2009

MO HealthNet Managed Care Program

External Quality Review

Report of Findings

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1.0 EXECUTIVE SUMMARY

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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 MO HealthNet MCHPs (MCHPs) and their contractors to participants of MO HealthNet 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 State of Missouri contracts with the following MO HealthNet MCHPs represented in this report:

- Molina Healthcare of Missouri (Molina)
  (Referred to as Mercy CarePlus (MCP) for all data prior to October 2009)
- HealthCare USA (HCUSA)
- Harmony Health Plan of Missouri (Harmony)
- Missouri Care (MO Care)
- Children's Mercy Family Health Partners (CMFHP)
- Blue-Advantage Plus (BA+)

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

1) Validating Performance Improvement Projects[1]

Each MO HealthNet Managed Care Health Plan (MCHP) 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, MO HealthNet Division (MHD).

[1] 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.

2) Validating Performance Measures[2]

The three performance measures validated were HEDIS 2009 measures of Adolescent Well Care Visits (AWC), Follow Up After Hospitalization for Mental Illness (FUH), and Annual Dental Visit (ADV).

3) Validating Encounter Data[3] (optional activity)

Validation of Encounter Data examined the completeness, accuracy, and reliability of specific fields in the SMA database; and the extent to which paid claims in the SMA were represented in the medical records of MO HealthNet Managed Care Members; and

4) MO HealthNet MCHP Compliance with Managed Care Regulations.[4]

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

[2] 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.
[3] 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.
[4] 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.

1.2 Validation of Performance Improvement Projects

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs for each MO HealthNet MCHP that were underway during 2009. A total of 12 PIPs were validated. Eligible PIPs for validation were identified by the health plans, SMA, and the EQRO. The final selection of the PIPs for the 2009 validation process was made by the SMA in December 2009. Below are the PIPs identified for validation at each Health Plan:

Molina Healthcare of Missouri	Members at High Risk of Cesarean Wound Infection
	Improving Adolescent Well Care
HealthCare USA	Follow-Up After Hospitalization for Mental Health Services
	Improving Adolescent Well Care
Missouri Care	Improving Chlamydia Screening Rates in Women
	Improving Adolescent Well Care
Children' Mercy Family Health Partners	Improving Dental Health Screening Rates
	Improving Adolescent Well Care
Blue-Advantage Plus	Ambulatory Follow-Up After Hospitalization for Mental Health Disorders
	Improving Adolescent Well Care
Harmony Health Plan of Missouri	Lead Screening
	Improving Adolescent Well Care

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes, and/or the healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. Under the State contract for MO HealthNet Managed Care, Health Plans 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 Health Plan by the EQRO during the site visits for improving study methods, data collection, and analysis.

Access to Care

Access to care was an important theme addressed throughout all the PIP submissions reviewed.

- One PIP attempted to impact the access to dental care (CMFHP).
- One PIP focused on education and support to obtain appropriate care after surgery or hospitalization (Molina of Missouri) and actively provided access to home health services.
- Two of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for mental health related issues (BA+ and HCUSA).
- One PIP focused on improving health care screening through provider and member education on the importance on obtaining healthcare that also enhanced member access to ancillary services (MO Care).
- One PIP focused on a key aspect of prevention by improving access to lead screening (Harmony).
- The on-site discussions with health plan staff indicate that they realize that improving access to care is an essential aspect of all projects that are developed.

The PIPs based on the statewide topic of improving Adolescent Well Care utilized individualized interventions that informed or educated members about the availability of these services and encouraged increased utilization of health care services available.

Quality of Care

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

access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

TIMELINESS OF CARE

Timeliness of care was a major focus of a number of the PIPs reviewed.

- One project addressed the need for timely and appropriate care for members to avoid further inpatient hospitalization (Molina of Missouri).
- Other projects focused on subjects such as timely utilization of preventive care (MO Care and Harmony).
- Improved access to dental services (CMFHP).
- Improved access to timely treatment after in-patient hospitalization for mental illness (BA+ and HCUSA).

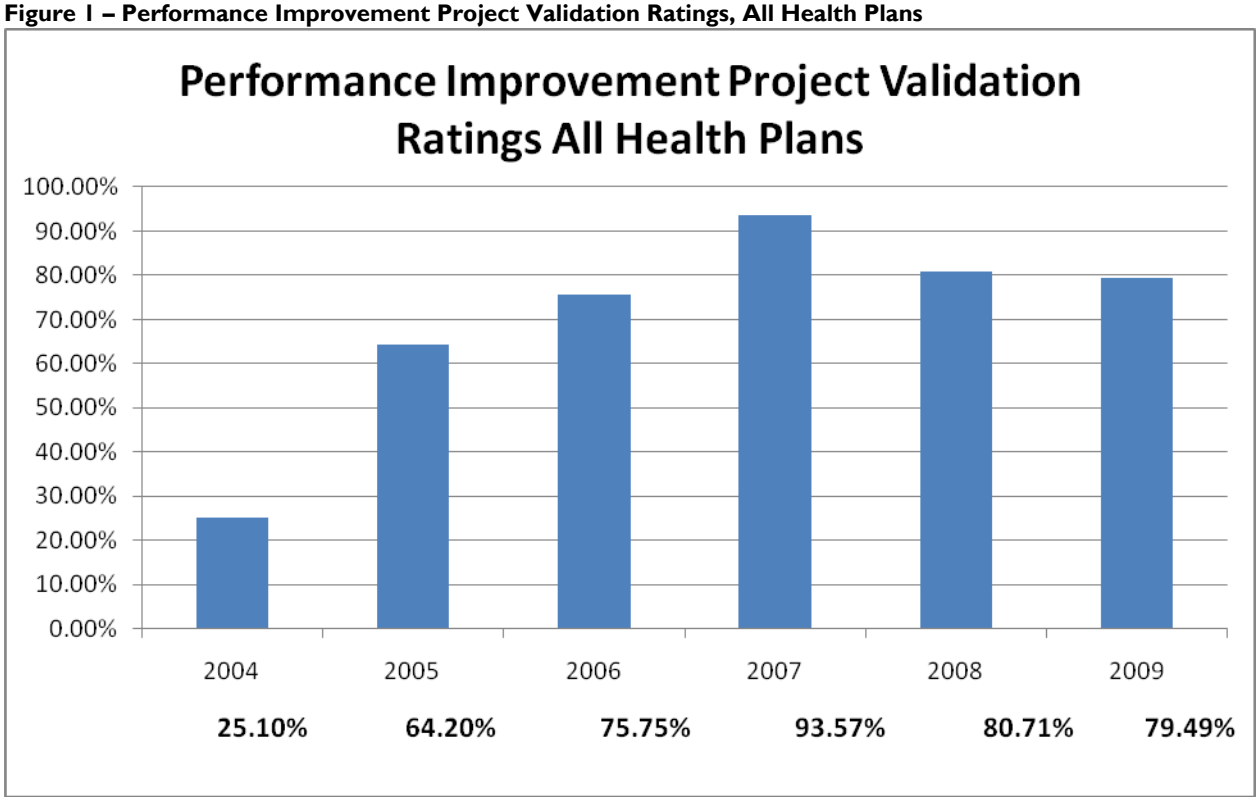
All addressed the need for timely access to preventive and primary health care services. The health plans all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness in that they addressed internal processes and direct service improvement.

The PIPs related to improving Adolescent Well Care included a focus on obtaining timely screenings into their interventions and recognized that this is an essential component of effective preventive care.

CONCLUSIONS

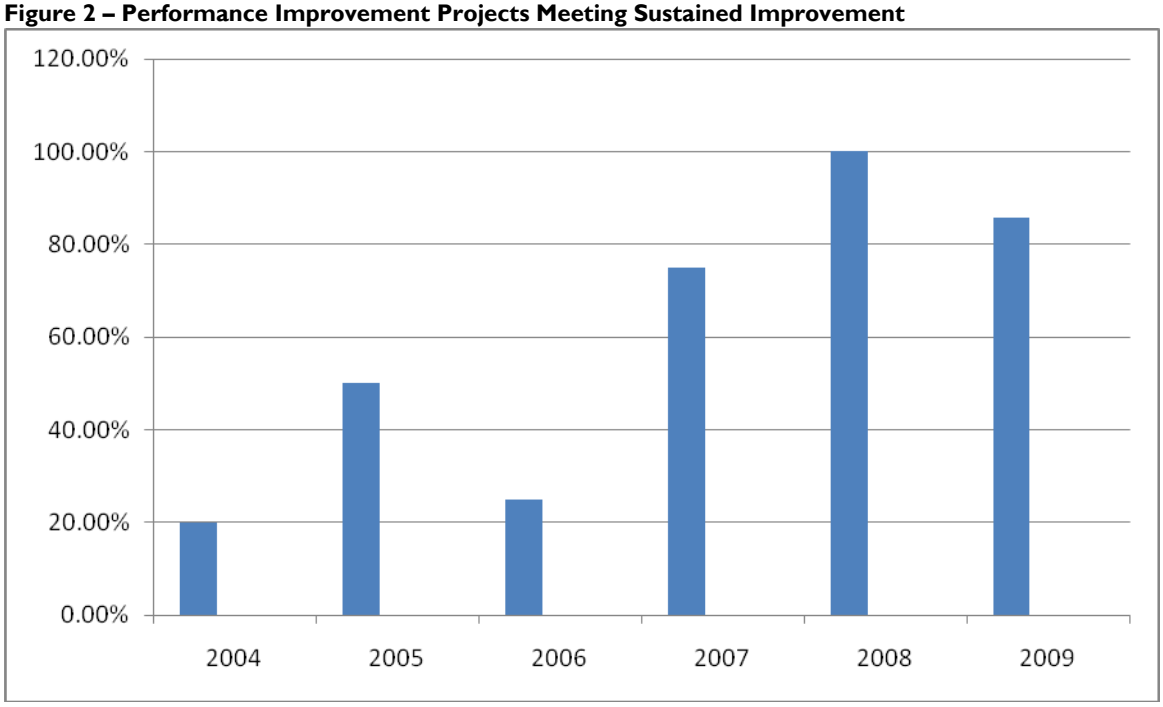
The Health Plans have made significant improvements in utilizing the PIP process since the current measurement process began in 2004. Figure 1 indicates the improvements the Health Plans have made in providing valid and reliable data for evaluation.

Figure 1 – Performance Improvement Project Validation Ratings, All Health Plans



An essential element in validating these projects is analyzing the projects ability to create sustained improvement. In 2004 this measure of the PIPs submitted was rated at 20% compliant. In 2009 this measure was rated at 100% for the projects mature enough to complete this evaluation. The Health Plans also exhibit the commitment to incorporating their successful Performance Improvement Projects into daily operations when the study process is complete. Examples of this can be found in the "Best Practice" section of this Executive Summary.

Figure 2 – Performance Improvement Projects Meeting Sustained Improvement



An essential element in validating these projects is analyzing the projects ability to create sustained improvement. In 2004 this measure of the PIPs submitted was rated at 20% compliant. In 2009 this measure was rated at 85.71% for the projects mature enough to complete this evaluation. The Health Plans also exhibit the commitment to incorporating their successful Performance Improvement Projects into daily operations when the study process is complete. Examples of this can be found in the "Best Practice" section of this Executive Summary.

1.3 Validation of Performance Measures

The Validating Performance Measures Protocol requires the validation or calculation of three performance measures at each MO HealthNet MCHP by the EQRO. The measures selected for validation by the SMA are required to be submitted by each health plan 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 Managed Care Organizations (MCOs) operating in the State of Missouri. For the HEDIS 2009 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Adolescent Well-Care Visits (AWC), and Follow-Up After Hospitalization for Mental Illness (FUH). 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, health plan 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 MO HealthNet MCHP performance during 2008.

QUALITY OF CARE

The HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by health plan members.

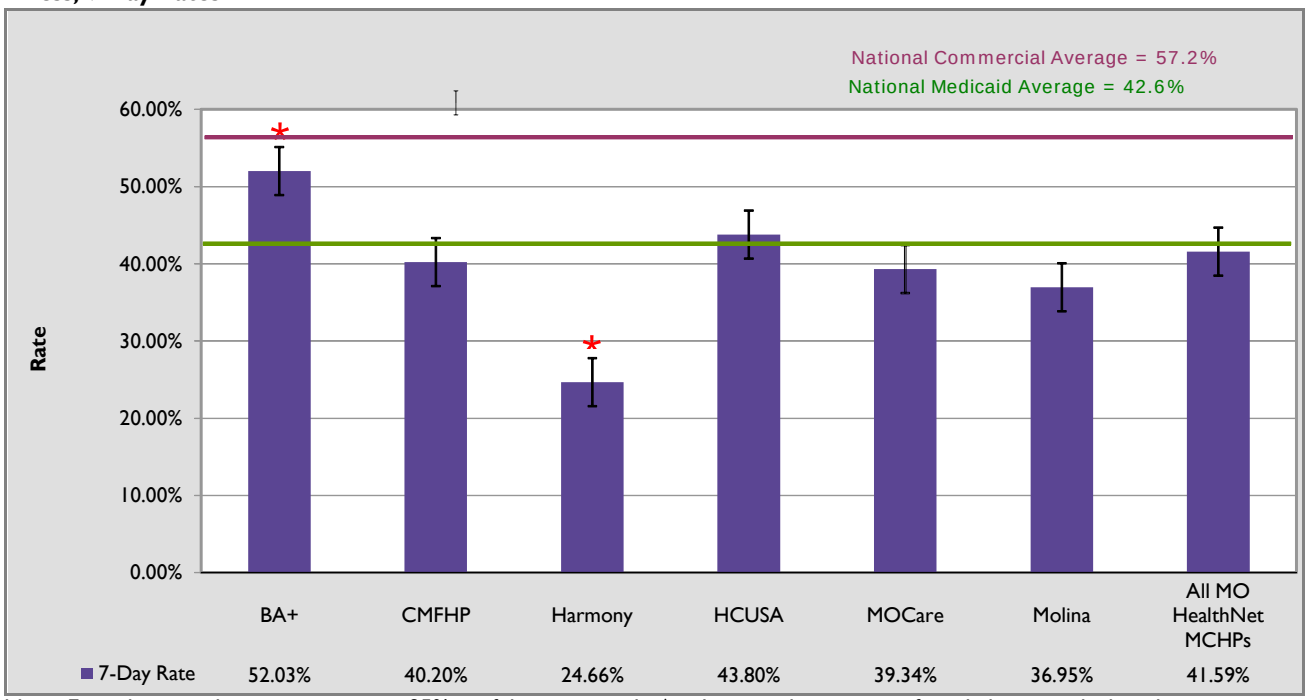
One MO HealthNet MCHP was Fully Compliant with the specifications for calculation of this measure. The five remaining MO HealthNet MCHPs were substantially complaint with the specifications for calculation of this measure.

For the 7-day follow up rate, two MO HealthNet MCHPs (BA+ and HCUSA) reported rates (52.03% and 43.80%, respectively) that were higher than the National Medicaid Average (42.6%) for this measure.

For the 30-day follow up rate, five MO HealthNet MCHPs (BA+, CMFHP, HCUSA, MO Care, and Molina) all reported rates (73.31%, 68.70%, 69.62%, 62.13% and 61.69%, respectively) that were at or above than the National Medicaid Average (61.7%) for this measure. The overall MO MCHP rate (66.46%) was also higher than the National Medicaid Average.

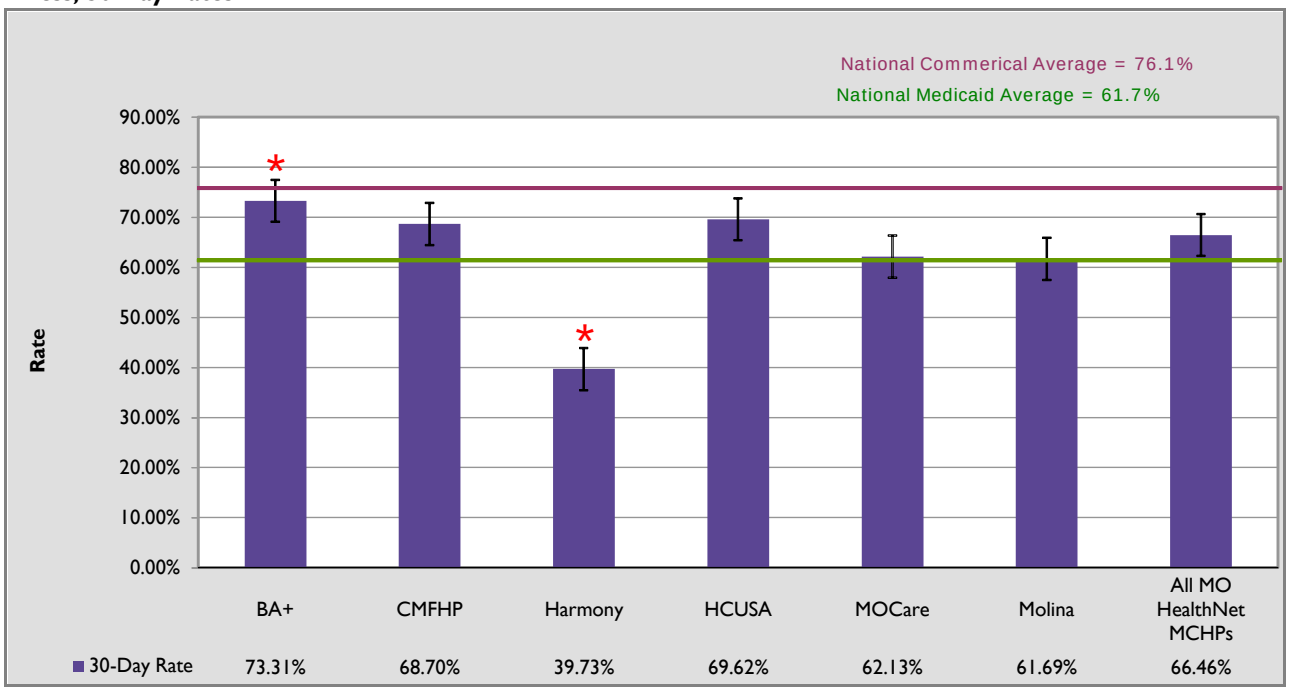
From examination of these rates, it can be concluded that MO HealthNet MCHP members are receiving a higher quality of care in the area of Follow-Up After Hospitalization for Mental Illness overall than other Medicaid participants across the country within the 30-day timeframe, but not quite as high a quality of care within the 7-day timeframe. However, the quality of care for Follow-Up After Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes.

Figure 3 - MO HealthNet Managed Care Program HEDIS 2009 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA).

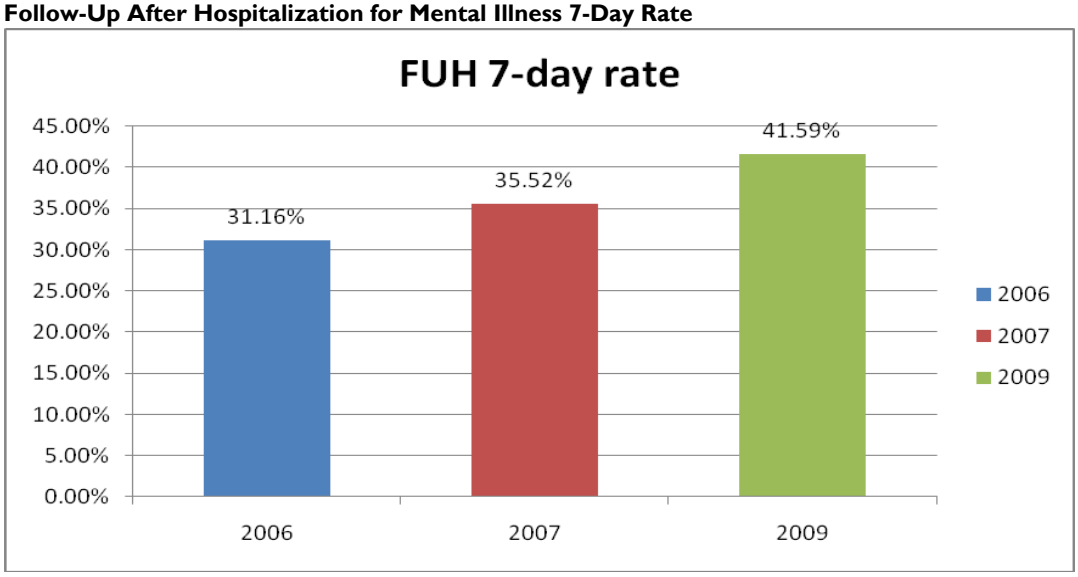
Figure 4 - MO HealthNet Managed Care Program HEDIS 2009 Follow-Up After Hospitalization for Mental Illness, 30-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals.
Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA)

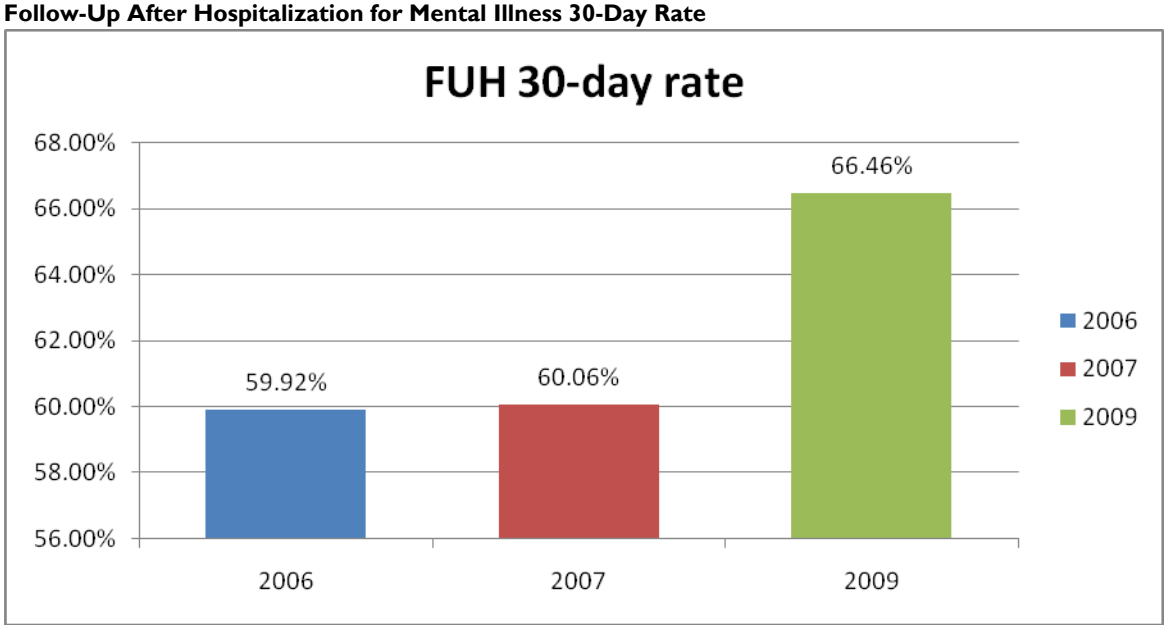
This measure was previously audited by the EQRO in audit years 2006 and 2007 (See Figure 5). The 7-Day reported rate for all MO HealthNet MCHPs in 2009 (41.59%) was a 10.43% increase overall since the rate reported in 2006 (31.16%); it is 6.07% higher than the rate reported in 2007 (35.52%).

Figure 5 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 7-Day Rate



This measure was previously audited by the EQRO in audit years 2006 and 2007. The 30-Day reported rate for all MO HealthNet MCHPs in 2009 (66.46%) was a 13.54% increase overall since the rate reported in 2006 (52.92%); it is 6.4% higher than the rate reported in 2007 (60.06%).

Figure 6 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 30-Day Rate

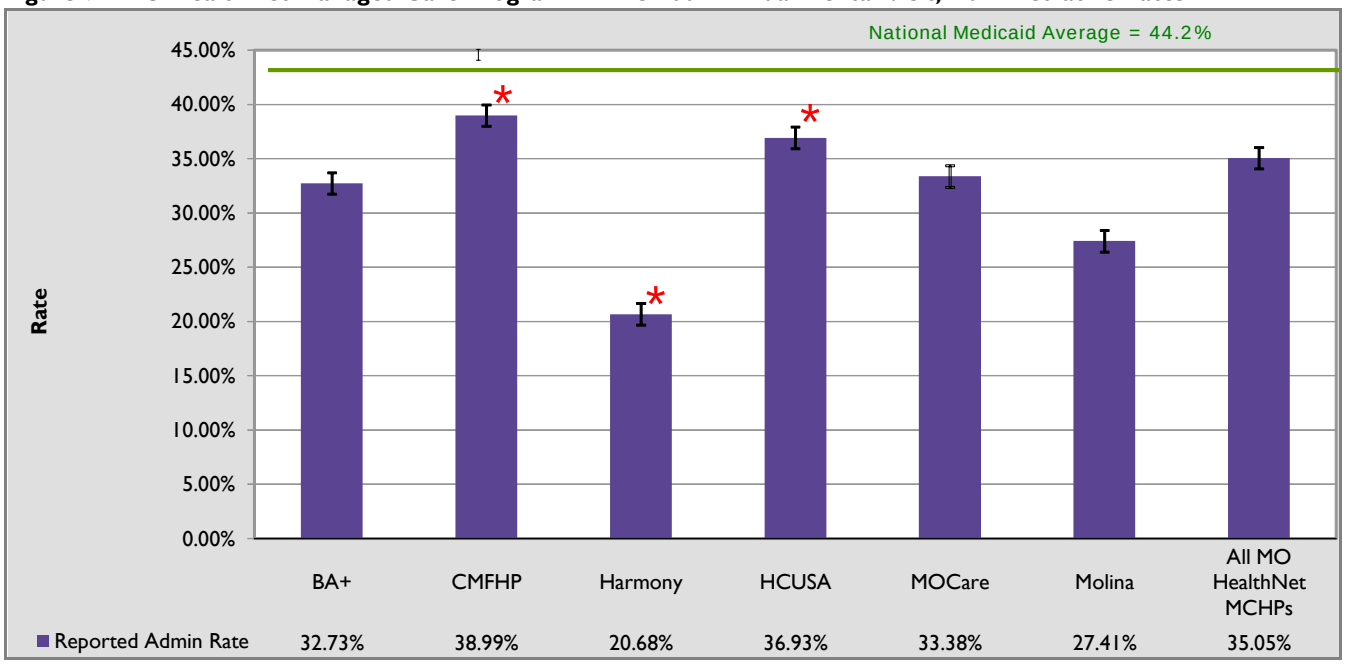


ACCESS TO CARE

The HEDIS 2009 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

For the Annual Dental Visit measure, five of the six MC HealthNet MCHPs reviewed were substantially compliant with the calculation of this measure. One health plan's calculations were rated as not valid.

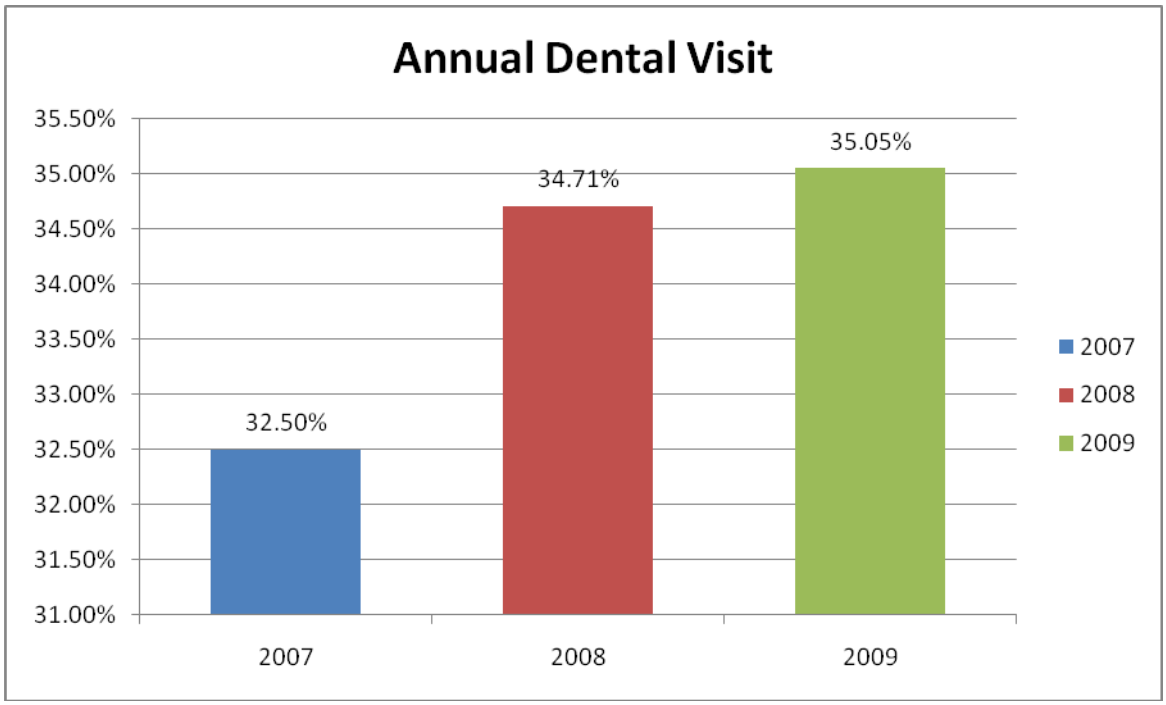
Figure 7 – MO HealthNet Managed Care Program HEDIS 2009 Annual Dental Visit, Administrative Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

The Annual Dental Visits measure has been audited in the 2007, 2008 and 2009 external quality reviews (See Figure 8). Over the course of these review periods, the rates for all MO HealthNet MCHPs have improved a total of 2.55%; the rates reported were 32.50% in 2007, 34.71% in 2008 and 35.05% in 2009. Although the rates have increased for the Annual Dental Visit measure, none of the health plans reported a rate in 2009 higher than the National Medicaid Average of 44.2%.

Figure 8 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit



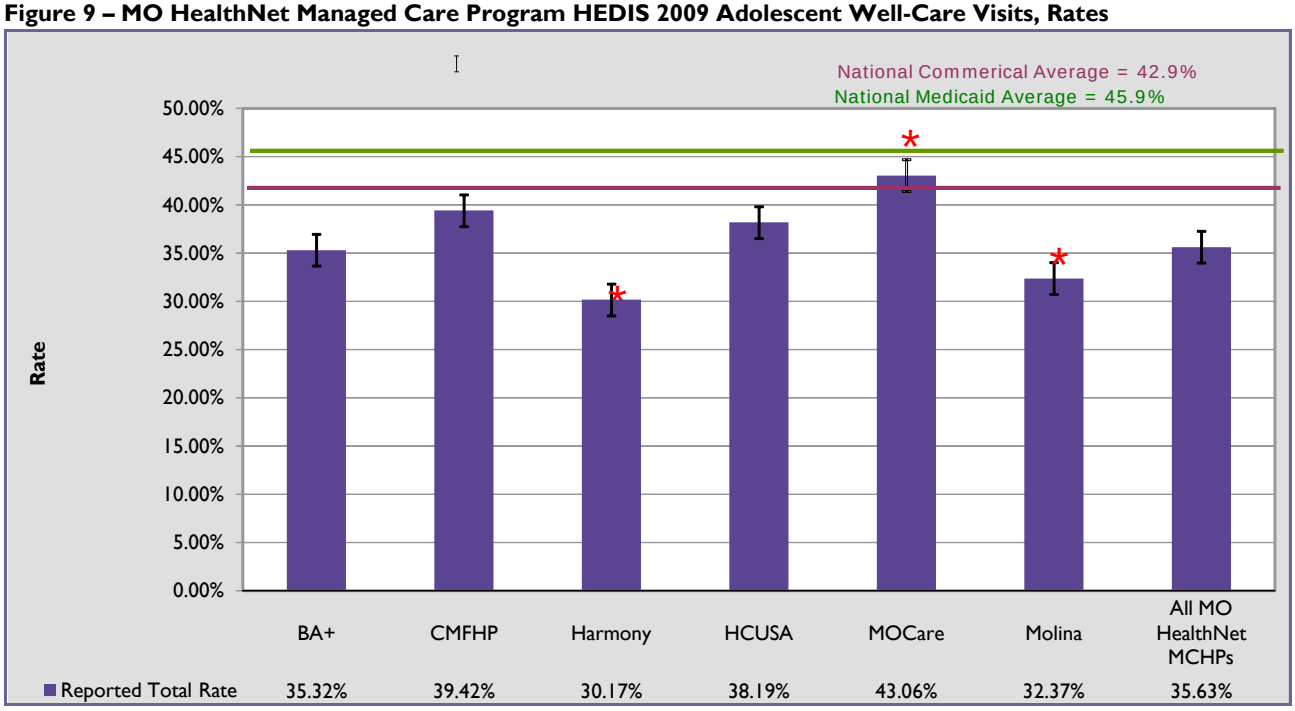
This trend shows an increased level of dental care received in Missouri by MO HealthNet members, illustrating an increased access to care for these services for the HEDIS 2009 measurement year.

Timeliness of Care

The HEDIS 2009 Adolescent Well Care Visits is categorized as a Use of Services measure and aims to measure the timeliness of the care received. To increase the rates for this measure, age specific services must be delivered to members on a yearly basis.

For the Adolescent Well Care Visits measure, two health plans were fully compliant with the specifications for calculation of this measure, and the remaining three were substantially compliant with the measure's calculation (see Figure 9).

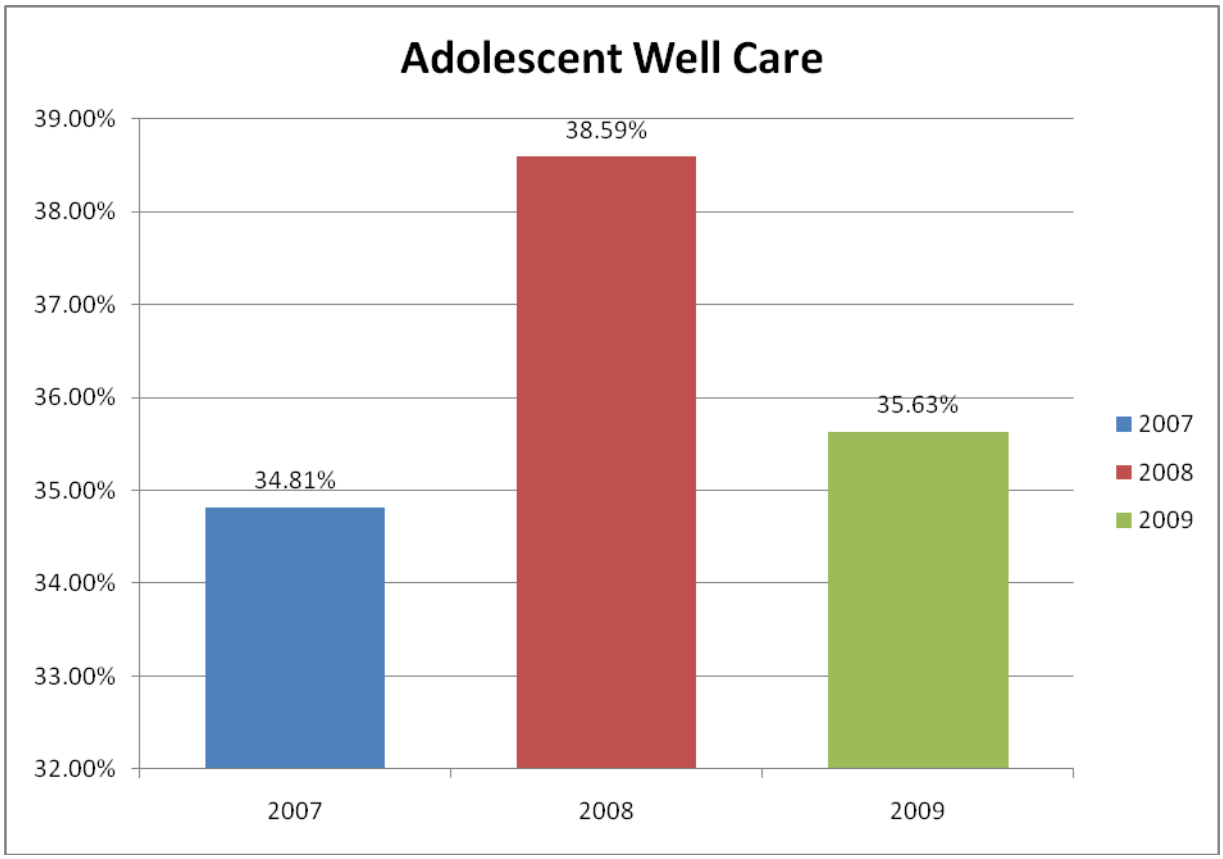
Figure 9 – MO HealthNet Managed Care Program HEDIS 2009 Adolescent Well-Care Visits, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

The Adolescent Well Care Visits measure has been audited in the 2007, 2008 and 2009 external quality reviews (see Figure 10). Over the course of these review periods, the rates for all MO HealthNet MCHPs has fluctuated; the rate reported in 2009 (35.63%) is an improvement over the rate reported in 2007 (34.81%), but is down 2.96% from the rate reported in the previous 2008 review year (38.59%). This illustrates a decrease in the timeliness of care for well care visits delivered to adolescents in Missouri during the HEDIS 2009 measurement year. In addition, one health plan exceeded the National Commercial Average of 42.9%; however, none of the health plans reported a rate in 2009 higher than the National Medicaid Average of 45.9% (see Figure 9).

Figure 10 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Adolescent Well Care Visit

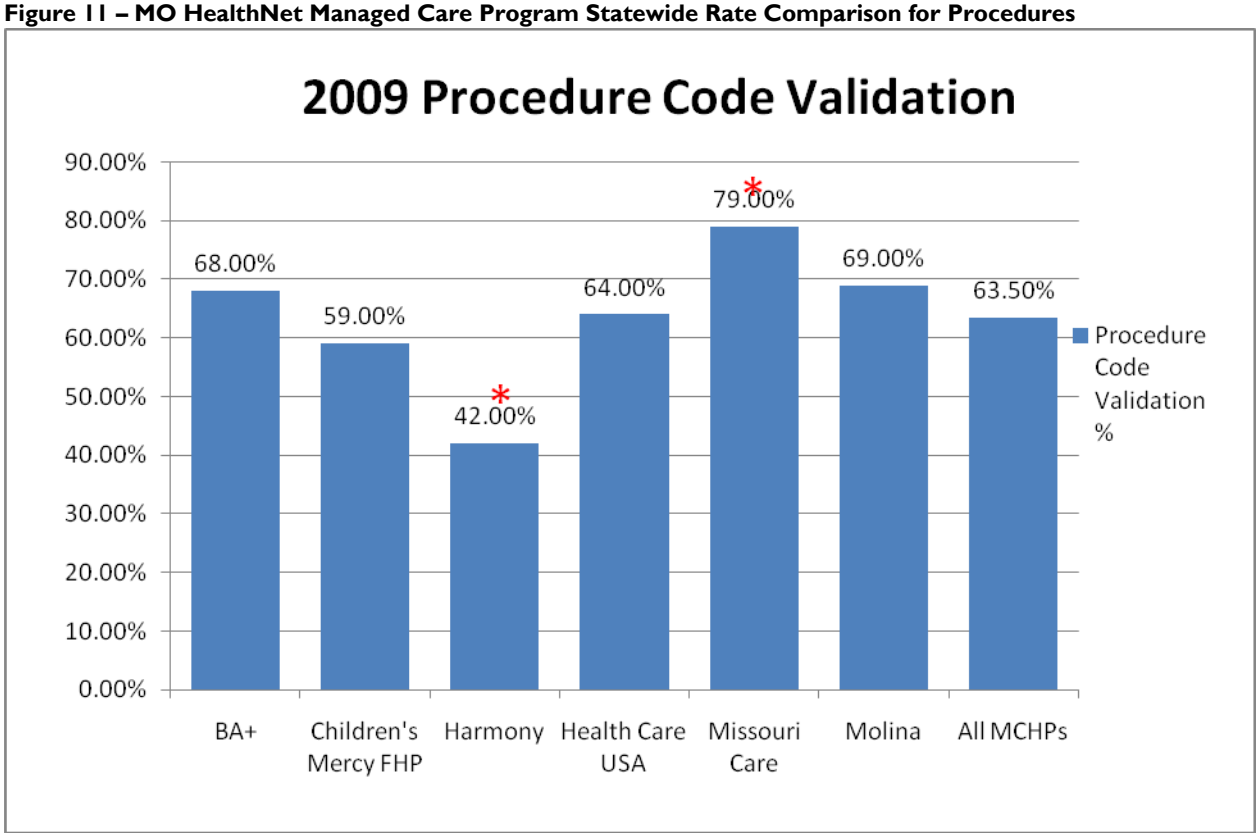


1.4 Encounter Data Validation

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 MO HealthNet MCHPs); 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: 1) diagnosis codes and descriptions and 2) the procedure codes and descriptions in the SMA encounter claims database with documentation in MO HealthNet member medical records.

Figure 11 – MO HealthNet Managed Care Program Statewide Rate Comparison for Procedures



The match rates between the SMA database and MO HealthNet MCHP medical records for claim type procedures were 63.50 %, which is an increase over 2007 (52.0%) and 2008 (59.20%), although an a significant decrease from the 2006 match rate of 73.24% (see Figure 11). Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

Figure 12 – MO HealthNet Managed Care Program Rate Comparison for Procedures (2006-2009)

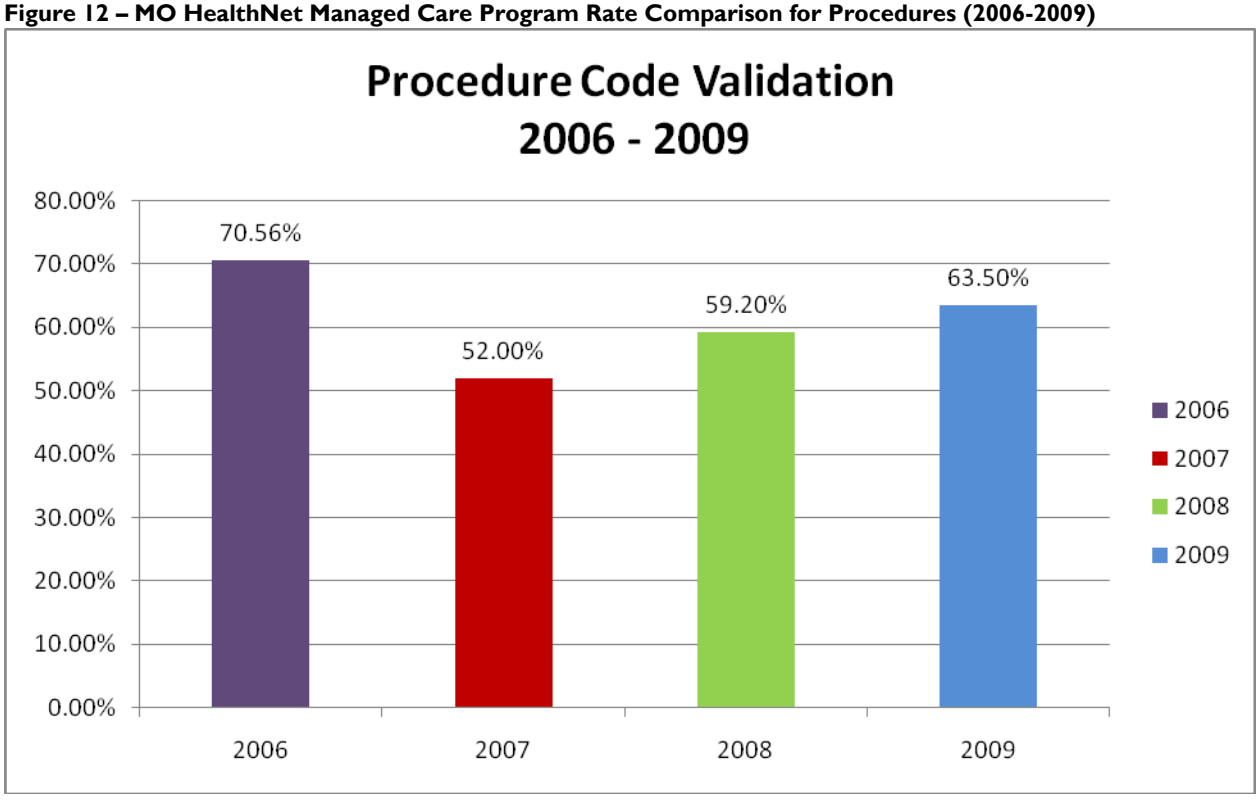
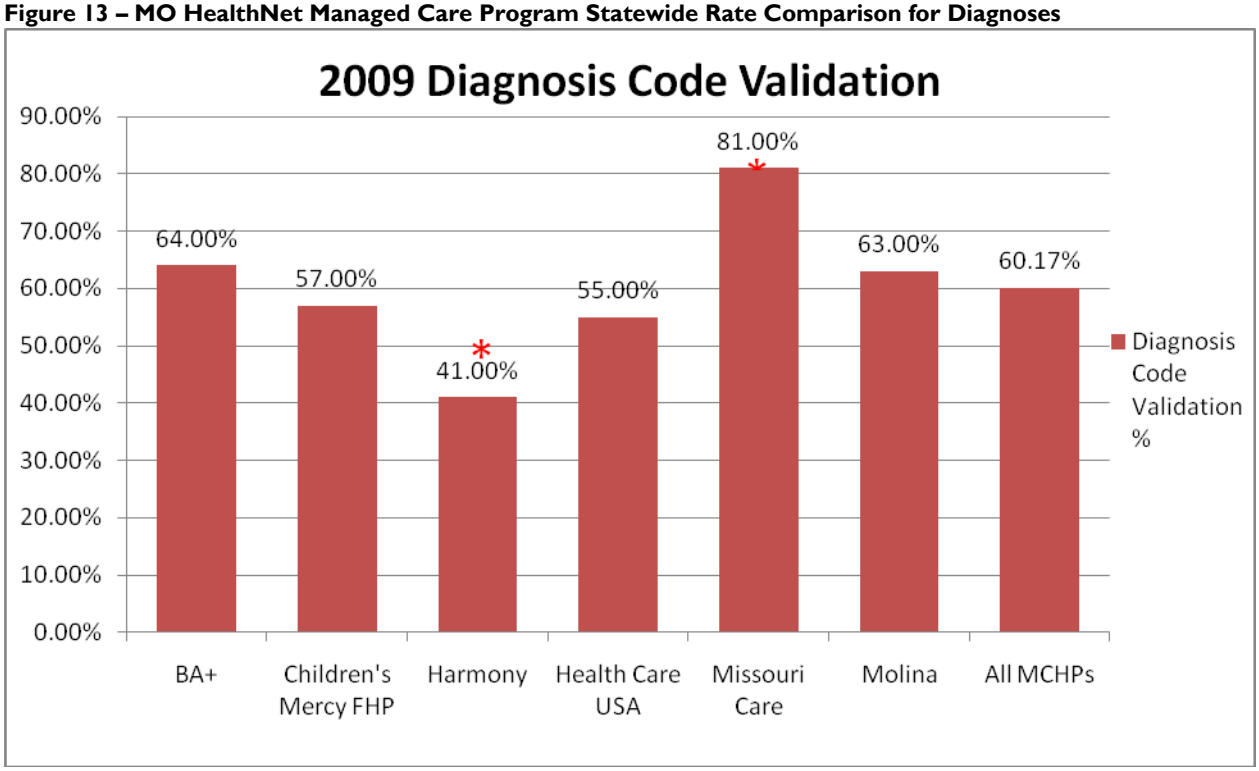
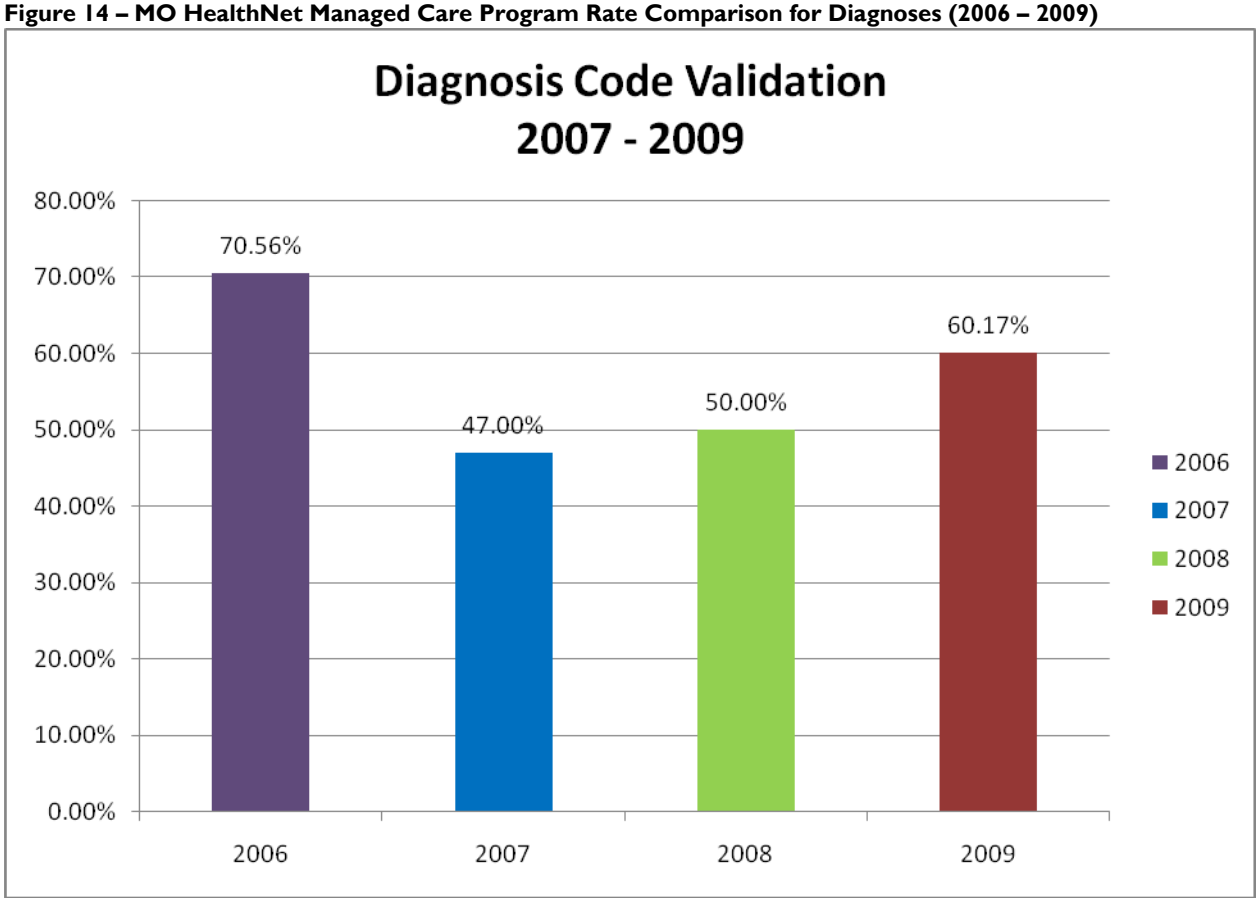


Figure 13 – MO HealthNet Managed Care Program Statewide Rate Comparison for Diagnoses



The match rates between the SMA database and MO HealthNet MCHP medical records for claim type diagnoses were 60.17%, although an increase over 2007 (47.0%) and 2008 (50.0%), this is significantly lower than the 2006 match rate of 70.56%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

Figure 14 – MO HealthNet Managed Care Program Rate Comparison for Diagnoses (2006 – 2009)



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 MO HealthNet MCHP records of paid and unpaid claims. All six MO HealthNet MCHPs 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. All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet MCHPMCHPs. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.
2. All MO HealthNet MCHPMCHPs submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.
3. The examination of the level, volume, and consistency of services found significant variability between MO HealthNet MCHPMCHPs in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), however, no patterns of variation were noted by Region or type of MO HealthNet MCHPMCHP.
4. There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all MCHPs.
5. Unpaid claims represented less than .0001% of all claims submitted to the SMA during the period July1, 2009 through September 30, 2009.

AREAS FOR IMPROVEMENT

1. The Procedure Code field in the Outpatient Home Health, Outpatient Hospital and Outpatient Medical claim types included some invalid information. Most of this was due to blank fields or fields containing "00000".
2. The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.
3. The match rates between the SMA database and MO HealthNet MCHP medical records for claim type procedures, although higher than last year, are still a significant decrease from the 2006 match rate. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.
4. The match rates between the SMA database and MO HealthNet MCHP medical records for claim type diagnoses were an increase over the prior two years' reviews, however they are still lower than the rate found in 2006. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

1.5 MO HealthNet MCHP Compliance with Managed Care Regulations

The purpose of the protocol to monitor Health Plan Compliance with Managed Care Regulations is to provide an independent review of MO HealthNet MCHP activities and assess the outcomes of timeliness and access to the services provided. 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 Health Plan personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MO HealthNet MCHP.

The policy and practice in the operation of each Health Plan 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 MO HealthNet MCHP's policy to determine compliance with the requirements of the MO HealthNet Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO.

The 2009 report is a full compliance review. The MO HealthNet Division reviewed current policies and procedures to ensure that they were in compliance with the current contractual requirements, as well as federal regulations. The EQR Compliance Review focused on implementation of policies and procedures, as required in the Case Management process. The review included case record reviews and interviews with Case Management staff, and with Administrative staff.

Additionally, the interview tools were based on information included in the Health Plans' 2009 Annual Reports to the SMA, and the SMA's Quality Strategy.

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MO HealthNet MCHP's contract compliance. This information was analyzed to determine how it related to compliance with the federal

regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or 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 each health plan's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision.

QUALITY OF CARE

There are thirteen regulations pertaining to Enrollee Rights and Protections. Nine were found to be 100% compliant by all Health Plans, and include:

- Communicating MO HealthNet Managed Care Members' rights to respect, privacy, and treatment options were primary and compliant.
- Communicating, orally and in writing, in the member's native language or with the provision of interpretive services is an area of strength for all Health Plans.
- The MO HealthNet MCHPs recognized that these requirements are essential to create an atmosphere of delivering quality healthcare to members.
- The Health Plans maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare.
- The Health Plans responded to physical, emotional and cultural barriers experienced by members with diligence and creativity.
- The Health Plans demonstrated an awareness of Enrollee Rights and Protections by have standards and practices in place that were compliant and evident in discussions with the staff who interact directly with members. The attention to ensuring quality care was apparent throughout each of the Health Plans.

There are 10 regulations for Structure and Operations Standards that lead to the provision of quality healthcare. The Health Plans were 100% compliant with six of these regulations.

- These regulations included provider selection, and network maintenance, subcontractual relationships, and delegation.
- The Health Plans had active mechanisms for oversight of all subcontractors.
- The Health Plans improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their MO HealthNet Managed Care Members.

ACCESS TO CARE

There are seventeen (17) regulations pertaining to Access Standards. Nine of these regulations were found to be 100% compliant by all of the Health Plans. Four of the MO HealthNet MCHPs were fully compliant with the 17 federal regulations concerning Access Standards. Five MO HealthNet MCHPs monitored high risk MO HealthNet Managed Care Members and had active case management services in place. These nine regulations found to be fully compliant included:

- Second Opinions;
- Utilization of out-of-network services, including cost sharing and adequate and timely coverage;
- Timely access to care;
- Cultural Competency in Provider Services;
- Timeliness for decisions and expedited authorizations;
- Compensation of utilization management activities; and
- Timeliness of decisions regarding care and emergency and post-stabilization services.

Five MO HealthNet MCHPs monitored high risk MO HealthNet Managed Care Members and had active case management services in place.

- Each health plan described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs. Many of these case management programs exceeded the strict requirements in the MO HealthNet Managed Care contract.
- Five of the health plans could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required.
- The Case Management staff at each Health Plan described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs.

One area of concern is care coordination. Although five of six health plans had all required policy in place. Two health plans were unable to demonstrate that they had fully compliant care coordination processes in place. All six health plans state that complete care coordination is an area where they seek improvement.

TIMELINESS OF CARE

There are twelve (12) regulations for Measurement and Improvement that address the need for timeliness of care. Four of these were found to be 100% compliant by all of the Health Plans. All six health plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members.

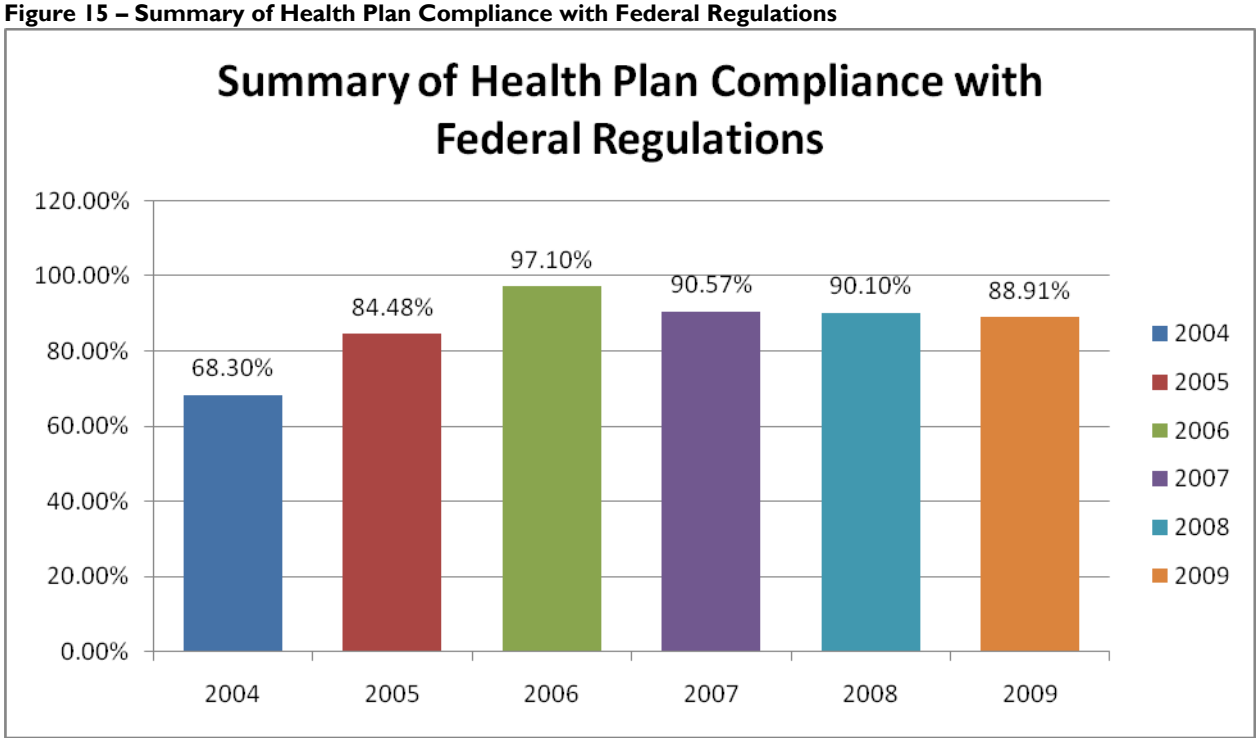
- All six Health Plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members.
- The Health Plans used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.
- The Health Plans continue to exhibit improvement in the utilization of data and demographics in their systems to track and trend information on members to assist in determinations of risk and prevention initiatives.
- Several Health Plans began using member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery.
- The Case Management departments communicated that they had integral working relationships with the Provider Services and Relations Departments of the Health Plans.
- All front line staff and administrators interviewed 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 Health Plan members.
- The Health Plans all provided examples of how these relationships served to ensure that members received timely and effective healthcare. An example is that at each Health Plan staff contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

CONCLUSIONS

The MO HealthNet MCHPs have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially in 2004 the Health Plans did not have complete and approved written policy and procedures. Health Plan processes did not exhibit compliance with contractual and regulatory requirements. In subsequent measurements the Health Plans made concerted efforts to complete policy and procedural requirements. In 2007, 2008 and 2009 the review examined not only the written policy, but also conducted interviews to identify if the activities of front line and administrative staff were in compliance. With the exception of one Health Plan (Harmony), which has not yet completed required policy, and is continuing to develop

compliant organizational processes, continued improvement was observed. The Health Plans have used previous External Quality Reviews to ensure that compliant policies are in place, and continue their efforts to ensure compliant and member focused procedures.

Figure 15 – Summary of Health Plan Compliance with Federal Regulations



1.7 MO HealthNet MCHP Best Practices

For this year's review, it was requested of the EQRO to obtain a best practice from each health plan to be included in the Annual Report. Below are summaries of these best practices by health plan.

Blue-Advantage Plus of Kansas City	Emergency Room Interventions
Children's Mercy Family Health Partners	Customer Service Best Practices
Harmony Health Plan of Missouri	Case Management Information System
HealthCare USA	Neonatal Intensive Care Unit (NICU) Project
Missouri Care Health Plan	Dental Outreach Initiatives
Molina Healthcare of Missouri	Cesarean Section Wound Infection Project

BLUE ADVANTAGE PLUS

Emergency Room Interventions

To reduce non-emergent emergency room (ER) utilization and educate members about appropriate care, Blue-Advantage Plus has implemented several interventions. Below is a listing and description, by year, of all interventions implemented for Blue-Advantage Plus members

2007

- Intervention 1: Well Aware - Ongoing
  The Blue-Advantage Plus Well Aware member newsletter has adopted a strong focus on educating the member on how to access appropriate care, where to get appropriate care and transportation options. The newsletter is sent to all Blue-Advantage Plus member households each quarter. The following articles have been included in Well Aware.
  - Well Aware (Spring 2007, Spring 2009) – When to Go to the ER
  - Well Aware (Winter 2007, Fall 2007, Winter 2008, Winter 2009, Winter 2010) - When It's Not Quite An Emergency
  - Well Aware (Winter 2008, Winter 2009) – How to Know When It's An Emergency
  - Well Aware (Summer 2008, Summer 2009) – Where Should You Go For Care?
  - Well Aware (Fall 2008) – Urgent Care
  - Well Aware (Winter 2009) – A Medical Emergency: Are You Ready?
  - Well Aware (Fall 2009) – Is It Really An Emergency?

2008

- Intervention 2: Transportation - Ongoing
  One of the findings associated with barriers to appropriate ER utilization was members did not know the details of their transportation benefit. To remove the transportation barrier, Blue-Advantage Plus began to include articles on transportation in Well Aware. By including articles on transportation in Well Aware, Blue-Advantage Plus is educating and informing members of their transportation benefits. The following articles have been included in Well Aware.
  - Well Aware (Spring 2008) – We'll Pick You Up
  - Well Aware (Summer 2008, Winter 2008, Winter 2009) – Take the Bus
  - Well Aware (Winter 2010) – Get Paid for Gasoline
- Intervention 3: Urgent Care Centers - Ongoing
  In 2008, Blue-Advantage Plus developed a member-friendly list of urgent care centers (see attachment A) and included it in all information packets that were mailed to members (i.e., new member letters, Self-Care Guide packets, vaccination packets, and lead packets).
- Intervention 4: Welcome Call Script - Ongoing
  In 2008, the Blue-Advantage Plus Welcome Call Script was modified to include a paragraph educating new members about the importance of their PCP. In addition, information is provided on how to obtain medical help for no-emergent or emergent situation. Members are also informed to contact the customer service line if they are having trouble making an appointment.
- Intervention 5: Nurse Advice Line – Ongoing
  It was discovered on analysis of the Nurse Advice Line's regular reports that they were not referring members to any urgent care centers. Upon investigation, it was discovered that Nurse Advice Line did not have an urgent care center option in their decision algorithm when referring a member to a treatment setting. State Programs sent Nurse Advice Line detailed information of the Blue-Advantage Plus urgent care center network and requested that Nurse Advice Line incorporate this information in the decision algorithm when referring a member to treatment. As a result of this recommendation, Nurse Advice Line acted promptly in updating their decision algorithm, and conducted 130 hours of training to the nurse advice line staff on urgent care center options for treatment.
- Intervention 6: Case Management Outreach – Ongoing
  State Programs runs a report on a weekly basis to identify members who went to an ER within the last week and a member who went to the ER four or more times in the previous year. A Blue-Advantage Plus of Kansas City nurse case manager reviews the report and makes outreach calls to the parent or guardian of 0-6 year old members who appear on the report. The case manager conducts a biopsychosocial assessment and offers education to the member on alternative treatment settings and encourages contact with the PCP. In addition, the nurse case manager provides education about transportation, self-care, and the Nurse Advice Line. In 2009, BA+ began offering to send a Self-Care Guide to members who received Case Management Outreach. Results for 2008 and 2009 are listed below

2009

- Intervention 7: Blue-Advantage Plus ER Magnet Mailer - Ongoing
  Blue-Advantage Plus implemented the magnet mailer (see attachment B) intervention in 2009. A flyer educating the member on appropriate settings for care, promoting the use of urgent care centers, explaining the transportation benefit and providing a magnet with the telephone numbers for the Nurse Advice Line is sent to members in the target population. The flyer also contains the PCP contact information for each individual member. In addition, each consecutive time a member visits the ER for a non-emergent reason, a follow-up letter will be mailed to the

member reminding them of urgent care centers, their PCPs contact information, the Nurse Advice Line and the transportation benefit. Results for 2009 are listed below.

- Intervention 8: Blue-Advantage Plus Website - Ongoing
  On October 1, 2009, Blue-Advantage Plus launched a new website (www.bapluskc.com) dedicated to Blue-Advantage Plus members. The website contains information on the benefits of the urgent care center and a list of urgent care centers that are in the Blue-Advantage Plus provider network. Blue-Advantage Plus members are able to visit the Blue-Advantage Plus website and quickly locate an urgent care center if they need to seek treatment.
- Intervention 9: PCP Collaborative Outreach – Ongoing
  In 2008, Blue-Advantage Plus set out to collaborate with high-volume PCP groups to partner with them to encourage members to use the PCP as their "medical home." By providing PCPs with our report of members who visit the ER, on a weekly and timely basis, PCPs can conduct their own outreach and intervention with these members. Ideally, Blue-Advantage Plus would like to see the PCPs provide active coordination of the care of these members across all settings of care. Due to time constraints and staffing issues with the PCP groups, Blue-Advantage Plus was unable to engage any high volume PCP offices for collaborative outreach efforts.
  In 2009, Blue-Advantage Plus revised the PCP collaborative intervention. Blue-Advantage Plus identified eight members who belonged to a high volume PCP group and utilized the ER excessively for non-emergent reasons in 1Q09. Throughout 2009, Blue-Advantage Plus offered all in-house interventions and monitored ER utilization.
  ER utilization for the eight members continued to rise and an ER report was developed and presented to the BCBSKC Director, Provider Relations for possible referral to the PCP's at Swope Health Services to determine if any outreach by the PCP's could be provided.

2010

- Intervention 10: ER Magnet Mailer – Ongoing
  Blue-Advantage Plus will send a mass mailing of the ER Magnet Mailer to all Blue-Advantage Plus households. This intervention will serve as a tool for educating members about appropriate use of the PCP, urgent care centers, transportation, and the Nurse Advice Line.

Measurable Results

Outcomes of the Case Management and ER Magnet Mailer Interventions are listed below.

Case Management Outreach - 2008

In 2008, 115 members received case management outreach. Twelve months prior to the initiation of this case management intervention, the 115 targeted members had 276 visits to the ER (costs totaling $70,356). Eighty-five percent of the visits (238 visits) were for non-emergent cases (costing $54,220), while the remaining 15% (38 visits) were for emergent cases (costing $16,136).

Post Intervention (12 months), there was a 37% reduction [(238-151)/238] in non-emergent ER visits and a 20% decrease [($54,220 - $43,245/$54,220]. In addition, the case management outreach decreased non-emergent cost by $10,975 generating a total net savings of $14,665 in ER cost.

Case Management Outreach - 2009

In 2009, 135 (0 to 6 year old) members received case management. Post intervention results show an annualized 36% [(519-334)/519] **reduction** in non-emergent ER visits. In addition, results show an annualized 38% [($240,314- $148,294)/$240,314] **decrease** in non-emergent ER cost

ER Magnet Mailer Intervention - 2009

In 2009, 2,252 members received and ER Magnet Mailer. The charts below show ER cost and utilization for twelve months pre-intervention and twelve months post intervention for the 2,252 members. In analyzing this data, there is a projected 18.3% [(5,707 – 4,662)/5,707] **reduction** in non-emergent ER utilization and a projected 9.6% [($2,497,127 - $2,256,459)/$2,497,127] **decrease** in non-emergent ER cost.

CHILDREN'S MERCY FAMILY HEALTH PARTNERS

Customer Service Best Practices

Customer Service Availability

Customer Service is based in Kansas City, MO and staffed 7AM to 6PM Monday-Thursday and 7AM to 5PM on Friday. The RFP requires that we have the Customer Service department staffed for 9 hours per day. CMFHP feels that by extending our hours, we provide additional support that the families and providers need.

CMFHP implemented a new automatic call distribution system (ACD) to monitor and track our telephone statistics in 2009. This system allows us to more efficiently answer, monitor and route calls from members and providers and provide improved quality control.

CMFHP measures telephone statistics for call abandonment rate, average speed of answer (ASA) and service level (percent of calls answered less than 30 seconds) on a daily basis and aggregates this information into a monthly report.

We have been consistent in meeting goals for calls abandoned as well as average speed of answer. In 2009 our Customer Service department received 170,009 inbound calls. 91.27% of these calls were answered in 30 seconds or less with an average speed of answer of 12.42 seconds and an

abandonment rate of 2.54%. In Fiscal Year 2009, even with an increase in call volume, all phone statistics were met consistently for the 12 month period.

Many call centers will not count hang up calls unless the caller is on hold for a specified amount of time or even block calls when queue hold times reach certain levels. CMFHP considers an abandoned call as any call in queue that hangs up before it can be answered, regardless of the amount of time the caller has been on hold and does not block calls (i.e., if a caller hangs up after 10 seconds, the call is counted in our service levels).

Improvements in Providing Customer Relations

In Fiscal Year 2009, the following enhancements to improve quality within the Customer Relations department were implemented:

Skills Based Routing

We employ skills based routing of calls to ensure that representatives skilled in certain areas have priority in answering the calls first. This formula is used primarily for claims and bilingual calls. Thirty percent of the Customer Service representatives are bilingual and all our system allows for our Hispanic population requiring a Spanish bilingual rep to be offered the first chance to answer the call. When a call has not been answered in a predetermined amount of time, then these calls go into an overflow category. The customer service representative not fluent in the member's preferred language will then connect the member with our contracted language line service for a three way conversation.

Customer Service Call Back

The Customer Service department at CMFHP administers a customer call back program to ensure the quality of service provided to our members and monitor how well we are meeting member expectations. The program involves randomly selecting 15 calls each week (using the previous week's call logs) and having a Senior Customer Service Representative call the member to ask some focused questions related to his/her recent experience with Customer Service staff. When contact is made with the member we ask if their issues were resolved, questions were answered and if they were treated with respect and professionalism. Member satisfaction is judged in two ways. First by reviewing the notes and determining if correct actions were taken by the customer service representative regardless if the member was contacted or not. Secondly, satisfaction is judged by the member's response to our questions. A negative member response or incorrect actions taken by the representative would indicate an unsatisfied member. In 2009, CMFHP CS representatives

made 3,709 outbound attempts and contacted 1007 members (27.15%). This program has shown a 96% member satisfaction where both correct actions were taken and the member's satisfaction was achieved. Follow up education is then provided to the Customer Service team to improve quality. The general comments have been very positive from members. We believe that there is a lasting impression left with each member contacted ensuring they have a voice in the service provided.

Post Call Satisfaction Survey

In order to keep a pulse on quality, we also began administering an automated Post Call Satisfaction Survey through our phone system in 2009. Members are informed they have the right to be transferred to a satisfaction survey at the end of the call. There are seven questions and the calls can be traced to the individual representative who answered the call. Return calls are made to members who indicate a poor experience with a customer service representative and any additional assistance is offered at that time. Based on the information from the member, training is conducted with that customer service representative. Overall member satisfaction survey results show 94.4% rated the help they have received as Excellent or Very Good with 2,557 members completing the survey.

Post Call Evaluations

100% of all inbound and outbound calls into the Customer Service queue are recorded. Calls are both live monitored and recorded. Recorded calls are assessed for quality assurance. A grading system has been developed to rate the call for accuracy of information as well as overall courtesy. Representatives are first trained on the standards of the grading system. Feedback is then provided to the specific representative as well as the department for education and any identified follow up needs. Our goal is to offer answers to members and providers with one call resolution.

HARMONY HEALTH PLAN OF MISSOURI

Case Management Information System

WellCare maintains a health information system called Enterprise Medical Management Application (EMMA). This system maintains a member record that is transparent across the company and very complete regarding all aspects of the member's involvement with WellCare. The system is

compliant with HIPAA and protects PHI, with many system level security options and regulations. The implementation of EMMA took place during June 2008.

The case management software system is user friendly, offers comprehensive assessments, a care plan that drives the members' care through goal setting, and safely maintains the member record in a member centric fashion.

Goals:

The goals of the CM program are in accordance with, and contribute to the achievement of the mission and vision statements of WellCare in the delivery of quality healthcare in the most cost effective manner for members and are as follows:

- Enhance a member's safety, productivity, satisfaction and quality of life
- Provide coordination of care services to members utilizing evidence based guidelines
- Identify and eliminate barriers to care and wellness
- Ensure and facilitate access to quality healthcare
- Offer education and information on available resources, clinical topics and access to services
- Empower members to be advocates for their care and foster independence and knowledge of self-care
- Provide members with ongoing access to qualified healthcare professionals
- Maintain ongoing documentation and reporting of goal achievement
- Maintain cost effectiveness in the provision of health services

The EMMA system allows for WellCare to focus on integration of the following areas:

- Care management
- Behavioral health
- Pharmacy
- Utilization management (intake to appeals)
- Increase in membership within Case Management in 2008 and continue to increase membership in case management through 2009 with the use of EMMA.

Integration assists in the elimination of silos and offers our members and providers an integrated model of care.

Enhancement to EMMA in 2009
October 2009

- Can choose to add a Problem from existing Problem list.
- Can use CUSTOM Goals and Interventions.
- Can label your goals either Long Term and Short Term Goals
- Target Completion Date field
- Care Plan Reviewed/Revised Date and Signature field

July 2009

- SF-8 document placed in system.
- Adding additional fields to the Program tab to better track Case Managed members.
- New print-out version of the Care Plan
- A new compliance-driven feature to automatically generate approval letters to members for authorizations that are pre-service, expedited-requested, approved, and for Medicare LOBs. The letters will generate with no user intervention. When an authorization is processed, a pop-up message appears notifying the Case Manager that a letter has gone out and a note will automatically be written in the Notes tab.
- The OB CM Referral Task feature has been improved to eliminate unnecessary messages and ensure the tasks generate at the appropriate times

May 2009

- UM Decision Support (Auth Lookup)
- UM—Inpatient automation
- Benefit accumulator
- Exception alerts
- 2 BH Assessments (stand alone Cage and Edinburgh).
- Pediatric and Transplant Assessments
- Custom Care Plan Printout
- Disease State Indicator/ Med Screens
- Lab Data (Qwest and Lab Core)

HEALTHCARE USA

Neonatal Intensive Care Unit (NICU) Project

According to the 2001 Nationwide Inpatient Sample from the Healthcare Cost and Utilization Project, 10% of U.S. newborns are admitted to neonatal intensive care units (NICUs). Approximately 8% of all admissions in the first year of life included a diagnosis of preterm birth/low birth weight. NICU stays for preterm and low birth weight infants contribute to 50% of all infant hospitalization costs in the first year of life. NICU admissions account for 25% of national health care costs for ALL children, demonstrating an enormously disproportionate share of healthcare dollars spent on these conditions.

At HCUSA, where approximately 85 percent of the member population is children and pregnant women, the percent of NICU admissions increased from 8.8 percent in 2004, and to 12.5% percent in January of 2007. During 2007, HCUSA experienced approximately 43 NICU admissions per month with an average length of stay of 24.6 days and an average cost of $33,329 per NICU admission, with outliers removed from the data.

HCUSA was able to track 425 NICU admissions for the first two full years of life. The average length of time on plan for these infants was 18.2 months Of these 425 NICU graduates, 68 or only sixteen percent were adherent to immunizations at the end of the second year of life and the average number of Primary Care Provider visits within two years was 4.8. These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life. Within this population, there were 193 hospital readmissions and 1,121 Emergency Department visits contributing to an average cost per NICU graduate of $49,498 within the first two years of life. The lack of preventive services received, frequency of emergency department visits and hospital readmissions, and subsequent cost of care and services suggests that there is an opportunity for improvement in adherence to well care and preventive services, which could lead to a reduction in Emergency Department utilization and hospital readmissions.

> *Aim: Work in tandem with providers, the community, and parent/caregivers of NICU babies to improve outcomes of care and quality of life as evidenced by a five percent decrease in NICU graduate emergency department and unplanned hospital readmissions rates, improvements in immunization rates and well child visits in NICU graduates to the 75th percentile of National*

(Commercial/Medicaid) HEDIS measures for immunizations, and improve member, provider and staff satisfaction with NICU care management services.

The Baby Bears Club NICU program is based on the disease management model used for all of our disease management programs.

For the NICU program there are two parts or components. The first part, upon admission to the NICU, is to collaborate with the NICU team and parents to provide assistance, education, coordination and collaboration to achieve a safe, well-planned discharge for babies. Interventions in this stage include eliminating any barriers to transportation for parents/caregivers to the NICU for bonding, breastfeeding and education. Interventions also include confirming the parent/caregivers choice of primary care providers (PCP) and that the PCP is aware that this member is on their panel as soon as possible to begin establishing the relationship between the PCP/medical home and the parent/caregiver. The NICU nurse uses standardized written education materials that were developed in collaboration with neonatologists and other NICU care providers, community physicians and parents input to reinforce the information provided by the hospital and help the parent learn what to expect and what they can do for their baby and their family during their journey through the NICU and in preparing to take their baby home.

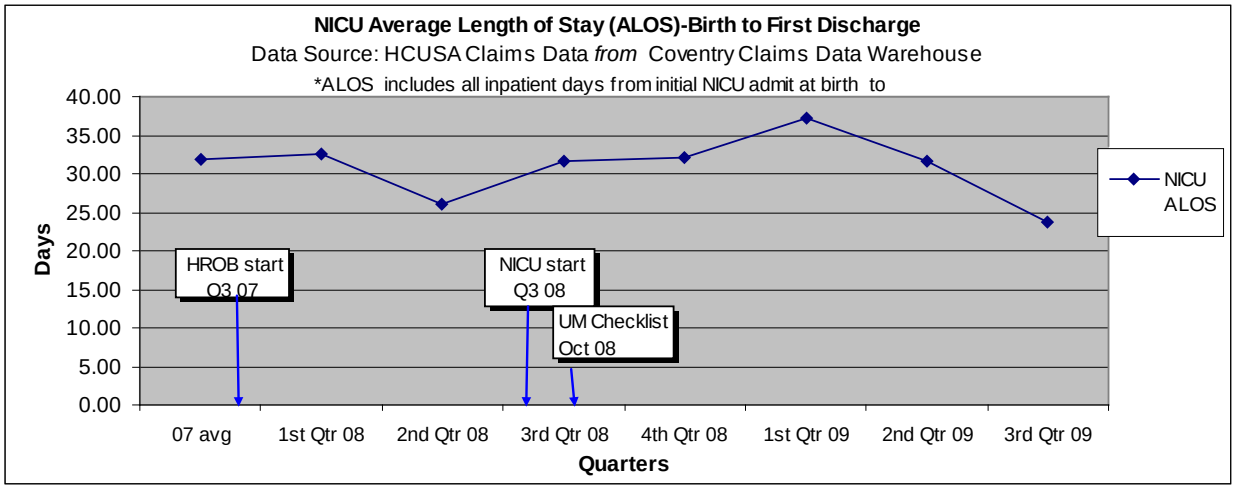
The second part of the program is to actively help the parent/caregiver prepare for discharge and learn what to expect in the transition to home and through at least the first year after discharge. Standardized education materials developed in collaboration with providers and members particular to this time frame/part of the journey are used. The NICU nurse helps assure that all discharge plans are in place including helping to set up and coordinate scheduling of post discharge follow up visits and eliminating barriers to parents/caregivers being able to complete these visits. HealthCareUSA implemented a patient-and-family centered program encouraging bonding from birth, adherence to the AAP well care/specialist visits and immunization schedule by providing standardized nursing assessments, intense education and health coaching in collaboration with members and providers.

The primary role of the NICU nurse is to establish a positive, trusting relationship with the parent/caregivers, the NICU team and the primary care provider to identify and resolve real and perceived barriers to parents/caregivers successful self-management in caring for their NICU baby. In year 1, there were 58 continuously enrolled. Results for these 58 participants include:

- PCP visit rate per member month increased from an average of 4.8 in the first two years to an average of 9.2 visits in the first year of the NICU program.
- 77% of program participants are fully compliant with all components and frequency of HCY/EPSDT visits.
- 50% were fully adherent to immunizations at the end of the first year; and another 41% were mostly adherent, with "mostly" meaning members missing 1or 2 immunizations and missing only flu, pneumonia and/or rotavirus vaccinations.

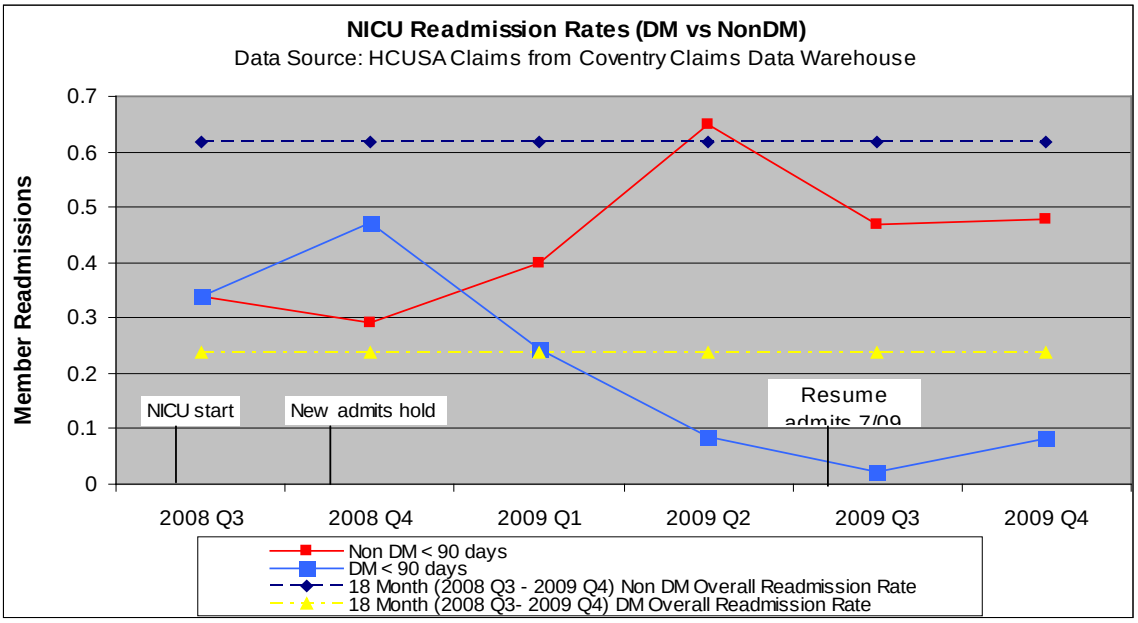
Outcome metrics for the program participants as compared the 425 NICU graduates identified as the baseline data and non-program participants includes the following:

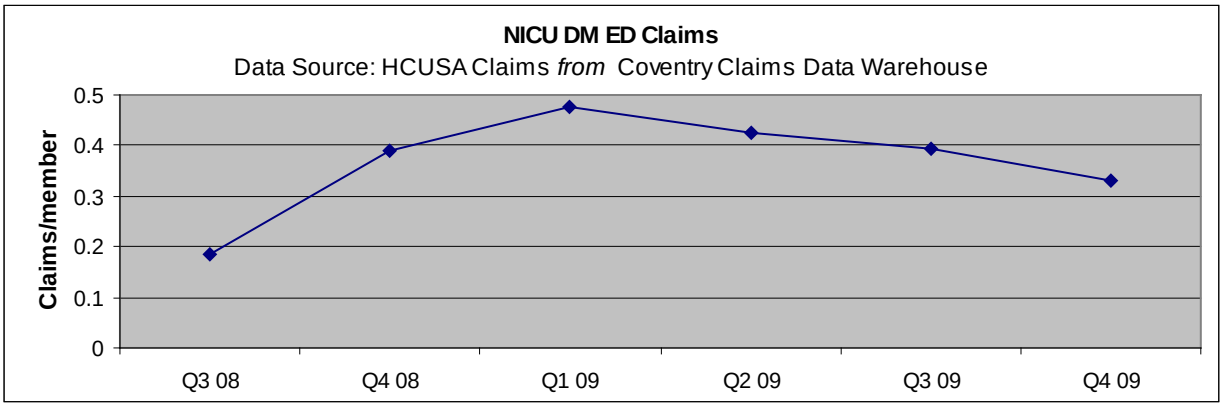
- NICU ALOS from 24.6 to 23.75.
- ED visit rate per member months from 0.34 to 0.021 participants as compared to non NICU program participant rate of 0.47.
- 90-day readmission rate per member months decreased from 0.34 overall to 0.08 for program participants and 0.48 for all other NICU graduates.
- Mean 18-month readmission rate per member month for participants is 0.24, as compared to the non-participant rate of 0.62.



Since program criteria stratifies to the most acute, a higher treatment failure rate would be anticipated among participants than other NICU-graduates, which did not occur and would suggest the program interventions contributed significantly to the improved outcomes..

Relationships with parents, collaboration with NICU staff and PCPs positively impact our ability to implement program interventions. Non-participants includes those NICU graduates who did not participate in the program because they opted out, they were admitted during the time the new admissions to the program were on hold or because, even though they were admitted to the NICU, they did not meet program criteria.





The active work of the DM nurse has resulted in the number of ED visits/member dropping from 0.475 in January of 2009 to 0.33 in December of 2009.

It is possible that if new program admissions had continued without interruption, the overall results may have been better as the program would have been able to impact a greater number of members. Likewise, if additional NICU staff was available, the program would be able to enroll a larger number of NICU babies.

MISSOURI CARE HEALTH PLAN

Dental Outreach Initiatives

During February 2010, National Dental Month, MO Care partnered with Head Start Programs, daycare centers, and preschools across the state. The initiative, known as Show Me Smiles, was to provide oral health information and education, a toothbrush, and toothpaste to each child in the program. MO Care hoped that through early education, dental diseases and the need for costly treatments later in life could be avoided. Through these partnerships, MO Care was able to get information to parents about their child's oral health and the importance of regular dental visits and preventative care.

Show Me Smiles featured a fun, interactive 15-20 minute presentation that taught children about dental hygiene and the basics of keeping their teeth clean and healthy. They were taught proper brushing techniques with a dental puppet, what makes cavities, why healthy foods, snacks, and drinks are important and how to identify them. The children were also given educational materials, a coloring page, and other appropriate handouts, in addition to their toothbrush and toothpaste. The initial goal of Show Me Smiles was to form 140 partnerships and provide toothbrushes and tubes of toothpaste to 7,000 children. By the end of National Dental Month in February, the MO Care outreach team had made 152 visits and provided 6,000 toothbrushes and toothpaste. In fact, the Dental initiative was so popular that MO Care had to schedule visits well into summer to meet the request of the school partners.

On August 7th, MO Care partnered with the Saint Louis Dream Center for a back-to-school fair. The Dream Center is one of the largest inner city ministries of the Saint Louis community sponsored by Joyce Meyers. We were asked by the ministry to provide health screenings, backpacks, and dental screenings for the event. DentaQuest provided the dental screenings. Last year approximately 2,500 potential members attended the fair. The dentists set up lamps and tables like a real dental office and stated that they could handle anything that was normally

completed within a dental office setting. The Pastor was so grateful that MO Care could provide such a service. Through our partnership with DentaQuest, we were able to provide much needed dental services on the spot to MO Care members as well as potential members.

MOLINA HEALTHCARE OF MISSOURI

Cesarean Section Wound Infection

Molina Healthcare of Missouri (Molina) is a Medicaid Managed Care Organization in Missouri with over 78,000 MO HealthNet members in the Eastern, Central and Western regions. Molina provides medical coverage for approximately 4600 pregnant women a year. Approximately 30% of the pregnancies result in a cesarean section delivery, and a small subset of these women will have a post-operative wound infection.

As with any surgical procedure, cesarean sections (CS) have an established rate of complications. The most common CS complications are a post operative wound infection. The medical literature establishes the cesarean section wound infection (CSWI) rate at 1.5%. Approximately 10% of these infections require hospitalization, for an overall rate of 0.15% of all cesarean sections leading to a hospitalization due to infection. The vast majority of these infections and hospitalizations are preventable.

Molina hypothesized that the incidence and severity of CSWI can be reduced via increased home health nursing visits and member education on wound care, follow-up doctor appointments and early, appropriate treatment of any developing infections. This would, in turn, lead to a decreased rate of re-hospitalization related to CSWI. Decreasing the rate of re-hospitalizations will benefit Molina's members by improving the overall status of their health and decreasing risks related to developing a surgical site infection that is severe enough to warrant hospitalization. Additionally, decreasing the rate of re-hospitalization will benefit Molina's members by decreasing any potential physical separation between the member and the newborn during the immediate postpartum period as well as separation from family and support systems.

To test this hypothesis, Molina developed processes to proactively identify members at risk for a post operative CSWI, and increase post-operative home health care and member education. Once identified, those women with CSWI risk factors were to be followed throughout their pregnancies by Molina's Obstetrical Case Management (OBCM) team which consists of Missouri Registered

Nurses with extensive obstetrical experience. These proactive measures would, in turn, decrease the incidence and severity of CSWI and avoid unnecessary hospitalizations related to CSWI. Claims analysis would be used to support the contention that increased case management and proactive home health care would lead to decreased rates of CSWI-related hospitalization. This new process was started in 2009, with results compared to 2008.

In 2008, Molina had a 1.07% CSWI hospitalization rate. In 2009, the CSWI hospitalization rate dropped to 0.82%. This represents a 33% total reduction in the number of members experiencing CSWI requiring hospitalization. The average length of stay for these preventable hospitalizations was 2.61 days in 2008 and 2.58 days in 2009.

In 2008, the cost associated with the admissions was $203, 627. In 2009, this cost decreased 80% to $39,705. This large decrease in CSWI hospitalization costs is due to earlier identification and treatment of these infections. This leads to shorter hospital stays, less imaging required, and fewer cases that require surgical interventions and other invasive treatments.

The most common factor associated with hospitalization due to CSWI was a pre-pregnancy weight ≥200 pounds. This factor occurred in 50% of the hospitalizations due to CSWI in 2008 and in 83.3% of the hospitalizations due to CSWI in 2009.

If a member who underwent a cesarean section had any CSWI risk factors, Molina's OBCM staff increased the post-operative home health visits from one (1) visit to two (2) visits. Additional home health visits were authorized and arranged as clinically indicated. The visit is initiated by a Molina Registered Nurse OBCM, and performed by a contracted, licensed home health agency nurse. The visit includes the collection of delivery history, a limited physical exam, inspection of the CS wound, and records detailing all findings. Information on appropriate wound care is reviewed with the member. All of the home health visits are sent in a HIPAA-compliant manner to the Molina OBCM. This information is acted upon by the Molina OBCM as indicated. For instance, the obstetrical provider would be immediately notified if there are any signs of CSWI, and the member would be assisted with getting an appointment and provided transportation as necessary. Home health visit frequency and duration is adjusted to meet the member's needs as clinically indicated.

Due to consistent data tracking, extensive outreach via the Molina OBCM team coordinated with home health visits for education and wound assessment, Molina has been able to achieve favorable

results which reflect sustained improvement. These results include decreased hospitalizations for CSWI. The processes and interventions described herein will, over time, continue to improve the overall health of members during the post-partum period as well as decrease any potential physical separation between the member and the newborn during the immediate postpartum period.

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2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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2.1 Definition

A Performance Improvement Project (PIP) is defined by the Centers 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 health plan 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, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2009. All of the health plans submitted continued non-clinical projects regarding Adolescent Well Care Visits, which was originally initiated as a Statewide PIP. The aggregate report was evaluated, and each individual health plan's response and interventions were examined. 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 the goal of a PIP is to improve processes and outcomes of care over time.

The State of Missouri contract for Medicaid Managed Care describes the following requirements for Health Plans in conducting PIPs:

> Performance Improvement Projects: The health plan shall conduct PIPs 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. As requested, the health plan shall report the status and results of each PIP to the state agency, which must include state and/or health plan designated PIPs… The PIPs 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 PIP in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.
- Performance measures and topics for PIPs 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 health plans during the calendar year 2009. The MO HealthNet MCHPs were to have two active PIPs in place, one clinical and one non-clinical. The validation process examines the stability and variability in change over multiple years. The evaluation in 2009 included the initial and ongoing methods utilized in the Statewide PIP, which was the non-clinical PIP evaluated for each health plan for the second or follow-up year. Each health plan committed to implementing individualized interventions to create improved outcomes for their members. These PIPs were evaluated as the nonclinical PIP for each health plan.

2.3 Findings

Below are the PIPs identified for validation at each MCHP:

Molina HealthCare of Missouri	Members at High Risk of Cesarean Wound Infection
	Improving Adolescent Well Care
HealthCare USA	Follow-Up After Hospitalization for Mental Health Services
	Improving Adolescent Well Care
Missouri Care	Improving Chlamydia Screening Rates in Women
	Improving Adolescent Well Care
Children' Mercy Family Health Partners	Improving Dental Health Screening Rates
	Improving Adolescent Well Care
Blue Advantage Plus	Ambulatory Follow-Up After Hospitalization for Mental Health Disorders
	Improving Adolescent Well Care
Harmony Health Plan of Missouri	Lead Screening
	Improving Adolescent Well Care

STEP 1: SELECTED STUDY TOPICS

Study topics were selected through data collection and the analysis of comprehensive aspects of member needs, care, and services; and 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. Two of the clinical PIPs addressed follow-up care after discharge from hospitalization from mental illness; one addressed members at risk of cesarean wound infection; one addressed lead screening; one addressed dental utilization; and one focused on improving the rates of Chlamydia screening for women. All six non-clinical projects addressed improving adolescent well care through health plan specific interventions, as extensions of the Statewide PIP.

Table 1shows the ratings for each item and PIP by MO HealthNet Health Plan. All twelve (12) PIPs provided some rationale demonstrating the extent of the need for the PIP and provided adequate information to support selection of the study topic. Most discussed literature or research supporting the activities to be undertaken, and provided some benchmark comparison data. This section met all the criteria required 100.0% of the time. All of the MO HealthNet MCHPs addressed a broad spectrum of key aspects of member care and services (100.0%). One health plan (Molina of Missouri) originally placed a significant focus on cost savings, but was able to include strategies on identifying and correcting a deficiency in care for their non-clinical PIP. Each health plan submitted one clinical and one non-clinical intervention for review. An array of aspects of enrollee care and services that were related to the identified problem was described.

Utilization or cost issues may be examined through a PIP, but are not to be the sole focus of any study. There were some descriptions of the member populations targeted for intervention in the PIPs. Because the health plans vary widely in the member populations they serve (e.g., other state Medicaid managed care members, commercial members, or Medicare members), it was previously not entirely possible to determine the extent to which the PIP identified, addressed, and measured the needs of the MO HealthNet Managed Care Program population in all cases. During 2009 the PIPs submitted did reflect projects that were focused on the Missouri MO HealthNet population. In addition, PIPs should specifically indicate whether all enrolled populations within the MO HealthNet Managed Care Program were included in the interventions. Finally, age and demographic characteristics should be described. All twelve of the PIPs (100%) "Met" this criteria (Step 1.3).

Table 1 – Performance Improvement Project Validation Findings by Health Plan

		MO HealthNet Managed Care Health Plans											
		Molina		HCUSA		Harmony		MOCare		CMFHP		BA+	
Step	Item	Members at High Risk of Cesarean Wound Infection	Improving Adolescent Well Care	Follow-Up After Hospitalization (MH)	Adolescent Well Cre	Lead Screening	Adolescent Well Care	Improving Chlamydia Screening Rates in Women	Adolescent Well Care	Improving Dental Utilization Rates	Adolescent Well Care	Ambulatory Follow-Up After Mental Health Hospitalization	Adolescent Well Care
	1.1	2	2	2	2	2	2	2	2	2	2	2	2
	1.2	2	2	2	2	2	2	2	2	2	2	2	2
Step 1: Selected Study Topics	1.3	2	2	2	2	2	2	2	2	2	2	2	2
Step 2: Study Questions	2.1	2	2	0	1	2	2	2	2	2	2	2	2
	3.1	2	2	1	2	2	2	2	2	2	2	2	2
Step 3: Study Indicators	3.2	2	2	0	2	2	2	2	2	2	2	2	2
	4.1	2	2	1	2	2	2	2	2	2	2	2	2
Step 4: Study Populations	4.2	2	2		2	2	2	2	2	2	2	2	2
	5.1	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
Step 5: Sampling Methods	5.3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	6.1	2	2	0	2	2	2	2	2	2	2	2	2
	6.2	2	2	1	2	2	2	2	2	2	2	2	2
	6.3	2	2	0	2	2	2	2	2	2	2	2	2
	6.4	2	2	0	2	2	2	2	2	2	2	2	2
	6.5	2	1	0	2	2	2	2	2	1	2	2	2
Step 6: Data Collection Procedures	6.6	2	2	0	1	2	2	2	2	2	2	2	2
Step 7: Improvement Strategies	7.1	2	1	1	1	2	1	1	2	2	2	2	2
	8.1	2	2	0	2	1	1	1	2	2	2	2	2
	8.2	2	1	1	2	1	1	1	1	2	2	2	2
Step 8: Analysis and Interpretation of Study Results	8.3	2	1	1	2	1	2	1	1	1	2	2	2
	8.4	2	1	1	2	1	2	1	1	2	2	2	2
	9.1	2	1	0	2	1	1	NA	2	2	2	2	2
	9.2	2	1	1	2	NA	NA	NA	2	2	2	2	2
	9.3	2	1	1	1	NA	NA	NA	2	2	2	2	2
Step 9: Validity of Improvement	9.4	2	1	1	1	NA	NA	NA	2	1	2	2	2
Step 10: Sustained Improvement	10	2	2	0	NA	NA	NA	NA	2	NA	2	2	2
Number Met		24	15	3	18	15	16	15	21	19	24	24	24
Number Partially Met		0	9	10	5	5	4	5	3	4	8	0	0
Number Not Met		0	0	10	0	0	0	0	0	0	0	0	0
Number Applicable		24	24	24	23	20	20	20	24	23	24	24	24
Rate Met		100.0%	62.5%	12.5%	78.3%	75.0%	80.0%	75.0%	87.5%	82.6%	100.0%	100.0%	100.0%

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

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 MO HealthNet MCHPs 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. Ten (83.33%) of the PIPs included clearly stated study questions (Step 2.1). The study purposes identified were consistent with the remainder of the PIP (the target population, interventions, measures, or methods) in most instances. One health plan (HCUSA) did not include a study question for its clinical PIP and in the non-clinical did not indicate any new or updated interventions. This study question was not updated from the health plan's 2008 submission to the 2009 project.

Table 2 - Summary of Performance Improvement Project Validation Ratings by Item, All Health Plans

		All MOHealthNet MCHPs				
Step	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	12	0	0	12	100.00%
	1.2	12	0	0	12	100.00%
	1.3	12	0	0	12	100.00%
Step 2: Study Questions	2.1	10	1	1	12	83.33%
Step 3: Study Indicators	3.1	11	1	0	12	91.67%
	3.2	11	0	1	12	91.67%
Step 4: Study Populations						
	4.1	11	1	0	12	91.67%
	4.2	11	0	1	12	91.67%
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	11	0	1	12	91.67%
	6.2	11	1	0	12	91.67%
	6.3	11	0	1	12	91.67%
	6.4	11	0	1	12	91.67%
	6.5	9	2	1	12	75.00%
	6.6	10	1	1	12	83.33%
Step 7: Improvement Strategies	7.1	7	5	0	12	58.33%
Step 8: Analysis and Interpretation of Study Results						
	8.1	8	3	1	12	66.67%
	8.2	6	6	0	12	50.00%
	8.3	6	6	0	12	50.00%
	8.4	7	5	0	12	58.33%
Step 9: Validity of Improvement	9.1	7	3	1	11	63.63%
	9.2	7	2	0	9	77.77%
	9.3	6	3	0	9	66.66%
	9.4	5	4	0	9	55.55%
Step 10: Sustained Improvement	10.1	6	0	1	7	85.71%
Number Met		**217**	**45**	**11**	**273**	**79.49%**

Note: Percent Met = Number Met/Number Applicable; Item refers to the Protocol specifications.
Source: BHC, Inc., 2009 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

Most of the PIPs "Met" the criteria for defining and describing the calculation of study indicators. Eleven (91.67%) of the PIPs "Met" the criteria for using objective, clearly defined, measurable indicators (Step 3.1). The calculation of measures was described and explained. Even when well-known measures were used (e.g., Healthcare Effectiveness Data and Information Set--HEDIS; Consumer Assessment of Health Plans Survey--CAHPS), there was a detailed description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Again, because MO HealthNet MCHPs vary in their method of calculation, details regarding the measures and methods of calculating those measures should be included in PIPs. One health plan (HCUSA) did not clearly define indicators. Conflicting information was presented and never clarified. All but one of the 12 PIPs identified and detailed at least one study indicator that was related to health or functional status; or to processes of care strongly associated with outcomes. Eleven of the 12 (91.67%) were rated as "Met" (Step 3.2); and one was rated as "Not Met." In this case the health plan (HCUSA) did not relate improved numerical measures with any improvement of services or healthcare to members. The link between the intervention and the outcomes measured by the PIP should be explicit in the narrative.

STEP 4: STUDY POPULATIONS

The MO HealthNet MCHPs all made an attempt to meet the criteria for adequately defining the study population. The evaluation examines if all the MO HealthNet Managed Care Program Members to whom the study question(s) and indicator(s) were relevant are included. Eleven (91.67%) did include adequate information to make this determination (Step 4.1). Eleven of the PIPS, including those considered non-clinical, made an attempt to define the applicable study population considered. The selection criteria should clearly describe the MO HealthNet Managed Care Member populations included in the PIP and their demographic characteristics. Eleven of the 12 PIPs (91.67%) described data collection approaches indicating that data for all members to whom the study question applied were collected (Step 4.2). In most cases there was a description that at least allowed inference of how data were collected and how participants were identified. One health plan (HCUSA) failed to define the population or provide narrative on how the study methodology would capture the population.

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. It should be noted that for the six (6) PIPs concerning Adolescent Well Care results were based on the HEDIS technical specifications, which are an actual sample. However, this was accepted by all health plans and an assessment of this sampling technique was audited in the Performance Measure section of this report.

STEP 6: DATA COLLECTION PROCEDURES

Eleven of the 12 PIPs (91.67%) described the data to be collected with adequate detail and description of the units of measurement used (Step 6.1). Eleven of the 12 (91.67%) PIPs clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). Several MO HealthNet MCHPs used the National Committee for Quality Assurance (NCQA) Quality Improvement Activity (QIA) Form to write up their PIP narrative. This form provides a structure for reporting measures and data sources. However, when there is more than one source of data, it is important that the health plan specifically states the sources of data for each measure. The health plans were reminded that the strict use of this format limits the narrative and explanation that must accompany the PIP in order for the EQRO to validate each element. Eleven of the 12 PIPs (91.67%) clearly described systematic and reliable methods of data collection (Step 6.3). There was some description of the data collection procedures in all cases. It is not possible to judge the reliability or credibility of any PIP without sufficient detail regarding data collection processes, procedures, or frequency. Eleven of the PIPs used a data collection instrument that was described in detail. This step requires that data be presented utilizing instruments that allowed that consistent and accurate data would be collected over time (Step 6.4). Eleven PIPs (91.67%) met this element of the required study submissions. One health plan (HCUSA) did not include a study design in its clinical PIP submission so these elements could not be adequately evaluated.

Nine of the PIPs (75.0%) included a complete data analysis plan, while two additional PIPs were rated Partially Met for specifying a plan (Step 6.5). Two PIPs submitted did not include any information that prospectively specified a data analysis plan. The data analysis plan should be developed prior to the implementation of the PIP, be based on the study questions, explain the expected relation between the intervention(s) and outcome(s) being measured (i.e. independent and dependent

variables), and include the method(s) of data collection, and the nature of the data (e.g., nominal, ordinal, scale). One PIP did not include a study design and presented no prospective data analysis plan.

Ten of the 12 (83.33%) PIPs identified the project leader and qualifications of that individual in the narrative submitted. They also identified who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). Health plan staff interviewed on-site also included team members who were involved and knowledgeable about the PIPs and methods. With the exception of two PIPs (HCUSA) information about all the PIP team members and their qualifications and roles were described in detail for the first year. This information provides clarification and validity to the process and the measures.

STEP 7: IMPROVEMENT STRATEGIES

Seven of the 12 (58.33%) PIPs identified reasonable interventions to address the barriers identified through data analysis and quality improvement processes undertaken. Five 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

All twelve PIPs were mature enough to have data to analyze. The MO HealthNet MCHPs conducted the analyses according to the data analysis plan (Step 8.1) in eight of the PIPs (66.67%). In 6 of the 12 (50.0%) there was a complete and thorough analysis of the data presented. These six PIPs presented baseline or re-measurement data, and all 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 percentages in graphic format while the description of the calculation of measures indicated rates per 1,000). The remaining 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. In one case the baseline data was in table form and the re-measurement was in a graphic form. This creates difficulty in evaluation of the data presented.

Of these twelve PIPs that presented at least one re-measurement period, six (50.0%) indicated the re-measurement period for all of the measures identified in the study (Step 8.3). Of the twelve PIPs describing the findings, seven (58.33%) described the extent to which the intervention was effective (Step 8.4).

STEP 9: VALIDITY OF IMPROVEMENT

Seven of the eleven PIPs (63.63%) 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. The same source of measures should also be used at re-measurement points. Seven of nine PIPs (77.77%) 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 significant improvement over multiple re-measurement points; however, this improvement was not always statistically significant. Six of nine (66.66%) 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 health plans. 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. Five of the nine PIPs (55.55%) 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 seven PIPs examining multiple measurement points over time, six (85.71%) PIPs used statistical significance testing to demonstrate improvement. The PIPs reaching this level of maturity provided arguments for continuing the improvement efforts leading to success, and their reasoning for maintaining sustainability.

2.4 Conclusions

Across all MO HealthNet MCHPs, the range in proportion of criteria that were "Met" for each PIP validated was 12.5% through 100% (see Table 1). Across all PIPs validated statewide, 79.49% 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. 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.

Generally the PIPs presented included thoughtful and complex information. In some of the PIPs, enhanced information obtained at the on-site review, made it clear that the health plans intended to use this process to improve organizational functions and the quality of services available or delivered to members. In several cases the PIP had already been incorporated into health plan daily operations. PIPs are to be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the health plan regarding the need to address barriers to implementation. Health plan personnel involved in PIPs had 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 four health plans (CMFHP, BA+, Molinaand MO Care) had active and ongoing PIPs as part of their quality improvement programs. One health plan (Harmony) submitted PIPs for review for the second time, and the results indicated some improvement to their commitment to the PIP process. They have a stated commitment to develop quality programming although their projects reflect areas that need improvement. One health plan (HCUSA) has historically utilized the PIP process as an essential component of their quality improvement program. They, as were all of the health plans, were encouraged to submit updated information on the PIP submissions at the time of the on-site review. They chose not to submit additional information or analysis. An improved commitment to the quality improvement process was observed during the on-site review at all health plans.

Table 3 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Members at High Risk for Cesarean Wound Infection (Molina)	High Confidence
Improving Adolescent Well Care (Molina)	Moderate Confidence
Follow-UP After Hospitalization for Mental Health Services (HCUSA)	Low Confidence
Improving Adolescent Well Care (HCUSA)	Moderate Confidence
Lead Screening (Harmony)	Low Confidence
Improving Adolescent Well Care (Harmony)	Low Confidence
Improving Chlamydia Screening Rates in Women (MO Care)	Moderate Confidence
Improving Adolescent Well Care (MO Care)	Moderate Confidence
Improving Dental Utilization Rates (CMFHP)	Moderate Confidence
Improving Adolescent Well Care (CMFHP)	Moderate Confidence
Ambulatory Follow-Up After Mental Health Hospitalization (BA+)	High Confidence
Improving Adolescent Well Care (BA+)	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., 2010 External Quality Review Performance Improvement Project Validation.

The following summarizes the quality, access, and timeliness of care assessed during this review, and recommendations based on the findings of the Validation of Performance Improvement Projects activity.

Access to Care

Access to care was an important theme addressed throughout all the PIP submissions reviewed. One specific PIP attempted to impact the access to dental care (CMFHP). One health plan focused on education and support to obtain appropriate care after surgery or hospitalization (Molina) and actively provided access to home health services. All the projects reviewed used the format of the

PIP to improve access to care for members. Two of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for mental health related issues (BA+ and HCUSA). One PIP focused on improving health care screening through provider and member education on the importance on obtaining healthcare that also enhanced member access to ancillary services (MO Care). One PIP focused on a key aspect of prevention by improving access to lead screening (Harmony). The on-site discussions with health plan staff indicate that they realize that improving access to care is an essential aspect of all projects that are developed.

The PIPs based on the statewide topic of improving Adolescent Well Care utilized individualized interventions that informed or educated members about the availability of these services and encouraged increased utilization of health care services available.

Quality of Care

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

Timeliness of Care

Timeliness of care was a major focus of a number of the PIPs reviewed. One project addressed the need for timely and appropriate care for members to avoid further inpatient hospitalization (Molina). Other projects focused on subjects such as timely utilization of preventive care (MO Care and Harmony), improved access to dental services (CMFHP), and two projects focused on improved access to timely treatment after in-patient hospitalization for mental illness (BA+ and HCUSA). All addressed the need for timely access to preventive and primary health care services. The health plans all related their awareness of the need to provide not only quality, but timely services to

members. Projects reflected this awareness in that they addressed internal processes and direct service improvement.

The PIPs related to improving Adolescent Well Care included a focus on obtaining timely screenings into their interventions and recognized that this is an essential component of effective preventive care.

RECOMMENDATIONS

1. It is recommended that health plans continue to refine their skills in the development and implementation of the Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available.
2. In the design of PIPs, health plans 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 health plan 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. Ongoing PIPs should include new and refined interventions.
4. PIPs that are not yet complete should include narrative reflecting next steps and the plan for how the PIP will be maintained and enhanced for future years.
5. Efforts to continue to improve outcomes related to the Statewide PIP topic should be continued. Several health plans provided results indicating some improvement in their HEDIS measure has occurred. A number of innovative approaches were used to impact this issue. The health plans should continue with their individualized interventions and their individual approaches to obtaining positive outcomes when working on a statewide topic.
6. It appears that most of the health plans 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 is beneficial.

3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Purpose and Objectives

The EQRO is required by the Validating Performance Measures Protocol to evaluate three performance measures reported by each MO HealthNet MCHP. These measures are selected by the State Medicaid Agency each year (SMA; the Missouri Department of Social Services, MO HealthNet Division; MHD). For the HEDIS 2009 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Adolescent Well-Care Visits (AWC), and Follow-Up After Hospitalization for Mental Illness (FUH). All three of these measures were also reviewed for the HEDIS 2007 evaluation period, and two of these (Annual Dental Visits and Adolescent Well-Care Visits) were reviewed for the HEDIS 2008 period. Protocol activities performed by the EQRO for this audit included: 1) Review of the processes used by the MO HealthNet health plans to analyze data; 2) Evaluation of algorithmic compliance with performance measure specifications: and 3) Recalculation of either the entire set of performance measure data (administrative rates) or a subset of the data (hybrid rates) to verify and confirm the rates reported by the health plans are based upon accurate calculations.

The objectives for validating performance measures were to: 1) evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, MO HealthNet MCHPs; and 2) determine the extent to which MO HealthNet MCHP-specific performance measures calculated by the health plans (or by entities acting on behalf of the health plans) 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).

3.2 Findings

MO HealthNet MCHPs 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 MO HealthNet MCHPs with recommendations for reporting or not reporting findings of specific measures to the NCQA. Regardless of the NCQA audit rating or rotation, the health plans are required to report the performance measures validated to the SMA and SPHA. Table 4 summarizes the names of HEDIS-certified software used, medical record vendors, and HEDIS auditors for each of the MO HealthNet MCHPs.

Table 4 - Software, Vendors, and Auditors for the HEDIS 2009 Measures

MO HealthNet MCHP	Name of Software	Name of Medical Record Vendor	Name of HEDIS 2008 Auditor
Blue-Advantage Plus	Software from ViPs, Inc. MedMeasures*	QMark/HEDISHelp	Ernst & Young, LLP
Children's Mercy Family Health Partners	Software from ViPs, Inc. MedMeasures*	Children's Mercy Family Health Partners	Healthcare Data.com, LLC
Harmony Health Plan of Missouri	CareEnhance Resource Management Software (CRMS)*	UNIVAL	Healthcare Data.com, LLC
Healthcare USA	Quality Spectrum* HEDIS repository by Catalyst Technologies	Not Applicable. Did not use Hybrid Method.	Healthcare Data.com, LLC
Mercy CarePlus (now Molina Healthcare)	Amisys (Novasys)	QMark/HEDISHelp	Healthcare Research Associates
Missouri Care	Quality Spectrum* HEDIS repository by Catalyst Technologies	Missouri Care	Thomson MedStat

Note: * NCQA-certified

Table 5 shows the method of calculation used by each MO HealthNet MCHP. This information was taken from the MO HealthNet MCHPs' self-report to the EQRO.

Table 5 - Summary of Method of Calculation Reported and Validated by MO HealthNet Health Plans

MO HealthNet MCHP	Adolescent Well-Care Visits	Annual Dental Visit	Follow-Up After Hospitalization for Mental Illness
Blue-Advantage Plus	Administrative	Administrative	Administrative
Children's Mercy Family Health Partners	Hybrid	Administrative	Administrative
Harmony Health Plan	Hybrid	Administrative	Administrative
Healthcare USA	Hybrid	Administrative	Administrative
Mercy CarePlus (now Molina HC)	Hybrid	Administrative	Administrative
Missouri Care	Hybrid	Administrative	Administrative

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 2009 Annual Dental Visit

Data Integration and Control

The objective of this activity was to assess the MO HealthNet MCHPs' 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 2009 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. Table 6 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were met was calculated across MO HealthNet MCHPs and from the number of applicable items for each health plan. All the MO HealthNet MCHPs that calculated the measure, met all criteria for every audit element As such, each health plan Met 100% of the criteria for data integration and control.

Table 6 - Data Integration and Control Findings, HEDIS 2009 Annual Dental Visit Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/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	6	0	0	6	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.3	MCHP'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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	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	6	0	0	6	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%
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	6	0	0	6	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 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. The findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol are summarized in Table 7. Items 7.2, 7.3, 7.5, 7.7, 7.9, and 7.10 did not apply to this measure. All MO HealthNet MCHPs (100.0%) met the criteria for applying appropriate data and processes for the calculation of the HEDIS 2009 Annual Dental Visit measure.

Table 7 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2009 Annual Dental Visit

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	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	6	0	0	6	100.0%
7.2	Maps to standard coding if not used in original data collection.	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	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	6	0	0	6	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	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	2	2	2	2	6	0	0	6	100.0%
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	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	2	6	0	0	6	100.0%
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	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	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.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	5	5	5	5	5	5	30	0	0	30	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 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 8 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS 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. All six of the MO HealthNet MCHPs reviewed met 100% of the criteria for producing denominators according to specifications.

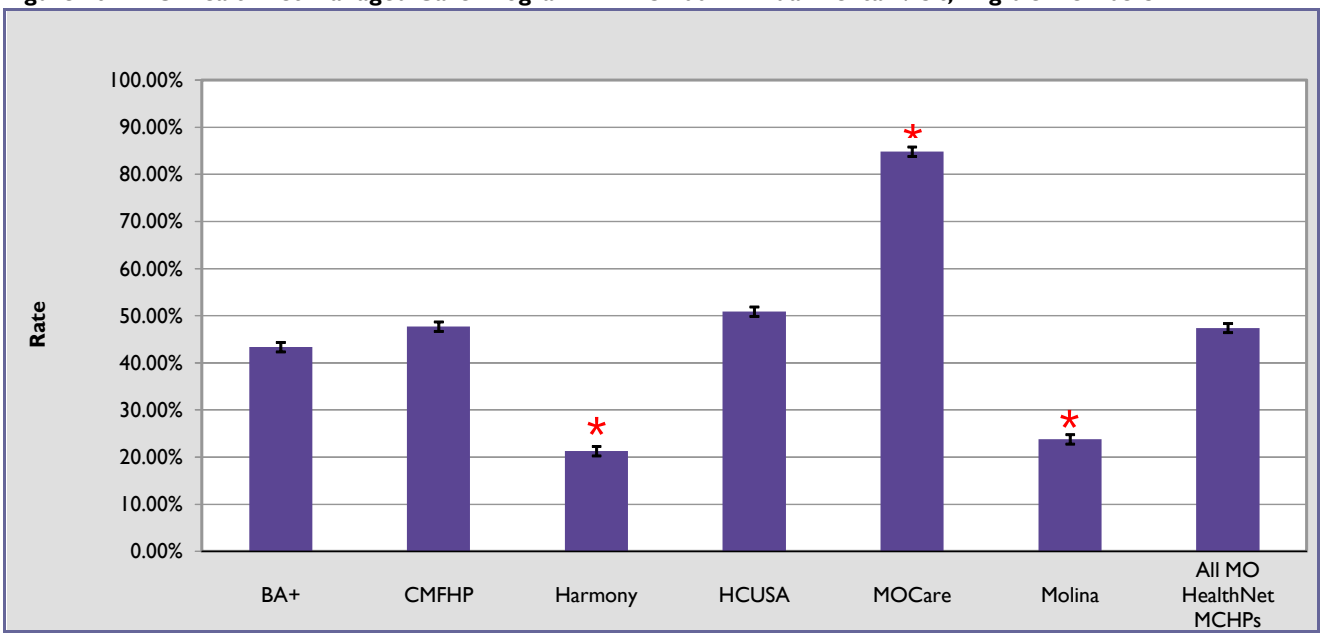
Table 8 - Denominator Validation Findings, HEDIS 2009 Annual Dental Visit

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	6	0	0	6	100.0%
10.5	The MCHP/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 MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/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	2	2	2	2	6	0	0	6	100.0%
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	6	0	0	6	100.0%
10.9	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	6	0	0	6	100.0%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	7	7	7	7	42	0	0	42	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	7	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 External Quality Review Performance Measure Validation

When determining the denominator, it was expected that all MO HealthNet MCHPs would identify similar percentages of their total population as eligible for this measure. The identification of eligible members for the HEDIS 2009 Annual Dental Visit measure is dependent on the quality of the enrollment and eligibility files. The rate of eligible members (eligible population identified / total MO HealthNet enrollment) was calculated for all health plans and is illustrated in Figure 16. Two-tailed z-tests of each health plan were conducted comparing the health plans to the rate of eligible members for all MO HealthNet MCHPs at the 95% level of confidence. The percentage of eligible members identified by MO Care (84.84%) showed a statistically higher rate when compared to the group average. Harmony and Molina showed statistically lower rates (21.32% and 23.83% respectively) than the MCHP average. These differences 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.

Figure 16 – MO HealthNet Managed Care Program HEDIS 2009 Annual Dental Visit, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2008 (the measurement year) was used to calculate the rate.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 26, 2008.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet MCHPs' 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. The Technical Specifications for the HEDIS 2009 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply.

Table 9 shows the numerators, denominators, and rates submitted by the MO HealthNet MCHPs to the SPHA on the DST for the HEDIS 2009 Annual Dental Visit measure. It is the task of the EQRO to compare health plan to health plan on a statewide level. Therefore, for all MCHPs who reported rates by region (e.g. HCUSA, MO Care, and Molina), the regional numbers were combined to create a plan-wide rate.

The Annual Dental Visit measure has been reviewed for the last three audit years: 2007, 2008, and 2009 (see Figure 17). In all three of those audits, the MO HealthNet MCHPs reported individual rates lower than the National Medicaid Average. The combined rates for all plans were also lower than this average. However, the National Medicaid Average has increased over time, as has the combined rate for all health plans. The rate for all MO HealthNet MCHPs was 32.50%, 34.71%, and 35.05% in 2007, 2008, and 2009 respectively. This indicates an increase in access to dental visits within the MO HealthNet Managed Care population. The 2009 health plan rates ranged from 20.68% (Harmony) to 38.99% (CMFHP) (see

Table 9 and Figure 18). Harmony reported a significantly lower rate than the average combined rate for all MO HealthNet MCHPs; the rates reported by CMFHP and HCUSA were significantly higher than the average.

Figure 17 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit

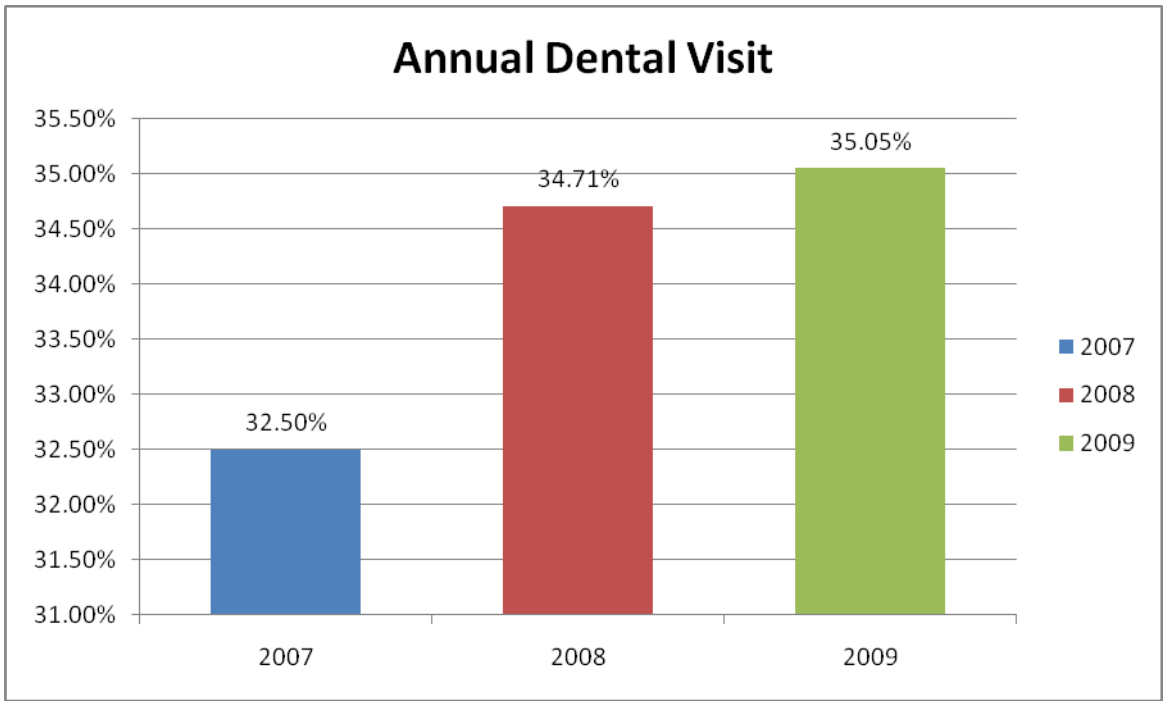
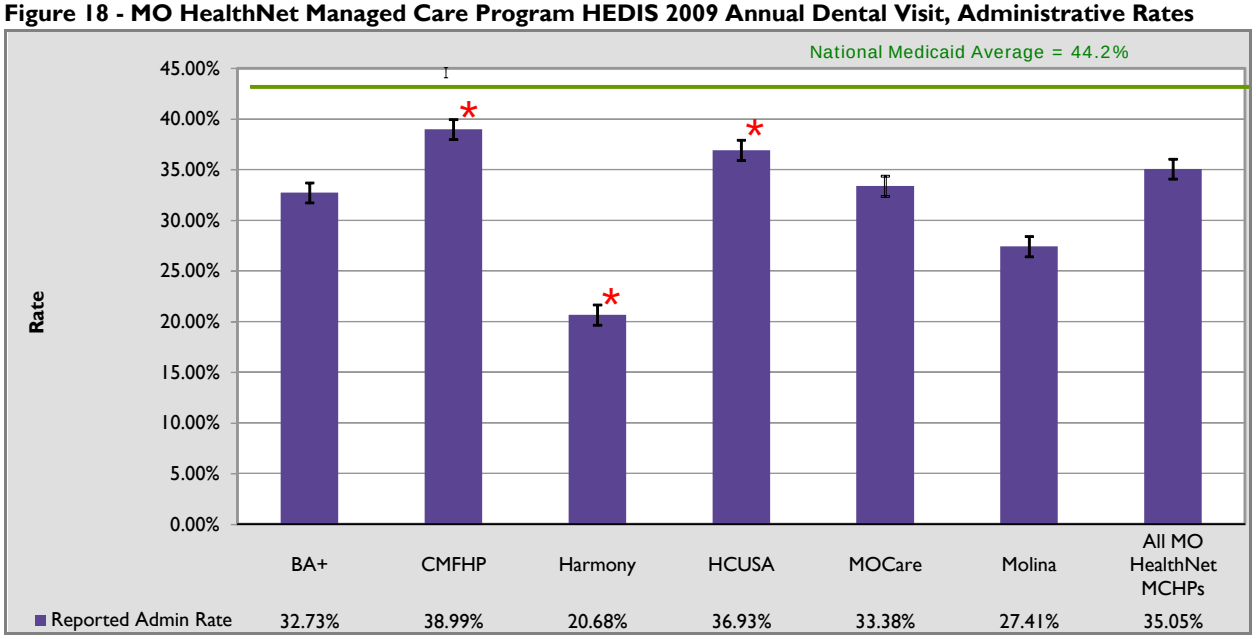


Table 9 - Data Submission and Final Validation for HEDIS 2009 Annual Dental Visit (combined rate)

MO HealthNet Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	13,405	4,388	32.73%	4,380	32.67%	0.06%
Childrens Mercy Family Health Partners	26,320	10,263	38.99%	10,252	38.95%	0.04%
Harmony Health Plan	3,525	729	20.68%	725	20.57%	0.11%
HealthCare USA	98,716	36,451	36.93%	36,195	36.67%	0.26%
Missouri Care	38,620	12,868	33.38%	12,868	33.32%	0.06%
Molina Healthcare	18,580	5,084	27.41%	5,084	27.36%	0.05%
All MO HealthNet MCHPs	**199,166**	**69,783**	**35.05%**	**69,504**	**34.90%**	**0.15%**

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 MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MO HealthNet MCHPs' HEDIS 2009 Data Submission Tools (DST).

Figure 18 - MO HealthNet Managed Care Program HEDIS 2009 Annual Dental Visit, Administrative Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Table 10 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 this measure, as the services reported could not easily be obtained outside the health plan. Item 13.6 also did not apply, as none of the MO HealthNet MCHPs used non-standard codes to determine the numerators. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable for the Annual Dental Visit measure. HCUSA did not provide correct dates of service in the numerator file submitted to the EQRO and therefore Item 13.7 was Not Met. Across all MO HealthNet MCHPs, 96.7% of the criteria for calculating the numerator were met.

Table 10 - Numerator Validation Findings, HEDIS 2009 Annual Dental Visit Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/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	6	0	0	6	100.0%
13.2	The MCHP/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 MCHP/PIHP.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP'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	2	2	2	2	6	0	0	6	100.0%
13.4	The MCHP/PIHP correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	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	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	0	2	2	5	0	1	6	83.3%
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	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	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	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	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	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	0	0	0	0	NA
	Number Met	5	5	5	4	5	5	29	0	1	30	96.7%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	1	0	0					
	Number Applicable	5	5	5	5	5	5					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 External Quality Review Performance Measure Validation.

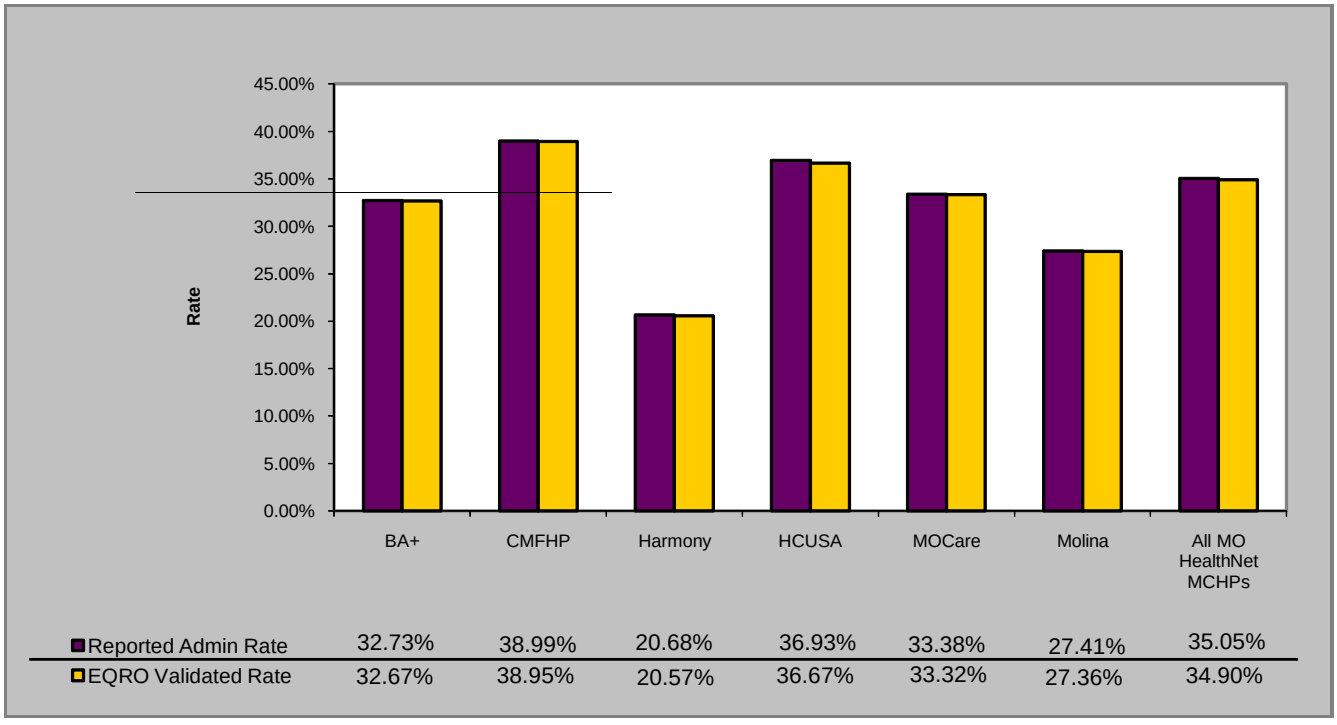
Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2009 Annual Dental Visit measure. All six MO HealthNet MCHPs calculated and submitted the measure to the SPHA and SMA. All health plans in the State of Missouri are required to calculate and report the measure to the SPHA, and MO HealthNet MCHPs are required to report the measure to the SMA.

Final Validation Findings

Table 9 shows the final data validation findings and the total estimated bias calculation based on the validation and review of the MO HealthNet MCHPs' extract files for calculating the HEDIS 2009 Annual Dental Visit measure. Figure 19 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO for Annual Dental Visit calculations. The EQRO validated rate was 34.90%, while the rate reported by MO HealthNet MCHPs was 35.05%, a 0.15% overestimate.

Figure 19 - Rates Reported by MO HealthNet MCHPs and Validated by EQRO, HEDIS 2009 Annual Dental Visit Measure



Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); BHC, Inc. 2009 External Quality Review Performance Measure Validation.

HEDIS 2009 Adolescent Well-Care Visits

Data Integration and Control

The objective of this activity was to assess the MO HealthNet MCHPs' ability to link data from multiple sources for the calculation of the HEDIS 2009 Adolescent Well-Care 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 2009 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 11 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were Met was calculated across MO HealthNet MCHPs and from the number of applicable items for each health plan.

No data integration and control issues were discovered by the EQRO. All MO HealthNet MCHPs (100.0%) met the criteria for all areas of data integration and control.

Table 11 - Data Integration and Control Findings, HEDIS 2009 Adolescent Well-Care Visits

Item	Audit Elements	MO HealthNet MCHP								All MO HealthNet MCHPs		
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/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	6	0	0	6	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.3	MCHP'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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	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	6	0	0	6	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%
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	6	0	0	6	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 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 2009 Adolescent Well-Care Visits measure. Table 12 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply to any MO HealthNet MCHPs for this measure, as none of the MCOs used non-standard codes. 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 this measure. Items 7.5, 7.7, and 7.10 are only applicable for the Hybrid method of calculation, and therefore did not apply to BA+. Each MO HealthNet MCHP calculating the measure met 100.0% of the criteria for processes used to calculate and report the HEDIS 2009 Adolescent Well-Care Visits measure.

Table 12 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2009 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	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	6	0	0	6	100.0%
7.2	Maps to standard coding if not used in original data collection.	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	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	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	2	2	2	2	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	2	2	2	2	6	0	0	6	100.0%
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	2	2	2	2	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.	2	2	2	2	2	2	6	0	0	6	100.0%
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	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	2	2	2	2	2	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.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	4	7	7	7	7	7	39	0	0	39	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	4	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 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 2009 Adolescent Well-Care Visits measure, the sources of data include enrollment, eligibility, and claim files. Table 13 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS 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 2009 Adolescent Well-Care Visits measure. Overall, 100% of the criteria were met for the processes used to produce denominators.

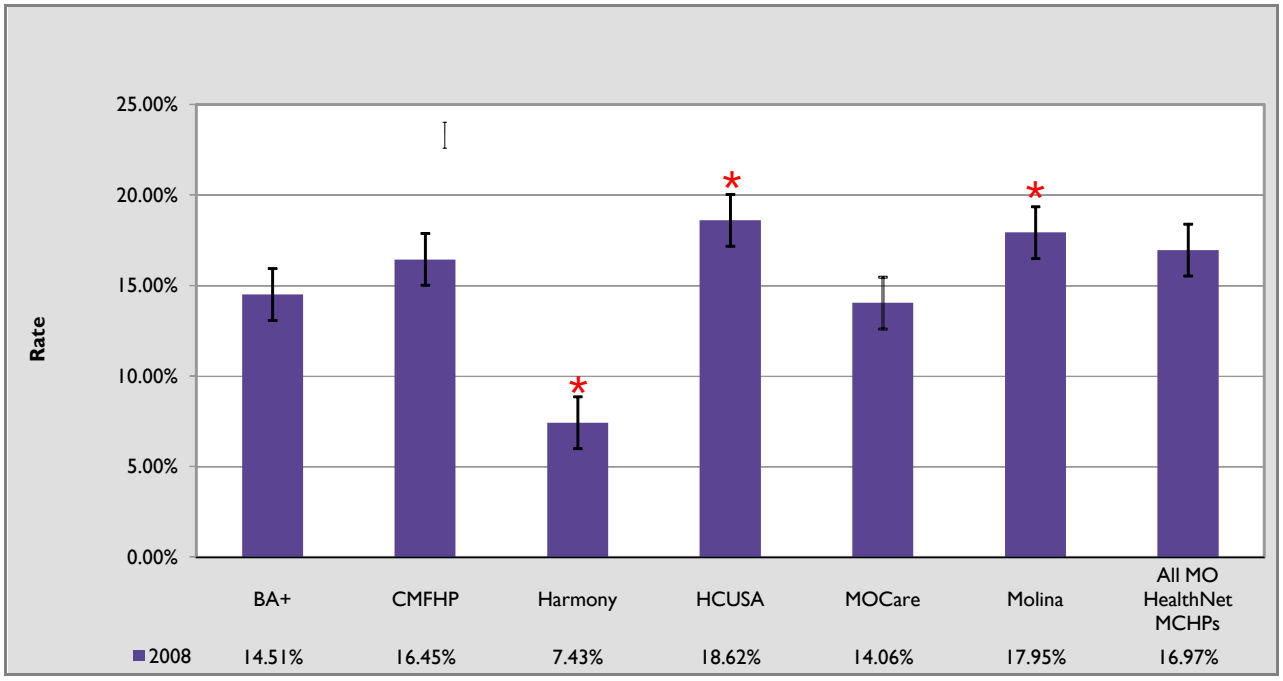
Table 13 - Denominator Validation Findings, HEDIS 2009 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	6	0	0	6	100.0%
10.5	The MCHP/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 MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/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	2	2	2	2	6	0	0	6	100.0%
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	6	0	0	6	100.0%
10.9	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	6	0	0	6	100.0%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	7	7	7	7	42	0	0	42	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	7	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 External Quality Review Performance Measure Validation.

Figure 20 illustrates the rate of eligible members identified by each MO HealthNet MCHP, based on the enrollment of all MO HealthNet Managed Care members as of December 26, 2008 (the end of the CY2008 measurement year). It was expected that MO HealthNet MCHPs would identify similar proportions of eligible members for the HEDIS 2009 Adolescent Well-Care Visits measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MO HealthNet MCHPs and two-tailed z-tests of each health plan compared to the state rate of eligible members were conducted at the 95% level of confidence. Harmony (7.43%) identified a rate that was significantly lower than the MO HealthNet MCHP average (16.97%). The percentage of eligible members identified by HCUSA (18.62%) and Molina(17.95%) were significantly higher than the MO HealthNet Managed Care average.

Figure 20 - MO HealthNet Managed Care Program HEDIS 2009 Adolescent Well-Care Visits, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2008 (the measurement year) was used to calculate the rate.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 26, 2008.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet MCHPs' 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 2009 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 14 shows the numerators, denominators, and rates submitted by the MO HealthNet MCHPs to the SPHA on the DST. The "combined" rates for HCUSA, MO Care, and Molinawere calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western). The rate for all MO HealthNet MCHPs was 35.63%, with health plan rates ranging from 30.17% (Harmony) to 43.06 % (MO Care).

Table 14 - Data Submission for HEDIS 2009 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCHP (DST)	Hybrid Hits Reported by MCHP (DST)	Total Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)
Blue Advantage Plus	Administrative	4,488	1,585	NA	1,585	35.32%
Childrens Mercy Family Health Partners	Hybrid	411	143	19	162	39.42%
Harmony Health Plan	Hybrid	411	106	18	124	30.17%
HealthCare USA	Hybrid	1296	467	28	495	38.19%
Missouri Care	Hybrid	432	171	15	186	43.06%
Molina Healthcare	Hybrid	1353	346	92	438	32.37%
All MO HealthNet MCHPs		**8,391**	**2,818**	**172**	**2,990**	**35.63%**

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 statewide rate for all MO HealthNet MCHPs 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: MO HealthNet Managed Care Organization HEDIS 2009 Data Submission Tools (DST)

The Adolescent Well Care Visits measure has been audited in the 2007, 2008 and 2009 external quality reviews (See Figure XX). Over the course of these review periods, the rates for all MO HealthNet MCHPs has fluctuated; the rate reported in 2009 (35.63%) is an improvement over the rate reported in 2007 (34.81%), but is down 2.96% from the rate reported in the previous 2008 review year (38.59%).

Figure 21– MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Adolescent Well Care Visit

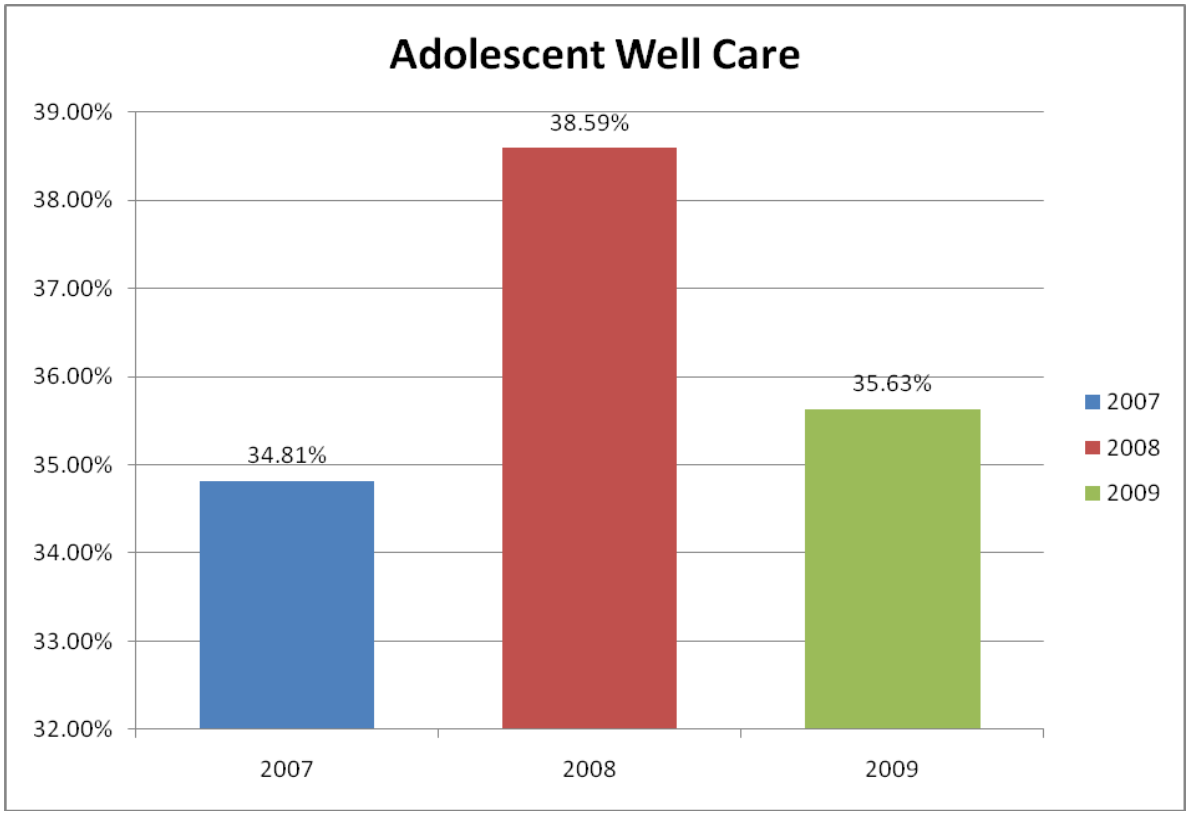
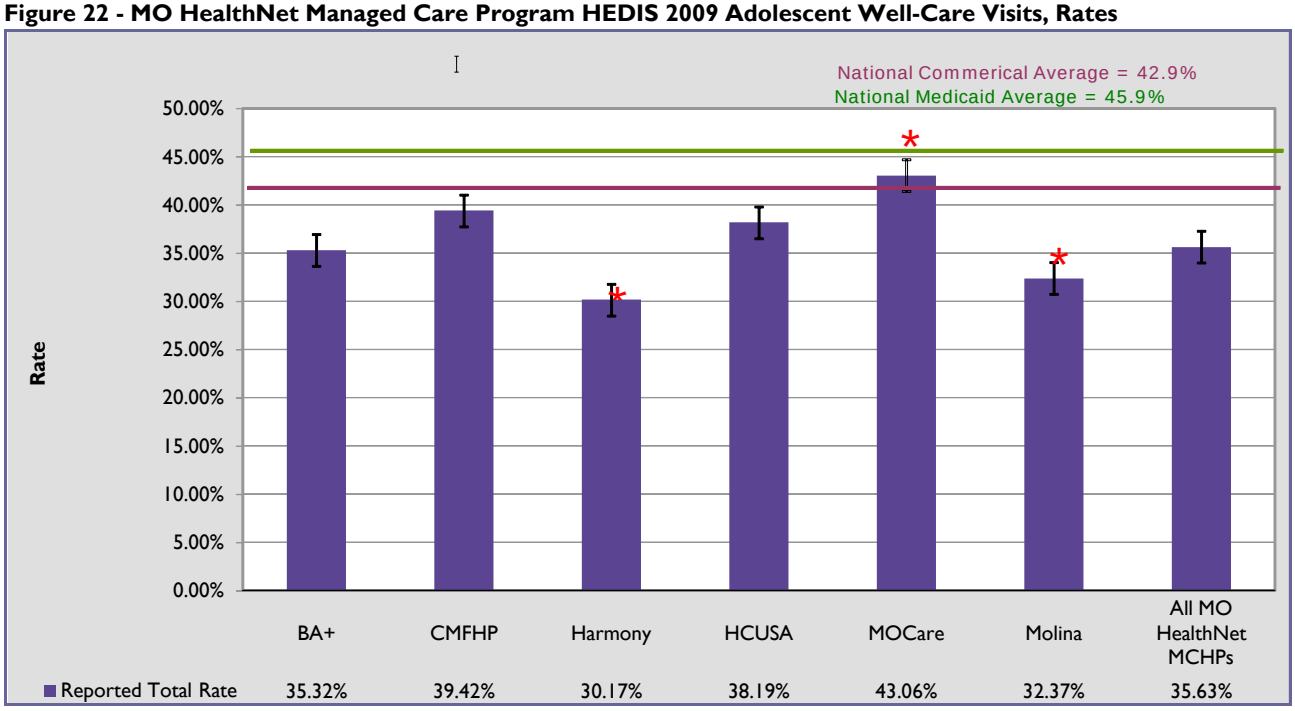


Figure 23 and Figure 24 illustrate the rates reported by the MO HealthNet MCHPs and the rates of administrative and hybrid hits for each MO HealthNet MCHP. The rate reported by each health plan was compared with the rate for all MO HealthNet MCHPs. Two-tailed z-tests of each MO HealthNet MCHP comparing MO HealthNet MCHPs to the rate for all MO HealthNet MCHPs were calculated at the 95% confidence interval. The rate for all MO Health Net health plans (35.63%) was lower than both the National Medicaid rate (45.9%) and the National Commercial Rate (42.9%). This was also found to be true in the 2007 and 2008 External Quality Review audits.

This rate has also fallen lower than the rate reported in 2008 (38.59%), but is still higher than the 2007 reported rate (34.81%). The rate for MO Care (43.06%) was significantly higher than the overall MCHP average. This rate was also higher than the National Commercial Rate. Harmony and Molina reported rates of 30.17% and 32.37% respectively, both of which were significantly lower than the statewide rate for all MO HealthNet MCHPs.

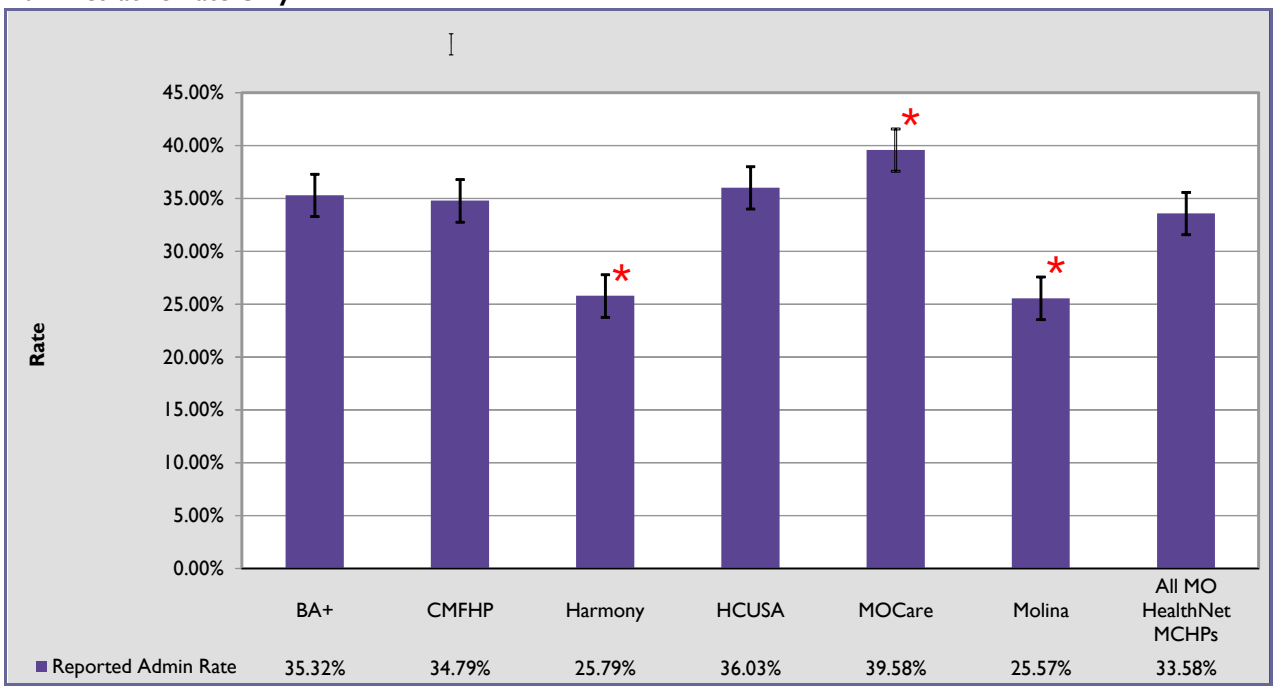
Figure 22 - MO HealthNet Managed Care Program HEDIS 2009 Adolescent Well-Care Visits, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

When the rate of administrative and hybrid hits was examined separately, there did not appear to be a great deal of variability among MO HealthNet MCHPs from the administrative rate for all MO HealthNet MCHPs (33.58%). Rates ranged from 25.57% (Molina) to 39.58% (MO Care). Statistically, the rates reported by Harmony and Molina were significantly lower than the statewide rate for all health plans, while the rate for MO Care was significantly higher than the average rate.

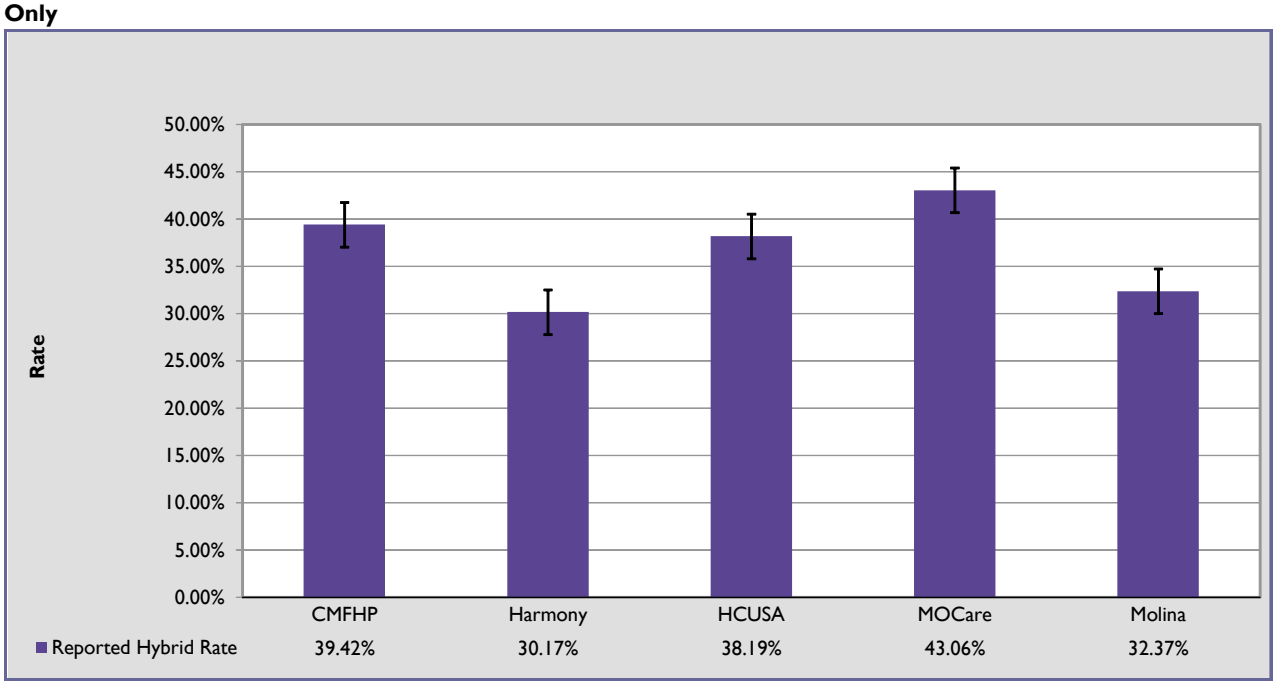
Figure 23 - MO HealthNet Managed Care Program HEDIS 2009 Adolescent Well-Care Visits, Administrative Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Five of the six MO HealthNet MCHPs calculated the Adolescent Well-Care Visits measure hybridly. There were no statistically significant differences found in these rates.

Figure 24 - MO HealthNet Managed Care Program HEDIS 2009 Adolescent Well-Care Visits, Hybrid Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA)

Table 15 and Table 16 summarize the findings of the EQRO medical record review validation and Attachment XII (Impact of Medical Record Findings) of the CMS Protocol. Five of the MO HealthNet MCHPs used the Hybrid Method of calculation: CMFHP, Harmony, HCUSA, Molina, and MO Care. CMFHP and Harmony each selected a sample of 411 eligible members, consistent with HEDIS technical specifications. MO Care selected a sample of 432 eligible members, as determined by the number of eligible members and in accordance with HEDIS technical specifications. HCUSA and Molinaeach operate in multiple regions; therefore, the sample sizes selected for each region were combined to represent overall health plan rates. HCUSA selected a sample of 432 eligible members in each of the three regions. Molinaselected a sample of 453 eligible members in each region, and six records were excluded due to valid data errors. These samples are consistent with HEDIS technical specifications. A total of 110 of the 172 reported medical record hybrid hits by MO HealthNet MCHPs were sampled for validation by the EQRO. Of the records requested, 109 were received for review. The EQRO was able to validate all 109 of the records received, resulting in an Error Rate of 0.9% across all MO HealthNet MCHPs. The number of False Positive Records (the total amount that could not be validated) was 2 of the 172 reported hits. The estimated bias for individual MO HealthNet MCHPs based on the medical record validation ranged from a 0.0% to 0.2% overestimate in the rate, with an average overestimate of 0.0% for all health plans. Table 16 shows the impact of the medical record review findings.

Table 15 - Medical Record Validation for HEDIS 2009 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	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	False Positive Records	Estimated Bias from Medical Records
Childrens Mercy Family Health Partners	411	19	19	19	19	100.0%	100.0%	0.0%	0.002	0	0.0%
Harmony Health Plan	411	18	18	18	18	100.0%	100.0%	0.0%	0.002	0	0.0%
Healthcare USA	1296	28	28	28	28	100.0%	100.0%	0.0%	0.001	0	0.0%
Missouri Care	432	15	15	15	15	100.0%	100.0%	0.0%	0.002	0	0.0%
Molina Healthcare	1353	92	30	29	29	100.0%	96.7%	3.3%	0.001	3	0.2%
All MO HealthNet MCHPs	3,903	172	110	109	109	100.0%	99.1%	0.9%	0.0003	2	0.0%

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); False Positive Records = Error Rate * Numerator Hits Reported by MCHP (DST); Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record. Source: MO HealthNet MCHP Data Submission Tools (DST); BHC, Inc. 2009 External Quality Review Performance Measures Validation.

Table 16 - Impact of Medical Record Findings, HEDIS 2009 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP					
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina
12.1	Final Data Collection Method Used (e.g., MRR, hybrid,)	Administrative	Hybrid	Hybrid	Hybrid	Hybrid	Hybrid
12.2	Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	NA	0.00%	0.00%	0.00%	0.00%	0.00%
12.3	Is error rate < 10%? (Yes or No)	NA	Yes	Yes	Yes	Yes	Yes
	If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	NA	Passes	Passes	Passes	Passes	Passes
	If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	NA	NA	NA	NA	NA
12.4	Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	5541	411	411	1,296	432	1,353
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	NA	NA	NA	NA	NA
12.6	Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA	NA	NA	NA	NA
12.7	Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA	NA	NA	NA	NA
12.8	Estimated Bias in Final Rate (The amount of bias caused by medical record review)	NA	NA	NA	NA	NA	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the Health Plan; Administrative Method was used by the Health Plan 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.
Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.

Table 17 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.6 did not apply to any of the MO HealthNet MCHPs, as none of the health plans used non-standard codes. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable to BA+. Across MO HealthNet MCHPs, 98.3% of the criteria for calculating numerators were met. All six (100%) of the health plans met the criteria for using the appropriate data to identify the at-risk population, using complete medical event codes, correctly classifying members for inclusion in the numerator, eliminating or avoiding double-counting members, and following applicable time parameters. Five of the six health plans calculated this measure using the Hybrid Method (CMFHP, Harmony, HCUSA, MO Care, and Molina). Four of these five met all criteria (100.0%) relating to medical record reviews and data. One MCHP, Molina, Met 90.9% of the criteria; item 13.12 was Partially Met, as the EQRO was unable to verify 1 of the 30 medical record hits sampled. The MO HealthNet MCHPs met 98.3% of criteria for calculating the numerator for the HEDIS 2009 Adolescent Well-Care measure.

Table 17 - Numerator Validation Findings, HEDIS 2009 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/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	6	0	0	6	100.0%
13.2	The MCHP/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 MCHP/PIHP.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP'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	2	2	2	2	6	0	0	6	100.0%
13.4	The MCHP/PIHP correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	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	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	6	0	0	6	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	2	2	2	2	2	5	0	0	5	100.0%
13.9	Record review staff have been properly trained and supervised for the task.	NA	2	2	2	2	2	5	0	0	5	100.0%
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	2	2	2	2	2	5	0	0	5	100.0%
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	2	2	2	2	2	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)	NA	2	2	2	2	1	4	1	0	5	80.0%
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	2	2	2	2	5	0	0	5	100.0%
	Number Met	5	11	11	11	11	10	59	1	0	60	98.3%
	Number Partially Met	0	0	0	0	0	1					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	11	11	11	11	11					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 External Quality Review Performance Measure Validation.

Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MO HealthNet MCHPs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Table 18 summarizes the findings of Attachment XV (Sampling Validation Findings) of the CMS 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 MO HealthNet MCHPs for this measure; and none of the items were applicable to BA+. Across all MO HealthNet MCHPs, the criteria for sampling were met 100.0% of the time. The health plans using the Hybrid Method of calculating the HEDIS 2009 Adolescent Well-Care Visits measure met 100.0% of the criteria for proper sampling.

Table 18 - Sampling Validation Findings, HEDIS 2009 Adolescent Well-Care Visits Measure

		MO HealthNet MCHP						All MO HealthNet MCHPs				
Item	Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	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	2	2	2	2	5	0	0	5	100.0%
15.2	The MCHP / 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 MCHP/PIHP kept adequate documentation of that activity.	NA	2	2	2	2	2	5	0	0	5	100.0%
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	0	0	0	0	NA
15.4	any bias was detected, the MCHP/PIHP is able to provide documentation that describes any efforts taken to correct it.	NA	2	2	2	2	2	5	0	0	5	100.0%
15.5	The sampling methodology employed treated all measures independently, and there is no correlation between drawn samples.	NA	2	2	2	2	2	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.	NA	2	2	2	2	2	5	0	0	5	100.0%
15.7	The MCHP/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	2	2	2	2	5	0	0	5	100.0%
15.8	Sample sizes meet the requirements of the performance measure specifications.	NA	2	2	2	2	2	5	0	0	5	100.0%
15.9	The MCHP/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	0	0	0	0	NA
15.10	The MCHP/PIHP properly oversampled in order to accommodate potential exclusions	NA	2	2	2	2	2	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.	NA	2	2	2	2	2	5	0	0	5	100.0%
15.12	and the percentage of substituted records was documented.	NA	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	0	10	10	10	10	10	50	0	0	50	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	0	10	10	10	10	10					
	Rate Met	NA	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2009 Adolescent Well-Care Visits measure. All MO HealthNet MCHPs reported the measure to the SPHA and SMA.

Final Validation Findings

Table 19 shows the final data validation findings for the calculation of the HEDIS 2009 Adolescent Well-Care Visits measure and the total estimated bias in calculation based on the validation of medical record data and review of the MO HealthNet MCHP extract files.

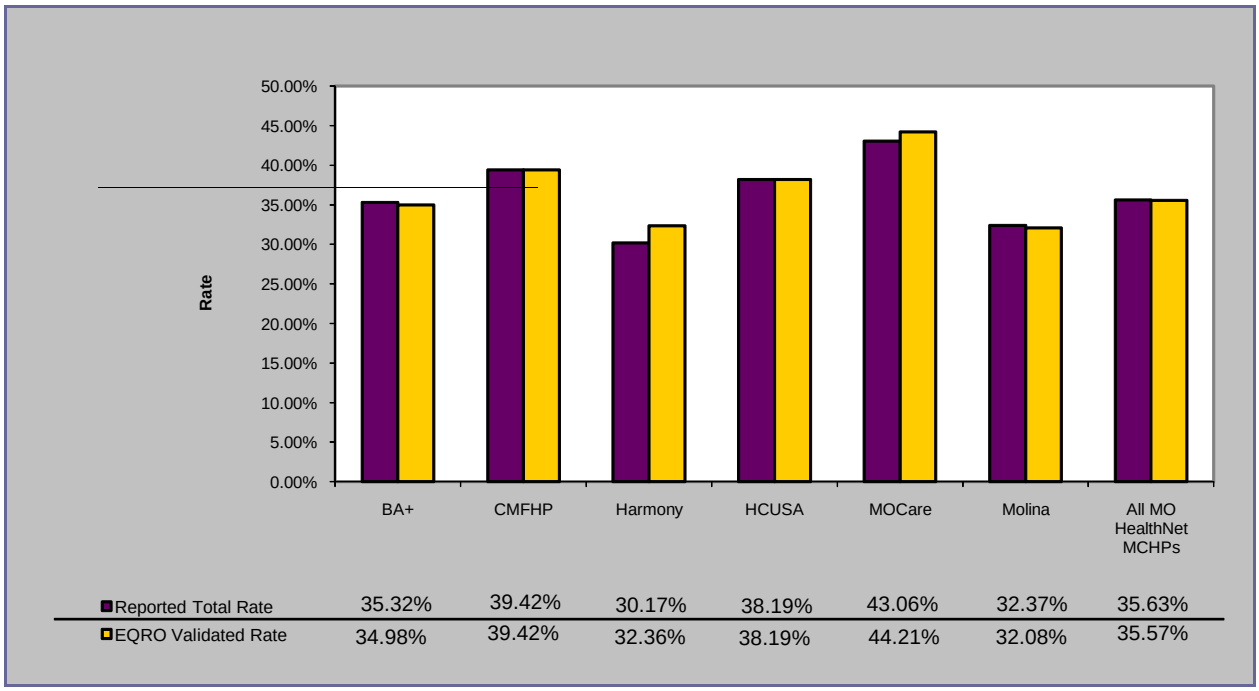
Figure 25 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MO HealthNet MCHPs calculated based on data validated by the EQRO was 35.57%, while the rate reported by all health plans was 35.63%, a 0.06% overestimate.

Table 19 - Final Data Validation for HEDIS 2009 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Administrative Hits Validated by EQRO	Percentage of Medical Record Hits Validated by EQRO*	Total Hits Validated by EQRO	Rate Reported by MCHP (DST)	Rate Validated by EQRO	Total Estimated Bias
Blue Advantage Plus	1570	NA	1570	35.32%	34.98%	0.34%
Childrens Mercy Family Health Partners	143	100.00%	162	39.42%	39.42%	0.00%
Harmony Health Plan	115	100.00%	133	30.17%	32.36%	-2.19%
HealthCare USA	467	100.00%	495	38.19%	38.19%	0.00%
Missouri Care	176	100.00%	191	43.06%	44.12%	-1.06%
Molina Healthcare	346	96.67%	434	32.37%	32.08%	0.29%
All MO HealthNet MCHPs	**2817**	**98.22%**	**2985**	**35.63%**	**35.57%**	**0.06%**

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

Figure 25 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2009 Adolescent Well-Care Visits Measure



Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); BHC, Inc. 2009 External Quality Review Performance Measure Validation.

HEDIS 2009 Follow-Up After Hospitalization for Mental Illness

Data Integration and Control

The objective of this activity was to assess the MO HealthNet MCHPs' 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 2009 Follow-Up After Hospitalization for Mental Illness measure, the sources of data included enrollment, eligibility, and claim files. Table 20 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were Met was calculated across MO HealthNet MCHPs and from the number of applicable items for each MO HealthNet MCHP.

Across all MO HealthNet MCHPs, 100.0% of the criteria were met. Each MO HealthNet MCHP calculating the measure met 100.0% of the criteria for data integration and control.

Table 20 - Data Integration and Control Findings, HEDIS 2009 Follow-Up After Hospitalization for Mental Illness

		MO HealthNet MCHP						All MO HealthNet MCHPs				
Item	Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/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	6	0	0	6	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.3	MCHP'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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	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	6	0	0	6	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%
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	6	0	0	6	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 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 21 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply as none of the MO HealthNet MCHPs used non-standard codes. Item 7.4 is also not applicable as a member would not receive services for this measure outside of the health plan's system. Items 7.3 (statistical testing of results and corrections made after processing), 7.5 (detailed medical record review methods and practices), 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, as the measure must be calculated using only the Administrative method. All MO HealthNet MCHPs met 100.0% of the criteria for calculating and reporting performance measures.

Table 21 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2009 Follow-Up After Hospitalization for Mental Illness

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	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	6	0	0	6	100.0%
7.2	Maps to standard coding if not used in original data collection.	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	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	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	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	2	2	2	2	6	0	0	6	100.0%
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	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	2	6	0	0	6	100.0%
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	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	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.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	4	4	4	4	4	4	24	0	0	24	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	4	4	4	4	4	4					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 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 2009 Follow-Up After Hospitalization for Mental Illness measure, the sources of data include enrollment, eligibility, and claim files. Table 22 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS 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 MO HealthNet MCHPs, 100% of criteria for calculating and reporting performance measures were met. The MO HealthNet MCHPs met 100% of the criteria for the process used to produce denominators.

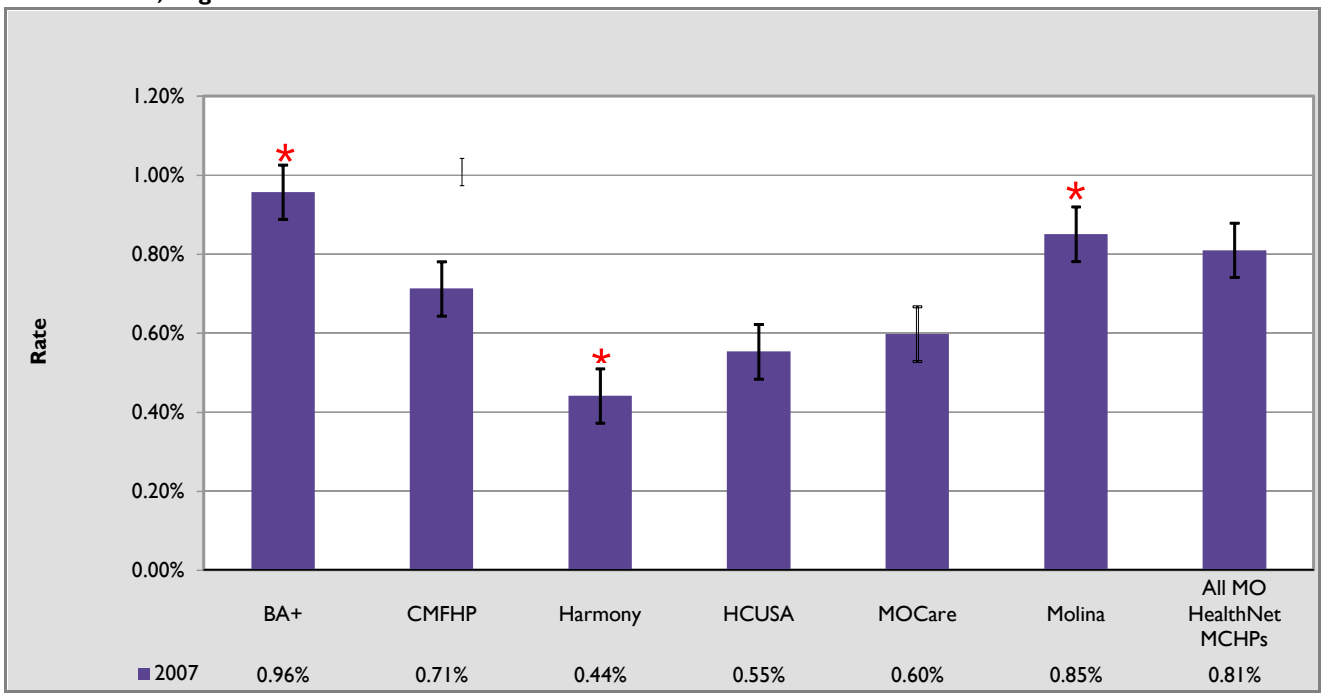
Table 22 - Denominator Validation Findings, HEDIS 2009 Follow-Up After Hospitalization for Mental Illness

		MO HealthNet MCHP						All MO HealthNet MCHPs				
Item	Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	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	6	0	0	6	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	6	0	0	6	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	6	0	0	6	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	2	6	0	0	6	100.0%
10.5	The MCHP/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 MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/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	2	2	2	2	6	0	0	6	100.0%
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	6	0	0	6	100.0%
10.9	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	6	0	0	6	100.0%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	7	7	7	7	42	0	0	42	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	7	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 External Quality Review Performance Measure Validation.

Figure 26 illustrates the rate of eligible members per MO HealthNet MCHP based on the enrollment of all MO HealthNet Managed Care Waiver Members as of December 26, 2008 (the end of the CY2008 measurement year). It was expected that MO HealthNet MCHPs 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 MO HealthNet MCHPs. Two-tailed z-tests of each MO HealthNet MCHP comparing each MO HealthNet MCHP to the state rate of eligible members for all MO HealthNet MCHPs were calculated at the 95% level of confidence. BA+ (0.96%) and Molina (0.85%) identified significantly higher rates that the statewide rate (0.81%) for all MO HealthNet MCHPs. Harmony (0.44%) identified a significantly lower rate than the average. This variability could be due to differences in the composition of these particular health plans' populations.

Figure 26 - MO HealthNet Managed Care Program HEDIS 2009 Follow-Up After Hospitalization for Mental Illness, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2008 (the measurement year) was used to calculate the rate.
Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 26, 2008.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet MCHPs' 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 2009 Follow-Up After Hospitalization for Mental Illness measure, the procedures for the Hybrid Method did not apply, as HEDIS 2009 technical specifications allow only for the use of the Administrative Method of calculating the measure.

Table 23 and Table 24 show the numerators, denominators, rates, and confidence intervals submitted by the MO HealthNet MCHPs to the SPHA on the DST for the Follow-Up After Hospitalization for Mental Illness measure. HCUSA and Molina reported regional rates (Eastern, Central, and Western); the EQRO combined these rates to calculate a plan-wide combined rate.

Just as reported in 2006 and 2007, the 7-Day reported rate for all MO HealthNet MCHPs was below both the National Medicaid Rate of 42.6% and the National Commercial Rate of 57.2%. The 7-Day reported rate for all MO HealthNet MCHPs has continued to rise, however, from 31.16% in 2006 to 35.52% in 2007 to 41.59% in 2009. This shows a 10.43% increase in the rate over the last four reporting years.

For 2009, the 30-Day reported rate for all MO HealthNet MCHPs was 66.46%, higher than the National Medicaid rate (61.7%) but lower than the National Commercial average (76.1%). This was also true of the rate reported in 2007 (60.06%), while the rate from 2006 (59.92%) was lower than both the National Medicaid rate and the National Commercial average for those years. However, across MO HealthNet MCHPs, the 30-day rate has also continued to increase by a total of 13.54% from the 2006 to the 2009 reporting years.

Table 23 - Data Submission and Final Data Validation for HEDIS 2009 Follow-Up After Hospitalization for Mental Illness Measure (7 days)

MO HealthNet MCHP	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	296	154	52.03%	157	53.04%	-1.01%
Childrens Mercy Family Health Partners	393	158	40.20%	156	39.69%	0.51%
Harmony Health Plan	73	18	24.66%	18	24.66%	0.00%
HealthCare USA	1,073	470	43.80%	440	41.01%	2.80%
Missouri Care	272	107	39.34%	106	38.97%	0.37%
Molina Healthcare	663	245	36.95%	243	36.65%	0.30%
All MO HealthNet MCHPs	**2,770**	**1,152**	**41.59%**	**1,120**	**40.43%**	**1.16%**

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 MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MO HealthNet Managed Care Organization HEDIS 2009 Data Submission Tools (DST).

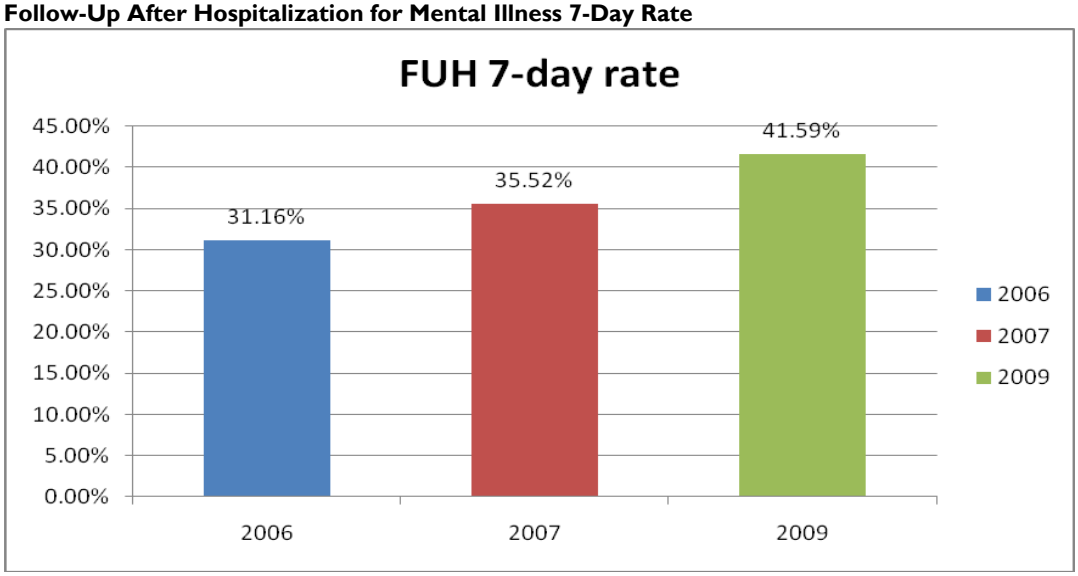
Table 24 - Data Submission and Final Data Validation for HEDIS 2009 Follow-Up After Hospitalization for Mental Illness Measure (30 days)

MO HealthNet MCHP	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	296	217	73.31%	217	73.31%	0.00%
Childrens Mercy Family Health Partners	393	270	68.70%	267	67.94%	0.76%
Harmony Health Plan	73	29	39.73%	29	39.73%	0.00%
HealthCare USA	1,073	747	69.62%	703	65.52%	4.10%
Missouri Care	272	169	62.13%	164	60.29%	1.84%
Molina Healthcare	663	409	61.69%	407	61.39%	0.30%
All MO HealthNet MCHPs	**2,770**	**1,841**	**66.46%**	**1,787**	**64.51%**	**1.95%**

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 MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MO HealthNet Managed Care Organization HEDIS 2009 Data Submission Tools (DST).

This measure was previously audited by the EQRO in audit years 2006 and 2007 (See Figure 31). The 7-Day reported rate for all MO HealthNet MCHPs in 2009 (41.59%) was a 10.43% increase overall since the rate reported in 2006 (31.16%); it is 6.07% higher than the rate reported in 2007 (35.52%).

Figure 27 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 7-Day Rate



This measure was previously audited by the EQRO in audit years 2006 and 2007. The 30-Day reported rate for all MO HealthNet MCHPs in 2009 (66.46%) was a 13.54% increase overall since the rate reported in 2006 (52.92%); it is 6.4% higher than the rate reported in 2007 (60.06%).

Figure 28 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 30-Day Rate

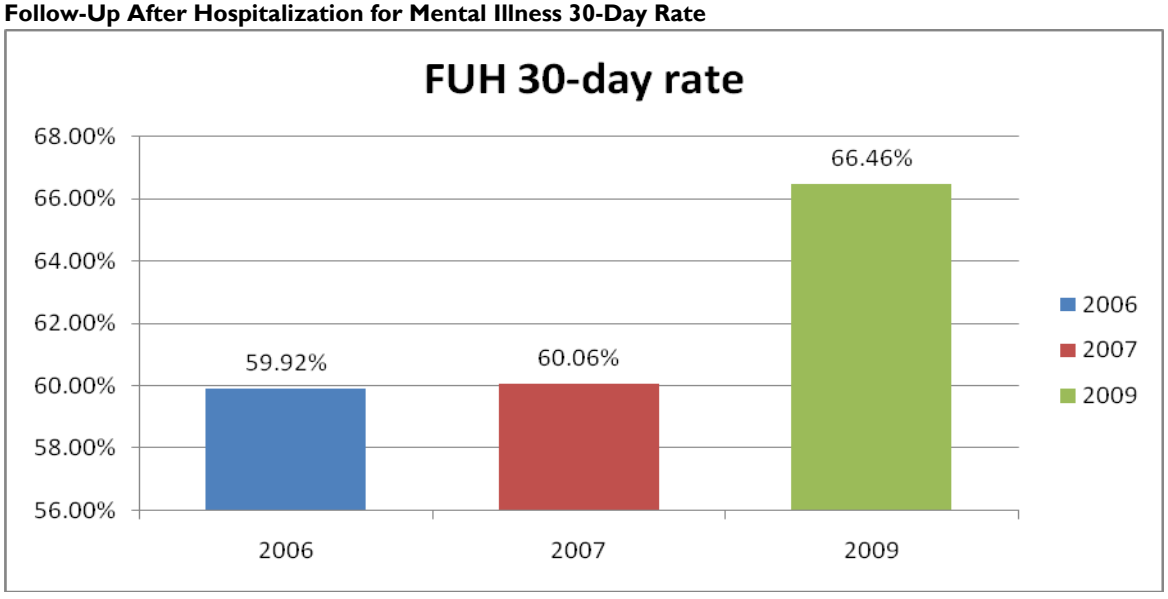
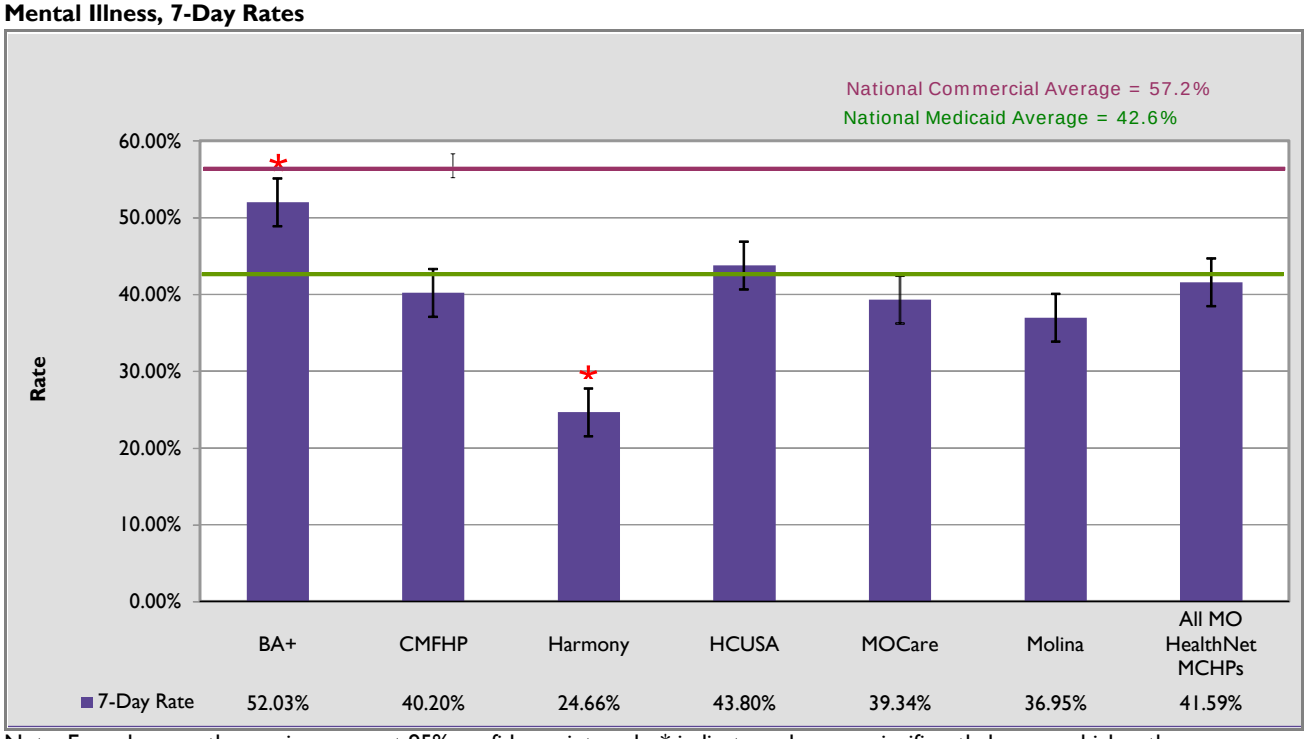


Figure 29 and Figure 30 illustrate the 7-Day and 30-Day rates reported by the MO HealthNet MCHPs. The rate reported by each MO HealthNet MCHP was compared with the rate for all MO HealthNet MCHPs, with two-tailed z-tests conducted at the 95% confidence interval to compare each MO HealthNet MCHP with the rate for all MO HealthNet MCHPs. The 7-Day rate reported for Harmony (24.66%) was significantly lower than the statewide rate (41.59%) for all MO HealthNet MCHPs. BA+ reported a rate (52.03%) significantly higher than the average. BA+ and HCUSA both reported rates higher than the National Medicaid Rate (42.6%), although all MCHPs were below the National Commercial Rate (57.2%).

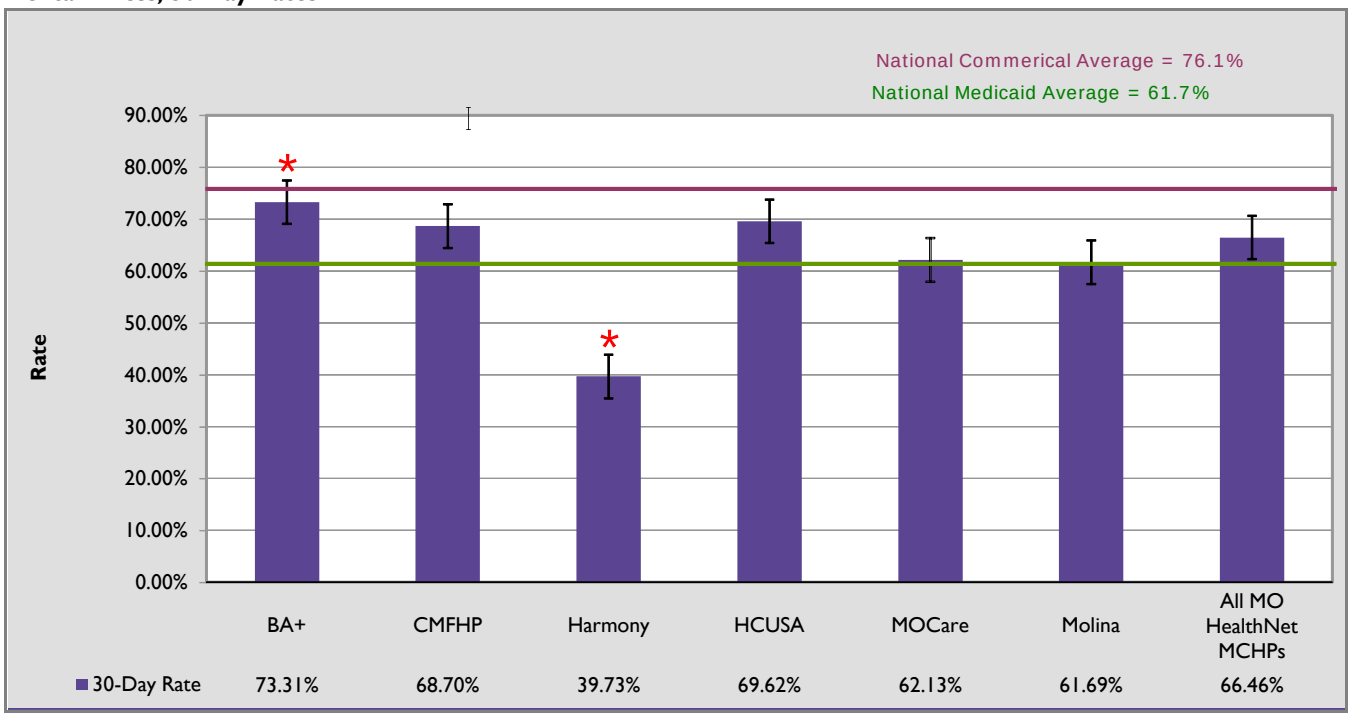
The 30-Day rate reported for BA+ (73.31%) was significantly higher than the statewide rate (66.46%). Although all MO HealthNet MCHPs reported rates lower than the National Commercial Average (76.1%), all MCHPs with the exception of Harmony were at or above the National Medicaid Rate of 61.7%. Harmony reported a rate (39.73%) significantly lower than the statewide rate (66.46%) for all MO HealthNet MCHPs.

Figure 29 - MO HealthNet Managed Care Program HEDIS 2009 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA).

Figure 30 - MO HealthNet Managed Care Program HEDIS 2009 Follow-Up After Hospitalization for Mental Illness, 30-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals.
Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA)

Table 25 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 2009 Follow-Up After Hospitalization for Mental Illness measure. Item 13.6 did not apply, as none of the MO HealthNet MCHPs used non-standard codes. Items 13.8 through 13.13 relate to the Hybrid Method of calculation and were not applicable to the measure. Across all MO HealthNet MCHPs, 100% of the criteria for calculating numerators were met. Each of the MO HealthNet MCHPs met 100.0% of criteria for the calculation of the numerator.

Table 25 - Numerator Validation Findings, HEDIS 2009 Follow-Up After Hospitalization For Mental Illness Measure

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	MCP	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/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	6	0	0	6	100.0%
13.2	The MCHP/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 MCHP/PIHP.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP'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	2	2	2	2	6	0	0	6	100.0%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	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	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	6	0	0	6	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	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	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	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	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	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	0	0	0	0	NA
	Number Met	5	5	5	5	5	5	30	0	0	30	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP 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. 2009 External Quality Review Performance Measure Validation.

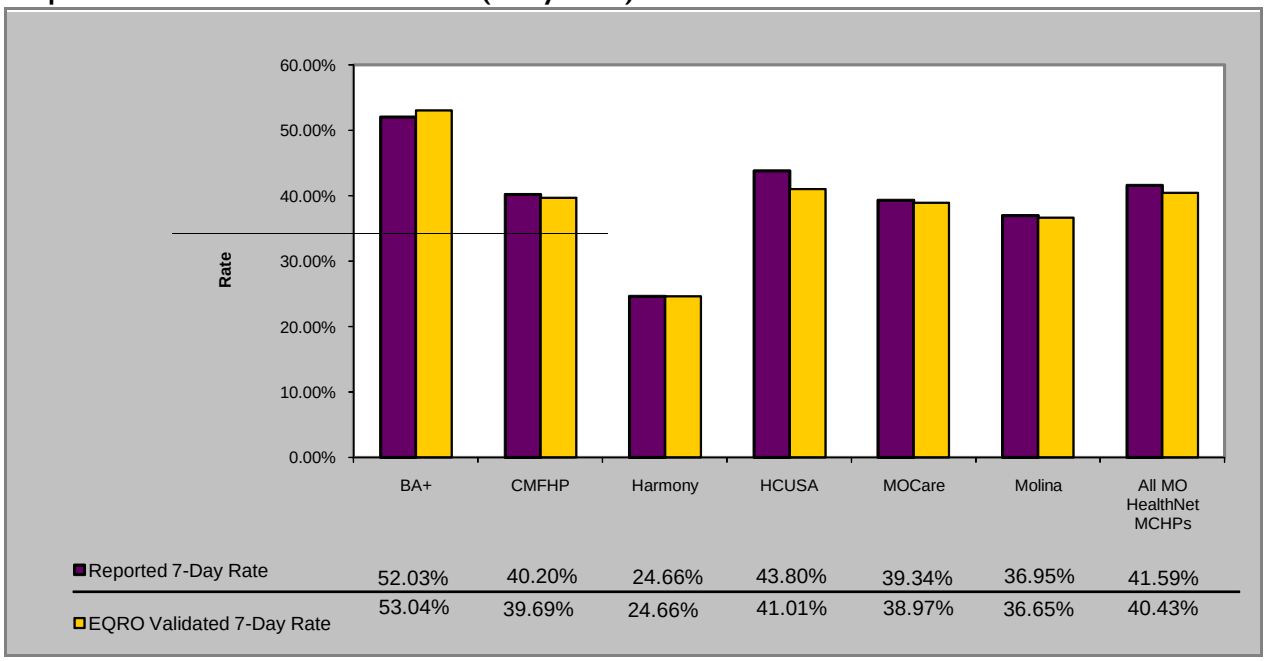
Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness Measure. All MO HealthNet MCHPs calculated and submitted the measure to the SPHA and SMA.

The 7-Day rates reported by MO HealthNet MCHPs ranged from 24.66% (Harmony) to 52.03% (BA+). The rate of all MO HealthNet MCHPs calculated based on data validated by the EQRO was 40.43%. The MO HealthNet MCHPs reported an overall rate of 41.59%, a 1.16% overestimate (see Figure 31).

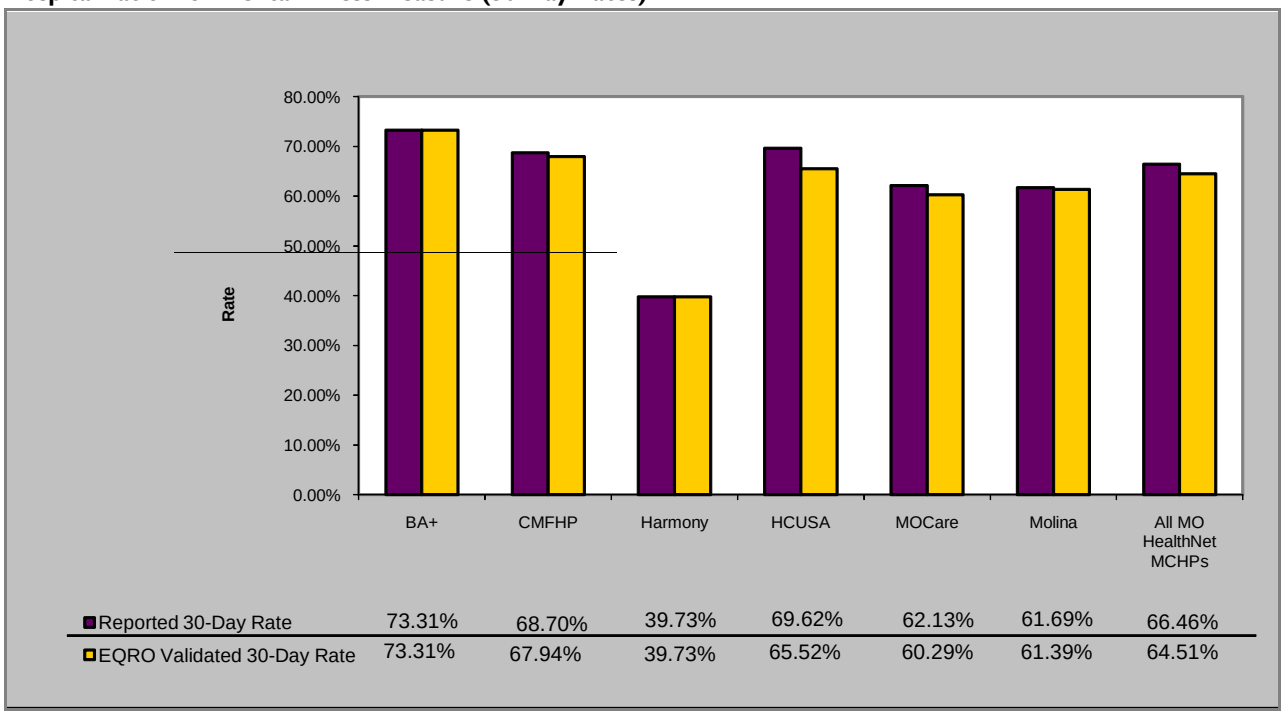
The 30-Day rate reported by MO HealthNet MCHPs ranged from 39.73% (Harmony) to 73.31% (BA+). The rate of all MO HealthNet MCHPs calculated based on data validated by the EQRO was 64.51%. The rate reported by MO HealthNet MCHPs was 66.46%, a 1.95% overestimate (see Figure 32).

Figure 31 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2009 Follow-Up After Hospitalization for Mental Illness Measure (7-Day Rates)



Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); BHC, Inc. 2009 External Quality Review Performance Measure Validation.

Figure 32 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2009 Follow-Up After Hospitalization for Mental Illness Measure (30-Day Rates)



Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); BHC, Inc. 2009 External Quality Review Performance Measure Validation.

Final Validation Findings

Table 26, Table 27, and Table 28 provide summaries of ratings across all Protocol Attachments for each MO HealthNet MCHP and measure validated. The rate of compliance with the calculation of each of the three performance measures across all MCOs was 99.4%, 100%, and 100% for ADV, AWC, and FUH respectively.

Table 26 - Summary of Attachment Ratings, HEDIS 2009 Annual Dental Visit Measure

	All MO HealthNet MCOs						
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MO HealthNet MCOs
Number Met	30	30	30	29	30	30	***179***
Number Partially Met	0	0	0	0	0	0	***0***
Number Not Met	0	0	0	1	0	0	***1***
Number Applicable	30	30	30	30	30	30	***180***
Rate Met	100%	100%	100%	96.7%	100%	100%	***99.4%***

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2009 EQR Performance Measure Validation

Table 27 - Summary of Attachment Ratings, HEDIS 2009 Adolescent Well-Care Measure

	All MO HealthNet MCOs						
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MO HealthNet MCOs
Number Met	29	48	48	48	48	48	***269***
Number Partially Met	0	0	0	0	0	0	***0***
Number Not Met	0	0	0	0	0	0	***0***
Number Applicable	29	48	48	48	48	48	***269***
Rate Met	100%	100%	100%	100%	100%	100%	***100%***

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2009 EQR Performance Measure Validation

Table 28 - Summary of Attachment Ratings, HEDIS 2009 Follow-Up After Hospitalization for Mental Illness Measure

	All MO HealthNet MCOs						
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MO HealthNet MCOs
Number Met	29	29	29	29	29	29	***174***
Number Partially Met	0	0	0	0	0	0	***0***
Number Not Met	0	0	0	0	0	0	***0***
Number Applicable	29	29	29	29	29	29	***174***
Rate Met	100%	100%	100%	100%	100%	100%	***100%***

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2009 EQR Performance Measure Validation

Table 29 summarizes the final audit ratings for each of the performance measures and MO HealthNet MCHPs. 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 MO HealthNet MCHP 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, if the rate could not be properly validated by the EQRO due to missing or improper data, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MO HealthNet MCHPs on the DST.

Table 29 - Summary of EQRO Final Audit Ratings, HEDIS 2009 Performance Measures

MO HealthNet MCHP	Annual Dental Visit	Adolescent Well-Care Visit	Follow-Up After Hospitalization for Mental Illness (7 day)	Follow-Up After Hospitalization for Mental Illness (30 day)
Blue-Advantage Plus	Substantially Compliant	Substantially Compliant	Substantially Compliant	Fully Compliant
Children's Mercy Family Health Partners	Substantially Compliant	Fully Compliant	Substantially Compliant	Substantially Compliant
Harmony Health Plan of Missouri	Substantially Compliant	Substantially Compliant	Fully Compliant	Fully Compliant
Healthcare USA	Not Valid	Fully Compliant	Substantially Compliant	Substantially Compliant
Missouri Care	Substantially Compliant	Substantially Compliant	Substantially Compliant	Substantially Compliant
Molina Healthcare of Missouri	Substantially Compliant	Substantially Compliant	Substantially Compliant	Substantially Compliant

CMFHP and HCUSA reported rates for the HEDIS 2009 Adolescent Well-Care Visit measure that were able to be fully validated by the EQRO, garnering ratings of Fully Compliant. Likewise, the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness 30-day rate for BA+ was Fully Compliant. Both the 7-day and 30-day Follow-Up After Hospitalization for Mental Illness rates for Harmony were found to be Fully Compliant. The Annual Dental Visit rate reported by HCUSA was rated Not Valid as no valid service dates were provided in the numerator data. Although all other ratings were not fully validated, each of them fell within the expected confidence intervals and therefore all were determined to be Substantially Compliant.

3.5 Conclusions

In calculating the measures, MO HealthNet MCHPs have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2009 measures validated.

Among MO HealthNet MCHPs there was good documentation of the HEDIS 2009 rate production process. HCUSA provided numerator data for the Annual Dental Visit measure that did not contain service dates, and therefore could not be appropriately validated by the EQRO. However, the rate for the numerator file was still calculated (assuming the service dates were correct) for purposes of providing comparison data.

The rates of medical record submission for the one measure allowing the use of the Hybrid Methodology was excellent, with the EQRO receiving all but one of the medical records requested.

QUALITY OF CARE

The HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by health plan members.

One MO HealthNet MCHP was Fully Compliant with the specifications for calculation of this measure. The five remaining MO HealthNet MCHPs were substantially complaint with the specifications for calculation of this measure.

For the 7-day follow up rate, two MO HealthNet MCHPs (BA+ and HCUSA) reported rates (52.03% and 43.80%, respectively) that were higher than the National Medicaid Average (42.6%) for this measure.

This measure was previously audited by the EQRO in audit years 2006 and 2007. The 7-Day reported rate for all MO HealthNet MCHPs in 2009 (41.59%) was a 10.43% increase overall since the rate reported in 2006 (31.16%); it is 6.07% higher than the rate reported in 2007 (35.52%).

For the 30-day follow up rate, five MO HealthNet MCHPs (BA+, CMFHP, HCUSA, MO Care, and Molina) all reported rates (73.31%, 68.70%, 69.62%, 62.13% and 61.69%, respectively) that were at or above than the National Medicaid Average (61.7%) for this measure. The overall MO MCHP rate (66.46%) was also higher than the National Medicaid Average.

This measure was previously audited by the EQRO in audit years 2006 and 2007. The 30-Day reported rate for all MO HealthNet MCHPs in 2009 (66.46%) was a 13.54% increase overall since the rate reported in 2006 (52.92%); it is 6.4% higher than the rate reported in 2007 (60.06%).

From examination of these rates, it can be concluded that MO HealthNet MCHP members are receiving a higher quality of care in the area of Follow-Up After Hospitalization for Mental Illness overall than other Medicaid participants across the country within the 30-day timeframe, but not quite as high a quality of care within the 7-day timeframe. However, the quality of care for Follow-Up After Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes.

Access to Care

The HEDIS 2009 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

For the Annual Dental Visit measure, five of the six MC HealthNet MCHPs reviewed were substantially compliant with the calculation of this measure. One health plan's calculations were rated as not valid.

The Annual Dental Visits measure has been audited in the 2007, 2008 and 2009 external quality reviews. Over the course of these review periods, the rates for all MO HealthNet MCHPs have improved a total of 2.55%; the rates reported were 32.50% in 2007, 34.71% in 2008 and 35.05% in 2009. Although the rates have increased for the Annual Dental Visit measure, none of the health plans reported a rate in 2009 higher than the National Medicaid Average of 44.2%.

This trend shows an increased level of dental care received in Missouri by MO HealthNet members, illustrating an increased access to care for these services for the HEDIS 2009 measurement year.

TIMELINESS OF CARE

The HEDIS 2009 Adolescent Well Care Visits is categorized as a Use of Services measure and aims to measure the timeliness of the care received. To increase the rates for this measure, age specific services must be delivered to members on a yearly basis.

For the Adolescent Well Care Visits measure, two health plans were fully compliant with the specifications for calculation of this measure, and the remaining health plans were substantially compliant with the measure's calculation.

The Adolescent Well Care Visits measure has been audited in the 2007, 2008 and 2009 external quality reviews. Over the course of these review periods, the rates for all MO HealthNet MCHPs has fluctuated; the rate reported in 2009 (35.63%) is an improvement over the rate reported in 2007 (34.81%), but is down 2.96% from the rate reported in the previous 2008 review year (38.59%). In addition, none of the health plans reported a rate in 2009 higher than the National Medicaid Average of 45.9%.

This illustrates a decrease in the timeliness of care for well care visits delivered to adolescents in Missouri during the HEDIS 2009 measurement year.

RECOMMENDATIONS

1. The SMA should continue to encourage the use of the Hybrid Method of calculation for HEDIS measures that allow these reviews. The Hybrid review process produces higher rates on average than an Administrative method alone.
2. MO HealthNet MCHPs with significantly lower rates of eligible members (Annual Dental Visit (Harmony, Molina), Adolescent Well Care Visits (Harmony) and Follow-Up After Hospitalization for Mental Illness (Harmony)) should closely examine the potential reasons for fewer members identified.
3. MO HealthNet MCHPs with significantly lower administrative hits (Annual Dental Visit (Harmony, Molina), Adolescent Well Care Visits (Harmony) and Follow-Up After Hospitalization for Mental Illness (Harmony)) should closely examine the potential reasons for fewer services identified. This may be due to member characteristics, but is more likely due to 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.

4. The SMA should continue to have the EQRO validate the calculation of at least one measure from year to year, for comparison and analysis of trend data.
5. MO HealthNet MCHPs should run query reports early enough in the HEDIS season so that they may effectuate change in rates where interventions could easily be employed.
6. All MO HealthNet MCHPs should carefully review both the EQRO data request formats and the health plan data files extracted prior to submission deadlines to ensure that data provided to the EQRO for validation is complete, accurate, and submitted in the correct format. Examination of these files prior to the submission deadlines would also allow for communication with the EQRO to clarify any questions or problems that may arise.
7. All MO HealthNet MCHPs should focus efforts on improving Adolescent Well Care rates as this is the only rate validated that showed a downward trend during HEDIS 2009.

4.0 VALIDATION OF ENCOUNTER DATA

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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."*[5]

An encounter is the unit of service provided to a Member by the health plan. 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 MO HealthNet MCHPs' contract with the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division; MHD) details the requirements for an acceptable submission of an encounter. The SMA's requirements for encounter data submitted by the MO HealthNet MCHPs 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."*[6]

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 MO HealthNet MCHP paid and unpaid claims; and validating medical records against the SMA encounter claims database. The following were the objectives and associated evaluation questions.

[5] 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.
[6] 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 6 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 health plan?
    - What types of encounter claim data are missing and why?

2. The second objective was to examine the match between MO HealthNet MCHP 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 MO HealthNet MCHPs paid claims. The alternative hypotheses were that 100% of MO HealthNet MCHPs paid claims are represented in the SMA encounter claims database, and 0.00% of MO HealthNet MCHPs 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 MO HealthNet MCHPs 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 MO HealthNet MCHP 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[7]. 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?

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

4.3 Findings

One limitation of the present analysis is that the encounter claim completeness and accuracy analysis was based on paid encounter claims and does not account for all claims that are submitted and rejected through system edits. Also, because the SMA encounter claims extract file was for service dates from July 1, 2009 through September 30, 2009, some service dates might extend beyond this period. For example, if the first date of service was later in the period (e.g., September 30, 2009), the last date of service may extend beyond the period specified by SMA parameters for the validation process (e.g., a Discharge Date of October 1, 2009). When last dates of service appeared to be within a reasonable period, dates outside the valid range were considered valid. 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. Thereby, the information contained in this aggregate section is available at the MO HealthNet MCHP level in the individual MO HealthNet MCHP summaries. The findings of the encounter data validation are presented in response to each evaluation question, by claim type and critical field for all MO HealthNet MCHPs.

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

For the Medical claim type, there were a total of 1,115,158 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant 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, 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, and 99.6% valid. The remaining fields contained invalid codes (n=6 "Y0025", n=4978 "Y0051" and n= 29 "Z0020").
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 99.6% complete, accurate and valid. The remaining fields were blank.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they all fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 23.6% complete, accurate and valid. The remaining fields (n = 852,524) were blank. The third Diagnosis Code field was 22.3% complete, accurate and valid. The remaining fields (n= 866,580) were blank (incomplete, inaccurate, and invalid). The fourth diagnosis code field was 12.0% complete,

accurate and valid. The remaining fields (n = 981,576) were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 99.0% complete, accurate and valid. The remaining fields (n=1,103,931) were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 214,662 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All critical fields examined were 100.00% complete, accurate and valid for all MO HealthNet MCHPs.

For the Home Health claim type, there were a total of 135 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 100.00% complete, accurate and valid.
7. The first Diagnosis Code field was 100.00% complete, accurate and valid.
8. The second Diagnosis Code filed was 63.0% complete, accurate and valid. The remaining fields (n= 50) were blank (incomplete, inaccurate, and invalid).
9. The third Diagnosis Code field was 39.30% complete, accurate and valid. The remaining fields (n=82) were blank (incomplete, inaccurate, and invalid).
10. The fourth Diagnosis Code field was 34.10% complete, accurate and valid. The remaining fields (n=89) were blank (incomplete, inaccurate, and invalid).
11. The fifth Diagnosis Code field was 23.0% complete, accurate and valid. The remaining fields (n =104) were blank (incomplete, inaccurate, and invalid).

For the Outpatient Hospital claim type, there were a total of 472,397 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 98.0% complete and accurate. The remaining fields (n=9,666) were blank (incomplete, inaccurate, and invalid). The fields were 98.16% valid. There were 56,425 fields containing invalid codes (including n=43,016 containing the code "00000").
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 all fell well below the 100% threshold established by the SMA for this validation. The Diagnosis Code fields were 51.6%, 38.2%, 18.9% and 8.6% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (n= 228,863; 291,992; 383,030; 426,863 respectively) (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were a total of 41,963 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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. The field was 99.99% valid. The remaining fields (n=19) contained the date 10/07/2008.
5. The Discharge Date field was 100.00% complete. The field was 98.1% accurate and valid. The remaining fields (n=780) contained the value "99999999".
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 99.99% complete, accurate and valid. The remaining fields (n=2) were blank (incomplete, inaccurate, and invalid).
8. The first Diagnosis Code field was 77.00% complete, accurate and valid. The remaining fields (n = 9639) were blank (incomplete, inaccurate, and invalid).
9. The second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (72.6%, 59.7%, 47.1%, and 33.4%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Billing field was 100.00% complete, accurate and valid.
11. The Last Date of Billing field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 99.99% complete, accurate, and valid. The remaining fields (n=11) were blank (incomplete, inaccurate, and invalid).
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Pharmacy claim type, there were 535,249 claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All fields examined were 100.00% complete, accurate and valid (Participant ID, First Date of Service, Prescription Number, Quantity Dispensed, Days Supply, and National Drug Code).

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 MO HealthNet MCHP is consistent with the remaining MO HealthNet MCHPs and the average of all MO HealthNet MCHPs 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 MO HealthNet MCHPs, vendors, and providers, the accessibility of services, member utilization patterns, and provider practice patterns influence the data. With the large number of members enrolled in each MO HealthNet MCHP, 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 MO HealthNet MCHPs having similar rates of encounters per 1,000 members as the rate for all MO HealthNet MCHPs. Statistically significant findings are more likely a function of the data quality and completeness resulting from the processing of data by providers, vendors, MO HealthNet MCHPs, and the MMIS rather than the accessibility or quality of services.

Another method of examining the level, consistency, and volume of services is to compare the baseline per 1,000 member encounter data collected during the 2007 and 2008 EQRO audits to the data obtained during this audit. By comparing service levels received during the July 1, 2007 – September 30, 2007 and July 1, 2008 – September 30, 2008 with the service levels reported during the time July 1, 2009 – September 30, 2009, a comparison of accessibility to services and member utilization patterns can be made.

Using the SMA encounter claims extract files from July 1, 2007 through September 30, 2007; July 1, 2008 through September 30, 2008; and July 1, 2009 through September 30, 2009 the volume of services for each claim type and MO HealthNet MCHP 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 September for each year, by 4, then calculating the rate of claims per 1,000 members. The following figures illustrate the rates of claim types and the results of two-tailed z-tests comparing each MO HealthNet MCHP with the statewide rate of claims. Statistically significant differences between an MO HealthNet MCHP and the rate for all MO HealthNet MCHPs

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 MO HealthNet MCHPs.

The results for the 2007 and 2008 EQR audit were similar, however, there was a higher rate of Medical encounter claims in 2008 than in 2007. The rate of Medical encounter claims for 2009 is very similar to the rate in 2007.

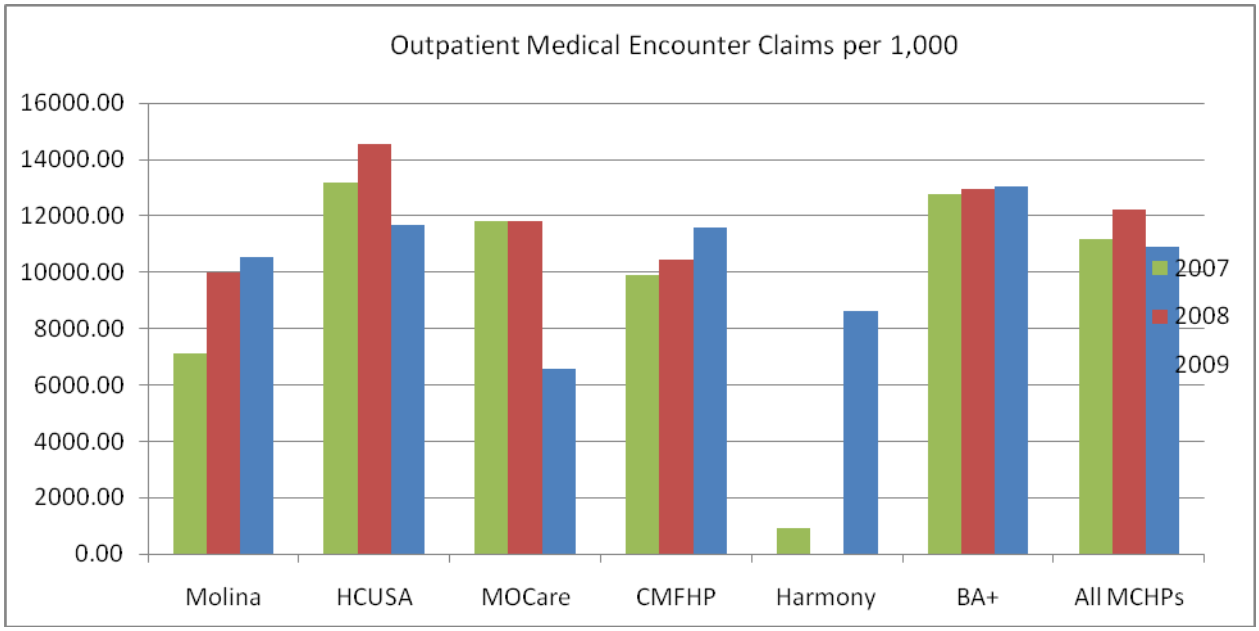
For 2007, as shown in Figure 33, there was some variability across MO HealthNet MCHPs in the statewide rate per 1,000 members of Medical encounter claim types compared to the rate for all MO HealthNet MCHPs (11,184.04 Medical encounter claims per 1,000 members). One MO HealthNet MCHP (HCUSA, 13168.60, $z = 0.833$; 95% CI: 9717.69, 16619.51; $p < .01$) showed a significantly higher rate, while one MO HealthNet MCHP (Harmony 928.49, $z = -1.79$; 95% CI: -2522.42, 4379.40; $p < .01$) had a significantly lower rate of Medical Encounter claims than the rate for all MO HealthNet MCHPs.

For 2008, as shown in Figure 33, there was also variability across MO HealthNet MCHPs in the statewide rate per 1,000 members of Medical encounter claim types compared to the rate for all MO HealthNet MCHPs (12,248.70 Medical encounter claims per 1,000 members). One MO HealthNet MCHP showed a significantly higher rate, (HCUSA, 14543.67, $z = 0.8993$; 95% CI: 10724.95, 18362.39; $p < .01$) while one MO HealthNet MCHP (Harmony 0, $z = -1.93$; 95% CI: -3818.72, 3818.72; $p < .01$) had a significantly lower rate of Medical Encounter claims than the rate for all MO HealthNet MCHPs.

For 2009, as shown in Figure 33, there still continues to be variability across MO HealthNet MCHPs in the statewide rate per 1,000 members of Medical encounter claim types compared to the rate for all MO HealthNet MCHPs (10,916.57 Medical Encounter claims per 1,000 members). One health plan had a significantly higher rate of Medical Encounter claims than the rate for all MO HealthNet MCHPs, (BA+, 13060.31, $z = 1.150$: 95% CI: 11,169.62, 14,951.00; $p < .01$). One health plan

(MOCare 6572.73, z=-1.5965; 95% CI: 4682.04, 8463.42; p < .01) had a significantly lower rate of Medical Encounter claims than the rate for all MO HealthNet MCHPs.

Figure 33 - Medical Encounters Claim Types per 1,000 Members, July 1 – September 30 (2007, 2008 & 2009)



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-September 30/ (Number members / 4) X 1,000. Enrollment as of the last week of September (2007, 2008, 2009) 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, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Dental encounter claims consist of claims submitted by providers, vendors, and MO HealthNet MCHPs.

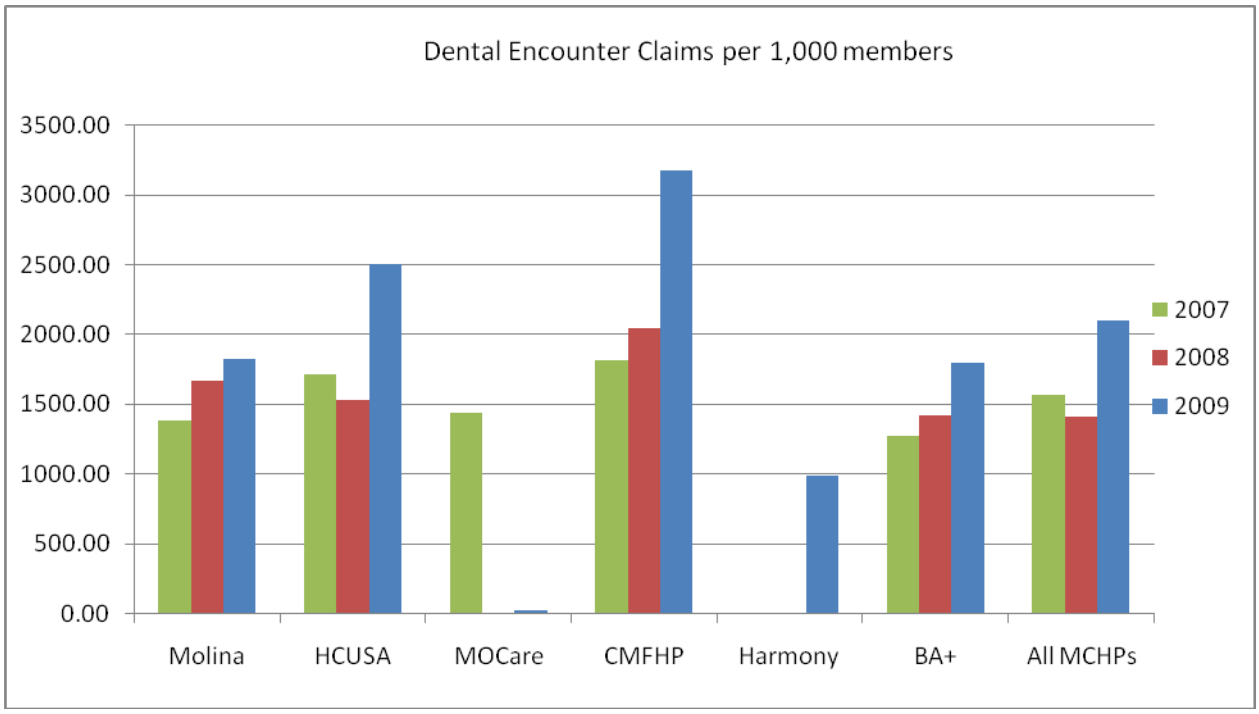
The 2009 rate for all MO HealthNet MCHPs of Dental encounter claims (2101.38 per 1,000 members) is significantly higher than both the 2007 rate (1569.47 per 1,000 members) and the 2008 rate (1411.94 per 1,000 members).

In 2007, there was a higher rate for all MO HealthNet MCHPs of Dental encounter claims (1569.47 Dental encounter claims per 1,000 members) than in 2008 (1411.94 Dental encounter claims per 1,000 members). For 2007, one MO HealthNet MCHP (CMFHP, 1819.80, z = .84; 95% CI: 1334.04, 2305.56538.40; $p < .05$) had a significantly higher rate. While one MO HealthNet MCHP (Harmony, 000.00, z = -1.94; 95% CI: -485.76, 485.76; $p < .05$) had a significantly lower rate of Dental encounter claims per 1,000 members than the rate for all MO HealthNet MCHPs (see Figure 34).

In 2008, one MO HealthNet MCHP (CMFHP, 2041.76, z = .01; 95% CI: 1385.23, 2698.29; $p < .05$) had a significantly higher rate than the all MO HealthNet MCHPs (1411.4). Two MO HealthNet MCHPs (Harmony, MO Care; 000.00, z = -1.25; 95% CI: -656.53, 656.53 $p < .05$) had a significantly lower rate of Dental encounter claims per 1,000 members than the rate for all MO HealthNet MCHPs (see Figure 34).

In 2009, the all MO HealthNet MCHP rate (2101.38 Dental encounter claims per 1,000 members) was significantly higher than both the 2007 and 2008 all health plan rates. The 2009 all health plan rate had one MO HealthNet MCHPs with a significantly lower rate of Dental encounter claims per 1,000 members than the rate for all MO HealthNet MCHPs (MOCare, 17.96, z = 0.0; 95% CI: -872.48, 908.40; p <.01). There was one health plan with a significantly higher rate than that of the All MCHP rate (CMFHP; 3178.80, z = 1.312; 95% CI: 2288.36, 4069.24; p <.01; see Figure 34).

Figure 34 - Dental Encounters per 1,000 Members, July 1 – September 30 (2007, 2008 & 2009)



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-September 30/ (Number members / 4) X 1,000. Enrollment as of the last week of September (2007, 2008, 2009) 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, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

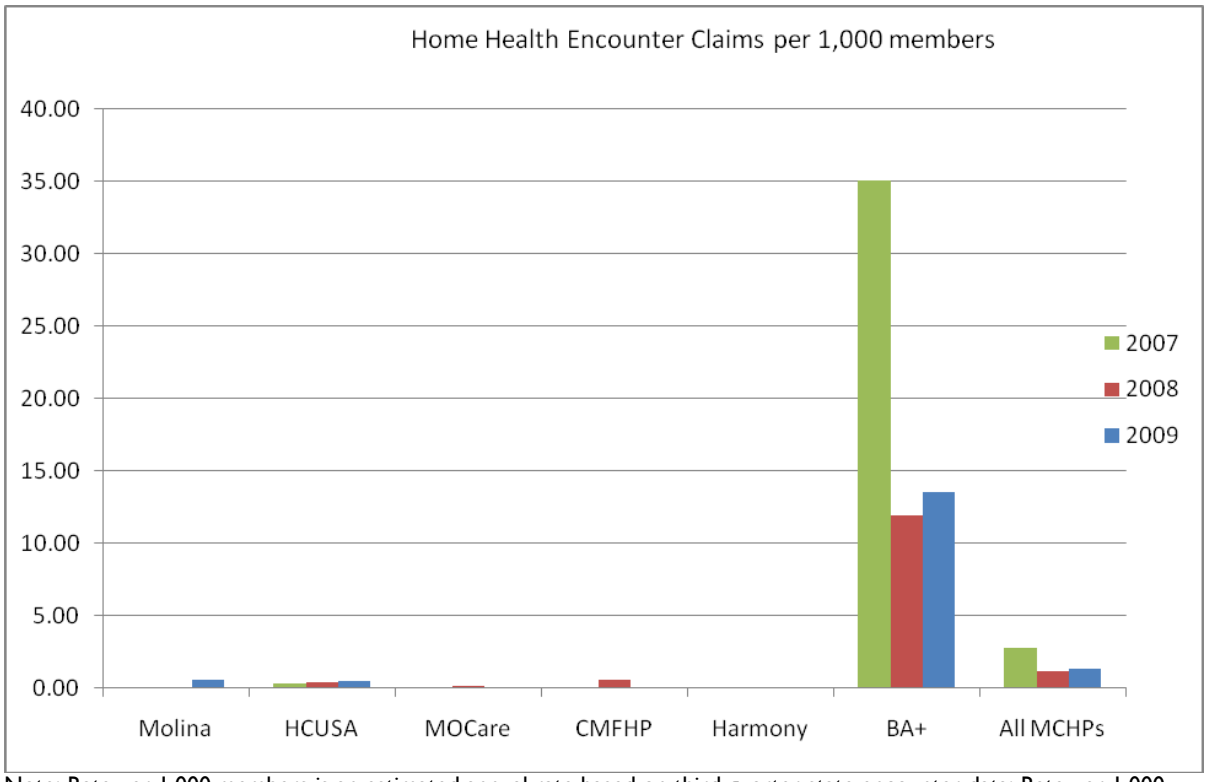
In 2007, only two of the six health plans submitted Home Health encounters (BA+ 35.02 and MCHP, 2.73), see Figure 35. However, only one of these health plans (BA+, 35.02, z = 2.04; 95% CI: 24.43, 45.61; p = 0.00) submitted a significantly higher rate of Home Health encounter claims than the rate for all MO HealthNet MCHPs (2.73 Home Health encounter claims per 1,000 members).

In 2008, four health plans submitted Home Health encounter claims (Figure 35). However, only one submitted a significantly higher rate than the rate for all MO HealthNet MCHPs (BA+, 11.90, z= 2.04; 95% CI: 8.36, 15.44; p = 0.00). The all plan rate was 1.11 Home Health encounter claims per 1,000 members.

In 2009, three health plans submitted Home Health encounter claims. Again, one of these health plans (BA+, 13.48, z=1.059; 95% CI: 0.70, 20.86; p < .01) submitted a significantly higher rate of

Home Health encounter claims than the rate for all MO HealthNet MCHPs (1.32 Home Health encounter claims per 1,000 members). It should be noted that the 2009 all MO HealthNet MCHPs rate of 1.32 claims per 1,000 members is significantly lower than the 2007 all MO HealthNet MCHPs rate of 2.73 claims per 1,000 members.

Figure 35 - Home Health Encounter Claim Types per 1,000 Members, July 1 – September 30 (2007, 2008 & 2009)



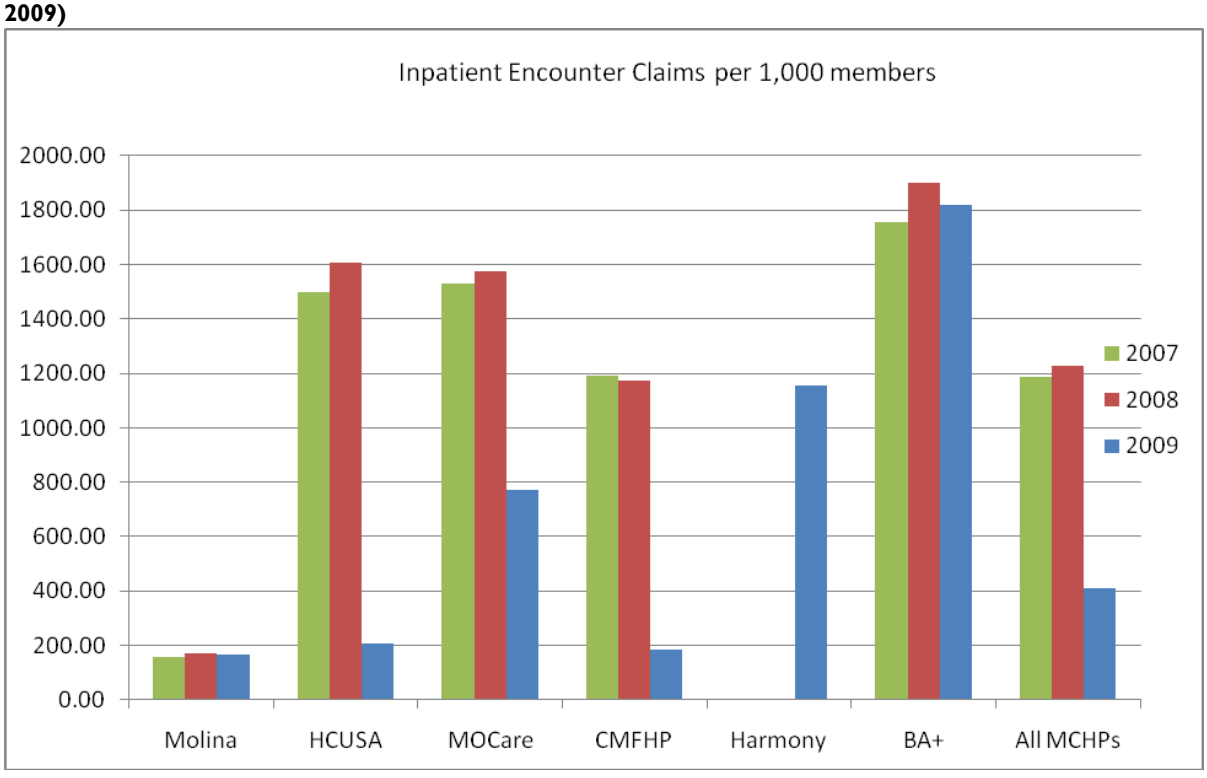
Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-September 30/ (Number members / 4) X 1,000. Enrollment as of the last week of September (2007, 2008, 2009) was used to calculate the rate per 1,000 members. 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, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

The results for the 2007 review of Inpatient Encounter claims are strongly comparable to the 2008 results (see Figure 36). In 2007, the EQRO found that two MO HealthNet MCHPs had significantly lower rates of Inpatient encounter claims (Harmony, 0.00, $z = -1.36$; 95% CI: -558.98, 558.98; $p < .01$; MercyCare Plus, 157.47, $z = -1.15$; 95% CI: -401.51, 716.45; $p < .01$). One health plan had a significantly higher rate of Inpatient encounter claims (BlueAdvantage Plus of Kansas City, 1755.65, $z = 0.97$; 95% CI: 1196.67, 2314.63; $p < .05$) compared to the rate for all MO HealthNet MCHPs.

In 2008 the EQRO found that two MO HealthNet MCHPs had significantly lower rates of Inpatient encounter claims (Harmony, 0.00, z = -1.34; 95% CI: -592.39, 592.39; p < .01; MercyCare Plus, 172.56, z = -1.12; 95% CI: -419.38, 764.95; p < .01). One health plan had a significantly higher rate of Inpatient encounter claims (BlueAdvantage Plus of Kansas City, 1901.66, z = 1.04; 95% CI: 1309.27, 2494.05; p < .01) compared to the rate for all MO HealthNet MCHPs.

For the 2009 review, the EQRO found that one MO HealthNet MCHPs had a significantly lower rate of Inpatient encounter claims (Molina, 167.52, z = -0.819; 95% CI -369.78, 704.82; p < .05). Blue Advantage Plus of Kansas City once again had a significantly higher rate of Inpatient encounter claims (1819.62, z = 1.64, 95% CI: 1282.32, 2356.92; p =0.00.) compared to the rate for all MO HealthNet MCHPs. (see Figure 36).

Figure 36 - Inpatient Encounter Claim Types per 1,000 Members, July 1 – September 30 (2007, 2008 & 2009)



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July1-September 30/ (Number members / 4) X 1,000. Enrollment as of the last week of September (2007, 2008, 2009) 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, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

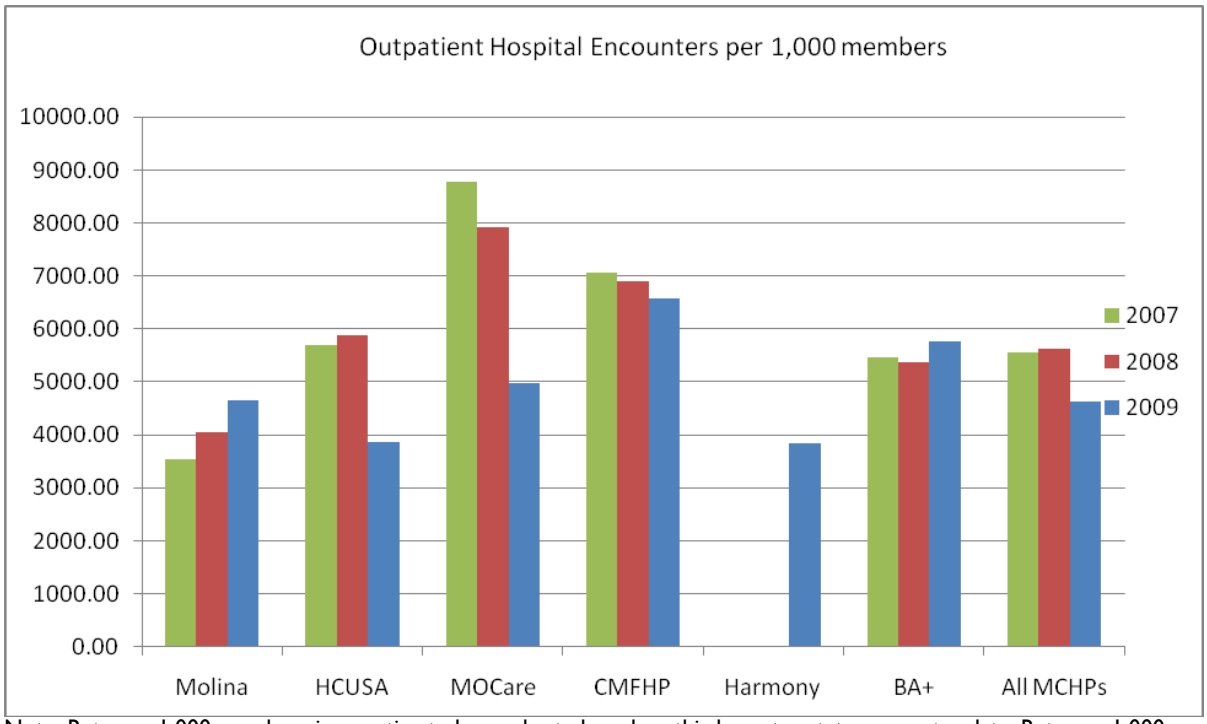
Outpatient Hospital encounter claim types consist of claims submitted by outpatient hospital facilities and MO HealthNet MCHPs. In 2007, the EQRO found that the rate of Outpatient Hospital encounter claims per 1,000 members for all MO HealthNet MCHPs was 5,547.72. In 2008 this rate was comparable at 5,614.23. However, the rate of Outpatient Hospital encounter claims per 1,000 members for all MO HealthNet MCHPs in 2009 was significantly lower than the two previous years at 4,624.42 (see Figure 37).

In 2007, the EQRO found that one MO HealthNet MCHP had a significantly higher rate of Outpatient Hospital encounter claims (MO Care, 8785.34, $z = 1.21$; 95% CI: 6530.31, 11040.37; $p < .01$). While one MO HealthNet MCHP had a significantly lower rate of Outpatient Hospital encounter claims per 1,000 members (Harmony, 3.43, $z = -1.67$; 95% CI: -2251.60, 2258.46; $p < .01$) than the rate for all MO HealthNet MCHPs.

In 2008, again the EQRO found that one MO HealthNet MCHP had a significantly higher rate of Outpatient Hospital encounter claims (MO Care, 7930.52, $z = 1.04$; 95% CI: 5861.86, 9999.18; $p < .01$). While one MO HealthNet MCHP had a significantly lower rate of Outpatient Hospital encounter claims per 1,000 members (Harmony, 0.00, $z = -1.80$; 95% CI: -2068.68, 2068.68; $p < .01$) than the rate for all MO HealthNet MCHPs.

In 2009, one MO HealthNet MCHP had a significantly higher rate of Outpatient Hospital encounter claims (CMFHP, 6569.04, $z = 1.51$; 95% CI: 5709.17, 7428.91; $p = 0.00$) than the rate of the all MO HealthNet MCHPs. While all other health plan rates were consistent with the all MO HealthNet MCHP rate.

Figure 37 - Outpatient Hospital Encounter Claim Types per 1,000 Members, July 1 – Sept. 30 (2007, 2008 & 2009)



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 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: MO Dept of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

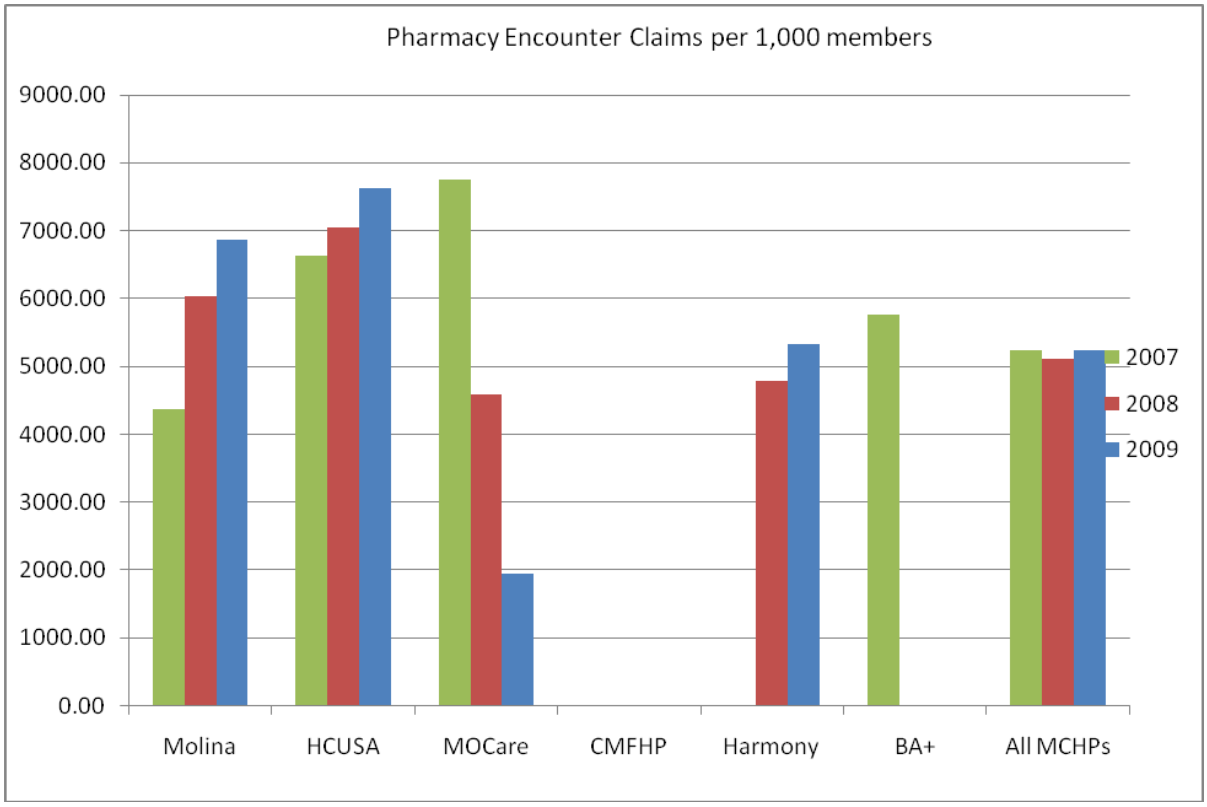
Pharmacy encounter claim types consist of claims submitted by pharmacy providers and MO HealthNet MCHPs.

In 2007, there was wide variability across MO HealthNet MCHPs in the rate per 1,000 members of Pharmacy encounter claims compared to the rate for all health plans. MO Care (7748.92, z = 1.09, 95% CI: 5267.69, 10230.15; $p < .01$) had a significantly higher rate of Pharmacy encounter claims, see Figure 31. While two MO HealthNet MCHPs (CMFHP, 2.49, z = -1.22; 95% CI: -2478.74, 2481.23; $p < .01$; and Harmony, 0.00, z = -1.22; 95% CI: -2481.23, 2481.23; $p < .01$) had a significantly lower rate of Pharmacy encounter claims per 1,000 members than the rate for all MO HealthNet MCHPs (see Figure 38).

In 2008, there was again wide variability across MO HealthNet MCHPs in the rate per 1,000 members of Pharmacy encounter claims compared to the rate for all health plans. HCUSA (7040.25, z = .94, 95% CI: 4674.16, 9406.34; p < .01) had a significantly higher rate of Pharmacy encounter claims. While one MO HealthNet MCHP (CMFHP, 1.57, z = -1.66; 95% CI: -2364.52, 2367.66; p < .01) had a significantly lower rate of Pharmacy encounter claims per 1,000 members than the rate for all MO HealthNet MCHPs (see Figure 38).

In 2009, there was not as much variability, as in the prior two years, across MO HealthNet MCHPs in the rate per 1,000 members of Pharmacy encounter claims compared to the rate for all health plans. In addition, there were only four health plans who made Pharmacy encounter claims during the review period of July 1, 2009 – September 1, 2009, as two health plans had "carved-out" the payment and processing of those pharmacy claims to the SMA. No health plan had a significantly higher rate of Pharmacy encounter claims than the rate for all MO HealthNet MCHPs (5239.69). While one health plan (MO Care, 1944.14, z = -1.39; 85% CI: -526.07, 4414.35; p < .01)) had a significantly lower rate of Pharmacy encounter claims per 1,000 members than the rate for all MO HealthNet MCHPs (see Figure 38).

Figure 38 - Pharmacy Encounter Claim Types per 1,000 Members, July 1 – Sept. 30 (2007, 2008 & 2009)



Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2008 – September 30, 2008 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2008 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: MO Dept of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Table 30 and Figure 39 show the proportion of claim types for each MO Health MCHP based on the SMA encounter claims extract file. In 2009, Blue Advantage Plus of Kansas City had the highest proportion of Medical, Home Health, and Inpatient claims relative to all other MO HealthNet MCHPs; CMFHP had the highest proportion of the Dental and Outpatient Hospital claim types; and HCUSA had the highest proportion of Pharmacy claims. This is the third consecutive year that CMFHP has had the highest proportion of Dental claims; it is also the second year in the last three years that Blue Advantage Plus of Kansas City had the highest proportion of Medical, Home Health, and Inpatient claims. This suggests that either these two health plans have a population that seeks these services more often than that of the other health plans, or these health plans are targeting areas of need that correspond to these claim types.

Table 30 - Numerical Proportion of Claim Types per MO HealthNet MCHP, July 1, 2009 – September 30, 2009

MO HEALTHNET MCHP	Medical	Dental	Home Health	Hospital	Inpatient	Pharmacy
Molina	10545.23	1829.01	0.52	4645.59	167.52	6872.46
HCUSA	11678.41	2503.19	0.48	3870.70	206.09	7624.73
MOCare	6572.73	17.96	0.00	4972.26	772.76	1944.14
CMFHP	11586.70	3178.80	0.00	6569.04	185.89	0.00
Harmony	8626.58	987.83	0.00	3842.48	1153.54	5319.01
BA+	13060.31	1793.52	13.48	5767.41	1819.62	0.00
All MCHPs	10916.57	2101.38	1.32	4624.42	410.79	5239.69

Figure 39 - Percentage Proportion of Claim Types per MO HealthNet MCHP, July 1, 2009 – September 30, 2009

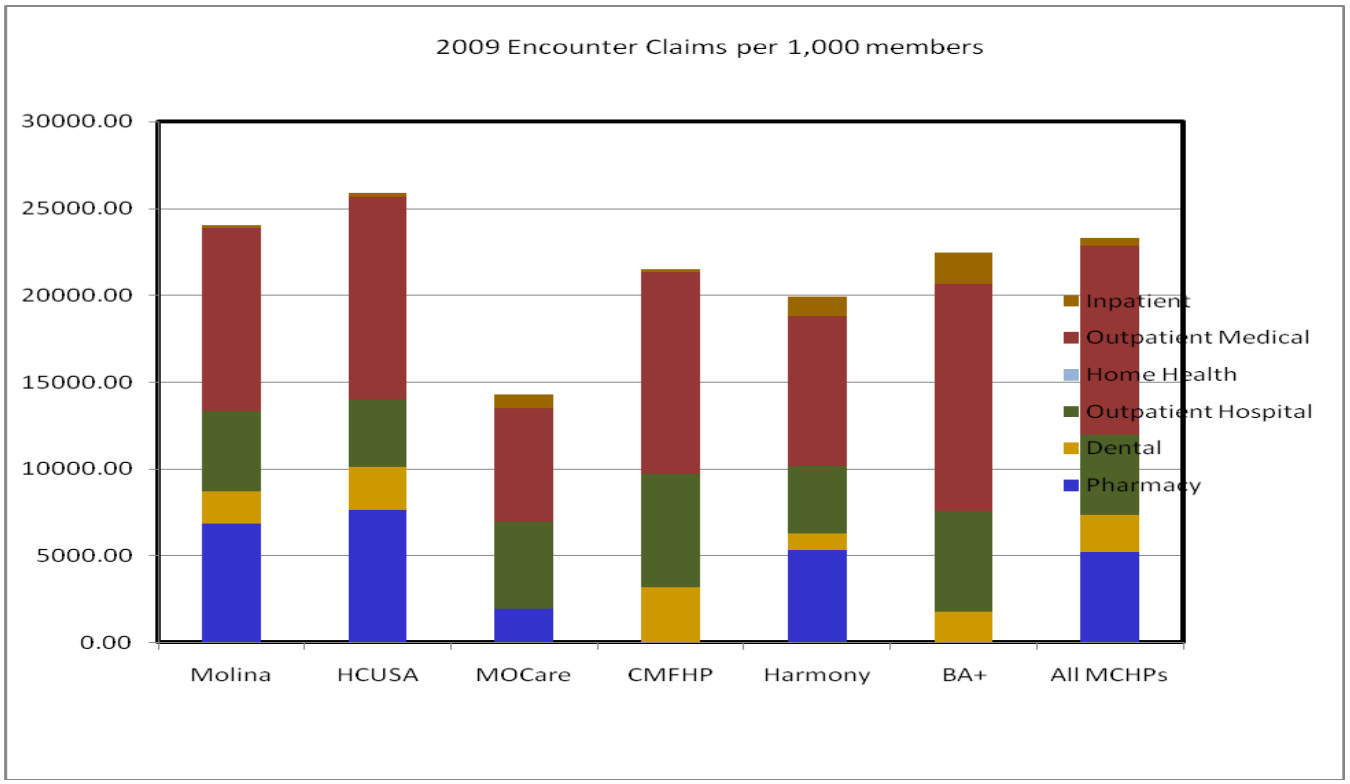


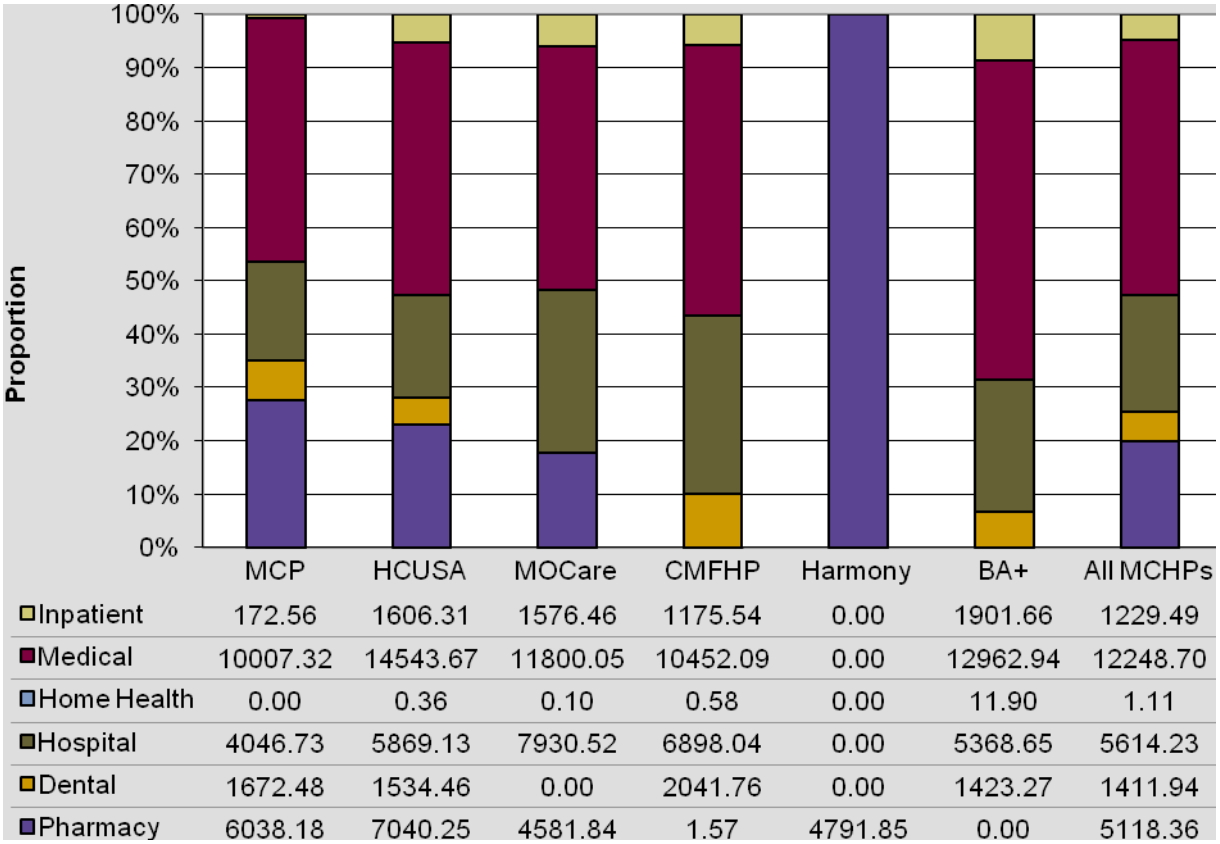
Table 31 and Figure 40show the proportion of claim types for each MO HealthNet MCHP based on the SMA encounter claims extract file. In 2008, HCUSA had the highest proportion of Medical and Pharmacy claims relative to all other MO HealthNet MCHPs; CMFHP had the highest proportion of the Dental claim types; BA+ had the highest proportion of Home Health and Inpatient claim types; and MO Care had the highest proportion of Hospital claims. There were no patterns observed

across MO HealthNet Plans, suggesting that the variations are not related to member or provider practice characteristics.

Table 31 - Numerical Proportion of Claim Types per MO HealthNet MCHP, July 1, 2008 – September 30, 2008

MCHP	Medical	Dental	Inpatient	Home Health	Hospital	Pharmacy
MCP	10007.32	1672.48	172.56	0.00	4046.73	6038.18
HCUSA	14543.67	1534.46	1606.31	0.36	5869.13	7040.25
MOCare	11800.05	0.00	1576.46	0.10	7930.52	4581.84
CMFHP	10452.09	2041.76	1175.54	0.58	6898.04	1.57
FG	0.00	0.00	0.00	0.00	0.00	4791.85
BA+	12962.94	1423.27	1901.66	11.90	5368.65	0.00
All MCHPs	12248.70	1411.94	1229.49	1.11	5614.23	5118.36

Figure 40 - Percentage Proportion of Claim Types per MO HealthNet MCHP, July 1, 2008 – September 30, 2008



Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, February13, 2009.

In 2007, MO Care had the highest proportion of Pharmacy and Hospital; HCUSA had the highest proportion of Medical claims; BA+ had the highest proportion of Home Health and Inpatient claims;

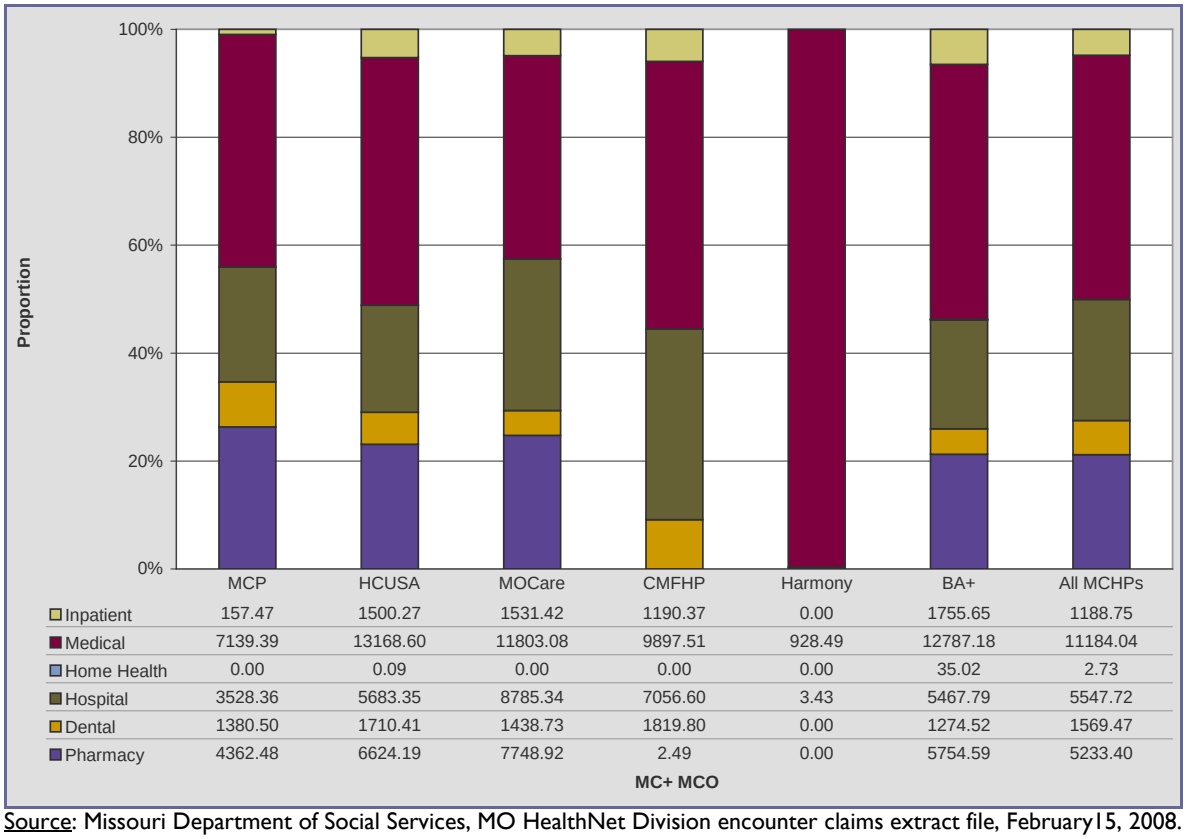
and CMFHP again had the highest proportion of Dental claims relative to all other MO HealthNet MCHPs (see

Table 32 and Figure 41).

Table 32 - Numerical Proportion of Claim Types per MO HEALTHNET MCHPs, July 1, 2007 –September 30, 2007

MCHP	Medical	Dental	Inpatient	Home Health	Hospital	Pharmacy
MCP	7139.39	1380.50	157.47	0.00	3528.36	4362.48
HCUSA	13168.60	1710.41	1500.27	0.09	5683.35	6624.19
MOCare	11803.08	1438.73	1531.42	0.00	8785.34	7748.92
CMFHP	9897.51	1819.80	1190.37	0.00	7056.60	2.49
Harmony	928.49	0.00	0.00	0.00	3.43	0.00
BA+	12787.18	1274.52	1755.65	35.02	5467.79	5754.59
All MCHPs	**11184.04**	**1569.47**	**1188.75**	**2.73**	**5547.72**	**5233.40**

Figure 41 - Percentage Proportion of Claim Types per MO HealthNet MCHP, July 1, 2007 – September 30, 2007



Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, February15, 2008.

Table 33 - MO HealthNet MCHPs, Rate per 1,000 Members all Encounter Claims (2009)

Claim Type	Number of Claims	Total Members	Claims Per 1000 Members
Home Health	135	408,611	1.32
Dental	214,662	408,611	2101.38
Medical	1,115,158	408,611	10916.57
Outpatient	472,397	408,611	4624.42
Drug	535,249	408,611	5239.69
Inpatient	41,963	408,611	410.79

Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2008 – September 30, 2008 / (Number members) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file.

Table 34 - MO HealthNet MCHPs, Rate per 1,000 Members all Encounter Claims (2008)

Claim Type	Number of Claims	Total Members	Claims Per 1000 Members
Home Health	107	383,933	1.11
Dental	135,523	383,933	1,411.94
Medical	1,175,670	383,933	12,248.70
Outpatient	538,872	383,933	5,614.23
Drug	491,277	383,933	5,118.36
Inpatient	118,010	383,933	1,229.49

Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2008 – September 30, 2008 / (Number members) X 1,000. Enrollment as of the last week of September 2008 was used to calculate the rate per 1,000 members. Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file.

Table 35 - MO HealthNet MCHPs, Rate per 1,000 Members all Encounter Claims (2007)

Claim Type	Number of Claims	Total Members	Claims Per 1000 Members
Home Health	235	343,998	2.73
Dental	134,974	343,998	1,569.47
Medical	961,822	343,998	11,184.84
Outpatient	477,101	343,998	5,547.72
Drug	450,070	343,998	5,233.40
Inpatient	102,232	343,998	1,188.75

Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2007 – September 30, 2007 / (Number members) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file.

Figure 42 – Rates of Encounter Home Health Claims for All MOHealthNet MCHPs, 2007-2009

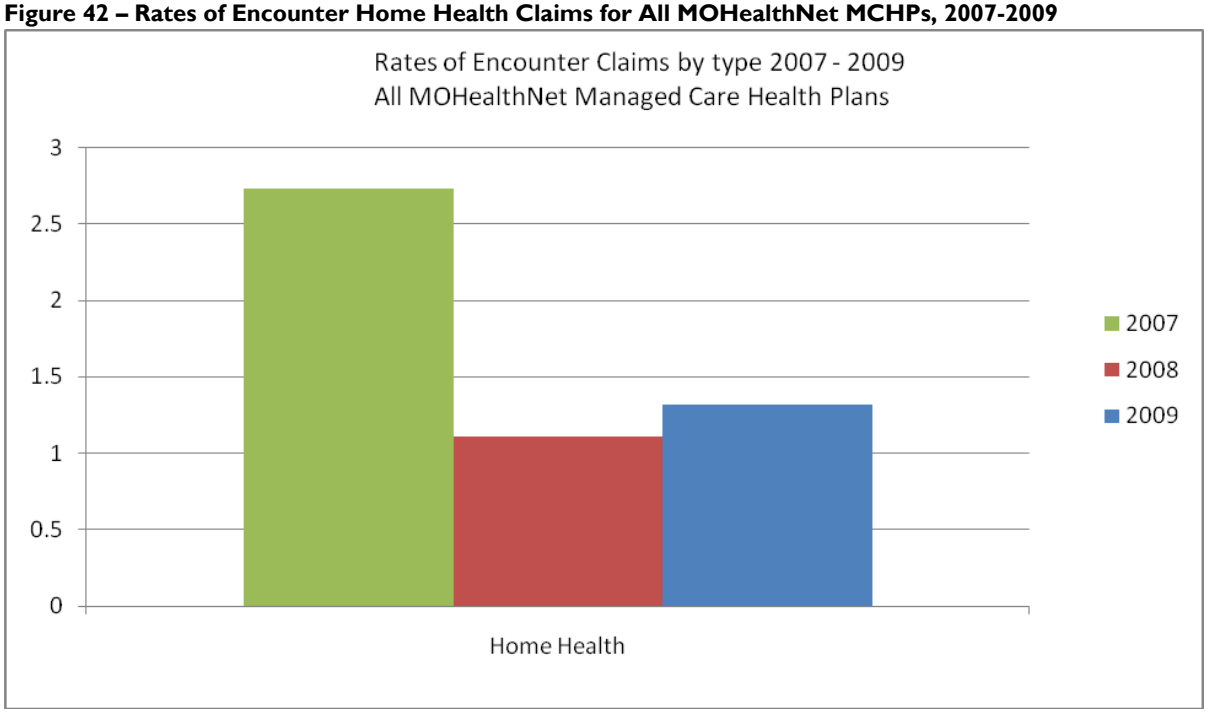
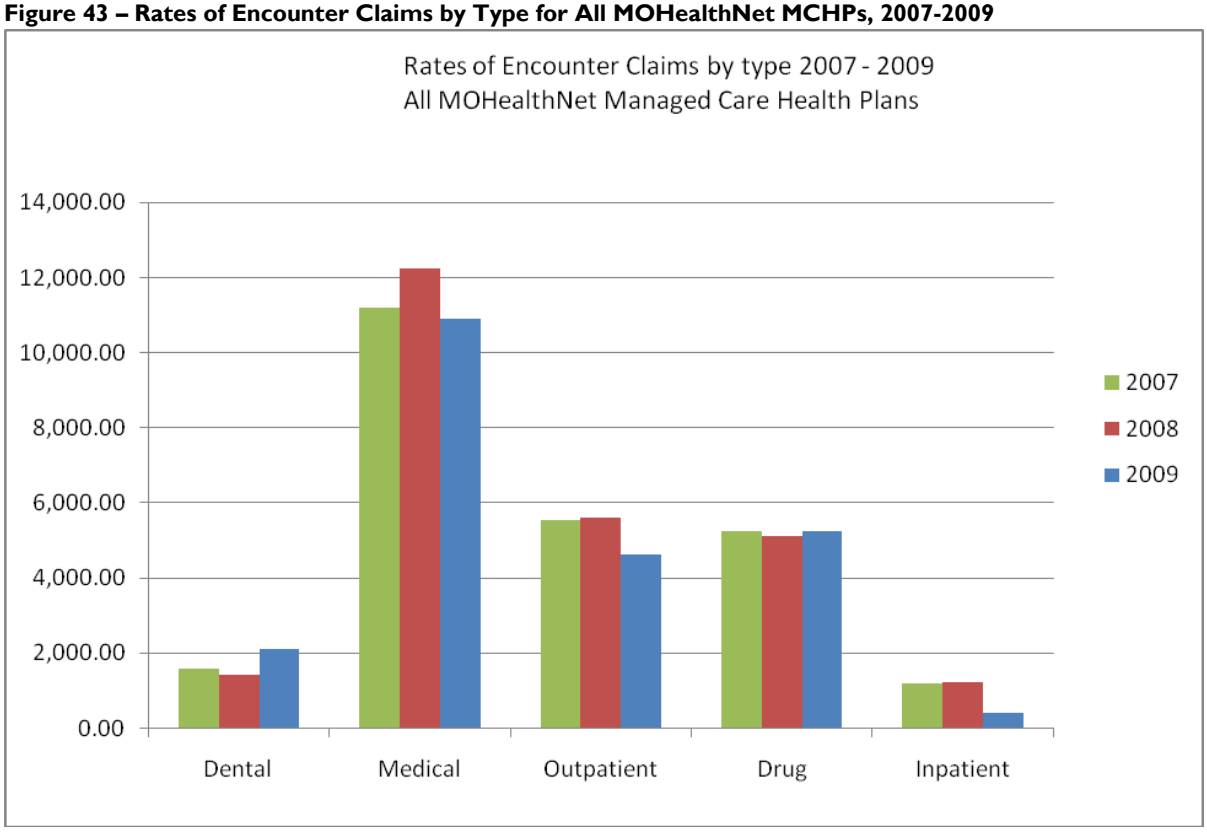


Figure 43 – Rates of Encounter Claims by Type for All MOHealthNet MCHPs, 2007-2009



To What Extent do the MO HealthNet MCHP claims (paid and unpaid) match the State Encounter Claims Paid Claims Data Base?

All six MO HealthNet MCHPs submitted the requested internal control numbers (ICNs) generated by the SMA data system for the "paid" vs. "unpaid" analysis. Health Care USA, MO Care, CMFHP, Harmony and BA+ submitted encounter claims that were "paid" or "denied" status. BA+, Harmony and MO Care also submitted claims with a status of "unpaid".

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

What types of paid encounter data are missing and why?

There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all MO HealthNet MCHPs.

For all MO HealthNet MCHPs, 100.0% of the unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA. There were no unmatched encounters within the Pharmacy Claim type. For the Outpatient data, 99.9% of the 857 unmatched claims were missing ICN numbers. Of the 782 unmatched claims, 782 of those were of "denied" status and would not be expected to be present in the SMA file. The remaining 75 were "unpaid" and only 2 ICN's were present, these were also not found in the SMA file. For Inpatient Claims, 634 unmatched claims were missing ICNs, 20 ICN's were present, but those ICNs were not found in the SMA database. Therefore, all were legitimately missing from the SMA file.

What is the fault/match rate of paid and unpaid encounter claims in the SMA encounter claim database and the MO HealthNet MCHP claims database?

For all Outpatient Claim Types (Medical, Dental, Home Health, & Hospital; n = 1,802,352), 782 "denied" claims were submitted by all MO HealthNet MCHPs. All of these claims were unmatched with the SMA encounter data. There was a "hit" rate of 99.99% between Outpatient encounter claims and the SMA encounter data. For the Inpatient Claim Type, data submitted to the EQRO (n = 41,963), 634 "denied" claims were submitted. These claims were not found in the SMA

encounter data. There were a total of 1416 unmatched records (151 "unpaid" claims were submitted) between all MO HealthNet MCHPs and the SMA, yielding a 99.99% "hit" rate.

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

Unpaid encounter claims were submitted for only Outpatient and Inpatient categories. 1151 unpaid claims were submitted for all MO HealthNet MCHPs for all Outpatient claims and Inpatient services. These unpaid claims represent 0 .0001% of all claims submitted to the SMA.

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 36 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 1,802,352 Medical encounter claim types in the SMA encounter claims extract file for July 1, 2009 through September 30, 2009, 600 encounters (100 per MO HealthNet MCHP) were randomly selected. This was an oversample, as the minimum required sample size was 88 per MO HealthNet MCHP. Providers were requested to submit medical records for review.

For the 600 selected encounters, there were 528 medical records (88.00%) submitted for review. This is comparable to the 2008 submission rate of 90.0%, but is a decrease from the 97.40% and 93.50% submitted for the 2006 and 2007 audits, respectively. For 2007, MO HealthNet MCHP submission rates ranged from 88.0% (CMFHP) to 98.0% (MO Care). For 2008, the submission rates ranged from 76.0% (MO Care) to 100.0% (BA+ and HCUSA). For 2009, the submission rates ranged from 60.0% (Harmony) to 99.0% (MO Care). Encounters for which no documentation was submitted were unable to be validated.

Table 36 - Encounter Data Validation Samples and Medical Record Submission Rate

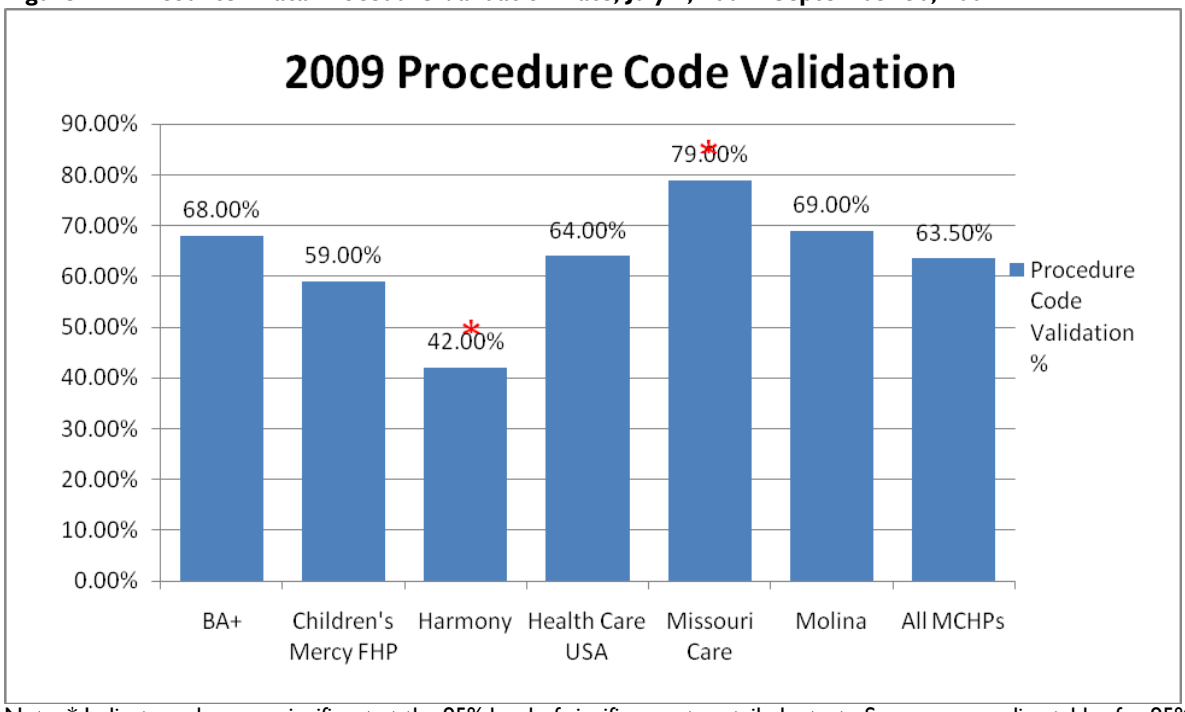
MO HealthNet MCHP	Number Encounters	Minimum Sample Size	Number Encounters Sampled	Number Medical Records Received	Submission Rate
Molina	324,408	88	100	92	92.00%
Health Care USA	858,518	88	100	87	87.00%
Missouri Care	120,379	88	100	99	99.00%
Children's Family Health Partners	288,763	88	100	95	95.00%
Harmony	54,187	88	100	60	60.00%
Blue Advantage Plus	156,09	88	100	95	95.00%
All MCHPs	**1,802,352**	**528**	**600**	**528**	**88.00%**

Note: The number of encounters represents the number of unique Outpatient Medical claim types found in the SMA encounter claims extract file for the period July 1, 2009 through September 30, 2009. 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 MO HealthNet MCHP providers; Number Claim Forms Received = Number claim forms submitted by MO HealthNet MCHP providers; Submission Rate = Proportion of medical records submitted of the number of encounters sampled.
Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, March 2010.

Table 37 and Figure 44 show the results of the match for procedures. Across all MO HealthNet MCOs, in 2008, 59.20% of the medical records contained matching procedure codes or descriptors; this is an increase of 7.20% from the 2007 audit which found 52.00%, but a decrease of 14.04% from the 2006 audit which found 73.24%. The 2009 rate of matching medical record rate for procedure codes or descriptors was 63.50%, a 4.30% and 11.50% increase over the 2008 and 2007 rates respectively. The 2009 rate is still 9.26% less than the 2006 rate.

MO HealthNet MCHP match rates ranged from 42.0% (Harmony) to 79.0% (MO Care). One MO HealthNet MCHP (MO Care, 79.00%; z= 1.25, 95% CI: 54.62, 100.00) had a match rate significantly higher than the rate for all MO HealthNet MCHPs. One MO HealthNet MCHP (Harmony, 42.00%; z=-1.73, 95% CI: 17.62, 66.38) had a rate significantly lower than the rate for all health plans. The remaining MO HealthNet MCHPs had match rates consistent with the rate for all MO HealthNet MCOs. The CMS Protocols suggest a 99% match rate as a validity criterion. When considering only the documentation submitted for review, the match rate for all MO HealthNet MCHPs for procedures was 72.16%

Figure 44 - Encounter Data Procedure Validation Rate, July 1, 2009– September 30, 2009



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, MO HealthNet Division encounter claims extract file, . BHC, Inc. 2009 External Quality Review Validation of Encounter Data.

Figure 45 – MO HealthNet Managed Care Program Rate Comparison for Procedures (2006-2009)

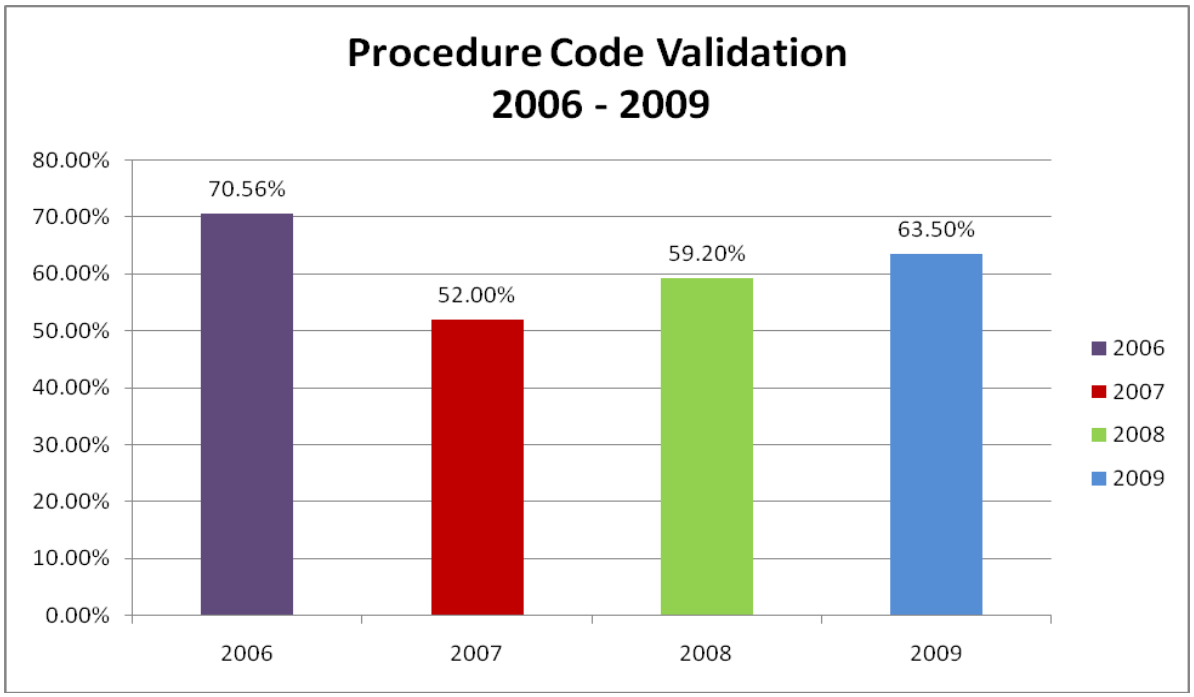


Table 37 - Procedure Validation Rate

MO HealthNet MCHPs	Number Encounters Sampled	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	z	p	LCL	UCL
Blue Advantage Plus	100	95	68	71.58%	68.00%	32.00%	0.3617990	0.375	43.62%	92.38%
Children's Mercy FHP	100	95	59	62.11%	59.00%	41.00%	-0.3617990	0.375	34.62%	83.38%
Harmony	100	60	42	70.00%	42.00%	58.00%	-1.7285952	0.000	17.62%	66.38%
Healthcare USA	100	87	64	73.56%	64.00%	36.00%	0.0401999	0.922	39.62%	88.38%
Missouri Care	100	99	79	79.80%	79.00%	21.00%	1.2461965	0.002	54.62%	100.00%
Molina	100	92	69	75.00%	69.00%	31.00%	0.4421988	0.279	44.62%	93.38%
All MCHPs	600	**528**	**381**	**72.16%**	**63.50%**	**36.50%**	0	1	39.12%	87.88%

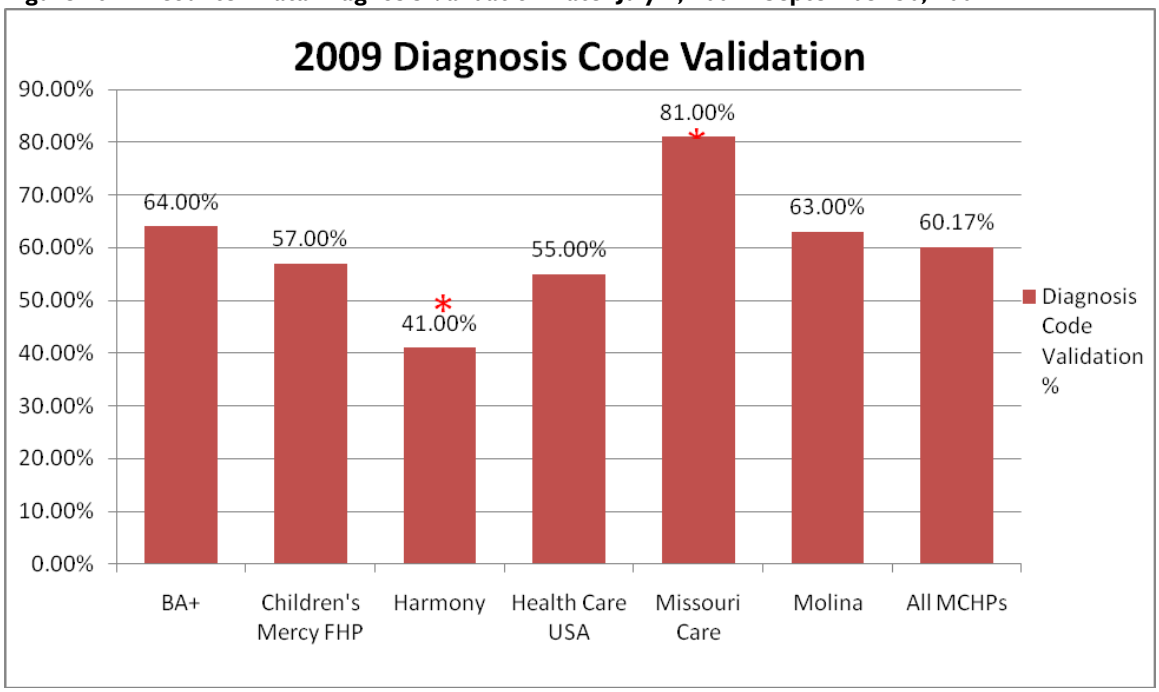
Note: Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by MO HealthNet MCHP providers for validation; Number Validated = Number of encounters for which there was 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, MO HealthNet Division encounter claims extract file, January 2008.
BHC, Inc. 2009 External Quality Review Validation of Encounter Data.

For the validation of the diagnosis, 60.17% matched the diagnosis found in the SMA encounter claims extract file across all MO HealthNet MCHPs (see Figure 46 and Table 38). This was a significant decrease from the 2006 audit when the EQRO found that 70.56% matched the diagnosis found in the SMA encounter claims extract file, but an increase from 2008 and 2007 when only 50.0% and 47.0%, respectively, matched the diagnosis found in the SMA file.

For the 2009 audit, MO HealthNet MCHP match rates ranged from 41.0% (Harmony) to 81.00% (MO Care) of the medical records or claim forms for diagnosis codes. One MO HealthNet MCHPs (MO Care, 81.0%, z=1.59, 95% CI: 55.28, 100.00) had a match rate significantly higher than the rate for all MO HealthNet MCHPs; while one health plan (Harmony, 41.0%, z= -1.46, 95% CI: 15.28, 66.75) had a rate significantly lower than the rate of all health plans. All other health plans had rates consistent with the All Health Plan rate. The CMS Protocol suggests a greater than 90% validity criterion. No MO HealthNet MCHP met that validity criterion.

Figure 46 - Encounter Data Diagnosis Validation Rate- July 1, 2009– September 30, 2009



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, January 15, 2009. BHC, Inc. 2009 External Quality Review Validation of Encounter Data.

Figure 47 – MO HealthNet Managed Care Program Rate Comparison for Diagnoses (2006-2009)

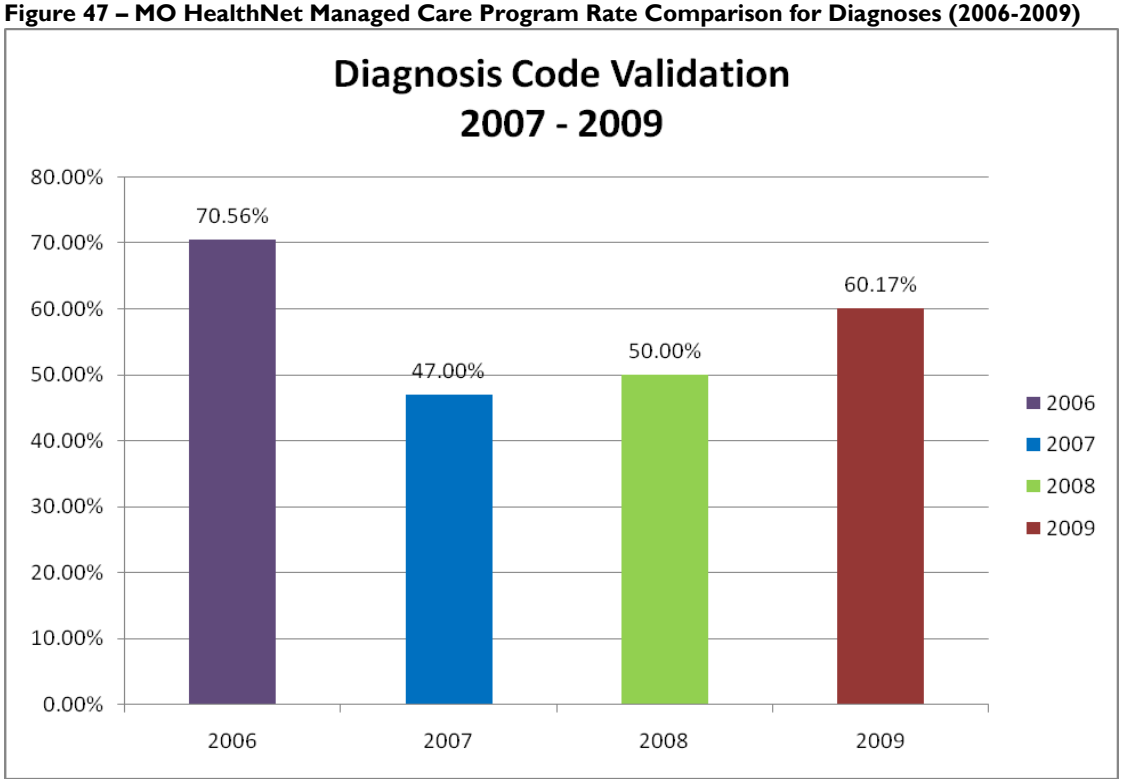


Table 38 – Encounter Data Diagnosis Validation Rate- July 1, 2009 – September 30, 2009

MC+ MCO	Number Encounters Requested	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	z	p	LCL	UCL
Blue Advantage Plus	100	95	64	67.37%	64.00%	36.00%	0.2921474	0.474	38.28%	89.72%
Children's Mercy FHP	100	95	57	60.00%	57.00%	43.00%	-0.2413392	0.554	31.28%	82.72%
Harmony	100	60	41	68.33%	41.00%	59.00%	-1.4607371	0.000	15.28%	66.75%
Healthcare USA	100	87	55	63.22%	55.00%	45.00%	-0.3937639	0.335	29.28%	80.72%
Missouri Care	100	99	81	81.82%	81.00%	19.00%	1.5877577	0.000	55.28%	100.00%
Molina	100	92	63	68.48%	63.00%	37.00%	0.0600000	0.597	37.28%	88.72%
All MC+ MCOs	**600**	**528**	**361**	**68.37%**	**60.17%**	**39.83%**	0	1	-25.15%	26.32%

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 MO HealthNet MCHP 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 MO HealthNet encounter claims extract file, BHC, Inc. 2009 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 = 32), missing information/incomplete record (n = 197), downcoded (n=3) and upcoded (n = 7). Incorrect information included that the diagnosis code listed did not match the descriptive information in the record. Missing information included the coders being unable to find a diagnosis code or diagnosis description in the medical records received for review.

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/incomplete record (n = 179), upcoding (n=15), downcoding (n=3) and incorrect codes (n = 22). Examples of incorrect information included: incorrect codes (n = 18) and codes that did not match the procedure description (n = 4).

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

The EQRO had no problems with how files are compiled and submitted by each MO HealthNet MCHP.

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

The EQRO had no data quality issues with SMA and MO HealthNet MCHP encounter data during the course of conducting the EQRO. This was the fourth year that the EQRO has received all encounter data in the format requested.

4.5 Conclusions

STRENGTHS

1. All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet MCHPs. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.
2. All MO HealthNet MCHPs submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.
3. The examination of the level, volume, and consistency of services found significant variability between MO HealthNet MCHPs in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), with no patterns of variation noted by Region or type of MO HealthNet MCHP.
4. There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all MCHPs.
5. Unpaid claims represent less than .0001% of all claims submitted to the SMA.

AREAS FOR IMPROVEMENT

1. The Procedure Code field in the Outpatient Home Health, Outpatient Hospital and Outpatient Medical claim types included some invalid information. Most of this was due to blank fields or fields containing ".00".
2. The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.
3. The match rates between the SMA database and MO HealthNet MCHP medical records for claim type procedures although higher than last year, are still a significant decrease from the 2006 match rate. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

4. The match rates between the SMA database and MO HealthNet MCHP medical records for claim type diagnoses were an increase over the prior two years' reviews, however they are still lower than the rate found in 2006. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

RECOMMENDATIONS

1. 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").
2. The SMA should continue to provide timely feedback to MO HealthNet MCHPs regarding the rate of acceptance of each claim type and the types of errors associated with rejected claims.
3. 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 MO HealthNet MCHPs or Regions.
4. MO HealthNet MCHPs' medical record reviews should be targeted toward validation of diagnosis and procedure codes and/or descriptors. MCHPs should consider receiving medical records directly from providers and assuring they are complete prior to their submission to the EQRO for validation, quite often the reason for missing Diagnoses or Procedure data was due to the receipt of incomplete records.
5. The MCHP should investigate and report to the SMA the reasons for and corrective action to prevent the substantial decline in medical records matches for both diagnoses and procedures since 2006.
6. The MCHPs should submit all requested records for Encounter Data Validation, those records not submitted represented 12% of the total requested.

5.0 MO HealthNet MCHP COMPLIANCE WITH MANAGED CARE REGULATIONS

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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 2003 review was to analyze and evaluate the MO HealthNet MCHPs 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 2004 and culminating in 2005, the objective was to complete follow-up reviews to ensure improved and continued compliance with these regulations on the part of the MO HealthNet MCHPs. To complete this process, the Monitoring Medicaid Managed Care Organizations (MCHPs) 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 MCHPs failed to comply or were in only partial compliance at the time of the prior reviews. Specifically, the MCHPs were reviewed to assess MO HealthNet MCHP compliance with the federal Medicaid managed care regulations; with the State Quality Strategy; with the MO HealthNet contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous review year. To enhance this process in 2006 two additional activities occurred. A case review of Grievance and Appeal files, following up on findings from 2004 and 2005, was completed. A second case review focusing on Behavioral Health Case Management files, a follow-up from the 2003 External Quality Review occurred.

The 2008 report on compliance with federal regulations was a follow-up to the compliance reviews conducted in 2006 and 2007. Previous reviews revealed that five of the MO HealthNet MCHPs had nearly reached full compliance with completing written policy and procedures that meet both the requirements of the federal regulations and the MO HealthNet Division (MHD), which is the State agency administering the federal Medicaid program (SMA). To enhance this review it was decided to complete in-depth interviews with Member Services staff and Case Management staff, and separately with Health Plan Administrators.

The 2009 report is again a full compliance review. The MO HealthNet Division reviewed current policies and procedures to ensure that they were in compliance with the current contractual requirements, as well as federal regulations. The EQR Compliance Review focused on implementation of policies and procedures, as required in the Case Management process. The review included case record reviews and interviews with Case Management staff, and with Administrative staff.

Additionally, the interview tools were based on information included in the Health Plans' 2009 Annual Reports to the SMA, and the SMA's Quality Strategy.

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occurred with individuals from the SMA from February 2010 through June 2010 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:

Susan Eggen – Assistant Deputy Director, MO HealthNet Managed Care

Andrea Smith – Quality Nurse Reviewer

In February 2010, Compliance Review team members began discussions with the SMA to determine the direction and scope of the review. The decision was made to review the numbers of prior authorizations and denials in the second and fourth quarters of the calendar year, to cover both the old and new contracts with the State. Case Management lists for these quarters were also requested. The denial logs and Case Management lists would be compared, and a random case sample would be pulled for case reading. The Case Management Record Review would occur prior to the time of the on-site review. These cases would determine the questions asked during both the Case Management Interviews, as well as the administrative reviews. This documentation was used as a guide for the 2009 review. The SMA provided updated policy compliance information for this review to support the practice information obtained. Due to the change in contracts and requirements, Case Management Activities would be discussed as they were occurring in 2009 with any enhancements that were apparent at the time of the on-site review. Case reviews and reported case management activities were compared against the Case Management Policy submitted to the EQRO. 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. SMA expectations, requirements, and decisions specific to the MO HealthNet Managed Care Program were identified during these discussions.

Document Review

Documents chosen for review were those that best demonstrated each MO HealthNet MCHP'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 were reviewed to ensure that consistent information was shared regarding enrollee rights and responsibilities. SMA MO HealthNet Managed Care contract compliance worksheets and case management policies were reviewed as a basis for interview questions that made up the main focus of the 2009 Compliance Review. Other information, such as the Annual Quality Improvement Program Evaluation was requested and reviewed to provide insight into each health plans' compliance with the requirements of the SMA Quality Improvement Strategy, which is an essential component of the MO HealthNet Managed Care contract, and is required by the federal regulations. Health Plan Quality Improvement Committee meeting minutes were reviewed. Case Management policies and instructions were reviewed and used in assessing both the case management records review, and in discussions with health plan staff. In addition interviews, based on questions from the SMA and specific to each Health Plan's Quality Improvement Evaluation, were conducted with administrative staff to ensure that local procedures and practices corresponded to the written policies submitted for approval. When it was found that specific regulations were "Partially Met," additional documents were requested of each health plan. Interview questions were developed for case management staff to establish that practice directly with members reflected the health plans' written policies and procedures, as well as compliance with the federal regulations. Interviews with Administrative staff occurred to address the areas for which compliance was not fully established through the pre-site document review process, and to clarify responses received from the staff interviews.

The following documents were reviewed for all MO HealthNet MCHPs:

- State contract compliance ratings from 2009 and updated policies accepted through August 2010
- Results, findings, and follow-up information from the 2008 External Quality Review
- 2009 Annual MO HealthNet MCHP Evaluation, submitted April 20, 2010

CONDUCTING INTERVIEWS

After discussions with the SMA, it was decided that the 2009 Compliance Review would include in-depth interviews with Case Management Staff. The goal of these interviews was to validate that practices at the health plans, particularly those directly affecting members' access to quality and timely health care, were in compliance with the approved policies and procedures. After completing the initial document review, it was clear that the MO HealthNet MCHPs had made significant progress in developing appropriate and compliant written policies and procedures. The interview questions were developed using the guidelines available in the Compliance Protocol and focused on areas of concern based on each health plan's adherence to their case management policy. Specific questions were also posed, using examples from the case records reviewed. Questions focused on a lack of case management in some instances and also enhanced the discussion about the provision of case management services.

Previous interviews, generally conducted with administrative and management level health plan staff, did enable reviewers to obtain a picture of the degree of compliance achieved through policy implementation. Corrective action taken by each health plan was determined from previous years' reviews. This process revealed a wealth of information about the approach each health plan took to become compliant with federal regulations. The current process of a document review, supported by interviews with front line and administrative staff, was developed to provide evidence of systems that delivered quality and timely services to members and the degree to which appropriate access was available. The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. Additionally, this approach would continue to provide follow-up from previous EQRO evaluations. A site visit questionnaire specific to each health plan was developed for case managers, and a separate interview tool for administrators was developed for each health plan. The questions were

developed to seek concrete examples of activities and responses that would validate that these activities are compliant with contractual requirements and federal regulations.

Collecting Accessory Information

Additional information used in completing the compliance determination included: discussions with the EQR reviewers and MO HealthNet Health Plan 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 health plan compliance with the pertinent regulatory provisions within the Compliance Protocol. A combination of the information gained through the on-site interviews, case record reviews, and information on policy completion obtained from the SMA lead to the final ratings provided for each section evaluated.

Analyzing and Compiling Findings

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MO HealthNet MCHP's contract compliance. This information was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or 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 each health plan's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision.

Reporting to the State Medicaid Agency

During the August 2010 meeting with the SMA, preliminary findings 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 determinations. The SMA approved the process and allowed the EQRO to finalize the ratings for each regulation. The actual ratings are included in this report.

COMPLIANCE RATINGS

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," "Not Met") for measuring compliance, as determined by the EQR analytic process. The determinations found in the Compliance Ratings considered SMA contract compliance, review findings, health plan policy, ancillary documentation, and staff interview summary responses that validate health plan practices observed on-site.

If the SMA considered the policy submission valid and rated it as complete, this rating was used unless practice or other information called this into question. If this conflict occurred, it was explained in the narrative included in the individual health plans Compliance Section. The scale allowed for credit when a requirement was Partially Met. Ratings were defined as follows:

Met:	All documentation listed under a regulatory provision, or one of its components was present. MO HealthNet MCHP staff was 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 health plan was in full compliance with regulatory provisions.
Partially Met :	There was evidence of compliance with all documentation requirements, but staff was 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.

5.2 Findings

ENROLLEE RIGHTS AND PROTECTIONS

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of heath plans 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 all MO HealthNet MCHPs rated as "Not Met" (see Table 39). Across all Health Plans 94.87% of the regulations were rated as "Met." This maintains the 2008 rating and the overall

improvement over the 90.77% "Met" rating in 2006. Five of the health plans (CMFHP, MO Care, and Molina, HCUSA and BA+) were found to be 100% compliant. One health plan (Harmony) was rated as 69.2% "Met." This is the third year that Harmony is being rated for compliance with the MO HealthNet Managed Care contract and the federal regulations. They have submitted policies, but these have not yet met all the SMA and federal requirements. Harmony has developed compliant practices in a number of areas, but the complete system, particularly in the provision of case management, is not yet in place.

Table 39 – Subpart C: Enrollee Rights and Protections

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.100(a) Enrollee Rights: General Rule	2	2	2	2	2	2	6	0	0	100.0%
438.10(b) Enrollee Rights: Information Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2	2	2	2	6	0	0	100.0%
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2	2	2	2	6	0	0	100.0%
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2	2	2	2	6	0	0	100.0%
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2	2	2	2	6	0	0	100.0%
438.10(f) Information for All Enrollees: Free Choice, etc.	2	1	2	2	2	2	5	1	0	83.3%
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2	2	2	2	6	0	0	100.0%
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2	2	2	2	6	0	0	100.0%
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	1	2	2	2	2	5	1	0	83.3%
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	1	2	2	2	2	5	1	0	83.3%
438.100(b)(3) Right to Services	2	1	2	2	2	2	5	1	0	83.3%
438.100(d) Compliance with Other Federal/State Laws	2	2	2	2	2	2	6	0	0	100.0%
Number Met	13	9	13	13	13	13	74	4	0	94.87%
Number Partially Met	0	4	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	69.2%	100.0%	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 (MCHPs) 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., 2009 External Quality Review Monitoring MCHPs Protocols.

All health plans had procedures and practices in place to ensure that members: receive pertinent and approved information [438.100(a) and 438.10(b)]; were addressed in their prevalent language [438.10(c)(3)]; have access to required interpreter services [438.10(c)(4,5)]; that all information is provided in an easily understood format [438.10 (d)(1)(i)/438.10(d)(1)(ii) & (2); that members are treated with respect and dignity and receive information on available treatment options and alternatives [438.100(b)(2)(iii)/438.10(g)]; and that the health plans are in compliance with other state requirements [438.100(d)].

A number of health plans (CMFHP, MO Care, Molina, BA+, and HCUSA) utilized EQR information 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 health plans 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 health plans 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.

Three of the health plans (CMFHP, BA+, and HCUSA) utilized a Member Advisory Committee to provide insight into the issues faced by members in trying to obtain healthcare services. The health plans incorporated member suggestions into their operations and marketing materials. These activities were indicators of the health plans' commitment to member services and to ensuring that members have quality healthcare.

All health plans continued to operate programs for the provision of behavioral health services. Four of the health plans subcontract with Behavioral Health Organizations (BHO) for these services. Two health plans (MO Care, Harmony) utilize an "in-house" model for the provision of behavioral health services. One of these plans (MO Care) uses a system of integrated case management and maintenance of the provider delivery system within their health plan structure. One health plan (Harmony) utilized a subsidiary of their parent company to provide behavioral health services during 2009.

All health plans provided active oversight, if not direct involvement, of their behavioral health subcontractors. Behavioral Health Services have evolved into an important resource for MO HealthNet Managed Care members. All of the health plans approved the use of in-home services to reach members who would not attend appointments in an office setting. This not only ensured that members obtained the help they needed, but also prevented missed appointment for providers. One BHO (New Directions Behavioral Health) serves members from CMFHP and BA+. This BHO continues 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. This service is available to both health plans. Two health plans (Molina, HCUSA) reported on initiatives to engage members who were pregnant, in an attempt to identify any behavioral health issues that might affect the mother and/or baby. These efforts also focused on prevention of postpartum depression. One health plan (CMFHP) 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. MO HealthNet MCHPs and BHOs described a number of interventions that met members' needs, but were extraordinary for Medicaid programs. This reflected a level of performance indicative of their strong commitment to access and quality services for all members.

Health Plan/Case Management Interventions

The following are examples of extraordinary interventions and activities by the MCHPs:

- Projects focused on engaging pregnant women in early behavioral health interventions in an attempt to prevent or alleviate the effects of post partum depression.
- Provision of in-home services immediately following in-patient treatment to ensure proper follow-up after hospitalization.
- Utilization of intensive in-home services to prevent the need for in-patient behavioral health treatment, and to prevent re-hospitalization, should in-patient treatment be required.
- Provision of short term residential treatment to prevent the need for inpatient treatment, or to remediate situations that may lead to re-hospitalization.
- Ensuring that all pregnant women receive case management services.
- Provision of in-depth home health services following a Cesarean delivery to prevent wound infection and re-hospitalization.
- New information systems that track members and needed services. These systems provide reminders to case managers when contacts are required, and when upcoming appointments are scheduled so reminders to members can occur.
- Identification of ancillary services needed, such as pest control, and other household members with healthcare needs. Referring members and their families to community resources that can assist when a needed service is outside of the MCHP's scope.

COMPLIANCE INTERVIEWS –CASE MANAGERS

Interviews were held at each health plan with case management staff. Subsequently an interview occurred with Administrative staff to obtain clarification on issues identified from the policy and document reviews, and additionally to clarify some responses received from the case managers. Interview questions were developed from the review of each health plan's case management policy and from the case records reviewed prior to the time of the on-site review. These interview questions were specific to each health plan, and focused on issues that might compromise compliance with required case management activities. The interview questions utilized at each health plan are included in the individual sections of this report.

The case managers interviewed exhibited a sense of commitment and professionalism when interacting with clients. At five health plans (Molina, MO Care, CMFHP, BA+ and HCUSA) the case managers are located in their Missouri offices and were familiar with the regions they served. At one health plan (Harmony) the case managers are located in Tampa, Florida. At the time of the on-site review Harmony had recently hired a case manager to be located at their St. Louis office. However, this individual's services were not available in any of the cases reviewed or examples of case management provided for the 2009 service year. Three health plans (Molina, MO Care, and HCUSA) serve all three MO HealthNet Managed Care regions. Each of these plans locates case management staff in each region.

The responses received from the case managers reflected sound knowledge of each health plans' policies and procedures, and of their organization's focus regarding member services. The case managers at all health plans are experienced in ensuring that MO HealthNet members have access to someone who speaks their language, or have access to a method of communication that enables them to obtain complete and thorough information.

Case managers reported a clear understanding of the referral process. They were familiar with health plan procedures ensuring that they received referrals from all sources. Case managers described processes for contacting new referrals and the activities required for existing members cases. One health plan (Molina) refers all pregnant members for case management. The OB Case Managers discussed the referral sources, and the assessment process that ensures that members receive the types and frequency of services required. The case managers

understand that accepting their services is a choice for members, but state that most members are willing to accept case management, although some do have reservations. If a health plan member refuses case management services initially, they can request these services at a future date. Treatment planning occurs with the member to ensure that they understand their service issues and additional assistance that will be provided. Providing a written copy of the treatment plan to health plan members did not occur regularly.

The case management staff, in general, exhibited an understanding of community resources and of alternative service systems that may assist members with service needs beyond health care. At one health plan (Harmony) the case managers interviewed had limited information available in their system. They did not exhibit a profound understanding of what is available throughout the MO HealthNet Managed Care region they serve. One example is that the Lead Case Manager was not aware of the location or resources of the Health Departments in any of the counties they serve outside of St. Louis City and St. Louis County.

The case managers from all of the health plans did describe a methodology and provided concrete examples of coordination of care with behavioral health team members or Behavioral Health Organization (BHO) staff. They were also aware of the need to ensure that Primary Care Providers were involved when members were receiving both physical and mental health services.

Case managers were keenly aware of members' rights and responsibilities. These health plan staff members shared a commitment to providing services to members in the least restrictive environment and most respectful manner possible.

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 40). Across all MO HealthNet MCHPs, 86.7% of the regulations were "Met," which is a slight decrease from the rate of 90.20% achieved in 2008. Four of the MCHPs (CMFHP, HCUSA, Molina, and MO Care) were found to be 100% compliant. One health plan (Blue Advantage Plus) is rated at 82.4%. The case records reviewed did not include substantial evidence of complete adherence to policy or complete documentation of the assessment process and services provided. Blue Advantage Plus staff reported that there were planned enhancement to their case management system which would improve this, but these enhancements were not available for demonstration at the time of the on-site review. One Health Plan (Harmony) is rated as 47.1%. This is the third year that Harmony is subjected to the full compliance review. They are in the process of submitting written policy and procedures to the SMA that are Missouri specific. These new policies are reported to be improved over those previously submitted. Practice in this area is lacks commitment to the Missouri project or to providing case management to their Missouri members. In the sixty (60) case records reviewed the majority were closed after perfunctory attempts to make a contact with a member. The case managers interviewed did not demonstrate a significant attention to the provision of services in this project.

Table 40 – Subpart D: Quality Assessment and Performance Improvement: Access Standards

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	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	5	1	0	83.3%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	1	2	2	2	2	5	1	0	83.3%
438.206(b)(3) Second Opinions	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(1)(i-vi) Timely Access	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	2	2	2	6	0	0	100.0%
438.208(b) Care Coordination: Primary Care	1	1	2	2	2	1	3	3	0	50.0%
438.208(c)(1) Care Coordination: Identification	2	1	2	2	2	1	4	2	0	66.7%
438.208(c)(2) Care Coordination: Assessment	2	1	2	2	2	1	4	2	0	66.7%
438.208(c)(3) Care Coordination: Treatment Plans	1	1	2	2	2	2	4	2	0	66.7%
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	1	2	2	2	2	5	1	0	83.3%
438.210(b) Authorization of Services	2	1	2	2	2	2	5	1	0	83.3%
438.210(c) Notice of Adverse Action	2	2	2	2	2	2	6	0	0	100.0%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	2	2	2	6	0	0	100.0%
438.210(e) Compensation of Utilization Management Activities	2	1	2	2	2	2	5	1	0	83.3%
438.114 Emergency and Post-Stabilization Services	2	2	2	2	2	2	6	0	0	100.0%
Number Met	15	8	17	17	17	14	88	14	0	86.27%
Number Partially Met	2	9	0	0	0	3				
Number Not Met	0	0	0	0	0	0				
Rate Met	88.2%	47.1%	100.0%	100.0%	100.0%	82.4%				

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 (MCHPs) 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., 2009 External Quality Review Monitoring MCHPs Protocols.

All MO HealthNet MCHPs 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)]. Other areas where all health plans were 100% compliant with complete and approved policy were Adequate and Timely Service and Cost Sharing for Out of Network Services; Timely Access to Care, Provider Cultural Competency; Timeframes for Decisions for Expedited Authorizations, Utilization Management Activities, and Emergency and Post-Stabilization Services. 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 health plans excelled. Five of the health plans were fully compliant in having SMA approved notifications of adverse actions [438.210(c)]. One health Plan (Harmony) did not have approved Utilization Management policy. There were no identified incidents of incentivizing staff or contractors for utilization management decisions that were in the favor of the MO HealthNet MCHPs. All policies and practices in this area [438.210(e)] were compliant.

The area of access to care was a primary focus of improvement for all the health plans during 2009. Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. Health plans in all three MO HealthNet Managed Care regions reported the addition of urgent care centers, and physicians with extended hours of services. The need to ensure that members received appropriate referrals to PCPs and specialty providers was clearly reflected in case manager interviews. Required documentation and approved policies did exist in all areas for all health plans but one (Harmony). All six of the MO HealthNet MCHPs had complete policy and practices, and Provider Manual language in the area of emergency and post-stabilization services [438.114]. The health plans made efforts to ensure that the problems they experienced did not affect services to members. All health plans provided evidence of strong relationships with their providers and maintained strong communication with them particularly in solving member service problems. Harmony reported that they are continuing active recruitment efforts in the outlying counties in the region. However, their network has improved during the past year of operation.

The health plans make a concerted effort to ensure that members have appropriate and timely access to services. They continued to express concern over the shortage of specialists in the areas of orthopedic surgery, pediatric neurology, rheumatology, and child/adolescent psychiatrists. All health plans reported utilizing out-of-network providers and often paying commercial or higher rates to obtain these services. One health plan (CMFHP) had a number of specialists who requested that they not be included on the MO HealthNet MCHP's published network, but readily agreed to serve members when requested, at the MO HealthCare Managed Care rate. A number of the health plans (HCUSA, MO Care) continued to partner with teaching hospitals in their Regions, in order to increase their available surgical and specialist capacity. All health plans had an internal system that could provide specialist services, even in specialties that were normally difficult to access, when required to meet members' healthcare needs.

All health plans exhibited a commitment to delivering and providing oversight of behavioral health services. One health plan (MO Care) no longer uses a subcontracted network for behavioral health. This health plan recognized a number of advantages in directly supervising the provision of behavioral health services. They are able to recruit additional providers through the use of solo practices, particularly those who provided in-home treatment services. Some of the benefits identified included: reducing the use of inpatient treatment; more timely and complete prior authorizations; and improved multi-disciplinary case management, when members require both physical and mental health treatment. They did experience some difficulties in motivating the smaller providers to comply with timely claims submission requirements, but through training are seeing improvements in this area. This health plan's case managers maintain an integrated system, where the assigned case manager assists the member with behavioral health and physical health needs regardless of their area of specialization. The case managers receive consultation from both the Medical and Behavioral Health Directors, and from other case managers. They believe that this has simplified members ability to obtain the services they need and greatly improved their service delivery system.

The area of care coordination continues to be an aspect of services where improvement is needed. Four health plans (HCUSA, MO Care, CMFHP, and Molina) were rated as 100% compliant. One health plan (Blue Advantage Plus) is rated at 82.4%, and one Health Plan

(Harmony) is rated at 47.1%. Blue Advantage Plus is in the process of making changes in their case management information system that will more appropriately capture coordination of care information. The case records reviewed for 2009 did not demonstrate the level of coordination of care that is required in approved policy. The case managers approach case management in a business model that does not always demonstrate an attention to services that might be required. Harmony continues to need to have approved policy in place. Interviews indicated that they are making some efforts to ensure coordinated care for members, but this area continues to lack full compliance.

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 two items across MO HealthNet MCHPs that were rated as "Not Met." One health plan (Harmony) did not have approved credentialing policy. Across MO HealthNet MCHPs, 93.3% of the regulations were "Met," which a decrease from 2008, when health plans achieved a rate of 95% compliance in this area (see Table 41).

The decrease overall is the result of the lack of credentialing policy by Harmony.

Table 41 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	0	2	2	2	2	5	0	1	83.3%
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	1	2	2	2	2	5	1	0	83.3%
438.214(d) Provider Selection: Excluded Providers	2	2	2	2	2	2	6	0	0	100.0%
438.214(e) Provider Selection: State Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2	2	2	2	6	0	0	100.0%
438.56(c) Disenrollment Requested by the Enrollee	2	2	2	2	2	2	6	0	0	100.0%
438.56(d) Disenrollment: Procedures	2	2	2	2	2	2	6	0	0	100.0%
438.56(e) Disenrollment: Timeframes	2	2	2	2	2	2	6	0	0	100.0%
438.228 Grievance System	2	1	2	2	2	2	5	1	0	83.3%
438.230(a,b) Subcontractual Relationships and Delegation	2	0	2	2	2	2	5	0	1	83.3%
Number Met	10	6	10	10	10	10	56	2	2	93.3%
Number Partially Met	0	2	0	0	0	0				
Number Not Met	0	2	0	0	0	0				
Rate Met	100.0%	60.0%	100.0%	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 (MCHPs) 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., 2009 External Quality Review Monitoring MCHPs Protocols.

The Provider Services departments of all MO HealthNet MCHPs exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and MO HealthNet Managed Care requirements. Five of the MO HealthNet MCHPs (CMFHP, BA+, MO Care, Molinaand HCUSA) were 100% compliant with all regulations. The final health plan (Harmony) met 60% of the regulations. Six of the individual regulations were 100% met. This included Provider Selection [438.214(d) and 438.214(e)]. The staff at each health plan understood the requirements for disenrollment. They were 100% "Met" for the applicable regulations for timeframes [438.56(e)]. All of the health plans met all regulations for disenrollment procedures. Five of the health plans achieved 100.0% compliance (CMFHP, BA+, MO Care, Molina, and HCUSA) and had appropriate grievance systems in place meeting the requirements of this regulation [438.228]. Two of the health plans (HCUSA, and BA+) described credentialing and re-credentialing policies that exceeded the requirements of the regulations. All health plans report that they are in the process of developing policy and procedures that all comply with NCQA criteria. Providers were willing to submit to these stricter standards to maintain network qualifications in both the health plans and other commercial networks. Overall, five (83.3%) of the health plans had all required policies and practices in place regarding credentialing. One health plan (Harmony) continued to have outstanding policy in the area of credentialing, non-discrimination, an approved grievance system, and sub-contractual relationships (438.214 (a,b)/438.214(c)/438.230)(a,b)/438.228.

Five of the health plans understood the required oversight of subcontractors. The compliance rate for this regulation [438.230(a,b)] decreased from 2008 review (100.0%) and is currently 83.3%.

All previous deficiencies for Structure and Operation Standards related to a lack of submitted or approved policies or subcontractor agreements. The health plans exhibit a significant understanding and attention to these details and requirements during this review. Interviews revealed that health plan staff quickly identifies problems if they receive calls related to these

issues. All health plans require referral of these issues and questions to the Provider Services staff as quickly as possible.

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 PIPs; 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 41). A total of 92.4% of the criteria were "Met" by the MO HealthNet MCHPs, which continues to indicate improvement in meeting federal requirements, over the 2008 rate of 89.4%. This number again reflects that one health plan (Harmony) is continuing to submit policy for SMA approval and to enhance practice. One health plan (HCUSA) did not submit all Performance Measure data in a format that allowed for required validation. Four health plans (MO Care, CMFHP, Molina, and BA+) met all the requirements (100%) in this area.

It is noted that all health plans have a Case Management system in place. These systems are undergoing enhancements and four of the health plans demonstrated greatly improved documentation and assessment recording. The case managers receive referrals, get updates on member's demographics, can view authorization information, claims information, and maintain their case notes. The case managers report that these enhancements have had a positive impact on completing assessments, documenting their interactions with members and providers, and receiving reminders for member contacts.

Table 42 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2	2	2	2	6	0	0	100.0%
438.236(c) Practice Guidelines: Dissemination	2	2	2	2	2	2	6	0	0	100.0%
438.236(d) Practice Guidelines: Application	2	2	2	2	2	2	6	0	0	100.0%
438.240(a)(1) QAPI: General Rules	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	1	2	2	2	5	1	0	83.3%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	1	2	2	2	2	5	1	0	83.3%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	2	2	2	2	2	6	0	0	100.0%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2	2	2	2	6	0	0	100.0%
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2	2	2	2	6	0	0	100.0%
Number Met	11	7	10	11	11	11	61	5	0	92.4%
Number Partially Met	0	4	1	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	63.6%	90.9%	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 MCHP'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 MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable to the MO HealthNet 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 (MCHPs) 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., 2009 External Quality Review Monitoring MCHPs Protocols.

During previous reviews the area of practice guidelines has continued to improve. During the on-site review in 2009 practice guidelines were discussed as part of normal operations. It appears that these guidelines have been implemented as part of health plan daily operations. Practice guidelines are in place and the health plans are monitoring providers to ensure their utilization. Currently all six of the health plans (100%) met all the requirements for adopting, disseminating and applying practice guidelines. In the Western Region, staff from the health plans meets 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 meet or exceeded nationally accepted guidelines, were developed. All health plans 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.

Five of the Health Plans (83.3%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the health plans reported using included the InterQual Clinical Decision Support Tool, 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 and the Milliman Care Guidelines. These sources provided evidence-based criteria and best practice guidelines for healthcare decision-making. The health plan staff was able to articulate how they utilized these tools and apply them to member healthcare management issues. The MO HealthNet MCHPs used all information available to them to ensure that evidence-based practice ensuring member safety while controlling medically unnecessary care. All health plans report that members do occasionally request treatment procedures, particularly in the instance of member with asthma. Members were provided with this information that assisted in ensuring that their children obtained appropriate levels of information.

The health plans were actively involved in developing and improving their Quality Assessment and Improvement Programs. Three of the health plans (BA+, CMFHP and HCUSA) utilized community based advisory boards, one of which (CMFHP) included members. These groups assisted the health plans in assessing member needs and barriers to services. These health plans

utilized the recommendations of these groups in their operations, member information, and daily activities. All of the health plans developed internal systems for monitoring, analysis and evaluation of their own programs. Five (83.3%) had a program and all required policy and procedures in place to meet the requirements of the federal regulations [438.240(a)(1)]. Harmony continues to work with the SMA on submission and approval of all required policy.

All health plans' compliance improved in the section 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 MO HealthNet MCHP summaries.

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. Five of the six health plans excelled (100%) in their compliance with the regulations related to grievances and appeals (see Table 43). These five health plans (Molina,HCUSA, CMFHP, MO Care, and BA+) were found 100% in completing required policy, procedure, and practice in their Grievance Systems.

One health plan (Harmony) continued to have policy and procedures that required approval by the SMA. The six health plans overall score for this section is 83.3%. This number reflects that Harmony has not completed the policy submission and approval process. The grievance system for this health plan could not be validated.

Table 43 – Subpart F: Grievance Systems

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	Molina	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.402(a) Grievance and Appeals: General Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	1	2	2	2	2	5	1	0	83.3%
438.404(a) Grievance System: Notice of Action - Language and Format	2	1	2	2	2	2	5	1	0	83.3%
438.404(b) Notice of Action: Content	2	1	2	2	2	2	5	1	0	83.3%
438.404(c) Notice of Action: Timing	2	1	2	2	2	2	5	1	0	83.3%
438.406(a) Handling of Grievances and Appeals: General Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	1	2	2	2	2	5	1	0	83.3%
438.408(a) Resolution and Notification: Basic Rule	2	1	2	2	2	2	5	1	0	83.3%
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	1	2	2	2	2	5	1	0	83.3%
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	1	2	2	2	2	5	1	0	83.3%
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	1	2	2	2	2	5	1	0	83.3%
438.410 Expedited Resolution of Appeals	2	1	2	2	2	2	5	1	0	83.3%
438.414 Information about the Grievance System to Providers and Subcontractors	2	1	2	2	2	2	5	1	0	83.3%
438.416 Recordkeeping and Reporting Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	1	2	2	2	2	5	1	0	83.3%
438.424 Effectuation of Reversed Appeal Resolutions	2	1	2	2	2	2	5	1	0	83.3%
Number Met	18	0	18	18	18	18	90	18	0	83.3%
Number Partially Met	0	18	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	0.0%	100.0%	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 (MCHPs) 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., 2009 External Quality Review Monitoring MCHPs Protocols.

The health plans reported different numbers and types of concerns. The number of member grievances and appeals varied between the health plans. However, the numbers were proportional to health plan enrollment. Provider complaints, grievances, and appeals also varied but were not disproportional to the provider network.

There were no deficiencies in the Grievance System policy submission for five of the six health plans. These five are diligent in maintaining policies and practices in this area to ensure that these systems are up-to-date and comply with the SMA contract requirements and federal regulations. Appropriate practice for addressing member grievance and appeals, and provider complaints, grievances and appeals appeared to be in place for five of the six health plans.

Interview results reflect that the health plans have specific units or persons who respond to member grievances and appeals and provider complaints grievances and appeals. Most plans described a case management system where the number and type of cases or issues are reflected in the notes that staff record on all member contacts. These processes are resulting in timely processing of the complaints, grievances and appeals. Staff is aware that it is the member's decision to file a grievance or appeal. However, they record their conversations regardless of the choices made. Staff states that if a member chooses not to file a grievance or appeal, and it appears that the health plan or a provider had an issue with a member, they send these notes on to the Grievance and Appeal Unit, and/or to Provider Services for follow-up to ensure that all issues are resolved.

5.3 Conclusions

Across all MO HealthNet MCHPs there continues to be a commitment to improving and maintaining compliance with federal regulations. There are only a few regulations rated as "Not Met." All of these occurred within one health plan. All other individual regulations were rated as "Met" or "Partially Met." Four of the health plans were 100% compliant with all requirements. One health plan was 100% compliant with the exception of the Access Standards. In this case the health plan was not able to demonstrate case management information that fully exhibited compliance with the aspects care coordination.

The remaining health plan was non compliant with the regulations related to Grievances; 69.2% compliant with Enrollee Rights and Protections; 47.1% compliant with Access Standards; 60% compliance with Structure and Operations; and 63.6% compliant with Measurement and Improvement. This health plan was undergoing their third compliance review. They only exhibited improvement in the area of Measurement and Improvement. In the remainder of the sections measured there was a decrease in compliance.

All of the health plans exhibit attention to becoming and remaining compliant with the SMA contractual requirements and the corresponding federal regulations. 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 health plans made it clear that they used the results of the prior EQR to complete and guide required changes. One health plan (Blue Advantage Plus) reported that they are enhancing their system and future reviews should reflect an improved case management recording system that will bring them into full compliance. This health plan achieved compliance of 100% in all but one category. The following summarizes the strengths in the areas of Access to Care, Quality of Care and Timeliness of Care.

Recommendations are based on the findings utilizing the Protocol for Determining Compliance with Medicaid Managed Care Regulations.

Quality of Care

Nine of the 13 regulations for Enrollee Rights and Protections were 100% "Met." Communicating MO HealthNet Managed Care 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 health plans. The MO HealthNet MCHPs communicated that meeting these requirements with members and providers, created an atmosphere with the expectation of delivering quality healthcare. The health plans maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare. The health plans responded to physical, emotional and cultural barriers experienced by members with diligence and creativity. The health plans were aware of their need to provide quality services to members in a timely and effective manner.

Six of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, and network maintenance, subcontractual relationships, and delegation. The health plans had active mechanisms for oversight of all subcontractors in place. All health plans improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their MO HealthNet Managed Care members.

Access to Care

Four of the MO HealthNet MCHPs were fully compliant with the 17 federal regulations concerning Access Standards. Five MO HealthNet MCHPs monitored high risk MO HealthNet Managed Care Members and had active case management services in place. Each health plan described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs. Many of these case management programs exceeded the strict requirements in the MO HealthNet Managed Care contract. Five of the health plans could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required. The health plans were crucially aware of their responsibility to provide access to care and services, and to

communicate complete information on this topic to their members. One area of concern is care coordination. Although five of six health plans had all required policy in place. Two health plans were unable to demonstrate that they had fully compliant care coordination processes in place. All six health plans state that complete care coordination is an area where they seek improvement.

TIMELINESS OF CARE

Four of the 12 regulations for Measurement and Improvement were 100% "Met." Five of the six MO HealthNet MCHPs met all of the regulatory requirements. All six health plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. The health plans used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. The health plans 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 health plans began using member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments had integral working relationships with the Provider Services and Relations Departments of the health plans. All front line staff and administrators interviewed 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 members. The health plans all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The health plan staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

All 18 regulations for Grievance Systems were 100% "Met" for five of the health plans. One health plan (Harmony) continues to work toward completion of adequate and approved policy with the SMA and enhanced practice. The five remaining health plans were 100% compliant with the requirements for policy, procedure and practice in the area of Grievance Systems. The health plans provided examples of how timely decision-making allowed members to obtain their

healthcare quickly and in the most appropriate setting. The health plans understood that maintaining this system was an essential component to ensuring timely access to healthcare.

MO HealthNet MCHPs 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 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 members. The health plans observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

RECOMMENDATIONS

1. MO HealthNet MCHPs must continue to recognize the need for timely submission of all required policy and procedures. The majority of the health plans 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 health plans.

2. MO HealthNet MCHPs identified the need for continuing to monitor provider availability in their own networks. Although most health plans had the number of primary care providers (PCPs) and specialists required to operate, they admitted that a number of these PCPs do have closed panels and were not accepting new patients. Ensuring that there is adequate access for all members, including new members, should be a priority for all health plans. The health plans admit to struggling with recruitment of certain specialty physicians so availability in this area must be a focus of continued improvement.

3. MO HealthNet MCHPs identified continued need to enhance their Quality Assessment and Improvement programs. These programs were described as strengths for 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. The efforts to ensure that the quality, timeliness and access to care required for member services is maintained at an exceptional level must continue.

4. All MO HealthNet MCHPs are operating a case management program. Attention to the depth and quality of case management services is a priority of the SMA. The health plans must recognize this as a priority aspect of their systems of service and continue to enhance case management, needs assessment, documentation, and care plan development for the members they serve.

5. MO HealthNet MCHPs 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.

6. The use of data for quality improvement purposes and examination of healthcare outcomes has increased dramatically. 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.

6.0 Blue-Advantage Plus

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This section of the 2009 EQRO report summarizes health plan specific findings and recommendations for improving the quality, timeliness, and access to care for the MO HealthNet MCHP members. Please refer to the Supplemental report for detailed technical objectives, methods and presentation of data that are referenced here for the MO HealthNet MCHP.

6.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Blue Advantage Plus supplied the following documentation for review:

- Ambulatory Follow-Up after Hospitalization for Mental Health Disorders for BA+ Members
- Statewide Performance Improvement Project – Improving Adolescent Well-Care BA+

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 8, 2010 during the on-site review. Interviews included the following:

Judy Brennan – Director State Programs BA+, Plan Administrator
Tee-Ka Johnson – Special Programs Coordinator
Cheryl Banks – Manager, Quality Performance Measurement
Shelly Bowen – Assistant Vice President Quality Management
Garth Smith – NDBH
Don Howard – NDBH
Michelle Hills – NDBH
Suzanne Chaput -- NDBH

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 instruments were used for data collection?
- How were 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 MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

FINDINGS

The first PIP evaluated was Ambulatory Follow-Up after Hospitalization for Mental Health Disorders for BA+ Members. This project was submitted for the third time as a clinical PIP. This clinical project focused on improving the number of members who complied with the HEDIS measure requiring follow-up services within seven (7) and thirty (30) days after hospitalization for mental health services. The health plan identified this as a problem based on the results of their HEDIS reviews of previous years. The narrative information provided the basis for making the choice to embark on this project. This decision was based on the literature review supporting the importance of compliance with timely follow-up care in reducing the risk of readmission to inpatient mental health treatment services. The PIP exemplifies the commitment of the health plan and New Directions Behavioral Health (NDBH), to produce better and more productive mental health services for the benefit of BA+ members. The supporting information included references from studies indicating the importance of care management as part of aftercare from inpatient psychiatric hospitalizations. The information supporting the rationale for the study is fully integrated into the topic description on local issues and needs.

The study choice is supported as a relevant area of clinical care. How the study relates to issues relevant to Blue Advantage Plus members is well defined. The documentation gave a sound argument for not only impacting a key aspect of member care, but also related this choice to meeting health care mandates for BA+ members. It did provide the information meeting the EQR protocol requirements. All enrollees between the ages of six and 65 were included in this study. No members were excluded based on the need for special health care services. Why this population is specified is delineated in the narrative.

The study question submitted was, "Will follow-up care and coordination with members who are discharged from inpatient care increase the rate of follow-up through ambulatory appointments within seven and thirty days?" The concept of the need for follow-up care and coordination is included in the explanation supporting the study question. The process of jointly identifying opportunities to improve performance between the health plan and the Behavioral Health Organization (BHO) is also described. The study indicators for all measures are defined. Baseline information and goals for achievement are presented in significant detail. The health plan states that they use a HEDIS-like measurement methodology to obtain their quarterly indicators. The measurements are based on and defined by the HEDIS specifications. In addition to the improved HEDIS measures, the indicators are focused on delivering a positive impact on detecting the incidence of deteriorating behavioral health disorders, and preventing the need for additional inpatient treatment. Collecting this data quarterly allowed them to obtain data more frequently, which assists in providing insight into project progress and in meeting protocol standards.

The study did present clearly defined indicators that were measurable. Information provided defined the numerators and denominators that would be used to calculate success. The indicators were directly based on the HEDIS methodology. Due to inconsistencies in obtaining HEDIS data from the BHO, or subcontractor providing these services, a "HEDIS like" measurement was developed to compare to the actual HEDIS statistics gathered. The HEDIS-like measures utilized the technical specifications of how to measure the follow-up rates. The data from this quarterly measure will be analyzed and compared to the actual certified HEDIS data when it becomes available on an annual basis. Detailed demographic characteristics were presented in the narrative. The focus of this study includes Blue Advantage Plus members only. The indicators measured the occurrence of timely adherence to aftercare plans.

The population included in the study are all members, ages 6 through 65 with a HEDIS qualifying diagnosis, discharged from inpatient psychiatric treatment during each study year. The health plan used the HEDIS specifications in defining this population. No sampling was used to determine who would be included.

The study design delineated the data sources to be utilized and the planning was specific. The additional information received explained the methodology for data collection. The sources of data included claims and encounter data that are sampled on a yearly basis. Quarterly runs occurred and were updated at the time of each data collection period. The details of these sources were provided with adequate detail to produce confidence in their reliability and validity. The methodology remained constant across all time periods studied. The data included information exclusive to MO HealthNet Managed Care members.

The study design specified the data collection and analysis plans and included a detailed definition regarding how the HEDIS and HEDIS-like methodologies were used for internal monitoring of the follow-up service compliance. This explanation includes a narrative explanation of the case management process to be employed for improving this measure. An in-depth prospective data analysis plan was detailed in the documentation including a plan for quantitative and qualitative analysis. This plan provided information on how results would be presented and compared.

The information provided did include data representing the baseline data, 1/1/05 through 12/31/05, for each intervention, and the results of all follow-up periods, which were 1/1/06 through 12/31/06, and 01/01/07 through 12/31/07, and 01/01/08 through 12/31/08. HEDIS-like data was included for the periods form 01/01/09 to 12/31/09. An update of the yearly data was obtained at the time of the on-site review for the period of 01/01/09 through 12/31/09. Overall improvement was identified, although the stated goals of the project and comparison benchmarks were not completely met throughout this period. A significant improvement was shown by the end of 2009 – a HEDIS rate of 49.2%. However, this continued to fall below the health plan's stated goal of 53%. The improvement from 2008 through the end of 2009 was statistically significant.

The project manager, and all individuals involved in this study, was included in the information provided. Roles and qualifications were included in sufficient detail.

The interventions utilized and the barriers to success were documented in great detail. Interventions, barriers, and opportunities for improvement were included for both facility issues and member issues. A discussion of methods or plans to improve or enhance these interventions to obtain a more successful outcome was included. In addition, process problems

that occurred during the project were presented, analyzed, and ongoing assurances of corrections were provided. Methods to avoid the problems presented were also detailed to provide assurance that these issues would be avoided in the future. The information included provided confidence that this project can continue to have substantive impact on member's compliance with obtaining the follow-up care required after a hospitalization for mental health services.

All interventions and analysis were discussed in relation to the outcomes achieved. This information was presented according to the data analysis plan presented. This project has shown overall and sustained improvement. The 2009 results again showed improvement from the baseline, and indicated sustained improvement. All influences on this data are included. The data indicates that initial and continued positive trends were the result of the interventions introduced during each measurement year. This PIP is rated as having a high confidence of having credible results. The analysis of all interventions and outcomes was detailed and convincing. Barriers were addressed in a manner that positively impacted member services and member behavior. This is a successful PIP that has improved the methods in which services are provided to members and has also positively impacted provider responses. The health plan and NDBH provided assurances that the interventions presented have become an integral part of agency functions and will continue in the future.

The second PIP evaluated was the BA+ individualized approach to the Statewide PIP "Improving Adolescent Well-Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The rationale presented was thorough and clearly based on the need to enhance the approach to improving adolescent well-care on a statewide basis. The BA+ project, based on individualized interventions pertinent to its members was supported with health plan specific data in this section of the project documentation. The narrative information effectively made the argument that this non-clinical approach to a PIP was focused on improving the key aspects of member services. The BA+ narrative further hypothesized that an added positive consequence was that improving adolescent well-care may also improve adolescent compliance with immunizations and improve their understanding of living a healthy lifestyle.

The study question for this project is, "Will educating and reminding adolescent members (12 –

21 years of age) and their providers about the need for well-care visits and next appointments, improve the BA+ HEDIS rate for AWC by 5%?" The study question is clear, concise, and conveys the intent of the project, although it does imply two specific interventions. The design of the PIP does lead to the conclusion that the impact of both interventions can be measured. The primary indicator is an improvement in the Adolescent Well-Care (AWC) HEDIS measure. This measure and its technical specifications were discussed in detail. The BA+ specific information included their most recent HEDIS rate, 32.6%, and their goal for improvement of 5%. The indicators were constructed to focus on improving the process of care and associating this with improved health care outcomes for adolescents.

The study design specified that administrative data will be used to calculate the health plan rate for adolescent well care. The health plan will submit this information to VIPs, the NCQA certified vendor used to calculate their HEDIS rate. The information provided ensured that all data in this system was valid and reliable. It also identified all information to be submitted to ensure that all relevant claims and encounters were used in the appropriate calculations.

A baseline methodology was provided and included pertinent measures for each indicator. A detailed data analysis plan was part of this documentation. This plan explained all data to be utilized and the qualitative and quantitative analysis that will occur to complete all required data analysis. Statistical testing for each measurement period was described. The analysis will include barrier analysis and improvements identified. The method for analysis was clearly presented in a prospective data analysis plan.

All staff involved, including the project leader, their roles, and qualifications were all provided in detail.

Interventions described included:

- Statewide interventions completed by all Health Plans;
- EPSDT Reminder Letters, which is ongoing;
- Letters to new members, with reminders to their PCP, which is ongoing;
- Education and retraining of BA+ staff regarding EPSDT compliance, and on printing and sending reminder letters; and
- Decreasing denied encounters, which is ongoing.

The PIP submission included the planned interventions for the on-going project for 2009 and 2010.

Data analysis, including the baseline rate, the re-measurement rates, and statistical significance were included. A description of the barriers to success was provided. Causes and possible solutions were also described. The findings for baseline year and two follow-up years, one utilizing the statewide interventions, and the second utilizing the BA+ specific interventions were included. A detailed quantitative and qualitative analysis was provided in the narrative. The analysis described the measures meeting the study goals, and those that indicated some improvement without reaching the desired outcome. This analysis provided a discussion about variables that intervened in reaching the desired goals. Enhancements to improve these interventions were also described. The analysis identified initial and repeat measurements, statistical significance, and internal and external validity.

This study produced evidence of credible findings. The three re-measurement cycles included in the information presented covered the three years post baseline. The second year did indicate a statistically significant improvement based on the interventions implemented. A detailed barrier analysis was included. A cogent evaluation of the data presented was included. The discussion presented described the effectiveness of the interventions, gave comparisons on increased transportation rates, and how all available resources were utilized by members, creating an overall positive outcome.

This PIP provided quantitative improvement in the process of care. These improvements could be directly related to the interventions employed with members and providers. The letters sent to members, including reminders regarding transportation, increased the number of AWC visits,

and the use of available resources. Implementation of the Prevent Trac System improved appointment planning for providers. Training to providers also had a positive impact on the outcomes desired.

Measurements from the baseline through the third re-measurement period indicated initial and sustained improvement. Repeat measures validated the sustained positive statistics for the health plan. This PIP, and the interventions utilized, can be considered successful. The health plan has demonstrated that attention to a measure, such as AWC, can improve their ability to provide important member services.

CONCLUSIONS

QUALITY OF CARE

These PIPs focused on creating quality and adequate services to members in both the clinical and non-clinical approach. A quality approach to assisting members, educating members, providers and facilities, and improving internal processes was evident throughout the documentation provided for both PIPs. By including an active case management process to assist any member who had inpatient mental health treatment, the quality of life and approach to providing services were an obvious component for the clinical PIP. Continued allocation of resources and process improvement were evident throughout the non-clinical PIP. In both projects the health plan sought to improve the quality of services, or the quality of internal processes, which will result in improved member care.

ACCESS TO CARE

Both Performance Improvement Projects submitted by the health plan had a focus that addressed improved access to health care services. The first PIP, regarding improved compliance with obtaining mental health aftercare services, exhibited a clear understanding that access to these services was essential to assisting members in achieving positive mental health outcomes. Efforts were made to ensure that adolescent members were aware of the type and necessity of preventive health care to improve their quality of life was evident in the efforts made in the non-clinical project. The attention to reminding members of available ancillary resources, such as transportation, enhanced member access and directly impacted a positive

outcome. By addressing both inpatient facility barriers, as well as member issues, the health plan made a concerted effort to improve access for members. By ensuring that the health plan system itself encouraged members to get the health care services needed, access is improved.

TIMELINESS OF CARE

Both projects had a distinct focus on timely and adequate care. In the first PIP regarding follow-up care after inpatient mental health treatment, the health plan sought to ensure that members obtained outpatient treatment within the seven and thirty day time frames required by HEDIS specifications. In the second PIP regarding improving adolescent well care there was attention to timely notification and encouragement of the use of benefits to assure that the services needed by the member could be delivered in a timely fashion. The focus of both projects were to ensure that the most timely care be available to members, and to ensure that internal processes or other barriers did not hinder this outcome.

RECOMMENDATIONS

1. Continue to provide narrative that ensures discussion on how the PIP process can be enhanced to improve outcomes based on the barriers and opportunities recognized to create improved outcomes. Include steps in the information provided to reviewers. The inclusion of this information ensures that the plan for these ongoing PIPs is clarified.
2. Continue using the expanded written format in the information submitted for review to communicate the intentions, planning, and processes utilized in developing and implementing the PIPs.
3. Continue to utilize the Conducting Performance Improvement Project protocol to assist in the process of project development and reporting.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for BA+. BA+ submitted the requested documents on or before the due date of March 19, 2010. The EQRO reviewed documentation between March 19, 2010 and June 30, 2010. 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:

- Ernst & Young's NCQA HEDIS 2009 Compliance Audit Report
- Letters of communication between the EQRO and BA+
- BA+ policies pertaining to HEDIS 2009 rate calculation and reporting
- BA+ Information Services (IS) policies on disaster recovery
- BA+'s HEDIS implementation work plan and HEDIS committee agendas for 2009
- Data warehouse validation procedures for the CRMS software
- DB2 data warehouse models of the interim data warehouse

The following are the data files submitted by BA+ for review by the EQRO:

- ADV_File1_Enrollment_Data.txt
- ADV_File2_Denominator_Numerator_Data.txt
- AWC_File1_Enrollment_Data.txt
- AWC_File2_Denominator_Numerator_Data.txt
- FUH_File1_Enrollment_Data.txt
- FUH_File2_Denominator_Numerator_Data.txt
- FUH_File2_Denominator_Numerator_Data_07072010.txt

The initial numerator file submitted by BA+ for the FUH measure did not contain the needed discharge dates to verify the reported HEDIS rates. The MCHP was asked to submit a corrected file that included the necessary discharge dates to allow for proper processing by the EQRO.

INTERVIEWS

The EQRO conducted on-site interviews with Cheryl Banks, UM Training and Compliance Manager at BA+ in Kansas City, MO on Wednesday, July 7, 2010. Ms. Banks was responsible for overseeing the calculation of the HEDIS performance measures. The objective of the visit was to verify the data, methods, and processes behind the calculation of the three HEDIS 2009 performance measures. This included both manual and automatic processes of information collection, storing, analyzing, and reporting.

FINDINGS

BA+ used the Administrative Method for calculation of the HEDIS 2009 Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits measures. MO HealthNet MCHP to MO HealthNet MCHP comparisons of the rates for Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits 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 2009 combined rate for Annual Dental Visits reported by BA+ was 32.73%, comparable to the statewide rate for MCHPs (35.05%, z = 0.16; 95% CI: 27.38%, 38.09%; n.s.). This reported rate is a slight increase over the rate (32.54%) reported by this health plan in the 2008 EQR report, but a decrease from the rate (33.72%) reported in the 2007 EQR findings (see Table 44 and Figure 48).

The reported rate for BA+ for the HEDIS 2009 Adolescent Well-Care Visits measure was 35.32%, which is comparable to the statewide rate for MCHPs (36.11%; z = 0.04, 95% CI: 32.13%, 38.50%; n.s.). The rate for this measure has increased over time, from 31.54% in 2007 to 34.79% in 2008 to 35.32% in 2009 (see Table 44 and Figure 48).

The 7-day reported rate for BA+ for the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was 52.03%, significantly higher than the statewide rate for all MCHPs (41.59%; z = 1.40, 95% CI: 44.85%, 59.21%; $p > .95$). This rate is an increase from the rate

reported in 2006 (50.17%), but is down from the rate reported in 2007 (58.67%; see Table 44 and Figure 48).

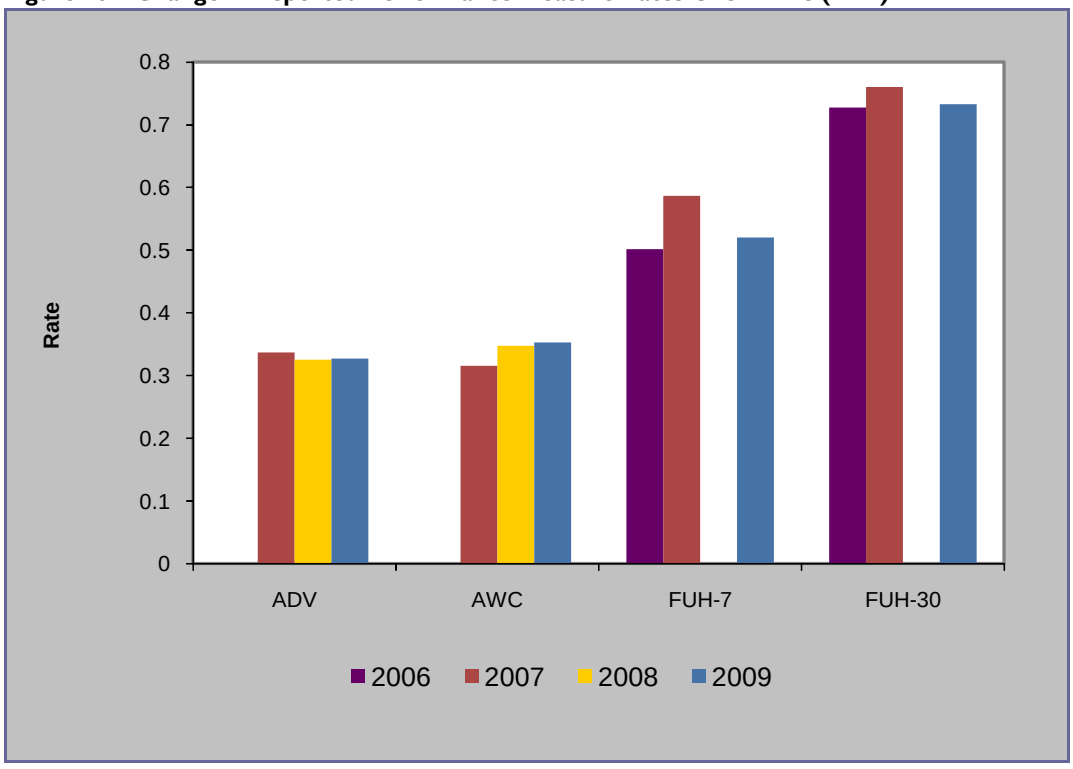
The HEDIS 2009 30-day rate for Follow-Up After Hospitalization for Mental Illness reported by BA+ was 73.31%, significantly higher than the statewide rate for MCHPs (66.46%, z = 3.77; 95% CI: 66.13%, 80.49%; p > .95). This reported rate is a slight increase over the rate (72.76%) reported by this health plan in the 2006 EQR report, but a decrease from the rate (76.00%) reported in the 2008 EQR findings (see Table 44 and Figure 48).

Table 44 – Reported Performance Measures Rates Across Audit Years (BA+)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate
Annual Dental Visit (ADV)	NA	33.72%	32.54%	32.73%
Adolescent Well-Care Visits (AWC)	NA	31.54%	34.79%	35.32%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	50.17%	58.67%	NA	52.03%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	72.76%	76.00%	NA	73.31%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 48 – Change in Reported Performance Measure Rates Over Time (BA+)



Sources: BHC, Inc. 2006, 2007, 2008, and 2009 External Quality Review Performance Measure Validation Reports

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

BA+ used a NCQA-certified vendor application (MedMeasures) for calculation of rates for the HEDIS 2009 measures. 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, BA+ 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 BA+ transferred data into the repository used for calculating the HEDIS 2009 measures of Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits.

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). BA+ met all criteria that applied for the three measures validated. BA+ did utilize statistical testing; BA+ continues to partner with Ernst & Young to best assess how to utilize the information that they obtain from the statistical analysis process.

PROCESSES USED TO PRODUCE DENOMINATORS

BA+ 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 dates of birth ranges were valid.

There were 13,405 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 4,488 eligible members were reported and validated for the Adolescent Well-Care Visits measure.

A total of 296 eligible members were reported and validated for the denominator of the Follow-Up After Hospitalization for Mental Illness measure.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures were calculated using the Administrative Method. Measures included the appropriate data ranges for the qualifying events (e.g., dental visits, well-child visits, or follow-up visits) as specified by the HEDIS 2009 Technical Specifications (see Attachment XIII: Numerator Validation Findings). No medical record reviews were conducted or validated.

BA+ reported a total of 4,388 administrative hits for the HEDIS 2009 Annual Dental Visit measure; 4,380 of these hits were validated by the EQRO. This resulted in a reported rate of 32.73% and a validated rate of 32.67%, an overestimate of 0.06%.

For the HEDIS 2009 Adolescent Well-Care Visits measure, there were a total of 1,585 administrative hits reported and 1,570 hits found. This resulted in a validated rate of 35.32%; with a reported rate of 34.98%, this is an overestimate of 0.33%.

The number of administrative hits reported for the 7-day rate for the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was 154; the EQRO found 157. This resulted in a reported rate of 52.03% and a validated rate of 53.04%. This represents a bias (underestimate) of 1.01% for this measure.

The HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure 30-day rate showed 217 administrative hits reported by the MCHP; the EQRO found all 217. This resulted in both a reported rate and a validated rate of 73.31%, yielding no bias for this measure.

SAMPLING PROCEDURES FOR HYBRID METHODS

No medical record reviews were conducted or validated. CMS Protocol Attachments 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

BA+ 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, some bias was calculated in all three of the HEDIS 2009 measures evaluated. Two measures were overestimated, and one was underestimated. However, the bias observed was minimal (less than or right at 1% in each case). The rate validated for each measure fell within the 95% confidence interval reported by the MCHP for that measure.

Table 45 - Estimate of Bias in Reporting of BA+ HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.06%	Overestimate
Adolescent Well-Care Visits	0.33%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	1.01%	Underestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	No Bias	N/A

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. The rates for BA+ for the Annual Dental Visit and Adolescent Well-Care Visits measures were overestimated and one of the rates for the Follow-Up After Hospitalization for Mental Illness measure was underestimated. However, all fell within the confidence intervals reported by the health plan.

Table 46 - Final Audit Rating for BA+ Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially 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 health plan. 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, or measures for which the submission data was incomplete and therefore could not be fully validated by the EQRO; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Two of the three of the health plan's performance measure reported rates were consistent with the average for all MO HealthNet MCHPs; the remaining rate was higher than the average.

QUALITY OF CARE

BA+'s calculation of the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was substantially complaint with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. BA+'s rates for this measure were significantly higher than the average for all MO HealthNet MCHPs. The health plan's members are receiving the quality of care for this measure greater than the care delivered to all other MO HealthNet Managed Care members. While both the 7-day and 30-day rates fell below the National Commercial Average for this measure, both rates were higher than the National Medicaid Average rate. The health plan's members are receiving a quality of care for this measure greater than the average National Medicaid member but below

the average National Commercial member across the country. However, both the 7-day and 30-day rates were lower than the rates reported by the health plan during the audit of the HEDIS 2008 measurement year, indicating an apparent decrease in the quality of services received by members over the past year.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

ACCESS TO CARE

The Annual Dental Visit measure was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. BA+'s rate for this measure was comparable to the average for all MO HealthNet MCHPs. This rate was higher than the rate reported by the health plan during both the 2007 and 2008 reports, thereby showing that BA+ members are receiving more dental services than during the 2007 and 2008 HEDIS reporting years. The health plan's dedication to improving this rate is evident in the consistently increasing averages. BA+'s members are receiving the quality of care for this measure consistent with the level of care delivered to all other MO HealthNet Managed Care members. This rate was below the National Medicaid Average for this measure; the health plan's members are receiving a lower access to care than the average National Medicaid member.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2009 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was consistent with the average for all MO HealthNet MCHPs. The rate was higher than the rate reported for the 2007 and 2008 EQR report years, showing a steady

increase across audit years. BA+'s members are receiving the timeliness of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. However, this rate was lower than both the National Medicaid and National Commercial averages for this measure. The health plan's members are receiving a lower timeliness of care than the average Medicaid or Commercial member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. BA+ should utilize hybrid methods where HEDIS specifications recommend using the hybrid approach.
2. Continue work with Ernst & Young to conduct and document statistical comparisons on rates from year to year.
3. The Follow-Up After Hospitalization for Mental Illness Rate showed a decrease over the previous audit year's (2007) rate. The EQRO recommends that the health plan monitor this decrease and attempt to determine the possible reasons for this decline.
4. The EQRO recommends that the health plan continue to monitor trending in rates from year to year and responding to those trends by increasing efforts for those rates that do not increase (FUH) or only increase slightly (ADV).
5. BA+ should thoroughly review both the data request format file and the resultant data extract files for accuracy prior to submitting data to the EQRO. This will ensure that the EQRO receives the most complete data possible for validation.

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 98,798 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant 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, 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, accurate and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.0% complete, accurate and valid.
9. The second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual. Each of these Diagnosis Code fields fell well below the 100% threshold established by the SMA for this validation. The second, third, fourth and fifth Diagnosis Code fields were 29.8%, 23.7%, 13.0%, and 0.01% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 13,568 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All of the fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were 102 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All of the fields examined were 100.00% complete, accurate and valid.

For the Inpatient claim type, there were 13,765 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 valid.
5. The Discharge Date field was 100.00% complete accurate and valid.
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 73.86% complete, accurate and valid. The remaining fields (n = 3596) were blank.
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 (65.43%, 54.25%, 42.23%, and 32.07%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 100.0% 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 43,629 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All fields examined were 100.00% complete, accurate, and valid except for the Procedure Code and second through fifth Diagnosis Code fields. The Procedure Code fields were 97.88% complete, accurate and valid. The remaining fields were blank (n = 926). The second, third, fourth and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (52.3%, 32.5%, 15.5% and 7.8%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were zero (0) claims paid by the SMA for the period July 1, 2009 through September 30, 2009. It is important to note that the MCHP had pharmacy claims "carved-out" of their contract with the SMA that began on July 1, 2008. This explains the extremely low numbers of encounter claims during the time period reviewed.

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 BA+, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. Dental claim type critical fields examined were 100.00% complete, accurate, and valid. For Outpatient Hospital claims, the Procedure Code field was the only critical field to contain invalid data.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, BA+ demonstrated rates consistent with the average for all MCHPs for the Outpatient Hospital and Dental claim types; and a significantly higher rate for Home Health, Outpatient Medical and Inpatient encounter claims. These findings suggest moderate to high access to care for Outpatient Medical and Hospital, Dental, Inpatient and Home Health Care services for BA+ members.

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MCHP were randomly selected from all claim types for the period July 1, 2009 through September 30, 2009 for medical record review.

Of the 156,091 Outpatient encounter claim types in the SMA extract file for July 1, 2009 through September 30, 2009, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 95 medical records (95.0%) submitted for review. This was a slight decrease over the 2008 submission rate of 100 records.

For the 2007 review, BA+' match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 59.0%, with a fault rate of 41.0%. During the 2008 review, BA+' match rate for procedures was 67.0%, with a fault rate of 33.0%, the match rate for diagnoses was 56.0%, with a fault rate of 44.0%. For this year's review, BA+' match rate for procedures was 68.0%, with a fault rate of 32.0%, the match rate for diagnoses was 64.0 %, with a fault rate of 36.0%

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure and diagnosis, was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were blank or missing (n = 33) and upcoded (n=3). 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 = 25), incorrect code (n=5), and upcoded (2). Examples of missing information included no code; code is wrong for place of service; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since BA+ included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MCHP 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 all Outpatient Claim Types (Medical, Dental, and Hospital, Home Health), 156,091 "paid" encounters 222 "denied" and 78 "unpaid" claims were submitted. All paid encounter claims matched with the SMA encounter claim extract file. The 222 denied claims and 78 unpaid claims were not present in the SMA database (as expected); there was a "hit" rate of 99.81% between BA+ submitted encounter claims and the SMA encounter data.

For the Inpatient Claim Type, the State database contained 13,765 BA+ encounter claims of "paid" status and BA+ submitted additional claims in the amounts of 58 "denied" and 15 "unpaid" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied and unpaid claims were not present in the SMA database.

Why are there unmatched claims between the MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

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

While the MO HealthNet MCHP 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. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet MCHP data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet MCHP 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.

CONCLUSIONS

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 five of the 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.
4. The rate of Home Health and Inpatient encounter claims was significantly higher than the average for all MO HealthNet MCHPs.

AREAS FOR IMPROVEMENT

1. For the Home Health and Outpatient Hospital and Medical claim types, the Procedure Code fields contained invalid entries.

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
2. Run validity checks after the programming of new edits.
3. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis. The Health Plan should consider collecting medical records and reviewing the submissions prior to providing them to the EQRO for review, as some incomplete records were received, thereby missing the information necessary for validation.

6.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet MCHP's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). This ensures that each MO HealthNet MCHP's documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations. Prior to the on-site review Case Management cases were reviewed by the EQRO for compliance with policy, and to ensure that practice reflected policy requirements. On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. Interviews occurred with Case Management Staff and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds the federal regulations.

Initial interviews were conducted with the Case Management Staff. These interactions and responses were compared to policy requirements and to the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff.

The interview questions posed to Case Management staff were generated by the cases reviewed as well as the review of Health Plan Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the Health Plan processes. Additionally, interview questions were formulated for Administrative staff to validate and clarify these practices, to follow-up on questions raised from the case management staff interviews, and to respond to questions that arose from the document review. These interview questions were developed the BA+ Annual Appraisal of the Quality Improvement Program and the SMA's Quality Improvement Strategy.

Document Review

The MO HealthNet Division supplied:

- Mo HealthNet Policy Tracking Log
- BA+ Annual Appraisal of the Quality Improvement Program

The following documents were requested prior to the on-site review:

- Case Management Policies or instructions
- Listings of Case Management Cases, Prior Authorizations, and Service Denials for the second and fourth quarters of 2009
- Case Management cases randomly selected from these listings

The following documents were requested for on-site review:

- Member Handbook
- 2009 Marketing Plan and Marketing Materials
- 2009 Quality Improvement Committee minutes

Additional documentation made available by Blue Advantage Plus included:

- Blue Advantage Plus of Kansas City Organizational Chart
- BA+ Brochures – English/Spanish versions
- KC Health Resource Guide
- Physician Guide for the Prevention and Treatment of Pediatric Obesity and Diabetes
- "Whiz Zip Zap" Cookbook for Kids and Families and BA+ Nutritional Guideline Information
- Health Information Exchange Documents
- Member Welcome Packet and "On Track Monthly Mailing Process – BA+"
- "Well Aware" Newsletters
- Program Quality Initiative Information

Interviews

Interviews were conducted with the following group:

Case Manager Interviews

Melinda Armstead
Donna Bundy
Rhonda Taylor
Sarah Sudfeld

Plan Administration

Judy Brennan – Director, State Programs, Plan Administrator
Dr. Loretta Britton – VP, Medical Director
Sandy Wederquist, RN – Director, Medical Management
Shelly Bowen – AVP, Quality Management
Dennis Radio – Director, Professional Services
Randy Meyer – Director, Hospital Services
Sandy Wederquist – Director, Medical Management
Tee-Ka Johnson – Special Programs Coordinator
Cheryl Banks – Manager, Case Management
Patricia Mahurin – Supervisor, BA+ Customer Service
Tylisa Wyatt – BA+ Compliance Analyst

INTERVIEWS

Case Manager Interviews

- Describe what you understand constitutes the need for case management services.
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Describe the Healthy Companion program. Does everyone with the defining conditions receive these services? Is there an assessment specific to this program?
- What occurs if you find that a member is in need of disease management services? What occurs if, through the assessment process, you find a member in need of other case management qualifying conditions?
- Explain the process for completing assessments, and how the information is utilized? How is it stored?
- Policy states that "at Risk Assessments must be part of the members' records." Where are these assessments kept? What services do they dictate?
- Questions regarding specific cases were addressed individually.

Findings

In response to the question regarding referral sources, the case managers explained the need to review the SMA Special Needs Listing that they receive monthly, look at the prior authorization lists for anything unusual, look at the special needs DME (durable medical equipment) lists, to recognize customers who may have unmet medical services. They review lists of out-of-network hospital admissions, and provide follow-up when it appears that services are necessary.

One of the case managers focuses on members who appear to have "chronic care" needs. She discusses the member's health care needs with them, and their families or caregivers to facilitate and solve problems whenever necessary. The case managers report completing a lot of outreach activities to assess member's needs and services. They described an individual who left the hospital with a spinal cord injury. The case manager learned that the member and family had other health issues as well, and subsequently provided comprehensive case management services. In another case, a member was referred upon release from the hospital after a radical mastectomy. The case manager discussed available services with the member, who reported that she was doing well, was aware of these services, and did not feel the need for additional assistance so this case was closed.

One of the case managers reported specializing in transplant services. She has extensive knowledge of the medical network available, and refers members to Washington University in St. Louis, the University of Nebraska, and Kansas University. The case manager was aware of all types of ancillary services required by these patients. However, in the recent past the case manager had only one referral of a MO HealthNet Managed Care member.

Another case manager is the program coordinator for prenatal education. Her program is offered to all pregnant health plan members. She does seek out the MO HealthNet members. Her efforts include making visits directly to provider offices to ensure that she receives all referrals. She then provides these members with educational materials and other supportive services. This case manager further explained that she does receive multiple referrals on some members through the health risk assessment process, and review of the ME Code report. She then opens a case in the FACETS system, mails out materials from the BA+ Little Stars program, and makes a contact with the physician's office if the member cannot be located.

This case manager provided an example of working with a teen parent. A formal assessment did not occur, but the need for services was evident. The case manager did contact the teen's parent and provided outreach calls for 4 – 6 weeks. During the work with this family, all enrollee rights were explained to the member and her mother, when the pregnant teen expressed dissatisfaction with her care (she went to a clinic and saw a different doctor at each visit) several options were provided to the member and her mother. The mother made an effort to ensure consistency of care was provided to the daughter, that all of their questions

were answered, and that they were treated with respect. At the end of this pregnancy the member exhibited a great deal of maturity. Additional referrals for community support services were made for this family and both the case manager and member viewed the experience as positive and supportive for this young woman.

The case managers report that they are actively involved with the Customer Services department. These staff often makes the first contact with new members, or with members who are experiencing a crisis. The customer service staff problem-solves with members over the telephone and makes immediate referrals to case managers when appropriate. Issues such as a need for an interpreter or for a provider who speaks a language other than English are identified at this point of service. The case managers then ensure that these types of ancillary services are maintained throughout the member's service experience.

The case managers explained that after receiving a referral they make at least three attempts to contact a member. They make telephone calls, write letters, and contact listed primary care physicians, who often have the most current address information. The case managers utilize the Cyber-Access system and MOSAIC through the Department of Health and Senior services to utilize all possible resources to identify the most recent contact information for members. One case reviewed did not appear to have the required number of contacts. The case manager looked at the case, and also checked the FACETS system. She stated that she did send a denial letter in this case in error. She was aware of the contact policy and planned to attempt to reconnect with the member to correct this oversight.

The case managers discussed the need for continuity of care for members. They provided examples of seeing members in the hospital to assist them in making plans to enable them to have all required aftercare services in place before returning home. They try to enhance communication between physicians and members when problems are identified. In some cases they report coordinating meetings between the member, parents, social workers involved, and home care workers to advocate for the services required by the member.

The case managers described the Disease Management program. This program section focuses on a specific disease and coordinates care with case managers to problem solve members' service issues. One case from the Healthy Companion Program was highlighted. The mother of

the family called to talk about one child in the home who was the member with the primary medical needs. She mentioned two other children in the home who have asthma. These two children, who are also health plan members, were referred to Disease Management. The asthma specialist identified medical needs for these children, and then coordinated the appropriate medical interventions with the primary case manager.

The case managers interviewed did indicate a tendency to work only with families who can clearly articulate a need for assistance. In cases reviewed, even when flags existed that would lead the reader to believe that case management services would be beneficial, these services were not provided unless the member or parent clearly indicated a need for and desire to have case management services included. In one case reviewed a five year old was coded as having only "functional mobility." Notes included a comment by the mother that the member had a "rare genetic disorder." However the case was not opened as the mother did not clearly indicate a desire for case management services. There were no notes indicating that this issue, services, or benefits were explored with the family during an assessment process.

In another case, a member on the initial assessment form was coded as have a "moderate risk pregnancy." There was conflicting information regarding whether or not the member smoked, there were conflicting member names in the record, and no services were provided. There were no notes in the record clarifying this information or explaining these discrepancies. In other cases there were notes that pregnant members were to be followed by the "Little Stars" program, however, there were no case notes or follow-up information provided.

In one case a child was identified as "special needs." The child was to be followed to ensure that a Kiddy Cart (DME) was provided. There was an initial reference to a need for the "Integrated Health Management Team" collaboration in the notes provided. In the remainder of the record provided, the only ongoing notes indicated that the case manager followed the scheduled appointments to assure compliance, with no direct contact with this family or the team mentioned. In other cases reviewed there were statements such as "case management needed for intervention to accomplish goals." No goals were recorded or follow-up service notes included. In other records notes were found that indicated "no dental claims" and "no lead testing." These cases provided no indication of follow-up services or contacts with families.

A number of obstetric cases were closed prior to sixty (60) days post delivery. No explanations were available in the records provided.

Administrative Interviews

- Give examples of measures that the Health Plan implemented to improve follow-up processes for members included in the State's Special Needs report.
- Discuss new initiatives to improve the case management processes.
- Describe any evidence that providers are conducting outreach to their patients who are not in compliance with preventive case or disease management guidelines.
- Discuss ongoing or new initiatives involving New Directions Behavioral Health.
- How do the Case Management and Utilization Review departments work together?
- What feedback has the Health Plan received from outreach activities?

Findings

During the administrative interviews a number of programs and projects were presented. An overview of community education and outreach efforts was presented. The health plan continues to be involved in community organizations that focus on identifying the population with unmet health care needs. A number of programs were described, such as "Care Scope," which focuses on assisting physicians and their staff in identification of individuals with unmet service needs, and providing a reliable service reference list. Efforts also include educational efforts with schools, Head Start centers, physician offices, and local publications to provide educational materials to the public on health service resources. Work has also started on ensuring that eligible individuals, who are involved in WIC or the Food Stamp program, are included in the MO HealthNet program.

The Health Plan has implemented new software that prompts Customer Services staff members through a more accurate assessment process on members who should be referred to case management. The process involves a list of questions that are answered by members. When a "yes" answer is received a referral to a case manager will occur for follow-up. This system captures the member's telephone number to provide the case manager with reliable contact information. The staff is also working to resolve members' issues during their original contact with the health plan whenever possible. Through a benchmark, set prior to implementation, the health plan believes that they are making progress in this area.

The health plan is now making referrals on all members seen in the Emergency Room for follow-up from a case manager or a disease management nurse. The case managers/disease management nurses attempt to make a contact with the member within two (2) days. This involves approximately 400 contacts per month. The belief is that this program will avoid unnecessary admissions into in-patient care, and ensure that members receive the supportive services, or medical equipment needed that brought them to the emergency room. It will also remind the member how to contact their PCP.

Other initiatives that the health plan has initiated include a social worker who discusses advance directives with members, and the availability of hospice or other out-patient interventions. The medical management staff is striving to help members take an active part in their health care by working with providers on how to make initial and on-going contact, and providing expanded prenatal care. Members are strongly encouraged to use the Nurse Help Line after hours and during the day, in an effort to promote contact with PCP's or the use of Urgent Care. The health plan continues to assist physicians to have after hours clinics or to provide supportive after-hours care.

The health plan also describes a number of efforts they are undertaking to comply with NCQA (National Committee for Quality Assurance). All case management nurses are now considered complex case managers. They will utilize new case management software and NCQA tools that administrative staff believes will enhance their performance and member interactions. The new software will improve documentation capabilities, is predictive and prescriptive. It includes an automated assessment tool that will build a care plan for each member receiving case management services. This new software will also generate reminders for case managers that include services to be authorized or scheduled.

Provider services staff relate that they continue new and innovative efforts to recruit new medical groups to ensure that all services are available to members. The MO HealthNet fee schedule has created some barriers, but the health plan reports continued success in engaging both PCP practices as well as necessary specialists.

ENROLLEE RIGHTS AND PROTECTIONS

Blue Advantage Plus continues to exhibit commitment and enthusiasm toward ensuring that member rights and protections are in place. An atmosphere that empowered the Blue Advantage Plus (BA+) administrative and front line staff to meet all program requirements could be observed. The Annual Appraisal of Quality Improvement included an informative discussion of cross-departmental integration. It served to emphasize the corporate approach to management of BA+ and supported the management philosophy of BA+. Review of the meeting minutes indicated the corporate involvement of the staff from BA+ and a support for the growth of BA+ programs.

Contacting members continues to be a struggle. However, case managers and member services staff make continued efforts to impact this in a positive way. A variety of continued contacts are made if initial attempts fail. Case managers routinely contact the office of the listed PCP to obtain their latest contact information, when other measures fail. Written information was provided in English or Spanish. If additional interpretive services were required, this was arranged for the member. They also report that several staff speaks Spanish. Translators and interpreters are available, and the BA+ staff often use AT & T linguists.

Case managers report that improving the process for case management referrals is a continued improvement strategy for the health plan. They discussed the need to increase inter-departmental information sharing in an effort to improve results. The health plan's policy is to enroll members earlier into case management or special programs if these services are indicated. They described their process as a Health Management approach. However, the records reviewed and interview responses indicate an atmosphere where members must openly advocate for case management for themselves or their children. Inclusion in case management is approached in a businesslike manner and does not appear to be overly inclusive.

Case managers focus on ensuring that all members assigned to them are referred to all available services. They believe that care coordination and case management are synonymous in their system, and that all members receiving case management services do receive care coordination. This process is currently being relabeled as complex case management to ensure compliance with NCQA guidelines. They try to think "outside the box" when interacting with members

and make all types of referrals, including to community based organizations that can meet more than medical needs. The case managers described their role as including community-based problem solving. They make referrals to Head Start, WIC, and a number of educational programs. The health plan shares their resources, pamphlets about their programs, and other information with the community-based agencies to ensure that members are informed about what is available.

Typical case management activities include researching the member's location and contact information, and learning about their service needs. Internal referrals come from Prior Authorization nurses, Member Services, Utilization Review, the Health Information line, and the Medical Director. After making contact with members, the case manager assesses the member's acuity level, and reviews medical information. Case managers are also responsible for checking emergency room reports, reviewing the claims system and MOSAIC to obtain information about member activity, and conducting outreach. They attend member case conferences and conduct follow-up as required.

The staff was asked about utilizing the report from the SMA regarding members with special health care needs. The health plan has an RN who attempts to make contact with everyone on this report who is not currently enrolled in case management. When members are contacted the case manager updates all contact information, assesses the member for needed services, and collects information about PCPs or specialists that the member is currently seeing. They then make additional referrals, inform the member regarding transportation that is available, and attempt to resolve any barriers to effective service provision. The case managers utilized a report that is run for lead case management and cases relating to the Jackson County Consent Decree. The health plan utilizes the State Health Needs Assessment, which is helpful in identifying members who need behavioral health services, and those who are pregnant.

The case manager provides education and assistance as needed by the member. Blue Advantage Plus made changes in a number of processes to make service delivery easier for members. Communication is requested between physicians, with the goal of contact occurring between specialists and PCPs, within one day. If the situation is an emergency the Medical Director, Dr. Loretta Britton, is involved. Dr. Britton is sometimes involved if a timely appointment cannot be

made. Quality improvement staff monitors appointment access regularly to insure that this important component meets all requirements.

Case management nurses now get regular reports from the emergency rooms and from hospitals. Nurses review all emergency room visits within one week. If a visit is not urgent, contact is made with the member to educate them on obtaining PCP care regularly and to provide assistance in overcoming barriers to the member utilizing PCP services. These case managers also review claims histories to assess where healthcare is received. Outreach to PCPs requesting their contact with members to engage them in utilizing their medical home is also made.

BA+ operates the Healthy Companion program, which is an umbrella for healthy living initiative that includes prevention, disease management, and a relationship with a nurse case manager. This information and process is potentially available to all BA+ members. The case manager schedules calls at the member's convenience. Outreach additionally occurs when a problem arises, such as a negative laboratory report. The program includes an interface with local public health departments and a monitoring program for diabetics and members with hypertension. The system is also shared with New Directions Behavioral Health the health plan's behavioral health subcontractor. Feedback is provided regarding the medical perspective on consultations for members with multiple problems. This process ensures timely access to follow-up care when referrals are made.

Case managers report that they work with the Utilization and Concurrent Review nurses regularly. These nurses are one of the case management referral sources, and are also the source for initiating care coordination for many members. The case managers are involved in an initiative to complete research on follow-up after discharge. A team reviews each case in a methodological manner, to initiate appropriate ongoing care and resource management. The case manager then contacts the member two days after release from the hospital to ensure that they do have a follow-up appointment, to identify any immediate health issues that may need to be addressed, and to ensure that the member has required instructions and medications.

The rating for Enrollee Rights and Protections (100.0%) reflects Blue Advantages Plus' ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the fourth consecutive year and have practices in place that reflect these policies. The health plan provided evidence of their practice throughout the on-site review process. It appears that the health plan is in compliance with all MO HealthNet Managed Care contract regulations and federal requirements.

Table 47 – Subpart C: Enrollee Rights and Protections Yearly Comparison (BA+)

Federal Regulation	BA+		
	2007	2008	2009
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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.

Behavioral Health

New Directions Behavioral Health continues to provide mental health services to BA+ members. NDBH was interviewed regarding their Performance Improvement Project, but not directly regarding compliance. The BHO meets with provider office managers quarterly and all transactions are handled electronically. They have a broad network of providers.

New Directions Behavioral Health continued to jointly operate the Parents and Children Together (PACT) program with the Gillis Center. The PACT program has been in place for ten years. This program provides intensive interventions for members and their families, with follow-up services within the community. Gillis Center now employs 26 trained therapists for this program. The BHO estimates that between twenty and thirty percent of members receiving sub-acute level care are referred for PACT services. PACT provides direct services and assists the family with community resources. For example, the program connects members and their family with their Community Mental Health Clinic (CMHC) for wrap around services or other beneficial interventions. Referrals are also made to Marillac Center for coordination with school programs and residential placement, if this becomes necessary. This service usually lasts only slightly longer than average inpatient treatment stays, and avoids court-involved out-of-home placement. These services, exceptional to the requirements of the MO HealthNet Managed Care contract, assists members leaving in-patient care, and in some cases prevents in-patient care. Providing this type of support mechanism allowed the health plan to increase ambulatory follow-up for members leaving in-patient services at the seven and thirty-day time frames.

NDBH has continued to develop their collaborative efforts with PCPs. They ensure that the PCP is notified immediately if a member enters inpatient treatment. Anytime there is a drug overdose reported, the BHO ensures that the PCP receives notification.

The BHO has developed clinical guidelines that are posted on their website. These are reviewed annually by the BA+ Quality Improvement Team. They have also developed ADHD guidelines for providers and members, which are also posted on the BHO website. They have been unable to produce this information at the sixth grade reading level, so are unable to distribute to all MO HealthNet Managed Care members. However, these are mailed to members any time they are requested.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

Blue Advantage Plus continues to have an extensive provider network available. The health plan reports that some providers are dissatisfied with the reduced fee schedule, but they have not lost providers at a rate that is disruptive to members or their network in general. The health plan reports that specialists remain dissatisfied with the MO HealthNet Managed Care reimbursement rates. Blue Advantage Plus does utilize specialists from their commercial network and reimburses them at twenty percent over the MO HealthNet Managed Care fee schedule when necessary. Provider Relations staff continues active recruitment efforts for specialty medical providers. The Administrative staff report that several additional urgent care centers, providing after-hours care, have opened. A number of physicians are now providing after-hours coverage as well.

The Health Plan reported that they continue to improve their relationships with providers. They are always anxious to recruit new providers. The health plan reports that they continue to have a very stable network of providers, but continue to work on finding new resources. They recognize that having psychiatrists in every county is a struggle.

Blue Advantage Plus does operate a providers' advisory committee that they utilize for review of internal policies and activities. Provider representatives meet with provider office staff monthly. They use these resources to obtain feedback on policy issues and to obtain input on pilot programs. Physician complaints and member satisfaction surveys were used to trigger corrective actions and educational opportunities with providers. Provider Relations representatives contact any office that is found to be out of compliance with the after-hours access requirements. All member complaints regarding lack of after-hours access are forwarded to provider relations. The appropriate representative contacts the provider office and conducts educational sessions with staff. The Blue Advantage Plus requirements are reviewed and coaching is provided about what type of after-hours directions for members must be in place. Follow-Up continues until all corrective action is taken. Additionally, representatives visit their assigned providers quarterly. The health plan does monitor to assure that PCPs have open panels.

Case managers are involved to ensure that members have access to quality and timely health care on a daily basis. They assist members in locating specialists, in obtaining appointments, in securing normal health care services, as well as extra ordinary services when they are required. Through the Care Coordination programs and the Healthy Companion Program, members with specific diseases obtain regular and adequate health care.

The rating regarding Access Standards regulations is (82.35%). Blue Advantage Plus submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff full evidence of assessments and treatment planning for members with special health care needs was not available. Blue Advantage Plus staff indicates that some of these gaps are the result of the case management system that did not allow for recording of all pertinent information. New case management software, which will allow for more detailed notes, follow-up recording, and a reminder system for member contacts will improve this issue. The current system creates an environment where exclusion into case management, rather than inclusion, appears to be the norm. During the on-site review the commitment to good case management practice was observed by the staff involved. The health plan's current practice indicates an approach to case management based on strong business practice, sometimes at the expense of dedicated member care. The health plan exhibits a strong commitment to compliance with the MO HealthNet Managed Care contract requirements and all federal regulations.

Table 48 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (BA+)

Federal Regulation	BA+		
	2007	2008	2009
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	1
438.208(c)(2) Care Coordination: Assessment	2	2	1
438.208(c)(3) Care Coordination: Treatment Plans	2	2	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	14
Number Partially Met	0	0	3
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	82.35%

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.

Structures and Operation Standards

Blue Advantage Plus provided regular oversight to all subcontractors. The health plan meets with New Directions Behavioral Health, Doral Dental and MTM at regular Delegated Oversight Quality Meetings.

Blue Advantage Plus 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. The Health Plan also used specific practice guidelines from the American College of Obstetricians and Gynecologists (ACOG) and the Academy of Pediatrics. Practice guidelines are distributed by the Provider Relations Representatives. This group also assesses if the practice guidelines are in place and utilized. All providers were encouraged to recognize best practices and follow nationally accepted guidelines.

The credentialing policies and procedures continue to be compliant with SMA contract requirements and federal regulations. BA+ follows NCQA criteria for credentialing and site reviews are included. Medical record reviews are conducted in compliance with HEDIS requirements. A list of all providers and their credentialing dates is maintained by the Health Plan to assure that re-credentialing is completed as required.

The Blue Advantage Plus Customer Service operation has continued to improve. Customer representatives offer members options for care, especially after hours. A scripting matrix was added so representatives can look up procedures pertaining to the member's inquiry, and provide adequate information. The system incorporates prompts for staff to insure that language and level of explanation meet member needs. Talking points are highlighted in all links. Cross training of this system occurs with Member and Customer Services so they can provide back up.

Ratings for compliance with Structure and Operation Standards regulations (100%) reflect that Blue Advantage plus has completed all policy and procedural requirements of the SMA for the fourth consecutive year. All practice observed during the on-site review supported that the health plan has made every effort to be compliant with both the MO HealthNet Managed Care contract requirements and federal regulations.

Table 49 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (BA+)

Federal Regulation	BA+		
	2007	2008	2009
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	10
Number Not Met	0	0	0
Rate Met	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.

Data used by the case managers included claims, pharmacy utilization, laboratory results, and self-reported information. Follow-Up contact with members occurs with all at-risk members detected, particularly those with diabetes, heart disease, and COPD. These case managers receive prompts to: make medical appointments; identify the need for chronic disease treatment; and to create comparisons to best practice guidelines for the members. The case managers perform 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.

Measurement and Improvement

Blue Advantage Plus continues its efforts to recognize and deal with the issue of Fraud and Abuse. They moved their Special Investigation Unit into Audit Services to assist in facilitating the process of identifying and rectifying fraud and abuse. When fraud and abuse is suspected,

the health plan does not renew provider contracts at their next renewal date. Other actions involve education of providers regarding problem areas identified. The professional investigation unit continues to assist when a suspected problem of fraud or abuse arises.

The health plan reports that its network includes over 1,600 physicians. It is experiencing fewer complaints each year from members. Blue Advantage Plus staff believes this is due to the longevity of the relationships with most of these providers. The health plan employs a Physicians Advisory Committee and provides information and training prior to making policy and procedural changes. This group assists in communicating necessary changes within the provider community. Physician profiling occurs and incentives are in place through the health plan's Quality Program. Quarterly audits are completed and communicated to all providers.

Blue Advantage Plus continues to ensure that providers use practice guidelines accepted by national organizations, as well as those based on local standards. The health plan uses the Provider's Office Guide and provider newsletters to disseminate information about practice guidelines to the provider community.

Blue Advantage Plus submitted information to complete the Validation of Performance Measures. They continue 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%) for the fifth consecutive year, which reflects that all required policy and practice meets the requirements of the MO HealthNet Managed Care contract and the federal regulations.

Table 50 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (BA+)

Federal Regulation	BA+		
	2007	2008	2009
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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 MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable tot the MO HealthNetManaged 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

The Grievance and Appeals system is under the umbrella of Blue Advantage Plus. This facilitates improved response time to member and provider complaints, grievances and appeals. The health plan reports that this process continues to exhibit positive results. The grievance and appeal processes have now changed from manual folders to uploading all information into the health plan's case management and information system. Information is now routed electronically which is a more efficient method of tracking. The Complaint Analyst reports that this process assists in meeting all timeliness guidelines.

The health plan utilizes a Medical Member Appeal Panel, staffed by the Medical Director, two

policy holders, and a Blue Advantage Plus representative, who serves as a neutral team member. Decisions are made by the panel. If an appeal is not overturned by the panel, the appeal is sent out for review by an independent review organization.

Grievances involving subcontractors are sent to the Quality of Care Committee. When the issue involves a provider, the health plan's provider relations staff investigates and then assists in addressing the problem. Case managers are aware of all the requirements of the Grievance and Appeals system. They assist members in making referrals and negotiating the system, as necessary.

Rating for compliance with Grievance System regulations (100%) remained complete as occurred for five consecutive program years. The health plan takes pride in their Grievance and Appeal policy and procedures. All practice witnessed at the time of the on-site review, was in compliance.

Table 51 – Subpart F: Grievance Systems Yearly Comparison (BA+)

Federal Regulation	BA+		
	2007	2008	2009
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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

CONCLUSIONS

Blue Advantage Plus continues to excel in meeting policy and procedural requirements of compliance with both the MO HealthNet Managed Care contract and the federal regulations. The health plan 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 points to their member loyalty as proof of their focus on meeting member needs. The health plan continues 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. The health plan believes that in the areas of case management where full compliance was not evident will improve with the implementation of the new case management recording requirements.

QUALITY OF CARE

The quality of healthcare services produced through Blue Advantage Plus remains high as the result of their commitment to continuing quality improvement. The health plan utilizes advisory groups. This includes one comprised of community members and another of physicians, to ensure that they have a sound perspective on methods that work and where improvements are necessary. The health plan subcontracts with New Directions Behavioral Health. Quality services are produced and are reflected in their exceptional initiatives, such as coordination of case management activities, the PACT, and Personal Transition Services (PTS) programs.

ACCESS TO CARE

Blue Advantage Plus exhibits their commitment to access to care through their enhanced service initiatives. The EQRO questions the depth and amount of case management being produced as the result of the case records reviewed and the interviews with case managers. The methods used to define members into the case management program are not always inclusive. They have developed new initiatives that improve member services and utilize health plan resources, such as Care Advance, a project that uses BA+ data to inform them about member issues. They participate in community activities to ensure that members have the best information on primary care providers and specialists.

TIMELINESS OF CARE

Blue Advantage Plus demonstrates their commitment to ensure the timeliness of healthcare by the improvement projects they undertake and new initiatives started each year. The case managers are aware of the need to assist members in obtaining timely health care and make every effort to intervene if they can assist. Examples of these programs include the BA+ Complaint Process, "Race for Resolution," which is a well constructed and important initiative that improved the health plan's responsiveness and timelines to both member grievances and appeals, and provider complaints, grievances, and appeals.

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 and behavioral health case management practices, to ensure a coordinated approach to member care.
4. Continue to recruit additional network providers with open panels, specialists, and psychiatrists to ensure access to services is available throughout the Health Plan region.
5. Ensure that case management records are inclusive of all pertinent information, particularly assessments and notes regarding follow-up and outcomes of care.

7.0 Children's Mercy Family Health Partners

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7.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

CMFHP supplied the following documentation for review:

- Improving Dental Utilization Rates
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Children's Mercy Family Health Partners

The health plan supplied data at the time of the on-site review providing additional information and data analysis. Some additional information was supplied after the on-site review as a final submission of statistical analysis.

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 8, 2010, during the on-site review, and included the following:

Ma'ata Touslee – Chief Clinical Officer
Jenny Hainey – Manager, Quality Management
Greg Hanley – Manager, Health Improvement
Melody Martin – Accreditation Manager

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:

- Discuss the study population.
- How were the accuracy, consistency, and validity assured?
- What findings were relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

FINDINGS

The first PIP evaluated was "Improving Dental Utilization Rates." The study topic was well developed. It was well documented and referenced. The topic justification includes comparisons of national, state, and local data. The importance of the goal of improving preventive care versus providing episodic treatment is clearly presented and explained. The health plan identified barriers for members and utilized this information to assist in defending their topic selection. The study focused on correcting deficiencies in care of members who are ages 2 – 20, and should be obtaining annual dental screenings. No members were excluded based on having special health care needs. The topic choice and rationale were well supported by a review of local issues and comparisons to state and national trends. A thorough literature review was conducted and the outcomes included in the documentation submitted.

The hypothesis utilized was that Health Plan participants, ages 2 – 20, residing in Jackson and Clay Counties receiving educational postcards will be more likely to schedule a dental screening.

The original study was designed to answer the question: "Do educational postcards to CMFHP eligible children from the ages of 2 through 20 years old, who reside in Jackson or Clay counties, result in a 10% increase in dental screenings?" During the second year of the project, the study question was expanded to: "Does added information on dental benefits to the CMFHP website, in the member newsletter, and on the Customer Service "on-hold" recordings targeted to CMFHP eligible children from the ages of 2 through 20 years old result in a 3% increase in dental screenings?" Both approaches utilized allowed the health plan to analyze if these interventions were effective.

The 2009 study indicator was the rate of children enrolled in CMFHP and meeting the eligibility requirements of the HEDIS specifications who had had at least one dental exam post intervention. The indicator looks at a change in health status and is focused on the issue of improving preventive care. The query group was defined as children within a specific age range. The members involved in this study were from thirteen (13) Missouri counties in the MO HealthNet Western region. Participants must have been continuously enrolled with no more than a 45 day gap in enrollment during the 2009 measurement year.

The study plan was to collect data according to the American Dental Academy's (ADA) Current Dental Terminology (CDT). The study design does identify the type of data to be used and its sources. The 2009 study design does include 13 counties, including Henry and Johnson, who have a high rate of members with no dental screening. The database report was to be generated from the dental subcontractor's (Bridgeport) claims system. Specific data collection specifications were included. The narrative clearly defined the sources of data and a systematic approach to obtaining data that provided confidence that it would be valid and reliable. A prospective data analysis plan was partially documented. It was based on the measurement of increased dental screenings post intervention, but the analysis plan lacked depth and detail. It is noted that the study design was developed in cooperation with Bridgeport Dental. The development of the study design included input from health plan and subcontractor staff. This approach to the study design provides evidence of the health plan's commitment to improve access to preventive care available to members throughout the MO HealthNet Managed Care region.

The information originally submitted did include the project manager, other study staff, their roles, and their qualifications. This area should be updated to correct for staff who are no longer working on the project. This section is coded as "met" as the staff involved was involved at the time of original submission.

Proposed interventions, barrier analysis, data analysis, and the quality improvement processes were described and explained in a manner that enhanced project analysis. In 2008 a reasonable and simple intervention was developed. The Health Plan and Bridgeport Dental mailed educational postcards to members in Jackson and Clay counties. This approach was expanded for the 2009 project. The health plan included information about dental screening and access on their website, including information in the "teen corner" to discuss prevention and wellness topics. Other educational strategies included information on the "on-hold" recordings to encourage members regarding dental benefits available and specifically dental care. Information was also included in the member newsletter on this topic.

The documentation received included an analysis, including initial and repeat measurement factors with observations on comparability from each measurement period. This information identified threats to internal and external validity. There was an analysis of the information available including the 2009 HEDIS data. The information provided indicated considerable success. The graphs and charts provided were clear and understandable. They did correlate to the narrative explanation. The information provided compared the baseline and re-measurement data for two years. The analysis explained the data and the results. The enhanced information submitted after the on-site review indicated testing for statistical significance. These tests determined that there was a positive impact as the result of implemented interventions. The results indicate an overall improvement of 22% of participants in the study obtaining annual dental screenings. The intervention is considered to have had a positive impact of the health plan's HEDIS rate, which has increased from 37.07% in 2006 to 45.3% based on 2009 activity. The plan for improvement indicated that the new interventions are creating positive results, including continued improvements in the HEDIS 2010 rate.

This was the second measurement period for this PIP. Improvement in Annual Dental Screening will become the statewide PIP in 2010. The health plan intends to make necessary changes in the structure and focus of the performance improvement strategies to comply with the requirements of the statewide PIP. Sustainability will be evaluated at that time.

The second PIP evaluated was the CMFHP individualized approach to the Statewide PIP "Improving Adolescent Well Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The rationale presented included information relating this topic to the needs of health plan members. CMFHP chose an individualized intervention pertinent to their members and supported this with plan specific data in the project documentation. They identified the adolescent population as one that poses challenges to serve. This project documentation reflected a desire to improve health care to the adolescent population. It looked at the topic as a serious attempt to solve a performance problem that will enhance preventive health care services to members. It is also based on a desire to improve the ability of members to access health services.

The CMFHP study question for the 2008 intervention was: "Will educational postcards sent to CMFHP participants from the ages of 12 through 21 increase adolescent well care (AWC) visits by 10% among the participants in this study population and also impact the CMFHP AWC HEDIS rate?" The 2009 study question was "Will educational magazines sent to CMFHP participants from the ages of 12 – 21 increase adolescent well-care (AWC) visits by 10% among the participants in this study population and also impact the CMFHP AWC HEDIS rate?" The indicators are the Statewide and CMFHP HEDIS rates. This HEDIS measure and its technical specifications were explained. The information provided focused on improving the process of care and associating this with improved outcomes for adolescents.

The study population included all health plan members ages 12 through 21, which is comparable to the HEDIS requirements, and who had at least one comprehensive well care visit with a PCP or OB/GYN. The Health Plan noted that this was a constant as each health plan implemented individualized interventions during the 2008 and 2009 measurement years. The same study population, as previously measured in 2007 was included.

The study design described the specific data to be collected. It highlighted the differences in the combined study approach, where each Health Plan will use its own NCQA certified software, and how this might impact data collection and measurement. The health plan specific information identified the Health Plan's MC400 claims database, and the process utilized to monitor and report outcomes. HEDIS technical specifications will continue to be used throughout the project. The health plan will query their MC400 claims database, and store the information extracted in Excel spreadsheets for tracking. The health plan identified the CPT and ICD9 codes that will be utilized to identify member claims. The health plan will utilize a quarterly tracking process and analysis to ensure that progress relating to their intervention is occurring. They did include a prospective data analysis plan in the narrative provided.

The planned intervention was developing and sending a teen magazine, Your Space, to all currently eligible CMFHP members between the ages of 13 & 17. Some members received the postcards, utilized in the previous measurement year, and later the magazines. The health plan also included a new section on their website entitled "Teen Corner" that included information on wellness and preventive topics. The health plan continued the intervention of sending

written notification to families that have not accessed well care visits after 120 days from the previous visit. They continued to send listings to providers of everyone due for a well-care visit.

The PIP staff remained consistent through 2009. All staff members involved in this project were named, including their qualifications and roles in the project. A new project leader was assigned in early 2010, who is familiar with this PIP, and the process. She stepped in when the previous project leader transferred positions.

Data analysis was completed for the baseline year 2007 and the re-measurement year 2008 and again for 2009. The Health Plan reported on the actual number of hits to the Teen Website. The number of hits in 2009 was 63. This number increased to 69 in early 2010, and did not include the entire calendar year. The HEDIS rate improved from the baseline year of 2006. That year's rate was 33.09%. The 2010 rate, based on 2009 numbers, is 45.5%. This is a significant increase and from the baseline rate and indicates that the interventions are positively impacting this population and their behavior. Tables and graphs were used to illustrate results throughout the PIP submission. These tables compared the HEDIS rates and were clear and concise. The analysis discusses data collection issues which may reflect some disparity in the numbers. They cite a lack of continuity in the data collection process that may have skewed past data slightly. The health plan has instituted corrective action to assist in ameliorating this situation, but all of this occurred prior to 2009.

CMFHP collaborated with all MO HealthNet MCHPs in an attempt to impact a problem with a population that is traditionally difficult to serve. They used an educational approach to make changes in their members' behavior. They individualized their approach and analysis to comply with the direction of the Statewide Performance Improvement Project. As a result of the positive impact these interventions have had on this issues, the health plan will continue to intervene with the adolescent population through direct mailings of postcards, semi-annual teen newsletters, and a continuation of the website information. The teen website has an innovative feature, allowing them to email the health plan to provide feedback and suggestions on topics they are interested in hearing about.

CONCLUSIONS

QUALITY OF CARE

Quality services are provided in the most appropriate environment, and in a preventive manner, whenever possible. These two projects reported on here embodied these values and sought to enhance the services available to the MO HealthNet Managed Care members. Quality health care is evident in the types of interventions used in these projects. The strong reliance on member education in informing members about the services available to them, particularly with a focus on preventive care, is evidence of the health plan's commitment to quality services to members.

ACCESS TO CARE

The focus of both of the Performance Improvement Projects developed by the health plan indicated a strong commitment to improving access to and knowledge about the preventive health care services available to members. In the first PIP the health plan provided education about the importance of accessing preventive dental care services. In the second project reviewed the health plan provided member education regarding the availability of adolescent well care screenings. Both projects enhanced members' knowledge about the availability of services and enhanced their access these services.

TIMELINESS TO CARE

The PIP regarding Dental Screenings concentrated on timely preventive care for children. The educational approach taken by this PIP empowers families to make sound decisions that can lead to continued efforts to obtain timely preventive healthcare services on an ongoing basis. The PIP that focused on improving adolescent well care services directly impacted members' knowledge about the availability of timely healthcare and implanted innovated methods of achieving their goal. The project sought to ensure that members had transportation services available in both projects.

RECOMMENDATIONS

1. Continue the work the health plan is doing to perfect PIP methodology and data analysis. Ensure that results are reported with clarity and enough detail to allow for an appropriate evaluation of information submitted.
2. Ensure that data analysis reflects all of the information to be measured. Interpret this data, whether it reflects a successful intervention or not, and investigate any negative results to build upon this knowledge.
3. Include the names, titles, and responsibilities of all health plan staff involved in the PIP.
4. Provide clear, understandable graphs and tables to illustrate PIP findings.

7.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for CMFHP. CMFHP submitted the requested documents on or before the due date of March 19, 2010. . The EQRO reviewed documentation between March 19, 2010 and June 30, 2010. 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:

- Children's Mercy Family Health Partners' information systems (IS) Policies and Procedures pertaining to HEDIS 2009 rate calculation
- The NCQA RoadMap submitted by Children's Mercy Family Health Partners for the HEDIS 2009 data reporting year
- Children's Mercy Family Health Partners' information services (IS) policies on disaster recovery
- Children's Mercy Family Health Partners' HEDIS committee agendas for 2009
- Children's Mercy Family Health Partners' HEDIS 2009 Training Manual for the medical record review process
- System edits for the claims management system

The following are the data files submitted by CMFHP for review by the EQRO:

- 2009_EQRO_ADV_Enrollment.txt
- 2009_EQRO_ADV_NUM_DENOM.txt
- 2009_EQRO_AWC_Enrollment_Hybrid.txt
- 2009_EQRO_AWC_MR.txt
- 2009_EQRO_AWC_NUM_DENOM.txt

- 2009_EQRO_FUH_Enrollment.txt
- 2009_EQRO_FUH_NUM_DENOM.txt

INTERVIEWS

The EQRO conducted on-site interviews with Janet Benson, IT Analyst; Tish Fisher-Krings; Johanna Groves, Senior Quality Management Nurse; Bob Clark, Director, IT/IS; and Jenny Hainey, QM Manager at the Children's Mercy Family Health Partners in Kansas City, MO on Wednesday, July 7, 2010. 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 2009 performance measures.

FINDINGS

CMFHP used the Administrative Method for calculation of the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures. The Hybrid Method was used for the calculation of the Adolescent Well-Care Visit measure. MO HealthNet MCHP to MCHP comparisons of the rates of Follow-Up After Hospitalization for Mental Illness, Adolescent Well-Care 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 ($p < .05$) were reported.

The HEDIS 2009 combined rate for Annual Dental Visits reported by CMFHP was 38.99%, which is significantly higher than the statewide rate for MO HealthNet MCHPs (35.05%, z = 1.09; 95% CI: 33.64%, 44.35%; $\underline{p} > .95$). This reported rate is higher than the rates reported in both 2007 (37.49%) and 2008 (38.59%; see Table 52 and Figure 49).

The rate for the HEDIS 2009 Adolescent Well-Care Visit reported to the SMA and the State Public Health Agency (SPHA) by CMFHP was 39.42%. This was comparable to the statewide rate for MO HealthNet MCHPs (35.63%; z = 0.63 95% CI: 35.62%, 43.22%; n.s.). This reported rate has continued to decrease from the rates reported by this health plan in the 2007 and 2008 EQR reports (42.82% and 41.61%, respectively; see Table 52 and Figure 49).

The 7-day reported rate for CMFHP for the 2009 HEDIS Follow-Up After Hospitalization for Mental Illness measure was 40.20%. This rate was comparable to the statewide rate for MO HealthNet MCHPs (41.59%; z = 0.08, 95% CI: 33.02%, 47.38%; n.s). This rate was lower than the rate reported in the 2007 EQR audit (58.67%), but an increase over the rate reported in 2006 (50.17%; see Table 52 and Figure 49).

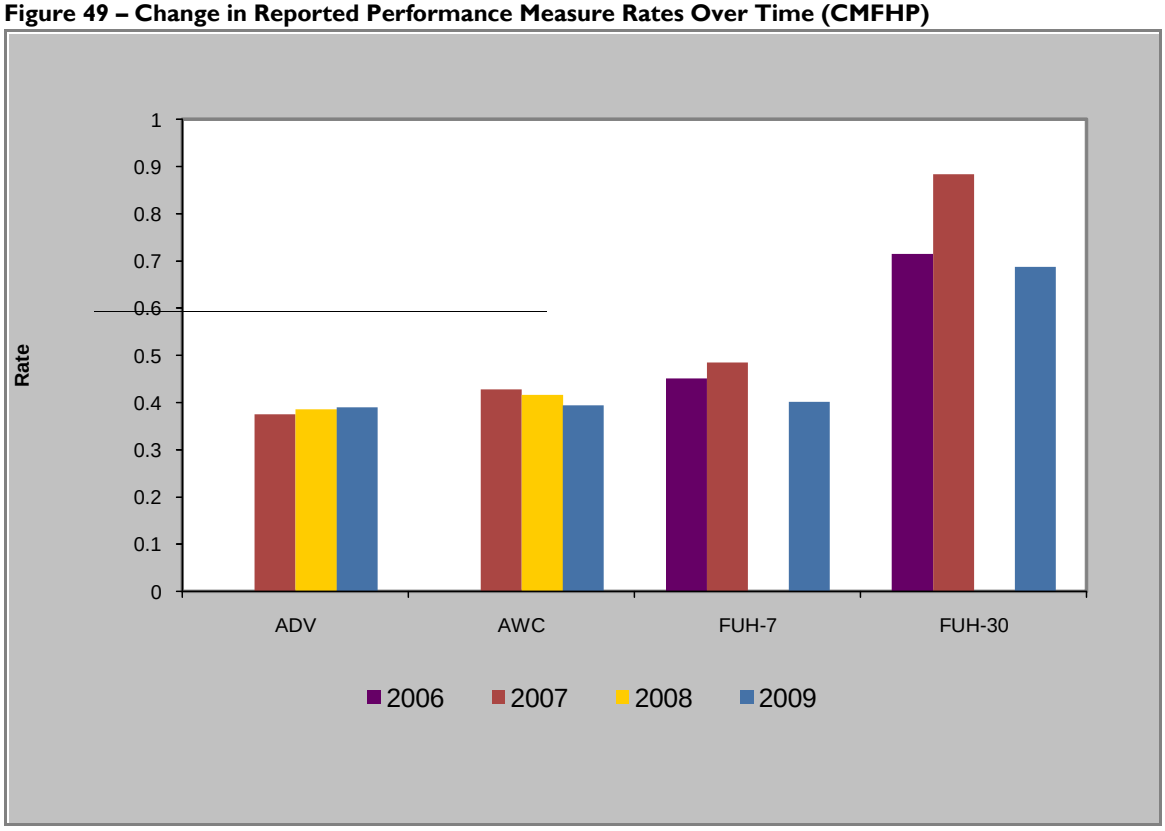
The 2009 HEDIS Follow-Up After Hospitalization for Mental Illness measure, 30-day rate reported for CMFHP was 68.70%. This rate was also comparable to the statewide rate for MO HealthNet MCHPs (66.46%; z = 3.25, 95% CI: 61.52%, 75.88%; n.s). This rate was lower than the rates reported in both the 2006 and 2007 EQR audits (71.52% and 88.40%, respectively; see Table 52 and Figure 49).

Table 52 – Reported Performance Measures Rates Across Audit Years (CMFHP)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate
Annual Dental Visit (ADV)	NA	37.49%	38.59%	38.99%
Adolescent Well-Care Visits (AWC)	NA	42.82%	41.61%	39.42%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	45.15%	48.50%	NA	40.20%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	71.52%	88.40%	NA	68.70%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 49 – Change in Reported Performance Measure Rates Over Time (CMFHP)



Sources: BHC, Inc. 2006, 2007, 2008, and 2009 External Quality Review Performance Measure Validation Reports

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 CMS Protocol 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 MedMeasures software system. The

accompanying MedCapture system was also demonstrated; this system allows for the calculation of the Hybrid hits from the input medical record data.

For all three measures, CMFHP 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 2009 measures. Although the data was complete, the administrative data for the Follow-Up After Hospitalization for Mental Illness measure was not provided to the EQRO in the format requested. Excess columns were added to the original data request format and therefore required additional processing.

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). CMFHP met all criteria applicable for all three measures. CMFHP does utilize statistical testing and comparison of rates from year to year.

PROCESSES USED TO PRODUCE DENOMINATORS

CMFHP 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. The Annual Dental Visit denominator included 26,320 reported and EQRO-validated eligible members. For the denominator of the Adolescent Well-Care Visits measure a sample of 411 eligible members were reported and validated. For the Follow-Up After Hospitalization for Mental Illness measure, a total of 393 eligible members were reported and validated by the EQRO. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2009 criteria.

PROCESSES SED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, follow-up visits and dental visits) as specified by the HEDIS 2009 criteria (see Attachment XIII: Numerator Validation Findings).

Review of the administrative hits for the combined rate of the Annual Dental Visit measure validated 10,252 of the 10,263 hits found by the health plan. The rate reported by the health plan was 38.99%; the rate validated by the EQRO was 38.95%. The total estimated bias for the Annual Dental Visit measure was a 0.04% overestimate of the rate by the health plan.

CMFHP used the Hybrid Method to calculate HEDIS 2009 Adolescent Well-Care Visits measure. All 19 of the medical records requested were received, and all 19 were able to be validated by the EQRO. As a result, the medical record review validated 19 of the 19 hybrid hits reported. The health plan reported 143 administrative hits; of these, the EQRO was able to validate all 143. Based on the number of hits validated by the EQRO, the rate calculated was 39.42%, as was the reported rate. There was no observed bias in the rate reported by the health plan.

For the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure, the health plan reported 158 administrative hits for the 7-day follow up rate. The EQRO found 156 hits. The rate reported by the health plan was 40.20% and the rate calculated by the EQRO was 39.69%, with a bias of 0.51%: an overestimate by the health plan in the reporting of the measure.

CMFHP reported 270 hits for the Follow-Up After Hospitalization for Mental Illness measure 30-day rate. The EQRO was able to validate 267 hits. This resulted in a reported rate of 68.70% and a validated rate of 67.94%. This shows a bias of 0.76% overestimate by the health plan.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. CMFHP was compliant with all specifications for sampling processes.

SUBMISSION OF MEASURES TO THE STATE

CMFHP 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 53 shows no bias for the Adolescent Well-Care measure and only slight overestimates (inside the 95% confidence interval) for the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures.

Table 53 - Estimate of Bias in Reporting of CMFHP HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.04%	Overestimate
Adolescent Well-Care Visits	No Bias	N/A
Follow-Up After Hospitalization for Mental Illness (7-day)	0.51%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	0.76%	Overestimate

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 54 shows the final audit findings for each measure. The Adolescent Well-Care Visits

measure was Fully Compliant, while the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures were Substantially Compliant.

Table 54 - Final Audit Rating for CMFHP Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Fully Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially 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 health plan. 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, or where incomplete data was submitted such that the EQRO could not fully validate the rate; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the health plan. Two of these rates were consistent with and one was significantly higher than the average for all MO HealthNet MCHPs.

QUALITY OF CARE

Children's Mercy Family Health Partner's calculation of the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The health plan's reported rate was consistent with the overall MO HealthNet MCHPs calculated rate. Therefore, CMFHP' members are receiving a quality of care for this measure equal to the care delivered to the average MO Health Net Managed Care member in both the 7-day and 30-day timeframes. The reported 7-day rate was lower than both the National Medicaid and National Commercial averages. Therefore, CMFHP is delivering a lower level of quality service than the average Medicaid or Commercial member across the nation in the 7-day time period. The 30-day rate reported was higher than the National Medicaid Rate, but lower than the National Commercial Rate. Therefore, CMFHP is delivering a slightly higher level of quality than that received by the average Medicaid member, but slightly lower quality care than that received by the average Commercial member across the nation in the 30-day time period. Both the 7-day and 30-day rates reported in the HEDIS 2009 measurement year were lower than the last time

this measure was validated (HEDIS 2007) which shows a decrease in the quality of services provided to members over the past two years.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

ACCESS TO CARE

The calculated rate by CMFHP for the HEDIS 2009 Annual Dental Visit rate was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The health plan's reported rate for this measure was significantly higher than the average for all MO HealthNet MCHPs; the rate is higher than the rate reported by the health plan in 2007 and 2008. CMFHP members are receiving a quality of care that is higher than the level of care delivered to the average MO HealthNet Managed Care member. However, the rate reported was lower than the National Medicaid Average rate for this measure, showing that CMFHP members have a lower access to care than the average Medicaid member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2009 Adolescent Well-Care Visits measure was fully compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was consistent with the overall MO HealthNet MCHPs calculated rate; this rate has fallen over the last two audit years (2007 and 2008). CMFHP' members are receiving the timeliness of care for this measure at a level equal to the care delivered to all other MO HealthNet Managed Care members. This rate was lower than both the National Commercial Rate and the National

Medicaid Rate, indicating that CMFHP' members are receiving the timeliness of care for this measure at a lower level than the average Commercial or Medicaid member across the nation.

The EQRO was able to fully validate this rate and thereby has extreme confidence in the calculated rate.

RECOMMENDATIONS

1. Continue to conduct and document statistical comparisons on rates from year to year.
2. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
3. The health plan experienced a reduction in the Adolescent Well-Care Visit rate over the last three years: the rates reported in 2009 were lower than the rates reported in both 2008 and 2007. The EQRO recommends that the health plan focus on improving this rate to reverse this trend.
4. The Follow-Up After Hospitalization for Mental Illness Rate showed a decrease over the previously audited rate in 2007 for both the 7-day and 30-day rates. The EQRO recommends that the health plan monitor this decrease and attempt to determine the possible reasons for this decline.
5. CMFHP should thoroughly review the data request format file prior to submitting data to the EQRO. This will ensure that the EQRO receives the data in the appropriate format to allow for the most complete validation possible.

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 54,140 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant 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 99.97% complete, accurate and valid. The remaining fields (n=11) included invalid code "Z0020".
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 97.4% complete, accurate and valid. The remaining fields (n = 4004) were blank.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, and fourth Diagnosis Code fields were well below the SMA threshold of 100.00% completeness, accuracy and validity. The second, third, fourth and fifth Diagnosis Code field were (30.3%, 24.3%12.6% and 0.6%) complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 43,025 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All fields were 100.00% complete, accurate and valid.

For the Home Health claim type, there were zero (0) encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

For the Inpatient claim type, there were 2,516 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 valid.
5. The Discharge Date field was 100.00% complete and accurate and valid.
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 75.19% complete, accurate and valid. The remaining fields (n = 624) were blank. (incomplete, inaccurate, and invalid).
9. All other Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA. The second, third, fourth, and fifth Diagnosis Code fields were 74.92%, 56.84%,45.31%, and 34.93% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 100.0% 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 88,912 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Hospital Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 98.2% complete and accurate, and valid. There were 1,599 blank fields.
7. The Outpatient Hospital Revenue Code field was 100.00% complete and 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, the second, third, fourth, and fifth Diagnosis Code fields were well below the 100% threshold for completeness, accuracy and validity set by the SMA. The second, third, fourth and fifth Diagnosis Code fields were 46.9%, 29.3%,15.1% and 8.4% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were zero (0) claims paid by the SMA for the period July 1, 2009 through September 30, 2009. It is important to note that the MCHP had pharmacy claims "carved-out" of their contract with the SMA that began on July 1, 2007. This explains the extremely low numbers of encounter claims during the time period reviewed.

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. The critical fields examined for the Dental and Inpatient claim type fields were 100.00% complete, accurate, and valid (see previous findings). The Outpatient Procedure Code fields and First Diagnosis Code field in the Medical claim types contained invalid codes. The Outpatient Hospital Claim type contained missing fields in the Procedure Code field.

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, Home Health, and Medical claim types were consistent with the average for all MO HealthNet MCHPs, while the rates for Dental and Outpatient Hospital claim types were significantly higher than the average for all MO HealthNet MCHPs. 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 CMFHP 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 MO HealthNet MCHP were randomly selected from Medical claim types for the period of July 1, 2009 through September 30, 2009 for medical record review. Of the 234,038 Outpatient encounter claim types in the SMA extract file for July 1, 2009 through September 30, 2009, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 95 medical records (95.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated.

During the 2007 review, the match rate for procedures was 51.0%, with a fault rate of 49.0%. The match rate for diagnoses was 47.0%, with a fault rate of 53.0%. For the 2008 review, the match rate for procedures was 50.0%, with a fault rate of 50.0%. The match rate for diagnoses was 42.0%, with a fault rate of 58.0%.

The match rate or this review is 59.0% for procedures, with a fault rate of 41.0%. The match rate for diagnoses was 57.0%, with a fault rate of 43.0%.

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 =38) with 5 records containing incorrect information. Incorrect information included the diagnosis code listed did not match the descriptive information in the record and the documentation sent was not complete.

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 = 30), incorrect (n=8), and upcoding (n=3). 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 MO HealthNet MCHP?

Since CMFHP included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet MCHP encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the MCHP denied for payment, unpaid claims do not include claims paid via a capitation plan.

MO HealthNet MCHPs were requested to submit data, as specified by the EQRO (see Appendix 6), for the Members represented in the encounter claim sample selected for validation.

For all Outpatient Claim Types (Medical, Dental, Home Health and Hospital), the State extract file contained 288,763 CMFHP submitted "paid" encounters and 110 "denied" claims and 2 "unpaid" claims. All paid encounter claims matched with the SMA encounter claim extract file. The 110 denied and 2 unpaid claims were not present in the SMA database (as expected); there was a "hit" rate of 99.99% between CMFHP's encounter claims and the SMA encounter data.

For the Inpatient Claim Type, the State extract file contained CMFHP submitted 2,516 encounter claims of "paid" status and 336 "denied" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims were not present in the SMA database. This produced a "hit" rate of 86.65% between CMFHP's encounter claims and the SMA encounter data.

Why are there unmatched claims between the MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

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

While the MO HealthNet MCHP 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. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet MCHP data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet MCHP 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.

CONCLUSIONS

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 two claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The rate of Dental claim types were significantly higher than the average for MO HealthNet MCHPs, suggesting high rates of encounter data submission and at least moderate access to preventive and acute care.

AREAS FOR IMPROVEMENT

1. The Outpatient Procedure Code fields in the Outpatient Hospital claim type contained invalid codes.
2. The match rate between the medical record and SMA encounter claims data was comparable to the average for all MO HealthNet MCHPs for the procedure and diagnosis code.
3. The Outpatient Medical and Outpatient Hospital first Diagnosis code fields contained missing codes.

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 first Diagnosis code fields are complete and valid for all claim types, and institute error checks to identify invalid data.
3. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis. The Health Plan should consider collecting medical records and reviewing the submissions prior to providing them to the EQRO for review, as some incomplete records were received, thereby missing the information necessary for validation.

7.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet MCHP's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). This ensures that each MO HealthNet MCHP's documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations. Prior to the on-site review Case Management cases were reviewed by the EQRO for compliance with policy and to ensure that practice reflected policy requirements. On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. Interviews occurred with Case Management Staff, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds the federal regulations.

Additional document review, including reading and evaluating the 2009 CMFHP Annual Appraisal, occurred prior to the on-site review. The health plan assisted the on-site review team by providing additional documents at that time. This process was used to validate that practices and procedures were in place to guide organizational performance and were in compliance with the State contract and federal regulations. The health plan requested that the EQRO conduct an additional case pull to ensure that a representative number of open cases be included in the case pull. This was the result of an error made by the health plan in providing the original case management record listing. The original thirty (30) records were received, and included only two active case management cases. A second random sample of 30 cases provided eight additional open cases. Information was provided to the health plan to ensure that the original random case pull would be the official pull used for their report. The additional case management cases were included in the case reading for a more substantive view of case management service.

Initial interviews were conducted with the Case Management staff. These interactions and responses were compared to policy requirements and the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff interviews.

The interview questions posed to Case Management staff were generated by the cases reviewed as well as the review of Health Plan Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the Health Plan processes. Additionally, interview questions were formulated for Administrative staff to validate and clarify these practices, to follow-up on questions raised from the case management staff interviews, and to respond to questions that arose from the document review. These interview questions were developed from the Children's Mercy Family Health Partners Annual Appraisal and the SMA's Quality Improvement Strategy.

Document Review

The following documents pertaining to Children's Mercy Family Health Partners were reviewed prior to and at the on-site visit:

The MO HealthNet Division supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- Children's Mercy Family Health Partners Annual Appraisal Fiscal Year 2009

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2009 Marketing Materials
- Case Manager Program Policy
- 2009 Community Project Report – "Bringing It Together"
- Case Management Philosophy and Standards of Practice
- Policies regarding Documentation Standards, Case and Care Management, and Children with Special Health Care Needs
- Health Plan brochures, such as "Lead Poisoning Prevention – Care Management"
- Quality Management Committee Minutes -- 2009

Additional documentation made available by CMFHP included:

- 2009 Marketing Plan
- Children's Mercy Family Health Partners' Organizational Chart
- Connection – Member Newsletter
- New Directions Behavioral Health – Referral to the Prevention Team Policy & Care
- Cross-Cultural Health Care Resource Guide

INTERVIEWS

Interviews were conducted with the following groups:

Case Management Staff

Sandy Granetello – Case Manager
Karen Mayes – Case Manager
Sydney Mackesty – OB Case Manager
Melody Derks – Lead Case Manager
Audrey Roberts – Case Manager
Robin Neal – Case Manager

Plan Administration

Ma'ata Touslee – Director of Health Services
Jenny Hainey – Manager, Quality Management
Dr. Elizabeth Peterson – Medical Director
Greg Hanley – Manager – Health Improvement
Lisa Gable – Manager, Clinical Services

The following are the interview questions used in the Case Management Interviews:

Case Management Interviews

- Discuss the CMFHP multi-source plan for identifying members needing case management services. How is this working?
- Talk about the process of coordinating care for members with multiple or complex health care needs.
- Tell us about the assessment process. How does this enable and interface with Plan of Care development?
- Describe the communication process between the case managers and the other sections of the health plan that deal directly with members.
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Discuss how you are using the Diabetic education position and how it is beneficial to members.

- How do you decide that a case should be closed?
- Discuss the case management auditing procedure. How does this work? What are the outcomes?
- Describe activities that have occurred during 2009 to improve the process of contacting and providing services to members included in the State's report of members with Special Healthcare Needs.
  -- What additional action is taken to identify members with special needs?

Findings

Thirty open case management cases were requested of CMFHP, as was done from each health plan. In the original thirty cases, only two cases from the random sample contained information on active case management services. The health plan requested that the EQRO conduct an additional case pull to ensure that a representative number of open cases be included in the case pull. They explained that they maintain all cases in the data base, even if not in active case management, when a referral has been received. In some cases members were not located after initial contacts. In others, healthcare service needs seemed apparent, but the member did not wish to be involved in case management at the time they were contacted. CMFHP may contact these members again, or a new referral or service needs emerges, and they are again asked if they want or need case management services. A second random sample of 30 cases provided eight additional open cases. Information was provided to the health plan to ensure that the original random case pull would be the official pull used for their report. The additional case management cases were included in the case reading for a more substantive view of case management service.

The cases reviewed provided evidence of maintenance of effort in providing case management to members was evident. In cases that were not open, reasons for closing and attempted contacts were recorded. Case management staff did explain that in the cases reviewed all services and case details are not available. They did exhibit their current case management system, which is much more detailed and allows the case managers to record all contacts, and a wealth of information about their involvement with each family or member.

The case managers explained that they obtain new referrals from a variety of sources. They have an outreach coordinator who pulls claims, researches diagnoses, and hospital discharges to learn about members service needs. This individual helps with identifying the need for

interpreter services, correct contact information, and all services that are currently being utilized by the family. The case managers also work closely with physicians, city and county coalitions, state agencies, and various support groups to identify members who are in need of case management and also to provide resources to members in case management. They work closely with the customer service staff to maintain contact with members, to get help with sending out educational materials and reminders to members.

The Lead Program case manager reported working directly with the county health departments in their region. These health departments oversee most of the cases where elevated lead levels are reported. The health plan contracts directly with the Jackson County Health Department for case management services for members with identified elevated lead levels. This case manager provides education to community groups such as the Pregnancy Coalition, First Steps, WIC, and Parents as Teachers. She does send educational mailings for all members receiving Lead Case Management. A case example was provided. The case manager received a referral for a four year old with an elevated lead level. After contacting the family she learned that there was a rat problem in the home. The family explained that the father was barbequing and curing hams in the basement of their home. A referral was made to the health department and "Healthy Homes". The family received education and assistance in cleaning the home, which has resulted in an improved lead level for the child and elimination of the rats.

The health plan has a case manager who participates in outreach for the OB cases. She also provides education to physicians' offices on recognizing issues such as elevated lead levels and substance abuse problems in pregnant women. This case manager works directly with pregnant members who have had drug exposure. These case management services are coordinated with services available through New Directions Behavioral Health (NDBH). NDBH provides direct services regarding improving life skills, and appropriate living arrangements, as an example. The health plan and the behavioral health provider coordinate their services, share their database information and communicate regularly. The case manager provided an example where a member needed support that could be provided through Swope Health Services. Supportive services were provided until enrollment in Swope Behavioral Health could be achieved. This effort has assisted both CMFHP and NDBH to improve timeliness and accessibility to Swope Health Services. Through this cooperative effort these improvements have been achieved.

A case manager continues to be assigned to work with members who present to the emergency room for care. This case manager assists the members in problem solving and educates them regarding utilizing their PCP as their primary health resource. This can include assignment to a new PCP or information on transportation services. The case manager often makes calls with the member, accompanies them to their first appointment, or assists in identifying additional service needs. In one instance a member came into the emergency room with anxiety and alcohol involvement. After their initial ER treatment, a referral was made to NDBH and a behavioral health case manager was assigned to work with the member on an ongoing basis.

The health plan utilized an adult case manager, who works with adult members and their families, or any children in the home. She reports that her services often include interpreting health care information for members, when they fail to understand a physician's explanation of disease conditions and instructions. The case manager assists members in writing out questions for providers to ensure that their questions are answered. The case managers report that they work closely with provider offices to understand individual practices, so they can assist members in understanding health issues and instructions.

The case managers report that they open all referrals, and make all required attempts to contact and locate members. Cases are closed when contact cannot be achieved. They send the member informational brochures and other educational material in the interim in an attempt to encourage members to contact the health plan. In some cases this does lead to successfully engaging members in the case management process. The case managers report that in most cases their services are seen as helpful and beneficial by members. They gave an example of a member who has two children, one with significant special needs. The member planned to move to the Springfield, Missouri area as she located a school that could assist in meeting this child's educational needs. In planning for the move, this mother learned that she would no longer be able to be part of MO HealthNet Managed Care services if she relocated to Springfield. The parent contacted her case manager and reported that she decided not to move because she did not want to loose the quality health care her child was receiving, supported by the medical case management, which she identified as very important, and she did not want to be in a fee-for-service region.

The case managers report that they average about 40-50 open cases. They also report that their cases are audited regularly by their supervisor.

Administrative Interviews

- Give examples of measures that the Health Plan implemented to improve follow-up process for members included in the State's Special Needs report.
- What impact has the Provider of the Quarter awards had? Do you believe this is an effective program?
- Discuss the case management auditing process and how this works.
- Describe any evidence that providers are conducting outreach to their patients who are not in compliance with preventive case or disease management guidelines.
- How have the Provider of the Quarter awards worked? Has this been a positive and effective program?
- What feedback has the Health Plan received from outreach activities?
- Discuss the new position of Diabetes Educator. How is this and other new staff assignments working?
- Discuss the use of quarterly measures and how this is improving health plan operations.

Findings

The administrative staff described the case management referral process in detail. They explained that they have two new outreach staff to support the work of the nurse case managers. The outreach staff supports case management activities. They contact members and obtain correct contact information. At a case manager's request they can set up transportation, and perform other non-clinical tasks. This effort is being made to increase the case managers' capacity to effectively work with members on clinical issues.

The administrative staff also discussed the case management auditing process. They explained that the supervisor reviews cases for completeness, accuracy, and to provide suggestions that might augment current case management efforts that are occurring. These reviews occur at least twice each year unless problems are noted. In these cases the supervisor will review cases more often. They case managers are also encouraged to conduct self-audits to ensure that they are performing optimally.

The administrators admitted that they are experiencing some budget constraints, but are actively working together to ensure that all requirements are met, and that services are not negatively impacted. The health plan hopes that no lay-offs will occur, but have redefined some roles, such as adding the outreach workers rather than hiring additional case management staff. They have stratified case management duties into complex case management, care management, and outreach activities. Each stratification has specific and well-defined job expectations. A positive outcome of this change is the ability of the health plan to gather better assessments for all members who need them. These changes are being made in an effort to work smarter since there are not additional financial resources available.

The administrators discussed the challenges they are having integrating all the requirements of the state contract, federal regulations, and NCQA standards into their operating procedures, and staff functions. This has been very time consuming. The health plan finds that the contract requirement and NCQA standards are sometimes in conflict. They are actively seeking to achieve their NCQA certification, so have had to work differently in some areas. An example is relabeling case manager roles as "complex case management."

The health plan has initiated a process for recognizing providers. They are looking at providers and provider groups who are going beyond the strict confines of contractual requirements. These providers are seeing members immediately, providing outstanding levels of care, and receive positive feedback from the members they serve. The health plan is acknowledging these providers with banners, plaques, and in other ways that build good will and camaraderie. The health plan feels this has been a positive investment so far and will continue with this process.

The health plan has implemented the new position of diabetic educator to improve information to members and the community. They hope it improve compliance for both children and adults with diabetes. The case manager has had an impact on members who are calling for assistance and advice. This case manager has also engaged the cooperation of a number of physicians specializing in the treatment of patients with diabetes, and who have not been in the health plan's network in the past.

The health plan continues to strive to improve their services to members. They now have their handbook available on DVD, and their "Welcome" information available on a CD. All members receive the DVD version of the handbook in their member packet. They are also continuing to develop specialty resources through the efforts of the medical director. Quality committees are being added to place more focus on member satisfaction, NDBH clinical services, and NCQA standards. The health plan is currently exploring methods to improve communication between the behavioral health provider and medical side of the service continuum. The health plan is strongly encouraging better coordination of care, as the feedback they have received from PCPs is that they are uninformed about the behavioral health received by their patients.

ENROLLEE RIGHTS AND PROTECTIONS

The staff at CMFHP continues to exhibit a strong commitment to ensuring that member rights are protected, and to solving member's health care problems. The health plan utilizes interpreter services, pre-translated written materials, including the Member Handbook and all brochures, and a variety of methods for those members who speak a language other than English. The health plan provides 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.

The staff feels included in efforts to create plans for changing internal processes. They believe that these efforts improve member perceptions, and also the way members are engaged and receive services. The health plan conducts a "post call survey" for members and a random customer call-back program. The health plan continues to document member needs, to conduct quality reviews and to seek measures to improve service. The staff believes there has been a positive impact from all of these efforts.

Case managers discuss their roles with members in a positive and animated fashion. They understand that they have some levels of care, such as complex case management and now outreach staff, but believe all services are member focused. The staff shared information describing case management as open to all members. Any member exhibiting a need for assistance in negotiating the health care system is eligible for case management. One supervisor

explained that the health plan is moving to a system with some differentiation in levels of service. Case managers and complex case management both accept members based on their expressed or assessed needs. The case management staff will work with members who have more short-term and manageable needs. Complex Case Managers and Disease Managers will work with members whose level of care is described as acute, or who have specific long-term diagnoses associated with their health issues.

The case managers explained that they receive both internal and external referrals. Referrals come from utilization review nurses, physicians' offices, the emergency room, members themselves, and internal sources. The staff explains that their current case management system provides an excellent source of electronic communication when a member is identified as having a problem resulting in a need for case management services. Staff described a variety of services available through the health plan to enhance their availability to members.

Case managers reported that their case loads are adjusted based on an internally defined acuity level. OB case loads average in the forties. The case load may be slightly larger depending on the time of year, or the complexity of cases. Generally all other case managers carry a caseload of 40 – 60 members. One level of case management pertains to Healthy Lifestyles. These members receive home visits from their care coordinators, who carry approximately thirty (30) cases each.

Case managers reported that they review the SMA generated report regarding children with special health care needs monthly as it is received, and attempt to contact every member listed. In some cases they find the members are previously enrolled in case management. If they have difficulty locating the member, they pursue other methods of contact such as looking at hospital records and claims data. These members are offered case management services and receive an assessment when located. The case managers report the availability of the services is promoted in the Member Handbook and members make contact as the result of this information.

The health plan continues to exhibit its strong commitment to the member advisory committee. Membership now includes school nurses, social workers, Head Start teachers, and Parents as Teachers advocates. Quarterly meetings of this group are continuing and attendance has

improved significantly. Monthly meetings of the Consumer Advisor Group occur in Bolivar, Missouri to encourage participation in the expansion counties of the Western MoHealthNet Managed Care Region. Topics of these meetings included disease management programs and benefits. Information from the presentation was included in a member newsletter, at the recommendation of a committee member.

CMFHP continues to participate in community events including back-to-school fairs, work with area churches, the Chamber of Commerce, and events targeting the Latino and African American communities. They work with two groups specifically, El Central and CoHo. A Latino staff member attends many of these events to ensure appropriate information is shared with members about access to care. One case manager described their relationship with members as "their advocate." The health plan and staff are involved in the community and a number of activities.

When a new referral is received it is reviewed within 48 hours. A review of utilization activity and claims activity is performed. A parent may be called for information and clarification if a child is involved. The case manager meets with the member, completes an assessment and formulates a treatment plan. Permission is obtained from parents when a care plan is written for a child. Case managers are aware that a member may refuse these services. When this choice occurs, the case managers report that they work within the system to assist the member without direct contact being required.
Case managers understand that the records reviewed did not always exhibit all services provided to a member or a family. They did present their current case management system to reviewers, which has significantly enhanced not only their case management documentation capabilities, but also their ability to share information internally.

Ratings for Compliance with Enrollee Rights and Protections (100%) reflected policy and procedures that were submitted and approved by the SMA for the fourth year in a row. All written information has been submitted and approved. All practice observed, as well as additional documentation viewed while on-site, indicated that the health plan is fully compliant in this area.

Table 55 – Subpart C: Enrollee Rights and Protections Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2007	2008	2009
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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 MCO Protocols.

Behavioral Health

CMFHP began contracting with New Directions Behavioral Health (NDBH) for the provision of behavioral health services for members during 2007. The approach to case management by the BHO is very supportive of members, accepting of the need to provide adequate services, and doing so in a timely manner. NDBH is known for providing in-home services, and for contracting with a local provider who provides intensive in-home treatment for members to ensure that the family has a full array of in-home services and supports. This service is extraordinary to those required by the MO HealthNet Managed Care contract. These services are available to CMFHP members. The case managers described NDBH as an advocate for members. NDBH staff does serve on the Consumer Advisory Group.

Co-Case Management meetings with NDBH occur regularly. Currently the health plan and BHO are looking at a Depression Disease Management program and collaborate on training tools. The depression tool is utilized with members receiving OB and post partum care services. The Health Plan is also working with NDBH on engaging school nurses in making referrals if they suspect depression or other behavioral health issues.

The case managers reported that they are now located in "pods" and work directly with case managers from NDBH. They have weekly case management rounds for information sharing purposes. There are also case rounds with the medical director that enhances problem solving. During the shared rounds with NDBH and health plan case managers there are often outside speakers and the two groups share available resources for members. The two agencies are exploring more effective ways to document services and progress with members, as well as methods to ensure inclusion of the PCP in information sharing.

Quality Assessment and Performance Improvement

Access Standards

CMFHP continued to have a strong provider network throughout the MO HealthNet Managed Care Region. The health plan has worked one-on-one with providers, including specialists who agreed to become panel members. The health plan recognizes a continued need for neurosurgeons and orthopedic surgeons. CMFHP continues to work with specialists who

agreed to be in the network, but request to remain silent and not be published in the Provider Manual. These providers see members when contacted directly by health plan staff. CMFHP paid a higher fee to OB, orthopedic surgeons, urologists, and neurologists outside of their network to ensure members have adequate access to these specialties. CMFHP continues to monitor their PCP availability and continues recruitment to ensure that adequate open panels are available.

The health plan continues 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.

Staff reports that they assist members with a number of access issues. They supply information on available providers and their locations. They instruct members on utilization of the handbook to identify providers, including those that speak other languages or provide special services. If a provider contract is terminated, members receive a letter. Follow-Up by telephone occurs, particularly if a member's information indicates that they have literacy difficulties. Staff also discussed efforts made to assist member in obtaining copies of their medical records. If there is a problem with provider compliance, the Member Services staff intervenes, but also makes a referral to Provider Relations for follow-up.

Case managers are involved in assisting members in accessing appropriate medical care. They ensure coordination of services, and ensure that all levels of health care required are available. The CMFHP case managers meet regularly with BHO case managers to ensure that they are serving clients appropriately when they have multiple service needs. Case managers also receive a listing twice a year that identifies all members who have not seen their PCP in a year. Contact is made by letter, and additional outreach occurs to ensure that health care services are received, and to identify changes that may be needed. CMFHP also reports that PCP offices are not conducting outreach to the extent that the health plan would prefer.

Ratings for compliance with Access Standards (100%) reflected completion of all required written policies and procedures for the fourth year in a row. Observations and interviews that occurred during the on-site review provided additional evidence that Health Plan practices and operations appear to be compliant with the MO HealthNet Managed Care Contract and federal regulations.

Table 56 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2007	2008	2009
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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 (MCO) 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 MCO 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 the health plan's case managers. When a member has a specific problem, and care coordination is needed between clinicians, this service is provided by the appropriate case manager. The health plan continues the formal means of facilitating communication between PCPs and specialists. They report that letters detailing the care provided flow between the two. Case managers facilitate this communication, with member approval, to ensure that pertinent information is shared.

The health plan continues to follow NCQA standards regarding credentialing. Re-credentialing is conducted every three years. Sanctions and quality are reviewed monthly. Current credentialing policies and procedures were approved by the health plan oversight committee, and were approved by the SMA in March 2010. Information reviewed indicated that a delegated review of University Physicians Associated, Bridgeport Dental, Children's Hospital and Physicians, New Directions and HealthFirst were conducted in 2008 and all were found 100 percent compliant.

The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the fourth year. The health plan appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

Table 57 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2007	2008	2009
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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.

Measurement and Improvement

CMFHP continues 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 health plan continued to meet or exceed nationally accepted standards. All clinical guidelines used are reviewed through the Clinical Criteria Committee prior to implementation. The Health Plan utilizes Milliman Care Guidelines as a primary resource for pre-certifications, Utilization Review, and Care Managers for medical necessity determinations.

CMFHP continues to send providers a quarterly report card covering lead and EPSDT rates. This is used as an incentive to increase the screening rates. Solo-practice PCPs have the best rates in the health plan.

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 health plan 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 health plan 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.

The case managers report that the health plan's internal communication system is available so everyone has access to needed information. All staff can enter updates regarding members and send this information to Medical Management as necessary. They report that the system has been developed to be member focused and is very useful. They also report that new technology has been developed for the health plan's website. There is now an audio program available for members to obtain education regarding benefits.

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 MO HealthNet Managed Care contract and the federal regulations for the fourth consecutive year.

Table 58 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2007	2008	2009
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of HEALTH PLAN Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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 MCOs 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 MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable tot the MO HealthNetManaged 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

Ratings for compliance with the Grievance Systems regulations (100%) indicate that the health plan completed all requirements regarding policy and practice. This is the sixth consecutive year that the health plan is fully compliant in this section of the review.

Staff was aware of the grievance process and related that they do provide assistance to members who contact them with concerns. When a member calls, the staff tries to assist them so they know what questions to ask, and how to get answers to these questions throughout the

grievance process. If a member does not realize that their concern is a grievable issue, the staff advises them further on navigating this system and the importance of filing a grievance.

Case managers report that they become involved when members receive an adverse authorization decision. The case managers then refer the member to the Grievance/Appeal Department. Case managers are aware that the information is available in the Member Handbook, but assist members in any way that they can.

Table 59 – Subpart F: Grievance Systems Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2007	2008	2009
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	10	0	0
Rate Met	100%	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., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

CMFHP continues their strong commitment to meeting all policy, procedure, and practice areas of compliance with both the MO HealthNet Managed Care contract requirements and the federal regulations. The health plan exhibits a meticulous attention to meeting all the details of the regulations, submitting policy and procedural updates in a timely fashion, and utilizing the prior External Quality Reviews as a guideline for meeting required standards. The CMFHP staff exhibit a sincere commitment to excellence in serving MO HealthNet Managed Care members. They demonstrated respect and dignity toward members, while meeting their healthcare service needs efficiently and effectively. The health plan goes 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 of healthcare services.

QUALITY OF CARE

CMFHP has initiated a number of programs to ensure that members from the diverse population in their area have access to providers and information in their native language and in a manner that is understandable to them. They work diligently to ensure that providers are serving members in a quality manner. The health plan monitors their service delivery system, including providers, regularly to produce quality services from the organization, and from the healthcare providers involved. CMFHP has demonstrated a number of creative approaches to engaging providers, particularly in hard-to-reach specializations. They actively engage new health management programs to benefit members. The health plan has a strong relationship with the community to obtain feedback on their programs and ensure that quality care and services are achieved.

ACCESS TO CARE

CMFHP demonstrates its commitment to ensuring access to care for members throughout their organization. For example, their focus on development and utilization of a Member Advisory Committee in various areas of the region they serve to ensure that members have a forum to discuss access issues directly with the health plan. Their willingness to assist members'

attendance, by creating reminders and providing transportation highlights this effort. The health plan demonstrates its sincerity in these efforts by implementing suggestions that come from these meetings. The health plan has also made many accommodations to ensure that members have access to the array of specialists they require to obtain quality healthcare services.

TIMELINESS OF CARE

The health plan has ensured that the treatment of members and providers during the grievance and appeal process is of primary importance. They examine the reasons for grievances and appeals to ensure that their processes are not causing a problem. If this is the case, the health plan is willing to take steps to rectify the problem, thus ensuring that timely care takes place for members. CMFHP continues their 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.
3. Continue to look for creative methods to use as motivators, such as available incentives, to encourage member utilization of health plan resources, particularly for high-risk populations.
4. Continue to ensure that front line staff, particularly case managers, are integral members of the health plan team, as they are keenly aware of member needs, and difficulties in obtaining appropriate health services.
5. Work with New Directions Behavioral Health to ensure that care coordination, and documentation of services occurs in a timely manner that clearly reflects all members' interventions.
6. Work with NDBH to improve communication with PCPs.
7. Continue a commitment to the case management process for all members.
8. Ensure that case managers record all contacts, services, and attempted contacts with members to ensure that case records accurately reflect the amount and depth of work being conducted.

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8.0 Harmony Health Plan of Missouri

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8.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Harmony supplied the following documentation for review:

- Performance Improvement Project 2007: Lead Screening
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Harmony Health Plan

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 14, 2010 during the on-site review, and included the following:

Vijay Kotte – Region President
Dr. Olusegun Ishmael – Medical Director
Carole Ouimet – Senior Manager, Regulatory Affairs
Ramona Kaplink – Manager, Accreditation and HEDIS

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 Harmony want to study or learn from their PIPs?

The PIPs submitted for validation included substantial information. Additional analysis occurred between the time of the original submission of information and the time of the on-site review. The health plan was instructed that they could submit additional information that included enhanced outcomes of the intervention. Additional clarifying written information was received after the on-site review.

FINDINGS

The first PIP evaluated was titled "Lead Screening Performance Improvement Project." This study was considered clinical and focused on improving the rates of lead screening for young children ages 0 - 2. The project narrative identified how complying with screening requirements is associated with enhanced preventive services and improved healthcare outcomes. The Centers for Disease Control (CDC) and Department of Health and Human Services (DHHS) resources are quoted and substantiate the need to improve the number of lead screenings for children 0 – 2 years of age. The literature review provided is thorough and interesting. The decision to enact this study was well defined and supported by both state and national data sources. The information presented compared both national and regional standards. This review and analysis provided a positive argument for the topic choice and for the interventions identified. The approach to this Performance Improvement Project was not just to present a clinical study, but to implement successful interventions to improve health care service to members with the overarching goal of improving health outcomes for the children affected.

A barrier analysis was completed to identify areas of concern. This was completed for each project year including 2009. A trend analysis was included that supported the contention that this is an ongoing and present problem creating a deficiency in healthcare for children. The study included all children who are MO HealthNet Managed Care members within the identified age range. No members were excluded based on special health care needs.

The study question presented was "Will targeted Harmony interventions for members and providers increase the rates of lead testing in members reaching their second birthday and meeting the HEDIS study population description for Lead Screening in Children?" The question framed the content and intention of this study. The question includes a stated goal, including the provision of member and provider education.

Indicators for this study were included and defined with information about how they were to be counted and analyzed. The indicators did include quantifiable information. The information provided clearly leads the reader to understand that the focus of the study is to improve compliance with recommended lead screening guidelines in an effort to improve health outcomes for children. The population served by this study includes all members' children in the age range and does not exclude any member with special health care needs.

The study design specified the data to be collected, the sources of that data, and the methodology to be utilized in the data collection process. Data will be obtained from programmed pulls from claims and encounter files. The systematic method is supported by the use of the HEDIS technical specifications. The health plan will utilize both the administrative and hybrid methods for data collection. These planned pulls are to occur one time per year. However, the narrative did not include sufficient detail to ensure that there is confidence in the plan and the process. The narrative does not discuss how medical record reviews will occur, or the expected improvement that might occur employing this process. A detailed prospective data analysis plan is included.

The health plan personnel involved in the PIP, including the team leader, and support team, are all identified. Their roles and qualifications are included.

A detailed description of the planned interventions was included for the 2008 and 2009 project years. The interventions planned are focused on educating members and providers. The health plan utilized newsletters, handbook updates, community outreach, mailings, and periodicity postcards with members. The approach with providers included newsletter information, office visits, listings of non-compliant members for PCPs, and their Pay for Quality program to encourage providers' involvement. The health plan utilized a large number and a vast array of interventions. It was difficult to evaluate which intervention had the most significant impact on member behavior. Barriers and other issues that may affect outcomes were identified and discussed, particularly in how they impact member behavior.

The desired outcomes and the evaluation process were included. The narrative included the baseline data and 2 years of re-measurement. The ultimate goal of the proposed interventions was detailed in the information submitted. The health plan did present some results. The documentation also included narrative about the need to better focus PIP strategies allowing for a more focused study methodology and the ability to analyze results. The health plan presented a frank and detailed assessment of previous attempts to complete the PIP process and plans for future improved submissions were included. This discussion does provide a renewed confidence in the ability of the health plan to utilize the PIP process to identify areas where improvement in needed, and to devise methods to creatively impact those areas in a positive

manner. Although this PIP has been ongoing, it appears that the health plan will continue attention to impacting this issue, as 2010 strategies are included.

The second PIP evaluated was the Harmony individualized approach to the Statewide PIP "Improving Adolescent Well Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The rationale presented was thorough and clearly based on the need to enhance the approach to improving adolescent well care on a statewide basis. The Harmony project cited their need for improvement on this measure, and did elaborate on the rationale for individualizing their approach based on specific member needs.

The study question presented was: "Will a focused effort, with Health Plan specific interventions, improve the HEDIS rate of adolescent well care?" The study question was clear, concise, and measureable. It did focus on improving the HEDIS measure and improving the availability of preventive services or health care for members. The health plan did individual research on the need to provide focused adolescent preventive healthcare. Both regional and national sources were investigated. The health plan was able to identify why and how this topic is important to their members. The primary indicator for adolescent well care is the HEDIS measure. The technical specifications defining the measure and its calculation were included. The Health Plan did include its 2007 HEDIS rate of 21.61% with the observation that this was 13.39 percentage points below the NCQA 25th percentile.

The study question presented is "Will targeted health plan interventions for members and providers increase the rates of adolescents receiving well care visits and improve HEDIS rates for adolescent well care?" The health plan included a discussion of how improving adolescent well care will improve healthcare in the region. It described the importance of improving preventive health as having a relationship to impacting ancillary issues such as intervening in other preventable issues like alcohol and tobacco use, substance abuse, poor diet, and unsafe sex practices all of which contribute negatively to adult morbidity and mortality. The health plan tied this discussion to their interventions, particularly in the need for provider engagement and education.

The indicator for this issue is the HEDIS measure regarding adolescent well care. The health plan provided details regarding the indicator including the determination of the denominator and numerator. The specific population is defined and no member is excluded based on special health care needs.

The study design is based on the information provided in the Statewide Combined Report and information individualized for Harmony Health Pan. It specified that administrative and hybrid data will be used to calculate the health plan rate for adolescent well care. The health plan provided sufficient detail including the use of an NCQA auditor and NCQA certified software. The health plan indicated that they began enrolling members in June 2006 and that HEDIS 2008, which is data from calendar year 2007, was their first reportable year. Reference is made to yearly comparisons to identify statistically significant increased from the previous year and from the baseline. All aspects of the study design are referenced with detail included on their prospective data analysis plan.

The Health Plan included an extensive list of interventions to be implemented. The 2009 interventions included:

Member Level

- Enrollment and orientation: Opportunity to educate prospective members about the importance of HCY/EPSDT/AWC visits. They will utilize an enrollment checklist to ensure topic coverage.
- New member packets including self-assessment forms
- Member newsletters featuring articles on HCY/EPSDT components, including information on immunizations and transportation
- Member Handbook

Provider Level

- Educational articles in Providers' Newsletter and Health Service Newsletter with education on components of a well child visit and also capturing missed opportunities
- Over 350 provider and provider office staff educational site visits
- Provider Handbook for education and documentation tools
- Provider relations staff sponsored education regarding the importance of complying with EPSDT services. Presentation of outreach lists and improvement in coding issues will be included in these contacts.
- Pay for Quality Program rewarding providers with greater than fifty (50) members and group practices with greater than one hundred (100) members that reach NCQA HEDIS AWC benchmarks. Many providers have increased their outreach to non-compliant members as a result of this program.

Health Plan Level

- Periodicity letters to members (beginning in 4th quarter of 2009)
- Contract with Care Management International to place outreach calls to parents of non-compliant members
- Pay for Quality Program
- Member outreach lists. These list members who are non-compliant (delivered to provider offices by provider relations staff),

The member interventions are based largely on activities that are required for all members, such as sending out member welcome packets including handbooks that address periodicity schedules. The number of interventions creates an atmosphere where no assessment can be made about their impact on member behavior. The information provided for the 2009 project year did not focus on making any significant change to member behavior.

There is a data analysis plan incorporated into this section of the report. Actual data analysis indicated that the health plan has not yet had success at improving this measure or member behavior. Harmony's first reportable year for HEDIS data was 2008. They did not meet their stated goals for 2008 or 2009. They did conduct a barrier analysis and reflected this in the interventions chosen. The conclusion in the narrative states that "…there is no clear-cut method of determining the impact, if any…" of evaluating the impact of the strategies employed on the outcomes achieved.

The health plan's membership has expanded, as have the counties where their members reside. They are broadening their focus to reflect their new and additional population. The data to be collected was defined in the narrative. The Health Plan recognized that they did have baseline data and two re-measurement years of data. The interpretation of the results in the documentation provided indicated a new understanding of how the PIP process can help in identifying areas for improvement and focusing strategies in a more targeted manner. Due to the number and array of interventions, it is difficult to speculate on what may be the most effective, if improvements are noted.

Based on the information currently available real or sustained improvement cannot be determined. The health plan does recognize the need to develop a more focused approach to performance improvement. It is hoped that this will lead to the development of improved projects in the future.

CONCLUSIONS

QUALITY OF CARE

Both PIPs are designed to improve the quality of services to members. The non-clinical PIP did have the stated focus of improving the health plan's HEDIS rates. However, if the interventions are effective, there should be an improvement in the health care provided to their adolescent members. The interventions described in the clinical PIP are clearly targeted to improve the quality and effectiveness of preventive services for children, thereby improving health care outcomes. By educating providers and members in accessing available and appropriate lead screening services, the health plan will ensure that preventive and the most effective services will be in place.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members who were eligible for lead screening received these services in an efficient manner. By undertaking the methodology involved in the Performance Improvement Project the access to care will enhance the members' ability to appropriately utilize these services. The non-clinical PIP also included the theory that by educating members, the community, and providers, better health care will be available to the adolescent member population.

TIMELINESS OF CARE

The services and interventions used in the clinical PIP did have the specific outcome of improving the timeliness of appropriate preventive services for children. In this PIP the areas of access, quality, and timeliness of care were stated goals. The outcome was focused on improving the availability and awareness of the need for services so they would be received in a timely manner. The non-clinical PIP considered timeliness in looking at timely well care visits for adolescent members. The narrative provided included limited discussion about how these interventions would improve timely services to members. It should be noted that timely access to care was a stated and implied goal of both projects.

RECOMMENDATIONS

1. Harmony has attempted to improve the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The focus on improving services to members through the PIP process needs to be reflected in the outcome of these studies to ensure that these goals are met in an efficient and effective manner.
2. The interventions of each PIP should be focused and measureable. The interventions should not include regular expected activities of the health plan, but be specifically designed to improve the performance of the health plan with the ultimate goal of improving health care or services to members.
3. The health plan should explicitly address how its projects are extended to and pertinent to the entire MO HealthNet Region served.
4. The health plan should recognize that an important aspect of the PIP process is creating new methods of improving services or member behavior that can then be incorporated into regular organizational activities.
5. The health plan should include an assessment of how the interventions used in its PIPs contributed to its success. If interventions were not successful, this should be assessed frankly, with alternative proposed activities for future PIPs.

8.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Harmony. Harmony submitted the requested documents on or before the due date of March 19, 2010. The EQRO reviewed documentation between March 19, 2010 and June 30, 2010. 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 NCQA RoadMap submitted by Harmony for the HEDIS 2009 data reporting year
- HealthCareData Company's NCQA HEDIS Compliance Audit Report for HEDIS 2009
- Harmony's information systems (IS) Policies and Procedures pertaining to HEDIS 2009 rate calculation
- Harmony's information services (IS) policies on disaster recovery
- Harmony Health Plan's HEDIS committee agendas for 2009
- Harmony Health Plan's HEDIS 2009 Training Manual for the medical record review process

The following are the data files submitted by Harmony for review by the EQRO:

- Tab_4_WellCare_ADV_File1.txt
- Tab_4_WellCare_AWC_File1.txt
- Tab_4_WellCare_FUH_File1.txt
- Tab_5_WellCare_ADV_File2.txt
- Tab_5_WellCare_AWC_File2.txt
- Tab_5_WellCare_FUH_File2.txt
- Tab_6_WellCare_AWC_File3.txt

INTERVIEWS

The EQRO conducted on-site interviews via telephone with the WellCare (Harmony's parent company) HEDIS department located in Tampa, FL and Operations at the Harmony in St. Louis, MO on Tuesday, July 13, 2010. 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 2009 performance measures.

FINDINGS

The Administrative Method of calculation was used by Harmony for the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures. The Hybrid Method was used for the calculation of the Adolescent Well-Care Visit measure. MO HealthNet MCHP to MCHP comparisons of the rates of Follow-Up After Hospitalization for Mental Illness, Adolescent Well-Care 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 ($p < .05$) were reported.

The HEDIS 2009 combined rate for Annual Dental Visits reported by Harmony was 20.68%, which is significantly lower than the statewide rate for MO HealthNet MCHPs (35.05%, $z = -1.64$; 95% CI: 15.32%, 26.04%; $p < .05$). However, this rate is higher than the rate reported by the health plan in 2008 (16.94%; see Table 44 and Figure 48)..

Harmony's reported rate for the HEDIS 2009 Adolescent Well-Care Visit reported to the SMA and the State Public Health Agency (SPHA) was 25.79%. This was significantly lower than the statewide rate for MO HealthNet MCHPs (33.58%; $z = -1.32$ 95% CI: 26.37%, 33.97%; $p < .05$). However, this rate has increased more than 3% over the rate reported by the plan in 2008 (25.06%; see Table 44 and Figure 48)..

The 7-day reported rate for Harmony for the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was 24.66%, significantly lower than the statewide rate for all MCHPs (41.59%; $z = -1.65$, 95% CI: 17.48%, 31.84%; $p < .05$).

The HEDIS 2009 30-day rate for Follow-Up After Hospitalization for Mental Illness reported by Harmony was 39.73%, significantly lower than the statewide rate for MCHPs (66.46%, z = 0.03; 95% CI: 32.54%, 46.91%; p < .05).

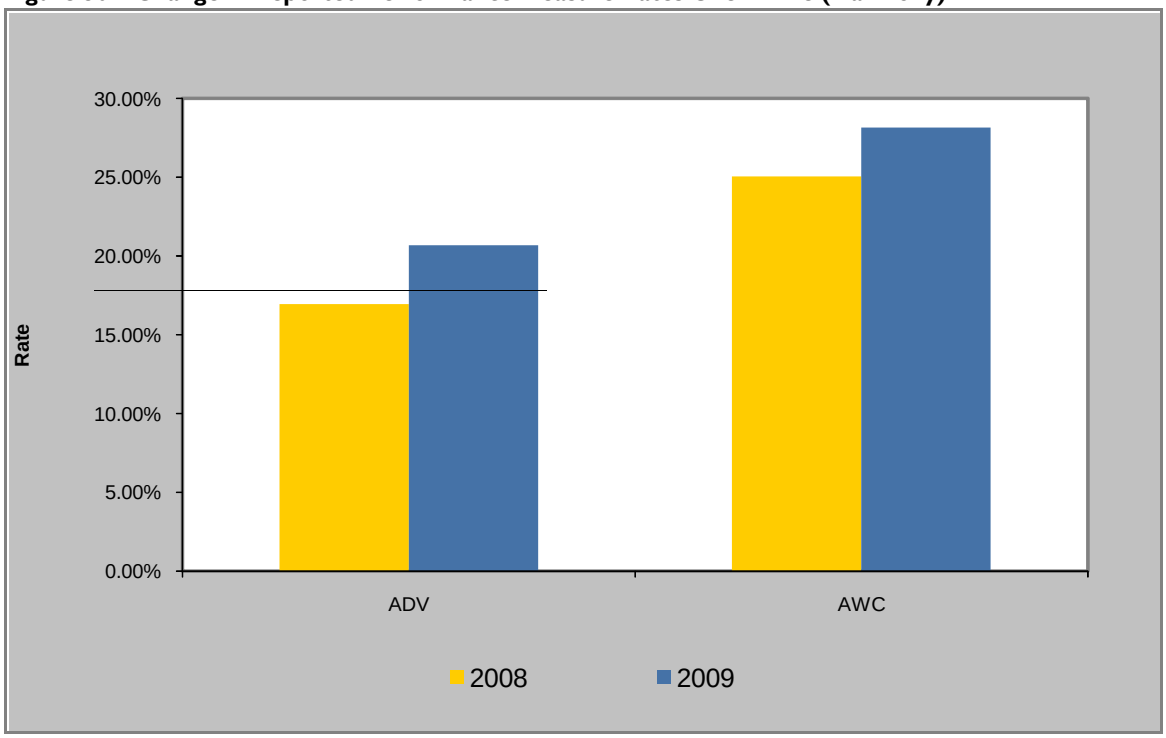
Harmony is a relatively new MO HealthNet MCHP, so there is no data from previous EQR reports with which to compare the FUH rates at this time.

Table 60 – Reported Performance Measures Rates Across Audit Years (Harmony)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate
Annual Dental Visit (ADV)	NA	NA	16.94%	20.68%
Adolescent Well-Care Visits (AWC)	NA	NA	25.06%	28.17%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	NA	NA	NA	24.66%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	NA	NA	NA	39.73%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 50 – Change in Reported Performance Measure Rates Over Time (Harmony)



Sources: BHC, Inc. 2008 and 2009 External Quality Review Performance Measure Validation Reports

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 CMS Protocol 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 MedMeasures software system. The accompanying MedCapture system was also demonstrated; this system allows for the calculation of the Hybrid hits from the input medical record data.

For all three measures, Harmony 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 2009 measures. Although the data was complete, the administrative data for the Follow-Up After Hospitalization for Mental Illness measure was not provided to the EQRO in the format requested. Excess columns were added to the original data request format and therefore required additional processing.

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). Harmony met all criteria applicable for all three measures. Harmony does utilize statistical testing and comparison of rates from year to year.

PROCESSES USED TO PRODUCE DENOMINATORS

Harmony 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 Follow-Up After Hospitalization for Mental Illness measure, 73 eligible members were reported and validated by the EQRO. For the denominator of the Adolescent Well-Care Visits measure a sample of 411 eligible members were reported and validated. The Annual Dental Visit denominator included 3,525 reported and EQRO-validated eligible members. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2009 criteria.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, follow-up visits, and dental visits) as specified by the HEDIS 2009 criteria (see Attachment XIII: Numerator Validation Findings). A medical record review was conducted for the Adolescent Well-Care Visit measure.

For the HEDIS 2009 Annual Dental Visit measure, the EQRO validated 725 hits from administrative data, while 729 were reported. The health plan's reported rate was 20.68% and the EQRO validated rate was 20.57%, resulting in a bias (overestimate by the health plan) of 0.11%.

For the Adolescent Well-Care Visit measure, Harmony reported 100 administrative hits from the sample of the eligible population; the EQRO's validation of the data yielded 115 hits. For the medical record review validation, the EQRO requested 18 records. A total of 18 records were received for review, and all 18 of those were validated as hits by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 32.36%, while the plan reported a total rate of 28.71%. This represents a bias of 3.65%, an underestimate by the health plan.

For the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure (7-day rate), the health plan reported 18 hits, and all 18 were verified by the EQRO. This yielded both a reported rate and a validated rate of 24.66%.

The number of hits reported by Harmony for the Follow-Up After Hospitalization for Mental Illness measure 30-day follow-up was 29; the EQRO found 29 valid hits. The rate reported by the health plan and the rate validated by the EQRO were both 39.73%.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Harmony 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 shows the estimated bias and the direction of bias found by the EQRO. The Annual Dental Visit measure was slightly overestimated and the Adolescent Well-Care Visit measure was underestimated, but these results still fell within the 95% confidence interval reported by the health plan for these measures. There was no bias found for the Follow-Up After Hospitalization for Mental Illness measure.

Table 61 - Estimate of Bias in Reporting of Harmony HEDIS 2009 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.04%	Overestimate
Adolescent Well-Care Visits	3.65%	Underestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	No Bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	No Bias	N/A

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 54 shows the final audit findings for each measure. The Follow-Up After Hospitalization for Mental Illness measure was determined to be Fully Compliant. The Adolescent Well-Care Visits and Annual Dental Visit measures were Substantially Compliant.

Table 62 - Final Audit Rating for Harmony Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	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 health plan. 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 MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were reported and validated for Harmony. All three of these rates were significantly lower than the average for all MO HealthNet MCHPs.

QUALITY OF CARE

Harmony's calculated rate for the HEDIS 2008 Follow-Up After Hospitalization for Mental Illness measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. Both the 7-day and 30-day rates reported by the health plan for this measure were significantly lower than the average for all MO HealthNet MCHPs, as well as below both the National Medicaid and National Commercial Averages. This indicates that Harmony members are receiving a lower quality of care, for both the 7-day and 30-day timeframes, than the average MO HealthNet, National Medicaid, and National Commercial members.

The EQRO was able to completely validate this rate and thereby has extreme confidence in the calculated rate.

ACCESS TO CARE

The calculated rate by Harmony for the HEDIS 2009 Annual Dental Visit rate was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The health plan's reported rate for this measure was significantly lower than the average for all MO HealthNet MCHPs. Harmony members are receiving a quality of care that is lower than the level of care delivered to the average MO HealthNet Managed Care member. This rate is also lower than the National Medicaid Average, indicating the health plan's members receive a lower access to care than the average Medicaid member nationwide.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2009 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was significantly lower than the overall MO HealthNet MCHPs calculated rate. Harmony's members are receiving the timeliness of care for this measure at a lower level than the care delivered to all other MO HealthNet Managed Care members. This rate was lower than both the National Commercial Rate and the National Medicaid Rate, indicating that Harmony's members are receiving the timeliness of care for this measure at a lower level than the average Commercial or Medicaid member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. All three of the rates validated for this health plan were significantly lower than the MO HealthNet averages. The EQRO recommends that the health plan focus on these rates to reverse this trend.
2. One of the rates validated for this health plan showed a bias of underestimation. The EQRO recommends that the health plan review their data collection, integration, and measure calculation practices to help alleviate this issue.
3. Continue to conduct and document statistical comparisons on rates from year to year.
4. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.

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 34,722 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant 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, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 96.4% complete, accurate and valid. The remaining values were blank (n= 4128).
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. The second, third, fourth and fifth Diagnosis Code fields were well below the SMA threshold of 100.00% for completeness, accuracy and validity. The Diagnosis Code fields were 27.4%, 25.5%, 14.0% and 1.1% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate and invalid).

For the Dental claim type, there were 3,976 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. Harmony had 100.00% complete, accurate and valid data for all fields examined.

For the Home Health claim type, there was zero (0) encounter claim paid by the SMA for the period July 1, 2009 through September 30, 2009.

For the Inpatient claim type, there were 4,643 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 valid.
5. The Discharge Date field was 100.00% complete, accurate and valid.
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. All Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (89.87%, 75.09%, 66.42%, 57.01% and 37.80% respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
9. The First Date of Service field was 100.00% complete, accurate and valid.
10. The Last Date of Service field was 100.00% complete, accurate and valid.
11. The Revenue Code field was 100.00% complete, accurate, and valid.
12. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 15,466 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. Harmony had 100.00% complete, accurate and valid data for all fields examined, except the Procedure Code, second, third, fourth and fifth Diagnosis Codes.

1. The Procedure Code field was 96.7% complete, accurate. The remaining fields were blank (n=508). The field was 95.5% valid, as invalid codes (n=181) were observed.
2. The second Diagnosis Code field was 49.8% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).
3. The third Diagnosis Code field was 29.8% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).
4. The fourth Diagnosis Code field was 16.1% complete, accurate, and valid. The remaining Diagnosis Code fields were blank (n = 12,973).
5. The fifth Diagnosis Code field was 8.8% complete, accurate and valid. All remaining Diagnosis Code fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 21,409 claims paid by the SMA for the period July 1, 2009 through September 30, 2009. MO Care had 100.00% complete, accurate and valid data for all fields examined.

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

For the Dental, Inpatient, and Pharmacy claim type, all critical fields examined were 100.00% complete, accurate and valid data for all fields examined.

For the Outpatient Medical and Hospital claim types, there were missing codes in the Procedure Code field.

There were zero (0) claims in the Home Health claim type paid by the SMA for the period July 1, 2009 through September 30, 2009.

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 Harmony , 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, other than the Procedure Code fields of the Outpatient Medical and Hospital claim types, were 100.00%.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Harmony demonstrated rates statistically lower than the average for all MO HealthNet MCHPs for the Outpatient Hospital claim type. All other rates were comparable to the average of all MO HealthNet MCHPs.

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 health plan were randomly selected from all Outpatient claim types for the period July 1, 2009 through September 30, 2009 for medical record review. Of the 54,187 Outpatient encounter claim types in the SMA extract file for July 1, 2009 through September 30, 2009, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 60 medical records (60.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated.

For the 2009 review, the match rate for procedures was 42.0%, with a fault rate of 58.0%. The match rate for diagnoses was 41.0%, with a fault rate of 59.0%.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed was conducted.

For the procedure codes in the medical record, the reasons for diagnosis codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 55) and incorrect information (n = 4). 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 was missing information (n = 50) and incorrect (n = 8). Examples of incorrect information include codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Harmony included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet MCHP encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as

those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

Harmony submitted 30 "unpaid" claims and a total of 325 "denied" claims. Of those claims 20 ICN's were included, none of these ICN's were found in the SMA encounter claim extract file, as should be expected.

Why are there unmatched claims between the MO HealthNet MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

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

While the MO HealthNet MCHP 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. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the health plan data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet MCHP 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.

CONCLUSIONS

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 claim types submitted resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.

AREAS FOR IMPROVEMENT

1. The health plan should consider requesting medical records directly from providers to determine the quality of records being sent to the EQRO for review. The receipt of incomplete records contributed to the health plan's low rates of Diagnosis and Procedure Code matches.
2. The health plan should strive to supply all medical records requested, records not received cannot be validated and therefore contribute to low match rates.

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
2. Run validity checks after the programming of new edits.
3. Continue to work with the SMA to resolve the compatibility issues between the Encounter claims system so that the MCHP can submit and be paid for all member encounters.

8.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet MCHP's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). 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. Prior to the on-site review Case Management cases were reviewed by the EQRO for compliance with policy and to ensure that practice reflected policy requirements. On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. Interviews occurred with Case Management Staf, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds the federal regulations.

Additional document review, including reading and evaluating the Health Plan's 2009 Annual Appraisal of the Quality Improvement Program, occurred prior to the on-site review. The Health Plan assisted the on-site review team by providing additional documents at that time. This process was used to validate that practices and procedures were in place to guide organizational performance and were in compliance with the State contract and federal regulations.

The interview questions posed to Case Management staff were generated by the cases reviewed as well as the review of Health Plan Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the Health Plan processes. Additionally, interview questions were formulated for Administrative staff to validate and clarify these practices, to follow-up on questions raised from the case management staff interviews, and to respond to questions that arose from the document review. Interview questions were also developed from the Harmony's Annual Evaluation, and the SMA's Quality Improvement Strategy, .

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- 2009 Harmony Health Plan of Missouri's Managed Care Annual Report

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2009 Marketing Plan and Materials
- Case Management Policies
- 2009 Quality Improvement Committee Minutes

Additional documentation made available by Harmony included:

- Marketing Plan and Educational Material Development Policy
- Harmony Care Organizational Chart
- Grow Missouri Training Curriculum
- Harmony Health Plan of Illinois – Physician's Scorecard

INTERVIEWS

Interviews were conducted on-site at Harmony Health of Missouri's St. Louis offices on July 14, 2010 with the following:

Case Management and Member Engagement Staff

Current Case Managers for Missouri –
Roxanne Cropp – Case Manager, Transplant 5 States including Missouri
Robin Clark (T) – Case Manager, MO
Sandy Verrechio – Case Manager, MO

Member Engagement Staff—
Karen Mejea – Supervisor with Member Engagement Duties
Suzette Torres – Member Engagement
Melinda Riveria – Member Engagement
Brenda Biro – Member Engagement (Florida Special Needs/Multi-State)

Plan Administration

Vijay Kotte – Region President
Dr. Olusegun Ishmael – Medical Director
Carole Ouimet – Senior Manager, Regulatory Affairs
Ramona Kaplink – Manager, Accreditation and HEDIS
Ellen Gallagher – Senior director, Corporate Network Serivces
Margaret Pryce – Manager, Member Engagement

Susan Arias – Manager, Case Management
Lori Harris – Senior Director – Case & Disease Management
Beverly Chase – QI Specialist
Tracy Brown – Manager, Clinical Compliance and Audit
Brian Gibson – Manager, Case Management and Concurrent Review

The following are the interview questions used during each interview at Harmony:

Case Management and Member Engagement Staff Interviews

- What information triggers you to become involved with a family and provide active case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members. What makes a member eligible for care coordination or case management services?
- What are the requirements for contacting members before a case is closed?
- What actions are taken to assist members in finding PCP's in their geographic area? How often do members complain that all the PCP's they contact have closed panels?
- What additional action is taken to identify members with special needs?
- What case management policy do you currently follow?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members in general, and specifically members with mental health care needs.

Findings

Harmony was asked to submit thirty (30) case management files for review, as were all the health plans. They originally reported that they had no case management cases from the first quarter of 2009. Based on discussions with the SMA, a listing was pulled of all referrals from the SMA listing "Children with Special Health Care Needs," from that period of time. The health plan was then asked to submit a random pull of thirty (30) cases from that listing. At that time the health plan reported that there were case management cases open, but not cases identified as being "complex case management." A listing was submitted and a random pull of thirty additional cases was requested, to create a case listing comparable to the remainder of the health plans. All sixty (60) cases were reviewed for the types of actions and activities that occurred during the time frames in question.

There were a number of problems identified in the cases reviewed. Many of the cases were coded as "unable to contact." In one record a child identified as "special needs" received a prior authorization approval for diapers. At the next contact, the prior authorization was

denied. There was no explanation of this change, the case record indicated that there was no "par" facility in the families' county of residence, and the case was closed for inability to contact. Another case was identified as a referral from the SMA's special needs report. An identified child's lead level was 14 mcq per dl. There was no telephone number included in the file, and the available case notes indicated that a responsible provider could not be located. The case was closed.

In another case the member was identified as a diabetic through a prior authorization for an insulin pump. An aunt responded to an "unable to contact" letter, and explained that the grandmother was the guardian of these children. A telephone number for the grandmother was provided. The case was closed stating that there was no contact because "the member does not have a current phone number listed." A pregnant member was living in a homeless shelter with three small children. According to available case notes, the case manager contacted the member and promised an ongoing contact in two weeks. A referral was made to the Harmony HUGS program. However, the next case management note, dated six weeks later, indicated the "member termed our program." No explanation or additional follow up was included. Another pregnant member was found to be having difficulties due to having only one kidney. There was a note that a home health nurse was needed, following delivery of the baby. The next note indicated that the member had delivered and the case would be closed.

The cases reviewed were difficult to follow and appeared to contain a consistent lack of documentation. Assessment information and case management goals were not included. In most cases three attempted contacts prior to closer could not be located. The files did include some member services notes, a few prior authorizations, and cryptic, but incomplete, case management notes. In many cases a contact was made with the PCP office listed. When the Member Engagement worker learned that the PCP was not familiar with a member, an "Unable to Contact" letter is sent, and the case is closed. As a result many of the questions to the case managers focused on what they viewed as the case management responsibility and the need to produce records that could verify any work conducted.

The case managers interviewed were located in Tampa, Florida. The interviews were conducted through a conference call. The member engagement staff reported that they are assigned cases "within a few days" of the health plan receiving a referral. They attempt to make

original contacts with members, prior to assignment to an actual case manager. Their explanation of their role included a comment that "Missouri is now receiving more on-site recognition" and that they believed communication with case managers about Missouri cases was improving. More case managers are now assigned to the Missouri project. The Member Engagement staff was aware that they were to make three attempts to contact members. If they had no success they then closed cases without any further activity by a case manager. They could not describe any "valiant" attempts to contact members. Both the member engagement staff and the case managers were aware of policy and procedures specific to the Missouri market. They also had access to the Missouri contract.

The Member Engagement staff does a "mini-screening" with referrals and "stratify" cases. This stratification creates criteria that trigger a referral to case management or case closure. They reported that if a case did not meet case management criteria, but there was a "red flag", they would consult with a case manager for a final decision about opening or closing the case. After assignment case managers have three (3) business days to contact members. The case manager then again attempts to contact the member, reminds them that inclusion in case management is voluntary, and then develops a care plan with the member. They often refer members to community resources, ensure that the member is aware of their primary care provider, and ask about disease management issues. They describe their assessment process as including a psycho-social component.

The case managers were aware of community resources by using the Salvation Army and calling the United Way 211 number. They did admit that they are only peripherally aware of resources outside of the St. Louis area. The case manager specifically assigned to Lead Case Management was very aware of the resources available through the St. Louis City and County Health Departments. However, this case manager was not aware of resources or contacts in health departments in any counties outside of St. Louis City or County. She did not believe they received referrals in any other counties.

The case managers reported having a varying number of cases. The caseloads ranged from approximately 30 to 70 cases. These caseloads were not all Missouri cases. The OB case manager reported having 70 cases, 15 of which were Missouri members. The health plan had employed a local case manager who receives referrals and makes home visits to families as

needed. She had made 12 home visits prior to the on-site review in 2010. She could not report on home visits made during 2009.

The case managers did discuss the disease management program. They actively refer to Disease Management, particularly if their case management case is being closed. They also receive referrals from Disease Management if the member or family has complex service needs. Both groups make referrals to behavioral health if necessary.

The Lead Case Manager did provide an example of working with a 3 year old member who was admitted to the hospital with cold symptoms and a lead level of 44. The family was referred to the health department and within a month the child's lead level was down to 12. The case manager did follow-up and ensured that the health department was assisting with improving the home environment. New paint had been applied and other problem areas were rectified. The parents were very concerned and were engaged in improving their living environment.

The case managers reported that there are many of the "systems" in place to facilitate good case management. The health plans case management system is being upgraded so that assessments and case notes are available within the system. New staff members are receiving enhanced training. The case managers stated that as they learn about additional local resources, they feel more competent in dealing with Missouri members. No examples of improved case recording or enhanced case management were available for review. The case managers could not demonstrate or provide concrete examples of system improvements. The case managers also reported that they believe they may be receiving training on "motivational interviewing." They believe this process will also assist in their ability to communicate with members.

They admit that there are many barriers in working with a case management market that is far removed from their location. They also understood that they do not have a thorough understanding of community resources, particularly outside of St. Louis City.

After the interviews were complete, the case managers identified a number of cases where services were provided. Eight cases were copied and sent for further review. In these eight cases, all dated in June 2010, not part of any random sample, case management services were identified. In a number of cases the contacts were with the provider office. In one case there

was a note that "the provider was asked if he was satisfied with the services received." In this case there was no apparent contact with the member.

Administrative Interviews

- What is the status of policy submission and approval?
- Give examples of any measures the Health Plan implemented to improve the follow-up process for members included in the State's Special Needs report.
- Has the Health Plan undertaken initiatives to reduce the number of mental/behavioral health practitioners in the outlying counties?
- How does the Health Plan handle cases where problems are identified with specific providers? Do case managers receive feedback?
- What feedback has the Health Plan received from outreach activities?
- Explain attention being given to case management activities and any quality initiatives underway.

Findings

The current health plan administrator discussed changes currently being made in the Missouri product in great detail. He explained that the health plan is exercising greater oversight and a much more "hands on" approach to managing this contract. The health plan is conscious of the cultural diversity in the MO HealthNet Managed Care region and is attempting to improve their methods of meeting member needs. One example provided was the attention to policy and procedures specific to their Missouri contract. In the past the health plan has utilized policy that was pertinent to other products and they recognize that this has been ineffective. They are in the process of submitting policy to the SMA that is specific to the Missouri contract and better sets out the expectations and requirements of the contract.

There is a new medical director for Missouri. He is actively involved in improving relationships with providers and resolving issues that arise. The medical director is conducting follow-up on all cases that are reported as "closed" when case managers, health plan staff, or members attempt to contact them. The medical director has an active medical practice in St. Louis and East St. Louis, and is involved with other local physicians. He is familiar with the St. Louis area FQHCs and has a positive working relationship with these entities.

The Quality Improvement Coordinator is actively involved in the Missouri product. She is working on focusing the health plan staff on quality improvement issues. Quality initiatives, specific to Missouri, will be followed on site and not supervised remotely. This individual has

experience with accreditation, and is overseeing the Harmony initiative to become NCQA certified. The QI Coordinator admits that she is not completely familiar with the Missouri product, but is learning the regions' demographics, and service needs. The health plan staff all indicated that previous efforts had focused on marketing their product in the region. This focus has changed to a focus on quality services, as this is seen as the fastest path to both improvement and growth. The plan administrator stated that his commitment is to creating a health plan structure that assures positive outcomes for all health plan activities. Goals include service issues such as improved access to care, reduction in NICU days, and improved HEDIS results.

The health plan reports that they now have access to the MOSAIC system and are using it. This provides increased access to case managers regarding their home counties and local county health departments. The health plan is also working to ensure that they case managers have the proper information regarding members' PCP of choice.

The administrative staff stressed that their current initiatives focus on services and member satisfaction. They reiterated the switch from a focus on marketing to a focus on improved service accessibility and quality.

ENROLLEE RIGHTS AND PROTECTIONS

Harmony is a part of WellCare Health Plans, Inc., whose home offices are located in Tampa, Florida. Harmony has been providing Medicaid Managed Care Services in states other than Missouri for a number of years. The behavioral health organization providing services is another WellCare subsidiary, Harmony Mental Health. This group assumed responsibility for providing behavioral health services on September 1, 2007 and is reported to be working satisfactorily.

The Health Plan reported having approximately 16,000 members at the time of the on-site review. The predominant health plan population continues to be pregnant women and children according to Harmony data. The majority of members reside in St. Louis City and County, but their member population and their provider network is expanding to all of the counties in their service area. The health plan reports to be striving to upgrade their service delivery system and to ensure that staff and programs provide quality care for their members. The health plan

reports that they track the ethnicity of members through use of the enrollment questionnaires, from questions asked during Welcome Calls, and other personal contacts made with members. They utilize the TTY-TDD lines available through AT&T when they learn that a member is more comfortable communicating in a language other than English. Harmony does employ staff with different language capabilities, but they use all the tools available, such as the AT&T language line to ensure that linguistic needs are met.

The health plan medical director, Dr. Ishmael, is an active member of the health plan team. It is the Harmony's goal to improve community partnerships, to enhance staff engagement, and to lay ground work for future growth. Dr. Ishmael has a medical practice in the St. Louis area, is involved in community initiatives, and has developed a strong working relationship with the FQHCs. He is providing oversight of provider issues, and does follow-up on all cases brought to his attention. Dr. Ishmael has continued health plan projects such as the Medical Advisory Committee. This committee provides oversight of Customer Service Initiatives, such as the development and use of the Customer Satisfaction Survey. The Medical Advisory Committee reports its findings to the Physicians' Committee, which has led them to believe there continues to be a need for outreach and provider education.

The health plan continues to operate a Consumer Advisory Work Group. This Group reviews the information provided by the Customer Satisfaction Survey. They assist in developing training topics. In the past year training has included Compliance Training which has focused on correctly interpreting policy and procedures specific to the Missouri project.

The Case Management Team, which includes Member Engagement staff, is located at the Health Plan facility in Tampa, Florida. Case management specialties include lead, special health care needs, and complex case management. Members receive case management at their request or if referred by a provider, hospital staff, or from the information listing received from the SMA. There is now a case manager located in the Missouri office of the Health Plan who does make community and direct member contact when a member's situation dictates this level of intervention.

Case managers receive referrals from internal and external sources, which are screened by Member Engagement. If a case management case is opened, an assessment is completed on each

member referred. Contact information remains the most significant barrier to timely and effective member engagement. Member contact with case managers is by telephone. The case managers discussed the importance of gaining and maintaining contact with members who are considered as High Risk/Obstetrics (OB) patients. The case managers are aware that their role is to ensure that the member is obtaining services and that a care plan is in place. The Case managers state that they communicate with other members of the health plan staff, such as concurrent review nurses, primarily when they are a referral source. They are not limited in their work by the utilization review process. The OB Case Managers work with the member and provide follow-up to make appointments, arrange transportation, refer to the Women, Infants, and Children (WIC) program, and to enroll them in the Harmony HUGS program.

Harmony does have an active Obstetrics Program for pregnant women. The focus of the program is to send out OB notification forms, conduct direct member outreach, and complete a thorough needs assessment. The health plan reports that it makes an immediate referral for behavioral health services when a need is assessed, and also makes referrals for postpartum support. The Harmony network does include Peoples Clinic and Grace Hill, two St. Louis area Federally Qualified Health Centers (FQHCs). The health plan regards their relationship with the FQHCs as vital to ensuring adequate access to care for members. Provider Representatives conduct monthly visits to the FQHCs to maintain this resource.

Harmony has developed a system where they provide lists to PCPs and Provider Groups of members who are not compliant with EPSDT examinations and/or immunizations. Providers are requested to ensure that records are up-to-date. They are asked if examinations or immunizations have occurred, if they are aware of updated contact information, and if they have contacted the member regarding preventive health needs. The FQHCs also participate in this process. The providers are approached about the need to contact members to encourage them to obtain these services.

The health plan states that they have had some problems in the past with the Case Management and Utilization Review departments being too interconnected. They have worked to empower case managers to make member focused decisions, while working collaboratively with UR nurses when appropriate. The two departments' communications have improved with the implementation of the EMMA case management system.

The rating for Enrollee Rights and Protections (69.2%) reflects a lack of complete and approved policy and procedures. This is the Health Plan's third full compliance review. They continue to submit policy to the SMA, who reports that completing the approval process is improving with the development of MO HealthNet contract specific policy. The Health Plan did not demonstrate any type of established tracking and internal processes to ensure responses to the SMA and completion of all required policy, at the time of the on-site review. Harmony exhibited a businesslike approach and commitment to continue their efforts to improve in the area of policy submission and completion. They state the goal of partnering with the SMA to ensure compliance with the State contract and with all required federal regulations.

Table 63 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2007	2008	2009
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	1	1	1
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	0	0	1
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	0	1	1
438.100(b)(3) Right to Services	1	1	1
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	9	9	9
Number Partially Met	3	3	4
Number Not Met	1	1	0
Rate Met	69.2%	69.2%	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., 2004 External Quality Review Monitoring MCOs Protocols.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

Harmony continues to make an effort to improve in the area of access standards. The health plan is submitting policies and procedures to the SMA for annual review as required. They are actively working to increase their provider panel throughout the MO HealthNet Managed Care Eastern Region, including active recruitment in the counties outside of St. Louis City and St. Louis County. The Behavioral Health Provider Network is also continuing to grow.

The Administrative staff reports that they continue to focus on recruiting providers and urgent care centers with after-hours access. Physicians were contacted regarding their contractual requirements to provide after-hour access to services. A number of physician groups hired additional doctors. Additionally, the health plan was able to contract with urgent care centers that provide after-hours access to care. Educational counseling was also conducted with PCPs and other physicians regarding providing adequate access to care.

Case managers relate that they do assist members in obtaining appointments and locating the health care services the member requires. They also discussed how they handle situations when a member reports receiving an adverse action decisions regarding an authorization. The case manager explains member benefits and assists the member in contacting the Appeals Department.

Ratings for compliance with Access Standards (47.05%) reflect that although the health plan continued its efforts to submit required policy that meets the requirements of the MO HealthNet Managed Care contract and federal regulations, it does not have complete policy and practice to be considered compliant. Harmony voiced their willingness to continue their efforts to develop necessary policy and practice to be in full compliance and to obtain full compliance. Observations made at the time of the on-site review indicated that these efforts were continuing and that practice is being improved that will support both the State contract requirements and the federal regulations. The health plan expresses the desire to be in full compliance with these requirements, yet continues to have work to do to satisfy this goal.

Table 64 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2007	2008	2009
438.206(b)(1)(i-v) Availability of Services: Provider Network	1	1	1
438.206 (b) (2) Access to Well Woman Care: Direct Access	1	1	1
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	1	1	1
438.208(c)(1) Care Coordination: Identification	1	1	1
438.208(c)(2) Care Coordination: Assessment	1	1	1
438.208(c)(3) Care Coordination: Treatment Plans	1	1	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	1	1
438.210(b) Authorization of Services	1	1	1
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	1
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	9	9	8
Number Partially Met	8	8	9
Number Not Met	0	0	0
Rate Met	52.9%	52.9%	47.05%

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.

Structures and Operation Standards

Harmony continues to develop their credentialing standards. The health plan assures that all providers maintained licensure and the right to practice in Missouri. The health plan developed a work plan to ensure that the remaining provider list would be current during the coming year. The health plan reported that they are current on all providers due for credentialing and that NCQA standards are utilized in conducting credentialing audits. The health plan does not yet have approved provider credentialing policy.

The health plan operates a dedicated quality improvement program that includes an active Medical Advisory Committee. They also operate physician outreach and education programs to enhance their ability to communicate and support providers. This includes one-on-one physician education sessions. They utilize provider newsletters and other outreach activities to provide information and feedback to the provider network.

Health plan staff appears to have knowledge of the policies and procedures to utilize if a member calls and requests disenrollment. They do ask questions to reason with members and to identify the type of problem and if a resolution is possible. When they can assist with problem resolution, they often find that the member no longer wishes to pursue disenrollment. Another cause of members' request for "opt outs" is daily eligibility and auto assignments. The members give the health plan staff the reason as "network issues, or they can not go to the PCP or specialist of their choice."

The rating for Structure and Operation Standards (60.0%) reflects the efforts the Health Plan has made for the past year of submission of policy to the SMA for their review and approval. The health plan has made an effort to submit all required policy, but has not returned corrected policy in a timely manner. The health plan understood that continued efforts in this area is required and that validation of all practice in this area cannot be considered compliant until approved policy is in place. Observations at the time of the on-site review support that Harmony has a commitment to completing and improving areas that may be viewed as problematic.

Table 65 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2007	2008	2009
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	1	0
438.214(c) and 438.12 Provider Selection: Nondiscrimination	1	1	1
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	1	1	1
438.230(a,b) Subcontractual Relationships and Delegation	2	2	0
Number Met	7	7	6
Number Partially Met	3	3	2
Number Not Met	0	0	2
Rate Met	70%	70%	60%

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.

Measurement and Improvement

Harmony has developed and implemented specific practice guidelines with providers at the time of the 2009`review. The health plan reports that they actively employ and distribute clinical practice guidelines for Adult Prevent Services, Asthma, Chronic Health Failure, Diabetes Mellitus in Adults, Hypertension, Cholesterol Management, Chronic Kidney Disease, Adult and Pediatric Obesity, Pediatric Preventative Health and Preconception Perinatal Care. These guidelines are reviewed and approved by the Medical Advisory Committee prior to implementation. This information and methods for utilizing these guidelines are distributed to all health plan providers.

Harmony is continuing to develop their Quality Assessment and Performance Improvement activities during 2009. Their Quality Improvement group meets regularly and includes local physicians who actively participate. The health plan's goal of providing quality services to

members was a significant focus of the health plan's discussions. The health plan reports that the Quality Improvement section is an active and essential part of operations.

Harmony did submit two Performance Improvement Projects (PIPs) for validation. Although these PIPs lacked complete maturity to allow for validation, they indicated that the health plan does utilize this process as a tool for growth. The structure of both PIPs followed the federal protocol and showed potential. These PIPs indicated an understanding of the importance of the PIP process in improving operations and health care services to members.

The health plan was required to submit information for Validation of Performance Measures for validation. All three Measures were available for validation. Harmony continued to operate a health information system within the guidelines of that protocol. Encounter Data was available for validation as requested. The complete details of each of these areas of validation can be reviewed within specific sections of this report.

The rating for Measurement and Improvement (63.63%) reflects the fact that the health plan has submitted and received approved on policy in the majority of the areas evaluated. The health plan is actively engaged in improving their Quality Improvement activities. Although Harmony exhibits practices that have improved, and appear to be in accordance with the State contract requirements, and the federal regulations, they cannot be considered fully compliant until all aspects of their Quality Improvement program can be validated.

Table 66 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2007	2008	2009
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	1	1	1
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	1	1	1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	1	1	1
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	1	1	1
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	1	1	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	1	2
438.242(b)(3) Health Information Systems: Basic Elements	1	1	2
Number Met	4	4	7
Number Partially Met	7	7	4
Number Not Met	0	0	0
Rate Met	36.4%	36.4%	63.63%

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 MO HealthNetManaged Care Program. This percent is calculated for the regulations that are applicable to the MO HealthNet 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

Information regarding a member's grievance is recorded and forward to the Grievance Department in Tampa, Florida. Written information from members regarding grievances and appeals are received by fax, mail and e-mail. The information is logged in the health plan's information system, the member is contacted to obtain clarification and additional information, and an acknowledgement letter is sent to the members. If a provider is involved, the Provider Relations office is notified. If the issue is actually an appeal, the information is then forward to the Appeals Department. Grievances are also referred to the Service Escalation Unit, which works with dissatisfied customers. WellCare has separated their units into Medicaid and

Medicare specialties. This unit attempts to resolve member issues or assist the member in understanding the outcome of the process.

Case management staff relates that they most often become involved is a member receives an adverse reply to a request for authorization. The case managers explain member benefits, and assist the member in contacting the Appeals Department. The case managers feel that they remain involved, if possible, acting as a member advocate through both the grievance and appeals processes.

The rating for the Grievance System (0%) reflects a lack of approval of the policy and procedures required to meet MO HealthNet Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that Harmony has an understanding regarding operation of a grievance and appeals system. However, policy submission, revisions, and approval are not complete.

Table 67 – Subpart F: Grievance Systems Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2007	2008	2009
438.402(a) Grievance and Appeals: General Requirements	1	1	1
438.402(b)(1) Grievance System: Filing Requirements - Authority	1	1	1
438.402(b)(2) Grievance System: Filing Requirements - Timing	1	1	1
438.402(b)(3) Grievance System: Filing Requirements - Procedures	1	1	1
438.404(a) Grievance System: Notice of Action - Language and Format	1	1	1
438.404(b) Notice of Action: Content	1	1	1
438.404(c) Notice of Action: Timing	1	1	1
438.406(a) Handling of Grievances and Appeals: General Requirements	1	1	1
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	1	1	1
438.408(a) Resolution and Notification: Basic Rule	1	1	1
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	1	1	1
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	1	1	1
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	1
438.410 Expedited Resolution of Appeals	1	1	1
438.414 Information about the Grievance System to Providers and Subcontractors	1	1	1
438.416 Recordkeeping and Reporting Requirements	1	1	1
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	1	1	1
438.424 Effectuation of Reversed Appeal Resolutions	1	1	1
Number Met	1	1	0
Number Partially Met	17	17	17
Number Not Met	0	0	0
Rate Met	5.6%	5.6%	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

CONCLUSIONS

Harmony is the newest health plan in the MO HealthNet Managed Care system. The health plan continues to emerge as an important option in the Eastern MO HealthNet Managed Care Region. The staff is able to articulate their health plan's goals and requirements for service delivery associated with the SMA contract and the federal guidelines. The health plan is familiar with the requirements in meeting all written policies and procedures and has improved in receiving SMA approval of the Missouri specific policy that has been submitted. This process is not yet complete. In addition, the health plan has not been able to exhibit that they are able to meet all member service needs, particularly in the area of case management and working with members with special health care needs. They have reportedly implemented a number of improvement strategies, including upgrades to their case management system. However, these improvements were not yet reflected in the cases reviewed for 2009, in the case manager interviews conducted, or demonstrated at the time of the onsite review.

QUALITY OF CARE

The Harmony staff is keenly aware of their responsibility to ensure adequate access to quality healthcare in a timely manner. They realize obtaining full compliance is an essential component in the compliance process. The health plan's efforts and commitment to provide quality of services to members was apparent in meeting with Administrative staff. The health plan must continue to strive to meet all the SMA requirements. They voiced their awareness that creating an environment where all member services meet their quality standards must continue. The health plan staff could cite areas of improvement, yet voiced their awareness of areas where continued efforts are needed.

ACCESS TO CARE

HARMONY has improved their provider network and continues to fully develop all service delivery in their MO HealthNet Managed Care region. The health plan has not met policy and procedure requirements in this area of operation. The case management staff expresses an understanding of the importance of access to care for members and provides examples of their efforts to meet this requirement. The information obtained during the on-site review reflects improved collaboration between departments within the health plan. They hope this will lead to members experiencing a more coordinated or collaborative approach to problem solving.

TIMELINESS OF CARE

Harmony is aware of the importance of timeliness in the provision of health care to members. This is an area where complete and approved policy is the foundation for ensuring that members receive services in a timely fashion, have a timely response to question, and a timely turnaround on issues such as grievances and appeals. Harmony has strong goals, supported by internal leadership, and communicated throughout the organization to meet all of the requirements for policy development and implementation that will ensure that they will become fully compliant in this area, and ensure timely delivery of health care services to members.

RECOMMENDATIONS

1. Continue to develop the atmosphere within Harmony that motivates the attention to compliance with contractual requirements and federal regulations.
2. Continue to enhance internal communication enabling front line staff to have a coordinated and collaborative work environment that supports adequate information sharing.
3. Utilize the resources at Harmony to complete all necessary policy documentation and submission to the SMA.
4. Utilize the Performance Improvement Project process to assess and enhance operations and member services. Submit all PIP topics to the SMA for evaluation when requested.
5. Establish case management practices that encourage active service delivery and improved knowledge of available community resources.
6. Encourage Member Engagement staff to contact members and define them into case management services, rather than an atmosphere where they are assessed out of the need for case management.
7. Support case managers in their efforts to be primary advocates for members and to provide an atmosphere based on the desire to provide excellent health care services to members.
8. Continue to utilize available data and member information in order to drive, change, and measure performance.
9. Continue development of efforts to improve community relations.
10. Provide oversight for behavioral health services to ensure that members maintain provider relationships, and continue to receive the services required.

9.0 Healthcare USA

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9.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

HCUSA supplied the following documentation for review:

- Follow-Up After Hospitalization for Mental Health Services
- Statewide Performance Improvement Project – Improving Adolescent Well Care HCUSA

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 15, 2010, during the on-site review, and included the following:

Jackie Inglis – VP Health Services
Kate Darst – Quality Improvement Director
Rudy Brennan – Quality Improvement Coordinator
Carol Stephens-Jay – Healthcare Consultant
Ann Mugo – Quality Coordinator
Janelle Biermann – Quality Improvement Specialist

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:

- How was the topic identified?
- How was the study question determined?
- Discuss the interventions and the outcomes.
- What were the findings?
- What does HCUSA want to study or learn from their PIPs?

The PIPs submitted for validation included a substantive amount of information. Additional analysis has occurred between the time of the original submission of information and the time of the on-site review. The Health Plan was instructed that they could submit additional information that included enhanced outcomes of the intervention. No additional information was received.

FINDINGS

The first PIP evaluated was the clinical PIP submission entitled "Follow-Up After Hospitalization Project." The study topic presentation explained the research completed in justifying the decision for topic selection. The narrative included national, state and HCUSA specific data that provided support for topic choice. The topic choice was well documented, particularly explaining the impact on members. The justification for the topic choice informs the goal of strengthening partnerships, allowing greater continuity of care, and enhancing transitions between inpatient treatment settings and follow-up care. The project focused on a broad spectrum of services designed to enhance outpatient follow-up services. The goal of the project clearly enhances member services by avoiding additional in-patient treatment whenever possible.

There was no specific study question included in the documentation provided. The health plan submitted the information in the NCQA format, which does not require the development of a study question. This aspect of the PIP is rated as "not met."

The only stated indicator was "Ambulatory Follow-Up rate after discharge from Inpatient Mental Health Hospitalization." This was solely based on improving the HEDIS rate. It is based on the HEDIS technical specifications. However, the narrative indicated that the 2003 baseline was not developed using this process. This leaves a question about the comparability of the data included. The baseline indicator and the specifications of its development were not included in the information provided. The information provided did not provide adequate documentation to determine if the indicators would measure a change in health status, or if they were associated with improved member outcomes.

It can be assumed that the study addressed all members receiving inpatient treatment services. The narrative included did not overtly discuss the population and how they will be identified other than through a reference to the HEDIS technical specifications. The methodology designed to capture all members to whom the study applies was not included. The data collection approach that was used to capture the entire appropriate population was not referenced.

A study design was not included in the narrative or documentation provided. However, the information did include information indicating that data would be collected from programmed pulls from the health plan's claims and encounter data files. It is assumed that this data will be the basis of the HEDIS data that was analyzed. The NCQA form indicated that data would be collected on a quarterly basis and would be analyzed annually. This information is gathered from checked boxes on the NCQA form, and not from narrative included that provided insight into the health plan's processes. A study design that specifies the sources of data or why they are applicable is not present. A systematic method of collecting valid and reliable data could not be verified. The instruments or data collection tools that were used were not provided. As there was no actual study design, no prospective data analysis plan was available. There was narrative for each section of the "analysis cycle," which provided information that might have been included in a prospective plan, but no actual study design precluded the existence of this plan.

The name of the project leader was provided. However her qualifications or role in completion of the study were not specified. No additional information was available regarding team members who may have participated in this study, or the analysis of the data provided.

The interventions utilized in this study, their rationale, and the manner in which they were implemented is described. The intervention barriers and their impact on member behavior are included. However, the PIP is described as ongoing through 2009. The health plan did not include any information based on 2009 data collected.

There was some analysis of the data included in the narrative. However, this analysis was not based on a prospective data analysis plan. The data available through 2008 is provided in detail. The study documentation included tables and graphs regarding the information collected. The

results were explained in sufficient detail in the documentation provided through 2008. There was no preliminary or final information included for 2009.

The narrative does not specify if the same sources of data, the same method of data collection, or if the same tools were used. It appears that the 2003 baseline data was collected in an acceptable manner, but it is unclear if it is comparable to the methodology utilized in collecting and analyzing the HEDIS data. There was an increase in the first year of measurement after implementation of the PIP process and a decrease after the second year. Some explanation is provided but actual reasons for these differences must be assumed. There is no discussion of organizational success and no discussion of the differences experienced in the three MO HealthNet Managed Care regions. In the data collected for the 2007 measurement year, the findings indicated that the interventions applied had some positive effect. During 2008 the results appeared to show a decline in the number of members who received follow-up care in the prescribed time frames. There was no discussion about possible impacts that created this decline, or of the results of the 2009 interventions. There was not adequate data or analysis to make a determination that any observed performance improvement is true improvement. The health plan does not make any statements regarding their belief about the impact of the interventions that they operationalized. It is unclear if the health plan has an opinion about the impact of their interventions in creating any sustained improvement regarding members obtaining follow-up care after an inpatient hospitalization for mental health.

The second PIP evaluated was the HCUSA approach to the Statewide PIP "Improving Adolescent Well Care." This study is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP combined report documentation. The application of this topic to HCUSA members was well researched and included throughout the narrative. The narrative further included an argument of the applicability of this topic to the HCUSA population. The topic selection criteria focused on improving a key aspect of member care, and explained the importance of improving the rates of adolescent well care screenings as an aspect of preventive care. All members of the age group studied, individuals between the ages of 12 – 21, are included. No members are excluded based on the existence of special health care needs.

The HCUSA specific study questions presented are: "Will provider reminders and provider education improve the HEDIS rate of adolescent well care?" "Will member reminders improve the HEDIS rate of adolescent well care?" "Will member and provider reminders in tandem improve the HEDIS rate of adolescent well care?" The Health Plan specific questions relate this study to their members and are focused on improving their outcomes, however these are the identical questions presented in the 2008 study. The protocols clearly state that: "if a PIP is continued from year to year, each year should include new and updated interventions to show that the PIP retains validity and the ability to affect change in organizational functions that will improve member services, or enhance outcomes for members."

The indicators concentrated on the HEDIS rates which are quantifiable. The narrative did lack a discussion about the importance of this measure in improving the quality of member health care. The narrative indicates that the health plan recognizes that improving the rates of Adolescent Well Care may result in higher rates of prevention of adolescent related risky behaviors, such as drug use and unsafe sex. There is no measurement or study of the impact of these behaviors included in this study. The information provided clearly led the reader to understand that the focus of the study is to improve compliance with obtaining well care screenings, which may translate into improving outcomes regarding better adolescent health care. The population served by this study includes all three MO HealthNet Managed Care regions. Results are to be defined by region.

The initial study design information relies on the information developed for the statewide combined report. The study designed presented in the 2009 report was specific to HCUSA, and to their methodology for obtaining data. The health plan did include a discussion of how the Coventry Data Warehouse (CDW) will be utilized. How data will be extracted and reported is available. This data will be tracked and analyzed quarterly. The health plan uses NCQA certified software to calculate their HEDIS results, ensuring consistent and accurate data collection. The study design discussed the systematic method, using NCQA certified software, in which the data was to be collected. In addition the health plan reviews the data internally. The methodology for determining statistical significance was available. It was clear that the instruments to be used for data collection would create accurate and reliable data. The documentation further describes how the HEDIS and other annual data measures were to be

analyzed and reviewed within the health plan. The final rates were to be tested for statistical significance using Chi-square analysis. The effectiveness of the interventions is to be assessed with interim and final HEDIS rate production. Comparisons are to be made between regions and compared to the national Medicaid benchmark. In addition tracking interventions are to occur quarterly to assure that the interventions are implemented as planned.

The health plan specific intervention implemented included Customer Service electronic flags for missed appointments; a script for contacting members when these flags appear; and a comprehensive member and provider reminder system. The interventions were described in detail. An intervention tracking log was presented with the HEDIS 2009 and 2010 barriers, interventions and timeframes explained. All information was focused and measurable. It also showed how the health plan would provide evidence that they had an impact of adolescent well care visits.

An analysis of the findings was included. This analysis did specifically follow the presented data analysis plan. Each year's interventions and outcomes were reviewed. The information, including tables and graphs, was explained in the narrative included. The tables and graphs that highlighted the work produced were clearly presented, accurate, and understandable. The accompanying narrative was not only explanatory, but it provided the health plan's assessment of the outcomes presented.

The health plan presented information including baseline and repeat measurements. It included barrier analysis and any environmental factors that might have an impact on outcomes were explained. The analysis looked at the results regionally, and attempted to analyze statewide outcomes. The information provided did discuss the validity of the interventions and their relationship. The health plan included information on next steps in intervening to continue to improve the number of adolescent well care exams. They discussed a two-pronged approach for member and provider reminders for the remainder of the 2009 calendar year, which is a part of the intervention process. The 2009 update was included in the information provided. The health plan did analyze their outcomes based on the interventions implemented to date.

The calendar year 2007 PIP created a baseline measurement. The information from the original PIP was based on the statewide intervention effort. The interventions implemented were the same across all health plans. In calendar years 2008 and 2009, individual health plan interventions were implemented. The measurement methodology and baseline were used consistently. The health plan speculates that the attention placed on the issue of adolescent well care has created a number of improvements. Not only have the adolescent well care visits increased, but billing errors and other barriers to adequate measurements were corrected. The health plan believes that the coordinated effort, and focus on both member and provider reminders continue to have merit and should continue to positively impact this measure. Although the improvement seen at the end of 2008 was not as significant as in 2007, they are continuing their interventions focused on improving the availability of these visits for members.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The non-clinical PIP seeks to improve the rates of adolescent well care screenings that occur for Health Plan members. If the health plan continues to engage in appropriate follow-up it may be able to identify members who are not receiving screenings and continue to positively impact their behavior. The interventions described in the clinical PIP are clearly targeted to improve the quality and effectiveness of health care services for members who had a hospitalization for a mental health issue. By assisting members in obtaining timely after-care services, they should be able to stabilize effectively.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members received outpatient mental health in a timely fashion. However, this Performance Improvement Project was not sufficiently documented to make strong assumptions about its goals or effectiveness. The non-clinical PIP also included the theory of improving services by ensuring that members received well care screenings for a population that has been previously

hard to serve. The supporting documentation indicating how these PIPs would improve access to services was evident throughout the project.

TIMELINESS OF CARE

The services and interventions used in the clinical PIP may have the specific outcome of improving the timeliness of appropriate services for any member who has been hospitalized as the result of a mental health issue. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcomes were not analyzed as current information was not provided. Timely access to care was a main focus of this project. The non-clinical PIP considered timeliness in looking at the members obtaining adolescent well care screenings yearly. The narrative provided discussed how the interventions employed would improve the members' awareness of the need for annual screenings, and reduce barriers to obtaining these services.

RECOMMENDATIONS

1. HCUSA has attempted to improve the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The non-clinical project information clearly supported the goal of improving services and benefits to members in a timely manner. The information provided for the clinical PIP was limited and did not allow a thorough or complete evaluation of the work completed. Narrative information, responding to the requirements of the PIP protocols, is required to adequately assess theses project. Use of the NCQA forms does not provide the information required to complete this evaluation.
2. The format of all PIPs should contain complete narrative information on all aspects of the project to ensure that the project is understandable and complete.
3. The health plan should continue to address how their projects are extended to and pertinent to all the MO HealthNet Regions served. Projects involving HEDIS measures assist in this as rates are provided for each Region. However, some analysis of the regional differences would benefit the project evaluation.
4. The Health Plan indicated that the processes described in both PIPs are to be incorporated in the regular agency processes. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.

5. All health plans are given ample time to submit additions and corrections to PIPs after the on-site review. HCUSA should have taken the reviewers suggestions and submitted additional information and narrative. It is likely that this would have improved the PIP evaluation significantly.

9.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for HCUSA. HCUSA submitted the requested documents on or before the due date of March 19, 2010. The EQRO reviewed documentation between March 19, 2010 and June 30, 2010. 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 HCUSA NCQA RoadMap for the HEDIS 2009 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2009
- HCUSA's information systems policies and procedures with regard to calculation of HEDIS 2009 rates
- HCUSA 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 2009 Data Submission Tool
- HEDIS 2009 product work plan

The following are the data files submitted by HCUSA for review by the EQRO:

- ADV denom_num.xls
- ADV enroll.xls
- AWC denom_num.xls
- AWC enroll.xls
- AWC_Hybrid_Chases_View_2009.xls
- FUH denom_num.xls
- FUH enroll.xls

The initial numerator file submitted by HCUSA for the ADV measure did not contain the service dates needed to verify the reported HEDIS rates. The MCHP was asked to submit a corrected file that included the necessary service dates to allow for proper processing by the EQRO. However, the second file received also did not contain valid service dates. The hybrid file initially submitted for the Adolescent Well Care Visit measure (File 3) was not provided in the requested format and did not contain the correct data; the health plan was asked to resubmit.

INTERVIEWS

The EQRO conducted on-site interviews at HCUSA in St. Louis on Tuesday, July 13, 2010 with Carol Stephens-Jay, Consultant. Also available by phone were Rena David-Clayton and Geoff Welsh, who represented the software vendor Catalyst Technologies. This group was responsible for calculating the HEDIS 2009 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2009 performance measures.

FINDINGS

HCUSA calculated the Adolescent Well Care Visit measure using the Hybrid method. The remaining two HEDIS 2009 measures being reviewed (Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness) were calculated using the Administrative method. The data file provided for the Annual Dental Visit measure was invalid, as no service dates were included.

This prohibited the EQRO from validating this measure; however, a modified "validation" was performed to provide data for comparison. MO HealthNet MCHP to MCHP comparisons of the rates of Annual Dental Visit, Adolescent Well-Care Visits, and Follow-Up After Hospitalization for Mental Illness 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 combined rate for the HEDIS 2009 Annual Dental Visit measure reported by HCUSA to the SMA and the State Public Health Agency (SPHA) was 36.93%. This was significantly higher than the statewide rate for all MO HealthNet MCHPs (33.58%, z = 0.78; 95% CI: 31.57%, 42.28%; $p > .95$). This rate has trended upward or remained steady over the past three EQR report years: from 32.23% in 2007 to 36.93% in 2008 to 36.93% in 2009 (see Table 68 and Figure 51).

The reported Adolescent Well-Care Visit rate was 38.19%; this is comparable to the statewide rate for all MO HealthNet MCHPs (35.63%; z = 0.37, 95% CI: 34.39%, 42.00%; n.s.). This reported rate is higher than the rate (36.37%) reported by the health plan during the 2007 EQR review, but not quite as high (39.31%) as the 2008 EQR rate (see Table 68 and Figure 51).

The 7-day rate reported for the Follow-Up After Hospitalization for Mental Illness measure by HCUSA was 43.80%, which is comparable to the statewide rate for all MO HealthNet MCHPs (41.59%; z = 0.48, 95% CI: 36.62%, 50.98%; n.s.). This rate was also substantially higher than the rates reported by the health plan during the last periods this measure was audited in HEDIS 2006 and 2007 (29.04% and 27.35% respectively; see Table 68 and Figure 51).

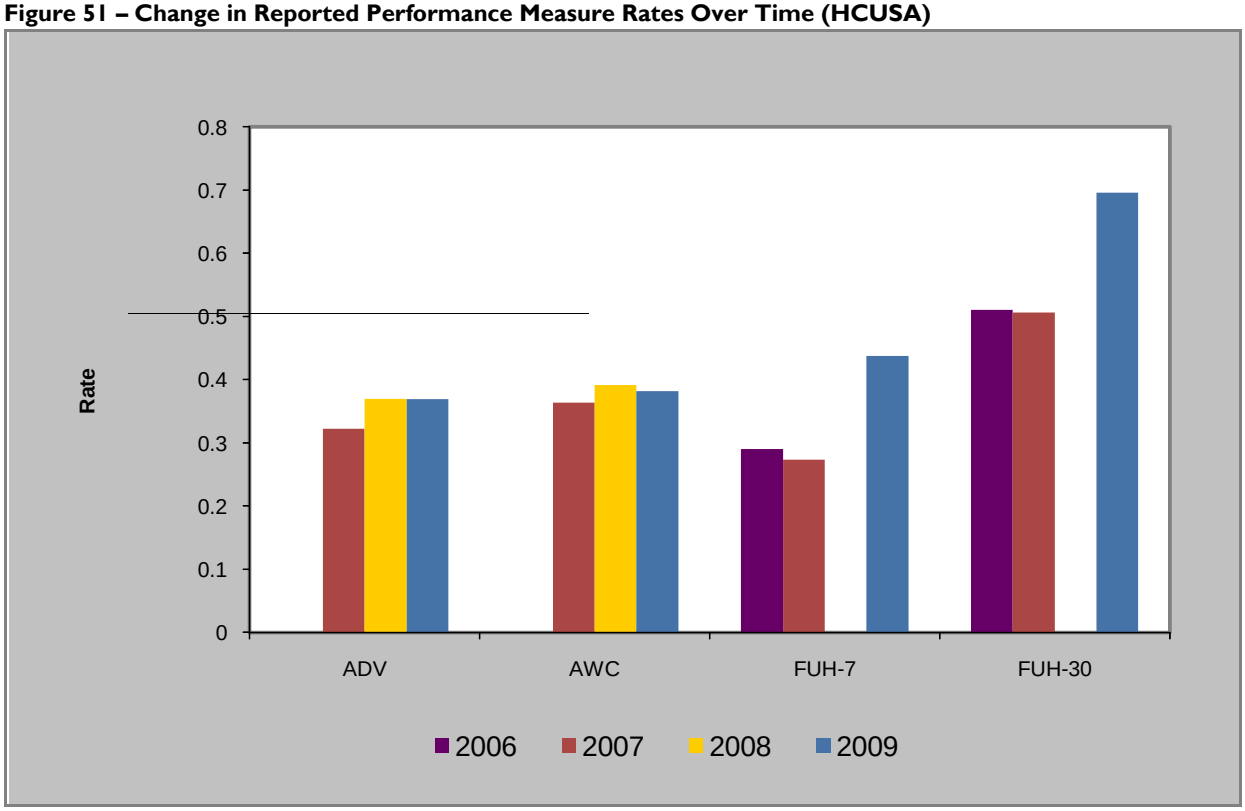
The Follow-Up After Hospitalization for Mental Illness measure 30-day rate reported by the health plan (69.62%) was also comparable to the statewide rate (66.46%; z = 3.36, 95% CI: 62.44%, 76.80%; n.s.). This rate has also continued to trend upward overall, from 51.03% in 2006 to 50.58% in 2007 to 69.62% in 2009 (see Table 68 and Figure 51).

Table 68 – Reported Performance Measures Rates Across Audit Years (HCUSA)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate
Annual Dental Visit (ADV)	NA	32.23%	36.93%	36.93%
Adolescent Well-Care Visits (AWC)	NA	36.37%	39.10%	38.19%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	29.04%	27.35%	NA	43.80%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	51.03%	50.58%	NA	69.62%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 51 – Change in Reported Performance Measure Rates Over Time (HCUSA)



Sources: BHC, Inc. 2006, 2007, 2008, and 2009 External Quality Review Performance Measure Validation Reports

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 CMS Protocol 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, HCUSA was found to meet all the 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 HCUSA transferred data into the repository used for calculating the HEDIS 2009 measures. However, none of the data files provided to the EQRO were submitted in the requested data format (eg. .xls vs. @ delimited .txt).

DOCUMENTATION OF DATA AND PROCESSES

Although HCUSA uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. 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). HCUSA met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

HCUSA 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 dates of birth ranges were valid.

There were 98,716 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 1,296 eligible members were reported and validated for the Adolescent Well-Care Visits measure.

A total of 1,073 eligible members were reported and validated for the denominator of the Follow-Up After Hospitalization for Mental Illness measure.

PROCESSES USED TO PRODUCE NUMERATORS

Two of the three measures were calculated using the Administrative Method (ADV, FUH). The remaining measure (AWC) was calculated using the hybrid methodology. Measures included the appropriate data ranges for the qualifying events (e.g., well-child visits, follow-up visits, or dental visits) as specified by the HEDIS 2009 Technical Specifications (see Attachment XIII: Numerator Validation Findings). A medical record review was conducted for the Adolescent Well-Care Visit measure.

The numerator files provided to the EQRO by HCUSA for the Annual Dental Visit measure did not contain valid service dates. Therefore, the EQRO was unable to validate this rate with the data provided. However, a modified validation procedure was performed (assuming all otherwise-valid hits also had valid service dates) to provide a basis for comparison. HCUSA reported a total of 36,451 administrative hits for the Annual Dental Visit measure; 36,195 of these hits were found by the EQRO. This resulted in a reported rate of 36.93% and a "validated" rate of 36.67%, an overestimate of 0.26%.

For the HEDIS 2009 Adolescent Well-Care Visits measure, there were a total of 467 administrative hits reported and 467 hits found. A total of 28 medical records were requested; all 28 were received and were able to be validated by the EQRO, resulting in a 100% validation

rate for this measure. Therefore, the reported and validated hybrid rates were both 38.19%, showing no bias in the rate.

The number of administrative hits reported for the 7-day rate for the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was 470; the EQRO found 440. This resulted in a reported rate of 43.80% and a validated rate of 41.01%. This represents a bias (overestimate) of 2.80% for this measure.

The Follow-Up After Hospitalization for Mental Illness 30-day calculation showed 747 reported hits; of these, the EQRO was able to validate 703 of them. This yielded a reported rate of 69.62% and a validated rate of 65.52%, an overestimated bias of 4.10%.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

HCUSA 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 is shown in Table 69, the health plan overestimated the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures. No bias was observed in the Adolescent Well-Care Visits measure.

Table 69 - Estimate of Bias in Reporting of HCUSA HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.26%	Overestimate
Adolescent Well-Care Visits	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (7-day)	2.80%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	4.10%	Overestimate

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 (see Table 70). The Annual Dental Visit measure was determined to be Not Valid because the correct service dates were not provided in the data. The rate for the Follow-Up After Hospitalization for Mental Illness measures was overestimated, but still fell within the confidence intervals reported by the health plan. The rate for the Adolescent Well-Care Visits measure was Fully Compliant with specifications.

Table 70 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Not Valid
Adolescent Well-Care Visits	Fully Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially 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 health plan. 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 MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Two of the three of the health plan's performance measure reported rates were consistent with the average for all MO HealthNet MCHPs; the remaining rate was higher than the average.

QUALITY OF CARE

HCUSA's calculation of the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was substantially complaint with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. HCUSA's rate for this measure was consistent with the average for all MO HealthNet MCHPs. The health plan's members are receiving the quality of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. Both the 7-day and 30-day rates were above the National Medicaid Averages and below the National Commercial Averages for this measure. The health plan's members are receiving a quality of care for this measure higher than the average National Medicaid member but below the average National Commercial member across the country. However, these rates were significantly higher than the rates reported by the health plan during the audit of the HEDIS 2007 measurement year, indicating an improvement in the quality of services received by members over the past two years.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

ACCESS TO CARE

The Annual Dental Visit measure was determined to be Not Valid due to missing data needed by the EQRO; however, if the missing service dates had been found to be within range, this measure would have been substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. HCUSA's reported rate for this measure was significantly higher than the average for all MO HealthNet MCHPs. This rate was higher than the rate reported by the health plan during the 2007 report, and consistent with the rate reported in the 2008 audit.

This shows that HCUSA members are receiving more dental services than in the past. The health plan's dedication to improving this rate is evident in the increasing averages. HCUSA's members are receiving the quality of care for this measure higher than the level of care delivered to all other MO HealthNet Managed Care members. This rate was below the National Medicaid Average for this measure; the health plan's members are receiving a lower access to care than the average National Medicaid member.

The EQRO was unable to validate this rate within the reported 95% confidence interval and therefore is unable to specify substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2009 Adolescent Well-Care Visits measure was fully compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was consistent with the average for all MO HealthNet MCHPs. The rate was higher than the rate reported for the 2007 EQR report year; however, the rate was lower than the rate reported for the same measure during the 2008 report. HCUSA's members are receiving the timeliness of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. However, this rate was lower than both the National Medicaid and National Commercial averages for this measure. The health plan's members are receiving a lower timeliness of care than the average Medicaid or Commercial member across the nation.

The EQRO was able to fully validate this rate and thereby has extreme confidence in the calculated rate.

RECOMMENDATIONS

1. The Adolescent Well-Care Visits rate showed a decrease over the previously audited rate in 2008. The EQRO recommends that the health plan monitor this decrease and attempt to determine the possible reasons for this decline.
2. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
3. Continue to conduct and document statistical comparisons on rates from year to year.
4. Work to increase rates for the Annual Dental Visit and Adolescent Well-Care Visit measures; although they were consistent with the average for all MO HealthNet MCHPs, they were at or below the National Medicaid averages.
5. HCUSA should thoroughly review both the data request format file and the resultant data extract files for accuracy prior to submitting data to the EQRO. This will ensure that the EQRO receives the most complete data possible for validation.

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 555,393 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete and 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, and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code fields were 100.0% complete, accurate valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell well below the 100.00% threshold set by the SMA for completeness, accuracy and validity. The second Diagnosis Code field was 18.40% complete, accurate and valid. All remaining fields (n=453,194) were blank.
10. The third Diagnosis Code field was 20.34% complete and accurate (blank fields n= 442,393), and only 19.53% valid, with 4,534 fields containing invalid code "X01".
11. The fourth Diagnosis Code field was 10.92% complete and accurate (blank fields n= 494,742), and only 10.60% valid, with 1,756 fields containing invalid code "X01".
12. The fifth Diagnosis Code field was 1.76% complete and accurate (blank fields n = 545,604), and only 1.32% valid, with 2,420 fields containing invalid code "X01".

For the Dental claim type, there were 119,045 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were zero twenty-three (23) encounter claims paid by the SMA for the period July 1, 2009 through September 1, 2009. All fields examined, except the third, fourth, and fifth Diagnosis Code fields were 100.0% complete, accurate and valid. Those Diagnosis Code fields were all blank, thereby making those fields incomplete, inaccurate and invalid.

For the Inpatient claim type, there were 9,801 encounter claims paid by the SMA for the period July 1, 2009 through September 1, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 valid.
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 93.50% (with 637 entries of "99999999"); thereby the Discharge Date field was 93.50% accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete and accurate, and valid.
8. The first Diagnosis Code field was 76.16% complete, accurate and valid. The remaining fields (n=2,337) were blank.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (76.16%, 75.61%,52.50%, and 39.20%, respectively).
10. The First Date of Service field was 100.00% complete and accurate, and valid.
11. The Last Date of Service field was 100.00% complete and accurate, and valid.
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 184,080 encounter claims paid by the SMA for the period July1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 Outpatient Procedure Code field was 97.73% complete, accurate, and 85.98% valid. There were 21,641 invalid entries of "00000" and 4,174 missing values.
7. The first Diagnosis Code field was 100.00% complete, accurate and valid.
8. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (59.35%, 54.29%, 26.66%, and 13.39%, respectively).

For the Pharmacy claim type, there were 362,611 claims paid by the SMA for the period July 1, 2009 through September 30, 2009. 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 HCUSA, 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 Inpatient claim type contained invalid data in the Discharge Date fields. The Revenue Code field contained blank entries. For the Outpatient Hospital claim type, the Outpatient Procedure Code fields contained invalid entries.

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 claims was significantly lower than the average for all MO HealthNet MCHPs. All other encounter claim types were consistent with the average for all MO HealthNet MCHPs. This suggests average rates of encounter data submission and good access to preventive and acute care. This could also be a function of the fact that HCUSA has the greatest number of encounter claims processed for all plans and thereby the outliers (if there are any) are not as prominent.

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 MO HealthNet MCHP were randomly selected from all claim types for the period of July 1, 2009 through September 30, 2009 for medical record review.

Of the 858,518 Outpatient encounter claim types in the SMA extract file for July 1, 2009 through September 30, 2009, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 87 medical records (87.0%) submitted for review.

The 2007 match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 39.0%, with a fault rate of 61.0%. The 2008 match rate for procedures was 74.0%, with a fault rate of 26.0% and the match rate for diagnoses was 59.0% with a fault rate of 41.0%. For the 2009 review, the match rates were 64.0% for procedures and 55.0% for diagnosis. This is a decrease in both rates from the prior year's review.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed 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 = 39) and incorrect (n=6). 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 = 32), incorrect (n=3) and upcoded (n=1). 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 MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since HCUSA included internal control numbers that matched those of the SMA, the planned analysis of comparing MO HealthNet MCHP encounter data to the SMA encounter claim extract file was performed. The SMA defined "unpaid claims" as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type (n= 362,611), only one encounter claim submitted to the EQRO was of "denied" status, all others were of "paid" status. The Inpatient Claim type (n=9,801), contained two (2) encounter claims with "denied" status. For the Outpatient Hospital and Medical Claim Types (n= 739,473), 21 "denied" claims were submitted by HCUSA but all other encounter claims were of "paid" status. Of the encounter claims submitted by HCUSA, 57 records were unmatched with the SMA encounter data. There was a "hit" rate of 99.99% between HCUSA encounter claims and the SMA encounter data.

For the Dental Claim type, HCUSA submitted 119,045 encounter claims. Only 4 of these encounter claims were of "denied" status; all other claims were of "paid" status. There were 00 unmatched records between HCUSA and the SMA, yielding a 99.99% "hit" rate.

Why are there unmatched claims between the MO HealthNet MCHP and SMA data files?

For all claim types, the unmatched encounters were missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, there were no documented "missing" claims from the SMA database.

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

While the MO HealthNet MCHP 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. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet MCHP data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet MCHP 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.

CONCLUSIONS

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 MO HealthNet MCHP and SMA data files.
2. The critical field validation of five of the six claim types (Home Health, Inpatient, Outpatient Hospital, Dental and Pharmacy) 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.

AREAS FOR IMPROVEMENT

1. For the Medical claim type, there were invalid entries for the Procedure Code fields.
2. For the Outpatient Hospital claim type, there were invalid data in the Outpatient Procedure Code field.
3. The health plan submitted fewer records than they have in the past years' reviews and had lower match rates.

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 Diagnosis fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
3. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis. Consider having records shipped to the plan from the provider prior to sending them to the EQRO, as numerous incomplete records were received, which also contributed to the analysis.

9.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet MCHP's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). This ensures that each MO HealthNet MCHP's documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations. Prior to the on-site review Case Management cases were reviewed by the EQRO for compliance with policy, and to ensure that practice reflected policy requirements. On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. Interviews occurred with Case Management Staff, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds the federal regulations.

Initial interviews were conducted with the Case Management Staff. These interactions and responses were compared to policy requirements and to the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff.

The interview questions posed to Case Management staff were generated by the cases reviewed as well as the review of Health Plan Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the health plan processes. Additionally, an interview questions were formulated for Administrative staff to validate and clarify these practices, to follow-up on questions raised from the case management staff interviews, and to respond to questions that arose from the document review. These interview questions were developed from the HCUSA Annual Evaluation Report and the SMA's Quality Improvement Strategy.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)
- HealthCare USA Annual Evaluation Report (2009)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2009 Marketing Plan and Materials
- Case Management Policy
- Quality Improvement Committee Meeting Minutes - 2009

Additional documentation made available by HCUSA included:

- HCUSA of Missouri Organizational Chart
- Care Management: Case Management, Complex Case Management, and Disease Management Policy
- Assessment of Members with Special Health Care Needs policy

INTERVIEWS

Interviews were conducted with the following groups:

Case Management Staff

Denise Sommerer, RN – Case Manager, Jefferson City
Cynthia James, RN – Case Manager
Tasha Sharp, RN – Case Manager
Valerie Walter, RN – Complex Case Manager
Janet Wilson, RN – Complex Case Manager
Jennifer Pickens, RN – Complex Case Manager
Beverly Krohn, RN – Case Manager
Kammara Jackson, RN – NICU Disease Management

Plan Administration

Jackie Inglis, VP Health Services
Resmi Jacob-Schrieber, Director of Provider Relations
Lisa Fillback, Health Services, Pre-Authorization/Complex Case Management
Christine Miller, Manager, Case Management
Kate Darst, Manager, Disease Management

Case Management Interviews

- Explain the referral process. How are referrals received?
- Discuss the case management assessment process. How are members defined into the need for case management? When are members excluded?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- What services are provided to members with special health care needs?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members with mental health care needs.
- What areas do case managers serve? What is the size of case loads?

Findings

Interviews and case record reviews revealed a staff with a strong focus on member services with a commitment to appropriate documentation and record keeping. The reviewers' impressions of the case records read were provided. There was evidence of intense case coordination and appropriate responses by case managers. When services needs were identified, service delivery activities were reflected in the notes available. The administrative staff expressed a strong commitment to supporting case management activities. The results of this commitment were evident in the records reviewed. Cases indicated referrals from providers and hospitals. In many cases authorizations existed for in-home health services. Case managers maintained current information about members through communications with the home health providers seeing the family, even if they were not able to contact them by telephone or letter. In a case involving a child with an elevated lead level, the case manager maintained contact with the family through in-home service providers, and community-based resources. Even though the family did not directly return the case managers' telephone contacts, she was able to verify continued lead level testing, and a reduced lead level for the child.

In cases involving referrals for behavioral health services, the documentation included references to on-going communication between case managers and the behavioral health providers. In a complex case management case, the member was diagnosed with left ventricular hypertrophy, and signs of depression. The case notes indicated that the case manager assisted in obtaining a vest defibrillator for the member, and engaged the member in accepting behavioral health case

management to deal with the depression. The case manager maintained frequent contacts with the member throughout involvement with this health plan member.

In another case a child was diagnosed with cellulitis of the right index finger. The member's mother spoke Arabic, although the father did speak English. The case manager showed a caring and thorough approach to working with the family. Following the initial treatment of the wound, a home health nurse was approved to assist with dressing changes and IV antibiotic administrations. The case manager was tenacious in maintaining contact with the parents. The case was not closed until a final report was received from the home health provider.

The case managers described their role as being service oriented and being there to assist members. They make significant efforts to engage members so that they are comfortable calling the health plan and case manager to request assistance. The case managers report that they are trained, from the beginning of their employment, to be invested in this process. They assist members in dealing with social issues, particularly when they inhibit the member from accessing needed health care services.

Referrals for case management come from member calls, PCPs, specialists, health risk assessments, Member Services, MH Net, the 24-Hour Nurse Line, various state agencies, home health professionals, claims analysis, and from members themselves. The case managers report receiving anywhere from 3 to 10 new referrals per day.

The actual process for case management includes a check for member eligibility, a review of the system to obtain a history that points to the services needed, a review of pharmacy claims, and any previous case notes. All of these activities prepare a knowledge base about the member prior to the initial contact. The case managers, after a member accepts case management services, complete the assessment process. A standard assessment includes information from the member, nurses involved with the family, and the PCP. They investigate any additional questions generated by these interviews. The care plan is then generated based on the member's responses and questions they have, discharge summaries, and information provided by the physicians or medical providers involved. The case managers report that they are able to assess a member's ability to navigate the health plan and medical system based on these

discussions. During these conversations with members a need for additional referrals for behavioral health services are often identified as well. The case managers believe that education is an essential component of their contacts with members. Resources, such as lead inspections, are often explained. These explanations also include the benefits that are available from other community based agencies.

The case managers interviewed were aware of community based resources throughout all three of the MO HealthNet Managed Care Regions that the health plan serves. They collaborate with staff at these agencies, and around the state to identify resources for their members. All case managers do complex case management. During the discussions with the case managers, including those contacted through conference calling, it was obvious that they were aware of the cases reviewed, and used these members as examples of the work they were describing. The case managers' comments indicated a very strong involvement with their members.

There is one case manager who is the main contact for members receiving NICU services for all three managed care regions. She is keenly aware of the resources available to these infants and their families. NICU babies are routinely followed for eighteen (18) months. All babies born at 32 or fewer weeks of gestation, or having a birth weight of less than 1500 grams, or any other complications at birth, are included in a High Risk Program. There were sixty infants enrolled in this program at the time of the on-site review. Contact with mothers is made regularly, and many of these families have access to in-home nurses. Case managers work through the in-home providers to ensure that adequate services are available to the family.

The case managers work with the Disease Management nurses. The Disease Management staff goes out into the community to collaborate with other resource organizations. They provide information on the assistance available through the health plan. The health plan is actively involved in a variety of community organizations and groups. They also attend provider group meetings and share information on the services available to members and methods to contact the health plan and home health agencies.

HCUSA has Community Development staff that goes to health fairs and other events. Obstetrical information and other issues such as SIDS, symptoms of alcoholism, and other problems are presented. The health plan also holds "Baby Showers" that are open to all pregnant members. The case managers reported that at the most recent Baby Shower, held at St. Mary's Hospital in St. Louis County had approximately forty (40) attendees. The health plan assists with coordinating transportation for any member that needs it to attend these events. The Baby Showers are produced in all three MO HealthNet Managed Care regions at least annually.

Administrative Interviews

- Is the health plan continuing to operate the Physicians' Advisory Group? How is this working? Elaborate on the outcomes.
- Give examples of measures that the Health Plan implemented to improve the follow-up process for members included in the State's Special Needs report.
- Discuss the recent changes in case management, and record keeping requirements.
- Discuss the health plan's relationship with MH Net. What is working? Are any program improvement activities occurring?
- Is the health plan working with the C-STAR program? Discuss current activities.
- Discuss current challenges in the health plan and what is occurring to deal with these challenges.

Findings

A summary of the morning's discussion was provided to the administrative staff. The reviewers' impressions of the case records reviewed, the intense case coordination that was observed, and the responses to service delivery expectations were provided. The administrative staff expressed a strong commitment to support case managers in their activities was observed.

The administrative staff discussed the Physician's Advisory Council. This group has been actively involved in defining the roles of the case managers, but particularly in the Disease Management Program. Program reviews are provided at their meetings, and the physician's group provides feedback on these activities and their experiences with both the case and disease managers.

The health plan also operates a members' advisory committee in all three regions. This group provides insight and feedback on existing services, program initiatives, and community

development activities. The health plan views these meetings as an essential component of their operations.

The health plan has initiated a new system to ensure that members in all Disease Management programs receive similar services. They are attempting to meet all corporate expectations and NCQA regulations. This will allow follow-up with all members to ensure that they are receiving all tests and screenings in their best interest. The health plan believes this process will enhance their tracking for issues related to improving HEDIS measures, and will better follow provider activities to ensure that they are providing the expected services. The system also requires a health risk assessment to be completed for the members involved in Disease Management. The assessment is available to accompany the member to the provider's office.

In the rural areas served by the health plan, HCUSA is identifying differences in the populations served, and the resources available. HCUSA is identifying alternative language needs in these areas, and working with the University of Missouri hospital and clinics to better serve diverse groups.

The health plan reports the continuation of co-location of MH Net case managers within their offices. This places a greater emphasis on coordination of care and assists in providing behavioral health information to PCPs. The co-location of behavioral health and physical health case managers, who both participate in grand rounds, increases discussion and information sharing on in-common members.

The health plan has made an effort to improve utilization and communication with the C-STAR programs. Staff members identify and work with C-STAR providers. They are going to meetings with these agencies and are attempting to improve communication avenues about in-common patients. The health plan staff is discussing the importance of care coordination at these meetings. They report that C-STAR staff did not readily understand the health plan's role in members' care. These efforts have improved acceptance into C-STAR for members and the communication with these agencies about member treatment.

ENROLLEE RIGHTS AND PROTECTIONS

A strong commitment to member rights continues to be a cornerstone of HCUSA's service philosophy. The emphasis placed on continuous quality improvement by the health plan was apparent in both the documentation reviewed and throughout staff interviews. Quality services to members, with a particular emphasis on families and children, were observed within the organization. HCUSA views cultural diversity as an essential component of their interactions with members. The health plan maintains cultural diversity as a cornerstone of initial and ongoing staff training. HCUSA employs staff that speaks 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 shown by the health plan's approach to their work and to their interactions with members.

HCUSA has expanded its ability to communicate with visually and reading impaired members by contracting to produce their member handbook and other materials in Braille and on CD. They have information translated into other languages as well.

Staff was asked how a member becomes eligible for care coordination or case management services. They report that certain conditions automatically trigger a referral for case management, but more often, opening a case management case is in response to a situational need or medical condition. After any referral is received, case management contacts the member. Any type of referral creates a trigger for the case manager assigned to apply their algorithm and the completion of an assessment. The algorithm provides a baseline for the degree of intervention that a member will require. The case managers relate that they use all means necessary to contact the member. They believe their persistence positively impacts their success.

Typical case management activities include locating members and assessing their medical and ancillary needs. The case managers often make referrals for members to community based services that will assist them. This often includes working with a social worker, who is on-site at HCUSA, from MHNet to ensure that mental health referrals are fulfilled in a timely fashion. The case managers and social worker believe this has contributed to improvement in their ability to achieve care coordination for members.

The case managers have developed a NICU program that provides case management for the transition of newborns being released from the hospital to home. They collaborate with nurses at St. Louis Children's Hospital on this project and on a project for children diagnosed with Sickle Cell Anemia. An active outreach program is in place through the Post-Partum Department to ensure that follow-up services are in place as needed. Another outreach program is in place to inform members about services related to ADHD.

The case managers also described their Baby Shower program that is now available in all areas of the MO HealthNet Managed Care regions. These "Showers" are held at physician's offices, hospitals, and clinics. Transportation is provided and vendors are present, including representatives from Parents as Teachers, and the SIDS prevention program. A bank representative is included to assist members in setting up savings accounts for infants. Other community resources are included and information is given to all members present. They also provide gifts, as approved by the SMA, to all members who attend. The case managers believe this program sets members up to have success with their newborns and small children, as it assists the member in becoming aware of resources available to them.

HCUSA is making efforts to leverage community relations in all three MO HealthNet Managed Care regions. They work with the FQHCs in these regions and have developed a number of special projects. The health plan is working with LINC in the Western MO HealthNet Managed Care region, which is the local community partnership group, and the Spanish Center to ensure that they are addressing the needs that might be peculiar to the Kansas City population. They are working with community groups in the MO HealthNet Managed Care Central Region to address issues specific to the rural population. One example is that HCUSA providers are conducting dental screening at community based activities.

As a follow-up on their asthma initiatives, the health plan provided information on a project that is occurring in all three MO HealthNet Managed Care Regions. The health plan monitors member adherence to physician visits and medication. When a member does visit their physician or pharmacy, they are asked to verify all contact information and future commitment to keeping appointments. After attending so many appointments, they receive a gift card, with information on "Kids' Health" aimed at parents, teens, and younger children.

Case managers and the social worker in their department also exhibited a strong sense of collaboration and coordination. This collaborative effort includes the MH Net case manager, with whom they exchange information freely. The social worker provides a linkage with community based agencies that can provide the members with services that may exceed their health care needs.

The staff reports that an administrative assistant processes the report received from the SMA regarding children with special health care needs. After locating the members appearing on the list, their chart is flagged and information is forwarded to the case manager regarding the member's specific needs. The case manager contacts these members to ensure that they attend scheduled appointments, and to provide additional information regarding available services. The health plan may also contact other agencies such as WIC and the Family Support Division to ensure that they have accurate contact information and are aware of needed services.

The case managers maintain communication with the Disease Management Nurses, and the Concurrent Review Nurses to make sure that they obtain timely referral information. The Member Services staff often identifies members with special health care needs during Welcome Calls. This information is sent to the case managers immediately after a call is completed. The case managers' members who are in their case management program often refer friends and others who then self-refer. The case managers interview these individuals and complete an assessment, which often leads to the identification of a need for case management services.

The health plan does have case management staff located in all three MO HealthNet Managed Care regions. They utilize the Health Risk Assessment received through the SMA as much as possible. The health plan reports that community connections, particularly in the rural areas, and provider referrals are more effective in identifying members with special health care needs.

Ratings of compliance with Enrollee Rights and Protections (100%) indicate that HCUSA continues to make a concerted effort to improve their compliance in this area. The health plan completed all required policies and these were approved by the SMA. Interviews with administrative and case managers indicate a commitment to ensure that all approved policies are operationalized in daily work activities. They actively seek to maintain this level of success, and

further to ensure that these policies are operationalized in interactions with health plan members. The Health Plan had a stated goal of 100% compliance with SMA contract requirements and federal regulations, which was achieved for the fourth year.

Table 71 – Subpart C: Enrollee Rights and Protections Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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.

BEHAVIORAL HEALTH

The liaison social worker from the behavioral health subcontractor, MH Net, was included in the case manager interview during this on-site review. Questions were asked of the health plan to follow-up on information from prior reports. The Behavioral Health Organization's (BHO) system underwent enhancements to capture baseline information on members receiving behavioral health services. MH Net continues the practice of authorizing family therapy, in

addition to required individual therapy, for all children under age 21 who need behavioral health services. This additional resource is thought to assist in ensuring that each family has an understanding of the 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, it is reported, works closely with HCUSA to identify expectant mothers to ensure that required behavioral health services were in place in an effort to prevent post partum problems. The BHO continues its concerted effort to ensure that information and educational material is translated into different languages. Multilingual providers are available to members.

The Health Plan, in collaboration with MHNet, reports making a concerted effort to offer adequate case management services between the two agencies. They provide case management to any member requiring a hospital admission, who attempts suicide, during and immediately after pregnancy, who has a history of non-compliance, and/or those with serious disease management issues. Case managers maintain regular phone contacts to ensure coordinated and necessary services and supports, such as transportation, are in place. HCUSA reports that having a MHNet liaison on-site has improved coordination of care issues.

Quality Assessment and Performance Improvement

Access Standards

HCUSA continues to work with both members and providers to ensure proper access to services is available. The health plan maintains a large provider network throughout all three MO HealthNet Managed Care regions. They continue to recruit providers to expand available services, particularly in the Central Missouri area. This network enables members to have an adequate choice of both PCPs and specialty providers. The health plan does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

HCUSA reports that a number of new urgent care centers opened in St. Louis, which are now under contract. The health plan has also recruited within its own network. They now have a number of PCPs with weekend and evening hours. This information is published in brochures that are distributed to members. Members, in some cases, are now assigned to physicians'

groups, rather than to just one PCP, which assists in the availability of convenient appointment times, and sometimes eliminates the message that a specific PCP has a closed panel. This practice enables members to see the PCP of their choice in close proximity to their home.

The health plan reports that with the availability of both the Washington University and St. Louis University systems, the number of specialists, particularly in the area of orthopedics, has greatly improved. The case managers in the Western and Central Regions work with their hospitals to identify a specialty provider for specific member's needs. They relate that finding behavioral health providers in the MoHealthNet expansion counties was previously a problem, but this has greatly improved during 2009.

A continuing effort by HCUSA is recruiting dental providers. They report that their work with Doral Dental has created positive results in all three regions. Doral continues to participate in expansion activities with the health plan. They are improving their customer service network, and adding administrative services with HCUSA. Doral Dental has focused efforts in the Central MoHealthNet Managed Care region with success. Doral Dental placed a provider representative in the Central Region to ensure that ample recruitment occurred and that a representative was available locally to assist in problem solving when this was required. They have also recruited a number of dentists who ensure availability to HCUSA members.
The health plan continues its efforts to monitor their provider network for accessibility and availability of both primary care physicians and specialists in all three MO HealthNet Managed Care Regions. They report that they have recruited a new orthopedic group in the Eastern Region, which has greatly improved access to these services for their members. The health plan has "non-par" provider agreements that they utilize as needed. HCUSA reports that they have this type of agreement with an orthopedic group in the Central Region, and are now working with the University of Missouri Health Care System.

The health plan makes an effort on behalf of members to share information about changes in provider availability, and to provide assistance in making appointments or identifying an appropriate provider if necessary. HCUSA has developed community based programming in all three Regions. These include programs dealing with back pain, asthma, and the baby showers. The case managers report that they get a reminder when a member is overdue for an EPSDT

examination. This information is then relayed to the member and their PCP. The health plan is also participating in member events, such as Back to School Fairs, to provide information about the availability and accessibility of services. In the Western MO HealthNet Managed Care Region, an FQHC, Swope Health Services, is providing school physicals, dental screenings, and vision screenings for children. HIV screens and mammograms are provided for adults.

Case managers discussed their efforts to ensure that members obtain timely and appropriate services. They directly contact PCPs and specialists if barriers exist to obtaining appointments or other necessary services. Case managers also discussed members' rights to refuse case management services. When this occurs, the case managers attempt to educate members on other community services available, and how to work with their providers. The case manager then sends a post card with their name and a message that they can be available again if the member has future service needs.

Ratings of compliance with Access Standards regulations (100%) are excellent for the third year, and reflect the fact that all HCUSA policies have been submitted, reviewed, and approved by the SMA, and that the practice validated at the on-site review supports that all requirements are occurring. The health plan has improved in this area each year, and continues to strive to meet all required SMA contract requirements and federal regulations.

Table 72 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	2
Number Not Met	0	0	0
Rate Met	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.

Structures and Operation Standards

HCUSA instituted a number of measures to improve practice in this area in previous years that have continued during 2009. The health plan holds quarterly oversight meetings with all subcontractors in each region to discuss service provision and to monitor their activities. The meetings are used to monitor key performance indicators and to review provider panels. Annual evaluations are completed on each subcontractor and daily contact is maintained.

HCUSA reported this increased contact and monitoring allows them to address administrative and member issues in a timely and effective manner.

On-site reviews continued to be conducted by Provider Relations staff during 2009 to assess providers' use of practice guidelines, and to review that all required documentation is in place. This has been effective in ensuring the quality and timely provision of care. The health plan is currently URAC accredited, and are actively working toward obtaining their NCQA accreditation. On site visits, to complete credentialing, occur at least annually for PCPs and OB/GYNs. An on-site visit occurs with any office where a complaint has been reported. The health plan reviews areas related to member safety and cleanliness, which reflect the majority of issues. Some delegated credentialing occurs with larger providers, such as Cox and St. John's in Springfield, Missouri.

HCUSA created a provider advisory group, which began functioning in the Eastern Region, but is now operational in all three MO HealthNet Managed Care regions. The committee is made up of high volume providers and representatives from across specialties. The sharing of ideas and information pertaining to any member dissatisfaction is encouraged. These groups seek provider feedback and provide information in a framework that allows the health plan to develop a true partnership with their provider network.

Ratings for compliance with Structure and Operation Standards (100%) reflected completed and approved policy and procedures in this area for the third year.

Table 73 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.214(a,b) Provider Selection: Credentialing/Re-recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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.

Measurement and Improvement

The MO HealthNet MCHP continued to use InterQual as a guide for decision-making in terms of utilization review. InterQual criteria were originally cited when asked about practice guidelines. However, the health plan has instituted a number of practice guidelines and has instituted a number of initiatives to ensure their distribution to and use by providers. HCUSA's Medical Director ensures that monitoring utilization of practice guidelines is occurring at the provider level.

HCUSA continued to have a well developed internal written quality assessment and improvement program. The Health Plan shared their Quality Management Charter and minutes from meetings with reviewers. The Quality Management Program focused on monitoring, assessment, and evaluation of clinical and non-clinical service delivery. The result has been the implementation of quality programs that target members with special healthcare needs, but also

provided enhanced services to all members. HCUSA indicated that they recognized the need to stratify data by MO HealthNet 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 health plan maintained a record of activities, recommendations, accomplishments, and follow-up.

The health plan did report data for Validating Performance Measures, which is validated in the appropriate section of this report. However, one Performance Measure could not be validated as the data was submitted erroneously. The health plan did submit clinical and non-clinical Performance Improvement Projects. The details of the audit are located in the appropriate section of this report. HCUSA continues 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 (90.90%) reflect the completion of all policy and procedures in this area. The decline in this rating reflects the health plans inability to submit all data for validation of Performance Measures in the correct format. The health plan did submit the remainder of required data in requested formats, allowing the proper validation processes to occur.

Table 74 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	1
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	90.90%

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 MO HealthNetManaged Care Program. This percent is calculated for the regulations that are applicable tot the MO HealthNetManaged 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

Rating for compliance with Grievance Systems regulations (100%) indicates that the HCUSA completed all requirements regarding policy and practice in their grievance system. This is the sixth year that HCUSA has been 100% compliant in the area of Grievance Systems and reflects that the health plan considers this an important aspect of compliance in both policy and practice. Out-of-network providers are informed of policies and procedures regarding complaints, grievances and appeals through the Provider Manual and Web Link.

The health plan resolves to obtain timely grievance resolution for both members and providers. The grievances are placed in their health information system, which tracks timeframes and generates notices and letters. Specific staff is assigned to appeals for members. They assist in obtaining the most complete information to present to an appeals committee. The member is notified by telephone and in writing of any decision to ensure that they have the information as quickly as possible. HCUSA utilizes an appeals form for members and does provide assistance with the written request for an appeal.

During the case manager interviews it was learned that these staff are not integrally involved in the Grievance and Appeal process. They are aware of their role in the referral process. They reported that the health plan receives approximately sixty grievances per month, forty appeals per month, and 1-2% may become a State Fair Hearing. They estimated that 75% of calls come directly from members.

Outside physicians are utilized for review of the case and responsible for the final appeal decision. The Compliance Analysts all reported that adverse decisions are often the result of a lack of complete medical information. When additional information is available the denial is often overturned. All decisions are recorded in the health plan system, and appropriate correspondence is sent to members and providers.

Table 75 – Subpart F: Grievance Systems Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	1	0
Number Not Met	0	0	0
Rate Met	100%	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., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

HCUSA continued to exhibit a commitment to completing, submitting and gaining approval of required policy and procedures by the SMA, and developing operations that ensure that these procedures are reflected in daily operations. The health plan maintained improvements to achieve 100% compliance in all sections of the protocol for the fourth year. The operations and practices revealed during interviews at the on-site review indicated a commitment by HCUSA to provide quality healthcare services to its members. Health plan 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; engaging provider input regarding improving and delivering services effectively; and to responding to prior authorizations and grievances in a timely and efficient manner.

The health plan 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 services to members is their primary focus and that there was a commitment to comply with the requirements of the MO HealthNet Managed Care contract and federal regulations.

It is also noted that all staff interviewed reflected the health plan's culture of respect for members and the priority for meeting member service needs. Staff members were open and animated in their responses. They were eager to give examples of how they assist members in normal and extraordinary circumstances.

QUALITY OF CARE

The staff at HCUSA exhibits a commitment to excellence that creates an atmosphere where both members and providers experience quality services. The provider relations staff made regular contacts with providers to troubleshoot problems that may be reported by members, and to assist provider staff in making interactions with members and the health plan less complicated. Efforts within the communities served, involvement with FQHCs, and with Community Mental Health Clinics, are examples of HCUSA's working to produce quality care in the most convenient environment, and working to improve access to care for members. These

relationships have also allowed education to occur that improves the quality of services for both the member and organizational level. Case Managers relate the importance placed on training and collaboration to ensure that they are aware of issues that may arise and can respond quickly and efficiently to ensure that members have access to quality health care.

ACCESS TO CARE

HCUSA provided numerous examples of initiatives they are involved in to ensure that members have information on obtaining services and have adequate access to services. Several projects were explained that bring providers directly to places where members are available. The health plan has also undertaken provider recruitment and retention efforts that ensure that providers are available to members throughout all three MoHealthNet Managed Care Regions served.

Internally HCUSA, as an organization, has made efforts to ensure interdepartmental integration to create thorough knowledge of their service delivery system thus enabling staff to assist members effectively. Staff exhibited enthusiasm in describing the services they deliver and a desire to ensure that members' health care needs are met in spite of the barriers sometimes experienced.

TIMELINESS OF CARE

HCUSA was able to complete all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations. The focus on obtaining timely health care services and responses to member needs reflects the attention needed to effectively provide a managed system of services to members. HCUSA has also initiated a number of practices that enhanced timely response and resolution of grievances and appeals for both members and providers. This decision-making process enables members to obtain the healthcare they require in a timely manner. The health plan recognizes the importance of timely and adequate services.

RECOMMENDATIONS

1. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the health plan.
2. Continue 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 requires.
5. Maintain involvement in community-based services and activities.
6. Continue training efforts with front line staff to ensure that they are versed in health plan policy and procedures and remain confident in their interactions with and advocacy for members.

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10.0 Missouri Care Health Plan

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10.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

MO Care supplied the following documentation for review:

- Improving Chlamydia Screening Rates in Women
- Statewide Performance Improvement Project – Improving Adolescent Well Care Missouri Care

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 21, 2010, during the on-site review, and included the following:

Marcia Albridge – Director, Government Program Operations

Karen Holt – Accreditation and Quality Management

Christina Schmidl – Quality Coordinator

Dena Jennings – Quality Coordinator

Shaunda Hamilton—Quality Coordinator

Mark Kapp – 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 were the staff involved in this project and what were their roles?
- How were the topics identified? Expand on why they are important to the health plan and its members.
- Discuss the findings and how they were interpreted.
- How were the interventions determined and why did the Health Plan choose this approach?
- Are these studies ongoing?
- Discuss the effects of these interventions and how they impacted services to members.
- What does MO Care want to study or learn from their PIPs?

Both of the PIPs submitted for validation did not contain enough information to allow for a thorough evaluation. The health plan was instructed during the site visit that they could submit additional information that included updates to the outcomes of the interventions or additional data analysis. Additional information was received for these PIPs.

FINDINGS

The first PIP evaluated was, "Improving Chlamydia Screening in Women." This PIP was identified as a clinical project. This PIP was designed as a creative approach to improve a relevant area of member care. The rationale for the topic study choice was well documented in the information presented. The topic was justified utilizing national literature and research supporting the assertion that it would improve health outcomes for health plan members. It included information on the population and provided a strong argument for choosing the topic for a performance improvement project. The overarching goal of the project was focused on improving the knowledge about the importance of screening for an important health care issue. The hypothesis stated was that continued member health risk education, regarding the need to be screened for Chlamydia (CHL), along with educating health department billing staff about

correctly identifying when screenings occurred, will lead to an increased awareness by female health plan members of the health risks on contracting Chlamydia and the importance of Chlamydia screenings.

This project focused on counties in the Health Plan's MO HealthNet Managed Care Central Region. The stated intention is to expand this project into the Eastern and Western Regions for its 2011 PIP.

The PIP sought to answer the following study question: "Can continued outreach to MO Care members, and education on billing procedures to network health departments, increase the CHL rate of MO Care female members ages 16-24?" The focus of the question clearly states the goal of improving screening rates. The outcome of improved member screenings is measureable and understandable.

The main indicator is the health plan's HEDIS rate. The HEDIS indicators are to be used to evaluate the effectiveness of the proposed interventions. Because HEDIS is an annual indicator, the health plan will also monitor monthly and quarterly "HEDIS-like" rates that use a monthly rolling 2-month calculation. All information about how these rates will be tracked and utilized, including the HEDIS technical specifications, were included. The method of calculating denominators and numerators was also included.

The study population, women ages 16-24, was defined. All applicable members, defined by the HEDIS technical specifications, are included in the study. The data collection approach will capture all members of the population who are to be included.

The interventions included were:

- A Health Department billing letter was sent in October 2009 explaining how to correctly bill for Chlamydia screenings to ensure that all screenings would be appropriately counted. (The health plan stated that in the future this letter will be sent at least two times per year.)

- Birthday cards are sent to members annually, reminding them to obtain a yearly PAP test, and including a reminder about Chlamydia screening. These cards were sent from 2006 through 2009.
- Educational letters were sent to providers in the years 2007 through 2009 summarizing the importance of Chlamydia screenings, including a copy of the national guidelines.
- Quarterly rosters of members who need a Chlamydia screenings were sent to providers from 2007 through 2009.
- Corrections to the State Lab Billing errors for Chlamydia screenings were made.
- A new intervention (2009) targeting teens was initiated, including a teen health brochure including information on nutrition, immunizations, and Chlamydia screenings was sent to members.
- A provider preventive care toolkit was initiated in 2009, included information on Chlamydia testing. A questionnaire for members was initiated, with a guide for providers regarding the types of questions to be used regarding sexual history and Chlamydia screenings.

The number of interventions makes assessment of what approach is having a positive effect difficult to measure. Several of the stated interventions were used in previous years and were not a part of a PIP intervention, but are included as they do address this identified problem. The health plan collaborated with one health department (Boone County) with monthly meetings that focused on ethnic and racial health disparities in the community. Internally the health plan ensured collaboration between case managers, behavioral health, and provider relations staff for outreach to providers and members.

The study design clearly identified the data to be collected and the sources of this data. The health plan will use the administrative method of obtaining HEDIS data and will query pharmacy data. The study design included information, such as the correction of billing codes used by the State Lab, which appeared to improve their health plan's percentage by 3% from calendar year 2008. The update received after the on-site review provided the details of how the data was pulled and how they ensured that consistency is an essential component of their measurement techniques and interpretations. Time frames for collection and analysis were provided in enough detail to give confidence in the methodology used. An assumption can be made, as a

result of the original and updated information included, that the health plan is collecting data in a consistent and accurate manner.

A prospective data analysis plan was described in detail, including all planned analysis and a prospective look at the definition of success of the interventions. The confidence level in all data obtained and evaluated was discussed. The health plan personnel involved in this study, including the project leader, their roles and qualifications were included. The prospective data analysis plan discussed obtaining quantitative data and provided adequate information about how this information would be evaluated. The health plan is looking for an increase in the HEDIS rate for Chlamydia Screening in Women during each quarter. They are looking at the HEDIS-like rolling 12-month administrative rated during each month of the study to assess whether the planned interventions are having a positive effect.

The baseline year for analysis was HEDIS 2007 (calendar year 2006). This year's HEDIS rate for Chlamydia Screening in Women was 54.24%, which was significantly lower than the state average of 59.60%, and is also lower than the NCQA 75th percentile of 60.60%. The health plan experienced decreased rates in 2008 and 2009, which they believe was influenced by the addition of ten (10) expansion counties, where none of the interventions occurred. This was part of the barrier analysis. The health plan believes that continued education and direct member intervention will have a positive effect over time. They plan to continue this PIP and track and trend data to learn if sustained improvement will occur. Adequate information is not available to make a thorough evaluation of the effectiveness of the strategies employed by the health plan at this time.

The second PIP evaluated was the MO Care individualized approach to the Statewide PIP "improving Adolescent Well Care." This is a non-clinical project. The decision to choose this study topic was supported by information provided in the MO HealthNet Managed Care Statewide PIP documentation. The topic selection also included information making this information specific to MO Care and its members. The topic selection narrative focused on the issue of improving adolescent well care as a key aspect of member health care and an important area of prevention. The Health Plan used their current HEDIS performance rates compared to

the NCQA benchmarks and MOHealthNet's required reporting on this measure as basis for evaluating the effectiveness of their individual project. MO Care's stated hypothesis is that member and provider education, as carried out by the Health Plan's individualized interventions, will lead to an increase in the HEDIS Adolescent Well Care Visit rate.

The study question presented was "Can a focused intervention in 2009 on teen health and their responsibilities improve the number of adolescents who receive a well child visit, as measured by the HEDIS Adolescent Well-Care Visit (AWC) rate?" The study question was well constructed and is measurable.

The study used indicators based on the requirements of the HEDIS measures and included a rolling 12-month AWC "HEDIS-like" rate to track data on a monthly basis, which was reported quarterly. The indicators were clearly tied to the issues addressed in this study. The methods prescribed to track and enumerate these measures were included in the narrative provided. The health plan implemented a number of individualized interventions in addition to those included in the Statewide PIP. These health plan specific interventions include:

<u>2009-2010</u>
Teen Health Campaign: Letter and Brochure/Card
Provider Preventive Care Toolkit

<u>2007-2009</u>
Statewide Member Letter and Provider Roster
Come In For Care Campaign
EPSDT Reminder Postcards
Expansion County Campaign

The details of these interventions were provided in the narrative. They were related to the goal of this project.

The data collection and analysis approach was well planned to capture all required information to evaluate this study. The narrative clearly described how data would be collected and analyzed. The information provided was detailed, but lacked a sense of a true study design. This section is coded as "Met" because the required information is included. The study described the process the health plan will utilize to extract data monthly and report quarterly. The specific elements of the HEDIS technical specifications that relate to AWC measure were included. Claims data for the study will be queried from the QNXT system, which is MO Care's claims processing system. Applicable CPT and ICD9 codes were specified. The health plan does utilize the hybrid method for calculating their HEDIS rates, which includes a medical record review. The reviewers, their qualifications, and the interrater reliability requirements were included. The HEDIS-like 12 month rolling calculations are administrative rates. The narrative included enough specificity to ensure confidence that this process was thorough and complete.

A prospective data analysis plan was presented. It did address some information about specific activities to occur in 2009. "In March 2009 MO Care added information to the PIP that included statistical tests of differences between groups, as well as across time periods. MO Care's AWC rates are compared against the statewide average, as well as the national Medicaid NCQA 75th percentile." It included a plan for ensuring that attention to all issues were addressed and explained the methodology to be employed. It outlined a plan to compare each year's data to the 2007 baseline statistics. Statistical calculations to produce the 95% confidence level calculated in the HEDIS methodology will be used to monitor the ongoing process. All data sources were clearly defined and the prospective data analysis plan was followed. The updated documentation did provide details about the staff who are involved in this project, their roles, and qualifications. The 2009 specific interventions were part of this planned analysis.

The study results were provided in the update received after the on-site review. In 2009 the MO Care HEDIS rate was 43.06% and in 2010 (2009 calendar year) the rate was 44.21%. This is a slight, although not a statistically significant increase. This HEDIS rate is above the statewide average, but remains below the NCQA's 75th percentile. The analysis provided did indicate that there is a continued influence of the expansion counties. These expansion counties were originally fee-for-service counties and did not have the advantages of the educational initiatives

the original managed care counties experienced. The health plan concludes that while they continue their current interventions, they will need to enhance their approach and implement new interventions to regain earlier reported improvement in the AWC HEDIS measure.

The analysis included confounding factors and barriers that interfered with improvement strategies. The PIP has matured to a level where evaluation could occur. The health plan recognizes that the number of interventions utilized complicates analysis of which of these offered a specific effect. They assert that given the initial upward trend of the data that this initiative is having a positive and significant effect on member and provider behavior. They did experience some decrease, which is associated with the inclusion of expansion counties where the benefits of the educational interventions did not occur. The teen brochure and educational efforts that began in March 2009 resulted in a new slight increase in rates. MO Care believes this intervention had success that will continue to occur and future measurements will reflect this. The data evaluated provided potential for positive performance improvement. The health plan will continue the most recent interventions and believe that these combined efforts will show sustained improvement over time.

CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the two PIPs undertaken by this health plan. The quality of health care and the overarching issue of the quality of life of health plan members were both addressed in these PIPs. Targeting measures to improve education about the need to utilize opportunities for primary preventive care enhances the quality of services received by members. In both projects the health plan stated their planned intention to incorporate these interventions into normal daily operations as the data indicated positive outcomes. Undertaking PIPs that will develop into enhanced service provisions for members indicates a commitment to quality service delivery.

ACCESS TO CARE

The study topics presented in these PIPs addressed issues that will create improved services and enhance access to care for the health plan members. Although each PIP approached the respective problems differently, each created a potential for improved access to appropriate services, in the least restrictive environment. Access to appropriate screenings and preventive health for teens through reminders and educational information will expand the utilization of available health care services.

TIMELINESS OF CARE

A major focus of these PIPs was ensuring that members had timely access to care. Implementing strategies to ensure that members obtain important health care screenings and adolescent well care screenings continues to positively impact timely access to care. The projects indicate that the health plan has a commitment to assisting members in engaging in timely treatment. Working with providers to encourage patients to make timely appointments for themselves and their children enables better health care outcomes.

RECOMMENDATIONS

1. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the studies submitted has improved. Both studies provided evidence that there was thought and consideration put into planning these studies, developing appropriate interventions, and creating a positive environment for the potential outcomes. This process will also ensure that as the studies are completed, effective data collection and analysis will occur.
2. Consider simplifying the interventions utilized in the studies initiated to enhance the health plan's ability to assess the effectiveness of the strategies employed to create change.
3. Continue to utilize a creative approach to develop projects and implement interventions that will produce positive outcomes. Ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.

10.2 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 MO Care. MO Care submitted the requested documents on or before the due date of March 19, 2010. The EQRO reviewed documentation between March 19, 2010 and June 30, 2010. 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 NCQA RoadMap submitted by MO Care
- MEDSTAT's NCQA HEDIS Compliance Audit Report for 2009
- MO Care's HEDIS Data Entry Training Manual
- MO Care's Policies pertaining to HEDIS rate calculation and reporting

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

- ADV File 1.txt
- ADV File 2.txt
- AWC File 1.txt
- AWC File 2.txt
- AWC File 3.txt
- FUH File 1.txt
- FUH File 2.txt

The hybrid file initially submitted for the Adolescent Well Care Visit measure (File 3) was not provided in the requested format and did not contain the correct data; the health plan was asked to resubmit this file to the EQRO. Also, the DST file submitted initially by MO Care was blank (e.g. did not contain any reported rates) and the EQRO requested a resubmission.

INTERVIEWS

The EQRO conducted on-site interviews with Karen Holt, Accreditation and Quality Management Manager; Christina Schmidl, Quality Coordinator; Mark Kapp, Quality Coordinator; Tammy Weisse, HEDIS, Aetna; and Alan Boyett, HEDIS, Aetna at MO CareMO Care in Columbia, MO on Tuesday, July 20, 2010. This group was responsible for the process of calculating the HEDIS 2009 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

MO Care calculated the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures using the administrative method. The hybrid method was used to calculate the Adolescent Well-Care Visits measure.

MO HealthNet MCHP to MCHP comparisons of the rates of Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, 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 reported rate for MO Care for the Annual Dental Visit rate was 27.41%; this was comparable to the statewide rate for MO HealthNet MCHPs (35.05%, z = 0.25; 95% CI: 28.02%, 38.73%; n.s.). This rate is also comparable to the rates reported in both the 2007 and 2008 EQR report years (27.76% and 27.50%, respectively; see Table 76 and Figure 52).

The HEDIS 2009 rate for MO Care for the Adolescent Well-Care Visits measure was 43.06%, which was significantly higher than the statewide rate for all MO HealthNet MCHPs (35.63%; z = 1.40, 95% CI: 39.25%, 46.86%; p > .95). However, this rate was lower than the rates reported in both the 2007 (44.91%) and 2008 (49.54%) EQR audits for this same measure (see Table 76 and Figure 52).

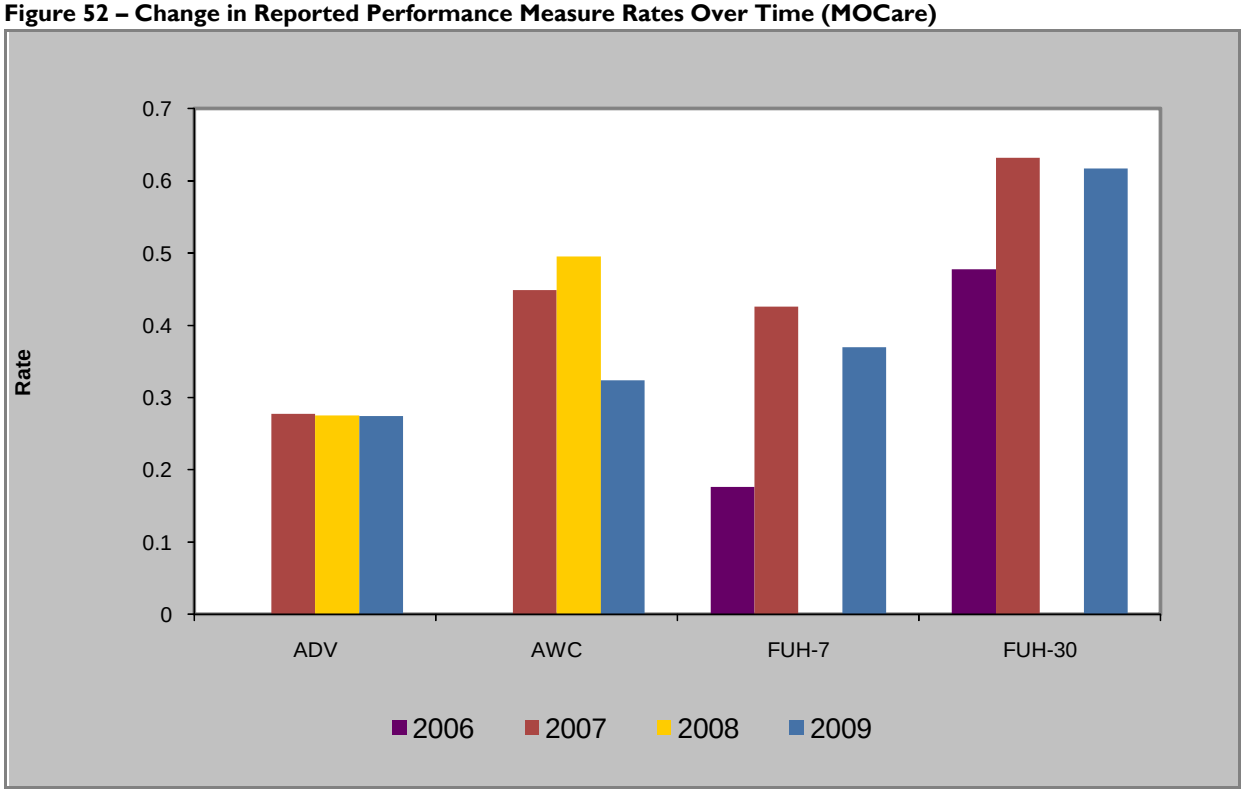
The Follow-Up After Hospitalization for Mental Illness measure 7-day rate reported to the SMA and the State Public Health Agency (SPHA) by MO Care was 39.34%. The rate reported was consistent with the statewide rate for all MO HealthNet MCHPs (41.59%; z = -0.02, 95% CI: 32.16%, 46.52%; n.s.). The rate was lower than the rate reported in 2007 (42.58%), but higher than the same rate reported for the HEDIS 2006 audit (17.65%). The 30-day reported rate was 62.13%, which was also consistent with the statewide rate for all MO HealthNet MCHPs (66.46%; z = 2.52, 95% CI: 54.95%, 69.31%; n.s.). This rate was lower than the rate reported in 2007 (63.16%), but higher than the same rate reported for the HEDIS 2006 audit (47.79%; see Table 76 and Figure 52).

Table 76 – Reported Performance Measures Rates Across Audit Years (MOCare)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate
Annual Dental Visit (ADV)	NA	27.76%	27.50%	27.41%
Adolescent Well-Care Visits (AWC)	NA	44.91%	49.54%	43.06%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	17.65%	42.58%	NA	39.34%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	47.79%	63.16%	NA	62.13%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 52 – Change in Reported Performance Measure Rates Over Time (MOCare)



Sources: BHC, Inc. 2006, 2007, 2008, and 2009 External Quality Review Performance Measure Validation Reports

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 CMS Protocol 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, MO 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 MO Care transferred data into the repository used for calculating the HEDIS 2009 measures. Although the data was complete, the administrative data for the Follow-Up After Hospitalization for Mental Illness measure was not provided to the EQRO in the format requested. Excess columns were added to the original data request format and therefore required additional processing.

DOCUMENTATION OF DATA AND PROCESSES

MO Care used Catalyst, an NCQA-certified software program in the calculation of the HEDIS 2009 performance measures. The EQRO was provided a demonstration of this software, as well as appropriate documentation of the processes and methods used by this software package in the calculation of rates. 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). MO Care met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

MO 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.

For the HEDIS 2009 Annual Dental Visit measure, there were a total of 18,580 eligible members reported and validated by the EQRO.

For the HEDIS 2009 Adolescent Well-Care Visits measure, there were a total of 6,398 eligible members listed by the health plan and validated by the EQRO. MO Care employed a 5% oversample for the Adolescent Well-Care Visits measure. No records were excluded for contraindications, making for a total sample of 432. This is within the specified range and allowable methods for proper sampling.

For the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure, a total of 272 eligible members were identified and validated.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, medication dispensing events, and dental visits) as specified by the HEDIS 2009 criteria (see Attachment XIII: Numerator Validation Findings). A medical records review was conducted for the Adolescent Well-Care Visit measure.

For the HEDIS 2009 Annual Dental Visit measure, the EQRO validated 5,084 of the 5,093 reported administrative hits. The health plan's reported rate was 27.41% and the EQRO validated rate was 27.36%, showing a bias (overestimation) by the health plan of 0.05%.

For the Adolescent Well-Care Visit measure, MO Care reported 171 administrative hits from the sample of the eligible population; the EQRO validation showed 176 hits. For the medical record review validation, the EQRO requested 15 records. A total of 15 records were received for review, and all 15 of those were validated by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 44.21%, while the rate reported by the health plan was 43.06%. This represents a bias of 1.16%, an underestimate by the health plan for this measure.

For the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure 7-day rate, the health plan reported 107 administrative hits from the eligible population; the EQRO was able to validate 106 of these hits. The reported rate was 39.34%, and the rate validated by the EQRO was 38.97%. This represents an overestimated reported bias of 0.37%.

The 30-day rate showed the reported number of administrative hits as 169; the EQRO validated 164 hits. This represents a reported rate of 62.13% and a validated rate of 60.29%, a 1.84% bias (overestimate) by the health plan for this measure.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

MO 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

The following table shows the estimated bias and the direction of bias found by the EQRO. The Adolescent Well-Care Visits measure showed an underestimate, and the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures were slightly overestimated, but all results fell within the 95% confidence interval reported by the health plan for these measures.

Table 77 - Estimate of Bias in Reporting of MOCare HEDIS 2009 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.05%	Overestimate
Adolescent Well-Care Visits	1.16%	Underestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	0.37%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	1.84%	Overestimate

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. The table below summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.

Table 78 - Final Audit Rating for MOCare Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially 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 health plan. 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 MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the health plan. One of these rates was significantly higher than and two were consistent with the average for all MO HealthNet MCHPs.

QUALITY OF CARE

MO Care's calculation of the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was substantially complaint with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The health plan's rate for this measure was consistent with the average for all MO HealthNet MCHPs. Therefore, MO Care's members are receiving the quality of care for this measure that is comparable to the average MO HealthNet MCHP member. The 7-day rate was lower than both the National Medicaid and National Commercial averages; the health plan's members are receiving a lower quality of care than the average Medicaid or Commercial member across the country in the 7-day timeframe. The 30-day rate was slightly higher than the National Medicaid average and below the National Commercial average; the health plan's

members are receiving a higher quality of care as the average Medicaid member across the nation, but a lower quality of care than the average Commercial member in the 30-day timeframe. Both the 7-day and 30-day rates are lower than the rates reported in the HEDIS 2007 audit, but higher than the 2006 rates.

The rate was able to be validated within the reported 95% confidence intervals and thereby the EQRO has substantial confidence in the calculated rate.

ACCESS TO CARE

The HEDIS 2009 Annual Dental Measure for MO Care was substantially compliant with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The rate reported by the health plan for this measure was consistent with the average for all MO HealthNet MCHPs. Therefore, MO Care's members are receiving a quality of care for this measure that is on level with the average MO HealthNet Managed Care member. However, this rate was much lower than the National Medicaid rate for this same measure, indicating the health plan's members are receiving a lower access to care than the average Medicaid member across the nation. This rate has fluctuated only slightly across the HEDIS 2007, 2008, and 2009 measurement years, but has continued to fall.

The rate was able to be validated within the reported 95% confidence intervals and thereby the EQRO has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2009 Adolescent Well-Care Visits measure was substantially compliant with specifications. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was significantly higher than with the average for all MO HealthNet MCHPs. Therefore, MO Care's members are receiving a higher timeliness of care for this measure than the care delivered to the average MO HealthNet Managed Care member.

This rate was higher than the National Commercial Rate but below the National Medicaid Rate; MO Care is delivering a higher level of care than that received by the average Commercial member across the nation, but a lower level of care than the average national Medicaid member. Additionally, the rate reported was lower than the rate reported by the health plan during both the 2007 and 2008 review periods.

The rate was able to be validated within the reported 95% confidence intervals and thereby the EQRO has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. The health plan's rates for the Annual Dental Visit measure have fallen over each of the past three review periods in which the measure was audited. The EQRO recommends the health plan concentrate efforts to improve this rate and reverse this trend.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Continue to participate in training of health plan staff involved in the oversight of coordination of performance measure calculation.
4. Continue to perform hybrid measurement on those measures that are available for this method of calculation.
5. MO Care should thoroughly review the data request format file prior to submitting data to the EQRO. This will ensure that the EQRO receives the data in the appropriate format to allow for the most complete validation possible.

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 68,427 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant 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, 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, 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, the second, third, fourth and fifth Diagnosis Code fields were well below the SMA threshold of 100.00% for completeness, accuracy and validity. The Diagnosis Code fields were 30.9%, 21.6%, 11.8%, and 0.00% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate and invalid).

For the Dental claim type, there were 187 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All required fields, except the fifth diagnosis field were 100% complete, accurate and valid.

For the Home Health claim type, there were zero encounter claim paid by the SMA for the period July 1, 2009 through September 30, 2009.

For the Inpatient claim type, there were 8,045 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 valid.
5. The Discharge Date field was 100.00% complete, accurate and valid.
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 through fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (78.01%, 80.01%, 60.61%, 44.19% and 24.87% respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
9. The First Date of Service field was 100.00% complete, accurate and valid.
10. The Last Date of Service field was 100.00% complete, accurate and valid.
11. The Revenue Code field was 100.00% complete, accurate, and valid.
12. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 51,765 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. MO Care had 100.00% complete, accurate and valid data for all fields examined, except the Procedure Code, second, third, fourth and fifth Diagnosis Codes.

1. The Procedure Code field was 95.2% valid. The remaining fields were blank (n=2,459).
2. The second Diagnosis Code field was 43.0% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).
3. The third Diagnosis Code field was 25.0% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).
4. The fourth Diagnosis Code field was 12.20% complete, accurate, and valid. The remaining Diagnosis Code fields were blank (n = 45,435).

5. The fifth Diagnosis Code field was 5.9% complete, accurate and valid. All remaining Diagnosis Code fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 20,240 claims paid by the SMA for the period July 1, 2009 through September 30, 2009. MO 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 MO 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 Inpatient, Home Health and Pharmacy claim types were 100.00% complete, accurate, and valid (see previous findings). The Outpatient Hospital Claim type had invalid data in the Procedure 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 for Outpatient Hospital claim types were significantly higher than the average for MO Health Net MCHPs. The rate for Outpatient Medical, Dental, and Pharmacy claims was significantly lower than the average for MO HealthNet MCHPs. The rates for all other claim types were consistent with the average for MO HealthNet MCHPs. 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 MO HealthNet MCHP were randomly

selected from all claim types for the period July 1, 2009 through September 30, 2009 for medical record review.

Of the 120,379 Outpatient encounter claim types in the SMA extract file for July 1, 2009 through September 30, 2009, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 99 medical records (99.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated.

For the 2007 review, the match rate for procedures was 58.0%, with a fault rate of 42.0%. The match rate for diagnoses was 60.0%, with a fault rate of 40.0%. For 2008, the match rate for procedures was 53.0%, with a fault rate of 47.0%. The match rate for diagnoses was 47.0%, with a fault rate of 53.0%.

For this review, the match rate for procedures was 79.0%, with a fault rate of 21.0%. The match rate for diagnoses was 81.0%, with a fault rate of 19.0%. These rates are significant improvements over the prior two years' reviews.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed was conducted.

For the procedure codes in the medical record, the reasons for diagnosis codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 18) and incorrect information (n = 1). 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 was missing information (n = 20), downcoding (n =1) and incorrect (n = 4). Examples of incorrect information include codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since MO Care included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet MCHP encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the health plan 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 was of "paid" status. There were zero unmatched claims that were in the MOCare encounter file and absent from the SMA data. Thus, 100.0% of the EQRO submitted encounters matched with the SMA encounter records.

For all Outpatient Claim Types (Medical, Dental, and Hospital), MOCare submitted 120,379 "paid" encounters, 217 "denied" claims and 38 "unpaid" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims and unpaids claim were not present in the SMA database (as expected); there was a "hit" rate of 99.79% between MOCare encounter claims and the SMA encounter data.

For the Inpatient Claim Type, MOCare submitted 8,045 encounter claims of "paid" status and 97 "denied" claims and 50 "unpaid" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims were not present in the SMA database.

Why are there unmatched claims between the MO HealthNet MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

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

While the MO HealthNet MCHP 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. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the health plan data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet MCHP 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.

CONCLUSIONS

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 MO HealthNet MCHP 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, Home Health and Pharmacy claim types were 100.00% complete, accurate and valid.
4. The health plan had the highest match rates of all health plans for both diagnosis and procedure codes for the medical record review.

AREAS FOR IMPROVEMENT

1. The health plan reported zero Home Health encounter claims during the review period.
2. The Outpatient Hospital Procedure Code fields contained invalid entries.

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 Revenue Code fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
3. Include all State issued ICN numbers for all encounters to allow more accurate matching of encounters between the MO HealthNet MCHP and SMA extract files.
4. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis. The Health Plan should consider collecting medical records and reviewing the submissions prior to providing them to the EQRO for review, as some incomplete records were received, thereby missing the information necessary for validation.

10.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet MCHP's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). This ensures that each MO HealthNet MCHP's documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations. Prior to the on-site review Case Management cases were reviewed by the EQRO for compliance with policy, and to ensure that practice reflected policy requirements. On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. Interviews occurred with Case Management Staff, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds the federal regulations.

Initial interviews were conducted with the Case Management Staff. These interactions and responses were compared to policy requirements and to the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff.

The interview questions posed to Case Management staff were generated by the cases reviewed as well as the review of Health Plan Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the health plan processes. Additionally, interview questions were formulated for Administrative staff to validate and clarify these practices, to follow-up on questions raised from the case management staff interviews, and to respond to questions that arose from the document review. These interview questions were developed from the MO Care 2009 Annual Evaluation Report and the SMA's Quality Improvement Strategy.

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)
- MO Care Health Plan 2009 Annual Evaluation

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2009 Marketing Plan and Materials
- Case Management Policies and Instructions
- 2009 Quality Improvement Committee minutes

Additional documentation made available by MO Care included:

- Missouri Care Organizational Chart
- Missouri Care Provider Directory
- 2009 Member and Provider Newsletters

INTERVIEWS

Interviews were conducted with the following groups:

Case Management Staff

Mary Strada, Adult/Pain Management Case Manager
Amanda Lucas, Perinatal Case Management Nurse
Janette Hagan, Case Management
Angela Lucas, Pediatric BH Care Planner
Archie Hamilton, Adult BH Care Planner
Gina Cooper, Pediatric Case Management, Jackson County
Shawna Guinn – Perinatal Case Management
Lisa Garrett – Perinatal Case Management
Denise Henry – Perinatal Case Management

Plan Administration

Pamela Johnson – Executive Director
Dr. John Esslinger – Chief Medical Officer
Marcia Albridge – Director, Government Program Operations
Melody Dowling – Director of Health Services
Christina Schmidl – Quality Analyst
Tony Gutierrez – Director of Operations
Stacy Meyr – Provider Relations
Jay Ludlam – Claims Reconciliation and Operations Manager
Karen Holt – Accreditation and Quality Management Manager

Case Management Interviews

- The cases pulled were "random", but all focused on behavioral health case management. Discuss the integrated case management process and how this effects member services.
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Discuss the assessment process.
- How do you determine if a member is having problems? Do you receive any reports that might indicate a red flag in member care? What actions are you required to take?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members with mental health care needs.

Findings

The case managers reported that beginning in 2009 MO Care case records were considered to be integrated. Integrated, it was explained, means that one case manager handles the case, whether the needs are primarily physical or mental health. The goal is to create less confusion for members. All information regarding the member's health plan services should be included in one record. However, in the cases reviewed the information provided concerned mental health services. No information was included, even about the simplest physical health issues, such as immunizations. The cases did include some evidence of case management services such as assessments and goal establishment.

In the records reviewed there was evidence that physical health needs existed. In one example the parent, according to case manager notes, was seeking a referral for dental and vision services. There was no documentation that this assistance was provided. In another example the member, who worked and attended school, needed an after-hours appointment. There was no documentation of assistance in finding a provider who saw members after-hours.

The case records did indicate that case managers were persistent in locating members. In some cases members declined services, but they were contacted directly by health plan staff. The case notes also provided information on referrals to disease management for members with asthma, COPD, diabetes, and depression.

Case managers reported that early in 2009 behavioral health and physical health records were separate. However, later in the year, these records were integrated and should reflect both

physical and mental health case management. The case manager is to be the single point of contact for the member for all health plan services. The case managers collaborate during rounds to assist each other with member issues. Seminars were provided for both physical and mental health to familiarize case managers from each discipline with the areas that were new to them. The case managers reported that new staff was added in October 2009, which reduced their caseloads, and improved their ability to adequately serve their members. In addition their case management system has been significantly enhanced and is much more inclusive of information on all member service needs. This system was reviewed during the on-site visit to validate improved case notes and documentation regarding case management services.

The case managers openly discussed the assessment process they employ. In their previous system the assessment captured what had occurred in members' past experience. The new system captures members' medical history, but also information about their current status and activities, as well as the services they need or are requesting. The current assessment system is a total health questionnaire, not just an assessment of physical or mental health. The assessment tool asks questions about daily living activities, and current conditions. This provides a broad spectrum of information that the case managers report using in providing a holistic evaluation of the member in question. The system also prompts the case manager to update the member's situation every thirty (30) days.

The case managers also discussed their experiences with expanding their service area into the Eastern and Western MO HealthNet Managed Care areas. In Jackson County the case managers collaborate with the social workers from the DSS Children's Division. A number of the members in foster care receive targeted case management services. The MO Care case managers ensure that services are received without complicating issues for the member. In some cases where complex case management is required the MO Care case manager may be the main coordinator of medical care, but also may be a resource to the lead social worker. Provider Relations staff members are also located in Jackson County and assist the case managers in identifying resources to meet members' service needs. The case managers report that they attend meetings of the Alternative Care Committee with other health plan representatives and share resource information.

Another case manager is primarily responsible for the Eastern Region. She explained that many of the current health plan members receive services from the FQHCs. They also serve a large number of members who are pregnant. A large percentage of these members are high risk obstetrics cases with special needs. She utilizes all available resources to meet members' service needs.

These case managers also discussed the problems they often have in contacting members. They utilize provider relations and medical office staff to assist in obtaining current and accurate telephone numbers and addresses. In addition the health plan has contracted with a company who will make visits directly to the member's home to validate their location.

The case managers reported that they have constantly evolving network resources for vision and dental care. The health plan recently changed vision subcontractors and they now work with March Vision. They are pleased with this change and believe service availability has improved. They did explain that Doral Dental is now DentaQuest. The contractor has assigned a Dental Representative for MO Care, through their member services section, who is actively involved in identifying available providers and making referrals for MO Care members.

The case managers did explain that one barrier that currently exists is the NCQA requirement regarding members voluntarily accepting case management services. In the past they would explain services to members, and if they did not object, they would open cases and become actively involved in assisting with services. Now the member must openly agree to case management services or the case cannot be opened. If the case appears to be high risk they may contact a member one more time to ensure they are not experiencing problems. If a member's name appears on the Special Needs Report, or their internal "Care Report" they will contact the member again and attempt to engage them in accepting services. In some cases provider offices have also contacted members and encouraged them to accept case management. Specialists and PCP's have asked for case management, and unless the member agrees they cannot open a case, even if the physician involved insists. When a member does agree with case management, they receive a "welcome letter" and a care plan. This plan is also sent to the physician involved.

Upon completion of the interview questions, the case managers demonstrated their new case management system. It provides a much improved format for documentation of both the physical health and mental health service needs and assistance provided. The documentation includes the assessment, goals, and interventions provided. It also provides prompts for future contacts and questions to ensure that the member's needs are thoroughly evaluated.

Administrative Interviews

- Give examples of measures that the Health Plan implemented to improve the follow-up process for members included in the State's Special Needs report.
- Has case management policy been approved by MO HealthNet?
- What is the status of changes to the MO Care data management system to allow the capture of more information specific to the case management process?
- What are the improvements in the specialist network in the Eastern and Western MO HealthNet Regions?
- The need for recruitment of dental and vision providers was a recurring theme in the case management records reviewed. How successful is the health plan on addressing these issues? What has occurred?
- The document review indicated that the health plan has had difficulty in finding OB and psychiatric providers (Eastern MO HealthNet Region).
- Discuss the health plan's cultural competency program.
- How does the internal Behavioral Health System interact with the case management system? The written information implies that Behavioral Health Case Management supersedes regular Case Management. What is the relationship between these departments? How does this enhance services to members?

Findings

Administrative staff gave a brief overview of the health plan's expansion into the Eastern and Western MO HealthNet Managed Care Regions. They reported about 4,000 members in each of these regions. They believe they now have adequate obstetrical services throughout the three regions, but continue to have difficulty in finding psychiatric services in the Eastern Region. Psychiatrists at Washington University are seeing MO Care members on an emergency basis, but are not yet in the health plan's network. The health plan also reports that finding adequate services for members with autism is difficult in the Western Region, but they are making out of network referrals to provider agencies in Kansas when necessary. The health plan does have a contract with the Thompson Center in the Central Region, and with transportation assistance it will provide assessments for members from all three regions.

The health plan reports recruiting new vision and dental providers through the contracting changes they have made. Their current vision service is through Marsh Vision, and their dental services are through Doral Dental (DentaQuest). They believe their HEDIS rates for dental care will increase as the result of this change in subcontractors.

Cultural competency is a targeted goal for the health plan. They are providing web based training to staff and providers. The training is free of charge and CME credits are given for completion. The training materials were reviewed and critiqued by advocates. The health plan believes this process has strengthened the training contents. The health plan has noted a growth in the Spanish speaking and Vietnamese populations.

The health plan has also initiated a project to impact misuse of emergency room services. They are partnering with providers to identify non-emergency cases and referring members to alternate medical services, including urgent care centers and to providers with expanded office hours. When a member uses the emergency room the health plan sends a letter with information on their medical home and brochures about working with their providers.

Enrollee Rights and Protections

MO Care has an assigned compliance officer who maintains a record of all internal policies and presents reminders to appropriate staff when annual reviews are required. Compliance reviews are 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 Chief Medical Director, and the Executive Director prior to submission to the SMA.

Case Management staff focus on referrals received from a variety of sources, but particularly from Member Services and provider offices. They report that when interacting with members both Member Services and Behavioral Health recognized members' needs for additional case management. The case managers utilize the system generated predictive modeling system to identify the service needs throughout the assessment process. They ask questions of members

to additionally evaluate a need for services. The case managers related that certain diagnoses trigger the referral for case management, such as identifying a member with asthma.

The case managers gave an example to explain typical case management activities. In this situation a family was identified who had special needs that were not being met. The case managers often contact the Family Support Division to assist with services, the Department of Mental Health Regional Center and the Bureau of Special Health Care Needs.

The case managers described a number of members as having problems with issues such as pain management. In these cases they consult with the Medical Director, who may have denied the member for narcotic medication. The case manager works with the member to utilize a pain management clinic or specialist. They do extensive follow-up and focus on education and coordination of care needs for these members.

MO Care continues to participate in community-based programs throughout all three MO HealthNet Managed Care regions. They were involved in school-based health clinics whenever possible. The health plan 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. One local Federally Qualified Health Center (FQHC) conducts evening appointments to do Pap tests and adolescent EPSDT examinations. Through efforts with the Columbia Public Schools, the health plan 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 the Frederick Douglass High School building. A quarterly newsletter for school nurses was developed and continues to be distributed by the Health Plan.

The case managers report that they do a lot of research regarding community based services as the result of their large and diverse service area. They utilize the Internet, the local Family Support Division offices, the county libraries, local churches, and food pantries all as sources of information and assistance for their members. The case managers discussed their relationship with the Nurse Help Line, which is located out-of-state through Aetna, their parent company. They reported that this resource is working effectively for health plan members due to training

about the Missouri program. The Nurse Line sends a daily report of their calls and contacts and makes direct referrals for case management.

The rating for Enrollee Rights and Protections (100%) reflects that the health plan 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 health plan appears to be fully compliant with MO HealthNet Medicaid Managed Care Contract requirements and federal regulations in this area.

Table 79 – Subpart C: Enrollee Rights and Protections Yearly Comparison (MO Care)

Federal Regulation	MO Care		
	2007	2008	2009
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	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., 2004 External Quality Review Monitoring MCOs Protocols.

Behavioral Health

MO Care reports that their Behavioral Health system continues to improve. The use of an "in-house" model of Behavioral Health has led to an integrated system of case management. In all cases the case managers involved ensure that the member has access to both the physical and mental health services and remain involved and aware of the services needs of the member. The staff participates in weekly case presentations with both Medical Directors. The case managers from both departments attend monthly training sessions and collaborate in consulting on member issues to get support in an area where they are not experts. This training focuses on health issues that are common to both and on working together in an interdisciplinary approach. The staff reports that communication is a strength and that they consider their method a bio-social-psychological model.

MO Care reports that provider availability continues to improve. There is a large network using smaller in-home provider groups, as well as independent providers. The health plan reports that through working directly within the communities they serve, they have been able to identify and recruit mental health providers that are regionally based. These providers are often keenly aware of community and family issues and assist members in obtaining the best service in the most convenient environment. The health plan finds that issues such as drug overdoses are now treated appropriately. In the past, members were seen in an emergency room and released. Efforts to educate providers have created an atmosphere where the health plan is notified and follow-up services are put in place in an expedient manner.

Case managers have access to all member information, whether it comes from a physical or mental health source through their case management system. The system is linked to the authorization and claims system. All demographics and PCP identification are automatically added to the member's screens.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

The health plan continues to work to develop new and additional resources for their members. The MO Care network includes Kansas City Children's Mercy Hospital, St. Louis Children's Hospital, and the University of Missouri Health Care System. These resources make specialties, such as orthopedic services accessible to members. Pediatric cardiology and neurology are available at the University of Missouri Hospital and Clinics.

The health plan contracts with Doral Dental (DentaQuest) that does have an extensive network, which includes providers in the rural counties. Missouri Care describes Doral Dental's network as having a national presence. The company understands the health plan's population. MO Care has a liaison from Doral who understands local needs and issues, and is able to effectively improve the local network. The health plan reports that dental providers are more satisfied with the current system and do not report problems working with Doral. The Doral Dental staff responds to members needs in a timely manner. If a member is not able to obtain an appointment the dental subcontractor will contract with a non-network provider to allow quick access to services. Doral Dental has also developed a strong working relationship with PCPs in the area, which is a benefit for members.

The health plan uses a predictive model to identify candidates for case management. This model, Pathways, gives a profile which assists in identifying the potential for case management. Through the information obtained from this system, the case manager can determine the reasons for accessing care. Other categories of care explored include the providers utilized, the amount and types of pharmacy usage, and the durable medical equipment authorized and purchased. Through the daily patient census, a drill down can provide reasons for admission such as maternity, behavioral health verses physical health, as well as identifying the inpatient facility used and the length of stay. This program refreshes every three hours and is linked to Milliman Guidelines for the utilization review purposes. A link does exist to review notes. The model gives a quick look at member activity for a one year timeframe. The health plan relates that the model is useful to both case management staff and providers. Another advantage is

providing information to the Medical Director to discuss a case with the Primary Care Physician. This often enables the physicians to ask and resolve questions quickly.

The rating for Access Standards (100%) indicates that the Health Plan has actively worked toward becoming fully compliant with all MO HealthNet Managed Care requirements and the federal regulations. All practice in this area observed at the time of the on-site review indicated that MO Care worked toward ensuring that members have access to all the healthcare services that they may require.

Table 80 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (MO Care)

Federal Regulation	MO Care		
	2007	2008	2009
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	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., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

All credentialing performed by MO Care meets NCQA standards and complies with federal and state regulations, and the SMA contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS OIG/OPM (Office of Inspector General/Office of Personnel Management) web site. The Health Plan reports that in the credentialing process they review malpractice and complaint history. The physician write up explains specific information on each issue revealed in the investigation.

Internal information regarding grievances and quality issues are monitored. Compliance with policies relating to advance directives is monitored. The advance directives are to be in the records of primary care providers prior to re-credentialing (for PCP, hospital, home health agency, personal care provider or hospice). Confidentiality, nondiscrimination and rights to review files and to appeal are all included. Delegation agreements are developed in accordance with MO Care policy. The delegation of responsibility must include all delegated activities and the organization's accountability for those activities.

The health plan does monitor the subcontractors, including MTM Transportation, March Vision, and Doral Dental. Detailed histories, problem resolution, and performance improvement are reviewed each year.

The rating for Structure and Operations (100%) reflects full compliance with the MO HealthNet Managed Care contract requirements and federal regulations. The Health Plan 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 subcontractor requirements were met.

Table 81 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (MO Care)

Federal Regulation	MO Care		
	2007	2008	2009
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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.

Measurement and Improvement

MO 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 health plan initiatives. MO Care adopted and disseminated practice guidelines in the area of diabetes, asthma, chronic obstructive pulmonary disease (COPD), ADHD, and congestive heart failure. This information was available to all providers on the Health Plan website. MO Care indicated that they continue to utilize the practice guidelines for depression management. Disease management is directed from the health plan corporate office and covers asthma treatment, COPD, diabetes and CHF. Co-case management can occur when it is in the member's best interest.

The health plan's information system now captures information on ethnicity, which is utilized to expand the health plan's cultural competency program. MO Care recognizes that these improvements allow them to capture useful data that will inform the health plan as they expand services in all three MO HealthNet Managed Care regions.

The health plan did submit 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. MO Care also submitted all required encounter data in the format requested. The specific details can be found in the appropriate sections of this report.

The health plan discussed instances of fraud and abuse discovered during 2009. In most of these cases an investigation uncovered billing errors as the causal factor. The health plan did conduct follow-up through the Provider Relations unit. The health plan staff exhibited a depth of knowledge about the fraud and abuse issue. It is apparent that they have a great deal of expertise on this subject matter and follow this issue closely.

The rating for the Measurement and Improvement section (100%) 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 MO HealthNet Managed Care contract and the federal regulations.

Table 82 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (MO Care)

Federal Regulation	MO Care		
	2007	2008	2009
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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 MO HealthNetManaged Care Program. This percent is calculated for the regulations that are applicable tot the MO HealthNetManaged 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

The grievance system operated efficiently in this office. The health plan reports that when they receive provider complaints, these are reviewed by the provider representatives in the provider offices. They find that most of these complaints are the result of claims issues, such as timely filing. Many of these resulted from behavioral health providers who do not submit invoices within prescribed timeframes. MO Care reports that this issue will be resolved with training and continued support from the provider representatives. The Medical Director is maintaining regular communications with the providers, resulting in fewer calls or formal complaints being filed.

The health plan maintains a data base that is available to staff for reviewing grievances and appeals. Trends are identified and discussed quarterly. The health plan staff looks at repeated complaints regarding any specific provider or clinic. When a problem, such as inability to obtain timely appointments, is identified the provider relations unit does follow up with that office. Updates and expansion is planned for this system in the coming year.

The rating for Grievance Systems (100%) reflects that all policy and practice met the requirements of the MO HealthNet Managed Care contract and federal requirements.

Table 83 – Subpart F: Grievance Systems Yearly Comparison (MO Care)

Federal Regulation	MO Care		
	2007	2008	2009
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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

CONCLUSIONS

MO Care continues to maintain compliance in all areas of policy, procedure, and practice required by the MO HealthNet Managed Care contract and the federal regulations. The health plan utilizes a proactive approach to identifying issues discussed in previous External Quality Reviews, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to the SMA in a timely and efficient manner.

The staff at MO Care exhibits a commitment to quality and integrity in their work with members. The health plan utilizes 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. They are committed to this integrated approach where case managers utilize the areas of expertise of their team members, yet provide individualized services to members to eliminate confusion. MO Care has created tools to educate and inform the community and providers. The health plan 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 health care needs. MO Care attempted to create a health care service system that was responsive and assisted members in overcoming the barriers they encounter in all three diverse areas that they serve.

QUALITY OF CARE

Quality of care is a priority for MO Care. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are evidence of the commitment to quality healthcare. They are making a concerted effort to extend this approach to all three MO HealthNet Managed Care regions. MO Care completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements. A commitment to obtaining quality service for members is evident in interviews with health plan staff, who express enthusiasm for their roles in producing sound healthcare for their members.

ACCESS TO CARE

MO Care has made concerted efforts to ensure that members throughout their MO HealthNet Managed Care Regions have adequate access to care. They have recruited additional hospitals and individual providers into their network. The health plan has participated in community events to promote preventive care and to ensure that members are aware of available services. The health plan exhibits an awareness and commitment to resolving issues that are barriers to member services.

TIMELINESS OF CARE

MO Care has developed procedures to ensure that policy is submitted in a timely manner and that all tracking tools are up-to-date. They are utilizing greatly improved case management software and systems tools to have the most accurate and up-to-date information available on members to support them in obtaining appropriate healthcare services in a timely manner. The health plan has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

RECOMMENDATIONS

1. Continue health plan 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 and other community-based entities throughout the all three MO HealthNet Managed Care Regions to contact members for educational opportunities.
3. Continue monitoring access to dental care and assist in recruitment of providers throughout all Regions.
4. Continue to develop and improve the multi-disciplinary approach to working with members that have complex health care issues.

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11.0 Molina Healthcare of Missouri

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11.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Molina supplied documentation for review of two Performance Improvement Projects.

- Members at High Risk for Cesarean Wound Infection
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Molina HealthCare of Missouri

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 16, 2010 during the on-site review. Interviewees included the following:

Joanne Volovar – Plan President

Robert Profumo, MD – Chief Medical Officer

Jennifer Goedeke – Director, Quality Improvement

Christine Cybulski – Quality Improvement Analyst

April Gross – Clinical Case Manager II

Mary Luley – Manager, 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 were the members of the staff involved with the project and what were their roles?
- How was the topic identified and the choice justified ensuring that the PIP truly addressed an important aspect of member care and services?
- How was the study question determined?
- What were the interventions?
- What was the time period of the study and is it complete?
- What were the findings?
- Were the interventions effective?
- What does Molina want to study or learn from their PIPs?

The PIPs presented did contain significant documentation. However, it was stated that additional data analysis would be available at the time of the on-site review. Additional time was provided following the on-site review for Molina to supply an update of both Performance Improvement Projects prior to final evaluation.

FINDINGS

The first PIP evaluated was Members at High Risk for Cesarean Wound Infection. This PIP was submitted as the clinical Performance Improvement Project (PIP). This project grew from previous years' PIPs, which have developed into the Health Plan's practice of providing case management services to all pregnant members. The original PIP "Early Intervention in Prenatal Case Management and the Relationship to Very Low Birth Weight Babies," was evaluated in the 2006 and 2007 EQR. The current PIP looks at members who require a cesarean section at the time of delivery and have risk factors for wound infection. The concept is presented with background concerning health plan members. The research includes the methodology for determining the risk factors. The documentation presented does explain the costs associated with unnecessary hospitalizations and costs associated with Cesarean Section Wound Infections (CSWI). However, it clearly identifies that the PIP was created in an effort to increase the use of post operative home health and member education in an attempt to proactively impact this

issue. This topic was identified as a serious issue regarding member health and a costly issue for the health plan. References and research information was provided, but the topic selection was largely generated by recognizing CSWI as a serious health care issue for members that could be impacted by a health plan intervention.

The topic selection is defined as a key aspect of member care. It recognizes that "prolonged recovery time for post-partum mothers, and in some instances that may require further surgical interventions," as not in the members' best interest.

The objective of the study is to reduce the number of CSWI and improve women's recovery time. It will include all women having a cesarean section, with identified risk factors. The study question is: "Will increased home health care visits and member education provided to high risk OB members decrease the rate of re-hospitalizations due to cesarean section wound infection?" The documentation discusses why this population was chosen, and potential interventions. It is measurable.

The Health Plan defines their measurable indicator as any member receiving a cesarean section with specific diagnosis codes included in the PIP documentation. This notification will trigger a review of health and case management history. A second indicator is any health plan member delivering by cesarean section with one or more CSWI risk factors. When CSWI risk factors are identified, additional home health care and enhanced educational activities are put in place, including follow-up with the member's provider and antibiotics. These activities promise to have a positive impact on member health care. The health plan has clearly defined all members to whom the study question applies, and has implemented a data collection approach to capture all appropriate members.

The study design was presented in detail. The data will be collected from all pregnant women (health plan members), women participating in the case management assessment process, members who have risk factors, women having a cesarean section, and women requiring hospitalization. All sources of data to be included in this plan were explained. The members in the OB Case Management (OBCM) program are tracked in a specific case management system. These members are tracked and services are maintained, unless the member "opts out" of the program voluntarily. This system will also track members having a Cesarean section and service

interventions will be recorded there. The health plan will also utilize their claims system to ensure that all eligible members are identified. The health plan defined the system it plans to use to compile statistics regarding the outcomes of the project. It does appear that they will collect valid and reliable data. The health plan could provide additional detail that will ensure the collection of accurate and consistent data over time.

The study design and prospective data analysis plan are further detailed in the data collection section of their report. This information includes data collection and barrier analysis descriptions. All members of the health plan team, including the team leader, are identified, including their roles and qualifications.

The interventions and improvement strategies listed are as follows:

- Promote communication and advocacy with OBCM between members and providers in identifying members having one or more of the seven risk factors identified.
- Education about post partum wound infections and the necessary educational tools provided prior to discharge and/or during the first home health visit.
- Home health visits for those members delivering by cesarean section including education on the signs and symptoms of CSWI.
- Assess Members' educational level and understanding of proper wound care as well as signs and systems of infection.
- Identify language barriers and provide translation when needed for members during education on wound care.
- Assess the member's ability to cleanse and care for wound through demonstration.
- Provide tools for providers to disperse to members who are at risk of developing post cesarean wound infection and/or delayed tissue healing with one or more of the identified risk factors.
- Track and trend providers and facilities to ensure that the CSWI rate is not due to individual issues requiring more focused educational efforts.
- Educate Provider Relations in promoting provider compliance in completing pre-natal assessment forms and returning to the Health Plan to assist with identifying members "at risk."
- Inform providers using the Health Plan newsletter, on the purpose of this PIP and the importance of Health Plan notification of members with potential risk.

The project was initiated in 2008. In 2009 CSWI decreased by 33%, although this was not a statistically significant decrease. Although statistical significance could not be determined, the health plan did determine that there was a decrease in the number of hospitalizations and the number of inpatient hospital days. The stay and costs associated with CSWI all show improvement. The health plan included a diagram of how risk is determined. All tables and graphs included were understandable and supported the information in the narrative provided. The health plan can identify a significant decrease in costs due to early identification and treatment for infections that do occur. This is an indicator of improved care and services to the members involved. The health plan believes that the approach, which mirrors the case management approach in the previous PIP, is sound and has produced solid measureable outcomes. The health plan also reports that the number of members currently experiencing CSWI is below the national average of 1.5%

The narrative supplied provides a sound argument about the health plan's ability to maintain sustained improvement through utilization of this approach to member health care. Early statistics from 2010 support this contention. The health plan states that "The processes and interventions established by this PIP will, over time, continue to improve the overall health of members during the post-partum period as well as decrease any potential physical separation between the member and the newborn during the immediate postpartum period." This comment is an excellent summary of the positive benefit that undertaking this project has created.

The second PIP evaluated was the Molina individualized approach to the Statewide PIP "Improving Adolescent Well Care." This is a non-clinical project. The decision to choose the study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. In addition the Health Plan included information about how this subject is relevant to Molina members. The Molina HealthCare plan stated that it was focused on correcting a deficiency in health care. Their population base is members ages 12 – 21 as detailed in the Statewide PIP and in the HEDIS technical specifications.

The 2009 study question stated by the health plan is "Will focused educational efforts and outreach to Molina providers and members aged 12 to 21 increase the number of annual Adolescent Well Care Visits?" The health plan's stated goal is to reach the 50th percentile for the HEDIS 2009 (CY 2008) data set and 75th percentile for future data sets. The question was formulated using the Statewide PIP as a foundation, while including health plan specific goals as well. The identified indicator is the Molina HEDIS rate for the Adolescent Well Care measure. The information provided describes an objective measure, which indicates an improvement in the process of data collection as well as improving information to members and providers. Little information was provided that indicates that the health plan is seeking an improvement in the process of care and how this will impact member health care. The study population, specific to Molina members is defined. The narrative indicates that all data will be collected in accordance with the HEDIS technical specifications.

The study design does clearly indicate the data to be collected and its sources. This includes claims information and the specific CPT and ICD9 codes. The health plan will use the hybrid methodology to calculate their HEDIS rates so the utilization of a medical record review is discussed. The study design does specify a systematic method of collecting valid and reliable data. This portion of the documentation discusses data collection within the scope of the HEDIS specifications in great detail. The health plan included detailed information regarding data collection instruments and methods including a description of the NCQA software used by a previous vendor and the certified software they are currently using. The health plan discusses the use of the hybrid methodology, but did not include a medical record abstraction tool in the information provided.

All members of the PIP team, including the project leader, are identified. Their roles and qualifications are included.

The data analysis plan for Molina includes specific interventions as follows:

- Treating AWC as a hybrid measure, therefore, requiring a medical record review to determine a more accurate HEDIS rate.
- Developing and distributing "EPSDT At-A-Glance" to all providers.
- Continue to mail Welcome Packets with Immunization Schedules and the need for well-care visits.
- Continue to send notices to members reminding them that it is time for an EPSDT examination.
- Develop and publish articles about adolescent well-care in member and provider newsletters.
- Use of a report of non-compliant members on a monthly basis. Contacts are made with these members to encourage them to obtain their well-care visits.
- Community outreach activities.

The PIP narrative did elaborate on the challenges of engaging adolescents needing well care examinations. The first intervention is actually changing the way that the Health Plan calculates its HEDIS rates, and is not actually a PIP intervention. The remaining interventions are specific to the population defined in this PIP. Some activities, such as mailing welcome packets, regularly occur with all health plan members. The health plan did comment on the difficulty of assessing the effectiveness of mailings. A commitment was made to continue to develop improvement strategies that are not impeded by the barriers identified.

The PIP narrative does include analysis of the health plan's HEDIS rates. The health plan's assessment is that by utilizing the hybrid methodology to calculate this HEDIS measure, Molina was able to significantly improve their rates during the first measurement year. The rates varied by MO HealthNet Managed Care region. In one case there was a statistically significant decrease, although the rate did rebound slightly in 2009. The related improvement is related to the addition of member and community educational events, in addition to the change in the measurement system.

The health plan asserts that they will be able to maintain the improvement achieved, and continue to show improvements in this measure. Although the Eastern MO HealthNet Managed Care region experienced some fluctuation in rates, improvement overall has been achieved.

The education of members and providers contributed to the improved rates. The health plan has continued planned ongoing interventions as they believe there continues to be ongoing potential for improvement.

CONCLUSIONS

QUALITY OF CARE

The best care in the most appropriate environment is the focus of the first PIP. The interventions incorporated methods to ensure that members obtained services in a timely and appropriate manner, which will improve the quality of their lives as well as the care received. There is evidence that Molina is utilizing the PIP process to inform the organization about the most effective methods to improve and provide quality health care. The health plan states a desire to incorporate positive outcomes from the PIP into organizational operations. They articulate plans to use the PIP process to assist in program enhancement and organizational development in an effort to improve member services.

In the second PIP the health plan made an effort to improve their ability to measure the effectiveness of the services they provide, while also improving the quality of care to members. They did improve their reportable HEDIS rate, which they assess as a combination of improved measurement and member and provider education.

ACCESS TO CARE

The focus of the first PIP does address access to care, and it is an overtly stated goal of the project. The intention of the interventions is to ensure that members' have in-home services that provide good health care and education to improve members' quality and access to care. By ensuring that members have access to additional services to prevent more complex and invasive health care, and using an in-home method of providing this services, greatly improves access to care.

The second PIP did create an improved focus on member access to care by providing education for members and providers, and the implementation of community activities that created an opportunity to directly contact members.

TIMELINESS OF CARE

The educational efforts of the first PIP were implemented in an attempt to encourage members to engage in the best self-care possible. Members received in-home treatment regularly as soon as they were home from the hospital. Appointments were made prior to the member leaving the hospital which additionally enhanced the timeliness of care. An attention to provide services quickly and efficiently was an essential component of this PIP.

In the second PIP the issue of timeliness was addressed through the educational efforts and contacts with non-compliant members.

RECOMMENDATIONS

1. The study design of Performance Improvement Projects should link the questions, the interventions, and the proposed outcomes to determine whether or 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. Continue to use monthly and quarterly measurements. This will provide information on the ongoing effects of the planned program. Data analysis should incorporate methods 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. Narrative should also be provided to defend the conclusions and defined outcomes of the study. This will provide justification, particularly if the process is to be an ongoing change in the health plan operations.
4. Create interventions that address the needs of members or that enhance their ability to utilize the services available.

11.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Molina Healthcare. Molina Healthcare submitted the requested documents onor before the due date of March 19, 2010. The EQRO reviewed documentation between March 19, 2010 and June 30, 2010. 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 NCQA RoadMap submitted by Molina Healthcare for the 2009 HEDIS review year.
- Healthcare Research Associates' (HRA) HEDIS 2009 Compliance Audit Report
- NovaSys Health Network, LLC, policies and procedures related to the HEDIS rate calculation process.
- NovaSys Health Network, Molina Healthcare 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 2009 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 Molina Healthcare for review by the EQRO:

- Central_ADV_File 1.txt
- Central_ADV_File 2.txt
- Central_AWC_File 1.txt
- Central_AWC_File 2.txt
- Central_AWC_File 3.txt
- Central_FUH_File 1.txt
- Central_FUH_File 2.txt
- Eastern_ADV_File 1.txt

- Eastern_ADV_File 2.txt
- Eastern_AWC_File 1.txt
- Eastern_AWC_File 2.txt
- Eastern_AWC_File 3.txt
- Eastern_FUH_File 1.txt
- Eastern_FUH_File 2.txt
- Western_ADV_File 1.txt
- Western_ADV_File 2.txt
- Western_AWC_File 1.txt
- Western_AWC_File 2.txt
- Western_AWC_File 3.txt
- Western_FUH_File 1.txt
- Western_FUH_File 2.txt

Initially, all "File2"s submitted by Molina Healthcare contained descriptions instead of valid service codes in the service code field. The MCHP was asked to submit corrected files that included the necessary service codes to allow for proper processing by the EQRO.

INTERVIEWS

The EQRO conducted on-site interviews with Mike Albornos, Director HEDIS Ops, Molina Corp; Jennifer Goedeke, Quality Improvement Manager; and Ainette Martinez (representing Bridgeport Dental) and on Monday, July 12, 2010. A subcontractor, Novasys was responsible for calculating the HEDIS 2009 performance measures of Follow-Up After Hospitalization for Mental Illness and Adolescent Well-Care Visits, and Bridgeport Dental provided the Annual Dental Visit rate. Novasys no longer contracts with Molina for these services.

FINDINGS

Molina Healthcare calculated the Annual Dental Visit and the Follow-Up After Hospitalization for Mental Illness measures using the administrative method. The Adolescent Well-Care Visits measure was calculated using the hybrid method. MO HealthNet MCHP to MCHP comparisons

of the rates of the three 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 reported rate for Molina Healthcare for the Annual Dental Visit rate was 33.38%. This was consistent with the statewide rate for MO HealthNet MCHPs (35.05%, z = -0.64; 95% CI: 22.05%, 32.77%; n.s.). This rate is higher than the rates reported by the health plan during the 2007 and 2008 reviews (30.45% and 30.53%, respectively; see Table 84 and Figure 53)..

The HEDIS 2009 rate for Molina Healthcare for the Adolescent Well-Care Visits measure was 32.37%, which was significantly lower than the statewide rate for all MCHPs (35.63%; z = -0.85, 95% CI: 28.57%, 36.17%; n.s.). This rate was higher than the rate reported by this health plan during the 2007 (29.49%) EQR report, but lower than the rate reported for the 2008 report (34.83%; see Table 84 and).

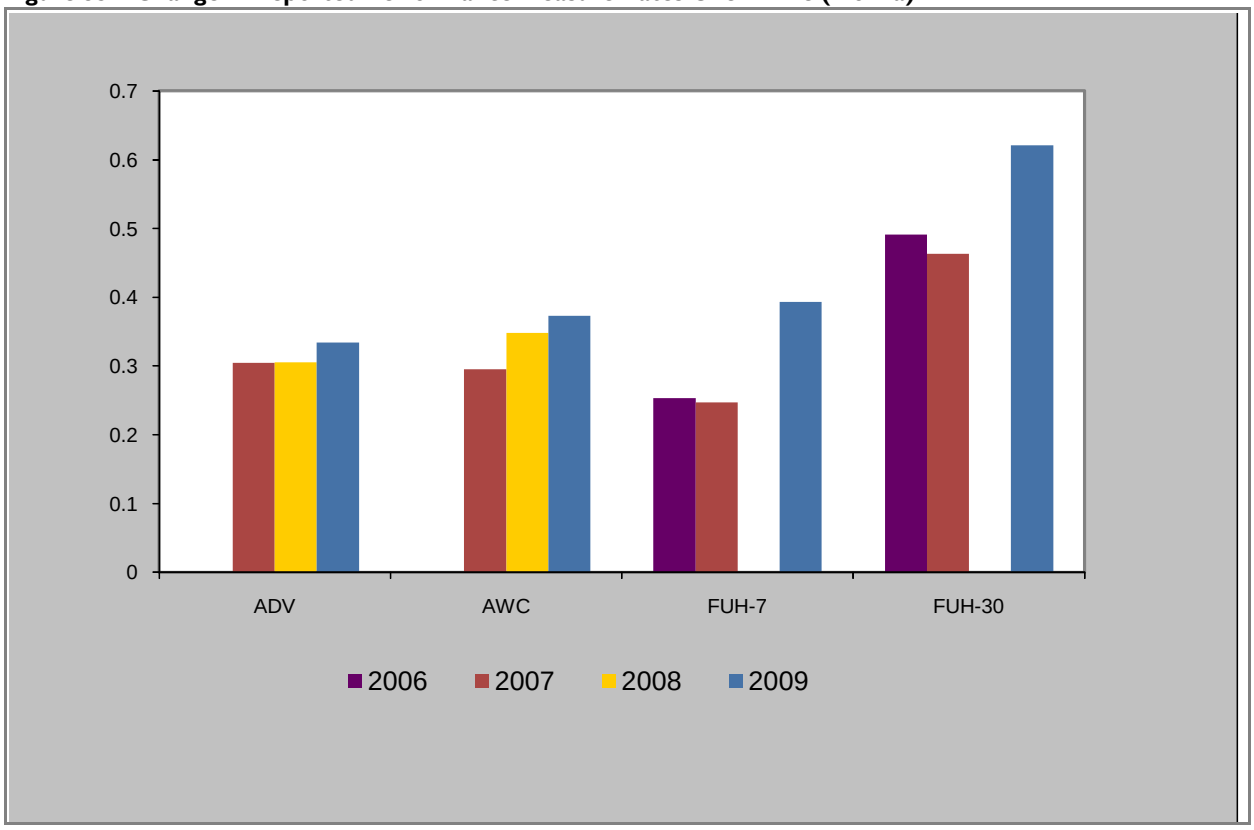
The HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure 7-day rate reported to the SMA and the State Public Health Agency (SPHA) by Molina Healthcare was 36.95%. This rate was consistent with the statewide rate for all MO HealthNet MCHPs (41.59%; z = -0.28, 95% CI: 29.77%, 44.13%; n.s.). The 30-day rate reported was 61.69%, also consistent with the statewide rate (66.46%; z = 2.47, 95% CI: 54.51%, 68.87%; n.s.). Both the 7-day and 30-day rates were higher than the rates reported for HEDIS 2006 (25.30% and 49.10% respectively) and HEDIS 2008 (24.68% and 46.31%, respectively; see Table 84 and Figure 53).

Table 84 – Reported Performance Measures Rates Across Audit Years (Molina)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate
Annual Dental Visit (ADV)	NA	30.45%	30.53%	33.38%
Adolescent Well-Care Visits (AWC)	NA	29.49%	34.83%	32.37%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	25.30%	24.68%	NA	36.95%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	49.10%	46.31%	NA	61.69%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 53 – Change in Reported Performance Measure Rates Over Time (Molina)



Sources: BHC, Inc. 2006, 2007, 2008, and 2009 External Quality Review Performance Measure Validation Reports

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 CMS Protocol 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.

For all three measures, Molina Healthcare was found to meet all 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 Molina Healthcare transferred data into the repository used for calculating the HEDIS 2009 measures. However, none of the data files provided to the EQRO were submitted in the requested data format (eg. tab delimited .txt vs. @ delimited .txt). In addition, the data files were difficult to access; the encryption protocol used to protect the data disk was not accessible from a Windows 7 operating system environment.

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). Molina Healthcare met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

Molina Healthcare 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 EQRO found the age ranges, dates of enrollment, medical events, and continuous enrollment criteria were programmed to include only those members who met HEDIS 2009 criteria.

A total of 38,620 eligible members were reported and validated for the Annual Dental Visit measure.

The Adolescent Well-Care Visits measure contained an eligible population of 1,353.

For the Follow-Up After Hospitalization for Mental Illness measure, a total of 663 eligible members were reported and validated by the EQRO.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate administrative data ranges for the qualifying events (e.g., well-care visits, follow-up visits, or dental visits) as specified by the HEDIS 2009 criteria (see Attachment XIII: Numerator Validation Findings).

The number of Annual Dental Visit hits reported by the health plan was 12,890; the EQRO was able to validate a total of 12,868. The rate reported by the health plan was 33.38% and the rate validated by the EQRO was 33.32%; this resulted in a 0.06% estimated bias (overestimate) by Molina Healthcare.

For the Adolescent Well-Care Visits measure, Molina Healthcare used the Hybrid Method of calculation. Of the 30 medical records requested, 29 were received; all 29 of these were able to be validated by the EQRO. As a result, the medical record review validated 89 of the 92 hybrid hits reported. The health plan reported 346 administrative hits; of these, the EQRO was able to validate 346. Thus, the rate validated by the EQRO was 32.15% and the rate reported by the health plan was 32.37%, resulting in a bias of 0.23%, an overestimation of the rate by the health plan.

The Follow-Up After Hospitalization for Mental Illness measure 7-day rate contained a total of 245 administrative numerator events reported, of which 243 were able to be validated by the EQRO. Thus, the 7-day rate validated by the EQRO was 36.65%, and the rate reported for this measure by the health plan was 36.95%. This indicates a bias (overestimate) of 0.30%.

The 30-day rate showed reported administrative hits of 409; the EQRO was able to validate 407. This yields a reported rate by the MCHP of 61.69% and a validated rate of 61.39%, a 0.30% overestimation bias by the health plan.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Molina Healthcare 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 shows the estimated bias and the direction of bias found by the EQRO. All three measures reviewed were slightly overestimated, but these results still fell within the 95% confidence interval reported by the health plan.

Table 85 - Estimate of Bias in Reporting of Molina HEDIS 2009 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.06%	Overestimate
Adolescent Well-Care Visits	0.23%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	0.30%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	0.30%	Overestimate

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 86 - Final Audit Rating for Molina Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially 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 health plan. 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 MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the health plan. Two of these rates were consistent with and one was significantly lower than the average for all MO HealthNet MCHPs.

QUALITY OF CARE

Molina Healthcare's calculation of the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. Molina's rate for this measure was consistent with the average for all MO HealthNet

MCHPs. The 7-day rate was lower than both the National Medicaid and National Commercial averages; the health plan's members are receiving a lower quality of care than the average Medicaid or Commercial member across the country in the 7-day timeframe. The 30-day rate was at the National Medicaid average and below the National Commercial average; the health plan's members are receiving the same quality of care as the average Medicaid member across the nation, but a lower quality of care than the average Commercial member in the 30-day timeframe. However, these rates are higher than the same health plan's reported rates during the HEDIS 2006 and 2007 audits, showing that the quality of care provided to members has improved.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

ACCESS TO CARE

Molina Healthcare's calculation for the HEDIS 2009 Annual Dental Visit measure was substantially complaint with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The rate reported by Molina for this measure was consistent with the average for all MO HealthNet MCHPs. Molina's members are receiving a quality of care that is consistent with the care delivered to the average MO HealthNet Managed Care member. This rate was higher than the rates reported by the health plan during the 2007 and 2008 EQR audits. However, the rate was lower than the National Medicaid average rate, indicating the health plan's members are receiving lower access to care than the average Medicaid member across the country.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

TIMELINESS OF CARE

Molina Healthcare's calculation of the HEDIS 2009 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. Molina's reported rate for

this measure was significantly lower than the average for all MO HealthNet MCHPs. Therefore, Molina's members are receiving a lower timeliness of care for this measure than the average MO HealthNet MCHP member. This rate was lower than the rate reported in 2008 but higher than the rate reported for the same measure in 2007. It was also below both the National Medicaid and National Commercial averages; the health plan's members are receiving a lower timeliness of care than the average Medicaid or Commercial member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. Continue to utilize statistical comparisons of rates from one year to another to assist in analyzing rate trends.
2. Continue the use of medical record review (when allowed by HEDIS specifications) as a way to continue to improve reported rates.
3. The health plan's rates for both timeframes of the Follow-Up After Hospitalization for Mental Illness measure were substantially higher than the previously audited rates. The health plan should explore reasons for this increase trend and make every effort to apply similar practices to improve other rates.
4. The health plan should review the procedures and interventions in place for the Adolescent Well-Care Visit measure to attempt to determine why the rate decreased over the past audit year and work to reverse this decline.
5. Work to increase rates for all measures; although most measures were consistent with the average for all MO HealthNet MCHPs, they were below the National Medicaid averages.
6. Molina Healthcare should thoroughly review both the data request format file and the resultant data extract files for accuracy prior to submitting data to the EQRO. This will ensure that the EQRO receives the most complete data possible for validation.
7. If data requested by the EQRO is to be encrypted prior to submission, the health plan needs to ensure the encryption is accessible in a Windows 7 environment.

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 200,992 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant 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, 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, accurate, and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.0% complete, accurate and 97.40% valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, all of these areas fell well below the 100% threshold set by the SMA. The completeness, accuracy, and validity of the second, third, fourth, and fifth Diagnosis Code were 34.16%, 33.71%, 13.75%, and 0.00% respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 34,861 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there was ten (10) encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All critical fields examined were 100.00%

complete, accurate and valid. However, the completeness, accuracy, and validity of the second, third, fourth, and fifth Diagnosis Code were 80.00%, 40.00%, 20.00%, and 0.00% respectively.

For the Inpatient claim type, there were 3,193 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant 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 valid.
5. The Discharge Date field was 100.00% complete, accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Discharge Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100% complete, accurate and valid.
9. The remaining Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA. The second, third, fourth, and fifth Diagnosis Code fields were found to be 73.60%, 57.94%, 45.73%, and 35.11% complete, accurate, and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate, and valid.
11. The Last Date of Service field was 100.00% complete and accurate, and valid.
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 88,545 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant ID field was 100.00% complete, accurate and valid.
4. The First Date of Service field was 100.00% complete and accurate, and valid.
5. The Last Date of Service field was 100.00% complete and accurate, and valid.
6. The Units of Service field was 100.00% complete, accurate and valid.
7. The Outpatient Procedure Code field was 100.00% complete and accurate, and valid.
8. The Revenue Code 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 all fell well below the 100% threshold set by SMA for completeness, accuracy and validity. The second, third, fourth, and fifth Diagnosis Code files were 49.71%, 32.30%, 17.4%, and 7.1% respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 130,989 claims paid by the SMA for the period July 1, 2009 through September 30, 2009. 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 Molina, 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.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Molina demonstrated comparable rates to the average for all MO HealthNet MCHPs for all Claim Types.

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 MO HealthNet MCHP were randomly selected from Medical claim types for the period of July 1, 2009 through September 30, 2009 for medical record review. Of the 324,408 Outpatient encounter claim types in the SMA extract file for July 1, 2009 through September 30, 2009, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 92 medical

records (92.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated.

For the 2007 review, the match rate for procedures was 54.00%, with a fault rate of 46.0%. The match rate for diagnoses was 41.0%, with a 59.0% fault rate.

For 2008, the match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 46.0%, with a 54.0% fault rate.

For 2009, the match rate for procedures was 69.0%, with a fault rate of 31.0%. The match rate for diagnoses was 63.0%, with a 37.0% fault rate.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure, diagnosis, drug name, and drug quantity was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing (n = 33), incorrect (n=2) and upcoded (n=2).

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 upcoded codes (n = 4). 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 MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Molina included internal control numbers that matched those of the SMA, the planned analysis of comparing MO HealthNet MCHP encounter data to the SMA encounter claim extract file was performed. The SMA defined "unpaid claims" as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.
For all claim types, the health plan only submitted claims with a status of "paid". The EQRO

matched all of these claims to the files contained in the SMA database. Thus, 100.00% of the Molina submitted encounters matched with the SMA encounter records

What Problems are there with How Files are Compiled and Submitted by the MO HealthNet MCHP?

The analysis of comparing Molina encounter data to the SMA encounter claim extract file was conducted based on the file submitted by Molina that contained all claims for the selected sample of DCNs. While Molina did submit the data in the requested format (see Appendix 7) for the MO HealthNet Managed Care Members represented in the encounter claim sample selected by the EQRO for validation, there were no unpaid or denied claims submitted. There were no unmatched claims that were in the Molina encounter file and absent from the SMA data. Thus, 100.00% of the Molina submitted encounters matched with the SMA encounter records.

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

There are no data quality issues specific to this MO HealthNet MCHP. The data quality issue that continues to be a challenge for the EQRO is the lack of a unique identifier to match unpaid or denied claims to claims data present in the SMA database.

CONCLUSIONS

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 MCHP 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, Pharmacy and Inpatient claim types were 100.00% complete, accurate and valid.

4. The critical fields examined for Outpatient Hospital and Outpatient Medical were 100% complete and accurate.
5. Data was submitted in the requested format for encounter validation and all claim types were accessed.

AREAS FOR IMPROVEMENT

1. Molina did not submit any claims with an "unpaid" or "denied" status.
2. Molina did not have any rates of encounters "significantly higher" than the MO HealthNet All Plan rate.

RECOMMENDATIONS

1. The health plan 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. The SMA should 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. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis. Consider having records shipped to the plan from the provider prior to sending them to the EQRO, as numerous incomplete records were received, which also contributed to the analysis.

11.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet MCHP's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). This ensures that each MO HealthNet MCHP's documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations. Prior to the on-site review Case Management cases were reviewed by the EQRO for compliance with policy and to ensure that practice reflected policy requirements. On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. Interviews occurred with Case Management Staff, and separately with the Administrative Staff to ensure that the practices in place are within the scope of the contract and are conducted in a manner that meets or exceeds the federal regulations.

Initial interviews were conducted with the Case Management Staff. These interactions and responses were compared to policy requirements and to the SMA's Quality Improvement Strategy. The Administrative staff was interviewed separately. These interviews answered questions regarding compliance with the requirements of the Quality Improvement Strategy and validated information received from the direct services staff.

The interview questions posed to Case Management staff were generated by the cases reviewed as well as the review of Health Plan Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the Health Plan processes. Additionally, interview questions were formulated for Administrative staff to validate and clarify these practices, to follow-up on questions raised from the case management staff interviews, and to respond to questions that arose from the document review. These interview questions were developed from the Molina's 2009 Annual Evaluation and the SMA's Quality Improvement Strategy.

Document Review

The following documents pertaining to Molina 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)
- Molina HealthCare of Missouri Annual Evaluation FY 2009

The following documents were requested and reviewed on-site:

- Member Handbook
- 2009 Marketing Plan and Materials
- Provider Handbook
- 2009 Quality Improvement Committee minutes
- Complex Case Management Policy

Additional documentation made available by Mercy CarePlus included:

- Organizational Chart
- Wellness Handbook
- General Case Management Assessment Tool
- 2010 Quality Initiatives

Documents reviewed indicated that the Health Plan is moving toward NCQA accreditation and indicated a significant change in quality focus.

INTERVIEWS

Interviews were conducted with the following groups:

Case Management

April Gross – Clinical Care Coordinator
Martha Stauder – Complex Case Manager
Burnette Cothrine – Complex Case Manager
Kathy Osborne – Complex Case Manager
Rachel Meisel – UM Specialist

Plan Administration

Joanne Volovar – Plan President
Robert Profumo, MD – Chief Medical Officer
Jennifer Goedeke – Director, Quality Improvement
Bonnie Vielwever – Director, Member Services
Janet Conners – Director, Enrollment Growth
Lovey Barnes – Director, Government Contracts
Cherie Brown – Manager, Case Management

Case Management Interviews

- Explain how the health plan office is organized, and how case management fits into the organization. Where is complex case management in this process? How is it related to other activities, including utilization management?
- Tell us about the referral process.
- Do you have a routine or script you utilize in discussing case management activities with members?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- Policy continues to state that all OB members receive case management. Does this still occur? Where are assessments located? How do you recognize the level of services that should be offered to individual members?
- Explain the relationship, similarities and differences, between the assessment and claims review processes?
- Did the cases sent for review come through the Clinical Care Advisory System?
- Complex case management calls for the development of an individualized plan of care based on evidence, such as clinical care guidelines. How does this work?
- How are assessments and plans of care captured? These were not included in the cases sent for review.

Findings

The cases reviewed for Molina HealthCare indicated a degree of case management services, but lacked depth, detailed case management information, assessments, or plans of care. There were notes included that addressed specific episodes of care. Prior authorization requests and other ancillary information were interspersed throughout the records. Intermittent contacts were also included. One pregnant member was identified as scheduled for a Cesarean section. She was described as diabetic, obese, having recurring infections, and hypertension. The case information included no formal assessment, plan of care, or follow-up information. There were very few case notes, and it was never clear what services the member received.

It appeared that members were mainly identified for case management through claims data. After this identification is made, the member is informed that they are in case management. In one case there was a note that the referral was received from a utilization review nurse.

Another case example included a member who was diagnosed with sleep apnea, and was provided a Bi-Pap machine. He was also diagnosed with diabetes. There was no indication of additional or follow-up services. A number of cases included information about services

requested and reviewed, but no outcomes or follow-up services were identified, and no notes from these cases were included. Case managers explained that in cases during 2009 there was a lack of case notes. They are now working with a new software system that includes space for extensive documentation, assessments, follow-up reminders, and other tools that allow them to record all information and all activities that occur.

The case managers report that they carry cases throughout the state. They are all considered complex case managers. They provide the degree of services required for each individual member. This can range for simple care coordination to management of very complex services from a variety of providers. There is a specific case manager assigned to work with foster families in the Jackson County area. She ensures that all information in a case is correct. This review includes whether the member has an identified PCP, chronic illnesses, and coordinated care with mental health providers. The review also helps determine that equipment needs are met and special diets, home health care, and dental needs are met. The Case Manager will also ensures that appropriate referrals are made, such as to WIC and Parents as Teachers.

The lead case manager works with the local health departments in Jackson County and the St. Louis area. She ensures that members receive referrals to outside agencies, such as Citizens Advocates or Catholic Charities, if they need alternative housing or more in-depth assistance. Although she has found that the urban health departments are very active in remediation of lead problems, the rural health departments are also involved, and are willing to provide any assistance and resources they have at their disposal.

The OB case managers have their case loads distributed by alphabet. When they work with an OB case, they provide all services required during their involvement with a family. They stratify cases based on their assessed level of risk.

The case managers described the process for identification of cases needing case management, as coming from any available source. After receiving a referral they look for additional information from every available resource. The case managers review claims and medication utilization in an attempt to inform the member's needs assessment. In addition to their contacts with members they contact all providers and review the Medical Transportation Management (MTM) data base to determine the services members have utilized in the past. The case

managers also receive referrals from BioMed, the health plan's call center. BioMed begins the assessment process with OB members and collects initial information to assist in completing member assessments.

The development of a plan of care is then reviewed. The provider and member are included in this process. The case managers report that they contact the members several times at the beginning of their relationship. The first contact is made to explain case management services, then to initiate the assessment process, and then they complete the care plan development. They do not want to overwhelm members with information. If a case is emergent, this process occurs quickly, but in most instances a more tempered approach allows the case managers to engage the member and build a strong relationship with them. The case managers complete barrier analysis and provide information on available services and resources. Referrals are made to MH Net any time a mental health issue is identified.

The case managers reported that they utilized their prior case management system for approximately five years (2004 – 2009). Forms and notes outside of the system supplemented information about members. They are very pleased with their new case management software as it allows them to record all information and have it at their disposal. They are aware of the move to NCQA certification and believe the new standards are beneficial to members. The new formal assessment process is considered an essential component of the service delivery system.

The case managers report that they appreciate having all member information available in one place, and it allows them to openly demonstrate their compliance with information requirements. The new system also allows the case managers to input information about housing, mental health, life planning, social issues, educational information, and cultural and linguistic needs. This system became fully operationalized in April 2010.

The case managers related that Care Advance is the corporate member that provides disease management services. Depending on assessed risk, the member receives mailed information and educational materials. In some cases regular telephone contact is maintained. In high risk cases, actual case management services are requested and co-management can occur.

The case managers also shared that if they have a high risk case, and a member cannot be reached, the health plan utilizes a company that will go to a member's residence and leave information for the member. This includes information on the case management program, with a request that the member call the health plan. The case managers estimate that their caseloads average 50 to 65 members.

The case managers also report that they do make visits to the FQHCs and occasionally accompany provider relations staff to physician offices. They actively work with community resources such as WIC offices, Boys and Girls Clubs, and Catholic Charities. They work with staff and agencies in all three MO HealthNet Managed Care regions.

Administrative Interviews

- What improvements have been made in informing members about community providers and resources?
- What is the status of credentialing policy?
- Discuss the health plan's relationship with MH Net.
- Emergency Room usage has been a chronic problem addressed by the health plan. Are there any current initiatives in relation to this issue?
- How is the health plan dealing with the issues of providers with closed panels?
- What issues is the health plan experiencing in serving all three MO HealthNet Managed Care regions?

Findings

The health plan reports that one issue they have experienced since utilizing the Cyber Access system is that case managers have to access the system by region. This takes an inordinate amount of time and makes it more difficult to follow members. The health plan staff also mentioned that when a member changes health plans, the Cyber Access system drops them prior to the actual termination date. This creates a lack of necessary information in a number of instances. Another issue they have experienced is a lack of information on members if they are changing health plans and moving into Molina. If the system identified the new health plan, prior to the change date, the case managers could facilitate a better transition for members. The case managers try to maintain a positive working relationship with other health plans, but a lack of information makes the process of accepting a new member more difficult, and inhibits information sharing for the members they are losing.

The health plan reports that they are continuing to work at meeting the cultural and language needs of all members. They now have Spanish and Bosnian speaking staff. If information is needed in alternative languages they utilize Language Access Metro Project (LAMP) for interpretive services. This is available to all provider offices as needed.

The health plan reports that their relationship with MH Net is continuing to improve. MH Net has two specialists assigned to the health plan who assist case managers and members in obtaining needed services. They are continuing to work with MH Net on communicating with PCP offices for members receiving mental health services. They have found some improvement in this area, but continued work is needed. They are conducting meetings with the subcontractor at least quarterly, to discuss these issues.

Overall provider availability, and after hours requirements, are areas the health plan is actively working to improve. They have conducted after-hours cold calls to provider offices, and initiated corrective action plans whenever necessary. They report that they do have some providers with closed panels. The provider representatives are maintaining score cards on all providers to track progress and to ensure that there are enough available providers in specific areas. The health plan has seen a significant improvement in availability in rural areas. They are continuing to do recruitment in North Kansas City, and for OB providers throughout all regions. The provider services unit maintains a provider grid to show where providers are needed. The health plan is positive about expansion and believes they are adequately serving members in all three regions.

The health plan did discuss their efforts to impact the misuse of emergency rooms by members. Utilization Management staff held a quality meeting with providers to discuss the issue. Actions have been put in place that include an agreement that the emergency room staff will contact Molina Healthcare after a member's first visit. They then contact the member to provide education regarding their PCP hours, available urgent care centers, and any other resources that may be required. The health plan continues to explore new and creative approaches to impact this issue.

ENROLLEE RIGHTS AND PROTECTIONS

Molina continued its efforts to track and monitor all policy required to be submitted to and reviewed by the SMA. This included policy and procedures for initial and annual approval, as well as marketing materials. Additionally, the health plan 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 and the Annual Marketing Plan was compiled and shared during the on-site review.

The Member Handbook was approved by the SMA and continues to be recorded in a 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 Molina. The health plan reports receiving a number of calls every month that required interpretive services, these calls have been handled in a routine manner.

Training is regularly provided to ensure that the Molina staff is knowledgeable about members' rights and responsibilities. Examples of potential issues and problems were discussed, and were used to generate thought and discussion about appropriate problem solving strategies. Staff is also given self-help materials to utilize in their daily activities.

Molina understands the need to enhance case management services to members with special needs. They review a number of sources to identify members in need of case management, including the State supplied report of members who potentially have special health care needs, and provide them with individual attention as quickly as possible. Case managers provide direct services and track all pregnant members. Pregnant members receive varying levels of case management services, based on an assessed level of risk. The members with a moderate or high level of risk receive enhanced case management throughout their pregnancy and post partum with the goal of reducing the number of low birth weight babies. The rate of Obstetrical Case Management has increased across all three MO HealthNet Managed Care Regions. The health plan has tracked statistics indicating that babies born at 28 to 36 weeks are living, which has increased the number of newborn inpatient days in the hospital.

Case managers reported receiving referrals from a variety of sources. These include Member Services staff, Pre-authorization staff, providers, the SMA system, concurrent review nurses, behavioral health case managers, and members. They explain that any member with a need for help is considered for case management. Any member identified as having a need for additional service, or requiring follow-up care is referred for complex case management. These additional services may be hospice care, complex OB cases, or children who are seriously ill, such as requiring a ventilator full time. The case managers do outreach. They go to care conferences, and to physician offices to promote case management.

Case managers also described their efforts to decrease inappropriate use of Emergency Room services. They contact members to discuss information from ER visits within twenty-four (24) hours of the visit. The case managers find that they do have success in assisting members with finding urgent care centers and in making PCP appointments in a timely manner. When talking with members they discuss the use of the Nurse-Advice line as an alternative to visiting the ER. The case managers review all calls to ensure that there is no conflict and that members are visiting the Emergency Room appropriately.

Case managers were asked to describe typical activities with members. They described their role as providing member support, particularly in finding the correct health and ancillary resources to help the member meet their healthcare needs. These activities were described as "the foundation of case management" at Molina. The case managers provide community resource guides, make referrals, ensure that members have access to appropriate providers, and that they are aware of additional services such as WIC, and transportation. The families of infants, specifically NICU babies, are referred to an array of community services such as Parents as Teachers (PAT), which provides in-home services. Each member receives a resource guide with their Welcome Packet. The case managers also attend public events to educate members about the case management services available through the health plan. They also visit PCP offices and attend care conferences whenever possible.

The case managers did discuss that members have the right to accept or refuse both case management and any medical treatment offered. They make every effort to ensure that members have access to special services and required medical treatment. They also provided examples of the methods they utilize to ensure that members are aware of their right to have an

impact on treatment planning. These staff exhibit a clear commitment to the members they serve.

The rating for Enrollee Rights and Protections (100.0%), reflects a maintenance of this rating for the third consecutive year. This indicates that Molina continues to exhibit success in their efforts to have approved written policies and procedures, and to exhibit activities that indicate that services are available to members. Before a final determination was made consideration was given to the case record reviewed, and the records viewed on-site. The quality of the current records, added to the quality of the conversation with the case managers, allows the ratings to remain at its high level. Molina maintains a business-like approach and commitment to continued efforts in meeting all standards of policy development, submission and approval by the SMA.

Table 87 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Molina)

Federal Regulation	Molina		
	2007	2008	2009
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii)and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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.

Behavioral Health

MHNet is the Behavioral Health Organization (BHO) that subcontracts with Molina for mental and behavioral health services for members. This was the third full year of the BHO's relationship with Molina. The health plan reported no specific problems occurring in terms of members accessing services during the 2009 program year. The BHO makes an effort to assist members in obtaining timely access to services. Members are encouraged to contact the BHO to make appointments, particularly if they have contacted providers directly without success. Providers are listed on the BHO website in an effort to ensure that members have access to this information. The health plan reports that the BHO has developed an adequate provider network in all three MO HealthNet Managed Care Regions. The BHO continues to make an effort to improve coordination between behavioral health providers and the member's primary care physician. They are committed to continuing improvement in this area.

Quality Assessment and Performance Improvement

Access Standards

Molina continues to make improvements in the area of access standards during 2009. The health plan reports that they continue to improve their feedback to providers. This, in turn, enhances services available to members. Other changes that occurred include the use of InterQual Guidelines, improved corporate guidelines for provider interactions, and concurrent review guidelines. These updates were developed to improve services to members, meet community needs, and to interact more effectively with providers.

Molina staff measured member 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 health plan's system. All authorizations are tracked and monitored. The health plan reports that there is a system in place to ensure that communication with providers is efficient and that members obtain needed services in a timely manner. Molina has decreased the timeframes for responding to authorization requests. Tracking and trending of information occurred and is reviewed on a monthly basis.

Administrative staff report that case managers are not experiencing problems finding PCPs with open panels that are willing to serve Molina members. Most providers agree to see siblings of children who are already members or patients. PCP assignments are done with the consultation of the member whenever possible. If auto assignments are required, distance is the main consideration. Direct contact with physicians to assist members with appointments is made whenever necessary. The health plan reports adding physician groups in all three MO HealthNet Regions. These additions have enhanced the Health Plan's ability to serve all MO HealthNet members. They also state that their new member management system will assist with providing up-to-date and accurate information directly to the case managers. Case managers report that if they are having difficulty locating a physician for a specific member, they ask for assistance from Member Services who spends time finding an office for the member that is agreeable to them. This example is one of several received during the on-site review that exhibits the integrated nature of the work done a Molina HealthCare.

Molina admits that they are continuing to work to have a complete network of specialty providers, particularly pediatric neurologists, rheumatologists, and orthopedic surgeons. The health plan does negotiate for these services because the Provider Relations staff has developed individualized relationships with providers. They did report paying orthopedic surgeons 100% of billed charges. They also discussed contracting with an entire provider group in the Central Region at a rate that allows them to have a complete array of PCPs and specialists available to members.

The health plan continues to assess provider availability annually when producing their report to the Missouri Department of Insurance. The health plan has improved the availability of 24-hour coverage by providers, as required in their MO HealthNet Managed Care Contract. They continue monitoring activities that include review of provider telephone logs, blind telephone testing, and obtaining input directly from providers. The health plan continues provider education. They report that they are contracted with all of the Federally Qualified Health Centers (FQHCs) in the three MO HealthNet Managed Care regions. This effort improved daytime and some after-hours access.

Case managers discussed their efforts to ensure that members have access to all the services required, specifically for members with special health care needs. They encourage members to

utilize the nurse help line and educate them on all health care resources that are available. The case managers contact providers, review utilization, and participate in treatment planning to ensure that members have access to all required health care services. The case managers explained that the member supplies the information necessary to develop a treatment plan, and the case manager ensures that there are no gaps in providing treatment services. Coordination of services, with medical providers, and with behavioral health services, is an essential component of this process.

A rating for Compliance with Access Standards (100.0%) is an improvement over the 2008 rating of 88.2%. During the 2008 report interviews, it was learned that the areas of care coordination and treatment planning had not been fully operationalized. This has now been accomplished. The demonstration viewed during the on-site review validates that current case records reflect all care coordination and care plan requirements. Molina is continuing efforts to ensure that all required policy is in place, and is approved by the SMA. Observations made at the time of the on-site review indicated that strong efforts are being made to maintain full compliance.

Member Services has two Spanish and one Bosnian speaking staff members. They have one staff member who speaks four (4) languages including German. The health plan believes they have adequate diversity and provide members enough alternatives to be comfortable when contact is made.

Table 88 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Molina)

Federal Regulation	Molina		
	2007	2008	2009
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	15	17
Number Partially Met	0	2	0
Number Not Met	0	0	0
Rate Met	100.0%	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., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Molina continues to develop their credentialing standards. They report that credentialing of providers involves the review of the history of complaints regarding any specific activity related to members. The health plan is following NCQA guidelines regarding the credentialing process. They complete follow-up visits to physician offices if specific interventions are required. The Credentialing Team looks at all trends regarding adverse events, reviews records, and implements a corrective action plan if necessary.

Provider Relations staff visits all provider locations, including delegated providers, to ensure that they are meeting all requirements. The health plan continues to provide in-service training to larger providers as required. Utilization Management staff and case managers also visit provider offices to discuss issues and services directly. The health plan assured that all 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 Molina HealthCare to maintain current licensure information. They maintain a work plan to ensure that the provider list is current regarding all credentialing issues. Delegated credentialing is granted to the SSM hospital system and to the BHO MH Net. Certification of the delegated credentialing is completed by Source One.

Molina continues to create a more rigorous approach to training than in previous years. This change was implemented to ensure that staff is aware of new policies and procedures. The health plan relates that improved training initiatives led to improved services and enhanced interdepartmental communications.

In addition to care coordination, case managers discussed the use of practice guidelines and other information used to ensure that special issues are addressed in serving members. The case managers do work with the Utilization Review section and with the concurrent review nurses to ensure that all members receive the health care services needed.

The rating for Structure and Operation Standards (100%) reflects the submission and approval of policy to the SMA, as well as the ability to validate the existence of operations supporting this policy. The health pan understands that continued efforts in this area of practice will be needed.

Table 89 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Molina)

Federal Regulation	Molina		
	2007	2008	2009
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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.

Measurement and Improvement

Molina maintained specific practice guidelines with providers at the time of the 2009 review. They have instituted the National Heart, Lung, and Blood Guidelines for asthma care for adults and children. NIH clinical guidelines and Kansas City guidelines were adopted for several other areas of healthcare delivery. This information and methods to utilize these guidelines have been distributed to all providers.

Molina reports that they are in the process of modifying and improving the Quality Improvement Committee (QIC) structure. They are developing smaller groups with specific responsibilities that report to the larger QIC. The committees all monitor various data, such as that gathered through the Performance Improvement Project (PIP) process, satisfaction surveys, and HEDIS rates. They hope to clarify the mission of each group, and assist the subcommittees focused on specific topics to review. The explanation of the new structure revealed a strong

commitment to the Quality process. The operations and specific roles and duties are under development. The health plan's goal of providing quality services to members was the focus of the group's discussions. Administrative staff viewed this initiative as having a positive effect on the performance and focus of the health plan. The health plan hopes to use this information to ensure that all members have adequate access to health care services.

Molina submitted two Performance Improvement Projects (PIPs) for validation. Although these PIPs lacked complete maturity, they indicated substantial improvement in utilization of this process as a tool for health plan growth. The health plan did provide their current Quality Initiative plan, which clearly indicated their commitment to this process. The structure of both PIPs followed the federal protocol and showed a great deal of potential. These PIPs indicated an increased degree of understanding of the importance of the PIP process in improving health plan operations and health care services to members.

The health plan submitted all required information to complete the Validation of Performance Measures for all three measures, as requested. The specific outcomes of the Performance Measure are discussed in the appropriate section of this report. Molina continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The complete details of each of these areas of validation can be reviewed within specific sections of this report.

The rating for Measurement and Improvement (90.9%) reflects a continued diligence toward meeting the requirements of the MO HealthNet Managed Care contract and federal regulations. These policies and procedures are in place. Continued improvement in the area of completed Performance Improvement Projects is a stated goal of the organization.

Table 90 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Molina)

Federal Regulation	Molina		
	2007	2008	2009
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	1	1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	10	10
Number Partially Met	0	1	1
Number Not Met	0	0	0
Rate Met	100.0%	90.90%	90.90%

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 MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable tot the MO HealthNet 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

Molina has approved policy and procedures for their Grievance System compliant with MO HealthNet Managed Care contract requirements and federal regulations. The health plan put processes in place to capture member and provider contacts. They continue to report that they are working smarter and have 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. The health plan developed an on-line tracking system that contributes to timely responses in the complaint, grievance and appeal process.

Case managers were aware of the health plan's grievance and appeals process. They related that they are often contacted when an authorization is denied and the member receives this information in writing. They then coach the member about the process and further available actions. They also attempt to provide an explanation of the decision. The case managers advocate for the members through this process, including directly contacting the Medical Director for further input and assistance in the decision review.

The administrative staff reported that many provider grievances concerned balanced billing issues. There is a new supervisor for complaints and grievances. New staff has been hired to ensure that both member and provider issues are handled efficiently. The supervisor is auditing all grievance files, and ensuring that the processes used are in compliance with NCQA standards. A third level of review is planned for the Medical Appeals Section within the Health Plan.

The rating for the Grievance System (100%) reflects approval of the health plan's policy and procedures required to meet MO HealthNet Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that Molina was meeting all requirements of operating a functional Grievance System for both providers and members.

Table 91 – Subpart F: Grievance Systems Yearly Comparison (Molina)

Federal Regulation	Molina		
	2007	2008	2009
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	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

CONCLUSIONS

Molina was substantially compliant in all areas measured in 2008. In 2009 there is only one area that remains rated as "Partially Met." This reflects improvements in practice that were observed during the on-site review. These changes and enhancements are focused on improving services to members, and improving their quality initiatives. At the time of this review improvement in many areas of performance were observed. Molina continues their commitment to members and to providing healthcare services in an effective manner by demonstrating an atmosphere of respect and dignity toward members. The health plan's efforts to become fully compliant in both having approved policy and verifiable approved practice is evidence of their continuing efforts toward growth and development within the organization. These improvements will provide a sound foundation for continued efforts to make the changes required to achieve and maintain full compliance in the future.

QUALITY OF CARE

During the previous on-site reviews Molina recognized the need to continue to improve the development of policies and procedures, and to continue to review and upgrade their organization's performance. They currently exhibit the commitment to these goals, and provided sound examples of the progress made during 2009. These discussions took place in the context of providing quality care and services to members. The health plan exhibits a distinct recognition of the importance within the organization of the need for clear communication between departments to effectively meet members' service needs. Quality services at the health plan and provider levels were evident in the information presented. It should also be noted that Molina HealthCare maintains a system of regular direct contact with providers. Provider Relations staff makes regular in-person visits, at approximately six week intervals, to provider offices. This enhances the quality of relationships between the health plan and their providers, enabling them to troubleshoot, educate, and ensure that members receive the healthcare services they require. It is also recognized that the case managers are integrally aware of how their department interacts with and are supported by the other departments within the organizational structure. This enhances the staff's ability to serve members in an efficient and quality manner.

ACCESS TO CARE

Molina did make a number of changes during the past two years to improve access to care for members. They were able to contract with a number of hospitals and physician groups that were previously not in their network. Their provider panel has expanded in the availability of primary care physicians and specialists. The health plan instituted a method of contacting primary care physicians for members when members experience problems obtaining appointments. All of these activities, as well as improvements in training and additions in resources for case managers have created an atmosphere where assuring access to care is an essential aspect of the Molina program.

TIMELINESS OF CARE

An attention to the issue of timeliness of care was also evident at the health plan. They have improved significantly in the area of timely and complete policy submission. Changes and improvements of internal processes have also made timely response to member and provider issues a priority. Timeliness of healthcare improved as the result of changes and expansions within the organization. Case managers report that timely and adequate health care services are of primary importance in their involvement with members. These staff gave concrete examples of making direct contact with providers to ensure that appointment and services were delivered in a timely manner to illustrate this as an essential value supported by Molina.

RECOMMENDATIONS

1. Maintain improvements in the area of development and submission of policy and procedures for SMA approval. This is an important factor in establishing continued confidence in the health plan's operations.
2. Continue to develop and enhance the Quality Improvement program within the Molina HealthCare.
3. Continue to utilize the new case management system to ensure that treatment planning and care coordination reach optimal levels of operation and are adequately documented.

4. Continue to support front line staff in their efforts to be primary advocates for members and to provide an atmosphere based on the desire to excellent healthcare services to members.
5. Continue to utilize available data and member information in order to drive, change, and measure performance.