continues.

8.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for HealthCare USA. HealthCare USA submitted the requested documents on December 9, 2005, after a conference call between the EQRO and HealthCare USA additional information was supplied to the EQRO on January 9, 2006 to replace the data files submitted on December 9, 2005. The EQRO reviewed documentation between December 9, 2005 and February 27, 2006. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

Document Review

The following are the documents reviewed by the EQRO:

- The HealthCare USA Baseline Assessment Tool (BAT) for the HEDIS 2005 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2005
- HealthCare USA's information systems policies and procedures with regard to calculation of HEDIS 2005 rates
- HealthCare USA meeting minutes on information system (IS) policies
- A sample of Catalyst's production logs and run controls
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies
- Data field definitions & claims file requirements of the Coventry Corporate Data Warehouse
- Data files from the Coventry Corporate Data Warehouse containing the eligible population, numerators and denominators for each of the three measures.
- HEDIS 2005 Data Submission Tool
- HEDIS 2005 product work plan

The following are the data files submitted by HealthCare USA for review by the EQRO:

- adv denominator – hcusa central.txt
- adv denominator – hcusa eastern.txt
- adv denominator – hcusa western.txt
- adv events – hcusa central.txt
- adv events – hcusa easternl.txt
- adv events – hcusa western.txt
- w15 denominator – hcusa central.txt
- w15 denominator – hcusa eastern.txt
- w15 denominator – hcusa western.txt
- w15 events – hcusa central.txt
- w15 events – hcusa eastern.txt
- w15 events – hcusa western.txt
- cis denominator – hcusa central.txt
- cis denominator – hcusa eastern.txt
- cis denominator – hcusa western.txt
- cis events – hcusa central.txt
- cis events – hcusa eastern.txt
- cis events – hcusa western.txt
- Copy of field long names.xls

Interviews

The EQRO conducted on-site interviews at HealthCare USA in St. Louis Thursday, March 2, 2005 with Cathie Krueger, Lisa Baird, and Laura Frasier. Also available by phone were Rina David-Claytor and Geoff Welsh, who represented the software vendor Catalyst Technologies. This group was responsible for calculating the HEDIS 2005 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2005 performance measures.

FINDINGS

HealthCare USA calculated each of the three measures validated by using the Administrative Method and by region of operation (Eastern, Central, and Western). HealthCare USA failed to provide the detailed enrollment information for all three measures, including enrollment dates and any gaps in enrollment. This information is necessary to validate continuous enrollment and determine the eligible population for each measure. HealthCare USA did provide the EQRO with a denominator file that contained a list of eligible members for each measure. Athough these files were processed through HealthCare USA's Catalyst software and should contain only eligible members for each measure (as Catalyst is a NCQA-certified software), the EQRO was not able to independently validate the denominator files because enrollment history/dates were not supplied. Additionally, HealthCare USA did not provide service codes that could be validated against the HEDIS Technical Specifications. The service codes that were provided had been processed through the Catalyst software and were no longer in the ICD-9 or CPT Code format. The information provided did not include the CPT Codes or ICD-9-CM Codes, but a category or description of what services those service codes represented. It is necessary for the EQRO to receive service codes in the CPT or ICD-9-CM format not only because that is what was request, but also because those formats are the industry accepted standard and the only way for the EQRO to ensure that what they are matching between plans is the same information.

As noted, HealthCare USA calculated each of the three measures validated using the Administrative Method and by region of operation (Eastern, Central, and Western). Results were reported for each of the three regions and in the aggregate for the entire MCO, as the EQRO is charged with providing MCO level comparisons. MCO to MCO comparisons of the rates of Childhood Immunization Status Combination #2, Well-Child Visits, and Annual Dental

Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

HealthCare USA Aggregate:

The aggregate rate was calculated by the EQRO from the information reported by HealthCare USA to the SMA and the State Public Health Agency (SPHA). The HEDIS 2005 Childhood Immunization Status, Combination #2 measure was 18.46%, significantly lower than the statewide rate for all MC+ MCOs (28.17%; z = -1.88; 95% CI: 7.36%, 29.56%; $p < .01$). The aggregate rate for Health Care USA for the HEDIS 2005 Well-Child Visit measure was 41.50%, comparable to the statewide rate for all MC+ MCOs (38.42%; z = -.10; 95% CI: 28.97%, 58.43%; n.s.). The rate for Health Care USA for the HEDIS 2005 Annual Dental Visit measure was 28.89%, comparable to the statewide rate for all MC+ MCOs (29.76%; z = -.17; 95% CI: 24.61%, 33.17%; n.s.).

HealthCare USA Central Missouri Region:

The rate reported by HealthCare USA to the SMA and the State Public Health Agency (SPHA), for the HEDIS 2005 Childhood Immunization Status, Combination #2 measure in the Central Missouri region was 34.91%, comparable to the statewide rate for all MC+ MCOs (28.17%; z = -.79; 95% CI: 28.81%, 46.01%; n.s.). The rate for Health Care USA in the Central Missouri region for the HEDIS 2005 Well-Child Visit measure was 59.85%, significantly higher than the statewide rate for all MC+ MCOs (38.42%; z = .99; 95% CI: 47.32%, 72.38%; $p > .95$). The rate for Health Care USA in the Central Missouri region for the HEDIS 2005 Annual Dental Visit measure was 22.41%, significantly lower than with the statewide rate for all MC+ MCOs (29.76%; z = -1.29; 95% CI: 18.13%, 26.69%; $p < .01$).

HealthCare USA Eastern Missouri Region:

The rate reported by HealthCare USA to the SMA and the State Public Health Agency (SPHA), for the HEDIS 2005 Childhood Immunization Status, Combination #2 measure in the Eastern Missouri region was 14.96%, significantly lower than the statewide rate for all MC+ MCOs (28.17%; z = -2.12; 95% CI: 3.86%, 26.06%; $p < .01$). The rate for Health Care USA in the Eastern Missouri region for the HEDIS 2005 Well-Child Visit measure was 38.68%, comparable to the statewide rate for all MC+ MCOs (38.42%; z = -.27; 95% CI: 26.15%, 51.21%; n.s.). The

rate for Health Care USA in the Eastern Missouri region for the HEDIS 2005 Annual Dental Visit measure was 30.30%, comparable to the statewide rate for all MC+ MCOs (29.76%; z = .07; 95% CI: 26.02%, 34.58%; n.s.).

HealthCare USA Western Missouri Region:

The rate reported by HealthCare USA to the SMA and the State Public Health Agency (SPHA), for the HEDIS 2005 Childhood Immunization Status, Combination #2 measure in the Western Missouri region was 22.01%, significantly lower than the statewide rate for all MC+ MCOs (28.17%; z = -1.65; 95% CI: 10.91%, 33.11%; p < .01). The rate for Health Care USA in the Western Missouri region for the HEDIS 2005 Well-Child Visit measure was 27.06%, significantly lower than the statewide rate for all MC+ MCOs (38.42%; z = -.95; 95% CI: 14.53%, 39.59%; p < .01). The rate for Health Care USA in the Western Missouri region for the HEDIS 2005 Annual Dental Visit measure was 21.77%, significantly lower than the statewide rate for all MC+ MCOs (29.76%; z = -1.41; 95% CI: 17.49%, 26.05%; p < .01).

The EQRO did validate each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the aggregate report for activities, ratings, and comments related to the Attachments.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. For all three measures, HealthCare USA was found to meet nearly all the criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). The one criterion that was not met involved "detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator." There were no biases or errors found in the manner in which HealthCare USA transferred data into the repository used for calculating the HEDIS 2005 measures. HealthCare USA used an NCQA-certified software vendor, Catalyst, for the HEDIS 2005 measure calculation process. The EQRO was provided with a demonstration of the Quality Spectrum Hybrid Reporter™, the

application module for rate calculation, and with Coventry's corporate data warehouse. The use of NCQA-certified reporter software, which has been certified through a process of test files, indicates that the program specifications, codes, and measure parameters are adequate for validly reporting the rates. However, the codes, program specifications, and measure parameters could not be independently validated by the EQRO as we were unable to view the data prior to it being processed by the software. HealthCare USA supplied the EQRO with information that had already been processed once by their data system. The information provided did not include the CPT Codes or ICD-9-CM Codes, but a category or description of what services those service codes represent. It is necessary for the EQRO to receive service codes in the CPT or ICD-9-CM format not only because that is what was request, but also because those formats are the industry accepted standard and the only way for the EQRO to ensure that what they are matching between reported rates is the same information.

Documentation of Data and Processes

It is assumed that the data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). HealthCare USA met all criteria that applied for all three measures.

Processes Used to Produce Denominators

The EQRO was unable to determine whether HealthCare USA met the criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings), because this involves the selection of eligible members for the services being measured. Although the denominators for all three measures in the final data files supplied to the EQRO were consistent with those reported on the DST, the EQRO could not validate the denominator due to the absence of member enrollment dates. Member enrollment dates are necessary to determine the eligible population for HEDIS measures. HealthCare USA assured the EQRO that the software they used to process the data utilized the HEDIS 2005 Technical Specifications. This was not verifiable by the EQRO due to HealthCare USA's failure to provide the enrollment data and service codes requested. The eligibility numbers below were based on age ranges only.

In the Central Missouri region, 1,166 eligible members were reported and found for the Childhood Immunization Status, Combination #2 measure. A total of 1,051 eligible members

were reported and validated by the EQRO for the Well Child Visit measure. There were 13,786 eligible members reported and found by the EQRO for the denominator of the Annual Dental measure in the Central Missouri region.

In the Eastern Missouri region, 5,783 eligible members were reported and found for the Childhood Immunization Status, Combination #2 measure. A total of 5,083 eligible members were reported and validated by the MCO for the Well-Child Visits measure. There were 78,555 eligible members reported and found for the denominator of the Annual Dental measure.

In the Western Missouri region, 309 eligible members were reported and found by the EQRO for the Childhood Immunization Status, Combination #2 measure. A total of 340 eligible members were reported and validated by the EQRO for the Well-Child Visits measure. There were 2,968 eligible members reported and found for the denominator of the Annual Dental measure for the Western Missouri region.

Across all three regions, 7,258 eligible members were reported and found for the Childhood Immunization Status, Combination #2 measure. A total of 6,474 eligible members were reported and 6,435 were found for the Well-Child Visits measure. 95,309 eligible members were reported and found for the denominator of the Annual Dental measure across the regions. Age ranges, dates of birth, and medical events were validated solely for those members who met HEDIS 2005 criteria. Enrollment dates and continuous enrollment were not independently validated by the EQRO, but it is believed these were programmed correctly.

Processes Used to Produce Numerators

All three measures were calculated using the Administrative Method. The EQRO is unable to determine whether the measures included the appropriate data ranges for the qualifying events (e.g., immunizations, well-care visits, and dental visits) as specified by the HEDIS 2005 Technical Specifications (see Attachment XIII: Numerator Validation Findings). No medical record reviews were conducted or validated.

HealthCare USA appropriately included administrative events from the State Public Health Immunization Registry (MOHSAIC) in calculating the Childhood Immunization Status,

Combination #2 measure. For this measure, a total of 1,340 administrative hits were reported and 1,105 were found. This resulted in a rate of 15.22%, with an overestimate of 3.24%. HealthCare USA did not supply CPT codes, ICD-9-CM codes, and/or HCPCS/CDT-3 codes to the EQRO in order to facilitate validation. The service codes were requested by the EQRO in the original Performance Measures Data Submission Request (See Appendix 3). The service codes are an industry standard that is used by the EQRO to match the service the MC+ MCO delivered to its member(s) with the HEDIS Technical Specifications "Codes to Identify Childhood Immunizations". Without the acceptable service codes, the EQRO was unable to determine if valid services had been rendered to HealthCare USA's MC+ members. The dates of birth range were valid.

For the HEDIS 2005 Well-Child Visits measure, there were a total of 2,687 administrative hits reported and 2,528 hits found. This resulted in a rate of 39.05%, with an overestimate of 2.46%. HealthCare USA did not supply CPT codes, ICD-9-CM codes, and/or HCPCS/CDT-3 codes to the EQRO in order to facilitate validation. The service codes were requested by the EQRO in the original Performance Measures Data Submission Request (See Appendix 3). The service codes are an industry standard that is used by the EQRO to match the service the MC+ MCO delivered to it's member(s) with the HEDIS Technical Specifications "Codes to Identify Well-Child Visits". Without the acceptable service codes, the EQRO was unable to determine if valid services had been rendered to HealthCare USA's MC+ members. The dates of birth range were valid.

The number of administrative hits reported for the HEDIS 2005 Annual Dental Visit measure was 27,536; the EQRO found 27,679. This resulted in a rate of 29.04%, with an underestimate of -0.15%. The codes for numerator events were not provided and could not be validated. The service codes were requested by the EQRO in the original Performance Measures Data Submission Request (See Appendix 3). The service codes are an industry standard that is used by the EQRO to match the service the MC+ MCO delivered to its member(s) with the HEDIS Technical Specifications "Codes to Identify Dental Visits". The dates of birth were valid and in the correct range.

Sampling Procedures for Hybrid Methods

No medical record reviews were conducted or validated. Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

Submission of Measures to the State

HealthCare USA submitted the DST for each of the three measures to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

As previously noted, the MCO underestimated the Annual Dental Visit measure and overestimated both the Childhood Immunization Status and Well-Child Visits measures. However, the EQRO was unable to completely validate any of these measures due to the MCO's non-compliance with the production of information requested by the EQRO.

Table 64 - Estimate of Bias in Reporting of HEDIS 2005 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunization Status, Combination #2	3.24%	Overestimate
Well-Child Visits in first 15 months of Life	2.46%	Overestimate
Annual Dental Visit	0.15%	none

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources summarized in the Final Performance Measure Validation Worksheet for each measure. All three measures calculated were Not Valid as they did not comply with State specifications, due to the MC+ MCO not providing the required service codes.

Table 65 - Final Audit Rating for HEDIS 2005 Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status, Combination #2	Not Valid
Well-Child Visits in first 15 months of Life	Not Valid
Annual Dental Visit	Not Valid

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCO. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MC+ Members qualified for the measure.

STRENGTHS

1. There were significantly higher rates of HEDIS 2005 Well-Child Visit rates in the Central Missouri region, compared to the average for all MC+ MCOs. This rate was higher than the National Medicaid rates for this measure.
2. HealthCare USA employed NCQA-certified HEDIS reporter software, Quality Spectrum ™ of Catalyst Technologies. Most of the data for HEDIS measures are stored in the Coventry IDX data warehouse from which Quality Spectrum is used to automatically calculate rates.
3. The Quality Spectrum™ is a very well-designed application based in a SAS environment. On the whole, the application was very transparent and user friendly. The codes are updated as they are released by Catalyst.
4. The Catalyst application had the ability to provide detailed and in-depth information for "drilling down" and evaluation purposes. Even though the codes running behind the program were proprietary, the structure of the repository was very informative and provided the interviewers with information on flow charts for calculations; event, rule, and metadata definitions.
5. There were clearly defined data fields within the application, which automatically feeds the rates as required by the State in the HEDIS Data Submission Tool.
6. There were numerous quality checks in the reporting process done manually with a separate abstract of the data files. This helps in minimizing errors.
7. Efficient data integration, retrieval and analysis processes were in place. Members were identified with a unique primary key that avoids duplication errors. Datasets from CareMark, the pharmacy vendor; Quest Labs, the laboratory vendor and the dental vendors were used and integrated to Quality Spectrum for calculation of final rates.
8. There was a good disaster recovery plan in place.
9. MOHSAIC, the State Public Immunization Registry database, was used for collection of data regarding immunizations. The files were received as a text file and well integrated into the system. MOHSAIC data is loaded in a very specific format into the data warehouse. MOHSAIC is estimated to account for approximately 14% of the Adolescent Immunization Status rate.
10. HealthCare USA had well-documented procedures for the HEDIS 2005 rate calculation measures.
11. Upon review of preliminary validation findings for the performance measure validation, HealthCare USA recognized the importance of using the Hybrid Method to calculate the Adolescent Immunization Status measure and plans to use this method in the future.
12. HCUSA followed the EQRO's 2004 recommendation and Integrated HEDIS rate documentation procedures into its corporate IS policies.

AREAS FOR IMPROVEMENT

1. HealthCare USA should provide data to the EQRO in the format in which it was requested. By not doing so, the EQRO was unable to completely validate the Performance Measures.
2. HealthCare USA used the administrative method for the calculation of all HEDIS 2005 measures. Medical record review is likely to provide unique information regarding adolescent immunizations that is not captured in the State Public Immunization Registry for events prior to the implementation of the MC+ Managed Care Program and claims systems.
3. The HEDIS 2005 Childhood Immunization Status, Combination #2 rate was significantly lower in both the Eastern and Western Missouri regions than the average for all MC+ MCOs.
4. The HEDIS 2005 Well-Child Visits in the First 15 Months of Life measure rate was significantly lower in the Western Missouri region than the average for all MC+ MCOs.
5. The HEDIS 2005 Annual Dental Visit measure rate was significantly lower in the Central Missouri region than the average for all MC+ MCOs.

RECOMMENDATIONS

1. The use of the Hybrid Method for the calculation of Childhood Immunization Status is strongly recommended. HealthCare USA should explore the possible reasons for low rates of administrative hits for the Childhood Immunization Status measure. It is the EQRO's understanding that for the HEDIS 2006 season HealthCare USA will be utilizing the hybrid method for childhood and adolescent immunizations.
2. Provide data to the EQRO in the format requested; data cannot be truly validated according to the CMS Protocols if it is accepted in a format that has already been processed by a software program.

8.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 426,225 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Outpatient Claim Type field was 100.00% complete, accurate and valid.

The Outpatient Recipient ID field was 100.00% complete, accurate and valid.

The Outpatient First Date of Service field was 100.00% complete and accurate, and 99.90% valid. There were 426 invalid dates of service ranging from 01/01/2005 – 12/31/2005.

The Outpatient Last Date of Service field was 100.00% complete and accurate, and 99.90% valid. There were 432 invalid dates of service ranging from 04/01/2005 – 10/03/2005.

The Outpatient Units of Service field was 100.00% complete, accurate and valid.

The Outpatient Procedure Code field was 100.00% complete and accurate, and 99.72% valid. The following are the 1,204 invalid entries found.

Frequency	Code
903	99600
198	99601
5	B4034
27	B4035
4	B4036
66	H1000
1	K0635

The Outpatient Place of Service field was 100.00% complete, accurate and valid.

The first Diagnosis Code field was 100.00% (with rounding) complete, accurate and valid. Three fields were blank.

Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 12.74% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 5.15% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 2.06% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.00% complete, accurate and valid.

For the Dental claim type, there were 60,406 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were 64 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined except the fourth and fifth Diagnosis Code fields were 100.00% complete, accurate and valid. The fourth and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (79.69% for each).

For the Inpatient claim type, there were 53,367 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Inpatient Claim Type field was 100.00% complete, accurate and valid.

The Recipient ID field was 100.00% complete, accurate and valid.

The Admission Type field was 100.00% complete, accurate and valid.

The Admission Date field was 100.00% complete and accurate, and 93.60% valid. There were 3,415 invalid dates ranging from 06/17/2005 – 12/31/2005.

The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 97.09% (with 1,551 entries of "99999999"). Valid values were present 93.50% of the time. In addition to the invalid "99999999" entries, the 1,918 invalid dates ranged from 04/01/2005 – 04/27/2005.

The Bill Type field was 100.00% complete, accurate and valid.

The Patient Status field was 100.00% complete and accurate, and 99.93% valid. There were 1 invalid value of "00", 7 invalid values of "61" and 28 invalid values of "63".

The first Diagnosis Code field was 100.00% complete, accurate and valid.

The second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (99.73%, 98.74%, 89.20%, 72.41%, respectively).

The First Date of Service field was 100.00% complete and accurate, and 94.70% valid. There were 2,829 invalid dates of service ranging from 10/29/2005 – 12/31/2005.

The Last Date of Service field was 100.00% complete and accurate, and 94.80% valid. There were 2,775 invalid dates of service ranging from 04/01/2005 – 04/28/2005.

The Revenue Code field was 99.88% complete, accurate, and valid. There were 63 invalid blank fields.

The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 240,549 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Outpatient Claim Type field was 100.00% complete, accurate and valid.

The Recipient ID field was 100.00% complete, accurate and valid.

The First Date of Service field was 100.00% complete, accurate and valid.

The Last Date of Service field was 100.00% complete, accurate and valid.

The Units of Service field was 100.00% complete, accurate and valid.

The Outpatient Procedure Code field was 100.00% complete, accurate, and 35.05% valid. There were 156,255 invalid entries of "00000".

The Outpatient Revenue Code field was 99.91% complete and 79.59% accurate and valid. Of the 49,090 Invalid codes, 214 were blank and 48,876 were entries of "0".

The first Diagnosis Code field was 100.00% complete, accurate and valid.

Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 99.94% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 99.87% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 55.63% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 25.53% complete, accurate and valid.

For the Pharmacy claim type, there were 333,870 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for HealthCare USA, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. The Outpatient Procedure Code field in the Medical claim type included invalid procedure codes (see previous findings); while the Inpatient claim type contained invalid data in the Admission Date, Discharge Date, and Patient Status fields. The Revenue Code field contained 63 blank entries. For the Outpatient Hospital claim type, the Outpatient Procedure Code and the Outpatient Revenue Code fields contained invalid entries. For outpatient claims, a procedure code is required only when the Revenue Code is between 300 – 319.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rate of Outpatient Hospital encounter claim types were consistent with the average for all MC+ MCOs. The rates for Dental and Inpatient encounter claim types were significantly higher than the average for all MC+ MCOs. This suggests high rates of encounter data submission and good access to preventive and acute care.

To what Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review.

Of the 426,225 Medical encounter claim types in the SMA extract file for January 1, 2005 through March 31, 2005, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 91 medical records (91.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 42.0%, with a fault rate of 58.0%. The match rate for diagnoses was 91.0%, with a fault rate of 9.0%.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were incorrect information (n = 9). The diagnosis code listed did not match the descriptive information in the record.

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 41), incorrect codes (n = 12), illegible information (n = 15). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MC+ MCO paid/unpaid encounter claims match the SMA paid database?

Since HealthCare USA included internal control numbers that matched those of the SMA, the planned analysis of comparing MC+ MCO encounter data to the SMA encounter claim extract file was performed. The SMA defined "unpaid claims" as those claims that the MCO denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type, all encounter data submitted to the EQRO (n = 333,870) was of "paid" status. There were 33 unmatched claims that were in the HCUSA encounter file and absent from the SMA data. Thus, 99.99% of the HCUSA submitted encounters matched with the SMA encounter records.

For all Outpatient Claim Types (Medical, Dental, Home Health, & Hospital; n = 727,244), 79 "denied" claims were submitted by HCUSA but all other encounter claims were of "paid" status. Of the encounter claims submitted by HCUSA, 192 records were unmatched with the SMA encounter data. There was a "hit" rate of 99.98% between HCUSA encounter claims and the SMA encounter data.

For the Inpatient Claim Type, HCUSA submitted 53,367 encounter claims. Only 23 of these encounter claims were of "denied" status; all other claims were of "paid" status. There were 40 unmatched records between HCUSA and the SMA, yielding a 99.93% "hit" rate.

Why are there unmatched claims between the MC+ MCO and SMA data files?

The majority of unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Within the Pharmacy Claim type, 66.67% of the unmatched encounters were missing ICN numbers. Therefore, only 11 Pharmacy claims were legitimately missing from the SMA data. For the Outpatient data, 96.88% of the unmatched claims were missing ICNs. Of the 6 unmatched claims with ICNs, 2 of those were of "denied" status and would not be expected to be present in the SMA file. Thus, only 4 unmatched encounters were legitimately missing from the SMA data records. For Inpatient Claims, all unmatched claims were missing ICNs.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MC+ MCO did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. The Internal Control Number is unique only to the encounter but not to each service, thus one ICN may be represented in multiple lines of data. To match the MC+ MCO data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

STRENGTHS

1. All encounter data was submitted in the specified format and included internal control numbers (ICNs) which allowed the EQRO to conduct planned comparisons of the MC+ MCO and SMA data files.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental and Pharmacy claim types were 100.00% complete, accurate and valid.
4. There were significantly higher rates of claims for Dental and Inpatient services than the average for all MC+ MCOs.

Areas for Improvement

1. For the Medical claim type, there were invalid entries for Outpatient First Date of Service, Outpatient Last Date of Service, and Outpatient Procedure Codes.
2. For the Inpatient claim type, there were invalid entries for the Admission Date, Discharge Date and Patient Status, and blank Revenue Code fields. The Revenue Code is a required field regardless of the Procedure Code.
3. For the Outpatient Hospital claim type, there were invalid data in the Outpatient Procedure Code and Outpatient Revenue Code fields.
4. For the comparison of HCUSA encounters with the SMA data file, most unmatched claims were due to missing ICN numbers.
5. The match rate for procedures between the SMA encounter claims extract file and the medical records for HealthCare USA were significantly lower than the average for all MC+ MCOs.

Recommendations

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that Admission Date, Discharge Date, and Patient Status fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
3. Always include the Revenue Code regardless of the Procedure Code for the Outpatient Hospital and Inpatient claim types (UB-92 layout).

8.4 MCO Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MCO's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the Division of Medical Services. On-site review time was used to conduct interviews with those who oversee the daily practices of the MCO to ensure that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MCO Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the MCO and to follow-up on questions raised from the document review and from the 2004 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Provider Contracts
- Grievance and Appeal Policies
- Grievances and Appeals related to members were reviewed, as were Complaints, Grievances, and Appeal files for providers. These files were obtained from a random selection process of actions filed in the first quarter of 2005.
- 2004 Annual Quality Improvement Program Evaluation

Additional documentation made available by HealthCare USA included:

- Marketing Plan and Educational Material Development Policy
- HCUSA of Missouri Organizational Chart
- NCQA Quality Improvement Activity Form: Increasing the Rate of Compliance with Completion of a Family Therapy Session within 45 days of Initial Outpatient counseling Assessment of Members Under the Age of 18
- Obesity Performance Improvement Project 2006

Interviews

Interviews were conducted with the following group:

Plan Administration

Jackie Inglis, VP Health Services
William Rooney, MD, Medical Director
Jack Fennig, MD, Medical Director
Frank Siano, VP Community and Governmental Relations
Resmi Jacob-Schrieber, Director of Provider Relations
Pam Victor, Director of Government Relations and Regional Compliance -- Central
Gene Poisson, Director of Network Development
Alec Mahmood, CFO
Deb Fitzgerald, Director of Health Services

Mental Health

Vicki Bernard, MHNet
Susan Norris, MHNet
Cynthia Williams, MHNet
Gail Moss, MHNet
Jackie Inglis, HCUSA
Gene Poisson, HCUSA

FINDINGS

Enrollee Rights and Protections

A strong commitment to member rights continues to be a cornerstone of HealthCare USA's service philosophy. Quality services to members, with a particular emphasis on families and children, were observed within the organization. HealthCare USA views cultural diversity as an essential component of their interactions with members. The MCO maintains cultural diversity as an aspect of initial and ongoing staff training. HealthCare USA employed staff that spoke different languages and is able to provide written materials in languages other than English. Maintaining the ability to serve a culturally diverse population with a variety of special service needs is exhibited in the MCO's approach to their work and to their interactions with members.

Healthcare USA initially targeted Early Periodic Screening Diagnosis and Treatment (EPSDT) as an area for improvement. Within the past year they have expended considerable energy and resources in developing this measure. A plan was instituted to monitor members and produce a report on the receipt of the EPSDT screenings two times per year. HealthCare USA sent EPSDT fliers as reminders to 6,000 members on a monthly basis. The MCO worked with

providers to ensure claims submitted so a record exists of all examinations completed. They worked with the community by providing information to Girls and Boys Clubs, after school programs, and schools nurses. HealthCare USA met with school boards and districts in both the Eastern and Western MC+ Managed Care Program Regions. The objective was to engage them in the process of actively ensuring that students receive their health screenings. Efforts such as these resulted in a member participation rate of over ninety (90%) percent.

Ratings of compliance with Enrollee Rights and Protections (69.2%) indicate that HealthCare USA made a concerted effort to improve their compliance in this area. The MCO completed a number of required policies and that were approved by the SMA. Interviews with administrative staff indicated a commitment to attend to the details of completing required policies. The MCO had a stated goal of 100% compliance with SMA contract requirements and federal regulations. HealthCare USA was encouraged to produce all policy not yet submitted to the SMA, make any required revisions in a timely fashion, and to obtain full compliance as quickly as possible.

Table 66 - Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	HealthCare USA	
	2004	2005
438.100(a) Enrollee Rights: General Rule	1	2
438.10(b) Enrollee Rights: Information Requirements	1	1
438.10(c)(3) Alternative Language: Prevalent Language	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	1	1
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	1	2
438.10(f) Information for All Enrollees: Free Choice, etc.	1	1
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	1
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	2
438.100(b)(3) Right to Services	1	2
438.100(d) Compliance with Other Federal/State Laws	2	2
Number Met	5	9
Number Partially Met	8	4
Number Not Met	0	0
Rate Met	38.5%	69.2%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

Staff members from the behavioral health subcontractor MHNet were interviewed at the on-site review. The MHNet staff shared information regarding a number of initiatives undertaken during 2005. One project involved the support of members through targeted follow-up when they are discharged from inpatient treatment. Another measure focused on avoiding weekend discharges for members requiring inpatient treatment. MHNet's goal was to have the member ready for discharge prior to Saturday to avoid weekend emergencies.

The Behavioral Health Organization's (BHO) system was undergoing enhancement to capture baseline information on members receiving behavioral health services. MHNet also made the decision to authorized family therapy, in addition to required individual therapy, for all children under age 18 who need behavioral health services. The BHO believed that this additional resource would assist in ensuring that the family had an understanding of issues facing their child, that the entire family would be working together to ameliorate problems, and that the family would understand the child's emotional functioning. The BHO worked closely with HealthCare USA to identify expectant mothers to ensure that required behavioral health services were in place in an effort to prevent post partum problems. The BHO has also made a concerted effort to ensure that information and educational material is translated into different languages. Multilingual providers are available to members.

Quality Assessment and Performance Improvement

Access Standards

Healthcare USA worked with both members and providers to ensure proper access to services was available. They developed a large provider network throughout all three MC+ Managed Care Regions, and continued to recruit providers to expand services available, particularly in the Central Missouri area. This enabled members to have an adequate choice for both PCPs and specialty providers. The MCO does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

One area of concern for Healthcare USA has been locating adequate dental services for members, particularly in the Central MC+ Managed Care Region. The dental subcontractor, Doral Dental, placed a provider representative in the Central Region to ensure ample recruitment occurred and that a representative was available locally. Doral Dental initiated a

work plan to obtain additional providers. Healthcare USA Provider Relations worked with Doral to ensure that the subcontractor had assistance as needed. Special attention was given to the issue of transportation while this network development continues. The MCO paid for mileage when a member had a vehicle, or another method of transportation to attend dental appointments, when they occurred at an excessive distance. This assisted in increasing the availability of services. Another method utilized by the MCO was negotiating an alternative fee schedule for providers reluctant to participate due to reimbursement issues. Healthcare USA reported that the network did improve, but they continue to concentrate on development efforts.

HealthCare USA reported that the number of requests for PCP changes increased in 2004. The MCO obtained information that indicated the increase was partially based on a need for PCP accessibility. As a follow-up of a recommendation from the 2004 External Quality Review, the MCO implemented a follow-up system, hosted by Provider Relation's staff, to address a PCP change request that appeared to be related to an access problem. The MCO initiated a random survey of members as a method of gathering information about the reasons for these requests for change. The findings indicated that the greatest number of these requests were due to a convenience issue on the part of the member, not because a provider offered appointments out of prescribed timeframes. Reasons included a desire to have providers closer to the member's home after a move, a need for providers with extended office hours, and changes as the result of auto-assignment. HealthCare USA worked with their providers to offer extended hours to meet members' needs. Several providers have set up "after hours" clinics where office space is made available to clinicians willing to work after regular office hours have ended. The MCO planned to continue to monitor requests for PCP changes to ensure that access to care standards are met.

Ratings of compliance with Access Standards regulations (64.7%) reflect a number of HealthCare USA policies that continue to need submission to or clarification from the SMA. The MCO did improve in this area since 2004 and strives to meet all required SMA contract requirements and federal regulations.

Table 67 - Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison

Federal Regulation	HealthCare USA	
	2004	2005
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	1	2
438.206(b)(5) Out of Network Services: Cost Sharing	1	1
438.206(c)(1)(i-vi) Timely Access	1	1
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	2	2
438.208(c)(1) Care Coordination: Identification	1	1
438.208(c)(2) Care Coordination: Assessment	2	2
438.208(c)(3) Care Coordination: Treatment Plans	1	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2
438.210(b) Authorization of Services	1	1
438.210(c) Notice of Adverse Action	1	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2
438.210(e) Compensation of Utilization Management Activities	2	2
438.114 Emergency and Post-Stabilization Services	1	1
Number Met	9	11
Number Partially Met	8	6
Number Not Met	0	0
Rate Met	52.9%	64.7%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

HealthCare USA instituted a number of measures to improve practice in this area. The MCO held quarterly oversight meetings with all subcontractors in each region to discuss service provision issues and to monitor activities. Annual evaluations were completed on each subcontractor, and daily contact was maintained. HealthCare USA reported this increased contact and monitoring allowed them to address administrative and member issues in a timely and effective manner.

HealthCare USA created a provider advisory group in all three MC+ Managed Care regions. They encouraged provider feedback and provided information in a framework that allowed the

MCO to develop a true partnership with their provider network. A new method of obtaining prior authorizations was made available to HealthCare USA providers. WebMD became available to process on-line prior authorizations. Providers began using this method in greater numbers. The authorization requests are downloaded at the MCO. It is then the responsibility of HealthCare USA to respond in required timeframes.

Ratings for compliance with Structure and Operation Standards (60%) reflected a lack of approved policy and procedures regarding disenrollment and subcontractual relationships. Disenrollment policy was submitted to the SMA in December 2005. This policy has not yet been approved and contained wording conflicting with the MC+ Managed Care contract. Correction and approval of the disenrollment policy, and approval of all policy and requirements regarding subcontractors, are required for HealthCare USA to be fully compliant with this section of the federal regulations.

Table 68 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison

Federal Regulation	HealthCare USA	
	2004	2005
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2
438.214(d) Provider Selection: Excluded Providers	2	2
438.214(e) Provider Selection: State Requirements	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	1	1
438.56(c) Disenrollment Requested by the Enrollee	1	1
438.56(d) Disenrollment: Procedures	1	1
438.56(e) Disenrollment: Timeframes	2	2
438.228 Grievance System	2	2
438.230(a,b) Subcontractual Relationships and Delegation	1	1
Number Met	6	6
Number Partially Met	4	4
Number Not Met	0	0
Rate Met	60.0%	60.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

The MCO continued to use InterQual as a guide for decision-making in terms of utilization review. InterQual criteria were cited when asked about practice guidelines. HealthCare USA's

new medical director, who recently practiced in the Kansas City area was familiar with the community based practice guidelines developed there. The MCO expressed the hope that a similar group may be formed in the Eastern Missouri MC+ Managed Care Region to explore the issue of regionally appropriate practice guidelines. This is an area in which continued development is needed by the MCO.

HealthCare USA continued to have a well developed internal written quality assessment and improvement program. The MCO shared their Quality Management Charter and minutes from meetings. The Quality Management Program focused on monitoring, assessment, and evaluation of clinical and non-clinical service delivery. Initiatives developed as a result of the Quality Management Program include EPSDT, the 17-P program preventing premature delivery, asthma prevention program, subcontractor oversight, and the provider advisory group. These quality programs targeted members with special healthcare needs, but also provided enhanced services to all members. HealthCare USA indicated that they recognized the need to stratify data by MC+ Medicaid Managed Care region. The Quality Management charter ensured that meetings occur at least quarterly on a regular schedule and had representatives from all sections of the organization, as well as including providers. The quality management process ensured that the MCO maintained a record of activities, recommendations, accomplishments, and follow-up.

Through the administrative method, the MCO did report data for Validating Performance Measures. HealthCare USA HEDIS data did not include member enrollment dates. This omission affected the validity of the data, and compromised the accuracy of the MCO-to-MCO comparison. The MCO did submit clinical and non-clinical Performance Improvement Projects. The details of the audit are located in the appropriate section of this report. The MCO continued to operate a health information system that meets required standards. Encounter data was submitted in the format requested so that appropriate validation could occur. The details of this process are located in the Validating Encounter Data section of this report.

Ratings for compliance with Measurement and Improvement regulations (63.6%) reflect the inability to appropriately validate Performance Measure data, and the need to develop the MCO's approach to practice guidelines.

Table 69 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison

Federal Regulation	HealthCare USA	
	2004	2005
438.236(b)(1-4) Practice Guidelines: Adoption	2	2
438.236(c) Practice Guidelines: Dissemination	2	1
438.236(d) Practice Guidelines: Application	1	1
438.240(a)(1) QAPI: General Rules	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	1
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	2
438.242(b)(3) Health Information Systems: Basic Elements	1	2
Number Met	7	7
Number Partially Met	4	4
Number Not Met	0	0
Rate Met	63.6%	63.6%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Rating for compliance with Grievance Systems regulations (100%) indicate that the MCO completed all requirements regarding policy and practice in their grievance system. Six member files for grievance and appeals were reviewed during the on-site review. All records reviewed were handled appropriately and within prescribed time frames. One member grievance advanced to a State Fair Hearing where the decision to deny was upheld as the criteria for braces was not met. The member files were in order and copies of correspondence were included.

Provider complaints, grievances, and appeals were also reviewed on-site. Seven files were requested and all appeared to be in order. When possible, situations were resolved at the

complaint level. The provider files were complete with correspondence that met all required timeframes. Where appropriate, files contained information that a review occurred by a physician who had not been involved in the original decision, or in a previous level of the grievance process. HealthCare USA had access to physicians through an independent contract who could participate in the review process according to the medical specialty required.

Table 70 - Subpart F: Grievance Systems Yearly Comparison

Federal Regulation	HealthCare USA	
	2004	2005
438.402(a) Grievance and Appeals: General Requirements	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2
438.404(b) Notice of Action: Content	2	2
438.404(c) Notice of Action: Timing	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2
438.410 Expedited Resolution of Appeals	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2
438.416 Recordkeeping and Reporting Requirements	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2
Number Met	18	18
Number Partially Met	0	0
Number Not Met	0	0
Rate Met	100%	100%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Summary / Follow-up

HealthCare USA exhibited improvement since the 2004 audit in the completion and submission of required policy and procedures to the SMA. The MCO made improvements in compliance in three sections of the protocol, maintained 100% compliance in one section, and maintained the same rating in one section. The operations and practices revealed during interviews at the on-site review indicated a commitment by HealthCare USA to provide quality healthcare services to its members. MCO activities focused on enhancing preventative services, creating new approaches to providing access to services such as the development of after-hours clinics, obtaining member input on issues such as changing PCPs, and responding to prior authorizations and grievances in a timely and efficient manner.

HealthCare USA was not totally compliant in all areas of policy completion and submission. The MCO incorporated methods to track required policy submission into daily administrative practice and took this process seriously. The practice observed at the time of the on-site review provided confidence that the MCO had service to members as their primary focus and that there was a commitment to comply with the requirements of the MC+ Managed Care contract and federal regulations.

STRENGTHS

1. Integration of all specialty sections within the HealthCare USA organization enhances the service delivery system. Individuals interviewed could not only speak to their specific role at HealthCare USA, but how their work impacts that of other sections and how they need to know one another's focus and projects so they can ensure a holistic approach to service delivery.
2. A commitment to excellence in service delivery throughout the organization was observed. Staff at all levels exhibited enthusiasm for ensuring that healthcare services provided by HealthCare USA met the needs of all members and were high quality services. There was a common expectation that members are treated with respect and dignity.
3. The marketing and outreach plan clearly states and recognizes all components of enrollee rights. State requirements are clearly stated and detailed in written material.
4. HealthCare USA continues to work with Washington University to develop innovative approaches to solving problems and providing new alternatives to serve members.
5. Grievance and appeals files for members were easy to evaluate and followed MCO policy. All files contained appropriate notification and actions were timely.
6. There is recognition by HealthCare USA staff that there are some significant regional and cultural differences in the MC+ Managed Care Regions served by the MCO. The MCO recognizes the need for diversity within the organization, and in approaches to the different communities where services are delivered.

AREAS FOR IMPROVEMENT

1. Completion of all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations.
2. Explore development of the Performance Improvement Project process with MHNet to better coordinate member services and communication.

RECOMMENDATIONS

1. Hold the importance of complying with documentation requirements to the same standards as those reflected in the daily practice within the MCO.
2. Continue MCO development in the area of utilization of available data and member information to drive change and support opportunities for organizational growth and development.
3. Continue to track policies and other materials required for annual review.
4. Continue the commitment to oversight of subcontractors, such as MHNet and Doral Dental. Quarterly reviews ensure that member services are at the level the MCO required.

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SECTION 9.0
MISSOURI CARE HEALTH PLAN

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9.0 – Missouri Care™ HEALTH PLAN

9.1 Performance Improvement Projects

The previous sections of the 2005 EQRO report present the purpose and objectives, technical methods, procedures for evaluation, and MCO to MCO comparisons of analyses, findings, and recommendations for each of the protocols based on the aggregate analysis. This section of the EQRO report summarizes MC+ MCO specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for MC+ Managed Care Members. Please refer to the main report for detailed technical objectives, methods, and presentation of data that are referenced here for the MC+ MCO.

METHODS

Document Review

Missouri Care supplied the following documentation for review:

- 2005 Attention Deficit Hyperactivity Disorder Performance Improvement Project
- 2005 Lead Performance Improvement Project

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on March 15, 2006 during the on-site review, and included the following:

Tammy Weise – Manager, Quality Management
Dr. Jan Swaney – Medical Director
Brent Netemeyer – Manager, Operations
Katie Dunne – Senior Quality Coordinator

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the Project Leader?
- How was the topic identified?
- How was the study question determined?
- How can the ADHD study question be simplified to get at the actual issue Missouri Care wants to address?
- What were the findings?
- What was the intervention?
- What was the time period of the study?
- Was the intervention effective?
- What does Missouri Care want to study or learn from their PIPs?

The maturity of the PIPs submitted for validation was not complete at the time of the initial request for this information in October 2005. The MCO was instructed that they could submit additional information that included outcomes of the intervention.

FINDINGS

The first PIP evaluated was, "Attention Deficit Hyperactivity Disorder (ADHD) Performance Improvement Project." Originally this PIP was identified as a clinical project. This was discussed with the MC+ MCO at the time of the on-site review. The PIP was recoded as non-clinical. Although the goal of the project was to improve the quality of care for children with ADHD, the methodology and interventions presented to achieve this goal were non-clinical. Reviewers and MC+ MCO staff agreed upon this change in designation.

The rationale for identifying this topic of study was well documented in the information presented. The narrative related the literature included in the review to the rationale for the PIP. It included information on the population and provided a strong argument for choosing this topic for a performance improvement project. The overarching goal of the project was clearly focused on correcting deficiencies in health care services. To accomplish this goal, the PIP planned to implement the utilization of practice guidelines and education regarding the identification and quality treatment of children diagnosed with ADHD, specifically those children who have been prescribed medication to affect their symptoms. All physicians working with MC+ Member children diagnosed with

ADHD would be directly impacted. No children were excluded, and this member population would be considered as having a special health care need.

The study question presented was "Does the distribution of ADHD best practice guidelines to providers through a provider tool kit and continuing medical education (CME) conferences, increase the number of members who 'are diagnosed and treated appropriately.'" The presentation of the study questions, as stated in the project narrative, was very complex and actually addressed planned interventions. Simplification of the study question was required to identify the actual issue to be addressed and to develop a methodology to measure success.

The definition of each indicator was intricately linked to a related section of the study question. The indicators chosen were appropriate, but they added to the complexity of the narrative and the study questions, as originally written. This study had tremendous potential and should be reworded to ensure that the study question, indicators, and re-survey type questions are clarified. This would allow appropriate documentation and data analysis to evaluate the success of the project.

The identified population was all MC+ Missouri Care Member children age 6-12 who have been prescribed a stimulant drug during the study period. The justification for the age range was well defined and consistent with NCQA guidelines for assessing the quality of care for children with ADHD prescribed medications. No portion of the eligible population to be affected was excluded in the study. No sampling was used. The study design clearly identified the data to be collected and it documented a prospective data analysis plan. A plan for distributing survey tools to providers was clearly defined. A Chi-Square analysis was planned to evaluate change for each indicator. All claims and pharmacy data to be collected and how it will be analyzed was included in the information presented. Survey tools were presented with project narrative.

All planned interventions were described, but not in sufficient detail to ensure a thorough understanding of the rationale presented, or the expected outcomes to be achieved by this section of the study. A number of interventions were mentioned, but it did not include an anticipated outcome or a method for achieving and understanding the results of the intervention. This PIP was not mature enough to achieve compilation of data. No results were available. The study did identify post-interventions and a plan for continuing to collect data during a latter part of the study.

It appears that with proper implementation and data analysis, this study has high potential to produce real improvement that will positively impact the intended members. The study was developed through the use of a community-based physician group who had an interest in impacting this topic. The study design could be refined, but the intentions communicated in the narrative indicate a likelihood of significant findings.

The second PIP evaluated was "Lead Performance Improvement Project." The study topic provided was the need to increase the number of members receiving blood lead level testing at 12 and 24 months of age. There was a thorough presentation of the rationale for selecting this topic for study. The MC+ MCO initiated a performance improvement project in 2004 to increase blood lead level testing. The project presented built on the foundation of the original PIP. The narrative identified that the original intervention produced positive results, but they were not sustained. This PIP took a multi-staged approach to intervene in changing physician blood lead level testing practices. A pre-test was completed by surveying physicians about blood lead level testing practices and perceived barriers. The interventions were then planned around the results of the information obtained. The information provided supporting the selection of this topic included a literature review and research done by the Kaufman Foundation, as well as assessment of State data.

The study questions presented were:

1. Did the proposed interventions result in a significant increase in the number of children 11-15 months and 23-27 months who receive blood lead level testing?
2. Does monitoring physician testing practices and targeting education to physicians with low compliance, result in an increase in testing among physicians targeted?

The study used well-operationalized indicators including a range before and after the 12th and 24th month birthday. The indicators were clearly tied to the questions on the physician survey tool. The information acknowledged that ongoing barriers may continue, but the proposed interventions clearly sought to have a positive impact on these issues. Data sources were clearly identified including claims and MOHSAIC data. A predetermined algorithm was to be utilized in calculating data. All MC+ Members, within the definitions of the targeted age groups were included. No members within the prescribed age ranges were to be excluded. The two age ranges selected were based upon the Missouri Department of Health and Senior Services guidelines. The population of targeted providers was clearly defined to include primary care physicians and pediatricians in the Missouri Care Health Plan. No sampling was used in this project.

The narrative clearly described the survey information to be obtained from physicians and how this data would be analyzed and used. The study included information on how the MC+ MCO planned to collect the data on the children targeted. The narrative included enough specificity to ensure confidence that this process was thorough and complete. Statistical process control charts with a 95% confidence level were used to monitor the ongoing process. A Chi-square test was used to compare the percentage of children tested in the three months prior to the intervention with the percentage tested three months following the intervention. All data sources were clearly defined and the prospective data analysis plan was followed. The exact method of matching members and providers and testing data reliability were defined and detailed in the narrative.

There were specific interventions identified in the narrative. How these interventions were related to the topic and study questions was evident in the section related to provider education. The primary interventions described focused on what will occur with providers. The narrative discussion listed a number of interventions targeted at member education. These do not appear to be directly related to the study questions presented and may be related to the previous PIP that also focused on increasing blood lead level testing. The information provided stated that parent follow-through was seen as a barrier by physicians. However, this is not the focus of this PIP and impacting this issue may not be an appropriate activity for this study.

Data analysis was not complete. The results of the provider surveys did occur according to plan. All data from MOHSAIC was not available for analysis. This PIP was well-constructed. As it matures and all data becomes available it has a high potential for positive performance improvement. The analysis was planned and the documentation provided confidence that this project will be completed as described. The format and presentation led to ease in evaluating the project. Information was clear, organized, and understandable, all adding to the confidence in the potential outcomes.

STRENGTHS

1. Study topics were well defined and addressed issues that will create improved services for members.

2. The format of the Performance Improvement Projects utilized the *Conducting PIP Protocol*. It was easy to follow and enhanced the ability of reviewers to complete the validation process.

3. The studies presented showed promise for having a profound impact on performance improvement that can result in quality health care for MC+ Members.

AREAS OF IMPROVEMENT

1. In defining the study topics and study questions, be clear about the intent and direction of the study. In both PIPs reviewed, these topics might have been considered clinical or non-clinical. The reviewer should be given enough information to be able to justify the chosen direction and understand the intent of the stated study questions.

2. When defining measurements, provide enough clarity that the topic, intervention, and measurement to achieve the outcomes, all relate to one another.

RECOMMENDATIONS

1. Continue to utilize the protocols to evaluate performance improvement studies. These studies were not yet mature enough for complete data collection and analysis. The validity of the outcomes could not be assessed.

2. Consider all interventions that may affect the projected outcomes. Ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.

9.2 Validation Of Performance Measures

METHODS

Objectives, technical methods, and procedures are described under separate cover. This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Missouri Care. Missouri Care submitted the requested documents on December 9, 2005. The EQRO reviewed documentation between December 9 , 2005 and February 27, 2005. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

Document Review

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Missouri Care
- MEDSTAT's NCQA HEDIS Compliance Audit Report for 2005
- Missouri Care's HEDIS Data Entry Training Manual
- Missouri Care's Policies pertaining to HEDIS rate calculation and reporting

The following are the data files submitted for review by the EQRO:

- ADV_DenomAndNumer.xls
- ADV_EnrollmentData.xls
- CIS_DenomAndNumer.xls
- CIS_EnrollmentData.xls
- CIS_Hybrid.xls
- W15_DenomAndNumer.xls
- W15_EnrollmentData.xls
- W15_Hybrid.xls

Interviews

The EQRO conducted on-site interviews with Katie Dunne, Jean Gurucharri, Karen Richards, HEDIS Coordinator; Alan Boyett, HEDIS Administrator; and Greg Cohen (of Austin Provider Solutions), at Missouri Care in Columbia on Wednesday, March 15, 2006. This group was responsible for the process of calculating the HEDIS 2005 performance measures. The objective of the on-site visit was to verify the methods and processes behind the calculation of the three HEDIS performance measures. This included both manual and automatic processes of information collection, storing, analyzing and reporting.

FINDINGS

Missouri Care calculated the Childhood Immunization Status, Combination #2 and Well-Child Visits measures using the Hybrid Method. MCO to MCO comparisons of the rates of Childhood Immunization Status, Combination #2, Well-Child Visits, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The HEDIS 2005 rate for Childhood Immunization Status, Combination #2 reported to the SMA and the State Public Health Agency (SPHA) by Missouri Care was 63.66%. This was significantly higher than the statewide rate for all MC+ MCOs (28.17%; z = 1.13; 95% CI: 52.56%, 74.76%; $p > .95$).

The HEDIS 2005 rate for Missouri Care for the Well-Child Visits measure was 75.69%, which was significantly higher than the statewide rate for all MC+ MCOs (38.42%; z = 1.92, statewide 95% CI: 63.16%, 88.22%; $p > .95$). The 2005 HEDIS rate for Missouri Care for the Annual Dental Visit measure was 28.66%; comparable to the statewide rate for MC+ MCOs (29.76%, z = -0.21; 95% CI: 24.38%, 32.94%; n.s.).

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

Data Integration and Control

The information systems (IS) management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. For all three measures, Missouri Care was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Missouri Care transferred data into the repository used for calculating the HEDIS 2005 measures.

Documentation of Data and Processes

Missouri Care and its affiliate, Schaller Anderson, contracted with Austin Provider Solutions (APS) for the calculation of the HEDIS 2005 performance measures. The internally-developed application had received NCQA certification and been reviewed by NCQA for source code validation and efficiency of data integration. The EQRO was provided with a process overview of the QMACS claims management system, a registered trademark owned by Quality Care Solutions, Inc. (QCSI), and a validation overview of the HEDIS Data repository of APS. The EQRO was also provided with an overview of the data flow and integration mechanisms for external databases for these measures. Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Missouri Care met all criteria that applied for all three measures.

Processes Used to Produce Denominators

Missouri Care met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of members eligible for the services being measured. Missouri Care employed a 5% oversample rate for the Childhood Immunization Status and Well-Child Visits measures. For the Childhood Immunization Status measure, there was one record excluded due to contraindications identified through administrative data, and there was one record chosen from the auxiliary list for replacement, making for a total sample of 410.

For the HEDIS 2005 Childhood Immunization Status, Combination #2 measure, the DST showed a total of 1,181 eligible members for the denominator. The file of all administrative records supplied by the MCO contained 1,181 eligible members. There was no duplication of members and the dates of birth and dates of enrollment were within the valid range.

For the HEDIS 2005 Well-Child Visits measure, there were a total of 1,156 eligible members listed by the MCO; the EQRO was able to validate 1,150 eligible members. The DST showed a denominator of 288, with a final sample size of 303 after a 5% oversample. There were no exclusions allowed for the measure, and no exclusions or replacements reported. There were no duplicate member names, identification numbers or dates of birth. The dates of birth were within the valid range and the dates of enrollment and codes for well care visits were provided.

For the HEDIS 2005 Annual Dental Visit measure, there were a total of 4,271 administrative hits reported and 4,270 validated. There were no duplicate members and the dates of birth were in the valid range. The dates of enrollment were valid.

Processes Used to Produce Numerators

All three measures included the appropriate data ranges for the qualifying events (e.g., immunizations, well-care visits, and asthma medications) as specified by the HEDIS 2005 criteria (see Attachment XIII: Numerator Validation Findings). Medical record reviews were conducted for the Childhood Immunization Status and Well-Child Visit measures.

For the HEDIS 2005 Childhood Immunization Status Combination #2 measure, Missouri Care appropriately included administrative events from the State Public Health Immunization Registry (MOHSAIC). The DST reported 249 administrative hits from the eligible population; the EQRO validated 433 administrative hits, which represents an under reported bias of 27.00%. The MCO did not identify to the EQRO which records were selected for the sample, so it is difficult to know exactly how many administrative hits were in the sample of 410 records pulled for hybrid review. Whereas the MCO reported 94 administrative hits in the sample, the EQRO estimates 150. For the medical record review validation, the EQRO requested 30 of the 167 medical records reported to have contributed to the hybrid hits. A total of 30 of the 30 medical records were received for review; 23 of those were validated by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 76.67%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 67.89%, resulting in an underestimate of 4.23%.

For the HEDIS 2005 Well-Child Visits measure, 197 of the 194 administrative hits reported were validated. Of the 1,150 eligible members found, the EQRO validated 747 administrative hits. The plan reported 712 hits for the total population. The EQRO estimates 197 administrative hits within the sample, whereas, the MCO reported 194. The EQRO requested and received 27 medical records reported to have contributed to the hybrid hits. Of these 27 medical records, 23 were found to be a "hit", containing 6 or more well-child visits within the first 15 months of life. The remaining records included two (2) members with five well-child visits and two (2) members with zero visits. This resulted in a rate of 85.19% of medical records validated. The rate calculated by the EQRO based on validated administrative and hybrid hits was 75.50%. The rate reported by the MCO was 75.69%, which resulted in an overestimate of

0.19% by the MCO. Although the EQRO was only able to validate 85.19% of the hybrid record hits reported, the EQRO validated over 100% of the administrative hits reported by the MCO, thus resulting in a small overestimate.

The HEDIS 2005 Annual Dental Visit was the third measure validated. 4,270 of 4,271 numerator hits reported were validated. The dates of birth, enrollment and services were within the valid ranges. The final rate calculated by the EQRO was 28.66%, with no observed bias.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunization Status and Well-Child Visits measures. Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for each of these measures.

Submission of Measures to the State

Missouri Care submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

Table 71 shows the estimated bias and the direction of bias found by the EQRO. Both measures calculated by the Hybrid Method were within the 95% lower confidence limits reported by the MCO. There was no bias observed in calculation of the Annual Dental Visit measure.

Table 71 - Estimate of Bias in Reporting of HEDIS 2005 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunization Status, Combination #2	4.23%	Underestimate
Well-Child Visits in first 15 months of Life	0.19%	Overestimate
Annual Dental Visit	None	

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. Table 72 (see below) summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.

Table 72 - Final Audit Rating for HEDIS 2005 Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status, Combination #2	Substantially Compliant
Well-Child Visits in first 15 months of Life	Fully Compliant
Annual Dental Visit	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by Missouri Care. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MC+ Members qualified for the measure.

STRENGTHS

1. Missouri Care was fully compliant with the HEDIS 2005 Well Child Visits in the First 15 months of Life and Annual Dental Visit measure.
2. Missouri Care demonstrated a significantly higher rate of the HEDIS 2005 Childhood Immunization Status and Well-Child Visits measure compared to the average for all MC+ MCOs.
3. Missouri Care demonstrated a higher rate of the HEDIS 2005 Well-Child Visits than both the National Medicaid and National Commercial Averages.
4. Missouri Care demonstrated a higher rate of the HEDIS 2005 Childhood Immunization Status than the National Medicaid Average.
5. There was effective use of data from the State Public Health Immunization Registry (MOHSAIC) for the calculation of the immunization rates. Missouri Care provided the members' identification data to the SPHA and obtained an extract of immunizations for the members eligible. This data was loaded into the HEDIS data repository (SQL Server) by Austin Provider Solutions (APS) and integrated into the calculation of the numerators.
6. Missouri Care used reporting software by APS for calculation of HEDIS performance measures that had been reviewed by NCQA. This application software had also been reviewed and tested for source code verification by NCQA.
7. Missouri Care had no capitated providers, which may have contributed to higher rates of administrative hits.
8. There were effective edit and validity checks within the QMACS claims system. There was a mechanism to create error logs within QMACS which enabled the user to create reports and verify accuracy.
9. The relationship that MOCare had with vendors and subcontractors was very open.

10. MOCare corrected the deficiency from last year's report and located and archived data sheets for medical record review.
11. MOCare retrieved 100% of medical records requested for the performance measure validation.
12. MOCare is utilizing statistical significance testing to compare HEDIS rates from year to year.
13. MOCare has used the 2004 External Quality Review report to improve processes and procedures.

Areas for Improvement

1. Missouri Care used medical record review software, which was used as a tool for retrieving medical records that needed to be reviewed. This application had a module for data entry that did not indicate whether administrative data had been previously entered. The design of this module leaves open the possibility for data entry error by re-entry of valid administrative data. Missouri Care follows the process identified by the NCQA auditor, MEDSTAT.
2. Documentation on HEDIS rate calculation and policies related to calculation of HEDIS measures are weak at the Columbia office.
3. QMACS uses 2 systems with 2 different member ID numbers. At present, Missouri Care ends all ID's with an "n" for "new" or an "o" for "old". This does not seem like the most effective way to ensure the uniqueness of ID numbers, therefore Missouri Care should consider alternative routes when the system is upgraded.
4. The HEDIS rate end products are housed at the MOCare office in Columbia, however the staff at that office are still working to understand the inputs of the HEDIS calculations.

Recommendations

1. Improve documentation of the HEDIS rate calculation process by developing and maintaining a set of information system policies for the HEDIS rate production on-site. This will allow for continuity and validity of the process of rate production in the event of turnovers.
2. Increase ownership and control by Missouri Care over the process of calculation of HEDIS measures. This can be done by designating an employee to closely coordinate with APS and clearly assign responsibilities related to the HEDIS rate calculation processes within the organization.
3. Continue to conduct and document statistical comparisons on rates from year to year.
4. Continue to participate in training of MCO staff involved in the oversight of coordination of performance measure calculation.

9.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 101,758 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and 99.99% valid. Invalid dates of service ranged from 12/01/2005 –12/27/2005 for six fields.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and 99.99% valid. Eleven invalid dates of service ranged from 04/01/2005 – 04/29/2005.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete, accurate and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 18.44% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 3.07% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 0.44% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.00% (with rounding) complete, accurate and valid. Three fields were complete, accurate, and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 2,902 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were no encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

For the Inpatient claim type, there were 11,742 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, 97.24% valid. Invalid dates ranged from 02/24/2005 – 12/31/2005.
5. The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 99.69% of the time (with 36 entries of "99999999"). Valid values were present 95.88% of the time. In addition to the invalid "99999999" entries, invalid dates ranged from 04/01/2005 – 04/15/2005.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (87.06%, 70.72%, 53.64%, and 38.79%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete and accurate, and 97.29% valid. Invalid dates of service ranged from 10/10/2005 – 12/31/2005.
11. The Last Date of Service field was 100.00% complete and accurate, and 96.18% valid. There were four invalid dates of service ranging from 04/01/2005 – 04/15/2005.
12. The Revenue Code field was 100.00% complete, accurate, and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 69,657 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. Missouri Care had 100.00% complete, accurate and valid data for all fields examined, except the third through fifth Diagnosis Codes. Although the second through fifth Diagnosis Code fields are optional according to the Health

Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 49.75% complete, accurate and valid. The third Diagnosis Code field was 23.10% complete, accurate and valid. The fourth Diagnosis Code field was 10.37% complete, accurate and valid. The fifth Diagnosis Code field was 4.95% complete, accurate and valid. All remaining Diagnosis Code fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 78,685 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. Missouri Care had 100.00% complete, accurate and valid data for all fields examined.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Missouri Care, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. All critical fields for the Outpatient Hospital, Dental and Pharmacy claim types were 100.00% complete, accurate, and valid (see previous findings). The Medical Claim Type the Outpatient First Date of Service and the Outpatient Last Date of Service fields contained invalid data. The Inpatient Claim type had invalid data in the Admission Date and Discharge Date.

What is the Level of Volume and Consistency of Service?

When comparing the rate of encounter claim types per 1,000 members, the rates for Medical, Pharmacy, Inpatient and Outpatient Hospital claim types were significantly higher than the average for MC+ MCOs. The rate for Dental claims was significantly lower than the average for MC+ MCOs. This suggests high rates of encounter data submission and access to preventive and acute care.

To what Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review.

Of the 101,758 Medical encounter claim types in the SMA extract file for January 1, 2005 through March 31, 2005, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 100 medical records (100.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 71.0%, with a fault rate of 29.0%. The match rate for diagnoses was 100.0%, with a fault rate of 0.0%.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure codes was conducted. There were no errors found in the medical record review for diagnoses codes.

For the procedure codes in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 15), incorrect codes (n = 14). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MC+ MCO paid/unpaid encounter claims match the SMA paid database?

Since Missouri Care included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MC+ MCO encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the MCO denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type, all encounter data submitted to the EQRO (n = 78,685) was of "paid" status. There were 35 unmatched claims that were in the MOCare encounter file and absent from the SMA data. Thus, 99.96% of the EQRO submitted encounters matched with the SMA encounter records.

For all Outpatient Claim Types (Medical, Dental, and Hospital), MOCare submitted 174,317 "paid" encounters. Of these encounter claims 214 records did not match with the SMA encounter claim extract file. There was a "hit" rate of 99.88% between MOCare encounter claims and the SMA encounter data.

For the Inpatient Claim Type, MOCare submitted 11,742 encounter claims. All encounter claims were of "paid" status. 79 encounters from MOCare were not matched in the SMA extract file, yielding a 99.33% "hit" rate.

Why are there unmatched claims between the MC+ MCO and SMA data files?

The majority of unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Within the Pharmacy Claim type, 34.29% of the unmatched encounters were missing ICN numbers. Therefore, 23 Pharmacy encounter claims were legitimately missing from the SMA extract data. For the Outpatient data, 85.58% of the unmatched claims were missing ICNs. Thus, there were 33 unmatched encounters that were legitimately missing from the SMA data records. For Inpatient Claims, all unmatched claims were missing ICNs.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MC+ MCO did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. The Internal Control Number is unique only to the encounter but not to each service, thus one ICN may be represented in multiple lines of data. To match the MC+ MO data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format and even included internal control numbers which enabled BHC to conduct the planned comparisons between the MC+ MCO and the SMA extract files.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental, Outpatient Hospital, and Pharmacy claim types were 100.00% complete, accurate and valid.
4. In the Inpatient Claim type, Patient Status and Units of Service fields increased to 100.00% complete, accurate, and valid from 2005.
5. The rates for Medical, Pharmacy, and Outpatient Hospital claim types were significantly higher than the average for MC+ MCOs, suggesting high rates of encounter data submission and at least moderate access to preventive and acute care.
6. Revenue Code fields were complete and valid for all Outpatient Hospital claim type encounters.
7. The rates of identification of administrative hits for performance measures were significantly higher for Missouri Care, suggesting more complete claims data for immunizations and well-child visits.
8. Missouri Care had significantly higher rates of match for the procedure and diagnosis codes between medical records and the SMA encounter claims data than the average for all MC+ MCOs. This was largely accounted for by the higher rate of medical records submitted by providers.

AREAS FOR IMPROVEMENT

1. The Outpatient First Date of Service and Outpatient Last Date of Service fields contained invalid entries for the Medical claim type.
2. The Admission Date and Discharge Date fields had invalid entries for the Inpatient claim type.

RECOMMENDATIONS

1. Ensure that Admission Dates and Discharge Date fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
2. Include all State issued ICN numbers for all encounters to allow more accurate matching of encounters between the MC+ MCO and SMA extract files.

9.4 MCO Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MCO's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the Division of Medical Services. On-site review time was used to conduct interviews with those who oversee the daily practices of the MCO to ensure that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MCO Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the MCO and to follow-up on questions raised from the document review and from the 2004 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Provider Contracts
- Grievance and Appeal Policies
- Grievances and Appeals related to members were reviewed, as were Complaints, Grievances, and Appeal files for providers. These files were obtained from a random selection process of actions filed in the first quarter of 2005
- 2004 Annual Quality Improvement Program Evaluation

Additional documentation made available by Missouri Care Health Plan included:

- Marketing Plan and Educational Material Development Policy
- Missouri Care Organizational Chart
- Participating Health Provider Agreements
- Missouri Care Policy Tracking Log
- Missouri Care Provider Directory
- Lead Screening Initiative Handouts and Informational Packet
- Missouri Care ADHD Toolkit
- Missouri Care Informational Handouts

Interviews

Interviews were conducted with the following groups:

Plan Administration

Susan Christy, Health Plan Administrator
Dr. Jan Swaney, Medical Director
Melody Dowling, UM Manager
Tammy Weise, Manager, Quality Management
Brenda Moore, Manager, Medical Management
Debby Langley, Manager, Member Solutions

Mental Health

Dr. Jan Swaney, Medical Director
Melody Dowling, UM Manager
Tammy Weise, Manager, Quality Management
Brenda Moore, Manager, Medical Management
Debby Langley, Manager, Member Solutions

FINDINGS

Enrollee Rights and Protections

Missouri Care had an assigned compliance officer who maintained a record of all internal policies and presented reminders to appropriate staff when annual reviews were required. Compliance reviews were conducted every other month. Records included all initial approval dates to ensure that timely monthly reminders were produced. Revisions were made as necessary. Internal approval included the Quality Management Oversight Committee, Managers, the Medical Director, and the Chief Executive Officer or Plan Administrator prior to submission to the SMA. After this process was complete, the policies were presented to the MCO's Board of Directors.

The MCO continued to utilize the Child and Adolescent Health Measurement Initiative (CAHMI) survey instrument for member needs assessment. Missouri Care utilized the monthly special needs listing produced by the SMA and sent the survey to all of their members appearing on this listing. If they received no response in seven days, and again in fourteen days, they made additional attempts using telephone contacts. If the MCO was unable to contact the member after 30 days, the file was closed. Missouri Care reported they send out 75-100 CAHMIs each month and have a 30-35% response rate. The MCO found that by using the CAHMI, it assisted in correctly identifying members who needed physical or mental health case management services.

Missouri Care participated in community-based programs throughout their MC+ Medicaid Managed Care region. They were involved in school-based health clinics with the Morgan County School District. The MCO participated in a back-to-school fair where they not only contacted member families directly, but were able to network with regional primary care physicians (PCPs). Additionally, outreach calls were made to all eligible children. Seventy EPSDT examinations were performed as the result of these efforts. Missouri Care partnered with another MCO to do school based screenings with the School of the Osage. Fifty EPSDT examinations and fifteen referrals for follow-up services occurred as a result of this outreach effort. Two children were reported to the Child Abuse and Neglect Hotline. One local Federally Qualified Health Center (FQHC) held Thursday evening appointments to do Pap tests and adolescent EPSDT examinations. As a trial intervention, Missouri Care scheduled appointments for the FQHC utilizing demographic information obtained from their system. Theses efforts resulted in 46 Pap tests and fourteen EPSDT examinations. An additional 550 EPSDT examinations followed, after sending informational postcards and informational fliers to those members whose tests were past due. Through efforts with the Columbia Public Schools, the MCO targeted a campaign to increase EPSDT examinations in the Boone County section of the region. EPSDT examinations for high school students were planned at the new Family Health Clinic satellite location near Douglas High School. A quarterly news letter for school nurses was developed and distributed by the MCO.

During 2005 Missouri Care also attempted a cervical cancer screening initiative with the FQHC. All eligible members received reminder letters and follow-up telephone contacts. A larger sample received an informational flier that included a list of providers who could perform these examinations. One hundred sixty-one members obtained well-women examinations in a three month period following these efforts. The MCO considered this a successful initiative in terms of member response.

The rating for Enrollee Rights and Protections (84.6%) reflects that the MCO substantially complied with the submission and approval of all policy and procedures to the SMA. All practice observed at the on-site review indicated that the MCO appeared to be fully compliant with MC+ Medicaid Managed Care Contract requirements and federal regulations in this area.

Table 73 - Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	Missouri Care	
	2004	2005
438.100(a) Enrollee Rights: General Rule	1	2
438.10(b) Enrollee Rights: Information Requirements	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	1	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	1
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	2
438.100(b)(3) Right to Services	1	1
438.100(d) Compliance with Other Federal/State Laws	1	2
Number Met	7	11
Number Partially Met	6	2
Number Not Met	0	0
Rate Met	53.8%	84.6%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

Through efforts with the SMA, the University of Missouri, and other State agencies, Missouri Care had tele-psychiatry services available in six counties in the Central Missouri region. Access was made available in outpatient offices for use by specialist psychiatrists. Face-to-face sessions with the member's behavioral health provider were required. Pediatric and adolescent psychiatrists were made available through this method in outlying counties, where these services would normally be unavailable. In some cases, the parent and case manager participated in sessions with the member and psychiatrist. This innovation created a more comprehensive approach to treatment for a number of members.

Missouri Care began supervising the provision of behavioral health services themselves during 2005. In preparation for this transition, the MCO contacted all providers contracted with CommCare in the Central Missouri MC+ Medicaid Managed Care Region. Most active

providers were recruited directly into the Missouri Care system. Missouri Care utilized Mid-Missouri Mental Health, Boone Hospital, Audrain Medical Center, Royal Oaks Hospital, and St. Mary's Hospital for inpatient behavior health treatment. At the time of the on-site review, the MCO was completing a contract with Preferred Family Healthcare, which is based in Kirksville, but had centers in several Central Missouri counties. Missouri Care completed provider training for the transition of behavioral health services in August 2005.

Prior authorizations for outpatient behavioral health services were faxed or telephoned to the MCO's main office, and were handled similarly to medical prior authorization requests. Requests for inpatient services were called in to the MCO. The Level of Care Utilization System (LOCUS) or Child and Adolescent Level of Care Utilization System (CALOCUS) criteria were utilized for decision-making criteria. Scoring was completed by nursing staff using information submitted by the behavioral health providers and by physicians involved with the member. The request, with the corresponding score, was then sent to the Chief Medical Officer. Consultation with the Chief Medical Officer for Mental Health occurred as required.

Accessibility to behavioral health services was enhanced for Central Missouri members by incorporating the prior authorization and daily utilization management systems into the MCO's regular operations. Missouri Care found that when an inpatient stay is necessary, information was available and the decision-making process was performed quickly and more efficiently. Data was available at the MCO and could be processed immediately. The MCO reported that it had a clearer understanding of member needs, which led to the most effective levels of care for members. Missouri Care reported that inpatient hospitalizations decreased during 2005. One reason given was that Royal Oaks Hospital implemented an inpatient screening procedure for the MCO. Missouri Care believed this process reduced inappropriate admissions, although it did create a slight increase in outpatient services.

Case management for mental health was done by a master's level social worker and staff under the direction of the Chief Medical Officer for Behavioral Health.

Quality Assessment and Performance Improvement

Access Standards

Prior authorization policy was reviewed and approved by the SMA during 2005. All prior authorizations were faxed or called in to nurses, who screened requests using Milliman Criteria. Requests that did not appear to meet the criteria initially were forwarded to the Chief Medical Officer for final determination. Decisions were then returned to the nurses who submitted notification to the provider. If the MCO received an appeal of a denial, the medical information was reviewed by the corporate medical officer for a final decision. The Chief Medical Officer for Behavioral Health provides expertise in the review of requests for these services.

The Missouri Care Nurse Line call center, located in Phoenix, Arizona, is staffed 24 hours per day, seven days per week. Both nurse and physician coverage is available. The MCO reported that when behavioral health services moved to Missouri Care, they were able to transfer the previous CommCare toll-free telephone number for member usage. This enabled the transition to remain as seamless to members as possible. All calls received in Phoenix are tracked to the Columbia office the next day.

The MCO integrated physical and mental health services including prior authorizations, the Nurse Line, Provider Relations and Member Solutions. Missouri Care was in the process of integrating the physical and mental health case management information into one database at the time of the on-site review.

Missouri Care began to use predictive modeling to assist in the identification of members for case management. The system was only used for physical health case management during 2005. The process assisted the MCO in identifying members who needed case management, but who had not previously come to their attention. The MCO planned to incorporate non-compliance with medical recommendations into the logic of this program in the future. The language for care planning was being incorporated into all Missouri Care policy. The care plans were to be developed by the provider and member, with the assistance of the MCO case manager as needed. Provider education was completed in 2005.

Missouri Care reported that their dental subcontractor did continue to search for additional providers throughout the Central Missouri region. Dentists were added throughout 2005, but

recruitment continued. The MCO added the University of Missouri – Kansas City Dental School and several mobile dental units to their network.

The rating for Access Standards (84.6%) indicated the MCO has actively worked toward becoming fully compliant with all MC+ Medicaid Managed Care requirements and federal regulations. All practice in this area observed at the time of the on-site review indicated that Missouri Care worked toward ensuring that members have access to all the healthcare services that they may require.

Table 74 - Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison

Federal Regulation	Missouri Care	
	2004	2005
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2
438.206(c)(1)(i-vi) Timely Access	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	2	2
438.208(c)(1) Care Coordination: Identification	2	2
438.208(c)(2) Care Coordination: Assessment	1	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2
438.210(b) Authorization of Services	1	2
438.210(c) Notice of Adverse Action	1	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	1	1
438.210(e) Compensation of Utilization Management Activities	2	2
438.114 Emergency and Post-Stabilization Services	1	1
Number Met	12	15
Number Partially Met	5	2
Number Not Met	0	0
Rate Met	70.6%	88.2%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

The ratings for Structure and Operations (90%) reflect full compliance with the MC+ Medicaid Managed Care contract requirements and federal regulations. The MCO submitted all required policy for approval, and all practice observed at the time of the on-site review indicated compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete and all subcontractual requirements were met.

Table 75 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison

Federal Regulation	Missouri Care	
	2004	2005
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	1	1
438.214(d) Provider Selection: Excluded Providers	2	2
438.214(e) Provider Selection: State Requirements	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2
438.56(d) Disenrollment: Procedures	2	2
438.56(e) Disenrollment: Timeframes	2	2
438.228 Grievance System	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2
Number Met	9	9
Number Partially Met	1	1
Number Not Met	0	0
Rate Met	90.0%	90.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Missouri Care operated a Quality Management Oversight Committee made up of the Chief Executive Officer, Plan Administrator, Chief Medical Officer, and department managers. The goal of this group was to provide oversight of all operations and MCO initiatives. The MCO began an initiative to bring PCPs and psychiatrists together through their pharmacy service to look at polypharmacy issues. Pharmacy data was reviewed and members with fifty or more prescriptions within a six month period were identified. Letters were sent to all associated providers with the date of care and the prescription with drug category. A one page survey was

sent out to providers to obtain feedback in August 2005. The plan was to run the project for one year to see if the number of prescriptions per member was impacted.

Acting on a concern for the care of children with ADHD, Missouri Care developed an informational packet for PCPs. They reported the packets were well received, one clinic requested additional packets to share with residents. The Vice Chairman of Pediatrics at the University of Missouri agreed to champion the project with physicians, and to share this information during CME presentations.

The MCO adopted and disseminated practice guidelines in the area of diabetes, asthma, chronic obstructive pulmonary disease (COPD), and congestive heart failure. This information was available to all providers on the MCO website. Missouri Care indicated that they were in the process of developing practice guidelines for depression management.

The MCO submitted two Performance Improvement Projects (PIPs), which included enough information to complete validation. All Performance Measurement data and medical records requested were submitted for validation within requested timeframes. Missouri Care did have a health information system (HIS) capable of meeting the MC+ Medicaid Managed Care program requirements. The MCO also submitted all required encounter data in the format requested. The specific details can be found in the appropriate sections of this report.

The rating for the Measurement and Improvement section (63.6%) reflects that all required policy and procedure had been submitted to the SMA for their approval. It appeared that all practice observed at the time of the on-site review met the requirements of the MC+ Medicaid Managed Care contract and the federal regulations.

Table 76 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison

Federal Regulation	Missouri Care	
	2004	2005
438.236(b)(1-4) Practice Guidelines: Adoption	2	2
438.236(c) Practice Guidelines: Dissemination	2	2
438.236(d) Practice Guidelines: Application	2	2
438.240(a)(1) QAPI: General Rules	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs2	1	1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	1
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	1
438.242(b)(3) Health Information Systems: Basic Elements	1	1
Number Met	7	7
Number Partially Met	4	4
Number Not Met	0	0
Rate Met	63.6%	63.6%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

A pattern of claim denials for "duplicate claim line" was noted for Missouri Care. They explained that when duplicate procedures occurred for the same member, the same claim number was assigned by the SMA claim system. The MCO's health information system kicked these claims out as duplicates.

Five member appeals and three member grievances were reviewed. Two of the member appeals were reviewed and overturned, while three were upheld. Two of the member grievances concerned drivers with the transportation subcontractor, Medical Transportation Management (MTM). The drivers in these cases were counseled about their treatment of

members and their timeliness. The final grievance concerned dental care. It was investigated and no quality of care issues were identified. The member failed to appear at a follow-up appointment.

Six provider complaints were reviewed. Three of these were for claim denials where no prior authorization had been requested. These were reviewed and upheld. Two complaints stated claims had not been paid. Upon review it was found that one of the claims had been paid and the other had been billed incorrectly, therefore the denial was upheld. The final complaint concerned a denial for a requested drug. Additional information was provided and the denial was overturned.

All files reviewed were in order and all correspondence was dated according to policy timelines.

The rating for Grievance Systems (100%) reflects that all policy and practice met the requirements of the MC+ Medicaid Managed Care contract and federal requirements.

Table 77 - Subpart F: Grievance Systems Yearly Comparison

Federal Regulation	Missouri Care	
	2004	2005
438.402(a) Grievance and Appeals: General Requirements	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2
438.404(b) Notice of Action: Content	2	2
438.404(c) Notice of Action: Timing	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2
438.410 Expedited Resolution of Appeals	1	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2
438.416 Recordkeeping and Reporting Requirements	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2
Number Met	17	18
Number Partially Met	1	0
Number Not Met	0	0
Rate Met	94.4%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Summary / Follow-up

Missouri Care made significant improvement in meeting all policy, procedure, and practice requirements to be in compliance with the MC+ Medicaid Managed Care contract and the federal regulations. The MCO utilized the tools produced by the 2004 External Quality Review as guidelines in ensuring that required written materials were submitted to the SMA in a timely and efficient manner. The staff within Missouri Care exhibited a commitment to quality and integrity in the work with their members. The MCO utilized unique processes, such as bringing the provision of behavioral health services into the organization, as a method for improving the

access, quality and timeliness of member services. Missouri Care created tools to educate and inform the community and providers, evidenced by the efforts made to improve EPSDT examination numbers. The MCO demonstrated an attitude of respect toward their members in a number of outreach initiatives, as well as efforts to utilize software tools to better identify special healthcare needs. Missouri Care attempted to create a healthcare service system that was responsive and assisted members in overcoming the barriers they encounter in a largely rural area.

STRENGTHS

1. Utilization of both the State Contract Compliance tool and the EQRO tool to measure and track compliance with regulations and required policy submissions.
2. Tracking the submission and approval of required policy.
3. Transferring the provision of behavioral health services to Missouri Care. The work done to complete this transition was seamless for members. The MCO reported evidence that the provision of behavioral health services and case management was enhanced by their direct responsibility for this aspect of member services.
4. The dedication and enthusiasm of the medical director and all MCO staff interviewed.
5. Enhanced interdepartmental communication.

AREAS FOR IMPROVEMENT

1. Ensuring that the most current policy is submitted in a timely manner and that all tracking tools are up-to-date.
2. Continued attention to ensure that members have access to an adequate dental care network.

RECOMMENDATIONS

1. Continue MCO development in the area of utilization of available data and member information. This will drive change and create opportunities for further service development.
2. Continue working with school districts throughout the Central Region to engage their support and interest.
3. Continue monitoring access to dental care and assist in recruitment of providers throughout the Central Missouri Region.

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SECTION 10.0
CHILDREN'S MERCY FAMILY HEALTH PARTNERS

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10.0 – Children's Mercy FAMILY HEALTH PARTNERS

10.1 Performance Improvement Projects

The previous sections of the 2005 EQRO report present the purpose and objectives, technical methods, procedures for evaluation, and MCO to MCO comparisons of analyses, findings, and recommendations for each of the protocols based on the aggregate analysis. This section of the EQRO report summarizes MC+ MCO specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for MC+ Managed Care Members. Please refer to the main report for detailed technical objectives, methods, and presentation of data that are referenced here for the MC+ MCO.

METHODS

Document Review

Children's Mercy Family Health Partners supplied the following documentation for review:

- Improving Lead Screening for 6-36 Months Performance Improvement Project
- Access to Primary Care Services Performance Improvement Project

Additionally the MC+ MCO supplied data at the time of the on-site review, as promised with the original data submission.

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on March 8, 2006 during the on-site review, and included the following:

Ma'ata Touslee – Director, Health Services
Jenny Hainey – Manager, Quality Management
Lisa Gable – Manager, Health Services
Augusta Amadi – Case Manager
Melody Derks
Johanna Groves

Interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- What activities were added to this project for 2005?
- Was the population for the study expanded?
- How were the accuracy, consistency, and validity assured?
- Why was the lead project valid for continuation and used as a PIP for this project year?
- What findings were relevant to the MC+ population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

FINDINGS

The first PIP evaluated was "Improving Lead Screening at 6-36 Months." The MC+ MCO has conducted focused studies on the topic of rates of lead screening since 1999. Their annual analysis indicated that the blood lead level testing rates need to be higher. The topic of this PIP was designed to increase the percentage of members screened. The intervention was the use of provider and member education about the importance of lead screening. New activities included the provider education tools and face-to-face visits with area health departments to educate staff about the importance of blood lead level screening and the need to bill the MC+ MCO to ensure that proper records were available for MC+ Members. Additional study groups were added to the member activities. The topic was explained and supported with local, state, and national statistics. It did include a literature review and references. The MC+ MCO also conducted a comprehensive review of factors contributing to the problem during the previous year, which assisted in defining the parameters of the current study.

The study population was expanded to include all eligible children. No specific group was excluded. The study included two questions:

- Do letters and reminder calls to children identified as needing blood lead testing result in increased lead testing for those individuals?
- Do letters and reminder calls to children identified as needing blood lead level testing result in increased referrals to case management for individuals with high lead levels?

Both questions were designed to relate to specific indicators and interventions in the study. Indicators included rates of blood lead level testing per member of the study population, with a goal of reaching 75; and the rate of case management cases referred due to blood lead levels greater than10 units/dl. This information was queried every three months through the case management data base. These indicators were well defined and included a methodology for analysis in the study plan. Initial results indicated a significant increase in blood lead level testing that measured the changes in health status of MC+ Members. All eligible members were included and the definition of the included population was explained in the narrative.

The study design clearly specified the data to be collected in the study. The methodology prescribed utilized and provided analysis of all required information. This included claims data and analysis of the case management database. The project utilized quarterly scans of all specified data sources to ensure that a systematic and reliable method to collect required information occurred. Interventions included letters to members, presentations to and work with providers, and work with local health departments. The data analysis plan calls for quarterly queries of the claims data for the study population. Additionally, all members that the MC+ MCO is unable to contact will be placed in a control group to assist in evaluating the study effectiveness. Pre and post-intervention effectiveness will be measured. An analysis was performed as prescribed in the project planning. Preliminary findings were provided and updated at the on-site review. Graphs were included, but they were not clearly labeled. Additional clarification including an explanation of information presented would be helpful. Analysis included a comparison of members who received blood lead level testing before and after the interventions and correction for those who received tests prior to the beginning of the intervention. Real number and percentages were presented. The significance was identified and the actual changes were identified in the numbers available for review. A thorough analysis occurred according to the prospectively defined plan.

The 2005 results indicated a dramatic improvement in the number of children in the defined age groups that received blood lead level screenings. Increased numbers of members obtaining case management services was also captured and presented in this study. The MCO also contacted members as described in the post-intervention plan. The results of this activity supported the assumption that the multifaceted approach presented in this study resulted in the positive effects that were presented.

The narrative, documentation presented, and follow-up information indicated that this study provides a high confidence level and that this performance improvement project had the positive effect on member behavior sought. The information also indicates that the approaches described will be implemented into daily operations of the MC+ MCO to achieve ongoing and sustained improvement.

The second PIP evaluated was "Improved Access to Primary Care Services." The study topic was explained in detail and justified in the narrative and additional documentation provided. The presentation was generally based on the MC+ MCO's previous findings and project plan. This information was not based on any specified information or literature review. This project was also generated by the previous year's attempts to impact inappropriate use of emergency room services. The presentation is very well developed, but could have been enhanced by conducting a literature review and citing research conducted on the national level.

The project was clearly focused on correcting deficiencies in MC+ Member health care. It was based on the following hypothesis:

Use of the emergency room for non-emergent needs, as a choice over use of the assigned primary care physician (PCP), is not supporting the members' medical needs; and

Contact with and assistance to members in accessing their PCP or urgent care center will decrease the inappropriate use of the emergency room and strengthen PCP relationships.

The project was open to all members using the emergency room for non-emergent medical services. However, the description of the population included no specifics, including demographics of MC+ Members who utilized emergency room for non-emergent services in the past. This information may have enhanced the justification of the topic and the focus on prevention. The focus of the study appears to be on the adult population as the intervention takes place at Truman Medical Center which focuses on adult services. The study questions for this topic posed in the documentation were:

- Does placing a case manager in the emergency room (ER) during peak hours for education of members reduce overall ER utilization in the adult population?
- Does placing a case manager in the ER during peak daytime hours for education of members increase overall utilization of primary care services for the adult population?

The study questions were clearly stated and should assist in answering the questions raised in the topic discussion. The key indicators that the study focused on included: the rates of nurse-advice line calls per 1000 members; the rate of ER utilization per 1000 members; and use of a PCP or urgent care center as related to the ER visits during 2005. These indicators were thoroughly defined in the narrative and included specific measurement guidelines and data collection details. This included quarterly claims data queries, identification of the study population to ensure proper utilization identification, and quarterly call center data review.

The study population identified in the narrative documentation was the MC+ MCO members seeking care at the Truman Medical Center ER with a non-emergent diagnosis, who appear during the 4-6 hours each day that the case manager is present. MC+ MCO members are MC+ Medicaid Managed Care recipients in the nine county Western MC+ Managed Care Region. No actual sampling was conducted.

The documentation includes a data analysis collection plan that is appropriately detailed. Data will be collected on each member seen in the ER including demographics, reason for visit, education provided, barriers identified, and interventions completed. Members were to be followed to document post intervention compliance with the agreed upon treatment plan. Data analysis was to be performed using control charting, measurements of pre and post-intervention effectiveness, assessment of study variables, and ER statistics. Data sources were defined and specific. Controls for validity were not clearly identified. The study plan called for reporting to the MC+ MCO Internal Utilization Management Committee and Medical Oversight Committee on a regular basis. Periodically the Consumer Advisory Committee will receive updates on the project as well. The MC+ MCO was also working with a statistician from the University of Missouri – Kansas City to ensure that all data was collected, analyzed, and utilized in the most efficient and productive manner.

The main intervention planned was the placement of the case manager in the Truman Medical Center emergency room. The details of the activities required were detailed in the narrative. This appeared to be a reasonable and creative intervention to impact a problem that is reflected in comments from all MC+ MCOs.

Data analysis was not completed at the time of submission, but a detailed analysis plan was included. This included refining the member population to be followed, particularly for the entire post-intervention period. The numbers were affected by a change in Medicaid eligibility which occurred in the second half of 2005. The data analysis plan is detailed and comprehensive and promised to produce significant results. The initial information indicated that the project had a positive impact on MC+ Member health care services. The use of the statistician to assist with data analysis added confidence to the validity of the results yet to be published. This project was well-constructed and promised to produce significance results that could positively influence future methods of impacting how MC+ Members are educated about obtaining appropriate and effective health care services.

STRENGTHS

1. Excellent study topics and well-defined study questions.
2. Each Performance Improvement Project was well-developed and included a thorough and well-written narrative.
3. The focus of each project was clearly on improving the health, services, and processes for members receiving services. The projects also had the goal of becoming a part of the regular performance of the MC+ MCO.
4. The use of a professional statistician to ensure valid and reliable results indicated the investment the MC+ MCO was making in the project underway.

AREAS OF IMPROVEMENT

1. Continue development of performance improvement projects that include justification and planning, inclusive narratives, and projected outcomes.

2. Utilize available research and literature reviews to support the projects' hypotheses and the basis for conducting studies.

RECOMMENDATIONS

1. Continue the work the MCO is doing with the statistician to perfect PIP methodology.
2. Encourage staff to continue with these projects and with producing written narratives that were being considered for publication.

10.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Children's Mercy Family Health Partners. Children's Mercy Family Health Partners submitted the requested documents on December 9, 2005. The EQRO reviewed documentation between December 9, 2005 and February 27, 2005. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

Document Review

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Children's Mercy Family Health Partners for the HEDIS 2004 data reporting year
- Qualis Health's NCQA HEDIS Compliance Audit Report for HEDIS 2005
- Children's Mercy Family Health Partners' information systems (IS) Policies and Procedures pertaining to HEDIS 2005 rate calculation
- Children's Mercy Family Health Partners' information services (IS) policies on disaster recovery
- Children's Mercy Family Health Partners' HEDIS 2005 implementation work plan and HEDIS committee agendas for 2005
- Children's Mercy Family Health Partners' HEDIS 2005 Training Manual for the medical record review process
- Documentation, data files and source code of the in-house application for immunization rate calculation
- System edits for the claims management system

The following are the data files submitted by Children's Mercy Family Health Partners for review by the EQRO:

- ADVDenom&Num.txt
- ADVEnrollment.txt
- CISDenom&Num.txt
- CISEnrollment.txt
- CISHybrid.txt
- WC1Denom&Num.txt
- WC1Enrollment.txt

Interviews

The EQRO conducted on-site interviews with Janet Benson, Johanna Groves, and Jenny Hainey at the Children's Mercy Family Health Partners in Kansas City on Tuesday, March 7, 2005. This group was responsible for calculating the HEDIS performance measures. The objective of the visit was to verify the data, methods and processes behind the calculation of the three HEDIS 2005 performance measures.

FINDINGS

Children's Mercy Family Health Partners used the Administrative Method for calculation of Well-Child Visits and Annual Dental Visit measures. The Hybrid Method was used for the Childhood Immunization Status measure. MCO to MCO comparisons of the rates of Childhood Immunization Status Combination #2, Well-Child Visit, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) were reported.

The rate for the HEDIS 2005 Childhood Immunization Status, Combination #2 reported to the SMA and the State Public Health Agency (SPHA) by Children's Mercy Family Health Partners was 57.47%. This was significantly higher than the statewide rate for MC+ MCOs (28.17%; z = .72; 95% CI: 46.37%, 68.57%; $p > .95$).

The rate for the HEDIS 2005 Well-Child Visit measure reported to the SMA and the State Public Health Agency (SPHA) by Children's Mercy Family Health Partners was 23.91%. This was significantly lower than the statewide rate for MC+ MCOs (38.42%; z = -1.14; 95% CI: 11.38%, 36.44%; $p < .001$). The rate for Children's Mercy Family Health Partners for the 2005 HEDIS Annual Dental Visit measure was 39.10%; significantly higher than the statewide rate for MC+ MCOs (29.76%, z = 1.58; 95% CI: 34.82%, 43.38%; $p > .95$).

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of the in-house application developed for calculation

of the immunization measure, which used an MS Access data repository for retrieval and analysis.

For all three measures, Children's Mercy Family Health Partners was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which they transferred data into the repository used for calculating the HEDIS 2005 measures. Children's Mercy Family Health Partners used an external vendor application module for rate calculation. The MC400, a product of OAO HealthCare Solutions, Inc was part of the claims management system. The module was NCQA-certified for the 2002 HEDIS rate calculation, but the vendor had not sought certification since that HEDIS year. The EQRO was provided with a demonstration of the MC400, along with the data flow and integration mechanisms for external databases for these measures.

Documentation of Data and Processes

Data and processes used for the calculation of measures were adequate, as Children's Mercy Family Health Partners had worked diligently within the last year to significantly improve documentation of their processes. (See Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Children's Mercy Family Health Partners met nearly all criteria applicable for all three measures. The two criteria that were not met involved the use of statistical significance testing to document changes in performance over time and then using this information to support claims of improvement or stability in performance over time. Although many auditors conduct statistical tests to examine various aspects of data validity, such tests should be used by Children's Mercy Family Health Partners to assess the significance of change related to quality improvement activities and operational changes. Children's Mercy Family Health Partners indicated to the EQRO that they intend to utilize statistical significance testing prior to next year's audit.

Processes Used to Produce Denominators

Children's Mercy Family Health Partners met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of eligible members for the services being measured. For the Childhood Immunization Status, Combination #2 measure, a sample of 395 members were reported and validated. In regards to the Well-Child Visits measure, a total of

1,677 eligible members were reported and 1,673 eligible members were validated. For the denominator of the Annual Dental Visit measure, 24,342 eligible members were reported and 24,334 were validated. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2005 criteria. Denominators in the final data files were consistent with those reported on the DST for the Childhood Immunization Status, Combination #2 measure. All members were unique and the dates of birth ranges were valid. The denominators reported for the Annual Dental Visit measure were over-reported by 8 members. 7 of the 8 members were excluded from the denominator by the EQRO because they were not enrolled on the anchor date of December 31, 2004. The eighth member was excluded due to a gap of enrollment greater than 45 days during the measurement year. The denominators reported for the Well-Child Visits measure were over-reported by 4. The EQRO excluded those 4 members because they were not enrolled in the Children's Mercy Family Health Partners health plan on the anchor date of their 15-month birthday.

Processes Used to Produce Numerators

All three measures included the appropriate data ranges for the qualifying events (e.g., immunizations, well-care visits, and asthma medications) as specified by the HEDIS 2005 criteria (see Attachment XIII: Numerator Validation Findings).

For the HEDIS 2005 Childhood Immunization Status, Combination #2 measure, Children's Mercy Family Health Partners appropriately included administrative events from the State Public Health Immunization Registry (MOHSAIC). The EQRO's review of the administrative hits validated 109 of the 395 records provided. Thirty (30) of 30 medical records requested were received; 29 records resulted in validated hybrid hits. As a result, the medical record review validated 117 of the 121 hybrid hits reported. Based on the number of hits validated by the EQRO, the rate calculated was 57.21%. The total estimated bias for the Childhood Immunization Status, Combination # 2 measure was a .26% overestimate of the rate.

Children's Mercy Family Health Partners used the Administrative Method to calculate HEDIS 2005 Well-Child Visits measure. Review of the administrative hits validated 400 of the 401 hits found by the MCO. The rate calculated by the EQRO was 23.85%, with a bias of 0.06%, an overestimate by the MCO in the reporting of the measure.

The HEDIS 2005 Annual Dental Visit measure was the third measure validated. Review of the administrative hits validated 9,516 hits in the files provided for review by the EQRO. Although the MCO reported 9,517 hits, they only provided the EQRO with files containing 9,516 records. The dates of birth, dates of service, and dates of enrollment were in the correct range and valid. The rate calculated by the EQRO was 39.09%, with no bias in the reporting of the measure.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunization Status, Combination #2 measure. Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for each of these measures. Children's Mercy Family Health Partners was compliant with all specifications for sampling processes.

Submission of Measures to the State

Children's Mercy Family Health Partners submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

The following tables summarize the estimated bias in reporting each of the measures and the final validation findings. Table 78 shows a small overestimate (inside the 95% confidence interval) for the Childhood Immunization Status, Combination #2 and Well- Child Visits measures, and no bias observed in the calculation of the Annual Dental Visits measure.

Table 78 - Estimate of Bias in Reporting of HEDIS 2005 Measures

Measure	Estimate of Total Bias	Direction of Estimate
Childhood Immunization Status, Combination #2	0.26%	overestimate
Well-Child Visits in first 15 months of Life	0.06%	overestimate
Annual Dental Visit	None	

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet. Table 79 shows the final audit findings for each measure. Both the Childhood Immunization Status and Well-Child Visits measures were Substantially Compliant, as there was no significant

bias associated with the overestimated rates. The Annual Dental Visit was Fully Compliant with State specifications.

Table 79 - Final Audit Rating for HEDIS 2005 Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status, Combination #2	Substantially Compliant
Well-Child Visits in first 15 months of Life	Substantially Compliant
Annual Dental Visit	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCO. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MC+ Members qualified for the measure.

STRENGTHS

1. Children's Mercy Family Health Partners effectively integrates the MOHSAIC data into administrative rates for calculation of immunization rates. The sample files are sent to the SPHA for identifying members with an immunization history. The SHPA returns a file with relevant immunization information for Children's Mercy Family Health Partners' members. MOHSAIC data comprises a majority of hits within the administrative hits.
2. Rates for the HEDIS 2005 Childhood Immunization Status, Combination #2 and Annual Dental Visits measures were significantly higher than the average for all MC+ MCOs.
3. There was a well-designed HEDIS reporting module of the MC400 system. This module was certified by NCQA in 2002, but was not certified for 2004. Audit checks were conducted on this system by NCQA-certified auditors on an annual basis to confirm the system's output. The system generates appropriate production logs to track errors.
4. Data from external sources, such as the pharmacy vendor AdvancePCS, and data from medical record review was efficiently integrated. The format of data mapped in the integration process is automatically validated and also manually checked.
5. There were effective validity checks through automated system edits. The claims system had internal edit checks for each transaction and an error handling mechanism that validated the process.
6. Children's Mercy Family Health Partners had a separate application for combining the immunization data from medical record reviews and administrative searches. An MS Access database acted as a data repository for the application. This integrated the data from the claims system and effectively combined it with external data to produce the final immunization rates. This application was well-documented and produced accurate results. The data fields were clearly defined and business rules were well-documented.
7. Children's Mercy Family Health Partners had significantly improved its documentation of processes and organization of data.
8. Two members of the Children's Mercy Family Health Partners HEDIS team attended HEDIS training in October 2005.

AREAS FOR IMPROVEMENT

1. Data analysis should incorporate tests of statistical significance to assess whether the observed changes in rates are related to a specific intervention.
2. The HEDIS 2005 Well-Child Visits in the First 15 months of Life measure rate was significantly lower than the average for all MC+ MCOs.

RECOMMENDATIONS

1. Conduct and document statistical comparisons on rates from year to year.
2. Children's Mercy Family Health Partners should consider doing Administration/Hybrid optional measures as opposed to Hybrid, to find more hits.

10.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical fields?

For the Medical claim type, there were 117,554 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete and accurate, with 99.77% containing valid values. The following are the codes found in the 270 invalid fields.

Frequency	Code
138	99502
37	99601
93	B4035
1	E2603
1	K0638

7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 44.56% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 13.84% complete, accurate and valid (incomplete,

inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 6.91% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.00 % complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 16,061 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All of the fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were 36 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate, and valid except for the second through fifth Diagnosis Code fields. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (86.11%, 11.11%, 11.11%, and 0.00%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were 15,299 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate; and 96.24% valid. There were 576 invalid dates ranging from 12/01/2005 – 12/31/2005.
5. The Discharge Date field was 100.00% complete and accurate; and 96.50% valid. There were 536 invalid dates ranging from 04/01/2005 – 05/23/2005.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (92.01, 70.46%, 53.70%, and 15.71%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete and accurate, and 96.24% valid. There were 576 invalid dates of service ranging from 12/01/2005 – 12/31/2005.
11. The Last Date of Service field was 100.00% complete and accurate, and 96.50% valid. There were 536 invalid dates of service ranging from 04/01/2005 – 05/23/2005.

12. The Revenue Code field was 99.98% complete, accurate, and valid. There were 3 fields left blank.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 94,651 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Outpatient Hospital Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete and accurate, and 99.99% valid. This field requires five alphanumeric characters. There were 12 invalid fields of "99999".
7. The Outpatient Hospital Revenue Code field was 100.00% complete, and 100.00% (with rounding) accurate and valid. The two invalid fields contained 1 value of "30" and 1 value of "70". This field requires a three-digit code ranging 100-999.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 55.65% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 20.88% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 9.49% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 1.02% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 92,618 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid data for all fields examined.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Family Health Partners, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. Dental, Home Health, and Pharmacy claim type fields examined were 100.00% complete,

accurate, and valid (see previous findings). The Admission Date, Discharge Date, and Outpatient Procedure Code fields in the Medical claim type contained invalid procedure codes. For the Hospital Outpatient claim type, there were invalid codes for the Outpatient Procedure and Revenue Code fields.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rates of Inpatient, Medical, Pharmacy, and Home Health claim types were consistent with the average for all MC+ MCOs, while the rates for Dental and Outpatient Hospital claim types were significantly higher than the average for all MC+ MCOs. This suggests that the data are complete and that there is better utilization of dental services and high rates of access to preventive and acute care among Family Health Partners members.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review. Of the 117,554 Medical encounter claim types in the SMA extract file for January 1, 2005 through March 31, 2005, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 98 medical records (98.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 50.0%, with a fault rate of 50.0%. The match rate for diagnoses was 98.0%, with a fault rate of 2.0%.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file was missing information (n = 2) with no incorrect information. The diagnosis code listed did not match the descriptive information in the record.

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 31) and not enough information to code (n=19). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

What Problems are there with How Files are Compiled and Submitted by the MC+ MCO?

It was not possible to conduct the planned analysis of comparing MC+ MCO encounter data to the SMA encounter claim extract file due to the absence of an internal control number or crosswalk to compare the MC+ MCO files to the SMA extract files. The plan was to compare MC+ MCO paid and unpaid claims to the SMA encounter claim extract file. MC+ MCOs were requested to submit data, as specified by the EQRO (see Appendix 6), for the MC+ Managed Care Members represented in the encounter claim sample selected for validation.

For purposes of the EQRO, Family Health Partners was able to submit files in the requested format, but the ICN codes submitted were not the same number of characters of the ICNs in the SMA extract files.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MC+ MCO did submit the data in the requested format, there are a number of ways to improve the data quality by improving the database system. One variable that is not currently represented is that of a unique line number. To match up specific lines of data (each service provided within an encounter), this requires a unique number for each service provided for each member.

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Dental, Home Health and Pharmacy claim types were 100.00% complete, accurate, and valid.
4. The match rate between the medical record and SMA encounter claims data was statistically higher than the average for all MC+ MCOs for the diagnosis code.

AREAS FOR IMPROVEMENT

1. The Outpatient Procedure Code field for the Medical claim type contained invalid codes.
2. The Revenue Code for the Inpatient claim type contained 3 blank fields.
3. The Outpatient Procedure and Revenue Code fields in the Outpatient Hospital claim type contained invalid codes.
4. The match rate between the medical record and SMA encounter claims data was comparable to the average for all MC+ MCOs for the procedure code.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that the Outpatient Procedure and Revenue Code fields are complete and valid for the Outpatient Hospital claim types, and institute error checks to identify invalid data.
3. For audit purposes, submit extract files for encounter data in the requested file layouts with the requested ICN codes that are identical to the SMA extract file.

10.4 MCO Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MCO's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the Division of Medical Services. On-site review time was used to conduct interviews with those who oversee the daily practices of the MCO. This ensures that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MCO Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the MCO and to follow-up on questions raised from the document review and from the 2004 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

Document Review

The following documents pertaining to Children's Mercy Family Health Partners were reviewed prior to and at the on-site visit:

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Provider Contracts
- Grievance and Appeal Policies
- Grievances and Appeals related to members were reviewed, as were Complaints, Grievances, and Appeal files for providers. These files were obtained from a random selection process of actions filed in the first quarter of 2005.
- 2004 Annual Quality Improvement Program Evaluation

Additional documentation made available by Children's Mercy Family Health Partners included:

- 2005 and 2006 Marketing Plan
- Children's Mercy Family Health Partners' Organizational Chart
- Corporate Dashboard Indicators CY 2002-2006
- 2005 Welcome Calls summary by Quarter
- New Member Welcome Call Script
- Connection – Member Newsletter

- Are You Pregnant and Need Health Coverage brochure (2 languages)
- Do Your Children Need Health Coverage brochure (2 languages)
- Use Your Time Wisely brochure (2 languages)
- Resource Paper: Kansas City Children's Asthma Management Program: KC CAMP Family Health Partners (funded by the Center for Health Care Strategies)
- Health Management Quarterly Subcommittee Meeting Minutes – January, April, July, October 2005
- Community Relations 2005 Annual Report
- Children's Mercy Family Health Partners Initial Physician Utilization and Cost Comparison Profile Report

Interviews

Interviews were conducted with the following group:

Plan Administration

Robert Finuf – Chief Executive Officer, Plan Administrator
Ma'ata Touslee – Director of Health Services
Jenny Hainey – Manager, Quality Management
Linda Steinke – Director of Operations
Dr. Rubin – Medical Director

Mental Health

Brian Baker – CommCare
Lynn Durbin – CommCare
Eric Schmidt – CommCare
Ma'ata Touslee – CMFHP
Jenny Hainey – CMFHP
Linda Steinke – CMFHP

FINDINGS

Enrollee Rights and Protections

The staff at Children's Mercy Family Health Partners (CMFHP) continued to exhibit a strong commitment to ensuring that member rights were protected. The MCO utilized interpreter services, pre-translated written materials and a variety of methods for those members who spoke a language other than English. The MCO provided alternatives to members who may have reading, vision, or hearing problems that enabled them to obtain required information about the health plan or the services they can expect to receive. Member Services staff set up alternatives for individuals with any barrier to obtaining services and worked diligently to ensure that they received any necessary assistance.

During 2005, CMFHP developed a tracking system to guarantee that all required materials and policy are reviewed on an annual basis, as required, and are submitted to the SMA in a timely manner. This information is reviewed on a monthly basis and is stored in a locally maintained Access database. A quality committee reviewed the database information quarterly to ensure that all updates occurred timely. Member education and marketing materials were all submitted and approved during 2005.

CMFHP worked with an external contractor to develop applications of the ManagedCare.com software for their health information system. The company, using an internal utilization management committee, initially looked at all parts of the CMFHP system and narrowed the initial focus to ten areas. One of the preliminary projects involved completing provider profiling information in an effort to create a "report card" for providers. The MCO used the first part of 2005 to input and validate data. Profiling will be completed two times per year on all providers. The MCO also plans to use this software to create pharmacy profiles for members who have had difficulty managing their medication.

During 2005 the CMFHP Member Advisory Committee was established, and met four times during the year. The MCO exhibited its strong commitment to the advisory committee members by sending reminders and paying for transportation, thus eliminating this potential barrier to attendance. CMFHP raised issues with the committee and utilized their recommendations whenever possible. Examples included changing the format of the Member Handbook to include the Provider Directory in one document, changing the Welcome Call script to enhance understanding, and redesigning the appearance of brochures to be more appealing to the intended audience. CMFHP, upon committee recommendation, revamped their external Website to make it more user friendly. Reminders on enrollment, EPSDT, and other "hot topics" were created and sent out to members on a regular basis.

During, 2005 CMFHP made attempts to inform, engage, and reach out to the Latino community by employing an individual of Latin dissent. As a result, the MCO Welcome Call was amended and now includes a Spanish version. All written information regularly used by members is now automatically produced in Spanish. In addition, a Spanish language component became part of the Nurse Advice Line to ensure immediate availability to Spanish speaking members.

Ratings for Compliance with Enrollee Rights and Protections (100%) reflected policy and procedures that were submitted to and approved by the SMA. All written information has been submitted for approval. All practice observed, as well as additional documentation viewed while on-site, indicated that the MCO is fully compliant in this area.

Table 80 - Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	CMFHP	
	2004	2005
438.100(a) Enrollee Rights: General Rule	1	2
438.10(b) Enrollee Rights: Information Requirements	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	2
438.100(b)(3) Right to Services	1	2
438.100(d) Compliance with Other Federal/State Laws	2	2
Number Met	10	13
Number Partially Met	3	0
Number Not Met	0	0
Rate Met	76.9%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

CMFHP continued to work with CommCare for the provision of behavioral health services for members. This relationship continued as a strong partnership with a focus for providing effective services to members. CommCare was questioned about their policy regarding transferring members receiving services from out-of-network providers as a follow-up to the 2004 review. The BHO stated that they did explore changing the policy. The decision was made to continue with a four-week window of continued services with the out-of-network provider. This would allow the provider to become a member of their network, or to

transition the member to a new provider. The BHO recognized that this may restrict members in some situations, but reported that they had very few member complaints. CommCare stated that there was no evidence that any harm had come to members required to make a change. BHO staff provided assurances that when it appeared a clinical reason existed to maintain a therapeutic relationship with an out-of-network provider, all relevant factors would be considered. A decision would be made in the member's best interest. CommCare reported that they have recruited a number of new providers through these transitional cases, and always encourage providers to become a network member.

CommCare attempted to decrease the rate of readmissions following hospitalization and reported results as a follow-up to the 2004 review. The BHO engaged physicians to assist them in identifying issues that were triggers to readmission. CMFHP and CommCare staff, hospitals, and network providers were included in the review. This group identified that a key issue impacting readmissions, involved members who received inpatient treatment and had limited family support upon discharge. As a result, the BHO developed a system to provide in-home therapy and intensive case management for members at risk. CommCare agreed to absorb any cost for additional encounters not reimbursed by the SMA, such as late night telephone interventions. The BHO contracted with three specific providers to perform the intensive case management component of this service system. The result of this improved approach has been thirty-one fewer hospital readmissions July through December 2005. CMFHP and CommCare are assessing the clinical improvement achieved by these members. A committee is tracking the progress of the initiative. Another positive effect of the attention given to prevention of readmissions has been an improved rate of post-hospitalization follow-up for members in seven and thirty days after discharge. Emphasis was placed on discharge planning through work with hospital-based case managers and discharge planners. The goal was to initiate discharge planning within the first 24 hours of hospitalization.

A Psychiatric drug committee was formed during 2005, which included staff from the MCO, CareMark, a physician from Children's Mercy Hospital, and the medical director from CommCare. The committee met quarterly to review data pertaining to ADHD diagnosis, antipsychotic medications, and antidepressant drugs and discussed additional clinical findings available in the literature. The MCO did follow-up with physicians regarding prescription habits and published clinical findings that are applicable. Some formulary changes occurred to place edits on specific medications. All Community Mental Health Centers (CMHCs) were given

updated information about these changes from the physician committee members. The committee was in the process of developing training modules on polypharmacy issues at the time of the review. Education was planned for provider offices during the coming year and for providing a contact for consultation.

Quality Assessment and Performance Improvement

Access Standards

CMFHP continued to have a strong provider network through the MC+ Region. The MCO has worked one-on-one with providers, including specialists who agreed to become panel members. The MCO recognized a continued need for neurosurgeons and orthopedic surgeons. CMFHP recruited several specialists who agreed to be in the network, but requested to remain silent and not be published in the Provider Manual. These providers saw members when contacted directly by MCO staff. The MCO also engaged Truman Medical Center in this process, to ensure that members were triaged and received a referral and provider access quickly. CMFHP continued to monitor their PCP availability and continued recruitment to ensure that adequate open panels were available.

Prior authorization was an area of concern for the MCO. A committee of nurses was developed to review prior authorizations. They found that a number of procedures and medications existed that were always approved, and others that indicated a need for case management. The two medical directors also recognized that several types of denied claims, which were regularly overturned, were a recurring problem. They created a number of scenarios for the nurses to follow to allow for automatic approval. This measure offset any delay that might have occurred waiting for medical director review. The health information system had been programmed to automatically review certain procedures and medications. Analysis indicated that several of these procedure requests were routinely approved after the initial system generated denial. Therefore, the system was adjusted to allow for approval of certain procedures without prior authorization or medical director approval.

CMFHP worked with their subcontractor, Bridgeport Dental, to improve access to orthodontic services. Bridgeport used restrictive criteria for the authorization of braces. The MCO provided training to ensure the same criteria was applied as that used by the SMA for approval of braces. This decreased the number of appeals filed and overturned.

The MCO continued to use member surveys and on-site reviews to monitor access standards. When deficiencies were identified they were dealt with in writing. Direct provider contact occurred where required. Re-audits occurred to ensure that improvement was sustained.

Ratings for compliance with Access Standards (100%) reflected completion of all required written policies and procedures. Observations and interviews that occurred during the on-site review provided additional evidence that MCO practices and operations appear to be compliant with the MC+ Managed Care Contract and federal regulations.

Table 81 - Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison

Federal Regulation	CMCMFHP	
	2004	2005
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	1	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2
438.206(c)(1)(i-vi) Timely Access	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	1	2
438.208(c)(1) Care Coordination: Identification	2	2
438.208(c)(2) Care Coordination: Assessment	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	2
438.210(b) Authorization of Services	1	2
438.210(c) Notice of Adverse Action	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2
438.210(e) Compensation of Utilization Management Activities	2	2
438.114 Emergency and Post-Stabilization Services	1	2
Number Met	12	17
Number Partially Met	5	0
Number Not Met	0	0
Rate Met	70.6%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Structures and Operation Standards

CMFHP members have open access to specialists, with no referral from the PCP required. In some cases members receive assistance with referrals from MCO case managers. When a member had a specific problem, and care coordination was needed between clinicians, this was provided by the appropriate case manager. The MCO initiated a formal means of facilitating communication between PCPs and BHO providers, with member approval, to ensure that pertinent information was shared.

CMFHP formed a committee during the past year to discuss how the best methodology for making information about advance directives available to members. The goal was to have this information available at PCP offices. Education and materials were provided to PCPs on this topic. Two areas that remained problematic were accurate completion of all required documentation and proper recording in medical records. The MCO continued to work with PCP offices to improve these areas.

CMFHP participated in meetings during 2005 where discussions occurred regarding methods of reducing the number of high risk pregnancies in the MC+ Medicaid Managed Care population. The MCOs shared forms used, methods of identification of pregnant members, and methods of collecting information from members that identify potential high-risk situations. A pregnancy notification form was adopted. CMFHP recognized an improvement in the number of health assessments returned by members. This group's activities were reported to the SMA. CMFPH also reported joining a national group of Medicaid only organizations that share ideas and information on member services. The MCO hoped to be able to offer an incentive to pregnant members for attending all physician visits during their pre and post delivery time periods.

The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements. The MCO appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

Table 82 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison

Federal Regulation	CMCMFHP	
	2004	2005
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2
438.214(d) Provider Selection: Excluded Providers	0	2
438.214(e) Provider Selection: State Requirements	1	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2
438.56(d) Disenrollment: Procedures	2	2
438.56(e) Disenrollment: Timeframes	2	2
438.228 Grievance System	2	2
438.230(a,b) Subcontractual Relationships and Delegation	1	2
Number Met	6	10
Number Partially Met	3	0
Number Not Met	1	0
Rate Met	60.0%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

CMFHP continued to be an active member of the Kansas City Quality Improvement Consortium (KCQIC) and utilized the practice guidelines developed and supported by that group. The local guidelines that were used by the MCO continued to meet or exceed nationally accepted standards. The KCQIC was in the process of developing guidelines on obesity treatment. CMFHP will implement these guidelines upon their completion. The MCO continued to utilize Milliman and Roberson guidelines for utilization management.

CMFHP did submit two Performance Improvement Projects (PIPs) for validation. Specific details of these projects can be found in the appropriate section of the report. It was noted that the MCO utilized projects that had been started, and perfected these projects in an effort to create improved services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation.

The MCO submitted all required information to complete the Validation of Performance Measures, as requested. CMFHP continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The details of each of these areas of validation can be reviewed within specific sections of this report.

Ratings for the Measurement and Improvement sections were found to be (100%), which reflects that all required policy and practice meets the requirements of the MC+ Medicaid Managed Care contract and the federal regulations.

Table 83 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison

Federal Regulation	CMFHP	
	2004	2005
438.236(b)(1-4) Practice Guidelines: Adoption	2	2
438.236(c) Practice Guidelines: Dissemination	2	2
438.236(d) Practice Guidelines: Application	2	2
438.240(a)(1) QAPI: General Rules	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	2
438.242(b)(3) Health Information Systems: Basic Elements	1	2
Number Met	8	11
Number Partially Met	3	0
Number Not Met	0	0
Rate Met	72.7%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Ratings for compliance with the Grievance Systems regulations (100%) indicate that the MCO completed all requirements regarding policy and practice. Four member appeals and two member grievances were reviewed. Two of the member appeals were requests to review denials for cosmetic reasons. These were reviewed and overturned by the MCO. The third appeal concerned a denial for orthodontia, which was reviewed appropriately. The final finding was that criteria were not met. The fourth appeal was also upheld and this appeared within policy. Of the two member grievances, one was upheld. Although it stemmed from a concern over vehicle safety, the vehicle was inspected and found to be safe. The driver was counseled about safety and timeliness issues. The other pertained to inappropriate waiting time in a dental office and rude staff. The member was given an appointment with another provider. The original provider and staff were counseled about member treatment. A letter of apology was sent to the member from this medical group.

Six complaint files were reviewed concerning provider issues. Two were upheld due to lack of authorizations. Three were overturned with the receipt of additional information. The remaining complaint concerned what appeared to be a request for cosmetic surgery. With additional information it was learned that this concerned a mass that had changed or enlarged. It was also overturned. All member and provider files were in order and contained required and approved notification. All correspondence was sent within policy timeframes. Medical directors were appropriately involved to ensure that members obtained the healthcare they required.

Table 84 - Subpart F: Grievance Systems Yearly Comparison

Federal Regulation	CMFHP	
	2004	2005
438.402(a) Grievance and Appeals: General Requirements	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2
438.404(b) Notice of Action: Content	2	2
438.404(c) Notice of Action: Timing	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2
438.410 Expedited Resolution of Appeals	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2
438.416 Recordkeeping and Reporting Requirements	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2
Number Met	18	18
Number Partially Met	0	0
Number Not Met	0	0
Rate Met	100%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Summary

Children's Mercy Family Health Partners improved in meeting all policy, procedure, and practice areas of compliance with both the MC+ Medicaid Managed Care contract requirements and the federal regulations. The MCO exhibited a meticulous attention to meeting all the details of the regulations, submitting policy and procedural updates in a timely fashion, and utilizing the 2004 External Quality Review as a guideline for meeting required standards. The staff within CMFHP exhibited a commitment to excellence in serving MC+ Medicaid Managed Care members. They demonstrated respect and dignity toward members, while meeting their healthcare service

needs efficiently and effectively. The MCO went beyond the strict requirements of their contract to ensure that members are able to have a voice in the design of their healthcare system. The system created at CMFHP is responsive and strives to assist its members in overcoming the barriers often encountered in the areas of quality, access and timeliness in obtaining healthcare services.

STRENGTHS

1. Completion and approval of all policy and procedures required by the MC+ Managed Care Contract.
2. Development of an improved tracking system for all materials and policy that must be submitted annually, including monthly review of submission status.
3. Development and utilization of a Member Advisory Committee that meets quarterly. Commitment to assist members' attendance, including reminders and transportation.
4. Utilization of members' suggestions, such as combining the Member Handbook and Provider Listing into one document.
5. Commitment to the Latino community by employing a staff member for the purpose of community outreach and implementation of member suggestions.
6. Creative approach to engaging providers, particularly in hard-to-reach specializations.
7. Actively engaging new health management programs to benefit members. Working with Children's Mercy Hospital on a childhood obesity outreach program, PFITT.
8. Treatment of members and providers during the grievance and appeal process. In one record the provider sent a letter of apology to the member.

AREAS FOR IMPROVEMENT

1. Continue vigilant attention to continuous improvement within the organization and attention to improving services to members.

RECOMMENDATIONS

1. Continue to develop an organization that can exhibit energy and enthusiasm for its mission.
2. Continue to actively monitor providers and subcontractors and to develop corrective action initiatives when a problem is identified, such as advance directive utilization.
3. Continue to look for creative methods to use as motivators, such as available incentives, to encourage member utilization of MCO resources, particularly for high-risk populations.

SECTION 11.0
FIRSTGUARD HEALTH PLAN

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11.0 – FirstGuard Health Plan

The heart and soul of healthcare.®

11.1 Performance Improvement Projects

The previous sections of the 2005 EQRO report present the purpose and objectives, technical methods, procedures for evaluation, and MCO to MCO comparisons of analyses, findings, and recommendations for each of the protocols based on the aggregate analysis. This section of the EQRO report summarizes MC+ MCO specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for MC+ Managed Care Members. Please refer to the main report for detailed technical objectives, methods, and presentation of data that are referenced here for the MC+ MCO.

METHODS

Document Review

FirstGuard Health Plan supplied the following documentation for review:

- NCQA Quality Improvement Activity Form: Improving Asthma Medication Management
- NCQA Quality Improvement Activity Form: Improving Birthweight Outcomes

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on March 10, 2006 during the on-site review, and included the following:

Jean Rumbaugh – COO, Plan Administrator
Dr. William Pankey – VP, Medical Affairs
Barbara Maloney – VP, Development and Regulatory Affairs
Celia Humphreys – Director, Quality Improvement and Credentialing
Susan Richart – Senior Business Analyst
Sandra Clausen

Interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the project leader?
- How were the topics identified?
- How were the study questions determined?
- What were the findings?
- What interventions were chosen?
- How effective were these interventions?

Additional information was provided at the time of the on-site review and was considered in the final validation of these Performance Improvement Projects.

FINDINGS

The first PIP evaluated was "Improving Asthma Medication Management." Topic selection was clearly defined. The MC+ MCO had worked with the Kansas City Quality Improvement Consortium (KC-QIC) through 2002 to develop regionally specific practice guidelines for asthma management and treatment. Part of this project included guidelines for asthma medication management. The problems associated with uncontrolled asthma were discussed in the narrative. National data and a national literature review references were utilized in developing this topic. This information, coupled with regional and MC+ MCO data, supported the decision to choose this topic as a valid Performance Improvement Project (PIP). The information provided also identified the indicators of uncontrolled asthma, as well as new and improved asthma medication management strategies. This was incorporated into the study. The stated goal of the study was to positively impact the use of preventive services by educating providers and members who depend on rescue medication over the use of regular and preventive medications. The parameters of the population included were clearly defined as all members ages 3-56 with special health care needs, particularly asthma. The research supported the age range targeted due to the increased need and diagnosability of this group.

There is not a clearly specified study question presented. The question inferred was "Is an intervention that was based on educational mailing to providers and members, adequate to improve asthma medication usage over time?" The information provided did not distinguish a measurable or strongly worded study question.

The study did include objective and clearly defined indicators. The narrative delineated quantifiable measures that included baseline measurements. The indicators included were: identification of MC+ MCO members needing asthma management and MC+ MCO asthmatics with suboptimal asthma medication management. The population was clearly defined and was justified by the information provided. The population included MC+ Members and members of the Healthwave program, which is the Kansas Medicaid Managed Care program. How data on the two groups would be distinguished was not presented and could lead to confusion about outcomes. Data collection sources were identified and included: encounter data; pharmacy data; and case management records. No sampling was conducted in this study.

The data collection process for each measure was identified and well-defined. The follow-up information provided supported the assertion that accurate and valid data was collected. All data collection procedures were stated. The methodology was followed and included in the narrative. All data collection instruments are well-documented and the results included in the body of the study. A prospective data analysis plan for each measure was part of the study narrative.

Interventions included mailings to the PCPs, Pulmonologists, and Allergists/Immunologists (pediatric and adult) treating the members identified. Mailings included a number of educational materials. Educational material was also mailed to members; this included a version of the Asthma Medication Guidelines. Analysis of all data collected was performed according to the documented plan. Data analysis material included baseline and updated information. All data was analyzed and described in detail including timeframes, type of analysis used, statistical significance testing, and results achieved. The overall results indicated positive results were achieved. The information provided indicated unexpected findings, which may create an additional study. The documentation provided also included new activities for the next project year. Emergency room utilization did decline for the members involved in the study; this was a result of the preventive medications administered and the availability of appropriate rescue medications. The narrative recognized variables that may have influenced the results, but asserted that the statistically significant changes that occurred were directly related to the impact of the study intervention. The results, including an analysis of significance testing, were documented and presented in the study narrative. The results presented also included the plan to follow the process for an additional year to obtain data to determine a sustained

improvement. The data, analysis, and information presented provide a high level of confidence that this project positively impacted the members included in the study. The MC+ MCO, in following this study should also develop strategies to incorporate these interventions into normal agency operations.

The second PIP evaluated was "Improving Birthweight Outcomes." The topic was supported by literature review and research information; however, the references for this information were not included. The MC+ MCO was operating the Guardian Angel Program for pregnant women who were MC+ Members. The MC+ MCO did not view this program as being as effective as necessary to impact high-risk pregnancies and premature deliveries. The topic of this study became "Reducing the number of high-risk pregnancies and premature deliveries will reduce the number of low birthweight infants born." The goals of the study focused on identifying and correcting deficiencies in care in an effort to improve birth weight outcomes, thus improving the overall health of the infant population by reducing the probability of chronic lung disease, failure to thrive, potential developmental delays, and vision problems associated with low birth weight. This project focused on all pregnant MC+ Members. No specific portion of the population was excluded or omitted. The study question put forth was "Can prenatal case management, targeted at psychosocial factors, decrease the percentage of low birthweight infants?" The question appeared to be well-constructed and targeted. However the "psychosocial factors" or other issues leading to low birth weight were not specifically explored.

Indicators were not well-defined. The only indicator listed was the percent of "Healthwave low birthweight infants." Although the numerator and denominator specifications indicated "MC+ infants with birthweights $\leq$ 2500 grams," and "number of MC+ liveborn infants" respectively. Measured changes to be tracked were implied. The actual indicators that measure these outcome goals were not specifically delineated in the narrative provided.

The study did include all pregnant MC+ members who were due to deliver after January 1, 2005. A variety of methods to correctly identify all pregnant members were included in the project description. It appeared from the description provided that the focus of the study was members in the Kansas City metropolitan area, and not necessarily those from the surrounding counties in this region. The MC+ MCO partnered with four in-home agencies to serve the pregnant population with the main intervention defined as a community-based approach to

providing services. Each of the agencies identified had different criteria for service eligibility. One only served Kansas. There was no clarification presented about how all enrollees needing these services might gain access to them. None of the contracted agencies provided services outside of Jackson County in Missouri. No sampling was conducted as part of this study.

Data to be collected in the study was specified. The sources included information gathered from a focus group, OB registration forms, home visitor agency referral forms to be tracked in an Access database; CareEnhance clinical management software; and Amysis data. The narrative included information for baseline data collection, and a plan for future development. These sources and the data collection methodology were defined in the narrative. Most of the information to be gathered was to come from the MC+ MCO's MMIS system. The methodology described appeared consistent with the data analysis plan. Tools to be used for tests of reliability and validity were discussed. The information provided did leave questions about timeframes and how home visitor data would be collected and tracked. The MC+ MCO did provide training about the Access database collection tool prior to study implementation. There was a prospective data analysis plan included that had sufficient detail to provide confidence in the methodology presented.

The main intervention included in the project plan was referring all pregnant women, up to 20-30 weeks of pregnancy, to the home visitor programs for visits and face-to-face interactions. This intervention indicated a lot of promise for a positive impact on members. The substance of the intervention was not described. No follow-up or additional activities were described. Baseline data was established. Some preliminary data was also included in the narrative provided, but sufficient data for meaningful analysis was not yet available. This study concept has potential for a positive impact on members. The interventions could be more multi-faceted. Placing the success of the project on one intervention, in the hands a variety of agencies, all with their own eligibility criteria does not lead to confidence in production of measurable outcomes. It appeared that the impact of all variables that could impact this approach was not considered. Some additional structuring and alternate interventions for member who are not eligible, or fall outside of the catchment area for the community-based agencies involved, would add credibility and access to members that may fall into the high-risk pregnancy category.

STRENGTHS

1. The study topics selected were areas that have a strong potential to benefit and improve member services.

2. The narrative and documentation included was improved.

3. Data, updated narrative, and project analysis received at the site visit provided good data and measurement tools.

AREAS FOR IMPROVEMENT

1. The narrative should include enough information that a correlation can be made of the study question, interventions utilized, and outcomes.

2. Ensure that interventions are comprehensive enough to produce real change and potential for improvement in services to members.

RECOMMENDATIONS

1. Utilize the *Conducting Performance Improvement Projects* protocol to ensure that all questions are answered and that the narrative is responsive to all areas that will be validated.

2. Refine the format of the PIPs to ensure that enough detail is included to define the population studied and all details of the PIP process.

11.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for FirstGuard Health Plan. FirstGuard Health Plan submitted the requested documents on December 9, 2005. The EQRO reviewed documentation between December 9, 2005 and February 27, 2006. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

Document Review

The following are the documents reviewed by the EQRO:

The Information Systems Capability Assessment (ISCA) submitted by FirstGuard Health Plan
The Baseline Assessment Tool (BAT) submitted by FirstGuard Health Plan
MetaStar's NCQA HEDIS 2005 Compliance Audit Report
Letters of communication between the EQRO and FirstGuard Health Plan
FirstGuard Health Plan's policies pertaining to HEDIS 2005 rate calculation and reporting
FirstGuard Health Plan's HEDIS Project Outline for 2005
FirstGuard Health Plan HEDIS 2005 Medical Record Review Manual
HEDIS 2005 Software Logs
CRMS data warehouse tables - data field and definitions
CRMS extract file build process documentation
MC400 Data file extracts and print screens
HEDIS analyzer error messages
MOHSAIC data preparation process documentation
HEDIS data file layout in the IDS SAS Warehouse

The following are the data files submitted for review by the EQRO:

FILE_1_CHILD_IMMUNIZATION_ENROLLMENT_DATA.txt
FILE_2_CHILD_IMMUNIZATION_DENOMINATOR_AND_NUMERATOR.txt
FILE_3_ CHILD_IMMUNIZATION_HYBRID.txt
FILE_1_DENTAL_ENROLLMENT_DATA1.txt
FILE_2 DENTAL_ DENOMINATOR_AND_NUMERATOR.txt
FILE_1_WELL_CHILD_ENROLLMENT_DATA.txt
FILE_2_WELL_CHILD_ DENOMINATOR_AND_NUMERATOR.txt
FILE_3_WELL_CHILD_HYBRID.txt

Interviews

The EQRO conducted on-site interviews with Susan Richart and Regina Webb, Eligibility Analyst, at FirstGuard Health Plan in Kansas City; and on the phone with Keith Hibbard, IT Director and Corey Waters, IT at Centene in St. Louis on Thursday, March 9, 2006. Subsequent interviews took place with Mr. Hibbard; Kelly Verhague, First Guard; Marsha Eversole, Stratum Med; and Carol Bostick, WebMD Business Services to complete First Guard's

Information Systems Capabilities Assessment (ISCA) Report. They were in charge of explaining the process of calculating the HEDIS 2005 performance measures, as there had been a recent turnover in the HEDIS team. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS performance measures. This included both manual and automatic processes of information collection, storing, analyzing and reporting.

FINDINGS

FirstGuard Health Plan used the Hybrid Method for the Childhood Immunization Status, Combination #2 and Well-Child Visits Measures. MCO to MCO comparisons of the rates of Adolescent Childhood Immunization Status, Combination #2, Well-Child Visits Measure, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p > .05$) were reported.

The rate for the HEDIS 2005 Childhood Immunization Status, Combination #2 reported to the SMA and the State Public Health Agency (SPHA) by FirstGuard Health Plan was 55.72%. This was significantly higher than the statewide rate for all MC+ MCOs (28.17%; z = .60; 95% CI: 44.62%, 66.82%; n.s.).

The rate for FirstGuard Health Plan for the HEDIS 2005 Well-Child Visits measure was 51.58%, significantly higher than the statewide rate for all MC+ MCOs (38.42%; z = .50, 95% CI: 39.05%, 64.11%; $p > .95$). The rate for FirstGuard Health Plan for the 2005 HEDIS Annual Dental Visit measure was 27.07%, comparable to the statewide rate for MC+ MCOs (29.76%, z = -.48; 95% CI: 22.79%, 31.35%; n.s.).

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

Data Integration and Control

For all three measures, FirstGuard Health Plan was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which FirstGuard Health Plan transferred data into the repository used for calculating the HEDIS 2005 measures.

Documentation of Data and Processes

FirstGuard Health Plan Health Plan used NCQA-certified software from McKesson Inc, for the sampling and calculation of HEDIS measures. The EQRO was provided with a demonstration of the Health Plan Reporter (HPR), the application module for rate calculation, along with the CareEnhance Resource Management System (CRMS) data warehouse. Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). FirstGuard Health Plan met all criteria that applied for all three measures.

The information systems (IS) management policies and procedures for rate calculation were evaluated consistently with the Validating Performance Measures Protocol. FirstGuard Health Plan Health Plan was subject to a full Information Systems Capabilities Assessment (ISCA) this year due to a change in information systems after the Centene purchase. The EQRO found FirstGuard Health Plan to have most of the automated systems, management practices, data control procedures and rate calculation procedures required to assure that data is adequately captured, sorted, translated, analyzed and reported as mandated by the ISCA Review Protocol Appendix Z. The only area that the EQRO found to be lacking was FirstGuard Health Plan's data quality monitoring; specifically FirstGuard Health Plan does not monitor quality beyond confirmation of value (i.e. record per batch). FirstGuard Health Plan should consider additional investigation to assure them of data quality that comes from vendors.

Processes Used to Produce Denominators

FirstGuard Health Plan met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involves the selection of eligible members for the services being measured.

The HEDIS 2005 Childhood Immunization Status denominator file contained 411 denominator cases. This is the minimum required sample size; there were no exclusions or replacements for the denominator of 411. Dates of birth and enrollment were within valid ranges, and there were no duplicate cases.

The denominator file for the HEDIS 2005 Well-Child Visits measure contained a total of 411 members, all members in the file were determined to be eligible for the measure. There were no duplicate entries and the dates of service were in the valid ranges.

For the HEDIS 2005 Annual Dental Visit measure, there were a total of 18,573 eligible members (denominator) in the FILE_2 DENTAL_ DENOMINATOR_AND_NUMERATOR.txt file. There were no duplicate members. The dates of birth and the dates of enrollment were both in the valid range.

Processes Used to Produce Numerators

All three measures included the appropriate data ranges for the qualifying events (e.g., immunizations, well-care visits, and asthma medications) as specified by the HEDIS 2005 criteria (see Attachment XIII: Numerator Validation Findings). Medical record reviews were conducted for the Childhood Immunization Status, Combination #2, and Well-Child Visits measures.

For the HEDIS 2005 Childhood Immunization Status measure, FirstGuard Health Plan appropriately included administrative events from the State Public Health Immunization Registry (MOHSAIC). The dates of birth and dates of service were within valid ranges. Review of the administrative hits validated 233 of the 128 administrative hits reported in the files provided for review by the EQRO. This is an underestimate of 27.13%. Thirty (30) of 30 medical records requested for review were received; 6 records resulted in valid hybrid hits. Therefore, the medical record review validated 20 of the 101 hybrid hits reported. Based on the number of administrative and medical record review hits validated by the EQRO, the rate calculated was 61.61%. The total estimated bias for the Childhood Immunization Status, Combination #2 measure was a 5.89% underestimate of the rate. Although the rate of bias is not considerably significant, the EQRO found substantially more administrative hits than was reported on the DST. And although the hybrid hits reported by the MCO were not substantially supported by

the EQRO's medical record review, the MCO had a small estimated bias due to the surplus of administrative hits found.

For the HEDIS 2005 Well-Child Visits measure, the EQRO found 211 administrative hits, however only 152 hits were reported by FirstGuard Health Plan. All 30 medical record hits were requested and received by the EQRO for review. Twelve (12) of the records were validated for six or more well-child visits. Of the other 18 records, two (2) were found to have one visit, eight (8) were found to have four visits, and eight (8) were found to have five visits. A total of 235 hits were validated, although FirstGuard Health Plan only reported 212, for a rate of 51.58%, a final underestimate of 5.60%.

For the HEDIS 2005 Annual Dental Visit measure, a total of 18,573 unique members reported and validated. The dates of birth and service were within the valid ranges. The final rate was calculated to be 27.07% with no bias.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunization Status and Well-Child Visits measures. Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for each of these measures. There were no exclusions calculated for the Childhood Immunization Status measure. None were allowable for the Well-Child measure.

Submission of Measures to the State

FirstGuard Health Plan submitted the DST for each of the three measures validated to the SPHA, (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

Table 85 summarizes the estimated bias in the rates reported by FirstGuard Health Plan, with the direction of bias. Although data processes and procedures for calculating both the Childhood Immunization Status, Combination #2 and Well-Child Visits measures were

adequate, the administrative rate calculated by the EQRO fell outside the 95% confidence interval reported by FirstGuard Health Plan.

Table 85 - Estimate of Bias in Reporting of HEDIS 2005 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunization Status, Combination #2	5.89%	Underestimate
Well-Child Visits in first 15 months of Life	5.60%	Underestimate
Annual Dental Visit	None	

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure.

Table 86 - Final Audit Rating for HEDIS 2005 Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status, Combination #2	Substantially Compliant
Well-Child Visits in first 15 months of Life	Substantially Compliant
Annual Dental Visit	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCO. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MC+ Members qualified for the measure.

STRENGTHS

1. FirstGuard Health Plan demonstrated significantly higher rates of Childhood Immunization Status and Well-Child Visits than the average for all MC+ MCOs.
2. The rates for HEDIS 2005 Well-Child Visits was higher than the National Medicaid average for the measure.
3. FirstGuard Health Plan used NCQA-certified software, CRMS/HPR of McKesson, for calculation of HEDIS measures. This software was reviewed and tested by NCQA auditors for source code verification. There were effective CRMS validation processes in place.
4. There was effective use of the State Public Health Immunization Registry (MOHSAIC) data for calculation of the immunization measures. The data was directly loaded with mapping of data fields into the CRMS warehouse, which then processed it for reporting in the HPR module.
5. FirstGuard Health Plan maintains close relationships with its vendors. These relationships are effectively supported by both FGHP policy and by appropriate staff allocation.
6. FirstGuard Health Plan has a formal membership reconciliation process in place which increases accuracy and reliability of membership data and reporting drawn from that data.

7. FirstGuard Health Plan has a strong IS system in the use of Amisys and in the IS team at Centene. The manager of IS at Centene effectively demonstrated extensive knowledge of both the Amisys software and of the day- to- day operations at FirstGuard Health Plan.
8. FirstGuard Health Plan, Centene, and the vendors, with whom the MCO has contracted for other data services, have effective industry best practice security measures in place.

AREAS FOR IMPROVEMENT

1. Data validation/integrity checks are lacking; no verification is done when data is transferred between systems. FirstGuard Health Plan assumes that a majority of verification is done by McKesson; this could not be verified.

2. Data analysis should incorporate tests of statistical significance to assess whether the observed changes in rates are related to a specific intervention.

3. FirstGuard Health Plan should also implement a plan though which its upper level managers can gain additional knowledge regarding the IS and its limitations. Such understanding, coupled with the demonstrated IS team understanding of FirstGuard Health Plan day-to-day operations would assist the MCO in reaching its quality control efforts.

RECOMMENDATIONS

1. Provide more comprehensive access to actual data used to calculate HEDIS rates. The on-site review was only of end-user level data, as the individuals with access to data in its original format are located at the Centene Headquarters office in St. Louis, MO.
2. FirstGuard Health Plan should reduce its dependence on its contracted vendors as principals in data quality management. The MCO should look to random auditing, routine data sampling and other methods in addition to its use of log file and batch size to and from vendors to evaluate data quality.

11.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical fields?

For the Medical claim type, there were 84,391 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Outpatient Claim Type field was 100.00% complete, accurate and valid.

3. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
4. The Outpatient First Date of Service field was 100.00% complete and accurate, and 99.99% valid. The 12 invalid dates of service ranged from 1/120/2005 – 12/29/2005.
5. The Outpatient Last Date of Service field was 100.00% complete and accurate, and 99.98% valid. The 19 invalid dates of service ranged from 4/01/2005 – 5/13/2005.
6. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
7. The Outpatient Procedure Code field was 100.00% complete, accurate and valid.
8. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
9. The first Diagnosis Code field was 100.00% complete, accurate and valid.
10. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 34.67% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 0.55% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 0.05% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.00% complete, accurate and valid.

For the Dental claim type, there were 9,923 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were 577 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete accurate and valid.
6. The Outpatient Procedure Code field was 74.70% complete and accurate, with 62.39% containing valid values. The following are the codes found in some of the 71 invalid fields.

Frequency	Code
10	90378
3	A4217
24	A4221
1	A4222
1	Y9009

7. The first and second Diagnosis Code fields were 100.00% complete, accurate and valid.
8. Although the third through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The third Diagnosis Code field was 16.12% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 7.45% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 6.07 % complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were 4,833 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, and 97.93% valid. There were 100 invalid dates ranging from 12/02/2005 – 12/31/2005.

5. The Discharge Date field was 100.00% complete and accurate and 95.32% valid. There were 226 invalid dates ranging from 04/01/2005 – 04/16/2005.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete and accurate and 99.81%valid. There were nine invalid codes of "09".
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (99.63%, 77.90%, 59.78%, 45.62%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete and accurate, and 97.93% valid. There were 100 invalid dates of service ranging from 12/02/2005 – 12/31/2005.
11. The Last Date of Service field was 100.00% complete and accurate, and 95.32% valid. There were 226 invalid dates of service ranging from 04/01/2005 – 04/16/2005.
12. The Revenue Code field was 99.94% complete, accurate, and valid. Three fields were blank (incomplete, inaccurate, invalid).
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 47,984 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete, 99.99% accurate, and 99.91% valid. There were three entries that contained codes with fewer than the required 5-digit alphanumeric reference (one entry each of "981", "9925", and "9928"), resulting in the 99.99% accuracy for this field. In addition, there were 3 entries of each invalid procedure code of "99601" and "99602" and 36 entries of "INVAL".
7. The Outpatient Revenue Code field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 99.87% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 24.01% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 10.59% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code

field was 5.59% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 70,413 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for FirstGuard Health Plan, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. For the Medical claim type, the Outpatient First Date of Service, Outpatient Last Date of Service, and Outpatient Procedure Code fields contained invalid codes (see previous findings). For the Inpatient Claim type, there were invalid codes in the Admission Date, Discharge Date, and Patient Status fields, and three blank entries in the Revenue Code field. There were invalid codes in the Outpatient Procedure Code field for the Outpatient Hospital claim type.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the Pharmacy claim type was consistent with the average for all MC+ MCOs, while Medical, Dental, Inpatient and Outpatient claim types were lower. The rate of Home Health claims was significantly higher for FirstGuard Health Plan than the average for all MC+ MCOs. These findings suggest a high level of completeness of data and at least moderate access to and utilization of services.

What is the Fault/Match Rate Between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review. Of the 84,391 Medical encounter claim types in the SMA extract file for January 1, 2005 through March 31, 2005, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 76 medical records (76.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match

rate for procedures was 51.0%, with a fault rate of 49.0%. The match rate for diagnoses was 76.0%, with a fault rate of 24.0%

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing information (n = 22) or incorrect information (n = 2). The diagnosis code listed did not match the descriptive information in the record.

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 12) and not enough information (n = 37). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

What Problems are there with How Files are Compiled and Submitted by the MC+ MCO?

It was not possible to conduct the planned analysis of comparing MC+ MCO encounter data to the SMA encounter claim extract file due to the absence of an internal control number or crosswalk to compare the files. The plan was to compare MC+ MCO paid and unpaid claims to the SMA encounter claim extract file. MC+ MCOs were requested to submit data in a standard format (see Appendix 6) for the MC+ Managed Care Members represented in the encounter claim sample selected by the EQRO for validation.

For purposes of the EQRO, FirstGuard Health Plan was able to submit files in the requested format, but the ICN codes submitted were not the same number of characters of the ICNs in the SMA extract files.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MC+ MCO did submit the data in the requested format, there are a number of ways to improve the data quality by improving the database system. One variable that is not currently represented is that of a unique line number. To match up specific lines of data (each

service provided within an encounter), this requires a unique number for each service provided for each member.

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Dental and Pharmacy claim types were 100.00% complete, accurate, and valid.

AREAS FOR IMPROVEMENT

1. For the Medical claim types, the Outpatient First Date of Service, Outpatient Last Date of Service, and Outpatient Procedure Code field contained invalid codes.
2. Within the Home Health claim type, the Procedure Code field contained invalid entries.
3. For the Inpatient claim type, the Admission Date, Discharge Date, Patient Status, and Revenue Code fields contained invalid data.
4. For the Outpatient Hospital claim type, the Outpatient Procedure Code field contained invalid values.
5. The match between the SMA encounter claims data and the medical records for diagnosis codes and procedure codes was not significantly lower than the average for all MC+ MCOs. The primary reasons for errors were missing and illegible information.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that Admission Date, Discharge Date, Revenue Code and Patient Status fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
3. Institute edits and error checks for the Outpatient Hospital claim type Procedure Code field (UB-92).
4. For audit purposes, submit extract files for performance measures and encounter data in the requested file layouts with the requested documentation of files and include the SMA generated internal control numbers.

11.4 MCO Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MCO's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the Division of Medical Services. On-site review time was used to conduct interviews with those who oversee the daily practices of the MCO. This ensures that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MCO Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the MCO and to follow-up on questions raised from the document review and from the 2004 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

Document Review

The following documents pertaining to FirstGuard Health Plan were reviewed prior to and at the on-site visit:

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Provider Contracts
- Grievance and Appeal Policies
- Grievances and Appeals related to members were reviewed, as were Complaints, Grievances, and Appeal files for providers. These files were obtained from a random selection of actions filed in the first quarter of 2005.
- 2004 Annual Quality Improvement Program Evaluation

Additional documentation made available by FirstGuard Health Plan included:

- 2005 and 2006 Marketing Plan
- FirstGuard Health Plan's Organizational Chart
- Missouri Medicaid Managed Care Program Primary Care Physician Attachment
- Missouri Medicaid Managed Care Program Referral Physician Attachment
- Subject Criteria Submission – MC+ Medicaid Managed Care Proposal
- FirstGuard Health Plan MC+ Marketing Plan

- Quality Project Summary – 2004 Documentation Form for Grievances and Appeals
- Wooden Apple Award Criteria and Information
- Member Grievance Category Trends 2004
- Quality Project Summary – ID Card Automation
  HIPAA Privacy Report automation
  State Payment Reconciliation
  CRMS Upgrade
- "Departments in the Spotlight" – Office Newsletters

Interviews

Interviews were conducted with the following group:

Plan Administration

Jean Rumbaugh, Plan President/COO
William Pankey, MD, VP Medical Affairs
Barbary Maloney, VP Development and Regulatory Affairs
Celia Humphreys, Director, QI & Credentialing
Sharon Taylor, Director, Customer Service
Jackie Jones, Director, Utilization Management
Susan Richart, Quality Improvement Project Manager
Sandra Clausen, QI Program Manager

Mental Health

Claudia Sumrall, Clinical Manager
Cindy Peterson, Service Center Director

FINDINGS

Enrollee Rights and Protections

FirstGuard Health Plan continued to exhibit excellent practices in the area of Enrollee Rights and Protections. The MCO discussed their business transition to Centene Corporation during 2005. FirstGuard Health Plan admitted facing a number of barriers to providing effective services, but were able to work through these in an effective manner. During the transitional period they received few member complaints. The MCO reported that the entire change remained seamless and transparent to members. Members, with very few exceptions, were unaware of the change. All telephone and contact numbers, interpreter services, and other methods of sharing information remained consistent for members.

FirstGuard Health Plan's rating for compliance with Enrollee Rights and Protections regulations (100%) reflected their commitment to their members and to completing policy and procedure

as required. The MCO exhibited a firm commitment to ensure that members had access to healthcare services and obtained these services in an efficient and timely manner. FirstGuard Health Plan's practice of treating members with respect and dignity during telephone and personal contacts remained unchanged. The MCO regularly provided training initiatives that focused on nondiscrimination, cultural competency, and minority inclusion.

Table 87 - Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	FirstGuard Health Plan	
	2004	2005
438.100(a) Enrollee Rights: General Rule	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2
438.100(b)(3) Right to Services	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2
Number Met	13	13
Number Partially Met	0	0
Number Not Met	0	0
Rate Met	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

In October 2005, FirstGuard Health Plan changed subcontractors for behavioral healthcare services. They previously utilized Magellan Behavioral Health and now subcontract with Cenpatico, a subsidiary of Centene Corporation. The MCO provided assurances that all attempts were made to make this transition seamless and transparent to members as well. A sixty day transition period, requiring no pre-authorizations for services, was enacted. The MCO

ensured that the toll-free contact numbers for members remained constant. FirstGuard Health Plan facilitated meetings between Magellan and Cenpatico to discuss members who needed case management services, outreach services, and other specialized attention. Discussion between the behavioral health organizations continued throughout the transition phase of this subcontractor change. FirstGuard Health Plan and Cenpatico received no member grievances associated with the transition during this time. Cenpatico made the commitment to include all providers into their panel that were willing to make the change and the majority did contract with them. The MCO expressed the opinion that members were notified, but did not suffer therapeutically, as a result of required provider changes. FirstGuard Health Plan continued to hold oversight meetings with Cenpatico after completing the transition. The MCO continued to monitor Cenpatico's performance and to meet monthly to ensure that member services were met.

Cenpatico conducted case management services from a remote location. The MCO provided assurances that these case managers are familiar with and in close contact with local providers. FirstGuard Health Plan met two times a week to discuss specific cases and to identify new referrals to Cenpatico. The MCO's stated goal was to formalize a collaborative process while working with the new subcontractor. FirstGuard Health Plan took monitoring activities seriously and watched cases closely to ensure that members received the attention and depth of services required.

A number of FirstGuard Health Plan members were receiving in-home services, which were initiated since this subcontractor change occurred. Cenpatico staff explained that in-home services are consistent with their belief in the effectiveness of wrap around services. The BHO hoped that in appropriate member situations this type of service system could be built and delivered effectively.

Quality Assessment and Performance Improvement

Access Standards

Both Centene Corporation and Cenpatico made a serious effort to contract with all providers previously within FirstGuard Health Plan's network. The MCO's efforts were successful in most cases and they considered these efforts a success. FirstGuard Health Plan acknowledged that they did experience payment issues during the transition, due to in health information system

deficiencies. The majority of the problems occurred with payment to non-participating providers as the new system would not allow payment. The MCO quickly resolved this problem by creating an internal process that by-passed these edits. This rectified most problems and allowed payment to occur. At one point, Centene Corporation allowed FirstGuard Health Plan to pay providers locally and later ensured that all invoices were properly completed, and that all required health information was included. At no point was there a denial of services to members. FirstGuard Health Plan historically had a strong relationship with providers and they maintained communication with affected providers during this period. Even when providers were unhappy with the MCO, they trusted that FirstGuard Health Plan would resolve these problems and correct payment errors. This gave providers the confidence needed to provide ongoing member services.

FirstGuard Health Plan added staff in a number of areas, which positively affected their ability to respond to member and provider problems, complaints, and requests. The MCO related that this allowed them to recover quickly and effectively from the transitional issues.

The MCO was using a new system called NurseWise for after-hours calls. The systems, which is physically located in El Paso, Texas, had bilingual staff available. The staff at NurseWise received training on the FirstGuard Health Plan system of care. With this system 24-hour nurse triage and nurse advice line was available. The MCO reported that this change provided several benefits to members. Members were assisted with information on providers, received help with scheduling if required, and were given information that allowed them to decide if the medical situation was urgent rather than emergent. Previously an administrator on call took after hours calls from members.

FirstGuard Health Plan did implement a community advisory board during 2005 to assist the MCO in the assessment of member needs. The MCO also added a pharmacist to their staff and appointed this individual to a multidisciplinary team in an effort to add depth to the assessment process. This multidisciplinary team is utilizing improved data to complete trend analysis applicable to both members and providers.

FirstGuard Health Plan continued to recruit new providers, but not as actively in previous years. They planned to renew recruitment efforts after the transition issues were completely resolved.

The rating for Access Standards (100%) reflects the effort made by FirstGuard Health Plan to have all policy and procedures completed and submitted to the SMA in a timely fashion. All information obtained and practice observed during the on-site review supported that FirstGuard Health Plan is in compliance with the MC+ Medicaid Managed Care contract requirements and the federal regulations.

Table 88 - Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison

Federal Regulation	FirstGuard Health Plan	
	2004	2005
438.206(b)(1)(i-v) Availability of Services: Provider Network	1	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2
438.206(c)(1)(i-vi) Timely Access	1	2
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	2	2
438.208(c)(1) Care Coordination: Identification	2	2
438.208(c)(2) Care Coordination: Assessment	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2
438.210(b) Authorization of Services	2	2
438.210(c) Notice of Adverse Action	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2
438.210(e) Compensation of Utilization Management Activities	2	2
438.114 Emergency and Post-Stabilization Services	2	2
Number Met	15	17
Number Partially Met	2	0
Number Not Met	0	0
Rate Met	88.2%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

At the beginning of the transition to Centene systems, all data and providers were not properly transferred. Providers identified contracted procedures that were not in the system properly

and services were suddenly denied. All out-of-network providers and services were also denied. The MCO reacted to these problems proactively. Implementation staff and processes were put in place to assist in problem identification and resolution. Additional staff was added to enhance communication efforts with the provider community and to ensure that member services were not adversely affected. FirstGuard Health Plan administrators were very frank about the barriers and operational frustrations they encountered. They explained actions taken to resolve problems and how they worked through systematic and operational difficulties. The MCO made a concerted effort to regain the level of success they experienced in service delivery prior to the onset of the transition. This standard was restored in a matter of months, allowing FirstGuard Health Plan to refocus their efforts directly on provision of quality healthcare services for their members.

FirstGuard Health Plan reported that they have experienced advantages of being associated with Centene Corporation. The MCO now has access to the Centene Fraud and Abuse system. Claim profiles were being reviewed and provider educational opportunities are identified. Some prescription abuse has been identified, most often related to pain management. FirstGuard Health Plan took action to assist members with appropriate services when this occurred. The MCO recognized opportunities within the Centene system, including a special investigations unit and additional software enhancements to capture and analyze data. FirstGuard Health Plan hoped to implement a number of enhancements within the next year.

Ratings regarding compliance with the Structure and Operation Standards (100%) reflect FirstGuard Health Plan's completion of all required policy and procedure. Although a number of operational issues were discussed during the on-site review, the MCO met these challenges proactively and resolved these issues in acceptable timeframes. It appears that FirstGuard Health Plan is fully compliant in meeting the requirements of the MC+ Medicaid Managed Care contract requirements and federal regulations.

Table 89 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison

Federal Regulation	FirstGuard Health Plan	
	2004	2005
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2
438.214(d) Provider Selection: Excluded Providers	2	2
438.214(e) Provider Selection: State Requirements	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2
438.56(d) Disenrollment: Procedures	2	2
438.56(e) Disenrollment: Timeframes	2	2
438.228 Grievance System	2	2
438.230(a,b) Subcontractual Relationships and Delegation	1	2
Number Met	9	9
Number Partially Met	1	1
Number Not Met	0	0
Rate Met	90.0%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

FirstGuard Health Plan was an active participant in the Kansas City Quality Improvement Consortium. This group developed locally accepted clinical guidelines for asthma and diabetes. The group was working on guidelines for treatment of obesity. The MCO disseminated and monitored application of these and other nationally accepted practice guidelines. The MCO continued one-on-one efforts with providers assisting in the acceptance of local and national guidelines.

FirstGuard Health Plan continued operation of a Quality Assessment and Improvement program, which utilized a system of internal monitors, analysis, and evaluation. The focus was on improving the delivery of healthcare by MCO staff and providers. FirstGuard Health Plan's staff, with experience in quality assessment, utilization management, and continuous quality improvement, performed the monitoring activities. Although much of 2005 was focused on transitional issues, they did not ignore Quality Assessment and Improvement activities.

Monitoring and analysis continued, incorporating changes that resulted from transition driven changes and requirements.

FirstGuard Health Plan continued development and utilization of the Cactus software system for credentialing. Centene acknowledged the benefits of the Cactus system and was considering using it elsewhere. Not only does the system speed up the credentialing process, it produces a one page report for review of all information, rather than a set of laborious files. Organizational vendors and delegated entities, such as Children's Mercy Hospital, are to be added to the database.

FirstGuard Health Plan submitted two Performance Improvement Projects (PIPs) for validation. Specific details of these projects can be found in the appropriate section of this report. These PIPs were well-constructed and provided adequate information for validation.

The MCO submitted all required information to complete the Validation of Performance Measures, as requested. FirstGuard Health Plan did begin using a new health information system during 2005, and they completed an Information System Capability Assessment (ISCA) in late 2005, which is discussed in the appropriate section of this report. All encounter data requested was provided in the correct format. The details of each of these areas of validation can be reviewed within their specific sections.

Ratings for the Measurement and Improvement section (100%) reflect that all required policy and procedure are in place. Observations and additional information obtained at the on-site review indicated that practice in this area is in compliance with the SMA contract requirements and the federal regulations.

Table 90 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison

Federal Regulation	FirstGuard Health Plan	
	2004	2005
438.236(b)(1-4) Practice Guidelines: Adoption	2	2
438.236(c) Practice Guidelines: Dissemination	2	2
438.236(d) Practice Guidelines: Application	2	2
438.240(a)(1) QAPI: General Rules	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	2
438.242(b)(3) Health Information Systems: Basic Elements	1	2
Number Met	7	11
Number Partially Met	4	0
Number Not Met	0	0
Rate Met	63.6%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Five member grievance files were reviewed for FirstGuard Health Plan. Six provider files were reviewed, all concerning complaints. There were some concerns about how these situations were handled, and the condition of the records. One member grievance indicated that the member attempted to make appointments, left a voice message, and no response was ever provided to the member. Corrective action occurred and an appointment was made. In another situation a member requested a new PCP because the current provider misplaced their file. The case manager involved did offer a new PCP, but education or other action with the provider or their staff was not documented. The third grievance involved a provider billing the member for a denied claim. It was learned that the denial was incorrect and the decision the

claim was paid. The correspondence to the member did not include language explaining that they were to be held harmless. The fourth grievance revealed that there had been a misunderstanding concerning physician office procedures. This was resolved, however, the letter to the member did not correspond to the situation surrounding the grievance. The letter referred to care received in an emergency room and stated that the situation would be investigated, but findings would be confidential.

The content of files and the correspondence was inconsistent and often out of order. Terminology used was often confusing, including the use of terms such as complaint and appeal interchangeably.

Six provider complaints were reviewed. Three of these complaints pertained to timely filing of claims. One was reviewed and upheld, while the other two were reviewed and overturned. The fourth complaint, which was upheld, involved a denied claim due to lack of prior authorization. The fifth complaint was an out-of-state provider who billed the out-of-state rate. The MCO paid this claim at the fee-for-service rate. The final complaint concerned denial of an inpatient admission, based on lack of medical necessity. The response letter was addressed to the member. The file contained no correspondence from the provider or member. Correspondence in these files was not always filed correctly, did not appear to contain all pertinent information, and was often confusing.

Information about these records was shared with FirstGuard Health Plan at the on-site review. It was recommended that they include some type of tracking form, particularly for correspondence received and sent, to clarify the chronological order of events, and to make the resolution easier to follow, for both internal and external reviews.

FirstGuard Health Plan did complete all required written policy and procedures for Grievance Systems. Although the MCO had a Grievance System in place, their practice regarding maintenance of records and correctness of correspondence needed improvement. The rating for compliance with Grievance Systems (88.9%) reflects the practice witnessed at the time of the on-site review. The random selection of files that were reviewed came from the first quarter report submitted to the SMA. These files, which yielded both member and provider

records, created questions about the MCO's monitoring of the grievance system and completion of correspondence regarding resolution for both members and providers.

Table 91 - Subpart F: Grievance Systems Yearly Comparison

Federal Regulation	FirstGuard Health Plan	
	2004	2005
438.402(a) Grievance and Appeals: General Requirements	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2
438.404(b) Notice of Action: Content	2	2
438.404(c) Notice of Action: Timing	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2
438.408(a) Resolution and Notification: Basic Rule	2	1
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2
438.410 Expedited Resolution of Appeals	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	1	1
438.416 Recordkeeping and Reporting Requirements	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2
Number Met	17	16
Number Partially Met	1	2
Number Not Met	0	0
Rate Met	94.4%	88.9%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Summary

The 2005 healthcare service year presented FirstGuard Health Plan with a number of barriers to the provision of healthcare to their members. The MCO admitted that they experienced a number of challenges to maintaining the level of excellence that they expect their organization to produce. Struggles for administrative and front line staff were created with FirstGuard Health Plan's transition to a new parent corporation, Centene, and the change in behavioral health organizations, from Magellan to Cenpatico. The organization admitted that the move to a new health information system was a massive effort, did not always occur as planned, and stressed their relationship with providers. Despite all the issues that occurred, the MCO maintained a strong focus on their members and meeting the members' health care service needs. The transition itself and the problems encountered were transparent to members. FirstGuard Health Plan took a proactive approach to solving transition problems and built a stronger organization as the result of these efforts. FirstGuard Health Plan continued to accept recommendations for change throughout the process.

The on-site review did identify some problems with maintenance of grievance records and correspondence. The MCO accepted recommendations made and was eager to rectify these issues.

FirstGuard Health Plan completed required written policy and procedures to comply with the MC+ Medicaid Managed Care contract and the federal regulations. They continued to provide healthcare services that exceeded their strict contractual requirements in an effort to ensure that the children and families they serve have the best care available. FirstGuard Health Plan was able to maintain a positive relationship with providers during the transition period. The MCO implemented a community advisory committee to bring attention to unmet needs of both providers and members. They exhibited exceptional service in the areas of quality, access, and timeliness of services to members.

STRENGTHS

1. The efforts made by FirstGuard Health Plan to ensure that the transition from Magellan Behavioral Health to Cenpatico Behavioral Health was transparent to members.
2. The efforts made by FirstGuard Health Plan to maintain a positive relationship with their participating providers during the transition. The MCO discussed problems they experienced with billing and other changes. They were able to give examples of problem-solving techniques that allowed them to maintain or restore the relationship with their contracted providers.
3. Improved internal processes, such as credentialing and fraud and abuse monitoring that are now available with the resources from Centene Corporation.
4. Continued commitment of the FirstGuard Health Plan staff to produce and provide a quality product for their members and the community they serve.
5. Completion of all required policy and procedures to be in compliance with the MC+ Medicaid Managed Care contract.

AREAS FOR IMPROVEMENT

1. The grievance and appeal files were difficult to evaluate and follow. The files did not contain all required correspondence, making it was difficult to ascertain if chronological requirements were met.
2. Provide continued oversight to problem issues to ensure that local member needs and provider concerns are address in a timely and appropriate manner

RECOMMENDATIONS

1. Continue to development processes and services that are now available to FirstGuard Health Plan as part of Centene's resource pool.
2. Continue the attention the organization exhibits to identifying areas for quality improvement and responding to these issues quickly and efficiently.
3. Include a tracking form in Complaint, Grievance, and Appeal files to ensure that all necessary information is included, and to highlight chronological decision-making process.
4. Continue attention to the details required to maintain all policies and procedures in compliance with state and federal regulations.

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SECTION 12.0
BLUE-ADVANTAGE PLUS OF KANSAS CITY

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12.0 – Blue ADVANTAGE Our most popular individual plan

12.1 Performance Improvement Projects

The previous sections of the 2005 EQRO report present the purpose and objectives, technical methods, procedures for evaluation, and MCO to MCO comparisons of analyses, findings, and recommendations for each of the protocols based on the aggregate analysis. This section of the EQRO report summarizes MC+ MCO specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for MC+ Managed Care Members. Please refer to the main report for detailed technical objectives, methods, and presentation of data that are referenced here for the MC+ MCO.

METHODS

Document Review

Blue-Advantage Plus of Kansas City supplied the following documentation for review:

- NCQA Quality Improvement Activity Form: Improving Care for Asthmatics
- NCQA Quality Improvement Activity Form: Lead Testing Improvement Project

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on March 9, 2006 during the on-site review, and included the following:

Judy Brennan – Director State Programs BA+, Plan Administrator
Janelle Martin – Quality Improvement Coordinator
Dr. Bryan Sitzmann – Medical Director
Wes Wadman – MHIP Coordinator
Gwendolyn Nickles – Quality Improvement Project Director

Interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- What study questions were used?
- What instruments were used for data collection?
- How was the accuracy, consistency, and validity assured?
- What interview instruments were used?
- Why were the projects valid for continuation and used as PIPs for this project year?
- What findings were relevant to the MC+ population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

Several questions were presented during the on-site review and the MC+ MCO requested time to provide a response and additional information. Information was sent on April 11, 2006. This information was considered in the final validation process.

FINDINGS

The first PIP evaluated was "Improving Care for Asthmatics." This project was originated in 1999. The additional information provided explained that the MC+ MCO chose to continue this project as a PIP because they were "still trying to address the high emergency room visitation rate" for members who are asthmatic and they had not reached the stated goals. Additionally, the MC+ MCO wanted to try and increase the participation of the membership into "the asthma program and link the number of members participating to improved functional status and symptom control." The original information presented indicated that the MC+ MCO had experienced success with previous interventions. It appeared that this PIP was continued with no new activities. No information presented indicated any comparison of prevalence rates for people with asthma in the MC+ Member population to state or national statistics. No literature review or research was presented that would justify continuing these interventions, with no new activities or indicating that additional significant improvement was likely to occur.

The study presented clearly defined indicators:

- Targeted goals for the number of inpatient admissions for the care of asthma;
- The number of emergency room visits for the care of asthma;
- The percentage of MC+ MCO members identified with persistent asthma that were being prescribed medications acceptable as primary therapy for long term control of asthma. This indicator is based on HEDIS specifications.
- Symptom frequency for nighttime awakenings in the program population. This measure is reported separately for adults (age 18 and over) and children.
- The percentage of MC+ MCO members identified with asthma that filled prescriptions for greater than five canisters of a short-acting beta-agonist medication in a 12-month period.

These indicators were well-defined and included methods of measurement. No detailed demographic characteristics were presented in the narrative. It could be inferred that no portion of the population was excluded from the study. The information presented made it difficult to distinguish between the commercial and MC+ population. A more detailed description of study participants would assist in specifying how the results related to the MC+ membership.

There was no study question included in the original document presented. However, in the follow-up information provided the MC+ MCO provided the following: "Does engaging members in a disease state management program have an impact on decreasing emergency room utilization and/or symptom control as reported by the member?" Long term outcomes could be assumed, but the study narrative does not provide an explanation of how the interventions presented and the measures and outcomes are connected, or how any of these are related to the study question.

The information provided creates some confusion about sampling. It does not appear that any actual sampling occurred. It appears that all eligible members "who could be reached," were included in the personal interview, however, measure number C4 discusses a "convenience sample" and "sampling size." It describes the sample as "how many people we were able to contact during the quarter being measured." The information does not explain what methods were used to contact members, the number of attempted contacts per member, or the number of contacts compared to the total members included in the measure.

The data sources described were specific. The additional information received explained that the methodology and interviewing results and the corresponding data collection methodology remained constant across all time periods studied. Information was provided by the contractor used to collect and compile the results of this study. The information presented outcomes from March 2000 through September 2005. It clarified that this information included all Blue Cross Blue Shield of Kansas City HMO and PPO members. It did include information specifically on the MC+ MCO members. The interview tool was not presented as it was considered confidential and proprietorial to AirLogix, Inc. The report that was provided did include the results of the questions asked. The subject of the questions could be inferred from the information provided, and the aggregate of the responses were presented.

Barriers were identified throughout the original documentation, but they did not address how they led to any new strategies for improvement. The newest measures implemented were two years old. The referral source, information obtained through MC+ MCO claims data, and emergency room utilization reports were all updated. The contractor reinitiated the process of contacting members, providing an education plan, and working with physicians' offices when deemed necessary. Large quantities of data from the sources identified were included, and analysis of the data was provided. The results were clarified with the report provided by AirLogix, Inc. The interpretation of the study findings indicated that the interventions were successful. It appears that the program allowed for measurement of sustained improvement as well as opportunity for additional improvement. The baseline methodology, which was modified, was clearly described and the implications for this change were understandable. The additional information provided, including the AirLogix, Inc. report, presented statistical significance testing and findings.

This study, with the additional information, led to credible and valid findings. The study produced a high confidence for program improvement. The methodology should be implemented into regular practices of the MC+ MCO at this time and become part of their regular operations.

The second PIP evaluated was "Lead Testing Improvement Project." The topic was defined by the hypotheses presented, which was that "Lead testing rates will increase with education of providers and members about who should be tested and when the tests should be done". The

need for improvement was explained in the narrative and was supported by review of the literature on this topic, as well as an examination of State and local issues. A broad range of enrollee issues were addressed by evaluating the effectiveness of provider and member education with the goal of increasing blood lead level testing rates. The narrative did not detail the participants included in this study, although the description of the measures consistently referenced "BA+" services and members. Eight indicators were presented with well-defined measures. The indicators defined benchmarks, sources, and baseline goals. The association between the indicators, measures, and outcomes was implied and apparent, but was not detailed in any narrative provided.

No detailed description of the study population was included. The study focused on one county in the MC+ MCO service area, but this decision is not supported by the information or explanation included in the narrative provided. At the time of the on-site review MC+ MCO staff provided reasoning that Jackson County was identified because certain zip codes in the county had the highest percentage of individuals in high risk areas, and included a high number of disadvantaged families. The Department of Health and Human Services map concerning lead risk areas identified other counties in this MC+ Medicaid Managed Care region as high risk. The MC+ MCO did not respond to this observation.

No study question was included in the original documentation submitted for this study. The MC+ MCO did provide additional information that included the following study question for this topic: "Will lead testing rates increase with education to providers and members about who should be tested and when the tests should occur?" No sampling was conducted for this study. The sources of data were clearly identified and the study design included specific methods of collecting valid and reliable data over time. There was no prospective data analysis plan included in the narrative.

Interventions included the educational material mailed to members, reminder letters for EPSDT testing to providers and members, supplies of filter paper to providers. This information was not well documented in the written information, but the details were provided at the time of the on-site review. The information provided a good description of analysis of barriers.

The findings for this study were not well described. Numerical and year-to-year comparisons were presented. Narrative documentation discussed some results and findings, but it was not clear how the accuracy of findings was documented. The analysis discussed initial and repeat measurements and identified that there were difficulties in tracking specific individuals because of the age factor and the changes that occur in the population that was studied. Figures presented accurately represented the number of lead tests conducted for each year presented. The narrative identified opportunities for improvement by restructuring the target groups and perfecting the methodology for measurement.

The study had potential for producing credible findings. However, the information presented did not describe the effectiveness of the intervention with regard to the measurements completed. No impact on members was identified in the narrative. No significant improvements were identified in the findings presented. Any sustained improvement could not be determined. The format used to document the study findings made it difficult to validate the findings based on the requirements of the Validating Performance Improvement Protocol.

STRENGTHS

1. The MCO engaged in good topic selection in developing the Performance Improvement Projects.

2. Each project had well-developed baseline data that assisted in the definition of success in defining the necessary interventions and in measuring PIP outcomes.

3. The performance improvement projects included a focus on improving services to MC+ MCO members.

4. The projects were based on sound research and literature studies although all information was not presented in a method that was easy to follow.

5. Data collection was explained and understandable and in sufficient detail to complete the validation process, particularly with the additional information that was submitted after the on-site review.

AREAS OF IMPROVEMENT

1. Ensure that the PIP narrative indicates the relationship between the study topic and question, interventions, the measures used, and expected outcomes.

2. Include a clearly defined study question in the performance improvement project narrative that is related to the topic.

3. Ensure that the population included in the study is well-defined and that this information is included in the narrative.

RECOMMENDATIONS

1. Utilize the performance improvement initiatives that are underway or proposed within BA+, such as the Complaint Process, as a non-clinical PIP for MC+.

2. If utilizing on-going projects, ensure that a new activity is included and that the rationale for inclusion is provided.

3. Utilize the *Conducting Performance Improvement Project Protocol* to assist in the process of project development and reporting.

4. Include supporting narrative with submission of PIP, providing adequate explanation of the project, including graphs, surveys, or other instruments utilized to assist in the validation process.

12.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Blue-Advantage Plus of Kansas City. Blue-Advantage Plus of Kansas City submitted the requested documents on December 9, 2005. The EQRO reviewed documentation between December 9, 2005 and February 27, 2006. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

Document Review

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Blue-Advantage Plus of Kansas City
- Ernst & Young's NCQA HEDIS 2005 Compliance Audit Report
- Letters of communication between the EQRO and Blue-Advantage Plus of Kansas City
- Blue-Advantage Plus of Kansas City policies pertaining to HEDIS 2005 rate calculation and reporting
- Blue-Advantage Plus of Kansas City Information Services (IS) policies on disaster recovery
- Blue-Advantage Plus of Kansas City's HEDIS implementation work plan and HEDIS committee agendas for 2004
- Data warehouse validation procedures for the CRMS software
- DB2 data warehouse models of the interim data warehouse

The following are the data files submitted for review by the EQRO:

- childhood_immun_denominator.txt
- childhood_immun_numerator.txt
- dental_visit_denominator.txt
- dental_visit_numerator.txt
- Well_Child_denominator.txt
- Well_Child_numerator.txt

Interviews

The EQRO conducted on-site interviews with Phil Johnson, Director, Application Development; Judy Reynolds, Senior Application Developer; Barb Purdon, Project Lead; Darren Taylor, Vice President Enterprise Information and Access at Blue-Advantage Plus of Kansas City in Kansas City on Tuesday, March 8, 2006. This group was responsible for calculating the HEDIS performance measures. The objective of the visit was to verify the data, methods, and processes behind the calculation of the three HEDIS 2005 performance measures. This included both manual and automatic processes of information collection, storing, analyzing, and reporting.

FINDINGS

Blue-Advantage Plus of Kansas City used the Administrative Method for calculation of the HEDIS 2005 Well-Child Visits in the First 15 Months of Life, Annual Dental Visit, and Childhood Immunization Status, Combination #2. MCO to MCO comparisons of the rates of Childhood Immunization Status Combination #2, Well-Child Visits, and Annual Dental Visit were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The rate for Blue-Advantage Plus of Kansas City for the 2005 HEDIS Childhood Immunization Status measure was 45.06%, comparable to the statewide rate for MC+ MCOs (28.17%; z = -.11, 95% CI: 33.96%, 56.16%; n.s.). The rate for Blue-Advantage Plus of Kansas City for the HEDIS 2005 Well-Child Visits measure was 33.06%, comparable to the statewide rate for all MC+ MCOs (38.42; z = -.60, 95% CI: 20.53%, 45.59%; n.s.). The rate for Blue-Advantage Plus of Kansas City for the 2005 HEDIS Annual Dental Visit was 33.80%, significantly higher than the statewide rate for MC+ MCOs (29.76%, z = .68; 95% CI: 29.52%, 38.08%; $p > .95$).

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

Data Integration and Control

Blue-Advantage Plus of Kansas City used a NCQA-certified vendor application from McKesson, Inc. for calculation of rates for the HEDIS 2005 measures. The EQRO was provided with a process overview of the FACETS claims management system and a validation overview of the CareEnhance Resource Management System (CRMS) data warehouse. The EQRO was given a demonstration of the data flow and integration mechanisms for external databases for these measures, and provided with a layout of the data structure of the internally-developed data warehouse for storing interim data. For the three measures calculated, Blue-Advantage Plus of Kansas City was found to meet all criteria for producing complete and accurate data (see

Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Blue-Advantage Plus of Kansas City transferred data into the repository used for calculating the HEDIS 2005 measures of Well-Child Visits in the First 15 Months of Life, Annual Dental Visit, and Childhood Immunization Status.

Documentation of Data and Processes

Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Blue-Advantage Plus of Kansas City met nearly all criteria that applied for the three measures validated. The two criteria that were partially met involved the use of statistical significance testing to document changes in performance over time and using this information to support claims of improvement or stability in performance over time. Blue-Advantage Plus of Kansas City has begun to utilize statistical testing, BA+ is partnering with Ernst & Young to best assess how to utilize the information that they obtain from the statistical analysis process.

Processes Used to Produce Denominators

Blue-Advantage Plus of Kansas City met all criteria for the processes employed to produce the denominators of the performance measures validated (see Attachment X: Denominator Validation Findings). This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the date of birth ranges were valid. A total of 1,201 members eligible were reported and 1,1195 were validated for the Well-Child Visits measure. The 6 excluded from the measure by the EQRO were not enrolled in the MCO on their 15 month birthday, which is the anchor date for this measure.

There were 15,634 eligible members reported for the denominator of the Annual Dental Visit measure, 15,446 were validated. The EQRO received files containing 16,268 records, 15,456 were unique members, while 10 members were ineligible due to a gap in enrollment over 45 days. 1,225 eligible members were reported for the Childhood Immunization Status measure, 1,218 were validated. The seven (7) members excluded by the EQRO, were not enrolled in the MCO on their 2nd birthday which is the anchor date for this measure.

Processes Used to Produce Numerators

The measures validated included the appropriate data ranges for the qualifying events (e.g., immunizations, well-child visits, and dental visits) as specified by the HEDIS 2005 criteria (see Attachment XIII: Numerator Validation Findings).

There were a total of 397 administrative hits reported and 361 validated for the HEDIS 2005 Well-Child Visit measures. The dates of service and medical event codes (CPT and ICD-9 CM) were all within the valid ranges. The rate validated by the EQRO for Well-Child was 30.06%, with an observed bias of 3.00%.

For the HEDIS 2005 Annual Dental Visit measure, a total of 5,285 administrative hits were reported and 5,282 validated by the EQRO. The final rate calculated by the EQRO was 33.79%, with no observed bias.

There were a total of 552 administrative hits reported and 115 validated for the HEDIS 2005 Childhood Immunization Status measure. The dates of birth and dates of service were all within the valid range. The rate reported by the MCO was 45.06%, the rate calculated by the EQRO was 27.98% with bias of 17.08%.

Sampling Procedures for Hybrid Methods

No sampling or medical record reviews were conducted or validated for the performance measures validated. Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

Submission of Measures to the State

Blue-Advantage Plus of Kansas City submitted the DST for all three measures validated to the SPHA (the Missouri Department of Health and Senior Services: DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

As noted earlier, there was no bias found in the reporting of numerators, denominators, or rates of the Annual Dental Visit performance measure validated. The Well-Child Visits measure was overestimated, but was within the 95% confidence interval for the rates reported by the MCO. The Childhood Immunization Status measure was below the lower confidence level of the 95% confidence interval reported by the MCO.

Table 92 - Estimate of Bias in Reporting of HEDIS 2005 Measures

Measure	Estimate of Bias	Direction of Estimate
Childhood Immunization Status, Combination #2	17.08%	Overestimate
Well-Child Visits in first 15 months of Life	3.00%	Overestimate
Annual Dental Visit	None	

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure.

Table 93 - Final Audit Validation Rating for Performance Measures

Measure	Final Audit Rating
Childhood Immunization Status, Combination #2	Not Valid
Well-Child Visits in first 15 months of Life	Substantially Compliant
Annual Dental Visit	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCO. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MC+ Members qualified for the measure.

STRENGTHS

1. Blue-Advantage Plus of Kansas City demonstrated significantly higher rates of Annual Dental Visits than the average for all MC+ MCOs.
2. Calculation of the HEDIS 2005 Annual Dental Visit measure was fully compliant with specifications.
3. Blue-Advantage Plus of Kansas City used NCQA-certified software (CRMS of McKesson) for the HEDIS rate calculations. This application was reviewed and tested by NCQA-certified auditors and has been found to accurately generate rates. There is an effective and documented CRMS validation process in place. The data for the calculation of HEDIS measures is loaded into the CRMS warehouse from the internally-developed central decision support (CDS) repository.

4. Blue-Advantage Plus of Kansas City utilized many system checks to ensure data accuracy. Examples include production logs and control reports in the FACETS claims management system and the CDS repository.
5. Blue-Advantage Plus of Kansas City had documented policies and procedures on calculation of HEDIS measures. There was an organization-wide, high-level policy for the calculation of HEDIS measures. There were associated project plans for calculation of HEDIS measures and effective disaster recovery policies in place, including live tests of disaster policies.
6. There was an efficient data integration process in place. The pharmacy data was incorporated from Argus into the CDS repository, which also collects data from the FACETS claims management system.
7. The information system had a unique business entity key for the calculation of the members' continuous enrollment. This facilitates non-duplication of member data entry.
8. Blue-Advantage Plus of Kansas City used a data warehouse system that incorporated an NCQA-certified vendor, MedMeasures, for HEDIS rate calculations.
9. Blue-Advantage Plus of Kansas City had begun work with Ernst & Young to ensure the statistical significance of HEDIS rates.

Areas for Improvement

1. Blue-Advantage Plus of Kansas City should utilize hybrid methods where HEDIS specifications recommend using the hybrid approach.

2. Blue-Advantage Plus of Kansas City should continue its good efforts to full data systems integration.

Recommendations

1. Hybrid measures should be considered for all measures where the HEDIS specifications recommend a hybrid approach. Blue-Advantage Plus of Kansas City should compare the effects that the hybrid approach has on commercial rates to determine the possible increase in rates for MC+ HEDIS measures.
2. Continue work with Ernst & Young to conduct and document statistical comparisons on rates from year to year.
3. Continue the migration to a new data warehouse system with an integrated NCQA-certified vendor. This would provide better analytical processes for future performance.

12.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 85,707 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.

The Outpatient Last Date of Service field was 100.00% complete, accurate and 100.00% (with rounding) valid. Three invalid dates of service ranged from 4/20/2005--4/27/2005

The Outpatient Units of Service field was 100.00% complete, accurate and valid.

The Outpatient Procedure Code field was 100.00% complete, accurate and 99.96% valid. The 31 invalid procedure codes consisted of 29 "B4035" and 2 "Y0043" entries.

The Outpatient Place of Service field was 100.00% complete, accurate and valid.

The first Diagnosis Code field was 100.00% complete, accurate and valid.

Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 48.76% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The third Diagnosis Code field was 18.96% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (incomplete, inaccurate, and invalid). The fourth Diagnosis Code field was 8.69% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.00% complete, accurate and valid.

For the Dental claim type, there were 10,039 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All of the fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were 485 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All of the fields examined were 100.00% complete, accurate and valid except the Procedure Code Field and the second through fifth Diagnosis Code fields. The Procedure Code field was 73.61% complete and accurate, and 70.52% valid. There were 128 blank fields (incomplete, inaccurate, and invalid). There were 14 invalid entries of "97001" and 1 invalid entry of "A4245". The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (72.65%, 51.55%, 24.33%, and 19.59%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were 1,250 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005.

The Inpatient Claim Type field was 100.00% complete, accurate and valid.

2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, and 95.52% valid. There were 56 invalid dates ranging from 12/01/2005 – 12/31/2005.
5. The Discharge Date field was 100.00% complete and 99.76% accurate (with 3 entries of "99999999"). Valid values were present 96.72% of the time. In addition to the 3 invalid "99999999" entries, 38 invalid dates ranged from 04/01/2005 – 04/15/2005.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (83.76%, 62.48%, 46.64%, and 33.20%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete and accurate, and 95.52% valid. There were 56 invalid dates of service ranging from 12/01/2005 – 12/31/2005.
11. The Last Date of Service field was 100.00% complete and accurate, and 96.72% valid. There were 41 invalid dates of service ranging from 04/01/2005 – 05/18/2005.
12. The Revenue Code field was 99.92% complete, accurate and valid. There was one missing field.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 32,969 encounter claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate, and valid except for the second through fifth Diagnosis Code fields. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (54.45%, 25.76%, 11.40%, and 5.50%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 52,273 claims paid by the SMA for the period January 1, 2005 through March 31, 2005. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Blue-Advantage Plus of Kansas City, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. Dental, Hospital, and Pharmacy claim type critical fields examined were 100.00% complete, accurate, and valid. For Medical claims, Outpatient Last Date of Service and Procedure Code contain some invalid fields. For Home Health claims, the Procedure Code field contained some invalid data. The Admission Date and Discharge Date fields for the Inpatient claim type contained some invalid codes, and the Revenue Code field contained one blank entry.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Blue-Advantage Plus of Kansas City demonstrated rates consistent with the average for all MC+ MCOs for the Medical and Dental claim types; and a significantly higher rate for Home Health encounter claims. There was a significantly lower rate of Inpatient, Outpatient Hospital, and Pharmacy encounter claim types for Blue-Advantage Plus of Kansas City than the average for all MC+ MCOs. These findings suggest moderate to high access to care for Medical, Dental and Home Health Care services and lower access to Inpatient, Hospital, and Pharmacy services for Blue-Advantage Plus of Kansas City members. Another explanation might be that since preventative care appears to be readily available, BA+ members are healthier and do not require as many acute services.

To what Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MC+ MCO were randomly selected from Medical claim types for the period of January 1, 2005 through March 31, 2005 for medical record review. Of the 85,707 Medical encounter claim types in the SMA extract file for January 1, 2005 through March 31, 2005, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 89 medical records (89.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 65.0%, with a fault rate of 35.0%. The match rate for diagnoses was 89.0%, with a fault rate of 11.0%.

What Types of Errors were Noted?

An error analysis of the errors found in the medical record review for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing information (n = 11).

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 27) and not enough information to code (n = 8). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

What Problems are there with How Files are Compiled and Submitted by the MC+ MCO?

It was not possible to conduct the planned analysis of comparing MC+ MCO encounter data to the SMA encounter claim extract file because there was not a common key to match the files. The plan was to compare MC+ MCO paid and unpaid claims to the SMA encounter claim extract file. MC+ MCOs were requested to submit data in a format specified by EQRO (see Appendix 6) for the MC+ Managed Care Members represented in the encounter claim sample selected for validation.

For purposes of the EQRO, Blue-Advantage Plus of Kansas City was able to submit files in the requested format, but the ICN codes submitted were not the same number of characters of the ICNs in the SMA extract files.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While Blue-Advantage Plus of Kansas City did submit the data in the requested format, there are a number of ways to improve the data quality by improving the database system. One variable that is not currently represented is that of a unique line number. To match up specific lines of data (each service provided within an encounter), this requires a unique number for each service provided for each member.

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Dental, Outpatient Hospital and Pharmacy claim types were 100.00% complete, accurate, and valid.
4. The match between medical records and the SMA encounter claims database for procedure codes was significantly higher than the average for all MC+ MCOs; and the match rate between diagnosis codes was consistent with the average for all MC+ MCOs.

AREAS FOR IMPROVEMENT

1. For the Medical claim type, Outpatient Last Date of Service and Procedure Code fields contained invalid entries.
2. For the Inpatient claim type, there were invalid dates in the Admission Date and Discharge Date fields; also there was one blank Revenue Code.
3. The Outpatient Procedure Code field in the Home Health claim type contained invalid fields.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the UB-92 file layout for the Outpatient Procedure Code and Discharge Date fields, and run validity checks after the programming of new edits.

12.4 MCO Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MCO's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the Division of Medical Services. On-site review time was used to conduct interviews with those who oversee the daily practices of the MCO to ensure that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MCO Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the MCO and to follow-up on questions raised from the document review and from the 2004 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Provider Contracts
- Grievance and Appeal Policies
- Grievances and Appeals related to members were reviewed, as were Complaints, Grievances, and Appeal files for providers. These files were obtained from a random selection process of actions filed in the first quarter of 2005.
- 2004 Annual Appraisal of the Quality Improvement Program

Additional documentation made available by Blue-Advantage Plus of Kansas City included:

- 2005 and 2006 Marketing Plan and Educational Material Development Policy
- Blue-Advantage Plus of Kansas City of Kansas City Organizational Chart
- BA+ Brochures – English/Spanish versions
- Complete Policy and Procedure Manuals
- 2005 BA+ Member Survey Results
- BA+ Oversight Committee Charter and Minutes
- BA+ 2005 Report Card
- BA+ Complaint Process "Race for Resolution" – Presentation and Materials
- 2005 Well Aware Newsletters (Member)
- 2005 Blue Speak Newsletters (Provider)

Interviews

Interviews were conducted with the following group:

Plan Administration

Judy Brennan, Director, State Programs, Plan Administrator
Dr. Loretta Britton, VP, Medical Director
Sandy Wederquist, RN, Director, Medical Management
Dr. Blake Williamson, VP. Senior Medical Director
Shelly Bowen, AVP, Quality Management
Tylisa Wyatt, Complaint Analyst
Wes Wadman, MHIP Coordinator

Mental Health

Myron Unruh, AVP Clinical Operations
Garth Smith, Director, Network Operations
Lisa Woodring, Director, Prevention and Support Services
Judy Brennan, Director, State Programs

FINDINGS

Enrollee Rights and Protections

Blue-Advantage Plus of Kansas City continued to exhibit commitment and enthusiasm toward ensuring the member rights and protections are in place. Members were contacted quickly after the MCO learned of enrollment. A variety of continued contacts were made if initial attempts failed. Written information was provided in English or Spanish. If additional interpretive services were required, this was arranged for the member.

Blue-Advantage Plus of Kansas City made changes in a number of processes to make service delivery easier for members. In January 2005 the MCO stopped requiring a primary care physician (PCP) referral for specialist care. The MCO made the policy and procedure review process less complex for ease in approval. Turnaround time on changes and requests for exceptions or review was occurring in a more timely manner.

The MCO began use of a wellness van to participate in group events throughout the Kansas City area. The van made more than sixty appearances throughout 2005. Health information was provided and staff did screenings for lead poisoning, cholesterol, blood sugar, BMI and blood pressure.

A Radiology Advisory Committee was established with Doral Dental, a BA+ subcontractor for dental services, to evaluate high technology procedures offered in the communities surrounding Kansas City. Doral Dental released a series of privileging criteria to dental offices. There was an emphasis on advanced machinery in an effort to prevent excessive radiation exposure. New contracts were initiated utilizing the enhanced privileging criteria as the process was extended to dental practices where similar technology was available. Originally Doral Dental contracted with eighteen imaging centers. Three were unable to meet the new contract requirements. Both Doral Dental and Blue-Advantage Plus of Kansas City stressed that the new requirements are a benefit to members. Fewer contracted imaging centers have not limited member services as they provided a low volume of services to MC+ Medicaid Managed Care members. There was no negative impact on member access to services.

Blue-Advantage Plus of Kansas City explained that they were transitioning from the traditional managed care medical management model to a care management model that provided more focused attention to members. The ultimate goal of the project is to empower members to be more responsible for improving their health status. The MCO began using a predictive modeling tool, Care Advance, to search through data and detect members who are at risk of needing care management services. Data used by the MCO included claims, pharmacy utilization, laboratory results, and self-reported information. When this process is fully operational follow-up contact will occur with all at-risk members detected. The members will receive prompts to make medical appointments, chronic disease treatment will be identified, and comparisons will be made to best practice guidelines. The MCO will produce assessments to submit to involved providers. Tutorials for chronic diseases, such as asthma and diabetes are available and providers will be able to use this information, as well as tracking patient information.

During 2005, Blue-Advantage Plus of Kansas City had $700.000 in additional community service funding approved. Targeted initiatives included EPSDT, immunizations, and childhood issues. The MCO started an outcome based program called P.E. for Life, where they worked with schools to construct physical education areas. The MCO's parent company, Blue Cross/Blue Shield of Kansas City donated funds to bring an "academy" type project to an urban school that did not have resources for this type of project. The MCO also assisted with the purchase of heart monitors to allow children to achieve improved health and fitness outcomes according to their own biometrics. Open houses were sponsored to promote this program. Before and

after-school programs were offered to assist with fitness objectives. Physical education grants continued to be available as start-up funding to allow additional districts to set up Physical Education for Life programs.

The rating for Enrollee Rights and Protections (100.0%) reflects Blue Advantages Plus's ability to have all policy and procedures submitted and approved by the SMA in a timely manner. The MCO also provided evidence of their practice throughout the on-site review process. It appears that the MCO is in compliance with all MC+ Medicaid Managed Care contract regulations and federal requirements.

Table 94 - Subpart C: Enrollee Rights and Protections Yearly Comparison

Federal Regulation	Blue Advantage +	
	2004	2005
438.100(a) Enrollee Rights: General Rule	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	1	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2
438.100(b)(3) Right to Services	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2
Number Met	11	13
Number Partially Met	2	0
Number Not Met	0	0
Rate Met	84.6%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

Interviews occurred at the time of the on-site review with Blue-Advantage Plus of Kansas City and administrators from their Behavioral Health Organization (BHO), New Directions Behavioral Health. They reported on new programs that occurred during 2005, and responded to questions about follow-up to 2004 issues. The BHO reported on 2005 case management activities, such as work with all in-patient facilities to ensure that proper discharge planning occurred for members. This effort assisted in linking members with after-care services, such as those provided by area Community Mental Health Centers (CMHCs). The case management staff maintained a smaller, more manageable caseload that allowed for increased care coordination. New Directions did report that co-morbid cases increased during the past five years. The BHO reported that forty percent of the case management cases are Blue-Advantage Plus of Kansas City members, and that forty-one percent of these were identified by emergency room providers.

As the result of efforts made by the SMA and the Missouri Department of Mental Health (DMH), a committee that reviews the use of psychotropic medications has been meeting for the past year. The BHO was an active member of this committee. Committee members included practicing psychiatrists and pharmacy representatives from the MCOs; the committee was chaired by Dr. Parks from the DMH. The committee reviewed pharmacy information and identified apparent misuses or duplication of pharmaceuticals. If abuse was detected through this process, the Blue-Advantage Plus of Kansas City member was contacted and prescriptions were monitored. All suspected pharmacy abuse was reported to the SMA on a quarterly Fraud and Abuse Report. The member was locked into a specific pharmacy for the period of one-year.

New Directions Behavioral Health continued to jointly operate the PACT program with the Gillis Center. The PACT program has been in place for eight years. This program provided intensive interventions for members and their families, with follow-up services within the community. For example the program connected members and their family with their Community Mental Health Clinic (CMHC) for wrap around services or other beneficial interventions. These services, exceptional to the requirements of the MC+ Medicaid Managed Care contract, assisted members leaving in-patient care, and in some cases prevented in-patient care. Providing this type of support mechanism allowed the MCO to increase ambulatory

follow-up for members leaving in-patient services at the seven and thirty-day time frames. The follow-up numbers increased from 67% to 75.5% during the 2005 measurement period. New Directions met with providers and educated them about the importance of good discharge planning and about the availability of the PACT Program. The BHO reported that in 2003 their readmission rate was 10 percent. In 2004 and 2005 the readmission rate was reduced and sustained at 6-7 percent.

New Directions reported that they established a practice of contacting all members presenting to emergency rooms three or more times in a quarter to ensure that any necessary follow-up services were available. Sharing information and reporting on outcomes was closely coordinated with Blue-Advantage Plus of Kansas City.

The MCO worked with the BHO and sought the assistance of the Kansas City El Centra Group to inform both marketing and management staff about the large Latin population in the region. Spanish speaking consumers were brought into the staff training to inform staff of appropriate cultural considerations and barriers faced by this population in obtaining healthcare services. The group continued to work on written and verbal materials to ensure that all members have equal access to MCO basic information.

Quality Assessment and Performance Improvement

Access Standards

Blue-Advantage Plus of Kansas City continued to have an extensive provider network available. The MCO reported that having regular access to orthopedic surgeons, neurologists and urologists was difficult. These specialists remain dissatisfied with the MC+ Medicaid Managed Care reimbursement rates. Blue-Advantage Plus of Kansas City did utilize specialists from their commercial network and reimbursed them at twenty percent over the Medicaid fee schedule. Customer Service staff continued active recruitment efforts for specialty medical providers.

The MCO reported that their relationship with providers improved during 2005. Blue-Advantage Plus of Kansas City solicited participation from providers on an advisory committee that the MCO utilized for review of internal policies and activities. Physician complaints and member satisfaction surveys were used to trigger corrective actions and educational opportunities with providers. The MCO sent staff to provider offices to both monitor activities

with members and to assist Blue-Advantage Plus of Kansas City in defining problem areas reported. The MCO presented circumstances to the Advisory Committee to assist with problem solving. Blue-Advantage Plus of Kansas City placed forms and information on their web site for prior authorizations for provider convenience.

Emphasis continued on active case management services within Blue-Advantage Plus of Kansas City, as additional attention was given to pregnant members. The MCO used a number of referral methods to identify pregnant members including the state health risk assessment, claims reports for first obstetrical visits, self-referrals, physician referrals, and information obtained at the Nurse Line. The MCO averaged 160 referrals each month, with eighty percent coming directly from providers. After a referral was received, the member was sent a packet of information, including health assessment forms (25% were returned). Any members identified as high-risk were sent to case management where contact was made and necessary follow-up services offered. The MCO collaborated with New Directions Behavioral Health for co-case management when this benefited members.

Ratings regarding Access Standards regulations (100%) reflect that Blue-Advantage Plus of Kansas City submitted all required policy and procedures to the SMA for their approval. During the on-site review all practices observed indicated that the MCO made a concerted effort to ensure that they were compliant with the MC+ Medicaid Managed Care contract requirements and all federal regulations.

Table 95 - Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison

Federal Regulation	Blue Advantage +	
	2004	2005
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	1	2
438.206(b)(3) Second Opinions	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	1	2
438.206(c)(1)(i-vi) Timely Access	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2
438.208(b) Care Coordination: Primary Care	2	2
438.208(c)(1) Care Coordination: Identification	2	2
438.208(c)(2) Care Coordination: Assessment	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	2
438.210(b) Authorization of Services	2	2
438.210(c) Notice of Adverse Action	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2
438.210(e) Compensation of Utilization Management Activities	2	2
438.114 Emergency and Post-Stabilization Services	2	2
Number Met	14	17
Number Partially Met	3	0
Number Not Met	0	0
Rate Met	82.4%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Blue-Advantage Plus of Kansas City provided regular oversight to all subcontractors. The MCO met with New Directions Behavioral Health, their Behavioral Health Organization (BHO), at least monthly. Discussions with New Directions included access to services and completion of all studies to comply with URAC, NCQA, and MC+ Managed Medicaid regulations. Responsibility was delegated to New Directions for member grievance and appeal resolution and correspondence. This activity was monitored regularly by the MCO. Blue-Advantage Plus of Kansas City used Doral Dental, Inc. as their subcontractor for dental services. The MCO met with Doral Dental semiannually for oversight activities. The MCO used MTM as their transportation subcontractor. Although, Blue-Advantage Plus of Kansas City, like all of the

MCOs, identified problems with this subcontractor, they reported an effort by MTM to take complaints seriously and to utilize reliable service providers. The committee providing subcontractor oversight included a cross section of department heads who meet monthly to discuss pending issues and to create action plans for MCO staff or departments. In addition, Blue-Advantage Plus of Kansas City staff track this information on a daily basis.

Blue-Advantage Plus of Kansas City implemented CareGuide QI software. This tool allowed for more efficient documentation of the Milliman Criteria and has allowed nursing staff to make more informed medical management decisions. Using this tool in collaboration with provider discussions allowed for the most appropriate authorization of inpatient services. The Milliman Criteria provided a guide for medical practice. However, the MCO also used specific practice guidelines from American College of Obstetricians and Gynecologists (ACOG) and the Academy of Pediatrics. All providers were encouraged to recognize best practices and follow nationally accepted guidelines.

Ratings for compliance with Structure and Operation Standards regulations (100%) reflect that Blue-Advantage Plus of Kansas City has completed all policy and procedural requirements of the SMA. All practice observed during the on-site review supported that the MCO has made every effort to be compliant with both the MC+ Medicaid Managed Care contract requirements and federal regulations.

Table 96 - Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison

Federal Regulation	Blue Advantage +	
	2004	2005
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2
438.214(d) Provider Selection: Excluded Providers	2	2
438.214(e) Provider Selection: State Requirements	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2
438.56(d) Disenrollment: Procedures	2	2
438.56(e) Disenrollment: Timeframes	2	2
438.228 Grievance System	2	2
438.230(a,b) Subcontractual Relationships and Delegation	1	2
Number Met	9	10
Number Partially Met	1	0
Number Not Met	0	0
Rate Met	90.0%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Emergency Room utilization was a topic of study during 2005. Blue-Advantage Plus of Kansas City was exploring this topic for a possible 2006 Performance Improvement Project (PIP). At the time of the on-site review some initial information was shared, but the MCO was in the process of completing a barrier analysis to make a final decision about implementing this topic as a PIP. Blue-Advantage Plus of Kansas City did submit two Performance Improvement Projects for validation that were conducted or completed during 2005. The detailed discussion regarding these PIPs can be found in the appropriate section of this report.

Blue-Advantage Plus of Kansas City was involved in the community-based Kansas City Quality Improvement Consortium. The group developed clinical practice guidelines for diabetes and asthma. The group was continuing to work on obesity guidelines. The MCO continued to encourage all providers to use practice guidelines accepted by national organizations, as well as those based on local standards. The MCO used the Providers Office Guide and MCO newsletters to disseminate information about practice guidelines to the provider community.

Blue-Advantage Plus of Kansas City submitted all required information to complete the Validation of Performance Measures, as requested. The MCO continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The details regarding these areas of validation can be reviewed within specific sections of this report.

Ratings for the Measurement and Improvement sections were found to be (100%), which reflects that all required policy and practice meets the requirements of the MC+ Medicaid Managed Care contract and the federal regulations.

Table 97 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison

Federal Regulation	Blue Advantage +	
	2004	2005
438.236(b)(1-4) Practice Guidelines: Adoption	2	2
438.236(c) Practice Guidelines: Dissemination	2	2
438.236(d) Practice Guidelines: Application	2	2
438.240(a)(1) QAPI: General Rules	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2
438.240(e) QAPI: Program Review by State	NA	NA
438.242(a) Health Information Systems	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	2
438.242(b)(3) Health Information Systems: Basic Elements	1	2
Number Met	8	11
Number Partially Met	3	0
Number Not Met	0	0
Rate Met	72.7%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Four member grievances and three member appeals were reviewed during the on-site review. Three of the member grievances concerned the transportation provider MTM. The issues concerned delays or failure to pick-up members. The drivers were counseled in all three cases. The fourth member grievance concerned a request by a member for a specific procedure, however, all appropriate paperwork was not submitted in a timely manner and the decision was upheld. Two of the member appeals were submitted by the provider on behalf of the members. One appeal requested payment for Synagis and the other requested payment for Enteral Feedings. Both denials were overturned. An appeal concerning a dental claim was originally upheld due to member ineligibility, but was later overturned upon a review of the member's eligibility.

Seven provider complaints were reviewed, three of which involved claims for inpatient hospital days. Upon review of medical necessity, all were approved. Two complaints involved payment for speech therapy; and both decisions were overturned with additional information. The final two complaints were reviewed and paid based on updated information and a correction of procedure codes.

All files reviewed were conducted in a timely fashion and included enough information to understand the action taken and the basis of the decision made. All correspondence was sent in a timely manner. One letter concerning a decision in a member situation was worded incorrectly, which changed the meaning of the decision. This was shared with the MCO who agreed to send out a correct version immediately.

Rating for compliance with Grievance System regulations (100%) remained complete as occurred in the 2004 review. The MCO takes pride in their Grievance and Appeal policy and procedures. All practice witnessed at the time of the on-site review, with the exception of one incorrectly worded letter, was also in compliance. The MCO agreed to correct the letter. They explained that when this type of error was identified, corrections were submitted to members and providers immediately.

Table 98 - Subpart F: Grievance Systems Yearly Comparison

Federal Regulation	Blue Advantage +	
	2004	2005
438.402(a) Grievance and Appeals: General Requirements	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2
438.404(b) Notice of Action: Content	2	2
438.404(c) Notice of Action: Timing	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2
438.410 Expedited Resolution of Appeals	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2
438.416 Recordkeeping and Reporting Requirements	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2
Number Met	18	18
Number Partially Met	0	0
Number Not Met	0	0
Rate Met	100%	100.0%

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2005 External Quality Review Monitoring MCOs Protocols

Summary

Blue-Advantage Plus of Kansas City has improved in meeting all policy, procedure, and practice areas of compliance with both the MC+ Medicaid Managed Care contract requirements, and the federal regulations. The MCO strengthened their programs, and engaged in a number of initiatives that served to improve the quality, access and timeliness of service to their members. Blue-Advantage Plus of Kansas City pointed to their member loyalty as proof of their focus on meeting member needs. The MCO continued to operate, expand, and create initiatives, several

in conjunction with the Behavioral Health Organization, that go beyond the strict requirements of their contract. These initiatives focus on prevention in an effort to avoid more intrusive treatment for members. Blue-Advantage Plus of Kansas City dedicated resources enabling staff to be responsive and supportive to members by ensuring that their healthcare needs were met in an effective and efficient manner.

STRENGTHS

1. Completion and approval of all required policy and procedures.
2. Continuous development of new initiatives that enhance member services and utilize MCO resources, such as Care Advance, a project that uses MCO data to inform the MCO about member issues.
3. The BA+ Complaint Process, "Race for Resolution," a well constructed and important initiative that improved the MCO's responsiveness and timelines to both member grievances and appeals, and provider complaints, grievances, and appeals.
4. New investments in community initiatives such as the wellness van that participated in over sixty community events.
5. Continued partnership with New Directions Behavioral Health and their exceptional initiatives, such as coordination of case management activities, the PACT, and PST programs.

AREAS FOR IMPROVEMENT

1. The parent company, BCBSKC, should assist the state programs section, BA+, in their focus on the MC+ program. In discussing many projects, BA+ often seems to get lost in overall activities.

RECOMMENDATIONS

1. Continue development of projects utilizing available resources and data to justify and assist in understanding member service needs.
2. Continue development and use of products, such as CareAdvance, in predictive modeling and supporting empowerment of members to seek appropriate health interventions.
3. Continue efforts to improve behavioral health services, such as monitoring inpatient facilities, completing proactive discharge planning, and aftercare services.

APPENDIX 1 ORIENTATION POWERPOINT SLIDES

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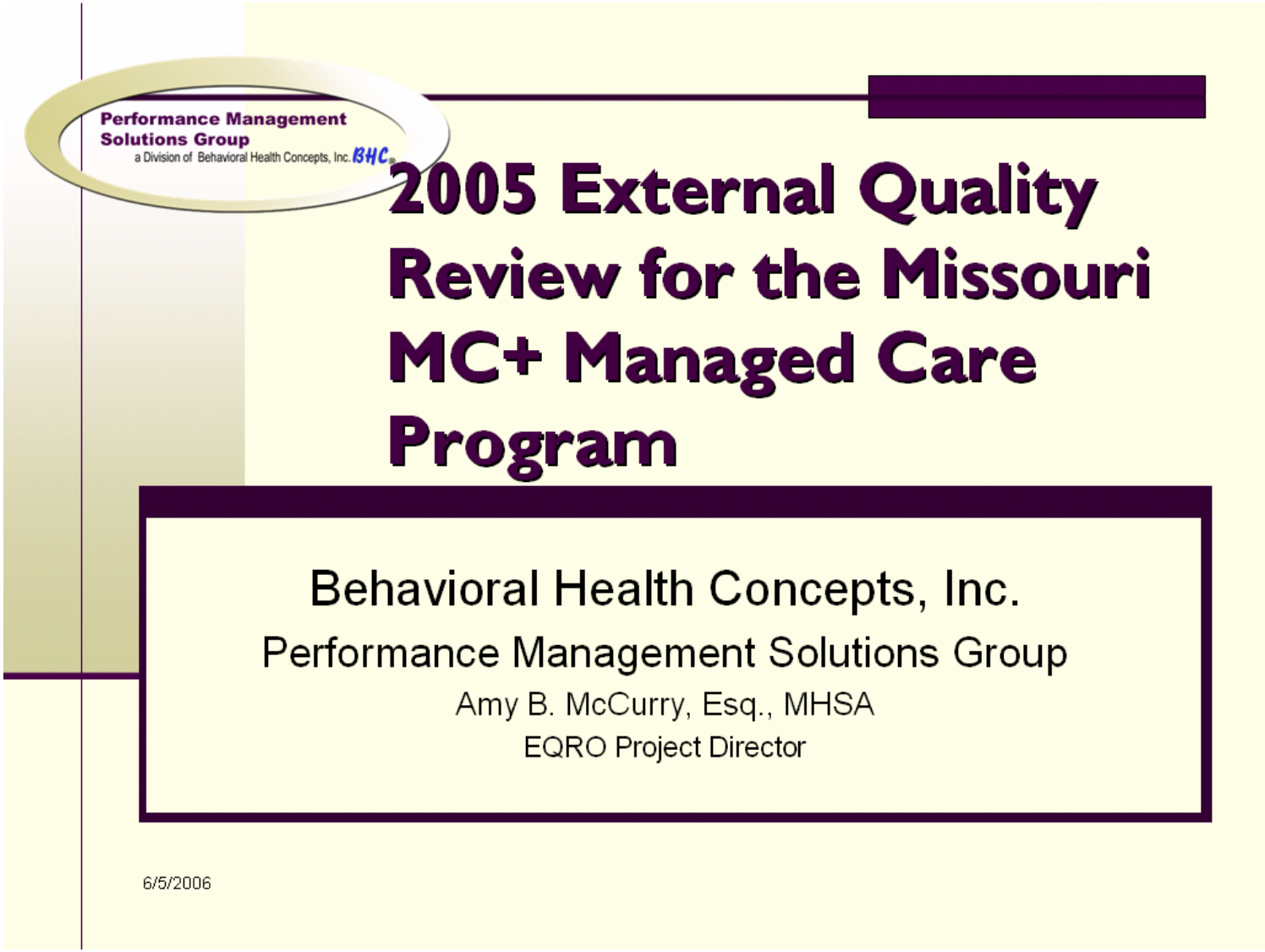
Performance Management Solutions Group
a Division of Behavioral Health Concepts Inc. BHC

Orientation Agenda

- Introductions
- Orientation to Technical Methods and Objectives of Protocols
- Review of Information, Data Requests, and Timeframes
  - Performance Measures
  - Performance Improvement Projects
  - Encounter Data Validation
  - Compliance and Site Visits
- Closing Comments, Questions

6/5/2006

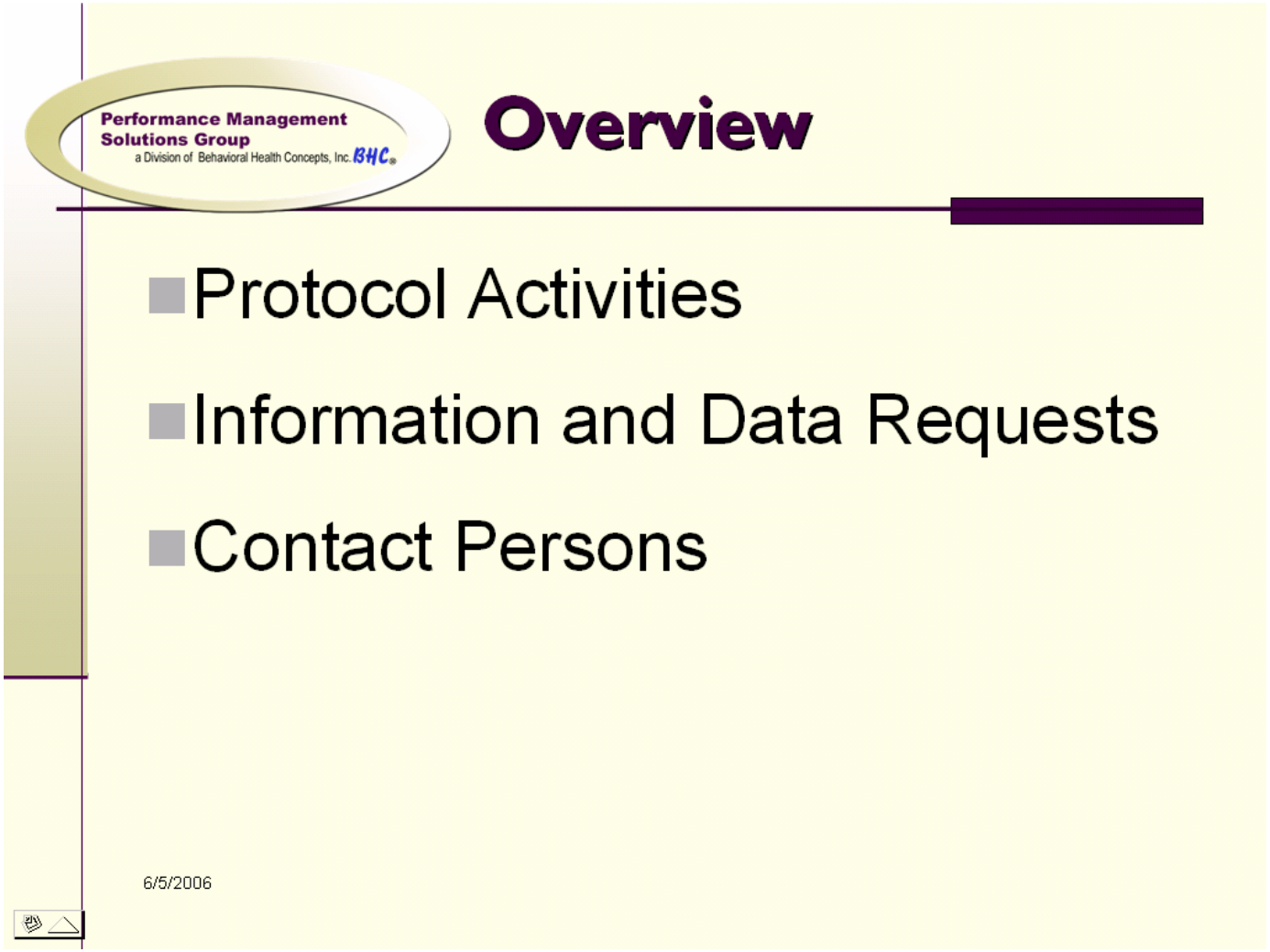

Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
2005 External Quality Review for the Missouri MC+ Managed Care Program
Behavioral Health Concepts, Inc.
Performance Management Solutions Group
Amy B. McCurry, Esq., MHSA
EQRO Project Director
6/5/2006

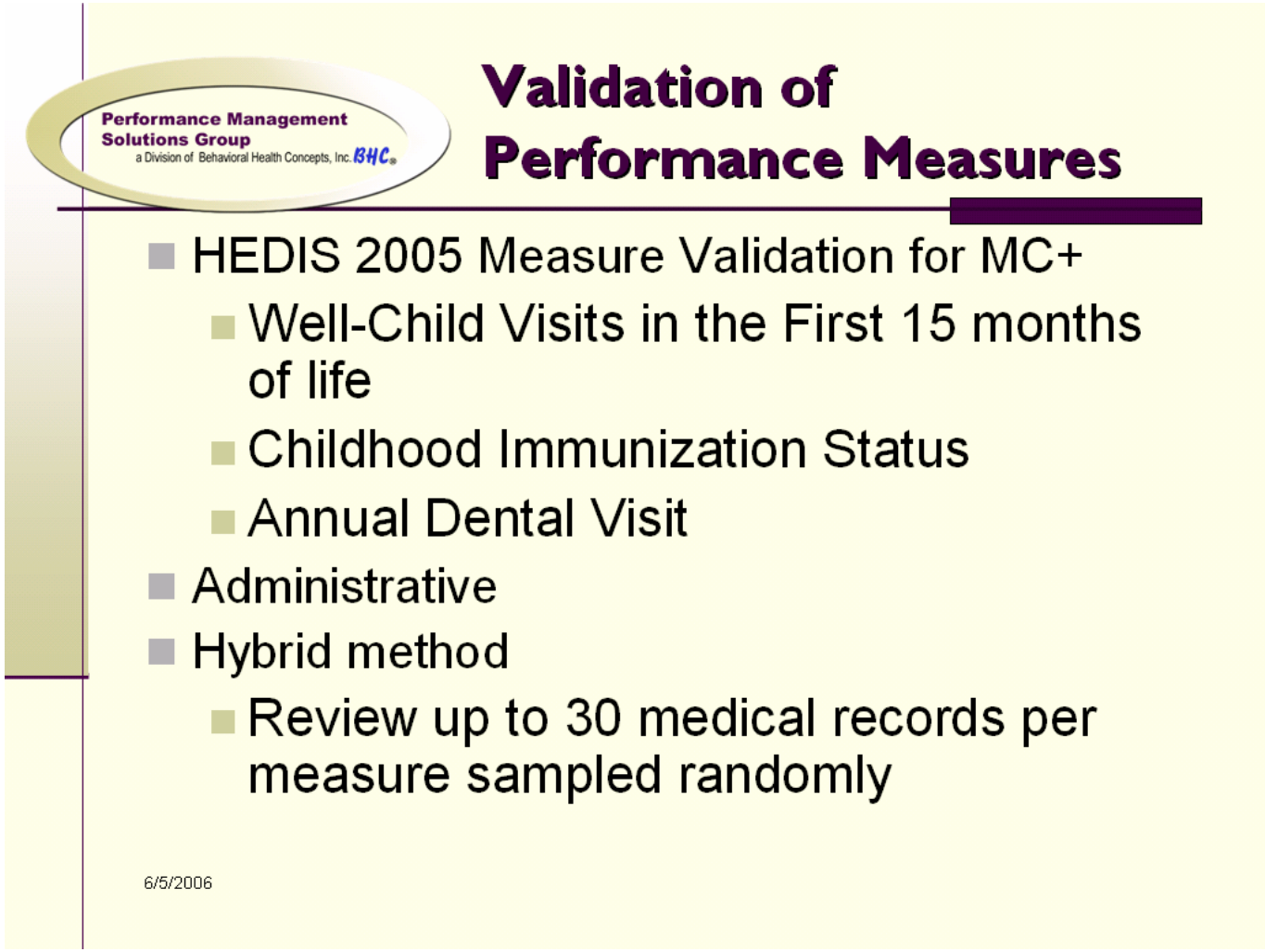
Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

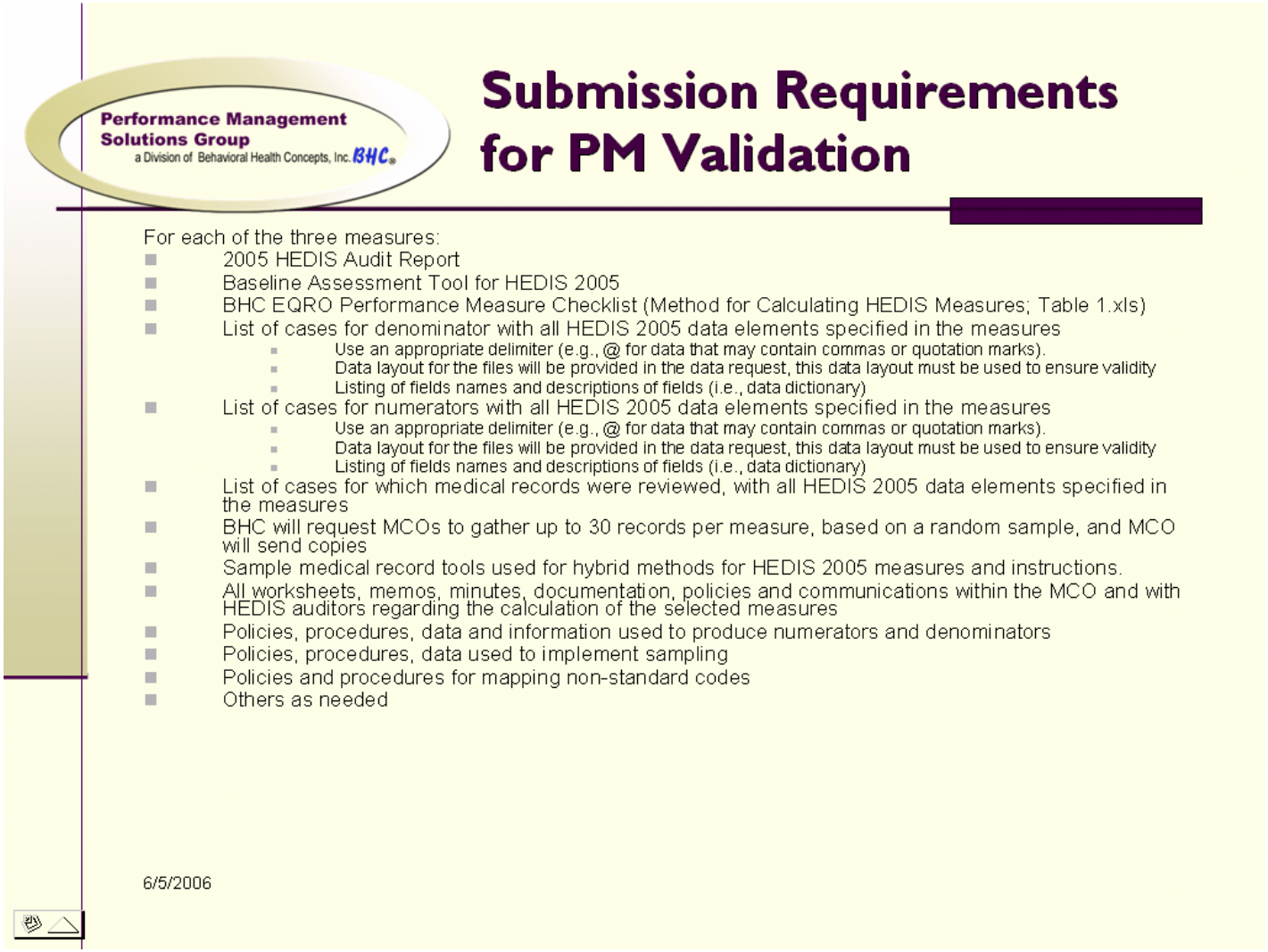
Materials Provided

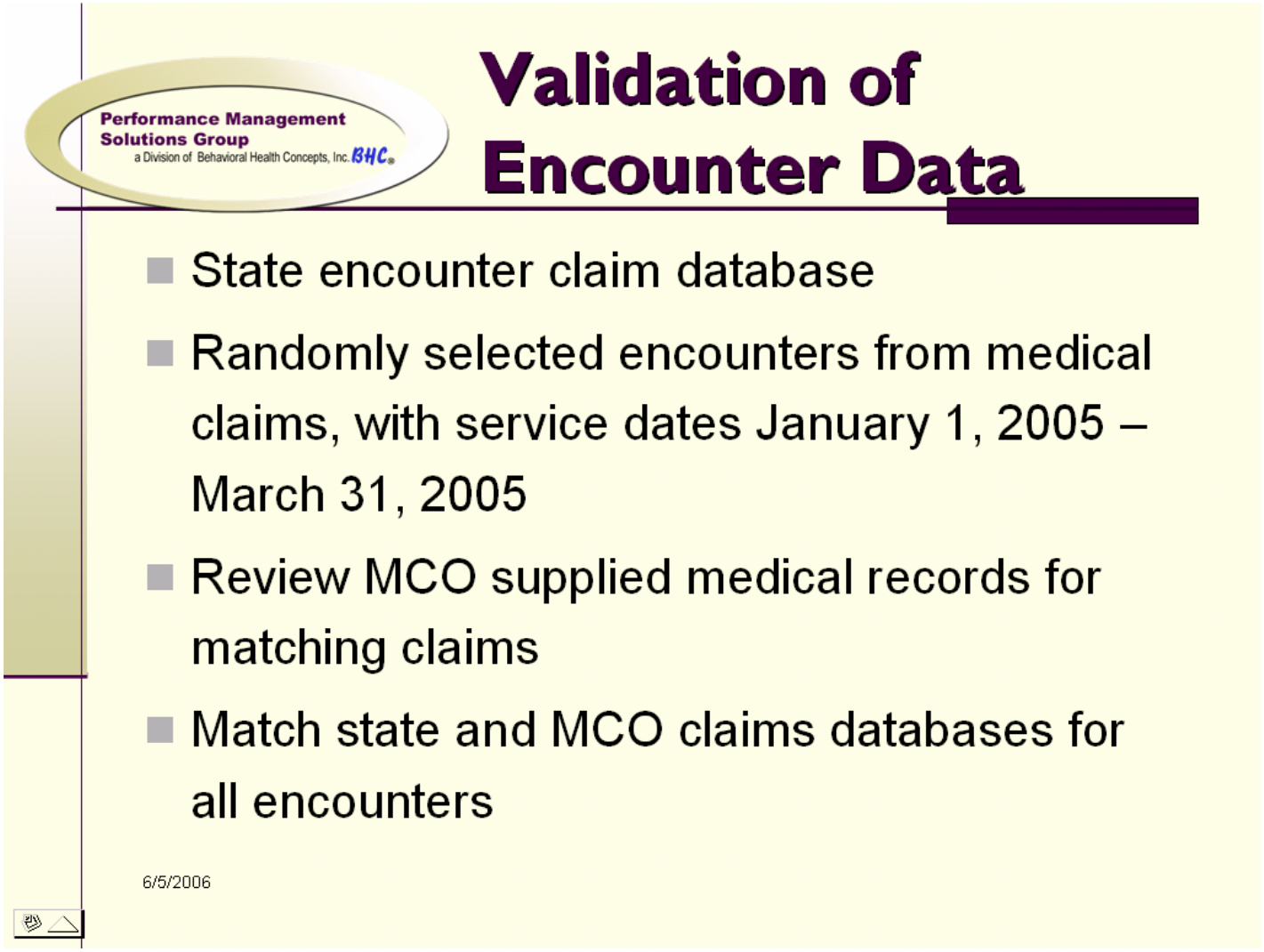
- Objectives and Technical Methods
  - Validation of Performance Measures
  - Validation of Encounter Data
  - Validation of Performance Improvement Projects
  - MCO Compliance
- Requests for information and data
- List of BHC contacts for each protocol
- Presentation

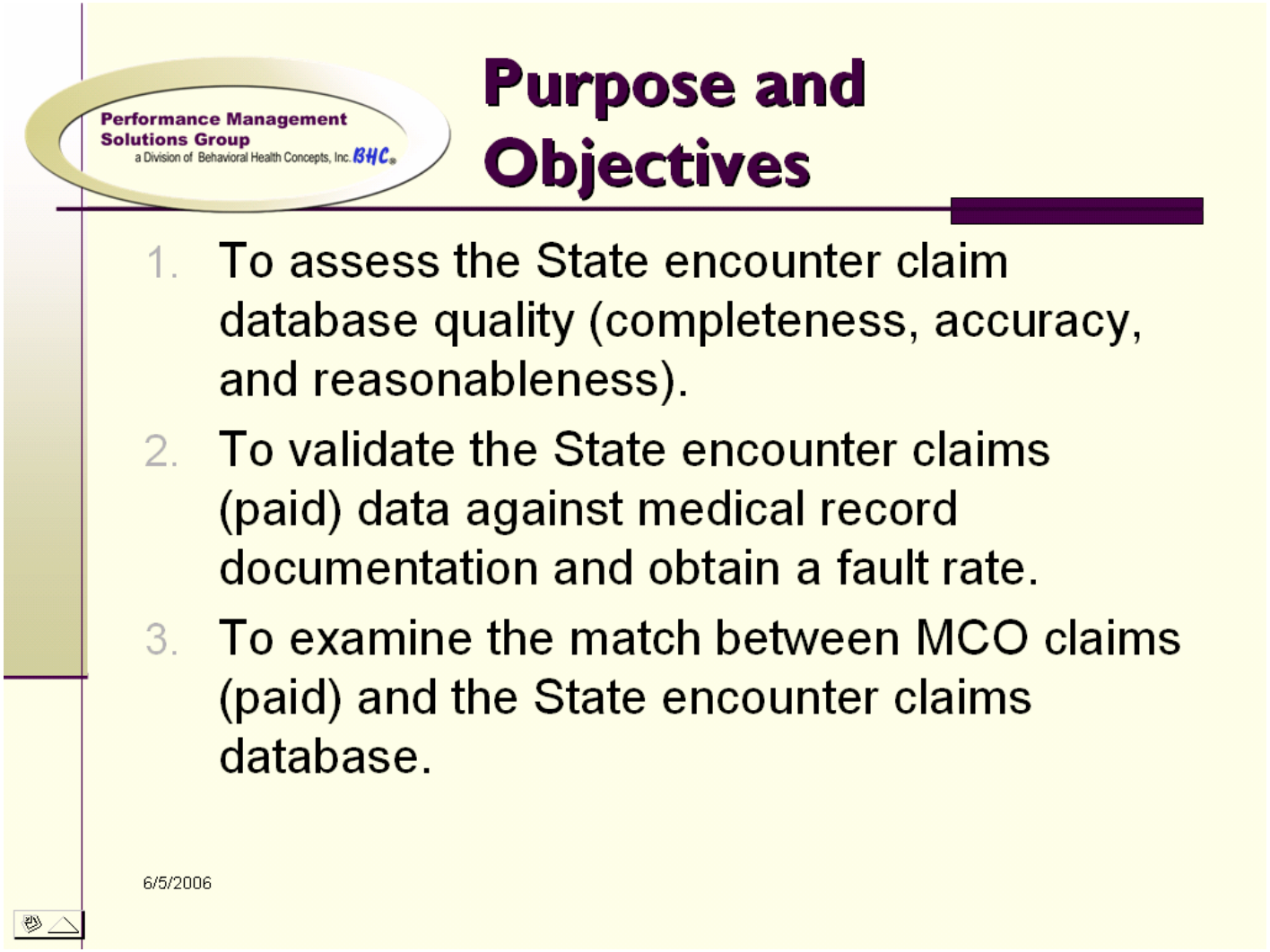
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Overview
Protocol Activities
Information and Data Requests
Contact Persons
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Validation of
Performance Measures
HEDIS 2005 Measure Validation for MC+
Well-Child Visits in the First 15 months of life
Childhood Immunization Status
Annual Dental Visit
Administrative
Hybrid method
Review up to 30 medical records per measure sampled randomly
6/5/2006


Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Submission Requirements for PM Validation
For each of the three measures:
2005 HEDIS Audit Report
Baseline Assessment Tool for HEDIS 2005
BHC EQRO Performance Measure Checklist (Method for Calculating HEDIS Measures; Table 1.xls)
List of cases for denominator with all HEDIS 2005 data elements specified in the measures
Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
Listing of fields names and descriptions of fields (i.e., data dictionary)
List of cases for numerators with all HEDIS 2005 data elements specified in the measures
Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
Listing of fields names and descriptions of fields (i.e., data dictionary)
List of cases for which medical records were reviewed, with all HEDIS 2005 data elements specified in the measures
BHC will request MCOs to gather up to 30 records per measure, based on a random sample, and MCO will send copies
Sample medical record tools used for hybrid methods for HEDIS 2005 measures and instructions.
All worksheets, memos, minutes, documentation, policies and communications within the MCO and with HEDIS auditors regarding the calculation of the selected measures
Policies, procedures, data and information used to produce numerators and denominators
Policies, procedures, data used to implement sampling
Policies and procedures for mapping non-standard codes
Others as needed
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Validation of Encounter Data
State encounter claim database
Randomly selected encounters from medical claims, with service dates January 1, 2005 – March 31, 2005
Review MCO supplied medical records for matching claims
Match state and MCO claims databases for all encounters
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Purpose and Objectives
1. To assess the State encounter claim database quality (completeness, accuracy, and reasonableness).
2. To validate the State encounter claims (paid) data against medical record documentation and obtain a fault rate.
3. To examine the match between MCO claims (paid) and the State encounter claims database.
6/5/2006

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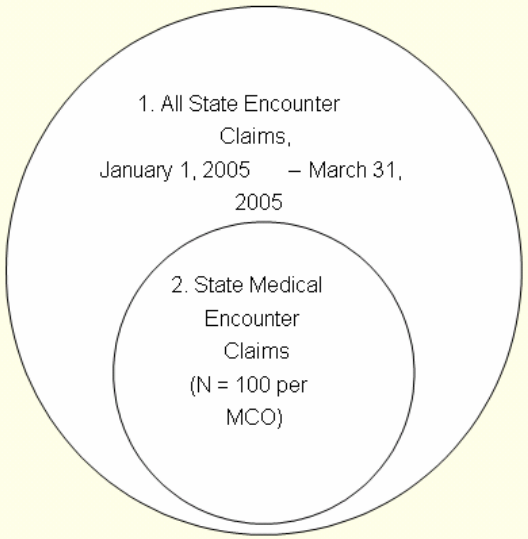
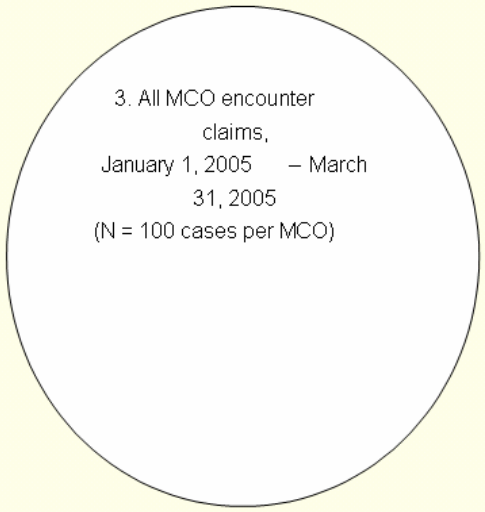
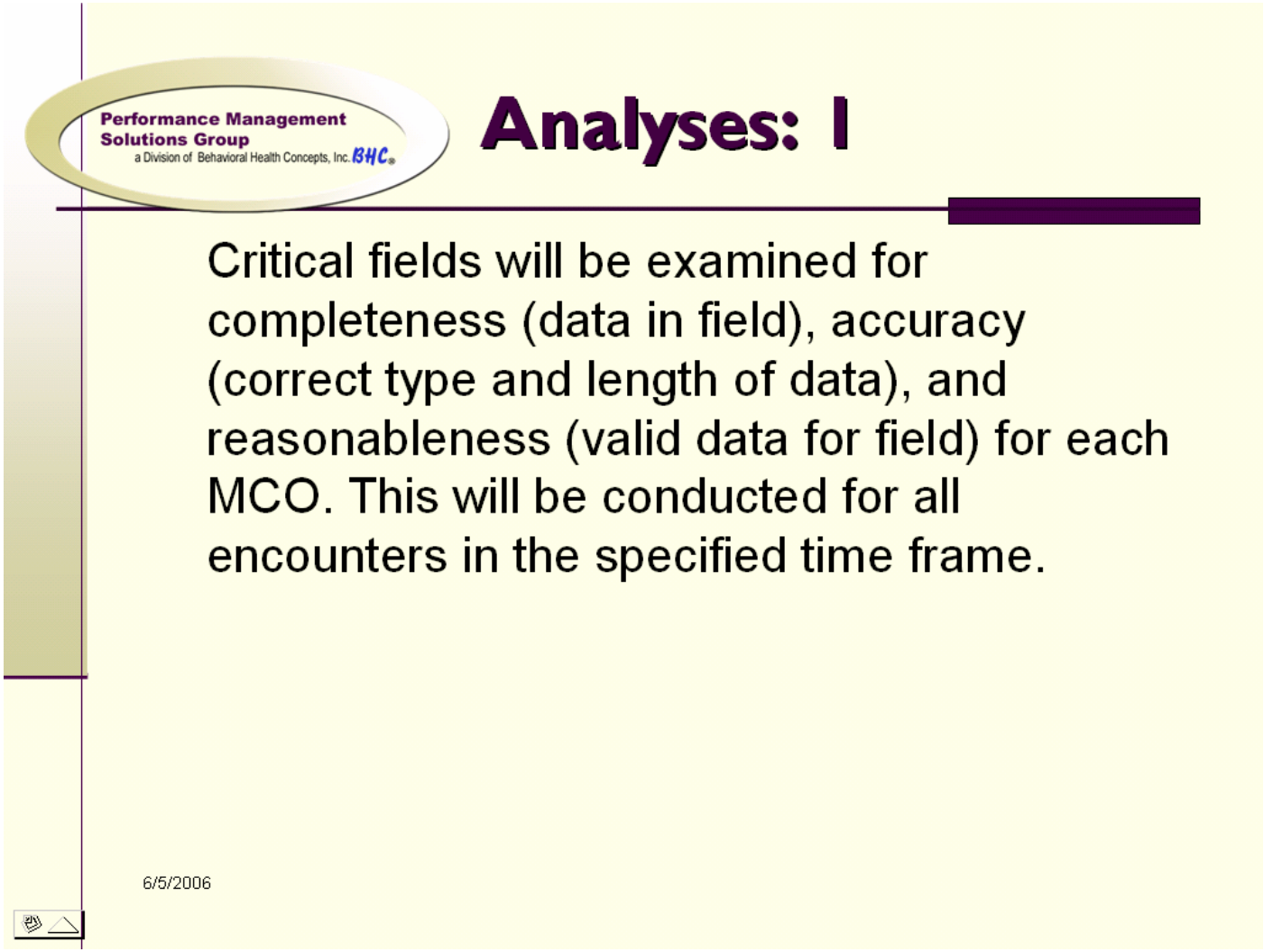
Sampling





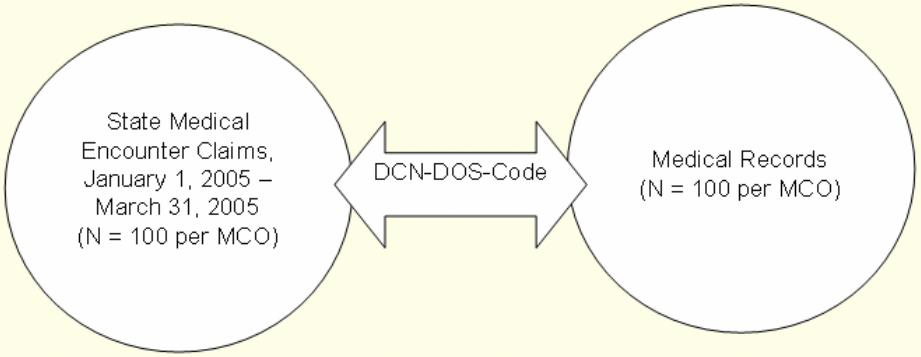
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Analyses: I
Critical fields will be examined for completeness (data in field), accuracy (correct type and length of data), and reasonableness (valid data for field) for each MCO. This will be conducted for all encounters in the specified time frame.
6/5/2006

Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

Analyses: 2

BHC will abstract the medical records and claims history/forms for each patient for the medical service provided during the entire time frame, enter into a database, and determine the rate(s) of matches, omissions and commissions between the medical record and the State encounter claims for each MCO. Matches will be cases that are consistent on patient DCN, date of service, and diagnosis or procedure code.

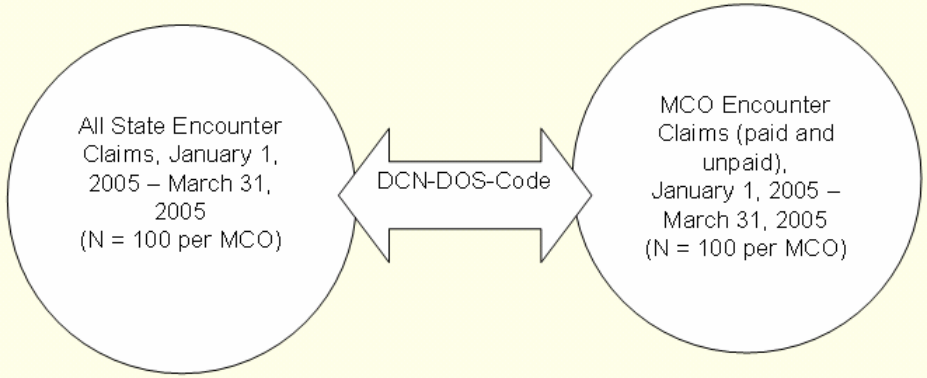


6/5/2006

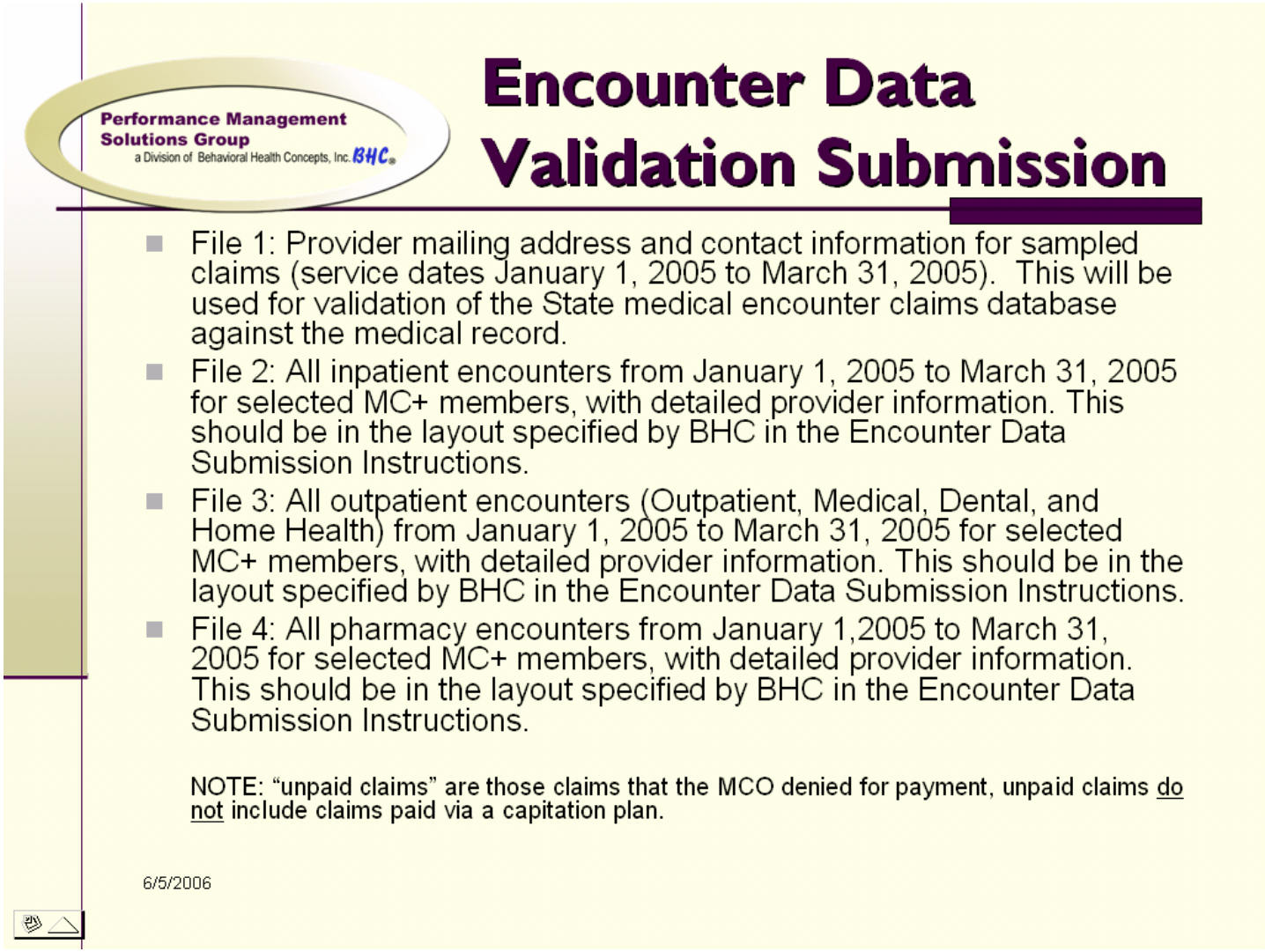
Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

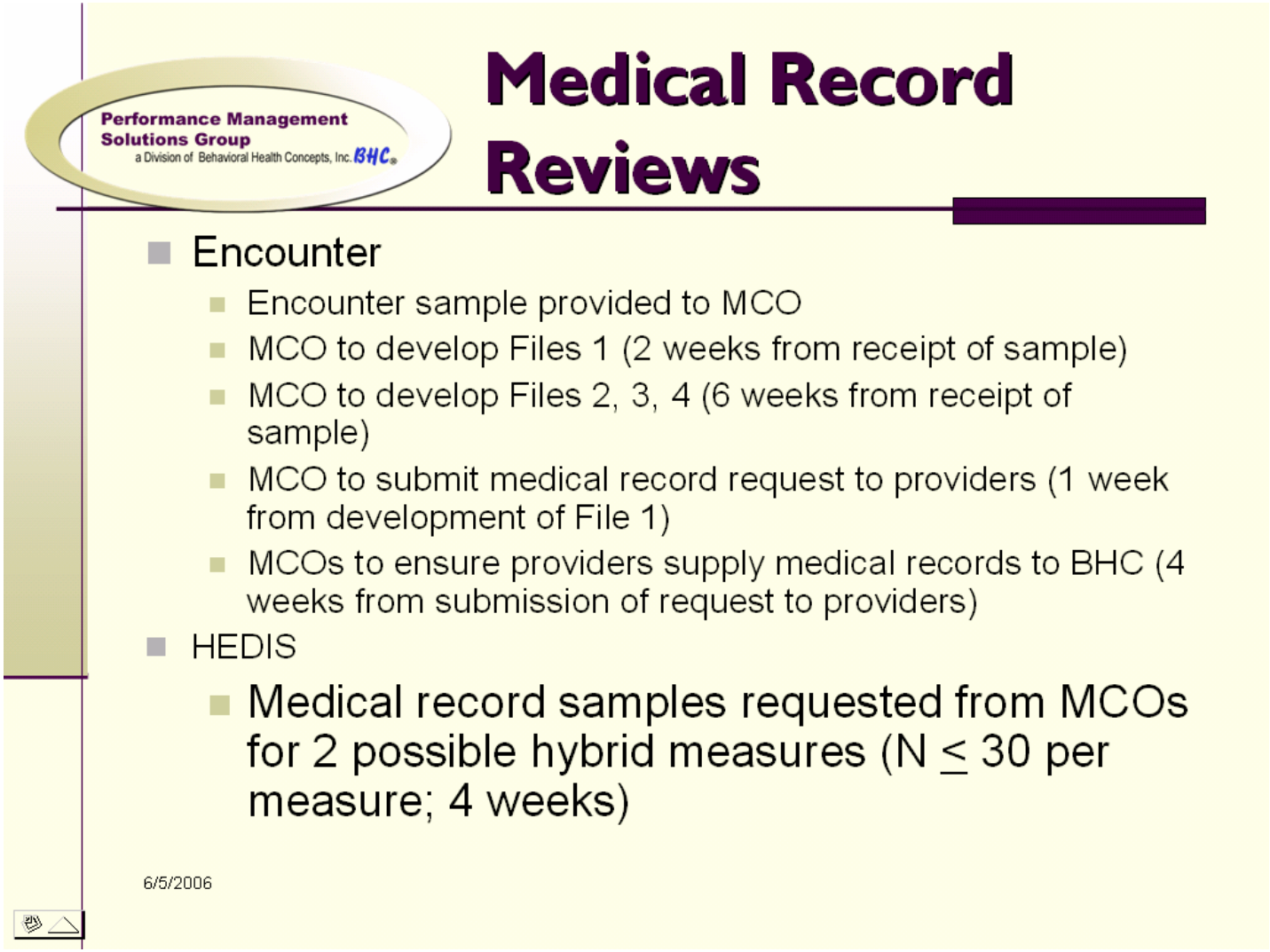
Analyses: 3

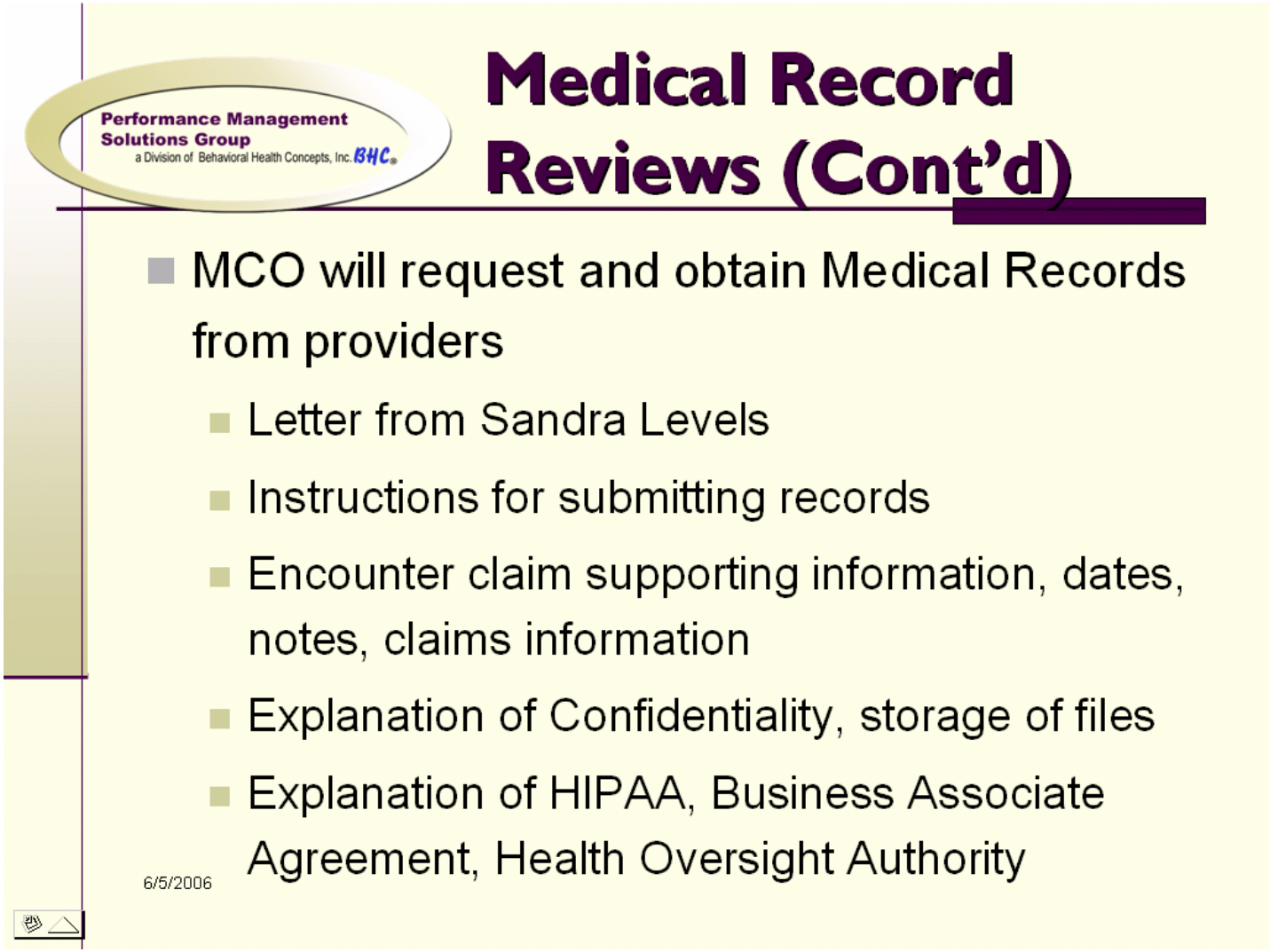
BHC will determine the rate(s) of matches, omissions and errors between the State encounter claims and MCO encounter claims for each MCO for the sample of selected cases.

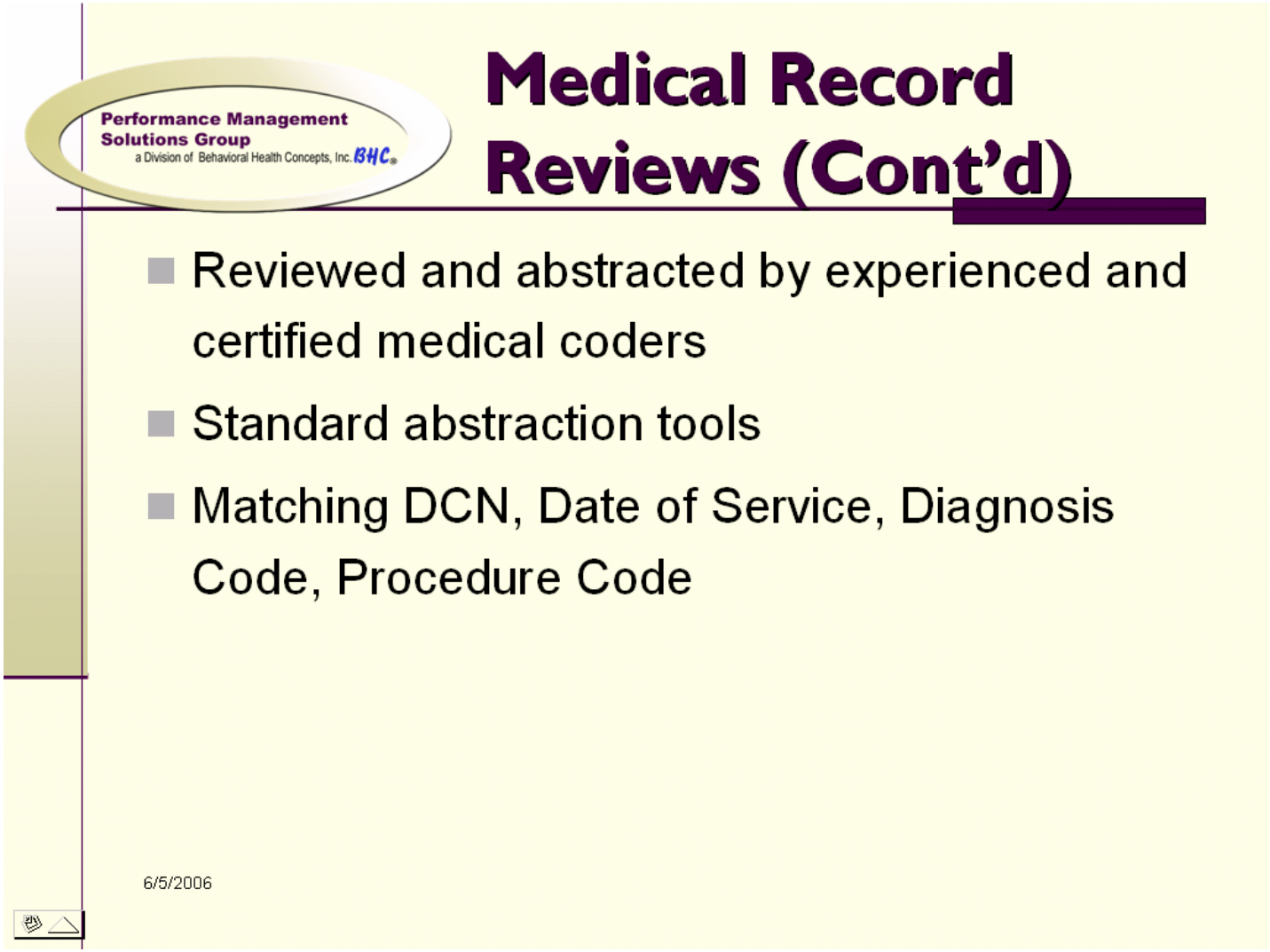


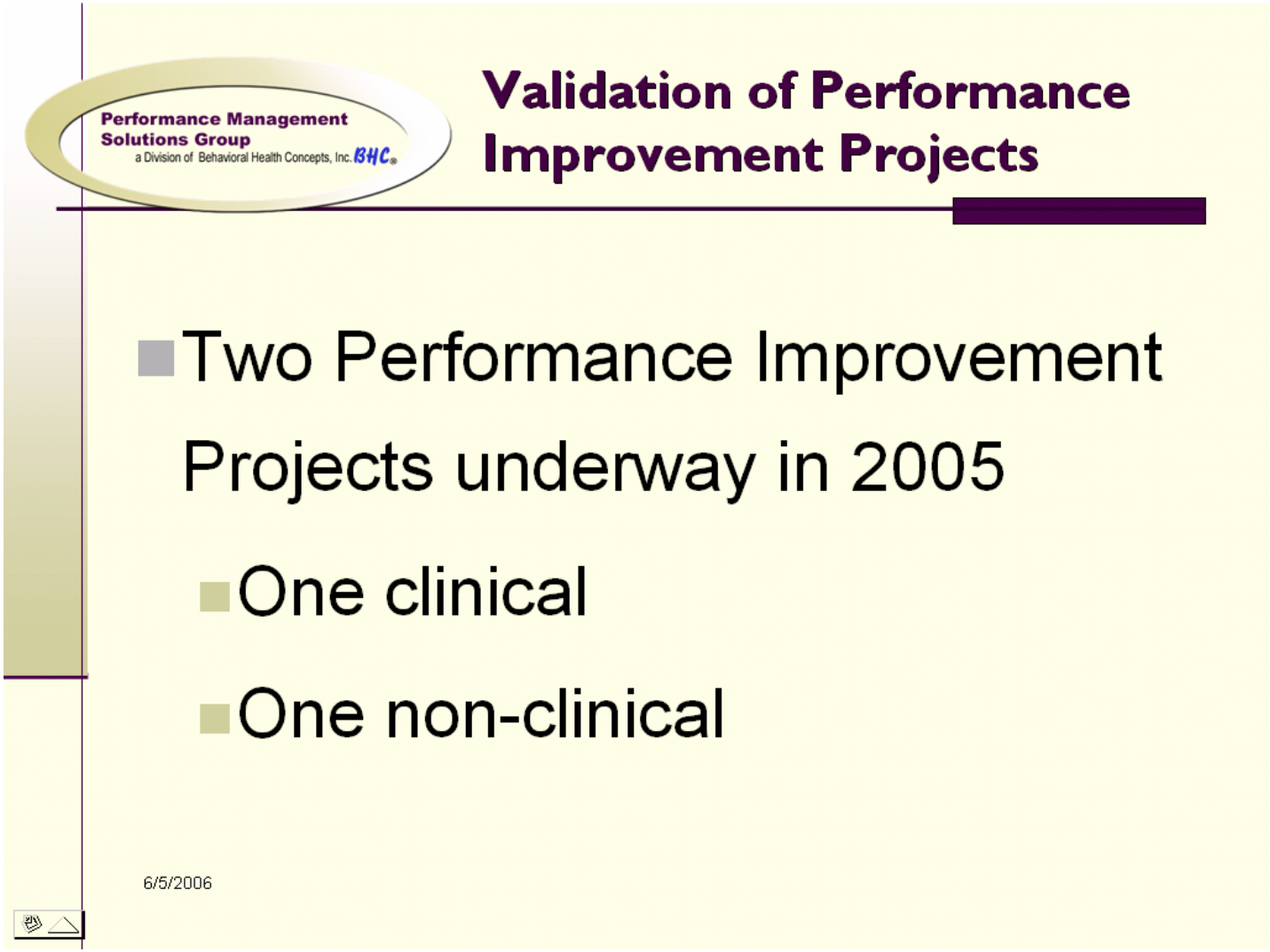
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Encounter Data
Validation Submission
File 1: Provider mailing address and contact information for sampled claims (service dates January 1, 2005 to March 31, 2005). This will be used for validation of the State medical encounter claims database against the medical record.
File 2: All inpatient encounters from January 1, 2005 to March 31, 2005 for selected MC+ members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from January 1, 2005 to March 31, 2005 for selected MC+ members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
File 4: All pharmacy encounters from January 1,2005 to March 31, 2005 for selected MC+ members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
NOTE: "unpaid claims" are those claims that the MCO denied for payment, unpaid claims do not include claims paid via a capitation plan.
6/5/2006


Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Medical Record Reviews
Encounter
Encounter sample provided to MCO
MCO to develop Files 1 (2 weeks from receipt of sample)
MCO to develop Files 2, 3, 4 (6 weeks from receipt of sample)
MCO to submit medical record request to providers (1 week from development of File 1)
MCOs to ensure providers supply medical records to BHC (4 weeks from submission of request to providers)
HEDIS
Medical record samples requested from MCOs for 2 possible hybrid measures (N ≤ 30 per measure; 4 weeks)
6/5/2006


Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Medical Record Reviews (Cont'd)
MCO will request and obtain Medical Records from providers
Letter from Sandra Levels
Instructions for submitting records
Encounter claim supporting information, dates, notes, claims information
Explanation of Confidentiality, storage of files
Explanation of HIPAA, Business Associate Agreement, Health Oversight Authority
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Medical Record Reviews (Cont'd)
Reviewed and abstracted by experienced and certified medical coders
Standard abstraction tools
Matching DCN, Date of Service, Diagnosis Code, Procedure Code
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Validation of Performance Improvement Projects
Two Performance Improvement Projects underway in 2005
One clinical
One non-clinical
6/5/2006

Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

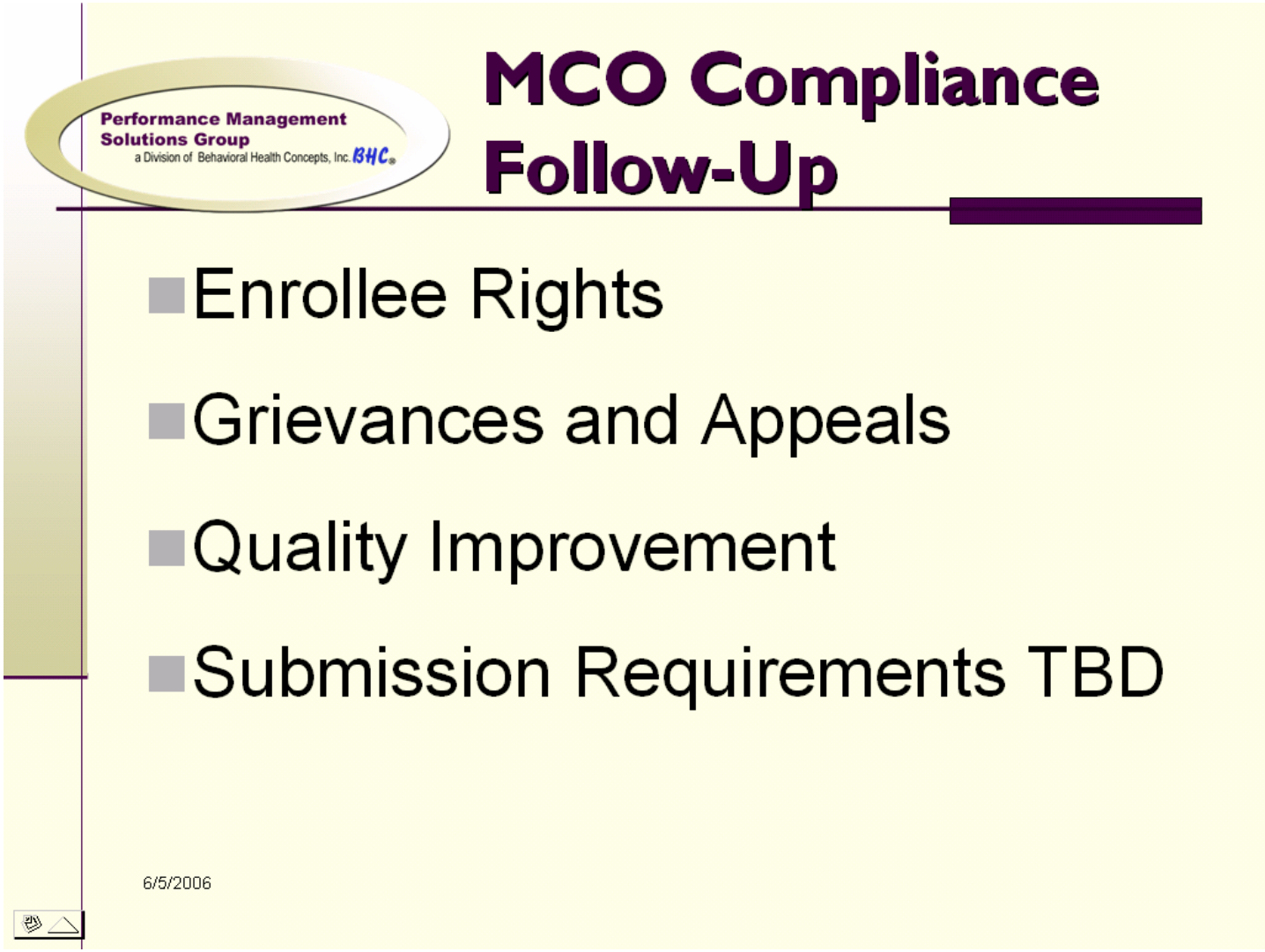
Validation of Performance Improvement Projects and Submission Requirements

PIP Checklist Elements

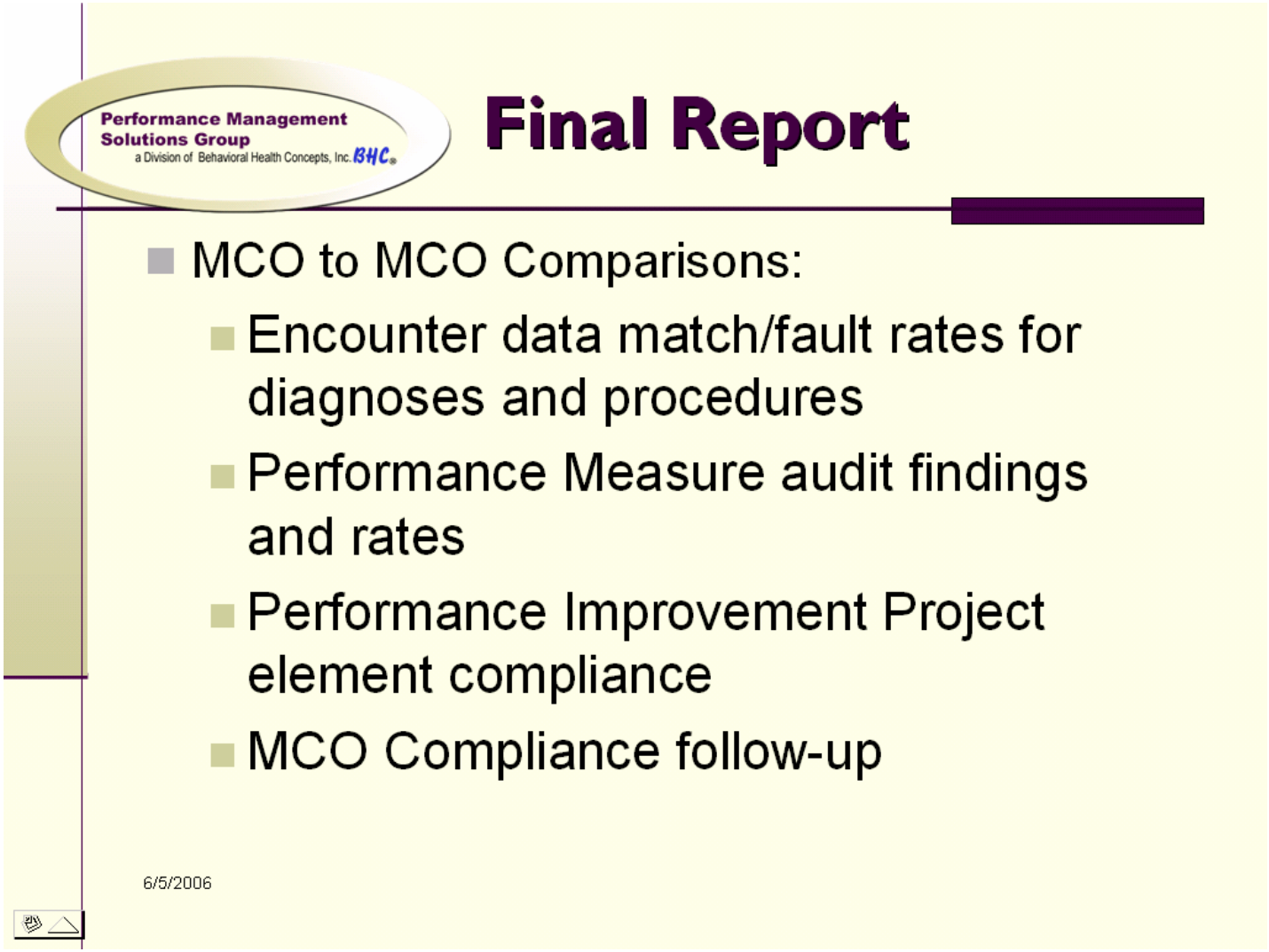
- Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocol, Validation of Performance Measures[1]
- Phase-in/timeframe for each phase of each PIP[1]
- Problem identification
- Hypotheses
- Evaluation Questions
- Description of intervention(s)
- Methods of sampling, measurement
- Planned analyses
- Sample tools, measures, surveys, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Raw data files (if applicable, on-site)
- Medical records or other original data sources (if applicable, on-site)
- Additional data as needed

[1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (2002) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS A protocol for use in Conducting Medicaid External Quality Review Activities: Final Protocol Version 1.0 May 1, 2002

6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
MCO Compliance Follow-Up
Enrollee Rights
Grievances and Appeals
Quality Improvement
Submission Requirements TBD
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Site Visits
Target for February, 2006
MCO Compliance Reviews follow-up
On-site activities
Information Systems Capability Assessments
Performance Measure Validation
Performance Improvement Project Validation
6/5/2006


Performance Management
Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Final Report
MCO to MCO Comparisons:
Encounter data match/fault rates for diagnoses and procedures
Performance Measure audit findings and rates
Performance Improvement Project element compliance
MCO Compliance follow-up
6/5/2006

Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

BHC Team and Coordination

Protocol/ Activity	BHC Contact Behavioral Health Concepts, Inc. 2716 Forum Blvd., Suite 4a Columbia, MO 65203 Tel. 573-446-0405 Fax 573-446-1816	MCO Contact
Performance Measures (HEDIS 2005)	Ms. Amy McCurry Project Director amccurry@pmsginfo.com	
Performance Improvement Projects	Ms. Mona Prater Assistant, Project Director mprater@pmsginfo.com Ms. Mariya Chumak Research Associate mchumak@bhcinfo.com	
Encounter Data	Mariya Chumak mchumak@bhcinfo.com	
MCO Compliance	Mona Prater mprater@pmsginfo.com	
Site Visits	Amy McCurry amccurry@pmsginfo.com Mona Prater mprater@pmsginfo.com	
Medical Records	Mariya Chumak mchumak@bhcinfo.com	

6/5/2006

APPENDIX 2
PIPS CHECKLIST/WORKSHEETS

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Appendix 2 – PIPs Checklist/Worksheets

Performance Improvement Project Validation Worksheet

Use this or similar worksheet as a guide when validating MCO/PIHP Performance Improvement Projects. Answer all questions for each activity. Refer to protocol for detailed information on each area.

ID of evaluator Mona Prater Date of evaluation _____

Demographic Information

MCO/PIHP Name or ID **Project Leader Name** **Telephone Number**

_____ _____ _____

Name of the Performance Improvement Project

_____

Dates of Study **Date Study Initiated**

_____ _____

Type of Delivery System (check all that apply)

☐ Staff Model ☐ Network ☐ Director IPA

☐ IPA Organization ☐ MCO ☐ PIHP

_____	Number of Medicaid Enrollees in MCO or PIHP*	_____	Number Medicare Enrollees in MCO or PIHP
_____	Number of Medicaid Enrollees in the Study	_____	Total Number of MCO or PIHP Enrollees in Study
_____	Number of Members in Study	_____	Population of Members in Sample Frame
_____	Number of MCO/PIHP primary care physicians	_____	Number of MCO/PIHP specialty physicians
_____	Population of physicians in sample frame	_____	Number of physicians in study

Note: DK = Don't Know; NA = Not Applicable

* Source: Missouri Medicaid Management Information System COLD Reports, State Session MPRI Screen, Revised June 25, 2004. Enrollment totals include enrollees with a future start date; 1115, 1915b, and Title XXI enrollees as of June 25, 2004.

Page 1 of 11

Activity 1: ASSESS THE STUDY METHODOLOGY

Step 1. Review the selected study topics(s)

1.1 The topic was selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Topic or problem statement: _____

Clinical

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☐ High volume services
☐ High risk coniditions

Nonclinical

☐ Process of accessing or delivering care

Comments

1.2 MCO's/PIHP's PIPs, over time, addressed a broad spectrum of key aspects of enrollee care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Project must be clearly focused on identifying and correcting deficiences in care or services rather than on utilization or cost alone.

Comments

1.3 MCO's/PIHP's PIPs over time, included all enrolled populations: i.e., did not exclude certain enrollees such as those with special health care needs.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population
_____ Age
_____ Gender
_____ Race
Payor
_____ MC+
_____ Commercial

Comments

Step 2: Review the study question(s)

2.1 Study question(s) stated clearly in writing. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Study question(s) as stated in narrative:

Comments

Step 3. Review selected study indicators(s)

3.1 The study used objective, clearly defined, measurable indicators. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Indicators (list):

Comments

3.2 The indicators measured changes in health status, functional status or enrollee satisfaction; or process of care with strong association with improved outcomes. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Long term outcomes implied or stated: ☐ Yes ☐ No

Health status: _____ Satisfaction (members): _____

Functional status: _____ Satisfaction (providers): _____

Comments

Step 4: Review the identified study population

4.1 MCO/PIHP clearly defined all Medicaid enrollees to whom the study questions and indicators are relevant.

☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population sampled: Age _____ Gender _____ Race _____ MC+ _____ Commercial _____

Did it include:

1115	☐ Yes	☐ No	☐ Unable to determine	☐ NA
1915b	☐ Yes	☐ No	☐ Unable to determine	☐ NA
Children in state custody	☐ Yes	☐ No	☐ Unable to determine	☐ NA
Consent Decree (Western)	☐ Yes	☐ No	☐ Unable to determine	☐ NA

Comments

4.2 If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?

☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Methods of identifying participants:
☐ utilization data ☐ referral
☐ self-identification ☐ other _____

Comments

Step 5: Review sampling methods

5.1 Sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of the error that will be acceptable.

☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Previous findings from:
☐ literature review ☐ baseline assessment of indices ☐ Other _____

Comments

5.2 The MCO/PIHP employed valid sampling techniques that protected against bias.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

The type of sampling used:

☐ Probability ☐ Nonprobability ☐ Random ☐ Simple ☐ Stratified
☐ Convenience ☐ Judgment ☐ Quota ☐ Cluster

Comments

5.3 Sample contained sufficient number of enrollees.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

_____ N of enrollees in sampling frame

_____ N of sample

_____ N of participants (i.e., return rate)

Comments

Step 6: Review data collection procedures

6.1 Study design clearly specified the data to be collected.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

6.2 The study design clearly specified the sources of data.

Met Partially met Not met
Not applicable Unable to determine

Source of data:

☐ Member ☐ Claims ☐ Provider ☐ Other _____

Comments

6.3 The study design specified a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.

Met Partially met Not met
Not applicable Unable to determine

Comments

6.4 The instruments for data collection provided for consistent, accurate data collection over the time periods studied.

Met Partially met Not met
Not applicable Unable to determine

Instrument(s) used:

☐ Survey ☐ Medical Record Abstraction Tool ☐ Other _____

Comments

6.5 The study design prospectively specified a data analysis plan.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

6.6 Qualified staff and personnel were used to collect the data.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Name _____ Title _____

Role(s) of Project Leader _____

Comments

Step 7: Assess improvement strategies

7.1 Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes undertaken.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Describe Intervention:

Comments

Step 8: Review data analysis and interpretation of study results

NA if study is not yet complete

8.1 An analysis of the findings was performed according to data analysis plan.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Not met if study is complete and no indication of a data analysis plan (see step 6.5)

Comments

8.2 The MCO/PIHP presented numerical PIP results and findings accurately and clearly.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

☐ Are tables and figures labeled? ☐ Labeled clearly, accurately?

Comments

8.3 The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurement, and factors that threaten internal and external validity.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Indicate time periods of measurements: _____

Indicate statistical analyses used: _____

Indicate statistical significance level or confidence level used: ☐ 99% ☐ 95% ☐ Unable to determine

Comments

8.4 Analysis of study data included an interpretation of the extent to which its PIP was successful and follow-up activities. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Limitations described: _____

Conclusions regarding the success of the interpretation: _____

Recommendations for follow-up _____

Comments

Step 9: Assess whether improvement is "real" improvement

Note: NA only if study period is not yet complete: otherwise "Unable to Determine" or "No"

9.1 The same methodology as the baseline measurement was used when measurement was repeated. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Same source of data	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same method of data collection	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same participants examined	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same tools used	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine

Comments

9.2 There was a documented, quantitative improvement in process or outcomes of care. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

☐ increased ☐ decreased

Statistical significance _____ Clinical significance _____

Comments

9.3 The reported improvements in performance have "face" validity: i.e., the improvement in performance appears to be the result of the planned quality improvement intervention.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Degree to which the intervention was the reason for change:

☐ No relevance ☐ Small ☐ Fair ☐ High

Comments

9.4 There is statistical evidence that any observed performance improvement is true improvement.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

☐ Weak ☐ Moderate ☐ Strong

Comments

Step 10: Assess sustained improvement

10.1 Sustained improvement was demonstrated through repeated measurements over comparable time periods.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND RECOMMENDATIONS

Conclusions

Recommendations

Check one:

- ☐ High confidence is reported
- ☐ Low confidence level is reported in MCO/PIHP PIP results
- ☐ Moderate confidence is reported MCO/PIHP PIP results
- ☐ Reported MCO/PIHP PIP results not credible
- ☐ Not Applicable, study not complete

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APPENDIX 3
PM & PIP REQUEST DOCUMENTS

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Appendix 3 – PM & PIP Request Documents

Performance Improvement Project Validation
General Instructions

Mail Binder To:
Attn: External Quality Review Submission
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4a
Columbia, MO 65203

Due Date: December 9, 2005

Please refer to Performance Improvement Project Validation Submission Requirements and the MCO Performance Improvement Project Summary.

2005 External Quality Review of the MC+ Managed Care Program

Performance Improvement Project Validation Submission Requirements

Instructions: The following listing includes relevant source data for the EQR process. Submit paper print outs or photocopied items in the supplied EQR 2005 binder using the associated tabs. Please refer to the enclosed MCO Performance Improvement Project Summary. Submit information for the two PIPs at your MCO to be validated by the EQRO. Place information in the binder behind the associated tab and complete the form below. You may also mark PIP sections if desired. Use separate tabs and summary sheets for each PIP.

If you have any questions about this request, contact Amy McCurry, EQRO Project Director, amccurry@pmsginfo.com.

Key	
Check submitted	Use this field to indicate whether you have submitted this information. If you are not submitting the particular information, please indicate "NA". You may have submitted the content by other means or as part of some other documentation. If so, indicate "submitted", and reference the document (see below).
Name of Source Document	Please write the name of the document you are submitting for the item. If you are submitting pages from a procedure manual, indicate so by writing "HEDIS submission manual, pages xx – xx."
MCO Comments	Use this space to write out any concerns you may have or any clarification that addresses any issues or concerns you may have regarding either the items requested or what you submitted in the response.
Reviewed By (BHC use)	This space will be for BHC staff use. The purpose will be for tracking what is received and what is not received. It will not indicate whether the documents actually address the specific issue.

Name of PIP

_____

Tab		✓ if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
1.	Cover letter with clarifying information (optional)				
2.	Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocol, Validating of Performance Improvement Projects[1]. We will be looking for the following information in the Performance Improvement Project descriptions. a. Phase-in/timeframe for each phase of each PIP b. Problem identification c. Hypotheses d. Evaluation Questions e. Description of intervention(s) f. Methods of sampling, measurement g. Planned analyses h. Sample tools, measures, surveys, etc. i. Baseline data source and data				

Note: BHC may request raw data files, medical records, or additional data.

Performance Measure Validation
General Instructions

Mail Binder To:
Attn: External Quality Review Submission
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4a
Columbia, MO 65203

Due Date: December 9, 2005

When applicable, submit one for each of the three measures:

- Childhood Immunization Status
- Well-Child Visits in the First 15 Months of Life
- Annual Dental Visits

Unless otherwise indicated, please send all documents in hard copy, using the enclosed binder and tabs. If an item is not applicable or not available, please indicate this in the tab.

General data submission instructions
Data file formats all need to be ASCII, and readable in a Microsoft Windows environment. Use an appropriate delimiter (e.g., @) for data that may contain commas or quotation marks. Insure that date fields either contain a null value or a valid date. Files will be accepted only in the specified layout. Make all submissions using compact disk (CD) formats. Data files submitted via e-mail will not be reviewed. Insure that files on the CD are accessible on a Microsoft Windows workstation prior to submitting.

There should be at least 2 files for each measure:

1. File 1. Enrollment Data;
2. File 2. Denominator and numerator file;
3. File 3. For Hybrid Method ONLY; Listing of cases selected for medical record review.

The file layouts to be used for each measure are presented on pages 4-6 of this document.

Annual Dental Visit

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MC+ Member to verify continuous enrollment and enrollment gaps.

Field Name	Content
MCO	MC+ Managed Care Organization name
MEASURE	ADV = Annual Dental Visits
DCN	The Missouri Medicaid recipient identification number
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth
ENROLL_FIRST	First date of enrollment
ENROLL_LAST	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Content
MCO	MC+ Managed Care Organization name
MEASURE	ADV = Annual Dental Visits
DCN	The Missouri Medicaid recipient identification number
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth
STRAT_GROUP	1=4 - 6-year-olds 2=7 - 10-year-olds 3=11 - 14-year-olds 4=15 - 18- year-olds 5=19-21-year-olds
SER_DATE	Date of service
SER_CD	Code used to identify Annual Dental Visit
TYPE_CD	Type of coding system: C=CPT Codes; I=ICD-9-CM Codes; H=HCPCS/CDT-3 Codes

Well-Child Visits in the First 15 Months of Life

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MC+ Member to verify continuous enrollment and enrollment gaps.

Field Name	Content
MCO	MC+ Managed Care Organization name
MEASURE	W15 = Well-Child Visit in the First 15 Months of Life
DCN	The Missouri Medicaid recipient identification number
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth
ENROLL_FIRST	First date of enrollment
ENROLL_LAST	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Content
MCO	MC+ Managed Care Organization name
Measure	W15 = Well-Child Visit in the First 15 Months of Life
DCN	The Missouri Medicaid recipient identification number.
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth
SER_DATE	Date of service
SER_CD	Code used to identify numerator event
TYPE_CD	Type of coding system: C=CPT Codes; I=ICD-9-CM Codes; M= MCO Internal Code*
DATA_SOURCE	For Hybrid Method ONLY Please specify source of data: A – Administrative; MR – Medical Record Review
HYBRID_EVNT	For Hybrid Method ONLY Hybrid numerator event (positive event "hit"): y=yes; n=no
ADMIN_EVNT	Administrative numerator event (positive case "hit"): y=yes; n=no
NUM_ID	Seven separate numerators are calculated for this measure. Please indicate if this case was counted toward: 0 = O visits numerator; 1 = 1 visit numerator; 2 = 2 visits numerator; 3 = 3 visits numerator; 4 = 4 visits numerator;5 = 5 visits numerator; 6 = 6 or more visits numerator.
Note: If MCO used internal codes, please provide codes used and their description in a separate file.	

File 3. For Hybrid method ONLY - please provide a listing of the cases selected for medical record review. Use the following layout:

Field Name	Content
MCO	MC+ Managed Care Organization name
MEASURE	CIS = Childhood Immunization Status
DCN	The Missouri Medicaid recipient identification number
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth
MR_STATUS	Medical record review status: R = reviewed;

	NR = not reviewed; S = substituted
PROVIDER_NAME	Primary Care Provider who supplied the record
PROVIDER_ID	Primary Care Provider identification number

Childhood Immunization Status

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MC+ Member to verify continuous enrollment and enrollment gaps.

Field Name	Content
MCO	MC+ Managed Care Organization name
MEASURE	CIS = Childhood Immunization Status
DCN	The Missouri Medicaid recipient identification number
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth
ENROLL_FIRST	First date of enrollment
ENROLL_LAST	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Content
MCO	MC+ Managed Care Organization name
MEASURE	CIS = Childhood Immunization Status
DCN	The Missouri Medicaid recipient identification number.
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth
SER_DATE	Date of service
SER_CD	Code used to identify numerator event
TYPE_CD	Type of coding system: C=CPT Codes; I=ICD-9-CM Codes.
DATA_SOURCE	For Hybrid Method ONLY Please specify source of data: A – Administrative; MR – Medical Record Review
HYBRID_EVNT	For Hybrid Method ONLY Hybrid numerator event (positive event "hit"): y=yes; n=no
ADMIN_EVNT	Administrative numerator event (positive case "hit"): y=yes; n=no
EXCLUD	Was the case excluded from denominator Y=Yes; N=No
EXCLUD_REASON	Reason for exclusion

File 3. For Hybrid method ONLY - please provide a listing of the cases selected for medical record review. Use the following layout:

Field Name	Content
MCO	MC+ Managed Care Organization name
MEASURE	CIS = Childhood Immunization Status
DCN	The Missouri Medicaid recipient identification number
MEMBR_FIRST	MC+ Member First Name
MEMBR_LAST	MC+ Member Last Name
DOB	MC+ Member date of birth

MR_STATUS	Medical record review status: R = reviewed; NR = not reviewed; S = substituted
PROVIDER_NAME	Primary Care Provider who supplied the record
PROVIDER_ID	Primary Care Provider identification number

Please see the Performance Measure Validation Submission Requirements and the Summary of Calculation Methods for Performance Measures.

2005 External Quality Review of the MC+ Managed Care Program

Performance Measure Validation Submission Requirements

Instructions: The following listing includes relevant source data for the EQR process. Submit paper print outs or photocopied items in the supplied EQR 2005 binder using the associated tabs. Within each tab, include information specific for each of the three measures for the MC+ population. Some items may not apply. For example, if you do not use a HEDIS vendor and perform measure calculations on site, then you may not have documentation on electronic record transmissions. These items apply to processes, personnel, procedures, databases and documentation relevant to how the MCO complies with HEDIS measure calculation, submission and reporting.

If you have any questions about this request, contact Amy McCurry, EQRO Project Director, amccurry@pmsginfo.com.

Key	
Check submitted	Use this field to indicate whether you have submitted this information. If you are not submitting the particular information, please indicate "NA". You may have submitted the content by other means either on the BAT or as part of some other documentation. If so, indicate "submitted", and reference the document (see below).
Name of Source Document	Please write the name of the document you are submitting for the item. If you are submitting pages from a procedure manual, indicate so by writing "HEDIS submission manual, pages xx – xx."
MCO Comments	Use this space to write out any concerns you may have or any clarification that addresses any issues or concerns you may have regarding either the items requested or what you submitted in the response.
Reviewed By (BHC use)	This space will be for BHC staff use. The purpose will be for tracking what is received and what is not received. It will not indicate whether the documents actually address the specific issue.

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
1.	HEDIS 2005 Data Submission Tool (MO DHSS 2005 Table B HEDIS Data Submission Tool) for all three measures for the MC+ Managed Care Population only. Do not include other measures or populations.				
2.	2005 HEDIS Audit Report. This is the HEDIS Performance Audit Report for the MC+ Managed Care Program product line and the three MC+ measures to be validated (complete report). If the three measures to be validated were not audited or if they were not audited for the MC+ Managed Care Program population, please send the report, as it contains Information Systems Capability Assessment information that can be used as part of the Protocol.				
3.	Baseline Assessment Tool (BAT) for HEDIS 2005. The information submitted for the BAT will include descriptions of the process for calculating measures for the MC+ Managed Care Program population.				
4.	List of cases for denominator with all HEDIS 2005 data elements specified in the measures.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
5.	List of cases for numerators with all HEDIS 2005 data elements specified in the measures, including fields for claims data and MOHSAIC, or other administrative data used. Please note that one of the review elements in the Protocol is: The "MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced."				
6.	List of cases for which medical records were reviewed, with all HEDIS 2005 data elements specified in the measures. Based on a random sample, BHC will request MCOs to gather a maximum of 30 records per measure and submit copies of the records requested to BHC.				
7.	Sample medical record tools used if hybrid method(s) were utilized for HEDIS 2005 Well-Child Visits or Childhood Immunization Status measures for the MC+ Managed Care Program population; and instructions for reviewers.				
8.	All worksheets, memos, minutes, documentation, policies and communications within the MCO and with HEDIS auditors regarding the calculation of the selected measures.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
9.	Policies, procedures, data and information used to produce numerators and denominators.				
10.	Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of: a. Statistical testing of results and any corrections or adjustments made after processing. b. Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology. c. Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance.				
11.	Policies and procedures for mapping non-standard codes.				
12.	Record and file formats and descriptions for entry, intermediate, and repository files.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
13.	Electronic transmission procedures documentation. (This will apply if the MCO sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry.)				
14.	Descriptive documentation for data entry, transfer, and manipulation of programs and processes.				
15.	Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.				
16.	Documentation of proper run controls and of staff review of report runs.				
17.	Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such corrections or adjustments.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
18.	Documentation of sources of any supporting external data or prior years' data used in reporting.				
19.	Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.				
20.	Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.				
21.	Procedures used to link member months to member age.				
22.	Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the MCO's/PIHP's process to re-draw a sample or obtain necessary replacements.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
23.	Procedures to capture data that may reside outside the MCO's/PIHP's data sets (e.g. MOHSAIC).				
24.	Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)				

Performance Measures to be Calculated for MC+ Members			
METHOD FOR CALCULATING HEDIS 2005 PERFORMANCE MEASURES			
Please complete this form and place in the HEDIS 2005 section of the binder supplied by BHC. Please direct any questions to Amy McCurry or Mariya Chumak.			
MCO			
Date Completed			
Contact Person			
Phone			
Fax			
NCQA Accredited for MC+ Product (Yes/No)			
Certified HEDIS Software Vendor and Software			
Record Abstraction Vendor			
Measure to be validated by EQRO	**Childhood Immunization Status**	**Well-Child Visits in the First 15 Months of Life**	**Annual Dental Visits**
What was the reporting Date for HEDIS 2005 Measures ?			
What was the Audit Designation (Report/No Report/Not Applicable) ?			
Was the measure publicly Reported (Yes/No) ?			
Did denominator include members who switched MCOs (Yes/No) ?			
Did denominator include members who switched product lines (Yes/No) ?			
Did the denominator include 1115 Waiver Members (Yes/No) ?			
Were proprietary or other codes (HCPC, NDC) used ?			
Administrative			
Were exclusions calculated (Yes/No) ?			
Hybrid			
On what date was the sample drawn ?			
Were exclusions calculated (Yes/No) ?			
How many medical records were requested ?			
How many medical records were received ?			

APPENDIX 4
PERFORMANCE MEASURES WORKSHEETS

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Appendix 4 – Performance Measures Worksheets

Final Performance Measure Validation Worksheet: HEDIS 2005 Well-Child Visits in the First 15 Months of Life

The percentage of enrolled members who turned 15 months during the measurement year, who received either zero, one, two ,three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	year.		
Enrollment	31 days - 15 months of age. Calculate the 15-month birthday as the child's first birthday plus 90 days.		
Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled on the day the child tuns 15 months old		
Benefit	Medical		
Event/diagnosis	None		
Sampling			
Sampling was unbiased.			
Sample treated all measures independently.			
Sample size and replacement methods met specifications.			
Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Documentation tools used were adequate.			
Integration of administrative and medical record data was adequate.			
The results of the medical record review validation substantiate the reported numerator.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.

Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: HEDIS 2005 Childhood Immunization Status

The percentage of enrolled children two years of age who had four DTaP/DT, Three IPV, one MMR, three H influenza type B, three hepatitis Ba nd one chicken pox vaccine (VAB) by the time period specified and by their second birthday. The measure aslo calculates two separate combination rates.

Element	Specifications	Rating	Comments
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	Children who turn two years of age during the measurement year.		
Enrollment	Twelve months prior to the child's second birthday.		
Gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a MC+ member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during the 12 months prior to the child's second birthday		
Anchor date	Enrolled on the child's second birthday		
Benefit	Medical.		
Event/diagnosis	None.		
Sampling			
Sampling was unbiased.			
Sample treated all measures independently.			
Sample size and replacement methods met specifications.			
Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.

Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: HEDIS 2005 Annual Dental Visit

The percentage of enrolled MC+ Managed Care Program Members who were 3 -21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	4 -21 years of age as of December 31, 2004. The measure is reported for each of the following age stratifications and as a combined rate: * 4 -6 year-olds * 7-10 year-olds * 11 - 14 year-olds * 15 - 18 year-olds * 19 - 21 year-olds		
Enrollment	Continuous during 2004		
Gap	No more than one gap in enrollment of up to 45 days during 2004. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled as of December 31, 2004		
Benefit	Medical		
Event/diagnosis	None		
Sampling - Not Applicable to this measure, calculated via Administrative calculation			
Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.

Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

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APPENDIX 5
ENCOUNTER DATA MINIMUM CRITERIA

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Appendix 5 – Encounter Data Minimum Criteria

Recommended Encounter Data Validation Criteria

Data Element	Expectation	Validity Criteria
Enrollee ID	Should be valid as found in the State's eligibility file.	100% valid
Principal Diagnosis	Well-coded lead-related diagnoses (or well-child visit)	> 90% non-missing and valid codes.
Date of Service	Dates should be evenly distributed across time	If looking at a full year of data 5-7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% non-zero <70% should be one if CTP code in range of 99200-99215, 99241-99291
Procedure Code	This is a critical element and should always be coded. Will be assessed only for presence of code except for lead-related codes which will be validated with medical records.	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.

Source: Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data:: Second Edition

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APPENDIX 6
ENCOUNTER DATA REQUEST LETTER

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Appendix 6 – Encounter Data Request Letter

Behavioral Health Concepts, Inc.
Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203
(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com

December 22, 2005

Re: 2005 External Quality Review Encounter Data Validation Protocol

Dear < >,

As discussed with MCO staff at the All-Plan meeting and during the 2005 EQR orientation meeting over teleconference, BHC is requesting the following information for Encounter Data Validation from each MCO:

1. File 1: Mailing address and contact information of provider associated with each Internal Control Number (ICN) for the sampled claims (service dates January 1, 2005 to March 31, 2005). BHC requires this information for tracking purposes. **Due date: January 6, 2006.**

2. File 2: All inpatient encounters from January 1, 2005 to March 31, 2005 for the selected recipients (MC+ members associated with each sampled claim).

3. File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from January 1, 2005 to March 31, 2005 for the selected recipients (MC+ members associated with each sampled claim).

4. File 4: All pharmacy encounters from January 1, 2005 to March 31, 2005 for the selected recipients (MC+ members associated with each sampled claim).

Due date for file 2, 3, and 4 is **February 10th 2006.**

Enclosed is a CD-ROM containing a file of the sample of encounters. This file contains claim ICNs (Internal Control Number) and patient identifying information. Please use this sample to request medical records from providers.

We recognize that it is a busy holiday season, and are allowing up to seven business days for preparation of the medical record requests. The requests must be submitted to providers by January 6th, 2006. This will allow the providers 4 weeks to gather records. Providers should supply records directly to BHC, Inc. by February 3, 2006. MC+ Managed Care Organizations

are extended an additional week to submit records you collect from providers. Records not received by February 10th, 2006 will be considered undocumented encounters. Please be advised that BHC and/or DMS do not provide reimbursement for the cost of photocopying or mailing records.

During the past three years BHC provided a status report to MCOs indicating the submission rate of records during the collection process. This practice is intended to facilitate a higher return rate. In order to provide this service, BHC must obtain requested provider information. Please return provider contact information to BHC, in the requested format, by **January 6th, 2006.**

To assist with the medical record request process, we have also enclosed medical records submission instructions, a letter from Sandra Levels, and information regarding federal and state requirements for adherence to HIPAA and the External Quality Review.

If you have any questions, please contact BHC's External Quality Review team at 573-446-0405.

We would like to take this opportunity to wish you very Happy Holidays!

Thank you,

Amy McCurry, Esq.
EQRO Project Director

Encl:

1. **Encounter Validation Submission Instructions**
2. **File layouts for submission of inpatient, outpatient and pharmacy data**
3. **Medical Records Submission Instruction**
4. **Letter from Sandra Levels**
5. **CD-ROM with sample of encounters for encounter data validation**
6.

CC:
Ms. Judy Muck, Assistant Deputy Director, MC+ Managed Care, Missouri Department of Social Services, Division of Medical Services
Wes Wadman

Encounter Data Validation Submission Instructions

Mail To:

Behavioral Health Concepts, Inc.
Attn: Mariya Chumak
2716 Forum Blvd., Suite 4a
Columbia, MO 65203

Label the package CONFIDENTIAL

Due Dates:

1. **Provider information file – January 6th, 2006;**
2. **Inpatient, Outpatient, Pharmacy encounter data – February 10th, 2006.**
3. **Provider must submit medical records to BHC, Inc. – February 3, 2005**
4. **MC+ MCOs are extended an additional week to submit medical records they collected from providers – February 10, 2006**

General data submission instructions

All data file formats must be ASCII, and readable in Microsoft Windows environment. Use an appropriate delimiter (e.g., @) for data that may contain commas or quotation marks. Insure that date fields either contain a null value or a valid date. Make all submissions using compact disk (CD) formats and mail it to BHC, Inc. No files will be accepted via e-mail. Insure that files on the CD are accessible on a Microsoft Windows workstation prior to submitting.

Specific data submission instructions

EncounterDataRequest.xls. file contains six worksheets.

1. The first worksheet, "Read Me", provides detailed instructions for responding to this data request.
2. The second worksheet contains a sample of claims selected for Encounter Data Validation for your Health Plan.

Please use the listing of ICNs in "Data to BHC" and generate a report that contains the following information for the sample:

PROVIDER FIRST NAME
PROVIDER LAST NAME
PROVIDER TITLE
PROVIDER ADDRESS 1
PROVIDER ADDRESS 2
PROVIDER CITY
PROVIDER STATE

PROVIDER ZIP CODE

Return the ENTIRE worksheet "Data to BHC" to BHC, Inc. by January 6th, 2006 with detailed provider information.

Please use this sample to request medical records from providers. The requests must be submitted to providers by January 6th, 2006. This will allow the providers 4 weeks to gather records. Providers should supply records directly to BHC, Inc. by February 3, 2006. MC+ Managed Care Organizations are extended an additional week to submit records you collect from providers. Records not received by February 10th, 2006 will be considered undocumented encounters.

3. The third worksheet, "Sample", contains a sample of DCN numbers selected to conduct comparison between State encounter claims and MCO encounter claims. Please provide all inpatient, outpatient, and pharmacy encounter claims for the selected DCNs for service dates from January 1, 2005 to March 31, 2005. This information must be received by February 10th, 2006.

Files will be accepted ONLY in layouts provided in worksheets 4, 5 and 6.

4. The worksheet "Inpatient" contains the file layout to be used for submission of inpatient encounter data.
5. The worksheet "Outpatient" contains the file layout to be used for submission of outpatient encounter data.
6. The worksheet "Pharmacy" contains the file layout to be used for submission of pharmacy encounter data.

Encounter Data Request File Layout

File layout for submission of inpatient claims.

Field Name	Content Description
ICLAIM_TYPE	Claim type: I = Inpatient
ICLAIM_STATUS	P=Paid U=Unpaid D=Denied
IICN	Health Plan Claim Internal Control Number
IPAID_AMT	This field indicates the amount of money paid to the hospital for the billed services.
IRECIP_ID	The Missouri Medicaid recipient identification number.
ILAST	Recipient last name
IFIRST	Recipient first name
IACCT_NUM	The recipient's account number used by the doctor's office.
IADMIT_TYPE	Admission Type The only valid values are: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information Not Available
IADM_DT	The date the recipient was admitted to the hospital. This date cannot exceed the current date.
IDSCH_DT	The date the recipient was discharged from the hospital. If the patient is still in the hospital, the latest date of service that applies to the claim.

IBILL_TYPE	Valid bill type codes are: Inpatient 11x 12x 18x Outpatient 13x 14x 71x (Rural Health) 81x (Hospice) 82x (Hospice) Home Health 30x 31x 32x 33x 34X 35x 36x 37x 38x 39x

ISTAT	The code that represents the condition under which the recipient was discharged. 01 Home 02 Hospital 03 Skilled Nursing Facility (SNF) 04 Intermediate Care Facility (ICF) 05 Institution (Inst) 06 Home Health Agency (HHA) 07 Left 08 Other 20 Death 30 Still A Patient 50 Discharge from Hospice to Home 51 Discharge from Hospice to Another Medical Facility 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
IPROV_NUM	The Health Plan's 9-digit provider number.
IPRIM_DX	The recipient's primary diagnosis. Decimal points are implied.
IDX_2	Second diagnosis. Decimal points are implied.
IDX_3	Third diagnosis. Decimal points are implied.
IDX_4	Fourth diagnosis. Decimal points are implied.
IDX_5	Fifth diagnosis. Decimal points are implied.
IKEY	A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill. 3 = No, patient does not have other insurance.
IFDT_SVC	The date that the billing period begins.

ILDT_SVC	The date that the billing period ends.
IREVENUE_CD	The three-digit code from 100 to 999 that represents the services that are billed on this particular line item. The combined total number of accommodation and ancillary services billed cannot exceed 28 lines per claim. Accommodation revenue codes range from 10X through 21X. Ancillary revenue codes range from 22X through 99X. NOTE: Emergency Room (rev 450 and 459) and Ambulance (rev 540 to 549) may only be billed as inpatient if the patient is admitted to the hospital.
IUNITS_SVC	The number of days per room rate for both covered and non-covered accommodations (revenue codes 100 through 239). Whole numbers only are accepted for the days.

File layout for submission of outpatient claims.

Field Name	Content Description
OCLAIM_TYPE	O=Outpatient M=Medical L=Dental H=Home Health
OCLAIM_STATUS	Claim Type: O, M, L, H P=Paid U=Unpaid D=Denied
OICN	Health Plan Claim Internal Control Number
OPAID_AMT	Claim Type O, M, L, H This field is informational only and reflects what FFS would pay.
ORECIP_ID	Claim Type: O, M, L, H The Missouri Medicaid recipient identification number.
OLAST	Claim Type: O, M, L, H Recipient last name
OFIRST	Claim Type: O, M, L, H Recipient first name
OACCT_NUM	Claim Type: O, M, L, H The recipient's account number used by the doctor's office. This field may be left blank or used for other purposes, such as the Health Plan Claim Internal Control Number.
OPROV_NUM	Claim Type: O, M, L, H The Health Plan's 9 digit provider number.
OPRIM_DX	Claim Type: O, M, L, H The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_2	Claim Type: O, M, L, H Second diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_3	Claim Type: O, M, L, H Third diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.

ODX_4	Claim Type: O, M, L, H Fourth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_5	Claim Type: O, M, L, H Fifth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
O_KEY	Claim Type: O, M, L, H A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
OFIRSTDT_SVC	Claim Type: O, M, L, H This is the first date the service was performed. This date cannot exceed the current date.
OLASTDT_SVC	Claim Type: O, M, L, H This is the last date the service was performed. This date cannot exceed the current date.

OPLACE_SVC	Claim Type: M, L C-14 PLACE OF SERVICE 03 School 04 Homeless Shelter 05 Indian Health Service Free-Standing Facility 06 Indian Health Service Provider-Based Facility 07 Tribal 638 Free-Standing Facility 08 Tribal 638 Provider-Based Facility 11 Office 12 Home 13 Assisted Living Facility 14 Group Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance - Land 42 Ambulance - Air or Water 49 Independent Clinic 50 Federally Qualified Health Center (FQHC) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility - Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residence Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Facility 57 Non-Residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 97 Parochial/Private Schools 98 Schools 99 Other Unlisted Facility Claim Type: O, H Not applicable
OUTPAT_UNITS_SVC	Claim Type: O, M, L, H The number of units of services performed. Whole numbers only.

ODTL_PROC	Claim Type: M, L, H The procedure code that represents the service preformed. Claim Type: O For outpatient claims, a procedure code is required only when the revenue code range for outpatient services is 300 through 319. This revenue code range represents laboratory services. The appropriate CPT procedure code range for laboratory services is 80048 through 89399. All other outpatient services must be designated by revenue code.
ODTL_PROC_MOD_P	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL_PROC_MOD_I	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL_DIAG_CODE	Claim Type: O, M, L, H The diagnosis code of the recipient's diagnosis. Decimal points are implied.
OREVENUE_CD	Claim Type: O The three digit code from 100 to 999 which represents the services that are billed on this particular line item. A revenue code is required on all Outpatient claims. For those revenue codes representing lab services (300-319), a procedure code must also be submitted. Claim Type: M, L, H Not applicable

File layout for submission of Pharmacy Claims.

Field Name	Content Description
PH_TRANSACTION_CD	This field shows the number of claims being billed on the record. Valid values are: 01 - 1 Claim 02 - 2 Claims 03 - 3 Claims 04 - 4 Claims (maximum)
PHCLAIM_STATUS	P=Paid U=Unpaid D=Denied
PHICN	Health Plan Claim Internal Control Number
PH_PROV_NUM	The Health Plan's 9-digit provider number
PH_NABP_NUM	This field will always contain the 7-digit National Association of Boards of Pharmacy (NABP) identification number assigned to the pharmacy. The NABP number must be in the first 7 positions of the 9-digit field (left justified).
PHRECIP_ID	The Missouri Medicaid recipient identification number.
PHKEY	A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
PH_FIRST_DT_SVC	The dispense date.
PH_LAST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_FIRST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_PRESCRIP_NUM	The prescription number of the prescription filled or refilled.
PHREFILL_IND	The only valid values are: Original - 00 (zero) Refill - 01-99
PHDRUG_QTY	The metric or non-metric quantity of the drug being dispensed. For example: A quantity of 100 would be 0100.
PHDAYS_SUPPLY	The estimated number of days the dispensed amount represents. A days supply greater than 365 is invalid.

PHCOMPOUND_IND	An indicator identifying the prescription as a non-compound or as an ingredient of a compound prescription. A value of '0' or '1' is used to indicate non-compound prescriptions or the FIRST ingredient of a compound prescription. A value of '2' is used to indicate any additional ingredients of a compound prescription.
PHARM_DRUG_NDC_CODE	The National Drug Code designated for the drug dispensed. The field is 5-4-2 format no hyphens or spaces
PHPROV_NUM	The Medicaid, DEA number, or name of the prescribing physician. If not available, enter the dispensing pharmacy NABP number unless you are a pharmacy having FQHC status.
PHEPSDT_IND	A code indicating whether or not a drug was dispensed to a recipient under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program. Y = yes

Medical Record Submission Instructions

As discussed with MCO staff in the 2005 EQR orientation meeting over teleconference, this year MCOs will be requesting medical record for encounter data validation. The CD submitted with this request contains a Microsoft Excel file with 100 sample encounters. Please match each encounter with a provider that substantiates a claim and request them to supply medical records to BHC, Inc. We are interested in all services provided to these patients by the designated provider from January 1, 2005 through March 31, 2005. This information is used to document the volume and type of services provided to MC+ Managed Care Program Members and to validate the accuracy and completeness of the State encounter claims database.

For each medical record please request the following:

- Face/Demographic sheet or other documentation that identifies the patient receiving services and primary care provider, January 1, 2005 through March 31, 2005. This information includes:
    - Patient Name
    - Medicaid ID Number
    - Date of Birth
    - Provider Name
    - Provider Number
- Documentation of all services (professional, physician's/doctor's orders, laboratory test results) from January 1, 2005 through March 31, 2005. Sources for this information may include:
    - Primary Diagnosis
    - Progress Notes
    - Laboratory findings
    - Treatment Plans
    - Claim Forms or Superbills
    - Flow Sheets

Behavioral Health Claims:
Due to the sensitive nature of these records, please instruct your providers to submit only the primary diagnosis code, claim information, and minimum necessary information to support the diagnosis and procedure codes for which services were billed during the specified time frame (January 1, 2005 – March 31, 2005). Providers must not send raw test data, protocols, or shadow charts. Additionally, recommend your behavioral health providers to de-identify names of individuals related to the patient in progress notes.

Providers should include any and all information to support the procedures for which a claim was submitted.

Records not received by the due date will be considered undocumented encounters

Please note that providers should submit records directly to BHC by February 3, 2005

Please note that BHC will not reimburse providers or copy services for copy and postage costs. Please encourage providers not to submit invoices.

In the interest of confidentiality, please DO NOT FAX or E-MAIL any forms or portions of medical records.

Records should be mailed to:

Attn: Mariya Chumak
Behavioral Health Concepts, Inc.
2716 Forum Blvd. Ste. 4A
Columbia, MO 65203

Please label the package "CONFIDENTIAL"

APPENDIX 7
MEDICAL RECORD REQUEST LETTER
TABLE OF CONTENTS: MED. REC. TRAINING MANUAL
ABSTRACTION TOOLS

(This page intentionally left blank.)

Appendix 7 – Medical Record Request Letter
Table of Contents for Med. Rec. Training Manual
Abstraction Tools

Behavioral Health Concepts, Inc.
Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203
(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com

January 6, 2005

Subject: 2005 External Quality Review Performance Measure Validation Protocol Medical Records Request (hybrid methodology only).

Due Date: February 10, 2006

Dear < >,

We have reviewed < > for the HEDIS 2005 Childhood Immunization Measure and Well-Child Visits in the First 15 Months of Life Measure.

Please find enclosed a CD-ROM containing a file with a listing of cases selected for medical record review. We are requesting copies of medical records for the sampled cases that contributed to the numerator. Please forward copies of the medical records to Behavioral Health Concepts, Inc. (BHC) at the address listed above, and mark the package as confidential.

If you have any questions, please contact BHC's EQRO team at (573) 446-0405 or via e-mail: eqro@bhcinfo.com

Thank you,

Amy McCurry
EQRO Project Director

Encl.:
1) CD with a sample of cases for medical record review

cc: Ms. Judy Muck, Assistant Deputy Director, MC+ Managed Care, Missouri Department of Social Services, Division of Medical Services

Table of Contents

Well-Child (WI5) Abstraction Tool

Patient Name												
	Last											
	First											
	m	m	d	d	y	y	y	y				
Date of Birth												
Missing = 99999999												
Provider Name												
	Last											
	First											

Name of MCO (Check only one)

- ❑ Community Care Plus (1)
- ❑ Mercy Health Plan (2)
- ❑ HealthCare USA (3)
- ❑ Missouri Care (4)
- ❑ Family Health Partners (5)
- ❑ FirstGuard (6)
- ❑ Blue Advantage Plus (7)

Abstractor Initials						
	m	m	d	d	y	y
Date of abstraction						
Data entry operator initials						
	h	h	m	m		
Start Time		:				

Search the medical record for a well care visit during the calendar year

Source of Documentation:
- ❑ Medical Record (1)
- ❑ Claim Form (2)
- ❑ Both (3)
- ❑ None (0)

Documented Components of Well Care Visit:
(Check all that apply)

Health and Developmental History
- ❑ Yes (1)
- ❑ No (0)

Physical Exam
- ❑ Yes (1)
- ❑ No (0)

Anticipatory Guidance
- ❑ Yes (1)
- ❑ No (0)

Date of Well Care Visit 1
Unless ALL components above are checked, code Missing = 99999999

m	m	d	d	y	y	y	y

Procedure Code 1

Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

See list to the right of Procedure Codes. Does procedure code match one of these?

Procedure Code Match 1
- ❑ Yes (1)
- ❑ No (0)

Diagnosis Code 1
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.

Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

Diagnosis Code Match 1
- ❑ Yes (1)
- ❑ No (0)

Acceptable Procedure Codes:

99381 99382 99391 99392 99432

Acceptable Diagnosis Codes:

V20.2	V70.5	V70.9
V70.0	V70.6	
V70.3	V70.8	

Notes:

Date of Well Care Visit 2	m	m	d	d	y	y	y	y	
Unless ALL components above are checked, code Missing = 99999999									
									Acceptable Procedure Codes:
Procedure Code 2									99381 99382 99391 99392 99432
Missing = 99999									
Insufficient Information = 22222									
Don't Know = 88888									
See list to the right of Procedure Codes. Does procedure code match one of these?									Acceptable Diagnosis Codes:
Procedure Code Match 2	❑ Yes (1)								V20.2 V70.5 V70.9
	❑ No (0)								V70.0 V70.6
									V70.3 V70.8
Diagnosis Code 2									**Notes:**
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.									
Missing = 99999									
Insufficient Information = 22222									
Don't Know = 88888									
Diagnosis Code Match 2	❑ Yes (1)								
	❑ No (0)								

Date of Well Care Visit 3	m	m	d	d	y	y	y	y	
Unless ALL components above are checked, code Missing = 99999999									
									Acceptable Procedure Codes:
Procedure Code 3									99381 99382 99391 99392 99432
Missing = 99999									
Insufficient Information = 22222									
Don't Know = 88888									
See list to the right of Procedure Codes. Does procedure code match one of these?									Acceptable Diagnosis Codes:
Procedure Code Match 3	❑ Yes (1)								V20.2 V70.5 V70.9
	❑ No (0)								V70.0 V70.6
									V70.3 V70.8
Diagnosis Code 3									**Notes:**
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.									
Missing = 99999									
Insufficient Information = 22222									
Don't Know = 88888									
Diagnosis Code Match 3	❑ Yes (1)								
	❑ No (0)								
Date of Well Care Visit 4	m	m	d	d	y	y	y	y	
Unless ALL components above are checked, code Missing = 99999999									
									Acceptable Procedure Codes:
Procedure Code 4									99381 99382 99391 99392 99432
Missing = 99999									
Insufficient Information = 22222									
Don't Know = 88888									
See list to the right of Procedure Codes. Does procedure code match one of these?									Acceptable Diagnosis Codes:
Procedure Code Match 4	❑ Yes (1)								V20.2 V70.5 V70.9
	❑ No (0)								V70.0 V70.6
									V70.3 V70.8
Diagnosis Code 4									**Notes:**
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.									
Missing = 99999									
Insufficient Information = 22222									
Don't Know = 88888									
Diagnosis Code Match 4	❑ Yes (1)								
	❑ No (0)								

Date of Well Care Visit 5
Unless ALL components above are checked, code Missing = 99999999

m m d d y y y y

Procedure Code 5

Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

Acceptable Procedure Codes:

99381 99382 99391 99392 99432

See list to the right of Procedure Codes. Does procedure code match one of these?

Procedure Code Match 5

❑ Yes (1)
❑ No (0)

Acceptable Diagnosis Codes:

V20.2 V70.5 V70.9
V70.0 V70.6
V70.3 V70.8

Diagnosis Code 5
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.
Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

Notes:

Diagnosis Code Match 5

❑ Yes (1)
❑ No (0)

Date of Well Care Visit 6
Unless ALL components above are checked, code Missing = 99999999

m m d d y y y y

Procedure Code 6

Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

Acceptable Procedure Codes:

99381 99382 99391 99392 99432

See list to the right of Procedure Codes. Does procedure code match one of these?

Procedure Code Match 6

❑ Yes (1)
❑ No (0)

Acceptable Diagnosis Codes:

V20.2 V70.5 V70.9
V70.0 V70.6
V70.3 V70.8

Diagnosis Code 6
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.
Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

Notes:

Diagnosis Code Match 6

❑ Yes (1)
❑ No (0)

h h m m

End Time h h : m m

Childhood Immunization Abstraction Tool

Patient Name
Last
First

Date of Birth:
Missing = 99999999
m m d d y y y y

Provider Name
Last
First

Name of MCO
(Check only one)

- ❑ Community Care Plus (1)
- ❑ Mercy Health Plan (2)
- ❑ HealthCare USA (3)
- ❑ Missouri Care (4)
- ❑ Family Health Partners (5)
- ❑ FirstGuard (6)
- ❑ Blue Advantage Plus (7)

Abstractor Initials

Date of abstraction
m m d d y y y y

Data entry operator initials

Start Time
h h : m m

Search the medical record for the complete immunization history

MMR

Source of Documentation:	❑	Medical Record (1)
Check One	❑	Claim Form (2)
	❑	Both (3)
	❑	None (0)
Type of Documentation	❑	Dated Immunization History (1)
Check One	❑	Immunization Certificate (2)
	❑	Both (3)
	❑	None (0)
Is There Evidence of a History of:		
Measles	❑	Yes (1)
	❑	No (0)
Mumps	❑	Yes (1)
	❑	No (0)
Rubella	❑	Yes (1)
	❑	No (0)

	m	m	d	d	y	y	y	y
Measles Seropositive Test Date								
Missing = 99999999								
Not Applicable = 88888888								
Mumps Seropositive Test Date								
Missing = 99999999								
Not Applicable = 88888888								
Rubella Seropositive Test Date								
Missing = 99999999								
Not Applicable = 88888888								
MMR Date 1								
Missing = 99999999								
Not Applicable = 88888888								
First Birthday								
42 days old								
Second Birthday								

Was one of the MMRs completed after the member's first birthday and before the member's second birthday?	❑ Yes (1) ❑ No (0)

Hep B

Source of Documentation:	❑ Medical Record (1)
(Check all that apply)	❑ Claim Form (2)
Type of Documentation:	❑ Dated Immunization History (1)
(Check only one)	❑ Immunization Certificate (2)

Is there documented evidence of a history of Hep B? ❑ Yes (1) ❑ No (0)

	m	m	d	d	y	y	y	y
Hep B Seropositive Test Result Date								
Missing = 99999999								
Not Applicable = 88888888								
Hep B Date 1								
Missing = 99999999								
Not Applicable = 88888888								
At delivery/birth = 11111111								
Hep B Date 2								
Missing = 99999999								
Not Applicable = 88888888								
Hep B Date 3								
Missing = 99999999								
Not Applicable = 88888888								

Was a Hep B completed between 6 months of age and the member's first birthday? ❑ Yes (1) ❑ No (0)

Notes:

DTa/DT

Source of Documentation:	❑	Medical Record (1)
Check One	❑	Claim Form (2)
	❑	Both (3)
	❑	None (0)
Type of Documentation	❑	Dated Immunization History (1)
Check One	❑	Immunization Certificate (2)
	❑	Both (3)
	❑	None (0)
Is There Documented Evidence of a History of:		
Diptheria	❑	Yes (1)
	❑	No (0)
Tetanus	❑	Yes (1)
	❑	No (0)

	m	m	d	d	y	y	y	y
DTaP/DT Date 1								
Missing = 99999999								
Not Applicable = 88888888								
DTaP/DT Date 2								
Missing = 99999999								
Not Applicable = 88888888								
DTaP/DT Date 3								
Missing = 99999999								
Not Applicable = 88888888								

Notes:

OPV/IPV

Source of Documentation:
Check One

- ❑ Medical Record (1)
- ❑ Claim Form (2)
- ❑ Both (3)
- ❑ None (0)

Type of Documentation
Check One

- ❑ Dated Immunization History (1)
- ❑ Immunization Certificate (2)
- ❑ Both (3)
- ❑ None (0)

Is There Documented Evidence of a History of:

OPV seropositive Test date
- ❑ Yes (1)
- ❑ No (0)

IPV seropositive Test date
- ❑ Yes (1)
- ❑ No (0)

\

OPV/IPV Date 1
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

OPV/IPV Date 2
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

OPV/IPV Date 3
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

Notes:

HiB

Source of Documentation:
Check One

- ❑ Medical Record (1)
- ❑ Claim Form (2)
- ❑ Both (3)
- ❑ None (0)

Type of Documentation
Check One

- ❑ Dated Immunization History (1)
- ❑ Immunization Certificate (2)
- ❑ Both (3)
- ❑ None (0)

HiB Date 1
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

HiB Date 2
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

HiB Date 3
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

HiB Date 4
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

Notes:

VZV

Source of Documentation:
Check One

- ❑ Medical Record (1)
- ❑ Claim Form (2)
- ❑ Both (3)
- ❑ None (0)

Type of Documentation
Check One

- ❑ Dated Immunization History (1)
- ❑ Immunization Certificate (2)
- ❑ Both (3)
- ❑ None (0)

Is There Documented Evidence of a History of Chicken Pox?

- ❑ Yes (1)
- ❑ No (0)

Date of positive Chicken Pox?
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

VZV Date 1
Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

End Time

h	h	m	m
	:		

Medical Record Abstraction Tool

ICN	Primary Key	
Patient Name	OUTPAT_RECIP_LAST_NAME	OUTPAT_RECIP_FIRST_NAME
Date of Birth	OUTPAT_RECIP_BIRTHDATE	
Patient DCN	OUTPAT_PROCESSED_RECIP_ID	
Provider Name	FIELD	
Clinic Name	FIELD	
Clinic Address		
First Date of Service	FIELD	

Abstractor Initials [ ]

Date of abstraction [m][m][d][d][y][y][y][y]

Data entry operator initials [ ]

Start Time [h][h] : [m][m]

Examine only the information provided in physician and professional documentation. **DO NOT** use the CMS-1500, any claim forms, or any claim histories.

Medical Record											
Element	**Comparison**									**Match**	**Error Type**
Date of Service	**OUTPAT_FIRST_DT_SVC** m	m	d	d	y	y	y	y		0 = No 1 = Yes	Code only 1, 8, 9, or 0
Missing = 99999999											
Comment (Required if Error Type = Other)											
Primary Diagnosis	**OUTPAT_DX_1**									0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.											
Missing = 99999											
Comment (Required if Error Type = Other)											
Primary Diagnosis Description	**DX_DESCRIPTION**									0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Add description from medical record; Required if Error Type = Other)											

Patient Name OUTPAT_RECIP_LAST_NAME OUTPAT_RECIP_FIRST_NAME
Date of Birth OUTPAT_RECIP_BIRTHDATE
Patient DCN OUTPAT_PROCESSED_RECIP_ID

Element	**Code**
Procedure Code	**To be coded by reviewer**
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.	
Not Enough Information = 22222	
Comment (Required if Error Type = Other)	
Procedure Description	**To be coded by reviewer**
Comment (Add description from medical record; Required if Error Type = Other)	

Referrals Documented in the Medical Record (check all that apply; only if not related to the claim validated)

- ❑ None (0)
- ❑ Laboratory (1)
- ❑ Pharmacy (2)
- ❑ Specialist (3)
- ❑ Radiology (4)
- ❑ Other (5)

List _____

See next page for the procedure code and procedure code description to be validated.
Does the medical record documentation adequately support the procedure code and description?

- ❑ Yes (1)
- ❑ No (0)

If no, Reason (check only one):

- ❑ Not enough information (e.g., the date of service and information are present, but there is not enough information to make a determination) (1)
- ❑ Upcoded (2)
- ❑ Incorrect (3)
- ❑ Missing (9)
- ❑ Other (4) _____

Comment

Patient Name	OUTPAT_RECIP_LAST_NAME	OUTPAT_RECIP_FIRST_NAME
Date of Birth	OUTPAT_RECIP_BIRTHDATE	
Patient DCN	OUTPAT_PROCESSED_RECIP_ID	

Examine the CMS-1500 or any claim forms. If there is no claim form or history, code as missing.

Claim Form or History											
Element	**Comparison**								**Match**	**Error Type**
Date of Service	**OUTPAT_FIRST_DT_SVC**								0 = No 1 = Yes	Code only 1, 8, 9, or 0
	m	m	d	d	y	y	y	y		
Missing = 99999999										
Comment (Required if Error Type = Other)										
Primary Diagnosis	**OUTPAT_DX_1**								0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.										
Missing = 99999										
Comment (Required if Error Type = Other)										
Primary Diagnosis Description	**DX_DESCRIPTION**								0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Required if Error Type = Other)										
Procedure Code	**OUTPAT_DTL_PROC**								0 = No 1 = Yes	Code only 1,3,8, or 9
Comment (Required if Error Type = Other)										
Procedure Description	**OUPT_DESCR**								0 = No 1 = Yes	Code only 3,8, or 9
Comment (Required if Error Type = Other)										

	h	h	m	m
End Time		:		

APPENDIX 8
AGENDA FOR SITE VISITS

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Appendix 8 – Agenda for Site Visits

Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

Together we can chart the course, measure accomplishments, and quantify the outcomes.

February 21, 2006

RE: SITE VISIT AGENDA AND DOCUMENT REVIEW

We are finalizing plans for the on-site reviews of each MCO. We are providing the following information in an effort to make preparation for the on-site review as efficient as possible for you and your staff. The following is information or persons needed at the time of the on-site review at (MCO name).

Performance Improvement Projects

Time is scheduled in the afternoon to conduct follow-up questions, review databases, and provide verbal feedback to the MCO regarding the planning, implementation, and credibility of findings from the Performance Improvement Projects (PIPs). Any staff responsible for planning, conducting, and interpreting the finings of PIPs should be present during this time. The review will be limited to the projects and findings submitted at the end of 2005. Please be prepared to review databases and any data collection forms not originally submitted.

Performance Measure Validation

As you know, BHC is in the process of validating the following three performance measures:

- HEDIS 2005 Annual Dental Visits
- HEDIS 2005 Childhood Immunization Status, Combination #2
- HEDIS 2005 Well-Child Visits in the First Fifteen Months of Life

BHC is following the CMS protocol for validating performance measures. The goals for this process are to:

- Evaluate the accuracy of Medicaid performance measure reported by the MCO; and
- Determine the extent to which Medicaid-specific performance measures calculated by the MCO followed specifications established by the Division of Medical Services. These specifications consist of the HEDIS 2005 Technical Specifications.

To complete this process we will review the following documents while on-site:

- **Data Integration and Processes Used to Calculate and Report Performance Measures**

1. Documentation of the performance measure generating process
2. Report production logs and run controls
3. Documentation of computer queries, programming logic, or source code (if available) used to create denominators, numerators and interim data files - for each of the three measures
4. Code mapping documentation
5. Documentation of results of statistical tests and any corrections with justification for such changes, if applicable - for each of the three measures
6. Documentation showing confidence intervals of calculations when sampling methodology used – for each of the three measures
7. Description of the software specifications or programming languages instructions used to query each database to identify the denominator, and/or software manual
8. Source code for identifying the eligible population and continuous enrollment calculation – for each of the three measures
9. Description of the software specification or programming languages used to identify the numerator
10. Programming logic and/or source code for arithmetic calculation of each measure to ensure adequate matching and linkage among different types of data

- **Sampling Validation**

1. Description of software used to execute sampling sort of population files
2. Source code for how samples for hybrid measures were calculated
3. Policies to maintain files from which the samples are drawn in order to keep population intact in the event that a sample must be re-drawn or replacements made
4. Documentation that the computer source code or logic matches the specifications set forth for each performance measure, including sample size and exclusion methodology
5. Documentation of "frozen" or archived files from which the samples were drawn
6. Documentation assuring that sampling methodology treats all measures independently, and there is no correlation between drawn samples

Performance Measure Interviews

In addition to the documentation reviews, interviews will be conducted with the person(s) responsible for:

- Overseeing the process of identifying eligible members from MCO data sources for the measures to be validated;
- Programming the extraction of required elements from the MCO data sources for the measures to be validated;
- Integrity checks and processes of verifying the accuracy of data elements for the measures to be validated;
- Overseeing the process of medical record abstraction, training, and data collection for the measures to be validated; and
- Contractor oversight and management of any of the above activities.

On-site activities may also include, but are not limited to, the following:

- Demonstration of HEDIS software
- Demonstration of the process for extracting data from MCO databases
- Possible data runs for identifying numerator and denominator cases

Compliance Review

The final activity to prepare for during the on-site visit will be the compliance follow-up review. Documentation review and interviews with Division of Medical Services staff have occurred prior to the on-site visit. This will enable BHC to use the time at the MCO as efficiently as possible. The following information will be needed at the time of the on-site review:

Compliance Documents

- Member Handbook
- Provider Handbook
- Provider Agreements
- Marketing Plan and materials
- Policies and procedures requested on-site

Attached is a listing of grievance and appeal records, for both members and providers, which will be reviewed during the on-site visit. We are requesting that you have these records available when BHC arrives on-site.

Compliance Interviews

The agenda requests an interview in the morning with the leadership from the MCO. It would be helpful to include the following staff:

- Plan Director
- Medical Director

- Quality Assurance Director
- Provider Services/Provider Relations Director
- Member Services Director
- Utilization Management Director

Interviews are scheduled in the afternoon to discuss mental health services. We are requesting that staff from subcontractors be available during this time period.

There are concurrent activities and interviews scheduled in the morning and the afternoon. If separate conference rooms or meeting space can be arranged, this will make the process much easier to coordinate. Also, the on-site review team will need to order a working lunch on the day of the visit. If lunch facilities are not available, please provide the name and telephone number of a service in the vicinity to accommodate ordering lunch. Your assistance will be appreciated.

The MCO staff involved in any of the referenced interviews or activities, or anyone identified by the MCO, is welcome to attend the introduction or the exit interview.

Your assistance in organizing the documents, individuals to be interviewed, and the day's activities is appreciated. If you have questions, or need additional information, please let me know.

Sincerely,

Mona Prater
Assistant Project director

Cc: Amy McCurry, Esq., Project Director
Plan Administrator
Judy Muck, Division of Medical Services

Attachment:
On-Site Review Agenda
Grievance and Appeal Case Review Listing

APPENDIX 9
COMPLIANCE REVIEW SCORING FORM

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Appendix 9 – Compliance Review Scoring Form

2005 BHC MCO Compliance Review Scoring Form

This document is used to score the number of items met for each regulation by the MCO.

1. Review all available documents prior to the site visit.
2. Follow-up on incomplete items during the site visit.
3. Use this form and the findings of Interviews and all completed protocols to complete the Documentation and Reporting Tool and rate the extent to which each regulation is met, partially met, or not met.

Scores from this form will be used to compare document compliance across all MCOs.

0 = Not Met: Compliance with federal regulations could not be validated.

1 = Partially Met: MCO practice or documentation indicating compliance was observed, but total compliance could not be validated.

2 = Met: Documentation is complete, and on-site review produced evidence that MCO practice met the standard of compliance with federal regulations.

	Contract Compliance Tool	Federal Regulation	Description	Comments	2004 Site Visit and Findings	2005 Site Visit and Findings	2004 Rating 0 =Not Met 1 = Partially Met 2 = Met	2005 Rating 0 =Not Met 1 = Partially Met 2 = Met
	Subpart C: Enrollee Rights and Protections							
1	2.6.1(a)1-25, 2.2.6(a), 2.6.2(j)	438.100(a)	Enrollee Rights: General Rule					
2	2.6.1(a)1, 2.9, 2.6.2(j), 2.6.2(n)	438.10(b)	Enrollee Rights: Basic Rule					
3	2.15.2(e), 2.8.2	438.10(c)(3)	Alternative Language: Prevalent Languages					

	Contract Compliance Tool	Federal Regulation	Description	Comments	2004 Site Visit and Findings	2005 Site Visit and Findings	2004 Rating 0 =Not Met 1 = Partially Met 2 = Met	2005 Rating 0 =Not Met 1 = Partially Met 2 = Met
4	2.8.2, 2.8.3, 2.6.2(n)(2)	438.10(c)(4,5)	Language and format: Interpreter Services					
5	2.6.1(a)1, 2.6.2(n)1	438.10(d)(1)(i)	Information Requirements: Alternative Formats					
6	2.6.1(a)1, 2.6.2(n)2 - dot point 35, 2.6.2(q), 2.8.2, 2.8.3	438.10(d)(1)(ii)and (2)	Information Requirements: Easily Understood					
7	2.3.5, 2.6.1(a)2/3, 2.6.2(k)1, 2.6.2(n), 2.6.2(n)(2), 2.6.2(q)	438.10(f)	Enrollee Rights: Information, Free Choice					
8	2.6.2(n)(2)	438.10 (g)	Information to Enrollees: Physician Incentive Plans					
9	2.4, 2.4.5, 2.4.5(a)2-4, 2.20.1(all), 3.5.3(f)	438.10(i)	Liability for Payment and Cost Sharing					
10	2.2.6(a), 2.2.6(b), 2.6.1(a)(3), 2.6.2(j), 2.9.1	438.100(b)(2)(iii)	Specific Enrollee Rights: Provider-Enrollee Communications					
11	2.6.2(j), 2.30.1, 2.30.2, 2.30.3	438.100(b)(2)(iv,v)	Right to Services, including right of refusal. Advance Directives					
12	2.6.2(j), 2.4.8, 2.13, 2.14	438.100(b)(3)	Right to Services					
13	2.2.6, 2.14.3, 2.14.8, 2.14.9	438.100(d)	Compliance with Other State Requirements					
		Total Enrollee Rights and Protections						
	Subpart D: Quality Assessment and Performance Improvement							
	Subpart D: Quality Assessment and Performance Improvement: Access Standards							

	Contract Compliance Tool	Federal Regulation	Description	Comments	2004 Site Visit and Findings	2005 Site Visit and Findings	2004 Rating 0 =Not Met 1 = Partially Met 2 = Met	2005 Rating 0 =Not Met 1 = Partially Met 2 = Met
14	2.3.1, 2.6.2(j), 2.14.3, 2.7.1(g), 3.5.3	438.206(b)(1)(i-v)	Availability of Services: Provider Network					
15	2.7.1(e), 2.7.1(f), 2.14.8	438.206(b)(2)	Access to Well Woman Care: Direct Access					
16	2.13	438.206(b)(3)	Second Opinions					
17	2.3.2, 2.3.18, 2.7.1(bb), 2.12.3, 2.12.4, 2.14.5	438.206(b)(4)	Out of Network Services: Adequate and Timely Coverage					
18	2.4, 2.20.1(d)	438.206(b)(5)	Out of Network Providers: Cost Sharing					
19	2.3.14(a)2, 2.14.1, 2.14.4(a-f), 2.17.1, 3.5.3	438.206(c)(1)(i-vi)	Timely Access					
20	2.2.6(a)1-3, 2.17.1	438.206(c)(2)	Cultural Considerations					
21	2.14.11, 2.3.5(e)	438.208(b)	Primary Care and Coordination of Healthcare Services					
22	2.6.2(m), 2.14.11, 2.5.3(e)	438.208(c)(1)	Care Coordination: Identification					
23	2.12.10, 2.14.2(c), 2.14.11, 2.17.5, Attachment 3 - Children with Special Healthcare Needs	438.208(c)(2)	Care Coordination: Assessment					
24	2.7.1, 2.12, 2.14.11	438.208(c)(3)	Care Coordination: Treatment Plans					
25	2.3.8, 2.3.7, 2.6.1(k)(3), 2.14.6, 2.14.7	438.208(c)(4)	Access to Specialists					
26	2.2.1(i), 2.3.7, 2.7.4, 2.9.2, 2.10.2, 2.14.1, 2.14.2(a-h), 2.14.2(d)1-2	438.210(b)	Authorization of Services					

	Contract Compliance Tool	Federal Regulation	Description	Comments	2004 Site Visit and Findings	2005 Site Visit and Findings	2004 Rating 0 =Not Met 1 = Partially Met 2 = Met	2005 Rating 0 =Not Met 1 = Partially Met 2 = Met
27	2.15.4, 2.14.2(d)6	438.210(c)	Notice of Adverse Action					
28	2.6.2(k)(3), 2.14.2(d)6, 2.15.4(a-c), 2.16.3(e)	438.210(d)	Timeframe for Decisions					
29	2.17.5(b)	438.210(e)	Compensation for Utilization Management Decisions					
30	2.4.8, 2.7.1, 2.7.1(y), 2.7.3(v), 2.14.2	438.114	Emergency and Pos-stabilization pgs 24/25 Rev. Checklist					
	Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards							
31	2.17.2(n), 2.17.5(c), 2.30.2	438.214(a,b)	General Rules for Credentialing and Recredentialing					
32	2.2.6(b)(c)	438.214(c) and 438.12	Nondiscrimination and Provider Discrimination Prohibited					
33	2.31.5	438.214(d)	Excluded Providers					
34	2.3.9, 2.3.17	438.214(e)	Other State Requirements: Provider Selection					
35	2.6.2(n)(2), 2.6.2(s)(all), 2.6.2(u)	438.226 and 438.56(b)(1-3)	Disenrollment: Requirements and Limitations					
36	2.5.1, 2.5.2, 2.5.6, 2.6.1(g), 2.6.2®	438.56(c)	Disenrollment Requested by Enrollee					
37	2.6.2(r,s-1,t)	438.56(d)	Procedures for Disenrollment -- Pgs 29/30 Rev. Checklist					
38	2.6.2(u)	438.56(e)	Timeframe for Disenrollment Determinations					

	Contract Compliance Tool	Federal Regulation	Description	Comments	2004 Site Visit and Findings	2005 Site Visit and Findings	2004 Rating 0 =Not Met 1 = Partially Met 2 = Met	2005 Rating 0 =Not Met 1 = Partially Met 2 = Met
39	2.15, 2.15.3(a,b)	438.228	Grievance Systems					
40	2.6.1(a)(18), 2.16.2(c), 2.31.2(a)8, 2.31.3, 3.5.1, 3.5.2, 3.5.3	438.230(a,b)	Subcontractual Relationships and Delegation					
	Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement							
41	2.17.2(d)	438.236(b)(1-4)	Adoption of Practice Guidelines	There is very little in the contract compliance tool regarding practice guidelines.				
42	2.17.2(d)	438.236(c)	Dissemination of Practice Guidelines					
43	2.17.2(d,f)	438.236(d)	Application of Practice Guidelines -- Pgs 32/33 of Rev. Checklist					
44	2.17.1, 2.17.5	438.240(a)(1)	Quality Assessment and Improvement Program					
45	2.17.5(d)	438.240(b)(1) and 438.240(d)	Basic Elements of MCO QI and PIPs					
46	2.17, 2.17.3, Attachment 6	438.240(b)(2)(c) and 438.204(c)	Performance Measurement					
47	2.17.5(b)	438.240(b)(3)	Basic elements of MCO QI and PIPs: Monitoring Utilization					
48	2.17.5	438.240(b)(4)	Basic elements of MCO QI and PIPs					
49	Attachment 6 - State Quality Strategy	438.240(e)	Program Review by State					
50	2.25	438.242(a)	Health Information Systems					

	Contract Compliance Tool	Federal Regulation	Description	Comments	2004 Site Visit and Findings	2005 Site Visit and Findings	2004 Rating 0 =Not Met 1 = Partially Met 2 = Met	2005 Rating 0 =Not Met 1 = Partially Met 2 = Met
51	2.25(all) - 2.25.1, 2.25.2(a,b), 2.25.3, 2.25.4	438.242(b)(1,2)	Basic Elements of HIS					
52	2.26.1, 2.29.1	438.242(b)(3)	Basic Elements of HIS					
		Total Quality Improvement and Assessment						
			Subpart F: Grievance Systems					
53	2.15	438.402(a)	Grievance and Appeals: General Requirements					
54	2.15.2, 2.15.5(a), 2.15.6(a)	438.402(b)(1)	Grievance and Appeals: Filing Authority					
55	2.15.6(a)	438.402(b)(2)	Grievance and Appeals: Timing					
56	2.15.2(a), 2.15.5(a), 2.15.6(a,b)	438.402(b)(3)	Grievance and Appeals: Procedures					
57	2.15.2(e), 2.15.4(a),2.6.2(q)	438.404(a)	Notice of Action: Language and Format					
58	2.15.4(b)	438.404(b)	Notice of Action: Content					
59	2.15.4(c)	438.404(c)	Notice of Action: Timing					
60	2.15.5(b,c,d), 2.15.6(h,i,j)	438.406(a)	Handling of Grievances and Appeals: General Requirements					
61	2.15.6(g) 2.15.6(h) 2.15.6(i) 2.15.6(j)	438.406(b)	Handling of Grievances and Appeals: Special Requirements					
62	2.15.5(e), 2.15.6(k)	438.408(a)	Resolution and notification: Grievances and Appeals - Basic rule					

	Contract Compliance Tool	Federal Regulation	Description	Comments	2004 Site Visit and Findings	2005 Site Visit and Findings	2004 Rating 0 =Not Met 1 = Partially Met 2 = Met	2005 Rating 0 =Not Met 1 = Partially Met 2 = Met
63	2.15.5(e,f), 2.15.6(k-l)	438.408(b,c)	Resolution and notification: Grievances and Appeals - Timeframes and extensions					
64	2.15.5(e), 2.15.6(k,m)	438.408(d)(e)	Resolution and notification: Grievances and Appeals - Format and content					
65	2.15.2(i), 2.15.6(m)	438.408(f)	Resolution and notification: Grievances and Appeals - Requirements for State fair hearing					
66	2.15.6(n,o)	438.410	Expedited resolution of appeals					
67	2.15.2(c), 3.5.3(c)	438.414	Information about the grievance systems of providers and subcontractors					
68	2.15.3	438.416	Recordkeeping and reporting					
69	2.15.6(p)	4388.420	Continuation of Benefits while the MCO/PIHP Appeal and the State Fair Hearing are Pending					
70	2.15(q,r)	438.424	Effectuation of reversed appeals					
		Total All Items						

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APPENDIX 10
MCO COMMENTS ON DRAFT REPORT

Appendix 10 – MCO Comments on Draft Report

BlueAdvantage Plus of Kansas City

From: Judy Brennan [mailto:Judy.Brennan@BCBSKC.com]
Sent: Monday, May 15, 2006 4:40 PM
To: Amy McCurry
Cc: Darren Taylor; Carrie Cowdin; Michelle Williams; Barb Purdon
Subject: RE: Performance Measure DRAFT documents

We have no comments. Thanks.

Judy Brennan
Director, State Programs
BCBSKC
816-395-2421 * FAX: 816-802-4437
judy.brennan@bcbskc.com

From: Amy McCurry [mailto:amccurry@pmsginfo.com]
Sent: Wednesday, May 10, 2006 3:04 PM
Subject: Performance Measure DRAFT documents

Hello All –

BHC has sent Performance Measure DRAFT documents to you for plan review. You should receive them via Fed-Ex today.

Your packets should include copies of the following:

- Performance Measure Objectives and Technical Methods
- Final Performance Measure Validation Worksheets for each performance measure (Draft)
- Validation of Performance Measure summary for your MCO (Draft)

The due date for Plan comments is May 22nd – this is a receipt date – all comments must be received by May 22, 2006 in order to give BHC time to review and include them in the final report if necessary.

If you have any questions or need further clarification, as always, please don't hesitate to contact me.

Thank you.

Amy B. McCurry, Esq., MHSA
EQRO Project Director
Performance Management Solutions Group
a division of Behavioral Health Concepts, Inc.
2716 Forum Blvd, Suite 3A
Columbia, MO 65203
(573)446-0405
(573)446-1816 (fax)
amccurry@pmsginfo.com

Children's Mercy Family Health Partners

Children's Mercy Family Health Partners
Draft review 5/13-5/15/2006
Response to draft of Validation of Performance Measures, EQRO 2005

Pages 3 and 4, Processes Used to Produce Denominators

Well-Child Visits measure

"A total of 1,677 eligible members were reported and 1,454 eligible members were validated for the Well-Child Visits measure." "The denominators reported for the Well-Child Visits measure were over-reported by 223. Of the 223 members the EQRO excluded from the denominator, 7 were excluded because their date of birth did not fall between October 1, 2002 and September 30, 2003, the other 216 were excluded because they were not enrolled in the health plan on the anchor date of their 15-month birthday."

The NCQA specification for the measure indicates that the 15-month birthday should be calculated by adding 90 days to the first birthday. Using this logic to determine the range of birthdays that would result in a 15-month birthday anchor date during the 2005 measurement year, *the correct range should be October 3, 2002 through October 2, 2003*. All of the members submitted had birthdates within this range, eliminating the 7 exclusions due to date of birth.

The other 216 exclusions need further explanation from BHC because the data we sent them shows that the 15-month anchor date does fall within a valid enrollment period.

Annual Dental Visit measure

"24,342 eligible members were reported and 24,334 were validated for the denominator of the Annual Dental Visit measure." "The denominators reported for the Annual dental Visit measure were over-reported by 8 members. Of the 8 members that the EQRO excluded from the denominator, 7 were excluded because they were not enrolled on the anchor date of December 31, 2004 and one was excluded because the member had a gap of enrollment greater than 45 days during the measurement year."

The denominator for the Annual Dental Visit measure was prepared on April 28, 2005. The data for the EQRO audit was prepared on November 28, 2005. Eligibility data for the denominator members was extracted from the health plan's production system eligibility file on that date. In reviewing the draft report, it was discovered that retroactive eligibility terminations and changes occurred after the denominator was prepared, and that the production eligibility file records only the changed eligibility dates. However, all work files from the denominator processing were archived, and these files show the eligibility dates that were in production at the time the denominator was processed, and that all members were eligible on the December 31 anchor date. In

addition, there is an eligibility history file in the production system that shows when the changes were made, and the before and after values of the changes, confirming that eligibility of these members was valid for the measure.

Tables of the archived denominator data and eligibility history for the 7 members whose eligibility end date are in question can be provided.

I was not able to identify the member who had a gap of more than 45 days in eligibility from our copy of the data.

Page 4, Processes Used to Produce Numerators – Childhood Immunizations Status measure

"Thirty (30) of 30 medical records requested for review were received, and 19 records resulted in validated hybrid hits."

Children's Mercy FAMILY HEALTH PARTNERS Hospitals & Clinics

215 W. Pershing, Suite 600
Kansas City, MO 64108
(816) 855-1888 • (800) 347-9363
(816) 855-1890 Fax
www.fhp.org

May 19, 2006

Behavioral Health Concepts, Inc
ATTN: Amy B. McCurry, Esq., MHSA
2716 Forum Blvd., Suite 3a
Columbia, MO 65203

Dear Ms. McCurry:

Children's Mercy Family Health Partners is mailing this response to your email and draft documents dated May 15, 2006 and May 18, 2006. I have enclosed a copy of the documents I'm referencing for your convenience. Please note the following areas that need updates:

May 18, 2006 Draft, page 6, Final Audit Rating, sentence 3. Please change the text to read that the Childhood Immunization Status measure was Substantially Compliant as there was not a significant bias associated with the overestimate. This will reflect the updates noted in the text of the document as reworked after our teleconference on May 17, 2006.

May 15, 2006 Draft, Final Performance Measure Validation Worksheet: HEDIS 2005 Well-Child Visits in the First 15 Months of Life. I did not receive in the May 18th draft an update of this worksheet. Please update the table with the corrected Estimate of Bias (per May 18th draft text, page 5, 0.18% overestimate) and Audit Rating (per the May 18th draft text, page 6, Table 2, Substantially Compliant)

Thanks again for your collaboration on this project.
Please call me for questions or concerns at 816-855-1828.

Sincerely,

Jenny Hainey, RN, MSN, CPHQ
QM Manager

Enclosures

Community CarePlus

COMMUNITY CARE PLUS

May 19, 2006

Amy McCurry, Esq. MHSA
Behavioral Health Concepts, Inc.
Victoria Park, 2716 Forum Blvd.
Suite 4
Columbia, MO 65203

Dear Amy,

This letter is in response to the 2005 External Quality Review Performance Validation Protocol findings for Community CarePlus. Because immunizations are part of a well child visit, the score for Childhood Immunizations should co-relate to the score for Well-Child Visits. The final audit rating for Well-Child Visits was found to be fully compliant, yet the final rating for Childhood Immunization was found to be not valid.

Reasons for the result in the Childhood Immunization results may be due to the tight schedule allowed for administration of immunizations. Missed appointments may cause delay in administration of the immunization causing the event to fall out of the timeline.

Community CarePlus requests to review the thirty (30) medical records that were used in the audit. Please let me know if you can send the records by fax to 314-432-9295 or mail to me at 10123 Corporate Square Dr., St. Louis, MO 63132.

Community CarePlus has incorporated immunization events from the State Public Health Immunization Registry (MOHSAIC) into the 2006 HEDIS report.

Please call me at 314-432-9295 with any additional questions.

Sincerely,

Susan E Danis

Sue Danis, RN, CPHQ, MHA
Manager, Quality Improvement

HealthCare USA

May 22, 2006

VIA FACSIMILE & U.S. MAIL

Amy McCurry, Esq., MHSA
EQRO Project Director
Behavioral Health Concepts, Inc.
2716 Forum Blvd, Suite 4
Columbia, MO 65203

RE: 2005 External Quality Review Performance Measure Validation Protocol

Dear Ms. McCurry:

I am writing on behalf of HealthCare USA of Missouri, LLC ("HCUSA") regarding the 2005 External Quality Review Performance Measure Validation Protocol ("EQR Protocol") performed by your company, Behavioral Health Concepts, Inc. ("BHC") as the external quality review organization ("EQRO") for the Missouri Medicaid Managed Care Program ("Missouri MC+ Program"). We are in receipt of your May 9, 2006 report and have significant concerns with your findings. As explained in greater detail below, while HCUSA appeared to score well in the tested areas, and your report stated only a few areas for improvement, HCUSA's overall performance measure validation review was deemed "Not Valid" due to HCUSA's data not having been provided to the EQRO "in the format requested." Specifically, your report stated that "data cannot be truly validated according to the CMS Protocols if it is accepted in a format that has already been processed by a software program." Based on HCUSA's commendable performance in the EQR Protocol in previous years, using the same processes and software as it did for this most recent audit, BHC's findings come as a surprise, and do not seem justified. Further, the EQR Protocol report contained factual inaccuracies that HCUSA would like to clarify for the record.

As you are likely aware, HCUSA uses the Catalyst Technologies ("Catalyst") *Quality Spectrum* software for its HEDIS data collection and processing. *Quality Spectrum* is a SAS-based application. Each month, data is extracted from HCUSA's internal data warehouse and loaded into *Quality Spectrum*. *Quality Spectrum* is NCQA-certified. Upon receipt of the results generated by *Quality Spectrum*, HCUSA provides such data to BHC for its review. This is the same process that was in place last year when HCUSA received a "fully compliant" review from BHC's EQR Protocol. Please see enclosed copy of last year's EQR Protocol report. Further, HCUSA also uses an NCQA-certified Auditor through HealthcareData.com, LLC, that audits the entire HEDIS process.

BHC's report faults HCUSA for BHC's inability to "independently validate the denominator files because enrollment history and dates were not supplied to the EQRO for the members in the denominator files. Additionally [HCUSA] did not provide service codes that could be validated against the HEDIS Technical Specifications." As was explained to the BHC reviewers who performed the EQR Protocol audit, HCUSA was unable to provide the enrollment history and the service codes because *Quality Spectrum* does not typically provide the data in the format in which BHC requested it. HCUSA staff indicated that the data could be obtained in the requested format

but more time would be needed to complete the different formatting. Instead, with BHC's consent, HCUSA, as it did last year, provided BHC with a detailed demonstration of the *Quality Spectrum* software. BHC never expressed any dissatisfaction or problems, nor conveyed to HCUSA that the HEDIS data and/or *Quality Spectrum* software was insufficient or deficient in any way. If BHC had done so, HCUSA would have certainly worked expeditiously to address any concerns. Furthermore, because the same demonstration and discussion had taken place last year, HCUSA had no reason to believe that its protocol would not be similarly sufficient this year. Even during the closing conference between BHC and HCUSA, there was no mention of invalidity of any measures.

BHC's report also indicates that "the one criteria that was not met involved "detailed computer queries, programming logic, or source code." Again, during the demonstration, HCUSA staff explained *Quality Spectrum's* functionality in this regard, and no questions or concerns were posed by BHC. HCUSA further explained at that time that the *Quality Spectrum* source code was proprietary to Catalyst, and that HCUSA could not provide it to BHC.

As stated above, the *Quality Spectrum* software is NCQA-certified and approved. Interestingly, BHC does not utilize NCQA-certified HEDIS auditors or software in conducting the EQR Protocol audits. Moreover, HCUSA has reason to believe that BHC does not even follow HEDIS specifications. For example in the Well Child Visits in the First 15 Months of Life measure the EQR excluded members for not turning 15 months old in the measurement year. The technical specifications for this measure state: "Calculate the 15-month birthday as the child's first birthday plus 90 days." It appears that children who BHC excluded, in an attempt to validate this measure, had a birthday of October 1st and 2nd indicating they would have been 15-months by December 31, 2004. Given that the *Quality Spectrum* software and the HealthcareData.com auditor are NCQA-certified, it would seem that BHC should defer to HEDIS rates generated by *Quality Spectrum* and validated by HealthcareData.com.

Indeed, federal regulations support this concept, and have enabled states to use information about MC+ organizations obtained from private accreditation reviews, such as NCQA, to provide information otherwise obtained from mandatory activities such as validation of MCO performance measures. *See* 42 CFR 438.360, "Non-duplication of mandatory activities." Specifically, 42 CFR 438.360 states, "to avoid duplication, the state may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review" subject to the following conditions:

> (a) the MCO is in compliance with standards established by CMS or a national accrediting organization and such standards are comparable to standards established by the state to comply with § 438.204(g) and the EQR-related activity under § 438.358(b)(3);
>
> ***Response:*** **HCUSA complies with NCQA standards, which are comparable to standards established by the state of Missouri. Further, HCUSA's NCQA-certified auditor Final Audit Report (copy enclosed) states that "measures . . . submitted 2005 Performance Report were prepared according to the HEDIS 2005 Technical specification and present fairly, in all material respects, the MCO's performance with respect to these specifications."**

(b) compliance with the standards is determined either by CMS or its Medicare contractor, or a private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare;

Response: **HCUSA complies because we use an NCQA-auditor who imposes standards pursuant to NCQA and such standards are as stringent as Medicare's standards.**

(c) the MCO provides to the state all the applicable reports, findings, and other results of the Medicare or private accreditation review, and the state provides the information to the EQRO; and

Response: **HCUSA is obligated by 19 CSR 10-5.010, *et seq.* to use NCQA-certified auditors, software, and processes, which HCUSA has done. When HCUSA submits its HEDIS data submission tools ("DSTs"), HCUSA is unable to make any changes, as the tools are locked by the auditors, and provided to the Department of Health and Senior Services and the Division of Medical Services as they were completed by the auditor. HCUSA has previously provided the state-required DST along with the full NCQA DST and a copy of the Final Audit Report from Healthcare Data.com, LLC.**

(d) in its quality strategy, the state identifies the standards for which the EQR will use information from Medicare or private review accreditation reviews, and explains its rationale for why the standards are duplicative. *See* 42 CFR § 438.360(b).

Response: **Again, 19 CSR 10-5.010(3) requires health care plans such as HCUSA to submit documentation from a NCQA-licensed organization that the quality indicator data have been audited according to HEDIS specifications. HCUSA satisfied this. Further, Table B of the regulation states that "data reported for each of the indicators . . . shall conform to the NCQA HEDIS Data Submission Tool and all other HEDIS technical specifications for indicator descriptions and calculations." Additionally, in discussing Member Satisfaction Reporting requirements, which are a subset of HEDIS, HCUSA's contract with the Division of Medical Services states "to reduce duplication and ensure consistent survey methodology, the state agency shall rely upon the member satisfaction survey data from this process. The health plan shall submit member satisfaction data to the Department of Health and Senior Services in accordance with 19 CSR 10-5.010, as amended.**

HCUSA's use of Catalyst, and *Quality Spectrum* and as NCQA-certified software, should satisfy BHC's need to validate HCUSA's HEDIS measures, not only because of the federal regulations supporting such deference, but more importantly because BHC itself is not NCQA-certified.

Finally, we request that BHC correct the various factual inaccuracies in the EQR Protocol report prior to issuing final findings. The following is a list of those inaccuracies:

- Page 2: Catalyst Technologies, not McKesson, is the software vendor.
- Page 3: The rate for HCUSA's HEDIS 2005 Annual Dental Visit measure was 28.89%, not 28.79%

- Page 4: The rate for HCUSA in Western Missouri Region for the HEDIS 2005 Annual Dental Visit measure was 21.77%, not 29.77%.
- Page 5: In Central Missouri Region, 1,166 eligible members were reported for the Childhood Immunization Status, not 412 members. In Eastern Missouri Region, 5,783 eligible members were reported, not 5,792.
- Page 6: Across all three regions, 7,258 members were found for the Childhood Immunization Status, not 6,504 members.
- Page 9: Recommendations:
    - 1. HCUSA did comply with the recommendation from 2004 to utilize the Hybrid methodology in 2005 for childhood and adolescent immunizations. BHC was made aware of this during the EQR review.
    - 2. HCUSA did comply with the recommendation from 2004 to integrate HEDIS rate documentation procedures into corporate IS policies. BHC verbally recognized this integration during the interview process.

Your prompt and thorough attention to this matter is greatly appreciated. HCUSA values greatly its perceived and actual compliance with state and federal requirements, and would like the EQR Protocol to accurately reflect such compliance. I can be reached at (314) 444-7237 if you have any questions.

Sincerely,

Jacqueline Inglis

Jacqueline Inglis
Vice President Health Services
HealthCare USA of Missouri, LLC

Attachments.

cc: Ms. Judy Muck, Assistant Deputy Director, MC+ Managed Care, Missouri Dept. of Social Services

Missouri Health Care Plan

May 19, 2006

Amy McCurry, Esq. MHSA
EQRO Project Director
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Ste. 4
Columbia, MO 65203

Re: 2005 External Quality Review Performance Measure Validation Protocol

Dear Ms. McCurry:

We have reviewed Behavioral Health Concepts' summary of the External Quality Review Organization (EQRO) findings of the 2005 Validation of Performance Measures Protocol for Missouri Care Health Plan. As permitted by Option 1 of the Protocol, we are submitting comments regarding several of the findings and the review process as a whole.

First, we would like to address our concern with the process for reporting of the results of the hybrid medical record review. From the information that Missouri Care received in the draft report, we are not able to respond to the accuracy of the EQRO's assessment of 23 of 30 and 23 of 27 Childhood Immunization Status Combination #2 and Well-Child Visits in the First 15 Months of Life respectively meeting the EQRO's standard for a positive hit nor are we able to learn from our mistakes and implement improvements for next year. Missouri Care recognizes that the EQRO is unable to provide the health plan with the specific records that did not meet the EQRO's standards for medical record review, but the health plan would benefit from a general description of the types of errors the health plan made during medical record extraction in order to prevent similar error in subsequent years.

Second, we want to address the areas for improvement and recommendations outlined on page 7 of the draft report. Below is the original EQRO recommendation, followed by Missouri Care's response:

Areas for Improvement

1. **EQRO Comment** - Missouri Care used a medical record review software, which was used as a tool for retrieving medical records that needed to be reviewed. This application has a module for data entry that does not indicate whether administrative data has been previously entered. The design of this module and the requirement to re-enter data leaves open the possibility for data entry error of valid administrative data. Missouri Care follows the process identified by the NCQA auditor, MEDSTAT.
   Missouri Care Response - The software does not require that Missouri Care re-enter administrative data. Missouri Care staff had inadvertently re-entered the data in 2005. The Missouri Care HEDIS staff have been trained and the problem

has been resolved in 2006.

2. **EQRO Comment** - Documentation on HEDIS rate calculation and policies related to calculation of HEDIS measures are weak at Columbia office.

   Missouri Care Response - Missouri Care's HEDIS rates are calculated in accordance with NCQA's HEDIS Technical Specifications. Missouri Care's Manager of Quality Management, Sr. Quality Management/HEDIS Coordinator, and Quality/HEDIS Nurse all have a copy of the current HEDIS Technical Specifications. The technical specifications are reviewed for updates each year when the new Technical Specification are released and then used as a resource throughout the data collection and calculation process. Furthermore, current HEDIS policies are being revised and updated based on the EQRO's recommendations.

3. **EQRO Comment** - QMACS uses 2 systems with 2 different member ID numbers, at present Missouri Care ends all ID's with an "n" for "new" or an "o" for "old" when the system is upgraded, this does not seem like the most effective way to ensure the uniqueness of ID numbers.
   Missouri Care Response - Over the years, new versions of the QMACS claims system have been released. Claims processed with older versions of the software are kept in separate databases. Schaller Anderson IT could not guarantee that the system ID for a member would remain the same from one version of QMACS to the next. Nor could they guarantee the system ID for a member on an older version wouldn't be reused on the newer version. When calculating HEDIS rates it is necessary to access both the claims database for the latest version of QMACS as well as the claims database for the older version. In order to ensure that a unique identifier is created for each member, APS creates an ID Bridge table. This table lists the member, his or her ID under the new version of QMACS and his or her ID under the old version. Their software then chooses one of these Ids, appends either an N (new version) or an O (old version) and uses this new moniker as the unique ID for that member in all of their calculations.

4. **EQRO Comment** - The HEDIS end products are housed at the MOCare office in Columbia, but the staff at that office are still struggling to understand the inputs of the HEDIS calculations.
   Missouri Care Response - Missouri Care staff are confident in their knowledge of the rate production process. Based upon the 2004 EQRO report, Missouri Care has taken steps to not only understand the rate production process, but also to perform checks on the rates produced by APS. For example, Missouri Care's Sr. Quality Management Coordinator attended four days of NCQA sponsored HEDIS training in September of 2005, Missouri Care checks a random sample of hybrid records from APS to verify that all data sources were incorporated into the results, and Missouri Care staff calculate hybrid rates for comparison to the rates APS populates on the DST.

Recommendation

1. **EQRO recommendation** - Improve documentation of the HEDIS rate calculation process by developing and maintaining a set of information system policies for the HEDIS rate production on-site to allow for continuity and validity of the process of rate production in the event of turnovers.
   Missouri Care response - Quality management staff will work on producing a HEDIS process flowchart, as well as process desktops, that clearly outline the entire HEDIS rate production process.

2. **EQRO recommendation** - Increase ownership and control by MOCare over the process of calculation of HEDIS measures by designating an employee to closely coordinate with APS and clearly assigning responsibilities related to the HEDIS rate calculation processes within the organization.
   Missouri Care response - Missouri Care's Senior Quality Coordinator is responsible for coordinating the HEDIS rate production and has coordinated with Missouri Care's corporate office and APS in the rate production process throughout 2005.

3. **EQRO recommendation** - Conduct and document statistical comparisons on rates from year to year.
   Missouri Care response - Missouri Care supplied BHC with documentation of statistical comparison's of rates from 2004 to 2005. Documentation was supplied in the original submission and on-sight. Please note that on page 6 of Missouri Care's report, the EQRO lists statistical comparisons of rates as a strength for Missouri Care.

4. **EQRO recommendation**- Training of MCO staff involved in the oversight of coordination of performance measure calculation is strongly recommended. The NCQA offers workshops on the calculation of HEDIS measures.
   Missouri Care response - Missouri Care is committed to improving its HEDIS process. To that end, the Senior Quality Coordinator attended training offered by NCQA in September of 2005 and will attend additional training in the fall of 2006.

Finally, please note the following minor editorial comments on the 05/15/06 draft report:

- On page 1 under "Interviews", 2nd sentence it states that "This group was partly responsible for the process of calculating..."
  Response: The individuals listed above this sentence are responsible for the entire process.

- On page 2 under "Findings", 2nd and 3rd paragraphs the EQRO reports 95% CI for CIS as 52.56% to 74.76% and for WC15 63.16% to 88.22%.
  Response: It is unclear where the reported confidence intervals were obtained. Missouri are reported a 95% confidence interval of 58.88% to 68.44% for CIS and 70.57% to 80.82% for WC 15.

- On page 3 under "Documentation of Data and Processes" the EQRO states "The application has received NCQA certification and has been reviewed by the NCQA-certified auditor, MEDSTAT" (see also page 6, item 6 under "strengths").
  Response: NCQA not MEDSTAT reviews the source code.

- On page 6, item 5 under Strengths" states "Austin Provider Solutions (APS) provides the members' identification data to the SPHA and obtains an extract of immunizations for the members eligible."
  Response: Missouri Care staff, not APS, sends the SPHA a list of eligible members to obtain an extract of immunizations for the member's eligible. The list is then returned by the SPHA to Missouri Care who sends the list to APS.

As we look to strengthening Missouri Care's Quality Management program, we welcome your recommendations for improvement and we appreciate this opportunity to respond to the review process and the findings of the EQRO. Should you have any questions, please contact me at 1-800-322-6027 ext.4623.

Sincerely,

Tammy Wiese
Manager, Quality Management
Missouri Health Care Plan